Results of Consultation:
Older Driver Safety Advisory Committee
Improving the safety of older drivers
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EXECUTIVE SUMMARY

It is projected that the number of older Australians aged 75 years and over will increase to 11.4% of the population by 2031, up from 6.2% in 2007 (an 83.9% increase). A similar pattern is projected for Queensland. This will result in an increase in the number of older drivers, who will either seek to maintain the mobility provided by the car, or need to make decisions about giving up driving and moving to other transport modes. It is therefore expected that older drivers will make up an increasing proportion of the road toll in the future. Accordingly, there will be an increasing need to focus attention on reducing the risk of older road users in crash involvement.

The Older Driver Safety Advisory Committee (ODSAC) was convened in July 2011 to provide the Government with input to the development of appropriate policies and initiatives to improve older driver safety outcomes in Queensland.

To assist the Committee, the Centre for Accident Research and Road Safety – Queensland (CARRS-Q) was engaged to provide a detailed research report on older driver safety, including: a detailed literature review; current Queensland policy compared with approaches in other jurisdictions; a review of Queensland crash statistics for the five year period 1 July 2004 – 30 June 2009; and identification of potential initiatives for improving older driver safety in Queensland.

The Committee reviewed CARRS-Q’s report and discussed the potential initiatives within their organisations. The Committee then met for a workshop and agreed upon 26 recommendations relating to:

- the age at which older driver requirements (including medical certificates) are imposed;
- frequency of driver licence renewal;
- reinstatement of vision testing at in-person driver licence renewal;
- widening the range of professionals who can report to the Department of Transport and Main Roads (TMR) with legal protection;
- restricted licences;
- on-road retesting for selected drivers;
- encouraging family involvement;
- providing a road environment which is safer for older drivers;
- attitudes towards speeding behaviour;
- reviewing speed limit criteria; and
- promoting purchase of vehicles with better occupant protection characteristics.

The CARRS-Q and Committee reports were released publicly via the Queensland Government’s Get Involved website on 9 October 2012 for a one month consultation period. The general public were invited to review the reports and complete an online survey to indicate whether they supported or did not support each of the recommendations. With one exception (recommendation 22), the majority of respondents supported the Committee’s recommendations. Table A summarises this report with a list of the Committee’s recommendations, and proportion of survey respondents who indicated they supported the recommendation.

The recommendations supported by the largest proportion of respondents (> 85%) included:

- Recommendation 5: Maintain the current automatic reminder system for licence renewals (96.41%).
Recommendation 6: Encourage routine eyesight testing as part of general practitioners’ assessment of drivers aged 75 years and over for provision of medical certificate, with referral of patients to optometrists/ophthalmologists for further advice if necessary (89.33%).

Recommendation 17: Increase the availability of safe, alternative transport options for older people, and look at ways to improve the provision of information to older people about the community and public transport options available to them (85.39%).

The least supported recommendations (< 60%) were:

- Recommendation 22: Review speed limit criteria to ensure they adequately take account of the ageing driver population (44.50%).
- Recommendation 3: Investigate the feasibility and benefits of requiring general practitioners to automatically send medical certificates to TMR for registration on the licensing database (54.63%).
- Recommendation 2: Introduce a new maximum life for medical certificates issued to older drivers (aged 75 years and over) of 12 months (59.65%).
- Recommendation 26: CARRS-Q to monitor research into in-vehicle systems and devices and their use by older drivers with a view to providing advice to TMR on which systems and devices are of greatest net benefit (59.91%).

There were some common themes within the reasons given for not supporting recommendations, including concerns about:

- an age rather than risk based system being discriminatory;
- additional costs for older drivers and/or taxpayers generally;
- access issues, particularly for older drivers in rural and remote areas; and
- making changes when the current system is perceived to be working well.

These largely reflected the concerns noted by the Older Driver Safety Advisory Committee in the Committee’s report outlining their recommendations for government, and their rationale.

Table A: Results of consultation

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age at which older driver requirements (including medical certificates) are imposed:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Maintain the current requirement for drivers aged 75 years and over to carry a current medical certificate and drive to any conditions imposed by their medical practitioner.</td>
<td>83.48%</td>
</tr>
<tr>
<td>2. Introduce a new maximum life for medical certificates issued to older drivers (aged 75 years and over) of 12 months.</td>
<td>59.65%</td>
</tr>
<tr>
<td>3. Investigate the feasibility and benefits of requiring general practitioners to automatically send medical certificates to TMR for registration on the licensing database.</td>
<td>54.63%</td>
</tr>
<tr>
<td><strong>Frequency of driver licence renewal:</strong></td>
<td></td>
</tr>
<tr>
<td>4. Maintain the current five year driver licence option for older drivers, as the validity of the licence is dependent upon the driver having a current medical certificate.</td>
<td>79.46%</td>
</tr>
<tr>
<td>5. Maintain the current automatic reminder system for licence renewals.</td>
<td>96.41%</td>
</tr>
<tr>
<td><strong>Reinstatement of vision testing at in-person driver licence renewal:</strong></td>
<td></td>
</tr>
<tr>
<td>6. Encourage routine eyesight testing as part of general practitioners’ assessment of drivers aged 75 years and over for provision of medical certificate, with referral of patients to optometrists/ophthalmologists for further advice if necessary.</td>
<td>89.33%</td>
</tr>
<tr>
<td>7. Encourage optometrists to routinely undertake all tests relevant for determining safe driving ability when patients of any age present for annual check-ups.</td>
<td>79.91%</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Support</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td><strong>8.</strong> Provide additional professional development opportunities to medical practitioners (general practitioners, optometrists and ophthalmologists) to support their ability to better understand the impact on driving of various eye conditions and be able to respond appropriately.</td>
<td>75.57%</td>
</tr>
<tr>
<td><strong>9.</strong> Encourage/monitor the investigation of best practice in predictive vision tests, and consideration of the most appropriate means of linking these tests to the licensing system.</td>
<td>68.92%</td>
</tr>
<tr>
<td><strong>Widen the range of professionals who can report to TMR with legal protection, triggering follow-up review:</strong></td>
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<tr>
<td><strong>10.</strong> Develop improved education and awareness of the existing legislative provisions around medical certification and fitness to drive reporting, targeting both general practitioners and the wide range of allied health professionals who advise about older driver safety, as well as TMR Customer Service Centre staff.</td>
<td>76.34%</td>
</tr>
<tr>
<td><strong>11.</strong> Review the current list of specialists to whom drivers can be referred to determine whether additional professions should be included, e.g. audiologists, psychologists.</td>
<td>62.44%</td>
</tr>
<tr>
<td><strong>Restricted licences:</strong></td>
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<tr>
<td><strong>12.</strong> Develop improved guidelines to enable medical practitioners to more effectively identify driving restrictions on medical certificates which will mitigate risks while still enabling mobility to be maintained.</td>
<td>77.83%</td>
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<tr>
<td><strong>On-road retesting for selected drivers:</strong></td>
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<tr>
<td><strong>13.</strong> Investigate options for ensuring that older drivers have the opportunity to explore the extent of their driving skills and strategies for continued safe driving in a non-threatening but professional environment, and promote the use of these options among all drivers as well as among older drivers.</td>
<td>79.28%</td>
</tr>
<tr>
<td><strong>14.</strong> CARRS-Q to monitor best practice systems for interactions between older drivers and licensing authorities in relation to fitness to drive with a view to providing advice to TMR on options for on-road retesting should a program be identified which has proven success in distinguishing between older drivers with future increased crash risk and older drivers who will continue to drive without increased risk.</td>
<td>61.06%</td>
</tr>
<tr>
<td><strong>Encourage family involvement:</strong></td>
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<tr>
<td><strong>15.</strong> Develop educational strategies to assist family members to engage in effective, positive conversations about safe driving with their older family members.</td>
<td>69.68%</td>
</tr>
<tr>
<td><strong>16.</strong> Develop initiatives to assist older people to increase their awareness of driver safety issues and self-assessment tools to enable them to plan a more positive transition from driving.</td>
<td>80.63%</td>
</tr>
<tr>
<td><strong>17.</strong> Increase the availability of safe, alternative transport options for older people, and look at ways to improve the provision of information to older people about the community and public transport options available to them.</td>
<td>85.39%</td>
</tr>
<tr>
<td><strong>Provide a road environment which is safer for older drivers:</strong></td>
<td></td>
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<tr>
<td><strong>18.</strong> Undertake a systematic implementation of the Austroads guidelines on road environment design for older road users in Queensland.</td>
<td>60.77%</td>
</tr>
<tr>
<td><strong>19.</strong> Review Queensland’s Manual of Uniform Traffic Control Devices to ensure that its standards take age-related change into account, in accordance with the Austroads guidelines.</td>
<td>66.67%</td>
</tr>
<tr>
<td><strong>Attitudes towards speeding behaviour:</strong></td>
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</tr>
<tr>
<td><strong>20.</strong> Develop communication strategies emphasising to all road users that posted speed limits are the maximum safe speed in optimum driving conditions. Driving below the speed limit is to be encouraged if conditions warrant it.</td>
<td>82.81%</td>
</tr>
<tr>
<td><strong>21.</strong> Develop communication strategies that encourage tolerance and respect of the judgement of other drivers of any age or road user group that choose to travel at speeds below the posted speed limit.</td>
<td>76.82%</td>
</tr>
<tr>
<td><strong>Review speed limit criteria:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>22.</strong> Review speed limit criteria to ensure they adequately take account of the ageing driver</td>
<td>44.50%</td>
</tr>
</tbody>
</table>
### Recommendation

