Age-friendly Cities and Communities

World experience and pointers for New Zealand

A review for the Office for Seniors

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Download the summary and report at: www.superseniors.msd.govt.nz

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Introduction

Recognising the global phenomenon of an ageing population, creating environments where people of all ages can actively participate and be treated with respect under the auspices of the World Health Organization's (WHOs) Age-friendly Cities and Communities (AFCC) programme is becoming a priority around the world, including New Zealand.

This report was written for the Office for Seniors to support the implementation of WHO's programme in New Zealand.

In particular, this report provides an overview of the international best practice for implementing the programme, in particular:

· evaluating the successes and benefits of AFCC programmes

· adapting the AFCC concept to fit local conditions and local resources

· incorporating public/stakeholder engagement into AFCC projects

· the criticisms of the AFCC concept and its processes

· the relevance of the AFCC process to New Zealand including standards, accreditation process, and formal associations.

For this review, the focus is on national and international literature from academic publications, including journal articles, research reports, think pieces and selected material from government sources. These have been found through internet searches, such as Google scholar. The results are selective as a result of the high number of sources and focused on works in English, from countries to which New Zealand may compare itself.

Part 1:

History of and case for the Age-friendly Cities movement

> AFCC [Age-friendly Cities and Communities] is probably, at the moment, the most internationally discussed meeting point for anyone interested in innovative public policies on ageing trying to adapt to global demographic changes and global urbanization.
>
> Moulaert and Garon 2016

Debates about securing optimum community environments for ageing populations emerged from a number of organisations during the 1990s (Phillipson 2016; Kalache 2016). The Age-friendly Cities (AFCC) framework reflects the key strategies of the Ottawa Charter for Health Promotion of 1986: creating supportive environments; strengthening community action; and developing healthy public policy, with an emphasis on participation, sense of belonging, and inclusion for older people (Dellamora 2014). The first World Assembly on Ageing, in Vienna in 1982, clearly reflected the belief that population ageing was becoming an issue of concern to developed countries[1]. The World Health Organization (WHO) shifted its emphasis from a disease focus to determinants of healthy ageing. Its programme was rebranded "Ageing and Health" and no longer talked about "the elderly" but "ageing". It adopted a "strong life course" approach to remind everyone that good health in older age is everybody's business.

1.1   Precursors to the age-friendly city initiative

A precursor to AFCC initiatives was the concept of "active ageing" developed during the United Nations' Year of Older People in 1999 (see also Part 2.1). This idea referred to the notion of older people's "continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour market"[2]. WHO acknowledged that:

> Physical environments that are age-friendly can make the difference between independence and dependence for all individuals but are of particular importance for those growing older. For example, older people who live in an unsafe environment or areas with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems.
>
> WHO 2002

In 2001, the WHO identified population ageing and increasing urbanisation as key problems that cities needed to address (WHO 2002). At the United Nations Second World Assembly on Ageing in Madrid in 2002 the Madrid International Plan of Action on Ageing (MIPAA) was produced, which promoted the participation of older people in decision-making at all levels, and encouraged organisations of older persons to represent them in decision-making at all levels[3]. MIPAA covers a wide range of issues and levels, from community to global. It emphasises a need for governments, in partnership with civil society, to promote age-integrated communities, invest in local infrastructure and environmental design to support multigenerational and multicultural communities, and to consider affordability and equity of access and choice in relation to housing.

The Vancouver Protocol was subsequently finalised at an international workshop organised by WHO in association with the Public Health Agency of Canada, and the WHO Global Age-Friendly

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1   www.monitoringris.org/documents/norm_glob/Scanned_Vienna_Int.Plan_Aging.pdf
2   http://www.who.int/ageing/active_ageing/en/
3   www.documents-dds-ny.un.org/doc/UNDOC/GEN/N02/397/51/PDF/N0239751.pdf?OpenElement

Cities project was launched in 2005. The purpose of this study was to gather information by asking older adults what features of their city are age-friendly; what problems or barriers they encounter; and what characteristics are missing from their environments that would improve their health, participation, and security. Overall, 158 focus groups of people aged 60 or over, with caregivers and service providers, were conducted in 33 cities worldwide (Dellamora 2014). These focus groups covered aspects of city structures, environments, services and policies to construct a comprehensive picture of the physical and social factors of the environment that promote or hinder active ageing (WHO 2007).

The themes that emerged from the focus groups were formed into eight domains of "age-friendliness":

1. Transportation

2. Housing

3. Outdoor spaces and buildings

4. Respect and social inclusion

5. Social participation

6. Civic participation and employment

7. Communication and information

8. Community support and health services.

From the outset, the AFCC movement meant much more than just aspects of the physical environment. Key features within each domain were summarised and compiled in Global age-friendly cities: A guide published by WHO in 2007. The aim was to stimulate the creation of accessible and inclusive urban environments to promote active ageing as defined by the WHO – "the process of optimizing opportunities for health, participation and security over the life course in order to enhance quality of life as people age"[4]. This was designed to apply to both individuals and population groups. Its intention was to assist people to realise their potential for physical, social and mental well-being throughout their life course, thus enabling them to participate in society according to their needs, desires and capacities.

1.2   Developing a global age-friendly network

The Guide identified the key features of an age-friendly city from the perspective of older people and service providers and is a reference for cities in developing and developed countries. This aroused interest from communities around the world and led to the development of the Global Network of Age-Friendly Cities and Communities (the Global Network). Any community that can demonstrate that it is actively engaged in the process of becoming more age-friendly can apply for membership to the network. Benchmarks or standards for the evaluation of age-friendliness within a city were developed later.

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4   www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf?ua=1

Instructions to cities wishing to join the Global Network emphasised that older people should be closely involved in all phases of age-friendly assessment, planning, and action. Applicants are required to include the eight WHO domains in their assessment, but they have flexibility to decide how best to measure age-friendliness in their own areas – WHO does not specify whether or how to use the checklist.

Specific elements of the AFCC assessment methodology include:

- documentation of the profile of the city, the older population, and an inventory of programmes and services for older people

- semi-structured focus groups with older people differing by age and socio-economic status, and, where possible, with the caregivers of older people unable to participate in focus groups

- discussions with service providers from the public, private, and voluntary sector.

Potential members of the Network must work through the four stages in the age-friendly development cycle: 1. Planning, 2. Implementation, 3. Progress evaluation, and 4. Continual improvement (WHO 2009).

The size of the city or community does not matter: membership of the Global Network includes rural villages as well as mega-cities. To accommodate smaller communities, including rural areas, the Global Network's name was changed from "Age-friendly Cities" to "Age-friendly Cities and Communities" (Warth 2016). Given criticisms of the AFCC approach (returned to later), it is worth reiterating that every member is free to apply AFCC principles flexibly, related to their specific circumstances. A mega-city will have different means and will have access to greater resources than smaller centres, but they will also face challenges at a different scale.

The WHO initiative and the Global Network spread rapidly and gained recognition as a global movement (Plouffe et al. 2012; Warth 2016). Membership has grown to over 500 cities and communities across 37 countries, covering over 155 million people[5]. The Global Network shares the local experiences of its members through a website, which features initiatives, resources and age-friendly practices developed and implemented by the network's members and affiliates[6]. It offers guidance on how to select, define and measure indicators in a way that is locally relevant and appropriate.

There have been two International Conferences on Age-friendly Cities hosted by network affiliates: in Dublin, Ireland, in 2011 and Québec City, Canada, in 2013. The International Federation on Ageing Global Conferences has dedicated conference streams on age-friendly cities and communities.

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5   www.extranet.who.int/afefriendly world. Retrieved 3/2/17
6   www.agefriendlyworld.org

1.3   Measuring the age-friendliness of cities

A significant recent publication from the WHO is *Measuring the age-friendliness of cities: A guide to using core indicators* (WHO 2015). This provides detail on how age-friendliness and adherence to the age-friendly concept should be measured.

> An "age-friendly city" is an inclusive and accessible community environment that optimizes opportunities for health, participation and security for all people, in order that quality of life and dignity are ensured as people age.
> WHO 2015

More specifically, in an age-friendly city, policies, services, settings and structures support and enable people to age well by: "recognizing the wide range of capacities and resources among older people; anticipating and responding flexibly to ageing-related needs and preferences; respecting older people's decisions and lifestyle choices; protecting those who are most vulnerable; and promoting older people's inclusion in, and contribution to, all areas of community life".

There are several features of note in the WHO definition and the statement that follows it (WHO 2015, p. 3), which are relevant to the interpretation and subsequent criticism of the AFCC concept and hence how it is applied in New Zealand and elsewhere.

- The definition suggests that there are benefits for all people rather than a total focus on people as they age.
- Health comes before participation and security in the definition. WHO itself is a health-focussed organisation: health policy and health service agencies have been in the forefront of the AFCC movement.
- It recognises diversity.
- The need for flexibility in the face of varied needs and preferences.
- A concern for most vulnerable groups in terms of equity.
- An emphasis is on respect, inclusion and the contribution of older people.

In her contribution to *Age-Friendly Cities and Communities in International Comparison* (Moulaert and Garon 2016). Lisa Warth (2016) lists the challenges that face the Global Network. One of these is sustainable growth – to ensure that the Network, with its limited resources, will have governance and management structures that are fit for purpose to serve a significantly larger membership. Another challenge is whether access to the Network can remain free of charge. Language barriers are significant in a network which spans more than 20 languages. Another challenge will be to address the regional bias in membership. Most membership growth has been in Europe and North America. The WHO would like to intensify the Network's outreach to countries in Latin America, Africa, the Eastern Mediterranean region, and South East Asia.

1.4   The challenges and benefits of an age-friendly approach in cities

The argument for an age-friendly approach revolves around the mix of challenges and benefits which urban environments pose for older people.

Phillipson (2012) summarises the challenges:

- older people spend the greater part of their time at home or in their neighbourhood, hence the importance of maintaining a high quality physical environment
- cities must meet the needs of stable groups (eg older people who may have lived in the same community for much of their lives) and highly mobile groups (eg students, professional workers) who may stay for short periods; the two groups bring contrasting expectations of how communities should be developed
- fear of crime and feelings of insecurity may be especially strong among older people living in urban areas (despite low levels of victimisation); such perceptions may limit participation in daily life
- some neighbourhoods may suffer from "institutional disengagement" as traditional services – shops, banks, and health services – close, being unable to compete with out-of-town developments[7]; older residents (and other age groups as well) may be particularly vulnerable to such changes – especially those with limited mobility.

But there are also benefits for older people. Cities:

- have an infrastructure of facilities that can enhance the quality of life for older people (eg museums, galleries, libraries)
- are centres for creative and technical innovation – this can be used to develop new ways to engage with ageing populations
- provide specialist resources for minority groups – for example, migrants adjusting to old age
- provide a broad range of social networks around which healthy ageing can be built
- provide access to specialised medical services.

Neal and DeLaTorre (2016) also argue the case for age-friendly communities categorising the benefits as economic, social, and environmental. Economic benefits include:

- older adults are an important part of the workforce and expand the labour pool; attracting and retaining older workers will help address shortages of qualified workers. They also have significant accumulated knowledge and skills, and help to retain institutional memory; having an age-diverse workforce can result in positive outcomes for employers and employees
- continued work later in life brings economic benefits to the community, and financial, health, and other benefits to older adults themselves
- older adults start more new businesses than younger adults, helping to grow the local economy
- the older adult market is stimulating new companies, new products and services, and new technologies

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7   In New Zealand, bank closures are currently affecting service provision in many small towns and rural areas.

- older adults are consumers and can bring in tourism and leisure dollars
- attracting or retaining older adults, who might otherwise leave a community, can be an important economic development strategy[8].

Neal and DeLaTorre (2016) list social capital benefits. Older people:

- provide care and resources across generations
- serve the community through volunteering and civic engagement, and receive benefits from this activity
- make significant contributions to the social, political, and environmental fabric of society
- age-friendly environments reduce social isolation and improve health and community engagement.

Age-friendly housing and urban physical infrastructure may:

- enable older adults to "age in place", thereby maintaining their social, business, and service connections, which could postpone public and private expenditure for institutional care
- increase the demand for affordable and alternative housing
- promote communities with physical environments that work for everyone, with a range of transportation options, facilitating mobility
- produce healthy and connected neighbourhoods that save residents time and money, and improve quality of life
- encourage opportunities for cross-sector co-ordination and collaboration
- facilitate healthy behaviours of older adults through their design and infrastructure, for example by encouraging physical activity; many chronic diseases can be prevented or controlled through attention to the physical environment.

Age-friendly communities may also address issues that influence health, such as pollution, as well as facilitate access to health care and social services, safety, and social support.

Lui, Everingham, Warburton (2009) reviewed 32 articles and reports in English from the period 2005 to 2008, and noted common features relating to the question "What makes a community age-friendly?" They highlighted the integration of the physical and social environments and the model of participatory, collaborative governance.

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8   These benefits can be substantiated in the New Zealand environment. See The Business of Ageing (Ministry of Social Development 2011) and Davey (2014).

Key points included:

- "the climate of inclusiveness is one of the most important aspects of age-friendly communities"

- there is a "need to construct an environment where social and physical facilities and services are integrated and mutually enhancing to support people to age well"

- older people are not "just the beneficiaries of these communities but also have a key role to play in defining and fostering their distinctive features", hence many age-friendly models are based on extensive research with older people, whose "lives and experiences should be used as a starting point".

Part 2:

Basic concepts related to Age-friendly Cities and Communities

In examining the literature on age-friendly cities and communities, several basic concepts emerge. These should be taken into account in considering the application of AFCC in New Zealand, even though it is very clear that this country, and the communities within it must make their own decisions about the process and its implementation, as WHO expects. They must ensure features which promote age-friendliness are built upon and that pitfalls are avoided. The concepts are grouped as follows:

2.1   Policy concepts – active/successful/productive ageing, "ageing in place"

2.2   Environmental concepts – environmental gerontology

2.3   Planning and housing concepts – community development, innovative housing options, naturally occurring retirement communities (NORCS)

2.4   Psycho-social concepts – developmental tasks of later life, social inclusion/exclusion, engagement and contribution, quality of life

2.5   Political and global concepts.

2.1   Policy concepts

Active/Productive ageing

As already mentioned, debates about securing optimum environments for ageing populations emerged from a number of organisations during the 1990s. The theme of the United Nations' International Year of Older Persons in 1999 was "active ageing makes a difference". As a contribution to the 2002 Second World Assembly on Ageing, the WHO launched *Active Ageing: A policy framework* – a new initiative to address challenges and opportunities in an ageing world, with active ageing as "the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age" (WHO 2002; Buffel et al. 2012).

However, the roots of the term "active ageing" stretch back to the 1950s and 1960s (Walker 2016). The gerontological theory of "disengagement" argued that old age is an inevitable period of withdrawal from roles and relationships. This was challenged by the "activity" theory, which argued for maintaining into later life the activity patterns and values typical of middle age. Activity theory lay behind the WHO AFCC initiative. Like other terms (eg successful ageing, productive ageing, healthy ageing, ageing well) "active ageing" is simultaneously a scientific and political construction (Lassen and Moreira 2014). In some contexts, particularly in Europe, "active ageing" in public policies has been taken to mean supporting longer working lives, ie giving it an economic slant, similar to "productive ageing". The aim of the European Year for Active Ageing and Solidarity between Generations 2012 was to help older people stay at work longer. Given the increasing costs for pensions and health care associated with population ageing, it is not surprising that policies focus either on fostering labour market participation

or on increasing physical activity (and thus health) in older adults (Boudiny 2013)[9]. The WHO concept of active ageing refers to older people's "continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour market" (Pinheiro, Diogo, Góis and Paúl 2015).

