12-2020

Aging Strong for All: Examining Aging Equity in the City of Boston

Jan Mutchler
University of Massachusetts Boston, jan.mutchler@umb.edu

Caitlin Coyle
University of Massachusetts Boston, caitlin.coyle@umb.edu

Nidya Velasco Roldán
University of Massachusetts Boston, nidya.velascorold001@umb.edu

Paul Watanabe
University of Massachusetts Boston, paul.watanabe@umb.edu

Cedric Woods
University of Massachusetts Boston, cedric.woods@umb.edu

See next page for additional authors

Authors

Jan Mutchler, Caitlin Coyle, Nidya Velasco Roldán, Paul Watanabe, Cedric Woods, Lorna Rivera, Quito Swan, Elena Stone, and Laurie Nsiah-Jefferson

AGING STRONG FOR ALL

EXAMINING AGING EQUITY IN THE CITY OF BOSTON

UMASS BOSTON
UNIVERSITY OF MASSACHUSETTS BOSTON

21.125RC

This report resulted from a collaboration among researchers from six institutes and centers at the University of Massachusetts Boston—the city's only public university. Together, we describe the significance of the rapidly changing demographics of Boston's older residents and dimensions of their well-being in later life.

THE CENTER FOR DEMOGRAPHIC RESEARCH ON AGING (CSDRA) carries out basic and applied social and economic research on aging and engages in public education on aging policy issues, with an emphasis on economic security, age-friendly communities, senior center innovation and capacity building.

THE INSTITUTE FOR ASIAN AMERICAN STUDIES (IAAS) utilizes resources and expertise from the university and the community to conduct research on Asian Americans; to strengthen and further Asian American involvement in political, economic, social, and cultural life; and to improve opportunities and campus life for Asian American faculty, staff, and students and for those interested in Asian Americans.

THE INSTITUTE FOR NEW ENGLAND NATIVE AMERICAN STUDIES (INENAS) works to develop collaborative relationships, projects, and programs between Native American tribes and organizations of the New England region so that the New England Native peoples may participate in and benefit from university research, innovation, scholarship, and education.

THE MAURICIO GASTÓN INSTITUTE FOR LATINO COMMUNITY DEVELOPMENT AND PUBLIC POLICY works to inform the public and policymakers about issues vital to Massachusetts' growing Latino community, and to generate research, information, and analysis for the development of more effective public policies and advocacy for Latino communities.

THE WILLIAM MONROE TROTTER INSTITUTE FOR THE STUDY OF BLACK CULTURE aims to address the political, cultural, and socio-economic experiences of Black communities in Massachusetts through critical research, public advocacy, and community engagement. It serves as a thriving intellectual hub in support of social justice for Boston's Black Diasporas via digital humanities, innovative programs, and local and global collaborations.

THE CENTER FOR WOMEN IN POLITICS AND PUBLIC POLICY (CWPP) promotes women's political leadership through its intersectional graduate programs, policy research and initiatives, and public forums.

AGING STRONG FOR ALL

Examining Aging Equity in the City of Boston

Acknowledgements

This work was supported by the John W. McCormack Graduate School of Policy & Global Studies through the Dean's Office Faculty Funds for Advancing Research grant, and by the Tufts Health Plan Foundation's support of the Age-Friendly Boston Initiative, of which this work is an extension.

We are grateful to Cindy Bui and Shayna Gleason, UMass Boston doctoral students in the Gerontology department, for their assistance in compiling resources used in this report. Thanks go also to Rebecca Mailman for her assistance, and to Rose Coveney for her creative cover design. We offer appreciation to Rita Kiki Edozie, Associate Dean of the McCormack Graduate School, for her support and encouragement for this collaborative work. Finally, we thank Commissioner Emily Shea, Andrea Burns, and Melissa Carlson of the City of Boston's Age Strong Commission for their input on aspects of this report and their leadership on behalf of Boston's older residents.

Contributors

This report was produced by Jan E. Mutchler, PhD, Caitlin E. Coyle, PhD, and Nidya Velasco Roldán, MS of the Center for Social & Demographic Research on Aging; Paul Watanabe, PhD, the Director of the Institute for Asian American Studies; Cedric Woods, PhD, the Director of the Institute for New England Native American Studies; Lorna Rivera, PhD, the Director of the Mauricio Gastón Institute for Latino Community Development and Public Policy; Quito Swan, PhD, the Director of the William Monroe Trotter Institute for the Study of Black Culture; Elena Stone, PhD, Program Development Specialist, CANALA Institutes; and Laurie Nsiah-Jefferson, PhD, the Director of the Center for Women in Politics and Public Policy.

Recommended Citation

Mutchler, J., Coyle, C., Velasco Roldán, N., Watanabe, P., Woods, C., Rivera, L., Swan, Q., Stone, E. and Nsiah-Jefferson, L. (2020). Aging Strong for All: Examining Aging Equity in the City of Boston.

Table of Contents

Executive summary

The experience of being and becoming older differs substantially based on one's race, ethnicity, and gender. In the City of Boston, it has never been more critical to strategically pursue greater equity in the aging experience of residents. According to data from the US Census Bureau, the number of Boston residents aged 60 or older increased by more than a third just since 2010 and persons of color now make up half of Boston's older adults. As well, stakeholders share a growing recognition of the powerful ways in which inequity, racism and discrimination shape health outcomes and the aging experience, amplifying the need to scrutinize and remediate disparities in aging.

The purpose of this report is to examine these intersecting trends and to document disparities experienced by older residents across three major dimensions of healthy aging: economic security, health, and social engagement. The report tells a story of inequities across the life course that together challenge the ability of many people to thrive in later life and contribute to disparities across populations.

While community initiatives, like Age-Friendly Boston, cannot fully remediate the late-life impact of processes that have played out over a lifetime, often spanning communities, states, or countries of residence, it is critical for stakeholders to be aware of the disparities that exist in Boston, and seek to ensure that systems appropriately respond to those disparities. After all, everyone ages. Therefore, to create environments in which all Bostonians can "age strong" it is imperative to address the inequities that shape later life. To do so, we first need to understand the patterns of inequity. In this report we profile older Boston residents and compare the experience of aging in diverse ethnic and racial communities, as a means of summarizing the contours of disparity and identifying targets for intervention. This report also documents substantial disparities in each dimension of healthy aging across racial and ethnic groups.

Economic security

- Older persons of color have fewer material resources than their non-Hispanic White counterparts in Boston, with lower rates of employment and homeownership. Persons of color also have higher rates of poverty.
- Sizable gaps differentiate racial groups as well. For example, while a similar share of non-Hispanic White, Black and Native American people aged 66 or older receive Social Security benefits, percentages receiving Social Security are considerably lower for Latinos and Asian Americans.
- Poverty rates are especially high among Asian Americans and Latinos, and more than one-third of these residents age 60 or older live in households with incomes below the federal poverty line.
- Housing costs in Boston place a heavy burden on older residents and half or more of renters age 60 or older pay more than 30% of their incomes for housing. Fewer homeowners bear such a heavy cost burden for housing, but older Black, Latino and Native American homeowners are at amplified risk for being cost-burdened.
- A large majority of older Latinos and Asian Americans are not homeowners, with 20-25% of householders in these groups owning a home, compared to 63% of their non-Hispanic White counterparts.

Health and disability

- Racial disparities in health and disability are substantial among older Boston residents, with older Blacks, Latinos and Native Americans having especially high risk of health challenges and disability.
- Boston residents are fortunate to live in a state where insurance coverage is virtually universal for older people; however, persons of color are far more likely than non-Hispanic Whites to rely on Medicare only, or Medicare in combination with MassHealth, which may have implications for out-of-pocket expenses, options for obtaining care, and quality of care.
- Higher rates of disability and needs for assistance among older persons of color also yield disparities in the extent to which younger family members are drawn into providing care for disabled or frail older relatives. Although most caregiving is provided informally in the US across the board, alternatives to family care may be few if the care recipient does not speak English well or culturally appropriate services are not available.

Social engagement

- In Boston, persons of color are less likely than their non-Hispanic White counterparts to live alone, and a large share live in multigenerational households. While we lack data on the level of support provided within and across households, multigenerational settings may promote a level of social engagement that benefits participants, a disproportionate share of whom are persons of color.
- Community strengths in terms of mutual support, resilience, and cultural cohesion offset or buffer aspects of disadvantage for some people. Yet access to information may be challenging for older communities of color, many of whom have limited knowledge of English; as well, a larger share of older persons of color do not have access to digital technology.

Considerations for moving forward

Working within the context of Boston's Age-Friendly Initiative, tackling the issues laid out in this report will require a multifaceted approach. (1) It will be necessary to remove barriers to accessing community features, such as language barriers, obstacles relating to cost, and transportation limits. (2) Ensuring that community features align with needs, interests, and cultural and linguistic characteristics of residents—and continuing to do so as those characteristics shift over time—is fundamental to pursuing aging equity. (3) In this city of distinct and beloved neighborhoods, it will require efforts to ensure that the assets promoting healthy aging are distributed equitably across locations and communities. These strategies are important steps in implementing age-friendly practices. As well, because many obstacles disproportionately impact persons of color and those with lower income, these efforts can promote aging equity. Moreover, city and community offices and organizations must continue to strengthen existing partnerships and build new ones to support collaborative and equitable action.

In Boston and in cities throughout the United States, persons of color encounter systemic racism and disadvantage that shape their accumulation of health and material resources. Barriers to participating in education and training programs that prepare people for stable and well-paying careers result in persons of color having lower incomes and less wealth, on average, as they enter later life. Exposure to unhealthy environments and low access to healthcare result in health disparities that start early and ripple throughout the life-course, impacting health and disability profiles and, indeed, reducing the chances that some people will survive to old age at all. Stress resulting from bias and discrimination has well-known negative impacts on health, with consequences lasting a lifetime. Strengthening opportunities for healthy aging requires close attention to the social determinants of health, all of which are shaped to some degree by inequity.

The disparities described in this report make clear that for Boston to adequately meet the needs of its older population, it must redouble efforts to understand and respond to the full range of needs, the many different languages and cultural preferences, and neighborhood differences in assets.

Finally, this report moves us towards a definition of aging equity. The definition of this concept is intended to guide action towards a shared goal of creating environments in which older residents have a more equitable opportunity to "age strong."

Defining aging equity

Aging equity means that everyone has a fair and just opportunity to age well. This requires removing obstacles to accessing community features that support healthy aging, through establishing social and civic engagement opportunities, ensuring safe environments, establishing access to healthcare, and disseminating knowledge of available supports and services. It means ensuring that the features in place align with the needs and interests of the full range of residents, and does not privilege some segments of the older population over others. And it means ensuring that interventions and innovations are distributed across neighborhoods in ways that support fair access to Age-Friendly interventions.

Aging equity in the time of COVID and racial reckoning: A preface

The turmoil created by COVID-19 has revealed the breadth and depth of social inequity, as the infection disproportionately impacts both older people and persons of color. As of October 28, 2020, Boston has witnessed nearly 20,000 cases of COVID-19 and 777 deaths.[1] One out of four cases has occurred among people age 60 and older,[2] although just 17% of the Boston population falls into that age range. Among Boston cases where race or ethnicity of the patient is known, three out of four of those testing positive for COVID-19 are persons of color,[3] a population that represents just 56% of Boston's population. Blacks and Latinos are especially negatively impacted.

Initial evidence indicates that these disparities are influenced not just by age, but by social determinants of health accumulating over the life course. People who live in congested living situations, have preexisting health conditions, or lack the resources to keep themselves safe are at higher risk, as are those who must leave their homes for work or other necessary activities, or who live with people who are at higher risk of coming into contact with an infected person. These social conditions also amplify spillover impacts associated with the economic fallout of the COVID-19 crisis and the adjustments made to many of our key social institutions. During the COVID-19 crisis, many older people in Massachusetts have experienced a loss in household income and some have had difficulty paying their rent or mortgage. Many anticipate difficulties obtaining sufficient food. Older persons of color may be at amplified risk of experiencing these difficulties. Moreover, levels of depression and anxiety reported by older people in Massachusetts at this time are high relative to national standards.[4]

Aging Black communities have been the most vulnerable group impacted by COVID-19. Their lived experiences rest at the intersection of a mass of preexisting vulnerabilities—disparities by race, age, ethnicity, and gender, and systemic issues of racism in the health and aging care systems that existed prior to the pandemic of COVID-19. Yet this is not only a narrative of victimhood; Black communities have traditions of resilience that they have drawn on in the face of a myriad of crises.

Last summer another reflection of how systemic racism perpetuates disparities emerged in the highly visible tragic deaths and shootings of African Americans Breonna Taylor, George Floyd, Ahmaud Arbery and Daniel Prude, galvanizing global protests against police and systemic violence enacted on Black people. On the most visceral level, each of these persons left behind aging family members who now have to deal with the embers of these terrible losses. Without question, Black Lives Matter has significant relevance for aging Black people, who draw parallels between the Movement and their generational struggles against segregation, police brutality, and racism. For example, 77-year-old Patricia Blake, grandmother of Jacob Blake, hoped that protests around his shooting in Kenosha, Milwaukee would continue her family's strong legacy in fighting for social justice. Matriarchs like Patricia are critical social, political and cultural voices in Black communities, even as they have historically been faced with structural racism in aging systems. As stated by the nationally-based Alliance for Aging Research, "We cannot do impactful work in aging and health without recognizing and addressing the disparities that exist within it. Systemic racism and violence are major barriers to health and aging equity."[5] These linkages are being recognized here in Boston as well. In June 2020, Boston Mayor Martin Walsh declared racism to be a public health crisis. He announced plans to reallocate 20% of the Boston Police department's overtime budget to "make investments in equity and inclusion." This includes $2 million for the support of community-based programs such as the Age Strong Commission, which operates the Age-Friendly Boston Initiative.

It is these kinds of intentional programs to address aging equity in research, resource allocation and services for communities of color that the University of Massachusetts Boston organizations authoring this report—the Gerontology Institute, the Trotter Institute for the Study of Black Culture, the Gastón Institute for Latino Community Development & Public Policy, the Institute for Asian American Studies, the Center for Women & Public Policy, and the Institute for New England Native American Studies—are primed to engage in.

Under our current societal context, this work is, more than ever, in need of strengthening and widening in scope.

Introduction

The experience of being and becoming older differs substantially across groups structured by race, ethnicity, and gender. Late life disparities in health, in financial and social well-being, and in other aspects of quality of life stem from a myriad of experiences spanning the life course. Processes of cumulative inequality in achieving education and acquiring wealth lead to some people reaching later life without sufficient financial resources to live independently or acquire adequate healthcare.[6] Healthcare and social services may fail to adequately respond to the needs of people who do not speak English well or whose belief systems differ from those most prevalent in US healthcare delivery systems, leading to lifelong health disparities.[7] Discrimination and bias in our educational institutions, places of work, healthcare settings, and throughout the community yield unfair outcomes and provoke health-damaging stress responses that persist for a lifetime.[8] And many federal, state, and local policies relating to housing, health insurance, employment, and other aspects of life allow and often reinforce disparity.

In the City of Boston, it has never been more critical to strategically pursue greater equity in the aging experiences of residents. One reason relates to changes in the composition of our population: the number of Boston residents aged 60 or older increased by 32% in just eight years and persons of color now make up half of Boston's older adults.[9] As well, stakeholders share a growing recognition of the powerful ways in which inequity, racism and discrimination shape health outcomes and the aging experience, amplifying the need to scrutinize and remediate disparities in aging. Moreover, the Age-Friendly Boston[10] initiative, established by the city's Age Strong Commission, is reaching a new level of visibility and maturity in leveraging the resources of the city. In partnership with many community stakeholders, Age-Friendly Boston seeks to make Boston a better place in which to grow up and grow old. The Initiative's emerging focus on equity strengthens the opportunity to address inequitable aging experiences evident throughout the city.

The purpose of this report is to examine these intersecting trends and to document disparities experienced by residents of color across three major dimensions of healthy aging: economic security, health, and social engagement. The report tells a story of inequities across the life course that together challenge the ability of many people to thrive in later life and contribute to disparities in quality of life. Yet as described in this report, there is more to aging as a person of color than disparity and inequity. In fact, stories of resilience, innovation, community cohesion, and strength abound. These aspects are highlighted by stories and examples throughout this report. While community initiatives cannot fully remediate the late-life impact of processes playing out over a lifetime, often spanning communities, states, or countries of residence, it is critical for stakeholders to be aware of the disparities that exist in Boston, and seek to ensure that systems appropriately respond to those disparities.

Making Progress through the Age-Friendly Boston Initiative

In 2014, as he embarked on his first term in office, Mayor Martin Walsh committed the City of Boston to becoming an age-friendly community. This initiative is part of a larger movement started by the World Health Organization (WHO), and led in the US by the American Association of Retired People (AARP), to make communities more accessible and inclusive for people of all ages. The age-friendly movement identifies eight domains of community living that are essential to consider when planning improved environments for aging residents. This framework has guided the development and implementation of an action plan created by the city with support from UMass Boston's Gerontology Institute, AARP Massachusetts, and Tufts Health Plan Foundation, aimed at improving well-being for older residents.

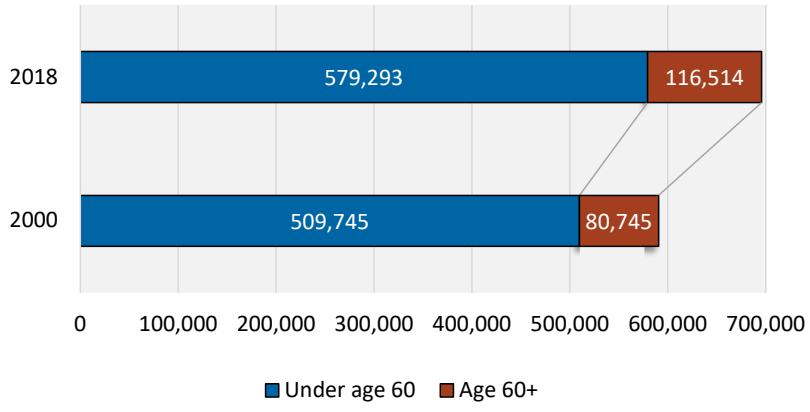
This work, while effective in improving community infrastructure for older Bostonians, uncovered inequities in residents' awareness of city resources and their levels of engagement in programs and activities meant to improve quality of life and social participation. In response, the AFBI is moving ahead with a more keenly-focused equity lens—an intentional effort to create a city where all are welcomed, everyone is informed about how to access age-friendly opportunities, and where city policies, structures and systems align with the diverse needs of its older population. The AFBI will focus its most immediate efforts on removing obstacles to accessing city resources (e.g., services, information); ensuring that community features (e.g., social and health programming, parks, transportation) align with the needs and interests of residents of all backgrounds; and ensuring that interventions, innovations, and assets are both distributed equitably across neighborhoods and tailored to the specific needs of groups that make up Boston's diverse population. This report aims to contribute to this effort by providing critical data and analysis about factors that impact the experience of aging for residents of color across the city. Although much work remains, examples of how the AFBI is working towards aging equity are highlighted throughout this report in sections titled "Making Progress through the Age-Friendly Boston Initiative."

Population trends and demographic characteristics in Boston

Over the past two decades, Boston's population has become larger, older, and more racially and ethnically diverse. The city now includes nearly 700,000 people, numbering 105,000 more residents than in the year 2000. Through a combination of aging in place and migration, older people made up a disproportionate share of the increase (see **Figure 1**) and residents aged 60 or older now make up 17% of Boston's population (up from 14% two decades ago).

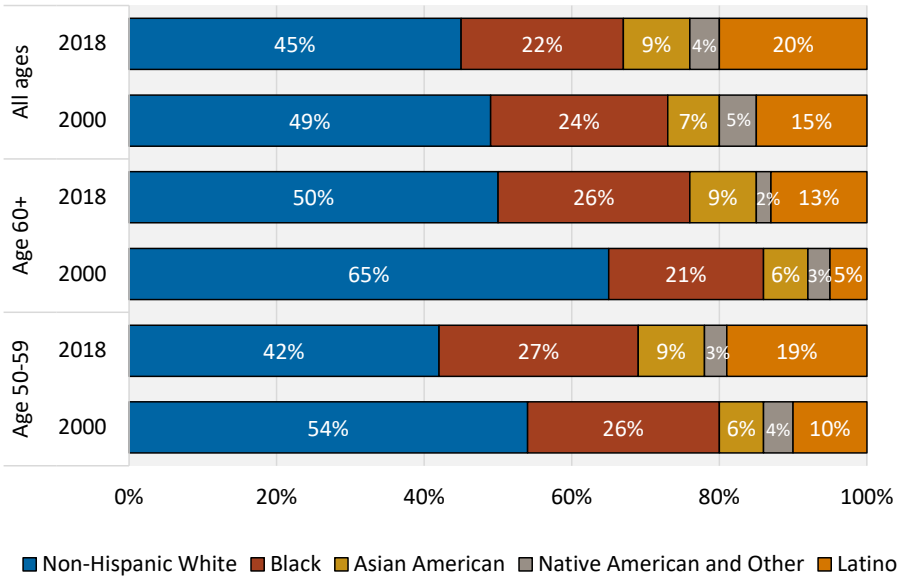
An estimated 55% of Boston's residents are now persons of color, up from 51% in 2000. In recent years, persons of color have also represented an increasing share of the *older* population, now comprising half of Boston's age 60-plus population, up

Figure 1. Boston's population growth by age group, 2000-2018



Sources: 2018 ACS, 1-year file, and 2000 Census, 5% sample, retrieved through the IPUMS.

