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CHAPTER 29

Growing Older in World Cities: Benefits and Burdens

Michael K. Gusmano

Marie lives in the Mott Haven section of the South Bronx. She is a seventy-two-year-old widow who lives alone. She has two children, but neither lives in New York City and she only sees them a few times each year. Marie knows a couple of her neighbors, but does not know them well. Her closest friends have either died or moved away from the neighborhood. Although crime rates in New York City have fallen dramatically in recent years, she is still afraid to leave her building after dark. Her arthritis makes it difficult for her to get around and truck traffic from the Hunt's Point market and the local bridges make her nervous about crossing streets, even during the day. She feels this is the dreariest time of her life and would like to move, but says, "Where would I go? I can't afford to live anywhere else?"

John, a retired New York City police officer, is married and lives with his wife in the Bay Ridge section of Brooklyn. He is seventy years old and extraordinarily active in the community. He is on the board of directors of several local community organizations and volunteers in programs designed to assist frail older people and children at risk. He and his wife regularly take the subway into "the city" to see shows on Broadway and to visit museums and shops. In his view, Bay Ridge is "the perfect place to grow old."[1]

Marie and John illustrate the benefits and burdens associated with growing old in a world city. New York, London, Paris, and Tokyo are the four largest cities among the wealthy OECD[2] nations of the world. They exercise a powerful influence in the world beyond their national boundaries. They are centers of finance, information, media, arts, education and a variety of specialized services; and they contribute disproportionate shares of gross domestic product (GDP) to their national economies. As centers of medical excellence, these world cities set a world standard for care through their medical training programs, biomedical research institutions, and university hospitals. But are these

Mott Haven

influential cities prepared to meet the challenges of what Dr. Robert N. Butler has called the "quiet revolution of longevity." As life expectancy rises, birth rates decline, and populations grow older, how will New York, London, Paris, and Tokyo accommodate significant demographic change? These cities offer great opportunities for those who are healthy and wealthy enough to take advantage of them. But for some, these cities are threatening, lonely places. Unfortunately, we do not know enough about the degree to which older residents of these cities are living in isolation.

The aging of the world's population provokes fears of impending social security deficits, uncontrollable medical expenditures, and transformations in living arrangements. Indeed, the likely causes and consequences of human longevity and population aging have been the subject of sustained study worldwide and the topic for important expert meetings of the United Nations (Vienna 1982, Malta 1986, and Madrid 2002). But there has been almost no attention to the impact of these trends on health and quality of life in cities where most of the world's population will reside in the future. In the United States, for example, a 2005 study by the National Association of Area Agencies on Aging, and allied organizations, concludes that most cities are unprepared to accommodate the needs of the aging "baby boom" generation (National Association of Area Agencies on Aging 2005).[3]

3

In this chapter, we draw on findings from the World Cities Project to discuss what we know about the benefits and burdens of growing older in these four world cities (Rodwin and Gusmano 2006; see also http://www.ilcusa.org/pages/

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projects/world-cities-project.php). In particular, we focus on the factors that influence the social connections of older people. The existence of affordable, easily accessible transportation, neighborhood shops and cultural opportunities, medical and social services that promote health and autonomy, and innovative programs that encourage social interaction exist, to varying degrees, in all of these cities. At the same time, these cities are crowded, expensive places to live, and older people do not always have access to affordable, appropriate housing.

What is the benefit of comparing the experience of aging in these cities? We believe that comparative analysis of urban aging is most valuable because it provides "the gift of perspective" and helps us to understand our own system "by reference to what it is like or unlike" (Marmor, Freeman and Okma 2005). Comparative analysis expands our vision of what is possible (Klein 1997). When scholars compare cities in the United States to those in other wealthy nations, it is clear that many common "urban problems"—the geographic concentration of poverty, inequality, and poor health—are not inevitable attributes of modern cities. Dreier and colleagues argue that "cities in Canada, Western Europe, and Australia do not have nearly the same levels of poverty, slums, economic segregation, city-suburb disparities, or even suburban sprawl as does the United States. The question is not whether we can ever solve urban problems, but whether we can develop the political will to adopt solutions that can work" (Drier, Mollenkopf, and Swanstrom 2004).

Not surprisingly, the evidence we present in this chapter suggests that, although these four cities have much in common, there are great differences among them in terms of the benefits and burdens faced by their older residents. In New York and London, the "hard" world cities of the postindustrial world, have characteristics that place older residents at greater risk for social isolation than do Paris and Tokyo, their "soft" world cities counterparts. Not only do London and New York have greater income inequalities than Paris or Tokyo, they have deprived neighborhoods with a high concentration of poverty, few middle- and upper-income residents, and low levels of collective efficacy. In New York, the problems faced by residents of these neighborhoods are exacerbated by poor access to medical services, to a much greater degree than they are in London.[4] When we examine indicators that are influenced by access to timely and effective health services, such as avoidable mortality and avoidable hospital conditions, we find that New Yorkers face much greater barriers to health care services than do residents of these other cities (Weisz et al. 2007).

4

THE GROWING IMPORTANCE OF URBAN AGING

While the general dimensions of global aging are becoming well known, the fact that the "longevity revolution" is taking place in the context of growing urbanization has not received sufficient attention. United Nations' estimates indicate that 60 percent of the population will live in cities in 2030 (United Nations 2007). Although older people are less likely than younger people to

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live in urban areas, more than 70 percent of older Americans live in metropolitan areas (Kinsella and Velkoff 2001; He et al. 2005). As population aging and urbanization increase, cities will have to respond to the needs of the most rapidly growing cohort of older people—the "older old," eighty-five years of age and over who are the most vulnerable. In particular, cities must find ways to identify and respond to the needs of older people who are isolated.

Why Examine Aging in World Cities?

