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Family Planning and Public Policy: Who Is Misleading Whom?

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Federal policies on family planning services and population research are currently under review as a result of the report of the President's Committee on Population and Family Planning (*1*). Judith Blake's article, "Population policy for Americans: Is the government being misled?" (*2*), which is presumably intended to influence this review, contains numerous errors of fact and interpretation which it is important to clarify. To support her position, she knocks down several straw men; ignores the bulk of serious demographic research on U.S. fertility patterns in the last 15 years, as well as research on differential availability of health care and the relative effectiveness of various contraceptive methods; and cites opinion-poll data in a manner that distorts the overall picture. The article's methodological limitations alone are sufficient to suggest that the question raised in its subtitle may more appropriately be turned around and asked of the article itself.

The article is based on six principal propositions.

1) That the reduction of U.S. population growth—indeed, the achievement of "population stability"—is "virtually unchallenged as an official national goal."

2) That, in pursuit of *this* goal, the "essential recommendation" by official and private groups has been a program of publicly financed family planning services for the poor.

3) That this program of family planning for the poor will not achieve the goal of population stability.

4) That advocates of this policy contend that the poor have been denied access to family planning services because of "the prudery and hypocrisy of the affluent."

5) That the poor desire larger families than higher-income couples do and are significantly less inclined to favor birth control.

6) That the estimate of 5 million poor women as the approximate number in need of subsidized family planning services is exaggerated.

With the exception of proposition 3, each of these statements is seriously misleading or in error. Let us examine the evidence on each point.

A Consensus on U.S. Population Stability?

If the United States had as a national goal the reduction of its population growth and the achievement of population stability—and if the program of publicly funded family planning services for those who cannot afford private medical care had been advanced as the principal or only means of achieving population stability—Judith Blake's contention that the government is being misled would have much validity. However, neither proposition is sustained by the evidence.

We have individually and jointly been associated with the evolution of

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Table 1. Number of children wanted, by education, color or race, income, and occupational status of respondents, as shown by studies made in 1960 and 1965.

Education, income, and occupational status	1960				1965‡			
	White*			Non-white†	White			Negro
	Total	Protestant	Catholic		Total	Non-Catholic	Catholic	
Education								
College	3.3	3.1	4.8	2.4	3.22	3.03	3.86	2.70
High school (4 yr)	3.2	3.0	3.9	2.7	3.21	3.01	3.65	2.89
High school (1–3 yr)	3.3	3.2	3.6	2.7				
Grade school	3.5	3.1	4.3	3.5				
High school (1–3 yr) or grade school					3.46	3.30	3.83	3.48
Husband's income§								
>$10,000	3.3							
$7,000–9,000	3.2							
$6,000–6,999	3.3							
$5,000–5,999	3.3							
$4,000–4,999	3.4							
$3,000–3,999	3.4							
<$3,000	3.2							
Occupation ||								
Upper white-collar	3.3							
Lower white-collar	3.3							
Upper blue-collar	3.3							
Lower blue-collar	3.3							
Farm	3.5							
Other	3.0							
Total	3.3	3.1	4.0	2.9	3.29	3.11	3.74	3.21

* From *12*, Table 54. † From *12*, Table 189. ‡ From *13*, Table 4. § Unpublished data from the 1960 "Growth of American Families Studies," made available by A. A. Campbell. \|\| From *12*, Table 71.

public policy in this field for more than a decade. To our knowledge, there has never been an official policy regarding the virtue or necessity of reducing U.S. population growth, much less achieving population stability. Nor has there emerged among Americans generally a "virtually unchallenged" consensus on what should constitute an official U.S. population policy.

The clearest statement of official U.S. *domestic* policy is contained in President Johnson's 1966 Health Message to Congress (*3*):

> We have a growing concern to foster the integrity of the family and the opportunity for each child. It is essential that all families have access to information and services that will allow freedom to choose the number and spacing of their children within the dictates of individual conscience.

Neither in this or in any other statement did the President cite stabilization of U.S. growth as the objective of federal policy. Nor has such a goal been articulated by Congress or the federal agencies. In 1966, Secretary Gardner of the Department of Health, Education, and Welfare (HEW) stated (*4*) that the objectives of departmental policy are "to improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and the size of their families." In 1968 he reiterated (*5*) that "the immediate objective is to extend family planning services to all those desiring such services who would not otherwise have access to them."

It is clear that the federal program has been advanced, not for population control, but to improve health and reduce the impact of poverty and deprivation.

