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Two Attempts to Medicalize Reproduction and Their Implications*

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Abstract

This article contrasts the Korean government's two interventions, separated by 50 years, in birth control policy and support for assisted reproductive technology. One of the two interventions achieved the goal of a sharp decline in birth rate, but the other did not achieve the goal of raising the birth rate. Thus the results of the two interventions varied greatly. It is the goal of this paper to identify the reasons for this difference. Incomparing the two cases, we examine several factors: phenomena, trends, individual differences, and their considerations and moral psychology. The fact that individuals engage in moral deliberation when deciding on reproductive behaviour can be considered a key reason why the two interventions produced different results. If this hypothesis is correct, policy intervention may not lead to the desired result unless the elements of moral deliberation are considered.

Keywords: Assisted Reproductive Technology, Health Care Policy, Medicalization, Parental Responsibility, Reproductive Responsibility

I. Introduction

Since 2006 the Korean government has subsidized in part medical expenses for assisted reproductive technologies (ART). This program, National Supporting Program for Infertile Couples, aims to increase the birth rate in Korea.[1] However, the program has been criticized for the inadequacy of its aims, negative side effects, and low efficacy. The program's aim

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[1] MHW. *A Study for the improvement of sub-fertility couple supporting program* (Sejong: The Ministry of Health and Welfare, 2013).

was to resolve the problem of Korea's low birth rate, rather than to promote welfare or recognize the reproductive rights of individuals. Feminists have argued that the nationalistic aims of the program ignore reproductive health rights and reduce the potential baby and mother to a mere statistic.[2,3] The side effects of these medical interventions are also a serious concern.[4,5] Above all, the lack of improvement in the birth rate (2006: 1.12, 2016: 1.17),[6] at the expense of reduced budget in other areas of maternal health policy, is interpreted as the most obvious evidence of policy failure. These criticisms suggest that a thorough re-examination of the program is required to determine the legitimacy of the Korean government's direct, medicalized intervention. In contrast to the current program, the other medicalized intervention by the Korean government, the Family Planning Program, first implemented in 1961, was considered very successful.[7]

This article examines these two cases of medicalized intervention, conducted 50 years apart, to determine the factors responsible for the different outcomes in each case. We begin by describing the current program, National Supporting Program for Infertile Couples, then describe the earlier program, the Family Planning Program. Following several commentators who pointed out that the two programs have nationalistic and medicalized features in common,[8,9] we will refer to these programs as government-initiated medicalization. After briefly examining the changes Korea has gone through in the last 50 years, we will compare

[2] Jung-Ok Ha. 2012. "Criticism of 'the National Supporting Program for Infertility Couples' as Part of the Low Fertility Rate Policy." *Journal of Korean women's Studies 28,* no. 1 (March): 35-69.

[3] Eun-Kyung Bae. 2012. *Human Reproduction in the Korean Modernity: Women, Maternity, and Family Planning.* Seoul: Time Travel.

[4] MHW. *A Study for the improvement of sub-fertility couple supporting program* (Sejong: The Ministry of Health and Welfare, 2013).

[5] Myung-Hee Kim. "Status and Problems of the National Supporting Program for Infertility Couples." Presented at the Korean Ministry of Health and Welfare. "A panel discussion for the improvement of the National Supporting Program for Infertility Couples." Symposium, Seoul, November 26, 2013.

[6] Statistics Korea. *Births Statistics 2016* (Daejeon: Statistics Korea, 2017).

[7] PPFK. *30-Year History of PPFK 1961-1990* (Seoul: Planned Parenthood Federation of Korea, 1991).

[8] Eun-Kyung Bae. 2012. *Human Reproduction in the Korean Modernity: Women, Maternity, and Family Planning.* Seoul: Time Travel.

[9] Jung-Ok Ha. 2014. "Advanced Approach to Pregnancy and Childbirth: Moving from a Perspective of Population Control to One Focused on Women's Health." *Journal of Korean Social Matern Child Health* 18, no. 1 (January): 24-34.

the programs' historical contexts with four criteria, in order to identify the root cause of their different outcomes. Answering these leads to a more fundamental question: how do people think about having a child?

