we the people:

key demographic trends in the United States

Recent projections from the U.S. Census Bureau and the Pew Research Center verify what demographers have long recognized: the United States is undergoing a demographic revolution. Immigration continues to increase our numbers, and we are growing older and more racially and ethnically diverse by the day. How we experience these changes will depend on a variety of factors, including social, economic, and political decisions that are ours to make. So while these demographic shifts present a challenge for families, communities, government, health care, and other sectors, forethought in policy planning and a willingness to invest resources where they are needed most can make the difference between this transformation being a crisis or an opportunity.

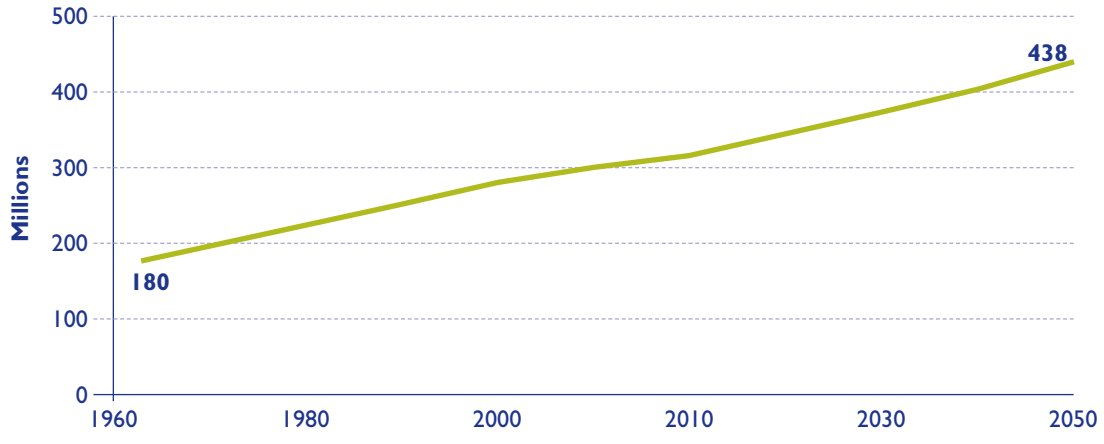
DEMOGRAPHIC TRENDS

In contrast to many other developed nations, the United States has sustained fairly vigorous population growth and will keep growing at a rapid pace over future decades. The current U.S. population is estimated to be 305 million, and it is expected to grow to over 438 million by 2050 (Figure 1). While it is true that the country's total fertility rate (2.1) is high for an industrialized country, the increase in population will come, for the most part, from immigration (Population Reference Bureau 2008).

The United States has always been a nation of immigrants. Over the past few decades, international immigration has been fueled by the global integration of economies, variations in population growth, and economic disparities across nations. In 2005 the United States had a larger foreign-born population (38 million) than any other nation (Population Reference Bureau 2008). Russia was second with 12 million immigrants, and Germany was third with 10 million. Immigrants make up approximately 13 percent of the overall U.S. population. According to projections from the Pew Research Center, new immigrants and their U.S.-born descendents will account for 82 percent of the nation's population growth, while the resident population and its descendents will account for 18 percent (Passel and Cohn 2008).

It can be argued that immigration is a vital counterbalance to another critical demographic trend: the aging of the baby boom generation (Puentes 2008). In 2030, when all of the baby boom generation will have reached retirement age, nearly one in five U.S. residents is expected to be 65 and

FIGURE 1: ACTUAL AND PROJECTED U.S. POPULATION INCREASE, 1960 TO 2050



Source: Passel and Cohn 2008

older (U.S. Census Bureau 2008). This age group is projected to increase to 88.5 million in 2050, more than doubling the number in 2008 (38.7 million). At that point, the elderly population will be 19 percent of the population (Passel and Cohn 2008). The 85 and older population is expected to more than triple, from 5.4 million to 19 million between 2008 and 2050 (U.S. Census Bureau 2008).

For many, diversity is this nation's demographic headline. It is projected that minorities will make up the majority of the U.S. population in 2042.

As the elderly increases as a share of the population, the percentage of the population in the traditional working ages of 18 to 64 is projected to fall. So although the working-age population will reach 255 million in 2050, the rate of increase will be lower than for the population as a whole, and the percentage of working-age adults will drop from 63 percent in 2008 to 57 percent in 2050 (Passel and Cohn 2008; U.S. Census Bureau 2008). All of the growth in the working-age population over this period will be among immigrants and their descendents born in the United States, and without new immigration, there would be a decline of 7 million people in this category (Passel and Cohn 2008).