Figure 2. Population share by age group and race and ethnicity, Boston, 2000 and 2018

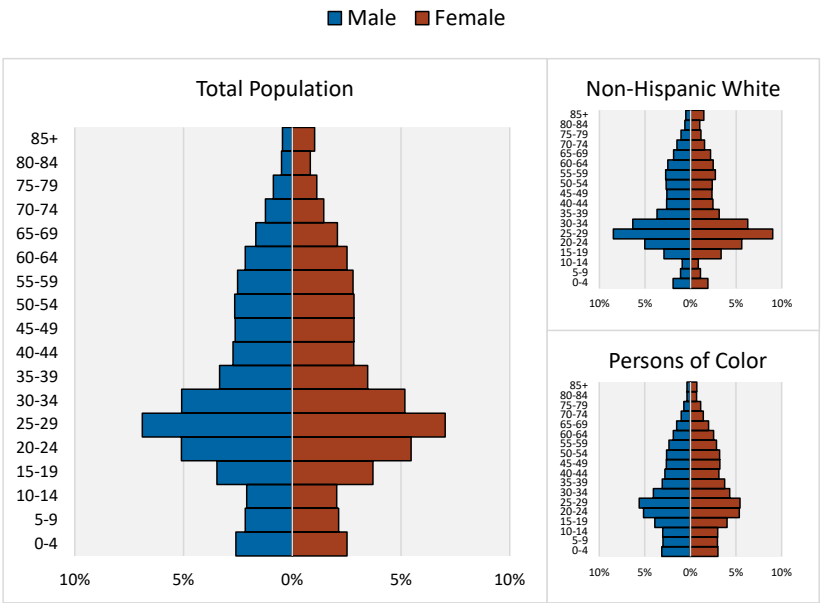


Source: 2018 ACS, 1-year file, and 2000 Census, 5% sample, retrieved through the IPUMS.

from 35% just two decades ago (see **Figure 2**). Older Blacks now represent 26% of Boston's residents who are age 60 or older, and Latinos represent another 13%. Persons of color make up an even larger share of Boston residents age 50-59, who will be aging into their 60s over the current decade, signaling continued expansion of diversity moving forward. Many groups, including African and Caribbean Americans, have deep roots in the city, and refugees from Vietnam, Cambodia, and Somalia have been living in the Boston area for decades. As younger residents from diverse origins age into their 60s and beyond, newcomers from Africa, Latin America, the Caribbean, and Asia will further add to the character of the city. Indeed, the growth of the older minority population in Boston reflects not only an insurgence of new immigrants but also the aging of populations that have long been a vital part of Boston.

To understand the disparities across race and ethnic groups in older age, it is important to recognize the generational dynamics within each population. Boston's population, economy, and character are heavily impacted by the large number of colleges and universities that attract cohort after cohort of young people to Boston as they pursue higher education. At any given time, this impacts Boston's age structure in somewhat predictable ways, contributing to a "bulge" in population in the age groups ranging from late teens to early 30s (see **Figure 3**). The impact of this higher education bulge is heavily expressed in the population that is non-Hispanic White (see top right figure), and nearly half (48%) of that population is aged 20 to 39. In comparison, just over one-third (37%) of persons of color are age 20-39 in Boston (see bottom right figure).

Figure 3. Population in Boston by age and gender, 2018

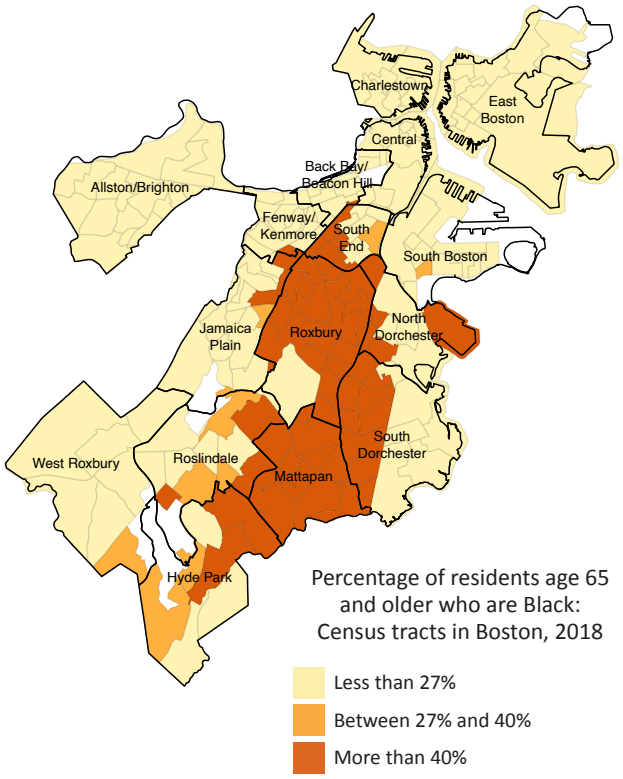


Source: 2018 ACS, 5-year file, retrieved through IPUMS.

Profiles of major racial and ethnic groups in Boston

Boston's aging population is increasingly made up of persons of color, representing a multitude of groups with rich diversity in points of origin, languages, cultures, and histories. As a practical matter, and due to limitations in the data available to us, much of this report involves discussion of familiar, albeit overly broad, pan-ethnic groupings. Before turning to those comparisons we offer brief demographic profiles of older people in Boston who are Black, Asian American, Latino, and non-Hispanic White. We also profile the older Native American population of Massachusetts. These sections focus on age structure, local geographic clustering, national origins and language—factors that contribute to diversity within each of these groups.

Map 1. Representation of Black older adults across neighborhoods, Boston



Source: 2018 ACS, 5-year estimates, Table B01001B. Retrieved from https://data.census.gov/cedsci/

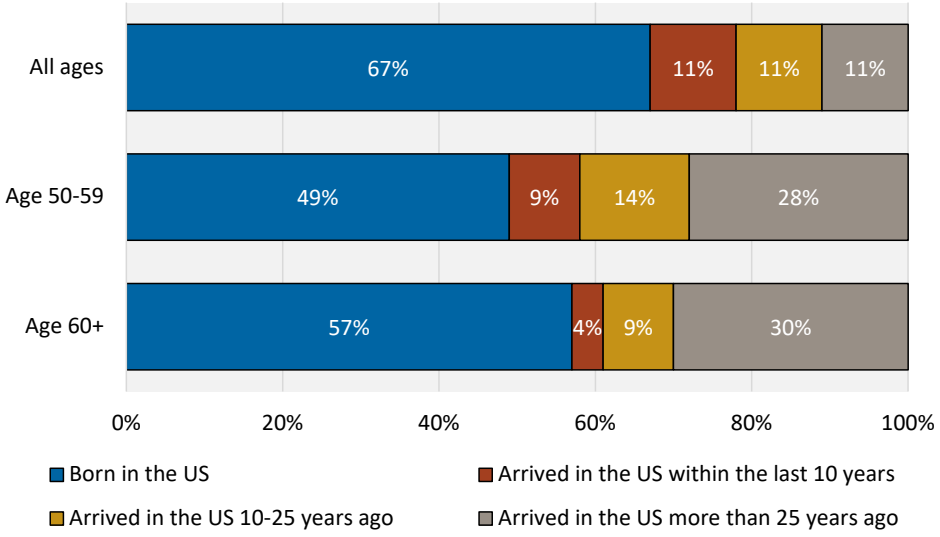
Boston's older Black population

Boston's Black population reflects a long legacy of economic contribution and cultural vibrancy.[11] Yet in Boston, as in many other cities, institutional racism and discriminatory practices have deep roots, with widespread impacts. A recent example of devastating impacts can be seen in the COVID-19 case rates in Boston, with Blacks representing far more of the known cases of COVID-19 than what would be anticipated based on the share of Boston's population that is Black.

As of 2018, an estimated 18% of Boston's Black population was age 60 or older, with an additional 14% age 50-59 and poised to enter later life over the coming decade (see Figure A1 in Appendix). As these individuals age in place, the older Black population in Boston is likely to continue increasing for some time. As shown in **Map 1**, older Blacks are disproportionately represented in central neighborhoods, including Roxbury, Dorchester, Mattapan and parts of Hyde Park, South End and Roslindale. The areas shaded in rust are those in which more than 40% of the age 65 and older population is Black, which is about 50% more than the share for Boston as a whole (which is 27%).

The number of older Black residents in the City of Boston has grown substantially in recent decades. Currently, one-quarter of Boston's older population is Black, representing more than 27,000 people, up from about 16,500 in 2000. Although most Black older Bostonians are US-born, more than four out of ten were born outside of the US (see **Figure 4**). Currently, immigration is contributing more heavily to the Black population than has been the case in recent decades, and half of the population aged 50-59 was born outside of the US. Top origin countries among Black immigrants are currently Haiti, Cape Verde and Jamaica, with others arriving from many different countries throughout the Caribbean, Africa, and around the world. A sizable share of older Black immigrants has lived in the US for more than 25 years, and a large majority of Boston's older Black population are US citizens, including 91% of those age 60 or older and 82% of those age 50-59.

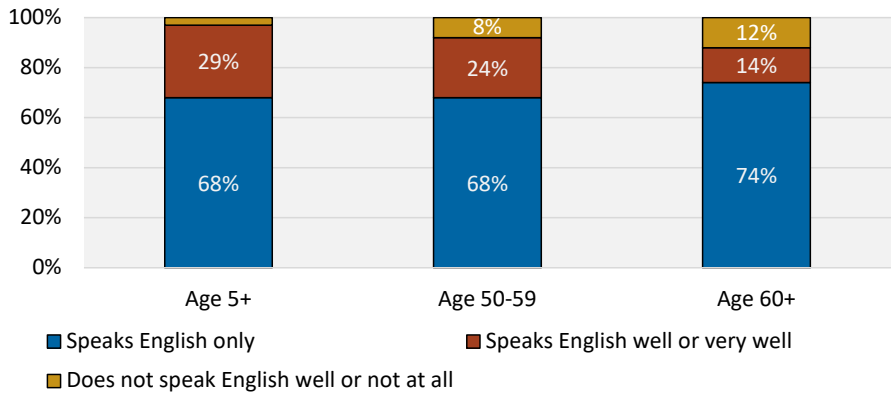
Figure 4. Immigration experience among Boston's Black population



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: Boston's US-born Black population includes a small share (1%) of people born abroad of US parents or born in a US territory including Puerto Rico, Guam, and the US Virgin Islands.

The diverse origins of Boston's older Black population contribute to this population's linguistic diversity. Three out of four older Black residents speak only English at home, but 12% do not speak English well or not at all (see **Figure 5**). Gaps in English proficiency can lead to needs for language assistance to meet routine needs for healthcare, social services, or to manage other life demands such as paying bills or using public transportation. Although many older adults who do not speak English well live in households containing another person who may be relied on for language assistance—a spouse, an adult child, or even an adolescent grandchild—10% of Boston's Black residents age 60 or older live in a "linguistically isolated" household, that is, a household in which *none* of its members age 14 or older speak English very well. Among the older Black residents who are linguistically isolated, three out of four speak French/Haitian Creole and an additional 13% speak Portuguese.

Figure 5. English proficiency among Boston's Black population



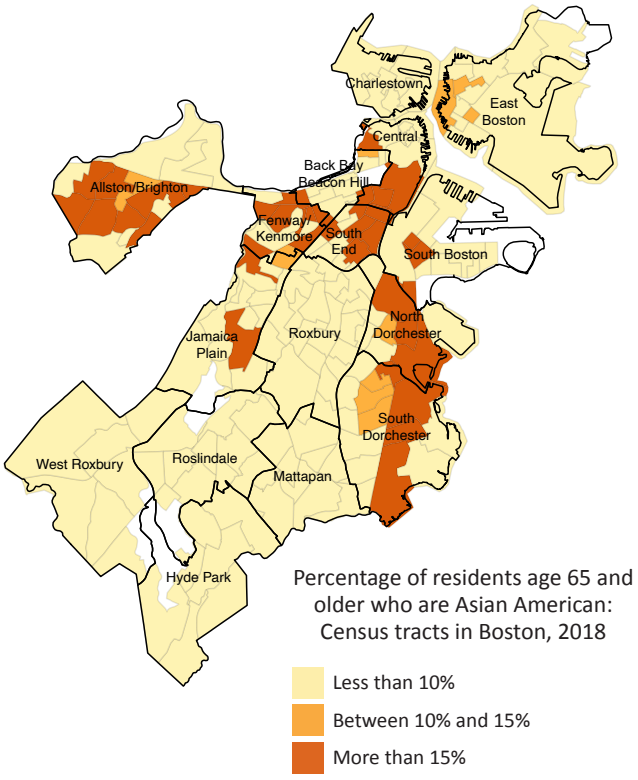
Source: 2018 ACS, 5-year file, retrieved through IPUMS.

Boston's older Asian American population

Residents of Asian American origins represent a large percentage of Boston's foreign-born population. This highly diverse population includes individuals tracing their families to origins around the world. Boston's Asian American population is embedded in a network of communities in and around the city, with a history of contributing to Boston's development through establishing small businesses and strong civic engagement and advocacy. The Asian American population is characterized by great heterogeneity. While some Asian American subgroups report high socioeconomic status and good health, others have especially high rates of poverty.[12]

As of 2018, an estimated 16% of Boston's Asian American population was aged 60 or older, with an additional 9% age 50-59 and set to enter later life over the coming decade (see **Figure A2** in **Appendix**). Forty-five percent of Boston's Asian American population is age 20 to 39, reflecting in part the appeal of Boston as a destination among young adults pursuing higher education and launching careers. Yet the sizable presence of Asian Americans in midlife age groups suggests that moving forward, the older population will continue to be significant. As shown in **Map 2**, higher concentrations of older Asian Americans live in Allston/Brighton, the South End, Downtown areas, Dorchester, and sections of other neighborhoods. The areas shaded in rust are those in which more than 15% of the population age 65 or older is Asian, which is about 50% higher than the share for Boston as a whole (10%).

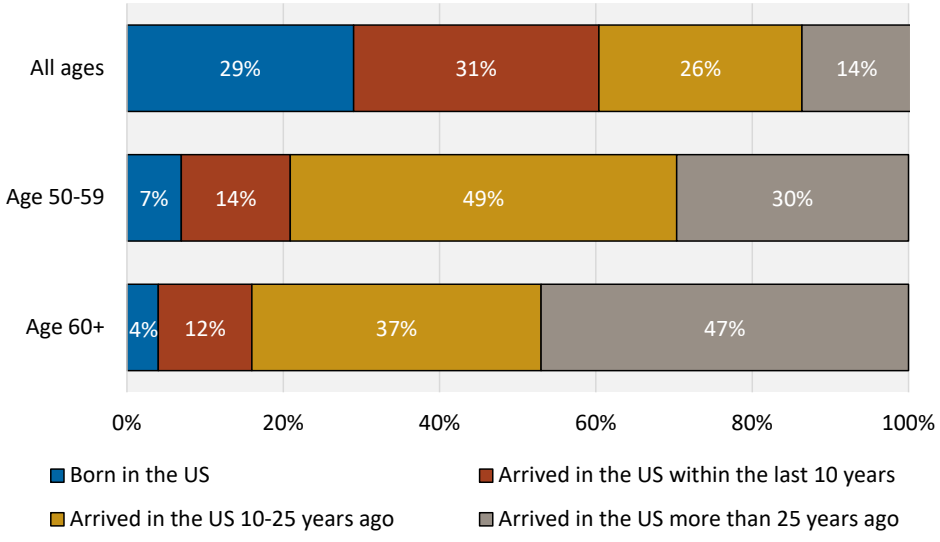
Map 2. Representation of Asian American older adults across neighborhoods, Boston



Source: 2018 ACS, 5-year estimates, Table B01001D.
Retrieved from https://data.census.gov/cedsci/

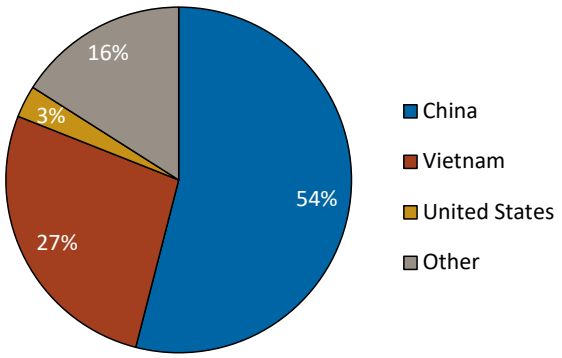
The number of Boston residents who are Asian American has steadily increased over recent years, growing from about 44,000 in 2000 to nearly 65,000 in 2018. Currently, Asian Americans represent 9% of the older population (see **Figure 2**, above). Immigration has contributed heavily to this growth, and nearly all Asian American residents of Boston aged 50 or older are immigrants (see **Figure 6**). As time lived in the US matters for integration as well as eligibility for citizenship and some social services, it is important to note the diversity of length of residence in the US. As of 2018, while 12% of Asian Americans age 60 or older had migrated to the US within the last 10 years, considerably larger

Figure 6. Immigration experience among Boston's Asian American population



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: Boston's US-born Asian American population includes a small share (2%) of people born abroad of US parents or born in a US territory including Puerto Rico, Guam, and the US Virgin Islands.

Figure 7. Place of birth among Boston's Asian American population age 60 or older



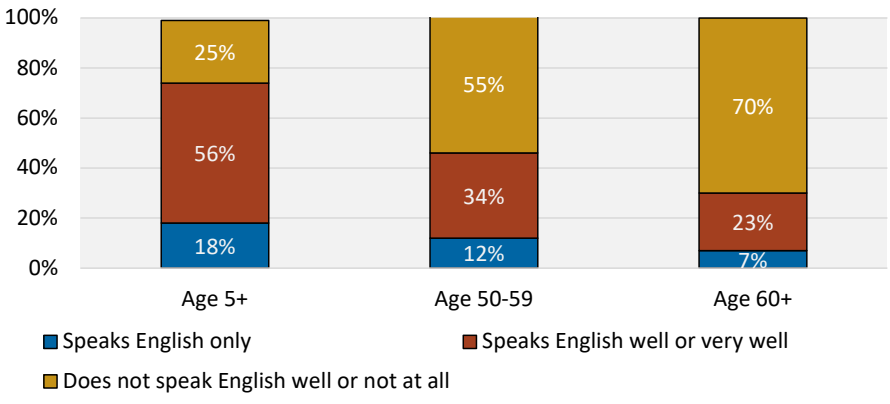
Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: "Other" place of birth includes India, Hong Kong, and a range of other countries in Asia and elsewhere.

proportions migrated earlier in life and nearly half have lived in the US for at least 25 years.

An important aspect of diversity among Asian American immigrants is country of origin. More than half (54%) of the older Asian American population was born in China, but a considerable share was born in Vietnam (27%), or another country outside of the US (16%; see **Figure 7**). Just under one-quarter (24%) of Asian Americans age 60 or older do not have US citizenship along with one-third of those age 50-59.

Limited English proficiency may serve as a challenge to some members of Boston's older Asian American population, impacting their access to and need for services. While one quarter of Boston's entire Asian American population does not speak English well, this language gap is doubled or tripled among older Asian American Bostonians (see **Figure 8**). Over half (55%) of Boston's Asian Americans aged 50-59 do not speak English well, and seven out of ten Asian Americans age 60 and older do not speak English well. Furthermore, 60% of Asian Americans age 60 or older are linguistically isolated, which means they do not have someone in their home over the age of 14 who can speak English well. Among linguistically isolated older Asian Americans the most common languages spoken at home are Chinese (73%; data do not fully distinguish between dialects at this time) and Vietnamese (23%).

