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Contemporary Geographical Gerontology: Reconciling Space and Place in Population Ageing

Hamish Robertson

Abstract

Geographical gerontology can look like a niche subfield of geography or a tenuous overlap between that discipline and gerontology, which is itself a broadly interdisciplinary affair. However, in the context of progressive global population ageing, this intersectional field of study offers more than its current popularity might suggest. Many of the problems with contemporary aged care provision resolve around, I suggest, issues associated with concerns of space and place. These two key geographical concepts are highly dynamic at both the theoretical and applied levels. In this chapter, I consider them as a dualism that offers the field of gerontology and associated applications, a growing utility. Space can be seen as abstracted and instrumental, with which place can be seen as relational, generative and pluralistic. On their own, neither is necessarily likely to address the full scope of societal issues that population ageing presents. However, drawing on developments across these two conceptual domains offers opportunities for a contemporary geographical gerontology. We face a variety of interconnected global problems that demand a spatially informed perspective. Here, I propose how a developmental synthesis of these two concepts that might add utility and value for those within and beyond the current aged care sector.

Keywords: geographical gerontology, population ageing, space, place

1. Introduction

Geographical gerontology may seem like a niche field in a discipline cluttered with many and varied interests but it’s topicality and relevance are growing. Geography addresses the issues associated with population ageing from a variety of perspectives: demographic; medical/health; critical theory; economic; and at the interface of gerontology to name some of the more relevant. In addition, it is clearly an interdisciplinary undertaking given the conjunction of geography and gerontology which makes for an additional level of undertaking in terms of theory, methods, practices and synthesis [1]. While the geographic interest in ageing is a long-established one, global population ageing makes it an increasingly relevant and practical field of inquiry and analysis.
In this chapter I examine some of the key issues for a non-geographical audience in considering the relationship between population ageing and gerontological thinking using geography as the lens of inquiry. The implication being that social phenomena, social policy and societal responses all have geographic implications. As I have stated elsewhere [2], social policy is fundamentally geographic in nature because the, often, uneven nature of policy design and implementation will be exhibited in and through associated spatial effects. So, for example, access to healthcare services or aged care services will exhibit a spatial dimension because both the demand and supply sides of those 'equations' will vary across geographic space. This scenario exists even without the effects of gerrymandering and associated political impacts on policy and funding arrangements which, if anything, increase differential spatial effects.

My position here is intended for a broad audience and not an exclusively geographical one. It also is developed in the awareness that the United Nations Decade of Healthy Ageing Strategy (2021–2030) presents a number of the issues discussed here from a somewhat different but related perspective. This includes key concepts such as age-friendly environments discussed through the lens of space-place relations in this chapter; combatting ageism including sites of abuse and carcerality in ageing as a focus here; long-term care, both community and institutional in my analysis; integration, which I see as untenable without improved space-place management; and an overarching theme of enablement which I present as the process of negotiating the space-place relations and relationships of a ‘reconciled’ geographical gerontology. In addition, this chapter discusses the variability of ageing as an individual and collective experience through this space-place approach. My intention is that this contributes to the emerging discussion represented by the UN strategy.

In the Australian context, and elsewhere, we know that factors associated with ageing as an individual experience and population ageing as an aggregate phenomenon, vary significantly across urban areas, and between metro and non-metropolitan regions. The implications for service provision and access are considerable, with factors such as frailty a central focus of research [3]. This type of differential patterning is also leading to the phenomenon described as ‘super ageing’ in several countries including Japan and South Korea [4, 5]. While central governments make claims to providing universal systems of care that support health and ageing, in reality this is much more difficult to achieve than policy proclamations indicate. Indeed, we can observe that ageing well is often highly geographically patterned, as the research on centenarians and the so-called ‘blue zones’ all illustrate [6]. The ‘blue zones’, for example, are quite specific geographic places, often sub-national in character, that exhibit unique combinations of factors that appear to support socially engaged and healthy ageing including Okinawa, Sardinia, Ikaria and Costa Rica [7]. A question then arises in studying these if we can genuinely replicate them for urban environments or draw on them to reshape our spatial and place-based approaches to population ageing ‘at large’?

Consequently, gerontology and the broader science of ‘healthy ageing’ can be seen to exhibit some key geographical characteristics including a differentiation between abstract ideas of space and those of a more embodied place production. From a geography of ‘ultra-aged’ communities, this is also likely to raise the ancient, even resurgent, concept of ‘genius loci’ in that we may seek to identify the unique characteristics of blue zones and other ageing ‘hot spots’ in order to research their replicability or, perhaps, replaceability, in the context of contemporary urban industrial societies [8]. Even the conventional concept of ‘neighbourhoods’ offers a place-based approach within major urban settings because it illustrates the idea that, as with scale
in spatial analysis, smaller units of analysis are both viable and useful for understanding individual and collective experiences, and the factors acting on them.

