From Ageism to Age Equity: Rethinking How We Design Aging Systems

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When people hear the phrase “reframing aging,” they often expect a conversation about language. They expect us to ask how we talk about older people, what images we use, and what assumptions are embedded in words such as “senior,” “frail,” “dependent,” “still living at home,” or “aging in place.”

That work matters. Narrative matters. Words matter. The stories we tell about aging shape public policy, family expectations, clinical encounters, funding priorities, and the way older adults understand themselves. If aging is described primarily as decline, burden, cost, or dependency, then it becomes easier to design systems that manage older adults rather than include them. If longevity is treated as a problem, then longer life becomes something to fear rather than something to plan for.

But narrative change, while necessary, is not sufficient. We cannot simply talk differently about aging while leaving the same systems in place. A more respectful vocabulary does not, by itself, create accessible housing, reliable transportation, coordinated care, safe sidewalks, inclusive public spaces, or meaningful opportunities for older adults to shape the communities in which they live.

The deeper question is this: what kinds of systems would we design if we truly expected people to live long lives, to contribute across the life course, and to remain connected to community?

That question is both public and personal. I am 72 years old. In another era, many of the systems around me would not have expected me to still be here. There is something revealing about living among institutions, buildings, assumptions, and policies shaped during periods when someone my age might have been expected to be dead seven years ago.

That is not a complaint. It is an observation about design.

We have added years to life, but we have not always added enough imagination, infrastructure, or equity to those years. Longevity has changed the facts of human life faster than many of our systems have changed their expectations. The challenge before us is not simply to help individuals age better. It is to redesign the environments, policies, services, and relationships that shape aging in the first place.

From Ageism to Age Equity

Ageism is often understood as bias against older people. That is true, but incomplete. Ageism includes stereotypes, prejudice, and discrimination based on age. It can appear in interpersonal exchanges, such as speaking to an older adult as though they are a child or directing questions to an adult child instead of the person receiving care. It can appear institutionally, such as designing programs around assumptions of decline rather than capacity. It can also be structural, embedded in housing, transportation, health care, employment, public space, and civic life.

Ageism shows up in small moments: assuming an older person cannot use technology, treating loneliness as inevitable, or describing older adults primarily as burdens on health care, Medicaid, families, or taxpayers. But ageism also shows up in the way systems are organized. A community may celebrate older adults while still having unsafe sidewalks, inaccessible housing, transportation that assumes everyone drives, health care that treats social needs as outside the clinical frame, and public meetings that are difficult for many people to attend.

That is why age equity is the stronger frame. Age equity asks not only, “Are we being respectful?” but “Are our systems producing fair opportunities for people as they age?”

Age equity moves us from attitude to structure. It asks whether older adults have real access to housing, mobility, care, public spaces, relationships, decision-making, and meaningful roles. It does not deny that aging may involve vulnerability, illness, disability, grief, or need. Those realities are part of the human condition. But age equity refuses to define older adults only through need.

Instead, age equity asks us to see older people as residents, neighbors, workers, volunteers, caregivers, voters, artists, learners, family members, culture bearers, and civic contributors.

This distinction matters deeply for health care and social service professionals. Many systems are designed to respond once someone has a problem: a fall, a hospitalization, a housing crisis, caregiver burnout, food insecurity, social isolation, a missed appointment, a medication issue, or a loss of transportation. Response matters. But if all we do is respond, we end up picking up the pieces after systems have already failed. Age equity asks us to move upstream.

The Limits of Reframing Alone

The movement to reframe aging has done important work. It has challenged harmful narratives: that aging is only decline, that older adults are a drain on society, or that demographic change is a "silver tsunami" threatening public systems. Those metaphors do damage. They teach us to fear longevity rather than plan for it.

Better language can open better possibilities. Instead of speaking only about burden, we can speak about contribution. Instead of dependency, we can speak about interdependence. Instead of treating "the elderly" as a separate group, we can speak about all of us aging across the life course.

But language does not install curb cuts. Language does not build affordable accessible housing. Language does not coordinate medical care and social supports. Language does not create reliable transit. Language does not make a public meeting accessible. Language does not ensure that a caregiver can keep working while supporting a parent, spouse, neighbor, or friend.

The work cannot stop with communication. Narrative change has to connect to policy, planning, design, and accountability.