Walker proposes key principles as the basis for a strategy on active ageing (Walker 2016). "Active ageing" should:

- include all meaningful pursuits which contribute to the well-being of individuals, their families, community or society at large and should not be concerned only with paid employment; volunteering should be as highly valued as paid employment

- be primarily a preventative concept, involving all age groups across the life course

- encompass all older people, even those who are frail and dependent; the link between activity (including mental stimulation) and health holds good into advanced old age

- be gender-sensitive not gender neutral

- maintain intergenerational solidarity ie fairness between generations as well as the opportunity to develop activities that span the generations

- embody both rights and obligations; the rights to social protection, lifelong education and so on should be accompanied by obligations to take advantage of such opportunities and to remain active in other ways

- be participative and empowering; there must be a combination of top-down policy action to enable and motivate activity but also opportunities for citizens to take action, from the bottom up, in developing their own forms of activity

- respect national and cultural diversity

- be flexible.

Successful ageing

The term "successful ageing" is linked to an activity perspective, but has been criticised as placing an unrealistic expectation on older people to maintain levels of activity and to defeat the causes of disease. This overlooks not only physical and mental limitations but also the economic and social structures that frequently inhibit or prevent people from remaining active – enforced retirement and age discrimination being obvious examples. The adjective "successful" implies that there are winners and losers in the ageing process and can stigmatise people as "unsuccessful" if they have a disease or disability. Even if a person suffers from such limitations, they may still engage in a range of activities and experience a relatively high quality of life. "Successful" and even "active" ageing as policy slogans can lead to damaging stereotypes (Timonen 2016; Walker 2016). The active/successful

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9   While engagement in paid labour is generally considered to be a positive indication of older people's social participation, inclusion and contribution, it is not a desirable situation if they would rather be retired. However this option is not always available as older people may need to work to ensure their economic security. Lehning (2010) suggest that participation in the workforce should not be the only indicator. Levels of satisfaction with, or the desirability of, opportunities for paid work from the older person's perspective are also important. Similarly, volunteer activity is generally considered to be a positive indication of social participation and contribution, but this is not a desirable situation if older people would rather be engaging in paid work. This option may not be available to them because of their age, and either overt or covert discrimination.

ageing stereotype of a super-fit pensioner who does extraordinary feats of gymnastics or athletics is likely to deter anyone other than the physically active from believing that active ageing has any relevance to their lives. It emphasises physical prowess and rarely focuses on mental capacity (Walker 2016).

Ageing in place

Ageing in place, as a policy concept, acknowledges that the majority of people prefer to remain living in their own homes as they age. It is supported by governments and policy makers as being more cost effective compared to older people living in long-term aged care facilities. Coleman (2015) argues that it is also cost efficient for both seniors and their families. There are externalities for the greater community. Seniors are often the "most stable forces in the neighbourhood, when they are forced to move out in search of more adequate and affordable health and housing services, communities suffer". In disasters, the most resilient survivors and the majority of responders are seniors[10]. On the other hand, "as a senior's health deteriorates, their inability to maintain their home and subsequent deterioration of the housing stock negatively affects the community's health" (Coleman 2015).

Wiles, Leibing, Guberman, Reeve and Allen (2011) explored the meaning of ageing in place to older people through focus groups and interviews in two New Zealand communities. They showed that AIP has the advantage of giving a sense of attachment or connection and feelings of security and familiarity in relation to both homes and communities. Ageing in place also provides a sense of identity through independence and autonomy, and through caring relationships in the places were older people live. It means much more than "home" or housing; it operates in multiple interacting ways, which need to be taken into account in policy.

Wiles et al. (2009) asked older people what ageing in place meant to them, and whether it necessarily meant staying in the same place. The phrase "ageing in place", so popular among policy makers and service providers, was not familiar to most of the older people who participated in the research. However, once this was explained, the overarching message was that they wanted to have choices about their living arrangements rather than decisions being driven by other people. They also wanted access to services and amenities. For them, ageing in place meant staying in one's home or community, and was linked to a sense of independence and autonomy. For many, having the financial resources to make choices was also an issue; units in retirement villages were often seen as too costly. The concept of choice appears in New Zealand's Positive Ageing Strategy, which defines ageing in place as "being able to make choices in later life about where to live, and receive the support needed to do so" (Schofield, Davey, Keeling and Parsons 2006). How such "choice" is to be supported by government policies and resources is not specified.

Attachment and connection for the New Zealand respondents operated at social and community levels in terms of friendships, clubs, access to resources and health facilities, and familiar environments. Being greeted by numerous people as they walked down the street provided daily evidence of belonging, and they derived a sense of security from familiarity with the wider community, both in terms of people and places. These were the important factors influencing the potential to age in place. Thomas and Blanchard (2009), among others, have advocated that "ageing in place" be replaced by

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10   Community development. This was made clear in the aftermath of the Canterbury earthquakes (see Davey and Neale 2013).

"ageing in community" as a policy goal, reflecting that independence and self-reliance are insufficient if not accompanied by opportunities to maintain important interpersonal bonds and participate in meaningful social roles. Although most discussions on ageing in place focus on home, there is growing recognition that, beyond the home, neighbourhoods and communities are crucial factors in people's ability to stay where they are. This is the link to environmental gerontology (see Part 2.2).

The ageing in place concept has been criticised in the literature. Wiles et al (2011) found the term ambiguous. "Home" is not just the house but also its surroundings which are subject to influences beyond the personal. Critical analysis of policy to support ageing in place highlights the tension between idealising "community care" and "family support" on the one hand, and the drive to cut costs on the other, which can mean that older people lack real choice about preferred support and living arrangements. Wiles et al. conclude that there is no "one-model-fits-all" answer to the question of "What is the ideal place to grow older?"

Scharlach (2016) asks whether ageing in place is inherently beneficial. If most older people want to continue to live in their current communities why then do people pay so much to live in senior communities? Are age-segregated communities a sign of the failure to provide genuine age-friendliness in age-integrated communities, or do some elderly "birds of a feather" truly want to "flock together", reflecting social stratification based on age and cohort-related similarities? Rather than sweeping generalisations about preferences, perhaps more research is needed on the relative advantages and disadvantages of age-integrated environments compared to age-segregated settings.

2.2   Environmental concepts

Environmental gerontology

To assist ageing in place, consideration needs to be given not only to housing options and features but also to transport, recreational opportunities, and amenities that facilitate physical activity, social interaction, cultural engagement, and ongoing education (Wiles et al. 2011). The rise of "environmental gerontology" – the relationship between older people and their socio-spatial surroundings – is strongly linked to the AFCC approach. As already stated, there is growing recognition that neighbourhoods and communities are crucial factors in people's ability to stay where they are and to age well. Mitchell, Burton and Raman (2006) reinforced this with respect to dementia-friendly outdoor environments (see Part 3.1). In the United States, the Environmental Protection Agency is active in supporting the Supportive Age-friendly Environments (SAFE) model and sponsoring a *Building Healthy Communities for Active Ageing* award programme, which recognises community efforts to integrate smart growth with active ageing (Clark and Glicksman 2012).

Ecological theory acknowledges the mutual relationship between individuals and their environment at multiple levels – behavioural, cognitive, and emotional (Wahl and Oswald 2010). The environment continually changes so older people must take from it what they need, control what can be modified, and adapt to conditions that cannot be changed (Emlet and Moceri 2012). Menec et al. typified this as the "person-environment fit" (Menec et al. 2011). Age-friendliness requires the reduction of environmental barriers and the improvement of environmental supports, so that older people can meet their needs more easily and maintain their independence for as long as possible. Ecological principles therefore have a place in the AFCC framework, linked to the concepts of active ageing and ageing in place.

Sustainable/harmonious cities

The aim of creating age-friendly cities links back to ideas around "sustainable" and "harmonious cities"' produced in the 1990s and early 2000s. The former raised questions about managing urban growth in a way that could meet the needs of future as well as current generations (the concept of sustainability originally formulated in *Report of the World Commission on Environment and Development: Our Common Future,* United Nations General Assembly, 1987).

The concept of sustainability also arises in considering the political environment for AFCCs. Achieving more equitable and sustainable cities for all age groups requires strong and sustained political leadership (Brasher and Winterton 2015; Kendig and Phillipson 2014) (see Part 2.5).

2.3 Planning and housing concepts

The ageing of the population presents an opportunity and an imperative to make changes in the housing sector to enable older adults to age in place and maintain their social, business, and service connections, according to AFCC principles.

Livability

Urban planning has a great deal to do with age-friendliness, epitomised in the concept of "livability" described by Scharlach (2016): "It is difficult to see how a city can be age-friendly if it is not a reasonably decent place for human beings to live". The American Association of Retired People (AARP) defines a "livable community" as one that is safe and secure, has affordable and appropriate housing and transport options, and has supportive community features and services. This is expressed in the AARP's Livability Index, which frames its Network of Age-Friendly Communities[11]. These descriptions echo the general characteristics of a "healthy city" identified by the WHO: basic sanitation and hygiene, access to health care, a health-supportive environment, and the opportunity to achieve a good quality of life[12].

Planning systems

There are barriers to age-friendliness inherent in many planning systems. Kennedy (2010), writing in the US, concludes: "city planning needs to reform" if the objectives of AFCC are to be realised. Creating communities that will support ageing in place requires re-imagining outdated visions, policies, building regulations, and zoning ordinances. It also requires cultivating a wider understanding of the social, economic, and demographic realities of the twenty-first century. A maze of bureaucracy can discourage new ideas, innovative projects, and creative renovations. Many city planners are occupied with zoning enforcement and plan checking, rather than acting as visionaries to help shape the future of their communities.

Healthy land use policy must allow for rather than prevent integrated uses so that jobs, services, and retail are within walking distance of housing. Local planning and zoning efforts in many developed countries have pushed these uses apart. Kennedy calls for zoning procedures to be assessed to see

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11   www.livabilityindex.aarp.org/livability
12   www.who.int/healthy_settings/types/cities/en/

whether they have been used in a way that is healthy for the community, particularly for vulnerable older adults. The segregation of homes, commerce, and workplaces has produced car-dependent growth patterns which limit transport choices, including opportunities for walking, and these can restrict housing options.

In the United Kingdom, Richard Rogers and Anne Power (2000) developed a new approach to urban planning, calling for spaces to be shared for the collective good and for a reversal of the drift towards "suburbanisation". These ideas are relevant to developing age-friendly cities. In discussions of dementia-friendly environments there is also a call for a good mix of land use, building form, styles and architectural features to improve "legibility" (see Part 3.1).

Further criticisms of current planning methods and approaches relating to AFCC include the time taken to achieve results. Scharlach et al. (2013) go even further: "Community-wide planning efforts such as [age-friendly initiatives] face a number of challenges, including inconsistent plan implementation, lack of community structures to facilitate translation from planning reports to ground-level actions, a focus on major system changes that typically occur very slowly".

Housing

Housing is part of the physical environment but also an important aspect of the psycho-socio environment in which older adults live and is linked to the AIP concept. Housing is one of the eight "domains of livability" in the original WHO AFCC model[13]. Housing issues figure strongly in AFCC policies around the world (Lewis and Groh 2016).

Local governments may play their part in promoting AFCC by providing social housing. The adaptation of social housing to reflect the needs of older people may be part of this, ideally negotiated with residents. Other local authorities adopt a liberalist approach leaving housing to the private market (Pennec and Le Borgne-Uguen 2016). Where home ownership rates are high, as in New Zealand, policies are required to support older homeowners. For many, housing expenses (repairs, taxes, electricity, etc.) can exceed their financial resources. Speaking in a French context, Pennec and Le Borgne-Uguen (2016) note that "new forms of impoverishment emerge among the population of small property-owners… in particular women whose retirement pensions remain notoriously lower than those of men". An example comes from São Paulo in Brazil. Experts responsible for conducting the AFCC consultations found that questions about housing options were not understood by participants. In Brazil, the vast majority of older people have no choice but to remain in their current dwellings or live with family, because adapted and assisted-living dwellings in both the public and private sectors are extremely scarce. They could not criticise the lack of possibilities when they did not know what could exist (Plouffe, Kalache and Voelcker 2016).

Housing is a determinant of health and a key component in quality of life, linked closely to age-friendliness. Accessibility to affordable housing is a recurrent concern among older adults in many countries. Much has been written about older peoples's living arrangements, housing preferences, home adaptations to reduce health risks (eg falls), and home-based interventions (Gitlin 2003; Howden-Chapman and Wilson 2000).

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13   In a recent public lecture in Wellington, Professor Chris Phillipson suggested that housing should be the central domain in WHO's "daisy-wheel" model

To take into account preferences, financial resources and differing capabilities, housing types for older people should be varied – single family, apartments, assisted living, communal options etc. Age-friendly communities should offer a continuum of housing options and supportive services, reducing the need for moves, and preventing or postponing costly public and private expenditure for long-term institutional care. Among the options could be communal or gated living. Lewis and Groh (2016) note the rapid growth of "retirement living" developments since the 1960s, which raises debates about the relative advantages of "age integrated" versus "age segregated" home environments and the degree to which older people wish to remain part of the larger community. Some surveys have raised concerns about privacy in senior housing which may have collective lifestyle features. This must be balanced with opportunities for social interaction.

In many countries, land use zoning and property taxes influence the availability and occupancy of various types of housing, as already mentioned. Such codes specify the type of building structures allowed in an area. Urban plans may segregate housing by type and use, restricting areas where smaller and multiple unit developments are allowed. This may prevent older people from moving home within their existing community environment. Older home owners may thus become "prisoners in their homes", according to Scharlach (2016), unable to move or down-size. Assistance with adaptation and renovation, retro-fitting schemes and assistance with down-sizing would be beneficial. Owners may be reluctant to allow modifications because they are concerned about not being able to sell or rent the house/apartment to a younger population. Lewis and Groh (2016) call for revisions in planning policies and zoning to allow accessory dwelling units on single detached lots, co-housing developments that provide private living units within communally managed living areas, and multi-generational "urban villages".

Financial accessibility will influence social participation and be a key factor in building an age-friendly community. High property taxes can limit housing options for lower-income older people, making some housing unaffordable. Age-friendly city initiatives may include strategies to reduce property taxes for low-income seniors.

Local and central government agencies are criticised in the literature for their inability to provide adequate housing of the right type and at the right price for older people. Local government may have limited control of the political or fiscal tools required to bring about change. Housing options, for example, are often determined primarily by the private consumer market, although local planning agencies can help to regulate and incentivise construction types and their location.

Christine Kennedy (2010) concludes that unless today's civic leaders shift outdated, suburban paradigms and begin creating "Cities for All Ages", the needs and expectations of ageing Baby Boomers for appropriate housing and services will dramatically threaten public resources. With an expanded housing spectrum and hubs of services, older adults can remain physically and socially integrated in their cities. This re-imagined city with ageing in place communities will be vibrant enough to attract young people, while allowing older people to stay in their communities for a lifetime.

Universal design

Universal design principles are routinely applied in new buildings to accommodate the functional needs of both able-bodied and disabled people. These principles could be extended to "visitability", as suggested by Fitzgerald and Caro (2014), as well as accessibility features. Older housing stock, however, often does not measure up to these principles. Cost is one of the major barriers to retrofitting accessibility features.

Surveys and focus groups with older people, reported in the literature, list features of housing (both new and adapted) that would assist ageing in place and a good quality of life. These include:

- the living space on one level, including full bathrooms and bedrooms on the main level
- stair-free environments
- walk-in showers
- wide doorways, and entrances without steps
- spaces large enough to manoeuvre a walker or wheelchair
- easy to use light switches, knobs and handles located at an appropriate height for a wheelchair user
- appropriate insulation, heating, lighting and soundproofing
- safety features, such as night lighting and security systems.

Innovative housing options

A variety of housing options is necessary to meet the preferences of a diverse older population. Progress has been slow beyond specialist provision such as retirement villages and extra-care schemes. Meeting this demand will require creative partnerships between older people, local authorities, building companies, housing associations and other relevant groups.

