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POPULATION POLICIES

At present there are two major concerns about population growth in the world:

- large-scale population growth in LEDCs
- declining population numbers in the MEDCs

Both national governments and non-governmental organisations (NGOs), e.g. the United Nations, have developed a range of policies to deal with these issues.

Population growth in LEDCs

In 2002, the total population of the world was 6.2 billion. This figure is growing by approximately 79 millions each year; 99% of this growth occurs in the LEDCs!

How can population growth in LEDCs be reduced?

The simple answer to this question is to reduce the fertility rate (FR) (average number of children that a women has in her lifetime). An FR of 2.1 is needed for a country's population size to remain stable. In 2002, the average FR for the world was 2.7, the lowest-ever value, although this was higher in LEDCs, (3.0) than MEDCs (1.6). A further reduction in FR can be achieved by:

- increasing the availability of family planning services and contraception
- informing people about the importance of family planning and contraception
- reducing infant mortality rates, as large families are often regarded as an insurance against child deaths
- improving the economic base of the country so that there are fewer rural people who have large families to work on family farms
- improving government care and financial provision for the elderly, so that couples do not have a large family to care for them in their old age
- increasing the age at which women marry
- improving the role and status of women within a country's economy
- improving education facilities for girls and women.

Two-thirds of LEDCs have national population growth policies, but their effectiveness varies considerably (see Figure 1). In recent years, in both Asia and Latin America, fertility rates have fallen and contraceptive use has increased. It is Central Africa that is still a major concern, with an average fertility rate of 6.1 and a low contraceptive use of 17%. This region has 622 million people (2002) and the high FR causes the population to double every 25 years!

There are two main approaches to the introduction of population control policies:

- using **incentives** for reducing family size, such as cash benefits, lower taxes, social housing or education benefits etc. For example, in Thailand, registered family planners can rent cattle to plough their land at half price, buy seeds at lower prices etc.
- using **disincentives** such as loss of social benefits or increased taxes if a couple has more than the number of children recommended by the government.

Another population issue that is affecting many LEDCs, and Central Africa in particular, is the increasing number of people who have AIDS or who are HIV positive. The development of this disease has favoured the use of condoms, to avoid catching the disease, which is a valuable form of contraception. However, in many countries the increased expenditure on AIDS awareness and prevention has decreased the amount of available capital to spend on family planning programmes.

Case study of Kenya

Kenya was the first African country to develop policies for population control. In the last 20 years the FR has fallen from 8.0% to 4.4%, and contraceptive use has increased from 7% to 39%.

These improvements have been achieved by:

- increasing the availability of contraception and family planning services, even in remote rural areas

