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Age-Friendly Communities

Are We Expecting Too Much?

Stephen M. Golant

Summary

- Aging successfully depends not only on the behaviours of individual seniors, but also on the quality of the places where they live and receive care.
- The age-friendly-communities movement proposes policies and programs that attempt to improve the material and social environments of older people and help them age successfully.
- Given limited funding and competing demands for resources, proponents of this movement must prioritize over-ambitious agendas and offer verifiable solutions that do not overlap with other housing, service and care programs.

Résumé

- Le fait de bien vieillir dépend non seulement des habitudes de vie des personnes âgées mais aussi de la qualité des lieux où elles vivent et reçoivent des soins.
- Le mouvement Collectivités amies des aînés propose des politiques et des programmes offrant aux personnes âgées un environnement social et matériel qui les aide à mieux vieillir.
- Vu les sources limitées de financement et la diversité des demandes, il faut prioriser les aspects de cet ambitieux plan et proposer des solutions qui n'empiètent pas sur d'autres programmes d'hébergement, de services et de soins.

Aging Successfully and Why Environment Matters

In their popular 1998 book, *Successful Aging*, prominent US experts John Rowe and Robert Kahn proposed a clear pathway to growing old successfully.[1] They argued that aging individuals must follow three tenets: avoid disease and disability, maintain high mental and physical functioning and keep actively engaged in life. Most importantly, these scientists maintained that these were achievable goals for all older adults, and that it is never too late to embrace these goals. Older people must and should be able to take proactive steps to influence how well they age.

Rowe and Kahn's prescription for an active, healthy and disability-free life is a familiar one. Aging adults must carefully follow their medication and disease

management regimens, exercise regularly, eat right, get enough sleep and get regular health checkups. If they want to avoid succumbing to Alzheimer's disease, they should keep their brains healthy by engaging in a host of stimulating mental activities, from puzzles to reading.

The authors were also very clear about what they believed were desirable lifestyles for successfully aging individuals. Based on a wealth of scientific findings, they argued that older adults should keep physically and socially active and engaged in their communities. Additionally, they should not be reluctant to maintain the physical appearance and vigour of their younger years. Consequently, they should have no qualms about taking Viagra or receiving Botox injections.

All this advice is scientifically correct and seems immune from criticism.[2] But what these experts left out of their formulation was troubling. Growing old is not just a personal affair and cannot be reduced to a set of individual indicators, such as health status, physical and cognitive functioning and demographics. Rowe and Kahn failed to recognize that successful aging also depends on the quality of older people's residential and community settings and care arrangements.

Individuals do not grow old in a contextual or situational vacuum.

Environmental gerontologists have long argued that individuals do not grow old in a contextual or situational vacuum.[3] Their ability to conduct their active and engaged lifestyles and follow those ideal physical and mental health regimens depends on their occupying places — their states/provinces, communities, neighbourhoods, buildings, dwellings and rooms — with compatible and supportive physical and social environments. Especially at higher chronological ages, older people spend a great deal of their time in their proximate environments and they are often more susceptible to the problems posed by their residential settings.[4] So, for example, older people with mobility limitations are more likely to remain independent in their own homes when the physical arrangements and designs of their dwellings and immediate surroundings do not restrict their activities or increase their risk of falling.[5] Practising good nutritional behaviours is easier when they have grocery stores within walking distance. They are less likely to be rehospitalized if they receive timely and easy-to-understand follow-up medical care in their own homes. Dental problems are less likely when older people occupy nursing homes and assisted living developments staffed with workers who administer regular dental checkups and cleanings.

