women with college degrees rose from 15% in 1982 to 23% in 1988 and 1995, but this finding may just reflect the overall increase in the proportion of U.S. women with a college education over the period.8

As discussed earlier, an increase in the number of women with impaired fecundity does not necessarily imply that the rate of impaired fecundity increased over time. For example, even if rates of impaired fecundity were the same in 1995 as in 1982, the number of women reporting impaired fecundity would have been markedly higher in 1995, simply because of the increase in the absolute number of women in their reproductive years, especially of women aged 35–44. In 1995, the number of U.S. women aged 15–44 (60.2 million) represented an increase of 11% from 1982, but between 1982 and 1995, the number of women aged 35–39 increased by 42% and the number of women aged 40–44 rose by 59%, while the number aged 15–29 decreased by 6–15%.*

When impaired fecundity rates derived from the 1988 NSFG were applied to the Census Bureau’s “middle series” population forecast for 1995, it was projected that 5.1 million women age 15–44 would have reported impaired fecundity in 1995.4 Given that the Census Bureau’s projections of population size and age composition for 1995 closely match the 1995 NSFG data, the fact that the actual number of women with impaired fertility exceeds the projections by more than one million cannot be explained solely by the fact that baby-boom women had reached their later reproductive years in 1995 (i.e., that there were simply more women trying to have babies at ages of lower fecundability). The increase is chiefly due to the fact that rates of impaired fecundity were about two percentage points higher (or 20% higher) in 1995 than in 1988, both among all women aged 15–44 and among key subgroups.

Table 2 shows that this increase occurred in almost all age, parity, marital status, education, income, and race and ethnicity subgroups. Although few of these increases were statistically significant (at an alpha level of 5%), the consistency across so many subgroups suggests potential social significance; since the rise over time was not concentrated in any one group (e.g., among nulliparous women or among older women), changes in the recognition or reporting of fertility problems may be responsible, including greater public awareness that the risk of fertility problems increases with age.

The decline from 1982 to 1995 in the proportion surgically sterile for noncontraceptive reasons, coupled with the substantial increase in the absolute numbers of women at risk of having and recognizing a fertility problem, could generate the observed increases in both the rates and numbers of women with impaired fecundity. Another factor might be the disproportionate increase (alpha level of 10%) in impaired fecundity among women who had ever had PID, which we mentioned earlier. While this finding might seem at odds with recent declines in overall self-report of PID, it could be explained by the fact that more older women were in fact trying to conceive in 1995 than in earlier years.