Ageing Int (2012) 37:1–15
DOI 10.1007/s12126-011-9136-x

Historical and Global Perspectives on Social Policy and "Aging in Community"

Sheying Chen

Published online: 6 December 2011

Abstract This article provides an introduction to the special issue of *Ageing International* on Aging in Community by putting related issues in perspective in order to maintain a comprehensive understanding of the changing fields of aging, family, community, and social policy. Going beyond a current trend of "aging in place" (AIP), it reviews community care that once dominated social policy dialog in the United Kingdom, as well as community service that was once regarded as a main solution to the social issues of reformist China. The case of the United States is also highlighted by reviewing a scholarly interest in social support. By citing America's "non-system" of community support for disabled elderly persons, the article recognizes an outstanding feature of AIP, that is, the "buy-in" from industry or the commercial sector in terms of its role in promoting aging at home. Other key social policy issues as seen in previous debates that baffled policy-makers in various countries, however, remain to be addressed in the much changed environment of the 21st century.

Keywords Community care and service · Social support · Aging in place · Active aging · Public policy · Comparative historical analysis

Abbreviations

AIP	Aging/age in place
CAPS	Certified Aging in Place Specialist
CCRC	Continuing Care Retirement Community
Danwei	Workplace (work unit)
GPP	General public policy
LSNS	Lubben Social Network Scale
LTC	Long-term care
n4a	National Association of Area Agencies on Aging

S. Chen (✉)
Pace University, New York, NY, USA
e-mail: sheyingchen@yahoo.com
URL: http://scholarlycorner.blogs.pace.edu/

NAOHB National Association of Home Builders
NORC Naturally occurring retirement communities
WHO World Health Organization

Introduction

"You've probably heard about the concept of 'Aging In Place,' adapting homes to support people being able to stay there as they age. We think that's great, but not nearly enough. We have witnessed the power of 'Aging In Community' making a difference in the lives of our friends and neighbors, and want to spread it to the world…" (http://www.agingincommunity.com/, retrieved November 20, 2010). Whether or not such a statement is valid by all accounts, it indicates a need to re-examine related concepts, theories, and practices using a historical and comparative perspective in order to achieve and maintain a comprehensive understanding of the changing fields of aging, family, community, and social policy.

Over two decades ago, having authored China's first public lecture series on community service to help start a national movement there (Chen 1988), I went to Hong Kong (then a British colony) to immerse myself in research including the study of aging. Intrigued by the subject of community care that had taken the center stage of social policy debates amid the transition of a troubled welfare state, I decided to further my case study of China by systematically examining and comparing with Western (particularly British) theory, policy, and practice. At that time, "aging in place" was not heeded (if ever heard) in that part of the world.

Community Care

The expansion of community psychiatric services in Britain dates back at least to the 1930s (Killaspy 2006). The British Royal Commission on the Law Relating to Mental Illness and Deficiency (1957) set a milestone for the official movement toward community care after various acts and reports (e.g., the 1956 Guillebaud Report of an accounting inquiry into the cost of the National Health Service) (Baugh 1987). Since then, community care evolved to also dominate or influence aging services and research in Britain, other Commonwealth nations, and beyond. While the meaning of community care was often criticized as ambiguous and varying, it emphasized care of those in need (e.g., physically and mentally disabled people, the frail elderly, etc.) in the community, or helping people to continue living in their own homes rather than hospitals, nursing homes, and other institutions (Rossiter and Wicks 1982).

"Care in the community," originally claimed as a better solution to the social needs than institutional care, however, generated numerous new questions, concerns, and debates. In order to tease out a comparative study framework from the seemingly endless confusion and contention, I had to clarify the historical factors (empirical-rational, organizational-technological, economic-financial, ideological-political, and social-cultural), mainstream ideology, structural parameters (e.g., contents, recipients, providers, and locations of care), practical issues, and policy responses based on a careful examination of the literature (Chen 1996). The historical forces that had

combined to shift the emphasis in policy to community care, for example, included early sociological research and public reaction against institutional care, vastly increasing practical problems associated with institutions such as costs and staffing difficulties, decreasing need to keep clients away from society because much behavior that was disturbing or bizarre could be controlled by drugs and other methods, demographic changes such as population aging, and growing opposition to welfare spending along with the recognition that people had a right where possible to live among ordinary people in society and not to be in a separate institution (Walker 1982; Tinker 1984).