II. Case 1: National Supporting Program for Infertile Couples

As in other countries that have accomplished rapid economic progress, Korea has experienced a dramatic drop in its birth rate. Between 1950 and 1955, the total fertility rate (TFR) of Korea was 5.6. Following a period of rapid decline starting in the 1960s, Korea's TFR finally dropped to 1.17 in 2016, which is below replacement-level.[10,11] Now the government fears that "the current low birth rate will lead to a weakening of national competitiveness as a consequence of the decline in the number of working-age population and reductions in savings, consumption and investment."[12] To directly address this concern and to increase the birth rate, the Korean government chose the medicalized strategy. The National Supporting Program for Infertile Couples, implemented in 2006, subsidises in vitro fertilisation (IVF) and artificial insemination. The program is part of a group of policies under the Plan for Aging Society and Population,[13] in which the government defines Korea's low birth rate as a social problem and aims to solve it. In line with that, other policies such as decreasing abortion, supporting potential single moms, decreasing accessibility to permanent methods of contraception are also implemented.[14,15]

[10] Statistics Korea. *Population of Korea 1* (Daejeon: Statistics Korea, 2002).

[11] Statistics Korea. *Births Statistics 2016* (Daejeon: Statistics Korea, 2017).

[12] Korean Government. *The First Basic Planning for Low Fertility and Aged Society 2006-2010* (Seoul: Government of the Republic Korea, 2006).

[13] Id

[14] Presidential Council for Future & Vision, 2009. "The first strategy meeting of responding low birth rate." *A news release in Presidential Council for Future & Vision.* November 25, 2009. www.kefplaza.com/labor/down.jsp?idx=7373&fileId=7017

[15] MHW, 2008. "Explanation of articles about contraceptive surgery at the institution of encouraging childbirth from Yonhap News, Culture, etc (08.9.8)." *A news release in the Ministry of Health and Welfare.* September 8, 2008. http://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0404&CONT_SEQ=45343&page=1

Assisted reproductive technology (ART) imposes a substantial cost on infertile couples (3.59 million won for IVF and 0.7 million won for insemination).[16] Although the National Health Insurance (NHI) in Korea covers medical expenses for basic health care, costly and cutting-edge medical technology such as ART was not covered by NHI until the third quarter of 2017 (the new administration changed its policy from subsidization to insurance coverage in October 2017).[17] The government aims to lower the monetary barrier to the treatment by the subsidisation; households having monthly income below 150% of the average receive 1.9 million won for IVF and 0.5 million won for insemination, while households having monthly income above 150% of the average will receive 1.0 million won for IVF and 0.2 million won for insemination. For up to four interventions, households earning less than 100% of the average monthly income receive a maximum of 2.4 million won per IVF intervention.[18] In 2014, which is the latest year for which statistics are available, the Korean government subsidised a total of 76,416 interventions for 59,872 couples.[19] The budget for these interventions was 92.5 billion won in 2016, which increased to 139.5 billion won in 2017. This represents over the half the total maternal and child health care budget.[20] The number of multiple births has abruptly increased since the program's inception (from 9,459 in 2005 and 10,767 in 2006 to 13,456 in 2007) and continues to increase despite a decrease in the total number of births.[21] Other negative health outcomes such as increased risk to maternal health due to multiple births, selective abortion in multiple pregnancies, and negative health

[16] MHW, 2017. "Criteria related the National Health Insurance Coverage of Treatment for Infertility." *A news release in the Ministry of Health and Welfare.* September 28, 2017.
http://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0403&CONT_SEQ=342170&page=1

[17] MHW, 2017. "Expanded Coverage of National Health Insurance Coverage for the Infertility intervention and Dementia mental state examination." *A news release in the Ministry of Health and Welfare.* September 15, 2017.
http://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0403&CONT_SEQ=341710&page=1

[18] MHW. *The Maternal and Child Health Services 2017* (Sejong: The Ministry of Health and Welfare, 2017).

[19] MHW. *The resulting analysis and assessment of the National Supporting Program for Infertile Couples 2014* (Sejong: The Ministry of Health and Welfare, 2015).

[20] MHW. *The Maternal and Child Health Services 2017* (Sejong: The Ministry of Health and Welfare, 2017).

[21] *Statistics Korea. Births Statistics 2016* (Daejeon: Statistics Korea, 2017).

indicators in neonates have been identified as consequences of this medicalized strategy.[22,23] However, despite the program, Korea's TFR has not increased significantly, rising from 1.12 in 2006 to 1.17 in 2016.