One reason for the increased focus among gerontologists on urban aging is that "cities are themselves undergoing radical change, notably through the process of globalization" (Phillipson 2004). Not surprisingly, the effects of globalization, both positive and negative, on life in cities are seen most acutely in world cities. The terms *world cities* and *global cities* have been used interchangeably to mean cities at the center of the global economy, or hubs in the international world of transnational corporations, financial services and information exchange (Hall 1984; Sassen 1994; Rodwin and Gusmano 2006; Gusmano et al. 2007). For thousands of years, cities have been regarded, simultaneously, as "the natural center of everything that mattered" and "the source of corruption and evil" (Zwingle 2002). When examining the characteristics of world cities and their implications for older persons, it is easy to understand why. High levels of congestion, pollution, and crime rates, as well as the high cost of housing and social polarization in world cities may undermine quality of life for older people. Yet these cities offer greater access to public transportation, pharmacies and stores, world-class medical centers, museums, parks, concert halls, colleges and universities, libraries, theaters and other venues for entertainment. They are important cases to study because while they share these characteristics, they are unique examples of city life within their national borders.

As command-and-control centers in the global economy, twenty-first century world cities are marked by a growing number of wealthy and poor residents, a shrinking middle class, and increasing socioeconomic inequalities (White 1998; Sassen 2001; Rodwin and Gusmano 2006). According to the predominant model of global city development, a concentration of financial, information, and specialized service industries, as well as headquarters of transnational corporations, in a few cities, have accompanied the dispersion of production and distribution around the world (Friedman 1986; White 1998). As a result, they attract large numbers of highly affluent people to work in their financial, legal and information technology sectors. At the same time, globalization has created a great number of service jobs in what Tobier calls the "under the stairs" economy in the "hospitality" industry: hotels, restaurants, tourism, convention centers; in health and home care; and in small businesses of all sorts. These relatively low-skill, low-wage jobs have attracted a large and growing number of immigrants to these cities. This dichotomy has helped produce stark inequalities, particularly in New York and London (Fainstein, Gordon and Harloe 1992; Tobier 2006).

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We do not know enough about the impact of this kind of urban environment on older people, yet there are reasons to believe that it may pose serious challenges to many. World cities offer tremendous cultural and entertainment opportunities, but only a small percentage of older persons have the resources to take advantage of the opportunities that these world cities provide. In New York, for example, Tobier estimates that only one out of twenty older households have "enough" money to take full advantage of New York's unique opportunities for a higher quality of life. John, from Bay Ridge, is capable of enjoying these opportunities, but Marie from Hunt's Point cannot. This is moderated, to some degree, by the range of free cultural events and subsidized transportation available to city residents, but the large and growing number of people working for low wages in service industries may have even greater need for assistance when they grow older. The substantial costs associated with long-term care, particularly assisted living, home care, and other alternatives to institutionalization, make them out of reach for many of the oldest old.

We know that aging in place in cities can be risky, particularly for older people living in poor, deprived neighborhoods (Phillipson 2004). Given the expense of living in a world city, the extraordinary inequality of wealth and cultural diversity within them, there is good reason to believe that these risks may be more pronounced in such places. As Warnes puts it, "World cities are different from the generality of urban settlements … These distinctive attributes are bound to be expressed in the activities and quality-of-life of older people. There will be positive and negative effects. Among the negative attributes may be an exceptional level of dispersion and separation of families, which in turn may generate above-average levels of social isolation and anonymity" (Warnes and Strüder 2006). These problems can be made worse if older people elect to live in a city or neighborhood, not because it is "consistent with their biographies and life histories," but because they have no choice (Phillipson 2007).

Recent findings from the English Longitudinal Study of Ageing (ELSA) appear to support these concerns, at least with regard to Greater London. Based on their analysis of ELSA, Barnes and colleagues found that "older people who live in London are most likely to suffer from neighbourhood exclusion." It is not possible to examine neighborhoods within London using the ELSA survey, but the study noted that greater degree of social exclusion among older persons in Greater London compared with the rest of the United Kingdom may be due to the fact that London has the most deprived areas in the country (Barnes et al. 2006).

Even in Tokyo, which has much lower rates of older persons living alone than the other cities we examine, there are growing concerns about the number of isolated older people. In recent years, the Japanese media has reported a growth in the number of criminals who prey on isolated older persons and attempt to swindle them out of their life savings. As one report concluded, "big cities are becoming hostile places in many ways for elderly people living alone … These con artists know all too well that elderly people who live in isolation and suffer from a weakening sense of judgment are easy targets" (*Japan Times* 2005).

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WHAT DO WE KNOW ABOUT SOCIAL ISOLATION AMONG OLDER PERSONS IN WORLD CITIES?

The past century, sociologists and anthropologists studied the effects of urbanization on social interaction among city residents. Many studies conclude that urbanization does not lead to social isolation, but social networks in urban areas appear to be different in nature than those in rural areas (Durkheim 1893; Sokolovsky and Cohen 1981; Mookherjee 1998). According to Putnam, relationships with friends and neighbors are more important to people living in urban areas, while relationships with family are more important for those living in rural areas. He argues that "Urban settings sustain not a single tightly integrated community, but a mosaic of loosely coupled communities. As mobility, divorce, and smaller families have reduced the relative importance of kinship ties, especially among the more educated, friendship may actually have gained importance in the modern metropolis" (Putnam 2000).

Much of the social network literature is focused on differences between urban and rural areas, but it is clear that the extent and nature of social networks also vary within cities. In addition to the individual characteristics that influence the scope and nature of social networks among older people in cities, neighborhoods in which older people live influence their social networks and the quality of their lives (Fischer 1982; Dreier Mollenkopf and Swanstrom 2001; Jackson et al. 2001). Recent studies of "productive aging," for example, highlight the importance of local institutions (Morrow-Howell 2000; Dreier et al. Mollenkopf and Swanstrom 2001).

Older people who live in neighborhoods with lower crime rates, more parks, fewer vacant lots, and greater recreational and social opportunities are more likely to have stronger social networks, more likely to exercise, and more likely to have a positive outlook on life than those who live with higher crime, less green space, and fewer recreational and social opportunities (Kuo et al. 1998; Wells et al. 2006; Wen and Christakis 2006).

Our examination of growing older in New York is consistent with these findings. John, the retired police officer from Bay Ridge in Brooklyn, lives in a safe, middle-class neighborhood with ample opportunities for social interaction. This is reflected both in his feeling about his neighborhood and his interactions with his neighbors. Marie, the widow from Mott Haven in the Bronx, lives in a poorer neighborhood with a built environment that is much less conducive to social interaction. She avoids leaving her apartment at night and does not have a close relationship with many neighbors. The attitudes of these two individuals are shared by other older persons in their neighborhoods. According to the 2002 New York City Housing and Vacancy Survey, 93 percent of older persons in Bay Ridge believe that they can trust their neighbors and 90 percent believe that neighbors are willing to help each other (U.S. Census Bureau 2002). In Mott Haven, only 45 percent of older persons believe they can trust their neighbors and 50 percent believe neighbors are willing to help each other (U.S. Census Bureau 2002).