A strong rationale for focusing on environmental influences is also offered by the human development and lifespan literature. Theoretical and empirical analyses have linked successful aging with older people's ability to manage or

overcome their difficulties.[6] More adaptable individuals have enriched "repertoires of coping strategies."[7] That is, they occupy localities with realizable opportunities and have the resources to change or manage inappropriate residential or care arrangements.[8] In these places, older people who are bored with their retirement lifestyles, feel alone or have difficulty maintaining their old dwellings or conducting their independent lifestyles do not have to sit back passively and do nothing. Rather, they become agents of change. They can find friends to comfort them when they are down and can easily access transportation to their medical appointments. They can find occupational therapists to counsel them on needed home modifications. When they need help performing their activities of daily living (such as dressing, bathing, eating, walking, toileting and transferring), they can find competent and well-trained workers.[9]

It is easier for seniors to age successfully in jurisdictions where older populations have been targeted as needing special assistance.

Political jurisdictions, their administrators, their regulations, their intergovernmental cooperative relationships and their styles of governance also matter. Social programs and policies that help older people cope with their physical vulnerabilities are not equally available in all locations. It is easier for seniors to age successfully in jurisdictions where older populations have been targeted as needing special assistance.

The Age-Friendly-Communities Movement

This context I have described provided the rationale and potential for the age-friendly-communities movement. The catalyst was the World Health Organization's (WHO) Global Age-Friendly Cities project, which was started in 2006. It initially involved some 33 cities in 22 countries where leaders analyzed whether their communities and neighbourhoods had the capacity to support the World Health Organization's Active Ageing Framework: "Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. In an age-friendly city, policies, services, settings and structures support and enable people to age actively."[10] It broadly conceptualized these environmental opportunities: "Active ageing depends on a variety of influences or determinants that surround individuals, families, and nations — material conditions as well as social factors that affect individual types of behavior and feelings."[11]

Age-friendly communities can offer their older residents a broad range of strategies, products, services and activities. Below is a summary of their scope; the first seven categories of initiatives are drawn from a report by the philanthropic membership organization Grantmakers in Aging, and the latter two from the World Health Organization:[12]

- Municipal and regional planning, with an emphasis on community and older adult input
- Housing and other building design, particularly affordable, adaptive/accessible housing and multigenerational options
- Social services, including meal delivery, adult day programs and caregiver support, with a focus on meeting the changing needs of frail, disabled and homebound older people
- Transportation projects, including increased public transit and free or reduced-cost taxis and other rides, and promoting walkability and accessibility
- Health promotion, including community activities to enhance wellness and greater access to health, mental health and home health care
- Civic engagement efforts, including intergenerational initiatives and opportunities for meaningful volunteering and paid work that benefit people of all ages
- Efforts to promote access to information, including an effective communication system reaching community residents of all ages and focusing on oral and printed communication accessible to older people
- Accessible, safe and attractive outdoor spaces and public buildings
- Opportunities for social participation with family, friends and neighbours, but also with new individuals, groups, congregations and organizations

Explaining Age-Friendly-Communities as a Worldwide Movement

A MAJOR IMPETUS FOR CREATING AGE-FRIENDLY COMMUNITIES was the explosive growth of older populations in countries throughout the world, along with higher rates of urbanization, producing settlement patterns that often disrupted traditional family support networks.[13] Beyond these macro-societal influences, however, there was another reason why the World Health Organization's message resonated with older people and stakeholders, including families, home care providers and government leaders charged with delivering and financing health and long-term care solutions. It was a growing awareness that, regardless of health and mobility declines or threats to their lifestyles, a sizable and growing majority of older people sought to stay put in their familiar homes and communities — what we now refer to as aging in place.[14] Most of all, they wanted to delay as long as possible, if not forever, going to a long-term care facility. Governments were especially sympathetic because of many studies showing that it was less expensive for them to provide long-term care and supportive services to older people in their own homes than in nursing homes.

More ambitiously, by encouraging the development of age-friendly communities, both the private and public sectors saw a pathway by which they could reinvent and rejuvenate the form and functioning of urban settlements and create sustainable (or smart growth) communities that could accommodate the lifestyles and activities of populations irrespective of their age or disabilities.