Goals of Federal Family Planning Policy

Given this unambiguous framework for federal policy, it is inexplicable how Blake could arrive at the statement that population limitation has become our national goal and that the "essential recommendation" for reaching *this* goal has been to extend family planning services to the poor. She attributes this "misleading" recommendation to a 1965 report by the National Academy of Sciences (*6*), a 1967 consultants' review of HEW programs written by us (*7*), and the report of the President's Committee (*1*), despite the fact that each of these reports clearly distinguishes a family planning program for the poor from an overall U.S. population control program or policy. For example, the National Academy of Sciences report stated explicitly (*6*, p. 6) that U.S. population growth "is caused more by the preference for larger families among those who consciously choose the number of children they have than by high fertility in the impoverished segments of the population. The importance of high fertility among the underprivileged lies not so much in its contribution to the national birth rate as in the difficulties that excessive fertility imposes on the impoverished themselves."

The 1967 HEW review sought to determine how well the department's stated policy was being implemented. It found the department's efforts lagging and recommended higher priority in staff and budget for family planning services and population research programs. It also distinguished this effort from an overall U.S. population policy and program (*7*, pp. 23–24):

> While study should be given to the present and future implications of the growth of the Nation's population as a whole—perhaps through a series of university studies sponsored by a Presidential commission—the Federal government should at present focus its *family planning assistance* on the disadvantaged segments of the population. The great majority of non-poor American couples have access to competent medical guidance in family planning and are able to control their fertility with remarkable effectiveness. The poor lack such access and have more children than they want. It should be the goal of Federal policy to provide the poor with the same opportunity to plan their families that most other Americans have long enjoyed. Public financing of family planning for the disadvantaged is clearly justified for health reasons alone, particularly for its potential influence in reducing current rates of maternal and infant mortality and morbidity. Additionally, there are excellent humanitarian and economic justifications for a major directed program to serve the poor.

The President's Committee did not concentrate on family planning alone but made numerous recommendations for short- and long-term programs of domestic and international services, research, and education. Its recommendation on domestic family planning services again was justified, not in terms of population control, but as a health and social measure (*1*, pp. 15–16):

> Excessive fertility can drive a family into poverty as well as reduce its chances of escaping it. The frequency of maternal deaths, the level of infant mortality, and the number of children who are chronically handicapped are all markedly greater among the poor than in the rest of the population. One of the most effective measures that could be taken to lower mortality and morbidity rates among mothers and children would be to help the poor to have the number of children they desire.

As for immediate programs to further reduce the incidence of unwanted pregnancy among the rest of the population, the committee recommended (*1*, p. 15) expansion of biomedical research for improved contraceptive techniques and expansion of social research; increased education in population dynamics, sex, and human reproduction, and improved training programs for physicians and other relevant professionals. It stated explicitly (*1*, p. 37) that these recommended programs "are only *one* of the important factors that influence population trends," and called for a Presidential Commission on Population to, among other things, "assess the social and economic consequences of population trends in the U.S. . . . [and] consider the consequences of alternative population policies" (*1*, pp. 37–38).

These reports only reiterate what has been the basic justification for publicly funded family planning services for the poor for more than a decade. The leaders of the U.S. family planning movement have not advanced this program as a means of achieving population stability, because it has been evident that the poor and near-poor, who constitute only about one-quarter of the U.S. population, are not the major contributors to U.S. population growth, despite their higher fertility.

Blake believes the U.S. policy should aim toward a zero rate of population growth, as is her right. But she has no right to accuse family planners of misleading the public into believing that extension of family planning to the poor would bring about such population stability—a claim they have never made. Of course, any reduction in births, wanted or unwanted, will result in *less* natural increase and, other things being equal, *less* population growth. Elimination or reduction of unwanted pregnancies among the poor and near-poor would thus reduce *somewhat* the rate of population growth, though not eliminate it entirely (*8*).

Prudery—or Politics?

Another straw man erected by Blake is the assertion that denial of birth control services to the poor has been attributed by advocates of family planning to the "prudery and hypocrisy of the affluent, who have overtly tabooed discussion of birth control and dissemination of birth control materials." As proof that this has not been the case, she cites opinion polls going back to 1937 showing majority support for making birth control information available to those who desire it.

Table 2. Percentages (by education and color of respondents) of women who favored fertility control, as shown by studies made in 1960 and 1965.*

Education	White		Nonwhite	
	1960*	1965†	1960†	1965†
College	97	97	97	94
High school (4 yr)	95	97	90	94
High school (1–3 yr)	93	94	78	90
Grade school	82	82	67	84

* Data from *12*, Table 102. † Data from *17a*, Table 7.

