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Sociology 541—Population and Society
Profs. Edmondson and Lee
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Term Paper

Pronatal Policy—Governmental and Otherwise

Topic #15: Population policies may or may not be effective. Select at least two countries to illustrate the differential impact of pro-natalist policies.

Demographers suffer from the Chinese curse. No, not the one-child policy. Not even forced abortions. The Chinese curse is, "May you live in interesting times." The current generation of demographers expected to spend their careers helping humanity fight the scourge of overpopulation. Now, within one professional lifetime they have seen overpopulation begin to evaporate in much of the world. More than half of the world's population (52%, according to 2002 United Nations data) now lives in countries whose fertility is declining, though not yet below replacement. The population problem now spreading over the earth is overpopulation's opposite: declining fertility, with its attendant burden of population aging. Almost half of the world's population (45%) now lives in countries with below-replacement fertility. (Morgan 2003).

For beleaguered demographers, it is as if the natural law of their science had suddenly been repealed. This never happens to physicists. Not lately, anyway.

Demographers, and the policymakers and health workers who relied on them, have had considerable success in combating overpopulation around the world. Fertility began to decline in parts of Western Europe early in the 20th century, before anyone hung out a shingle as a demographer. But in the Third World, modern reproductive health programs brought birthrates down to levels at which governments and families could afford to improve their quality of life.

Coercive antinatalist regimes such as China's one-child policy achieved their objectives, rewarding China with relatively few dependents and a large working-age population.

Policies to confront underpopulation have been another matter entirely. Most countries with declining fertility deny any sense of alarm about it. (Demeny 1999 and 2003). A handful of countries have applied various pronatal policies with little long-term success. France after World War II committed financially to the support of families with children, to rebuild its war-drained populace. French fertility responded with a baby boom—then returned to its downward track. (Chesnais 1999). East Germany, the former Soviet Union, and several former Soviet Republics declared pronatal programs in the 1970s and 1980s, winning only short-lived success. (Bourgeois-Pichat 1986). Romania's dictator Ceausescu took a blunt approach when he came to power in 1966, outlawing abortion, the only available method of birth control. The crude birth rate doubled in one year, causing dislocations in the public health system, as many female health care providers were sidelined carrying unwanted pregnancies to term. When Ceausescu fell, abortion rights were immediately restored, along with access to oral contraceptives. (Birzea 1993).

Some countries have established policies that are not specifically directed toward fertility, but support families. Sweden's generous system is among the most effectively pronatal, even reversing the inverse relationship seen between fertility and women's labor-force participation in most other industrialized countries. Swedish fertility has declined since a recession has reduced family benefits—but the decrease has been greatest among the least educated, who are the least secure in the job market. Birth rates have remained stable among the more educated and securely employed. (Hoem and Hoem 1999). This relationship of Swedish fertility to educational

attainment is reversed in the United States, where birth rates are higher in the less educated. (Rindfuss 1996).

Family policies are diverse and mutable among industrialized countries. Gauthier developed methods of quantitatively comparing different programs, and tracking their relative changes over time. She found that clusters of countries tended to converge on similar program strategies. (See Table 1 and Figure 4 in the appendix to this paper.) The Scandinavian countries clustered in the upper edge of the graph, with the most generous benefits, and moderate fertility. European countries evolved by different paths toward medium parental leave time, with southern European countries giving families less financial support and receiving in return very low fertility. Northern and western European families received more support and responded with low and variable fertility. Aggregated in the lower corner of the graph with little family support of any kind (confusingly labeled the "Liberal" regime), were the English-speaking countries, plus Japan and Switzerland. Family policies may be similar in this group, but fertility paradoxically runs the gamut from very low, in Japan, to near replacement levels in the United States and New Zealand. (Gauthier 2002).

Demographers, used to active partnerships with governments worried about overpopulation, seem to have lost their sense of direction in this new demographic milieu. Paul Demeny, former president of the Population Association of America, wrote, "Finally, even if the will were there, there is a paucity of effective pronatalist policy instruments. Exhortation from governments is not promising, and in any case unlikely to be tried in a democratic polity. Restrictions imposed on access to modern contraceptive technology are not politically acceptable; they would be also certain to prove a failure." (Demeny 2003 p. 18). One can almost hear a fatalistic shrug in these words.

