The Human Geography of Care

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The exponential increase in life expectancy in the twentieth century, coupled with a significant drop in fertility in the twenty-first century, demands rethinking family-based care for older people who require assistance with activities of daily living. We argue that age diversity in the population and a trend toward urbanization represent two emerging resources on which new care models can be built. By distributing care among age-diverse groups of kin and non-kin who live in close geographical proximity, demands on individuals can be minimized and social exchanges across generations can build social bonds. In this essay, we discuss features of cities and social infrastructures that can contribute to distributed models of community-based care and provide examples of ongoing efforts that can be scaled nationally and internationally.

Throughout human history, populations have included far more children and young adults than older people. As recently as 1900, only 4 percent of the U.S. population was over sixty-five years of age. Then, in a matter of decades, life expectancy increased by thirty years, and fertility dropped by 50 percent. Populations that once resembled pyramids are being reshaped into rectangles. The implications are far-reaching and will affect virtually every aspect of life as we know it.

The same demographic changes are reflected in the shape of American families, which are evolving from "horizontal" shapes with many siblings and cousins to "vertical" shapes with fewer siblings and cousins and more grandparents, great-grandparents, great-aunts, and great-uncles. Families that *routinely* include grandparents and great-grandparents are appearing for the first time in human history. In 1900, 6 percent of ten-year-olds had a full set of living grandparents. By 2000, 40 percent of ten-year-olds had a full set of living grandparents, a figure that continues to increase.[1] Although declining fertility decreases the odds of being a grandparent, those who are grandparents are living to see their grandchildren reach adulthood.

Because the fertility rate in the United States is now well below replacement level at 1.6 (children per woman), the total number of kin is also declining. The

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average sixty-five-year-old in 1950 had seven grandchildren. Today, the average is three. In 1950, the average sixty-five-year-old had twenty-five family members (including all living ascendents, descendants, aunts, uncles, nieces, nephews, siblings, and cousins). By the end of the century, the average sixty-five-year-old is projected to have sixteen family members.[2]

In addition to family structure, social norms and expectations about family are changing. In the 1970s, by the time adults reached their mid-thirties, they were married and had at least one child. Americans of the same age today are more likely to be single and live with their parents. About one-third of young adults today are opting out of marriage, which is roughly twice the number in 1970.[3] More women are choosing not to have children, and those who do have children are having them at older ages.[4] Although postponement of childbearing is most evident in relatively affluent women, similar trends are observed across the socioeconomic spectrum.[5] About 16 percent of today's older adults are childless.[6] This figure will increase as parenthood continues to grow less common. A recent Pew survey found that 42 percent of respondents aged eighteen to forty-nine did not have children, and while some will likely become parents at some point in the future, almost half reported that it was unlikely they would ever have children.[7] Divorce and separation also contribute to changing family structures and the strength of family ties. In the United States, about half of all marriages end in divorce or separation within twenty years, further complicating perceived obligations to care for older family members.[8]

Households are getting smaller. In 1950, the average U.S. household included four people, typically a married couple and their offspring.[9] Today, the modal household size is two, and soon, the mode will be one, as households led by people over eighty years old double over the next twenty years.

The growing mismatch between caregiving needs and available resources means that family-based models of care for older disabled relatives are becoming infeasible. The numbers simply do not work. Moreover, the family-based system of care, premised on the unpaid labor of (mostly) female relatives, is already ill-suited to the needs of older people and the capacity of their loved ones to provide support.

Family-based care in the United States can be traced back to its founding. Family farms were the economic unit of production and social centers of life.[10] Every member of the family contributed to the effort. By middle childhood, children worked alongside adults in fields, and eventually those children aged into heads of households and inherited the farms. In addition, women were tasked with household responsibilities that included caring for family members who were too young, too sick, or too old to contribute productively. Births and deaths both occurred at home. Acute diseases, namely influenza and foodborne

illnesses, were the top causes of death. Child mortality was high and the duration of illness before death was short. Although multiple generations resided together when needs demanded it, life expectancy limited the number of households that included three or more generations.[11] As recently as 1900, fewer than 10 percent of households at any point in time included members older than sixty-five.

