Can governments influence population growth?

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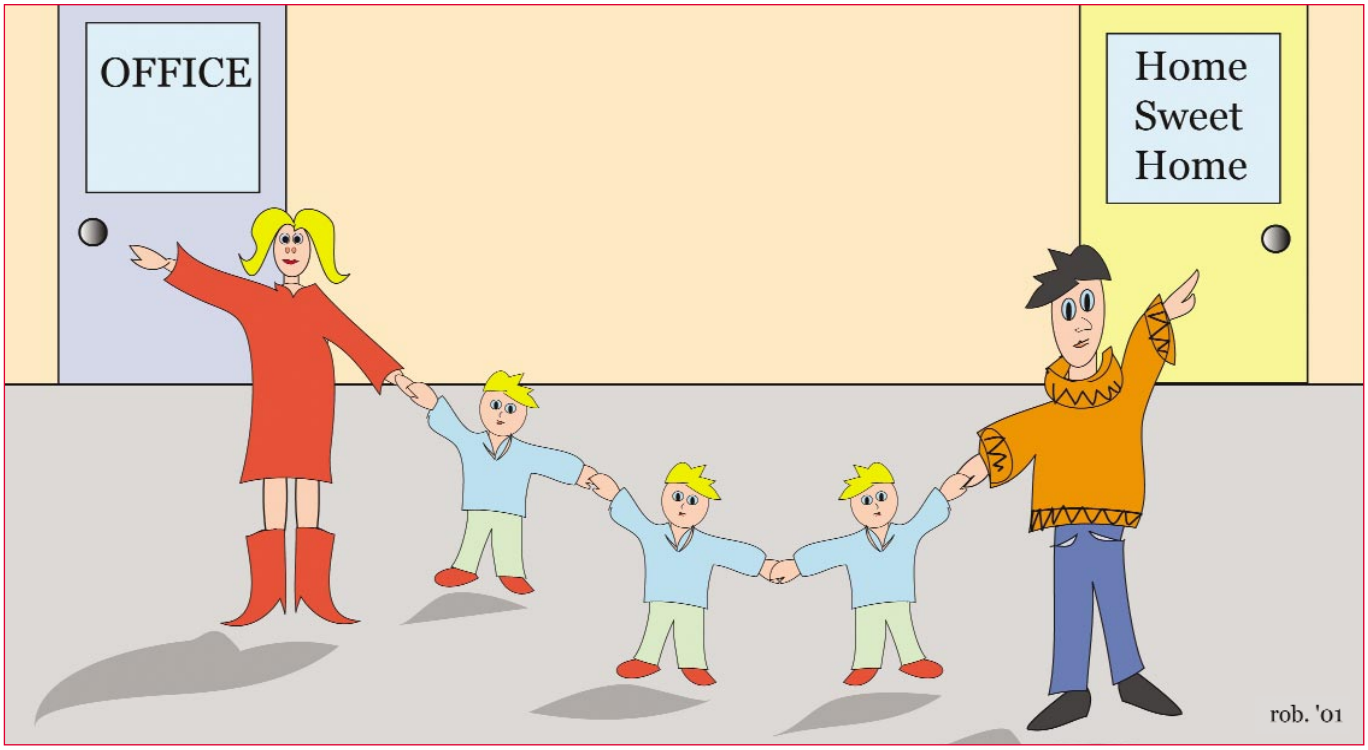


Fertility levels – the number of children being born to assure the next generation – are generally low in OECD countries. This is a cause of primary concern to governments because it contributes to ageing societies and means fewer taxpayers to fund pensions, health services and so on. Yet, almost a century of policies to encourage larger families has failed to boost birth rates. The case of Sweden may help explain why.

When many governments introduced their social welfare programmes during the economic depression of the 1930s and 1940s, they did so mainly to combat widespread poverty, unemployment and poor housing conditions. But in Sweden's case, there was less of a concern about these problems than about population. Influential Swedish economists, Alva and Gunnar Myrdal, argued in their 1934 book, *Crisis in the Population Question*, that Sweden must raise its birth rate; at the time the rate was below two children per woman, down from four at the turn of the century. The way to reverse this trend, they said, was by social reform that would support the family. Their proposals placed the responsibility for population targets in the hands of government and included maternal and child healthcare, free delivery, maternity and housing benefits, and general child allowances. Changes in social and welfare systems and marked reforms in the spheres of sexuality and reproduction saw the birth rate for most of the past half-century fluctuate at around two children per woman. It peaked at around 2.5 in the mid-1940s, when the general child allowance was introduced following the end of the Second World War, but never recovered its turn-of-the-century level.