Making more 'places' that satisfy the needs, wants and capabilities of ageing communities means we can combine the utilitarian quantitative spatial techniques of technologies like geographic information systems (GIS) with the more qualitative and subjective or lived experiences of people within communities, to knit together these space-place aspects. Instead of divergence in both form and function, I suggest, designing our environments for an aging society may help us reconcile the abstracted spatial instrumentalities with the demands of place-based ageing where people can delay or avoid institutional aged care, and the loss of autonomy that experience often entails, while maintaining community support and care in ways that enhance the ageing-in-place experience.

2. Space and place for a broader audience

Geography, architecture, philosophy, sociology and even psychology all concern themselves to varying degrees with the space-place duality. Quantitative geography followed quickly on from the emergence of computers in the post-war period and was informed by computer-based mapping technologies (now increasingly digital) of the kind pioneered by Roger Tomlinson and others. By the 1970’s there was a resurgence in qualitative and critical theory in geography, including phenomenology and the work of Tuan [9], Buttimer [10] and Relph [11]. By the 1980’s geographies of various aspects of ageing were emerging and associated categories of interest developed through the 1990’s and onwards. These included the impact of feminist geography, health geography (as contrasted with more traditional medical geography) and even geographies of institutional and personal services 'care' [12]. While these are specific to geography as a discipline, geographers often travel in a disciplinary and practice sense and so the concept of geographical gerontology became more explicit with the work of a number of geographers including, for example, Andrews, Cutchin and Wiles [13] and several influential others. In effect, I suggest, the humanistic turn in geography produced new generations of researchers in addition to the ongoing work of the pioneers in this area and their students.

Amongst the relevant considerations is the integration of an expanding science of ageing and associated methods and technologies that may expand and extend our understanding of ageing across space and place. The risks are, as with many of the technological responses to ageing (service robots, surveillance systems etc.) the abstract, quantified and technical realm substitutes for the human dimension, including understanding and support that older people actually need. In this framework we continue to produce spaces of ageing, with some environmental modifications, that provide institutional forms of care and treatment for unwell older people. What happens out in the community, so much less surveilled, remains something of a mystery in that formal systems of care are often episodic and disconnected. Hence the recognition of case management as a paradigm for connecting the various systems-based silos in aged care and elsewhere [14].

3. Geographical gerontology in context

The sub-field of geographical gerontology is close to 30 years old, depending on how the origin point is defined. While geographical gerontology gained visibility and,
perhaps, momentum with the work of it can also be seen more broadly as a consequence of the interest of geographers in ageing as a process and population ageing as a demographic dynamic. Even these two factors alone might be sufficient to have produced the field of geographical gerontology, but it nonetheless goes beyond this including concepts such as the ‘geography of care’, disability geography and so on in which the geographical patterning and implications of specific social phenomena lend themselves to both theorization and analysis by geographers [12]. The converse is social scientists and others seeking some common ground with geography through concepts such as ‘place making’ on the one hand or the use of GIS on the other [15].

My position here is that much of what we take to be the development of demographic theory, more specifically concepts such as the demographic and epidemiological transitions, were a result of and deeply influenced by geographic comparisons and analysis. Omran, for example, developed his theory of epidemiological transition based on population planning research in Egypt [16] which was taken further by researchers in other locations [17, 18]. The demographic transition theory emerged from a number of shared observations in France and the United States (e.g. Thompson, Landry, Notestein), although earlier concerns about population decline and ageing had driven some racist, classist and more broadly eugenic thinking for several decades previously [19, 20].

These factors illustrate how the science of ageing has been deeply enmeshed in the politics of population change for decades. This also suggests why responses to population ageing are so variable since, at a social and political level, they have inherited many of these formative positions and ideas. This in turn has influenced responses to building for the prospect of an ageing society. Instrumentalist spatial views see the functional response as sufficient—the top-down view—while place-based perspectives assume a connection between the individual, their community and their location. Rather than taking an either-or view, my position here is that there is utility in combining them for an emergent geographical gerontology that can assist in meeting the material and relational needs of individual and population ageing. Neither the spatial nor the place-based perspective are sufficient on their own and neither guarantee satisfactory outcomes for older people more generally. But an informed and ongoing synthesis may yet offer potential improvements as population ageing progresses.