III. Case 2: Family Planning Program

Since its selection as a national project in 1961, birth control initiatives have received large amounts of government support; the first budget was 7.8 million won in 1962, but it reached 1.3 billion won in 1989, and the project has long been considered successful in Korea.[24] While access to birth control was widely desired and was available to some extent in the 1950s, it was not until 1961, following the ascension to power of Park Chung-Hee in a military coup, that the Family Planning Program was implemented. The program sought to control population growth by distribution of oral contraceptive pills and intrauterine devices, sterilisation and sometimes even by overlooking abortion, which had always been illegal except in very limited cases. The program took a top-down approach whereby the central government set targets for implementation by agents who were mobilized by the government in each community.[25] In light of the drop in TFR from 6.0 in 1960 to 1.6 in 1990, the program has been considered very successful.[26]

The Family Planning Program was in line with the goal of "modernization" espoused by the military government: excess population was the problem to be solved by national policy, because overpopulation hindered economic development. Under the military government, "modernization" required people to change to fit into industrial society. Under a nationalistic ideology emphasizing diligence, honesty, planning, and responsibility, having a child

[22] Jung-Ok Ha. 2016. "The Effects of Legislation on the regulation of ART: Focusing on the Establishment of a Registry and Reducing the Number of Embryos Transferred." *Bioethics Policy Studies* 9, no. 3 (June): 103-131.

[23] MHW. *A Study for the improvement of sub-fertility couple supporting program* (Sejong: The Ministry of Health and Welfare, 2013).

[24] Mi-Kyoung Lee. 1989. "A Feminist Analysis of the State Policy on Birth Control." *Women's Studies Review* 6: 49-78.

[25] Id.

[26] PPFK. *30-Year History of PPFK 1961-1990* (Seoul: Planned Parenthood Federation of Korea, 1991).

changed from something that people did naturally to a goal requiring planning and control.

To solve the problem of high fertility, the Family Planning Program adopted a medicalizing strategy; that is, it implemented policies that privileged medical intervention by medical professionals. Highly medicalized and professionalised interventions such as sterilisation and use of intrauterine devices were given preference over condom use or the rhythm method. What mattered was the certainty of the method rather than the risk-benefit ratio to each individual. Not surprisingly, the more vulnerable a person was, the more likely they would be subjected to an aggressive method of preventing pregnancy. For example, women were sterilised disproportionately more often than men, while female peasants in rural areas were sterilised disproportionately more often than their educated counterparts in the city.[27]

The two programs under consideration are both government-initiated medicalization in which the government tried to implement physical interventions in order to achieve population control. Maybe because of quantifiability and certainty, the programs took the form of highly medicalized intervention by medical professionals. The fact that the Ministry of Health and Welfare, Ministry of Health and Society during Family Planning Program, was in charge of the program may also have played a significant role in choosing the strategy of medicalization, since the department deals with medical professionals and operates within the medical framework. As Conrad describes, government, not medical professionals, may become the primary source of these medicalizations.[28] It was government that initiated the programs, recruited medical professionals to play their role, and provided funding. Moreover, in these two policies, the nation's development, not professional imperialism, was the motivation.[29,30,31] The same nationalistic attitude was repeated in both programs;

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[27] Eun-Kyung Bae. 2012. *Human Reproduction in the Korean Modernity: Women, Maternity, and Family Planning.* Seoul: Time Travel.

[28] Peter Conrad. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18: 209-232.

[29] Similar motivation of medicalization can be found in Israel and Egypt cases. In the former case, the government provides ART with no cost in order to increase the population. In the latter case, the government associated fertility regulation and national progress. See also Morsy and Simonstein.

[30] Soheir A Morsy. 1995. "Deadly Reproduction among Egyptian Women: Maternal Morality and the Medicalization of Population Control." In *Conceiving the new world order: the global politics of reproduction,* edited by Faye D. Ginsburg and Rayna Rapp, Berkeley, 162-176. California: University of California Press.