However, there is evidence that in some countries, government is not the only body that can affect population policy. Non-governmental organizations (NGOs) intend to and are able to influence the environment in which individuals make the reproductive decisions that aggregate to demography. Particularly in the United States, liberal and conservative NGOs compete for influence, trying to recruit state and federal government to implement the policies they advocate. Both sides have done so. In 1973, liberal organizations won the Roe *v*. Wade Supreme Court decision legalizing abortion. In 1985, the Reagan administration abruptly withdrew support from the United Nations Fund for Population Activities. (Finkle and McIntosh 1994). State family policies fall to the victors of electoral battles and legislative lobbying.

Liberal and conservative NGOs can take actions that affect individual reproductive choices even without government partnership. For example, liberal NGOs have developed and released new contraceptive technologies, and conservative NGOs have condoned bombings of abortion clinics. The comparison is grotesque, but the parallels should be recognized—both actions pursue objectives. I remember that, as a new physician beginning practice in Clackamas County in the early 1990s, I briefly considered providing abortion services, but quickly ruled out the idea, in fear of certain and possibly life-threatening harassment. Conservative NGOs have successfully limited and isolated abortion providers with a wide range of policies, from bombings to zoning and licensing regulations. In 2000, one third of US metropolitan areas had no abortion provider, and 87% of counties had no provider. Abortion providers and abortion rates continue to decrease. (Finer and Henshaw 2003). Other obstacles to abortion access include parental or spousal notification requirements, and mandated 24 to 48 hour waiting times, which increase the cost of the procedure for women who must travel to obtain the procedure. Government has not been the driving force behind this pronatalist policy.

Conservative NGOs and elected officials have recently pursued the effectively pronatal objective of blocking emergency contraception, the so-called "morning after pill." Over-the-counter sale has been blocked, in spite of positive scientific recommendations. Pharmacists have been organized to take job actions, refusing to fill legitimate prescriptions for patients in immediate need.

Liberal NGOs and officeholders mount campaigns to defend already low state and federal family supports from budget cuts; to preserve abortion rights from conservative initiatives; and to maintain contraceptive availability. However, conservative NGOs are far better funded. In 1995, the leading conservative NGOs operated on a combined revenue base of greater than $77 million. (The Heritage Foundation, the American Enterprise Institute, the Free Congress Research and Education Foundation, the Cato Institute, and Citizens for a Sound Economy.) The leading liberal NGOs that year had a combined budget of $9 million. (The Institute for Policy Studies, the Economic Policy Institute, Citizens for Tax Justice, and the Center for Budget and Policy Priorities.) (Covington 1998 p. 7).

Conservative NGOs have a frankly pronatal policy agenda. Searching for "demography" on the website of just one organization, the American Enterprise Institute, http://www.aei.org, produces 62 short publications, ten scheduled events, and five books. They are consistently anti-Malthusian, arguing that unconstrained population growth is necessary for economic growth. Many of them feature Ben Wattenberg, a journalist and Senior Fellow at the American Enterprise Institute, and Nicholas Eberstadt, Ph.D., who holds the Henry Wendt Chair in Political Economy at the Institute. In congressional testimony in 1995, Sheldon Richman, Senior Editor of the libertarian Cato Institute, stated, "There is no population problem." He went on to

extol the worldwide economic and social benefits of population growth, the more, the better. (Richman 1995).

The United States has a fertility rate far higher than most industrialized nations, just under the replacement rate of 2.1, without an official government population policy. One distinctive hallmark of US fertility is the highest adolescent birth rate, by far, among industrialized countries: 48.7 per thousand women 15-19, of whom almost 80% are unmarried. In 1999 and 2000, births to women under 20 years of age made up 12% of the US total. The other English-speaking countries have teen pregnancy rates ranging from 34.0 (New Zealand) to 20.5 (Australia). Most European and Scandinavian countries have rates under 10.0. (Ventura 2001 p. 20, and Morgan 1996). Can the unofficial population policy promulgated by the US "NGOcracy" be the reason? (Bezruchka, no date).