4. Abstraction and the view from nowhere

Ageing as an individual experience and population-level ageing are two distinct phenomena. Individual ageing is heavily mediated through factors such as life experience, health status and even social and financial resources. Indeed, aged care policy in many countries is a fraught negotiation between established and emerging understandings of these complex factors. So, for example, the influence of the British Workhouse system on aged care policy is sometimes acknowledged but the values associated with that spatial formation (the aged care institution, in particular) have persisted well after the demise of the workhouse and thus influence political and associated attitudes towards older people, ageing and aged care. This can be seen, for example, in various inquiries into (ongoing) abuses of elderly patients and residents in such settings including the MidStaffordshire or Francis Inquiry [21].

Meanwhile, population ageing is an identified phenomena with specific features that make its study scientific. One of those features is a form of quantified abstraction
that aggregates the experiences of many people, indeed a growing proportion of the population, and then reduces those experiences to some ‘key’ phenomena and concepts. This is highly problematic because the complex nature of individual ageing makes for a lack of generalizability in my opinion. Instead, rising population ageing is generative of a growing diversity of individual and categorical forms of ageing. Olshansky and Ault [22], for example, proposed a fourth stage to Omran’s three-stage epidemiological transition, one of delayed degenerative diseases. Others have proposed yet a fifth stage or even a second phase, and so on [18]. The intersectionality of physical and cognitive ageing, for example, make for many highly unique scenarios which current health systems struggle to diagnose and treat effectively including the dementias for which there are currently no cures and limited treatments.

When we add the environments, both physical and social, within these people age this diversity grows yet again. We can add the highly female aspect of advanced ageing to this mix to suggest that policy made by male-dominated societies or with a lack of a relational place-based approach to ageing, bode poorly for the care and treatment of older women [23]. The exaggerated abstraction of the very human experience of ageing likewise makes for a limited response to the full scope of the ageing experience and the needs of older people. Seeing these factors through a ‘spatial’ lens has some benefits but the addition of a place-based one could, I propose, inform the more instrumental spatial formations we commonly see. Again, in the Australian context, the ‘big box’ approach to residential aged care is driven not by the needs of older people but by funding and regulatory requirements that make a minimum institutional size necessary, rather than desirable.

Taking comments from the previous section a little further here, we can see that at a systemic level, this spatialized view and its intersection with the ‘view from nowhere’ presents a number of concerns and problems for successful and supported ageing, in both community and institutional care contexts. The exaggerated top-down view tends to assume a uniformity of service provision and accessibility that rarely exist and, even if it does in principle, it is rarely accessible to all social groups in the same way. So, for example, different social groups based on factors such as ethnicity, indigeneity, migration status, or disability category may find the same ‘system’ a very different entity in their particular encounters with it.

Indeed, the diversity of the ageing population here in Australia, and elsewhere, suggests yet another reason why spatial representations are insufficient and even the place-making concept needs to be seen as multiple and not, simply, a relational form of replacement for the spatial perspective. Instead, we may need to be seeing place-making as polymorphic and polysemic in that I suggest place-making runs counter to an abstracted universal and instead represents localized responses to both shared, in a general sense, and unique conditions. So, for example, responses to population ageing and its associated challenges may be quite different in Japan, Australia and China even though all three countries are experiencing the phenomenon of population ageing [24].

5. Place-making in an ageing world

Given that a variety of spatial formations and practices already exist which regulate much of the ageing process and experience, ranging from acute care geriatric wards in hospitals to residential aged care facilities and even dementia-specific locked wards, the issue in this discussion is how we improve place-making for ageing. The clinical
view is effectively a view from nowhere unless mediated by genuine interaction with and understanding of the ageing individual. And many acute environments do not lend themselves to this kind of qualitative experience because they are designed and delivered on a ‘factory’ style model which emphasizes numbers and throughout, including a variety of metrics that tend to reinforce such models (e.g. length of stay). Thus, the ageing society requires a shift to a more qualitative approach that acknowledges these various complexities and their implications for the unwell older person, their careers and allied social supports. In effect, I am suggesting places within spaces as a form of not just redesign but reinvention.

