

Review

Blood and Thunder

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The Gift Relationship: From Human Blood to Social Policy. By Richard M. Titmuss. *New York: Pantheon Books, 1971.* Pp. 339. \$6.95 (clothbound).

The subtitle of this extraordinarily interesting book gives a fair indication of its ambitions. Most of it is a detailed comparison of two alternative ways of organizing the collection and allocation of human blood for transfusion and similar purposes. On this level, it appears to be—and probably is—a devastating and unanswerable indictment of the American system as inferior to the British in efficiency, morality, and attractiveness. From this secure beachhead, Professor Titmuss launches a broad attack on the market as a mechanism for the mobilization and allocation of scarce resources, and, even more generally, on the whole economizing mode of thought which—as he might have said if he were a different sort of man—knows the price of everything and the value of nothing. On this broader front he scores some important points but is ultimately confused. I hope to show that what arouses Titmuss's anger and scorn is usually not, as he thinks, the use of economic reasoning but its misuse. There is a lesson here for everyone interested in social policy, because some economists do have a way of drifting into sharp propositions that cannot be fully supported even on narrowly economic grounds. But blood first, thunder afterward.

I.

In Great Britain, the collection and allocation of blood is entirely in the hands of the National Blood Transfusion Service as an integral part of the National Health Service. (The actual functioning is decentralized through Regional Transfusion Centres corresponding roughly to the Regional Hospital Boards.) Essentially all blood is collected from volun-

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tary donors who receive no reward but a cup of tea. Blood is allocated from the Regional Centres to hospitals by negotiated quota; there is provision for renegotiation of quotas, for special allocation of emergency supplies, and for national pooling of rare blood types. Hospitals do not have to pay for the blood they use, nor do the patients who ultimately receive transfused blood. (Even private patients who have contracted out of the National Health Service receive blood free from the Service.) There is apparently no explicit or implied obligation to replace blood used by oneself or one's family, or to earn insurance credits by supplying blood in advance. In fact, in a sample survey slightly over a quarter of donors report that they or a member of their immediate family have received blood in the past. Since it seems unlikely that as many as a quarter of all immediate families have members who have received transfusions, the receipt of blood is probably a motive for subsequent giving by the recipient or his relatives. But there is no accounting system for such gifts, and presumably no unpleasant pressure to pay back.

Donors appear to be broadly, though not exactly, representative of the population at large: males and the young are over-represented for obvious reasons; "professional, etc." occupations are over-represented and semi-skilled and unskilled occupations are under-represented, though it is impossible to say how much of this social-class bias represents differences in past and present health and therefore in eligibility.¹

Blood is thus completely removed from the marketplace. It is supplied at zero fee and used at zero price. Recipients do not even know whom to thank.

In the United States, by contrast, there is no unified system for the collection and distribution of blood, but rather a variety of differentiated institutions. One of the consequences is that it is impossible to assemble comprehensive statistical information on any sort of uniform basis. There is a large element of guesswork, therefore, in any picture of how the apparatus actually works.

Titmuss classifies blood banks into five classes. (1) Red Cross Regional Blood Centers, based on 1700 local chapters, contribute about forty per cent of the total supply. (2) About one hundred non-profit community blood banks are believed to account for fifteen to twenty per cent of the total. (3) Some 6000 hospital blood banks are responsible for twenty to thirty per cent. (4) An unknown number of profit-making commercial blood banks, generally getting blood from paid donors,

1. See generally R. TITMUS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* 124-41 (1971) [hereinafter cited to page number only].

processing it, and selling it to hospitals, were believed in the early 1960s to account for some ten to fifteen per cent of the total supply; but Titmuss and others believe their role has increased since then. (5) An unknown number of commercial blood banks directly operated by pharmaceutical firms supply plasma, plasma protein components and platelets obtained from paid donors by a new method called plasmapheresis.² (In plasmapheresis, the red cells are separated immediately from the plasma and injected back into the donor. It is claimed by some authorities that a single donor can safely give blood several times a week by this method, provided his health is good and his diet appropriate; but the technique is new, and apparently there remains some uncertainty about long-run effects on donors.)