[31] Frida Simonstein. 2010. "IVF policies with emphasis on Israeli practices." *Health Policy* 97: 202-208.

the government does not recognize the intrinsic value of reproduction in terms of human flourishing of their citizens and the role of reproduction in realizing the value.[32] Then why did these two government-initiated medicalizations end up in different outcomes, and therefore receive quite opposite evaluations?[33]

IV. Possible factors that may influence the success of medicalization

Factors that influence the success, preconditions, or dimensions of medicalization have already been discussed in the literature.[34,35,36,37,38] However, It has been rarely analysed what factors influence success when a government defines a social issue as a problem and chooses medicalization as a strategy. The two policies on reproduction implemented across a 50-year interval might hint at those factors. During the last 50 years, Korea has undergone industrialization and democratization, representing an unprecedented degree of change for individuals as well as for social structures, including increases in women's education and

[32] Eun-Kyung Bae. 2012. *Human Reproduction in the Korean Modernity: Women, Maternity, and Family Planning*. Seoul: Time Travel.

[33] It is true that not all scholars agree on the contribution of Family Planning Program to the decrease in the birth rate. For example, feminist scholar Eun-Kyung Bae disagrees that Family Planning Program was the real driving force in lowering the birth rate. She lists rather women's pre-existing desire to reduce the number of children they give birth, increased child-rearing expense due to industrialization, change in social status of a mother and women who became to better assert their agency as a real driving force. However, if one sees the Program as part of the whole "modernization project" in Korea which includes those factors she mentioned, and acknowledging decrease of TFR from 6.0 in 1960 to 1.6 in 1990, one could say the Family Planning Program made a contribution to the birthrate decline to a certain degree. However, the same assessment cannot be applied to National Supporting Program for Infertile Couples. See *Id* : 194-221.

[34] Peter Conrad. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18: 209-232.

[35] Elizabeth A. Binney, Carroll L. Estes, Stanley R. Ingman. 1990. "Medicalization, Public Policy and the Elderly: Social Services in Jeopardy?" *Social Science & Medicine* 30, no. 7: 761-771.

[36] Paul M Roman. 1988. "The disease concept of alcoholism: sociocultural and organizational bases of support." *Drug & Society* 2, no. 3-4 (October): 5-32.

[37] Roman p., Blum T. 1991. "The medicalized conception of alcohol related problems: some social sources and some social consequences of murkiness and confusion." *Society, Culture and Drinking Patterns Reexamined*: 753-774.

[38] Carroll L. Estes, Elizabeth A., Binney. 1989. "The Biomedicalization of Aging: Dangers and Dilemmas." *The Gerontologist* 29, no. 5 (October): 587-596.

their advancement in society. However, rapid increases in gross domestic product during the "miracle of Korea" did not guarantee an individual's improved living prospects. As the economy has stabilised, belief in socio-economic improvement during economic growth has weakened. Younger generations are now experiencing great difficulties in getting a job, getting married, and having a baby.[39,40] These changes point to the reasons why two similar policies might reach different outcomes. We consider these different contexts of medicalization with four questions, which go deeper: (1) The phenomena that were problematized: what did the government problematize and try to medically intervene in?; (2) The trend that the policy tried to encourage or discourage: in what direction did the trend developand how does it interact with the policy?; (3) The people and their agency: how autonomous were they?; and (4) Considerations and moral psychology of individuals: what conclusion did they reach after their deliberation? The impact of these four on medicalization and the relationship among them are not yet rigorously constructed so as to constitute a hypothesis that can be tested through empirical data. However, these four questions may shed light on the prerequisites for success in medicalization of reproduction, and as a preliminary step, may help further theory building. Moreover, the authors also believe that the conditions for success reflect the moral nature of the act of reproduction. In other words, what made one policy achieve its goal while the other failed is due to the nature of reproduction, an act that requires moral deliberation and responsibility.

(1) The phenomena that were problematized; what did the government problematize and try to medically intervene in?

The suitability of medicalized strategies rests on whether or not the social phenomenon in question is medically solvable. Previous government-initiated medicalized strategies aimed to solve the problem of excess fertility. This aim is quantitatively attainable as every fertile woman and man could potentially be an object of the program. Moreover, in the qualitative sense, medical intervention guarantees the effect of suspending or sterilising fertility. Therefore, lowering birthrate is achievable through medicalized strategies. On the other hand, the National Supporting Program for Infertile Couples was less quantitatively promising than

[39] In this case, Sen's "capability approach" is right: in spite of increased gross domestic product and individual income, people come to have less capability and less freedom to pursue the lives they value. See Amartya Sen.