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote purchase of vehicles with better occupant protection characteristics:</td>
<td></td>
</tr>
<tr>
<td>23. Promote the purchase by all consumers (regardless of age) of vehicles with superior occupant protection ratings and in-vehicle systems and devices proven to reduce the risk and severity of crashes.</td>
<td>69.41%</td>
</tr>
<tr>
<td>24. Develop information for older drivers on vehicle safety features which provide the most protection for older vehicle occupants, in-vehicle technologies that can assist them to drive and park safely, and how to make the best use of these features and devices.</td>
<td>67.92%</td>
</tr>
<tr>
<td>25. Conduct research into patterns of older vehicle occupant injury and review vehicle crash test results to investigate vehicle safety features of most benefit to older drivers and passengers.</td>
<td>64.19%</td>
</tr>
<tr>
<td>26. CARRS-Q to monitor research into in-vehicle systems and devices and their use by older drivers with a view to providing advice to TMR on which systems and devices are of greatest net benefit.</td>
<td>59.91%</td>
</tr>
</tbody>
</table>
1 INTRODUCTION

It is projected that the number of older Australians aged 75 years and over will increase to 11.4% of the population by 2031, up from 6.2% in 2007 (an 83.9% increase). A similar pattern is projected for Queensland. This will result in an increase in the number of older drivers, who will either seek to maintain the mobility provided by the car, or need to make decisions about giving up driving and moving to other transport modes. There will also be a greater number of older pedestrians who will need a safe road environment and access to transport options.

It is therefore expected that older drivers will make up an increasing proportion of the road toll in the future. Accordingly, there will be an increasing need to focus attention on reducing the risk of older road users in crash involvement.

1.1 Older driver risks and safety issues

Based on analysis of Queensland crash statistics over the five year period from 1 July 2004 to 30 June 2009, the following is evident:

- Older driver crash risk begins to increase from age 75-79;
- Actual numbers of crash-involved drivers aged 75 years and over are relatively small (around 2%); and
- Older driver crashes tend to be more severe, more likely to occur in speed zones of less than 100 km/h, during the day, and are less likely to involve factors such as alcohol/drug use, speed or fatigue.

While older drivers may have long years of experience and good track records of being safe drivers, some will inevitably experience problems and difficulties as they continue to age, which will impact on their ability to drive safely. For example, diminished eyesight can affect a driver’s decision-making ability, especially gap judgement and awareness of traffic travelling at different speeds in different lanes. Intersections place additional demands on decision-making and attention, and declining visual ability and visual problems mean that signs and signals are more difficult to see, read and understand.

Other impacts can relate to:

- deteriorating hearing;
- reduced physical strength and flexibility;
- the onset of age-related diseases such as arthritis;
- changes in thinking and perception of events (slower reaction times); and
- side effects of taking medications.

Older people are also generally more physically fragile than younger drivers, and this fact, in association with other medical conditions they may be suffering related to ageing, may result in greater risk of fatality or serious injury from a crash. Further, the recovery period can be longer for an older person, and injuries can have a more lasting effect on their ongoing quality of life.

However, there are considerable individual differences in the ageing experience and impact on driving, so it is not appropriate to adopt a ‘one size fits all’ approach.

Many older drivers continue to drive safely by adopting self-regulatory or compensatory behaviours to limit their exposure to any increased crash risk. For example, driving fewer annual kilometres, making shorter trips, making fewer trips by linking trips, limiting peak hour and night driving, taking more frequent breaks and restricting driving to familiar and well lit roads.
Similarly, drivers of any age suffering medical conditions do not necessarily have a higher crash involvement. A given condition may affect drivers' 'fitness to drive' in different ways and to different degrees. For the same condition, some individuals may need to cease or restrict their driving while others may be able to continue driving without additional risk. Therefore, any decisions made regarding an individual’s licence based solely on age or on general medical grounds is not recommended.

However, a small proportion of older (and other) drivers do have diminished driving skills which result in them representing an unacceptable crash risk. These drivers are mainly restricted to certain sub-groups of older people. For example, older drivers suffering medical conditions such as dementia are less likely to be aware of the deficits in their driving ability and take precautionary or compensatory actions.

It is generally agreed that these unsafe drivers need to be identified through a more strategic and targeted approach, focussing on older (and other) drivers who have shown some evidence of having an elevated crash risk. However, there are currently no reliable tests available to screen the general older driver population in order to identify the small proportion of 'at risk' drivers.

The challenge is to identify these 'at risk' drivers and assist them with strategies to enable them to continue driving safely for as long as possible, and then to assist them to access alternative transport options once they are no longer able to drive safely in any conditions.

In addition to issues relating to road users, other areas of risk (road environment, speed and vehicle safety) will also be important contributors to an improvement in older driver road safety outcomes. The key difference between strategies and initiatives around these areas and those relating to the older driver is that they will also benefit the whole driving population, and not just older drivers.

### 1.2 Work of the Older Driver Safety Advisory Committee

The Older Driver Safety Advisory Committee (ODSAC) was convened in July 2011 to provide the Government with input to the development of appropriate policies and initiatives to improve older driver safety outcomes in Queensland.

The Committee was tasked with undertaking a review of older driver road safety in Queensland, including consideration of the issues, key older driver research, crash data and best-practice policies from other jurisdictions, and to make recommendations for drivers aged 75 years and over.

The Committee is chaired by Dr Graham Fraine, Deputy Director-General, Customer Services, Safety and Regulation (Transport and Main Roads), and comprises the following membership:

- Professor Mike Cleary (Queensland Health);
- Ms Ann Maree Liddy*/Ms Karen Dennien*/Dr Dilip Dupelia (General Practice Queensland);
- Ms Val French (Older People Speak Out);
- Chief Superintendent Bob Gee (Queensland Police Service);
- Emeritus Professor Mary Sheehan (Centre for Accident Research & Road Safety – Queensland);
- Mr Mark Tucker-Evans (Council on the Ageing);
- Mr Paul Turner (Royal Automobile Club of Queensland); and
- Professor Barry Watson (Centre for Accident Research & Road Safety – Queensland).

*Ms Ann Maree Liddy was later replaced by Ms Karen Dennien, who was replaced by Dr Dilip Dupelia after the workshop but prior to this report being finalised.*
To assist the Committee, the Centre for Accident Research and Road Safety – Queensland (CARRS-Q) was engaged to provide a detailed research report on older driver safety, including: a detailed literature review; current Queensland policy compared with approaches in other jurisdictions; a review of Queensland crash statistics for the five year period 1 July 2004 – 30 June 2009; and identification of potential initiatives for improving older driver safety in Queensland.

Committee Members provided input to the CARRS-Q report, which was initially tabled at a Committee meeting on 21 November 2011. After further feedback from members, a final report was provided to members on 22 December 2011 for consultation within their organisations. This consultation period continued to 14 February 2012, when members met to discuss the CARRS-Q report, finalise their positions on issues and formulate their recommendations.

All members were represented at the 14 February 2012 workshop, with the exception of Karen Dennien (General Practice Queensland), who was unable to attend. However, Ms Dennien provided verbal input on all issues via a teleconference with Transport and Main Roads officers on 16 February 2012. Cliff Pollard and Joel Tucker attended as delegates for Professor Mike Cleary (Queensland Health) and Paul Turner (RACQ) respectively.

Ms Kerry Mallon, representing the Occupational Therapists Association of Queensland, also attended the workshop as an observer, and provided the Committee with useful insights into the role of occupational therapists in assessing fitness to drive and other related matters. In addition, a submission from the Royal Australian College of General Practitioners outlining the College’s position on older driver safety issues was tabled at the workshop.

The result of the Committee’s work is a report that provided a perspective on older driver safety with 26 recommendations for new initiatives to better enable older drivers to continue to drive safely for as long as possible, and to appropriately plan for the time when driving is no longer an option.

1.3 Community consultation process

Both the CARRS-Q and Committee reports were released publicly via the Queensland Government’s Get Involved website on 9 October 2012 for a one month consultation period. The general public were invited to review the reports and complete an online survey to indicate whether they supported or did not support each of the recommendations, with an option of providing comments to explain their responses throughout. It was possible for respondents to skip questions if they did not wish to answer. No demographic data was collected from respondents.

Surveys were also provided in hard copy format for interested parties without internet access. Relevant material provided via other means, such as departmental correspondence, during the consultation period was also considered. In total, 234 survey responses were received (231 online, 3 in hard copy). In addition, 69 pieces of relevant pieces of departmental correspondence were received during the consultation period.

TMR also received written submissions through a mailbox created for the consultation process. These submissions varied in the range of initiatives addressed, from a focus on specific initiatives outlined in the report to a comprehensive review of all recommendations. A total of 21 written submissions through the mailbox were received by TMR, of which five were formal submissions by relevant stakeholder organisations or groups. The remaining 16 were submissions to the mailbox made by members of the community.

