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"Increasing Childlessness and its Solution by Reproductive Technologies – A Solution Only for the Rich?"

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Increasing Childlessness and its Solution by Reproductive Technologies – A Solution Only for the Rich?

1. Introduction

Since the late 19th century the proportion of childless couples has increased continuously in almost all industrialized countries. In Germany this rise was particularly strong: In 1989 8.4 % of the marriages were childless; by today this rate has risen to 18%. Calculations suggest that as many as 20% of the marriages contracted after 1970 will remain childless for life. The rise in childlessness becomes even more apparent with cohort-specific investigations: While only 9% of the women born in 1935 remained childless, this proportion rose to 20.5% with the 1955 cohort and increased further to 25% with those women born in 1961, with a tendency to rise. It must be emphasized that the proportion of childless marriages would have been even higher if women had not had access to reproduction treatments: the number of those who underwent this kind of treatment has constantly risen over time.

The emergence and continuous development of reproduction technologies triggered a social process, the end of which is not yet foreseeable: In public as well as scientific discussions the "benefits" of these medical developments have been hotly debated. This wide-ranging coverage of the issue supported the couples' view that they will finally be able to fulfill their wish for a child by means of a reproduction treatment. It appears that childless couples consider reproduction technology the only possibility to achieve the goal set by society, i.e. to have a family with children of one's own.

In the German language area theoretical aspects and empirical investigations of medical reproduction technologies have – from a sociological perspective – only been considered in discussions at a relatively late stage. The first texts covering this issue were published in the second half of the 1980s.

But studies focusing real effects of reproductive treatment on the part of involved couples rarely exist in Germany. Due to this our study was innovative because we reflected on the basis of the structure of social implications on reproductive technologies. Beyond that we developed an integrative model of coping and tested it empirically.

From the very beginning of medical reproductive treatment advocates and opponents are in opposition to each other. Mostly they discuss whether technical support by human procreation can be supported from an ethical point of view or not.

But in this lecture I would like to focus on a central argument that is often used by the clinical staff of fertility clinics to get legitimacy: "Reproductive technology is a solution against increasing childlessness."

In order to confirm this we have to look at the social structure of the patients who undergo reproductive medical treatment.

2. Empirical research and findings

Since 1993 we are following up empirical studies concerning different aspects for the increasing demand for medical reproduction technologies in Germany.

We collected data of couples who had undergone one or several treatments of medically supported procreation in the course of their lives with different methods of qualitative and quantitative social research.

The social structure of the patients is very simple to describe:

Mean age women	37.6
Mean age men	34.5
Female patients	38551
Baby-take-home-rate	16.9 (IVF), 17.1 (ICSI), 22.3 (IVF/ICSI)

Source: DIV 2006

The patients belong to all social milieus.

2.1 Social structure

We assumed that all women who undergo a reproductive treatment are involuntarily childless at the beginning of the treatment. Contrary to this assumption we found two groups of women under treatment:

- The "primary-childless women" had never born a child, and
- The "secondary-childless women" who had already born a child and who can't realize another wish for a child.

In contrast to this definition doctors differ between "primary sterility", "infertility", and "secondary sterility". "Primary sterility" means that the woman can't get fertilized (independent of the reason, i.e. the wife or the husband), "infertility" describes the impossibility to deliver, and "secondary sterility" the impossibility of another fertilization after an earlier conception (Stauber 1993:55). The main users of reproductive treatment belong with 60.6% to the first group of "primary sterility". Due to the authors definition of "primary-childless women" this group contents women, who are either sterile or infertile respectively whose husbands are sterile; the group of „secondary-childless women" contents women, too, who had already born one child or even more.

2.2 Reasons for the treatment

The interviews with patients of reproductive medicine show that many of them had internalized a concept of a mother and family role which is inconsistent with their professional orientation but seems to have still a major meaning for their life planning: all the interviewees talked without being asked about mothers employment respectively combination of job and family (cf. Nave-Herz 1988). When we asked about their future life goals at the youth age all of them said that they wanted to have a child some time. At those times as well as today they obviously orientate at the female "normal biography": marriage is considered as presupposition for the later birth of children, who again cause a complete or at least partly employment interruption of their mothers (cf. Levy 1977:44).

2.3 Costs

The medical reproductive treatment evokes costs in two directions:

– Psychological costs for the patients

– Social costs for the society

– Financial costs for the patients *and* the society

Psychological costs

Our most important findings are that the couple – and here the wife more than her husband – has to stand strain during the whole procedure, which often lasts up to eight years of medical treatment. Unfortunately I don't have enough time to discuss the painful process of strain the couple has to suffer from, but it is enough time to present the reasons why they stand it:

Two directions can generate strain in a system: either it arises out of the couple system and breaks into the partnership or it is created within the system. It is depending on the individual internalized coping-resources and -strategies how the strain can be compensated and whether it stabilizes or damages the system. Stress by involuntarily childlessness has a bearing on the marital system because of its combination with the couple's intimate privacy. In most of the cases the causes of involuntarily childlessness are produced by one of the partners – therefore at the beginning the stress is created within the system. Only the following reactions of social relatives add strain from outside the partnership.

My thesis that the burdens while undergoing a medical reproductive treatment have extremely results on the partners' quality of life was confirmed by data. The partners do have immense physical and even more psychological strain during the treatment. Especially women did feel stress. But social support mobilized by the couple on its own facilitates the treatment. I could show that the starting with a reproductive treatment postpones the individual dispute with its own infertility or sterility respectively – in most of the cases until the very end of the therapy.

