The Global Movement for Age-friendly Communities

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Philip B. Stafford, Indiana University

From the ethnographer's journal:

One elder in the study takes great pleasure in shopping. He spends hours in the grocery store, stopping to greet children along the way who, when riding in the grocery cart, are at eye level with him from the electric cart in which he rides. He enjoys making faces at the children who try to mimic his facial tricks and expressions. He explains *"I feel babies are the closest friends I have. Everyone smiles back at me. It's a heavenly thing.*"

He explains that he never used to have time to talk with people and clerks in the store when he was a young parent. He says, however, that *"Now it's part of my social life. Everybody knows me and I make myself known. Without relationships I'm a dead man."*

Anthropology has played a significant role in helping audiences understand the breathtaking variety of aging experiences over time and around the world, as exemplified in this volume. As an *applied* undertaking, anthropology has served as a check on interventions in the world of the elderly by so-called experts – medical professionals, housing developers, service providers, case managers, etc. They are well meaning people trying to improve the lives of others without always knowing elders' lives from the inside.

When we don't know things from the inside we will, of course, view things from the outside, which is the foundation for positive science. This approach has a venerable history, finding its roots in the 17th century as a new age of reason. Some see the origins of this philosophy in the work of René Descartes, who argued that detached thought (mind) is the only possible way to know the world. (cit.) This rationalism found its triumph in the form of a positive natural science which, it can be argued, placed "man" (and replaced God) on the throne of the all-knowing, the all-controlling. A scientific method based on objective observation and empirical (not intuitive or inward) knowledge took firm hold of the Western world and led to remarkable advances in certain fields where, pragmatically speaking, it worked – biology, chemistry, physics, and medicine, to name a few. Unfortunately, a few would say, the scientific method falls short of achieving truths in the social world of human relations (cit.). More recent work in cultural anthropology has contributed much to this discussion, in its application of alternative ways of knowing to the study of humans and the social world; ways of ethnography, accompanied by a suspicion of totalizing generalizations and grand theory.(cit.) Anthropology has come to play an important critical role in the so-called social sciences, questioning a method that would apply scientific reasoning to objects of study that, themselves, have something to say.

So it is that cultural anthropologists can play a vital role in helping communities plan around the lived experiences - the lifeworld - of older adults and avoid the practice of homogenizing the population - creating bureaucracies that deliver uniform services in easily measured units that are predicted to produce desired outcomes in X% of "cases."

Where gerontological (and medical) science sees older people as individual, atomized, even replicable units, a new movement (called age-friendly communities) sees older people as embedded in their surroundings, attached to place. In this model, aging is not simply about the body, but about the body in its environment. So it is with disability – it is not a quality of a person but exists in the relationship between a person and his/her environment. (cit.) This allows us to move away from the language of disabled people to a language of disabling environments. Obviously, it also politicizes aging and disability and eschews the practice of blaming frail people for not having properly taken care of themselves.

Wendell Berry (1995) offers a useful framework for re-thinking the notion of health in such fundamental terms: “To be healthy is literally to be whole... Our sense of wholeness is not just the completeness in ourselves but also is the sense of belonging to others and to our place... I believe that the community, in the fullest sense: a place and all its creatures... is the smallest unit of health and that to speak of the health of an isolated individual is a contradiction in terms." As Milton stated in the epigraph… “Without relationships I’m a dead man.” (cit.)

In suggesting that community is the smallest unit of health, we are drawn to an entirely new model of health in old age, one organized around the notion of the age-friendly community. In short, aging (and disability) is not about the body nor about chronological age, rather, about place and relationships.

In this chapter, I’ll review the development of the age-friendly community movement, identify what might be some weaknesses, and offer some modest suggestions for building on the work to date.

Shifting focus from the individual to the matrix of community, the age-friendly community movement is growing throughout the world under such rubrics as elder-friendly communities; communities for all ages and, here, age-friendly communities (after the WHO nomenclature). While the elements of an age-friendly community are stated in various ways, the first comprehensive model was developed as the AdvantAge Initiative, a nationwide community planning and development project of the Center for Home Care Policy and Research (Feldman and Oberlink 2003).[i] The AdvantAge Initiative organizes the elements of an "age-friendly" community into four domains.

An age-friendly community:

1. Addresses elders' basic needs
2. Optimizes physical and mental health and well-being
3. Maximizes independence for the frail and those with disability
4. Promotes social and civic engagement

The domains themselves were derived from a series of focus group discussions with elders and community leaders in four, diverse U.S. communities. Invited focus group participants were asked to bring homemade collages representing their idea of an elder-friendly community. These illustrations provided the perfect springboard for lively and enjoyable conversations. (Figure 1).