Neal and DeLaTorre (2016), in a US context, also recognise that an ageing population will increase the demand for alternative housing arrangements. Age-friendly communities need to take into consideration the changing housing landscape. They suggest that the retirement community industry is "in crisis", as age-segregated communities have faced difficulties in finding residents and maintaining high occupancy rates. Contributing factors include the high cost of retirement housing and a "growing disaffection with institutional living". These conclusions are yet to be observed in New Zealand.

The authors expect a growing demand for alternative housing arrangements that offer a combination of affordability, accessibility, and supportive services. They predict that people remaining in single family homes will increase spending on remodelling to meet their changing needs. Research on housing preferences in the US found that many Baby Boomers reported a preference for apartments or attached townhouses with an easy walk to services and a shorter commute, compared with single family homes in conventional suburban communities. There is likely to be a significant degree of interest in options such as co-operative and inter-generational housing.

Examples of innovative housing options

Senior co-housing is a way for a group of people to collaborate in creating a custom-designed neighbourhood and taking control, developing new types of housing directly tailored to their needs and aspirations. Such developments typically include individual private homes and socially oriented amenities such as a library, guest rooms, community gardens, laundry, dining room, and kitchen. The model, which originated in Denmark, was first adapted for elders in 1987 when one floor of a downtown Copenhagen apartment building was retrofitted as co-housing (Durrett 2009)[14].

The first three senior co-housing communities opened in America in 2006:

- Glacier Circle in Davis, California, is a townhouse-style community housing 12 friends who have known each other for 30 years.

- Elderspirit in Abingdon, Virginia, is the first residential community formed around later-life spirituality. It has 14 owner-occupied cottages, and 15 affordable rental apartments.

- Silver Sage is an upscale community of 16 duplexes and attached homes in Boulder, Colorado. Several more senior co-housing communities are now being developed in the US.

The collaborative efforts of a private developer, a redevelopment agency, a non-profit arts programme and an affordable housing provider built the first senior rental apartments offering independent living in a creative, art-inspired environment. The Burbank Senior Artists' Colony includes a theatre and art studios, as well as 147 rental units (70 percent at market rate; 30 percent affordable rentals). Residents host arts events for their neighbourhood, presenting live entertainment and opportunities to work in the art studios (Kennedy 2010).

Providing affordable housing for low-income older renters in high-cost suburbia has been accomplished by Senior Housing Solutions (SHS), a non-profit group in Santa Clara County, California. The group purchases and remodels single family homes to provide affordable group rental housing. The design template for each house includes five private bedrooms, a shared kitchen and living space, and landscaped front and back yards. By combining multiple funding programmes with rental income, SHS meets capital and operating expenses, including caseworker support[15].

The Human Investment Project (HIP) Housing in San Mateo County, California, is one of more than 100 home-share programmes in the United States that bring together home providers and home seekers through a match-up service (Kennedy 2010). The HIP programme, founded 35 years ago, facilitates two types of sharing. It can match homeowners – mostly older people – with home seekers who pay rent. It can also set up service exchanges that give home seekers free accommodation in return for providing needed services to the homeowner. Home sharing provides a creative solution for a growing number of ageing adults who want to maintain their independence and stay in their homes as long as possible.

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14   The available literature in the AFCC sphere is dominated by American examples. This is not to suggest that there are no examples elsewhere. For example, co-housing for older people or with a multi-generational focus is found throughout Europe. This discussion excludes supported and extra-care accommodation, rest homes and nursing homes.

15   Abbeyfield is a New Zealand example of this type of housing (Davey et al. 2004).

The "village" model is a grassroots approach, where older people develop membership associations that provide supportive services and social activities (Scharlach 2016). By paying annual rates, village members receive access to core services (eg weekly grocery shopping trips), referrals and discounts to outside services (eg home repair), social and educational activities, and opportunities to participate in governance and peer support roles. Consumer engagement is a key feature of these organisations, including development, oversight and governance, as well as offering support and services to other members.

Scharlach et al. (2013) report a survey of operational "villages" in the US, which examined activities consistent with the WHO Global Network model. These findings suggest that villages and other social organisations may have untapped potential for enhancing their members' ability to age in place, in line with with AFCC goals (Graham et al. 2014). Village members tend to be younger, more economically secure, and more likely to reside in wealthier communities than the general US population aged 65 and older (Scharlach et al. 2013). Consequently, concerns have been raised that such villages help older adults who are already relatively advantaged economically and socially. Most of the New Zealand equivalents – retirement villages – are commercial enterprises with varying degrees of consumer input. Many are part of "chains", but also include individual private sector developments and villages in the charitable and religious sector, however the same comment will apply.

Naturally occurring retirement communities

Naturally occurring retirement communities (NORCS) are areas within cities that have evolved over time into communities of older people. Areas not originally designed for older people may now have high concentrations of older residents, sometimes resulting from the departure of younger people. Once identified, these areas have the potential to develop age-friendly features.

A more formal NORC model is found in the US literature (Hudson 2015). The Naturally Occurring Retirement Community-Supportive Services Program (NORC-SSP) developed in 1985 in New York City (Scharlach 2016). These NORCs are buildings or neighbourhoods that have been retrofitted to provide services for older people. Often located in a single residential estate or tower block, a NORC will provide on-site, or in close proximity, health care management and prevention programmes, social care services, help with transport, education and recreation.

The model aims to promote older adults' access to services, and reduce social isolation. They may take the form of membership-based "villages", as mentioned above, or be part of larger multiservice, community-based organisations. They involve a partnership-building process between housing entities and their residents, health and social service providers, government agencies, philanthropic organisations, and other community organisations. These collaborate to help seniors to age in place for as long as possible by providing improved access to a variety of forms of tangible and social support (Scharlach 2016). NORC residents are often an essential part of programme development, governance, and volunteer service provision.

NORC-SSPs have been found to contribute to improvements in social connections, community participation, service access, and perceived ability to age in place (Bedney et al. 2007). In addition, some NORC-SSPs, at least in New York, have been able to generate sufficient political capital to successfully advocate for funding from state and local governments, as well as other age-friendly public policies. However, with the exception of New York, NORC-SSPs have proven relatively unstable as funding opportunities change and/or are withdrawn.

Community development

Many of the values set out for the AFCC approach are similar to community development principles. These are empowerment, community control, self-help, and motivated participants coming together to take collective action and generate solutions to problems – that is, building capacity through neighbourhood action. There is a link to "bottom-up" approaches and the generation of social and human capital. The engagement and participation of older people is an essential part of the AFCC approach, again linking with community development philosophy and positive ageing – "enhancing the power of elders in existing structures" (Dellamora 2014; Scharlach 2009a and b).

There are other links in terms of methods and evaluation. This is an area that could be further explored in New Zealand, although community development as a function of local government now receives much less attention. Austin, McClelland, Perrault and Sieppert (2009) point out that there is little documented experience of community development approaches with older people.

Barusch (2013) points out that "social workers have an important role to play" in the discourse and initiatives for age-friendly communities through their tradition of community organising and community development, as well as skills in policy analysis and advocacy. They can bring an ecological perspective on the interactions between older adults and their environments as well as a commitment to self-determination; to ensuring that elders have a say in matters that affect them.

The community development approach does, however, require collaborations between municipal government and community organisations, and with universities as sources of research expertise (Plouffe et al. 2016). Several examples of the use of community development approaches in AFCC initiatives are quoted from the US and Canada. In Quebec, an AFCC programme based on community development planning is seen as compatible with active ageing and the bottom-up approach advocated by the Madrid International Plan of Action on Ageing. This positioning emphasises the participation of seniors in all stages of development. This approach aims to be "user-led", rather than "service-led" (Carrier et al. 2012).

2.4 Psycho-social concepts

The developmental tasks of later life

The attributes of AFCC are beneficial to older people in addressing the tasks of later life as defined by developmental psychology (Lehning, Scharlach and Dal Santo 2009). Responsiveness to these five developmental tasks is reflected in a community's physical and social environment.

- Continuity – refers to the ability to maintain established patterns of social behaviour and social circumstances, to preserve health-promoting activities, as described by the continuity theory of normal ageing and Rowe and Kahn's notion of "successful ageing" (as cited in Scharlach 2012).

- Compensation – supports and accommodations in the form of services and infrastructure exist to help those with functional impairments meet their basic health and social needs. Home modifications and technological interventions can also support self-care.

- Connection – opportunities for meaningful interpersonal interactions that foster reciprocal support and maintain social connectedness.

- Contribution – older people as co-creators of age-friendliness through active contribution of wisdom and experience; the need to feel one is having a positive impact on one's environment

- Challenge – need for stimulation and growth – individuals of all ages have the opportunity to develop new interests and sources of fulfilment. There are age-appropriate opportunities for stimulation, whether in the form of physical exercise, intellectual demands, or social engagement, including life-long learning, so as to ward off physical and mental decline.

Social capital

The concept of social capital provides a useful framework for understanding the ways in which social environments can foster social inclusion and hence active ageing. Broadening Pierre Bourdieu's original definition of social capital, Putnam and others refer to community or organisational characteristics that foster mutually beneficial social interaction among community members, including trust (as cited in Scharlach and Lehning 2013). High levels of social capital are especially important for older people with chronic illness or disability, who may be more dependent on community social networks than other age groups.

Social engagement, whether formal participation in organisations or informal care-giving roles, provides a mechanism for older community members to contribute to the social capital of their communities using their lifelong experience and wisdom (generativity). Community-based associations tend to be informal and horizontal in their workplace structures, relying primarily on the experience and knowledge of members, often volunteers, and in so doing enhancing citizens' social and political capital (Sharlach 2016). The great benefit of grassroots initiatives is that they can focus on ideas most appropriate to their own communities (Buffel et al. 2012).

What helps social capital grow?

- Physical resources – facilities, equipment and materials accessible to a community or organisation

- Financial resources

- Human resources – the capacities of individuals in communities, their knowledge, skills and general abilities

- Organisational resources relating to leadership, management, planning, and co-ordination (ie institutional capital).

A related concept is social inclusion, reflecting the extent to which the perspectives and contributions of all community residents and population sectors are valued. Together, social capital and social inclusion contribute to an overall sense of community, "a feeling that members have of belonging and being important to each other, a shared faith that members' needs will be met by the commitment to be together" (Chavis et al. 1986).

Social inclusion/exclusion

One of the main purposes of the AFCC approach is to promote social inclusion among older people by enabling them to pursue lifelong activities and meet their basic needs, to maintain significant relationships and participate in the community in personally and socially meaningful ways, and to develop new interests and sources of fulfilment. Such efforts can enhance social capital, thereby promoting social inclusion.

Social inclusion refers to three central characteristics at the interface of individuals and their environments: social integration, social support, and access to resources.

- Social integration – reflects the extent to which individuals are embedded within a network of meaningful social bonds and societal structures (Scharlach and Lehning 2013).

- Social support – refers to the extent to which those social bonds enable network members to obtain help when they need it.

- Access to resources – good quality health care, consumption opportunities, social and economic networks, linked to social capital.

Social inclusion may have a variety of potential benefits: reciprocal social exchanges that foster interdependence rather than inequity and disempowerment; social recognition from community members; and self-efficacy and perceived control of oneself and one's environment.

Social exclusion may arise from economic vulnerability. While some older adults are quite well-off, others lack basic economic security. This is especially true for women and racial and ethnic minorities (due to lifelong processes of cumulative disadvantage) and all may suffer the effects of ageism. The inadequacies of the physical and social environment, coupled with limiting physical and mental conditions can limit full societal participation for older people. Dealing with environmental barriers to social inclusion is one of the aims of age-friendly programmes.

The physical environment encountered in daily activities is an important influence on older people's capacity for social inclusion. The walkability of streets and the supply of shops and services contribute to this. Individuals who encounter physical barriers tend to be socially excluded as well (Scharlach and Lehning 2013). This is an example of how the physical and social environments interact. Transport options also contribute to social inclusion/exclusion, given that they are a key aspect of how people relate to their environment. Transport is a key factor in what constitutes an age-friendly community. A great deal of research focuses on older drivers, given the importance of the private car for mobility (Dickerson et al. 2007). A car-dependent society can produce social exclusion among those who do not, or can no longer, drive. Driving cessation has been linked to depression and social isolation (Shergold and Parkhurst 2010). Driving is also a gendered issue. These issues have been explored in New Zealand, with similar conclusions (Davey 2007). The accessibility of public transport creates particular challenges in rural areas. Policy shapes what kinds of transport options are available and whether older people have access to them (Lewis and Groh 2016).

Quality of life

There has been a great deal of research on identifying measures of quality of life (QOL) (Bowling 2005). In many cases, the search is for statistical indicators. Quality of life figures in WHO statements and systems of age-friendly indicators, such as the proportion of older people who self-rate their overall QOL as "very good (5)" or "good (4)" on a scale ranging from "very poor (1)" to "very good (5)". The age-friendly approach, however, seeks to delve deeper, emphasising subjective measures that reflect the more detailed experiences and preferences of older people. Wellbeing and quality of life are connected to many dimensions of the physical and social environment, so promoting age-friendly approaches should have a positive impact on the quality of life of older people:

> An "age-friendly city" is an inclusive and accessible community environment that optimizes opportunities for health, participation and security for all people, in order that quality of life and dignity are ensured as people age.
>
> Novek and Menec 2014

Participation and contribution

The WHO AFCC framework includes opportunities for social and civic participation, such as volunteering, voting, and being involved in public affairs, as well as employment, which has both social and economic aspects. Participation also includes opportunities for physical activity, which plays a key role in health promotion (Alley et al. 2007). Opportunities in the community for participation may include exercise programmes, sport, lifelong learning programmes (eg computer classes) and volunteering options.

Social infrastructures in age-friendly communities should be designed to foster both participation and contribution. Ideally older people are valued for the contributions they have made, and continue to make, to their communities, and these contributions are encouraged and facilitated.

2.5   Political and global concepts

Top-down and bottom-up approach

All too often, age-friendly actions have not lived up to their promise either as a result of a lack of on-going political commitment or as a result of an over predominance of "top-down" interventions to the detriment of the all-important "bottom-up" protagonism (Kalache 2016).

Many age-friendly efforts are typically "top-down" – sponsored by local governments relying on experts to solicit input from key stakeholders, and based on pre-existing frameworks (Sharlach 2016). The primary role of central governments may be to set out a vision or agenda, and sometimes to provide financial support for local or regional efforts. The WHO's Global Age-Friendly Cities initiative might never have happened without the support of the Public Health Agency of Canada, but the Canadian government's subsequent role has been limited, leaving responsibility to individual provinces, cities, and towns (see Part 6). To some extent, this reflects efforts by central governments in some countries to devolve responsibility for services, and often financial responsibility, to local governmental and NGOs.

The WHO AFCC approach has been criticised as being top-down, despite assurances in the documents that cities and communities can apply their own measures and initiatives. As mentioned above, the AFCC philosophy has a lot in common with community development, giving prominence to self-help, and the voice and agency of older people, and acknowledging them as partners and informants in community decision-making. This recognises that people are in a better position to talk about their own situations and to help discern solutions to their problems, rather than "experts" who are detached from their reality. In many ways the AFCC model challenges top-down approaches.

Realistically, AFCC initiatives must often rely on funding from regional or national government, so that some degree of the top-down approach is inevitable. They must also depend on legislation and regulation from above. The solution is a combination of top-down and bottom-up elements and co-operation between government and communities. This should also be extended to private and voluntary sector agencies and universities.