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Indeed, a number of features of city life can limit the mobility of among older people, discourage social interaction and increase the probability of isolation. As Phillipson argues, the idea that cities threaten to "imprison" older residents has been around for centuries. Phillipson notes that "cities combine images of mobility with those of loss and abandonment" (Phillipson 2004). Moreover, "the image of confinement is still present in the city, notably with the fear of entering particular neighbourhoods, or the danger of moving around areas at certain times of the day or night, or the threats posed by natural disasters" (Phillipson 2004:964).

Fear of crime can provide a strong deterrent to social interaction. In their study of aging in Paris, for example, Joel and colleagues found that older persons in Paris were much more concerned than those who live in rural areas in France about the lack of security in their neighborhoods. Among persons aged sixty and over, 15 percent of those living in provincial cities and 22 percent in the Paris region are concerned about security, compared with less than 5 percent in the rural areas. These concerns limited mobility and interaction and feelings of "connectedness" with the neighborhood (Joël and Haas 2006). In New York, older persons in Central Harlem often expressed concerns about going out at night. One woman told us that she was not comfortable walking around the neighborhood after dusk because her eyesight was "not what it used to be." She was not worried about falling, but she could no longer recognize people who approached her on the street in the evening.

Living alone is not the same thing as being lonely or isolated (Victor et al. 2000; Jong-Gierveld 2004). In Nordic countries, for example, surveys show high rates of living alone, but low rates of loneliness, while in southern European countries, living alone is more closely associated with feelings of loneliness (Jong-Gieryeld 2004). Nevertheless, living alone is a risk factor for social isolation. The Commonwealth Fund Commission on the Elderly Living Alone indicated, based on a national telephone survey, that one-third of older Americans live alone and one-quarter of these persons, typically older women, live in poverty and report poor health: "the elderly person living alone is often a widowed woman in her eighties who struggles alone to make ends meet on a meager income. Being older, she is more likely to be in fair or poor health. She is frequently either childless or does not have a son or daughter nearby to provide assistance when needed. Lacking social support, she is a high risk for institutionalization and for losing her independent life style" (Commonwealth Fund 1988).

Rates of living alone among all age groups are typically higher in dense urban areas, which makes world cities a prime location for all the risks associated with such household arrangements. Indeed, there are millions of people who live alone in these world cities, and the oldest old living alone is the fastest-growing segment of these populations. When the percentage of older persons living alone in the urban core of each city is compared to its first ring, there is a striking convergence. In all four cities, rates of living alone among older persons are higher in the urban cores (Table 1). This is true for the population

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Table 29.1
Percentage of Persons Living Alone in New York City, Paris, London, and Tokyo, Ages 65+ and 85+

	65 and Over		85 and Over	
	Urban Core	First Ring	Urban Core	First Ring
New York City (2000)	44.1%	29.7%	55.3%	40.1%
Paris and First Ring (1999)	44.0%	33.6%	59.8%	48.5%
Greater London (2001)	50.4%	39.3%	57.4%	52.3%
Central Tokyo (2000)	24.7%	20.4	23.0%	19.2%

Sources: New York–U.S. Census, 2000; Paris–INSEE 1999; Tokyo–Census, 2000; London–Census, 2001.

over eighty-five years old and more generally for those over sixty-five years old.

When compared across the four cities, however, Tokyo stands out as a great contrast. Its inner core has the lowest rate of persons eighty-five years and older living alone (18 percent) in comparison to London (54 percent), Manhattan (55 percent), and Paris (59 percent). The contrast is even more striking when broken down by gender. Yet, it is important to note that the rate of living alone is more than twice as high in Tokyo as it is in Japan as a whole (Kudo 2006).

In addition to gender, data on characteristics of older persons in New York and London indicate that ethnicity and race are important factors in distinguishing among older persons who live alone. In New York, rates of living alone are significantly lower among Hispanics and Asians aged sixty-five and older, and slightly lower among African Americans in this cohort than among their white counterparts. Likewise, in Greater London, rates of living alone are higher among the white population than black Caribbean, Indian, and Bangladeshi populations. Some groups are more likely than others to have kin in the local area, but proximity does not always translate into greater support (Moriarty and Butt 2004; Cantor 2006).

Table 29.2
Percentage of Older Persons Living Alone, in New York City, Paris, London, and Tokyo, by Gender, Ages 85+

	Men	Women
Manhattan (1999)	41.3	67.9
Paris (1999)	39.6	67.6
Inner London (2001)	45.2	62.3
Inner Tokyo (2000)	15.9	26.4

Sources: Manhattan–New York City Housing and Vacancy Survey, 1999; Paris–INSEE, 1999; Inner Tokyo–Tokyo Metropolitan Government, 2000; Inner London–UK Census 2001.

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The challenge for policy makers and service providers is to distinguish among those older persons who live alone (and not exclude those who do not) how many are vulnerable due to social isolation, poverty, disabilities, lack of access to primary care, linguistic isolation, or inadequate housing (e.g., living in walk-up apartments without elevators). Recent events in these cities illustrate the importance of meeting this challenge.

In the United Kingdom, the group Age Concern has helped to push the issue of social isolation among older people onto the policy agenda by arguing that loneliness and isolation among older people is one of the contributing factors to the large number of annual winter deaths due to hypothermia (*Peterborough Evening Telegraph* 2006). In New York City, the International Longevity Center-USA emphasized the issue of isolation of older people in the wake of the September 11 terrorist attacks. They found that "within 24 hours following the 9/11 terrorist attacks, animal advocates were on the scene rescuing pets, yet abandoned older and disabled people waited for up to seven days for an ad hoc medical team to rescue them" and concluded that "currently, there is no effective way to identify vulnerable people who are not connected to a community service agency" (O'Brien 2003).