Johnson (1987) notes that community care was born in such a time that "welfarism" was on a full wing; it is thus quite natural that the original meaning of community care was mainly confined to the formal domiciliary services provided by statutory personnel. During the 1970s, however, the economic performance of the Western world deteriorated sharply, resulting in a dramatic turn-around of the "societal norm" regarding social welfare. The welfare states were believed to have suffered from the problems of government growth leading to overload (Rose 1980), for which Keynesian economic policies and Beveridge-style welfare policies were held (at least partly) responsible. By the 1980s, there had been much criticism and much talk of the welfare state in crisis, forcing a retrenchment in social policies and a change in emphasis which led to so-called welfare pluralism.

Welfare pluralism (or "mixed economy of care") is a term used to convey the fact that social and health care might be obtained from four different sectors—the statutory, the voluntary, the commercial, and the informal (Johnson 1987). However, "welfare pluralism implies a less dominant role for the state, seeing it as not the only possible instrument for the collective provision of welfare services" (Hatch and Mocroft 1983, p. 2). Johnson (1987) further points out that community care "as a policy objective is by no means new, but recent events have, of course, strengthened the commitment of governments to community care since it appears to offer the opportunity to cut public expenditure and reduce the role of the state. Especially, defining community care as care by the community is more in line with the ideas of welfare pluralism" (p. 67).

"Care by the community," a new meaning for community care, could be a venerable aim to involve outsiders in the provision of care in various ways (Payne 1986). The increasing reliance on the informal sector—family, friends, neighbors, and other volunteers, however, left people with many unanswered questions. In practice, scholars had long expressed their concern with a double equation of "community care = family care = care by women" (Finch and Groves 1980). Despite the "domiciled care" policy outlined by one official report after another under Margaret Thatcher (e.g., the 1988 Griffiths Report and the 1989 White Paper), researchers challenged the assumption that community care would be cheaper than institutional care. As Kinnaird et al. (1981) had already pointed out, it was cheaper because the accommodation and the services of the family were not counted; it's not necessarily cheaper in terms of social cost. Some critics had already seen community care policy as a failure and demanded "care for the community" as another, necessary dimension of community care, which is a state or government responsibility to support the caregivers (Walker 1982). As for the future of community care, it should be envisioned with some important forces, visible or

invisible, being taken into account, such as the New Right's claim for a minimal state and others' for the socialism. By saying this, Johnson (1987) insinuates the importance of a grasp of the general position of social policy to the understanding of the potential development of community care both in theory and in practice.

The National Health Service and Community Care Act of 1990 outlined community care reforms in the hope to regain momentum. However, after years of operation and evaluation no clear conclusion was reached, leaving "care in chaos" (Hadley and Clough 1996). For healthcare recipients, a recent literature review by Killaspy (2006) shows that community care was consistently associated with greater patient satisfaction and quality of life across mental health specialties. However, it was not a cheaper alternative to hospital care and it caused an exodus of experienced inpatient staff to community settings with the development of alternative institutions in the non-statutory sector (ibid.). For the family and other informal caregivers under an uneven burden of "care by the community," questions remain as to how the government would fulfill its role as once a leading welfare state to support them. Its agenda might be too overwhelmed by welfare reform, economic recession, anti-terrorism war, and etc. to sustain the advancement of community care with necessary and adequate "care for the community." On the other hand, the role of the commercial sector in community care has not been a constant focus of inquiry even after years of effort in privatizing public and social services. Particularly, how to engage businesses by turning the "mixed economy of care" into real opportunities for the home-building industry etc. is not yet settled.