Figure 8. English proficiency among Boston's Asian American population



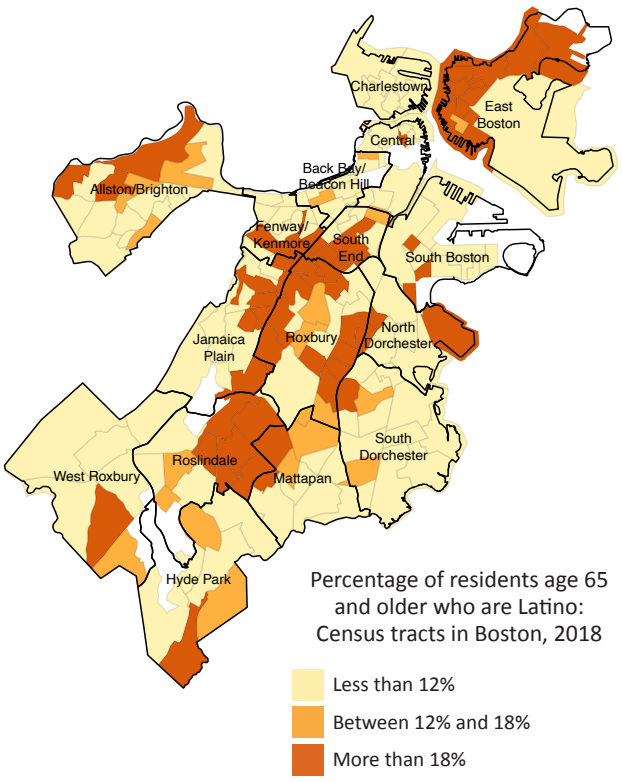
Source: 2018 ACS, 5-year file, retrieved through IPUMS.

Boston's older Latino population

Boston's Latino population represents a wide array of countries of origin, racial identities, and immigration statuses. Despite this heterogeneity, Latinos in Boston collectively face substantial disparities in terms of income, educational levels, homeownership, and other social determinants of health. Equity is a concern not only between Latinos and other ethnic groups, but also within the Latino population itself. Latinos tracing ancestry to "relatively poorer and less stable countries"[13] tend to find themselves with lower levels of economic security in the Boston area. Simply put, not all Latinos in Boston experience equal levels of advantage and disadvantage, making improving equity all the more challenging.

As of 2018, an estimated 10% of Boston's Latino population was aged 60 or older, with an additional 10% age 50-59 and poised to enter later life over the coming decade (see **Figure A3** in **Appendix**). This illustrates that Boston's Latino population is younger than is the case among other racial and ethnic groups. As shown in **Map 3**, older Latinos are concentrated in sections of neighborhoods throughout Boston, including parts of Roslindale and Jamaica Plain, Roxbury, Dorchester, East Boston, Allston-Brighton and others. Areas shaded in rust are those in which more than 18% of the population aged 65 or older is Latino, which is about 50% higher than the share for Boston as a whole (which is 12%).

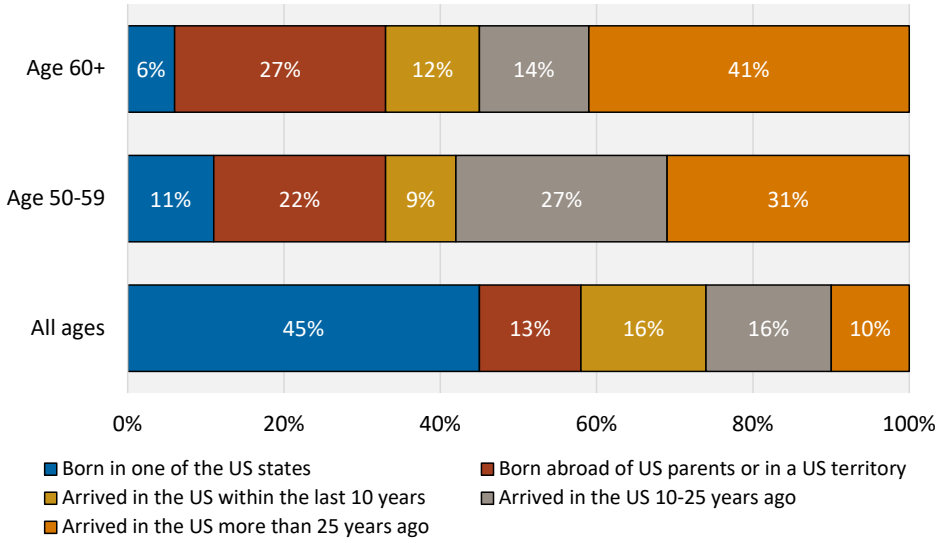
Map 3. Representation of Latino older adults across neighborhoods, Boston



Source: 2018 ACS, 5-year estimates, Table B01001I. Retrieved from https://data.census.gov/cedsci/

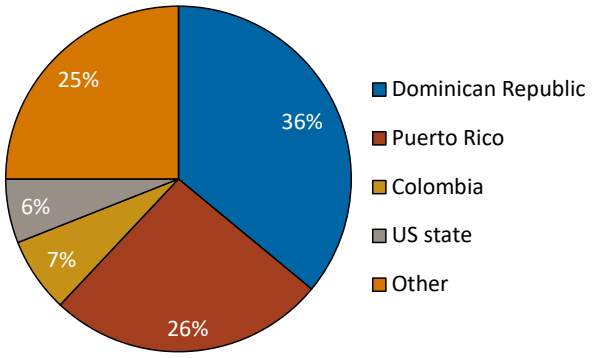
Since 2000, the Latino population in Boston increased from 86,000 to 133,500, and now makes up about 20% of the city's residents (see **Figure 2**, above). Recent projections suggest a rapid increase in the Latino population statewide, with the number of Massachusetts Latinos expected to grow to 1 million by 2030.[14] Although representing a smaller share of the older population—Latinos make up 13% of Boston residents who are age 60 or older—increasing numbers of older Latinos are likely given that nearly one in five Boston residents age 50-59 are Latino and many of these individuals are likely to age in place. The older segments of Boston's Latino population were primarily born outside of the US, with just 6% born in a US state and an additional 27% born in a US territory (e.g., Puerto Rico) or born abroad of US parents (see **Figure 9**). The remaining two-thirds of older Boston Latinos are

Figure 9. Immigration experience among Boston's Latino population



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: The people born abroad of US parents or born in a US territory include those born in Puerto Rico, Guam, and the US Virgin Islands.

Figure 10. Place of birth among Boston's Latino population age 60 or older



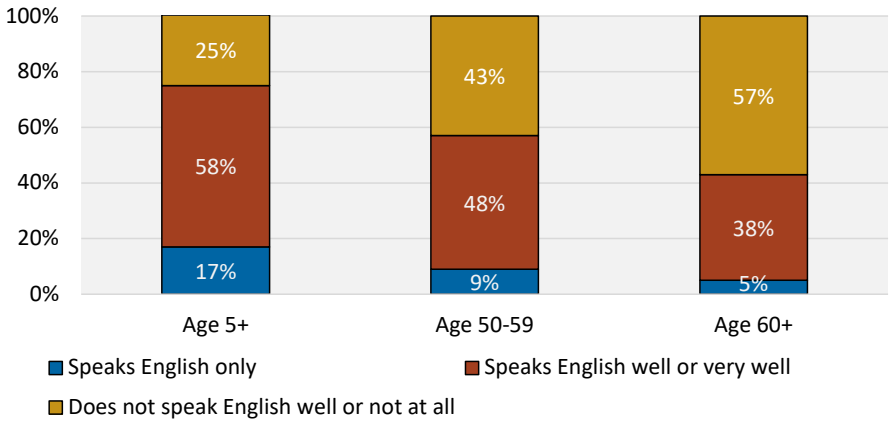
Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: Other includes El Salvador, Mexico, Cuba, other South American country, and other Central American country.

immigrants to the US, most arriving more than 25 years ago. About one-third of Latinos age 60 and over are citizens by birth, while another 43% are naturalized citizens, and the rest (24%) are non-citizens. Currently, Latino residents of Boston who are age 50-59 are less likely than their older counterparts to be naturalized citizens and more likely to be non-citizens.

Among older Boston Latinos, the Dominican Republic is the most heavily represented birthplace, followed by Puerto Rico and Colombia (see **Figure 10**). In comparison, Boston Latinos under the age of 50 are far more likely to have been born in one of the US states (54%, including 41% born in Massachusetts, not shown).

Most of the all-age Boston Latino population speaks English well or exclusively (see **Figure 11**). Yet older age groups have far lower levels of English proficiency, possibly owing to the high representation of immigrants in these age groups. Among those age 60 and older, 57% do not speak English well, or do not speak it at all; the proportion for those age 50-59 is 43%. Many older Latinos in Boston are linguistically isolated in that they live in a home without anyone over age 14 speaking English well, including one-third of Latino Bostonians aged 50-59, and more than half (54%) of those age 60 or older. Virtually all older Latinos in Boston who are linguistically isolated speak Spanish. However, equitable aging policies and practices must address linguistic diversity across Latino ethnic groups. Not all Latinos speak Spanish fluently, different Spanish dialects are spoken, and some immigrants from Latin American countries speak Indigenous languages.[15]

Figure 11. English proficiency among Boston's Latino population



Source: 2018 ACS, 5-year file, retrieved through IPUMS.

The older Native American population in Massachusetts

An accurate census tracking of people of Native American ancestry requires careful consideration of the history of deliberate ethnocide endured by the Native American population. Counting Native Americans as only those who consider themselves *solely* American Indian/Alaskan Native misrepresents the population's breadth and diversity by excluding multiracial people who identify as Native American along with another race. To illustrate, as of 2018, nearly 47,000 Massachusetts residents were estimated to be American Indian or Alaskan Native alone or in combination with another race. Of these, under 15,000 reported Native American as their *only* race, highlighting the multiracial character of this population. Accordingly, to obtain a more accurate reflection of people who self-identify as Native American, this report considers the Native American population to include anyone identified as American Indian or Alaskan Native alone or in combination with another race, including those who also indicate Latino ethnicity.

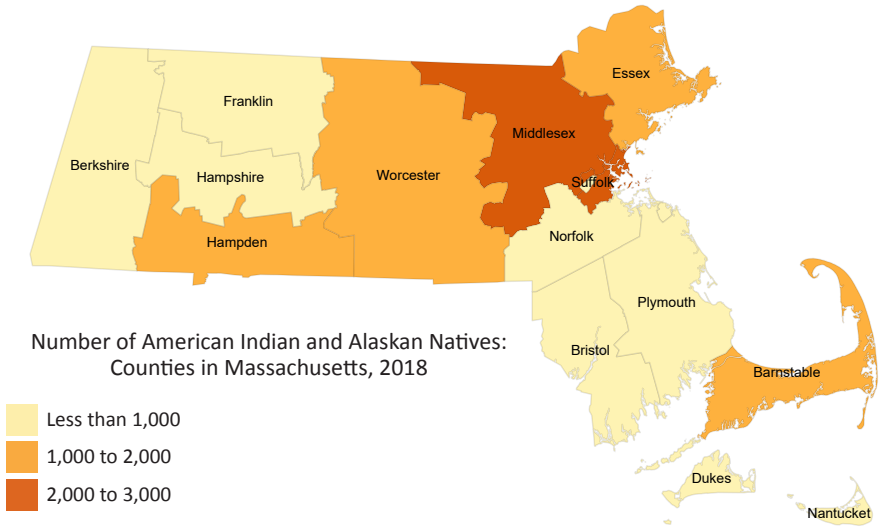
Native Americans are a small percentage of the city's population (0.9 percent), yet Boston's Native American population is the largest among Massachusetts cities.[16] While small, this Native population is characterized by a high degree of diverse Indigenous origins. In fact, according to self-reported data, there are just as many, or possibly more, Native Peoples in Boston who hail from outside the region as there are Natives descended from local tribes. The largest of these expatriate Native communities consists of Mi'kmaq and other First Nations Peoples from the Maritimes of Canada, whose longstanding presence leads some to consider Boston part of their homelands almost as much as the Maritimes.[17,18] Boston's urban Indian population is continually evolving, as new indigenous groups, such as the Maya from Guatemala's highlands, settle in this and other urban areas of the Commonwealth.[19]

Due to limited availability of data on the Native American population living in Boston, this report draws upon state-level data. The all-age Native American population is dispersed throughout Massachusetts, but numerically most prevalent in Suffolk and Middlesex counties (see **Map 4**). Indeed, Boston is considered a central hub to which people of many native/indigenous groups travel to access services. Organizations such as the North American Indian Center of Boston have been developed to support this increasingly diverse population.

As of 2018, an estimated 15% of the Native population of Massachusetts was age 60 or older, reflecting a slightly younger population than in some other groups. However, an additional 14% of this population is aged 50-59, suggesting that the older population may increase moving forward (see **Figure A4** in **Appendix**).

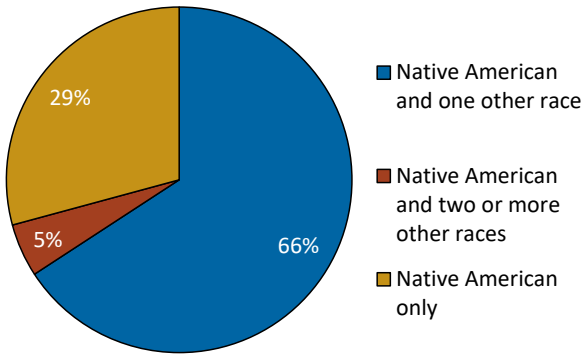
Among Massachusetts residents age 60 or older who identify as Native American, most report an additional

Map 4. Representation of Native American population across counties, Massachusetts



Source: 2018 ACS, 5-year estimates, Table B01001E. Retrieved from https://data.census.gov/cedsci/

Figure 12. Racial background of Massachusetts' Native American population aged 60 or older



Source: 2018 ACS, 5-year file, retrieved through IPUMS.

race and/or Latino background. As shown in **Figure 12**, 29% report Native American as their only racial identity. Sixty-six percent report one other race in addition to Native American, and 5% report two or more additional races along with Native American. The most common additional race reported is non-Hispanic White. Twelve percent of older Native Americans in Massachusetts also report Latino heritage.

The Native population in Massachusetts has increased from 41,500 in 2000 to nearly 47,000 in 2018. A large majority of Native Americans are US-born, but a small share are migrants to the US, arriving primarily from Latin America or Canada. Among the Massachusetts Native population aged 50 and older, 5% migrated over 25 years ago and nearly all are US citizens.

Given that a majority of the Native population is US-born, it is not surprising that nearly all Native Americans in Massachusetts speak English well or exclusively. Eight out of ten older Native individuals speak English only, with an additional 12% being bilingual—speaking another language at home but also speaking English well or very well. However, 7% of the Native population age 60 or older does not speak English well, or not at all. Most of the older Native individuals who do not speak English well report that they speak Spanish at home.

Making Progress through the Age-Friendly Boston Initiative

"Celebrating What Unites Us" is a cooking series that celebrates the immigrant experience and healthy aging through culture and food. In partnership with the Office of Food Access, Office of Immigrant Advancement, the Kitchen at the Boston Public Market, and Armenian Heritage Park, the ongoing series has covered cuisine and culture from Italy, Ireland, East Asia, West Africa, and many other regions. Attendance averages between 75-100 people for each class and the classes are aired regularly on Boston City TV.

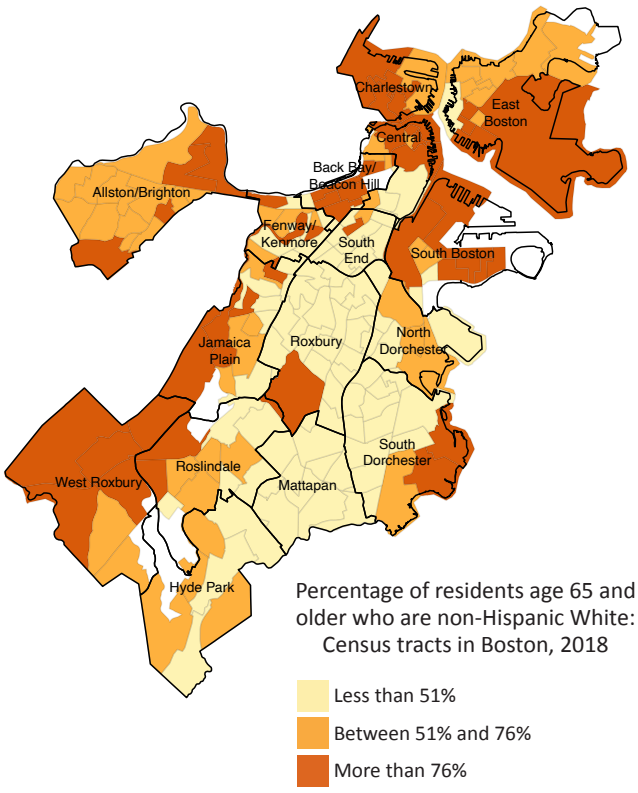
Boston's older non-Hispanic White population

A plurality of Boston residents is non-Hispanic White. Yet this segment no longer represents a *majority* of the population, and an estimated 45% of all-age Boston residents fall into this category. This population is culturally diverse, with many tracing their heritage to European backgrounds and origins around the world, in Boston including most frequently Irish or Italian heritage. As of 2018, an estimated 18% of the non-Hispanic White population was aged 60 or older, with an additional 11% age 50-59. Of all the groups identified in this report, this group is most heavily impacted by the college age/young professional age group, with 48% falling between the ages of 20 and 39 (see **Figure A5** in **Appendix**). As shown in **Map 5**, older non-Hispanic Whites are concentrated in neighborhoods on the edges of Boston, including northern neighborhoods such as Charlestown and East Boston, and western neighborhoods including West Roxbury and parts of Jamaica Plain. Other concentrations are present in Back Bay/Beacon Hill, South Boston, and sections of Roxbury and South Dorchester. Area shaded in a rust color are those in which more than 76% of the population age 65 or older is White and not Hispanic, which is about 50% higher than the share in Boston as a whole (at 50%).

The number of older individuals in Boston who are non-Hispanic White has increased somewhat in recent decades, rising from nearly 289,000 in 2000 to over 302,000 in 2018. Growth in this population largely includes US-born people (see **Figure 13**) and most are US-born citizens. However, 4% of non-Hispanic Whites age 60 or older and 6% of those age 50-59 are not US citizens.

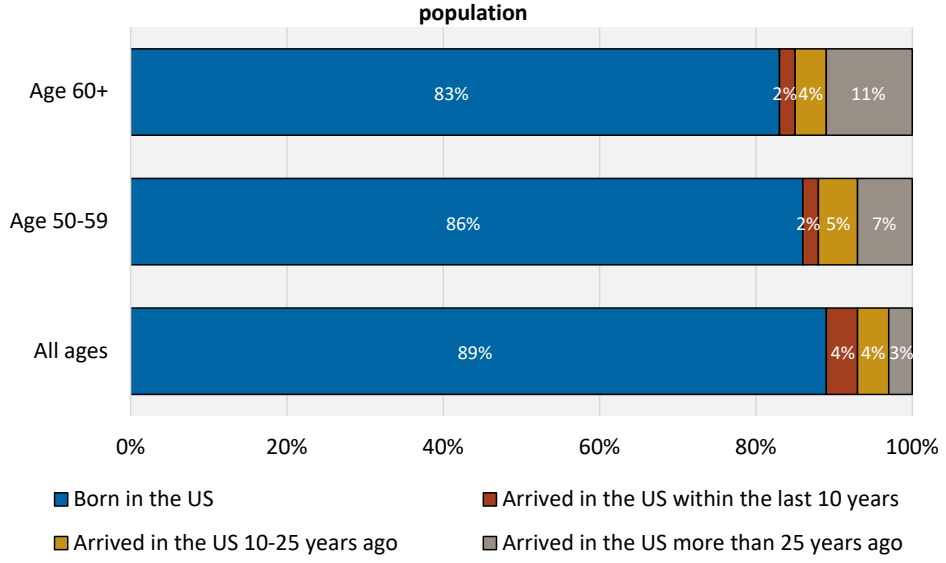
No doubt due to the relatively few immigrants among today's older members of Boston's non-Hispanic White population, coupled with long residence in the US among those who are not US-born, most older Boston residents in this group speak English only, or speak it well or very well. Among older non-Hispanic Whites in Boston, only 5% speak English poorly or not at all. Among those who do not speak English well, half speak Russian at home, and an additional 13% speak Italian.