The Chicago heat wave of 1995 provides another dramatic example of the consequences of isolated older persons (Klinenberg 2002). More recently, the 2003 heat wave in France provides a window into the extent of social isolation in Paris and its consequences. The French heat wave between August 1 and 20 of 2003 had devastating effects on older people, particularly in Paris, where there were 1,254 excess deaths over the preceding three-year average, an increase of 190 percent. Excess mortality was greatest among older women living alone (Cadot, Rodwin, and Spira 2007).

Unfortunately, we do not have direct, comparable measures of social isolation among older persons in these four cities. Instead, we examine the range of factors that are associated with isolation and social exclusion. These include: access to shops, amenities, transportation and medical care; innovative programs to encourage social interaction; the concentration of poverty in neighborhoods; and the cost and quality of housing.

FEATURES OF WORLD CITIES THAT PROTECT AGAINST SOCIAL ISOLATION

Neighborhood Amenities

In 1777, Samuel Johnson remarked that "When a man is tired of London he is tired of life; for there is in London all that life can afford" (as cited in Warnes and Strüder 2006:214). This assessment is, in many respects, still true today, and applies equally well to all four of our world cities. Each of these cities offers an extraordinary array of amenities, including retail shops, museums, theaters, concert halls and libraries.

Residents of these cities, and to a lesser extent, the inhabitants of nearby suburbs, enjoy an incomparable array of cultural activities. The concentration

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(" Paris Woman Café")

of theaters, cinemas, concert halls, museums, not to mention cultural institutions, is particularly high in these world cities. As one resident of the Stuyvesant Town neighborhood in lower Manhattan exclaimed, "I have everything I could want in my neighborhood. It is a wonderful place to live and I would never want to move!"

Furthermore, retired persons in all four cities benefit from numerous cultural institutions at reduced prices, where they can enjoy events that are reserved for them. Free concerts are not rare and certain time slots are reserved for retired persons, which confer on them advantages not given to those engaged in full-time professional activities.

In Paris, holders of the Paris Emerald card enjoy free access to certain institutions managed by the Paris Administration, such as museums (permanent exhibitions), parks and gardens, pools and public baths and outdoor sporting areas. Older persons are also eligible for subsidized meals in any of the forty-four Emerald restaurants that are operated by the Paris Administration.[5] One

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(Tokyo Woman in wheel chair)

can find at least one such restaurant in every arrondissement (administrative district) of Paris, and certain such areas have as many as four.

In the eastern area of London, interviews with older residents also emphasize the importance of "shops, cafes, youth clubs, sports and social facilities" (Cattell and Evans 1999). According to older persons in East London, these neighborhood institutions improve quality of life and produce a socially cohesive community, by encouraging interactions among different groups of people (Cattell and Evans 1999).

Yet, some researchers in Paris are concerned that the recent disappearance of neighborhood shops has eliminated an important venue for social interactions among neighbors. Despite their efforts, the Paris authorities have not managed to prevent this evolution, which is decidedly harmful to the quality of life and social interaction among many neighborhoods. Over the last decade, nearly a quarter of small businesses in Paris have closed for good.

The high value of land is reflected in the rents of commercial leases in the center of Paris. These high rents make it difficult for the small shops on which older people traditionally rely to remain in business. Even in the outskirts of the city, there has been a progressive disappearance of grocery stores that are now located some distance from the streets on which people live and which rent to most other shops. Likewise, banks, medical practices, and real estate agencies

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replace butchers, fishmongers and newsagents, and even cafes (de Chanay 2003). The lack of small shops is something that disturbs older persons in Paris when they assess the quality of their neighborhoods (Michaudon 2001).

Transportation

Adequate transportation is crucial to older persons and their ability to remain independent and avoid isolation. For example, one recent U.S. survey found that older persons listed a lack of transportation as one of the major barriers to seeing a physician (Fitzpatrick et al. 2004). Without adequate transportation, older persons are less likely to receive the services they need, less likely to be engaged in the community, and it is more difficult for them to remain in the community.

In rural and suburban areas of the United States, and in many cities as well, there is limited public transportation and automobiles are the primary source of transportation. If older persons do not own a car or are either unable or choose not to drive, their mobility is often severely restricted. Unfortunately, 21 percent of persons sixty-five years and over do not drive. Some older persons do not drive because of poor physical or mental abilities, and others do not drive because they are concerned about safety, but some do not drive because they do not own a car (National Household Travel Survey 2001). African American, Hispanic and Asian American persons sixty-five years and over are disproportionately affected by inadequate public transportation because they are much less likely than their white counterparts to drive.

Public transportation improves the mobility of older persons in many cities, but even in New York City, with its extensive bus and subway system, older people face limitations. Few subway stations have elevators, so for many older people, subways are not a realistic form of transportation. The New York City bus system is much better for people with disabilities, but in some sections of Queens and Staten Island, the bus routes are more limited and the stops less frequent than in the dense urban core of Manhattan. As Tobier explains, “Manhattan, because of its much greater degree of residential concentration and density, is second to none among the boroughs in respect to its user-friendly public transit facilities” (Tobier 2006). When interviewing older people living in these “outer boroughs,” we often heard complaints about the infrequency of bus service—or how impractical it was to use the bus system for grocery shopping. An eighty-two-year-old man living on the north shore of Staten Island told us he felt “trapped” because it was so difficult for him to visit places outside his immediate neighborhood.

Along with the problems faced by older people living in less densely population neighborhoods of the outer boroughs, older persons throughout New York complain about the adequacy of “access-a-ride,” the “paratransit” service for people unable to ride regular public transit. The service is mandated by the Americans with Disabilities Act (ADA) and operated by MTA New York City Transit. The people we interviewed for our study complained that although the

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"access-a-ride" vans usually show up, they are often late and this poses difficulty for older people who are frail and unable to wait on street corners for long periods of time. The transportation system to hospitals in Inner London is comparable to the "access-a-ride" program in New York—and seems to generate comparable complaints. According to a 2006 report by Anne Gray:

> Transport to medical appointments is particularly difficult. Because hospital transport involves a collective minibus which picks up several patients in turn from different places, the route is often very slow and roundabout and a journey of a mile or two can take an hour and a half each way. There is a risk of appointments being missed if hospital transport fails to arrive in time due to some delay or misunderstanding. One interviewee had missed several appointments from this factor. (Gray 2006)

The transportation situation in Paris is similar to that in New York City. Older Parisians are entitled to special passes for free transportation, and there is a dense network of public transportation; free access is granted to persons sixty years and over who are holders of specific cards (Emerald, Amethyst, or ONAC).[6] Nevertheless, it is important to note that if it is relatively easy to travel to and from Paris, traveling from one point in the suburbs to another can be very complicated and more time-consuming, even if the distances are shorter. The authorities and businesses involved are doing their utmost to correct these problems, but the transportation system remains oriented primarily towards the center of the region.