This requires a shift to aged care as a process of place-making, one which seeks to humanize the experience of older people and the care provided to them. Many spatial formations either distort or minimize the inherent relationality in ‘care’, and as such create or exacerbate problems inherent in many institutional forms designed through a lens of spatial logic (schools, prisons, hospitals, asylums etc.). Yet, as many feminist theorists and others have identified, ‘care’ needs to be in relational terms [25, 26]. My position here is that so too does place-making in that it represents a form of relational creation, including that cognitive and affective attachments that individuals and groups bring to ‘places’. And, as some observers have noted, this does not always ensure a positive outcome—place-making can also be negative and research domains associated with the Glasgow Effect (morbidity and mortality effects) or environmental racism illustrate all too readily [27, 28].

Closely linked to geographies of ageing, of mental health and feminist geographies is that of geographies of care [29]. Discussions in these fields have emphasised the interactional, relational and even co-productive nature of spaces and places. This would seem to support the ideas discussed here and reinforce the concept of geographical gerontology as a relational, pluralistic engagement of space, place and time. Indeed, my own position is that demographic change sits at the intersection of space, place and temporality [2]. Given that these can be seen as framing both individual and collective experiences, I suggest this enhances the role and value of a contemporary and emergent geographical gerontology.

6. Future space-place relations

Not only is population ageing a dynamic process but so too is the wider environment(s) within which people age. Structured and funded health, aged and disability care services not only intersect with the ageing process but also they are themselves dynamic, as they respond to new knowledge but also shifts in policy, funding, politics and so on. Ageing in place, for example, became a popular policy framework based on the idea of keeping people in their own homes (where they had them) for as long as possible [30]. This usually focused on some structural adjustments to the home often with a focus on the home as a modifiable space and some social supports, rather than an approach informed by ‘place’ thinking.

It also intersects with James Fries’ [31, 32] ideas around the compression of morbidity, because the home and the local environment are and tend to remain very familiar to older people even as physical impairments and dementing illnesses progress. Certainly, much more familiar than their potential relocation to aged care facilities that may be physically far from their own ‘place’, including familiar friends, neighbours and families. In the broader context of rising chronic disease levels at a population level, these ideas of adjustment and compression could be seen as going
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well beyond the ‘aged’ in terms of their utility. Whether they are really about place-making is another issue and hence unpacking such policy perspectives through a space-place lens is helpful here too.

Institutional aged care has become increasingly about caring for medically unwell older people and the definitions of such institutions are shifting in response to population ageing [33]. The common framing of aged care facilities as more ‘welfare’ oriented that health and illness oriented is at once both suspect and problematic. In the Australian context, for example, residential aged care is primarily about caring for these medically unwell older people, frailty and dementia being contributing factors, who in many cases cannot remain safely in the community [34]. And this has been the situation for many years now. The scope of that ‘unwellness’ includes physical disease impairments, cognitive disorders including the dementias, and a variety of, often multiple, sensory impairments including especially hearing and sight.

Additional complexity arises as the health problems associated with these various sub-domains intersect and overlap, making for an increasing variety of often quite specific symptoms and disease states in individual older people. How these individuals respond to space and place factors needs to be seen through this complex array of mediating factors which make generalisations both difficult and perhaps even inappropriate. We may still seek universals in knowledge production but ageing has a way of reinforcing the individual and the local. Consequently, I suggest, geographical gerontology will of necessity be pluralistic in the way it addresses both ageing in place and place-making (and place maintenance) for ageing.

The growth of clinical and research knowledge in this field also adds to the nature of these complexities. We know that, as with the neurosciences, our knowledge base is growing rapidly but there is a great deal yet to learn. Consequently, the assumption of certainties in this area is problematic. If our rate of knowledge doubles or quadruples in the coming decade, for example, then much of what we assume to be solid now is unlikely to be so in another decade. New knowledge will shift our thinking and the diversity of the ageing experience, and its growing documentation will greatly expand what is, currently, known. We will know more about more diverse spaces and places of ageing as time passes and, consequently, develop a greatly enlarged geographical gerontology.

Critical theory approaches add another layer to this scenario in that we can geographically examine the sites of aged care through a variety of theoretical and applied perspectives. To what extent does relational theory [35] in geography address ageing in the community compared to ageing in some form of institutional care? Does the production of aged care places vary between, say, low care environments where people generally need (or perhaps receive is the better emphasis) fewer supports, versus high-care ones where illness, dementia and sensory impairments are usually major factors? How do space and place function for unwell older people compared to those who age ‘well’? To what extent do we see institutional forms of aged care as exhibiting carceral aspects, as in secure dementia units, for example [36, 37] and what can we do about this through an expanding geographical gerontology?