The involvement of older people in the planning process is not just helpful, but essential to ensure that spaces and buildings meet the needs of older users. They can help to identify challenges and barriers for older people in current structures, contribute to the implementation and monitoring of age-friendly changes, and make recommendations for the future. City planners, architects, and property developers need to understand the needs of the ageing population. Traditional policy initiatives for older persons, such as health or long-term care provision, are designed to meet the needs of individual users. But planning guidelines must now consider the impacts of planning for housing, transportation and other amenities at a community or neighbourhood level, consistent with the objectives of healthy/active ageing and age-friendliness (Neal, DeLaTorre and Carder 2014).

While age-friendly city initiatives may include older adults among their key advisors, it is not always clear that they are actively engaged in planning or implementation. By engaging existing community social organisations, age-friendly initiatives can draw upon social capital to facilitate older adults' engagement in the change process, and ensure that interventions are targeted most effectively to their needs and preferences. Ideally this should involve co-production, ie the empowerment of older people themselves in driving forward the policies and agendas associated with the age-friendly movement. Active ageing may be seen as a "combination of top-down policy action to enable and motivate activity with, also, opportunities for citizens to take action from the bottom up" (Walker 2016).

There are several barriers to the optimum functioning of age-friendly initiatives. First there is the need for collaboration and co-ordination between agencies and communities. Alliances between civil society, municipality, and service providers can achieve the skills and resources necessary to achieve important projects, if they are working well (Garon et al. 2014). Within government organisations, collaborations often involve a variety of government sectors and ministries such as education, employment, housing, social security, health and social services. Outside of government, the involvement of non-governmental organisations (NGOs), not-for-profits, and other forms of civil society organisations are a feature of many age-friendly initiatives. For example, the Healthy Ageing in Canada report (2006) illustrates the importance of agencies working together[16].

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16   www.health.gov.bc.ca/library/publications/year/2006/Healthy_Aging_A_Vital_latest_copy_October_2006.pdf

Another barrier to collaboration is the allocation of material, social, and financial resources. Greenfield et al. (2015) maintain that this process serves to maintain the interests of groups already in power. It also highlights the overall lack of public funding to benefit older adults, especially those who are most vulnerable on account of socio-economic status and lack of control over resources.

The "silo effect"

The silo effect is a barrier to collaboration and co-ordination in AFCC objectives. It operates in professional practice, academia, health care, and government bureaucracies, preventing the development of shared efforts across sectors and disciplines (Greenfield et al. 2015). Everywhere, responsibilities are divided between ministries and departments. This division of labour encourages "silo thinking" and works against an effective active ageing approach. For example, in many countries older people and children are represented by ministries but no one is responsible for ageing (Garon et al. 2016). The silo effect creates a bureaucratic barrier, blocking the necessary holistic approach. Silos are maintained and reinforced by a number of factors: the disaggregation of funding streams, resource constraints, intergenerational conflicts, and a lack of strategic planning structures across institutions.

Political leadership and support

The AFCC aspirations for all age groups require strong and sustained political leadership because such initiatives may be expensive or contentious (Fitzgerald and Caro 2014). Public transport systems typically need substantial and continuing public subsidies. Higher-density residential development is likely to require politically contentious zoning changes, as has been seen in New Zealand. Political players are constantly changing, which can result in changes in policy interests. Continuity can only be achieved by establishing broad support for AFCC programmes (Kalache 2016). Interventions must go beyond a single elected administration. This does not, however, imply a purely top-down approach to policy making, nor does it deny the vital role of the voluntary and private sectors. All too often, age-friendly actions have not lived up to their promise either as a result of this lack of on-going political commitment or the dominance of top-down interventions.

Part 6 provides examples of how political leadership and support may either promote or impede AFFC initiatives.

Global trends and issues

The chances of success for the AFCC movement rely significantly on elements in both the local and wider social and political environment, given that this is a global initiative (Moulaert and Garon 2016). Under the influence of neoliberalism, many agencies see the concept of "active ageing" solely as an economic one, including the Organization for Economic Co-operation and Development (OECD), the World Bank, and the European Commission (Moulaert and Biggs 2013). In this context, the AFCC idea can become a policy instrument almost exclusively concerned with encouraging, enabling, and even forcing, older people to work longer (Walker 2016), as outlined in Part 1.

Communities may implement age-friendly principles when they perceive that it is in their best interest to do so, ie when the benefits of change, or the cost of not changing, exceed the perceived cost of those changes. Phoenix Mayor Greg Stanton, for example, launched an initiative to make Phoenix the most desirable place in the US for older adults to live – not primarily because of a desire to

promote their wellbeing, but because he anticipated the economic benefits of an influx of well-off older individuals. Other cities are trying to attract young professionals and the high-tech businesses that employ them – "few cities are going out of their way to promote an influx of economically disadvantaged, disabled older adults" (Scharlach 2016).

Other significant trends which influence AFCC include the impact of globalisation and economic austerity. Key questions to be considered are:

· to what extent are age-friendly communities possible given the economic crises affecting many societies?

· how is the debate affected by the rolling back of the welfare state in many countries?

· is there a danger that age-friendly policies will be used as a substitute for well-resourced social services delivered at a local level?

At both global and local levels, institutional ageism and the generally negative social construction of old age poses another widespread barrier to AFCC. Age discriminatory stereotypes still may portray older people as passive, acquiescent, and disinterested in social and political participation (Binstock 1991; Walker 2016). In political terms, population ageing has been perceived and depicted as an economic threat in terms of the fiscal cost of income support and health services; hence the potential for inter-generational conflict and resentment. This works against the AFCC agenda of empowering older people and the call for a "society for all ages". The AFCC philosophy emphasises participation, social inclusion and human rights for older people, and opposes age discrimination, whether overt or covert. In this new paradigm, public policies for the older people are no longer driven by a needs-based approach (which considers older people as passive targets) but are replaced by a rights-based approach, which recognises their rights to equal opportunities and treatment in all aspects of life.

Seniors need to be empowered to advocate on their own behalf and on behalf of oncoming cohorts of older people. Governments have an important role to play in this public awareness process, and in creating models, standards, and fiscal incentives for individuals and communities to undertake age-friendly improvements. Business also has an important role to play, not least in terms of the economic health of communities and their residents. Economic prosperity provides more financial resources for communities to employ in implementing age-friendly improvements in the built environment and social systems.

Intergenerational factors

The notion that "age-friendliness benefits all ages" can be used to support investment in urban improvements. Some studies in the AFCC literature emphasise the importance of opportunities for social integration and interaction between older and younger people (Emlet and Miceri 2012; Scharlach and Lehning 2013). This shifts the age-friendly focus away from older people to one in which social and physical facilities are beneficial to all. For example, a study of younger and older adult bus users found that both groups shared some of the barriers and facilitators to bus use. So the creation of an age-friendly bus service would benefit all users (Broome, Worrall and McKenna 2009). Social inclusion is a key theme in the literature of intergenerational interaction; social

relationships are important to the wellbeing of people of all ages. The aim is to counter social exclusion and its strong negative effect on health and well-being by challenging ageism, promoting intergenerational solidarity and promoting respect for socially and economically disadvantaged groups.

The maintenance of intergenerational solidarity should be an important feature of active ageing; the opportunity to develop activities that span the generations. Participation in volunteering activities can be a way to promote such relationships. These could include projects in which younger seniors are paired with older seniors. Younger seniors could be encouraged to provide psychological and physical support for older seniors.

Further examples of intergenerational programmes come from the US:

- Generations of Hope, in Illinois[17], represents an intergenerational approach designed to promote social capital and social inclusion. It fosters mutually beneficial social relationships between older adults and younger residents who are experiencing personal and social challenges, such as substance abuse, domestic violence and homelessness. The challenge is to be able to replicate this concept on a wider scale.

- Communities for All Ages (CFAA)[18] is also based on an intergenerational approach to community-building that involves residents of all ages, local organisations, policy makers and funders. Attempts to break through age-specific "silos" include multi-generational neighbourhood learning and community centres, farmers' markets and arts festivals. However, the extent to which intergenerational programmes and structures such as these result in sustained social capital formation and social inclusion is yet to be assessed.

- Other initiatives include intergenerational meeting places to facilitate social contact, programmes to encourage connection with neighbours, intergenerational and multi-ethnic community centres, library programmes, and cultural events. Such initiatives have been frequently identified as ways to encourage age-integrated neighbourhoods.

The notion of "a design for all ages" has been closely associated with universal design, which maintains that "design for the young and you exclude the old; design for the old and you include the young" (Biggs and Carr 2016). This can be extended to living areas in which different generational groups meet, interact and negotiate shared use of their environment. This requires empathetic understanding of the requirements of groups as diverse as children, working age adults, active and frail older people and people living with dementia. Each group may have distinctive requirements for public space. The aim of intergenerational urban space should be to enhance social and emotional understanding between age groups, increase harmony, and promote sharing (Biggs and Carr 2016).

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17   www.generationsofhope.org
18   www.communitiesforallages.org

Part 3:

Special aspects of the Age-friendly Cities and Communities movement

3.1   Dementia-friendly and AFCC

Williamson (2016) has criticised the AFCC movement for lacking a focus on dementia, but age-friendly communities are intended to be inclusive and potentially good for everyone, avoiding identifying people solely through a disability or "disease-specific" lens. Instead, the concept takes a whole person view, avoiding the negative stereotype of ageing as a period of decline and loss. A "dementia-friendly" approach is narrower and "disease specific".

Nevertheless, proponents point out that dementia is a unique and urgent issue that has not yet received enough recognition or attention within the disability, mental health or ageing realms. Despite this, there is a growing literature on the concept of dementia-friendliness. Williamson (2016) examined dementia-friendly communities in Europe for the European Foundations' Initiative on Dementia. Research by the Foundation in 2014 and 2015 gathered information through an online survey, telephone interviews and a literature review.

Respondents included people working for dementia organisations, local and national NGOs, health and social care services, local, regional and national governments, and academics. Few links were identified between "age-friendly initiatives" and "dementia-friendly communities" (DFCs). However, there is potential and opportunity for learning and collaborating between the two movements.

The UK's Alzheimer's Society defines a DFC as "a city, town or village where people with dementia are understood, respected and supported, and confident they can contribute to community life. In such a community, people will be aware of and understand dementia, and people with dementia will feel included and have choice and control over their day-to-day lives"[19]. An important impetus in the development of DFCs is the collective voice of people with dementia. In the UK, the Joseph Rowntree Foundation's (JRF's) support for the Dementia Engagement and Empowerment Project (DEEP)[20] has been a significant driver in enabling people with dementia themselves to shape and redefine what DFCs mean.

The JRF commissioned research in 2011 to explore the concept of a DFC, with particular reference to York. Its relevance was reinforced in the Prime Minister's challenge to establish DFCs in the UK. By February 2015, more than 82 communities were committed to becoming dementia friendly[21]. Evaluations published by the JRF commended York for its commitment, through training opportunities and positive media coverage, to becoming a more DFC (Crampton, Dean and Eley 2015).

Evidence supporting DFCs is found in *Building dementia-friendly communities: A priority for everyone* (2013)[22] and the *Code of practice for the recognition of dementia-friendly communities in England*[23]. This code provides a framework, recommendations and minimum standards for areas that are looking to become dementia-friendly. It provides guidance about who needs to be involved in setting up a DFC, the processes needed to operate successfully, and the expected outcomes (Williamson 2016).

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19   www.alzheimer.org.uk/downloads/id/2885/guidance_for_communities_registering_for_the_recognition_process.pdf
20   www.dementiavoices.org.uk/
21   www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020/prime-ministers-challenge-on-dementia-2020
22   https://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=1236
23   https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/BSI_Dementia_friendly.pdf

Dementia villages

"Dementia villages" exemplify the expansion of dementia-friendly environments from institutions for care to communities which aim to raise public understanding and reduce stigma. They can take a number of forms. Some have been criticised for segregating dementia sufferers, suggesting that a more general age-friendly approach would meet the needs of this group. De Hogeweyk in Weesp, the Netherlands, is a self-contained village where 50 people live with varying stages of dementia (Biggs and Carr 2016). The design of the village and living areas/units provides people with the ability to continue living (as closely as possible) the lifestyle they had prior to their need for, with social and retail facilities located in the village itself, which is gated and has monitored access. Inside, the village contains seven neighbourhoods, reflecting different social class, cultural, and faith-based identities. 'Normalisation' means allowing residents to 'go out' for grocery shopping, to have lunch, go to the theatre and see the doctor. A project labelled 'Dementiaville' (mainly by its critics), exists in the Swiss village of Wiedlisbach, near Bern. Like De Hogeweyk, the notion of maintaining normalcy is paramount and carers are disguised as gardeners, hairdressers, and shop assistants (Biggs and Carr 2016).

Hammondville in NSW, Australia, is designed as an environment that promotes independence, while compensating for cognitive impairment. In the city of Bruges, Belgium, a dementia-friendly community project has adopted the symbol of a knotted handkerchief to denote a dementia-friendly place or business where people with dementia will be welcomed. These are all examples which could be studied for possible application in New Zealand.

Mitchell, Burton and Raman (2004) identified design features that make an area 'legible' for older people with dementia, such as the character of street networks, and the presence and types of landmarks. Spatial disorientation and short–term memory problems experienced by people with dementia can make each trip around the local neighbourhood a journey into the unknown. They are at risk either of losing their way when they go out or of becoming housebound through fear of getting lost. The findings demonstrate that people with dementia rely increasingly on the legibility of their local neighbourhoods, especially at road crossings and junctions, as their ability to concentrate, to be aware of their surroundings, and to follow new routes, maps and directions decreases. By focusing on designing urban areas that are explicitly easy to understand, navigate and access, the findings are relevant to all members of society.

Street layouts – most participants with dementia showed a preference for short, narrow and gently winding streets rather than long, wide or straight streets. The former were perceived to be more interesting and therefore helpful in maintaining concentration.

- Building form and style – participants found streets with varied urban form and architectural features more interesting than those with repetitive form and features. Many became disoriented on streets identical to neighbouring ones or with few distinguishing features.

- Signage – people with dementia tend to be confused by an abundance of signs. They preferred simple, plain signs with large, dark lettering on a light background. Advertising and shop boards were considered extraneous and hazardous clutter.

- Environmental cues – participants used landmarks and environmental cues to help them clarify their location and determine which route they needed to take. Clues could include public buildings and street furniture, including telephone and letter boxes, public seating and bus shelters, attractive gardens, trees and planters.

An outdoor environment that people are able to confidently understand, navigate and use – regardless of age or circumstance – should be the ultimate goal of inclusive urban design.

3.2 Rural areas

According to Keating, Eales and Phillips (2013), the literature on age-friendly communities is predominantly focused on urban ageing, thereby failing to reflect the diversity of rural communities. They argue that the original WHO concepts should be reconceptualised to be more inclusive, interactive and dynamic, incorporating changes that have occurred over time for people and places. WHO's original concept of AFCC did in fact acknowledge lack of attention to rural and remote areas. But the core indicators were developed with a focus on the urban context at local government level, and this may have limited their utility for investigating related issues in suburban and rural contexts.

Several recent papers from Canada and Australia have examined age-friendliness in rural settings. Neville et al. (2016) reviewed nine studies mainly from Canada, (six from the province of Manitoba), and one from Ireland, to examine the theories and concepts related to building age-friendly rural communities. They found a considerable degree of active involvement of older people in these areas. However, marginalised older people who are not active community participants require support and services that are sometimes not available in rural areas. Strong leadership and support from all levels of government was stressed to help counter geographic and demographic disadvantage. Partnerships between university researchers and NGOs were considered to be key to the successful implementation of age-friendly initiatives in Manitoba (Menec et al. 2015a).

For age-friendly initiatives in rural areas to be sustainable, the following factors were considered imperative (Neville et al. 2016):

- strong leadership from all levels of government

- adequate and appropriate funding

- the inclusion of older people who are able to sit on committees and volunteer across a range of areas.

