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## Recent Changes in the Population Control Policy and Its Future Directions in Korea

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With successful implementation of the national family planning program and rapid socio-economic development during the last thirty years, the total fertility rate(TFR) in Korea has decreased from 6.0 in 1960 to 1.6 in 1987 which is considerably below the replacement-fertility level. It is estimated that if the current fertility rate continues, the nation's population will increase from 42.8 million in 1990 to 50.2 million in 2020, and then switch to a negative growth which leads to an aging and labor force problems due to the sudden change in the population structure. Considering the socio-economic conditions, and the large existing population in relation to the available land area and resources in Korea, however, future policy directions should aim at maintaining a minimum population growth rate, and to postponing the achievement of "Zero Population Growth" as long as possible in order to avoid the socio-economic problems that are bound to come as a consequence. This implies that although the family planning program has to change its objectives and strategies, it should continue as a main tool to adjust fertility and population growth rates in the immediate future. Therefore, this paper aims to review future population policy directions for Korea after taking into consideration future population growth and problems as well as recent changes in population control policy.

### I. Introduction

Korea's national family planning programme

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evolved primarily in response to the high population growth of the late 1950s. It has been an integral part of a series of Five-Year Economic and Social Development Plans since 1962. From the initial stage, the programme has been with government support used the large corps of family planning field workers to motivate clients through home visits, along with private

physicians to provide free contraceptive services. This strategy of using these diligent and cooperative field workers and physicians is fruitful and has been effective, particularly in rural areas.

In the 1970s, new issues in family planning emerged with post 1962 socio-economic development. An increasing number of the rural population began to migrate to urban areas, and as a result, more emphasis had to be given to family planning services for urban population, particularly for low-income groups and industrial-site workers.

In 1981 when the Fifth Five-Year Economic and Social Development Plan(1982~1986) was drawn up, the government took into serious consideration the future population growth rate which would seriously threaten to defeat its efforts toward national socio-economic development unless the existing population control policy measures were further strengthened, so the government has devised forty-nine innovative policy measures including revitalizing existing family planning programmes, the development of extensive social support policies for small family norms, and close interministerial coordination and cooperation for family planning programmes.

With the continued successful implementation of the family planning programme beginning in 1962, the contraceptive practice rate of married women aged 15 to 44 had increased to a high level of 77.1 percent by 1988 while the total

fertility rate had declined to below the replacement fertility level of 1.6 in 1987. If the current fertility level is maintained, the nation's population will increase from 40.8 million in 1985 to 50.2 million in 2020, and thereafter the population is expected to decrease gradually in its absolute numbers.(See Appendix 1~5)

In setting up a future population policy, it should, therefore, be borne in mind that there are two opposing views on future policy in Korea. The first viewpoint has to do with the fact that the current population control policy has to be maintained at all costs in view of the following unfavourable socio-economic conditions : Korea's cultivable land and other natural resources are limited ; there is a relatively low public health standard level, there is a seriously unequal income distribution, and the labor market segmentation is poor. The second viewpoint asserts that if the nation's population reaches the zero population growth level too soon, Korea will inevitably face a rapid population aging problem including a shortage of a young economically active population, so the realization of a zero population growth rate should be postponed as long as possible.

Since these views on future policy directions are considered realistic for Korea, this paper will discuss views that would be appropriate for future population policy and program directions for Korea after taking into consideration population growth and problems as well as recent changes in population policy and programs.

## II. Future Population Growth and Problems

### A. Future Population Growth

With an effective and efficient family planning programme launched in 1962, the total fertility rate was brought down from a high 6.0 per woman in 1960 to below the replacement level of 1.6 per woman in 1987. The population of Korea would increase from 40.8 million in 1985 to 50.2 million in 2020. If this trend continued, then there would be negative growth. Growth rates were 0.93 percent in 1985, would be 0.75 percent in 2000 and zero percent in 2020. Consequently, the population will age ; and the percentage of the 0~14 age group would go down from 30 in 1985 to 17 in 2020, while the corresponding percentage of population aged 65 and over would increase from 4 to 11. If the trend continues, Korea will soon face population aging problems.(See Appendix 1~3)

Fortunately, the economically active population, aged 15~64 years, will rise from 66 percent of the total population in 1985 to 72 percent in 2020, but this high proportion, which will reduce the dependency ratio, will decrease when the population ages rapidly as shown by the Japanese population. For example, in Japan in 2020, the economically active population will account for about 60 percent of the total, the 0~14 age group will be 16 percent and the over 64 age group will be 24 percent<sup>1)</sup> of the total.

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1) Kono (1989).

The relative young age structure of Korea's population is also shown by the median age of the population : 29 years in 1989 compared with 35 for the United States, 36 for Japan, and 30 for West Germany.(See Appendix 4)

The total female population aged 15 to 34 years had increased from 5.1 million by 1970 to 7.7 million in 1985. Of the proportion married in this age group, was 53 percent in 1970 and 46 percent in 1985. It is expected that up to 1991 the married female population aged 15~34 years will continue to rise, indicating that the need to continue the current population control program.(See Table 1)

Since the 1980s, the sex ratio (males/females) at birth has been on the increases, 107 in 1982 and 114 in 1988. This increase is even greater for the third and fourth birth, from 109 in 1982 to 171 in 1988 for the third birth, and from 114 in 1981 to 199 in 1988 for the fourth birth. This is attributed to the fact that sex selection procedures were used by a large number of parents. This trend may stop with the introduction of a revised law on medical services in 1986 in which the identification of the sex of an unborn child is strictly forbidden except in limited circumstances. The existing social prejudice for one gender against the other could be eradicated by the revised family law emphasizing female rights and improved female education.(See Table 2)

Korea has undergone unprecedentedly rapid urbanization since the 1960s. In 1985, about