6

Centers of Medical Excellence

One component of the World Health Organization's definition of an "age-friendly city" is "accessible and appropriate health services." Several studies indicate that health and functional status influence social relations (Cerhan and Wallace 1993; Bowling. Grundy and Farquhar 1995; Mendes et al. 1996). People in poor health are less likely to have strong social networks and interact regularly with others—and those with poor social networks tend to have worse health. As Lund explains, "this would mean that a vicious circle is developed resulting in continuous deterioration in functional ability and weaker contacts with other people" (Avlund 2004).

All four cities, particularly their urban cores—Manhattan, Inner London, Paris, and Inner Tokyo—are centers of medical excellence. They enjoy a concentration of physicians and acute hospital beds, including those among large university teaching hospitals (Rodwin and Gusmano 2006). Do older residents of these world cities benefit from living in close proximity to the world-class medical care that exists within them?

With some exceptions, the answer appears to be yes for older residents of Paris and Inner London. Residents of these urban cores are less likely than people living in other parts of the country to suffer from "avoidable mortality," and die before the age of seventy-five from a treatable condition. They are also are more likely to receive specialty medical services, like bypass surgery or

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angioplasty (Gusmano, Rodwin, and Weisz 2007). With regard to avoidable mortality, our city-level analysis of health and economic disparities highlights the differences across these systems with regard to the geographic distribution of access to health services that is powerful and previously not documented. We find that the lowest income neighborhoods of Manhattan have rates of avoidable mortality that are significantly higher than the rest of the city. This is not true in Inner London or Paris.[7]

When we examine the management of chronic conditions, which has significant implications for the functional status of older persons, our findings are similar. There are some geographic and racial disparities in access to primary care and the management of chronic conditions within Inner London, but these disparities are not as severe as those we observe in Manhattan (Gusmano, Rodwin and Weisz forthcoming). To document these disparities, we examine "avoidable hospital conditions" (AHCs) across and within these urban cores. Among adults, AHCs are hospitalizations for conditions like pneumonia, congestive heart failure, asthma, diabetes, and chronic obstructive pulmonary disease (COPD). These conditions, if managed properly, do not usually lead to a hospital admission. As a result, high rates of hospitalizations for these conditions are recognized in the literature as an indicator of poor access to timely and effective medical care (Gusmano et al. 2006).

In Manhattan, we find a strong correlation between median household income, by zip code of residence, and discharge rates for AHCs. Ethnicity and insurance status on AHCs are also significant factors. The odds of AHCs are much higher among African Americans and Hispanics than among whites, and AHCs are also significantly related to health insurance status. Moreover, the significant geographic variation in discharge rates among NYC zip codes reflects the fact that older residents of poor neighborhoods were less likely to have health insurance before they turned sixty-five and are less likely to be covered by Medicare (Parts A as well as B).[8]

In addition to these problems of insurance coverage for a portion of New York City's older population, there is also the problem of inequities in the spatial distribution of medical care resources, reflecting the unequal distribution of wealth, income, and other goods and services (Politzer et al. 1991; Fossett and Perloff 1995; Andrulis 1997; Rodwin and Gusmano 2006; Gusmano et al. 2007). For example, there are high concentrations of medical and social services in areas where high-income-yielding jobs are most dense and in those neighborhoods where most residents work in these jobs, with low concentrations elsewhere. Neighborhoods in which higher-income people live also have higher rates of utilization of medical and social services compared with lower-income neighborhoods (Lantz et al. 1998).

Centers of Innovation

Faced with the challenges of an aging population, each of the four world cities we examined have created programs designed to improve the health,

quality of life, and social interaction of older persons. Even the centralized unitary states of Japan, France and the United Kingdom have been unable to meet the needs of the oldest old without close collaboration with local government, nonprofit organizations, community and neighborhood organizations and families.

National health programs address many of these needs, but not all. In particular, national health programs do not cover social services. In all of these places, the financing and delivery of social services tends to be more decentralized. Even city governments find it useful to rely on nongovernmental organizations to identify and respond to the needs of the oldest old.

Japan has the most centralized system of long-term care, but since there is an important financial contribution by prefectures and municipalities in funding this program, Tokyo Metropolitan Government, and the individual wards within Tokyo, share financial risk with central government. They therefore have an incentive to plan the configuration of long-term care services and, to whatever extent possible, reduce the amount of institutional care people receive. This requires them to assess the housing, transportation, and health and social service needs of older persons within their jurisdiction. Some wards can afford to provide more services than others. For example, Tokyo's Nakano, Shinagawa, Ota and Shibuya wards all provide preventive activities that are not financed by the other wards in that city (Okamoto 2006).

In France, although the financing of home help for persons with significant disabilities is more centralized than in Japan, Parisian authorities are still required to produce a local master plan for long-term care services, which includes social services, some of which are locally financed and provided. Furthermore, Paris provides cash allowances for very poor older persons, who are typically neither eligible for a pension nor for the *"allocation personnalisée d'autonomie"* (APA). APA, which was adopted in 2002, contributes toward the costs of daily home help services for people over sixty years who meet the dependency criteria.

Paris also offers a range of services for frail older persons living alone, which are more generous than those available in most other parts of France. In the aftermath of the 2003 heat wave deaths, the mayor's office developed a plan to help vulnerable older persons. By June 2006, after receiving a letter of invitation from the mayor, about 13,000 people with severe handicaps—most of whom were sixty-five years old and over—registered to be contacted and offered special services by the city's Social Services Agency in the event of a heat wave. Under the plan, a physician-led medical team conducts a preliminary screening and, if necessary, provides urgent medical services, transportation to a cooling center, or other services. It is too early to evaluate this new plan, but during the 2006 heat wave in Paris, this new system appeared to increase the number of daily contacts for socially isolated older persons (Cadot et al. 2007).