States with high rates of teen pregnancy (State Health Facts Map 1) tend to also be states with high rates of child poverty (State Health Facts Map 2) and high rates of children without health insurance (State Health Facts Map 3). Teen birth rates, in US counties, are also positively correlated with low average income, and with high income inequity—that is, with greater socioeconomic distance between rich and poor. (Gold 2001). In counties and states with high rates of adolescent pregnancy, teenagers are therefore less likely to have access to the more effective modern forms of contraception; and hence more likely to get pregnant, with less access to abortion services.

Gender equity theory may also help explain the high US teen pregnancy rate. In low-fertility European countries where barriers to career women are falling, but home life retains its traditional expectations, gender equity theory explains women's choices to pursue careers instead of bearing children. (McDonald 2002). In low-income American counties where career choices

and educational options are limited, young women may reasonably prefer motherhood, even single motherhood, to jobs at Wal-Mart.

How would a demographer project on the US population the effects of the policies implemented by conservative NGOs, even if those policies were partially blocked by the smaller and lesser-financed liberal NGOs? Blocking availability of and access to contraception and abortion would increase unplanned births in those women with the least availability and access—uninsured adolescents in poverty. That is what has happened.

Over thirty years ago, Judith Blake wrote of the coercive pronatalism of the United States. She described the social coercion that restricted non-parental roles in society. (Blake 1972). If not for her untimely death in 1993, she might now be writing of an increasingly overt, explicit, coercive pronatalism in America—which, since it is not the official population policy of any government, is invisible to most demographers.

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Appendix

Figures and Tables

Gauthier Table 1. Types of Family Policies.

Gauthier Figure 4. State support for families in 1972, 1985, and 1999, by cluster.

Morgan Figure 9. Cross-national teenage pregnancy, abortion, and birth rates.

State Health Facts Map 1. Rate of Teen Births by State.

State Health Facts Map 2. Rate of Child Poverty by State.

State Health Facts Map 3. Rate of Uninsured Children by State.

TABLE 1.– TYPES OF FAMILY POLICIES AS OF THE LATE 1980S AND EARLY 1990S

Policy regime	Overall characteristics	Cash support	Support for working parents	Countries
Social-Democratic	Characterized by universal state support for families, and a high commitment to gender equality.	Medium-level of cash support for families in the form of universal cash benefits, but high level of other forms of support that result in low levels of child poverty.	High-level of support provided to both parents. Combines long parental and childcare leaves with extensive childcare facilities.	Denmark Finland Norway Sweden
Conservative	Characterized by a system of state support for families that tends to vary according to the parents' employment status, and that also tends to be driven by a more traditional view of the gender division of labour.	Medium-to-high level of cash support.	Medium-level of support. Relatively long parental and childcare leaves (in some countries), but more limited childcare facilities.	Austria Belgium France Germany Ireland Luxembourg Netherlands
Southern European	Characterized by a high degree of fragmentation along occupational lines, and a mix of universal and private services and benefits. It is also a regime characterized by no national guaranteed statutory minimum income scheme.	Low level of cash support that results in high levels of child poverty.	Low level of support.	Greece Italy Portugal Spain
Liberal	Characterized by a low level of support for families that tends to be targeted at families with greater needs, and that leaves room for market forces, especially with regard to the provision of childcare facilities.	Low level of support for all families, relatively higher for families in greater need.	Low level of support. Responsibilities for childcare provision given to parents and the private sector.	Australia Canada Japan New Zealand Switzerland U.K. U.S.A.

Sources: Adapted by the author from the work of Esping-Andersen, 1990; Ferrera, 1996; Flaquer, 2000; Gauthier, 1996; Rhodes, 1997.

Source: Gauthier, Anne H. 2002. "Family policies in industrialized countries: Is there convergence?" *Population—English Edition*, 57(3):447-474.