**Table 1. Number and Percentage of Married Women Aged 15~34, 1985~2000**

Unit : Thousand

	1970	1975	1980	1985	1991	1995	2000
1) Eligible Women	5,072	5,952	6,885	7,720	8,341	8,193	7,898
2) Married Women	2,712	2,823	3,262	3,667	3,959	3,892	3,751
3) Prop. of Married Women(2/1)	53.5	47.4	47.4	47.5	47.5	47.5	47.5

Source : Nam-Hoon Cho, et al., *Recent Changes in the Korean Population Control Policy and Its Perspectives*, KIPH, 1989

**Table 2. Sex Ratio(Males/Femals) at Birth by Parity, 1982~1988**

Parity	1982	1983	1984	1985	1986	1987	1988
Total	106.9	107.7	108.7	110.0	112.3	109.4	113.6
First	105.5	106.0	106.4	106.3	107.6	105.2	107.2
Second	106.1	106.3	107.5	108.2	111.7	109.5	113.5
Third	109.3	112.5	118.5	131.7	141.4	131.8	170.5
Fourth or More	114.2	122.1	131.7	153.8	157.4	157.2	199.1

Source : Bureau of Statistics, EPB., *Recent Changes in Vital Statistics and New Population Projection*, 1988.

44 percent of the population was found in four large cities : Seoul, Pusan, Taegu and Incheon. The urban population growth rate was most rapid in the 1960s : at 6.0 percent per year during 1960~66 period and at 7.2 percent per year during the 1966~70 period. In the 1970s, it declined somewhat and during the 1980~85 period, the growth rate went down to 4.3 percent per year. It is expected, however, to go down further to 2.3 percent per year for the 1985~90 period, to 2.0 percent in the 1990~95 period and to 1.6 percent for the 1995~2000 period. In particular, Seoul's population growth rate will go down from a high of 9.8 percent per year in the 1966~70 period. It still accounted for one quarter of the nation's total population in

1990(10.7 million), and will be about 27 percent of the total population in 2000.

As the urban growth rate is much higher than the national population growth rate, the urbanward population movement will continue, so there is a need to take appropriate measures to deal with the socio-economic problems arising from urban population concentration and growth.

## B. Socio-economic Problems<sup>2)</sup>

By the year 2000, the nation's population is expected to have increased to 46.8 million or a 15 percent increase over the 1985 population.

2) Nam-Hoon Cho, et al. (1989).

Concomitant with the population increase, there will be changes in the patterns of consumption, employment, housing, transportation, and a rapid nucleation of the family resulting from the unprecedented industrialization and modernization process.

The total number of households increased from 4.38 million in 1960 to 9.59 million in 1985, an annual increase rate of 3.2 percent over the 25 year period. This increase rate is much higher than the annual population increase rate, 2.0 percent per year, over this period. The rapid increase in the number of households is attributed mainly to family nucleation. In 2000, the housing problem will become more serious as it is increasingly difficult for the supply of housing to meet demand since the household growth rate will far surpass the population increase rate.

In addition, the nation's cultivable area decreased from 2.20 million hectares in 1980 to 2.14 million hectares in 1990, and is expected to further decrease to 2.10 million hectares in 2000. This will reduce agricultural output and create food grain shortage problems. It is estimated that by the year 2000 the nation will have to depend on imports for 65.8 percent of its food grains. In 1970, the nation was 84.6 percent self-sufficient in filling its annual food grain demand. This decreased to 61.2 percent in 1980, and further to 42.0 percent in 1990.

The nation's energy demand is likely to increase during the 1986~91 period by 6.1 percent

per year, and after that period, demand increase may slow down due to industry restructuring and technological development. During the 1987~2000 period, the growth rate will decrease to the annual 4.8 percent level. In 1986, 76 percent of the energy demand was met by imports from abroad, but in 2000, over 90 percent will have to be met by imports, thus creating a serious depleting in the nation's foreign currency reserves.

In the public health field, a World Bank Survey based on the data from 125 countries(1986) shows that infant mortality increased by 15.4 unit per unit increase in the annual population growth, and the per unit increase in annual population growth was accompanied by a 3.4 year decrease in life expectancy, and a 146.7 calorie decrease in the per capita daily calorie supply. The World Bank report also indicates that the unit increase in the total fertility rate was accompanied by 1.5 unit increase in the crude death rate, and 21.0 unit increase in the infant and childhood mortality rate, as well as by a decrease of 192 calories in the per capita daily calorie supply.

In general, as the fertility level decreases, life expectancy increases and the public health standard usually improves, but the fertility decline is also inevitably accompanied by population aging, an increase in medical costs for the aged due to an increase in the population suffering from chronic diseases. In 1985, about 5.7 percent of urban household income and 5.2 percent

of rural household income were spent on medical expenses, but the proportion spent on medical costs is expected to increase in 2000 to 9.0 percent in urban households and to 7.3 percent in rural households. As population aging continues, medical expenses will soon account for over 10 percent of total household expenses.

According to government statistics, the unemployment rate decreased from 3.1 percent in 1987 to 2.5 percent in 1988, but a series of past labor disputes and demands for wage increases produced negative effects on the nation's competitive power in the world trade. The future unemployment problem is likely to worsen due to industrial automation, and the increasing number of aged and females who want to participate in economic activities.

### **III. Recent Development of Integrated Family Planning and Health System<sup>3)</sup>**

Korea's family planning program has been carried out as part of the population control policy through the government's health centers since 1962. In 1962, the government established family planning sections in its 183 health centers throughout the country, and allotted nurses and mid-wives as family planning workers to the individual health centers. Gradually, family planning workers were allocated to health subcen-

ters in township areas to provide family planning services and conduct family planning IEC activities.

In the 1960s, eighty percent of the nation's population was in rural areas, and the family planning worker's main task was to make home visits to motivate and recruit contraceptive acceptors. Starting in 1967 health center and health subcenter was staffed with a family planning (FP) worker, a maternal and child health(MCH) worker, and a tuberculosis(TB) worker.