Map 5. Representation of non–Hispanic White older adults across neighborhoods, Boston



Source: 2018 ACS, 5-year estimates, Table B01001H.
Retrieved from https://data.census.gov/cedsci/

Figure 13. Immigration experience among Boston's non-Hispanic White population



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: Boston's US-born Native American population includes a small share (2%) of people born abroad of US parents or born in a US territory including Puerto Rico, Guam, and the US Virgin Islands.

Dimensions of aging equity

What would equitable aging look like in Boston? How would equitable opportunities for healthy aging be reflected across populations? These questions have no easy answers. The familiar concept of health equity is conceptualized as people experiencing "a fair opportunity to attain their full health potential."[20] However, when considering older adults, substantial disparities in health and well-being are already in place before entering later life and difficult or impossible to entirely reverse. Indeed, much of what we document in this report with respect to disparities in later life—in resources, in health, or in social engagement—reflects experiences that have accumulated over a lifetime.[21] High burdens of disease and low economic security in later life can result from a childhood spent in unhealthy environments, from poor educational experiences, from blocked employment opportunities throughout one's working years, and from inadequate and low quality medical care over a lifetime. When we see disparities between racial or ethnic groups in financial resources in retirement, for example, we are seeing the result of patterned differences in the accumulation of resources and experiences over the life course, differences that are structured by systemic racism, discrimination, and bias.

An equitable aging environment offers people access to services, programs, and supports that promote health and well-being in later life on an equitable basis—no matter who they are or what their current situation is. Because disparities in later life reflect inequalities cumulating from birth, equity efforts in older populations are about "leveling the playing field" for older residents, eliminating sources of bias and disadvantage that continue to amplify late-life disparities. Steps for building equity in aging include ensuring that people have equal access to local amenities and resources; aligning features of the environment with the population living there; and locating public resources equitably across neighborhoods. Understanding these factors using an equity lens can shape decisions about how to effectively leverage local resources and services to create a more equitable environment for all older adults to age well.

For a city like Boston whose aging population is highly multiethnic and multicultural, cultural responsiveness is a critical piece of the aging equity landscape. This can encompass a variety of factors, such as ensuring that information and services are available in residents' primary languages, incorporating culturally-specific food and activities into programming for elders, and sensitivity to the ways in which different cultures approach aging and elder care.

Disparities in survivorship shape the older population

When comparing groups of people who are age 60 or older, we are comparing people who have *survived* to later life, which itself is a reflection of health disparity. Estimates from the Boston Department of Public Health (2015) indicate that Asian Americans have the longest expectation of life at birth in Boston (86.9 years), followed by Latinos (83.3), non-Hispanic Whites (79.5) and Blacks (77.6).[22] These figures make clear that Blacks are at far higher risk of premature mortality. A larger share of Blacks than any other group do not reach age 60 at all. The comparisons offered in this report reflect what we see when we compare survivors – a partial view of the implications of racial and ethnic disparities.

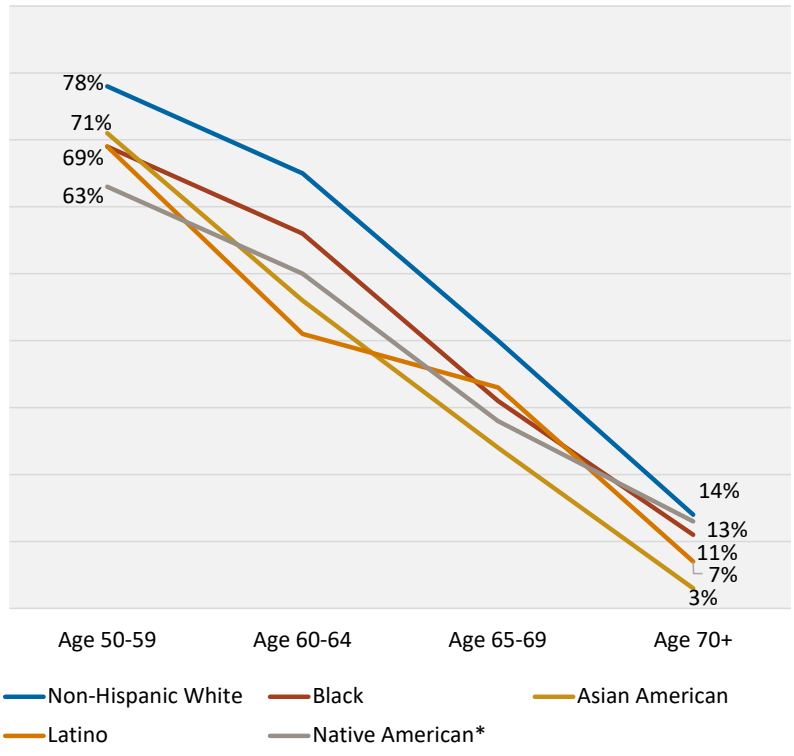
Socioeconomic resources and income adequacy

Most people experience flat or declining income profiles in later life. Opportunities to increase one's income dissipate as paid work commitments are reduced or discontinued, yet most expenses increase over time, such as rent payments, property taxes, and the cost of fuel or food. Some expenses may increase dramatically, especially if complex healthcare needs emerge involving higher medical costs. As incomes flatten or erode, covering expenses necessary for healthy aging becomes more difficult, including not only costs of healthcare and medications but also other social determinants of health such as adequate housing and a nutritious diet.

Income and employment

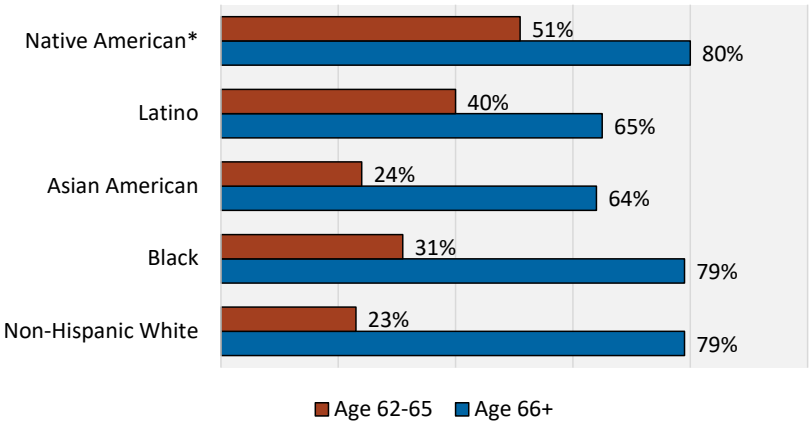
Most adults rely on employment for a sizable share of their incomes, and for many that persists well into later life. As shown in **Figure 14**, most Boston residents age 50-59 work for pay and generate wage income. Gaps among groups in this age range suggest disparities occur well before conventional retirement age, with persons who are non-Hispanic White having the highest rates of employment (78%) and Native Americans the lowest, at 63%. Among people in their early 60s, even more sizable gaps in employment open up. Nearly two-thirds of people who are non-Hispanic White are working in that age group, compared to 41% of Latinos. Employment rates decline substantially beyond age 65 but involvement in paid work continues for many. Data sufficient to determine the factors behind these patterns are not available, but the research literature suggests that early exits from the labor force may result from the onset of disability, from difficulty finding new work following job loss, or when facing competing demands on one's time such as the need to serve as caregiver for a spouse or parent. In any event, it is clear that employment income is less available to older persons of color than to non-Hispanic White Boston residents. Gaps by gender are also notable, with women having lower rates of employment than their male counterparts across most age groups. These intersectional identities impact work patterns into later life, with gender impacting race disparities in employment in somewhat

Figure 14. Percentage employed, by age group and race, Boston



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 50 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

Figure 15. Percentage receiving Social Security benefits, Boston



Source: 2018 ACS, 5 -year file, retrieved through IPUMS.
Note: Figures refer to the percentage of people for whom Social Security benefits account for 90% or more of all household income. All numbers for individuals not living in group quarters. Boston city population for non -Hispanic Whites, Asian Americans, Blacks, and Latinos.
*Massachusetts population for Native Americans .

distinctive ways (see **Figures A6** and **A7** in **Appendix**). A more in-depth discussion of intersectionality is provided later in this report.

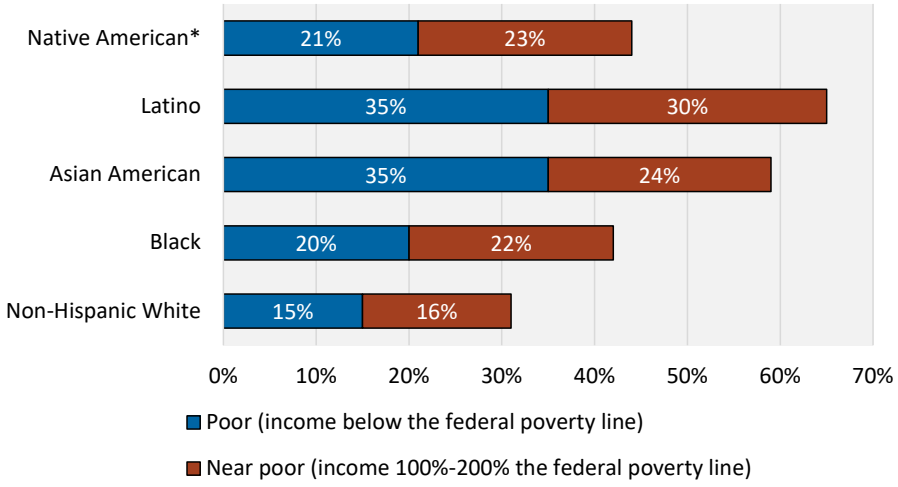
Most older adults are eligible for Social Security benefits, a federal entitlement meant to form part of an older person's retirement income.[23] Eligibility for Social Security is based on a person's contributions to the Social Security system through covered employment. People without necessary legal documentation, or those working in jobs where Social Security deductions are not made, are not eligible to receive Social Security benefits.[24] As well, the formula used to determine the benefit amount is based on annual income of the individual—meaning that those earning less over their lifetimes will receive lower Social Security benefits in retirement. A large share of older adults relies largely or exclusively on Social Security, including an estimated 17% of all Boston residents age **66** or older, and one-third of those age 66 or older who live alone.

To receive Social Security retirement benefits, a person must be at least 62 years old and meet other eligibility requirements. As shown in **Figure 15,** a majority of Boston residents age 66 and older receive Social Security benefits, including about 80% of non-Hispanic Whites, Blacks, and Native Americans. Latinos and Asian Americans lag behind in rates of benefit receipt, possibly due to not meeting work or other eligibility requirements. Many individuals aged 62-65 are already receiving Social Security benefits, including half of Native Americans and 40% of Latinos. Because taking Social Security retirement benefits before age 66 yields a permanent reduction of the monthly benefit amount,[25] for the rest of their lives these individuals will receive less income on a monthly basis through Social Security than they might have if they had delayed. While we cannot know the reasons for early take-up, some of the same issues that push people out of continued employment—unexpected job loss, hours

Making Progress through the Age-Friendly Boston Initiative

Age Strong @Work was a series of three employment workshops hosted by the city. Workshops held in Roxbury included an overview of job opportunities for older workers, skills building, and a job fair where residents could connect with employers. Free professional photos were taken. Over 200 people attended and Spanish translation was available. During the pandemic period, six additional virtual workshops have been hosted by the Age Strong Commission.

Figure 16. Percentage poor and near-poor, Boston residents age 60 and older



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 60 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

cutbacks, disability, or needing to provide unpaid care for others—are known to push people into taking early benefits.

Despite many older Bostonians continuing to work, and most receiving Social Security benefits at least by the time they are age 66, a sizable share has low income. Persons of color have especially high rates of poverty, with more than one-third of older Latinos and Asian Americans living in households with incomes below the federal poverty line[26] along with 21% of Native Americans, 20% of Blacks, and 15% of non-Hispanic Whites (see **Figure 16**). Another sizable share lives above the poverty line but below 200% of the FPL, the so-called "near poor." With the inclusion of the near-poor, well over half of the older Latino and Asian American populations live below 200% of the FPL. Older women—and especially women of color—are at especially high risk of poverty and near-poverty (see **Figures A8** and **A9** in **Appendix**): 71% of Latino women, 60% of Asian American women, 46% of Native American women and 45% of Black women live in households with incomes below 200% of the FPL, along with 35% of their non-Hispanic White female counterparts.

These figures, stark as they are, do not take into account the very high cost of living in Boston. Housing and other essentials are expensive, stretching the monthly budget of many individuals and families but perhaps especially those who are older and living on a fixed income. The Elder Index, a cost of living measure calculated county-by-county for older singles and couples, identifies Suffolk County is one of the ten most expensive counties in the nation for singles and couples age 65+[27,28] and suggests that a large share of Boston residents have incomes that fall short of what is needed to get by. In Boston, as elsewhere throughout Massachusetts and the nation, persons of color are at especially high risk of being economically insecure.[29]

Making Progress through the Age-Friendly Boston Initiative

In an effort to alleviate economic demands for all older adults in Boston, the Mayor proposed and the City Council approved an increase for the work-off credit maximum for the city's Senior Property Tax Work-Off Program from $1000 to $1500 beginning in 2018. In order to further address the economic burden created by property taxes, the Age Strong Commission created an outreach strategy for sharing tax-relief opportunities with older adults, including the Senior Circuit Breaker tax credit, senior abatements, and the Property Tax Work-Off Program. Commission staff have made a concerted effort to expand outreach through deepening connections in the community and sharing these resources with partners. Continuing to identify ways to ease the burden of housing costs for renters in the city remains a priority.

Housing and homeownership

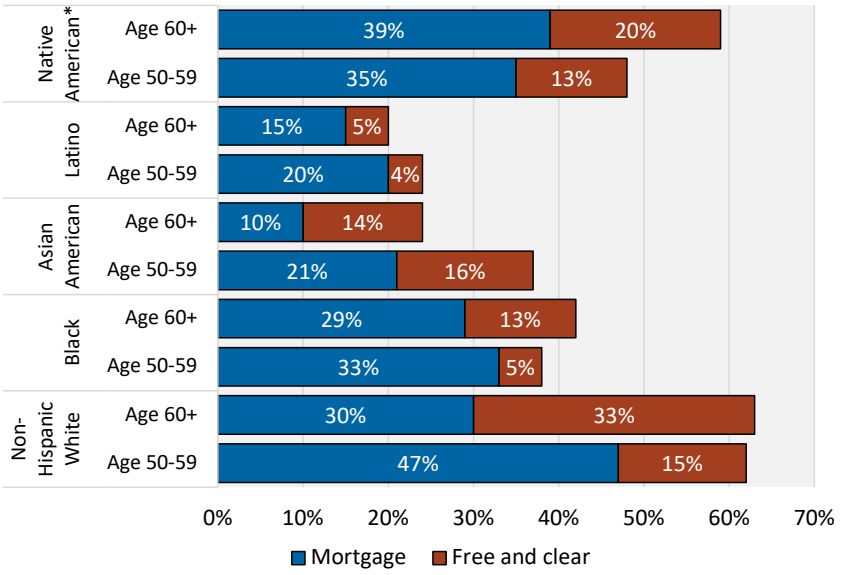
Boston is a city of renters, and nearly two-thirds of all Boston households rent rather than own their homes. Yet this characterization is less accurate among older residents of Boston, who make up the bulk of Boston's homeowners. Indeed, over one-third of Boston's homeowners are age 60 or older, and another 22% are age 50-59. In contrast, just one-third of Boston renters are age 50 or older, highlighting the age gap in homeownership.[30]

Almost half (48%) of householders age 60 or older are homeowners in Boston, a far higher rate of homeownership than is seen among younger residents. Yet homeownership is far more prevalent among people who are non-Hispanic White than among persons of color. As illustrated in **Figure 17**, more than 60% of Boston non-Hispanic Whites age 50+ own a home. Large shares of older Native Americans also own their homes, although recall that these figures are for Massachusetts as a whole rather than just in Boston. Among the other groups profiled, fewer than half are homeowners, with rates as low as 20% among Latinos age 60 or older.

Homeownership patterns are notable because of the residential stability that homeownership can bring, and also because for most families, the value of their owned home represents their single largest asset. The low rates of homeownership seen in Boston among older persons of color, especially older Asian Americans and Latinos, suggests that these groups may have little wealth to draw on as they grow older.[31,32]

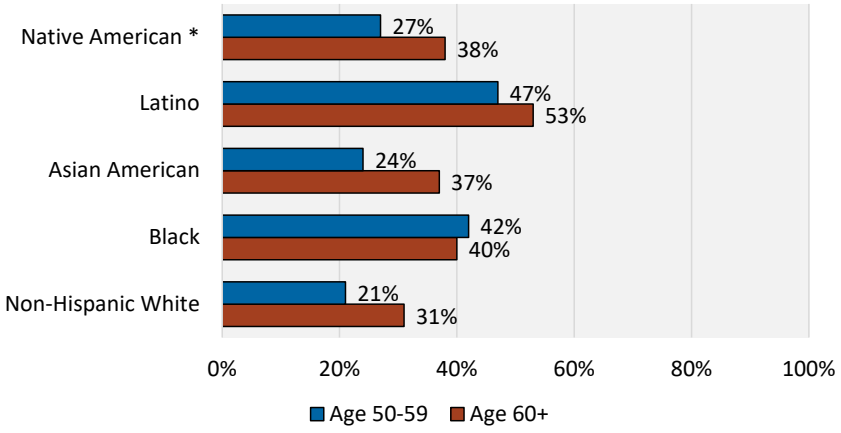
Whether owning or renting, housing in Boston is expensive and this can place a special burden on older people, many of whom are living on a limited income. One factor contributing to housing costs is the fact that many older homeowners are still carrying a mortgage, including most homeowner groups described in **Figure 17**. Households are considered "cost-burdened" if they pay more than 30% of their income for housing, with housing costs including not only a mortgage or rent but also property tax, home insurance, and utilities.[33] Among older Boston households, renters and persons of color are more likely to be cost-burdened than owners and persons who are non-Hispanic White. Moreover, the risk of being cost-burdened is typically higher among people age 60 or

Figure 17. Percentage of householders who are homeowners, by mortgage status, Boston



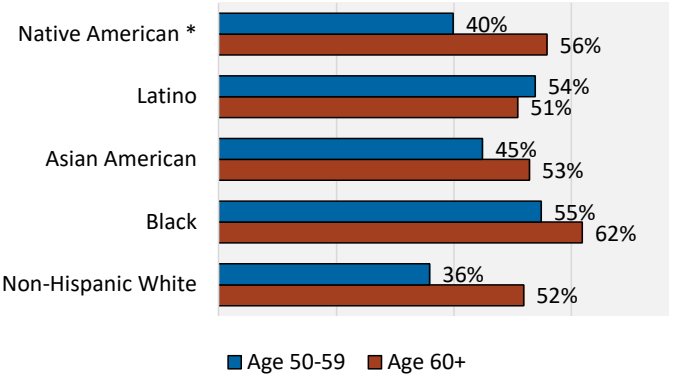
Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: Figures refer to Boston's householders age 50+. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

Figure 18. Percentage of Boston homeowners paying more than 30% of income for housing



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: Figures refer to Boston's homeowners age 50+ with positive household costs and income for non-Hispanic Whites, Asian Americans, Blacks and Latinos. *For Native American householders age 50+ with same characteristics in Massachusetts.

Figure 19. Percentage of Boston renters paying more than 30% of income for housing



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: Figures refer to Boston's householders age 50+ who rent their homes and have positive household costs and income for non-Hispanic Whites, Asian Americans, Blacks and Latinos. *For Native American householders age 50+ with same characteristics in Massachusetts.

older than among those age 50-59. As shown in **Figure 18**, 21% of non-Hispanic White homeowners age 50-59 pay at least 30% of their income for housing, a figure that jumps to 31% among non-Hispanic White homeowners age 60 or older. High rates of cost-burden are seen especially among persons of color who are age 60 or older, among whom 37% of Asian American, 38% of Native American, 40% of Black, and 53% of Latino homeowners pay at least 30% of their income for housing.

Cost burden is even higher among older renters (see **Figure 19**). Over half of renters age 60 or older pay at least 30% of their income for housing, including 51% of Latino, 52% of non-Hispanic White, 53% of Asian American, 56% of Native American, and 62% of Black renters. Rates of cost burden are somewhat lower among renters age 50-59, but remain at high levels among most groups. Although high cost burden impacts renters across the board, given that older persons of color in Boston are more likely than non-Hispanic Whites to be renters, they are more heavily impacted by these patterns.