To help support its initiatives, the World Health Organization prepared a community development tool, titled *Global Age-Friendly Cities: A Guide*,[15] which was based on information drawn from focus groups with older adults, caregivers and service providers. In the US, Portland, Oregon, and New York City were involved in the early data collection efforts. In Canada, cities in four provinces initially participated in the consultations that led to the guide: Saanich, British Columbia; Portage la Prairie, Manitoba; Sherbrooke, Quebec; and Halifax, Nova Scotia. In 2010, the World Health Organization created its Global Network of Age-Friendly Cities and Communities to promote and implement its age-friendly principles. This network now comprises some 137 member cities and communities in 21 countries.[16]

Organizational Catalysts in Canada and the United States

Age-friendly communities throughout the world share many commonalities — rationales and implemented solutions. Yet societies have embraced this movement in different ways. Consider the different catalysts for the age-friendly programs in Canada and the United States. The Public Health Agency of Canada identifies age-friendly communities as one of the federal public policy approaches to promote healthy aging.[17] Likewise, most of Canada's provinces have made age-friendly communities part of their public policy agendas. They may provide funding, implementation assistance, or technical and social marketing supports. An assessment by a Canadian expert identified 560 communities in eight provinces as participating in the age-friendly-communities movement; 316 of these communities are in Quebec.[18]

In contrast, the implementation of age-friendly communities is not an official strategy in the US federal government's or state governments' aging or long-term care policies. America's governmental institutions have generally not embraced age-friendly principles as part of a comprehensive aging and long-term care policy, and state and local government funding sources have been relatively insignificant.[19] As one American expert, Andrew Scharlach, correctly observes, in the US age-friendly initiatives have generally been "isolated efforts

by individual communities, developed independently from one another without state or federal involvement."[20]

Rather, as Grantmakers in Aging observes,[21] most US age-friendly-community networks have been sponsored or funded by nonprofit organizations, often foundations (such as the Robert Wood Johnson Foundation), large charitable organizations (such as the Jewish Federation of North America), consumer organizations (such as the AARP Foundation) and large not-for-profit home care providers (such as the Visiting Nurse Service of New York). Foundations have played a supportive role in Canada, but to a much smaller degree.[22]

Although the catalysts and financing of these initiatives differ in the United States and Canada, they do share an important characteristic. In their implementation, many projects in both countries have involved creative partnerships between municipal governments and businesses, architects, planners, designers, philanthropists, public health agencies and educational institutions. For example, Age-friendly NYC involved a public-private partnership between the New York Academy of Medicine, the Mayor's Office, the city's departments of aging and health, and the New York City Council.[23] Atlanta's Lifelong Communities Program was spearheaded by the Atlanta Regional Commission, which played multiple coordinating functions across the metropolitan area (10 counties and 67 cities); it acts as Atlanta's Area Agency on Aging, metropolitan planning organization and regional development centre.[24] Thus, it was able to pull together a diverse array of professionals (mayors, county commissioners, public health and planning and transportation officials, hospital administrators, housing developers, public safety officers, parks and recreation directors, librarians, doctors and lawyers). Likewise, Calgary's Elder-Friendly Communities Program, designed to encourage stronger neighbourhood involvement by older residents, was a collaborative effort that included the Faculty of Social Work at the University of Calgary, the United Way of Calgary, the City of Calgary (Senior Services Division), the Calgary Health Region (Healthy Aging) and Calgary Family Services.[25]

Age-Friendly Communities: Questions Needing Answers

Now, almost eight years after the beginning of the WHO's initiative, it is helpful to look critically at the age-friendly-communities movement.

Now, almost eight years after the beginning of the WHO's initiative, it is helpful to step back and take a critical look at the age-friendly-communities movement. Key to such an inquiry is asking the right questions. In the following sections I consider seven of the most important ones.

Would organizational or funding synergies result if age-friendly-community programs joined forces with other initiatives?

Do age-friendly-community initiatives have an identity problem?

This might seem an odd question. After all, the age-friendly-communities movement is a signature program of the World Health Organization and has become official policy of many governments; its initiatives are funded by both private and public sector organizations throughout the world.[26] Thus, it might seem strange to suggest that age-friendly initiatives might not have their own separate identity.