The potential scope of questions in this area is therefore an evolving one. Peak population ageing is occurring at different times in different countries, and can also vary within countries, for example in younger urban settings compared to aged rural contexts, or across provinces and regions. Growing data illustrates how even at the national level, the progressive geographies of population ageing vary considerably even across the richer countries [38]. Thus, we face a multiplicity of geographies of ageing and associated formations of geographical gerontology at the level of official
geographies (nation, province, region etc.) due to these spatial and temporal vari-
abilities. We are engaged in an unequivocally pluralistic undertaking in both trying to 
reconcile space and place, as well as in place-making for ageing societies. If we then 
turn our attention to the ‘place’ concept, this variability must be seen as having an 
existing and developmental scope because local environments, cultures and responses 
will vary, as will individual responses mediated by these, and the health-related fac-
tors identified above.

The implications of this interpretation include the need and desirability of a 
pluralistic approach to the domains of theory, policy and practice in this ‘emergent’ 
geographical gerontology. Perhaps obviously, progressive population ageing in 
different countries and cultures (and within multicultural societies) requires a 
capacity for theory that does not homogenize the ageing experience and associated 
knowledge. In the policy domain, this demands a commitment to and capacity for 
negotiated space-place relations that are adaptive since, for example, the needs of 
younger old communities will differ from those marked by advanced population 
ageing. While we still tend to ‘consolidate’ those aged 65 and over, their trajectories 
and experiences differ significantly at the individual and cohort level, as discussed 
earlier. And, lastly, at the practice level we need to build the skills across disciplines 
and within communities to negotiate space-place relations and relationships for 
successful population ageing.

Place-making implies a set of negotiated outcomes and yet it remains that much of 
what we see in ageing theory, policy and practice maintains the top-down perspective. 
So planning for sites of ageing services and aged care could be improved by better 
engagement with older people, their advocates and the knowledge base we currently 
possess. The lived realities of ageing in the community and/or in institutional care 
demand an improved synthesis and not the disciplinary silos that persist in many 
contexts. We know, for example, that nutritional support is extremely important for 
people to ‘age in place’ successfully and yet supportive meal services in countries like 
Australia were and remain largely based on charity models from a bygone era (e.g. 
meals on wheels). A consequence of this is that many community-dwelling older 
people present to acute care services with malnutrition already present [39, 40]. 
Despite considerable evidence-based research on this issue, and its consequences for 
individuals and healthcare services, little has changed in the past few decades. And, at 
the policy level, a marketized approach to social care services has done nothing, I sug-
gest, to improve this situation. Here too, an improved space-place synthesis offers a 
pathway to improved management of health and social care concerns that have wider 
systemic impacts.

7. Limitations

The chapter draws of a variety of literatures and, as such, is a conceptual piece. 
As noted earlier, the intended audience is not a strictly geographical one but rather a 
broadly gerontological audience for whom some geographical ideas may be of inter-
est. In addition, attempts at the synthesis of ideas from different fields carry some 
native risk in a piece of this length. The proposed benefit in doing this is that the 
result informs thinking and practice across those academic and professional disci-
plines. As mentioned earlier, my hope is that this can inform local through to interna-
tional discussions about the issues identified in the UN strategy and their implications 
for population ageing as an increasingly global phenomenon.
8. Conclusions

It is the contention of this chapter that geographical gerontology offers an opportunity to explore and, perhaps, even reconcile the key concepts of space and place in ways that avoid the problems associated with ‘the view from nowhere’ and the excessive abstraction often associated with quantification as a tool for understanding complex social phenomena. A key point explored here is that variation is normal at the individual level of ageing and, therefore, it is magnified when inquiring on population-level ageing and its associated complexities over space and time. By this I mean that the uniqueness of individual and aggregate level ageing is growing and will continue to do so as the ageing experience develops, as aged care models develop, and as new knowledge adds to what is already known or assumed to be known about ageing.

The conventional understandings of space and place, especially outside of disciplines that directly inquire on them, must change too. Geography’s intersection with gerontology has a key role to play in this process because adapting to population-level ageing requires an ongoing synthesis of new knowledge from the various research and clinical practice fields which engage with ageing. That makes ageing, to borrow from the philosopher of biology John Dupré [41], a process phenomenon rather than a categorical one given its pluralism and fluidity. In addition, the personal and community experience(s) of ageing will only grow in their diversity in coming years as the phenomenon progresses globally. It is in this sense that geographical gerontology may also become a way of linking the abstract and the personal as well as the spatial and the place-based experiences of ageing.

Conflict of interest

“The author declares no conflict of interest.”

Author details

Hamish Robertson
University of Technology Sydney, Ultimo, Australia

Address all correspondence to: hamish.robertson@uts.edu.au

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