Community Service

Aging in community has been a complex and complicated subject in the West in terms of the controversies over community care policies as shown by the British case. Aging in Chinese communities could be an even more intricate field because of the vast differences between its urban and rural areas. Rapid social changes over the past three decades have also challenged any attempt to apply or derive a paradigm in the hope to last very long. However, it was my scholarly conviction that the study of China's experience would help to enrich our understanding of aging in community from a unique historical and comparative perspective.

Prior to the start of sweeping socioeconomic reforms at the turn of the 1980s, China practiced an "occupation-based" system in which state- and collective-owned enterprises "ran society" in terms of performing various social control and welfare functions on behalf of the government (Chen 1996). In the countryside, it was the People's Commune and its production teams that took care of, for instance, the childless elderly who could no longer earn their own living as they aged. The economic reform after 1978 quickly broke down such an old safety net by dismantling the rural People's Communes and getting rid of the "iron rice bowl" (lifetime guarantee) for urban workers. The state tried to make up the loss of security with a "serialized reform" to "socialize" welfare provisions. One measure was to build up government-controlled pension funds based on new taxes while relieving enterprises from the uneven burden of direct welfare provision, which was deemed a major obstacle to starting equal market competition (ibid). The process, however, lagged behind economic reform while

many non-monetary provisions fell through the cracks. It was in such a situation that some innovative leaders in the reformist government discovered the potential utility of the "community" in the face of mounting social needs, with a desire to learn from the "advanced experiences" of Western nations (Chen 1988, 1996).

"Aging in community" at the time had several "Chinese characteristics." First, few Chinese people knew even what "community" meant, in Chinese or other languages, not only because most social science disciplines had been nonexistent for nearly 30 years but also because the people were so used to the occupation-based system, belonging only to their almighty *Danwei* (work unit) for all sorts of needs, that few cared about the "Street" (administrative division of Chinese urban neighborhoods). It was usually after retirement that one might "return" to the neighborhood by playing a role in the Residents' Committee etc. (there was no statutory retirement for peasants in the countryside, where local communities were organized as production teams). Second, while Chinese grassroots communities were well organized and effective in terms of social control, there was a lack of social service (particularly voluntary, nonprofit, or nongovernmental) organizations except local government agencies and collectives providing minimal care for some special groups such as the childless and dependent elderly (who were few, thanks to a relatively young population with a norm of large numbers of offspring). Third, there were a heavy reliance on and strong belief in family support (probably the only familist idea favored under the communist ideology), so that when the community service movement started some Chinese scholars fervently argued against overstating the need for developing social services in favor of family support as a virtuous cultural tradition. More researchers, however, were concerned about the negative side effects of economic reform affecting the elderly in the face of a "gray tide" coupled with a dramatic change of the family structure in China. Using today's terminology, "aging in place" would mean aging in "empty nests" with little home- and community-based service given the nation's "one child" policy in the urban areas and rural labor migration to the cities. The economic reform required welfare services (including housing provision) to be removed from the workplace to the community, yet the "community" was not prepared to take over that omnipotent role of the *Danwei* while nursing homes were almost unheard of (Chen 1996). This could mean "aging in no place" for the majority of the Chinese aging population.

Despite all the research findings, scholarly appeals, practical demands, and real problems, the reformist but still (self-proclaimed) socialist state appeared to be doing little to support the family and the "community" at the time of a hyped movement of community service (which changed to "community construction" later). Watchdogs outside China could not help but kept complaining. The paradoxical situation drove the analysis in my aging study all the way up to the level of a "general public policy" (GPP) in order to understand why that was the case and when a policy change could be expected from the "economic state in transition" (Chen 1996, 2010). Just as the welfare state in crisis had to take a turn with welfare reform, the economic state in real crisis (as a consequence of continued politicization culminating in the "Cultural Revolution") had no choice but to undertake economic reform. Compared with American "workfare," China took an opposite direction by laying off redundant employees from state- and collective-owned enterprises. Privatization further diminished the status of many (as once the "masters" of their workplaces and jobs),