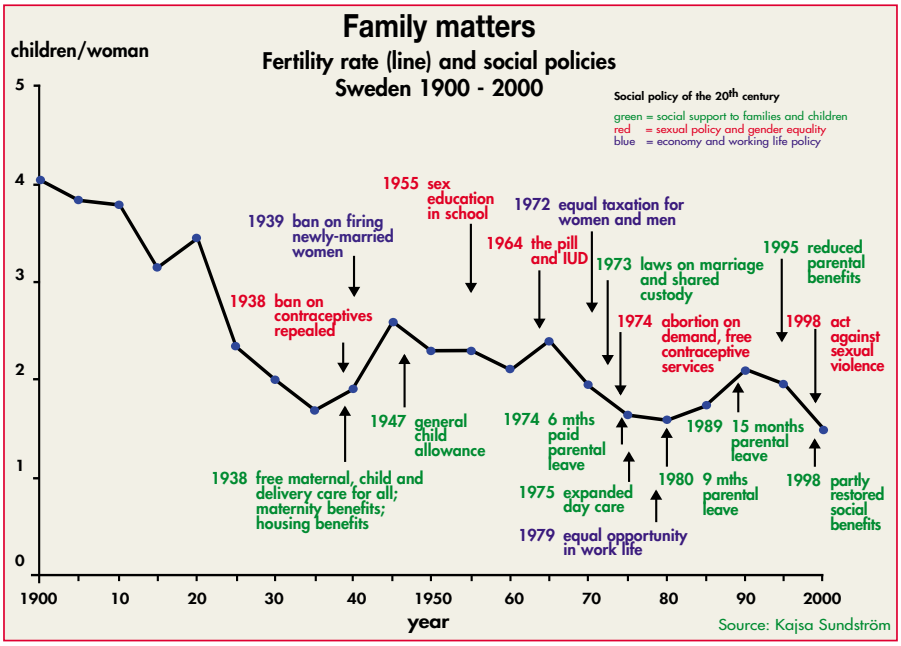
A recent sharp fall has brought the birth rate to its lowest ever – 1.5 children per woman. Again, government is increasing support to parents and benefits to families with children, hoping to reverse the trend.

Some changes over the past 60 years have clearly affected the birth rate, though not always in predictable ways. A law in 1939 preventing employers from dismissing women because of marriage, pregnancy or childbirth helped push up the birth rate, as more women became able to marry, have children and keep earning money. Indeed, since that time, most Swedish women have sought to combine family life and a career.

The next breakthrough for women on the labour market came in the 1960s, when rapid economic development led to increased opportunities for schooling and higher education, and well-paid jobs. Employers were crying out for staff (male or female); sexual equality and gender roles were under discussion; and women's economic freedom increased. Many women also took advantage of the new sexual freedom provided by the contraceptive pill and the IUD. Although contraceptive methods – chiefly condoms and diaphragms – had been part of sex education in school (introduced on a voluntary basis in 1942 and made compulsory in 1955), views on sexual relations had remained strict. Abstinence before marriage was all schools could recommend. The introduction of the pill as a reliable and simple contraceptive for women, helped change attitudes, allowing young people to live together without marriage.

Women without a foothold in the labour market or on very low incomes, whether due to unemployment or studies, have the lowest birth rate of all.

The economic expansion of the 1960s fuelled optimism about the future, and the birth rate rose to more than 2.5, if only temporarily. Many women found themselves struggling to balance a full-time job with taking care of the home and children due to inadequate childcare facilities. They had won the right to work full-time, but men were not clamouring to help share the responsibilities at home. As a result, many women remember these days of "progress" for their hard work and a constant feeling of inadequacy.



A need for effective birth control had become obvious. The pill was a help, but still expensive and restricted, especially for young, single women. Then, in 1974 the government introduced a law allowing abortion on demand. In order to ensure abortion was seen as a last resort, the government saw it as an obligation to make contraceptives equally accessible. Family planning services, provided by trained midwives, were soon created at health centres all over the country.