The proof is irrelevant in two major respects. First, the issue is not *information* about birth control, but *availability of services* (a distinction which Blake obscures throughout her article). And second, the operative factor in regard to the poor has not been generalized approval or disapproval, but the policies in regard to provision of contraceptive services of public health and welfare institutions on which the poor depend for medical care. As she notes, it was evident as long ago as the 1930's that most Americans approved of birth control and practiced it in some form (although it was not until the late 1950's that the mass media began to carry relatively explicit birth control material). But this public-opinion base did not control the policies of public institutions or the attitudes of political leaders. In most tax-supported hospitals and health departments there were explicit or implicit prohibitions on the prescription of contraceptive methods and materials, and many states had legislative restrictions which were enforced primarily in public agencies. To change these policies required protracted campaigns, which began in the New York municipal hospitals in 1958 (*9*), continued in Illinois, Maryland, Pennsylvania, and other states in the early 1960's, and culminated in legislative actions in 1965 and 1966 in at least 15 states and congressional action in 1967 in the Social Security and Poverty legislation.

The family planning movement has not ascribed the denial of birth control services to the poor to a generalized "taboo" but, rather, has ascribed it to concrete prohibitions on provision of services which stemmed from fear on the part of political leaders of the presumed controversial nature of the subject. The fears were perhaps exaggerated, but nevertheless real. The result was that very few poor women received contraceptive guidance and prescription in tax-supported agencies at times in their lives when it would have been of most importance to them —at the premarital examination and after the birth of a child, for example. It was not until the years 1964 to 1966 that several hundred public hospitals and health departments began providing family planning services, and it was not until 1967 that as much as $10 million in federal funds became available to finance identifiable family planning programs.

Family Size Desired by the Poor

Judith Blake contends that her data show that the poor desire larger families than the non-poor. She bases her assertion on responses to opinion polls and ignores the three major national studies conducted since 1955, covering larger and properly structured random samples of the U.S. population, which have probed these issues in depth. Even when the poll responses are accepted at face value, it is of interest to note that the "larger" family said to be desired by those in the lowest economic status group was larger by as much as 0.4 of a child in only 2 of the 12 years cited (*10*).

Also of interest is the fact that Blake treats responses to questions on *ideal* family size as evidence of the number of children the poor *want*. At various points in the text she refers to the data she cites as demonstrating "*desired* or ideal" number of children or "*preferred* family size," or states that the poor "say they *want* larger families" (emphasis added). The dubiousness of this methodology is revealed by the very different treatment of responses on *ideal* and *wanted* family size in the 1955 and 1960 Growth of American Families Studies (*11*, *12*) and in the 1965 National Fertility Study (*13*, *14–16*).

In the 1955 study, Freedman and his co-workers stated that the question on ideal family size "was not designed to discover the wife's personal ideal but sought a picture of her more stereotyped impressions on what family size should be" (*11*, p. 221). "The more realistic question about desired . . . family size," they concluded, "is that regarding the number of children wanted at the time of the interview" (*11*, p. 224). They found that the ster-

Table 3. Number of children wanted by white and nonwhite wives under 30 years old, by income and farm residence of respondents, as shown by a 1965 study.*

Residence	Family income			
	> $8,000	$6,000–7,999	$4,000–6,999	<$4,000
Now living on farm	3.97	3.12	3.25	3.21
Once lived on farm	3.08	3.13	2.99	3.19
Never lived on farm	3.13	3.21	3.12	3.06

* Unpublished data from the 1965 National Fertility Study, made available by C. F. Westoff.

Table 4. Percentages (by income and farm residence of respondents) of white and nonwhite wives under 30 years old who had ever used, or expected to use, any form of contraception, as shown by a 1965 study.*

Residence	Family income			
	> $8,000	$6,000–7,999	$4,000–6,999	<$4,000
Now living on farm	84	100	85	89
Once lived on farm	91	97	95	88
Never lived on farm	95	96	93	92

* Unpublished data from the 1965 National Fertility Study, made available by C. F. Westoff.

eotyped "ideal" generally was higher than the number wanted. In the 1960 study, Whelpton and his colleagues came to the same conclusion (*12*, p. 37). In the 1965 study, Ryder and Westoff expressed "profound reservations" about the usefulness of the "ideal" question and found that it "lacks face validity . . . is relatively unreliable and has a small variance" (*13*).

