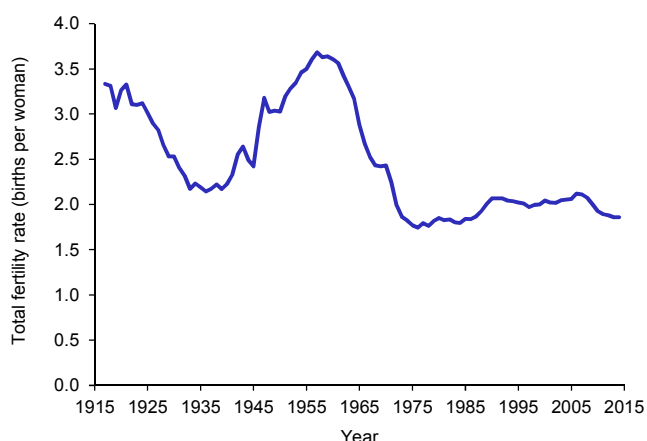


What accounts for near replacement-level fertility in the United States?

Policy Brief No. 19

After a decline during the Great Depression followed by a baby boom after the Second World War, the total fertility rate (TFR) in the United States has hovered for four decades at just under the replacement level of 2.1 births per woman. It currently stands at 1.9 births per woman. What accounts for this relatively robust United States fertility rate compared with rates in other high-income countries? And how does the United States experience contribute to our understanding of the determinants of low and very low fertility in other contexts?

Total fertility rate (births per woman), United States, 1917–2014

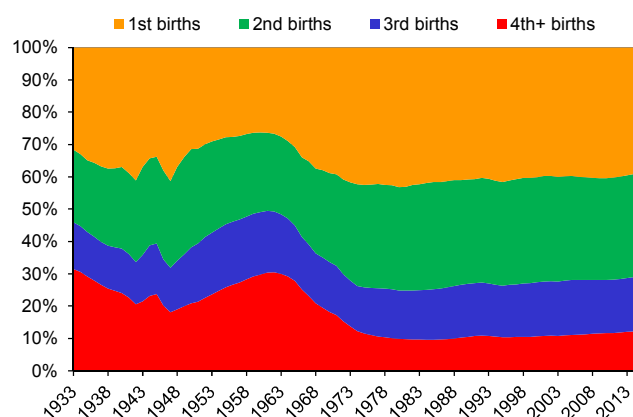


Since the early 1970s, most births in the United States have been first or second children, and surveys show that Americans as a whole want about two children. Their preference stems from a widely shared desire to have a small family, combined with a reluctance to be childless or to have only one child.

Americans tend to have about as many children as they want because factors that might cause people to have more children are roughly balanced by factors that might cause them to have fewer. Factors that raise fertility include high levels of unplanned pregnancies and unwanted births (increasing the TFR in the United States by an estimated 10–15 per cent) and very modest effects of additional births to balance the gender composition of offspring (increasing fertility by about 2 per cent). Opposing forces that reduce fertility include delayed childbearing. Because later ages at childbearing lead to some “fertility foregone”, the postponement of childbearing in the United States tends to

lower the TFR by about 10 per cent. In addition, competition between fertility and other valued activities, although difficult to estimate, may have caused a 10–15 per cent reduction in the TFR over the past few decades.

Per cent of all births by birth order, United States, 1933–2013



Fertility variation within the United States population

Fertility in the United States varies widely by state and region, with TFRs in 2011 as low as 1.6 births per woman (Massachusetts, Maine, Rhode Island, Vermont) and as high as 2.4 births per woman (Utah). Scholars have linked this variation in fertility to political partisanship, with low fertility characteristic of more liberal states and higher fertility more common in more conservative states. The higher fertility in the more conservative states is likely due to a combination of factors: higher intended fertility, higher unwanted fertility, less fertility postponement and less competition with other values.

Fertility variation can also be traced to religiosity, although not to a particular religion or denomination. Religiosity (measured at the individual level) shows a differential fertility pattern similar to the aggregate, state-level variation. To a large extent, being conservative in the United States means being religious. And being conservative and religious means supporting values that place importance on children and parenthood. Individuals tend to live in communities (and states) that include similar-minded persons, which may reinforce their own preferences and values.