Unlike some countries where the family planning program is included or integrated into the maternal and child health care program, Korea places a greater emphasis on the family planning program as part of the nation's population control policy than on the maternal and child health care program. This is one of the reasons family planning workers were assigned to the health centers far in advance of the maternal and child health care workers and the tuberculosis workers.

Starting with the Fourth Five-Year Economic Development Plan(1977-1981), however, the government's development program included not only public and medical health matters but also social concerns. It also began to recognize the need for integrating the functions of family planning workers, maternal and child health care workers, and tuberculosis workers into those of single multi-purpose public health workers.

In 1981, the status of the above three workers was upgraded from temporary position to a per-

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3) Eung-Suk Kim, et al. (1990).

manent public servant known as health worker. In the 1980s, however, there were many problems in transforming the 2,461 FP workers, the 916 MCH care workers, and the 2,101 TB workers into single integrated multi-purpose health workers. Three of the main problems were : 1) about 81 percent of these worker were nurse-aids whose qualifications as well-trained public health worker were in doubt, 2) in order for the integration program to be carried out properly, the organization of and management from the central government level down to the lowest health subcenters had not been fully instituted, and 3) a specific training program designed to integrate the existing three separate workers into a single multi-purpose health worker had not been developed.

Despite the ambitious integration program announced in 1981, therefore, the program could not take off until July 1985 when the practical integration program was put into effect at the health center and health sub-center level but without the reorganization of the existing management structure.

Korea could maintain an annual economic growth rate of over 8 percent, with the successful implementation of the six rounds of the Five-Year Economic Development Programs beginning in 1962 and part of this high growth ratio was attributed to the efficient implementation of the family planning, the maternal and child health care, and the tuberculosis programs.

Improvement in the maternal and child health care programs and the decline in the mortality due to tuberculosis control programme contributed to a large extent to lengthening of life expectancy, and much of the fertility decline during the period was due to the successful implementation of the family planning program.

A recent study shows that the contraceptive practice rate as of 1988 stood at 77.1 percent, the total fertility rate was at 1.6, a level far below the replacement level, and the annual population growth rate was down to the one percent level. In 1988, 93.8 percent of all births were delivered at hospitals and clinics, whereas in 1972 only 13.2 percent of all births were at these places.<sup>4)</sup> The tuberculosis prevalence rate is reported to have declined from 4.9 percent in 1966 to 1.8 percent in 1990.<sup>5)</sup> Public health is expected to improve further with the implementation in July 1989 of the national medical insurance system.

Though the nation's family planning program was the major force that helped achieve the current fertility level, which is as low as that of the development countries, it still has many problems to solve, some of them related to the contraceptive choice/mix and with contraceptive effectiveness/efficiency. That is, currently over 90 percent of contraceptive users were practi-

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4) Hyun-Sang Moon, et al. (1989).

5) Tb Association of Korea, 1991 Activity Report, Submitted to the National Assembly, Feb. 1991.

sing contraception primarily for fertility termination rather than birth spacing. Due to the high contraceptive discontinuation rates of temporary methods, the induced abortion is used extensively as shown by its extremely high rate. It is sad to note that the yearly number of induced abortions is greater than the number of children born per year.

The primary reason for the high discontinuation rate and the high induced abortion rate has to do with the fact that in Korea, the family planning program started as a population control policy, unlike the family planning programs in some developed countries where the family planning program was designed to help improve the maternal and child health care program. The Fertility Survey of KIPH in 1988 shows that the discontinuation rates for IUD and the pill at twelve months were : 47 percent and 66 percent, respectively in 1976 and 46 percent and 72 percent, respectively in 1985.(See Table 3) This high termination rate may be attributed

**Table 3. High Termination Rates of Contraceptive Use, 1985\***

Ordinal Month of Use	IUD	Oral Pill
1	12.8	23.0
3	24.6	45.8
6	34.2	59.9
9	39.0	65.5
12	46.0	71.8

\*Cumulative termination rates.

Source : KIPH, *Fertility Changes in Korea*, 1987.

to the shift from a temporary method to sterilization and induced abortions, the inflexible program target system for health workers, inadequate follow-up services for temporary contraceptive users, and other factors including side effects and the inconvenience of temporary methods.

In addition, the total abortion rate for married women increased more than 4 times from 0.7 abortion per women in 1963 to 2.9 in 1978, but it fell to 1.6 in 1987, but married women's abortions in 20s age group showed an increased trend. This means more attention should be given to motivating these young women to use contraceptives for spacing purpose.(See Table 4)

The future emphasis of family planning program should, therefore, be placed, not on increase in the contraceptive practice rate and decline in the fertility level, but on improvement of maternal and child health care through prevention of unwanted pregnancies and induced abortions. Accordingly, there is a need for future family planning program to be integrated with the maternal and child health care program. Despite major improvements in socio-economic development and in public health areas in the last twenty years, the family planning worker's activities are still confined mainly to the delivering of services through routine home-visits.

Though the government announced a plan in 1981 for integrate health workers, no specific



Table 4. Trends in Induced Abortion Rates for Currently Married Women, 1963~87

Age of Women	1963	1973	1978	1981	1984	1987
20~24	16	86	70	74	91	108
25~29	29	75	156	158	146	107
30~34	58	137	148	146	115	72
35~39	40	88	156	106	40	28
40~44	—	22	54	48	20	7
T. A. R.	0.7	2.1	2.9	2.7	2.1	1.6

Source : KIPH, 1988 *National Fertility and Family Planning Survey Report*, 1989.

or concrete measures had been implemented to integrate until July 1985 when specific instructions on the integration plan were given to provincial and city governments. The newly instituted program integrates family planning, maternal and child health care, tuberculosis services into the public health education and home health care programs. As with any newly developed program, it is expected that problems will be encountered in carrying out the integration plan, i. e. :

1. Family planning services have been integrated into maternal and child health care services under the title of home health care in name only, and the two programs are still being conducted independent of each other. Ideally, the health workers at the Eup and Myon offices are required to set up their monthly work plans under the supervision of the county health centers, but at the individual health centers the home health care section is separate from the tuberculosis section and the two sections have to be integrated in terms of the administrative

organization if the integration plan is to be efficiently worked out.