Insert plate 1 here

Each domain, as seen in Figure 2, includes several subsidiary "dimensions." In the AdvantAge Initiative, the dimensions further subsume 33 "indicators" of an age-

friendly community that are measured through random telephone surveys and employed as data for citizen participation planning efforts. The survey has been conducted in over 63 U.S. communities and neighborhoods and with a national sample, providing a wealth of comparative data that enables communities to “benchmark” themselves against others and establish their own goals and objectives.

-Insert Figure 2 about here

CAPTION: The AdvantAge Initiative Four Domains of an Age-friendly Community

On a more global basis, the United Nations has also shifted focus to the environmental aspects of aging. It declared 1999 as *International Year of Older Persons: Towards a Society for all Ages* and, since that time, has organized international conferences and research initiatives designed to increase the quality of elder environments in both rural communities and urban areas. The Madrid International Action Plan on Aging 2002 recommended “creating enabling and supportive environments” as a key focus area and this is currently being implemented through the World Health Organization Age Friendly Cities Project. A framework similar to the Advantage Initiative, titled A Blueprint for Aging, identifies eight domains around which participating communities can assess their needs and organize work. (See figure 3) (link)

Insert Figure 3 about here

The WHO has used this framework to develop a “certification” program that incentivizes communities around the world to plan age-friendly development. As of 2016, 1,000 communities in 20 nations were participating.

In 2013 the WHO program arrived on the shores of the U.S. as the first major city sought certification and developed a comprehensive age-friendly community plan – Portland, OR (links). Subsequent to the acceptance of the WHO program in Portland and then New York City, AARP, the largest organization of and for older adults in the world, with a membership of over 37 million, formally adopted the WHO framework and offered support to U.S. communities that sought to participate in the certification process. By 2016, three dozen U.S. towns and cities were seeking certification. This AARP initiative aligned well with the organization’s major commitment to broader issues of livability. The AARP website has become a rich resource of research publications, planning guidelines, policy recommendations, and links to funding sources sponsored by the organization. In a major livable communities project, AARP spent several years developing the Livability Index, a massive database on selected indicators that enables communities (down to the level of the household address) to score themselves across a set of key factors. An overall score can be provided, as can scores in specific areas of focus, including housing, neighborhood, transportation, environment, health, engagement and opportunity – areas which have a major impact on the quality of life for

older adults (any age, actually). (link) ***sidebar for students to retrieve a score for their home address would be nifty here.***

In the U.S., other major national organizations have taken up this age-friendly community approach with enthusiasm. The National Association of Area Agencies on Aging (with partners) produced the *Blueprint for Action: Developing a Livable Community for All Ages* (2007) and piloted age-friendly work in 6 towns and cities from 2013 through 2014. The Environmental Protection Agency (EPA) has ramped up its efforts to help create age-friendly communities through its initiative entitled Building Healthy Communities for Active Aging. The Centers for Disease Control (CDC) has developed a focus on healthy environments for aging, with special emphasis on the built environment and public health, tying research, policy and practice recommendations to the National Prevention Strategy – the Surgeon General's major commitment to health for all ages and groups. (link)

Challenging the Medical Model of Aging

While the age-friendly model aligns well with "healthy communities" thinking, it is important to understand that a healthy community is not merely an aggregate of healthy individuals. Too often, the field of public health itself is overly concerned with behavioral change in the individual and the importance of making "healthy choices." A more comprehensive framework would acknowledge that individuals can't make healthy choices if the choices are not available to them. This is the essence of a place-based approach to health and aging as evoked in the Wendell Berry quote.

Focusing on environments for aging, however, presents its own set of challenges. The dominant discourse on healthy aging, modeled after Western bio-medicine, is about individual aging bodies and not communities or environments. Individual lifestyle and personal responsibility are offered as the ticket to "successful aging." In their critique of the lifestyle discourse in American culture, Howell and Ingham (2001) quote former Surgeon General Louis Sullivan on how to improve the nation's health:

> "First, personal responsibility, which is to say responsibility and enlightened behavior by each and every individual, truly is the key to good health."
> In talking of the disparity of health between 'those of lower socio-economic status', the 'disadvantaged', and the 'poor of society' Sullivan continued:
> "If we are to extend the benefits of good health to all of our people, it is crucial that we build in our most vulnerable populations what I have called a 'culture of character', which is to say a culture, or a way of thinking and being, that actively promotes responsible behavior and the adoption of lifestyles that are maximally conducive to good health. This is 'prevention' in the broadest sense."
> (US Department of Health and Human Services, 1992: v)