Today, the family remains the primary source of emotional and physical care for its members, and female relatives are the most likely caregivers for older disabled members. Yet times and tasks have changed. More often than not, older relatives live on their own, and geographic dispersion means that care is often provided over considerable distances, complicating the logistics of care. Most working-aged American women are employed outside of the home; most households require two salaries to make ends meet. Many women who are caring for older relatives are also caring for young children. In addition to structural differences in circumstances, periods of disability now extend for months and often years before death; nearly one-quarter of caregivers provide care for more than five years.[12] More than three-quarters of caregivers report having out-of-pocket costs related to providing care, and nearly one-third report drawing on their own savings to pay for expenses.[13] Caregiving can take a toll on physical and emotional well-being. One in five caregivers report high levels of physical strain, and two in five report high levels of emotional stress associated with caregiving. The strain ultimately contributes to increased mortality risk.[14] It is not only care*givers* who suffer. Older relatives who receive care from family members often report feeling like they are a burden, adding guilt and shame to the emotional complexity of caregiving relationships.[15] Of course, family caregiving is often far from idyllic, with a significant minority of older people suffering physical and financial abuse at the hands of younger relatives [16]

Finally, systems of care can be greatly improved by identifying specific needs and tailoring support to those needs. More than one-third of Americans over sixty years old have at least one functional limitation and close to 60 percent of people over eighty-five years of age (the fastest growing age segment in the population) need assistance of some kind.[17] But the type and degree of need are highly varied. Dementia and other serious chronic conditions likely require round-the-clock care. However, more common limitations, such as managing medications or lifting heavy grocery bags, are relatively modest but may be required for decades.

Because more people are living longer in communities that are unprepared to meet their needs, models of care must be improved. It is time for the social contract to change, and to take proactive steps to build models that are less demanding on individuals and do not strain social networks and important relationships. Although the transition from models of care based on blood ties to more differentiated models will be challenging, we can and must do better, or the vulnerability of disabled older people will increase.

Formalizing and remunerating elder care would cost hundreds of billions of dollars.[18] More important, purely economic calculations do not adequately account for work based on love.[19] Most caregivers *want* to help their loved ones. Many say that they would not want to be paid for helping members of their own families. A Pew survey in 2014 found that while one-third of caregivers described it as stressful, 88 percent also described it as rewarding.[20] Caregiving can be an empowering experience, and many informal carers report gaining helpful new perspectives on life and knowledge about health care.[21] Giving promotes happiness.[22]

By nature, humans care for people they know. Even before young children can speak, they show a proclivity to help others. Through consistent and responsive caregiving interactions, the cared and the cared-for form attachments that are the basis for healthy relationships and well-being. In *The Philosophical Baby*, Alison Gopnik writes, "It's not so much that we care for children because we love them, as that we love them because we care for them."[23] Survival of the species requires strong attachments to others. In this sense, the propensity to care was selected by evolution.

Long before humans understood kinship, we were drawn to people near us. Presumably, the reliable preference for familiar people and places is rooted in evolution. Referred to as the "mere exposure" effect, proximity breeds liking in humans.[24] In daily life, familiarity with others increases the likelihood that we form strong bonds and friendships. In fact, close friendships are better predicted by proximity than by political affiliations or personality.[25] Seeing people on a regular basis contributes to affection and increases the odds of forming strong bonds. Even when social ties are weak, familiar faces give us a sense of feeling at home.

A sense of belonging, purpose, and worth are fundamental elements of human well-being, yet today, most Americans don't know their neighbors.[26] The U.S. Surgeon General declared a loneliness epidemic in the country. Although loneliness is common at all ages in adulthood, it is lowest in older people and highest in young adults.

Thus, people show strong proclivities to care for others, especially loved ones. However, the current system is too taxing and demographic trends stand to reduce resources further. We need a system that allows more people to participate in caring work while enhancing or at least preserving quality of life. In combination, urban dwelling and age diversity in the population present an unprecedented opportunity to rethink and improve the provision of care throughout life.