It is even more difficult to arrive at any estimate of the sources of blood by type of donor. A knowledgeable person could no doubt quarrel with Titmuss's guesses, but it is unlikely that he is so far off as to render his general picture false. He distinguishes eight types of donors, but some of these are minor variations on others. The figures are for 1965-67 and may be changing. About a third of all blood comes from paid donors, some of whom sell their blood occasionally, some regularly. This fraction includes a small amount from donors who receive a cash payment, but whose main reason for "volunteering" may be group pressure from a trade union or other organization with a quota it would like to fill. A little over half of all blood comes from those who are in effect exchanging blood for blood. Some of them are making "insurance deposits"; for instance, a donation of one pint a year by some member of a family insures all members of the immediate family for their blood needs for that year. (There are also policies which, in exchange for cash premiums, insure against the cash costs of blood, but these, of course, are not sources of blood to the system.) Other people give blood in exchange for blood already received. Hospitals levy a cash charge per unit of blood delivered to patients; in the 1960s a typical charge was \$30-\$100 a pint, and for some types of surgery many pints are required. As an alternative to cash payment, the patient is urged to replace the blood he has used with his own blood or with that from one or more friends, relatives, hired donors, or members of a "blood plan group" to which the patient belongs for just such contingencies. Many hospitals require the patient to supply two units of blood for each unit used, and set cash fees accordingly.³

2. Pp. 90-93.

3. Pp. 75-88.

About five per cent of all blood comes from "captive voluntary donors," mostly servicemen and prisoners. Some prisoners receive a small cash payment. In some states there appears to be formal remission of sentences as a reward for donation of blood; one presumes that generally parole boards look more kindly on prisoners whose records show a history of blood donation. (In Britain, according to Titmuss, prisoners are treated like other members of the community and allowed to volunteer. There is no formal reward of any kind, but it is difficult, as he says, to know how the prisoners themselves see the situation.) The remaining ten per cent of all blood supplied in the United States comes from the voluntary donor, who is the source of essentially all blood in Great Britain.⁴

These figures exclude blood components collected in plasmapheresis programs. Such programs draw entirely on paid donors, some "walk-in," some essentially salaried. When they are added in, about half of all blood is bought for cash, about forty per cent is exchanged for other blood, about seven per cent is voluntarily given, and the residue comes from the captive voluntary donor.⁵

Only the most fragmentary information exists on the demographic and socio-economic classification of blood donors. One blood bank, drawing mainly on replacement and individual and group credit donors, found that its donors were predominantly male, and somewhat younger and of higher socio-economic status than the community at large. Presumably this reflects the middle-class character of most tied programs. Data from blood banks, whether profit-making or not, which draw mainly on paid donors exhibit the expected heavy dependence on the low-paid occupational groups and, especially, on the unemployed. The Skid Row donor is real, but there are, no doubt, some who sell blood for bread, not booze.

II.

Which system works better? Even leaving aside moral and aesthetic considerations, there are several criteria against which one could judge. On all of them, the British seem to do as well or better, usually much better.

Both systems manage to collect about the same amount of blood in total, with due allowance for the different size of the two countries.

4. Pp. 84-89.

5. P. 96.

The statistics do not permit any precise comparison. Nevertheless, the official figures for England and Wales show that in the late 1960s the number of donations was about three per hundred of population; the fragmentary data for the United States suggest something similar. Plasmapheresis adds something to the American collections.

On the other hand, a much larger fraction of the available blood is wasted in the United States. (Blood can be safely stored only for about twenty days; outdated blood can, however, be converted to dried plasma and other products which last for much longer.) If conversion to plasma is not counted as waste, only a tiny fraction of blood collected in England and Wales is wasted—something like one to two per cent. On this question the American statistics are particularly unsatisfactory, with differential under-reporting of collections and transfusions, and no clear measure of the amount of outdated blood converted to plasma. In some years the apparent gap between collections and transfusions is as much as a third of collections. Actual waste must be less, because of conversion. If the rate of conversion is extrapolated from British data, and other similar guesses are made, it appears that the wastage rate in the United States is no lower than ten per cent of collections and may be higher than that. One may say, then, that the American system wastes about ten times as much blood as the British, proportionately, despite the fact that blood is expensive in the United States and "free" in Great Britain.⁶