For many, diversity is this nation's demographic headline. It is projected that minorities – defined by the U.S. Census Bureau as everyone except non-Hispanic, single-race whites – will make up the majority of the U.S. population in 2042. By 2050 Hispanics, African Americans, Asian/Pacific Islanders, and American Indian/Alaska Natives, now roughly one-third of the U.S. population, will account for 54 percent of the population (U.S. Census Bureau 2008). The non-Hispanic, single-race white population is expected to drop from 66 percent of the total population in 2008 to 46 percent in 2050. In the meantime, the Hispanic population is anticipated to nearly triple, from 46.7 million to 132.8 million (15 percent to 30 percent) during the 2008-2050 period. In 2050 it is projected that one-third of U.S. residents will be Hispanic (U.S. Census Bureau 2008).

Other minority groups will also grow, with the African-American population projected to increase to 65.7 million, or 15 percent; the Asian population projected to climb to 40.6 million, or 9.2 percent; the American Indian and Alaska Natives populations projected to rise to 8.6 million, or 2 percent; and the Native Hawaiian and Pacific Islander population expected to nearly double, to 2.6 million. The number of people who identify themselves as being of two or more races is projected to more than triple, from 5.2 million to 16.2 million (U.S. Census Bureau 2008).

This trend will have the largest effect on working-age and child populations. The working-age population is projected to become more than 50 percent people of color in 2039 and be 55 percent people of color in 2050 (up from 34 percent in 2008). Also in 2050, the working-age population is projected to be more than 30 percent Hispanic (up from 15 percent in 2008), 15 percent African American (up from 13 percent in 2008), and 9.6 percent Asian (up from 5.3 percent in 2008). In 2050 the nation's population of children is expected to be 62 percent people of color, up from 44 percent today. Thirty-nine percent are projected to be Hispanic (up from 22 percent in 2008), and 38 percent are projected to be single-race, non-Hispanic white (down from 56 percent in 2008) (U.S. Census Bureau 2008).

CHALLENGES

Each of these demographic trends brings its own challenges. Immigration has become an increasingly contentious issue, with many Americans being uneasy about the cultural impact of immigration and expressing concern – despite some evidence to the contrary – about whether immigrants replace native workers in available jobs, overwhelm hospital emergency departments, or place other strains on society. Public and private conversations about immigration quickly become divisive, politicized, and emotional (Grantmakers In Health 2005; The Opportunity Agenda 2007).

The aging of the population is of concern for two reasons. The first is because of the dependency ratio, the ratio of the economically dependent part of the population to the productive part. It is assumed that a larger number of older or younger Americans in proportion to the number of workers results in increased costs for (and strain on) workers to support the care of the economically dependent. The elderly dependence ratio was 20 people ages 65 and over for every 100 people ages 18 to 64 in 2005 and is projected to rise to 32 elderly per 100 people of working age in 2050 (Passel and Cohn 2008). In contrast, the child dependency ratio is projected to undergo little change, remaining at about 40 children for every 100 people of working age through 2050.

The second reason the aging of the population is of concern is because older adults experience high rates of chronic diseases, which cause pain and disability, sap function and independence, and are a major contributor to health care costs. Because older Americans are high users of

the health care system, they are also especially vulnerable to its failings, especially the lack of coordination between acute and long-term care systems. And determining how best to bolster the workforce of paid and unpaid caregivers and how care provided to the elderly will be financed in the future are major challenges.

Finally, projections about our country's increasing diversity give a new urgency to efforts to address racial/ethnic disparities in health and health care. Although aggregate data mask important differences between groups, in general, people of color have poorer health and shorter lives than whites, suffering disproportionately from many illnesses, even after controlling for socioeconomic status and insurance coverage (Grantmakers In Health 2007). Reducing these disparities is a complicated task that will require work to address the many factors that affect health, including: the condition of the social environment, including racism and poverty; access to care; health behaviors; structural aspects of the delivery system that affect both quality and patient care experiences; and the condition of the environments in which minorities live and work, including air and water quality and exposure to other environmental hazards (Grantmakers In Health 2007).

Fully aware of these demographic trends, many funders are investing in efforts to improve the health, social connectedness, and opportunities of immigrants; creating a movement for chronic care and long-term care reform; and building the public and political will to end health disparities.

IMPROVING THE HEALTH AND SOCIAL CONNECTEDNESS OF IMMIGRANTS

Many foundations play an important role in ensuring the health and well-being of immigrant populations and are engaged in activities that build capacity in immigrant communities, promote immigrant integration, expand health care coverage, educate immigrants on their rights and eligibility for health care services, increase public awareness and understanding of immigration, and address the cultural and linguistic needs of these populations. Two illustrative examples of this type of work follow.