2. The qualification of the health worker poses a major problem when the family planning, the maternal and child health care, and the tuberculosis services are carried out independent of one another, as most of the maternal and child health care services were performed by nurses and midwives, and most of the family planning and tuberculosis services were performed by nurse-aids. When the three services were integrated, however, one health worker had to carry out the work of family planning, maternal and child health care, and the tuberculosis service workers, and in addition, he or she had to perform public health education and home health care services.

3. Since the record and reporting forms currently being used for family planning, maternal and child health care, and tuberculosis services are not yet integrated, unnecessary time and effort are spent filing the separate records and report forms at the individual health centers.

4. According to the integration scheme, health workers are to spend two-thirds of their monthly working hours on home visits, and the remaining one-third on their in-clinic services, but unlike in the past when health workers had to spend most of their time on home visits, there is a greater need for health workers to concentrate on their in-clinic services.

Since in urban areas, the health worker's home visits are unlikely to bring about any substantial results, entirely new way of approaching the target population will have to be developed.

#### **D. Recent Changes and Future Policy Directions**

As Korea has completed its demographic transition with a low fertility and a low mortality level, it should shift its role to accommodate recent population policy and program changes as well as to develop future population policy and programme directions.

The Korean family planning program that was started in the early 1960s contributed substantially to alleviating rapid population growth, some housing and employment problems, and food grain shortages, but much remains to be done in view of the many issues and problems confronting the nation on its road to a progressive and enthusiastic people. The family planning strategies used so far have also helped in lowering the total fertility rate from 6.0 in 1960 to 1.6, below the replacement level, in 1987

while increasing the contraceptive practice rate from 9 percent to 77 over the period 1966~88. The factors that contributed to the decline of the fertility level include vigorously effective and efficient implementation of the national family planning programs with strong political support and commitment, wide use of induced abortion, rising marriage age, changing attitudes and norms in the direction of smaller families, and rapid socio-economic development.

With recognized success in reaching the replacement fertility level, the government feels the population problem has been solved and is thus gradually reducing its support for contraceptive supply services to encourage the private organizations to take over family planning services as well as reducing financial assistance and resources to implement provincial and county family planning programs. For example, the government has greatly reduced its government-supported sterilization target from 300,000 in 1986 to 60,000 acceptors in 1991, and the government-supported menstrual regulation services are to be discontinued starting in 1991. (See Appendix 5~6) Future contraceptive services including sterilization and intra-uterine device services are to be conducted through the national medical insurance system in which the clients, except for those from the low-income group, would have to cover part of the costs incurred by the services they receive. As a result of budget cuts, many health and sub-health centers, which provide family plan-

ning services, transferred their MCH staff of other centers, and thus gave low priority to family planning services.

All these measures will definitely lower the contraceptive practice rate, especially the sterilization and menstrual regulation, and increase the total fertility rate, indicating that the population will exceed the projected 50.2 million in 2020. A decrease in contraceptive use and the improper use of contraceptives due to a lack of contraceptive counseling and education would lead to higher use of induced abortion which the family planning programs have tried to reduce or replace with effective contraception. It is imperative, therefore, that the government not withdraw its financial support and commitment to the family planning programme to maintain the achieved low fertility level as well as to reduce undesirable induced abortion, especially among those in the younger age groups.

With the completion of demographic transition, it is strongly suggested that population control policies should be shifted from the current quantity-oriented policy which focuses on fertility reduction to a quality-oriented policy which stresses childspacing, child/family development and care of the elderly.

The four policy measures for influencing the qualitative approach include: 1) past family planning program emphasizing sterilization contraceptive supply/distribution should be directed toward reducing the contraceptive discontinuation rate and induced abortions, 2) policy

measures should be instituted to deal effectively with the spatial distribution of the population, dealing particularly the urbanization problem; 3) new public health measures designed to improve population quality should be worked out. Included in this category are measures to improve the home health care program, and measures to provide counseling and education services on matters relating to reproductive health and family planning for juveniles and unmarried men and women should be introduced.

To be more specific, these measures would include sex education for adolescents, improvement of existing maternal and child health care services and of home health care, counseling services on induced abortion, the development of programs for child-rearing and child welfare, improvement of the marriage counseling services, counseling on child-rearing for married female workers with pre-school children, control of chronic diseases of the aged, improvement of social welfare facilities for the aged, extension of the pensionable age, development of measures for the welfare of the handicapped, the optimal spatial redistribution of population, measures to deal with various urban pathologies including urban crime, traffic congestion, housing problems, and the environmental and ecological issues threatening the quality of life.

Instead of accelerating the fertility decline, future policy directions aim at postponing the achievement of zero population growth as long

as possible to avoid rapid population aging problems including a shortage of economically active and young population as well as to allow time to monitor fertility, mortality and population growth and trends for fine-tuning policy measures and directions. The following areas are suggested for careful consideration and future policy directions for the current family planning/health/MCH program.

**1. Strong government support for policy programmes and adoption of a self-paying contraceptive distribution system**

Strong government, both central and provincial, support and commitment as in the past should be provided to further strengthen quality-oriented population policy and programs which will eventually improve service quality as well as the quality of life. In addition, the free contraception services, including sterilization and reversible methods, should be shifted to a self-paying system, except for low income couples who would be provided free services. This will improve programme and service quality as well as relieving the government's financial burden. The government revised the Medical Insurance Law in 1982 to provide contraceptive services including male and female sterilization and IUD, but the 1988 survey data show that only 1.4 percent of all married women practiced contraception through medical insurance benefits, due to the mass distribution of contraceptive services free of charge under the government program.

**2. Elimination of incentive schemes for the one-child family**

Starting in 1982, the government adopted a variety of slogans, i. e. two is too many, to discourage people from having more than one child. For instance, those couples who had sterilization operations after having only one child were exempt from delivery expenses at maternity clinics, and those children in the 0~6 year category were given primary health care free of charge.