The increase in life expectancy occurred at the same time the population began to migrate from farms to urban areas. Across the twentieth century especially, young people began to seek economic opportunities in cities. The trend continues. Population density in urban areas in the United States grew

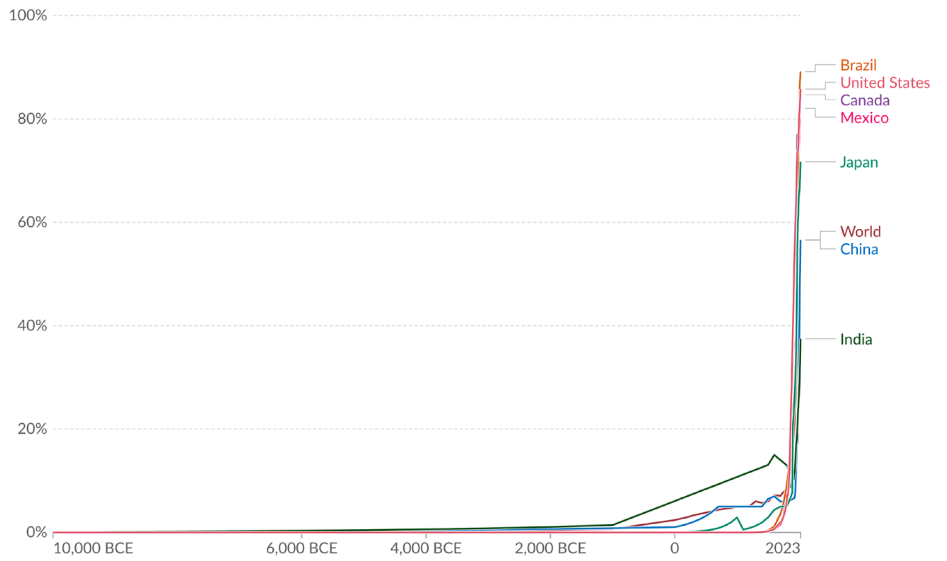
by 9 percent from 2010 to 2020.[27] By 2030, the majority of people worldwide will live in cities.[28] By 2050, nearly seven in ten people will be city-dwelling.[29] On a global scale, demographers expect that cities comprising more than ten million people, known as "mega cities" (such as Los Angeles and New York City), will become common. To quote science writer Michael Gross, "The city is now the main habitat of Homo sapiens" (see Figure 1).[30]

Aging in cities confers many advantages over aging in rural areas. Cities typically have infrastructures that afford accessible transportation, health care services, and greater opportunities for social engagement. New York City – considered one of the best cities for aging in the United States – has adopted the concept of the fifteen-minute city, in which basic necessities are available within a fifteen-minute walk or bike ride in all neighborhoods.[31] The fifteen-minute model promises to support people and benefit the environment.[32] In mega cities such as New York, neighborhoods also create a sense of belonging and community.

Neighborhood connectedness and well-being are intertwined. Although we are increasingly likely to live alone, living in close proximity can capitalize on the human tendency to form bonds. We propose familiarity and proximity can strengthen bonds within communities, increasing the likelihood that neighbors care about neighbors and, subsequently, are more likely to help when needed. Throughout most of human history, family members have lived nearby, but due to the shifts in fertility and life expectancy mentioned above, family members will not be available. Close neighborhood ties can facilitate "voluntary families" or "fictive kin" when people interact with one another.[33] Groups of friends are already choosing to live together and step up when someone requires care.[34] There is some evidence that voluntary connections benefit psychological well-being even more than family ties.[35] Because caregiving among friends is not often viewed as obligatory, it is sometimes appreciated more and contributes to the deepening of relationships.[36] Social exchanges among people who are providing and receiving care strengthen bonds and allow a more even distribution of power in relationships. Because caregiving takes time and entails exposure to people, caring for neighbors may further enhance community engagement, civic participation, and relational bonds. Social cohesion is associated with physical health and well-being among neighbors.[37]