This waste results from defects in planning and administration, from failures to match demand and supply properly, from the over-ordering and hoarding of blood by hospitals and blood banks, from incorrect estimates of the demand for blood by type, from transportation delays, and other such factors in the system. A different kind of waste is the medically unnecessary use of blood, but of course it is intrinsically impossible to have complete data on this. One survey in London suggested that six and one-half per cent of the blood use was medically unnecessary. One is tempted to say that the figure must be lower in a system in which hospitals and patients pay for blood, but it is precisely Titmuss's point that one ought not to say that, and the figures on administrative waste suggest that he is right. In any case, unnecessary surgery and unnecessary transfusions are certainly not unknown in the United States, but Titmuss quotes no figure comparable with the one just given for London. He mentions one survey of five common opera-

6. Pp. 22-23, 56-58.

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tions on two million patients in 1959-1962 which estimated a waste of 160,000 pints of blood, but gives no survey figure for the total use of blood, which could, but need not, exceed 2,000,000 pints.⁷

Waste of blood is not logically incompatible with the existence of occasional and local shortages of blood; supreme inefficiency might permit waste and near-chronic shortage to co-exist. Here again, Titmuss argues that the British system has proved superior. He claims that there have not been any significant or prolonged shortages of blood in England and Wales since 1948. In contrast, he is able to cite a number of statements by American students and medical men asserting that many hospitals and areas are chronically short of blood, and that elective surgery is frequently postponed or cancelled because the required blood is unavailable. He concludes: "Among the large urban and metropolitan areas only a minority of places . . . appear to have no chronic shortages of fresh blood. Generally, throughout the United States, there are widespread reports from many areas and by numerous experts of actual and potential demand exceeding the available supply of blood."⁸

This is not quite the same thing as data. Some mildly contradictory evidence is contained in a small mail survey of consultants to the National Blood Transfusion Service conducted by two English economists.⁹ It is a very small sample, with a response rate of only about a half. But thirty-six per cent of the surgeons who replied reported that they had "sometimes" postponed operations for lack of blood supply. (Another one per cent replied that they had "often" done so.) Some twenty-two per cent had "sometimes" experienced undue delay in obtaining emergency supplies through the NBTS (plus two per cent who had "often" experienced such delays). Nevertheless, in the full sample of physicians and surgeons, fifty-five per cent characterized the blood supplies to their hospitals as "excellent," forty-one per cent as "adequate," and only four per cent as "poor." It is very difficult to weigh this sort of evidence against a culling of alarmist statements about the situation in the United States. It is hard to escape the conclusion, however, that the British have it at least an order of magnitude better.

There is one other standard against which one can compare the two

7. Pp. 196-97.

8. P. 65.

9. M. COOPER & A. CULYER, *THE PRICE OF BLOOD 18-19* (1968). It should be noted that Cooper and Culyer are diametrically at odds with Titmuss's attitudes; their pamphlet is indeed an attempt to make the case for the buying and selling of blood in Britain. I shall come back to it later.

systems for supplying blood: the quality of the product. The main risk is serum hepatitis, incurred by transfusion recipients from contaminated blood. There are reports that three and six-tenths per cent of all transfused hospital patients in the United States later contracted the disease. Serum hepatitis has been said by the *Journal of the American Medical Association* to cause death in about one of 150 transfusions in persons older than forty (who receive much of the blood).¹⁰ In Great Britain, no study (there have only been a few) shows the incidence of hepatitis following transfusions to be greater than one per cent, and the most recent study estimates the risk to be negligible.¹¹

There appears to be no practical way to test donated blood for hepatitis. The only protection against contaminated blood is the willingness of the prospective donor to report that he has had or been exposed to hepatitis, if he knows it. It is evident that in any system in which blood is sold for money by donors who need the money, the donor has a motive to conceal his history of hepatitis if he has one and knows it. Further, since sellers of blood will come predominantly from the poor—not to mention the Skid Row syndrome—prospective donors can be expected to have a higher incidence of hepatitis than the population at large, and less knowledge of it. It is hardly a surprise, then, that “many studies in different parts of the United States have incriminated the paid donor (and blood obtained from commercial blood banks) as the major source of infection.”¹²