and peasants in the countryside were left on their own with tiny pieces of land to produce or lose. Ordinary people, particularly disadvantaged groups, paid the price of losing their *Danwei*-based social protection, once deemed a major indication of the "superiority of socialism." Similar to the shift from "welfarism" to welfare pluralism in the West, social policy of the economic state changed its aim from a superior "iron rice bowl" to a socialist welfare pluralism (Chen 1996). The state promised to "get rich together" after economic catch-up (Chen 2010), which would include social security for the unemployed and the elderly. The desperate need to survive its legitimacy challenge by making up past loss of economic opportunities under extreme politicization, however, required its new GPP to focus almost exclusively on the economy. This was made crystal clear by the post-Mao leadership's declaration of a "strategic transfer" of its work emphasis onto economic construction. It was this strategic transfer that made the economic reform possible after 1978. Those confusing "-isms" (i.e., socialism vs. capitalism), which had always taken the center stage of Chinese policy and frequently disrupted economic production, were put aside, with Deng Xiaoping effectively silencing ideological argument with his famous "white cat or black cat" principle to allow the newly de-politicized economic state to wage economic and all-encompassing (except political) reform (ibid.).

As predicted (although not without luck), in creating an economic miracle a new social security system with minimum income guarantee was built up. And housing ownership was given to workers and staff (often at a token price) (Li and Chen 2010), which provided the aging with a place in the urban community. Voluntary or nongovernmental organizations have also been on the rise. The elderly, however, had little savings while younger generations, or the elderly of the future, did not benefit from that unique real estate property rights transfer (privatization). Other services such as health and long-term care have remained problematic for all (Chen and Chen 2007). With the majority of the Chinese elderly now living alone or only with spouse (Li and Chen 2010), both housing policy and home-building practice have largely neglected the needs of the aging (as both social challenges and economic/business opportunities). Even less attention has been paid to the needs of older adults in the rural areas.

The Chinese government structurally is no longer an economic state after numerous economic and administrative reforms including privatization, which led to dramatic de-economicization of itself (Chen 2010). Yet the economic state ideology would still influence its GPP during the transitional period. Capitalism has taken roots in the country with remarkable economic achievements as well as serious social issues such as stunning inequality, poverty, and unemployment. It remains confusing whether the market economy is socialist as claimed or indeed capitalist (for even state ownership is not necessarily ownership by all). The government is now expected to learn more from the modern welfare state than early Laissez-faire capitalism. Given that the Western welfare state is also seriously handicapped, it remains to be seen whether or not the Chinese state will be able to move beyond (rather than a mere "convergence" with) the former to fulfill its promise of ultimate socialist welfare based on the market economy. In such a situation, the society has not found a clear answer as to how to support aging in community. Progresses have been made in community health, education and recreation, though personal social

and psychiatric services for the frail elderly and the disabled are still wanting in urban and rural communities, along with the issue of blatant employment discrimination against older adults under a high pressure of youth unemployment. As a developing country, the needs for more resources to support families and voluntary organizations are evident. A question is how to unleash the social potential of its rapidly advancing industries in the commercial sector.

Social Support

Unlike the Chinese and even the British, Americans tend to sanction more limited government and sometimes (if not always) appear to favor empirical research over policy speculations (as such they seem no less effective in leading various trends with innovations). One of the "culture shocks" after I relocated to the United States was to discover some unique features of American social policy studies. Community care and service were heard (not without learning from the experiences of other nations, especially the British Commonwealth), but it was not so prominent or symbolic to American scholars and policy-makers as to their British or Chinese counterparts. The terminology for public discourse could be more varied to include such other key terms as home-based, community-based, long-term care (LTC), and etc. with more pragmatic or programmatic interests than arguments over, for instance, the differences between care in, by, and for the community. Neither community care nor community service made an overarching theme or became the center of a lasting policy dialog (Cox 2004). Instead, a heated subject I was immediately drawn into its study was called "social support," or "social support network," which did not stem from an official push but was popularized via health-related research.