Why do they undergo such a treatment?

In view of the great psychological and physical strain involved in a reproduction treatment the question that poses itself is why the couples undergo a second, third or even fourth treatment if the first treatment has not been successful.

A major reason given by the women surveyed for continuing the treatment was that they were afraid of suffering from self-reproaches later on if they did not make several attempts to overcome childlessness.

The couples make a "benefit-cost analysis", i.e. the decision-making process of whether to drop out of a treatment if one does not get pregnant or to continue the treatment is dominated by the fear that one might regret the decision (to drop out) afterwards and by exaggerated hopes for a successful outcome of the treatment. The "benefit", i.e. to get pregnant eventually, seems to become the more desirable the more the individuals have

"invested", i.e. the more the couples have exposed themselves to organizational and physical strain. It can be assumed that this is the reason why 77% of the sample affirmed the following statement: "From every single step (of the treatment) I derive new hope for the next". These hopes of the women make one think of a lottery. Just like in a lottery, where the chances of winning are very limited, the success rate of reproduction treatments is low – we remember: the baby-take-home-rate per year at most is only 20% of the couples.

This low success rate does not prevent couples from trying to start a family. Options which childless couples had in the past, such as to adopt children (born out-of wedlock) or to take on children from poor families with many children (in general these children were given to rich childless relatives), are not available any more. The possibilities of adopting a child have been reduced significantly; frequently – just like foster children – adopted children are not considered an adequate substitute for a child of one's own. Only 25% of the women surveyed seriously considered adopting a child. They would do so only if several reproduction treatments had turned out unsuccessful.

Thus it becomes clear why the reproduction technology is in general considered the only possibility of achieving the cultural goal of "starting a family, entering parenthood", at least as long as this goal itself is not called into question.

The goal is giving birth to one's own child and this is different for example to life's goals in former times: nowadays the biological fact is the point of interest. One consequence is that the interest for adoption decreases and the interest for assisted procreation increases.

Social costs

Our main findings concerning the reproductive medical treatment are as follows: Reproductive medical treatment causes a different behavior concerning adoption in Germany. If an own child belongs to the normality of a marriage and a birth is impossible, than people try other ways to reach their goal and to correspond with the normality patterns.

Only about 20 years ago people had to come to terms without becoming pregnant – the only chance for a child and to correspond with family concepts was the adoption (Hoffmann-Riem 1989: 35). The ongoing development of reproductive technologies nowadays could promote a "pre-transfer" of control of family building processes in order to reach a kind of normality within the phase of procreation. So – as for the respondents – the normality could be reached very soon.

The great number of women who undergo reproduction treatments reflects the importance that is still attributed to the "nuclear family" (parents with children of their own) and the high priority that is given to the role of a mother, despite the great variety of lifestyles in today's society. 35% of the female patients indicated that it was their wish to have children and that they took the initiative when the decision of whether or not to undergo a reproduction treatment was made (cf. van Balen & Trimbos-Kemper 1995: 140f.). Only in 3% of the cases the husband forces his wife to undergo a treatment. 53% stressed out the conformity of their wish for a child. However it can't be spoken of the couple as a motor for reproductive medicine because only a few husbands took the active part and convinced their wife to undergo a treatment, as more than the wives did.

Above all older women didn't want to wait anymore and started the treatment on their own. There were more young couples and those with lower educational level who stressed their common decision (cf. Rauchfuß 1998: 229).

Financial costs for the patients *and* the society

In Germany the public health care system bears the cost of reproductive medical treatment. Although involuntarily childless – strictly speaking – has no bearing on diseases.

But I have to start a little digression concerning the German public health system. German public health insurance is divided into two groups:

1. *Compulsory health insurance fund* – This is for people with lower income up to a certain amount (at the moment about 3.500 EUR).
2. *Private health insurance fund* – This is for people with higher income.

In a very complicated system the professional organizations of health professionals, health insurances and politicians negotiate a regulation of medical fee that provides the basic for treatments, whether to pay for special treatment or not and so on.

This procedure allows a wide range for discussing with representatives of reproductive medical treatment and the patients whether the treatment has to be paid or not.

And my hypothesis becomes obvious:

1. People with higher income tend to be in jobs where they are often used to push through their interest against others. Therefore they can better negotiate with their health insurance about the coverage of costs.

2. People with higher incomes have private health insurances.

3. Reproductive medical treatment isn't financed completely by public health insurances.

In the 1980s – right at the beginning of the treatments – the health insurance system didn't realize the erasing costs. As long as there only were a few couples they paid the whole treatment. And currently the couple has to pay about 50% on their own. Total cost average 10.000 EUR, the couple has to pay at least 5.000 EUR for an IVF treatment. Mostly it is necessary to add another medical treatment before starting IVF and in those cases the treatment would make costs explode.

For couples purposes it is impossible to pre-estimate the total amount of cost and therefore a lot of couples in our sample didn't try any medical treatment for financial reasons, others who had enough money didn't care about the costs.

Therefore:

4. People who undergo reproductive medical treatment have more money available than average patients and vice versa: most patients of reproductive medical therapy are rich.

Then the deduction is clear:

5. If modern assisted reproduction should be a solution against increasing childlessness, and if the use of this technique is increasing as well, we would help single-sided the upper class of our society to fulfill their wish for a child. And the peak is: People with lower money even cannot procreate.