Studies have identified many challenges associated with growing older in rural and remote areas. Keating, Eales, and Phillips (2013), in the Canadian context, illustrate the difficulties in providing health and social services. They saw some rural communities as *bypassed*, being isolated and service-poor, lacking in infrastructure, and economically depressed. There is concern that migration of younger people seeking employment, along with volunteer shortages, will place pressure on informal systems that cannot compensate for a lack of formal services. However rural areas may also provide unique advantages to older people because of strong community connections. Some older people choose to migrate to rural communities, attracted by features such as a slower pace of life, attractive scenery,

and community size. Keating et al. designate them as "bucolic": having considerable resources and assets, a slow-paced lifestyle, and a culture of supportiveness. Such communities can compensate for a lack of formal services through contributions of older residents that buttress the lack of public infrastructures and provide opportunities for active ageing.

In the social environment a "sense of community and connectivity" emerges as a strong, supportive attribute for the age-friendliness of rural communities. People are connected to places, despite the scarcity of physical and service supports found in urban settings. Regardless of where a community falls on the urban/rural continuum, age-friendliness is a function of the distribution of environmental supports for active ageing in place, and whether those supports are locally available and easily accessible.

3.3   Cultural/ethnic diversity

Despite the growing recognition of cultural and ethnic diversity in many countries, these terms are not given a great deal of weight in the AFCC literature. "Cultural" is usually bracketed with "social" sometimes as "socio-cultural" and sometimes refers to high culture such as theatre and visual arts. This can result in ambiguity. Discussions on culture and age-friendliness include the proportion of older adults among visitors to cultural facilities and events, and the proportion who report participating in socio-cultural activities. These are taken to indicate social participation and inclusion, and may also include participation in formal or informal religious, cultural or other social activities. This omits culture in the ethnic sense.

For both definitions of culture, the AFCC emphasis calls for older people to have access to cultural opportunities and participation as part of ageing in place. Access, variety, affordability, awareness, encouragement to participate, and integration of the generations are key factors in how much an older person participates in the community (WHO 2007).

"Ethnicity" has even fewer mentions, except to link it with disadvantage and poverty, or to simply acknowledge the multi-ethnic/cultural nature of some cities. Buffel et al. (2012) emphasise the need to build relationships and trust with ethnic and cultural groups prior to "conducting [AFCC] business". In her research, Shenfil (2009) gives greater consideration to ethnic diversity, using ethnic and cultural media to reach target populations, and facilitators who know the language and culture of the group. Shenfil's researchers focused particularly on building the capacity of cultural and faith-based groups serving older adults in Fremont, California. Examples include a Senior Help Line to provide information about senior services in four languages – Spanish, Mandarin, Farsi, and English. Through the Afghan Elderly Association, the Afghan Health Promoter Project reached out to frail elders, many of whom are monolingual. A public health nurse trains and supervises Afghan health promoters who offer health education, nutrition support, medication management, and translation services for medical appointments.

Other examples of AFCC initiatives respecting cultural diversity include:

- consultations for Age-Friendly New York City (Goldman 2016) acknowledged diversity in race, culture and language, socio-economic level and disability, as well as LGBT. Town hall meetings were conducted in different community centres and in different languages.

- the City of Ottawa used focus groups to capture the diversity of voices, including First Nations and people with intellectual disabilities.

- the City of Toronto translated its age-friendly city consultation workbook into 11 languages to reach a highly multi-cultural population (Plouffe, Kalache and Voelcker 2016).

- the Community Ambassador Program for Seniors (CAPS) in northern California has trained volunteers from seven under-served ethnic and faith-based communities (Indian, Taiwanese, Muslim, Latino, Sikh, Filipino, and multi-ethnic Christian) to serve as "ambassadors" between older adults in these communities and the ageing services[24]. The ambassadors inform community members about the availability of services, and inform service agencies about the particular needs and values of their communities. They meet with family groups and social networks to foster intergenerational understanding and support. Social integration is enhanced as ambassadors meet with groups in places where they naturally congregate (Scharlach and Lehning 2013). The CAPS programme obtained private foundation funding, which prompts some concerns about its replicability in other communities.

One reason the AFCC literature says little about cultural and ethnic concerns is the fact that AFCC processes are adapted to "northern countries" rather than the developing world. How can the model take into account diverse local realities related to cultural diversity and inequality in social, economic and knowledge resources?[25]

3.4 Technology

Considerable literature has appeared suggesting that Assistive Technologies and Information and Communication Technologies may improve quality of life, extend length of community residence, improve physical and mental health status, delay the onset of serious health problems and reduce family and care-giver burden.

Blaschke et al. 2009

The key was to make the link between what technology can do for you and how inherently conservative systems can adopt and change and deliver new ways of providing health and care.

Zahid Latif, Head of Healthcare at Innovate UK

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24 www.capseniors.org

25 Age-Friendly Cities and Communities in International Comparison, edited by Moulaert and Garon (2016), includes case studies from Argentina, Hong Kong and Brazil to counter an otherwise North American bias.

Richardson, Marques and Morgan (2015) link assistive technology to social innovation and an age-friendly society, focusing especially on health, and also to assist ageing in place, listing 'solutions' for daily and independent living as:

- the internet can be used for daily shopping, travel, social life and public services by people with reduced mobility

- safety technology can ensure entrance doors and windows are locked/closed when leaving the house or sleeping, and it can also be used to check for water or gas leaks, and to activate a night light

- reminders for those with memory problems to take medication or do household tasks

- user-friendly interfaces for equipment inside and outside the home, taking into account impairments in vision, hearing, mobility and dexterity

- telecare and telemedicine for providing medical care to the home, including ways of monitoring wellbeing and providing a secure home environment

- personal health systems include wearable and portable systems for monitoring and diagnosis, therapy, repairing/substitution of functionality; these can support treatment plans for individuals with a chronic disease, and telemonitoring and telecare can help people to avoid hospitalisation

- support for people with cognitive problems and their carers to stay at home for longer and remain active for as long as possible, eg through cognitive training, reminders, GPS tracking

- easy access to phone and video conversations enables people to stay in touch with family and friends, thereby overcoming social isolation

- the Smart Home scheme equips homes with assistive technology, such as detectors that alert a central response unit when a person falls, thus providing a safer home environment for people experiencing physical frailty and/or memory problems.

Although the call for better use of information and communication technologies in planning and implementing AFCC is persuasive, it is possible that older people may not see this as a priority. This may change as Baby Boomers move through later life. The business sector may see opportunities for technology enhancements in an ageing society. There is also a link here to dementia-friendly initiatives (see Part 3.1).

Social connectivity is a fundamental aspect of an AFCC environment. Age-friendly cities and communities of the future are likely to have facilities to enable older adults to stay socially connected through email or social networking websites, participate in activities or classes through video-conferencing, and receive services such as primary health care through in-home technology. Cyber connectivity is a growing possibility given the rapidly increasing number of seniors using the internet. The narrowing of the rural/urban digital divide also opens up new opportunities that have the potential to overcome the challenges of distance and remoteness. Online conferences can help to forge connections and offer opportunities to share expertise across communities (Lehning, Scharlach and Dal Santo 2010).

Part 4:

Evaluation of Age-friendly Cities and Communities initiatives and the use of indicators

There is widespread agreement on the importance of evaluating AFCC initiatives if the movement is to expand, especially given the expenditure of public funds required and the public sector's demand for accountability of spending (Garon et al. 2016). Such evaluation is, however, not a large component of the literature, perhaps because AFCC is a comparatively new movement. Garon discusses the classical or experimental model of evaluation, which assumes that the causal links between programme activities and their effects are relatively easy to recognise and can then be weighed against the benefits. This works well with simple programmes, whose causality is predictable (eg vaccination against infectious diseases). But when applied to a social context which is complex, dynamic, subjective and unpredictable, this approach shows its limits. Even if it there has been an expected change, it cannot easily be explained or attributed to the activities under evaluation. The "black box" analogy illustrates very well the limitations of this model: inputs go into a box and emerge in the form of outputs, with no way of knowing if or why certain effects have taken place.

Another evaluative approach is called "user led", in which stakeholders participate, both in the preparation and implementation of the evaluative research. This seems consistent with aspects of age-friendliness and active ageing that have been discussed.

4.1 Indicators and their attributes

Whatever evaluative approach is adopted, assessing the age-friendliness of a city or community requires measures or indicators.

There are several requirements for indicators to be meaningful, they must be:

- relevant – meaningful to the target audience and aligned with local goals and targets

- measurable

- valid – is the indicator measuring what it is supposed to measure?

- easy to collect – is the data required to produce the indicator easy to collect in a timely manner?

- replicable – can the indicator be collected in a standard way across time?

- sensitive to change – will variations in the indicator be observable over time?

- technically sound

- amenable to disaggregation – can the indicator be disaggregated by gender, age group, ethnicity, socio-economic status, etc. and across neighbourhoods?

- linked to action – does the indicator provide an understanding of the actions to be undertaken?

- within local influence – does the local government or community have the mandate or authority to act on this indicator?

- socially acceptable – is the collection of this information acceptable to the communities and individuals concerned?

- able to use existing data bases – many indicators are routinely collected by local government, research institutions, community organisations and other stakeholders, or they could be derived or adapted from existing indicators. This has many benefits for validity and reliability, as these indicators are likely to have been validated, with no additional data gathering needed. Caution is

necessary, however, to avoid over-reliance on routinely used indicators, which could hamper the development of creative, aspirational measures. Furthermore, reductions in resources and finances can influence the sustainability of data collection for indicators as well their upkeep.

4.2   The WHO 'core' indicators

The WHO (2015) published *Measuring the age-friendliness of cities: A guide to using core indicators* in the process of measuring the age-friendliness of urban environments. This Guide sets out a framework and a set of indicators to inform the selection of local measures to monitor and evaluate progress in improving age-friendliness. The guide also includes references and additional resources, such as examples of local initiatives.

The indicators are not meant to be a prescriptive set of guidelines but rather something to be adapted, as necessary and appropriate, to build an indicator set that is most meaningful and relevant in the local context. Inter-city comparisons are something to be aspired to, but not an immediate priority. Measures are intended to be useful in promoting community engagement and empowerment, advocacy, and inter-sectoral collaboration. The framework does not establish a reporting requirement for members of the Global Network. Rather, it is a tool for defining a locally appropriate indicator set, intended for use by any interested city or community.

The guide points out that frameworks and indicators can be instrumental in establishing a common understanding among stakeholders about the key dimensions of age-friendliness that are valued in their city, and in setting goals and objectives in relation to them. The indicators can be used to measure a baseline level of age-friendliness and to monitor how this changes over time as interventions are implemented. Indicators should be an integral part of an outcomes-oriented accountability system for AFCC initiatives. They can also be leveraged to foster political and social commitment.

Five categories of indicators are set out, the first concerning equity as a guiding principle; the following four linked to the evaluation process. The key principles reflected in the core indicators are equity, accessibility and inclusiveness.

1. **Equity indicators** – the notion of equity implies a strong emphasis on ensuring "the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage or disadvantage".

   Equity indicators require the disaggregation of data by variables such as gender, age, wealth and neighbourhood. Whenever possible, data collection and analysis should be based on narrow age bands in order to better understand the finer nuances of chronological ageing[26]. Then, one of several available measures of inequality can be applied to compute an equity indicator.

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26   The definition used in this system for older people is age 60.

Two measures are suggested:

- difference between population average and highest attainable level of outcome

Measure – the difference between the population average and the level of outcome achieved by a subgroup which has the best outcome or the highest socio-economic position in the population of interest, eg percentage with self-reported health as good to excellent

- difference between two reference groups

The two groups are the subgroup with the best outcome or the highest socio-economic position (ie the best-off) and the subgroup with the worst outcome or the lowest socio-economic position (ie the worst-off) in the population of interest. This indicator shows the difference between the lowest and the highest attainable levels of outcome. It can also be used to assess gender equity by comparing women and men.

2. **Input indicators** – inputs are the resources and structures essential to the successful initiation, development and sustainability of AFCC initiatives. These indicators track the availability, allocation and use of resources over time and can be used for cost-effectiveness analysis. They could also be used to advocate for greater engagement and contribution from stakeholders.

3. **Output indicators** – outputs refer to the interventions to achieve desired outcomes and impacts, ie to create age-friendly physical and social environments. These interventions can take the form of policies, services or programmes designed to change the environment. They may be newly implemented interventions or modifications to existing initiatives.

4. **Outcome indicators** – these are short- to medium-term changes in the social and physical domains of the environment that are attributable to preceding interventions. Outcomes for the community as a whole can show the benefits of an age-friendly city to the wider population. The selection of outcome indicators should be directly linked to the objectives and desired outcomes of the age-friendly initiative, and closely related to actual interventions and their expected impact. Interventions often generate both intended and unintended outcomes beyond their primary expected outcome.

5. **Impact indicators** – long-term changes to people's health, their physical, cognitive and emotional function, and wellbeing, which are expected to be brought about (at least in part) by improvements in the age-friendliness of the physical and social environment. Thus, impact indicators should correspond to the outcome indicator.

The core indicators presented by the WHO mainly focus on outcome and impact indicators rather than on input and output indicators. This is because AFCC initiatives, regardless of context, share similar goals and objectives for improving the age-friendliness of the urban environment (ie outcomes) in order to ensure quality of life as people age (ie impact), whereas the resources they use (ie inputs) and the interventions they implement (ie outputs) can vary substantially depending on the local context.

The WHO Guide gives examples of indicators, with sources and references, relating to the domains of the AFCC model. The following are examples of these links, indicators and possible sources of data.

Accessibility of the physical environment

Measure:	**Neighbourhood walkability**
Example	Proportion of streets in the neighbourhood that have pedestrian paths which meet locally accepted standards.
Source of data	Data from field survey of city streets, administrative data roads and infrastructure.
	Data from surveys of older residents (self-reported data).
Measure:	**Inclusiveness of the social environment – positive attitudes towards older people**
Example	Proportion of older people who report feeling respected and socially included in their community.
Source of data	Data collected by local law enforcement authorities, health/social service providers, or community groups addressing elder abuse prevention.
	Number of reported cases of maltreatment of older people.
Measure:	**Availability of social and health services**
Example	Proportion of older people who have personal care or assistance needs.
Source of data	The proportion of older people who report having their personal care or assistance needs met in their home or community through the use of formal services.

Source: WHO (2015). *Measuring the age-friendliness of cities: A guide to using core indicators*. World Health Organization, Geneva.

The sources of data for these and other indicators are a mixture of objective measures from official sources, eg censuses, and subjective data derived from surveys of the opinions and experiences of older people. The latter align better with the AFCC philosophy, but are more difficult and expensive to collect.

The WHO offers a range of supplementary indicators to be used, as appropriate, in specific situations, including:

- proportion of new and existing houses that have wheelchair-accessible entrances (ie sufficient width, ramp)
- proportion of older people who were enrolled in education or training, either formal or non-formal, in the past year
- proportion of older people living in a household with internet access at home
- reported rate of crimes (per year) committed against older people
- emergency preparedness.

The WHO advocates careful consideration in adopting and adapting the core indicators, and also

supplementing them with additional indicators, in order to obtain an assessment that is most appropriate for the locality of interest. Operational definitions of the core indicators are not strictly standardised and this can lead to variations in measurement, and reduced accuracy and comparability. The core indicators were developed with a focus on the urban context and this may limit their utility for investigating issues in rural contexts. They do not perfectly match or correspond to the eight domains of an age-friendly city (WHO 2007). However, the original key concepts and principles are embraced by the core indicators.

The WHO system of indicators has been applied around the world. The results show considerable consistency and generally align with the WHO approach, with adaptations to local conditions. Here are some examples.

- The Active Aging Index was developed to assess age-friendliness in Europe and uses four measures – employment; participation in society; independent, healthy and secure living, capacity and enabling environment for active ageing[27].