A second emerging resource is age diversity. The relatively even distribution of age in the population generates unprecedented age diversity that includes the physical strength, speed, and ambition of youth along with the emotional balance, experience, and prosociality associated with age. Never before has the population included comparable numbers of children and adults. There are great opportunities for intergenerational exchange to occur, and because younger and older people often have complementary strengths, they are well suited

Figure 1
Share of the Population Living in Urbanized Areas, 10,000 BCE to 2023



Source: Hannah Ritchie, Veronika Samborska, and Max Roser, "Urbanization," Our World in Data, last modified February 1, 2024, https://OurWorldInData.org/urbanization.

to help one another. For example, young people, who have a lower likelihood of functional impairment than their older counterparts, can be of great help to older adults needing assistance with physical tasks.[38] Even young children can play roles in helping with simple chores. Older people can play supportive roles as well, since they tend to have increased emotional stability, better emotion regulation, and greater expertise in handling personal conflicts and navigating challenging social situations compared with younger people.[39]

Advantages widely observed at older ages align with important developmental milestones in early childhood. The acquisition of communication and social-emotional skills early in life are essential for healthy maturation. Some experts argue similar complementarities have been observed throughout human history.[40] An extended period of life post menopause freed older women to care for grandchildren. Referred to as the grandmother hypothesis, these cooperative and caring proclivities likely contributed to the human capacity to exchange knowledge in ways that accelerated human evolution.[41] In hunter-gatherer societies, for example, the presence of experienced older community members improves the pro-

ductivity of younger members.[42] In industrial societies, older adults continue to play important roles in the transmission of cultural knowledge and skills.[43]

In neighborhood contexts, older adults are often quite involved in different aspects of community life. Compared with younger adults, older adults tend to know more of their neighbors and feel greater attachment to neighborhood communities.[44] Older people also socialize more with neighbors and participate at higher rates in community activities.[45] Older adults often play the role of "eyes on the street," looking out for the safety of other neighbors.[46] When given helping roles in society, older adults can contribute to the emotional balance or atmosphere of the community, as well as the physical safety.

In general, those in more age-integrated neighborhoods seem to experience benefits: residents of neighborhoods that well represent the age diversity of the United States have higher generativity and feelings of solidarity, connectedness, and support, referred to as social cohesion.[47] This in turn leads to better physical health and psychological well-being.[48] It is possible that the diversity of age will be reflected in the types of care that community members display for one another. Notably, age diversity in the absence of social cohesion and generativity does not seem to convey benefits. Nonfamilial intergenerational exchanges of care within communities may not replace the care provided within families but it could reduce strains and provide benefits.

We see great potential in the role that city living and age diversity can bring to care work, while remaining skeptical it will happen without thoughtful planning and environmental design. It is essential that physical and social barriers are reduced. Arguably more than any other change, we must reduce age segregation. Despite increasing age diversity in the population and within households, most people continue to live their lives in largely age-segregated worlds. Institutional structures such as schools tend to group individuals by age, contributing to age-homogeneous social networks. Residential areas within the United States are also age-segregated, often overrepresenting families or young adults. Within neighborhood communities, gathering spaces are often designed to meet the needs of one age group, such as playgrounds for children or health services for older people. Lack of exposure to those of different ages increases the likelihood of ageism, and reduces the likelihood of intergenerational care relationships forming. Another challenge is presented by social norms to isolate from one another, with neighbors tending to keep to themselves. It would be naive to think that care relationships will occur simply due to proximity. In fact, only 24 percent of urbanites report knowing all or most of their neighbors.[49] About one-quarter of young adults report not knowing even one neighbor. Finally, ethnic diversity in the United States adds another layer of complexity to demographic trends that is unsettling many Americans. And because ethnic di-

versity within generations has been increasing over time, older Americans today are largely white and younger generations increasingly are ethnically diverse (see Figure 2).[50] Many questions remain unanswered: How will intergenerational tensions evolve as ethnic diversity continues to increase in America? How will young cohorts of Hispanics feel about supporting federal and state programs that assist mostly older non-Hispanic whites?