But do they? We often find that some of the most visible initiatives are remarkably similar to — indeed, are not easily distinguished from — other well-known community-based initiatives. These include Congress for New Urbanism, smart growth or sustainable communities, universal design, walkable communities and complete streets.[27] These planning and development strategies often call for physically compact, mixed residential- and nonresidential-use neighbourhoods that make walking easier, more attractive and safer and that offer older people access to public transit to make their usual trips to stores and services. The blurriness of these labels is exemplified by the Environmental Protection Agency's Building Healthy Communities for Active Aging initiative (launched in 2006), which supported the efforts of towns, cities and regional agencies to develop "smart growth communities" in order to promote "active aging."[28]

Depending on just how broadly one views the mission of age-friendly communities, many of the government-funded affordable rental housing and home- and community-based service programs in both the US and Canada could easily qualify. In the US, we have shown that government-subsidized affordable rental housing developments are more able to accommodate tenants aging in place when they provide supportive services and are staffed by service coordinators.[29] The availability of affordable rental housing in the US is critical to the success of a Medicaid-subsidized program (Money Follows the Person) that relocates very poor and frail elders from nursing homes back into community settings.[30]

We do not currently have any studies or even any serious commentary that examines how the initiatives subsumed under the umbrella of age-friendly communities overlap with these other planning, service, health and care efforts. It is worth asking, however, if organizational or funding synergies would result if age-friendly-community programs joined forces with these other initiatives. Perhaps age-friendly-community advocates can realize political or fiscal economies of scale by establishing partnerships with public or private sector stakeholders who share common community goals.

On the other hand, there may be downsides to such coalitions and good reasons for age-friendly-community advocates to stake out their own distinctive planning

and public policy turfs. It is easy to imagine age-friendly-community advocates not wanting to jump into bed with proponents of smart growth initiatives because they are often strongly criticized by private sector developers. There is also the danger that municipal or provincial/state policy-makers charged with home- and community-based care programs might not view the vast assortment of age-friendly-community initiatives as a high priority, as they consider that their primary mission is to help more physically and economically vulnerable older populations remain independent (that is, age in place) in their current homes.

Are age-friendly-community initiatives a long-term fix or simply a short-term bandage?

What we call "old age" often extends over a period of 20 or more years. Consequently, coping with the deficits of an aging body or a new retirement-oriented lifestyle is usually not a short-term proposition but requires solutions that are available over years, rather than months. This temporal context of old age means that advocates of age-friendly communities have an important responsibility. Older people expect programs to operate over the long haul and to not be susceptible to the whims of governments or fluctuating foundation or nonprofit organization priorities. When older people (or their family caregivers) have become accustomed to — and dependent on — a particular program, they do not want to see it abruptly and inexplicably end. Consequently, age-friendly-community initiatives that operate only for shorter periods because of their uncertain funding or political commitments have obvious drawbacks.

Older people expect programs to not be susceptible to the whims of governments' or other organizations' priorities.

Currently, I do not know of any database that allows for an assessment of the permanence or staying power of the many age-friendly initiatives now in operation in North America. Thus, research should be done on their expected lifespan, past failure rates and what funding sources — governments, foundations and other nonprofits — are the most sustainable.

How do age-friendly-community initiatives influence the caregiving responsibilities and burdens of family members?

The ability of older people to age in place or remain independent in their familiar abodes and communities depends heavily on the availability of informal care — that is, the assistance of family members and, to a lesser extent, friends and neighbours.[31] Only a small percentage of vulnerable older adults who are aging in place depend exclusively on formal care provided by paid professionals or front-line service workers. When trusted family members are unavailable, older people are at much greater risk of having to relocate to a long-term care facility.

Consequently, communities purporting to be age-friendly must also make it easier and less burdensome for families to perform their caregiving tasks, a commitment recognized by the World Health Organization. Its *Global Age-Friendly Cities* guide[32] outlines various ways to address the unmet needs of the family caregivers of aging populations. Without such targeted efforts, age-friendly-community initiatives convey conflicting messages. Even as they purport to help older people live independently in their own homes and communities, they may be erroneously assuming that these elders are able to avail themselves of family assistance. Older residents who lack this informal care will often be unable to reap the benefits of the age-friendly programs offered by their communities. Consequently, targeting the unmet needs of these family members may be just as important as helping older people themselves.