Moreover, hepatitis can be transmitted in plasma as well as in whole blood. Since plasma is often pooled from the blood of several hundred donors, one or two of whom can infect the whole lot, the risk from large-pool plasma is very high, though it is cheap and easy to process. In Britain, the risk is recognized and small-pool plasma (from fewer than ten donors) became the rule in 1945.¹³

By all these measures—and remember that I have not yet mentioned the morality of a system in which poor people sell their blood for the use of rich people who buy it—the British system seems to be far more efficient—more economical, one might say—than the American. There is a certain paradox, then, in the fact that in England blood is free, whereas here blood is dear.

10. P. 145.

11. Pp. 154-55.

12. Pp. 147-48.

13. Pp. 145-52.

III.

Titmuss thinks he understands why this happens, though I do not recall that he ever states clearly and concisely his view of the causal connection. I imagine it goes something like this.

Contrary to the view of "economists," it is precisely the element of commercialism that causes the American system to operate so badly, and precisely its absence that permits the British system to operate so well. There is in ordinary people a very large (inexhaustible?) fund of altruism, of feelings of solidarity, of willingness or need to enter into gift relationships.¹⁴ The British system taps this and finds as much as it needs.

Even a small admixture of commercialism, however, is enough to poison the well. The altruistic impulse is diminished or destroyed by the realization that what one is offering as a gift others are selling as a commodity. The existence of a market sector thus contaminates the voluntary system. The attitude of personal caring disappears; perhaps this accounts for the greater waste in the American system. Titmuss goes so far as to argue that the buying and selling of some blood is a narrowing of the freedom of potential voluntary donors; it restricts the "freedom to give" because one can not give and get satisfaction from giving what is elsewhere entering the market.¹⁵

It is not a convincing argument. We can all agree on one point, that the use of paid donors must be responsible for the substantial and growing risk of hepatitis from transfusion. A history of hepatitis and the

14. Obviously the gift of blood is not like a birthday present. Usually the donor and recipient never meet, do not know each other, do not even know each other's name. Nor is there really much resemblance between giving blood and the Melanesian kula or the Pacific Northwest potlatch, as Titmuss suggests there is. See M. MAUSS, *THE GIFT* (I. Cunnison transl. 1954) (originally published in 1925 as *ESSAI SUR LE DON, FORME ARCHAÏQUE DE L'ÉCHANGE*). The latter customs are in large part formal ceremonies; there is also a much larger element of exchange, and a definite tinge of aggression (*Id.* at 35). One motive for giving blood is certainly the wish to help maintain a system of which one might sometime be a beneficiary. But more usually it seems closer to a contribution than to a gift, for example the donation of goods or money to the victims of a famine or a flood. It is an important element, I think, that the thing given has only slight value to the giver, but very great value to the recipient.

15. At times one senses that Titmuss is going even further, to a claim that doing away with markets not only avoids pollution of altruism, but absolutely encourages more altruism. This line of argument is similar to the claim of anarchists, from Godwin to Kropotkin, that if only the whole panoply of harmful institutions could be disassembled, there would be found enough sense of one's responsibility for others, enough mutual aid, to provide for everyone's needs without compulsion. This claim is difficult enough to evaluate when made cleanly. But it is not Titmuss's claim. At least in this book, Titmuss seems to suggest that a fund of altruism can be released in one context at a time, without need for a transformation of society altogether. The selling of soap is commercial in Britain too. In any event, Titmuss has trouble enough advancing the position that markets are evil because they kill altruism. This review is directed at that narrower thesis.

motive to conceal it are likely to coincide only in those who sell blood for money. But the rest of the story seems far-fetched. I know that on none of the many occasions on which I have failed to appear at the local Bloodmobile has my realization of the existence of a market in blood played the slightest part. Each reader of this review can ask himself the same question. Professor Nathan Glazer did ask some students on the occasion of a Harvard University blood drive; this consideration was never raised.¹⁶ I would be tempted to guess that the historical connection was just the reverse: that the purchase-and-sale sector made headway in the United States only when the voluntary system proved inadequate to supply the medical needs for blood.