[40] Amartya Sen. 1999. *Development as Freedom.* New York: Anchor Books, a division of Random House.

the Family Planning Program, as it deals only with the number of couples with medically treatable infertility. Moreover, the success rate of IVF or artificial insemination in achieving pregnancy and childbirth is much lower than that of intrauterine devices or sterilisation in the prevention of pregnancy. These quantitative and qualitative factors negatively influence the policy outcome.

Moreover, the problem of low birth rate does not originate only from (physical) infertility. Other factors that have been posited to contribute to low birth rate include: increased higher education and economic participation of women, in an economic environment that nevertheless remains unfriendly to them; late marriage; youth unemployment; the heavy burden of raising children; and finally, as a result, pessimism amongst the younger generation.[41,42] To deal with these factors requires changes to the social structure rather than medicalized and individualised approaches to the problem. Medicine and medicalization cannot be the ultimate solution that deals with the root cause of the problem. In this respect, medicalization is ineffective as an intervention, so it inevitably lost its dominance in discourse. Conrad's battered women case provides the example of losing the dominant role in theory. As he insists, if certain social problem, e.g. domestic violence, are considered to be better defined and solved by other approaches — e.g., feminist approaches or a change in law— rather than medical remedies,[43,44,45] then the discourse of medicalization will lose dominance, as will government-initiated medicalization. As for analysis of the National Supporting Program for Infertile Couples, feminists' explanation of the root causes of the low birth rate seemed to be more persuasive than what the policy assumes to be the root cause, which is physical infertility. In addition to ethical claims citing concentrating resources only on ART subsidization and harm caused by the intervention, inefficiency claims became

[41] Eun-Kyung Bae. 2010. "Are Women Responsible for the Low Fertility?: For the Feminist Appropriation of the Discourses on Low Fertility." *Gender and Culture* 3, no. 2 (December): 37-75.

[42] Yoo-Mee Song, Je-Sang Lee. 2011. "Investigation of the Causes of Low Birth-Rage: Focused on the change in Industrial Society and the Expansion of the Opportunity of Women for Social Activities." *Health and Social Welfare Review* 31, no. 1 (March): 27-61.

[43] Conrad cites "battered women syndrome" as an issue that became feminist and jurisdictional rather than medical. See Conrad and also Kurz.

[44] Peter Conrad. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18: 209-232.

[45] Demie Kurz. 1987. "Emergency Department Responses to Battered Women: Resistance to Medicalization." *Social Problems* 34, no. 1 (February): 69-81.

a significant opposition to government-initiated medicalization. Medicalization fails when it is ineffective and inefficient in solving the problem it tries to address.

(2) The trend that the policy tried to encourage or discourage: in what direction did the trend develop and how does it interact with the policy?

The Family Planning Program gave incentives to individuals when they acted in accordance with the general trend, which was already prevalent in the 1950s, to have fewer children. Since the 1950s, women had sought access to birth control and the ability to limit the number of children they were having. Women's organisations also made bottom-up attempts to achieve these ends; however, insufficient resources and the patriarchy thwarted these attempts. The Family Planning Program gave individual women agency to follow their pre-existing desire to reduce family size. The government's policy corresponded to the existing trend and comported with people's desires and needs.[46]

On the other hand, the National Support Program for Infertile Couples gives incentives to individuals to act against the general trend of having no/fewer children. One can easily imagine that the intervention that opposes the trend is prone to fail. Moreover, the current trend toward lower birth rates reflects each individual's deliberation when faced with the various difficulties of having a baby, which cannot be reversed solely by paying medical expenses. Because of the many factors causing the low birth rate, women or couples have decided not to have a child or hesitated to do so.[47] Regrettably, government support was concentrated almost solely on ART and it was too narrowly focused to change the trend. Then where did the trend come from? If we define trend as "a general development or change in a situation or in the way that people are behaving,"[48] then where did this development or change come from? We will see below how individual agency and moral psychology have changed.

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[46] Eun-Kyung Bae. 2012. *Human Reproduction in the Korean Modernity: Women, Maternity, and Family Planning*. Seoul: Time Travel.