Figure 1: Contraceptive use worldwide

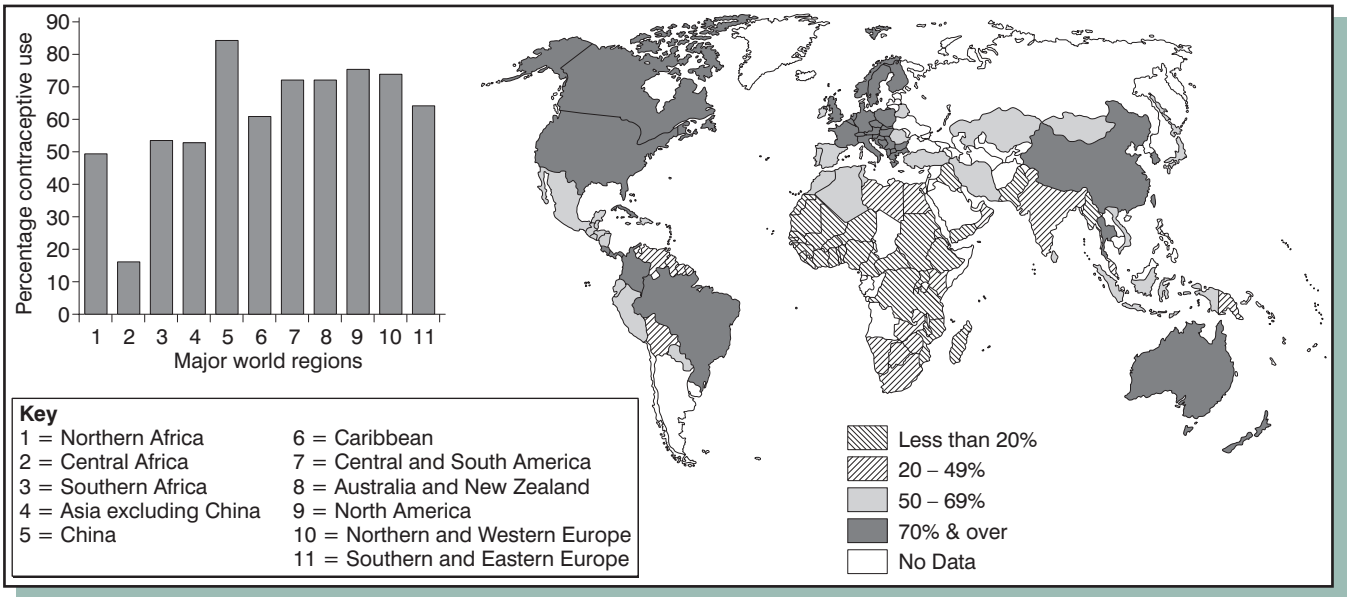


Figure 2: Factfiles for the case studies in this unit

Feature	World	MEDCS	LEDCS	China	India	Kenya	Japan	Sweden	UK
Total Population	6215	1197	5018	1281	1050	31	127	8.9	60.2
Birth rate	21	11	24	13	26	34	9	10	11
Fertility rate	2.8	1.6	3.1	1.8	3.2	4.4	1.3	1.6	1.6
Death rate	9	10	8	6	9	14	8	11	10
Growth rate	1.3	0.1	1.6	0.7	1.7	2.0	0.2	0	0.1
Infant mortality	54	7	60	31	68	74	3.2	3.4	5.6
Contraceptive use	61	68	60	84	48	39	56	na	72
Life expectancy	67	76	65	71	63	48	81	80	78
% of people aged 15 to 49 with HIV/AIDS	1.2	0.4	1.5	0.1	0.8	15.0	na	0.1	0.1

NB: data given is for 2002.

Figure 3: India's age structure, 1991—2016 (projected)

Year	0 to 14 years (%)	15 to 59 (%)	Over 60 years (%)
1991	37.8	55.6	6.6
2001	34.3	58.7	7.0
2011	28.5	63.4	8.1
2016	27.7	63.3	9.0

- increasing education and information services on family planning and contraception, e.g. a national campaign on TV, radio soap-opera programmes and radio broadcasts in urban markets dealing with these issues
- increasing training programmes for health workers
- trying to improve maternal health and infant mortality rates
- social developments to improve the education and status of girls and women.

Countries such as Japan, the UK and the USA as well as NGOs such as the World Bank and UN have helped financially. The National Family Planning Association receives 5 million dollars from the government each year, which is just one dollar for every six people in the country! AIDS affects 13% of the population aged 15 to 49 and has caused an increase in the overall death rate from 9 to 13 per thousand, a rise of 25% in child mortality rates, and a fall in life expectancy from 65 to 55. The future economic development of Kenya, needed to finance the social and health improvements to support population control, policies has been seriously affected by AIDS/HIV.

Case study of India

In 1952, India was the first LEDC to launch a national programme to introduce family planning, to 'stabilise the population at a level consistent with the requirement of the national economy'. The latest National Population Policy in 2000 set out the following aims:

- to achieve net replacement levels of population by 2010 by reducing FR to 2.0 and have a stable population by 2045. Reducing the population size before the middle of the century will be difficult as the percentage of the population in the child-bearing age group will only start to fall after 2011 (Figure 3)
- to reduce infant mortality (IM) from 50 to 30 per thousand by 2010.
- to improve child health by vaccination programmes against preventable diseases
- to increase the awareness and availability of family planning and contraception. Contraceptive use needs to be increased, especially in rural areas where 74% of the population lives
- to target adolescents before marriageable age
- to promote the delay of marriageable age to at least 18
- to educate the population to believe that a typical Indian family is smaller. The Indian government has introduced two incentives here, retirement benefits for smaller families and the availability of maternity leave for only the first two children in a family.