Health and disability

Expanded lifetimes are frequently accompanied by elevated exposure to health declines, chronic conditions and disability. However, these risks are unevenly experienced, and health disparities that accumulate throughout the life course persist into later life. As a result, some older populations are more vulnerable to experiencing poor health or disability. These differences can shape people's ability to engage with their communities and remain active, with implications for their ability to avoid isolation. As well, people with poor health and many chronic health conditions may have higher healthcare expenditures, and be less able to continue working, contributing to their economic insecurity.

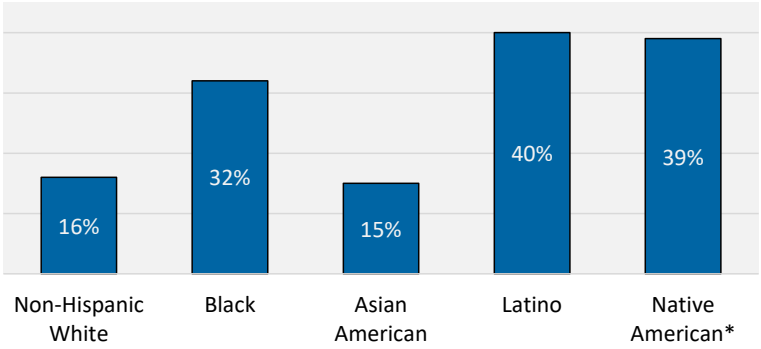
The scientific literature demonstrates that some persons of color, especially Blacks, Latinos, and Native Americans, report poor health relative to non-Hispanic Whites.[34] Yet considerable differences are observed within communities of color as well. Disadvantaged health statuses are documented for some segments of the older Asian American population (e.g., Vietnamese),[35] while other Asian American origin groups are shown to have better health on average (e.g., Japanese).[36] Similarly, while it has been well-documented that Latinos have higher rates of type 2 diabetes than non-Hispanic populations, Mexicans and Puerto Ricans have higher rates of diabetes than South Americans.[37,38]

Data from the Boston Public Health Commission[39] documents substantial health disparities by race and ethnicity along a wide range of indicators, but almost no comparisons are published specifically for older adults. Many documented disparities are relevant to health in later life, however. For example, Black and Latino residents are more likely to struggle with asthma, diabetes, hypertension, and obesity compared to non-Hispanic White residents, whereas Asian Americans are less likely to struggle with these conditions. Left untreated, these health conditions have lifelong impacts on well-being and functioning, and contribute to shortened life. In addition, Black and Latino residents of Boston are more likely to report having been emotionally impacted by race-related treatment in the previous month, an experience linked statistically with higher risk of persistent anxiety and sadness. The research literature is clear that experiencing racism heightens stress and negatively impacts health, with lifelong consequences.[40]

Self-rated health, a global indicator of health status that is highly correlated with clinically assessed health status,[41] suggests sizable disparities in health among older residents of Boston. As shown in **Figure 20**, one-third of Boston residents age 50 or older who are Black report their health as "fair" or "poor," as do four out of ten Latinos and Native Americans. This suggests worse health status in these groups compared to non-Hispanic Whites and Asian Americans, among whom 16% and 15% report fair or poor health, respectively.

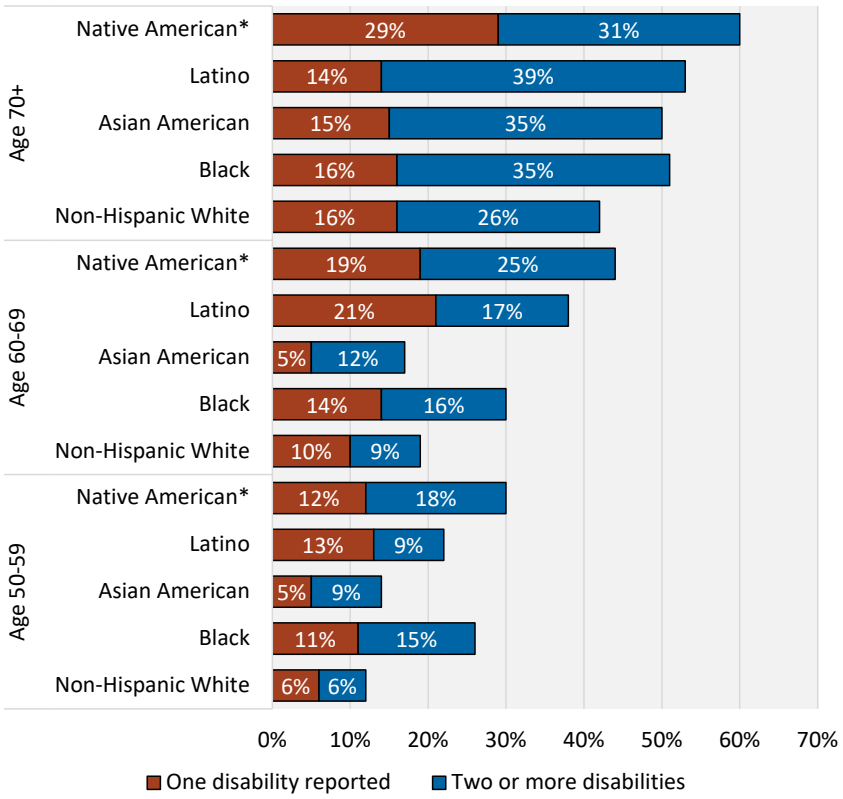
Disparities in disability are also significant in later life. At any point throughout the life-course a person may acquire a health condition or experience a functional limitation that impacts their ability to do some things, like manage stairs or go outside on their own. Some disabling conditions may require assistance through technology or equipment (e.g., use of a cane), while others may

Figure 20. Percentage of Boston residents age 50 and older reporting poor or fair health



Source: 2014-2018 CPS (March), retrieved through IPUMS.
Note: All numbers for individuals age 50+ not living in group quarters. Boston population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

Figure 21. Percentage with disability, community dwelling Boston residents



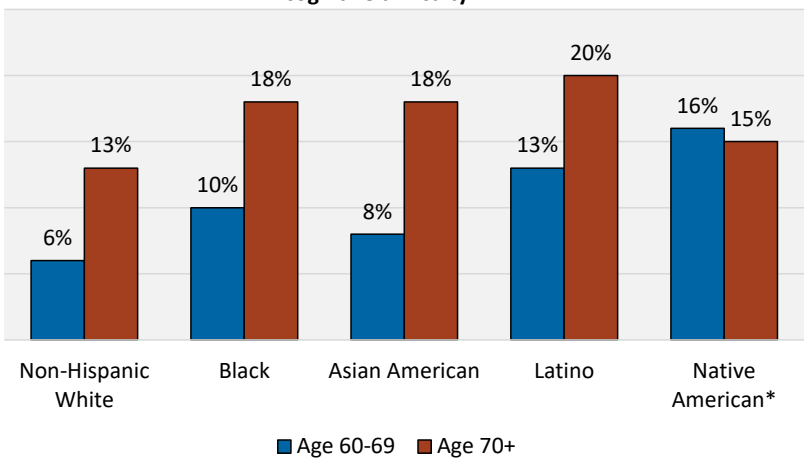
Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 50 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

require personal assistance (e.g., not being able to dress or bathe oneself). A person with a severe disability may encounter substantial limitations on participating in their community. Nationwide, sizable disparities in disability rates occur in later life, and rates are especially high among Blacks, Hispanics and Native Americans.[42,43]

Evidence from the American Community Survey show that in Boston, disability rates differ by age and race. Within every racial category, disability rates increase across age groups. For example, 22% of Boston Latinos aged 50-59 report one or more disability, compared to 53% of Latinos aged 70 or older (see **Figure 21**). Within age groups, disability rates are lowest among non-Hispanic Whites and Asian Americans, and higher among Native Americans, Latinos, and Blacks. For example, among those age 60-69, 17% of Asian Americans and 19% of non-Hispanic Whites have a disability, compared to 30% of Blacks, 38% of Latinos, and 44% of Native Americans. Non-Hispanic Whites and Asian Americans have comparatively low levels of disability—under 20%—among those age 50-69 with levels becoming more substantial among those age 70 or older. In contrast, levels of disability are already high at younger ages for Blacks, Latinos, and Native Americans. Indeed, for these three groups disability rates are higher among those age 50-59 than among Asian Americans and non-Hispanic Whites who are ten years older—age 60-69—suggesting an earlier onset of disability among these groups. Moreover, highlighting the significance of intersectional identities, disability rates are considerably higher for women, and especially for women of color (see **Figure A10** in **Appendix**). As a particularly stark example, we estimate that 45% of Boston Latinas age 60-69 have a disability, compared to 29% of same-age Latinos and just 19% of same-age non-Hispanic Whites. These disparities may have implications for the ability to continue to work and accumulate retirement resources that disproportionately impact not only persons of color in Boston, but especially those who are also women.

Among all groups profiled here, the most common type of disability reported is having difficulty walking or climbing stairs (ambulatory difficulty), reported by 20% of non-Hispanic Whites, 24% of Asian Americans, 30% of Blacks

Figure 22. Percentage of Boston residents age 60 or older reporting cognitive difficulty



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 60 or older not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

and Latinos, and one-third of Native Americans. Also frequently reported is "independent living difficulty," or difficulty doing errands alone such as visiting a doctor's office or shopping, which is reported by 13% of older non-Hispanic Whites and 17-19% of older persons of color. These types of disability can impact people's ability to get out of the house, socialize, and participate in meaningful activities.

Cognitive decline, including Alzheimer's disease and other forms of dementia, is another health-related risk that increases with age.[44] National estimates suggest that as many as 5.8 million people are living with Alzheimer's dementia right now, with numbers expected to increase to 13.8 million by 2050.[45] Data from the Massachusetts Healthy Aging Data Report suggest that 15.8% of Boston residents age 65+ have Alzheimer's disease or a related dementia, equivalent to 13,000 people.[46] Although risk of dementia is widespread, Blacks and Native Americans appear to have especially high incidence levels.[47] The causes of these ethnic/racial differences in dementia incidence are poorly understood, but they may be related in part to sociocultural differences and biases embedded within screening tools, diagnosis and treatment.[48] Rates of dementia for older people across race and ethnic groups are not available for Boston. However, the American Community Survey includes a self-reported item on having cognitive difficulty (defined as having difficulty remembering, concentrating, or making decisions because of a physical, mental, or emotional problem). This indicator suggests that persons of color in Boston may experience higher rates of cognitive impairment (see **Figure 22**), which for some may indicate a form of dementia.

Massachusetts residents benefit from many programs meant to ensure that people have access to medical care

Making Progress through the Age-Friendly Boston Initiative

For people living in the city with dementia and their care partners, feeling left out and misunderstood can exacerbate an already stressful set of circumstances. In order to improve the experience of persons and families living with dementia, the Age Strong Commission developed a short customer service training that includes communication techniques for working with individuals with cognitive impairment. To date, nearly 600 city staff who work directly with the public have received the training in hopes of improving the experience of persons with dementia in accessing city information and resources. Additionally, the City of Boston is supporting four memory cafés—free social programs for people living with dementia and their loved ones, one of which is a Spanish-speaking café. As memory cafés expand, programming is being sited in locations that are underserved and represent gap areas for senior programming in Boston.

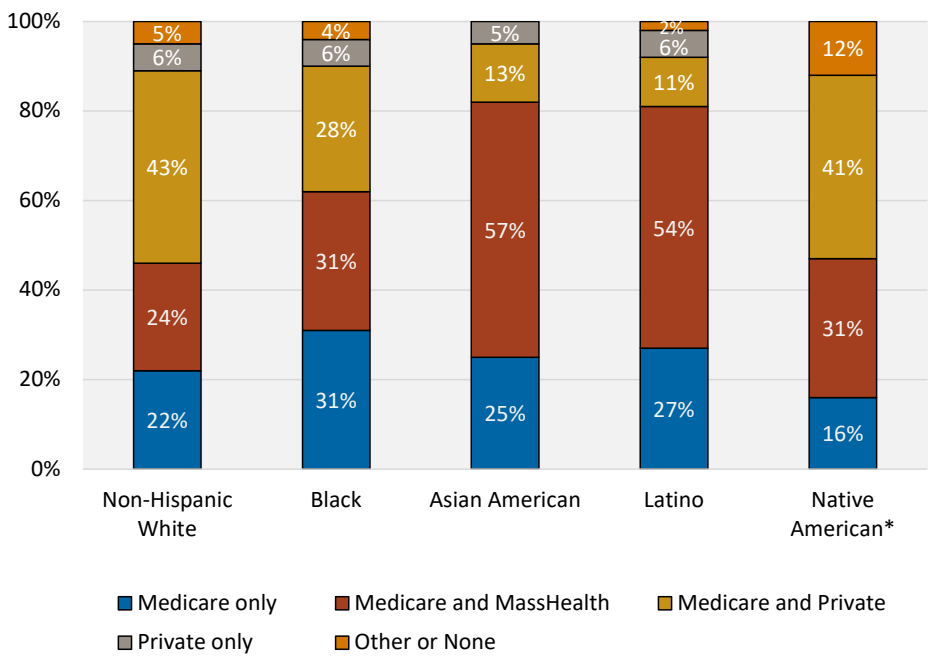
Encountering COVID-19: Boston's older Black community navigates the pandemic

Kwame Benjamin was a healthy seventy-year-old African American male. He lived in Jamaica Plain, Boston with his sixty-nine-year-old wife Ana, who was of Cape Verdean descent. In early April 2020, he received unfortunate news that his ninety-one-year-old father, Azizwe, was ill with symptoms of COVID-19. This was somewhat surprising—Azizwe worked out regularly and his callisthenic prowess was the envy of persons half his age. A close-knit family, Kwame, Ana and several other family members, including his son Kwezi, drove to New Jersey to visit his father. Azizwe was soon diagnosed with COVID-19. Shortly after their return to Boston, Kwame and Ana both became terribly sick themselves with COVID-19 symptoms.

Kwezi was troubled. The moment was chaotic—increased information was coming out about the disproportionate impact of COVID-19 on Black communities in Boston. Aside from this visit to New Jersey, he had gone to extreme lengths to social distance. He possessed the often-healthy suspicion that persons of African descent have about systemic racism in the American medical establishment. In discussing alternative health measures for his ailing parents, a Haitian friend suggested that his parents drink tea made from the plant cerasee, a strong herbal medicine that is popular in the Caribbean for a variety of ailments. This friend had used the tea for years and had in fact done so to stave off flu-like ailments, and had done so recently amidst concerns of being infected with COVID-19. Kwezi was convinced, but he was at loss as to how he could first find and then deliver cerasee to his parents in Boston. Amazon promised delivery over several days, but he did not think it wise to wait that long. Instead, he reached out to another West Indian friend who lived in Boston, and, ironically, knew exactly where to find the plant at a local Afro-Caribbean market. The next morning, a package of teas was safely delivered to Kwame's front door. He and Ana recovered over the next week. Unfortunately, Azizwe passed away.

This story captures the complexities in the impact of COVID-19 on Boston's aging Black communities. It is a generational narrative of deep cultural knowledge, Black Diaspora linkages, social technologies, anxiety toward the medical establishment, interfamilial questions of risk vs. reward, healing traditions and family kinship networks that stretch far beyond the physical and conceptual boundaries of Massachusetts. To understand the experiences of aging Black communities, one has to engage the broader cultural and social matrix of Black life that marks this demographic.

Figure 23. Insurance coverage and type: Boston residents aged 65 and older



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 65 and older not living in group quarters. Boston city population for non-Hispanic White, Black, Asian American and Latinos. *Massachusetts population for Native Americans.

and to health insurance that helps pay for it. Indeed, few older adults in Boston lack health insurance entirely—just 1% among those age 65 and older are not covered by insurance at all. The foundation of insurance coverage in later life for millions of Americans is Medicare, the federal entitlement program in which more than 90% of Boston residents age 65 and older participate. Having supplemental insurance coverage is important, however, because Medicare doesn't cover all necessary medical expenses (for example, traditional Medicare doesn't cover prescription drugs), and those with high medical needs, in particular, can find themselves struggling with very high out-of-pocket costs. Yet three out of ten older Blacks in Boston have only Medicare, compared to about one-quarter of most of the other groups and 16% of Native Americans (see **Figure 23**). Massachusetts residents with low income and few assets are eligible for MassHealth (Medicaid) as well as Medicare. In Boston, a large share of people aged 65 or older are covered by both Medicare and MassHealth, including more than half of Asian Americans and Latinos, nearly one-third of Native Americans and Blacks, and about one-quarter of non-Hispanic Whites. More than 40% of non-Hispanic Whites and Native Americans have both Medicare and private coverage, along with 28% of Blacks. Depending on the type of insurance coverage, an older person may be exposed to higher out-of-pocket expenses, fewer options for obtaining care, or lower quality care.[49]

Native Grandparents Holding Families Together

It was 2010 when Joanne Dunn, Executive Director of the North American Indian Center of Boston (NAICOB) felt compelled to respond to an escalating trend among the local Native American community. More and more, Dunn, a M'iq'M'aq elder and one of many members of the tribe whose families emigrated to Massachusetts from eastern Canada, was being approached by aging community members who had unexpectedly become the primary guardians and caregivers for their grandchildren, often due to domestic violence, substance abuse, incarceration, unemployment and other challenges that plague Native communities at disproportionately high rates. These newly-custodial grandparents felt overwhelmed and unprepared to raise grandchildren already scarred by family fracture and instability. But they were reluctant to seek help from government and mainstream social service agencies, their mistrust based on a history of forced removal policies that separated Native children from their homes and cultures, placing them in cruel boarding schools or the homes of non-Native families. They turned instead to a trusted Native American organization, NAICOB.

Dunn had helped to lead the agency since 1983, and she was determined to find the resources to respond to the emerging set of needs that Native grandparents were bringing to the organization. She decided to apply for funding to the federal Administration for Native Americans, a division of the Department of Health and Human Services. She reached out to the Institute for New England Native American Studies (INENAS) at UMass Boston to partner with NAICOB on the creation of Supporting Caregiver Grandparents, a program that would serve as a hub of information, services and support for Native grandparents raising grandchildren in the area served by the organization.

The program was informed by a needs assessment process intended to gain a fuller picture of the challenges faced by grandparents raising grandchildren in the Native American community. When the INENAS research team analyzed this data, several key themes were apparent. Of the households that participated in this project, a child, parent, or grandparent had an alcohol or drug problem in 36% of families. Substance abuse on the part of a parent was correlated with the reasons grandparents were raising their grandchildren. Most of these grandparents (2/3) were working and others received some federal benefits such as social security (44%) or disability (25%). Only 12.5% received pensions. Only 4% reported receiving any assistance from the Massachusetts Department of Transitional Assistance. These grandparents had many needs for services and resources, including financial assistance, housing access, employment, legal assistance, food stamps, medical care, and transportation. Legal counsel and support was especially critical for grandparents coping with custody issues that involved the state child protection agency. Native grandparents also viewed maintaining connections to Native culture as important to their own and their grandchildren's well-being.[50]

The program's overall perspective is perhaps best exemplified by Joanne Dunn's words on the opening page of the resource guide: *The role of grandparents as caregivers for our children has long been a sacred part of who we are as a People. Today, more than ever, we continue to rely on the goodness and selflessness of our grandparents. They are Mother Earth and Father Sky, they are the Ancestors, and they are our relatives. They represent warmth when it is cold, guidance when we are lost, and love always, unconditionally.*

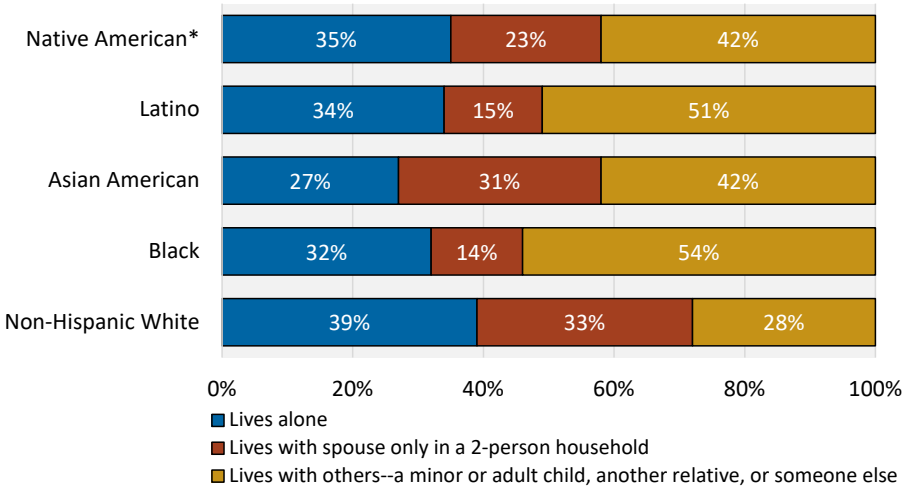
"Grandparents Bridging the Gap" is now a continuing resource offered by NAICOB, available at http://www.naicobfamilyresources.org/. It represents an approach that places care for elders squarely in the context of indigenous culture, in which respect for grandparents and the role they play is paramount.