As the correspondence and written submissions did not always explicitly state support (or non-support) of recommendations, it was not considered appropriate to attempt to ‘code’ these for data analysis. Rather, only survey responses were included in figures in this report displaying support for recommendations.
As no new issues or concerns were raised in these submissions they were not included in the analysis of comments accompanying the survey responses, summaries of these submissions have not been reported separately in this report. However, comments in these submissions were considered when determining the most common reasons for non-support of each recommendation.

1.4 Structure of this report

The purpose of this report is to summarise the research, recommendations and community consultation processes and results associated with the work of the Older Driver Safety Advisory Committee.

The CARRS-Q report, and report of recommendations of the Committee, were based on the four elements of the internationally recognised ‘Safe System’ approach to road safety: safer road users (primarily driver licensing and medical assessment issues); safer roads; safer speeds; and safer vehicles.

The structure of the Committee’s recommendations, and this report, reflects this approach. Section 2 of this report describes, by topic, the following:

- Summary of research evidence at the time the CARRS-Q report was finalised;
- Current situation in Queensland;
- Possible initiatives proposed by CARRS-Q;
- Summary of Committee’s discussion of proposed initiatives;
- Recommendations of the Older Driver Safety Advisory Committee; and
- Summary of the results of the community consultation process.

The report concludes with a brief summary discussion of the work associated with the Older Driver Safety Advisory Committee.
2 OLDER DRIVER SAFETY INITIATIVES CONSIDERED

2.1 Safer road users – Driver licensing and medical assessment issues

2.1.1 Age at which older driver requirements (including medical certificates) are imposed

Summary of research evidence in CARRS-Q report:

There is no particular age which provides a clear demarcation point for age-related road crash risk. As a result, it is commonly argued that all drivers should be subject to the same assessment criteria, regardless of age. However, there appears to be benefit in drivers being aware that their ability to continue to drive safely may change and therefore should be carefully monitored, with an age-related requirement acting as a cue for drivers to cease driving should they have doubts about their ability to drive safely.

Current situation:

From age 75, drivers must carry a current medical certificate in Queensland. In other jurisdictions, there are other requirements which apply from a range of different ages.

Other jurisdictions:

In Australia, the issue of driver licensing assessment is a state responsibility and as such, initial licensing procedures vary in different states and territories. Renewal procedures, however, are not as varied. Generally, an applicant's driving history is checked to ensure there are no suspensions/cancellations or outstanding fines, if not, the person pays a renewal fee and gets a new licence. In addition, some states require applicants to appear in person.

There are, however, two aspects of licence renewal that vary significantly: the length of time between renewals; and additional requirements that may be imposed on older drivers.

Renewal procedures for drivers older than a specified age — typically 75 — include accelerated renewal cycles that provide for shorter periods between renewals, a requirement to renew in person rather than electronically or by mail where remote renewal is permitted, and testing that is not routinely required of other drivers.

If a person's continued fitness to drive is in doubt (supported by a history of crashes or infringements, or reports by medical practitioners, police, or other professionals), state licensing authorities may require applicants to undergo physical or mental examinations or undertake a driving assessment (on road).

After receiving advice from a medical practitioner and reviewing a person's fitness to drive, the department may allow the person to retain their licence, refuse to renew the licence, or suspend, cancel, or restrict the licence.

Typical restrictions prohibit night time driving, require the vehicle to have additional mirrors, or limit driving to specified places or a limited radius from the driver's home. Where the renewal cycle is not shorter for older drivers, licensing agencies have the authority to shorten the renewal cycle for individual licence holders if their condition warrants this.

The following table provides the periods for which licences can be renewed in each state any accelerated renewal periods for older drivers and other provisions applicable to older drivers (as at 12 December 2012).
<table>
<thead>
<tr>
<th>State or Territory</th>
<th>Medical Report</th>
<th>Licence Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>Required for all individuals suffering certain medical conditions (regardless of age). Required from the age of 75 onwards – period of time on that certificate is determined by a medical practitioner.</td>
<td>5 years</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Required annually from age of 75 onwards. Conditional licences may be requested – flexible restrictions, and are based on the individuals’ personal driving needs.</td>
<td>5 years</td>
</tr>
<tr>
<td>ACT</td>
<td>Required for all individuals suffering certain medical conditions (regardless of age). Required from the age of 75 onwards.</td>
<td>5 years</td>
</tr>
<tr>
<td>Victoria</td>
<td>When reported. Licence valid for only 3 years (instead of 10 years) from age 75 onwards. Conditional licences may be requested – flexible restrictions.</td>
<td>10 years 3 years for 75+</td>
</tr>
<tr>
<td>Tasmania¹</td>
<td>Required annually from age of 75 onwards. Any change in medical status to be reported.</td>
<td>5 years</td>
</tr>
<tr>
<td>South Australia</td>
<td>Required annually from 70 onwards.</td>
<td>10 years</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Individuals 80 years of age and older must complete a Medical assessment certificate – senior driver’s licence renewal declaration. Undertake a medical examination with a Health Professional (to assess fitness to drive).</td>
<td>5 years</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Required for individuals suffering certain medical conditions regardless of age. Required when reported.</td>
<td>5 years</td>
</tr>
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</table>

Possible initiatives identified by CARRS-Q:

- Maintain the current requirement on the basis that it currently performs a useful role in reminding drivers and medical practitioners that there are age-related declines in performance that need monitoring.
- Remove any age-related requirement for a medical certificate and rely on medical practitioners to report drivers who are at risk, regardless of age.
- Increase the age for a medical certificate (to 85, for example) in recognition of the increasing health of older adults and their larger representation in the driving population.
- Decrease the age for a medical certificate (to 65, for example) as a means of increasing surveillance and conveying a message to drivers about the need to take age-related performance decline into account.

Summary of Committee’s discussion:

The Committee was generally supportive of the current requirement for drivers 75 years and over to carry a current medical certificate and drive to any conditions imposed by their medical practitioner. However, the Committee was concerned about age-based licensing on the basis that it is discriminatory. The Committee recognised that each individual experiences the ageing process differently, with different effects on their driving performance.

¹ While annual practical tests were required previously, the Tasmanian Government has recently announced that drivers aged 85 years and over no longer have to undertake an annual driving test.
The concept of a system that relies on a mix of self-assessment and self reporting, in combination with reporting by medical practitioners, appealed to the Committee. However, the Committee realised that there can be difficulties in identifying those individual older drivers who are a risk to themselves and others. Nevertheless, the Committee would like to see the long term goal of Government to be achieving an effective risk-based licensing system.

In the meantime, it was the Committee’s view that older drivers would benefit overall from more regular contact with their medical practitioners, and being guided by them regarding impacts on driving of various conditions or medications they may be dealing with.

The Committee was concerned about the risks relating to medical certificates being able to be issued to older drivers, particularly the oldest of drivers, for a five year period, given that the health of some older drivers may change substantially from year to year or deteriorate rapidly. For this reason, the Committee supported the idea of medical certificates being issued by older drivers’ medical practitioners with a maximum one year currency.

The Committee also considered that the system would be more effective if, as a control, it was possible for general practitioners to automatically send medical certificates to TMR for registration on the licensing database.

The Committee acknowledged that there are a range of issues that would need to be considered before making such a change, including: administrative issues relating to the submission of medical certificates; the noting of medical certificate details on TMR’s system; and older drivers being reminded of the impending expiry of their medical certificate. However, the Committee was strongly of the view that a policy change which encourages a higher level of monitoring of potential health risks to safe driving could result in improved road safety outcomes.

Should the development of an effective risk-based system not eventuate in the future, the Committee would be open to the future consideration of increasing the age for mandatory carriage of a medical certificate to 85 years, given the improved health of newer cohorts of aged persons.

### Recommendations relating to the age at which older driver requirements are imposed:

1. Maintain the current requirement for drivers 75 years and over to carry a current medical certificate and drive to any conditions imposed by their medical practitioner.

2. Introduce a new maximum life for medical certificates issued to older drivers (aged 75 years and over) of 12 months.

3. Investigate the feasibility and benefits of requiring general practitioners to automatically send medical certificates to TMR for registration on the licensing database.

### Results of community consultation process:

These recommendations achieved the highest response rate on the survey, with 230 (98.29% response rate), 228 (97.44%) and 227 (97.01%) responses received for each.

The figure below shows the proportion of survey respondents who did and did not support these recommendations.
Of the three recommendations, the strongest support was for recommendation 1, which maintains the current requirements for older drivers to carry a current medical certificate and adhere to any conditions imposed by the medical practitioner. There was less support, although more than half of respondents were supportive, for imposing a maximum period of 12 months for medical certificates, and exploring the option of enabling medical practitioners to automatically submit medical certificates to TMR for registration on the licensing database.

Among the 38 survey respondents who did not support recommendation 1, the most common reasons given included:

- Age-based requirements are discriminatory – medical certificate requirements should be based on risk/medical conditions known to affect driving for drivers of all ages;
- A test of driving performance is more relevant than a medical assessment;
- Medical conditions should be private; and
- Medical conditions can emerge/change rapidly, so certificates may not reflect risk/issues at a given time, or for the full period of the certificate.