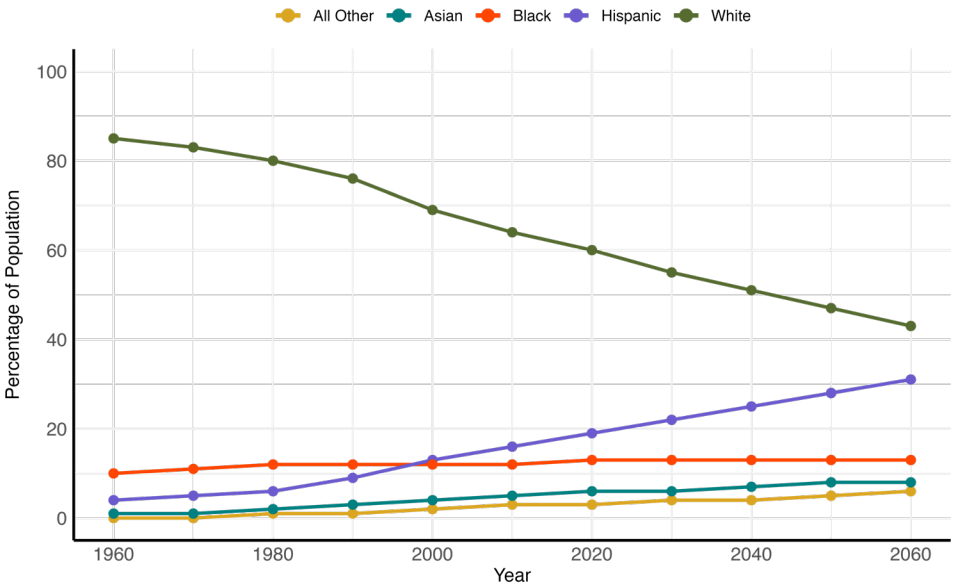
Creating new models of care will require that communities and customs are designed to facilitate intergenerational interactions. If cultures of care are adopted in some locations but not others, inequalities may be exacerbated. Thus, it is crucial that policies, infrastructures, and built environments be developed to facilitate care exchanges.

Where we live matters for health and well-being. Surveys reliably find that the vast majority of older people say that they want to age in their own homes and neighborhoods. Many older people, often widows, find themselves living alone in large homes that reflected family needs in earlier times yet gradually came to exceed their needs and their capacity to care for the property. Most rural areas and many suburbs also lack public transportation, which makes driving essential for running errands and socializing with friends. When driving is no longer possible, social isolation is likely. Adult children and social workers often agonize about decisions that fail to prioritize health and safety. However, relocations are challenging under the best circumstances, and because decisions are always made in temporal contexts, the perceived payoff may be too small. Steven Golant, a human geographer, argues older people make rational decisions about staying or leaving by weighing the unappealing costs of relocation, such as the time it takes to settle into new surroundings, against living in meaningful and familiar places.[51] Emotional meaning often wins when the options pit attachments to people and places against (even serious) safety risks.

There are enormous opportunities for architects and city planners to design cities to support health, well-being, and the capacity to age in place. Research shows that health within a city fluctuates by neighborhood independent of socioeconomic status. Death rates in geographically proximal neighborhoods varied substantially during the tragic Chicago heat wave of 1995, raising questions about which features of neighborhoods matter most.[52]

Cities offer opportunities to build effective infrastructures that promote meaningful social interactions and strengthen community ties. In the United States, cities already provide far more formal services than rural communities. The average distance to a hospital is four miles in urban areas and over ten miles in rural areas. Well-maintained and accessible infrastructures and public transportation are key to ensuring that residents can provide and receive care. Equally important is access to vibrant and inclusive community spaces that create op-

Figure 2
Changing Face of America: Percent of U.S. Total Population by Race and Ethnicity (1960–2060)



Source: Paul Taylor, "The Next America," Pew Research Center, April 10, 2014, https://www.pewresearch.org/social-trends/2014/04/10/next-america/?tabId=625b7b9a-c44e-4e63-a534-a18a57b73429.

portunities to form social ties. Urban planning models often overlook aspects of successful societies that do not entail clear spatial needs. In new models, space could be designed to encourage social participation, respect, and inclusion. Public spaces must be accessible to all ages, and afford people equal rights to a "share" of urban space. The built environment of cities would be greatly improved if they allowed for opportunities to connect in gathering places that are not age-segregated, with parks and recreation centers that encourage everyone's participation. Providing opportunities for engagement in healthy activities and social connection may reduce the need for more intensive care in old age and help form bonds with others who are physically close and can exchange care. We argue that successful transitions to models of care built on larger caring networks will rest largely on neighborhood and social cohesion, which will be influenced greatly by the physical structure of homes, buildings, and gathering places that create social ties and feelings of "home."