- The AdvantAge Initiative in the USA[28] is based on a survey of how older adults fare in their communities. Its four domains focus on housing and security; physical and mental health; independence for the frail, disabled, and homebound; and opportunities for social and civic engagement. The initiative has developed 33 indicators or pieces of information that are tracked over time to help communities evaluate their age-friendliness. The AdvantAge Initiative team sought suggestions from community development experts, journalists, survey-design experts and government officials who provided guidance for refining indicators and benchmarks.

- The AARP's Livability Index was launched in 2015 to measure a community's quality of life for all ages and the extent to which it fosters independence among older residents. This is based on data from the American Census Survey in the categories of housing, transportation, neighbourhood characteristics, environment, health and civic social engagement.

- Applying economic criteria. Siew (2016) used sustainability reporting tools (SRTs) for an age-friendly built environment. SRTs are used to guide the design and development of eco-friendly buildings but have expanded to consider the built environment. The aim of this exercise is to examine age-friendliness from an ecological perspective. Siew's report compares indicator systems in UK and USA and highlights common features.

- Coleman's thesis (2015) aimed to create a reliable and effective list of age-friendly indicators for policy makers, city planners, and ageing advocates.

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27 www.unece.org/stat/platform/display/AAI/Active+Ageing+Index+Home NOTE: up to this point in the document, footnote urls have not concluded with a fullstop. Consistency needed.

28 www.vnsny.org/advantage/whatis.html (http://www.vnsny.org/advantage/whatis.html)).

- Best Cities for Successful Aging was developed by the Milken Institute in the US[29]. This ranks metropolitan areas on their age-friendly capacity, using data focused on eight categories – health care, wellness, living arrangements, transportation, financial characteristics, employment, educational opportunities, community engagement, and overall livability.

- *Resilient Communities: Empowering Older Adults in Disaster* is an emergency preparedness report developed by the New York Academy of Medicine, incorporating community participation, services and programmes, as well as post-disaster recovery. Disaster management is an often-overlooked yet critical component to planning age-friendly communities (see Part 5).

- "Age-Friendly Portland" was the first American city to capture data consistent with the WHO's framework using 10 key domains: housing; transportation; outdoor spaces and buildings; respect and social inclusion; civic participation and volunteerism; employment and economy; social participation; community and information; community services; and health services[30].

- As part of their housing research, the Canada Mortgage and Housing Corporation developed a set of indicators to measure the effects of the built environment on older people's independence, health, quality of life, and wellbeing. These indicators are focused on six areas: neighbourhood walkability, transportation options, access to services, housing choice, safety, and community engagement in civic activities (Steels 2015).

- London, Ontario, was the first city in Canada to join the Global Network. In her thesis, Dellamora (2014) adapted an assessment tool – the Community Assessment Survey for Older Adults (CASOA) which proved to be effective and valuable for measuring age-friendliness[31]. It provided detailed information on all eight WHO domains, and the results highlight specific areas where improvement is needed. Also in the context of London, Kubach's doctoral thesis (2014), used a sequential mixed methods design. Questions were derived from a baseline survey in subsequent focus groups, and derived several themes such as uncertainty (barriers to social engagement); togetherness (social support through community relationships); and resentment (fairness, lack of equal access to opportunities), which are fairly abstract for planning purposes.

As yet, there are no readily available publications giving detailed accounts of the performance of these indicators, and how they have been used in evaluation and ongoing implementation of AFCC initiatives.

4.3   Criticisms of the use of indicators

While the AFCC framework has garnered a great deal of interest from policy makers, researchers, and interested communities, there is little consensus on how age-friendliness should be measured or evaluated. Michelle Dellamora (2014) suggests that the age-friendly indicators movement has so far lacked a coherent approach to the assessment of needs within the eight WHO domains, and there is a lack of accurate and specific measurements of AFCC characteristics.

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29   www.milkeninstitute.org/publications/view/671
30   www.portlandoregon.gov/bps/article/425455
31   The USA National Research Center's Community Assessment Survey for Older Adults asks older people about their circumstances and needs, using multiple community dimensions as they relate to older adults: http://www.n-r-c.com/survey-products/community-assessment-survey-for-older-adults/

Dellamora also asks whether there can be universally applicable guidelines to improve age-friendliness. While the research suggests that there are at least some characteristics of an AFCC approach that are common everywhere, significant variations in the expectations and needs of older people require a high degree of flexibility. The AFCC framework must be adaptable to the needs and resources of individual communities. This requires a mixed methods approach to age-friendly assessment, one that incorporates qualitative data from focus groups or interviews, as well as quantitative data which has been incorporated into indicators (Menec et al., 2011). A combination of methods provides communities with the means to accurately assess the needs of the community and the preferences of the older population.

4.4 Evaluation

Despite the considerable literature which has been generated by AFCC initiatives, scant information is available on implementation or evaluation (Gonzales 2009; Lui et al. 2009). While the WHO Guide outlines the process of conducting focus groups and the WHO Age-Friendly Cities checklist offers a list of basic indicators of age-friendliness, each community must decide how best to measure age-friendliness.

An exception to the dearth of information on evaluation is a paper by Neal and Wernher, *Evaluating Your Age-Friendly Community Program: A Step-by-Step Guide* (2014). This is based on the AARP's (American Association of Retired Persons) framework (affiliate to the Global Network) and sets out requirements for members of the network. They are required to conduct a baseline assessment of the community's age-friendliness, write an action plan based on the results of the assessment, identify indicators for assessing and monitoring progress, monitor progress and establish a process for continual improvement. They are expected to adhere to a five-year programme cycle. An evaluation report at the end of every cycle is mandatory to ensure continuing membership in the AARP and WHO networks.

The instructions for evaluation are quite specific and follow the WHO framework of inputs, outputs and outcomes. However, the items under these stages are a mixture of procedural items and evaluative data. Input examples include the formation of an advisory council and data from "focus group interviews". Output examples (resources and structures in the WHO report) are measures such as the number of housing units following "Universal Design" requirements (see Part 2.3), and the number of businesses certified as age-friendly. Outcomes are specified as either short/medium term (eg improved walkability, increased number of affordable housing units, increased volunteering) or long term (eg improved physical and mental health, improved economic wellbeing of residents. These would be called "impact indicators" in the WHO scheme). In this approach, the indicators would be chosen to measure the desired outcomes and activities from the planning process.

Coleman's thesis (2015) relates only to the built environment but aims to create a reliable and effective list of age-friendly indicators. Eighty-eight potential indicators were developed and shared with 34 professionals from the fields of ageing and the built environment. The iterative survey process suggested 24 key indicators that were considered the most effective. These were chosen based on their measurability, sensitivity to change, and action orientation. They were ranked according city policy, city implementation and infrastructure, greatest number of seniors served, and city-to-city comparison.

Key age-friendly indicators for the built environment emerged as:

· quality of sidewalks

· street lighting

· street connectivity and street conditions

· pedestrian crossing times

· flexible zoning for mixed-use and intergenerational uses.

· The highest ranked indicators (those that served the greatest number of seniors according to survey participants) were:

· home safety modifications and fall prevention services

· alternative transportation options

· involvement of elders in community-based decision making

· a phone and online clearinghouse for ageing-related information.

A further example of evaluation uses an approach similar to Coleman's, but comes from outside the "western" sphere. An assessment of Depok City, in Indonesia, as an age-friendly city was carried out in 2013 (Lasmijah 2014). This used WHO's eight-dimensional framework and experts were asked to judge the relevance of the indicators for assessing and monitoring age-friendliness. Those deemed most relevant related to accessibility to the built environment and health services. It was noted that the mere presence of physical infrastructure is not sufficient; this should be teamed with an adequate number of skilled workers, especially doctors and nurses. Also noted as important were support for older people; financial support; crime, literacy and employment rates (with a link to income); and access to learning opportunities. In this analysis there is endorsement of WHO measures but also a reflection of local circumstances and priorities.

Part 5:

Limitations and criticisms of the Age-friendly Cities and Communities approach

5.1   Definition

Despite growing worldwide interest in the AFCC concept, Scharlach (2016) suggests it is remarkable how little attention has been given to the basic question of what an age-friendly city is and the tacit assumptions and conceptualisations underlying models of age-friendliness.

For the most part, there seems to be the sense that "you know an age-friendly city when you see one" and, furthermore, that the same definitions of age friendliness can (or should) be equally salient for all cities and all populations.

A variety of terminology is used including the terms age-friendly, elder-friendly, ageing-friendly, community for all ages, healthy city, livable city, livable community for all ages, etc. As noted above, WHO focuses on creating "age-friendly cities and communities". The American Association of Retired Persons (AARP) aims at creating "livable" communities. Perhaps these terms all mean the same thing – that the basic idea is a community that is good for older adults and for everyone, and that differences are purely semantic. Taking this stand may be useful to smooth over current differences in the AFCC movement and to be as inclusive as possible, but it may be that variations in terminology will become significant differences in approaches to and evaluation of AFCC as the movement grows.

5.2   Coverage

One of the main areas of criticism of the WHO AFFC initiatives has been coverage. Earlier sections have highlighted groups that have been excluded from the process. Dellamora (2014), Plouffe and Kalache (2010) and others have called for strategies to encourage the inclusion and hear the voices of potentially marginalised, vulnerable, and older people from minority groups. Is it possible to ensure that everyone is included, given the level of resources which would be required? Golant suggests that the age-friendly cities initiative tries to reach too many groups with diverse needs, and public resources are too limited to meet all needs. Golant suggests that communities should use evaluative methods to prioritise the implementation of their AFCC programmes (Golant 2014).

The very old

Zamora (2015) suggested that recommendations made for the general ageing population may not reflect the needs of sub-groups within the older cohort. Priorities may change with age. Research with community-dwelling older people often involves younger, active retirees, or frailer adults in residential care. But a third group warrants closer scrutiny. These are people in advanced age, who are still relatively independent and for whom informal social supports are critically important, enabling them to stay connected to their communities, combatting social isolation, and delaying the need for health and support services. This group of at-risk individuals may be hovering around a "tipping point" of transition from independence to dependence. With strong growth in the 85 plus age group, a major future challenge, certainly in New Zealand, will be increasing numbers of people living in mainstream housing in the community and needing care and support.

All ages

The benefits of universal design and intergenerational approaches have already been presented. There is still the danger that a focus on older people may create harmful intergenerational fractures, especially in the competition for resources (McGarry 2012).

Rural populations

The point has already been made that the thrust of the AFCC movement is urban and does not give sufficient attention to or reflect the diversity of rural communities.

People with dementia and other limitations

Attention to the needs of older people with dementia is growing as their numbers increase (see Part 3.1). There may be other groups whose special needs arise from specific disabilities, such as people with sensory and mobility limitations.

Cultural diversity

This has also been covered elsewhere (see Part 3.3), but is increasingly recognised as an important element of AFCCs if they are to honour their objectives of inclusiveness and recognition of differing needs and aspirations. This should also include the needs of gay and lesbian people.

5.3   Lack of attention to developing areas and cultural differences

The WHO model claims a global perspective but focuses on ageing issues in the developed world and lacks a framework that can be used in both developed and developing countries, if indeed this is possible. Few studies, as yet, focus on age-friendly initiatives in the developing world, particularly in low income countries. Some age-friendly features are less applicable for older people in these countries. Examples include the availability of decent housing options and access to community support and health services. Even when similar issues are reported, such as social inclusion and elder abuse, non-western countries may have fewer resources to tackle them or there are significant cultural differences in approaches to these issues. For example, a study in China by Glass et al. (2013) found that family-based, long-term care is no longer sustainable. Changes in Chinese society such as the one child policy, rural to urban migration, and the increase of female workforce participation have reduced the availability of traditional family caregivers. Long-term care will need to be supplemented by formal services. However, cultural influences (most notably filial piety) must also be considered when developing services to ensure both the users and their families are supported through the process (Glass et al. 2013).

5.4   Adequate identification of indicators and evaluation

As already noted in Part 4, a major gap in the AFCC area is the evaluation of age-friendly initiatives. One of the major challenges in AFCC research is to provide communities with the appropriate guidance and tools to assess age-friendliness in a way that is appropriate, accurate and actionable. In the absence of established indicators, many communities have elected to create their own surveys or questionnaires using the WHO checklist as a guide – as the WHO, in fact, advocates. While this allows the assessment to be tailored to the needs of a particular community, the methods to assure validity, reliability, and sensitivity to change have been questioned.

5.5   Critique of the eight domains of age-friendliness and the WHO checklist

Various modifications have been suggested to the WHO domains. Many are part of an academic dialogue. For example, sometimes social participation, civic participation and employment are grouped as – "opportunities for participation" (Liddle et al. 2014; Menec et al. 2011), which highlights the potential of all forms of participation to promote social integration and individual fulfilment. Menec et al. (2011) regard respect and social inclusion as a basic value of the AFCC initiative rather than a separate domain. Instead, they propose that economic inequality and social disorder, which lead to social exclusion, be part of a new domain of social environment. A more practical suggestion is to make "harm protection" ie physical safety, a distinct domain as has been done by some municipal and state projects, rather than this being part of the outdoor spaces and buildings, transportation and housing domain. Protection from crime, and disaster preparedness could also usefully be given a higher profile among the AFCC domains.

5.6   AFCC framework too inflexible, static and top-down

The WHO framework has been criticised on several counts. The first is that it fails to recognise the diversity of older people and communities. The fact that there are many diverse groups of older people with different needs implies that there are correspondingly many potential age-friendly environments with matching resources. A second, and somewhat contradictory charge, is that the checklist is unrealistically broad in the range of needs identified. The third is that it subverts citizen engagement by older persons. The methodology promoted by the original *WHO Guide* in 2007 has been criticised by practitioners and researchers as promoting an "ideal city" and "top-down" perspective directed by local authorities to achieve pre-established criteria (Barusch 2013; Buffel et al. 2012; Lui et al. 2009).

Buffel et al. (2012) and Liddle et al. (2014) argue against the imposition of an arbitrary checklist for an "ideal city". Rather, using a "strictly bottom-up" approach, older people themselves should be the main protagonists in defining the "actual opportunities and constraints in cities for maintaining quality of life as people age" (Buffel et al. 2012). In this context, it is preferable to view the WHO checklist of age-friendly features as an inventory of commonly identified characteristics, a starting point for cities, which may be enriched, pared down or modified, depending on the particular context in which it is used.

To be fair, the WHO methodology has undergone adaptations and the eight original domains have been modified, adding elements that were not sufficiently detailed previously, such as informal social support, and safety and security concerns. Menec et al. (2011) and Keating et al. (2013) contend that what makes a community age-friendly is having a good fit between the older person and his/her living environment, not conformity to a standard or fixed set of features. Moreover, places evolve over time; a city that is age-friendly at one time may become "unfriendly" at another. Becoming or remaining age-friendly is therefore an ongoing process. This requires frameworks to recognise changes in living environments.

5.7   Coping with different scales of application and the problem of universal guidelines

The WHO is clear that every member of the AFCC network is free to apply the principles to their own local scale. Approaches to AFCC will vary greatly with the scale of the centres to which they are applied. But is there a danger that the term "Age-friendly City" will become so generalised that it will lose its usefulness as a clear, practical and specific solution to ageing and urbanisation? In this case, and in view of issues of coverage mentioned above, can there be universally applicable guidelines to improve age-friendliness? In order for AFCC to establish and maintain relevance, the framework must be continually adaptable to the needs and resources of each individual community (Menec et al. 2011).