Among the 92 survey respondents who did not support recommendation 2, the most common reasons given included:

- Current system works well;
- Frequency of medical certificate renewal should be based on individual’s health/medical practitioner’s discretion;
- Imposes additional costs and difficulties on older people, particularly those in rural and remote areas;
- Medical conditions can emerge/change rapidly, so certificates may not reflect risk/issues at a given time, or the full period of the certificate;
- Medical certificates should be valid for a maximum of two years until 80, then required annually; and
- Medical certificates approving driving by unsafe drivers may be issued by doctors who do not want to offend patients and lose business.
Among the 103 survey respondents who did not support recommendation 3, the most common reasons given included:

- Current system works well;
- This should not be implemented without option for second medical opinion/appeals process;
- Doctors have enough paperwork to do – individuals should submit medical certificates;
- Individuals should have responsibility to notify TMR of issues, unless experiencing memory loss, then the medical practitioner should be responsible;
- This would be a costly process for the taxpayer;
- Medical conditions should be private unless reported by the individual; and
- Capability of drivers is the responsibility of TMR (who should do regular, random practical driving tests of all drivers), not medical practitioners.

2.1.2 In-person driver licence renewal

Summary of research evidence in CARRS-Q report:

A requirement for in-person driver licence renewal is associated with lower fatalities among drivers aged 85 or above.

Current situation:

In Queensland, in-person driver licence renewal is required where drivers don’t have a current medical certificate lodged with the department. A medical certificate can be issued for up to five years. This means that a driver aged 75 years and over could be issued with a five year medical certificate regardless of the expiry date of their licence. So, when renewing their licence, they could do so without needing to present to the Customer Service Centre (as long as they had previously lodged the certificate with the department), as they would still have a current medical certificate registered on the licensing system.

Possible initiative identified by CARRS-Q:

- In-person renewal always required after the age of 75

Summary of Committee’s discussion:

The Committee questioned the value of this initiative, given that it would rely on Customer Service Centre officers, who are not medically trained, to assess ongoing fitness to drive. Also, the Committee was concerned about the impost of this initiative on people living in rural or remote locations, which would require them to drive long distances for no identifiable road safety benefit. The Committee was of the view that a driver’s general medical practitioner, in association with specialist medical practitioners, are best placed to make assessments of their medical fitness to drive.

Nevertheless, the Committee did support more regular assessments of older drivers’ fitness to drive than the system currently requires. The Committee’s preference was for medical certificates for older drivers to be issued with a maximum 12 month currency (as outlined in recommendation 2 above). Assuming that the recommended 12 month limit on the life of medical certificates is adopted, the Committee’s view was that a requirement for in-person driver licence renewal would be redundant.

2.1.3 Frequency of driver licence renewal

Summary of research evidence in CARRS-Q report:

In the US, States with increased frequency of renewal (i.e., fewer years between renewal) had lower older driver crash rates.
Current situation:
In Queensland, a licence is valid for up to five years, although the requirement for a current medical certificate moderates this. That is, the licence of a driver aged 75 years and over is only valid if they hold a current medical certificate. In some Australian States, there are reduced licence periods from age 75. In the US, requirements vary considerably from State to State, with special provisions for older drivers applying from a range of different ages.

The table below outlines the maximum licence duration in other Australian jurisdictions.

<table>
<thead>
<tr>
<th>State or Territory</th>
<th>Licence Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>5 years</td>
</tr>
<tr>
<td>New South Wales</td>
<td>5 years</td>
</tr>
<tr>
<td>ACT</td>
<td>5 years</td>
</tr>
<tr>
<td>Victoria</td>
<td>10 years</td>
</tr>
<tr>
<td></td>
<td>3 years for 75+</td>
</tr>
<tr>
<td>Tasmania</td>
<td>5 years</td>
</tr>
<tr>
<td>South Australia</td>
<td>10 years</td>
</tr>
<tr>
<td>Western Australia</td>
<td>5 years</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>5 years</td>
</tr>
</tbody>
</table>

Possible initiatives identified by CARRS-Q:
- A general reduction in licensing periods after age 75.
- A graduated reduction in licence periods (e.g., two years from age 75, annual from age 85).
- Tie licence renewal to medical certification (i.e., licence remains current only for the life of the medical certificate).

Summary of the Committee’s discussion:
The Committee was concerned about increased costs to drivers if they are forced to renew their licences for shorter periods of time, as a five year Queensland driver licence is currently significantly cheaper per year than a one year licence.

The Committee believed that it would be neither efficient nor effective to tie licence renewal to medical certification, as the period covered by a medical certificate can vary from a day, a week or a month, to much longer periods such as a year or more. There would be significant practical constraints on maintaining the currency of the licensing database under such circumstances.

The Committee was also of the view that tying licence renewal to medical certification is not necessary, as under the existing licensing system a licence can be issued to a driver aged 75 years and over for up to five years, with the driver having to obtain and drive in accordance with a current medical certificate in order to comply with their licence conditions. If a driver aged 75 years or over fails to maintain a current medical certificate and drive in accordance with any restrictions imposed by their medical practitioner, they can be prosecuted for failing to comply with the condition upon which their licence was granted. Therefore, it was considered that the effect of the current system is similar to what would be achieved by linking licence renewal to medical certificates.
However, as discussed above regarding recommendation 2, the Committee supported a requirement on drivers aged 75 years and over to consult their medical practitioner at least annually, to ensure their health is closely monitored in relation to their ability to drive safely, and to enable any appropriate response to be made. If this recommendation were implemented, it would have a similar outcome to limiting licence periods to one year without the additional cost to licence holders. If recommendation 2 were not implemented, the Committee may wish to recommend limiting licence periods of drivers aged 75 years and over to one year.

The Committee considered that the automatic licence renewal reminder system currently in place is useful to older drivers, and that this should be maintained.

**Recommendations relating to frequency of driver licence renewal:**

4. Maintain the current five year driver licence option for older drivers, as the validity of the licence is dependent upon the driver having a current medical certificate.

5. Maintain the current automatic reminder system for licence renewals.

**Results of community consultation process:**

These recommendations achieved high response rates on the survey, with 224 (95.73%) and 223 (95.30%) responses received for each.

The figure below shows the proportion of survey respondents who did and did not support these recommendations.

![Graph showing support and non-support for licence renewal recommendations](image)

On average, four in five respondents supported maintaining the option of renewing a driver licence for a period of up to five years (while meeting required conditions, including a medical certificate) for older drivers. Almost all respondents supported maintaining the current automatic reminder system for licence renewal for all drivers.

Among the 46 survey respondents who did not support recommendation 4, the most common reasons given included:

- Licences should be valid for a maximum of two years for older drivers;
- Licence renewal periods should be progressively shorter as you age;
- Licence renewal should be annual for older drivers;
- Practical tests should be required for drivers of any age to renew their licence, as vehicles, road rules and the road environment change; and
- Licences should be valid for a maximum of three years for older drivers, similar to other jurisdictions.

Among the eight survey respondents who did not support recommendation 5, no reasons were provided.

### 2.1.4 Reinstatement of vision testing at in-person driver licence renewal

**Summary of research evidence in CARRS-Q report:**

Vision testing research indicates that the tests formerly used by the driver licensing authority in Queensland (visual acuity) were not sufficiently sensitive or specific (i.e. they did not reliably identify at-risk drivers), but that tests such as “useful field of view” (UFOV) and contrast sensitivity can predict crash risk.

The table below outlines the vision testing requirements in other for older drivers in Australian jurisdictions.

<table>
<thead>
<tr>
<th>State or Territory</th>
<th>Vision Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>A general vision examination is included with the medical for driving. The General Practitioner can then refer to a specialist if required</td>
</tr>
<tr>
<td>New South Wales</td>
<td>A general vision examination is included with the medical for driving. The General Practitioner can then refer to a specialist if required</td>
</tr>
<tr>
<td>ACT</td>
<td>A general vision examination is included with the medical for driving. The General Practitioner can then refer to a specialist if required</td>
</tr>
<tr>
<td>Victoria</td>
<td>None. Required to report if vision condition has changed since last licence was issued.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>A general vision examination is included with the medical for driving. The General Practitioner can then refer to a specialist if required</td>
</tr>
<tr>
<td>South Australia</td>
<td>A general vision examination is included with the medical for driving. The General Practitioner can then refer to a specialist if required</td>
</tr>
<tr>
<td>Western Australia</td>
<td>A general vision examination is included with the medical for driving. The General Practitioner can then refer to a specialist if required</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>None. Required to report if vision condition has changed since last licence was issued.</td>
</tr>
</tbody>
</table>

**Current situation:**

Queensland ceased automatic testing of visual acuity in the 1990s, in part because an overwhelming proportion of drivers passed the test, but also because it was considered to impose an unnecessary load on TMR Customer Service Centre staff, who are not medically trained. Practices in other jurisdictions vary, although the most common test remains visual acuity. Some US jurisdictions include the UFOV test. Doctors in Queensland have the discretion to request an optometrist’s report when preparing a medical certificate, but it is not mandatory.

**Possible initiatives identified by CARRS-Q:**

- Reintroduce vision testing of older drivers by TMR at in-person driver licence renewal, using UFOV and contrast sensitivity tests.
- Require that preparation of all medical certificates for drivers over a given age include a report from an optometrist on visual ability, in particular, using UFOV and contrast sensitivity tests.
Summary of Committee’s discussion:
The Committee questioned the effectiveness of TMR administering vision testing on renewal, as TMR
Customer Service Centre officers are not medically trained.