There are some tantalizing loose ends in Titmuss's work that might have yielded more light on this issue had they been followed up. In isolation, they merely cast doubt on Titmuss's hypothesis. We learn, for instance, that ". . . Seattle, which had one of the best organized and effective blood banking and cross-matching agencies in the country . . . , and which collected 35,000 units annually, reported in recent years an outdated proportion of less than 2 per cent."¹⁷ One wonders why. Was there no access to paid donors in Seattle, or did hospitals there charge patients in some different and less commercial way? We are not told, though there is an indication that Seattle did have commercial blood banking, and even bought blood from derelicts.¹⁸

Similarly, the chapter on practices in other countries is all too short. One table states that half of the blood used in the Soviet Union comes from paid donors (and the fee paid is very high), as does forty per cent in Czechoslovakia and Hungary, and seventy-five per cent in Rumania.¹⁹ One would like to know the consequences of the purchase of blood in those very different institutional settings. It turns out that East Germany pays eighty-five per cent of its donors and West Germany something between forty and eighty-five per cent. Surely it would be interesting to compare those two systems. Denmark buys "some," and Sweden buys all of its blood though patients are not charged; France bought a "small" amount, and Italy a "substantial" amount in 1950-60.²⁰ How much difference does this make in the way the system works?

I do not mean to make work for an author, but merely to suggest that there may not be enough information in a simple comparison of Brit-

16. Glazer, *Blood*, THE PUBLIC INTEREST, Summer 1971, at 89.

17. P. 65.

18. P. 113.

19. Pp. 174-75.

20. *Id.*

ain and the United States to support any firm conclusion whatever about the causes of the difference in efficiency. It would be equally plausible, I think, to connect the difference in blood distribution systems with other historically conditioned differences between Great Britain in particular and the United States in particular, not least the existence of the National Health Service itself. More fancifully, I suspect there is a trace of Dunkirk still in those voluntary blood-donation sessions,²¹ or a little bit of the tight little island with its tradition of civic-mindedness, as compared with the larger, ethnically and geographically more heterogeneous, society of the United States. To put it at its strongest, I doubt that abolishing the purchase of blood or payment for transfusions would transform the American blood collection and distribution system into something that worked as well as the British.²²

This is not the only instance in which Professor Titmuss overestimates the cogency of his argument. At another point he refers to an earlier discussion of the "social costs arising from the wastes, shortages, inefficiencies, unethical practices and hazards involved in the American commercial blood market. We concluded that despite the difficulties of measuring such costs in money terms a disproportionate part was borne by poor people, the sick and the handicapped."²³ I presume that he is referring back to pages 200-01, but what is found there is by no stretch of the imagination evidence or argument, but merely the same assertion, in roughly the same words. It may in fact be true that the cost of the inefficiency of the American system is distributed regressively between rich and poor, but to say so twice is not more convincing than to say so once.

IV.

Even if Titmuss fails to produce a convincing explanation of the success of the British system and the failure of the American, the facts

21. It is remarkable that in a sample survey of donors' self-perceived reasons for first giving blood, almost twelve per cent of the responses mentioned the 1939-45 war effort or experience in the armed services. Some of another three and one-half per cent classified under "Duty" harked back to the war. And this is a sample in which older people are under-represented. (Some of the donors who began in the Armed Services mention the bait of an off-duty afternoon, or even pressure from above. This is hardly in the Dunkirk line. On the other hand, those replies may be more manner than substance—the respondents are after all back again as purely voluntary donors.)

22. It is doubtful that the American blood system can be transformed at all, except as part of a broader transformation of the whole system for the delivery of medical care. Indeed the waste of blood, so much larger here than in England, occurs after the blood has entered the larger medical system.

23. P. 221.

themselves pose more of a challenge to "economists" than to him. Dennis Robertson once gave a talk entitled "What Do Economists Economize?" His answer was "love"; he meant that altruism is a scarce resource, and the business of economists is to find institutional arrangements that will accomplish society's purposes without depending too much on disinterested kindness. That is what economists since Adam Smith have found so fascinating about the competitive market: that the unrestricted interaction of self-interested people under appropriate conditions²⁴ results in an outcome with certain socially desirable properties willed by none of them.