Social connection and communication

Social isolation is a critical public health issue that is associated with poor mental and physical health and high risk of mortality.[51] Indeed, some research suggests that the health consequences of isolation may be more sizable than that of obesity or smoking.[52] As people age, risk of isolation and its negative consequences may become more pronounced, especially among those with lower socioeconomic status, women, and those who are unmarried or live alone.[53-55] Although our understanding of how these factors shape isolation experiences is incomplete, risk of isolation in the US is also associated with race, immigrant status, and English language proficiency.[56-58]

A large share of older Boston residents lives alone in a one-person household. Considering just the community-residing population (e.g., those not living in nursing homes or other group quarters[59]), nearly four out of ten non-Hispanic White people age 60 or older live alone, along with about one-third of Blacks, Latinos, and Native Americans (see **Figure 24**) and about one out of four older Asian Americans. Many people who live alone are not isolated or lonely, as sizable and supportive networks can be maintained outside one's household. However, as living alone is considered to be a risk factor for isolation, the variability across groups in percentage living alone is notable. Overall, non-Hispanic Whites are far more likely than persons of color to live in a small nuclear household made up of just oneself, or oneself plus a spouse (72%). Fewer than half of Blacks and Latinos live in this type of setting, along with 58% of Asian Americans and Native Americans. The remaining individuals live in households that include someone other than or in addition to their spouse, such as an adult child, a grandchild, a sibling, or a friend. Persons of color are considerably more likely to be living in these "complex" households, including more than half of Latinos and Blacks. For most groups, older women are more likely than their male counterparts to live alone and less likely to live just with a spouse (see **Figures A11** and **A12** in **Appendix**). However, among Massachusetts Native American older adults a larger share of men lives alone than women.

Figure 24. Living arrangements among Boston residents aged 60 or older

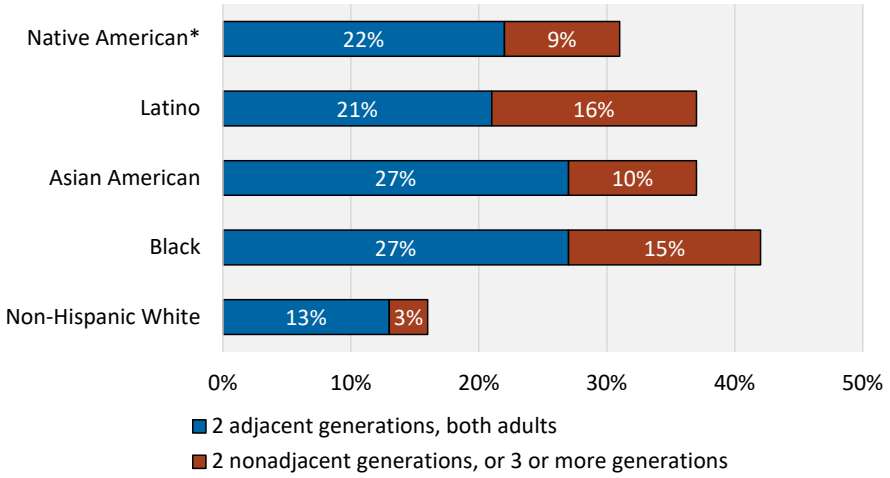


Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 60 and over not living in group quarters. Boston city population for non-Hispanic White, Black, Asian American and Latinos. *Massachusetts population for Native Americans.

Making Progress through the Age-Friendly Boston Initiative

In partnership with the city's Department of Innovative Technology, the Age Strong Commission secured more than 400 tablet computers that were pre-loaded with 3 months of free internet access. These tablets were distributed, via the Commission's partner organizations, to older residents of Boston who were identified as being socially isolated or without access to internet service. Those without access are disproportionally persons of color.

Figure 25. Percentage living in multigenerational households, Boston residents aged 60 or older

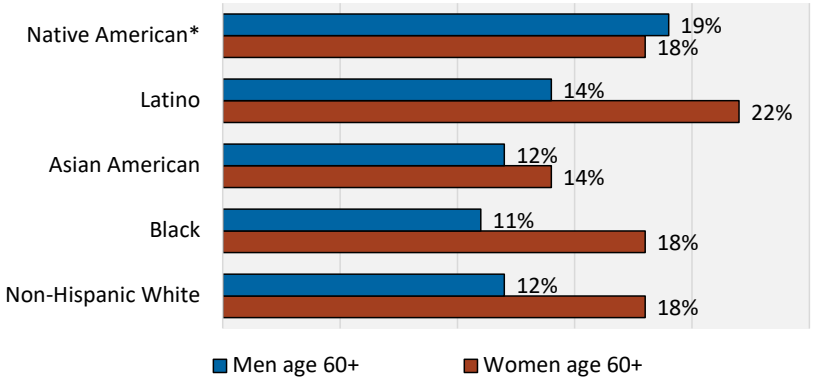


Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note. All numbers for individuals age 60 and over not living in group quarters. Boston city population for non-Hispanic White, Black, Asian American and Latinos. *Massachusetts population for Native Americans.

Many older individuals, especially persons of color, live in multigenerational households. As shown in **Figure 25**, 30-45% of persons of color age 60 or older live in multigenerational households that include either two adjacent adult generations (e.g., an older person living with his adult offspring), three generations (e.g., an older parent, an adult child and a grandchild) or two non-adjacent generations (e.g., an older person living with their grandchild). These types of household structures may reflect economic strategies for dealing with the high cost of living in Boston, a cultural preference for intergenerational living, or other factors shaping mutual support across generations. Although data are not available to evaluate the quality of life promoted in these settings, these arrangements may have implications for risk of isolation.

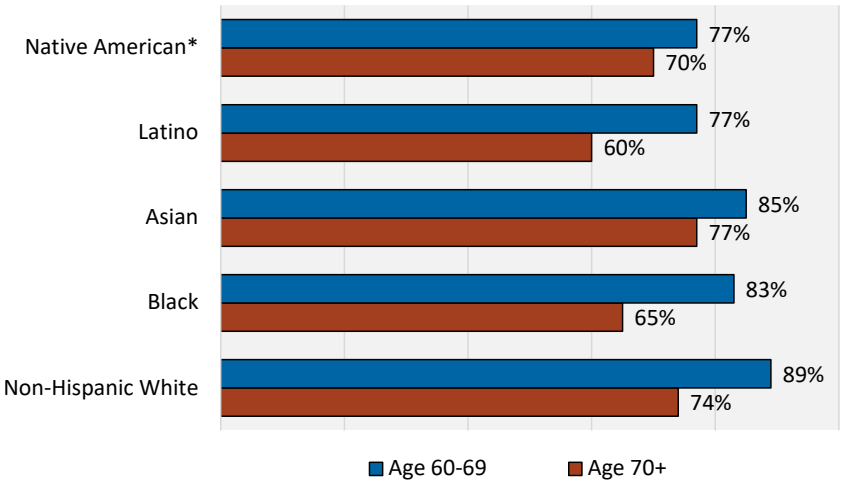
Some grandparents living in multigenerational households are the primary caretakers for minor grandchildren living with them. In some cases, the grandchild's parent is absent (a so-called "skipped generation" household) while in others, the grandchild's parent is also in the three-generation home. Persons of color make up a disproportionate share of grandparents living with and caring for a grandchild. Among Boston residents age 60 or older, an estimated 7-9% of persons of

Figure 26. Percent who live alone and also have at least one disability, Boston residents aged 60 or older



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note. All numbers for individuals age 60 and over not living in group quarters. Boston city population for non-Hispanic White, Black, Asian American and Latinos. *Massachusetts population for Native Americans.

Figure 27. Percentage with internet access at home, Boston residents



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note. All numbers for individuals age 60 and over not living in group quarters. Boston city population for non-Hispanic White, Black, Asian American and Latinos. *Massachusetts population for Native Americans.

color live with a grandchild, compared to 2% of their non-Hispanic White counterparts. Black and Native American grandparents are especially likely to be caretakers for co-resident grandchildren. Culturally appropriate supports are essential for grandparents who play this critical role in their families.

Isolation may be more common if a person experiences a combination of risk factors, including not just living alone but also having other characteristics that may place them at risk. **Figure 26** illustrates the percentage of Boston residents age 60 or older who both live alone and have at least one disability that may impact their ability to engage with the community or readily interact with others. Taking these attributes into account together suggests that risk may be higher among women than among men, and Latino women may be at especially high risk, among whom 22% live alone and also have one or more disability. Data are not available to establish the extent to which these individuals experience isolation. However, the combination of these characteristics, along with lower average resources and more communication barriers that impact a disproportionate share of some of these groups, suggest that many may experience negative consequences associated with isolation.

Technology access

For a growing share of people, digital access is critical in maintaining communication with family and friends, seeking information, and accessing services and supports. Yet access comes at a price, and some older Boston residents have neither the necessary equipment nor the internet access they need. Although most older Boston residents have access to the internet at home, the digital divide is evident. Among people age 60-69, nearly nine out of ten non-Hispanic Whites have internet at home, but access is lower among Asian Americans (85%), Blacks (83%), Native Americans (77%), and Latinos (77%) (see **Figure 27**).

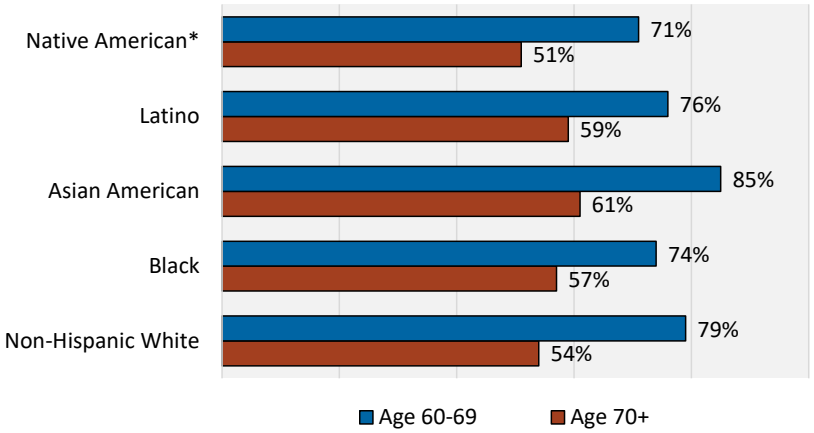
Generational Dynamics among Asian Americans

A central concern for the adult generation of Asian Americans is how to fulfill its generational "promise" to its elders. For example, Vietnamese families struggle to find culturally sensitive services for older family members in many cities across the country including Boston. Consequences of barriers to accessing appropriate services for isolation and depression is understudied, but may be substantial among older Vietnamese and other groups. The reproduction of a culturally appropriate, communal environment that is similar to how people age in their countries of origin is a priority for many of these families. The right of elder communities to have access to culturally competent care is a policy priority all stakeholders must consider.[60]

Making Progress through the Age-Friendly Boston Initiative

In the midst of the COVID-19 pandemic, the Age Strong Commission produced and distributed the June issue of its Boston Seniority publication featuring a message from the Mayor and content about preventing the spread of the virus, where to call for help, and other important information. This widely circulated content was translated into seven languages with the goal of reaching the older population as widely as possible.

Figure 28. Percentage with a smartphone, Boston residents



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note. All numbers for individuals age 60 and over not living in group quarters. Boston city population for non-Hispanic White, Black, Asian American and Latinos. *Massachusetts population for Native Americans.

Among those age 70 or older just 60% of Latinos and 65% of Blacks report internet access at home.

Having access to a smartphone is increasingly important as it is used for communications and also for accessing resources and information, like using the map feature when out and about, or arranging for an Uber. **Figure 28** shows that smartphone access declines substantially with age and among those age 70 or older, just 61% of Asian Americans have a smartphone, along with 54% of non-Hispanic Whites, 59% of Latinos, 57% of Blacks, and just about half of Native Americans. With respect to both internet access at home and ownership of a smartphone, older people—especially those age 70 or older—have lower access, with potential implications for disparities in retrieving information and communicating with friends and family.

Making Progress through the Age-Friendly Boston Initiative

As a member of the statewide Taskforce to End Loneliness & Build Community, the Age Strong Commission convened over 100 Boston-area community partner organizations to generate strategies for addressing social isolation, including six multicultural approaches to issues of loneliness and isolation. This work became increasingly important given the conditions of the COVID-19 pandemic. As well, the city has been instrumental in raising awareness and eroding the stigma around social isolation and loneliness through their leadership on the #reachoutMA campaign—a call to action for residents to take small steps to connect with those around them.

Vietnamese families and elder care in Dorchester

The term "sandwich generation" is often used to refer to middle-aged adults caught in the tension between raising their own children and caring for aging parents. In a recent study published by UMass Boston's Institute for Asian American Studies, researcher Loan Thi Dao referenced a different kind of sandwich pressuring Asian American adult children: navigating between cultural generational obligations of elderly care, and the financial and logistical challenges of living in US urban society.[61]

Focusing on the Vietnamese community concentrated in Dorchester, Dao begins her report, *How We Care: Provider Perspectives on Services for Vietnamese Elderly in Boston's Dorchester Neighborhood*, with the story of a local Vietnamese-American mother, Carol, and her daughter, Quynh, who were interviewed for a local news outlet.[62] Carol, who has diabetes and difficulty walking, had for years been taken care of by her husband, but when he died, she moved in with Quynh. The situation deteriorated quickly. Quynh needed to work during the day, and she had no choice but to leave her mother alone. Carol was not able to navigate without help, resulting in problems such as falls and burning food. Concerned for Carol's safety, Quynh finally made the difficult choice to help her mother find an assisted living placement.

The decision was fraught with emotional guilt, forcing her to wrestle with deeply held cultural expectations. She described the dilemma she faced this way: "Because I'm Vietnamese, I grew up with all these stories about parents sacrificing taking care of their kids, and kids growing up and taking care of their parents. And the idea of adulthood and independence is not growing older and moving away from your family. It's growing older and taking care of your family." Quynh's description perfectly captures the cultural contradiction faced by Asian American families as they confront the need for elder care. The dilemma is exacerbated by the busy nature and fast pace of US life, the economic need to work long hours outside the home, and the lack of extended family support.

Carol has found that there are many things to like about assisted living, especially the social contact that she missed while Quynh was at work. But she also feels isolated as the only Vietnamese resident among an overwhelmingly non-Hispanic White clientele. She notes that other residents have a hard time understanding her accented English, and says she wishes she had Vietnamese friends there with her. Carol's situation highlights the need for elder care options designed to meet the needs of a Vietnamese American population.

Aging in a Culturally Responsive Community: Latinx Elders at Villa Victoria

Walking through its plazas and small parks on a peaceful day, it can be easy to forget that Villa Victoria, a unique intergenerational housing complex serving a largely Latinx community, was born in struggle. Its beginnings go back to the 1960s, when the city of Boston undertook a massive urban renewal project that threatened to displace a largely Puerto Rican neighborhood in the South End. Residents fought back, forming an Emergency Tenants Council and a social service agency, Inquilinos Boricuas en Acción (IBA), which spearheaded an organizing campaign that won tenants the right to redevelop the area in a manner that addressed their needs and wishes. The result was a housing development designed to evoke the physical and cultural environment of a Puerto Rican barrio, while serving residents across the lifecycle through features including an elder care facility, a youth center, and one of the first bilingual preschools in the country.

Today, Villa Victoria, under the auspices of IBA, is a model of aging in community. Twenty-six percent of its more than 800 residents are 60 years of age or older. As Executive Director Vanessa Calderón-Rosado notes, "IBA strives to support and empower our elders through self-sufficiency programming to promote stability, mobility, and the well-being of the community." Calderón-Rosado emphasizes that a bilingual-bicultural approach, targeted to IBA's largely Latinx clientele, is central to its efforts to promote aging in community. "IBA's team not only speaks fluent Spanish, but also is Latinx" she notes. "They are able to establish meaningful connections and to understand our elders' needs and cultural assets, which allows them to build trust, develop respect, foster confidence and create a strong sense of cultural identity." She adds that all informational materials are translated into Spanish and created with basic levels of literacy in order to ensure that they are accessible to Spanish-speaking residents (personal communication with V. Calderón-Rosado).

This culturally responsive philosophy informs health and wellness programs that include a variety of exercise classes, access to affordable fresh produce and foods, nutritional workshops and health screenings. Activities promoting residents' social engagement include weekly Bingo and Domino games, coffee hours, arts classes, musical presentations, cook-outs and field trips. IBA's Resident Services Department offers care coordination, providing assistance and advocacy to help residents to access benefits, maintain their housing eligibility, and create supportive plans for their well-being. A variety of activities help older residents stay integrated with the community as a whole, including community arts programs that highlight Latinx culture, weekly Friday social gatherings, and holiday celebrations open to residents of all ages. A Community Ambassadors program recruits residents, including elders, and empowers them to take a leadership role in the community. The goal is not just to serve elderly residents, but to break down barriers and form relationships across generations.

A prime example is Reinalda "Chickie" Rivera. Rivera has lived in Villa Victoria since 1992, and has served on the board of IBA for more than 20 years, continuing a lifelong vocation as a community organizer and change agent. As a board member she has been at the forefront of the neighborhood's fight against gentrification, leading community forums and acting as a liaison to all sectors of the community. Until recently, she was the director of Estrellas Tropicales, a nonprofit started by her mother, Felicita Oyola, to promote cultural identity and leadership among Puerto Rican girls. Rivera is passionate about continuing to help build her community's future. "I want to mentor the next generation of grassroots organizers who will continue to fight for and defend our residents," she says, sharing her passion for "a better quality of life, preserving our culture and traditions, and fighting for justice." With support from Villa Victoria's empowering, culturally responsive programming, Latinx elders like Rivera can continue to make a difference in their community, and pass on their wisdom and experience to future generations.[63]

Supporting aging equity through Age-Friendly Boston

Although the efforts have been inclusive, it is not yet clear that the benefits of Age-Friendly Boston have been universally shared. As described in this report, disparities in health, in financial resources, and in social connectedness are widely evident in Boston. Older persons of color report poorer health, more disability, fewer financial resources and more economic struggles than their non-Hispanic White counterparts, although patterns of disparity are not consistent. Substantial differences across racial groups regarding where and with whom older people live may reflect affordability challenges, preferences for intergenerational living, or both. Although the consequences are unclear, these settings may promote a stronger sense of connectedness and mutual support. Access to information may be more challenging for older persons of color, many of whom have limited knowledge of English; as well, a larger share of older persons of color do not have access to digital technology, compared to their non-Hispanic White counterparts. We know that community strengths in terms of mutual support, resilience, and cultural cohesion offset or buffer aspects of disadvantage for some people. However, more work remains to pursue aging equity through the Age-Friendly Boston Initiative.

Pursuing aging equity requires action to address unequal experiences and sources of disparity in aging outcomes. Describing these experiences and sources is a critical first step, which we offer in this report. Seeking to ensure that community features align with the needs and interests of residents is an essential component in addressing

An intersectional approach to addressing aging equity

The concept of intersectionality illuminates the complex ways in which people's experiences over the life course and in older age emerge from the intertwining of their various categorical memberships within systems of inequalities. An intersectional approach offers scholars and practitioners in the field of aging a critical understanding that no one system of inequity is more important than another; they are intertwined in people's lives and experienced simultaneously, even if they might be analyzed one at a time.[64]

An intersectional approach reveals that experiences of men and women are not homogeneous across racial and ethnic groups, but differ by intersecting identities, which dictate their experiences. Equality theories note that as one group is privileged, the other group is disadvantaged.[65] For example, as a group of women, younger women benefit from the ageism older women face in the job market. Similarly, White people benefit from the racism encountered by persons of color in educational, employment, and other settings. Policies and services that target only one dimension of identity—be it gender, race, age or other social identities—are inefficient in addressing the needs of sub-population groups within these categories.[66,67] For example, although ageism, racism and sexism are all systems of inequities, when we factor age, race and gender simultaneously, we often find that Black women are especially disadvantaged in ways that none of the separate identities alone can explain.