What individual outcomes are they trying to achieve?

Communities initiating age-friendly programs must be clear on what active or successful aging means to older adults. I theorize that when older people feel they are living in places that are congruent with their needs and goals, they will have two kinds of favourable emotional experiences: they will be in their *residential comfort* and *residential mastery zones*. They will then achieve what I refer to as *residential normalcy*.[33]

First, when they are squarely in their *residential comfort zones*, older people will have pleasurable, appealing, hassle-free and memorable experiences. If age-friendly-community initiatives are to help older people achieve this goal, they must offer these elders opportunities to engage in a variety of enjoyable and stimulating leisure and recreational activities, part-time jobs and volunteer activities. Community centres should offer social opportunities for older people living alone. Nursing home staff should be compassionate, friendly and thoughtful.

Second, when they are squarely in their *residential mastery zones*, older people will occupy places in which they feel competent and in control of their lives and surroundings. Here they will find resources that enable them to effectively manage and compensate for their chronic health problems and physical and cognitive declines without assaulting their dignity or autonomy. They must not feel frustrated or inhibited by stairs, or overwhelmed by the demands of maintaining their older dwellings or not being able to perform their everyday activities — whether getting dressed or visiting their doctors. They must not fear walking in their neighbourhoods — because of either crime or heavy traffic. They should not have to tolerate domineering and insensitive care workers or professionals who make them more aware of their deficiencies or who continually violate their privacy; and they should have a major say in who delivers

Both young and old benefit when communities improve the safety and attractiveness of pedestrian walkways or make parks safer and more physically attractive.

their care. In short, in these places, they will not have to behave in personally objectionable ways or unduly surrender mastery of their lives or environments to others.

Making these distinctions, however, raises an important policy-related question. Are age-friendly communities expected to help older people achieve both of these lofty goals or one more than the other? Are they intended to help older people live fuller, more meaningful and more enjoyable lives or to help physically and/or cognitively impaired older people age safely and autonomously in place? Do both these goals have equal priority — or is one more expendable? In short, if there is a budget crunch, will the programs sacrificed be those designed "merely" to ensure a comfortable and enjoyable way of life for older people and will communities fund only programs that help the most vulnerable old?

What older (or younger) populations are they trying to reach?

Some age-friendly-community programs have more limited agendas than others. For example, they may target the needs of racial or ethnic minorities because they are rightly concerned that language or cultural values may restrict their access to the health and social programs they need. Some places across England, Wales and Northern Ireland are specifically focused on making their communities dementia-friendly. They target people with dementia with the goal of "empowering people with dementia to have high aspirations and feel confident, knowing they can contribute and participate in activities that are meaningful to them."[34]

In contrast, other age-friendly-community programs have wider mandates and seek to address the unmet needs of not just the old but also the young. This is a commendable goal, to be sure, and several intergenerational volunteer programs have resulted in older people assisting younger people with their educational needs. And it is certainly consistent with universal design imperatives: both young and old benefit when communities improve the safety and attractiveness of pedestrian walkways or make parks safer and more physically attractive. These are all highly worthwhile programs, but once again, in periods of overstretched budgets and competing goals, we must ask if we can afford programs with such broad mission statements.

