

Demographic Trends Influencing Public Health Practice

Christiane Hale **A**t the beginning of the twenty-first century, the United States is facing social changes as tumultuous as those of 100 years ago. Like echoes of an earlier era, these current changes impact who we are as a people and how we define ourselves. But, in unprecedented ways they also are altering our family lives and testing the limits of social institutions.

Three demographic trends underlie the social changes of the past quarter century:

- new family patterns catalyzed by high divorce rates and increasing out-of-wedlock childbearing;
- shifts in income distribution with widening income disparities between the poorest and richest households;
- increasing racial and ethnic diversity of the U.S. population.

We can see their impact in health care. As poverty has become a common condition of childhood, health care for children increasingly depends on societal willingness to adequately fund programs like Medicaid, the federal insurance program for low-income mothers and children, and the Basic Health Plan, Washington State's insurance program for the working poor. Adults who lack a high school education — often immigrants and people of color — are usually employed in low-wage jobs or under contract. Such work seldom includes health insurance or at best offers coverage just for the worker but not family members.

Understanding these demographic trends not only clarifies the issues related to health care, but also those that affect education and the relation between families and workplaces. Such trends have been intensifying since the 1960s and seem unlikely to reverse. Adapting our social arrangements — including those for health care — to accommodate the new social realities will be one of our biggest policy challenges in this decade.

Shifting Family and Economic Patterns

The first two demographic changes — new patterns of family formation and shifts in income distribution — are so intertwined that they still cannot be completely disentangled. A generation ago, the dominant family model was breadwinner-husband and homemaker-wife raising their own biological or adopted children. Today many people don't even live in what are generally defined as "families," that is, persons related by legal kinship.

About 30% of Americans live alone or in non-family combinations, such as with housemates, friends, or partnerships outside legal marriage. Even if we restrict "families" to the standard definition, 43% are married couples without children younger than 18, and 35% are married couples with children. Another 10% are female-headed families with children, 3% are male-headed families with children, and 10% are other family types (e.g., siblings living together).

What accounts for this dramatic change? By 1965 divorce rates had risen so sharply that more marriages ended in divorce than in the death of a spouse. Today nearly 50% of marriages end in divorce. One consequence is that before age 18, more than half of children whose biological parents were married will live two or more years in a single-parent household. Another trend is a steady increase in the proportion of births to single women. In 1970, fewer than 10% of women giving birth were single; by 1998 that figure had risen to a third. A similar trend occurred in Washington State where 15% of births in 1980 were to single women, compared to about 28% in 1998.

These changes in family formation have occurred against the backdrop of major economic shifts that have exacerbated

New Immigrant and Refugee Communities Mean New Challenges for Public Health

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Health care organizations in the 1990s struggled to meet the needs of increasingly diverse patient populations. Today's immigrants and refugees are not the educated professionals of the 50s and 60s. They are the poverty stricken and the survivors of war-ravaged nations, all seeking a better life in America. Refugees from Cambodia, Vietnam, Somalia, Ethiopia, Eritrea, and more recently Eastern Europe (Bosnia, Kosovo), represent all walks of life from the rural farmer to the diplomatic elite.

Over the past decade, refugees who originally settled in federally targeted regions across the nation have moved to join relatives and loved ones. Strongly identifiable immigrant communities are emerging in cities such as Seattle, Minneapolis, and Washington, D.C. Likewise, immigrants are moving to cities with expanding service industries where low-wage employment abounds. Descendants of these immigrants and refugees represent the largest percentage of the nation's population growth, a trend that will continue well into this new century.

These tight-knit communities, similar to the German, Italian, and Irish communities of the early 1900s, tend to shop at the same stores, seek work in the same locations, and use the same health and social services. Each community brings unique perspectives, beliefs, and expectations of America.

As members of immigrant communities enter health care organizations, both as patients and staff, the need for change within these institutions increases. The lack of linguistically and culturally competent services often leads to disastrous outcomes for patients and for institutions around the country. Expanded federal requirements for providing culturally competent services has forced institutions to reconsider the use of family members and untrained staff as interpreters. The movement to recognize the medical interpreter as a professionally trained medical staff member has grown dramatically over the last decade.

We have also witnessed pioneering efforts by medical institutions to translate health education materials, train their board members and management teams in cultural competency, and design services that are relevant to the needs of the communities they serve.

In this new century, health care organizations not only must consider the diversity of their clients, but identify the communities represented and design products, employment, educational materials, services, and programs to meet the particular needs of each community. As the Census Bureau has recognized, it is time to move beyond broad racial designations — so should health care organizations.