In the United Kingdom, the boroughs of London have responsibility for participating in the financing of, and deciding on placement of, older persons in social housing. Other examples, across all four cities, include city funding for

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telephone help lines, meal delivery for homebound older persons and transportation and rent subsidies.

Housing and long-term care can be strongly reinforced by such central government policies, as in Japan with preferential mortgage loans and long-term care insurance. Yet, there will always be a role for local government in implementing these policies, coordinating services, and making its own policies. This is seen in London and New York for housing and residential care, in Paris for provision of nursing and residential homes, or in New York, London and Paris to manage contracts for the provision of meals to frail older persons.

In addition, each of our four cities has developed new forms of housing to meet the needs of older persons who cannot or do not wish to live alone, either because they lack the support of informal caregivers who can assist them with daily activities, or because, even with such support, they desire the company of others as opposed to individualized home care. This housing take two forms: congregate housing with common services, or individual apartments with attached and collective services (hereafter called enriched apartments). The former involves the construction of facilities for long-term care use, whereas the latter involves the grafting of services to preexisting housing stock. We find that the latter is much more readily available in the urban cores of these cities, where land is most expensive. Apartments of this kind represent an important innovative use of urban resources. However, because such units are tied in some way to the housing market, rather than being designated for a particular purpose, they are usually more expensive than are congregate facilities, and are rarely fully funded through public means. Instead, various subsidies exist to pay for such housing and presume that the individual has some assets to pay for services. In the case of congregate housing, placement is means-tested in all four cities and is not readily available for the poor.[9] This type of subsidized care represents an intermediary form in an economic sense as well, somewhere between publicly funded long-term care and the private care one can procure in any of these cities.

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Among the four cities, New York has the greatest variety of such intermediary forms, spanning the funding spectrum from private, for-profit facilities to government-funded residential programs. For those who can afford them, a variety of high- to middle-income apartment complexes exist with attached social and home health services. To date, twenty-eight of these complexes have become officially recognized NORCs (naturally occurring retirement communities): apartment complexes in which over 50 percent of the population is over fifty years old and which receive public funding to support their services for older persons. At the opposite extreme, there are public housing facilities set aside for older persons, some of which provide common services.

Like New York, Tokyo and Paris both provide congregate housing with collective services, or individualized apartments with collective services. In Tokyo, neither type is fully publicly funded, but subsidies do exist. In Paris, there are both residential/retirement homes, which include the *foyers-logements* (individual apartments with collective services), operated by a city agency

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(CASVP), as well as the *maisons de retraite* (retirement homes). In London, there are residential care homes, but there are fewer of these places in London than in the coastal areas of the United Kingdom (Kilbey 2000). Unlike in New York and Paris, where funding exists from national sources, residential care homes in London are financed by each local authority. Residential care homes vary in terms of their size and the scope of services. Most provide room and board with congregate meals and some social services. A few also provide limited access to district nursing services. Although these homes may be appropriate for older people with mild cognitive impairment, they are designed primarily for people who do not have serious medical problems. Smaller residential care homes may only accommodate ten to fifteen older people, while others may accommodate more than one hundred older people.

In Tokyo, policy-makers face new incentives to develop more housing of this sort as a result of Japan's Long-Term Care Insurance program (LTCI). As Campbell and Campbell explain, "for a person at a given level of need, LTCI must pay at least $7–800 more per person per month for institutional care compared with the bill for community-based care. If the mayor of a Tokyo ward could arrange for 100 people to live in some sort of housing with community-based services, rather than an institution, it would save about $1 million" (Campbell and Campbell 2006). As a result, local officials in Tokyo are discussing with private developers the possibility of creating additional housing of this sort.

Paris provides the highest density of such community residential-care places, with 73.4 per 1,000 persons sixty-five and older, followed by New York City (60.8), Greater London (33.4), and Tokyo (11.9). With the exception of Tokyo, where cohabitation with children is still an important kind of living arrangement, the density of such community-based options is higher than that of institutional care settings. Even in London, nonmedicalized residential care places are more readily available than nursing home beds. Most notably, in Manhattan and Paris, the availability of enriched apartments far surpasses that of nursing home beds. Whether this is an outcome of deliberate policy or simply a reflection of market forces remains an open question; what is certain is that more care is currently provided in the community as opposed to in nursing home facilities.

Giving Voice to Older Residents

In all four world cities, municipal governments have invoked the rising importance of providing older persons with information about the multiplicity of services available to them and involving them in plans for the future. With respect to giving older persons greater voice, Paris's gerontological master plan called for a "Rights of Older People Charter," which is designed, in part, to provide older Parisians with an opportunity to voice their policy preferences. Tokyo Metropolitan Government conducted a consumer survey to evaluate the satisfaction of older persons with the implementation of LTCI. Furthermore,

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efforts to allow for greater voice vary within these cities. For example, in Tokyo, Nakano ward is notable for encouraging the direct participation of residents in policy-making. In this same spirit, Age Concern in the United Kingdom has advocated on behalf of "giving voice to all age groups" (Age Concern England 2000).

As for getting information to older persons, in Paris, the neighborhood coordination centers, or "Emerald Paris Points," provide information about existing services, address inquiries, and assist older persons and their families and caregivers with decision making. In New York City, Department for the Aging provides a wealth of information about federal, state, and local programs for older persons, including tools that help people determine their eligibility for different services. There are questions about how many older persons access this information on the Internet, but this is an important innovation that is likely to be used by an even larger portion of future cohorts of older persons.

FEATURES OF WORLD CITIES THAT PRODUCE SOCIAL ISOLATION

Just as the benefits of growing older in a world city are not shared equally among these cities, there are differences with regard to burdens associated with such places. In particular, the greater geographic concentration of poverty in New York and London distinguishes these "hard" world cities from their "soft" counterparts—Paris and Tokyo (Body-Gendrot 1996).