5.8   Research authenticity and representativeness

In reviewing research on AFCC initiatives, Dellamora (2014) concluded that, although the majority of surveys used some method of consultation with older adults in the community (whether through focus groups, interviews or the inclusion of older adults in steering committees and task forces) most did not meet rigorous methodology standards. They involved a bottom-up, participatory approach. While this is generally applauded, it lacks the validity, reliability and sensitivity to produce results which can be meaningfully translated into community action plans, programme development, and easy-to-understand indicators of age-friendly progress. How can all these requirements be reconciled? There are also complaints that individual communities and organisations have created new surveys and questionnaires with little awareness of similar instruments already in existence. This again produces a dilemma – whether communities should adopt recognised instruments for research or tailor their efforts to a specific case.

Dellamora's review (2014) was unable to identify any baseline surveys of age-friendliness which used a representative random sample of older adults. Focus groups and interviews are excellent methods to elicit rich, detailed information on participant experiences, but cannot ensure full representation of the community, nor a comprehensive or generalisable cross-section of the older population in a community, consistent with WHO's equity objective.

Linked to the challenges to research methods is comment on the disconnect between conceptual work being done by academic researchers and the practical, community-driven work being done by cities, town, and municipalities. Dellamora (2014) contends that the future of AFCC will depend on the unification of theory and practice, so that definitions of terms and concepts remain precise and useful (Clarke and Nieuwenhuijsen 2009). While academic researchers work on theory, exploring the mechanisms of the person/environment relationship and how it relates specifically to older adults, it would be useful for research effort to be increased on the practical application of the AFCC approach and the assessment of its benefits.

5.9   Need for better information systems

If older people are to participate fully in community life, make their own decisions and participate in a range of activities, as suggested by the age-friendly and active ageing models, they need good information and knowledge about appropriate programmes and resources (Everingham, et al. 2009). Communication and information are identified in the WHO (2007) framework as age-friendly domains. They are cross-cutting and facilitating themes which allow people to take advantage of other opportunities. Making information available may not be enough to ensure it is appropriate and relevant, and actually used. Access must be by those means preferred by older people and in places convenient to them, taking into account that they may face issues with hearing, vision and perception. In an age-friendly environment not only the content of information but also the method of communication need to be adapted for older people. Should it be transmitted in person, via newspapers, or through the internet? Is the print large enough? What facilitates or hinders communication in an age-friendly community?

New technologies can be a barrier if people do not have the skills and equipment to use them (see Part 3.4). Information must also be timely (eg as needed in a crisis); easy to use (personal, not automated help) and locally specific; topic-based rather than agency-based; holistic rather than siloed; easy to apply, authoritative and credible. The reputation or the providing organisation is important here.

5.10   Political and institutional barriers

The effect on AFCC programmes of changes in political leadership are outlined in Parts 2.5 and 6, with examples from Canada, the US and Australia. Changing policy stances will also affect the AFCC movement as well as strained budgets, conflicting priorities, and the challenge of maintaining momentum (Clark and Glicksman, 2012).

Menec et al. (2011) warn against an underlying agenda that might be driving the growing interest in age-friendliness. At a time when government agencies are facing economic challenges and seeking cost-cutting measures, the idea of making communities more age-friendly can seem appealing, often linked to the devolution of government programmes (Martinson and Minkler 2006). The effect might be to offload responsibility entirely onto the community itself.

5.11   Dominance of health/social care context

Curtis (2013) notes that ageing policy has been framed in a medical and social care narrative, rather than focusing on older people as acting in a wider social context. When compared, the resources in the medical system dwarf the allocation given to footpaths, parks, and civic spaces. But these are places where healthy routines can be encouraged and reinforced (Ball and Lawler 2014).

5.12   Lack of attention to age-friendly workplaces

Appannah and Biggs (2015) point out that there have been few studies of age-friendly workplaces (older workers are frequently mentioned, though not explicitly, in the context of active ageing). They call for a framework to guide organisational culture change, a better understanding of age-friendly concepts in workplaces, inclusion/valuing of older workers, attitude change, and a challenging of

stereotypes. This will require flexible work options, changes in job design to promote health, training, and development of older workers. Support from senior management is essential if these changes are to gain wide acceptance and reach all levels.

5.13 Emergency preparedness and disaster management

These often-overlooked but critical components in planning age-friendly communities are especially relevant for New Zealand. It is vital that emergency planning and training takes into account the special needs of older adults and people with disabilities. Older adults have special needs in an emergency, especially if they have chronic health conditions and functional limitations which increase their vulnerability and need for support. But older people can also be a resource in their communities after a disaster, as was seen in the Canterbury earthquakes (Davey and Neale 2013).

Some communities add disaster planning and/or food security as additional domains to the WHO suite (Oh 2015). Using Age-friendly New York City as a platform to leverage relationships with multiple city agencies, the private sector, and philanthropy, the New York Academy of Medicine produced *Resilient communities: Empowering older adults in disasters and daily life* (Goldman, Finkelsteing, Schafer, & Pugh 2014). This incorporates preparedness, community participation, services and programmes, as well as post-disaster recovery.

5.14 Need for a systems rethink to make AFCC work

Ball and Lawler (2014) call for a measure of "creative destruction" ' in local AFCC efforts. Physical barriers to successful ageing are now deeply embedded in the built environment, and policy barriers are deeply embedded in public institutions. The authors claim that current work comprises mostly "incremental tweaks" and does not tackle the difficult work of demolishing the overarching paradigms of land use, transportation, health care, and supportive service delivery. Instead of making existing paradigms more comfortable, workers in the AFCC sphere must instigate the very uncomfortable work of destructive re-creation. For example, most transport infrastructure supports only one way to get around – single occupancy vehicles. Most health care focuses on treating time-limited acute episodes rather than sustaining lifelong wellness or preventing disease and disability. Most housing is segregated by type and use, making it hard for older people to change housing type without changing community.

What is needed is the kind of metamorphosis that the internet has brought in every aspect of society in a very short time. Technology has been and continues to be a disruptive and powerful change agent in all areas of life. It is a new and permanent reality – much as longevity appears to be an established trend. The task is to adjust current systems of service, funding, regulation, and policy to reflect this new state and to enable the wealth of evidence and experience in hand to disrupt and reinvent systems from within. Thus, the current practice of age-friendly community work must engage in creative destruction: challenging entrenched interests, stagnant bureaucracies, and obsolete programmes, according to Ball and Lawler (2014).

Part 6:

Examples of applying an age-friendly approach

This section gives examples of how the WHO AFCC approach has been applied in a variety of countries, highlighting specific aspects of its development.

6.1 Victoria, Australia – collaboration but lack of public sector support

While two Australian cities participated in the research guiding the development of the original *WHO AFCC Guide* (WHO 2007), the uptake of the AFCC model nationwide since then has been relatively stagnant (Ozanne et al. 2013). Brasher and Winterton (2016) attribute this to the inability of various levels of government to foster coherent policies supporting the implementation of AFCC. There is currently no consistent federal or state policy leadership relating to age-friendliness as exists in other countries (Ozanne et al. 2013).

The early impetus for AFCC in Victoria was the release of *Positive Ageing: A Strategy for Current and Future Senior Victorians* by the Department for Victorian Communities in 2004[32]. This strategy was located in the positive ageing discourse, but also drew on age-friendly rhetoric following visits to Melbourne by Alex Kalache, then Director of Ageing and the Life Course Programme at the WHO. The aim of the strategy was to maximise the quality of life and social recognition of older Victorians.

The Positive Ageing Strategy in Victoria is underpinned by five key principles:

- confidence in the rights of older people to be upheld, their autonomy accepted and dignity respected

- certainty that older people are valued and listened to for their past, current and future contributions

- opportunities for older people to fully participate in their communities

- access to information, support, and services to maximise their independence and maintain health and wellbeing

- and government services and communities which are responsive to the particular needs and interests of older people, and which recognise the increasing diversity of our community.

The subsequent *Positive Ageing in Local Communities* project was a joint initiative between the Municipal Association of Victoria (MAV), the state's peak body for local government, and the Victorian branch of the Council of the Ageing (COTA), the nation's leading advocacy organisation for older people. This was a good example of collaboration between public and voluntary sectors. The aims of this project were to build local government capacity in planning for population ageing and to provide leadership in promoting age-friendly communities. The Victorian Government's Family and Community Development Committee in 2007 recommended liaison with the federal government to promote the development of a national age-friendly strategy. With COTA, it also recommended that the Victorian Government seek to join the Global Network and support local government authorities to achieve the same goal.

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32   www.ifa-fiv.org/wp-content/uploads/2012/11/060_Positive-Ageing-Strategy-Victoria.pdf

But, as a result of a lack of attention from federal and state government in the form of policies, funding, leadership, reporting criteria and collaborative partnerships, responsibility for the age-friendly agenda in Victoria has largely been devolved to the Positive Ageing Policy Advisory Group through MAV. Throughout Victoria's municipalities, there had been little in the way of common thinking about what age-friendly communities should look like. There are also issues about the capacity of rural and regional Victoria to implement age-friendly strategies and planning.

While all levels of government have acknowledged the benefits of active ageing, this has not translated into a willingness to accept responsibility for implementation. Where recommendations have been made to address the lack of attention to AFCC, these have mostly been abandoned with changes in government. This lack of continuity has resulted in inconsistent and piecemeal use of age-friendly terminology, and fragmentation of policies and programmes. While local government is attempting to implement AFCC with the assistance of COTA and MAV, the legitimacy and sustainability of their actions are threatened when they are not accountable to a wider network or lack the policy support to move forward. This has also led to limited collaboration between different sectors and inconsistent engagement of older people in steering the AFCC process. The lack of engagement of Australian academics in the AFCC initiative to date reflects current government priorities toward population ageing and therefore research funding.

6.2   New York City – practical assistance for older people with their input

Age-friendly New York City (NYC) is a public/private partnership between the New York Academy of Medicine (NYAM)[33], the Office of the Mayor[34], and the New York City Council dedicated to promoting active engagement by older people in all aspects of city life. Using WHO's framework and domains for age-friendly cities, NYAM and the city first conducted a comprehensive assessment of age-friendliness in 2007. Data was collected through community consultations, focus groups, interviews, and surveys, in 14 neighbourhoods and in six languages. Roundtable discussions were held with business, housing, social services, health, transportation, and higher education experts, as well as asset mapping and demographic analysis. This resulted in *Toward an age-friendly city: A findings report* (Goldman et al. 2016).

The Age-Friendly NYC Commission was appointed in 2010 and is comprised of leaders from government, business, education, health care, and law. The commission is charged with monitoring the progress of the "59 Initiatives" to improve the quality of life of older New Yorkers.

The commission is guided by the following principles, aligned with the WHO framework:

- an ageing population is an opportunity, not a crisis
- older people must be involved in all phases of problem identification and resolution within a community

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33   The New York Academy of Medicine (NYAM) is an independent, nonpartisan, non-profit institution which serves as the secretariat for Age-Friendly NYC. NYAM cultivates strategic partnerships with the non-profit and for-profit sectors, staffs the Age-Friendly NYC Commission and develops the evidence base to support citywide and sector-specific interventions and policy change.

34   The Office of the Mayor is the executive branch of city government. While NYAM conducted the initial community research, the Mayor's Office led an assessment of the age-friendliness of programmes and services provided by city agencies, held meetings of key agency leaders, and conducted seminars on topics such as promoting active ageing and universal design.

- initiatives should address the full diversity of a community's older population with respect to functional capacity, economic resources, and demographics

- initiatives should be grounded in evidence

- all sectors (public and private) must be engaged in developing solutions to eliminate barriers to older adults' full participation in society.

Next, an action plan was devised with short- and long-term goals to optimise the social, physical, and economic participation of older people through enhanced connections to services, entitlements, and opportunities. The advisory group tracked implementation progress and outcomes. The neighbourhood action plan is revisited annually to promote a cycle of continuous improvement.

The primary mechanisms through which Age-Friendly NYC effects change include:

- increased use of existing assets

- development of local solutions to local problems

- promotion of economic security and spending

- leverage of private sector resources.

Goldman et al. (2016) provide examples of practical measures to assist active ageing in NYC. Some examples are outlined here.

Streets

Older people reported significant barriers to pedestrian safety including inadequate street crossing times, poorly maintained sidewalks and lack of seating. As one person said, "I age every time I have to cross the street". The NYC Department of Transportation (DOT) established the Safe Streets for Seniors Program in 2008. DOT evaluates conditions in areas with high rates of senior pedestrian fatalities or injuries, and develops and implements mitigation measures such as extending pedestrian crossing times, constructing pedestrian safety islands, widening curbs and medians, narrowing roadways, and installing new stop controls and signals. DOT solicits ideas and feedback through presentations and workshops and also partners with the Department for the Aging to co-ordinate outreach and share resources. These changes have made streets safer for all New Yorkers.

Seating

The City Bench programme is another initiative to increase walkability. Through a federal grant, DOT is installing 1,500 benches around the city, particularly near senior centres and housing, hospitals and community health centres, commercial and shopping zones, and municipal facilities (eg public libraries). Individuals and communities can request a bench in a specific location. Older people report forming new bonds with people who frequent the same benches at the same times.

Bus shelters

In response to feedback from older people that bus shelters often lacked seating and felt unsafe, 4,000 new shelters were installed, with seating and transparent walls. These shelters are paid for by advertisements projected on their sides. DOT replaced almost all pre-existing bus shelters and installed additional shelters at locations identified by older people and community leaders. As a result older people can feel safe and independent walking their streets, shopping, and going about their daily lives. These interventions are also serving to decrease social isolation and increase social cohesion as people become more comfortable leaving their homes, using public spaces and interacting with neighbours.

Transport

Age-Friendly NYC has expanded public transport options for older people, through the use of school buses and taxis. Through a partnership between the Department of Education and the Department for the Aging, school buses can be used by senior centres to transport older people on shopping trips when buses are not in use for children.

Workforce

Older adults play an increasing and significant role in NYC's workforce but face significant barriers to ongoing participation. Challenges include lack of adequate computer skills and/or access to training, employers' perceived reluctance to hire older workers, the challenges of maintaining a work-life balance, and the scarcity of "bridge" jobs that support a gradual transition to retirement. Age-Friendly NYC promotes job retention and employment opportunities for older adults through public recognition of exemplary employer practices. The Age Smart Employer Awards honour employers who value workers of all ages and aims to support businesses looking to maximise the potential of their workers as they age by providing research and best practice. NYAM created an evidence-based compendium of strategies that characterise "age smart" workplaces. Job creation measures of this type lead to increased financial security among older people, help to decrease reliance on social insurance programmes, and drive economic growth through increased consumer spending.

Business and professions

The Age-Friendly Local Business Pilot Project was launched in 2011. Businesses were approached, provided with a resource guide and encouraged to carry out simple enhancements, such as offering chairs for older people. They were also given window decals so that older adults could identify age-friendly businesses. A small study suggested that participating businesses had higher average cash receipts than non-participating similar businesses.

Age-Friendly NYC has also leveraged the city's many professional associations as gateways to reach large groups of people who are open to thinking about their work in new ways and to seeing population ageing as an opportunity for professional growth. Professions approached included architecture and design, law, pharmacy, library sciences, and urban planning. "Best practices" brochures were created in collaboration with professional associations and disseminated to members.

Technology

As part of Age-Friendly NYC, the public library published "10 ways to make your library age-friendly". The library system provided training for staff to share best practices for older people, and partnered with the Department for the Aging to host borough-wide meetings of library branches and senior centres to share information. The library system also added special senior sections to its website and hosted technology classes and panel discussions around issues important to older people.

Recreation

When discussing local recreational opportunities, older people revealed that they had not used public pools in decades because they felt uncomfortable and unsafe among children and teenagers. This finding was relayed to the Department of Parks and Recreation which piloted senior-only swim hours at one public pool, known as "Senior Splash". The programme was so popular that it was expanded to 16 pools throughout the city and added water aerobics instruction. A preliminary evaluation of this programme indicated that older people who participated in regular water aerobics demonstrated greater lower body strength and flexibility than those who did not.