The poll responses cited by Blake appear to show that *ideal* family size varies inversely, among non-Catholic white women, with education and economic status. Responses to detailed surveys on *wanted* family size, however, either show insignificant differences between lower- and higher-status non-Catholic white respondents or *reverse the direction*. The data for 1960 show no difference in the number of children wanted by highest-status and lowest-status non-Catholic whites, and the data for 1965 show a very small increase in the number wanted by the group with only grade school education. (The pattern for Catholics was, of course, different.) Other measures of socioeconomic status show either no difference in the number of children wanted or, in the case of the measure of income, a smaller number for those with income below $3000 than for those with income above $10,000 (Table 1).

Judith Blake also uses opinion-poll responses, rather than the results of in-depth studies, to measure approval of birth control in the different socioeconomic groups. The result is, again, an overstatement of the differences between the highest and lowest social groups. In Table 2 are given excerpts from findings for 1960 and 1965 on approval of the practice of fertility control (including the rhythm method). The only deviation from the near-universal approval of fertility control is in the group with only grade school education, which is rapidly becoming a smaller proportion of all U.S. women and is hardly coterminous with the poor and near-poor. [Among all poor and near-poor women aged 18 to 44 in 1966, only 26.1 percent had grade school education or less; 31.9 percent had completed from 1 to 3 years of high school, and 42.1 percent had been graduated from high school; some of the latter had attended college (*17*).] Even in the grade-school group, however, more than four-fifths of white women approved of birth control in both 1960 and 1965—a proportion bettered by nonwhite grade-school women in 1965—and all other groups were nearly unanimous in their approval. It is extremely difficult, in the face of these data, to conjure up the notion of great hostility to fertility control among the poor and near-poor (*17a, 18*).

For purposes of policy determination, the most salient questions relate, not to all poor and near-poor persons, but to those who are in their prime child-bearing years—that is, less than 30 years old. Presumably it is this group which would be most affected by public programs and whose attitudes policy makers would consider most significant. Data from the 1965 study, presented in Tables 3 and 4, permit direct comparison, for farm and nonfarm women below 30 in four income groups, of the number of children wanted and the proportion of women then using, or expecting to use, some form of contraception. The conclusion is clear: younger wives in the "poor" and "near-poor" categories want as few children as wives in higher income groups—or want fewer children than the higher-income wives—and have used or expect to use some form of contraception to a similar degree.

Despite the fact that 70 percent of poor and near-poor women regarded as in need of subsidized family planning services are white (*19*), Blake frequently terms the recommended federal effort a "ghetto-oriented family planning program." She also describes the charge of "genocide" which has been leveled by some black militants as "difficult to refute." However, the desire of black couples for smaller families than are desired by whites—and for smaller families than they are now having—was clearly demonstrated in the 1960 study (*12*, pp. 41, 38) (see Table 5).

Substantially the same pattern emerges from the 1965 study, as shown in Tables 6 and 7: significantly higher percentages of nonwhites continue to prefer a family of two children or less, and the proportion of nonwhites approving and using, or expecting to use, some method of fertility control is indistinguishable from that of whites, especially in the prime child-bearing ages.

Excess Fertility

Serious demographic research has thus documented the disappearance of the traditional socioeconomic and ethnic differentials in fertility aspirations and in attitudes toward fertility control. "Clearly," as Westoff and Ryder have stated, "the norm of fertility control has become universal in contemporary America" (*17a*, p. 394). Yet within this general pattern the studies also reveal that many couples do not achieve the degree of control they wish. Some have more children than they want and can be classified in the "excess fertility" category; others fail to have their children when they want them and are described as "timing failures." More than half of U.S. couples reported one or another type of failure in 1965; 21 percent of all respondents acknowledged that at least one of their children was unwanted (*15*). (This must be regarded as an underestimate, since the questionnaire required that respondents characterize specific children already born as either wanted or unwanted.)

While excess fertility is found among all socioeconomic groups, it is more acute among the poor, among nonwhites (the majority of whom are poor or near-poor), and among those with higher parity and less education. In spite of the similarity in family-size

preferences in all socioeconomic groups, the poor and near-poor had a fertility rate from 1960 to 1965 of 152.5 births per 1000 women aged 15 to 44, as compared to 98.1 for the non-poor (*20*). And in spite of the expressed preference of almost all low-income parents for less than four children, nearly half of the children growing up in poverty in 1966 were members of families with five or more children under 18; moreover, the risk of poverty increased rapidly from 9 percent for one-child families to 42 percent for families with six or more children (*21*). In terms of poverty, the most significant demarcation appears to be at the three-child level—the average family size wanted by low-income as well as other American couples: more than one-quarter of all families with four or more children were living in poverty, and four out of ten were poor or near-poor. Their risk of poverty was two-and-a-half times that for families with three children or less (Table 8).