Since biomedical models of diseases appeared to have reached their limits, social and behavioral scientists weighed in with the evidence that morale and well-being are sustained through primary group ties, whose absence may result in psychological disorders and social problems (Lin et al. 1986). On the other hand, psychodynamic thinking such as Freudian theory suggests the importance of early attachment and the needs served by later social relationships that in some views harken back to childhood issues (Vaux 1988). Epidemiologists John Cassel (1974) and Sidney Cobb (1976) laid much of the groundwork for the discussion of the psychosocial processes implicated in disease etiology. In particular, Cassel (1976) argued that social support plays a key role in stress-related disorders, and both animal and human studies had provided evidence supporting this point of view. Such a "stress-buffering" hypothesis underlay much of the interest in social support (Chen 1997). With more and more researchers participating in this type of studies, the role of social support in maintaining good mental health was widely recognized in the 1980s.

While aging is not a disease, aging and health tend to be studied together by many gerontologists or geriatrists (e.g., Levkoff et al. 2000). That combined theme was a concentration for my graduate study in social policy research at the University of California at Los Angeles in the early 1990s. My advisor, Dr. James E. Lubben, was among the pioneers in applying social support theory to aging studies. The Lubben Social Network Scale (LSNS) was widely used (http://www.

lubbensocialnetwork.org/, retrieved November 23, 2010), even after some other researchers became more interested in a related term of "social capital" integrating economic thinking (Putnam 1995; Lin 1999). The LSNS was a brief instrument designed to gauge social isolation in older adults by measuring perceived social support from family, friends, and neighbors in terms of the size, closeness and frequency of contacts of a respondent's social network. Originally developed in 1988 and revised in 2002 (LSNS-R) along with an abbreviated version (LSNS-6) and an expanded version (LSNS-18), the purpose of the tool was to meet clinicians' needs and for basic social and health science research. Both the LSNS and the LSNS-R distinguish between kin and non-kin, though they do not differentiate between friends and neighbors. The tool has been used in settings ranging from the community to adult day care centers, to assisted living facilities, to doctors' offices, and to hospitals (ibid.).

Note that even the LSNS with a focus on the informal sector of social care specified no space factor that might dictate a debate or deliberation over living arrangements or care settings as seen in some other countries. This is probably because community care (or service) had never been made a central theme for aging study in the U.S., sometimes referred to as America's "non-system" of community support for disabled elderly persons (Scharlach 2004) even with the efforts of such networks as the National Association of Area Agencies on Aging (n4a, http://www.n4a.org/, retrieved November 23, 2010) . It is presumable, therefore, that after people finally realized that they had to do more to highlight the importance of the home (if not the family) and the community, they would have to reinvent the American version of social care, service, or support with a community focus, or at least to link it with a "place." A real breakthrough, however, was not brought about by a pure scholarly or public policy interest but by the "invisible hand" of the market.

Aging in Place (AIP)

It is not easy to summarize how "aging in place" (AIP, also "age in place") has gained its own place in contemporary policy, practice, and research. Some would trace it all the way back to Franklin Roosevelt in 1938, just like those who held Emile Durkheim (particularly his study of suicide in 1897) originally responsible for "social support" as a hot topic amid the surge of social or psychosocial epidemiology in the 1980s (Vaux 1988). Some argue that Roosevelt might not have invented AIP, but he was among the first to apply its principles in adapting a private place of his to suit aging and disability needs (http://blogs.consumerreports.org/home/aging_in_placeuniversal_design/, retrieved November 20, 2010). Then, 70 years later, why is AIP just reaching the mainstream? The needs of the aging but predicted longer and healthier-living baby boomers as a huge population of consumers for "aging-in-place environments" are cited as a main reason, which are preferred over such alternatives as assisted-living centers and nursing homes (ibid.).

