Creating Age-Friendly, Intergenerational Cities: A Public Health Imperative

Global life expectancy has more than doubled over the last 125 years. As the world undergoes this vast demographic transition, adapting to the multifaceted needs of a growing aging population is critical to maintaining public health. Global trends toward urbanization further illustrate the demand for age-friendly and intergenerational cities (AFIC). With a projected two-thirds of the global population living in cities by 2030, and with many urban areas seeing 25 percent or more of their populations over the age of 60, creating age-friendly cities is an increasingly pertinent issue for local governments, urban planners, public health professionals, and countless other sectors.[1,2] The concept of 'age-friendly cities' was first coined by the World Health Organization (WHO) in 2007. This initial work identified eight key domains that render a city or community as age-friendly. These include but are not limited to: available services such as health services and transportation, the built environment including quality housing stock and greenspaces, and social conditions such as opportunities to participate in civic and social life.[2]

The Current State of Urban Aging & Exclusion

Current experiences of aging and age-based exclusion in urban environments manifests as a function of the ways in which city environments are "imagined and structured with a younger, working age demographic in mind".[3] Currently, older people living in cities, particularly those with pre-existing vulnerabilities associated with the aging process and/or those of other marginalized identities, face exclusion in a number of ways that inhibit their ability to remain integrated in their communities, as well pose a number of direct and indirect health risks to this population.[4] The WHO defines social exclusion across four primary dimensions: social interaction, production, consumption, and political engagement.[5] These dimensions may be understood as the overarching rationale of the eight domains of age-friendly cities. This exclusion is magnified by events facing the aging population that are less commonly experienced by younger subgroups, including retirement from the formal workforce and loss of a spouse and/or peer group. Furthermore, defunding, or total lack thereof, of national social security systems and the corresponding limited incomes held by many aging people, coupled with globally increasing costs of living, particularly in urban areas, create a double burden of sorts. These social and economic forms of exclusion, in addition to related issues of changing mobilities, mental health, and more, all function as social determinants of health, lending themselves to increased morbidities and early mortality.[5]

A Case Example: Jangsu Village, Seoul

Perhaps nowhere else is it as critical to enact age-friendly efforts than in South Korea, the fastest aging country in the world.[6] One case study in Jangsu Village, an intercity neighborhood of Seoul, shows particular promise for implementation of the WHO framework's domains in non-Western and/or under-resourced settings. Jangsu Village, with nearly 65 percent of its residents over the age of 60, underwent a multistakeholder regeneration effort that included improvements to housing conditions and creation of age-friendly amenities as primary priorities.[7] Residents in Jangsu Village highlighted the neighborhood's alleys as important gathering spaces that fostered community and promoted inclusion. This input in turn drove the prioritization of improvements to streetlight infrastructure, security cameras, and construction of anti-slip pavement and a higher number of benches along the streets. The examination of Jangsu Village's efforts demonstrates the importance of community participation to actualizing locally-relevant AFIC as well as the ways in which age-friendly framework implementation needn't be narrowly defined as benefits to the aging population alone.

Incorporating a Social Model of Disability & Intergenerationality

As is the case in Jangsu Village, in the process of incorporating policies and planning measures that address the needs of the aging population, it's important to not foster an overreliance on age-specific service provision alone, that both perpetuate ageist perceptions of older adults and also limit possibilities for universally age-friendly initiatives.[8] Rather, drawing from the disability justice movement, approaching AFICs from a 'citizenship-based' perspective and

MEDICAL	CARE	CITIZENSHIP
PATIENT	CUSTOMER	CITIZEN
FOCUS ON INDIVDUAL	FOCUS ON INDIVDUAL, FAMILY AND INFORMAL NETWORKS	FOCUS ON NEIGHBOURHOOD AND CITY
CLINICAL INTERVENTIONS	CARE INTERVENTIONS	PROMOTING SOCIAL CAPITAL AND PARTICIPATION
COMMISSION FOR 'FRAIL ELDERLY'	COMMISSION FOR VULNERABLE PEOPLE	AGE-PROOFING UNIVERSAL SERVICES
PREVENTION OF ENTRY TO HOSPITAL	PREVENTION TO DELAY ENTRY TO CARE SYSTEM	REDUCING SOCIAL EXCLUSION
HEALTH (AND CARE SYSTEM)	WHOLE SYSTEM	CHANGING SOCIAL STRUCTURES AND ATTITUDES

The 'citizenship-based' model of ageing

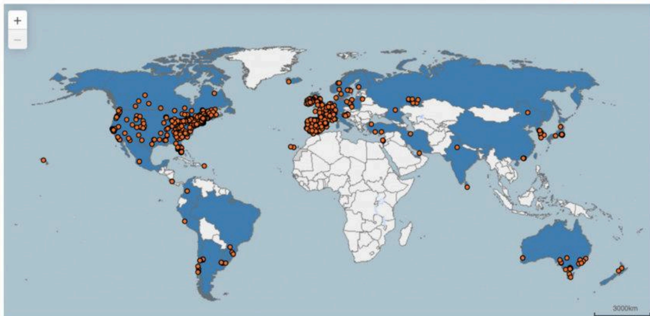
understanding both disability and aging as irrevocable locations on the full spectrum of the human experience enables policies and programs that cast the widest net, are more proactive in nature, and change environments and structures at their cores in a way that better services all ages and abilities.[9] In line with this, the WHO recommends intergenerational spaces and initiatives as opposed to those narrowly marketed for older people alone, especially those that are not strictly healthcare oriented.[10] The citizenship model, through its focus on "promoting social capital and participation," shifts the paradigm to intergenerationality as a protective factor against social exclusion and away from a focus on the medical model that aims to treat disease rather than promote health in aging.[3,10]

Moving Towards Universal AFIC

The following recommendations will further the goal of universal ascription and implementation of AFIC:

- Locally-oriented, multidisciplinary collaboration: As experiences in aging are far from universal, allowing local actors and priorities to drive the agenda setting of AFIC policy and planning in respective contexts is critical to successful implementation. Building strong cross-sectoral partnerships between local governments, public health professionals, urban planners and developers, community organizations, and older residents themselves are critical to implementing relevant infrastructure towards AFICs.[1]

Global Network for Age-friendly Cities and Communities



- Intersectional approaches for developing and rural settings: The localized nature of the responsibility of implementation of age-friendly planning and policies results in global disparities in AFIC participation, with a disproportionate share being in higher income countries that boast larger municipal and national budgets, among a number of other resources. Currently, there is a hyper saturation of AFIC within the WHO's Network located in North America and Western Europe. With 1 billion of the world's population living in urban slums, or informal settlements in the Global South, an intersectional approach is needed to pertinently address the needs of slum dwellers aging in the extremities of under-resourced environments. Universal improvements to living conditions in slums would likely carry positive benefits to older slum dwellers specifically and point to the ways that citizenship-model approaches hold greater promise than aging-focused and curative interventions alone: opportunities for economic assistance and mobility, increased access to health and other essential services, and improvements to substandard housing and lacking or nonexistent basic infrastructure, such as roads and water/sanitation.[11] An intersectional approach in this way will also better meet the age-friendly needs of rural communities and those existing outside stringent definitions of "urban" or "cities", for which bureaucratic decentralization and lower levels of socioeconomic development is a barrier.[12]

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