The 1965 National Fertility Study provides data on the percentage of unwanted births for each birth order, ranging from 5.7 percent of first births to 56.7 percent of sixth and higher-order births. Application of these percentages to actual births, by birth order, in the years 1960 to 1965 yields an estimated average of 850,000 unwanted births annually in all socioeconomic groups. Combination of these data with Campbell's calculation of differential fertility rates shows that approximately 40 percent of births to poor and near-poor couples were unwanted by one or both parents in the years 1960 to 1965, as compared to 14 percent of births to non-poor couples (*22*). [This result appears consistent with the 1960 finding of an inverse relation between education and excess fertility, with 32 percent of white, and 43 percent of nonwhite, grade-school-educated wives reporting more children than they wanted (*12*, p. 364).]

Equalizing Access to Effective Methods

It is precisely the reduction or elimination of this involuntary disparity between the poor and non-poor which has been the objective of publicly supported family planning service programs. Given the essentially similar preferences of the two groups concerning family size, programs which equalize access to modern methods of fertility control should also help to equalize the incidence of unwanted pregnancy for the two groups. Blake can regard this as a "fantastic . . . blanket decision" imposed by the family planners only if she ignores (i) the evidence on the type of birth control methods on which the poor rely, (ii) the evidence on the relative effectiveness of different contraceptive methods, and (iii) the response of poor persons to organized programs which offer them a complete range of methods.

Table 5. Number of children wanted by white and nonwhite wives, as shown by a 1960 study.*

Couples	Number of children wanted		Percentages wanting two children or less	
	Minimum	Maximum	Minimum	Maximum
White	3.1	3.5	41	29
Nonwhite	2.7	3.0	55	46

* Data from *12*, Tables 15 and 16.

The data on contraceptive practice cited above measure the combined use of all methods, including those methods known to be least effective in preventing conception. The cited studies also show that couples of higher socioeconomic status who can afford private medical care tend to use the more reliable medical methods, while low-income couples depend more on less reliable, nonmedical methods. Among white Protestants in 1960, for example, half as many wives with a grade school education as college graduates used the diaphragm and twice as many relied on withdrawal (*12*, p. 281). Published and unpublished findings for 1965 on methods employed by whites and nonwhites reveal the same picture. Three times as many nonwhites as whites relied on the douche (*16*) and on suppositories (*23*, p. 2), and twice as many relied on foam (*23*). When the condom is classified among effective methods and rhythm is omitted from the analysis because of the different proportions of whites and nonwhites who are Catholic, we find that half of nonwhite users of contraceptives rely on the least effective methods, as compared to about 30 percent of whites (*16*).

These findings are significant in two respects: (i) the methods on which the poor rely most heavily have considerably higher failure rates and thus would lead to a higher incidence of unwanted fertility; and (ii) the overwhelming majority of poor persons accept the best methods science has been able to develop when they are given the choice.

The relative rates of failure with the different methods range from 1 to 3 failures per 100 women-years of exposure for pills and IUD's to 35 to 38 failures for rhythm and douche, with the numbers for the condom, the diaphragm, and withdrawal clustering around 15 (*24*).

Response to Family Planning Programs

It is difficult to understand how the greater reliance of the poor on nonmedical methods can be attributed to their personal preferences in view of the considerable research demonstrating that the poor have little access to medical care for preventive services (*25*). When access to modern family planning services offered with energy and dignity has been provided, the response of poor and near-poor persons has been considerable. The number of low-income patients enrolled in organized family planning services under both public and private auspices has increased from about 175,000 in 1960 to 850,000 in 1968, as hospitals and public health departments have increasingly offered services which provide the new methods not associated with the act of coitus (*22*). In virtually all known programs offering a variety of methods, 85 to 90 percent of low-income patients voluntarily choose either pills or intrauterine devices (IUD's), the most effective methods currently known.

In 1965, a Chicago study found that three-fourths of patients continued to use the pills regularly 30 months after

Table 6. Desired family size, by race and by fertility planning status, as shown by a 1965 study.*

Desired number of children	Percentages of respondents who regard their fertility as completed			Percentages of respondents who desire more children		
	Total	White	Negro	Total	White	Negro
0–2	36.2	35.4	44.0	27 1	25.7	41.0
3	23.6	24.5	14.8	28.8	29.2	24.3
4	40.3	40.2	41.2	44.2	45.0	34.8

* Data from *13*, Table 7.