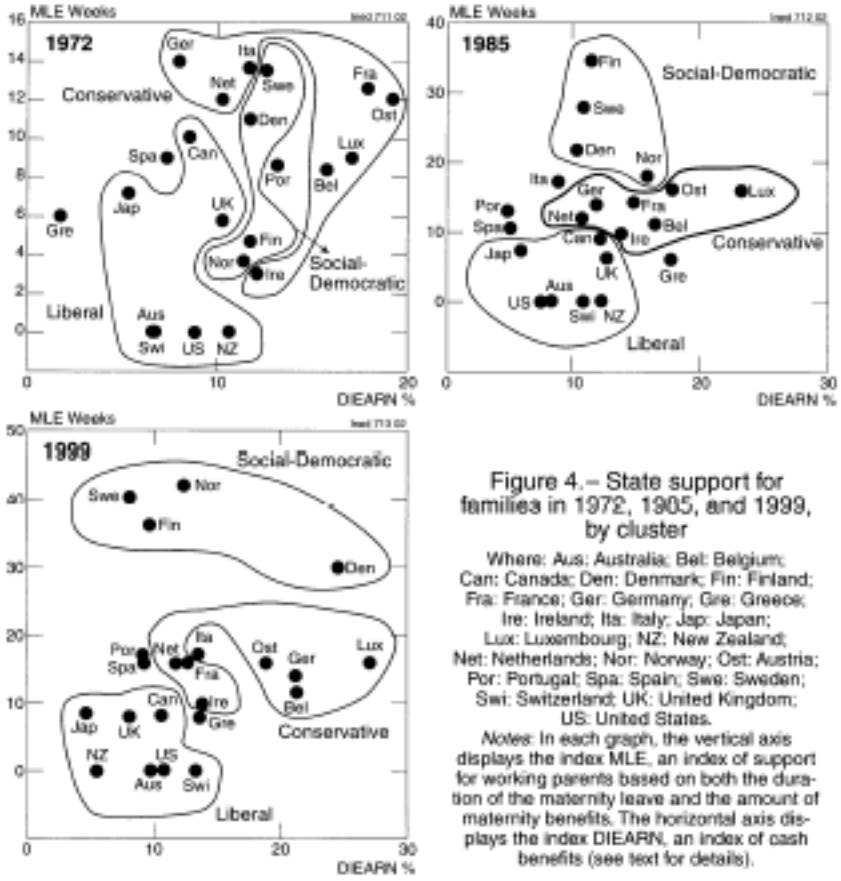


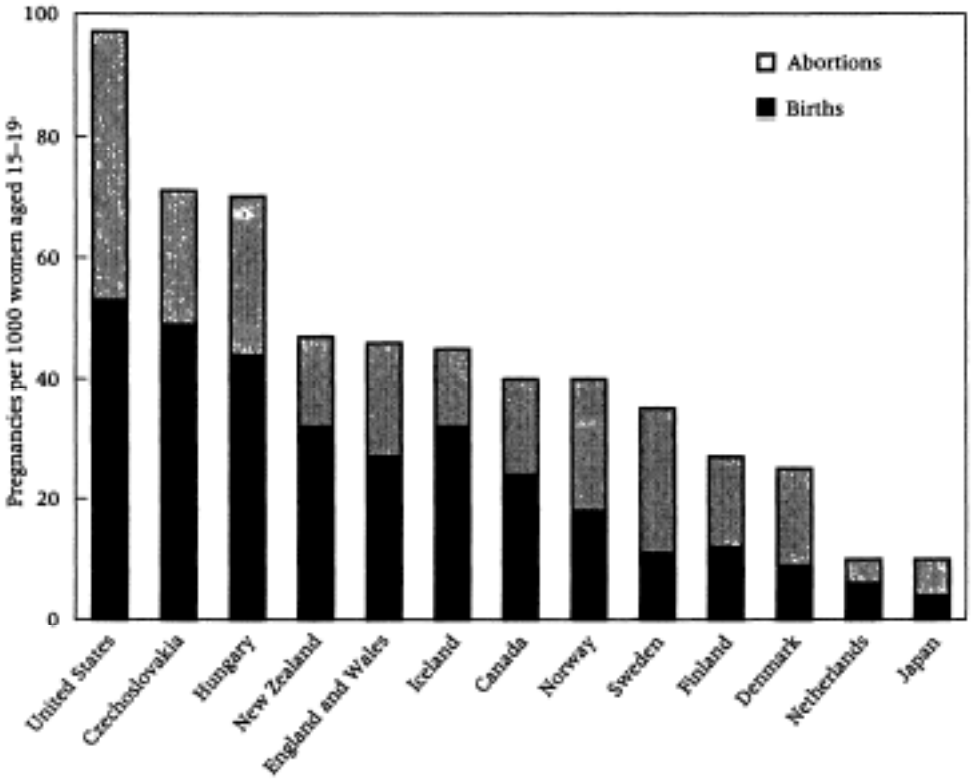
Figure 4.– State support for families in 1972, 1985, and 1999, by cluster