Real estate developers are beginning to design homes and communities with longevity in mind. By default, homes built in the 1950s included four bedrooms. Even if a family didn't have children, resale demanded such accommodations. Going forward, single-floor accessibility, wide corridors, bathrooms with handrails, and buildings with elevators will be included in all new structures. Homes that can accommodate three generations, that have shared spaces, and that allow for privacy will be important, as will designated onsite caregiver spaces.

There has been a strong focus on the potential for technological advancements to play roles in retrofitting suburbia, allowing for the redesign and revitalization of existing structures and areas to better serve the needs of contemporary society. Less attention has been paid to how to design home interiors. Design features of homes play an important role in ensuring the feasibility of care exchanges, the potential for people to age in place, and the promotion of residential mastery – feelings of competence and self-efficacy in one's living environment.[53] Advances in transformative artificial intelligence will generate solutions that enable independent living and robotic assistance that will alleviate physically burdensome caregiving. Smart home automation systems, sensors for fall detection and prevention, and robotic devices and automated exoskeletons (devices worn to detect and assist with movement) are among the technological innovations that will aid those aging in place. Together, structural redesigns and technologies hold promise for adapting existing single-family housing to better accommodate aging adults, allowing them to remain in their homes longer. Incorporating technologies into home environments will greatly alter caregiving dynamics, allowing for those receiving care to maintain autonomy and dignity without the help of human carers for many tasks. Human care can instead focus on the promotion of social and emotional well-being. This lessening of the physical labor of caregiving and increasing of the social labor of caregiving will also change the characteristics of who can be an effective carer, better enabling older adults with physical limitations to care for one another in emotionally gratifying ways that provide a sense of purpose. Ultimately, rather than lessening the need for care, technology in home interiors will increase the opportunities for providing care that comes with a deeper sense of connection and quality of life.

Ideally, homes will be able to convert to individual needs, accommodating young families at one life stage and adapting to their needs as they age. The need to transition to different homes will not be erased, however. Cities will include various housing options within communities, much like eldercare facilities now offer a "continuum of care," allowing for smooth transitions across stages of life. More diversity of homes within an area can promote age diversity among residents. For example, older adults often choose to downsize after adult children leave the family home. An optimally designed neighborhood would have an appropriate home ready and waiting so people can move nearby and retain existing social ties. It will

be advantageous for neighborhood communities to have various housing options in the same vicinity so when needs change and people downsize, they may stay in the same neighborhoods and retain their social connections. Care exchanges will be more likely with these familiar ties.

Multiunit housing is one way for urban development to accommodate older adults' downsizing and the potential need for homes with technological support for future physical care needs. In some cases, this entails constructing apartment buildings in the suburbs, a proposition that has been met with resistance and largely unjustified concerns about lowered property values, traffic, and parking issues.[54] Many suburbs have zoning clauses that exclude buildings designed with smaller housing units, meaning that current policies may not allow for the construction of apartments that are well suited to meet the needs of older adults in their current neighborhoods. As the need to house the aging population continues to expand, there is also a need to reconsider and amend zoning laws to permit the construction of multiunit housing in suburban areas. This shift would benefit not only older adults seeking housing options that would meet their changing housing needs, but also working-class families in search of affordable homes in desirable neighborhoods. Embracing multiunit housing in suburban communities would ultimately enhance the overall quality of life for residents of all ages and backgrounds.