Howell and Ingham, and others (cit), attribute the development of the lifestyle craze to a changing relationship among labor, capital, and government introduced during the Reagan years, changes favoring capital, of course. They describe the transformation of "public issues into personal troubles and problems of lifestyle" (331), and the redefinition of illness, health care and unemployment as private issues of

character (330). As the call for personal responsibility became ubiquitous, there arose a rich opportunity for the corporatization of wellness and the commodification of the body. Public governance became operative through the virtual redefinition of the self (after Foucault,). Given its numbers, it was no coincidence that the baby boom generation. With 75 million occupants (Ken Dychtwald's "Age Wave") became a prime target for the commodification of the aging self.

This is not to say that medicine was favoring treatment over prevention. The approach to prevention, following this medical model, shall still involve intervention at the level of the individual. Hartman-Stein and Potkanowicz (2003) provide an exemplary review of the many regimens available to be adopted by *individual* older adults:

"… the news for the baby boomer generation is indeed positive regarding their upcoming late life years. Behaviors, thinking patterns, and emotional and spiritual lifestyles in middle age, factors over which individuals have significant control, have much more impact on health and satisfaction in the seventh and eighth decade of life than was once believed possible. Successful or healthy aging is a goal within reasonable reach."

Behavior, as well as health care itself have been demonstrated to play a moderate but not dominant role in population health. While not much can be done to modify the genetic component of health, clearly environmental factors, broadly defined, play a major role in community health. It can be argued that investing in environmental interventions should be at least on par with the huge investments made in medical care and personal wellness.

If, as is argued here, aging is a place-based and relationship-based experience, is there a way to identify the assets embedded in place and in relationships to the benefit of elders, seen not as individual bodies but as members of communities?

Indeed, there is.

What if we were to position the older person not as an individual body but as a member of a commons? For one thing, our health care systems would take on a very different character, as reflected in the chart below.

Health Care Paradigms

Clinical Perspective	Place-based Perspective
Reimbursement for Acute Care	Reimbursement for Chronic Care
Disease model of old age	Aging as a natural, entropic process
Longevity and Anti-Aging Medicine	Quality of remaining years
Disease research	Basic biology of aging
Cure	Care
Reactive and corrective	Preventive
Diagnosis	Function
Patient	Community Member
Services	Community Building

The chart summarizes the contrast between the clinical (commodified) and the place-based perspective. Here's how one of Jaber Gubrium's interviewees, Lily Robinson, put it, discussing hospitals and nursing homes:

> I think they (hospitals and nursing homes) all seem about just alike. I stayed in the hospital quite a long time when they amputated my legs and the nurses are

> friendly, but it's not like home. No place, no hospital, not nursing home is like your own home, not to me. (...) Peace of mind I think at home makes you different. You run your home. These people here run the nursing home. At home, you're the overseer. You take care of everything and I think that's more like a whole being. Here you're just a part. When you're home, you're whole. You're a whole person. You're taking care of everything and everything comes to you by your means and it makes you feel more at home." (1993,128-9)

Seeing the older person as a member of a community provides an alternative paradigm for thinking about solutions to the so-called problem of age. In fact, there are two economies available to older persons. The dominant economy, mass market capitalism, where the elder is a consumer, meets the needs of the individual through the distribution of goods and services from the outside, through the currency of money. (11) An alternative economy, where the elder is a producer, meets the needs of the individual through providing access to shared goods and services, through the currency of mutuality and reciprocity.

In the market economy, the elder without currency is placed in a dependent role in society. Where the market fails, public policies, beneficence and altruism may fill the gap, but it does not change the position of the elder since she is still on the receiving end. Payment by the elder entails the provision of gratitude, deference, and compliance, reinforcing the definition of the situation as one of dependence. (cit. Dowd, 1975 et al)

In multiple ways have we commodified old age by coming to define this period of life as one of consumption rather than production. The market economy is extremely adept at siphoning off discretionary income by identifying positive aging with leisure, so

well modeled by Madison Avenue. Even that majority of older people who don't have significant amounts of discretionary income are, nevertheless, seen as individual consumers, albeit of essential, often life-giving services, as the chart above suggests. Their roles as consumers of health care simply fill pockets from public, rather than private, sources. Public and private insurance systems are organized around individual, not collective needs.