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income inequality. A measure called "relative income," based on median income, clarifies this trend. Median income is the midpoint value for incomes: 50% of people earn more than the median and 50% earn less. Low relative income is less than half the median, while high relative income is twice the median.

In 1969, 18% of people had low relative incomes and 15% had high relative incomes. Although a comprehensive report of current relative income awaits analysis of the 2000 census data, numerous surveys suggest that income disparity continued to increase during the 1990s. One survey found that in 1973, average income for the wealthiest fifth of households was \$83,000; by 1994, it had soared to \$105,000 (in adjusted dollars). For the poorest fifth of households, average income dropped from \$8,100 to \$7,800.

The drop in income has been particularly marked among young men, especially those with a high school education or less. In 1993, about a third of men aged 25–34 did not earn enough money to move a family of four out of poverty. Although these men would be potential husbands for women in the same age group with similar educational levels, this demographic group accounts for most of the out-of-wedlock childbearing. Some researchers suggest that women are choosing not to marry because their potential partners do not offer an opportunity for economic enhancement, so they prefer to stay single and depend on the welfare system to meet their needs. However, recent changes in the legislative basis of the welfare system are forcing poor women into the labor force and their children into day care.

Increasing Social and Ethnic Diversity

Just as family living arrangements and economic well-being began to intertwine in the late 1960s, Congress removed U.S. immigration restrictions in place since 1920 and made occupational qualifications and family reunification the joint bases of new immigration policies. After more than 50 years of low immigration, numbers began to rise and now have reached the levels of 100 years ago. About 800,000 legal immigrants entered the country in 1997. Worsening economic conditions in Mexico and Central America in the past 10 to 15 years appear to

have increased an always-steady flow of illegal immigrants, although their numbers cannot be determined accurately. Two figures suggest the magnitude of this stream. More than 1.5 million illegal entrants were apprehended in 1997. A year earlier, the Immigration and Naturalization Service estimated that 5.3 million people were illegally living in the United States.

Immigrants influence fertility data in two ways. First, regardless of their countries of origin, they tend to have higher fertility rates than do native-born people. Second, immigrants are concentrated in the 20- to 39-year-old age group, which is also the prime period of family formation. Under conditions of low fertility — such as have characterized the U.S. population in the past 30 years — immigration becomes especially important. For example, although Washington State is not one of the major destinations for immigrants, in 1998 about 19% of residents giving birth were foreign-born. Long-standing fertility differences between racial and ethnic groups contribute to increasing population diversity, in Washington State and nationwide. Table 1 compares the state's racial and ethnic makeup with the distribution of births.

Washington State data also demonstrate how immigration influences the shifting economic well-being of families. Two factors largely determine that well-being: marital status and education. In 1998, 22% of the foreign-born mothers but 29% of native born were unmarried when they gave birth. So, at least in this state, an increasing fraction of immigrants might slow down the rate rise in births to single mothers.

Education is the most important determinant of how both immigrants and native born fare economically. Nationally, education among immigrants is concentrated at the two extremes. In 1997 about 30% of foreign-born residents had at least an undergraduate degree (compared to 24% for the native-born population), but 34% had less than a high school education. Births to Washington State residents in 1998 echo this pattern: 35% of foreign-born mothers had less than a high school education compared with 14% of native-born mothers. However, 21% of foreign-born mothers had at least an undergraduate degree, as did 25% of native born. Whether educational differences

Table 1: Racial and ethnic distribution of Washington's population and births in 1998*

Racial/Ethnic Group	Percent of State Population	Percent of Births
White, non-Hispanic	83	75
Hispanic	6	12
Asian/Pacific Islander	6	7
African American	4	4
Native American	2	2

*Estimates from State Office of Financial Management

predict income differences among the foreign born, as they do among the native born, also must await the results of the 2000 census.

These different educational distributions probably also explain why Medicaid paid for 45% of deliveries to foreign-born women compared to 35% of deliveries to native-born women. Recent studies point out that immigrants represent an economic gain at the national level because they pay federal income tax, but are a net cost in states with large immigrant populations because they use programs, such as Medicaid, that are largely funded with state and local dollars.

How these demographic trends affect health care and public health services depends on the choices we make. As a society, we can continue to meet health care needs with a combination of employer-linked health coverage, Medicare, and subsidized insurance for those defined as the deserving poor (e.g., some poor mothers and children and the disabled). Alternatively, we can examine our current system to determine its appropriateness given the new realities of American family life, and change it accordingly.

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