The one-child slogans and incentive schemes were designed primarily to realize replacement level population as soon as possible, but in 1987, the nation's total fertility level had already gone below the replacement fertility level of 1.6 per woman, rendering it superfluous to emphasize the one-child policy. It is recommended that future population policy rather place emphasis on a two child policy.

**3. Expanding the family planning target population**

The past family planning target population had to be limited to married couples, as its primary objective was to lower the fertility level, but recent socio-economic, and cultural developments have brought with them a series of social problems involving unmarried men and women.

A recent survey by the KIHASA has revealed that as much as 28 percent of the induced abortions carried out in 1979 were on unmarried females, which increased to 33 percent in 1990.

That is, as the age at first marriage increases, a greater number of unmarried men and women are being exposed to a variety of sexual stimulations for a longer period of time, resulting in a greater number of induced abortions.

Future family planning program policy should, therefore, cover not only married couples but also unmarried men and women to prevent pre-marital pregnancies. The PPFK, a private organization has demonstrated that its counseling services on sex education for the unmarried population in industrial complexes has been successful.

#### **4. Change in institutional framework**

In 1970, the government established the Korea Institute for Family Planning(KIFP) and in 1976 it also launched the Korea Health Development Institute(KHDI). In 1981, for more effective coordination and implementation of related program activities these two institutes were merged into the Korea Institute for Population and Health(KIPH). In January 1990, better to cope with the increasing demand for research in the social welfare and social security areas, the name of KIPH was changed to the Korea Institute for Health and Social Affairs(KIHASA) to cover three separate research areas ; population, public health and medicine, and social welfare. KIHASA should be strengthened with technical staff and financial resources to conduct more applied policy and programme research as well as training workshops, based on Korea's successful experience, for developing countries

on how to formulate population policies as well as management, monitoring and evaluation of family planning/MCH programmes.

#### **5. Revision of family law**

In an effort to improve women's status and at the same time to ameliorate the still strong son preference attitude, the government introduced a revision to the current family law in December 1989. According to the revision that went into effect in January 1991, daughters are allowed to assume household headship, and daughters are allowed to claim an equal share of their parent's inheritance, regardless of birth order. In the past, sons were allowed to claim a greater share of their parental inheritance than daughters.

#### **6. Efficient utilization of health workers**

Future family planning should be directed not only toward population control policy, but also toward the improvement of maternal health and household welfare, and for this purpose, the following several points on the health worker utilization should be emphasized.

##### **a. Streamlining program organization**

For integration to be realized, the organizational structure of the health service at the health center and the health subcenter levels should be streamlined, so if the full integration is to be implemented, the family planning, the maternal and child health care, and the tuberculosis services should be placed under one organization which can exercise better control and supervision over the services.

b. Reassignment and training of health workers

About 71.5 percent of the total of 5,337 health workers are located in rural areas, resulting in a shortage of health workers in urban areas whose population accounts for 80 percent of the nation's population. Health workers should, therefore, be reassigned to increase the number of health workers in urban regions. As 63.5 percent of the total of health workers are nurse-aids, a training program should be instituted for them.

c. Improvement of health worker services

In the past, the family planning program's main emphasis was on fulfilling the target number of contraceptive acceptors set by the government, but the future program should focus on the low-income population. In the field of family planning, contraceptive information services should be provided to those who visit health centers for vaccination. Moreover, in urban areas, it is becoming increasingly difficult to conduct home visits for one reason or another, so it would be time and effort saving, if the health workers could keep in touch with their clients by telephone or mail, and home visits should be limited to those unable to go health centers.

d. Medical facility improvement

Health centers and subcenters should be equipped with a counseling room in which the client could discuss health matters with the health worker without any interference from

other people. The health center should also be able to provide reproductive health education for juveniles at the centers on a regular basis, i. e., weekly or monthly. Health centers and subcenters should have basic medical facilities which could provide simple medical service whenever necessary.

e. Standardization of record and reporting forms

As yet the record and reporting forms for the family planning, the maternal and child health care, and the tuberculosis programs have not been standardized, effort should be made to have all these forms standardized for a fuller integration of the program.

f. Development of manual for the integrated health workers.

At present, there are three separate manuals for the family planning, maternal and child health care, and tuberculosis programs. A standard manual covering the three programs should be developed for better management of the integrated program. The standard manual should specify the responsibilities and roles of the health workers, supervisors, the organizational structure, and the evaluation system.

7. The aging of the population, which resulted from low fertility and low mortality as well as longer life expectancy, suggest that a major shift of expenditures should be made from education, and other social welfare provisions to health care, support and welfare for the elderly. It also means that employment policy will have

to shift from new job creation for young entrants to development and retraining programmes for older workers.

Though the relatively young age structure in Korea will generate an older age structure in an eventually stationary population in about 30 years, its policy and programme implications must be given serious consideration now, to avoid the situations now faced by developed countries which have zero or negative population growth rates.

8. *Traditional Korean society is modernizing along with rapid socio-economic development.* In recent years, young people had problems related to drug abuse and risk-taking, violent behaviour. These problems may be due to social factors such as lack of civic and humanity education, confusions and conflicts in adjusting to value changes, changes in family structure and family ties due to fertility decline, and had mass media influences. In order to improve family welfare for young people, the FP/MCH programme needs to plan and implement activities including information, education, and motivation (IEM) for them.

## V. Conclusion

As Korea has achieved its demographic transition with a low mortality rate and a below replacement fertility level, it should change its role to accommodate recent population policy and program changes as well as design and de-

velop future population policy and program directions in accordance with its emerging socio-economic and demographic condition.