Previous studies of aging have often pointed to a close relationship between poverty and social isolation or loneliness (Townsend 1979; Lawton 1983). This is due, in part, because neighborhoods in which there is a high concentration of poverty, and an absence of middle- and upper-income residents, suffer from a lack of collective efficacy (Sampson, Raudenbush and Earls 1997). According to Browning and Cagney, places lacking collective efficacy are neighborhoods in which residents are less likely to trust their neighbors and are less capable of working to secure resources for the community (2003).[10]

With respect to neighborhood polarization of this kind, there are stark differences among these cities. London and New York are characterized by the largest socioeconomic disparities across neighborhoods, and both have neighborhoods in which there are high concentrations of deprivation and few affluent residents (Hamnett 1994). The "dualism" that we see in London and New York is one of the characteristics closely associated with world cities. In both cities, globalization has produced high-income jobs in the financial and technology sectors—and a host of low-income jobs in the service sector. Growing occupational polarization in these cities has led to greater income polarization and special segregation. In New York, this has reinforced existing racial and ethnic cleavages. In London, it has reinforced social class divisions (Buck and Fainstein, Gordon and Harloe 1992; Sassen 1994; White 1998).

Yet, as White explains, this characterization of world cities does not describe Paris or Tokyo particularly well.[11] Paris has become known as a "soft" global

city, in contrast to London and New York, because, reflecting national policy, it provides more income support, family services, and health services to the poor (Body-Gendrot 1996). This state role goes beyond the support of an incomes policy across occupational groups. It also tempers the tendency toward spatial segregation that is more pronounced in New York and London. Although there are increasingly small neighborhoods with concentrated ethnic minorities, such as the Goutte-d'Or, Belleville or Chateau Rouge, there are still no areas the size of an *arrondissement* that can claim a spatial division along ethnic lines. This outcome is partly the result of the explicit attempt to support social heterogeneity across spatial units of Paris—the policy of *mixité social* (Rodwin 2006). The central state, as well as the Paris authorities, attempt to alleviate the harsher impacts of globalization and the general difficulties of growing older in a city characterized by increasing polarization. Likewise, Tokyo is characterized by less social and spatial polarization, not only because there is less ethnic diversity than in the other cities, but also because income distribution is more equal.

Yet, in both Paris and Tokyo, income inequality increased significantly during the 1990s. In this sense, both of these cities are, indeed, global cities with the kinds of social polarization analyzed by Saskia Sassen (Sassen 1994). It will be important to monitor the evolution of these cities and the degree to which these nations and cities remains willing and able to protect residents from the pressures of globalization.

Cost and Quality of Housing

The quality of housing is a vital component of quality of life for older persons. Without decent, affordable housing, it is impossible to gracefully "age in place" (Stafford, Part V). Generally, housing for older persons in London is better than it was in the early 1990s, and, according to Warnes and Struder, "it is no longer the case that poor housing is associated with older occupants" (Warnes and Strüder 2006). Yet, there is still tremendous variation within the city of London. Most postwar public housing has high standards with basic amenities, but public housing in the poorer boroughs of London is often deficient, even lacking central heating. Neither the government, nor private landlords, have invested adequately in home improvement in many London boroughs.

Paris has a very old housing stock dominated by small units. In central Paris, housing is more antiquated and substandard than in its first ring. Within Paris, a slightly higher share of older persons live in housing units without bathrooms, and a slightly lower share live in housing units without toilets than their younger counterparts.

In contrast, the quality of housing in New York City is better for older persons compared with their younger counterparts. Nearly all older New Yorkers live in housing units with complete kitchen and bathroom facilities. Older persons are also more likely to own their homes (48.8 percent vs. 33 percent).

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Among those who rent, more than half enjoy some form of rent stabilization—either rent control or rent exemption. Another 20 percent of older persons live in public housing. Housing represents an important source of wealth, particularly for older persons in the United States (Muller et al. 2002). Despite this, housing costs are a major concern for older New Yorkers. While these expenses faced by older persons who own their homes are often lower than for the population as a whole, they tend to represent a higher percentage of income (Muller et al. 2002). The costs associated with both maintaining property and increases in property taxes represent significant financial burdens to older persons living on fixed incomes. According to the U.S. Census, ownership expenses represent more than 35 percent of income for 6 percent of New Yorkers aged sixty-five and over (U.S. Census Bureau 2000). Older renters face an even more difficult situation. Rent increases and fluctuations in the rental market place older renters in a precarious economic situation. Although many older New Yorkers enjoy protection against rent increases through rent control and rent exemption programs, 46 percent of persons sixty-five and over pay 35 percent or more of their incomes in rent.

In London, Paris, and New York, the percentage of older persons living in substandard housing is significantly higher in the poor neighborhoods of the city. For example, according to the New York City Housing and Vacancy Survey, about one-quarter of older persons living in the city's poorest neighborhoods live in quarters that are unsafe for human habitation (Knapp 2006). Although Marie from Hunts Point in the Bronx did not complain about any problems with the quality of her apartment during our interview, more than 40 percent of renters age 65 and over in the Bronx report the existence of four or more maintenance deficiencies (Knapp 2006). We do not currently have systematic data on the quality of housing among older persons in Tokyo, but John and Ruth Campbell argue that much of the housing in Tokyo is inadequate to meet the needs of frail older persons (Campbell and Campbell 2006).

CONCLUSION

The unprecedented convergence of population aging and urbanization presents great challenges and opportunities for cities and their older residents. Our project explores how the four largest cities in the wealthiest nations of the world—New York, London, Paris, and Tokyo—are confronting these changes.

Many of the institutions, neighborhood characteristics, and other social factors that influence the health and well-being of older people may be beyond the reach of city government and must be addressed at the national level. Cities are limited in their ability to redistribute income and address neighborhood-level poverty and inequality (Judd and Swanstrom 1994). Similarly, many environmental issues must be addressed at a regional level (Sclar 2003). Nevertheless, we should not underestimate the ability of city governments to address social issues, including the health and well-being of older residents. Nor should we overestimate the capacity of the existing national welfare states

to serve those who fall through the cracks of a host of health and social welfare programs. Cities, and other local governments, address many social problems that are not addressed adequately by the national government.

Similarities and differences

Although the cities face similar challenges, they do so within national health, social, and long-term care policy contexts that are quite different. With regard to heath care, Parisians and Tokyoites are covered by systems of national health insurance (NHI). The National Health Service (NHS) covers Londoners. Medicare (Parts A and B) covers most older New Yorkers, but not all. As a result, there are greater disparities in access to health care services among older residents of New York City than of any of the other cities we examine.