Women juggling work and family were at last able to plan their childbearing. Indeed, since the early 1970s it has become common and socially acceptable for young people to live in stable relationships without having children. Most young women want to finish their education and find a job before starting a family. In 1975, the mean age for a first-time mother was 24; by 1998 it was 28.

Population paradox

This trend of having fewer children caused the birth rate to fall in the 1970s to 1.6, a new low. This was the decade when public day-care facilities became widespread and men were officially encouraged to share the responsibilities of childcare, with six months' paternity leave at 90% of their salary. But at the same time, women became full economic equals with men through a new law on individual taxation which made all adults responsible for earning their own living and providing for themselves. One indirect result of all these changes was an increasing number of divorces, as no woman felt obliged to stay in a miserable relationship for either economic or conventional reasons.

The early 1980s brought more economic expansion. The participation rate of women in the labour force was high; 86% of women aged 20 to 64 and 90% of men of the same age group were gainfully employed, one of the highest in the OECD area. Most men worked full-time, while a third of women had reduced working hours. Still, the birth rate increased to 2.1, while other European countries such as Italy, Germany and Hungary reported rates of 1.3 to 1.5 children per woman.

The reasons behind Sweden's high fertility level, despite its high female employment rate, were generous parental benefits and improved childcare conditions, allowing working women to have a third child. By 1989, combined maternity and paternity leave had been extended to 12 months at 90% of salary and three months with

minimum pay. Moreover, either parent became entitled to up to 60 days paid leave a year to look after a sick child.

But a shift from economic boom to deep recession and high unemployment in the 1990s put an end to these reforms. Efforts to restore the economy to health led to cuts in almost every area of the welfare system, including parental benefits. The birth rate fell back to 1.5 children per woman at the end of the 1990s, the lowest ever recorded.

The last few years of the decade were economically buoyant, and child allowances and parental leave benefits were increased. Female unemployment remained high and fewer women wanted to start a family, as they felt uneasy about their economic future. Women without a foothold in the labour market or on very low incomes, whether due to unemployment or studies, have the lowest birth rate of all. What is more, there is no evidence of young women choosing to have children instead of seeking work or furthering their education. This is a break with previous trends in Sweden and differs from several other OECD countries, e.g. the US and the UK.

Meanwhile, the population continues to age. But any new social reform plans to solve this demographic crisis will have to take into account the fact that both women and men in Sweden want first and foremost to work and earn an income of their own before raising a family. ■

* Qweb is a global network on women's health and empowerment, www.qweb.kvinnoforum.se

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Ethics, medicine, economics and power

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Today's doctors face a bewildering array of choices and constraints, from technological discovery to increasing budget pressures. Their dilemmas go beyond diagnosis and treatment to weighing the benefits of new discoveries and whether society is willing to pay for them.

The health world has undergone a number of profound changes in recent years, from population ageing and the fact that people are increasingly well informed, to industrialisation of healthcare, squeezed budgets and the biotech revolution. These changes have raised serious questions for all those involved in healthcare. Is there a code of ethics regarding choices? And if so, how does it compare with the criteria on which the philosophy of medical practice has been built from antiquity to today?

In fact, it is the very purpose of the medical profession and the doctor's role that is at stake today. Time and again doctors are forced to question the purpose of their actions and accept the limited extent of their knowledge in the face of the dizzying array of new discoveries in molecular biology and genomic sciences. At the same time they must weigh their sense of compassion and altruism as they help the sick who entrust their lives to them, against the pressure to use community resources responsibly.

Increasing legal complications and the media spotlight do not help either. All of this has been compounded by the gradual breakdown of traditional social structures, and the doctor's diminished status in society.

In the midst of all these changes, what is a doctor, really? A learning machine supposed to know everything? An economic player whose sole job is to control the costs of treatment? A practitioner who must protect his livelihood from legal attack by practising a defensive form of medicine? Or is a doctor simply an illusory buffer against the suffering, anguish and solitude of his fellow human beings?

More than 80% of people nowadays die in hospital, far away from the places where they have spent their lives.

The answer would be easy if medicine were a science. But unfortunately (or perhaps fortunately), it is only an art. That is to say, a permanent quest for a philosophical absolute: Health, Well-being or perhaps even to some degree, Happiness.

And the problem does not stop with doctors. Hospitals are faced with an identity