With the current severe reduction in government support and commitment to the family planning/MCH program in terms of funds and resources, the contraceptive practice rate will drop substantially and the induced abortion rate increase significantly. This will result in a higher population growth rate, over than one percent, and an increased total fertility rate. Taking into account of the demographic and socio-economic situations of Korea it is, therefore, strongly suggested that the government change its policy and program directions to maintain the low fertility level and postpone the achievement of a zero population growth rate, to invigorate the population with more economically active individuals for greater economic development and improvement of the quality of life. This can be achieved through strengthening the existing FP/MCH programmes with a flexible target system, including higher targets for temporary contraceptives instead of sterilizations. That is, the qualitative aspects of the programs and services should be more substantially emphasized than the quantitative aspects as in the past. The improved program and service quality will not only drastically reduce harmful induced abortions but also facilitate the achievement of such future population policy and program directions as maintaining a low fertility level and postponing the realization of a zero population

rate to a much later date.

In view of the complexity involved in implementing future population policy and program management including program planning, monitoring and evaluation, KIHASA should streng-

then its research and evaluation capabilities so that it can play a more dynamic and effective role in providing technical assistance to the government and relevant program implementing agencies.

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## (Appendix)

Appendix 1. Age-Specific Fertility Rates and Total Fertility Rates by Residence, 1960~1987

Age	1960 <sup>1)</sup>	1966 <sup>1)</sup>	1968 <sup>1)</sup>	1970 <sup>1)</sup>	1971 <sup>1)</sup>	1973 <sup>1)</sup>	1974 <sup>1)</sup>	1976 <sup>2)</sup>	1982 <sup>2)</sup>	1985 <sup>3)</sup>	1987 <sup>3)</sup>
Whole country											
15~19	37	15	7	13	6	10	11	10	12	7	3
20~24	283	205	146	168	188	145	159	147	161	162	104
25~29	330	380	301	278	341	301	276	275	245	187	168
30~34	257	242	201	189	234	220	164	142	94	52	39
35~39	196	150	120	101	124	88	74	49	23	8	6
40~44	80	58	65	39	41	19	29	18	3	1	3
45~49	14	7	7	7	3	3	3	1	—	—	—
TFR	6.0	5.4	4.2	3.9	4.7	3.9	3.6	3.2	2.7	2.1	1.6
Urban											
15~19	22	4	6	8	3	7	6	5	6	8	1
20~24	223	119	113	141	166	104	135	163	137	155	92
25~29	316	278	297	258	316	284	262	258	229	183	165
30~34	250	209	169	141	196	195	129	120	87	53	40
35~39	184	92	77	63	91	50	42	36	9	5	4
40~44	81	48	28	18	29	13	13	11	4	—	4
45~49	—	8	—	3	—	—	2	3	—	—	—
TFR	5.4	3.7	3.5	3.1	4.0	3.3	2.9	2.8	2.4	2.0	1.52
Rural											
15~19	48	16	8	17	9	14	16	16	25	4	9
20~24	291	243	178	189	211	206	192	173	217	182	156
25~29	354	424	305	291	363	324	298	278	286	200	177
30~34	308	284	220	212	266	249	206	173	110	48	35
35~39	237	228	147	126	144	117	103	54	29	17	13
40~44	115	96	87	50	49	25	41	26	3	2	3
45~49	—	12	11	7	4	5	4	—	—	—	—
TFR	6.7	6.5	4.8	4.4	5.2	4.7	4.3	3.6	3.3	2.3	1.96

Source : 1) Byung Tae Park, et. al., *The 1976 National Fertility and Family Planning Evaluation Survey*, Korean Institute for Family Planning 1978, pp. 113~124.

2) Hyun Sang Moon, et. al., *National Fertility and Family Health Survey Report*, Korea Institute for Population and Health, 1982, pp. 26~33

3) KIPH, *1988 National Fertility and Family Health Survey Report*, 1989. pp. 123~128.

Appendix 2. Population and Selected Vital Rates, 1985~2020

(Unit : Thousand)

Year	Total Pop.	No. of Births	CBR	No. of Deaths	CDR	PGR(%)*
1985	40,806	669	16.38	251	6.16	0.93
1986	41,184	679	16.50	250	6.07	0.95
1987	41,575	687	16.53	248	5.98	0.96
1988	41,975	693	16.51	249	5.93	0.97
1989	42,380	697	16.45	246	5.81	0.97
1990	42,793	701	16.39	248	5.80	0.97
1991	43,207	705	16.31	250	5.79	0.96
1992	43,623	708	16.23	252	5.79	0.96
1993	44,040	711	16.14	255	5.80	0.95
1994	44,456	712	16.02	259	5.83	0.93
1995	44,870	713	15.88	264	5.87	0.91
1996	45,281	711	15.71	269	5.95	0.89
1997	45,684	708	15.49	275	6.02	0.86
1998	46,078	702	15.24	281	6.09	0.83
1999	46,461	695	14.96	289	6.22	0.79
2000	46,828	686	14.66	295	6.31	0.75
2005	48,407	631	13.03	335	6.93	0.53
2010	49,486	574	11.60	384	7.76	0.30
2015	50,025	540	10.79	443	8.85	0.11
2020	50,193	540	10.75	503	10.02	0.01

\* Included international migrants.

Source : BOS/EPB, *Recent Changes in Vital Statistics and New Population Projections*, 1988.

Appendix 3. Population Structure and Dependency Ratios, 1985~2020

( Unit : Thousand )