The Committee generally supported the idea of regular eye testing of older drivers, however preferred that
this occurs during regular medical check-ups (ideally, annually), with general practitioners. The
Committee accepted that the current practice of general practitioners is to refer patients to optometrists or
ophthalmologists for UFOV or other testing, as necessary, and considered that this practice could be
relatively efficient and cost effective for older drivers (due to the bulk billing and rebate arrangements
currently available under Medicare).

The Committee was concerned about the concept of requiring medical certificates to include a mandatory
report from an optometrist. The Committee was especially concerned about the impost on older drivers,
particularly those living in more remote communities which are not so well serviced by specialist medical
services. These imposts are exacerbated given that a blanket approach would result in older drivers with
good eyesight being inconvenienced and incurring the expense of consulting an optometrist, even where
there may be no road safety benefit to be gained.

The Committee wanted to see additional professional development and improved information and
education to assist general practitioners, optometrists and ophthalmologists to better understand the
impact of various eye conditions on driving and respond appropriately, as well as improve road safety
outcomes as a result of more effective conversations with patients. This should be standardised and
implemented state wide. A desired outcome from this would be that optometrists or ophthalmologists
routinely undertake all tests relevant for determining safe driving ability when patients present for their
regular testing (which would, ideally, occur on an annual or, at most, a biennial basis).

The Committee was of the view that should annual medical certificates not be introduced (as per
recommendation 2 above), further analysis and consultation is necessary to identify the optimal policy
position around this area.

Recommendations relating to reinstatement of vision testing at in-person driver licence renewal:

6. Encourage routine eyesight testing as part of general practitioners’ assessment of drivers aged 75
years and over for provision of medical certificate, with referral of patients to
optometrists/ophthalmologists for further advice if necessary.

7. Encourage optometrists to routinely undertake all tests relevant for determining safe driving ability
when patients of any age present for annual check-ups.

8. Provide additional professional development opportunities to medical practitioners (general
practitioners, optometrists and ophthalmologists) to support their ability to better understand the
impact on driving of various eye conditions and be able to respond appropriately.

9. Encourage/monitor the investigation of best practice in predictive vision tests, and consideration of the
most appropriate means of linking these tests to the licensing system.

Results of community consultation process:
These recommendations achieved high response rates on the survey, with 225 (96.15%), 219 (93.59%),
221 (94.44%) and 222 (94.87%) responses received for each.
The figure below shows the proportion of survey respondents who did and did not support these recommendations.

Each of these recommendations were supported by at least two thirds of survey respondents.

Among the 24 survey respondents who did not support recommendation 6, the most common reasons given included:

- Would result in increased cost for individuals, many of whom would have annual eye tests anyway;
- This requirement should be imposed on all drivers, not just older drivers;
- Access to specialists may be limited for individuals in rural and remote areas;
- Vision tests should not be conducted by general practitioners as conditions are not standardised – must be conducted by an optometrist/ophthalmologist; and
- People know when they have a vision problem and will address it with treatment/no longer driving on their own.

Among the 44 survey respondents who did not support recommendation 7, most did not give a reason. The only reason given was that there would be an increased cost for individuals unless subsidised by Medicare.

Among the 54 survey respondents who did not support recommendation 8, most did not give a reason. The only reasons given were concern about increased cost to the taxpayer (that they assumed would be offset by increasing licence fees), and that as professionals, medical practitioners should be aware of the most appropriate tests already.

Among the 69 survey respondents who did not support recommendation 9, most did not give a reason. The only reasons given were concerns about the costs of this investigation (and where the money would come from), and that as professionals, medical practitioners should be keeping abreast of best practice anyway.
2.1.5 Widen range of professionals who can report to TMR with legal protection, triggering follow-up review

**Summary of research evidence in CARRS-Q report:**
As there is a wide range of conditions that affect driving, many different health professionals will have knowledge of drivers with conditions that may make it unsafe for them to drive, or unsafe to drive given certain circumstances.

**Current situation:**
Medical certificates are completed by a general practitioner, and if uncertain about the impact of a particular medical condition on a person’s ability to drive safely, they seek advice from a “treating specialist, physiotherapist, occupational therapist, optometrist or ophthalmologist”. These professions would be able to report conditions potentially affecting driving directly to TMR, but are currently not afforded legal protection.

**Possible initiatives identified by CARRS-Q:**
- Enable allied medical professionals other than doctors to report to TMR with legal protection if they are aware of an older driver with a condition that may need to trigger a review of their medical certification, and establish systems in TMR to respond to such alerts by triggering the review.
- Review the current list of specialists to whom drivers can be referred to determine whether additional professions should be included (e.g., audiologists, psychologists).

**Summary of Committee’s discussion:**
The Committee believed that improved education and awareness of the existing legislative provisions around medical certification and fitness to drive reporting is necessary, targeting both general practitioners and the wide range of allied health professionals who advise about older driver safety, as well as TMR Customer Service Centre staff. Ensuring clarity around current policy and the respective roles and responsibilities of each stakeholder group is essential to ensuring the policy objectives can be achieved.

As an example, the Committee noted the professional development material developed by the Royal Australasian College of General Practitioners relating to assessing fitness to drive, and encourages all general practitioners to take advantage of this professional development opportunity.

As discussed above, the Committee was of the view that an individual’s general practitioner is best placed to advise on their continued ability to drive safely, after drawing on specialist advice of allied health professionals or driving assessors as necessary. However, the Committee noted that with the growing prevalence of the medical centre model for the delivery of health care, many individuals no longer have a primary general practitioner who may have monitored their health over an extended period of time. This lack of a trusting relationship between doctor and patient, built over time, can lead to difficulties, especially where issues such as cessation to drive need to be discussed and appropriately managed. The Committee would be concerned if this lack of established doctor patient relationship results in either negative road safety outcomes, or negative mobility and social exclusion outcomes for older people.

The Committee noted that the Austroads *Assessing Fitness to Drive* publication includes a list of referral specialists for advice in relation to various medical concerns. The Committee noted that while this list may be more detailed than reflected on the current medical certificate form, there are practical limitations relating to form design and the amount of information able to be included. The Committee supported a review, and enhanced professional development opportunities to ensure that general practitioners can access the most optimal guidance in this area.
The RACQ also suggested that consideration be given to not only offering legal protection to medical professionals who report drivers with medical conditions likely to affect their ability to drive safely, but requiring them to report these conditions. They reported that such an initiative was supported by 89% of RACQ members who responded to a 2008 survey. They also suggested that an appeals process involving an occupational-therapist monitored driving assessment should accompany such a change, to ensure that drivers whose licence may be cancelled have the opportunity to seek a second medical opinion.

The Committee considered a range of implications relating to the issue of compulsory reporting by medical practitioners of medical conditions which may impact on a person’s ability to drive safely, such as damaging the doctor-patient relationship, or inadvertently discouraging older people from seeing a medical practitioner. However, in the end, the majority of the Committee was of the view that the disadvantages outweigh the advantages. Hence, the Committee as a whole did not support compulsory reporting.

Recommendations relating to widening the range of professionals who can report to TMR with legal protection, triggering follow-up review:

10. Develop improved education and awareness of the existing legislative provisions around medical certification and fitness to drive reporting, targeting both general practitioners and the wide range of allied health professionals who advise about older driver safety, as well as TMR Customer Service staff.

11. Review the current list of specialists to whom drivers can be referred to determine whether additional professions should be included, e.g. audiologists, psychologists.

Results of community consultation process:

These recommendations achieved high response rates on the survey, with 224 (95.73%) and 221 (94.44%) responses received for each.

The figure below shows the proportion of survey respondents who did and did not support these recommendations.

There was more support for improving medical practitioners’ awareness of fitness to drive regulations than reviewing the list of specialists drivers can be referred to as part of a medical assessment process for licensing.
Among the 53 survey respondents who did not support recommendation 10, the most common reasons given included:

- Medical practitioners are sufficiently skilled already;
- Medical practitioners have enough to do without participating in education programs for a task that may not be a significant part of their “day job”;
- All drivers should be targeted given the large number of issues that can affect driving among drivers of any age; and
- Concerns regarding costs and where money would come from.

Among the 83 survey respondents who did not support recommendation 11, the most common reasons given included:

- The process should be managed by the individual’s regular general practitioner, with greatest knowledge of the individual, who should have final say on the outcome;
- Current system works well;
- The requirement to see multiple specialists will have cost implications for individuals, with additional costs and access issues for those in rural and remote areas;
- Risk of specialists using perceived risks (and testing required to assess these risks) for economic gain; and
- Medical professionals should remain focussed on health care, while driver testing is the responsibility of TMR.

### 2.1.6 Restricted licences

**Summary of research evidence in CARRS-Q report:**
Restrictions on drivers such as daylight-only, driving location, speed and vehicle adaptations, etc., are largely accepted by older drivers, and have been found to result in much lower crash risk. Further, drivers on such restrictions have been found to retain their licence and drive crash free for longer periods than unrestricted drivers. However, for some older drivers with higher crash risk who have had restrictions placed on them such as limiting them to driving only vehicles with an automatic transmission or the wearing of a hearing aid while driving, imposing such restrictions does not seem to affect their crash risk. This suggests that additional initiatives may be needed, such as improved guidance to medical practitioners in better understanding the relationship between their patients’ health condition and driving risk in order for them to choose the best response.

