women require medical attention regarding birth control—particularly that they need the pill and the coil. In the words of the Harkavy report (2, attachment A, p. 19) :

"This may be considered a high estimate of the number of women who need to have family planning services made available to them in public clinics, because some of the couples among the poor and near poor are able to exercise satisfactory control over their fertility. However, even these couples do not have the same access as the non-poor to the more effective and acceptable methods of contraception, particularly the pill and the loop. So, simply in order to equalize the access of the poor and the near-poor to modern methods of contraception under medical supervision, it is appropriate to try to make contraceptive services available to all who may need and want them."

Yet the 1960 Scripps study found that, among fecund women of grade school education, 79 percent used contraceptives (14, p. 159). The 21 percent who did not included young women who were building families and said they wanted to get pregnant, as well as Catholics who objected to birth control on religious grounds. As for the methods that women currently are using, it seems gratuitous for the federal government to decide that only medically supervised methods—the pill and the coil—are suitable for lower-income couples, and that a mammoth "service" program is therefore required. In fact, the implications of such a decision border on the fantastic—the implications that we should substitute scarce medical and paramedical attention for all contraceptive methods now being used by poor couples.

In sum, the argument supporting a "need" for nationwide, publicly sustained birth-control programs does not stand up under empirical scrutiny. Most fecund lower-class couples now use birth-control methods when they want to prevent pregnancy; in the case of those who do not, the blame cannot simply be laid at the door of the affluent who have kept the subject of birth control under wraps, or of a government that has withheld services. As we have seen, opinion on birth control has been, and is, less favorable among the poor and the less well educated than among the well-to-do. In addition, the poor desire larger families. Although it may be argued that, at the public welfare level, birth control has, until recently, been taboo because of the "Catholic vote," most individuals at all social levels have learned about birth control *informally* and without medical attention. Furthermore, the most popular birth-control device, the condom, has long been as available as aspirin or cigarettes, and certainly has been used by men of all social classes. When one bears in mind the fact that the poor have no difficulty in gaining access to illegal narcotics (despite their obvious "unavailability"), and that the affluent had drastically reduced their fertility before present-day contraceptive methods were available, one must recognize and take into account a motivational component in nonuse and inefficient use of contraceptives. Indeed, were relative lack of demand on the part of the poor not a principal factor, it would be difficult to explain why such an important "market" for birth-control materials—legal or illegal—would have escaped the attention of enterprising businessmen or bootleggers. In any event, any estimate based on the assumption that all poor women in the reproductive group "want" birth-control information and materials and that virtually all "need" publicly supported services that will provide them—including women with impaired fecundity, women who have sexual intercourse rarely or not at all, women who object on religious grounds, and women who are already using birth-control methods—would seem to be seriously misleading as a guide for our government in its efforts to control population growth.

Moreover, the proposal for government sponsorship takes no account of the possible advantages of alternative means of reaching that part of the "market" that may not be optimally served at present. For example, competitive pricing, better marketing, and a program of advertising could make it possible for many groups in the population who are now being counted as "targets" for government efforts to purchase contraceptives of various kinds. When one bears in mind the fact that an important reason for nonuse or lack of access to contraceptives may be some sort of conflict situation (between husband and wife, adolescent child and parent, and so on), it becomes apparent that the impersonal and responsive marketplace is a far better agency for effecting smooth social change than is a far-flung national bureaucracy loaded with well-meaning but often blundering "health workers." The government could doubtless play an initial stimulating and facilitating role in relation to private industry,