[47] Young-Lim Hong, 2018. "I'm just nervous, the 52% of 20's-40's generation have a phobia of having a child." *Chosun.com*, January 3, 2018. http://news.chosun.com/site/data/html_dir/2018/01/03/2018010300226.html?rsMobile=false

[48] Cambridge University Press. 2018. "Meaning of trend in the English Dictionary." Cambridge Advanced Learner's Dictionary & Thesaurus. https://dictionary.cambridge.org/dictionary/english/trend

(3) The people and their agency: how autonomous are they?

In the past 50 years, the people of Korea have changed greatly. When the Family Planning Program and other national modernization projects launched, it was legitimate, to some extent, to see the Korean population as docile subjects who could be mobilised by government policy. Most of the population impacted by the program were undereducated peasants with a naïve belief in "modernization" of the nation and their bright future prospects when that modernization was accomplished. To a certain degree, economic progress has met these expectations. Under the dictatorship of the 1960s and 70s, individuals had to comply with authoritarian control over their bodies. Moreover, insufficient medical access and low educational levels relative to medical professionals, made most of the population submissive to their doctor's advice. The population tolerated intrusions on privacy and their bodies in the name of medical practice. Thus, nationwide recruitment was launched in The Family Planning Program and community providers hired by the government made house-to-house visits, convinced people of the benefits of sterilization, and brought possible recipients to the clinic.

However, economic progress, democratisation, expansion of higher education, and increased medical access have made it easier for individuals to better assert their agency. Individuals have become more skeptical of government policy and/or other authority figures and have come to recognise themselves as rights-holders. Changes in the nature of the doctor-patient relationship eventually impact medicalization. When patients are less convinced of their doctor's goodwill and authoritative medical knowledge, this results in significant changes in what Morgan[49] called micro-institutionalisation through doctor patient relations and slows down the paternalistic push for medicalization. Nowadays, it is nearly impossible to directly violate people's privacy as The Family Planning Program did.

Moreover, women's rights have dramatically emerged since the 1960s, providing increased autonomy to Korean women. Although the supposed dichotomy between docile

[49] Kathryn Pauly Morgan. 1998. "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization." In *The Politics of Women's Health: Exploring Agency and Autonomy,* edited by Susan Sherwin, Health Care Ethics Research Network, 83-121. Philadelphia: Temple University Press.

third-world women and autonomous first-world women is another fallacy,[50,51] it is reasonable to say that women of the current generation enjoy more autonomy and freedom. Women of prior generations felt more pressure to conform to their prescribed role in their family and the community by the act of reproduction (of sons). Accordingly, the act of reproduction was not regarded as a subject of privacy but rather as a public resource, more or less. Fortunately, expanded women's education, their advancement in society, and women's rights in general gave women the ability to survive without using reproduction as a means of acquiring a position in society. This has liberated them to some degree from patriarchal domination by men, medical professionals, and the state. In other words, modern Korean women have achieved, to some extent at least, moral and political self-determination. Thus, this factor goes a long way towards explaining the differing results of the two medicalization programs.

(4) Considerations and moral psychology of individuals: what conclusion did they reach after their deliberation?

By answering this question, we aim to identify what individuals who contributed to a trend had in mind. The answer to this question might show how the individual sees the act of reproduction. Part of the medicalization process is making people internalise control and surveillance of their body, recognising it as an individual "responsibility". In relation to reproduction, medicalization makes people recognise that procreation is also an individual responsibility that requires deliberate consideration. In this framework, each individual, especially women, has a parental responsibility to choose what is best for their child. The Family Planning Program awakened a sense of parental responsibility toward the pre-existing child,[52] namely to provide them with more family resources and better prospects in life. It definitely requires reducing the total number of children. This sense of parental responsibility required women to receive medicalized methods of birth control and sometimes to place their own bodies at risk of various side effects. The Program was successful because it made

[50] Petchesky Rosalind P. 1998. "Introduction" In *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures*, edited by Petchesky Rosalind P., Karen Judd, 1-30. New York: Zed Books.

[51] Young-Rae Oum. 2003. "Beyond a Strong State and Docile Women: Reproductive Choices, State Policy and Skewed Sex Ratio in South Korea." *International Feminist Journal of Politics* 5, no. 3 (November): 420-446.

[52] Eun-Kyung Bae. 2012. *Human Reproduction in the Korean Modernity: Women, Maternity, and Family Planning*. Seoul: Time Travel.

it possible to fulfil one's parental responsibility. The high acceptance rate of the Family Planning Program demonstrated that people internalised the idea of parental responsibility.