The basic needs of daily life – housing, transportation, health care and food in the U.S. consume a large percentage of the income of ordinary older people.

- Housing: Today, 30 percent of elderly renters are paying more than half their incomes on housing. … those who are low-income renters face the greatest difficulties, as they often have little wealth or savings when they retire. The typical homeowner aged 65 and over has enough wealth to cover nursing home costs for 42 months and enough non-housing wealth to last 15 months. Alternatively, the median older renter cannot afford even one month in a nursing home.
- Transportation: In our car-dependent society, the American Automobile Association (AAA) reports that the cost of owning and maintaining a standard vehicle is $9,000 annually. (2)
- Health care: In 2010, Medicare beneficiaries spent $4,734 out of their own pockets for health care spending, on average, including premiums for Medicare and other types of supplemental insurance and costs incurred for medical and long-term care services. (3)
- Food: Food inflation in the U.S. averages 2.5% per year, in a year in which no cost of living raise was provided to Social Security beneficiaries. (4)

And how do older people pay for these things?

Where median income for individuals 65+ was $22,248 in 2014, 47% of unmarried persons over the age of 65 rely on Social Security for 90% of their income. The average annual Social Security benefit in 2014 was $15,626. (5)

In short, 25 million or 40% of Americans aged 60+ are economically insecure. One-third of senior households has no money left over each month or is in debt. Among senior households in debt, the median total debt was approximately $41,000. (6) 3 million senior households experience food insecurity, 3.5 million homeowners are underwater on their mortgages and have no home equity; older renters are most at risk for being economically insecure and are disproportionately single women and minority households.

While we argue for the importance of good environmental design, it is fair to ask whether commerce, planning and community design have actually increased the challenges older people face worldwide? The answer is an unqualified yes.

Given the buying power represented by older adult households, it is rather ironic that commerce pays so little attention to the goal of making businesses more age-friendly. Elders in our Bloomington study were vocal on this subject.

The basic offerings are incompatible with the lifestyles of older households:

"We'd buy half a loaf of bread if somebody offered it to us"

Salespeople are insensitive to the needs of older shoppers.

25% of our respondents reported that salesclerks were often unfriendly in the stores where they shopped.

The physical environments created for shoppers target only the robust.

"Well, many of the stores don't have enough seats or benches either, to sit down. One of the pluses for Morgenstern's Books is that they have numerous comfortable chairs and there are other stores, however, like Lazarus (sic), for instance, that have… the last time I was in there…have not a single bench in their changing rooms for men.

So I stopped buying men's clothes at Lazarus. It's the only way to get across. You know, I'm one person out of a thousand. That's the kind of message they need to receive."

Retail establishments, among other institutions, routinely underestimate the importance of the casual, and friendly public encounter in the lives of older people (among others).

"You know why I like to come to the bank (and never use the ATM?) It's one more human contact."

In addition to our failure to bring an age-friendly lens to the immediate experiences of shopping, older adults are poorly served at higher levels of planning and private/public investment.

First, let's point to retail redlining: the history of food retailing in urban areas is one of continuous disinvestment in urban cores and increased investment in urban food outlets. Seeking more affluent customers, cheaper land on which to build 50,000 square feet retail centers, and catering to shoppers in cars, the retail food industry has literally left urban elders on their own to seek nutritious, low glycemic and fresh foods. Too often, food choices in low income urban communities have been limited to non-fresh, more expensive foods. Declines in property values have led to declines in educational resources and the disappearance of home economics courses in school that might support healthy food traditions. The manufacturing base of many urban communities, the traditional base of the economy, has deserted urban areas, typically through the so-called modern practice of planning and zoning.

Secondly, let's point to what may be the most significant historical element of community planning affecting the current generation of older adults in the U.S.: suburbanization. Over the past 50 years the corollary to disinvestment in urban centers has been massive suburbanization and the flow of capital from urban centers to the margins. Having been ensnared by the lure of the suburbs decades ago, millions of older adults (in the U.S.), seven in ten, now live in homogenous, isolating, naturally

occurring retirement neighborhoods too often devoid of children, adequate public transportation, and walkable access to health services, entertainment, Third Places, and fresh food.

The current public health admonition to individuals – eat healthy and exercise – is hardly comforting in the face of significant structural barriers, including classism, racism, ageism and disastrous public planning. Even more egregious, we blame the older population itself for this unfortunate circumstance:

"By medicalizing the effects of poverty, oppression, abandonment, segregation, and ghettoization, the behavioral/medical approach both reflects and reproduces the existing social order by endorsing an interpretation of health and disease which places responsibility for the pathological effects of these conditions on individuals." (Eisenhauer, 2001.)

