After the Demographic Transition: Policy Responses to Low Fertility in Four Asian Countries

Global concern about rapid population growth in the developing world has tended to obscure the successful attainment of low fertility in many East and Southeast Asian countries. In just over two decades, countries such as South Korea, Taiwan, Singapore, and Thailand have completed, or nearly completed, a transition from rapid population growth to fertility rates at or near replacement levels.

The June 1994 issue of Asia-Pacific Population & Policy outlined the policy challenges facing Asian countries that have made the demographic transition from high to low fertility. This issue continues the discussion by surveying the fertility situation in four countries and examining their policy responses.

THE DEBATE

Throughout the region, national leaders and policymakers are increasingly concerned about the potential consequences of rapid fertility decline, including changes in household structure and family life, shifts in the proportion of elderly people in the population, and reductions in the number entering the labor force.

Demographers, meanwhile, caution against hasty, pronatalist reactions. Current low fertility rates may not necessarily result in long-term reductions in population growth since women may simply be deferring childbearing temporarily. Pronatalist responses also do not take into account the inevitability of continued population growth, even among low-fertility populations. The large number of children already born will ensure continued gains in population for decades to come.

Reducing support for family planning programs is likely to disadvantage just those groups already facing health and economic hardships—the poor, the young, and those living in remote areas. The high incidence of abortion in some East Asian countries suggests a continuing unmet need for modern contraception, even in countries considered to have successful family planning programs.

Declining fertility can provide new opportunities to enhance the quality of education.
COUNTRY RESPONSES

South Korea

Since the early 1960s, the Republic of Korea has implemented a family planning program generally acknowledged as one of the strongest in the world. Between 1966 and 1988, the contraceptive prevalence rate among married women increased from 9 to 77 percent. Total fertility fell from 6.0 children per woman in 1960 to 1.6 in 1987. Success has been based on efficient program implementation and strong political support as well as social factors such as rising age at first marriage, smaller desired family size, and rapid economic development.

There are still some causes for concern. Fertility differences between urban and rural areas remain large: a 1988 survey showed a total fertility rate in the cities of 1.52, compared with 1.96 in the countryside. In addition, the choice of family planning methods may not be the most favorable for every woman. Nearly 50 percent of all women using contraception in South Korea have been sterilized—one of the highest female sterilization rates in the world. Abortion rates are also extremely high. According to a 1985 survey, induced abortion accounted for 32.2 percent of total fertility reduction.

Assuming that the current low fertility level is maintained, the South Korean population will continue to expand for some time. The 1990 population of 42.9 million is expected to stabilize at around 50.6 million by 2021, with the proportion of the elderly (65 and over) increasing from 5 to 13 percent. In addition to higher health-care expenditures related to population aging, there will be severe pressure on available housing, energy, and cultivable land. By 2000, South Koreans will be dependent on imports for about 66 percent of their food grain consumption and 90 percent of their energy needs.

Given the achievement of replacement-level fertility, Korean leaders are now considering opposing views on future policy directions. Some policies are already being modified. The government is reducing support for public-sector family planning services, partly to encourage private-sector provision of family planning. In addition, targets for the government-supported sterilization program have been reduced fivefold. In 1982, the Medical Insurance Law was revised to provide some contraceptive services: clients, except those from low-income groups, are now expected to cover part of the costs.

The South Korean government is also placing renewed emphasis on integrating family planning with maternal and child health services, historically more widely separated in Korea than in many other countries. Apart from institutional reorganization, this effort entails training for health workers who must now assume broader functions. Services are being reorganized to reach low-income urban populations and rapidly expanding numbers of sexually active, unmarried adults. The Korea Institute for Family Planning was merged with the Korea Health Development Institute in 1981, and in 1990 the combined body, renamed the Korea Institute for Health and Social Affairs (KHAWA), assumed research responsibilities in population, public health, medicine, and social welfare.

Given Korea’s limited cultivable land and other natural resources, many argue that current population control measures should be maintained “at all costs.” In their view, family planning support should not be reduced but rather shifted to a focus on birth spacing, child and family development, sex education, and care of the elderly.

Taiwan

As early as 1983, Taiwan had attained replacement-level fertility and almost universal use of contraception. After many years of steady decline, the fertility rate is now estimated at a below-replacement level of 1.7. The Taiwanese government is now reassessing its population and family planning policies. There is concern that below-replacement fertility levels will lead to severe age imbalances in the population. Yet Taiwan is already one of the most densely populated countries in the world: further growth would have substantial costs.

Two questions dominate policy discussion. Should the family planning program be radically restructured now that numerical targets have been met? And second, should long-term fertility continue below-replacement level or should the goal be somewhat higher?

The first question has been answered by recent steps toward substantial privatization of contraceptive services and integration of other family planning services with maternal and child health programs. As in South Korea, the government plans to merge family planning with maternal and child health in a single institute with responsibilities for a wide range of health issues. Family planning workers are being retrained and redeployed with more general health surveillance and screening responsibilities. Future government efforts are expected to include outreach to disadvantaged populations, sex education programs for young people, introduction of new contraceptives (especially alternatives to sterilization), now the most popular method), a
broad information program on reproductive health issues, and program monitoring. The question of long-term fertility goals was addressed by a policy announcement in 1992 that accommodates opposing views. The new policy contains recommendations to improve reproductive health, strengthen the welfare and rights of women, enhance the quality of family planning services, and increase the labor potential of the elderly, the disabled, and the poor. It calls for gradually raising fertility from the current level of 1.6 to 2.1, a rate that would keep the population roughly stable, but proposes no special pronatalist interventions.