However, this internalised belief in parental responsibility, even in the procreation decision phase, is still at play and resulting in Korea's low birth rate. Today's individuals sometimes give their reason for not having children as their lack of capability, saying that they don't think they can do their duty as parents in this situation.[53] This demonstrates that they have a strong sense of parental responsibility. which demonstrates they have a strong sense of parental responsibility. It is this very sense of parental responsibility, the historical residue of past internalisation that discourages couples from becoming parents. Contrary to the previous project, the National Supporting Program for Infertile Couples was not helpful in meeting one's parental responsibility. A strong sense of parental responsibility means giving priority to the welfare of one's child. In other words, rather than being preoccupied with the physical ability to become a parent, one would need a better environment to ensure one's child's future prospects. Therefore, what people need is to believe that they are capable of fulfilling parental responsibility. Current medicalization policy does not further this goal.

V. Conclusion

The Family Planning Program and the National Supporting Program for Infertile Couples show that each individual exercises moral and political agency in making reproductive decisions. The trend to have children later, to have fewer children, or to have no children at all, can be seen as a result of moral deliberation. Each person is asking oneself whether reproduction is morally justifiable, i.e., whether one can assume the responsibility of having a child. And one lives out one's choice as a moral and political agent. From individual choices a trend developed. Since the trend toward a lower birth rate is deeply rooted in the evolution of Korean society and individuals' deliberation, it cannot be changed by simply subsidizing the expense of infertility treatments.

The act of reproduction is a moral act that may be right or wrong; it may deserve praise or blame. Therefore, it requires moral reflection in each and every case. This is why it is not

[53] Ga-Yeon Song. 2017. *Today, I decide not to give birth again*, 21-103. Seoul: Galapagos

something that can be promoted simply by government-initiated medicalization. In fact, moral agents seriously weigh the costs and benefits of having a child before deciding to reproduce. In their deliberation, people take seriously into account the quality of care they can give to their potential child. This is an actual example of feminist philosophers' claims, such as O'neill, Steinbock, and Overall, which point out the fact that the act of reproduction couldn't be considered without parental responsibility or responsibility of rearing.[54,55,56] Thus, the moral and ethical aspects of reproduction also show why the two government programs yielded such different results.

This article gives preliminary answers on what caused the different results of the two governmental interventions intended to alter the birth rate in Korea. We tried to explain why one has achieved the policy goal but the other has failed by analysing four criteria: phenomena, trends, individuals, and their considerations and moral psychology. In terms of phenomena that the government has problematized, ART subsidization was less promising both quantitatively and qualitatively. Moreover, because the phenomenon of low birth rate was explained more plausibly by non-medical concepts, the medicalizing strategy failed. As for the trend, the policy that corresponded to the existing trend and comported with people's desires succeeded while the opposite failed. Individuals and the degree of their autonomy also played a role. Because people of the current generation have been liberated to some degree from patriarchal domination by men, medical professionals, and the state, the direct medicalizing policy proved ineffective. Finally, we assert that people's consideration and moral psychology, of which the government was ignorant, is the root cause of the different result of medicalizing policies. As people feel a strong sense of parental responsibility both in deciding to become or abstaining from becoming a parent, government should consider it. Although this study refers to other qualitative research, we did not ask individuals the reasons why they participated or not in the Family Planning Program or the National Supporting Program for Infertile Couples. Therefore, our answer is not based on empirical data. However, we believe that this comparison of the policies can be a starting point for

[54] Onora O'Neill. 1979. "Begetting, Bearing and Rearing." In *Having Children: Philosophical and Legal Reflection on Having Children*, edited by Onora O'Neill, William Ruddick, 25-38. Oxford: Oxford University Press.

[55] Bonnie Steinbock. 1994. "Reproductive Rights and Responsibilities." *The Hastings Center Report* 24, no. 3 (May-June): 15-16.

[56] Christine Overall. 2012. *Why Have Children?: The Ethical Debate*. Cambridge: The MIT Press.

further research since its answer is preliminary attempt of capturing the actual example of the claims that have been repeated in the area of reproductive ethics; moral agents should and do assume parental responsibility when they decide reproduction.

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