This is not to say that analyzing inequities by race, ethnicity or gender are not critically important on their own. However, an intersectional lens provides a more nuanced or acute view of the challenges and opportunities encountered by sub-population groups, within a broad racial, gender or other social identity group. Applying the concept of intersectionality to the experience of aging in Boston suggests that inequities in race, class, gender, sexual preference, immigrant status, and other social locations are not compounded, but are intertwined to create unique experiences and life perspectives due to the specific social location of an individual.[68]

People do not "age out" of inequalities that exist earlier in life. Instead, disparities can become exacerbated in older age. This means that generalizations about "older people" can result in policy, research or interventions that are not generalizable to all groups, as their life opportunities and experiences are different depending on their multiple identities. A belief in human hierarchy is what underlies every social injustice and why improving the lives of older people through initiatives like Age-Friendly Boston intersects with disability justice, racial justice, gender justice, LGBTQ rights, economic justice, and every other freedom struggle. Older people, much like younger people, do not live single-issue lives.[69] Thus, a recognition of intersectionality can greatly improve our efforts to create inclusive spaces and environments in which Bostonians age by allowing us to hold multiple realities and develop more nuanced approaches to livability.

disparity. As the older population of Boston continues to grow and expand in diversity—along dimensions of race, culture, language, and others—organizations seeking to promote well-being of older people must ensure that their capacity not only expands to meet the growing numbers but also shifts to adequately serve the needs of diverse populations. Ensuring that communication mechanisms, participation opportunities, housing options, and other features that form the bedrock of an age-friendly effort are informed by the racial, cultural and linguistic characteristics of older residents is fundamental to pursuing aging equity. An additional necessary step is removing obstacles to accessing community features that may disproportionately impact segments of the older population. Minimizing obstacles to taking advantage of existing community resources, services, and supports—such as transportation or communication barriers—is an important step in implementing age-friendly practices. As well, because many of those obstacles disproportionately impact persons of color and those with lower income, these efforts can promote aging equity.

Lack of respect and barriers to social inclusion represent central points of intersection between age-friendly efforts and aging equity goals. Experiences of discrimination and exclusion are more commonly reported among persons of color than among their non-Hispanic White counterparts. For an age-friendly effort to promote aging equity, programs, services and initiatives must seek to ensure that all older adults are welcomed, and feel that they are welcomed, and that their experiences, culture and needs have been taken into account in the design and implementation of programs. Finally, pursuing aging equity must incorporate awareness of the ways in which different subgroups are spatially distributed throughout the city. Boston's history as a highly segregated city is reflected in the concentration patterns shown in this report across racial and ethnic groups. Ensuring that interventions, innovations, and age-friendly assets are available equitably across neighborhoods is a component of aging equity. By engaging with older residents where they are—in their life course and in their communities—Age-Friendly Boston can contribute to building equity in health and well-being as people age.

Defining aging equity

Aging equity means that everyone has a fair and just opportunity to age well. This requires removing obstacles to accessing community features that support healthy aging, through establishing social and civic engagement opportunities, ensuring safe environments, establishing access to healthcare, and disseminating knowledge of available supports and services. It means ensuring that the features in place align with the needs and interests of the full range of residents, and does not privilege some segments of the older population over others. And it means ensuring that interventions and innovations are distributed across neighborhoods in ways that support fair access to Age-Friendly interventions.

Considerations for moving forward

Working within the context of Boston's Age-Friendly Initiative, tackling the issues laid out in this report will require a multifaceted approach. (1) It will be necessary to remove obstacles to accessing community features, such as language barriers, obstacles relating to cost, and transportation limits. (2) Ensuring that community features align with needs, interests, and linguistic characteristics of residents and continue to do so as those characteristics shift over time is fundamental to pursuing aging equity. (3) In this city of distinct and beloved neighborhoods, it will require efforts to ensure that the assets promoting healthy aging are distributed equitably across locations and communities. These strategies are important steps in implementing age-friendly practices. As well, because many of those obstacles disproportionately impact persons of color and those with lower income, these efforts can promote aging equity. Moreover, city and community offices and organizations must continue to strengthen existing partnerships and build new ones to support collaborative and equitable action.

In Boston and in cities throughout the United States, persons of color encounter systemic racism and disadvantage that shape their accumulation of health and material resources. Barriers to participating in education and training programs that prepare people for stable and well-paying careers result in persons of color having lower incomes and less wealth, on average, as they enter later life. Exposure to unhealthy environments and low access to healthcare result in health disparities that start early and ripple throughout the life-course, impacting health and disability profiles and, indeed, reducing the chances that some people will survive to old age at all. Stress resulting from bias and discrimination have well-known negative impacts on health, with consequences lasting a lifetime. Strengthening opportunities for healthy aging requires close attention to the social determinants of health, all of which are shaped to some degree by inequity.

The disparities described in this report make clear that for Boston to adequately meet the needs of its older population, it must redouble efforts to understand and respond to the full range of needs, the many different languages and cultural backgrounds, and neighborhood differences in assets.

Notes and references

1. City of Boston. (2020). *Coronavirus Disease (COVID-19) in Boston*. www.boston.gov/news/coronavirus-disease-covid-19-boston
2. Boston Public Health Commission (2020). Boston COVID-19 Report – For the Week Ending 10/22/2020. https://bphc.org/whatwedo/infectious-diseases/Documents/COVID19%20Boston%20Report_2020_Week43.pdf
3. City of Boston. Racial Data on Boston Resident COVID-19 Cases. www.boston.gov/departments/mayors-office/racial-data-boston-resident-covid-19-cases
4. Somerville, C., Mutchler, J., and Coyle, C. (2020). Measuring the Impact of COVID-19 on Older Adults in Massachusetts. Center for Social & Demographic Research on Aging, University of Massachusetts Boston. https://scholarworks.umb.edu/demographyofaging/43/
5. Alliance for Aging Research. (2020). Alliance for Aging Research statement condemning ongoing racism and violence targeting Black communities across the US. https://www.agingresearch.org/press-release/alliance-for-aging-research-statement-condemning-ongoing-racism-and-violence-targeting-black-communities-across-the-u-s/
6. Crystal, S., Shea, D. G., & Reyes, A. M. (2017). Cumulative advantage, cumulative disadvantage, and evolving patterns of late-life inequality. *The Gerontologist*, 57, 910-920. doi:10.1093/geront/gnw056
7. Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press (US). doi:10.17226/12875
8. Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry*, 70, 42-57. doi:10.1037/h0087722
9. Unless otherwise noted, all statistics in this report were calculated by the authors and based on the US Census or the American Community Survey (ACS), retrieved from the IPUMS system through the University of Minnesota. www.ipums.org
10. City of Boston. (2020). *Age-friendly Boston*. www.boston.gov/departments/age-strong-commission/age-friendly-boston
11. Boston Indicators, The Boston Foundation, UMass Boston, & The UMass Donahue Institute. (2019). *Changing Faces of Greater Boston*. www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/changing-faces-2019/indicators-changing-facesf2web.pdf
12. Watanabe, P., & Lo, S. (2019). Asian American Americans in Greater Boston: Building communities old and new. *Changing Faces of Greater Boston*. www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/changing-faces-2019/changingfaces_4Asian American-americans.pdf?la=en&hash=C87B32F14828CFD383F61DC10C12329017A5380F
13. Rivera, L. (2019). Latinos in Greater Boston: Migration, new communities and the challenge of displacement. *Changing Faces of Greater Boston*. https://www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/changing-faces-2019/changingfaces_6latinos.pdf?la=en&hash=3D5F05E8E4FB5E53B5BCB0C66DCEA6FEAC9F759E
14. Lozano, I., Granberry, P., & Mattos, T. (2017). The diversity and dispersion of Latinos in Massachusetts. Gastón Institute Publications. 226. https://scholarworks.umb.edu/gaston_pubs/226/
15. Gieselman, J. (2017). An invisible wall: how language barriers block indigenous Latin American asylum-seekers. *Transnational Law & Contemporary Problems*, 27, 451.
16. Woods, J. C. (2019). Native Americans in Massachusetts: New homecomings and ongoing displacements. *Changing Faces of Greater Boston*. www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/changing-faces-2019/changingfaces_7native-americans.pdf?la=en&hash=D75276108D472C1F76996086E8617C825577DB29
17. Granberry, P.J. and Marcelli, E.A. (2006). American Indians in New England: A Demographic, Economic, and Health Portrait. Boston: McCormack Graduate School of Policy Studies and Department of Economics.
18. Guillemin, J. (1975). *Urban Renegades: The Cultural Strategy of American Indians*. New York: Columbia Univ. Press.
19. Capetillo-Ponce, J., & Abreu-Rodriguez, G. (2010). Immigration, ethnicity, and marginalization: The Maya K'iche of New Bedford. *Trotter Review*, 19. Article 5. scholarworks.umb.edu/trotter_review/vol19/iss1/5
20. World Health Organization. (2020). *Health equity*. www.who.int/topics/health_equity/en/
21. Crystal, S., Shea, D. G., & Reyes, A. M. (2017). Cumulative advantage, cumulative disadvantage, and evolving patterns of late-life inequality. *The Gerontologist*, 57, 910-920. doi:10.1093/geront/gnw056
22. Boston Public Health Commission. (2019). Chapter 15: Death. *Health of Boston 2016-2017*. www.bphc.org/healthdata/health-of-boston-report/Documents/18_C15_Death_16-17_HOB_final-19.pdf
23. Social Security Administration. (2020). *Retirement Benefits*. www.ssa.gov/benefits/retirement/
24. Eligibility for Social Security is based on a person's contributions to the Social Security system through covered employment. People who lack legal documentation are not eligible to receive Social Security benefits. To be eligible for Social Security, a person must have worked for at least 10 years in covered employment, with higher benefits resulting from longer work histories and higher work incomes. People who have not engaged in paid work are not eligible on their own work record, although they may be eligible as a surviving spouse or dependent based on someone else's work record.
25. People born between 1943 and 1954 are eligible for full benefits at age 66. For those born in 1960 or later, eligibility for full benefits is at age 67. www.ssa.gov/benefits/retirement/planner/agereduction.html
26. The federal poverty guidelines (commonly referred to as the FPL) are established annually by the US government. They are used by many means-tested assistance programs to set eligibility criteria. In 2020, the FPL for a one-person household is $12,760, and 200% of the FPL is $25,520 (see https://aspe.hhs.gov/poverty-guidelines). The FPL increases based on size of household, but assumptions about economies of scale mean that these thresholds are not considered to be 'per capita' amounts. For example, the FPL for a two-person household in 2020 is $17,240, just 35% more than the FPL for one person. The FPL is adjusted annually based on cost of living but consistently remains at a very low level.
27. To view Elder Index data for the entire US, see ElderIndex.org
28. Mutchler, J., Li, Y., & Velasco Roldán, N. (2019). *Living below the line: Economic insecurity and older Americans, insecurity in Massachusetts 2019*. Center for Social and Demographic Research on Aging Publications. 39. scholarworks.umb.edu/demographyofaging/39/
29. Mutchler, J., Velasco Roldán, N. & Li, Y. (2017). *Living below the line: Racial and ethnic disparities in economic security among older Americans, 2020*. Center for Social and Demographic Research on Aging Publications. 46. scholarworks.umb.edu/demographyofaging/46/
30. Note that all statistics in this section refer to age of the householder, who is the person who owns or rents the home. As will be noted later in this report, some older Boston residents live in a household with others, and in some cases they are not the householder (for example, they may live in their adult child's home). Propensity to live with others in extended family households is considerably higher in some ethnic communities than in others.
31. Hamilton, D., & Famighetti, C. (2019). Housing. In Stanford Center on Poverty and Inequality (ed), *State of the Union: Millenial Dilemma. Pathways*, Special Issue. https://inequality.stanford.edu/sites/default/files/Pathways_SOTU_2019_Housing.pdf

32. Meschede, T., Hamilton, D., Muñoz, A. P., Jackson, R. O., & Darity Jr., W. A. (2016). Wealth inequalities in Greater Boston: Do race and ethnicity matter? Federal Reserve Bank of Boston. *Community Development Discussion Paper*, No. 2016-2.

33. Joint Center for Housing Studies of Harvard University. (2020). *Many households burdened by housing costs in 2017*. www.jchs.harvard.edu/son-2019-cost-burdens-map

34. Hummer, R. A., Benjamins, M. R., & Rogers, R. G. (2004). Racial and Ethnic Disparities in Health and Mortality among the US Elderly Population. In Anderson, Norman B.; Bulatao, Rodolfo A.; & Cohen, Barney (Eds.), *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life* (pp. 53-94). Washington: National Academies Press.

35. Sorkin, D., Tan, A. L., Hays, R. D., Mangione, C. M., & Ngo-Metzger, Q. (2008). Self-reported health status of Vietnamese and Non-Hispanic White older adults in California. *Journal of the American Geriatrics Society*, 56, 1543-1548. doi:10.1111/j.1532-5415.2008.01805.x

36. Sorkin, D. H., Nguyen, H., & Ngo-Metzger, Q. (2011). Assessing the mental health needs and barriers to care among a diverse sample of Asian American older adults. *Journal of General Internal Medicine*, 26(6), 595-602.

37. National Hispanic Council on Aging. (2017). 2017 Status of Hispanic older adults: Insights from the field – Caregivers edition. Washington, D. C. www.nhcoa.org/wp-content/uploads/2017/09/2017-Status-of-Hispanic-Older-Adults-FV.pdf

38. Cortés, Dharma and Vega, Rodolfo R., "The Health of Latinos in Massachusetts: A Snapshot" (2010). Gastón Institute Publications. Paper 157. http://scholarworks.umb.edu/gaston_pubs/157

39. Boston Public Health Commission (2019). *Health of Boston* 2016-2017. Research and Evaluation Office. Boston, MA. www.bphc.org/healthdata/health-of-boston-report/Documents/_HOB_16-17_FINAL_SINGLE%20PAGES-Revised%20Feb%202019.pdf

40. Williams, D.R., Lawrence, J.A. & Davis, B.A. (2019). Racism and health: Evidence and needed research. *Annual Review of Public Health*, 40, 105-125.

41. Schnittker, J., & Bacak, V. (2014). The increasing predictive validity of self-rated health. *PLOS One*, 9, e84933. doi:10.1371/journal.pone.0084933

42. Brenner, A. B., & Clarke, P. J. (2018). Understanding socioenvironmental contributors to racial and ethnic disparities in disability among older Americans. *Research on Aging*, 40, 103-130. doi:10.1177/0164027516681165

43. Fuller-Thomson, E., & Minkler, M. (2005). Functional limitations among older American Indians and Alaska natives: Findings from the Census 2000 Supplementary Survey. *American Journal of Public Health*, 95(11), 1945-1948.

44. Guerreiro, R., & Bras, J. (2015). The age factor in Alzheimer's disease. *Genome Medicine*, 7, 1-3. doi:10.1186/s13073-015-0232-5

45. Alzheimer's Association. (2020). Alzheimer's Disease Facts and Figures. www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf

46. Massachusetts Healthy Aging Collaborative community profiles (n.d.). https://mahealthyagingcollaborative.org/data-report/explore-the-profiles/community-profiles/

47. Mayeda, E. R., Glymour, M. M., Quesenberry, C. P., & Whitmer, R. A. (2016). Inequalities in dementia incidence between six racial and ethnic groups over 14 years. *Alzheimer's & Dementia*, 12, 216-224. doi:10.1016/j.jalz.2015.12.007

48. Chin, A. L., Negash, S., & Hamilton, R. (2011). Diversity and disparity in dementia: The impact of ethnoracial differences in Alzheimer's disease. *Alzheimer Disease and Associated Disorders*, 25, 187-195. doi:10.1097/WAD.0b013e318211c6c9

49. Goldman, D. P., & Zissimopoulos, J. M. (2003). High out-of-pocket health care spending by the elderly. *Health Affairs*, 22(3), 194-202.

50. Mignon, S. I., & Holmes, W. M. (2013). Substance abuse and mental health issues within Native American grandparenting families. *Journal of Ethnicity in Substance Abuse*, 12, 210-227. doi:10.1080/15332640.2013.798751

51. Coyle, C. E., & Dugan, E. (2012). Social isolation, loneliness and health among older adults. *Journal of Aging and Health*, 24, 1346-1363. doi:10.1177/0898264312460275

52. Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspectives on Psychological Science*, 10, 227-237. doi:10.1177/1745691614568352

53. Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences*, 110, 5797-5801. doi:10.1073/pnas.1219686110

54. Pinquart, M., & Sörensen, S. (2003). Risk factors for loneliness in adulthood and old age – a meta-analysis. In S. P. Shohov (Ed.), *Advances in Psychology Research*, Vol. 19 (pp. 111–143). Nova Science Publishers.

55. Yeh, S. J., & Lo, S. K. (2004). Living alone, social support, and feeling lonely among the elderly. *Social Behavior and Personality*, 32, 129-138. doi:10.2224/sbp.2004.32.2.129

56. Dong, X., Chang, E. S., Wong, E., & Simon, M. (2012). Perception and negative effect of loneliness in a Chicago Chinese population of older adults. *Archives of Gerontology and Geriatrics*, 54, 151-159. doi:10.1016/j.archger.2011.04.022

57. Miyawaki, C. E. (2015). Association of social isolation and health across different racial and ethnic groups of older Americans. *Ageing & Society*, 35, 2201-2228. doi:10.1017/S0144686X14000890

58. Taylor, R. J., Chatters, L. M., & Taylor, H. O. (2019). Race and objective social isolation: Older African Americans, Black Caribbeans, and non-Hispanic non-Hispanic Whites. *The Journals of Gerontology: Series B*, 74, 1429-1440. doi:10.1093/geronb/gby114

59. In Boston, an estimated 4% of residents age 60 or older live in group quarters. Among older people, and especially among those age 80 or older, most group quarters residents live in nursing homes.

60. Chin, A. L., Negash, S., & Hamilton, R. (2011). Diversity and disparity in dementia: The impact of ethnoracial differences in Alzheimer's disease. *Alzheimer Disease and Associated Disorders*, 25, 187-195. doi:10.1097/WAD.0b013e318211c6c9

61. Dao, L. T. (2016). How we care: Provider perspectives on services for Vietnamese elderly in Boston's Dorchester neighborhood. *Institute for Asian American Studies Publications*. 42. scholarworks.umb.edu/iaas_pubs/42

62. Quinn, C. (2013). Dorchester mother, daughter upend Vietnamese elder care tradition. WGBH News. www.wgbh.org/news/post/dorchester-mother-daughter-upend-vietnamese-elder-care-tradition

63. Inquilinos Boricuas en Acción (2018). Building 50: Resident services (Blog). https://www.ibaboston.org/blog/building-50-resident-services

64. Crenshaw Williams, K. (1998). The intersectionality of race and gender discrimination. In *Background Paper, Expert Group Meeting on Gender and Race Discrimination*, November (pp. 1331-87).

65. Kendi, I. X. (2019). *How to be an antiracist*. New York: One World.

66. Calasanti, T. (2005). Ageism, gravity, and gender: Experiences of aging bodies. *Generations*, 29(3), 8-12.

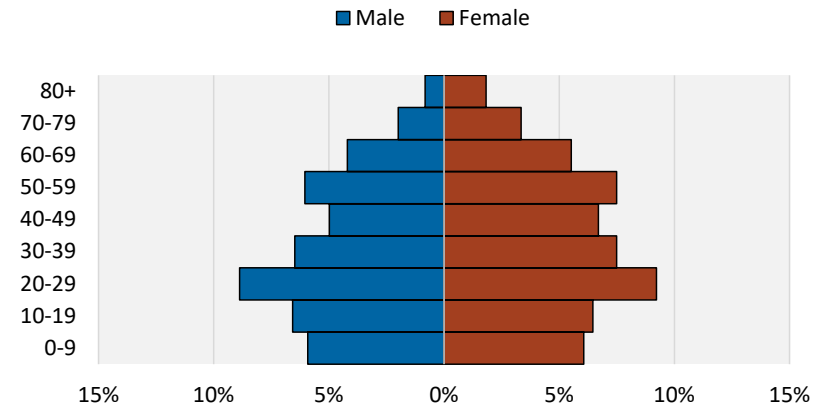
67. Hancock, A. M. (2019). Empirical intersectionality: A tale of two approaches. In O Hankivsky & JS Jordan-Zachery (Eds.), *The Palgrave handbook of intersectionality in public policy* (pp. 95-132). London: Palgrave Macmillan.

68. Collins, P. H. (2000). Gender, black feminism, and black political economy. *The Annals of the American Academy of Political and Social Science*, 568(1), 41-53.