In fact, Taiwan’s population will continue to grow over the next 40 years, and the proportion over 65 will increase substantially, regardless of policy decisions. Small differences in projected fertility levels will have significant long-term consequences, but these may be impossible to fine-tune by government intervention. Depending on fertility assumptions, the 1989 population of 20.1 million will reach 23.1 to 27.4 million in 2036, and the proportion over 65 (6 percent in 1989) will range from 19 to 22 percent. The actual outcome will be determined by such social and economic forces as participation of married women in the labor force, rising consumerism, the relative costs of childcare and education, and changes in traditional Chinese family structure.

**Singapore**

Singapore’s response to rapid fertility decline has been unique in the region. Concerned about balancing limited economic resources with the demands of an increasing population, the government instituted a vigorous national campaign in the 1960s to encourage smaller families through fertility disincentives, mass-media campaigns, and easy availability of family planning services. Legislation was enacted in 1970 to provide low-cost abortions and sterilization. As a result of these measures and the profound societal changes brought about by rapid economic growth, Singapore’s total fertility rate plummeted in 30 years—from about 6.5 in 1957 to 1.4 in 1988, among the lowest in the world.

Beginning in 1983, officials began to worry that fertility rates had fallen too far. Their fears initially centered on low marriage rates and sharp fertility declines among the most highly educated segment of the population, who tended to belong to the dominant Chinese ethnic group. Accordingly, the first pronatalist program focused on women university graduates. New fertility incentives initiated in 1987 and 1989 targeted high-income groups. Concerns included labor shortages, population aging, fears of family breakdown, and an increasingly explicit focus on the population’s ethnic makeup.

Specific pronatalist measures have been revised repeatedly since 1983. Current policies favoring couples with more than two children include tax rebates, priority in primary school registration, childcare subsidies, liberalization of rules on government-subsidized housing, and improved opportunities for part-time work and childcare leave. In addition, counseling is now compulsory before sterilization or abortion. A Social Development Unit, established in 1984, organizes dances, workshops, and holiday trips for single university graduates and runs a computerized matchmaking service.

It is too soon to tell how effective these policies will be, but most observers are skeptical. By 1989, the total fertility rate had rebounded, at least temporarily, to 1.8. However, recent trends indicate longer delays before marriage, increased numbers of never-married men and women, and large proportions of childless couples or couples with only one child—especially among university graduates under 40.

If the total fertility rate stays as low as, say, 1.6, the total population will peak at about 3.02 million in 2015 and then decline steadily, reaching 2.46 million in 2050. If fertility increases to replacement levels, the population will peak at about 3.39 million in 2030 and then remain constant. Current labor shortages will be exacerbated by low fertility, but even with a return to replacement levels Singapore will continue to be dependent on foreign workers to sustain economic growth. Similarly, a return to replacement fertility will diminish, but not reverse, population aging. The proportion 60 and over will increase from 7.8 percent in 1985 to 22.0 percent by 2050 with replacement fertility or 29.3 percent with low fertility.

The newly enacted pronatalist measures are seen by Singapore’s leaders as critical for maintaining an adequate workforce that can support the elderly and sustain current levels of economic development. However, given the many social forces working to hold down fertility—such as higher living standards and women’s participation in the workforce—most observers believe that the shift to pronatalism is unlikely to achieve the government’s long-term population goals.

**Thailand**

Thailand’s rate of fertility decline has been the most rapid among Asian countries not yet counted among the newly industrialized economies. In 1993, the total fertility rate reached 2.4—down from 6.4 just 30 years earlier. This dramatic reproductive transition has been attributed to four factors: rapid economic
development accompanied by fundamental social change, a cultural setting that facilitates acceptance of contraception, a strong latent demand for a means to control fertility, and success of the national family planning program.

Thailand's current five-year development plan has established a goal of reducing the population growth rate from 1.5 percent in 1992 to 1.2 percent in 1996, when the population is expected to reach 61 million. Government activities, including expanded family planning services and publicity campaigns, focus on remote rural areas and urban slum dwellers and industrial workers. No clear policy targets have been formulated for population growth after the current planning period.

Assuming that the current downward trend continues, total fertility rates are projected to approach or even fall below replacement level, perhaps as soon as 2000–2005. Yet such projections are uncertain at best. Most married women, even in the youngest age groups, still wish to have at least two children. Family size has not dropped to the extent that care for the elderly is seriously threatened, and current shortages of skilled labor might actually be alleviated by fertility declines associated with high investment in education. The growing problem of HIV/AIDS may also produce dramatic changes in reproductive behavior.

The time is approaching when the Thai government will likely reevaluate its long-term population goals and policies. However, future trends are not yet clear. Many observers urge a focus on information gathering and a refinement of current predictions.

**POLICY PERSPECTIVES**

South Korea, Taiwan, Singapore, and Thailand all represent family planning success stories. Rapid economic development and social change, combined with effective government programs, have brought these countries to replacement fertility with surprising speed. Concerns about resulting demographic imbalances and consequences for social welfare are now forcing their governments to reconsider population policies.

While all agree that low fertility populations should continue to have access to family planning services, the nature of these services remains to be resolved. The most common responses so far have been the closer integration of family planning with other health services and a shift of family planning goals from number of acceptors to quality of services.

It is also increasingly recognized that changes in economic behavior, family patterns, and the role of women will be crucial in shaping future reproductive behavior. As development patterns become less conducive to large families, a general convergence around a two-child family norm seems likely throughout the region. It remains to be seen whether proponents of pronatalist policies will be successful in overcoming the growing desire for smaller families and the powerful socioeconomic forces promoting the transition to low fertility.

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