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Many immigrants and refugees from Africa, Asia, Eastern Europe, and Latin America now call Minnesota home. According to the U.S. Census 2000, the number of Minnesotans born outside the United States increased by 130 percent between 1990 and 2000, and Minnesota was home to the country's largest Somali and second-largest Hmong and Liberian populations – most of them political refugees (Blue Cross and Blue Shield of Minnesota Foundation 2008). The Blue Cross and Blue Shield of Minnesota Foundation's Healthy Together: Creating Community with New Americans initiative bridges the foundation's former funding priority, which helped people with unique cultural needs navigate the complex health care system, and its new focus on the social determinants of health. Designed to reduce health inequities for immigrants and improve the health and vitality of the entire community, the initiative includes grants to projects that foster facilitated exchanges between immigrants and the receiving community, leading to greater social connectedness, healthier communities, and increased opportunities available for all; build the capacity and viability of immigrant-led organizations; and promote the mental health and social adjustment of new Americans. The initiative boasts an impressive list of desired outcomes, including:

- an intentionally more cohesive community of newcomers and long-time Minnesotans that is sustainable over time;
- strong organizations that serve as "bridging" institutions between immigrants and the larger community, including partnerships with other organizations to maximize program effectiveness and efficiency;
- increased resources to foster the healthy social adjustment of new immigrants through the use of community health workers; and
- prevention and early detection of mental health and social adjustment problems, especially through community-level programs.

The foundation is evaluating the initiative to document results; generate lessons for improved effectiveness; and show progress toward the desired outcomes related to health, immigrant integration, and social connectedness. The evaluation will be operated on collaborative and participatory principles, providing opportunities for grantees and foundation staff to learn along the way through engagement in evaluation design, data collection and interpretation, and peer reflection.

In 2006 the U.S. Census Bureau reported that there were more than 102,000 New Hampshire residents, five years and older, who speak a language other than English at home (Endowment for Health 2008). Within a five-year period, the number of New Hampshire residents who spoke other languages at home increased by almost 9 percent, and that number is expected to continue to grow. The New Hampshire-based Endowment for Health has made considerable investments in building the state's capacity for medical interpretation by supporting training, a statewide interpreter brokerage, and infrastructure for the state's Medical Interpretation Advisory Board (MIAB). The statewide interpreter brokerage is the Language Bank, administered through Lutheran Social Services of Northern New England, which provides language interpretation services, interpreter training, outreach and education to potential users of the service, as well as coordination for service providers. What began as an idea to provide language interpretation services to refugees has grown considerably – about 150 interpreters who collectively speak 60 languages serve nearly 300 organizations. Through its state-of-the-art database, Language Bank coordinates about 750 interpreter appointments each month. These services are offered in health care and legal settings and in school administration and social service environments. Through four active committees, the MIAB is implementing the New Hampshire Medical Interpretation Strategic Plan to improve systems to collect race, ethnicity, and language data; expand funding for medical interpretation; strengthen the medical interpretation workforce; and promote high-quality medical interpretation through advocacy. The endowment has also worked with ethnic-based community organizations to identify the unique mental health needs of African refugees and Latino immigrants. It has made a $134,000 grant to the city of Nashua to create and implement a plan for improved immigrant and refugee integration by strengthening coordination among municipal, social, and health care agencies to better serve new arrivals; empowering individuals to navigate various public systems; and improving the provision of culturally and linguistically appropriate services.

CREATING A MOVEMENT FOR CHRONIC CARE AND LONG-TERM CARE REFORM

Mindful of the challenges presented by the aging of the population, funders are focused on a number of efforts related to aging and health, from training and supporting paid and unpaid caregivers and extending independent living, to creating seamless systems of care and helping seniors navigate Medicare. Two illustrative examples of this type of work follow.

In April 2008 the Institute of Medicine (IOM) released *Retooling for an Aging America: Building the Health Care Workforce*, which examines the critical shortage of medical professionals and direct care workers who are needed to meet the health care needs of the United States' growing and diverse older population. It also proposes steps to address the shortage by enhancing geriatric competence of the workforce, increasing recruitment and retention, and redesigning models of care. During the development of the report, The Atlantic Philanthropies and The John A. Hartford Foundation approached the Meridian Institute to explore the "advisability and feasibility of convening a national alliance to use the recommendations of the IOM task force as the basis for collaboratively developing and implementing solutions to the challenges identified in the report" (Meridian Institute 2008). The broad goal of the alliance would be to "expand and improve the workforce responsible for ensuring that all older adults receive high-quality, patient-centered care." To gauge interest levels in forming such an alliance, the Meridian Institute conducted interviews and facilitated exploratory meetings with stakeholder organizations. A diverse group of stakeholders has expressed interest in participating in the effort to develop a workforce capable of meeting demands in care. Priority areas have been identified for action in the legislative and policy arenas, and alliance participants are in the process of creating a framework to begin work. Potential next steps include creating a leadership group and work groups; identifying actions to make progress in workforce recruitment, training, and retention; and promoting effective models of care.