Case study of China

China is the world's largest country, with a population of 1.2 billion in 2000, about 20% of the world total! Family planning is a basic state policy of China. Article 25 of China's Constitution states that:

> 'The state promotes family planning in order to make the population growth compatible with the plan for socio-economic development.'

Article 43 states that:

> 'Each married couple is obliged to practise family planning.'

With such a vast population China has a considerable responsibility to ensure that the future growth of its population is controlled (see Figure 4).

Declining populations in MEDCs

Many MEDCs also have population concerns, however these are linked to **negative growth**, or a **population implosion**. Most MEDCs are in the final stage of the **demographic transition** and death rates are sometimes higher than birth rates. The fertility rates for many MEDCs are now much lower than the population renewal value of 2.1 (see Figure 2). The main reasons for this declining population size are:

- social changes, as couples marry later and the average age at which a woman has her first child has increased from 23 to 27 in most MEDCs
- increasingly 'equal' roles in society for men and women so that women hold most jobs in the workplace
- most women find it difficult to cope with a demanding job and a family of more than one or two children
- fewer women want to give up work, or can afford to do so, to care for a young family
- children are expensive to rear and a small family allows extra money for other luxuries.

How can population growth be increased in MEDCs?

The simple answer here is to **increase** family size, and many MEDCs have introduced a variety of incentives to encourage this, including:

- extended family leave on the birth of a child
- financial benefits for the second, third and subsequent children, such as tax benefits and cash support

Figure 4: China's changing population policies

YEARS	MAIN EVENTS	Natural Increase per thousand
1949	People's Republic of China under Chairman Mao was declared Little agricultural or industrial development Life expectancy was 32	16.0
1950s	People were encouraged to have large families The 'Great Leap Forward' as China concentrated on industrial development	12.3
1960s	Unsuccessful attempts to control population growth. Increase of 55 million in three years!	9.5
Early 1970s	State family planning programmes were introduced: later marriages, fewer children; wider spacing Average family size was three children	7.6
1979	The 'One Child is Good' policy was started Couples with only one child received benefits such as free education, priority housing, pensions, family benefits etc. Couples with more than one child lost benefits/ were fined etc. Men could only marry at 22 and women at 20 Couples had to have permission to marry and have a child	6.2
1980s	Problems emerged with the one child policy: in rural areas, people wanted larger families to help on the farms a generation of spoiled only children was emerging too few young people to look after elderly parents female infanticide; forced abortions on second pregnancy	6.8
1990s	Easing of severe restrictive policies. Rural couples allowed two children if over a 3-year period. Reduction of application of targets	6.5
2002	New Population Law with more emphasis on informed choice and fewer restrictions and penalties. Review of necessity of policy and social and demographic effects. Aim of Government State Family Planning Commission is to continue to control population growth in the future.	6.9

- subsidies for lower and middle-income families who wish to have larger families but cannot afford to do so
- migration – this sounds an ideal solution in principle – move people who are living in countries of rapid growth to countries where the population is declining. However, this is usually politically unacceptable, as even the present small number of migrants is causing problems, and migration on a large scale would be needed. For example, for Italy to maintain its 2000 population size, it would have to accept 350,000 migrants each year for the foreseeable future!

Case study of Europe

The total population of Europe is expected to decrease by almost 10% by 2050. Italy's total population is forecast to fall by 28% over the same period. The situation is worse in the eastern Communist countries. Here the FR is 1.3 compared to 1.6 in the West, due to the collapse of communism and reduced child support benefits.

Case study of Sweden

The Swedish government could foresee problems with its future population growth in the late 1970s and 1980s, as Sweden's death rate and birth rate became very similar in value and the FR was falling. As a result of government policies, the FR increased from 1.6 to 2.1 (replacement value) by the early 1990s. However, since the mid-1990s, when the world economic situation started to worsen, the high levels of government support for larger families have been reduced. Fertility rates have fallen again, and by 1997 the birth rate was lower than the death rate, causing population decline for the first time in Sweden's recent history. This decline has since continued (see Figure 5).