**Current situation:**
The system currently in use in Queensland relies on the medical practitioner using the guidelines in the Austroads *Assessing Fitness to Drive* publication to determine any appropriate restrictions to include on medical certificates. These Guidelines are based on research and expert advice on medical conditions and medications relevant to safe driving, and this approach reflects best practice, in principle. However, medical practitioners have broad discretion in this area, and the “final decision/responsibility rests with the Driver Licensing Authority”.

**Possible initiatives identified by CARRS-Q:**
- Provide formal guidelines to enable doctors and TMR officers to impose licensing restrictions (time of day, region, etc).
Summary of Committee’s discussion:
As discussed above, the Committee’s position was that a person’s medical practitioner is best placed to provide advice about a person’s fitness to drive safely.

The Committee acknowledged that the Austroads Assessing Fitness to Drive publication already provides medical practitioners with guidance in this area. However, the Committee was supportive of enhanced tools which make it easier for medical practitioners to understand the link between medical conditions and the driving task, to be able to more effectively identify driving restrictions which will mitigate risks while still enable mobility to be maintained. For example, it was suggested that desktop tools for general practitioners would be particularly useful.

The Committee also noted that any restrictions imposed by medical practitioners need to be easily understood and remembered by drivers, so it is important that medical practitioners take into account such issues when having discussions with their patients. Also considered important is that medical practitioners are cognisant of the practicalities of an older person’s living situation and the impacts of any driving restrictions imposed.

Recommendations relating to restricted licences:
12. Develop improved guidelines to enable medical practitioners to more effectively identify driving restrictions on medical certificates which will mitigate risks while still enabling mobility to be maintained.

Results of community consultation process:
There were 221 responses to this recommendation (94.44% response rate).

The figure below shows the proportion of survey respondents who did and did not support this recommendation.

Among the 49 survey respondents who did not support recommendation 12, the most common reasons given included:

- Doctors should already have the requisite knowledge to identify appropriate restrictions;
- If restrictions are required, the individual shouldn’t be permitted to drive at all; and
- Unnecessary paperwork for bureaucrats.
2.1.7 On-road retesting for selected drivers

Summary of research evidence in CARRS-Q report:

On-road testing has poor predictive validity; however one study found that the threat of re-testing via a lottery system (i.e., random selection of drivers to be retested) was associated with lower crash rates.

Current situation:

Re-testing takes place in Queensland for drivers identified through medical assessment or other sources (e.g., police advice), as being a potential safety risk to themselves and other road users. Similar arrangements operate in other Australian jurisdictions (see table below). In the US, Pennsylvania has a lottery system under which a small proportion of drivers of any age are selected for on-road retesting. Although the process is generally random within age group, it is weighted so that older drivers have an increased ‘chance’ of being selected.

<table>
<thead>
<tr>
<th>State or Territory</th>
<th>Practical Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>When recommended by medical practitioner.</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Required every second year for an unrestricted car licence from age 85 onwards.</td>
</tr>
<tr>
<td></td>
<td>Not required for conditional licences.</td>
</tr>
<tr>
<td>ACT</td>
<td>Required when reported.</td>
</tr>
<tr>
<td>Victoria</td>
<td>Required when reported.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Required when reported by medical practitioner.</td>
</tr>
<tr>
<td>South Australia</td>
<td>Required from age 85 onwards, for a licence class higher than a car or motorcycle.</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Required annually from age 85 onwards.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Required when reported.</td>
</tr>
</tbody>
</table>

Possible initiatives identified by CARRS-Q:

- Introduce a lottery system for practical tests for drivers of all ages.
- Introduce a lottery system for practical tests for drivers over a given age (e.g., 75).

Summary of Committee’s discussion:

The Committee was opposed to the idea of a performance based policy initiative that would artificially bias impact towards older drivers, on grounds of discrimination.

The Committee was also concerned about the costs and impacts on older drivers of mandatory practical testing. Whether TMR developed and delivered a program of driver retesting, or whether retesting was undertaken by Occupational Therapists, the RACQ, professional driving instructors, or other similar providers, access to such services, particularly for those living in more rural or remote communities, could be difficult and costly.

The Committee was supportive of the concept of practical testing services being available at an affordable cost to all drivers, on a voluntary basis, as it considers that all drivers could benefit from a refresher/checking of their skills from time to time to ensure they meet current standards.

The Committee was of the view that, over time, Government policy should shift towards a more risk-based approach to driver safety. In the meantime, all drivers should be encouraged to undertake voluntary hazard perception testing or other types of self-administered perception/assessment tests to improve their safety. Thus, the Committee would support the ongoing monitoring of best practice surveillance systems.
with a view to reassessing options at a later date should a system be identified which has proven predictive validity.

**Recommendations relating to on-road retesting for selected drivers:**

13. Investigate options for ensuring that older drivers have the opportunity to explore the extent of their driving skills and strategies for continued safe driving in a non-threatening but professional environment, and promote the use of these options among all drivers as well as among older drivers.

14. CARRS-Q to monitor best practice systems for interactions between older drivers and licensing authorities in relation to fitness to drive with a view to providing advice to TMR on options for on-road retesting should a program be identified which has proven success in distinguishing between older drivers with future increased crash risk and older drivers who will continue to drive without increased risk.

**Results of community consultation process:**

These recommendations achieved response rates of 94.87 (n = 222) and 88.89 (n = 208) per cent on the survey.

The figure below shows the proportion of survey respondents who did and did not support these recommendations.

![Graph showing support and non-support](image)

Among the 46 survey respondents who did not support recommendation 13, the most common reasons given included:

- All drivers should be retested periodically;
- All drivers should be retested about every five to 10 years, but progressively more regularly as they age; and
- This would result in additional costs for the older driver.

Among the 81 survey respondents who did not support recommendation 14, the most common reasons given included:

- Unless applied to drivers of all ages, investigating tests for older drivers is discriminatory;
- Should explore tests for bad (i.e. large number of offences and/or crashes) drivers of any age instead; and
- Concerns regarding costs and where money would come from when research could be monitored internally by TMR.
2.1.8 Encourage family involvement

*Summary of research evidence in CARRS-Q report:*

There is evidence that families have a better understanding of the driving ability of older drivers than can be derived from clinical assessment and crash history. It is also known that family members can play an informal role in influencing the recommendations of medical practitioners.

*Current situation:*

There is no recognised role for family members, and there are practical difficulties in providing a formal role (who is “family”, possibility of disagreements between family members, vexatious reporting, etc).

*Possible initiatives identified by CARRS-Q:*

- Encourage families to look at the driving of older family members and to raise concerns with them in the first instance, and with their medical practitioners.
- Encourage reporting by family to TMR in cases of serious concern.

*Summary of Committee’s discussion:*

The Committee acknowledged and valued the role of family members in supporting older drivers to drive safely for as long as possible, and then in transitioning to the use of safe, alternative transport options. Therefore, the development of educational strategies to assist family members to engage in effective, positive conversations about safe driving was supported, with a view to encouraging respectful conversations with older family members about safe driving issues becoming the social norm.

However, the Committee was firmly of the view that it is more appropriate for a driver’s general/specialist medical practitioner to be responsible for advising about a person’s continued fitness to drive. Family members, despite meaning well, are not medically trained. The Committee also acknowledged that not all older people are part of a supportive family environment; and that some older people are socially isolated and others are from dysfunctional or unsupportive families/networks.

The Committee identified that driving cessation is a particularly difficult and stressful experience for older drivers, especially for those living in more rural and remote locations where alternative transport services are not readily available. However, even for those living in South-East Queensland where public transport options are greater, there are still access issues for older people who may need to traverse hilly or uneven terrain to reach local bus stops, etc.

Therefore, initiatives to assist older people to more positively transition from driving (including educating older people to more accurately understand the relative costs/benefits of transport options such as taxis compared with the costs of running their motor vehicle), and to increase the availability of safe, alternative transport options for older people are supported.

**Recommendations relating to encouraging family involvement:**

15. Develop educational strategies to assist family members to engage in effective, positive conversations about safe driving with their older family members.

16. Develop initiatives to assist older people to increase their awareness of driver safety issues and self-assessment tools to enable them to plan a more positive transition from driving.

17. Increase the availability of safe, alternative transport options for older people, and look at ways to improve the provision of information to older people about the community and public transport options available to them.

*Results of community consultation process:*
The numbers of responses for these recommendations were 221 (94.44% response rate), 222 (94.87%) and 219 (93.59%).

The figure below shows the proportion of survey respondents who did and did not support these recommendations.

![Survey Results Graph]

While all of the recommendations were supported by seven (or more) in 10 survey respondents, there was more support for recommendations giving the older person control over their transition from driving to alternative transport methods (recommendations 16 and 17) than recommendation 15, assisting family members with discussions about driving with older people.

Among the 67 survey respondents who did not support recommendation 15, the most common reasons given included:
- Family involvement may be unwanted or unwarranted;
- Discussions may lead to arguments and additional stress on family relationships; and
- Education/awareness campaigns are a waste of money/create unnecessary bureaucracy.

Among the 43 survey respondents who did not support recommendation 16, few provided reasons. The most common reasons given included:
- Concerns regarding costs and where money would come from; and
- Assessment should be conducted by a medical professional, not the individual.

Among the 32 survey respondents who did not support recommendation 17, the most common reasons given included:
- Sufficient, safe public transport outside of metropolitan areas is unlikely without significant costs to taxpayers; and
- This does not address mobility issues such as getting to public transport stops in hilly areas.