Such an anticipated shift of consumer interests and demands caught the attention of the mammoth healthcare, home-building, and financial industries and various

other manufacturers, suppliers, and service providers along with academic, public policy, and market researchers. By 1989, there had been much talk about AIP (e.g., Howard 1989) with conferences and publications (e.g., Tilson 1990) and even congressional hearings (e.g., United States Congress 1989) and the White House Conference on Aging bearing that theme. After continued development over the next decade in this direction, a national AIP movement came along (Allen 1999), if not yet widespread. The first annual National Aging in Place Week in November 2003 was sponsored by the National Association of Home Builders, the National Advisory Council on Aging, and the National Reverse Mortgage Lenders Association, with educational and informational events taking place in seven US cities. In 2004, Partners for Livable Communities and the National Area Agencies on Aging began working with nine laboratory communities in advancing policies, programs and services to promote AIP. With baby boomers entering old age, demand for services is at an all time high while most of them wanted to remain in their current home (Mathew Greenwald and Associates, Inc. 2003). And AIP as an idea is finally prevailing or popularized, with the establishment of a new profession (or professional qualification) called Certified Aging in Place Specialists (CAPS) sponsored by state and national associations of home builders (NAOHB).

Just as the meaning of community care became complicated in its evolution, AIP has meant differently to different people along the way. Historically, life-care communities (a.k.a. "continuing care [retirement] communities", or CCRC) were designed for AIP as one of the three main categories of group housing for the elderly (Allen 1989). AIP initiatives then referred to multiple levels of services within one campus/senior community. "Aging in place" today is still a term used in marketing by those in the rapidly evolving senior housing industry, embraced by such organizations as the American Association of Homes for the Aging which represents nursing homes, retirement communities, assisted living residences, and senior housing. Yet, for home-builders seeking to expand business in all desirable ways, it also meant adapting or modifying existing homes (called "retrofitting") to support people being able to stay there as they age until universal design grows more widespread. Thus, the AIP movement is sometimes called "Aging in Place through Home Modifications" (Kofsky n.d.). This is important for a belief in "naturally occurring retirement communities" (NORC), which defines AIP as growing older without having to move as required for such built environment as group housing (where one must move in first; in many cases one must also move from one wing of the campus to another to receive increased services) (http://www.seniorresource.com/ageinpl.htm, retrieved November 27, 2010). So AIP means staying in one's present residence or living where one has lived for many years in a non-healthcare environment and using products and support services to enable him or her to not have to move as circumstances change (ibid.). By reducing forced move, older adults may avoid relocation stress syndrome (a.k.a. transfer trauma).

Early planners for housing development actually only referred AIP to the phenomenon or tendency of residents growing older as a bloc in the community (called "silting up" as it would increase the need for expensive healthcare services and make younger people reluctant to move in). Demographers also used the term to simply describe locales or communities where, over time, concentrations of persons aged 65 years and older developed (Morrill 1995). It

was estimated that some 70% of seniors had already spent the rest of their life in the place where they celebrated their 65th birthday (http://www.seniorresource.com/ageinpl.htm, retrieved November 28, 2010). To the advocates for independent living, however, it is the ability to live in one's own home of choice and community - wherever that might be - for as long as confidently/safely and comfortably possible (even if it will become assisted living to certain degree) that guides the mission for AIP (http://www.aipathome.com/about-us/, retrieved November 27, 2010). Therefore, the emphasis of the AIP movement is on livability (http://www.aginginplaceinitiative.org/, retrieved November 28, 2010), or comfort and safety, of home with seniors having a choice in their care and living arrangements (be it in group housing, natural bloc, or alone) that will be extended to support independent living in later life. This entails the programs that go beyond what is required in the Americans with Disabilities Act to create both accessible and attractive settings for the elderly. On the other hand, laws and regulations can be amended to permit and facilitate AIP developments since federal and state regulations of long-term care may make AIP difficult if not impossible (some states passed legislation around the turn of the 21st century to designate some AIP demonstration sites so they would be regulated differently from traditional residential care/assisted living and nursing homes) (e.g., Sinclair School of Nursing 2010).