There are also differences in coverage of long-term care. Japan is the only country of the four with long-term care insurance. Home help and home nursing services for older persons are covered primarily by the national Long-Term Care Insurance (LTCI) scheme, and everyone forty years old and over contributes to this program. There are two broad categories of beneficiaries for LTCI. Those aged forty to sixty-four must pay insurance premiums, but are only eligible for services if their long-term care needs are the result of one of fifteen aging-related diseases. Those sixty-five and over pay higher premiums, which are deducted from their pensions, and are eligible for home care services regardless of the level of their needs. Users are expected to pay 10 percent of the cost of services, and the other 90 percent is covered by a mix of municipal, prefectural and national funds. Premiums in 2000 were around $24 per person per month, but they vary across municipalities (including across Tokyo's wards).

Yet, despite the differences in the national policy frameworks within which world cities operate, we see a host of important similarities. First, in all four cities, even in the most centralized unitary states such as France, Japan and Great Britain, there is also an area of discretionary local policy. This is particularly important with respect to the process of determining eligibility and subsequently arranging for home nursing services and a host of social services and home help services. For example, local authorities in London have a critical role in the allocation of residential care for frail older persons; social services for older persons may vary greatly by *ku* within Tokyo, and social welfare in Paris is reputedly more generous than in most other French departments, though there appears to be considerable variation within Paris.

Furthermore, despite differences in the extent of access to health and social services among these cities, they are all struggling to find ways to cope with the challenges associated with population aging. In Manhattan, Inner London and Paris, over half of the oldest old live alone. Within this group, however, we do not know the relative share of those who are isolated and lonely versus those who have the ability to remain independent. Learning more about the

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location of a city's most vulnerable oldest old is crucially important. The 2003 August heat wave in France served as a dramatic example of how a city with a high concentration of older persons can be completely unprepared to cope with its aging population. In Paris, the result was thousands of deaths. But many people do not realize that a comparable event took place in Chicago in 1995. Similarly, thousands of older New Yorkers were left stranded and dangerously isolated during the days immediately after 9/11. Despite a number of striking differences in the health and social systems of these nations, neither France nor the United States were prepared to address the needs of vulnerable older persons living in their major cities. During the coming decades we will learn whether lessons from these tragedies will lead to more effective efforts to address the needs of older urban residents.

NOTES

1. In this chapter, we draw on our original pilot survey of older residents from ten neighborhoods of New York City: Mott Haven (census tract 69) in the Bronx; Bay Ridge (census tract 52.01) and Williamsburg (census tract 481) in Brooklyn; Central Harlem (census tract 236), Upper East Side (census tract 154), Peter Cooper/Stuyvesant Town (census tract 60), and Clinton/Chelsea (census tract 93) in Manhattan; Bayside (997.02) and Flushing (census tracts 1033 and 1163)) in Queens; and the Rosebank section of North Shore (census tract 6) in Staten Island. During our semistructured interviews, we asked older residents a host of questions about: (1) the built environment and attitudes about the neighborhood as a place to live; (2) medical resources and neighborhood institutions; (3) social interaction, including: work and retirement; social and political activities, volunteer work; and participation in neighborhood groups and activities; (4) morale and life satisfaction; health, functional ability, and physical activity. The questionnaire was based on: (1) the survey used by Marjorie Cantor for the 1970 and 1990 studies of older New Yorkers conducted by the New York City Department for the Aging and the New York Center for Policy on Aging of the New York Community Trust; (2) the survey developed for the AdvantAge Initiative; and (3) the survey of social and health indicators across King County, Washington, developed by Communities Count. We recruited participants at senior centers, religious institutions, senior housing facilities, and other neighborhood institutions to produce a convenient sample of older persons living in these neighborhoods. The final sample included 216 interviews.

2. Organization of Economic Cooperation and Development

3. Fortunately, this is beginning to change (Stafford this volume). The World Health Organization began a program to promote "age friendly cities." This initiative is new and has not yet produced significant results, but the WHO's leadership in bringing attention to this issue is a welcome development. (http://www.who.int/ageing/age_friendly_cities/en/index.html)

4. Although a recent comparison of England and the United States indicates that Americans have inferior health status compared to the English (Banks et al. 2006), this study examined indicators that fail to distinguish between the determinants of population health that can be attributed to health care and those that cannot (poverty or lifestyle).

5. The Paris Emerald Card is given to Parisians sixty years and over and to certain individuals with disabilities who satisfy residency requirements (three years over the

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past five) and whose income tax does not exceed a ceiling set by the Council of Paris (2028 euros in 2003). This card is given for a one-year period and is renewable. Parisians living in institutions owned by the CASVP outside the city are also eligible.

6. The Emerald card allows for free public transportation in Paris. The Amethyst card, by contrast, is purchased on a means-tested basis and allows for free public transport in Paris and the surrounding region. The eligibility conditions are similar. The ONAC card is provided for veterans and also allows for free public transportation.

7. Comparable hospital administrative data are not currently available for Japan, so we had to exclude it from this aspect of our analysis.

8. Medicare Part A is the hospital insurance component of the program. Part A helps pay for inpatient hospital care, limited inpatient care in a skilled nursing facility, home health care, and hospice care. Part A has deductibles and coinsurance, but most people do not have to pay premiums for Part A. Medicare Part B helps pay for doctor's services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by Part A. Part B has premiums, deductibles, and coinsurance that an individual must pay through another insurance plan or by one of the Medicare savings programs that the state and the federal government have created to help low-income Medicare beneficiaries with their out-of-pocket expenses.

9. For example, while Medicaid does fund assisted living programs in adult homes, only around 3,000 such places were available in New York City in 2000. It is difficult to evaluate the "need" for this type of housing, but conversations with representatives of the New York City Department for the Aging and the New York City Housing Authority reinforce our view that there are not enough affordable assisted living facilities to meet the needs of older New Yorkers.

10. As Browning and Cagney explain, "collective efficacy may aid in correcting or avoiding the accumulation of neighborhood physical hazards such as decaying infrastructure and housing stock. Communities with the capacity to solicit and secure external resources to correct potentially risky conditions and monitor vulnerable residents (e.g., the elderly) are likely to enhance health" (2003). They find that "the prevalence of middle and upper middle class residents in urban communities is an important structural factor influencing health promoting conditions" (Browning and Cagney 2003).

11. This leads White to reject the "global city hypothesis" because it is too simple, overemphasizing the importance of capital mobility and globalization, while underemphasizing political variables that explain the differences among "world" or "global" cities.