Consider, for example, the array of problems that older people often encounter when they are reluctant to move from their long-occupied dwellings and neighbourhoods, even as these places become increasingly out of sync with their lifestyles or capabilities.[35] We can group them into six categories:[36]

- Unaffordable housing
- Dwellings that have physical deficiencies or are poorly designed
- Social isolation
- Unsafe neighbourhoods — because of crime issues or traffic hazards
- Transportation access problems
- Unmet needs for long-term services and support and for managing chronic health problems

Governments at all levels typically lack sufficient budgets to target all these problems effectively, and this raises various policy issues. Should certain categories of problems receive priority? Should these programs primarily target older people who are already receiving help from family members and only need a modest amount of formal assistance to maintain their independent households? Alternatively, should governments target isolated older people who have no informal assistance and have multiple aging-in-place problems? Should communities focus their budgets on the most urgent needs of the poor, or should they cast a wider net to address the less urgent needs of older people with moderate incomes? Should age-friendly-community initiatives primarily assist older people seeking to age in place, or should they allocate some share of resources to help older people transition to long-term care facilities that best match their unique demographic characteristics and capabilities?

Prior to developing their age-friendly initiatives, communities should attempt to answer these difficult questions. It may be unrealistic for them to develop programs that purport to assist a broad cross-section of older people. Consequently, the "use of a universal checklist of actions as a starting point for creating age-friendly communities"[37] may not be good public policy. Because the resources of communities and the unmet needs of their older populations both vary, communities should rely on carefully tuned diagnostic or evaluative methods to prioritize the implementation of their programs. It is unclear whether communities initiating age-friendly programs have gotten this message.

Why do some communities participate in age-friendly initiatives but not others?

Are age-friendly communities intended to help healthy older people live more meaningful lives or to help the most frail older people age safely in place?

A cursory examination of the locations of age-friendly initiatives shows that community participation in them is very uneven. One reason for the unequal distribution of these programs could be that it mirrors the distribution of older people with the greatest unmet needs.

Now this explanation is undoubtedly true to some extent, but another is more likely: the communities that most aggressively pursue age-friendly-community

initiatives have more motivated, caring or capable professionals, philanthropists or responsive leaders. That is, leadership indicators or qualities rather than need-based population assessments are driving the innovations in this movement. A sampling of such indicators would include the following:

- Leaders recognize the importance of empowering older people by improving their financial resources, education/training, civic engagement, and organizational and problem-solving skills.[38]
- Leaders prioritize their policies and fiscal resources by identifying the places with the greatest needs.[39]
- Leaders are willing to experiment and adopt novel planning and remedial strategies and revise outmoded solutions.[40]
- Leaders respect and incorporate older residents' feedback when deliberating solutions.[41]
- Leaders recognize the need for distinctive strategies, skills and solutions to respond to older residents with varied social, economic, racial and ethnic backgrounds.
- Motivated stakeholders (individuals and organizations) in private and government sectors with good leadership qualities initiate, fund and operate programs benefiting their older constituencies.
- Leaders recognize that good governance is not just about responding to crises but about continuously questioning the status quo, acknowledging lost opportunities and anticipating the problems that accompany new trends.[42]

Older people with the greatest unmet needs are not necessarily found in places with strong leadership.

Now perhaps we should be celebrating those communities with age-friendly initiatives, irrespective of their origins. After all, their older residents are benefiting, and attributing the presence of these programs to the leadership qualities of their communities is hardly a bad thing.

However, a less charitable conclusion is justified for two reasons. First, older people with the greatest unmet meets are not necessarily found in places with strong leadership — indeed, sometimes the opposite is true. For example, socio-economically depressed rural communities occupied by chronologically older and lower-income adults often have little effective leadership. And second, some localities have more limited resources to serve their vulnerable aging populations and would benefit more from age-friendly-community initiatives.[43] The confluence of these demand and supply indicators argues for a more comprehensive regional planning approach to ranking or prioritizing the places most in need of age-friendly-community initiatives. The presence of needy older residents should be the principal criterion for locating these age-friendly responses, and not the presence of resourceful leaders.

We know very little about how effectively the for-profit, public and nonprofit sectors are operating or administering these programs.

How do we know if these programs work?