6.3   Canada – government interest and a focus on rural ageing

In Canada, governments are the primary drivers of the age-friendly movement. Eight out of 10 provinces are engaged in promoting and supporting AFCC initiatives. The federal government provides funding support for activities aiming to stimulate volunteering among seniors and to support their social participation and inclusion. All provinces provide funding either directly or indirectly through foundations or third-party organisations to communities that undertake to become more age-friendly.

In September 2006, the Canadian ministers responsible for seniors, at both federal and provincial level, made the decision to raise the awareness of the challenges of ageing in rural areas and called for the production of a specific guide for rural communities. As a result, a Canadian working group published an adaptation of the WHO Guide, *Age-friendly rural and remote communities: A guide*, published by the Government of Canada in 2007[35].

In October 2012, a conference on age-friendly rural and remote communities was held in Winnipeg. Forty-two delegates were invited, representing researchers; older adult activists; representatives of NGOs working at local, national, and international levels; and representatives of municipal, regional, or national governments. The majority of delegates were Canadians. Before the conference, delegates were asked to provide insights into the strengths, weaknesses, opportunities, and threats (SWOT) to age-friendliness in rural and remote communities (Menec et al. 2015b).

The presence of strong social ties in the community was identified as strength, whereas a widely dispersed population and large geographic distances were noted as weaknesses. Similarly, increased awareness and government support for ageing-related issues was identified as an opportunity, whereas the ageing of the rural communities as a result of migration was identified as a threat.

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35   www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/public/healthy-sante/age_friendly_rural/AFRRC_en.pdf

Part 7:

Applying the Age-friendly Cities and Communities concept in New Zealand

7.1   Acceptability of AFCC values

The antecedents of AFCC ideas lie in the growing realisation that population ageing represents a significant change in social, economic and cultural environments, and will affect all human agencies, from global to neighbourhood level. There will be implications for government at all levels, the business, voluntary and community sectors, and for families and individuals. There will be consequences for all nations. At the global level, the impetus came from the United Nations (International Year of Older Persons in 1999) and WHO. The WHO has health as its mandate, and a health focus has been, and still is, a central focus for policies on ageing. However, the WHO soon developed a wider mandate on ageing, emphasising the creation of supportive environments and communities for older people. It emphasised the values of participation, inclusion, respect and empowerment for older people, and especially for vulnerable groups. This is summed up as 'active ageing' in its widest sense. How does this resonate in the New Zealand social and policy environment?

New Zealand has made its own contribution to the raft of policy statements on ageing (Davey and Glasgow 2006). In April 1996, the Prime Ministerial Task Force on Positive Ageing was set up (MacDonald 1998)[36]. The objective was to develop public consensus on:

> The environment that is necessary to ensure that people move through their lives towards a healthy, independent, safe, secure and dignified old age, in which they are able to participate in and contribute to society to the extent of their abilities and wishes, and enjoy the respect and support of their families and communities.

This statement clearly embodies age-friendly values. In 2001 the *New Zealand Positive Ageing Strategy* was published and subsequently renewed in the 2014 *Report on the Positive Ageing Strategy*. We therefore have policy positions, and the *Positive Ageing Strategy* in particular, expressing views consistent with the UN and WHO statements. This suggests ready acceptance of the international AFCC values and objectives.

WHO broadened its focus from "health" (absence of disease) to a whole-of-life course view, using the term "ageing" instead of "the elderly". This allowed social and environmental issues to be brought into its scope. Interestingly, the recent review of the Ministry of Health's *Health of Older People Strategy* has been similarly widened to become the *Healthy Ageing Strategy* (MOH 2016).

The concept of "environmental fit", 'the idea that older people should be seen in their environments and that environmental factors may hinder active and positive ageing – is not overt in the *New Zealand Positive Ageing Strategy*, although the *Healthy Ageing Strategy* talks about improving the social and environmental factors that influence health. Achieving equity and removing barriers to participation are also mentioned.

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36   The final task force report – Facing the Future: A strategic plan – appeared in July 1997 (its work was compressed into barely a year). But since 1997 the work of the task force has received little recognition.

7.2   Using the WHO AFCC framework and guide

The WHO AFCC framework, guide, indicators and domains have always been intended to be adapted to local contexts. Even the "domains" in the AFCC model are seen as flexible and have been amended in practice. The four-stage plan set out by the WHO, for communities wishing to affiliate to the global network, is clear, sensible and easy to follow. If New Zealand communities wish to take the WHO's AFCC path, these processes need to be publicised and debated, and central government can take a lead in this.

The WHO provides ongoing support through a website and forums, where interested parties can share ideas and experiences, whatever stage they are at in the AFCC process. These resources are likely to be of value in New Zealand at both central government and local levels. In Part 1, Warth outlines challenges to AFCC such as sustainability, language, and a bias towards developed countries. Given a commitment to AFCC principles, what can New Zealand do to help meet these challenges, while at all times and at all levels maintaining consultation with older people and including guidance from them?

7.3   Links to New Zealand policies

Active Ageing

There are clearly many benefits to be gleaned from the AFCC approach – shown in Part 1. Some of these are economic. The economic opportunities related to population ageing were pointed out in *The Business of Ageing* in 2011 and in the update report in 2013. As well as pointing out the significance of a growing older population as consumers, these reports highlighted the economic contribution of older people in the paid workforce and how this can contribute to economic growth, especially in the context of labour and skills shortages linked to demographic change. New Zealand already has a high rate of workforce participation in the 65 plus age group (Cameron 2014), which is facilitated by retirement income policy, such as the lack of the work test for receipt of New Zealand superannuation. The pros and cons of prolonging workforce participation need to be discussed in policy terms (Davey 2014) and in the context of AFCC. WHO statements and the literature surrounding AFCC are clear that policy moves to prolong or increase workforce participation need to respect older people's choices; whether or not to continue in paid work and under what conditions. Adjustments are needed both in terms of keeping up the functional capacity of workers and also in job demands.

While the concept of active ageing is often seen in economic terms, the WHO definition is couched rather in terms of optimising opportunity and realising potential. This definition includes volunteering, caring and other unpaid work. The AFCC approach also makes it clear that even frail and dependent people can continue to make some contribution, often based on generativity. In pursuing active ageing, no one should be left out, and damaging stereotypes should be avoided. The UN and WHO literature talks about rights and obligations – a reciprocal approach which could also be explored further in the New Zealand context.

Ageing in place

New Zealand, along with other similar countries, has implicitly adopted an ageing in place policy, although its definition and implications have not been fully set out. Remaining in familiar surroundings as they age is clearly a preference for many older people. In the New Zealand context, Wiles et al. (2011) illustrate the value of attachment to place and the feeling of security that this can give. While many older New Zealanders did not know the meaning of ageing in place they knew that they valued the idea. The ability to choose is again an important consideration and should be at the forefront in policy. Should more thought be given to 'ageing in the community rather than 'ageing in place', in order to acknowledge the importance of environmental factors?

What are the motives underlying policies to encourage ageing in place, over and above giving choice? How does this fit with the fact that the "oldest old" are the fastest growing age group; that the majority of this group will need supportive services? How will these be provided if dependent older people are living in mainstream housing – ie ageing in place? Where does responsibility for such care lie? How will responsibility be shared? This is a major policy challenge for the future which goes beyond the scope of AFCC but is closely related to it.

Housing for older people

Housing is a key factor in the physical, social and economic environments of older people and in what makes these environments age-friendly. There is a strong link between housing and health. Housing needs to be physically and financially accessible, appropriate to the needs of older people and consistent with their choices. Universal design in housing is consistent with AFCC approaches and has the potential to benefit all ages. Good local and overseas examples should be identified and promoted.

New Zealand lacks the wide variety of housing necessary to meet these requirements in an ageing population. Other options such as co-operative housing, shared housing, accessory units, co-housing and intergenerational housing could usefully be explored. A choice highlighted in the literature is between age-integrated or age-segregated communities. This has not received much discussion in New Zealand but relates to housing choices and local environments. What interest does the retirement village sector have in age-friendly approaches and the ageing in the community concept? The costs of retirement village units have risen and this may be a barrier to choice.

Additionally, falling rates of home ownership will inevitably affect older age groups[37]. Will rental stock meet age-friendly requirements? Will housing affordability become an increasing barrier to choice?

Part 5 covers planning and policy initiatives which might support or block older people moving to optimum housing and surroundings. Home modification and renovation schemes have a role in removing barriers, promoting ageing in place, and improving health and safety (James and Saville-Smith 2011). Local authorities in New Zealand have had a varied response to housing for older people. What should be their role and what part should be taken by the voluntary and private sectors? Planning, building and zoning regulations have presented barriers in other countries, but this aspect has not received detailed attention in New Zealand.

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37   http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-housing/home-ownership-households.aspx

Community development and social capital

This literature review shows increasing emphasis on the community level within the AFCC approach. There is great potential in the concept of community development, even though this receives much less attention now at the local authority level than was the case before the shift to an emphasis on resource management in the 1990s. Basic tenets of the community development approach – mobilising communities, self-help, community control, collective actions – are consistent with AFCC. They link directly with ideas about mobilising the contribution of older people through volunteering and neighbourhood initiatives[38]. New Zealand communities seeking to become age-friendly following the WHO model should also embrace these concepts.

There are some communities in New Zealand that fit the description of naturally occurring retirement communities (NORCS) (see Part 2.3), such as Tauranga and the Kāpiti Coast. Where these are identified, whether within cities or in rural areas, they could be receptive as testing grounds for AFCC approaches.

The fuel for community development is social capital, as described in Part 2.4. Growing and mobilising social capital depends on contribution, self-efficacy and reciprocity – on identifying personal and community resources. This in turn requires action to counter social exclusion and the economic and physical vulnerability which may be causing it. The empowerment of older people and ensuring their voices are heard are essential bases for community development and a bottom-up drive towards age-friendliness – for all ages.

Political and governmental factors

A major challenge to AFCC is achieving a balance between top-down and bottom-up approaches, recognising different motives, frameworks, research approaches and ways of assessing success. Funding and regulation tend to come from above and governments are concerned with measurement and accountability. As shown in Part 4, evaluation of AFCC initiatives is not easy and has not been well developed. Government requirements for accountability may be hard to meet. An example is quality of life, which is a subjective concept; subjective measures may not align with the government's need for statistical indicators and cost-benefit measurements.

There are other challenges. The "silo effect" (see Part 2.5) is not new, but it presents a bureaucratic barrier to a holistic approach and works against an effective AFCC approach. Social policies tend to be aimed at meeting individual needs, but a shift to considering the needs of a community or neighbourhood may present another challenge. Economic austerity and moves to "roll back" welfare policies have restricted AFCC in initiatives in some countries. Part 6 provides examples of how changes in political leadership can affect the sustainability of AFCC progress.

Decentralisation and the withdrawal of central governments from social provision may starve communities of funding for AFCC initiatives. However, it may also allow greater local autonomy and stimulate private and voluntary sector efforts. Emphasis on market-based responses is growing. What is the role of the private sector in the AFCC movement? The voluntary sector has been affected by

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38   A clear example of how the 'young-old' can be proactive at neighbourhood level can be found in Davey, J. and Neale, J. (2013): Earthquake preparedness in an Ageing Society, an Earthquake Commission publication. This illustrates such activity in the aftermath of the Canterbury earthquakes.

changes and uncertainties in the contracting environment– what is their response, given that social capital is their foundation? The different roles and contributions of the sectors with respect to AFCC need discussion and definition. Both top-down and bottom-up approaches are clearly needed, but how can they operate effectively together?

Governments can play a vital role in promoting AFCC initiatives, as shown in Part 6. They can either depict ageing as a threat, thereby encouraging intergenerational conflict, or they can takes steps to combat ageism, provide useful information for AFCC, and consult with older people and their representatives in policy development. The form and place of such communication must meet the needs of the audience, especially those with cognitive or sensory impairments (see Part 3.1). Information and communication should also relate to local requirements ie language, means of dissemination etc.

Research and evaluation

As already mentioned, examples of AFCC evaluations are scarce in the literature; there is little consensus on measurement and the selection of indicators. This may relate to the newness of AFCC initiatives or the difficulty of establishing clear causal links in complex and difficult-to-control real world situations. Neal and Wernher's (2014) step-by-step guide provides a starting point for evaluation, but needs interpretation and differs from the WHO framework and set of indicators. Part 4 points out the many problems in designing indicators and then finding appropriate data to apply them. Deriving indicators from existing data has the benefit of availability but there are shortcomings too. Initiating new surveys is expensive but will provide more real and current information. Benchmarking, even within one urban area, may be difficult. And recognising the probability of change means that evaluative frameworks and systems of indicators must be flexible.

A watch needs to be kept on forthcoming research findings in the area, and encouragement should be given to New Zealand researchers to work in the AFCC area. The literature asks whether researchers should use recognised instruments or develop new ones. How can a balance be reached between what is coherent and relevant to New Zealand and what is comparable internationally? There are incentives for university researchers to concentrate on theory and comparability – but AFCC is very much a practical and applied issue.

User-led research is appropriate to AFCC philosophy but may not be seen as rigorous and scientific, and hence is criticised by academics and policy-makers. The WHO framework is useful, but only as a starting point or tool. Given social diversity – recognised by WHO – it is probably wrong to look for or expect universal guidelines. Are there universal AFCC characteristics? There are certainly aspects of AFCC which are common internationally. We need to explore which of these are common to New Zealand and to develop New Zealand approaches which are local but consistent with AFCC principles.

Gaps in knowledge

Given the very recent development of interest in AFCC in New Zealand, there are many information and research gaps to fill, as shown in Part 3. What potential is there for dementia-friendly communities in this country and, if there is a need, how could they be supported? What can we learn from recent

work in rural areas overseas (Part 3.3)? Some of the findings from this work may be applicable here, eg capitalising on strong community feeling in rural areas.

The implications of cultural diversity are not yet extensively reported in the AFCC literature. What does age-friendliness mean to Maori, Pacific and to other cultural communities? What would a culturally diverse age-friendly community in Aotearoa/New Zealand look like?

Modern technology has a huge potential to assist AFCC and Active Ageing. Many potential applications need consideration and testing, but little has yet been done in this area in New Zealand. Technological development must be accompanied by ethical scrutiny and careful education, with understanding flowing in both directions between technicians and users. The fundamental consideration will be what older people want and what will be of benefit to them. This is an area where New Zealand can again learn from overseas development, with local adaptation.

7.4 Conclusion

The following general points, which arise from the literature review and discussion, appear to be particularly relevant to the development of the AFCC movement in New Zealand, but the list is not exhaustive.

- There is a lot more involved in the AFCC concept than simply the physical environment. Its full realisation requires consideration of the psycho-social, cultural and economic environments for older people. Housing is a critical factor in older people's wellbeing and quality of life. But housing should not be considered separately from the neighbourhoods and communities from which older people derive physical and social support.

- Older people need to have their voices heard, with dignity and respect, and be actively involved in all stages of AFCC development.

- AFCC processes and initiatives need to have in-built flexibility to cope with change and to recognise local geographical and demographic diversity.

- The need for adaptation and flexibility is especially important with respect to the evaluation of AFCC processes and initiatives and the assessment of their outcomes. Achieving meaningful evaluation is a significant challenge in this area.

- A workable balance must be sought between the requirements of government agencies and the needs and aspirations of local communities and neighbourhoods, ie between top-down and bottom-up approaches.

Nevertheless, although there is a great deal that can be learned from AFCC values and processes, developed internationally, these need to be adapted to New Zealand conditions and reflect New Zealand situations. This includes the special needs and aspirations of Māori, Pacific and other cultural groups. Some of the concepts and definitions found in the review need closer scrutiny from a New Zealand point of view, for example, the concepts of ageing in place, active ageing, liveability, empowerment.

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