### 2.2 Safer roads – Provide a road environment which is safer for older drivers

**Summary of research evidence in CARRS-Q report**

Older drivers as a group have more difficulty dealing with complex traffic situations, especially negotiating uncontrolled intersections and roundabouts, merging, and gap selection when turning.
They also have more difficulty detecting and reading road signs in daylight, and much more so at night. Road environment interventions have the potential to reduce crash risks and extend mobility of older drivers. Austroads has developed the *Road Safety and Environment Design for Older Drivers* guidelines, which include an extensive list of recommendations for road design improvements to improve older driver road safety, based on a US best practice model and issues identified in older driver research. Benefits from good road design flow on to all road users.

**Current situation:**

The Austroads guidelines have not been implemented systematically. For example, they do not appear to have been implemented in a focused way in Queensland. Queensland’s *Manual of Uniform Traffic Control Devices* (MUTCD) contains specifications for signs and line marking, but these are not based on the needs of older drivers.

**Possible initiatives identified by CARRS-Q:**

- Undertake a systematic implementation of the Austroads guidelines on road environment design for older road users.
- Review the MUTCD to ensure that its standards take age-related change into account.

**Summary of Committee’s discussion:**

The Committee acknowledged the work undertaken by Austroads in developing specific guidelines for road design for older drivers, and was of the view that improving the road environment will result in road safety benefits for all drivers, not just the older driving population.

The Committee recommended the implementation of the Austroads guidelines on road environment design for older road users. Specifically, it noted that work should be undertaken by TMR to review Queensland’s MUTCD to ensure its standards take age-related change into account, in accordance with the Austroads guidelines.

The Committee would encourage all road authorities to adopt a Safe System approach when undertaking road environment planning, construction and maintenance work. The Committee encourages road owners to be proactive in this regard, given the lengthy timeframes for implementation of infrastructure improvement programs. The Committee was concerned that if initiatives are not commenced until populations of older Queenslanders shift closer to their peak, the necessary improvements in this area will be impossible to achieve in time to avoid the inevitably higher road safety risks.

**Recommendations relating to safer roads:**

18. Undertake implementation of the Austroads guidelines on road environment design for older road users in Queensland.

19. Review Queensland’s *Manual of Uniform Traffic Control Devices* to ensure that its standards take age-related change into account, in accordance with the Austroads guidelines.

**Results of community consultation process:**

The numbers of responses for these recommendations were 209 (89.32% response rate) and 207 (88.46%).
The figure below shows the proportion of drivers who did and did not support these recommendations.

![Proportion of drivers supporting recommendations](image)

Approximately two thirds of survey respondents supported the recommendations relating to roads and roadsides, with slightly more support for reviewing traffic control standards than implementing Austroads guidelines for road environment design.

Among the 82 survey respondents who did not support recommendation 18, the most common reasons given included:

- Considered an unobtainable, costly waste of taxpayer funds;
- It is discriminatory to design roads based on age – roads are either good or bad, and changes should benefit all drivers of any age; and
- If older drivers cannot function in current road environment, they should not be driving at all.

Among the 69 survey respondents who did not support recommendation 19, the most common reasons given were the same as those for the previous recommendation:

- Considered an unobtainable, costly waste of taxpayer funds;
- It is discriminatory to design roads based on age – roads are either good or bad, and changes should benefit all drivers of any age; and
- If older drivers cannot function in current road environment, they should not be driving at all.

### 2.3 Safer speeds

#### 2.3.1 Promote changes in attitude towards speeding behaviour

**Summary of research evidence in CARRS-Q report:**

Older drivers do not represent a speeding risk. Some older drivers drive more slowly than other drivers, however moderating travel speed according to the conditions is an effective way of reducing risk and allowing more time for decision making. Problems arise when other drivers who might consider the speed limit to be a minimum rather than a maximum, become frustrated at slower drivers. This can manifest in road rage and intimidating driving behaviours. There does not appear to be research evidence on ways of addressing this problem in relation to older drivers.

**Current situation:**

There are general campaigns about speeding, but none which specifically target older drivers.
Possible initiatives identified by CARRS-Q:

- Develop public education about the safety benefits of slower driving by older drivers, and encourage other drivers to view this as desirable safe behaviour and not as a source of frustration.

Summary of Committee’s discussion:

The Committee cautioned against public communication campaigns which focus unduly on older drivers, due to the risks of strengthening existing held prejudices/misconceptions about the safety of older drivers, including those held by older drivers themselves. The Committee noted that there are other groups within the driving population that may drive slower than other drivers, such as novice drivers and moped riders.

The Committee’s preference was for public communication strategies not to target any single road user group, but rather to focus on the road safety behaviours to be generally encouraged. For example, messages targeting speeding behaviours would ideally encourage all drivers to comply with posted speed limits, emphasising that they are maximum limits. Further, messages should emphasise the need for tolerance as driving at reasonable, lower speeds is not only lawful but can result in improved road safety outcomes for the benefit of all road users.

Recommendations relating to attitudes towards speeding behaviour:

20. Develop communication strategies emphasising to all road users that posted speed limits are the maximum safe speed in optimum driving conditions. Driving below the speed limit is to be encouraged if conditions warrant it.

21. Develop communication strategies that encourage tolerance and respect of the judgement of other drivers of any age or road user group that choose to travel at speeds below the posted speed limit.

Results of community consultation process:

The numbers of responses for these recommendations were 221 (94.44% response rate) and 220 (94.02%).

The figure below shows the proportion of survey respondents who did and did not support these recommendations.

There was strong support (more than three quarters of respondents) for the recommendations regarding communication strategies about speed limit compliance and tolerance of drivers who opt to travel below the speed limit.
Among the 38 survey respondents who did not support recommendation 20, the most common reasons given included:

- There is too much emphasis on speed and speed enforcement;
- Do not believe evidence that speed is a crash risk;
- Speed limits don’t always reflect quality of road;
- Considered a waste of taxpayer funds; and
- Should have minimum speed limits to minimise variability in speeds between vehicles that can cause frustration or increase crash risk.

Among the 51 survey respondents who did not support recommendation 21, the most common reasons given included:

- If drivers cannot drive to conditions (including speed limit), they should not be permitted to drive at all;
- This should only be implemented if accompanied by education about courteous road use, such as keeping left and allowing faster vehicles to pass; and
- Should have minimum speed limits to minimise variability in speeds between vehicles that can cause frustration or increase crash risk.

2.3.2 Review speed limit criteria

Summary of research evidence in CARRS-Q report:
There is clear research evidence of the benefits of realistic and well-enforced speed limits; however the speed limits do not take specific account of older road users. This will become a more important consideration with demographic change.

Current situation:
Where there are high proportions of older adults, for example where an older adult’s residential complex is located, local governments take this into account in setting speed limits. However, this focuses on pedestrian activity and overall demographic change with respect to drivers is not considered.

Possible initiatives identified by CARRS-Q:
- Review speed limit criteria to determine whether they adequately take account of the ageing driver population and amend accordingly.

Summary of Committee’s discussion:
The Committee was of the view that this issue needs to be considered within a Safe Systems context. The Committee was supportive of ongoing assessment of speed limit setting criteria being undertaken as a matter of course by road owners and TMR, which will over time take into account improved planning decisions around risk issues associated with an ageing Queensland population.

Recommendations relating to reviewing speed limit criteria:
22. Review speed limit criteria to ensure they adequately take account of the ageing driver population.

Results of community consultation process:
There were 218 responses to this recommendation (93.16% response rate).
The figure below shows the proportion of survey respondents who did and did not support the recommendation.

![Proportion of survey respondents supporting recommendation 22](image)

This was the least supported recommendation in the survey, and the only recommendation supported by less than half of all respondents.

Among the 121 survey respondents who did not support recommendation 22, the most common reasons given were:

- If drivers cannot drive to conditions (including speed limit), they should not be permitted to drive at all;
- Speed limit reviews should take account of the area (including crash history) and pedestrians, not the age of drivers; and
- The bigger issue is the number of different speed limits and frequency of changes in speed limits on a given road, signs that may be difficult to see.

Some of the comments indicated respondents misinterpreted this recommendation, as they made comments about different speed limits for different drivers being confusing, or comments that implied they assumed the Committee was recommending reducing all speed limits.

### 2.4 Safer vehicles – Promote purchase of vehicles with better occupant protection characteristics

**Summary of research evidence in CARRS-Q report:**

While older drivers are less likely to be injured in a crash (on a population basis), they are much more likely to be killed or seriously injured when a crash occurs, due to their higher level of fragility.

Older drivers are more likely to be involved in crashes with other vehicles (rather than single vehicle collisions with fixed objects). Due to the types of crashes they are involved with, research indicates that improved occupant protection should be of benefit in reducing the severity of injuries resulting from side impact collisions, in addition to front or rear end collisions.

More evaluation is needed of the available technologies to ensure that in-vehicle devices do increase, rather than reduce the safety of older drivers through distraction and/or increasing the cognitive and attention demands required to perform the driving task. Research suggests that effort should be devoted to encouraging the purchase of safer vehicles by older adults to compensate for their greater fragility, and that this approach could be supported by a vehicle rating system.
Current situation:
Some motoring organisations and government agencies provide information on vehicle safety for older drivers. The Australasian New Car Assessment Program (ANCAP) and Used Car Safety Rating (UCSR) system provide ratings of vehicle occupant safety by awarding a “star rating”. However, these ratings are not oriented towards older vehicle occupants.