A health care system can use respectful language and still discharge someone into a home where they cannot safely bathe, cook, or get to follow-up care. A city can celebrate older residents and still approve development patterns that isolate people who no longer drive. A nonprofit can value dignity and still measure success only by units of service rather than changes in connection, access, or quality of life.

This is the difference between good intentions and system change.

Longevity as a Planning Reality

Longevity is not just a personal achievement. It is a public condition. More people are living into older age. More families are experiencing longer periods of caregiving. More communities include residents in their 70s, 80s, 90s, and beyond. More people are living with chronic conditions, disabilities, or changing support needs while also wanting autonomy, purpose, and belonging.

This is not a temporary situation. It is the world we now inhabit.

A longevity lens asks what a society needs when longer life becomes normal. It asks whether our systems are still organized around outdated assumptions: that retirement is a short final stage, that families can absorb all caregiving needs, that people can drive

indefinitely, that medical care alone determines well-being, or that public infrastructure can be designed primarily for younger, faster, fully able bodies.

A longevity approach does not treat aging as a niche issue. It treats aging as a core design condition for communities.

That shift is especially important for professionals who work with older and elder adults. They are often asked to help people adapt to systems. But the deeper work is helping systems adapt to longevity.

Age-Friendly Ecosystems

An age-friendly approach recognizes that no single program, agency, clinic, or department can create good aging outcomes alone. Housing affects health. Transportation affects medical access. Public spaces affect physical activity and social connection. Caregiving affects workforce participation. Broadband affects access to services. Social isolation affects mental and physical health. Zoning affects whether people can remain in their neighborhoods. Clinic design affects whether people can understand, navigate, and follow through on care.

An age-friendly ecosystem connects these pieces. It moves from asking, “What services do older adults need?” to asking, “What conditions allow people to age well in this community?”

That is a different question.

It means health care, social services, local government, housing providers, transportation planners, parks and recreation departments, employers, libraries, faith communities, neighborhood groups, advocates, and older adults themselves all have roles to play. It also means older adults should not be treated only as consumers of services. They should be co-designers of the systems that affect their lives.

Housing, Transportation, Health Care, and Public Space

Housing is one of the clearest examples of structural age equity. Many older adults want to remain in their homes or communities. But “aging in place” can become an empty phrase if the place itself is not livable.

A person may technically live at home but be trapped by stairs, unsafe bathrooms, poor lighting, unaffordable rent, lack of home maintenance, snow removal needs, or distance

from services. Aging in place should not mean aging in isolation. It should not mean staying in a house that no longer fits because there are no other options. It should mean having real choices: accessible apartments, smaller homes, home modification supports, supportive housing, service-enriched housing, and neighborhoods where daily needs are nearby.

For health care and social service professionals, housing is not background information. It is part of the care environment. A care plan that assumes a person can recover at home must ask: what kind of home, with what supports, in what neighborhood, with what transportation, and with what caregiver capacity?

Transportation is another structural determinant of aging well. Many communities are built around the assumption that adults drive. But what happens when someone reduces driving, stops driving, cannot afford a car, or never drove in the first place?

Without transportation, medical appointments become harder. Grocery shopping becomes harder. Social participation becomes harder. Volunteering, worship, recreation, and civic engagement become harder. Transportation is often discussed as a service gap, but it is also a dignity issue. Mobility is not merely getting from point A to point B. It is the freedom to remain part of the world.

Health care is central to this conversation, but health care cannot carry the whole weight of aging. Aging is too often medicalized. Older adults become collections of diagnoses, medications, risks, appointments, and discharge plans. Those things matter, but they are not the whole person.

An age-equity approach to health care asks whether systems are organized around what matters to the older adult, not only what is the matter with the older adult. That means listening carefully, respecting autonomy, recognizing caregivers, coordinating across settings, and understanding cognitive, sensory, mobility, financial, cultural, and transportation realities. A clinic can prescribe movement, but a community has to provide safe places to walk. A hospital can recommend a diet, but a person needs access to food. A care team can recommend follow-up, but a person needs transportation.

Public spaces are where belonging becomes visible. Parks, libraries, sidewalks, community centers, streets, trails, plazas, and public buildings all communicate who is expected, who is welcome, and who is considered in design. A park without benches tells one story. A meeting room without hearing support tells another. A sidewalk blocked by snow tells another. A public process held only online tells another. A trail without restrooms or shade tells another.