A conceptual framework frequently used to assess the quality of care found in medical establishments offers one approach for judging the effectiveness of age-friendly-community initiatives. Developed by Donabedian, this framework has three evaluative components.[44]

First, we must ask whether communities have acquired the structural capacity — that is, the resources and opportunities — to accommodate the needs and goals of their aging populations and to help improve their physical and psychological well-being. Alternatively, we may ask whether communities have the resilience or adaptive capacities to address the needs and goals of their aging constituencies.[45] This is by far the most researched topic by analysts of age-friendly communities. There is no shortage of very detailed descriptions of age-friendly interventions initiated by communities throughout the world and how they open up new opportunities or pathways for their populations to age successfully.

Second, we must inquire how well these interventions are performing — that is, evaluate their procedural aspects. Answering this question requires us to evaluate how many or how often older people are using or benefiting from these program interventions and whether they are appropriately designed for or successfully reaching their intended audiences. A focus on process also requires us to evaluate whether the providers or operators of these age-friendly-community products or services are administering them competently and effectively. Very few age-friendly-community studies have focused on these issues. Reporting about the demographics, lifestyles and health status of the older users of these program interventions and how they differ from nonusers is still very uneven. We also know very little about how competently or effectively the for-profit, public and nonprofit sectors are operating or administering these programs.

Third, we must evaluate the outcomes of age-friendly-community programs — that is, how they have changed, maintained or optimized the material or social conditions of older people, enabling them to more effectively realize their goals and needs. Can we causally link the presence of these age-friendly initiatives to improvements in the physical or psychological well-being of older people and their greater ability to pursue their activities? Alternatively, have these initiatives helped the public sector achieve its aging population policy agendas by remedying — perhaps less expensively than earlier solutions — the inappropriate housing, neighbourhood and long-term care conditions of its aging constituencies? This third inquiry is unquestionably the one for which current studies of age-friendly-community initiatives have provided the fewest answers. Few investigations have assessed program outcomes, and the majority of these

report on the satisfaction or happiness levels of small convenience samples of older users.[46] Few studies examine how these programs have influenced the self-reported health of older users.[47]

This dearth of evaluative studies makes it harder to justify the funding of new age-friendly-community initiatives and weakens arguments for their continuation. We have entered an era when evidence-based research has become ever more important for judging program success. Increasingly, policy analysts are demanding at a minimum a quasi-experimental research design to demonstrate that what we are manipulating (e.g., introducing demand-responsive transportation or a paratransit alternative) is responsible for a favourable outcome (e.g., the improved mobility, health and activity levels of a neighbourhood's older population). This requires analyses that compare how the outcomes differ for beneficiaries and nonparticipants of a program, carefully controlling for the possibility that the two populations were not similarly deprived at the outset — demographically or health-wise. These findings must be able to respond to skeptics who ask, "Can you demonstrate to me that if we hadn't introduced this program, these older people would have been any worse off?"

Careful measurement of the outcomes of age-friendly-community initiatives allows proponents and stakeholders to judge whether alternative program initiatives might yield better results.

When measuring these outcomes, researchers must also choose between two world views.[48] On the one hand, they can rely on the self-assessments or subjective experiences of older people;[49] alternatively, they can rely on objective indicators of well-being as measured by experts or professionals. Most age-friendly evaluative studies have focused on whether the older users of these programs are satisfied, feel good about their lives or estimate that they can remain independent for longer. Far less frequently, studies have reported on outcomes such as reduced falling rates, lower rehospitalization or nursing home admission rates, better medication management outcomes, fewer emergency room visits, more doctor visits, fewer depressive symptoms, increased volunteerism, reduced difficulties performing everyday activities or evidence of delayed entry of frail older people into nursing homes.[50]

Careful measurement of the outcomes of age-friendly-community initiatives is not just a prerequisite for ascertaining that a program is working as intended. These analyses also allow proponents and stakeholders to judge whether alternative program initiatives might yield better results — that is, whether communities are getting the biggest bang for their bucks.

Such analyses would address the concerns of critics who argue that communities are now merely funding "low-hanging fruit" projects.[51] By these they mean programs that are less complicated to implement, require relatively little

funding and yield visible but rather modest results. The cynics claim that communities are opting to achieve "quick wins" to demonstrate their commitment to their aging populations rather than big-ticket items that substantially impact the quality of their lives.