Swedish government solutions to try to reverse the declining population trend over the past decade have included:

- parental leave on 80% salary for up to 12 months after the birth of a child, for either parent
- up to 120 days' leave to care for sick children, on 80% salary
- adequate provision of heavily subsidised day care
- high tax rates of between 30 and 50%, to finance these schemes.

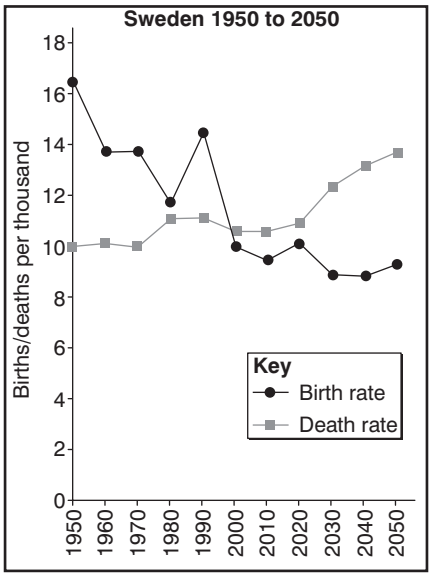
Sweden's current situation is typical of that of many MEDCs. There are fewer jobs in the current economic climate, and so less income per couple to finance a larger family or maybe any family at all. In the past one government solution in such a situation has been to encourage early retirement. However, that increases government spending on pensions, which has to come from increasing taxes on the workers!

Case study of Japan

It is forecast that by 2007 Japan's population numbers will start to decrease due to a low fertility rate of 1.3 (2002), the expense of having more than one or two children, and more career women in the workplace. Various solutions have been tried:

- a government policy was introduced in 1992 to allow workers up to one year's unpaid leave to care for their children. This was amended in 1995 so that parents also received 25% of their salary during that time
- the 'Angel Plan' was started in 1994, which provides financial support for child rearing and increases the money spent on childcare provision
- the child allowance scheme has been modified so that parents are given a one-off payment of 5,000 yen for the first and second child and 10,000 yen for third and subsequent ones
- company schemes such as that of the Bandai Toy Company (makers of the 'Tamagotchi pet'), have been started, where employees are given 6,000 yen for every third and subsequent child

Figure 5: Sweden's birth rate and death rate, 1950 to 2050



born to a couple.

- Daihatsu offers its workers 1,000 yen and free car rental for three years on the birth of a fourth child
- in some countryside areas, villagers have invited women from the Philippines to marry their men.

Conclusion

There are few countries in the world today which do not have problems linked to population growth. There does not seem to be any overall solution to the many problems, it is just the responsibility of individuals and countries to attempt to minimise their effects.

Useful Web addresses:

China: www.cpirc.org.cn

Asian countries' policies: www.unescap.org/pop/database/law_index.htm

NGO Work: www.policyproject.com

USAID (Kenya) www.usaid.gov/country/afr/ke/

Wide range of information: www.popcouncil.org

Figure 6: Population pyramids for Japan, 1998 and 2025

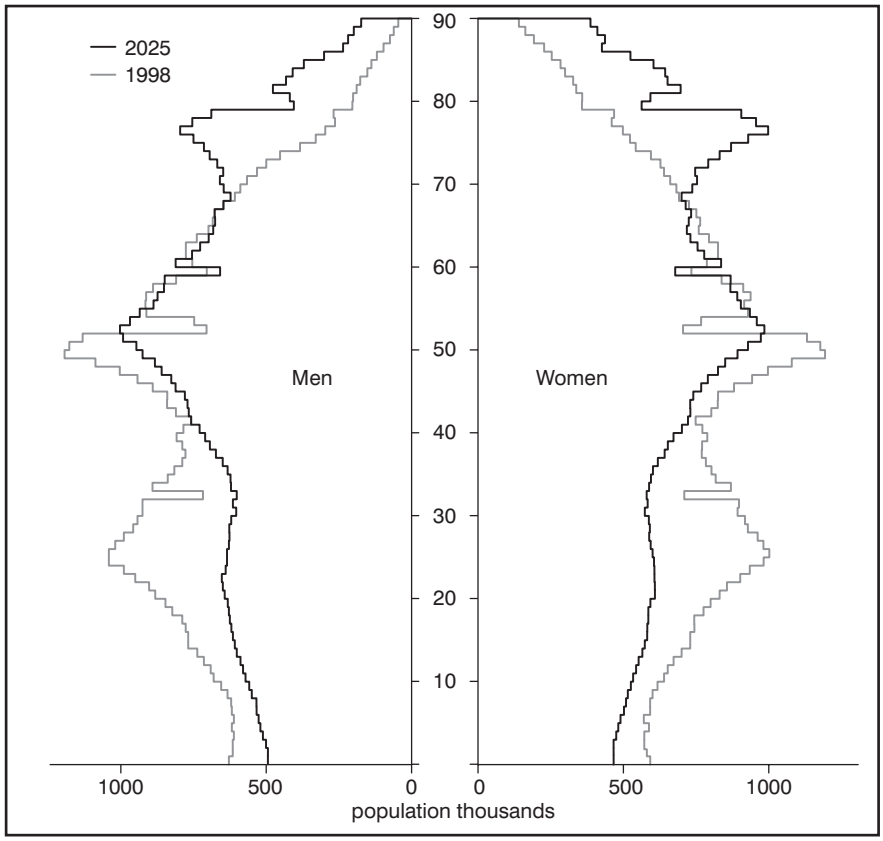
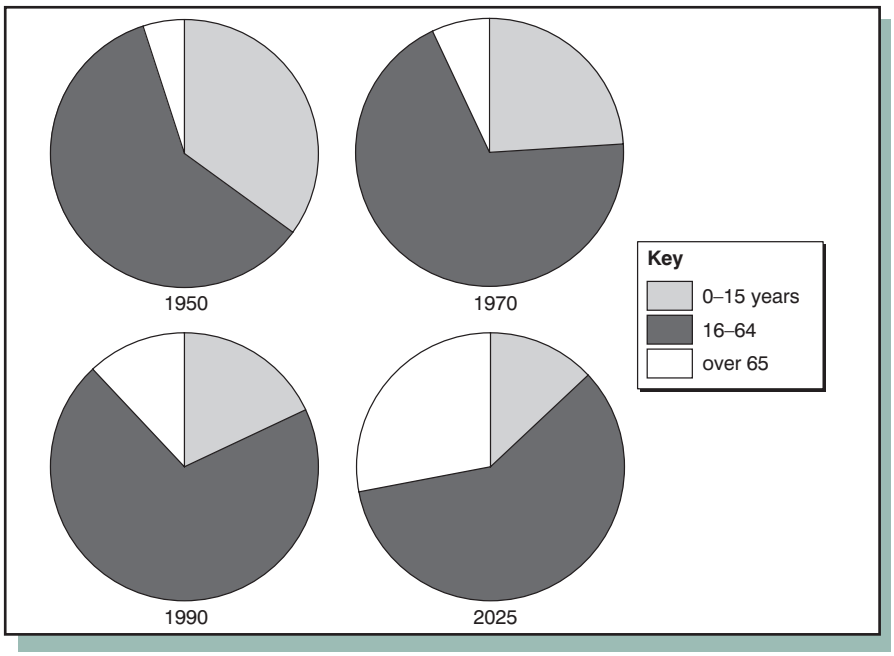


Figure 7: Changing age structure in Japan, 1950 to 2025



FOCUS QUESTIONS

1.Explain how the development of AIDS has affected the population growth of LEDCs such as Kenya.

2. The lowering of population growth in LEDCs involves many issues. Explain how and why the following actions are important:

- developing vaccination programmes against preventable childhood illnesses
- encouraging people to marry at a later age and then to have a family which is 'wider spaced'
- improving infant mortality rates.

3. Article 25 of the China's Constitution states that population growth must be 'compatible with the plan for socio-economic development' and India wants to stabilise its population 'at a level consistent with the requirement of the national economy'. Explain the meaning of these two aims and say why population control is not always as straightforward as it seems to be.