These are not minor amenities. They determine participation.

Age-friendly public spaces support movement, rest, safety, orientation, intergenerational connection, and civic presence. They make clear that older adults are not guests in public life. They are part of the public.

Aging in Place and Aging in Community

Aging in place is a powerful idea, but it needs to be expanded. The goal is not simply to keep people out of institutions. The goal is to support people in living meaningful lives in the settings they choose, with the relationships, services, and environments they need.

Sometimes that will mean remaining in a long-time home. Sometimes it will mean moving to a more accessible apartment. Sometimes it will mean living with family. Sometimes it will mean assisted living, supportive housing, or skilled care.

The key question is not whether someone stayed in the same physical place. The key question is whether they retained agency, connection, dignity, and belonging.

Aging in community may be the better phrase. It reminds us that people do not age well because of housing alone, or health care alone, or transportation alone. They age well when these systems work together.

The Professional Role

For health care and social service professionals, this work can feel both inspiring and frustrating. Many professionals may reasonably say: I do not control housing policy. I do not run the transit system. I do not design sidewalks. I do not set reimbursement rates. I do not decide zoning.

That is true.

But professionals working closest to older adults see the pattern.

They see when an individual “noncompliance” issue is really a transportation issue. They see when a hospital readmission is really a housing issue. They see when caregiver stress is really a workforce and family policy issue. They see when loneliness is really a community design issue. They see when aging in place is being used as a slogan without the infrastructure to support it.

That pattern recognition is powerful. Professionals who work closest to older adults can help translate individual stories into system learning.

This does not mean blaming any one organization. It means asking better questions together. Where are older adults falling through the cracks? Where do systems require people to ask the right question, at the right office, in the right language, during the right hours, with the right paperwork, before they can get help? Where are predictable aging-related needs being treated as individual emergencies? Where are older adults absent from decisions that affect them?

These are system questions.

From Programs to Ecosystem

Many communities, including Rochester and Olmsted County, have strong programs, committed professionals, capable institutions, and real assets. That should be acknowledged. But programs are not the same as a system.

A community can have excellent services and still be difficult to navigate. It can have caring professionals and still place too much burden on older adults and families to coordinate care. It can have public engagement opportunities and still miss the voices of those most affected. It can have health care excellence and still struggle with housing, transportation, isolation, and aging-in-community infrastructure.

Systems respond when asked. But requiring each older adult, caregiver, or professional to ask each system in turn is not efficient, equitable, or humane.

The opportunity is to build a more connected aging ecosystem: shared goals, shared referral pathways, shared accountability, and shared engagement with older and elder adults. It also means moving from consultation to co-creation. Older adults should not be brought in only after priorities are drafted. They should help define the priorities.

Closing

I began by saying that I wanted to explore three ideas.

First, the difference between ageism and age equity.

Ageism limits what we expect from older adults and what we design for them. Age equity asks a more demanding question: whether our systems create fair opportunities for people to live with agency, connection, care, and purpose as they age.

Second, I wanted to consider why communications-based strategies are important but limited.

Changing the story of aging matters. But better language must lead somewhere. It must lead to different choices about housing, transportation, health care, public space, caregiving, and community design. Otherwise, we have changed the words without changing the experience.

And third, I wanted to suggest that longevity planning and age-friendly ecosystems give us a way to move and third, how longevity planning and age-friendly ecosystems can help move us from a collection of aging services to a community designed for aging well.

This may be the most important shift. Many communities, including ours, have good programs, committed professionals, and real assets. But older adults and caregivers should not have to assemble a livable life by navigating one disconnected system after another.

The work before us is to connect the pieces. Not all at once. Not perfectly. But intentionally. To look for the system behind the individual problem. To treat older adults as co-designers, not only clients or patients. To build the habits of collaboration across health care, housing, transportation, public space, social services, and civic life.

If we do that, we begin to move from reacting to aging toward designing for longevity.

And that is the invitation I want to leave with you: Older adults are not outside the community; they are evidence of its success and a test of its design. Let us make ageing not merely something our systems respond to, but something our communities are thoughtfully built to include.

This goal is not heroic. It is deeply ordinary: that people can live safely, move freely, receive care, stay connected, and continue to matter in the places they call home.

Based on a presentation at the Olmsted Medical Center Active Aging Services Conference Rochester, Minnesota May 6, 2026