Year	Total Pop.	0~14		15~64		65 or More		Dependency Ratio(%)
		Pop.	%	Pop.	%	Pop.	%	
1985	40,806	12,305	30.15	26,759	65.58	1,742	4.27	52.49
1986	41,184	11,994	29.12	27,400	66.53	1,790	4.35	50.31
1987	41,575	11,706	28.16	28,024	67.41	1,846	4.44	48.36
1988	41,975	11,451	27.28	28,619	68.18	1,905	4.54	46.67
1989	42,380	11,238	26.52	29,178	68.85	1,964	4.64	45.25
1990	42,973	11,070	25.87	29,697	69.40	2,026	4.73	44.10
1991	43,207	10,942	25.33	30,176	69.84	2,089	4.83	43.18
1992	43,623	10,841	24.85	30,625	70.20	2,157	4.95	42.44
1993	44,040	10,747	24.40	31,062	70.53	2,231	5.07	41.78
1994	44,456	10,641	23.94	31,505	70.87	2,310	5.20	41.11
1995	44,870	10,516	23.44	31,957	71.22	2,397	5.34	40.41
1996	45,281	10,363	22.89	32,425	71.61	2,493	5.50	39.65
1997	45,684	10,227	22.39	32,859	71.93	2,598	5.69	39.03
1998	46,078	10,138	22.00	33,225	72.11	2,714	5.89	38.68
1999	46,461	10,111	21.76	33,510	72.13	2,839	6.11	38.65
2000	46,828	10,132	21.64	33,724	72.02	2,972	6.35	38.86
2005	48,407	10,079	20.82	34,641	71.56	3,687	7.62	39.74
2010	49,486	9,624	19.45	35,579	71.90	4,283	8.66	39.09
2015	50,025	8,884	17.76	36,239	72.44	4,903	9.80	38.04
2020	50,193	8,264	16.46	36,183	72.09	5,746	11.45	38.72

Source : Op. Cit.

Appendix 4. Changes in the Age Composition of Japan, 1890~2025

Year	Age Composition(%)			Mean Age	Dependency Ratio(%)			Elderly/ Child Ratio
	0~14	15~64	65+		Total	Child	Old-age	
1890	28.15	65.16	6.69	30.7	53.5	43.2	10.3	23.8
1910	33.89	60.68	5.43	28.0	64.8	55.8	8.9	16.0
1920	36.48	58.26	5.26	26.7	71.6	62.6	9.0	14.4
1925	36.70	58.24	5.06	26.5	71.7	63.0	8.7	13.8
1930	36.59	58.66	4.75	26.3	70.5	62.4	8.1	13.0
1935	36.89	58.46	4.66	26.3	71.1	63.1	8.0	12.6
1940	36.08	59.19	4.73	26.6	69.0	61.0	8.0	13.1
1947	35.30	59.90	4.79	26.7	66.9	58.9	8.0	13.6
1950	35.41	59.64	4.94	26.6	67.7	59.4	8.3	13.9
1955	33.44	61.24	5.29	27.6	63.3	54.6	8.7	15.9
1960	30.15	64.12	5.72	29.0	55.9	47.0	8.9	19.0
1965	25.73	67.98	6.29	30.3	47.1	37.9	9.2	24.4
1970	24.03	68.90	7.06	31.5	45.1	34.9	10.3	29.4
1975	24.32	67.72	7.92	32.5	47.6	35.9	11.7	32.6
1980	23.50	67.35	9.10	34.0	48.4	34.9	13.5	38.7
1985	21.51	68.18	10.30	35.7	46.7	31.6	15.1	47.9
1986	20.90	68.52	10.58	36.0	45.9	30.5	15.4	50.6
1987	20.24	68.86	10.90	36.4	45.2	29.4	15.8	53.8
1990	18.62	69.45	11.93	37.4	44.0	26.8	17.2	64.1
1995	17.55	68.33	14.12	38.7	46.3	25.7	20.7	80.4
2000	17.98	65.75	16.26	39.8	52.1	27.4	24.7	90.5
2005	18.74	63.23	18.02	40.6	58.1	29.6	28.5	96.2
2010	18.63	61.42	19.96	41.5	62.8	30.3	32.5	107.1
2015	17.56	59.89	22.54	42.4	67.0	29.3	37.6	128.3
2020	16.50	59.94	23.56	43.0	66.8	27.5	39.3	142.8
2025	16.40	60.24	23.37	43.3	66.0	27.3	38.8	142.5

Source : For 1980~1985, Japan, Bureau of Statistics, Population Censuses : For 1990~2025, Institute of Population problems, Ministry of Health and welfare, population projections for Japan 1985~2085 (Tokyo, 1987).

Appendix 5. Percentage of Married Women Practicing Contraception by Selected Characteristics, 1979~88

(Unit : %)

	1979	1982	1985	1988
Contraceptive Practice Rate	54.5	57.7	70.4	77.1
Method :				
Pill	7.2	5.4	4.3	2.8
Condom	5.2	7.2	7.2	10.1
I.U.D	9.6	6.7	7.4	6.7
Tubectomy	14.5	23.0	31.6	37.2
Vosectomy	5.9	5.1	8.9	11.0
Others	12.1	10.3	11.0	9.3
Residence :				
Urban	55.1	58.7	71.5	77.7
Rural	53.6	55.7	67.7	75.5
Age of Wife :				
15~24	18.3	22.3	35.8	44.4
25~29	40.9	44.4	60.8	65.4
30~34	68.5	71.6	84.2	86.8
35~39	71.9	79.9	87.2	89.6
40~44	53.3	62.5	69.6	81.6
Parity :				
0	7.0	11.0	13.8	21.0
1	20.7	24.3	44.7	58.1
2	58.7	66.7	82.5	89.3
3	69.0	76.4	84.5	90.5
4	68.9	70.8	80.1	87.6
5+	58.5	64.2	76.3	83.8

Source : KIPH, 1988 National Fertility and Family Health Survey Report, 1989.