Developing a sustainable continuum of quality care for seniors will improve outcomes, reduce the number and duration of acute care episodes, support patient involvement in decisionmaking, encourage independence, and reduce overall costs. The funding strategy of The SCAN Foundation, a new foundation dedicated to long-term care reform and to the creation of a continuum of care for seniors, is to support programs that stimulate public engagement, develop realistic public policy and financing options, and disseminate promising care models and technologies. Recently the foundation announced its first grants, which attempt to refocus the debate about health care for seniors. The University of California, San Francisco (UCSF) was awarded a two-year, $450,000 grant to support a patient- and caregiver-focused section on aging and independence to be submitted for peer review and possible publication in *The Journal of the American Medical Association*. UCSF will organize the section, interview patients, and work with experts in the field who will author articles on issues in aging related to maintaining independence and reducing morbidity. The journal *Health Affairs* was given two grants, totaling almost $950,000, to fund a policy briefing in Washington, DC, in 2009 to raise awareness around why long-term care must be

on the nation's broader health reform agenda and to support a special issue on themes such as lessons learned from successful programs aimed at keeping the elderly independent in their own homes, effective models from other countries, and issues surrounding financing long-term care and long-term care insurance. The foundation has also made a three-year grant to The Henry J. Kaiser Family Foundation to support the Kaiser Health News service, which provides in-depth coverage of health care issues of concern to America's senior population. Funding from the foundation will result in coverage of health care issues affecting the nation's age 65 and older population through articles, interviews, Web casts, and other Web-based materials. Topics covered will include long-term care, Medicare and other health coverage for seniors, affordability, and delivery of care for seniors, among others (The SCAN Foundation 2008).

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BUILDING THE PUBLIC AND POLITICAL WILL TO END RACIAL/ETHNIC HEALTH DISPARITIES

In the past decade, health philanthropy has contributed to our understanding of the causes of racial/ethnic disparities in health status and health care, how disparities differ between and within groups, disparity trends, and the impact of various interventions. In the coming years, foundations have a role to play in ensuring that the next generation of work on disparities explores interactions with social class, uses a life-course perspective, intervenes at both the individual and environmental level, emphasizes policy change, and experiments with strategies for building public and political will. Two illustrative examples of this type of work follow.

In order to make progress, it will be essential to disseminate lessons learned about how best to eliminate health disparities and tie disparities interventions to larger quality improvement efforts. The Robert Wood Johnson Foundation's recent work to reduce racial and ethnic disparities in health care focused on several goals and supported:

- research to document the extent of racial and ethnic health care disparities and evaluate potential solutions;
- efforts to understand the extent to which hospitals, health plans, and others were collecting race and ethnicity data on patients for the purposes of identifying gaps in care;
- learning collaborative projects with hospitals to test interventions to improve the quality of care for minority patients; and
- efforts to integrate the views of health care quality experts with those of leading disparities experts (National Quality Forum 2008).

The foundation learned several lessons from this work, including:

- Some barriers to improving the quality of care for minority patients are related to issues with increasing the overall availability of health care information.
- Collecting race and ethnicity data is legal, and more health plans are collecting this data than many thought.
- Racial and ethnic health care disparities vary within and across regions but remain a persistent problem.

The foundation is continuing to focus on reducing racial and ethnic health care disparities through a new strategic approach known as Quality/Equality. The foundation will work with up to 20 regions across the country to improve health care in both inpatient and outpatient settings.

Building the public and political will to end health disparities will require, among other things, leaders with the knowledge and skills to lead effective health strategies and advocate for policy change. The Connecticut Health Foundation's Health Leadership Fellows program is designed to "foster, support, and promote a generation of leaders committed to eliminating racial and ethnic health disparities in Connecticut" (Connecticut Health Foundation 2008). The program accepts up to 20 Connecticut residents to participate in the one-year program. The fellows represent a variety of public and private sectors in public policy, health practice, health care administration, community, law, business and commerce, advocacy, and academia. Fellows make a commitment to attend two weekend retreats, monthly seminars, and other education activities. Learning occurs through participatory sessions, team learning projects, and peer-to-peer consultations. Additionally, fellows participate in a project of their choosing that demonstrates their leadership ability to influence others to take collective action to eliminate racial and ethnic health disparities. The benefits of the fellowship include a stipend of $1,500 to aid a fellow's personal or professional development, a $500 grant to a fellow's nonprofit employer, opportunities to meet with national

and local health leaders and policymakers, and professional coaching sessions.

CONCLUSION

The fact that demographic changes will affect the future is inarguable. But attempting to predict the future by focusing solely on population size and distribution is too simplistic. We decide our fate. Decisions that grantmakers, policymakers, and the public make now can affect educational attainment, family formation, labor force participation, economic mobility, equal opportunity, and cultural competency. Setting thoughtful and just priorities will allow us to shape our own future. In the wise words of Robert Friedland and Laura Summer (2008), "Demography is not destiny."

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