Rarely are capitalism and the discipline of urban planning held responsible for our inability to assure a good old age for all earth's inhabitants.

Is there reason for optimism?

As for the field of urban planning, I would offer a definite yes. Recent policy statements and a guide to aging in place, as published by the American Planning Association, indicate that the age-friendly community movement may be growing up. The WHO Global Network of Age-friendly Cities and Communities cited earlier currently includes 287 cities and communities in 33 countries, covering over 113 million people worldwide. Moreover, the negative public health consequences of both inner city disinvestment and suburbanization are widely recognized by the field of urban planning, although tangible solutions have yet to get beyond the demonstration phase.

As for the role of capitalism in enabling quality of life for a significant portion of the older adult population, I am less sanguine. Given its basic premise about human nature and its unit of analysis, its focus on profit maximization, and its targeting of

individual consumers with money, many if not most older adults around the planet will not be well served.

In the commons, however, the elder can escape the monetary trap as well as the indignities of charity.

The market economy is an ownership economy. The sharing economy is an access economy – providing access to goods and services which are not owned. These two economies engender radically different forms of transaction and human interaction. In the sharing economy things are not bought and sold so much as bartered and shared. Consumption is collaborative.

The sharing economy is not a new invention so much as a rediscovery of the operating principles long practiced in traditional communities. It is exploding around the world and its force now is driven by the availability of digital platforms that serve as intermediaries for communication. Regretfully, many innovations are being monetized, such as Uber, Lyft and Air BnB. Yet, a wide variety of grass roots projects, usually local in character, are bringing people into the commons through the expenditure of social, human, and cultural capital and the use of open source platforms. At the local level, intermediaries and brokers are less important, as face-to-face relationships can be employed to share and exchange. This factor should loom all important to practitioners of urban design.

When thinking about what assets can be mobilized by older people to meet their needs for goods and services outside of the monetary economy, several come to mind:

TIME: Millions of older people have billions of hours to dedicate to the commons. In the growing movement called Time Banking, every individual's hour is as valuable as the next. An hour given generates an hour to be received. An elder instructs an hour in music and receives an hour in return from someone in the commons – perhaps an oil change, maybe a housecleaning. An hour tutoring a teen garners an hour of window cleaning, etc.

Insert Plate 2 about here

TALENT: One of the injustices of the digital economy is the invalidation and obsolescence of the knowledge of older persons. Increasingly, basic access to goods, services, and information requires digital literacy. Despite the growing use of computers by older adults, the rapid changes in the digital world make it ever more difficult for older people, and other disadvantaged groups to keep up. Yet, experienced people retain a vast pool of knowledge about human affairs and a vast pool of pragmatic experience that, in a sharing economy have lasting value. There are more than a thousand Repair Cafes around the world where people can bring appliances, toys, furniture, bicycles and other items and find experienced individuals who will freely repair and teach important daily living skills.

TREASURE: While older people with discretionary income are often generous with their money, in the sharing economy their treasure may include a lifetime of accumulated *physical* assets that *can* be shared. These assets can fuel many types of local sharing programs: garden share, tool share, car share, house share, shared storage. In an ownership society, these assets are meant to accrue to successful

individual consumers. In an access economy, these assets can enter the commons and be utilized by many more individuals, while paying dividends to the elders.

If actions in the sharing economy have the potential to benefit elders and other marginalized groups to transcend the limits of capitalism, it is worth considering how principles of the commons can inform urban planning and design. Design *for* the commons is not authentic unless it is also design *with* the commons. A city is only just when the experts turn over not only the power to govern it but also the power to co-design and co-create itself. Effective answers to the following questions are more likely to occur if elders are actually engaged in the process of asking them.

How can the evanescent and sociable interchanges in a public common space be transformed into more enduring relationships of mutual benefit?

How can the assets of elders (time, talent and treasure) be made known to community members who might wish to develop a sharing relationship? In other words, how does design demonstrate what older people have to offer our society?

How can elders learn to connect and stay up to date with changing digital platforms?

What design elements help elders occupy common space over time so that a true presence can be attained?

What design factors limit the participation of elders in common spaces?

What design factors engender and facilitate interaction across generations and other forms of difference?

How can designers compensate for the sensory and physical capacities and/or limitations that might prevent inclusion of older adults in the commons?

Finally, if holding memory valorizes the role of elders in our communities, how can a city remember itself – and, the reverse, how can elders be authentically included in our futures?