Fertility in the United States also varies by level of education, with more education associated with lower completed fertility. This difference is not due primarily to different fertility intentions, however. Rather, the more educated substantially “miss their fertility target” on the low side, while the least educated slightly exceed their fertility target.

Educational attainment can be seen as a proxy for the types of jobs available to young women and men and the corresponding workplace environments that they will occupy during their childbearing years. Postponement of fertility is a common strategy used by highly educated women to deal with long and demanding work schedules and a work environment that is not supportive of childbearing. In fact, much of the educational effect on underachieving fertility intentions is explained by the continued postponement of marriage and fertility — many of these postponed births become fertility forgone. In contrast, highly educated men are actually less likely to underachieve their fertility intentions than the least educated.

One common claim often heard is that the higher fertility of racial/ethnic minorities explains the robust fertility rate of the United States. The historically higher fertility of African Americans is now a modest difference, however. For cohorts recently completing childbearing, white women had 1.93 children on average and African Americans had 2.18 children.

The Hispanic TFR was estimated at 2.86 births per woman in 2006 but had dropped to 2.24 births per woman by 2011. Both the higher rate and the dramatic decline can be explained by the timing of fertility vis-à-vis migration. Immigrants tend to be young adults who partner and have children soon after arrival in the United States. Thus recent migrants appear to have high fertility in the short term, but not over their lifetime.

The case of unplanned pregnancies

Identifying different fertility levels among subgroups within the United States population begs the question of why levels of fertility vary. The phenomenon of unplanned pregnancies helps explain this variation by illustrating how fertility decisions play out.

Unplanned pregnancy is common in the United States. Roughly 50 per cent of all pregnancies are unintended, as are 37 per cent of all births. This pattern has changed very little over the past few decades.

How a woman with an unintended pregnancy views her situation and justifies her decision to end the pregnancy or not varies widely in different population groups. For women living in poverty, many role models and stories told suggest

that having children early (even if unintended) does not ruin lives; rather, these children bring order, meaning and stability. Among the wealthier and better-educated segments of the population, abortions are justified in terms of allowing women to fulfil their goals and dreams and/or to advantage existing children or potential future ones.

Do policies make a difference?

With fertility at approximately replacement level for four decades, the United States Government has no policies aimed at changing the aggregate rate. Policymakers are concerned about the high level of adolescent childbearing, however, and about the large proportion of births that are unintended or unwanted. Federally supported abstinence-only education programmes have grown rapidly since 2008. The recent decline in United States adolescent pregnancy rates follows the patterns observed in other developed countries, however, improved contraceptive use, not increasing abstinence, has been the primary determinant of declining rates. Much evidence indicates that government funding for family planning services reduces unintended pregnancies.

Several other policies are likely to have inadvertent effects on fertility. There is evidence that policies aimed at poverty reduction, including the annual child tax credit and earned-income tax credit, have some pro-fertility impact. Monetary policies aimed at making homes more affordable through government-backed mortgages may contribute to family formation at earlier ages. On the other hand, macroeconomic policies that reduce job and income security may lead to postponement of family formation. Taken together, it appears that some policies have had a modest effect on fertility levels in the United States, but cultural and historical factors play a much more decisive role.

NOTES

This policy brief was prepared as background material for the United Nations Expert Group Meeting on Policy Responses to Low Fertility. It can be found online at <http://esa.un.org/PopPolicy/publications.aspx>. Queries can be sent to PopPolicy@un.org.

The brief is based on S. Philip Morgan (2015), *Variation in U.S. fertility: Low and not so low, but not lowest low*. In Ronald R. Rindfuss and Minja Kim Choe (Eds.), *Low and Lower Fertility: Variations across Developed Countries*. Springer.

The findings, interpretations and conclusions expressed herein are those of the authors and do not necessarily reflect the views of the United Nations or the East-West Center.

Financial support from Korea Institute for Health and Social Affairs (KIHASA) to conduct the research on which this policy brief is based is gratefully acknowledged.