Table 7. Percentages (by age and color of respondent) of women who approved of fertility control (including the rhythm method) and were using or expected to use some form of contraceptive, as shown by a 1965 study.*

Respondents	Percentages by age group			
	20–24 yr	25–29 yr	30–34 yr	35–39 yr
Approved of fertility control				
White	95	97	95	93
Nonwhite	92	93	90	87
Were using or expected to use contraceptives				
White	94	93	88	84
Nonwhite	96	90	84	71

* Data from *17a*, Tables 8 and 14.

first coming to the clinic, an astonishingly high retention rate for any procedure requiring continuous self-medication (*26*).

A carefully planned program which introduced the first subsidized services in New Orleans, begun in 1967, has already enrolled nearly two-thirds of the target population, three-fourths of whom had not practiced birth control or had used nonprescription methods before attending the clinic. When given a genuine choice, 82 percent chose either pills or IUD's, while only 17 percent selected a nonprescription method (*27*). In the rural Louisiana parish where this program was first tested the birth rate among the indigent decreased by 32 percent in the first year after the clinic was opened, as compared to a decrease of only 6 percent in four surrounding control counties where no organized family planning services were available. The illegitimacy ratio in the county in question dropped from 172 per 1000 live births in 1966 to 121 in 1967, as compared to an increase in the control counties from 162 to 184 (*28*).

Five Million Women

Judith Blake challenges the estimate that there are 5 million poor and near-poor women who comprise the approximate population in need of subsidized family planning services. This estimate has been arrived at independently by Campbell (*20*) and the Planned Parenthood Federation Research Department (*19*), on the basis of Census Bureau tabulations of the characteristics of the poor and near-poor (*17*). Campbell estimated a total of 4.6 million, while Planned Parenthood estimated 5.3 million. The difference stems from the use of slightly different assumptions in analyzing the data available for obtaining a "need" figure which defines all women who are (i) poor or near-poor; (ii) not currently pregnant or wanting to become pregnant; (iii) fecund; and (iv) exposed to risk of pregnancy. The differences in the assumptions and results are not regarded as significant at this point, when fewer than 1 million low-income patients are reportedly receiving family planning services.

There exists, of course, no data base from which to define precisely women who have the characteristics listed above. Both estimates have been presented as approximations which reasonably interpret available information. It is important to note that 5 million represents a residual number of potential patients at any given time, after subtraction, from the total of about 8 million poor and near-poor women aged 15 to 44, of an estimated number of those who are sterile, those who are pregnant or seeking to become pregnant (allowance being made for the fact that poor couples say they want three children, on the average), and those who are not exposed to the risk of pregnancy (*20*) (Table 3). The estimate does involve the policy assumption that all others should have available competent medical advice on regulating fertility—even if they choose to practice the rhythm method, or if they are less than normally fecund, or if they have sexual relations infrequently—since such advice will tend to make their family planning practice more effective. Whether or not all 5 million women would avail themselves of the opportunity remains to be seen. Until the poor are offered a genuine choice, there is no way to determine how many would actually prefer nonmedical methods. Nor is there any way to judge whether low-income Catholics will voluntarily choose methods officially proscribed by their Church to a degree equaling or possibly exceeding the 53 percent of all Catholics who reported in 1965 that they have already used methods other than the rhythm method (*23*, Table 3).

It is interesting to note that Judith Blake does *not* cite the one factor which might be a significant limitation on these estimates—namely, the proportion of low-income women who have been able to secure competent guidance in fertility control from private physicians. There exists no adequate information on this question, perhaps because most researchers have been singularly uninterested in the *processes* through which fertility control techniques are diffused. Fragmentary data from several state Medicaid programs suggest that, at most, the proportion of poor and near-poor persons receiving family planning services from private physicians is no higher than 10 percent of the population in need.

In sum, then, the 5-million estimate has been presented as a reasonable approximation, based on the inadequate data that are available, of those who need subsidized family planning services and for whom wise social policy would attempt to develop programs.

Table 8. Relation of poverty to size of family, as shown by a 1966 study.*

Number of children	All U.S. families (in thousands)	The poor		The poor and near-poor	
		Number of families (in thousands)	Percentage of all U.S. families	Number of families (in thousands)	Percentage of all U.S. families
1	9,081	843	9.3	1,276	14.1
2	8,491	869	10.2	1,323	15.6
3	5,416	694	12.8	1,152	21.3
Total for parity 1–3	22,988	2,406	10.5	3,751	16.3
4	2,923	543	18.6	904	30.9
5	1,396	387	27.7	593	42.5
6 or more	1,286	541	42.1	747	58.1
Total for parity 4+	5,605	1,471	26.2	2,244	40.0

* Data from *21*, Table 4.