Possible initiatives identified by CARRS-Q:
- Increase public education about occupant protection for older drivers and promote the purchase of cars with superior occupant protection ratings.
- Advocate for a specialised version of the ANCAP/UCSR star rating systems applicable to older drivers.

Summary of Committee’s discussion:
The Committee noted that increased vehicle occupant protection is especially important for older drivers and passengers, due to fragility related risks.

The Committee supported the provision of increased information to older drivers on safety features to look for when purchasing a vehicle, and the importance of related safer driving behaviours (e.g., use of daytime running lights), as well as the promotion of vehicles with superior occupant protection ratings. RACQ provides advice and information to assist older drivers with vehicle purchase decisions at: http://www.racq.com.au/motoring/cars/car_advice/car_fact_sheets/vehicle_selection_for_older_drivers

However, in terms of public education strategies, the Committee preferred that promotion of the benefits of vehicle safety features target the broader driving and vehicle passenger population, rather than focussing on the needs of older people.

The Committee was interested in considering a specialised version of the ANCAP/UCSR star rating systems which is specifically targeted to older drivers in consultation with ANCAP and its stakeholders. Although, the Committee was also concerned that multiple star rating systems may cause confusion and reduce their effectiveness for the general buying public.

Therefore, the Committee wanted to see further research undertaken in the area of vehicle safety, to specifically investigate the vehicle safety features of most benefit to older drivers and passengers. These features should include primary safety features which prevent crashes from occurring, as well as secondary safety features which protect vehicle occupants in the event of a crash. Also, the Committee noted that some ‘in car’ devices can have a distractive effect on some older drivers, so a consideration of the relative costs and benefits in risk terms would be important.

The Committee also identified that the issue of vehicle safety for older drivers is not limited to private vehicles, but that it extends to taxis and public transport vehicles, as well as work-related vehicles.

This information is important to informing improved vehicle design, and more effective consumer choice, leading to improved road safety outcomes for drivers and their passengers.

Recommendations relating to safer vehicles:
23. Promote the purchase by all consumers (regardless of age) of vehicles with superior occupant protection ratings and in-vehicle systems and devices proven to reduce the risk and severity of crashes.
24. Develop information for older drivers on vehicle safety features which provide the most protection for older vehicle occupants, in-vehicle technologies that can assist them to drive and park safely, and how to make the best use of these features and devices.

25. Conduct research into patterns of older vehicle occupant injury and review vehicle crash test results to investigate vehicle safety features of most benefit to older drivers and passengers.

26. CARRS-Q to monitor research into in-vehicle systems and devices and their use by older drivers with a view to providing advice to TMR on which systems and devices are of greatest net benefit.

Results of community consultation process:

The numbers of responses for these recommendations were 219 (93.59% response rate), 212 (90.60%), 215 (91.88%) and 212 (90.60%).

The figure below shows the proportion of survey respondents who did and did not support these recommendations.

The safer vehicle recommendations were supported by approximately two thirds of survey respondents.

Among the 67 survey respondents who did not support recommendation 23, the most common reasons given included:

- Safer vehicles likely to be more (i.e. too) expensive;
- People will buy the best cars they can afford, so campaigns would be a waste of taxpayers money;
- Everyone already knows about safety features/information is already freely available; and
- Why focus on safer vehicles when it is up to the driver to prevent a crash in the first place.

Among the 68 survey respondents who did not support recommendation 24, the most common reasons given included:

- Older drivers are less likely to be in a financial position to afford the safest vehicles;
- People who require assistance driving and parking should not be driving at all; and
- Information is already freely available.

Among the 77 survey respondents who did not support recommendation 25, few gave a reason.
The only reason given by one respondent was that research is a waste of taxpayers' money that is better spent on roads/infrastructure.

Among the 85 survey respondents who did not support recommendation 26, few gave a reason. The only reasons given included:

- The information is already available;
- If people are going to choose the best car they can afford, the best safety features are irrelevant;
- By the time research is conducted, the safety features investigated will be obsolete; and
- Research is a waste of taxpayers money that is better spent on roads/infrastructure.

2.5 Other issues discussed by the Committee and during the public consultation process

Although outside the scope of the research undertaken by CARRS-Q, the Committee reported a number of views in relation to the areas of education/informational initiatives, alternative transport options, and road related issues. Although this information was included in the Committee’s report, no recommendations were made, and the public were not asked to comment on these issues.

One of the main themes raised in the written submissions was that policies which prematurely remove an older person’s ability to drive can have negative consequences for their health and quality of life. These consequences can outweigh the reduction in crash risk to the driver and the rest of the community. In short, respondents stated that any safety measure must be proportionate to the risk, and any individual measures introduced must find a balance.

Additionally written submissions raised concerns that program designers should be aware of the potential risks of ‘getting it wrong’. They suggested that initiatives need to be sensitive enough to help drivers, their family and friends and relevant health professionals to be able to make informed decisions about restricting an older driver or convincing them to give up driving entirely.

Although several of the recommendations contained in the report looked at self regulation it was brought up by several respondents that self regulation or self assessment is a very important aspect of older driver safety. One such aspect brought up in the consultation was a need for non-mandatory assessment and training courses to be made available to older drivers to assist in the decision making process.

Interestingly, research shows that drivers who self-regulate are more likely to be female, are not the principal driver in the household, have not been involved in a crash for at least two years and have had been experiencing problems with their vision.2 Further to this, there was a suggestion that research is required which helps develop a better understanding of the link between self-regulation and crash risk, and helps drivers match the environments that they drive in to their condition.

While medical condition reporting and fitness to drive are featured in the recommendations, a suggestion was made to the project team stressing the importance of general fitness and how it underpins many strands of injury prevention. There is evidence that regular exercise (3 times a week) can reduce injury severity when an older driver is involved in a crash.

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3 DISCUSSION

When reviewing the research in the CARRS-Q report and considering potential recommendations to Government, the Older Driver Safety Advisory Committee was of the view that any decisions to change current older driver policy should be based on risk, not age. The Committee acknowledged that age can be a practical ‘trigger’ for monitoring potential age-related issues that can increase risk, however the Committee believed Government should continue working to identify mechanisms which can accurately identify risk and introduce policies around these, rather than implement any ‘catch all’ initiatives with limited or no proven road safety benefit.

Further, the Committee was reluctant to make recommendations which may result in a policy change without clear evidence of road safety benefit.

Finally, the Committee was concerned about policy changes which may impact more significantly on certain sub-groups of older drivers. For example, initiatives with a greater impact on older drivers with limited family or social support, and/or those who reside in rural and remote areas. The Committee was keen to ensure that as Government works to develop policy in this area, potential consequences of increased social isolation, reduced access to services, or increased financial burden on older people be taken into account, and balanced with benefits to be achieved by proposed initiatives. Also important to the Committee was that Government consider policy initiatives that will assist older people with the transition from driving in a way that enables them to maintain their mobility and contribution to society.

Having noted these guiding principles and concerns, the Older Driver Safety Advisory Committee made 26 recommendations, which were released publicly along with CARRS-Q’s research report to give the public an opportunity to comment. With the exception of recommendation 22 regarding the review of speed limit criteria, the majority of respondents to the community consultation survey supported the recommendations of the Committee.

In cases where respondents did not support recommendation, the comments of survey respondents, and content of correspondence and written submissions received, largely reflect the Committee’s concerns.

For example, the most common reasons for not supporting recommendations were:

- Age rather than risk based requirements are discriminatory;
- Concerns regarding additional costs for the older driver/taxpayers generally;
- Concerns about access issues, particularly for older drivers in rural and remote areas; and
- Did not see a reason to change a system believed to be working well.

It is unclear whether the views of people who responded to the survey or provided other written submissions are representative of those of the broader road user population in Queensland. It is possible that there may be important differences between people who did and did not participate in the consultation process (self selection bias).

Although survey respondents were not required to report their age or circumstances, many provided this information in their comments throughout the survey, or in other written submissions. These showed a mix of younger and older drivers. However, it is acknowledged that many respondents felt very strongly about the issues of older driver safety, as older drivers concerned about losing their licences, or increased difficulty associated with proposed requirements for keeping their licence, or younger drivers concerned about the possibility of unsafe drivers of any age remaining on the roads.

Overall, older people are a large and increasing proportion of the Queensland population. Due to the geographic nature of Queensland, older people may be living in increasingly car dependent suburban and regional areas. The Government understands that on one side there are the safety issues associated with the aging population and on the other side the enormous implications on the independence and mobility
for many people when they can no longer drive. The Government will take into account these issues when considering the implementation of the 26 recommendations included in this report.

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Also, the Committee would be concerned about policy changes which may impact more significantly on certain sub-groups of older drivers. For example, initiatives with a greater impact on older drivers with limited family or social support, and/or those who reside in rural and remote areas. The Committee was keen to ensure that as Government works to develop policy in this area, potential consequences of increased social isolation, reduced access to services, or increased financial burden on older people be taken into account, and balanced with benefits to be achieved by proposed initiatives. Also important to the Committee was that Government consider policy initiatives that will assist older people with the transition from driving in a way that enables them to maintain their mobility and contribution to society.