Revising zoning laws could also make it easier to intentionally create small communities within cities. Colocation within a dense network of people who span generations, strengths, and needs may be more reliable and effective than dependency on a single caregiver (as devoted as she may be). This can be achieved through cohousing, which refers to intentional communities that comprise private homes and communal spaces. Sometimes referred to as ecovillages, the emerging movement aims to reduce both the carbon footprint of homes and energy costs.[55] For many Americans, cohousing offers affordable home ownership. Private dwellings ensure privacy, while shared spaces and governance foster social interaction and friendships, reducing loneliness and increasing a sense of belonging. Even though cohousing was not explicitly developed to reduce age segregation, studies of cohousing communities report considerable benefits of age diversity.[56] The beauty of the concept is that cohousing communities are sufficiently small that members know and trust one another and come to function as extended families. Leftovers from meals are easily shared, shopping trips minimized. Some studies suggest that they improve health and even reduce the need to use formal health care services.[57] Older people who are available for brief periods of childcare can be enormously helpful to working parents of young children and teens needing a watchful eye. Even young children can be helpful with supervised instrumental tasks, and adolescents are well suited for physically demanding chores. In both cases, benefits to the helpers match (if not exceed) those of the person receiving help.

In the United States, cohousing communities are increasing in number.[58] At Berkeley Cohousing, established on an old farm property, residents in fifteen units share childcare responsibilities, make decisions about community practices together, and eat community meals a few times a week.[59] In Oakland, California, the Temescal Commons cohousing community consists of nine units with a shared courtyard, vegetable garden, and additional facilities.[60] Residents take turns serving as chefs and share religious and secular readings at community gatherings. In these communities, it is everyone's responsibility to care for one another.

The well-known African proverb "It takes a village to raise a child" highlights the roles communities play in rearing children. In truth, we all need a village. It is time to appreciate the interdependencies we share with others throughout our lives and to build environments that meet these fundamental needs. Urban living holds the potential to address disruptions to traditional models of care by virtue of population density, distributing care across a number of providers and complemented by formal services. This can be achieved by embracing models of cohousing and designing neighborhoods that foster access to both social connections and professional care.

Old models of caregiving are unsustainable in light of demographic and social changes concerning the nature of families. As societies adapt to longer lives, smaller family sizes, and urbanization, we need proactive adjustments that address the challenges posed by these demographic shifts. Otherwise, we risk exacerbating existing inequalities and widening gaps in access to care and support. If the demand for informal services exceeds available resources, societal well-being will be diminished.

Amidst the challenges accompanying shifting demographics lies an opportunity to provide care in better ways. Building a future in which caregiving is a shared responsibility woven into the fabric of our communities won't happen automatically, but by carefully planning cities in ways that encourage exchanges of care and promoting policy that allows for non-kin care relationships to form. Through intentional urban planning, we can create longevity-friendly environments that promote social connection, facilitate intergenerational reciprocity, and foster a culture of mutual support and reciprocal giving and receiving to help individuals as they age in place. By leveraging advancements in technology, we can empower individuals to maintain their independence and autonomy while receiving the care and support they need.

Cities are already implementing changes. In Singapore, a health district is in development, carefully designed to incorporate colocation and multigenerational housing shaped to support residents' physical, mental, and social well-being.[61] There will be clinics in each housing unit, rooftop jogging loops, meditation gardens, and childcare centers right next to the active aging center to facilitate

intergenerational engagement and reduce the risk of social isolation among older adults.[62] Similarly, in Newcastle, United Kingdom, the City of Longevity initiative aims to create urban environments that support well-being at all stages of life and prevent health conditions.[63] Based on the premise that "the city must be an active and discreet partner in supporting citizens of all generations and all social and economic backgrounds to live longer and healthier lives," guidelines highlight pleasant and clean environments, green spaces, and places for people to connect with their community as key features that support flourishing at all life stages.[64]

The challenges posed by demographic shifts offer an opportunity to reimagine caregiving as a collective endeavor rooted in compassion and reciprocity. By embracing technological innovation, fostering community engagement, and advocating for inclusive policies, we can build a future in which individuals of all ages can flourish. Our efforts can pave the way for a more caring and compassionate society – one in which the proverbial village comes together to raise and support each other across generations.

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