Compared with the other efforts reviewed earlier in this article, an outstanding feature of AIP is the recognition or "buy-in" from various industries (i.e., the commercial sector) in terms of their role in promoting aging at home. As such, they help to keep the elderly in the community by creating a safe and comfortable environment for independent living with home modification, universal design, and retirement communities using new technology to ensure extended livability and meet their special and changing needs. By making the environment more supportive of their independence and reducing the risk of falls and the consequences for those wishing to be part of the AIP generation, the stress of their family caregivers is reduced so they may stay and concentrate more on their paid jobs. For the elderly, independence does fade into need for assistance as they continue to age, but living in the same apartment or house allows them to stay in familiar surroundings near friends and neighbors (for as long as safely and comfortably possible which is the goal of AIP).

AIP gives older adults leverage in the marketplace while businesses, from medical to construction to finance, are increasingly eager to provide services with government and academic support/partnership. High amenity and high social service housing was the original concept behind the idea of AIP, but it has also produced demands for telecare/telehealth and other communication and assistive technologies for health/wellness, safety/security, personal social services, entertainment/recreation, learning/education, and contribution. AIP is detail-oriented since changes may be made in every room of a home, from simple improvements to extensive remodeling. Commercial providers contributing to AIP may include architects, remodeling companies, interior designers, landscaping contractors, home health care professionals, geriatric care managers, food and product delivery services, home maintenance crews, transportation providers, financial planners, insurance companies, distance learning programs, and much more (National Aging in Place Council, http://www.ageinplace.org/, retrieved November 20, 2010). AIP has also meant more choices of

the elderly in their living arrangements, such as cohousing, elders' guild, and village networks (http://www.cohousing.org/taxonomy/term/225).

Given the decline or stagnation of community care in the West (as well as a once observed shift away from community service in China, see Wong and Poon 2005), AIP is gaining influence in scholarly thinking and policy dialog worldwide (e.g., Chui 2008), including the United Kingdom (Freyne 2010). AIP as a movement, however, has not fully addressed the role of the statutory sector although it is well-known that voluntary organizations have long relied on public funding or government grants. For those who were previously exposed to the research of community care, community service, social support, etc., the provision of social services vs. informal care may continue to be their focal interests. The caregiving role or burden of the family and necessary support from the government have remained to be a concern, especially in view of the uncertain future of Social Security funding. AIP services may represent great ideas and deeds, though who are able to afford them can be a big question, especially in view of the erosion of retirement savings of ordinary Americans during recent recessions. Healthcare costs and lack of personal/domiciliary social services are also prohibitive factors despite the needs of the elderly including those living in "empty nests". The stereotype of wealthy elderly homeowners may not be applicable to all, especially in view of the recent burst bubble of housing market that may take a long time to recover. It threatens "aging in no place" for the homeless despite a noble intent of AIP to enable older people to continue to live in their home safely, independently, and comfortably, regardless of age, income, or ability level. These have limited and will continue to limit the realization of AIP goals, with many older adults unaware of it and some community leaders unsure where to begin (www.livable.org/livability-resources/16-aging, retrieved November 29, 2010).

International Perspectives

Healthy, successful, productive, and active aging in community as an international undertaking requires historical and comparative perspectives to understand the roles of family, community, and social policy in the era of globalization. The new Springer Book Series on International Aging (http://www.springer.com/series/8818) has been launched recently to address the issues of aging in the 21st century on a global scale. This special issue of the *Ageing International* focuses on shedding light on the meaning of the community beyond a mere place in supporting aging populations in different cultures.

Specifically, Jason L. Powell provides a case study of the British system by updating the current situation of community care in terms of "personalization." The personalization agenda means a major shift in the way social care and individual support providers approach service. His article covers the conceptual and policy underpinnings of personalization and its relation to substantive issues in self-directed care. Trying to locate through research studies and thematic areas a baseline for measuring critical success factors, the paper identifies the themes that emanate from IBSEN report of 2008 as benchmarks to measure the effectiveness of the pilots of personalization, social care, and Individual Budgets in the U.K. and other Western societies.