Where: Aus: Australia; Bel: Belgium; Can: Canada; Den: Denmark; Fin: Finland; Fra: France; Ger: Germany; Gre: Greece; Ire: Ireland; Ita: Italy; Jap: Japan; Lux: Luxembourg; NZ: New Zealand; Net: Netherlands; Nor: Norway; Ost: Austria; Por: Portugal; Spa: Spain; Swe: Sweden; Swi: Switzerland; UK: United Kingdom; US: United States.

Notes: In each graph, the vertical axis displays the index MLE, an index of support for working parents based on both the duration of the maternity leave and the amount of maternity benefits. The horizontal axis displays the index DIEARN, an index of cash benefits (see text for details).

Source: Gauthier, Anne H. 2002. "Family policies in industrialized countries: Is there convergence?" *Population—English Edition*, 57(3):447-474.

FIGURE 9 Cross-national teenage pregnancy, abortion, and birth rates per 1,000 women aged 15–19: 1988



SOURCE: Alan Guttmacher Institute, 1994: Figure 55.

Source: Morgan, S. Philip. 1996. "Characteristic features of modern American fertility," *Population and Development Review, Supplement: Fertility in the United States: New patterns, new theories*, 22:19-63.

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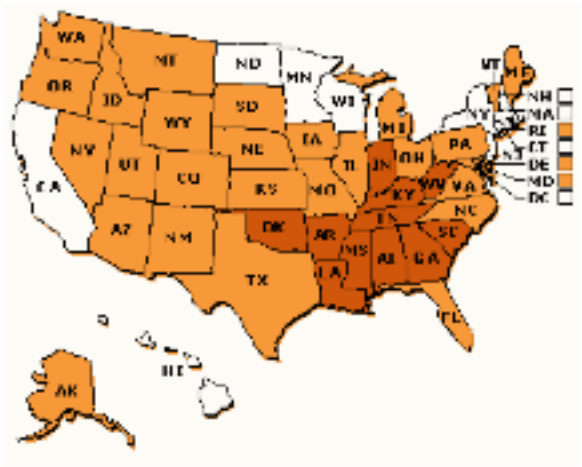
Rate of Teen Births per 1,000 Population by Race/Ethnicity, 2002
Map by group: White

Bar Graph | Table | Map

Map by: White View by: Rate/1,000



- Less than 21
- 21 to 27.9
- 28 to 37
- More than 37

This map may be broken into the four Census regions as defined by the 2000 U.S. Census: 1) Northeast; 2) Midwest; 3) South; 4) West. **Show Census Regions**.

Notes: Birth rates are live births per 1,000 women in specified age group in each area.

Definitions: Teens are defined as women between the ages of 15 and 19. Race/Ethnicity categories are mutually exclusive. Data for American Indians include births to Aleuts and Eskimos.
NSD: Not Sufficient Data (birth rates based on fewer than 20 births or fewer than 1,000 women in specified group).

Sources: University of California at Berkeley calculations based on Sutton PD, and Mathews TJ, Trends in Characteristics of Births by State: United States, 1990, 1995, and 2000-2002; National vital statistics reports; vol 52 no 19, Table 4, Division of Vital Statistics, National Center for Health Statistics, May 10, 2004, http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_19.pdf. and Vintage 2002 Postcensal Series by Year, County, Age, Sex, Race, and Hispanic origin, http://www.cdc.gov/nchs/about/major/dvs/popbridge/datadoc.htm#vintage2002.