Consequently, communities should be asking, for example, if they should allocate expenditures for improved street lighting and public benches or for smart home technologies that would allow older people (and their caregivers) to better monitor and respond to their health problems and monitor their risks for falling. Should they be making exercise and physical activity programs more available to older people or constructing adult daycare centres offering a full range of long-term care services and supports? Should they be improving pedestrian pathways or training older people to better access the Internet and to select an appropriate home care provider?

Conclusion

Age-friendly-community-based programs must respond to criticism that their agendas are over-ambitious.

Age-friendly-community initiatives that aim to change the material and social surroundings of older adults, thereby enabling them to age more successfully, are unquestionably good policy. But given the reality of limited funding and competing demands for resources, proponents must make a stronger case for the development of these programs.

Fundamentally, advocates must decide on how their mission statements differ from those of other housing, planning, service and care programs developed by the private, public and nonprofit sectors that also purport to improve the physical and psychological well-being of their aging constituencies. They must demonstrate that their programs offer solutions that do not overlap with those of other community-based efforts, and thus deserve distinctive organizational recognition and separate pools of funding.

Age-friendly-community-based programs must also respond to critics who argue that their agendas are over-ambitious and cannot adequately address all of the challenges faced by older people seeking to live active, productive and independent lives in their communities. That is, it is unrealistic for them to purport to offer aging-in-place solutions that run the gamut from improving the walking environments of older people to ensuring that they have access to affordable rental housing and good-quality home-based support services.

To avoid the criticism that they are trying to do too much and in the end will always fall short of achieving their goals, prospective age-friendly communities

We need more evidence-based research assessments to determine whether these programs are working.

should narrow their mission statements. I would argue for two possible strategies, while recognizing that these decisions deserve serious debate. First, they should primarily target relatively healthy and physically able older people and help them remain active, productive and involved in their communities, rather than try to help the most frail older people remain independent in their current abodes as long as possible and avoid moving into the homes of their adult children or to a group residential care facility. Second, they should primarily serve the large and growing segment of seniors who are neither income poor nor income rich. This often overlooked but very large group of modest- or moderate-income seniors often find themselves outside the current safety net of social, long-term care and housing programs offered by federal, provincial/state and municipal governments, even as they cannot afford the products and services offered by the private sector.

Proponents of age-friendly communities must also respond to other concerns. While the self-congratulatory attitudes of participating communities may be justified, there is a real danger that the primary catalyst for these initiatives has been strong leadership, rather than the unmet needs of their aging constituencies. Unfortunately, age-friendly communities have done little to blunt such criticisms and have offered little evidence that programs are being targeted to where they are most needed. Moreover, it is unclear what will happen when funding for these programs terminates. Will some of these age-friendly initiatives turn out to be only temporary solutions?

Lastly and most importantly, we need more evidence-based research assessments to determine whether these programs are working and benefiting the targeted subgroups of older people. We require resident-level data that report on how these initiatives have improved the physical or psychological well-being of older people, and we need community-based data that identify the ways in which local and provincial or state governments have realized social, health or fiscal benefits.

The residential and care environments of older individuals do influence how successfully they age, and investing in community-based solutions can produce considerable benefits. Proponents of the age-friendly-communities movement must be willing, however, to tackle the many issues I have raised in this paper. In so doing, they can present stronger arguments for the long-term funding of their programs, thereby making it feasible for larger numbers of older people to age in place happily, healthily and competently in their own homes and communities.

Notes

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51. I am indebted to my colleague IRPP Fellow Mark Rosenberg of Queen's University, Kingston, Ontario, for these terminological distinctions.

About the author

Stephen M. Golant, a gerontologist and geographer, is a professor in the Department of Geography at the University of Florida. He is a fellow of the Gerontological Society of America and has been a Fulbright Senior Scholar at the Gerontology Centre in Simon Fraser University, where he investigated the need and prospects for assisted living facilities in Canada. He is the author of *Aging Successfully: The Quest for Residential Normalcy* (Health Professions Press, forthcoming).

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