Andrew Scharlach's article describes the types of community aging-friendly initiatives that currently exist in the United States, and the roles that various sectors (e.g., public, non-profit, private) have played in their development. An Internet-based survey identified 292 current aging-friendly community initiatives that fall into four types: community planning, system coordination and program development, co-location of services, and consumer associations. Most local community interventions have been developed, and often hampered, without federal funding or guidance. Private sector solutions appear to be on the rise, though such initiatives are not widely accessible. The findings raise questions regarding the sustainability of current efforts, their availability to less-resourced individuals and communities, and the long-term ability of communities to make the infrastructure changes without an increasing government role.

The next article by Bonnie Schroeder, Jane MacDonald, and Judith Shamian focuses on older workers with caregiving responsibilities in terms of a Canadian perspective on corporate caring. Their overview of current research on the topic firstly presents relevant demographic and policy trends and then outlines impacts of these trends on caregiving employees, communities, employers, businesses and governments. The third section of the article identifies potential policy responses and program solutions that support the needs of older workers with caregiving responsibilities. The article concludes with a recommended plan of action to move forward in addressing the emerging challenges associated with this issue.

Michael D. Fine from Australia focuses on the issue of sustainability by examining employment and caregiving together. He provides an international overview of the current impasse concerning those who are employed and seek to provide care, to assess current and future possibilities for finding a way through the existing conflict between sustaining employment and providing informal care at home. Demographic, economic, and democratic and governmental policy causes of the current problems are explored, and the emerging care gap shown by the joint crisis of informal and formal care examined. A number of solutions are proposed to help re-embed care in the societies of the 21st century, including developments related to the workplace and employment, providing extra services, expanding the care workforce, paying family caregivers, and using technology.

The article by Baozhen Luo and Heying Zhan examines how functional solidarity impacted normative solidarity (filial piety) among families with migrated children in rural China. Analyzing data from a survey of 1,443 elders in three inland migrant-exporting provinces of China, their findings suggest both a continuation of traditional norms and an adjustment of rural elders' expectation for filial piety. Due to economic constraints faced by rural families, financial support was perceived as an important aspect of filial piety by rural elders. It is interesting that elderly parents who took care of grandchildren had a more positive evaluation of filial piety than those who did not. Taking into consideration the economic and cultural context of rural China, the authors conclude that functional support (in the form of intergenerational exchange) plays an important role in shaping and changing the face of filial piety as rural–urban migration progresses.

Nana Araba Apt's article illuminates aging in Africa in terms of past experiences and strategic directions. As she points out, the world including Africa has witnessed tremendous changes in the understanding of aging issues since the First World Assembly on Ageing in 1992. Much of Africa at that time viewed aging issues as unimportant for policy dialogue and planning. As part of the global debate on aging

in the developing world, discussions of population aging in Africa have gathered momentum in recent years, culminating most prominently with the Second United Nations World Assembly on Aging in 2002. Her article further discusses factors leading to widespread development of aging agenda in Africa and efforts by civil societies and governments to promote aging in place.

The article by Rafael Samper-Ternent, Alejandra Michaels-Obregon, and Rebeca Wong deals with challenges to aging in community by focusing on the coexistence of obesity and anemia among older adults in Mexico. Using data from the Mexican National Health and Nutrition Survey (ENSANut 2006), they examine the prevalence of anemia and obesity and provide evidence that the presence of either and both conditions varied according to socioeconomic status and health risk factors. They highlight the role of anemia within a worldwide epidemic of obesity as aging in community continues to advance in developing countries such as Mexico.

Different nations have different stories of aging as well as how they have dealt with it in their own ways as shown by all the country cases mentioned above. Their various innovations have influenced and been influenced by one another, however. The First World Assembly on Aging in 1982, for example, greatly affected China's aging policy which led to a formal expansion of its official aging undertaking, including efforts underpinning the community service movement. The newer policy framework proposed by the World Health Organization (WHO) at the Second World Assembly on Aging in 2002 helped to advance worldwide agendas for research and practice, from healthy aging, successful aging, and productive aging to active aging. All these provided new meaning to aging in community, with older adults as active participants and productive forces, in addition to the recognition of their increasing dependence and needs for caregivers as they continue to age.

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Sheying Chen is Professor of Social Policy and Associate Provost for Academic Affairs at Pace University in New York.