Appendix 6. Contraceptive Acceptors by Government Programme, 1962~91

(Unit : Thousand(%))

Year	IUD	Sterilization	Condom	Oral Pill	Total
1962~66	725.6 (47.9)	82.3 (5.5)	706.1 (46.6)	—	1,514.0 (100.0)
1967~71	1,460.8 (52.3)	87.1 (3.1)	759.8 (27.2)	487.7 (17.4)	2,795.4 (100.0)
1972~76	1,619.2 (42.3)	219.5 (5.7)	859.1 (22.4)	1,134.2 (29.6)	3,832.0 (100.0)
1977~81	1,067.0 (33.2)	1,089.9 (33.9)	447.5 (13.9)	612.2 (19.0)	3,216.6 (100.0)
1982~86	1,017.9 (27.6)	1,732.6 (47.0)	591.8 (16.1)	344.4 (9.3)	3,686.7 (100.0)
1987~91*	1,066.9 (39.5)	886.9 (32.8)	624.5 (23.1)	125.3 (4.6)	2,703.6 (100.0)
Total(62~91)	6,957.4 (39.2)	4,098.3 (23.1)	3,988.8 (22.5)	2,703.8 (16.2)	17,748.3 (100.0)
-----					
1982	199.1	286.7	101.6	113.0	700.4
1983	213.1	427.0	127.3	82.4	849.8
1984	195.4	378.7	129.7	59.2	763.0
1985	176.9	327.7	124.9	44.0	673.5
1986	233.4	312.5	108.3	45.8	700.0
1987	242.5	294.9	144.1	39.3	720.8
1988	251.9	236.7	137.8	29.3	655.7
1989	235.9	181.8	140.0	29.4	587.1
1990	186.6	113.5	102.6	22.3	420.5
1991*	150.0	60.0	100.0	5.0	315.0

\* 1991 Programme Target

Source : *Family Planning Monthly Reports*, 1962~91.

## 最近 人口抑制政策의 變化와 對應方向

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우리나라는 지난 30년에 걸쳐 家族計劃을 주축으로 한 人口抑制政策과 經濟開發政策을 성공적으로 推進하여 婦人의 合計出産率(TFR)이 1960~87年 期間中 6.0名에서 1.6名으로 人口代置를 위한 出産水準(2.1名)보다 훨씬 낮은 수준으로 저하시키는데 성공했다. 이와같은 出産水準이 앞으로 계속될 경우 우리나라의 人口規模는 1990年의 4,280萬名에서 2020년에는 5,020萬名으로 증가되고 그 以後부터는 人口의 減少가 예상된다.

이와같은 人口學的 狀況下에서 最近 우리나라의 社會一角에서는 向後 人口政策에 관한 두가지 見解가 對立되어 왔다. 첫번째 意見은 설사 우리나라의 出産率이나 人口增加率이 크게 低下된 것은 사실이지만 國土面積이 협소하고 賦存資源이 빈약한 우리나라의 實情에서 기존의 家族計劃事業은 계속 존속되어야 한다는 것이고, 두번째 意見은 人口成長의 停止時期가 빨리오면 人口構造의 급격한 變化로 老齡人口의 增加와 勞動力 不足 問題 등이 야기될 것으로 예상되기 때문에 人口抑制政策은 더 이상 존속시킬 필요가 없다는 것으로 요약될 수 있다. 이와같은

見解는 모두가 나름대로의 妥當性을 지니고 있지만 실제로 最近의 人口政策次元에서 시행된 내용을 보면 後者의 見解가 강력히 작용되어 그간 政府에서 力點을 두어온 家族計劃事業이 크게 위축되어 人口增加率이나 人工妊娠中絶率이 다시 增加되고, 반면에 避妊實踐率이 1988年의 77.1「퍼센트」에서 오히려 減少될 수 있는 가능성도 예견되고 있다.

한 例로서 1988년에 우리나라의 人口增加率이 1퍼센트 以下로 低下되었다는 人口統計의 公布와 더불어 家族計劃을 위한 政府의 豫算은 1986年의 318億원에서 1991년에는 95億원으로 무려 70퍼센트나 減少되었고 그간 避妊普及의 주축을 이루어 온 不妊施術의 普及量도 同 期間中 31萬3千件에서 9萬件으로 대폭 減少되었다. 지난 30年間에 이룩된 우리나라의 避妊實態는 政府主導型으로 형성된 것이기 때문에 自費에 의한 避妊實踐을 촉진시킬 수 있는 制度的 장치 없이 일방적인 政府事業의 축소는 오히려 그간에 이룩된 人口政策의 성과를 절감시키는 결과를 초래하게 될 것이다.

설사 出産率이나 人口增加率을 감소시키기 위한 家族計劃의 基本目標가 달성되었다 할 지라도 保健學的 또는 人口資質側面에서는 家族計劃이 해결해야 할 많은 問題가 常存해 있다. 즉 높은 避妊實踐率에도 불구하고 한해에 발생

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하는 人工妊娠中絶數는 年間 出生數를 증가하고 있으며 男兒選好에 의한 出生性比의 不均衡도 더욱 심화되고 있으며, 최근에 未婚男女 및 靑少年의 性問題는 社會問題로 더욱 擴大되고 있다. 이와같은 우리나라의 諸般 社會, 經濟, 人口學的 측면을 고려해 볼 때 向後 家族計劃事業의 政策方向은 첫째로 人口學的인 側面에서 우리나라의 實情에 부합되도록 最少限의 人口成長率을 유지하고, 동시에 人口成長의 停止時期도 가급적 늦게 오도록 향후의 出生率 및 人口變動에 신축성있게 事業이 전개되어야 할 것이다. 保健學的 側面에서는 願치 않는 妊娠과 人工妊娠中絶의 豫防 및 性比의 均衡維持, 그리고 靑少年의 性問題를 豫防하여 人口資質의

向上에 기여될 수 있도록 유도되어야 하겠다.

結論的으로 向後의 家族計劃事業은 과거와 같은 出生率低下에서 탈피하고 適正人口增加率의 유지와 동시에 人口資質의 向上에 力點을 두어야 할 것이며, 이를 위해서는 母子保健을 포함한 他 保健事業과의 統合推進을 위한 體制 確立, 避妊施術費의 一部 有料化轉換, 未婚男女를 포함한 事業對象의 擴大, 性比의 均衡 또는 男兒選好의 拂拭을 위한 弘報 및 社會支援施策의 強化, 人口 및 出生變動의 시계열적인 측정을 위한 分析評價機能의 強化와 신축성 있는 事業計劃의 樹立 및 推進, 그리고 地方自治制에 대비한 地域單位의 自律的인 事業推進이 가능하도록 事業管理機能이 強化되어야 할 것이다.