Population Policy

Judith Blake's article, hopefully, will stimulate responsible and dispassionate study and discussion of population policy in the United States. The scholarly community has thus far given little attention to this question, leaving the discussion largely to polemicists.

Her message is loud and clear: Our

society should not waste its resources on family planning for the poor but should seek ways to restructure the family, reconsider male and female sexual roles (*29*), and develop satisfying nonfamilial roles for women, if it is to achieve population stability in the long run. We regard the first part of this proposition as erroneous and misleading. The second part, however, needs thoughtful examination as to its feasibility and the costs and benefits to society. The development of voluntary family planning in the immediate future is in no way antithetical to such realistic consideration of population policy for the long run.

It would be useful if Judith Blake were to develop proposals for specific programs to advance the objective of encouraging women to seek satisfaction in careers outside the home. It would be particularly interesting to see whether those programs do not subsume, as a necessary first step, the extension of effective fertility control measures to all women who want and need them—which we believe is the immediate objective of federal policy on family planning.

References and Notes

1. President's Committee on Population and Family Planning, *Population and Family Planning—The Transition from Concern to Action* (Government Printing Office, Washington, D.C., 1968).
2. J. Blake, *Science* **164**, 522 (1969).
3. L. B. Johnson, Message to Congress on Domestic Health and Education, 1 March 1966.
4. J. W. Gardner, Statement of Policy of the Department of Health, Education and Welfare on Family Planning and Population Programs, 24 January 1966.
5. ———, Memorandum to Heads of Operating Agencies on Family Planning Policy, 31 January 1968.
6. "The Growth of U.S. Population," *Nat. Acad. Sci. Nat. Res. Counc. Publ. 1279* (1965).
7. O. Harkavy, F. S. Jaffe, S. M. Wishik, "Implementing DHEW Policy on Family Planning and Population—A Consultant's Report," *Dept. Health Educ. Welfare Publ.* (1967) (available from the U.S. Department of Health, Education and Welfare).
8. Calculation of data on unwanted births from the 1965 National Fertility Study yields an estimate of an annual average of about 850,000 unwanted births among all classes in the period 1960–65 [see F. S. Jaffe and A. F. Guttmacher, *Demography* **5**, 910 (1968)]. This figure must be regarded, for methodological reasons, as a minimum estimate of unwanted births. It amounts to about 40 percent of the excess of births over deaths in the 6-year period under study. Prevention of unwanted births among the poor and near-poor could have reduced the overall excess of births over deaths by slightly more than 20 percent, while prevention of unwanted births among the non-poor could have reduced it by slightly less than 20 percent. These approximations show the orders of magnitude of what might be expected from the extension of modern family planning to the poor and near-poor and from improved efficiency of fertility control for all Americans. They do not, of course, add up to a zero rate of growth, but they appear to offer the promise of more immediate progress toward reduced growth rates than any other proposed or currently feasible program of equivalent cost (or, for that matter, any cost).
9. See J. Rock, *The Time Has Come* (Knopf, New York, 1963), chap. 11; A. F. Guttmacher, *Babies by Choice or by Chance* (Doubleday, New York, 1959), chap. 8.
10. We are indebted to Dorothy Nortman of the Population Council for this observation.
11. R. Freedman, P. K. Whelpton, A. A. Campbell, *Family Planning, Sterility and Population Growth* (McGraw-Hill, New York, 1959).
12. P. K. Whelpton, A. A. Campbell, J. E. Patterson, *Fertility and Family Planning in the United States* (Princeton Univ. Press, Princeton, N.J., 1966).
13. N. B. Ryder and C. F. Westoff, "Relationships among intended, expected, desired and ideal family size: United States, 1965," *Population Res.* (March 1969) (available from the Center for Population Research, National Institute of Child Health and Human Development, Washington, D.C.). Their full statement of the limitations of the "ideal" question follows: "We asked the question to correspond exactly with the wording employed in many previous inquiries, *despite profound reservations about its usefulness.* The question can be interpreted as the respondent's opinion as to what she considers to be ideal for the average American family, or what the average American family considers ideal for themselves. In the second place, the wording prompts the further question, 'Ideal for whom?' That might be answered from the standpoint of the respondent, or of the average American family, or even of the total population—since it must face the consequences of the behavior of the 'average American family.' Thirdly, the question calls for a statistical judgment of the characteristics of the average American family, a judgment probably beyond the reach of most respondents and varying in relation to their own characteristics. In the fourth place, there is ambiguity about the scope of the term 'ideal': Does it mean the ideal parity considering the circumstances as well? Finally, there would seem to be a substantial risk with a question so worded that the respondent thinks she is being asked about the actual average number of children in an American family. In our opinion, the *sole justification for including this question in our inquiry is to explore statistically the validity of this very common but very dubious question* [emphasis added]."
14. Convergence is also demonstrated when actual behavior is examined, rather than attitudes. See C. F. Westoff and N. B. Ryder, in *Fertility and Family Planning: A World View*, S. J. Behrman, L. Corsa, Jr., R. Freedman, Eds. (Univ. of Michigan Press, Ann Arbor, 1969), Tables 13 and 15. In 1960 and 1965, by any measure of socioeconomic status, three-fourths to five-sixths of the lowest income groups had used or expected to use some form of fertility control (including relatively ineffective ones). As would be expected of a practice which has diffused down through the class structure, there is a lower level of practice in the lowest groups (which may also be a function of less availability of services).
15. N. B. Ryder and C. F. Westoff, "Fertility planning status of American women, 1965," paper presented before the Population Association of America, April 1968.
16. Unpublished data from the 1965 National Fertility Study, made available by C. F. Westoff.
17. Special tabulation by the Census Bureau of the characteristics of women living in poverty and near-poverty in March 1966.