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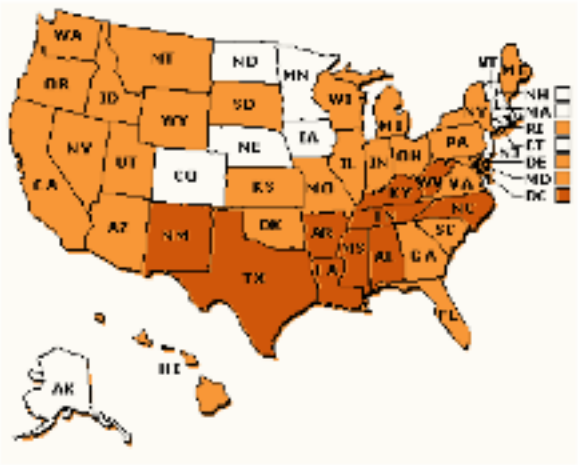
Poverty Rate by Age, states (2003-2004), U.S. (2004)
Map by group: Children 18 and under

Bar Graph | Table | Map

Map by: Children 18 and under View by: # | %



- Less than 17%
- 17% to 20%
- 21% to 25%
- More than 25%

This map may be broken into the four Census regions as defined by the 2000 U.S. Census: 1) Northeast; 2) Midwest; 3) South; 4) West. **Show Census Regions**.

Notes: Percentages may not sum to 100% due to rounding effects.
For all topics based on the CPS on statehealthfacts.org, the grouping used for analysis is the health insurance unit (HIU), which groups individuals according to their insurance eligibility, rather than by relatedness or household.
For more details, see "Notes to Demographic and Health Coverage Topics Based on the CPS" at http://www.statehealthfacts.kff.org/methodology.

Definitions: Persons in poverty are defined as those who make less than 100% of the Federal Poverty Level (FPL). The federal poverty level for a family of three in the 48 contiguous states and D.C. was $14,680 in 2003 and $15,067 in 2004. For more information, please see a detailed description of the federal poverty level provided by the U.S. Department of Health and Human Services, available at http://aspe.hhs.gov/poverty/faq.shtml.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

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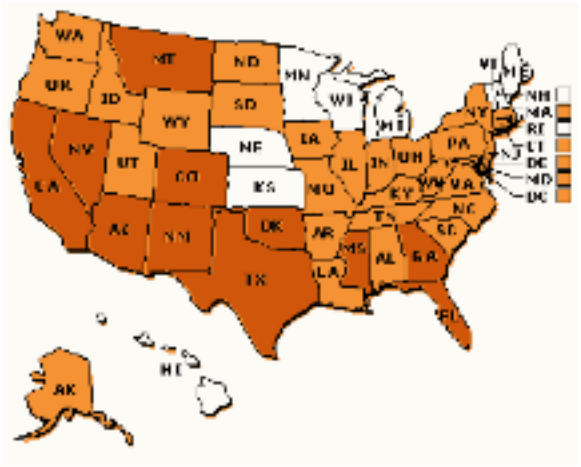
Health Insurance Coverage Rate of Nonelderly Uninsured by Age, states (2003-2004), U.S. (2004)
Map by group: Children 18 and Under

Bar Graph | Table | Map

Map by: Children 18 and Under View by: # | %



- Less than 8%
- 8%
- 9% to 12%
- More than 12%

This map may be broken into the four Census regions as defined by the 2000 U.S. Census: 1) Northeast; 2) Midwest; 3) South; 4) West. **Show Census Regions**.

Notes: For all topics based on the CPS on statehealthfacts.org, the grouping used for analysis is the health insurance unit (HIU), which groups individuals according to their insurance eligibility, rather than by relatedness or household.
For more details, see "Notes to Demographic and Health Coverage Topics Based on the CPS" at http://www.statehealthfacts.kff.org/methodology.

Definitions: Rate: In this case, the proportion of the population or subpopulation who are uninsured.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

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