69. Calasanti, T., & Giles, S. (2018). The challenge of intersectionality. *Generations*, 41(4), 69-74.

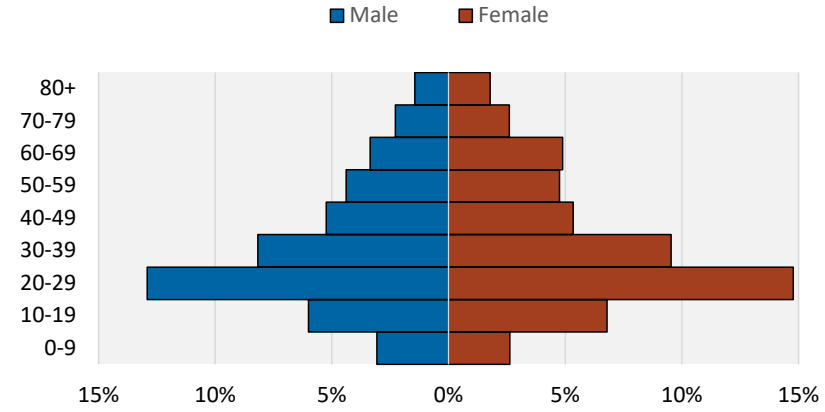
Appendix

Figure A1. Black population in Boston by age group and gender, 2018



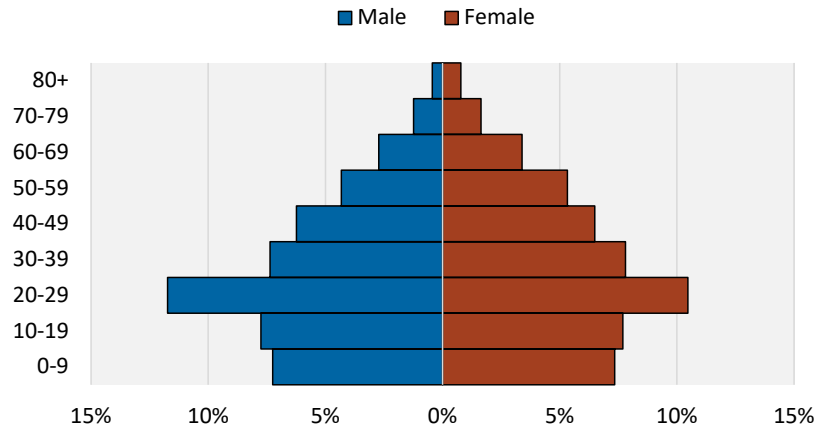
Source: 2018 ACS, 5-year file, retrieved through IPUMS.

Figure A2. Asian American population in Boston by age group and gender, 2018



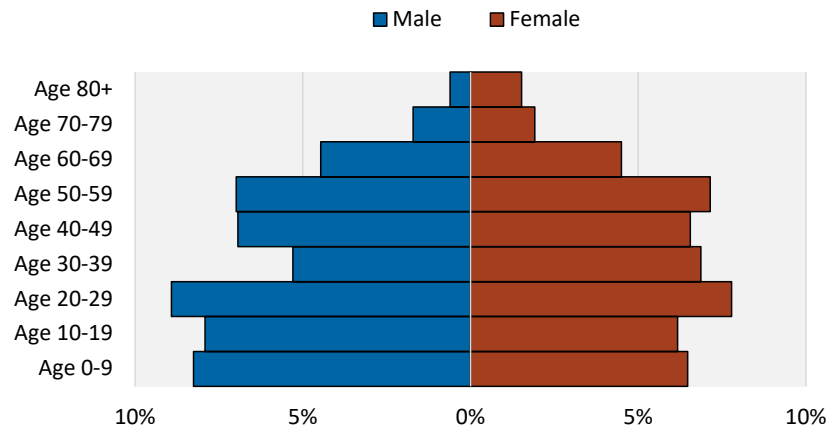
Source: 2018 ACS, 5-year file, retrieved through IPUMS.

Figure A3. Latino population in Boston by age group and gender, 2018



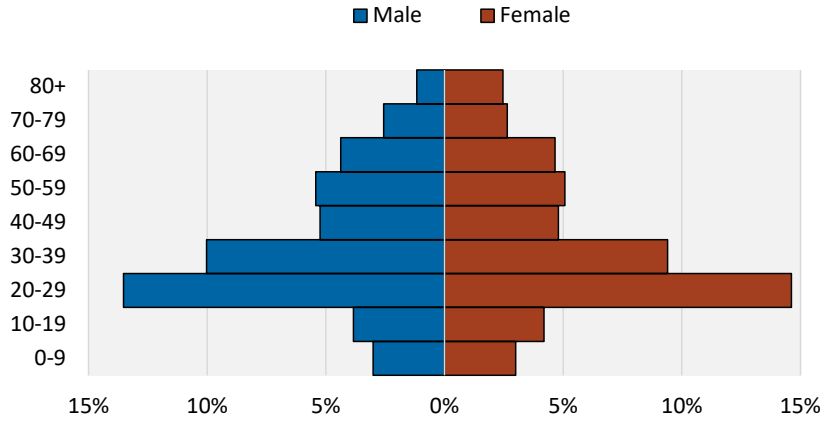
Source: 2018 ACS, 5-year file, retrieved through IPUMS.

Figure A4. Native American population in Massachusetts by age group and gender, 2018



Source: 2018 ACS, 5-year file, retrieved through IPUMS.

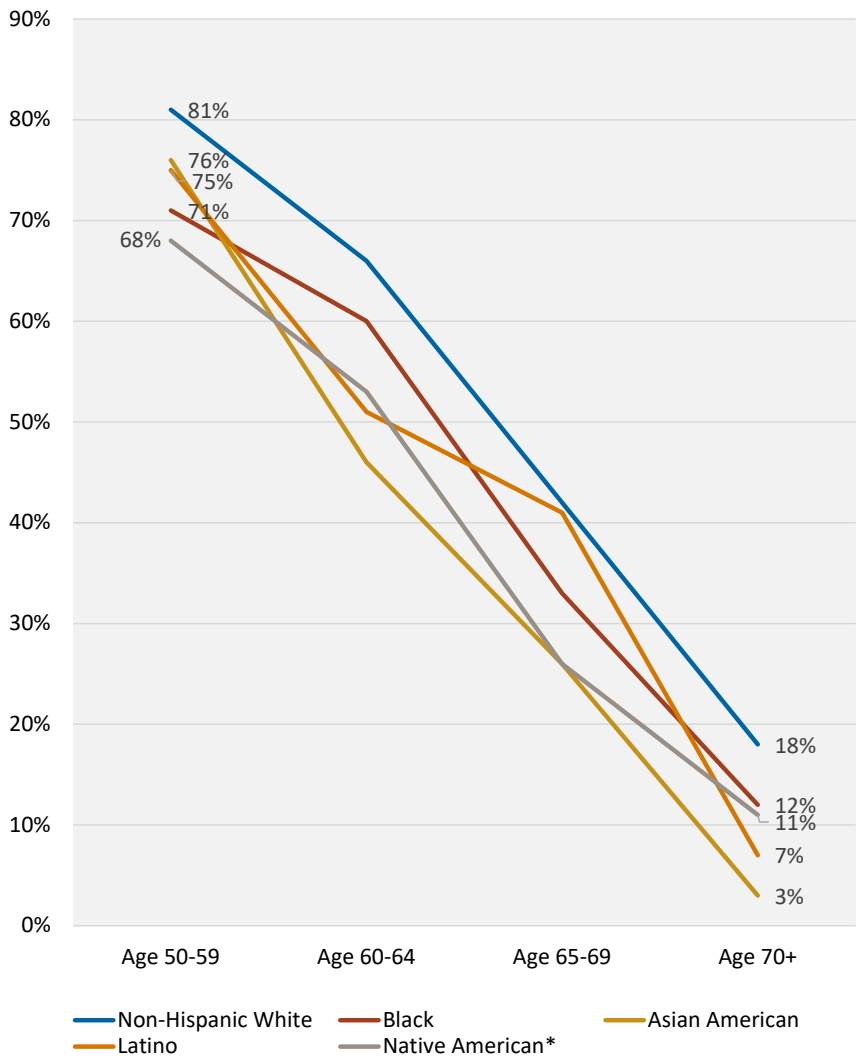
Figure A5. Non-Latino White population in Boston by age group and gender, 2018



Source: 2018 ACS, 5-year file, retrieved through IPUMS.

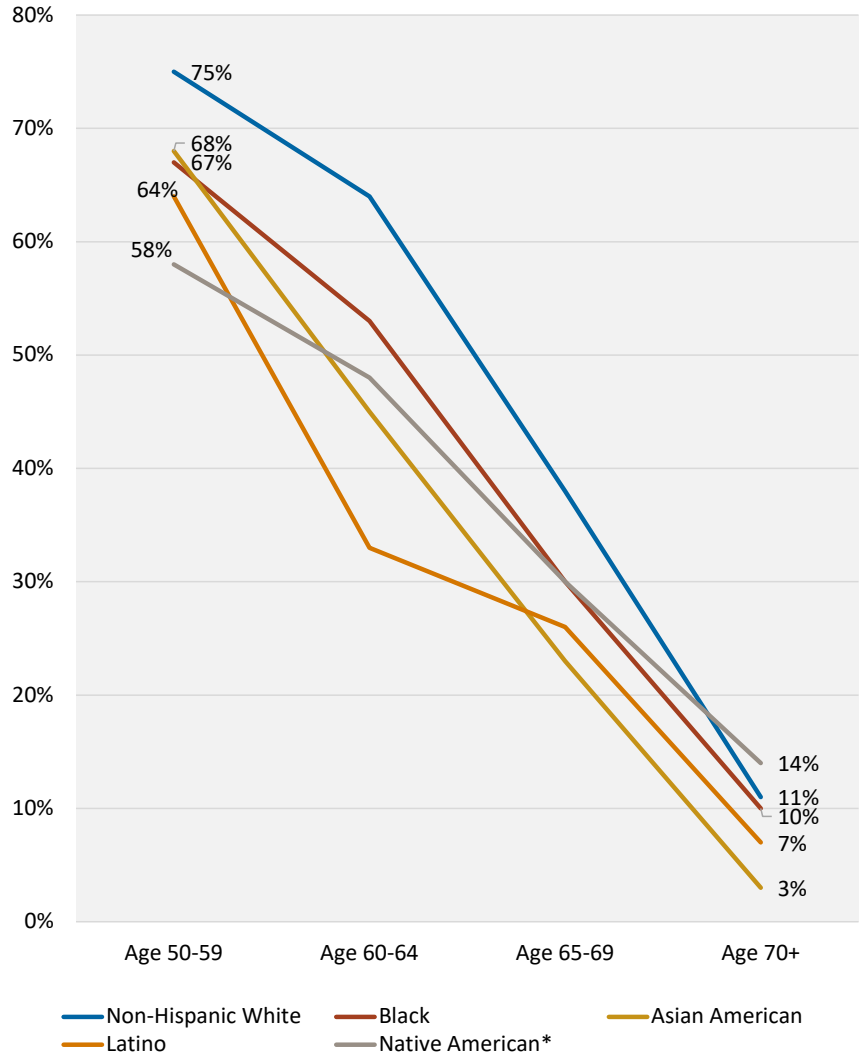
Appendix

Figure A6. Percentage employed by age group and race, Boston **men**



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 50 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

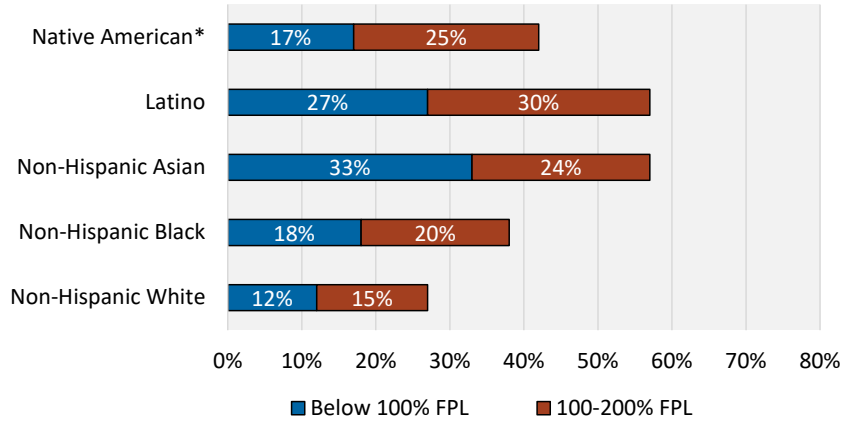
Figure A7. Percentage employed by age group and race, Boston **women**



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 50 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

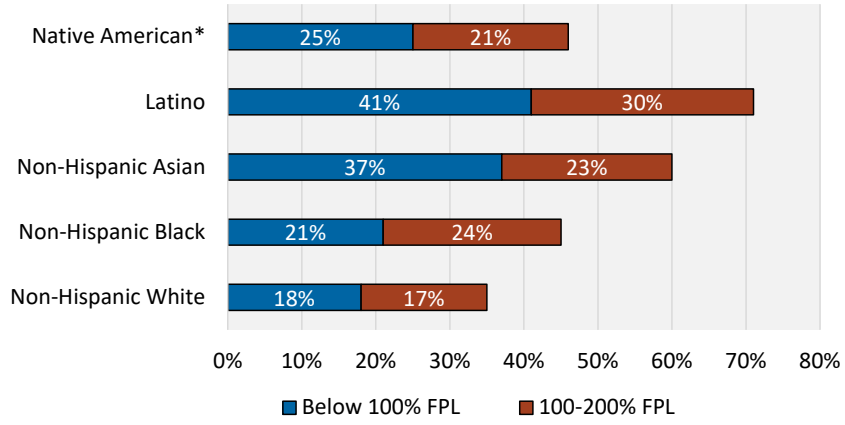
Appendix

Figure A8. Rates of poverty and near-poverty, Boston **men** age 60+



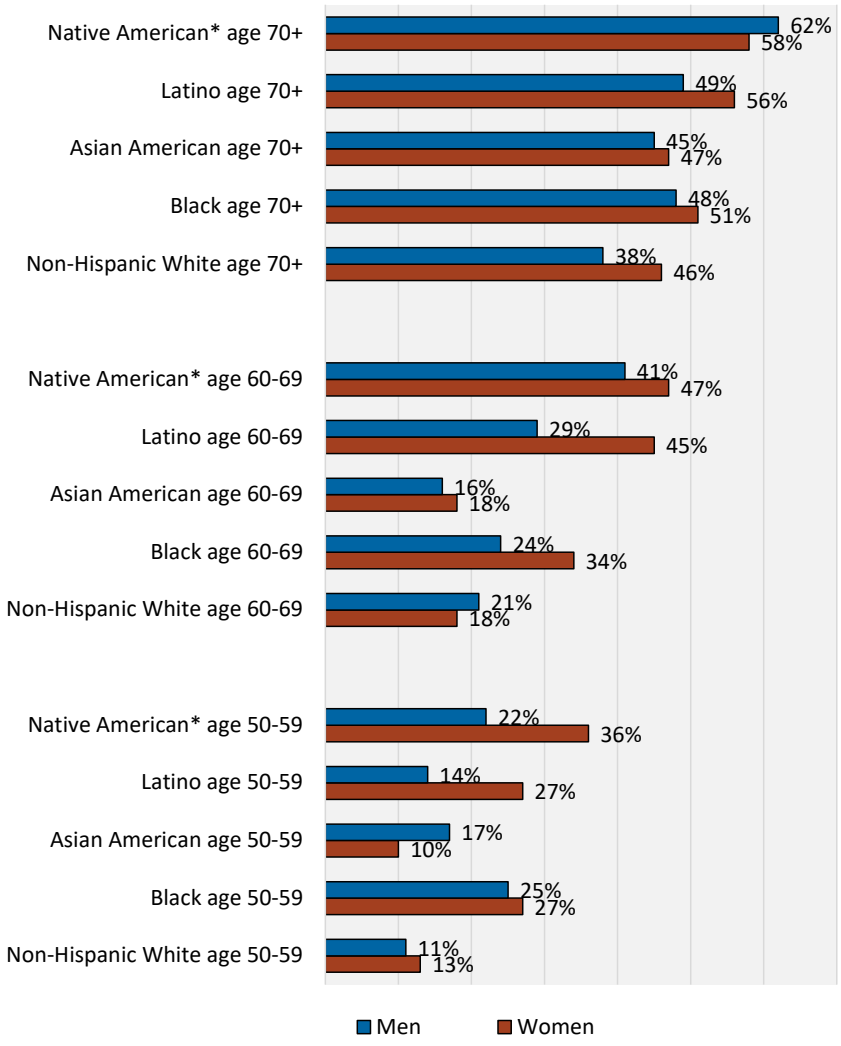
Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 60 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

Figure A9. Rates of poverty and near-poverty, Boston **women** age 60+



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 60 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

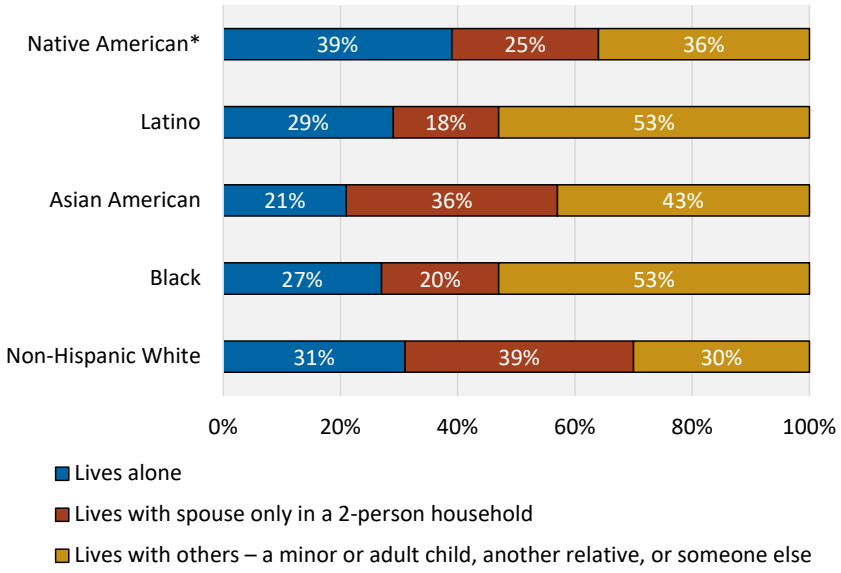
Figure A10. Rates of disability by age, gender, and race, community dwelling Boston residents



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 50 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

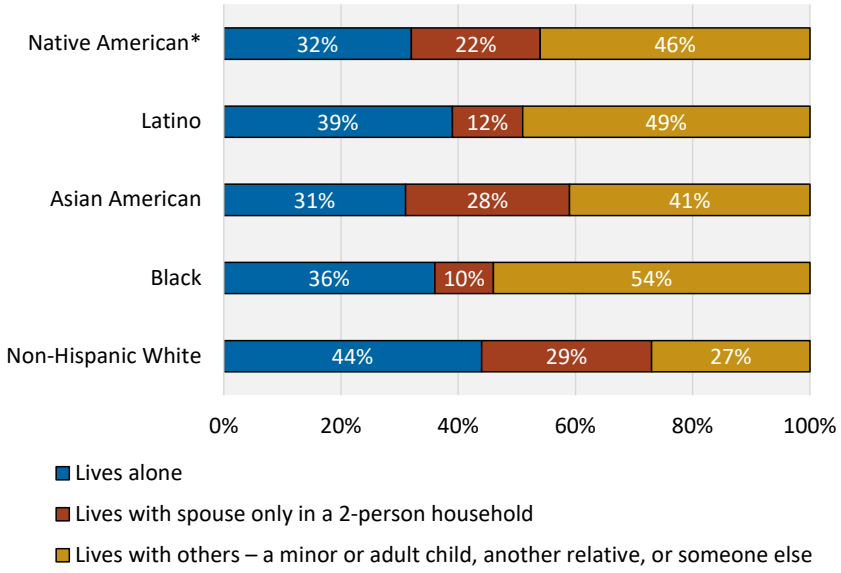
Appendix

Figure A11. Living arrangements, Boston **men** age 60+



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 50 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

Figure A12. Living arrangements, Boston **women** age 60+



Source: 2018 ACS, 5-year file, retrieved through IPUMS.
Note: All numbers for individuals age 50 and over not living in group quarters. Boston city population for non-Hispanic Whites, Asian Americans, Blacks, and Latinos. *Massachusetts population for Native Americans.

Aging Strong for All: Examining Aging Equity in the City of Boston

Jan E. Mutchler, Caitlin E. Coyle, Nidya Velasco Roldán, Paul Watanabe, Cedric Woods, Lorna Rivera, Quito Swan, Elena Stone and Laurie Nsiah-Jefferson

NOVEMBER 2020

UNIVERSITY OF MASSACHUSETTS BOSTON