17a. C. F. Westoff and N. B. Ryder, in *Fertility and Family Planning: A World View*, S. J. Behrman, L. Corsa, Jr., R. Freedman, Eds. (Univ. of Michigan Press, Ann Arbor, 1969).

18. Blake has much to say about the responses of white men and women of lower education and economic status to a poll question. "Do you think birth control pills should be made available free to all women on relief who are of childbearing age?" She ignores the ambiguity of the question, which would appear to require of the respondents judgment on at least four issues: (i) pills; (ii) the public assistance system ("welfare handouts"); (iii) the morals of women on public assistance; and (iv) the distribution of pills without medical supervision. If we were asked the question in this form, our answer would probably also be in the negative: "Not unless the distribution was under medical supervision and the assistance recipient wanted pills."
19. G. Varky, F. S. Jaffe, S. Polgar, R. Lincoln, *Five Million Women—Who's Who Among Americans in Need of Subsidized Family Planning Services* (Planned Parenthood–World Population, New York, 1967), a publication based on the Census Bureau tabulation cited in *17*.
20. A. A. Campbell, *J. Marriage and the Family* **30**, 236 (1968).
21. M. Orshansky, "The shape of poverty in 1966," *Soc. Security Bull.* (March 1968).
22. F. S. Jaffe and A. F. Guttmacher, *Demography* **5**, 910 (1968).
23. C. F. Westoff and N. B. Ryder, "United States: Methods of Fertility Control, 1955, 1960 and 1965," *Studies in Family Planning No. 17* (1967).
24. C. Tietze, in *Manual of Contraceptive Practice*, M. S. Calderone, Ed. (Williams and Wilkins, Baltimore, 1964), Tables 3 and 4.
25. See, for example, A. F. Yerby, *Amer. J. Public Health Nat. Health* **56**, 5 (1966).
26. R. Frank and C. Tietze, *Amer. J. Obstet. Gynecol.* **93**, 122 (1 Sept. 1965). See also S. Polgar and W. B. Cowles, Eds., "Public Health Programs in Family Planning," supplement to *Amer. J. Public Health Nat. Health* **56** (Jan. 1966); S. Polgar, "U.S.: The PPFA Mobile Service Project in New York City," *Studies in Family Planning No. 15* (1966); D. J. Bogue, "U.S.: The Chicago Fertility Control Studies," *ibid.*; G. W. Perkin, "A family planning unit for your hospital?," *Hosp. Practice* **2**, 64 (May 1967).
27. J. D. Beasley, *Family Planning Perspectives* **1**, 2 (Spring 1969).
28. ——— and V. W. Parrish, "Epidemiology and prevention of illegitimate births in the rural South," paper presented before the American Public Health Association, November 1968.
29. We confess that we do not comprehend how a society which has as much difficulty as Blake alleges ours does with regard to contraceptives for unmarried persons engaging in heterosexual activities can be expected to legitimate sexual deviancy as an antinatalist measure.