It is a routine observation that when a resource is made available at a price that does not adequately reflect its scarcity, it will be used wastefully, *i.e.*, in low-priority rather than in high-priority ways (perhaps including conservation). That is the standard case for tolls on congested roads and effluent charges on polluted rivers. Here we are presented with a case in which free blood is adequately supplied and carefully husbanded, while dear blood is wasted and contaminated. Is this reason to doubt the case for congestion tolls and effluent charges? I don't think so. But it is reason to remember that economic reasoning applies only where economic motives predominate.

It is one thing to suggest that the supply of altruism is limited and quite another thing to pretend that no motive but greed ever operated, even "in our culture." It is fair comment, I fear, that some devoted marketeers do just that. There is a pretty example of this in Cooper and Culyer. They say, discussing waste of blood: "If the price (of blood) to hospitals is zero, there will be no incentive to conserve blood to the limit, and hence the amount that would be considered 'adequate' will be larger than the amount that would be considered 'adequate' if a price had to be paid."²⁵ It is a standard economic argument, and I have no doubt that it applies in those situations that are institutionalized as "economic." But it is certainly gratuitous to assert that doctors and hospital administrators respond, presumably necessarily respond, to *no other* stimulus but money. That assertion is not itself economics: it is psychology, and very likely bad psychology.

Over-enthusiastic marketeers sometimes fall into another bad habit. It is a kind of cultivated moral obtuseness. Here is an example from

24. The conditions are pretty stringent: they include the ready availability of knowledge about prices and products to all participants, the absence of monopoly, and the insignificance of those "externalities" that are now beginning to seem very significant indeed.

25. M. COOPER & A. CULYER, *supra* note 9, at 21.

Cooper and Culyer. The text of their pamphlet nowhere mentions the hepatitis problem as a possible or even probable consequence of the introduction of a commercial market for blood. At the end, however, there are some suggested questions for discussion. One of them reads: "There is evidence to show that blood from 'professional' donors is more likely to carry disease. What difference does this make to the economic analysis of this Paper?" And the next question goes: "Is it right to subject patients to additional risks by transfusing them with inferior blood? Compare your answer with treatment by inferior surgeons, hospitals, etc. If inferiority is a reflection of the fundamental fact of scarcity, can anything be done to remove it?"²⁶

I am afraid I can imagine what they would find an acceptable answer to these questions. It would presumably involve the labelling of some blood as "risky" and some as "safe." (Since blood cannot practicably be tested for safety, presumably all blood from paid donors would have to be labelled as risky; perhaps one can imagine several grades according to the type of donor—alcoholic, penniless artist, poor but honest, little old lady. But the grade-labelling would have to be policed to avoid cheating, so there is danger of interference with economic liberty even here.) Risky blood would of course sell at a lower price than safe blood. Poor people would buy cheap blood; rich people could afford safe blood. If that strikes you as awful, reflect on the fundamental fact of scarcity. Upon reflection, it may not be clear to you that the mere fact of scarcity implies that the quality of blood a man receives should be correlated with his capacity to earn income.²⁷ You may even be troubled by the fact that the risky blood gets introduced into an otherwise reasonably satisfactory situation only through Cooper and Culyer's belief that buying and selling blood is a useful practice. Suppose that the introduction of a commercial market would in fact result in some marginal improvement in efficiency (though Titmuss's story suggests it wouldn't). The judgment that such an improvement could justify the creation of differentials in quality of blood received by income class does strike me as morally obtuse.

This leads to a deeper and more important point. In their enthusiasm for market allocations, many economists seem to drift into assertions that go beyond what economic analysis will support. The nice thing

26. *Id.* at 46.

27. Should the cut of meat a man eats be correlated with his capacity to earn income? It would carry me too far afield to discuss that question here. Perhaps most readers would agree that it is worse that poor people should be transfused with risky blood than that they should eat inferior meat.

about free competitive markets is that—under the right conditions, some of which I mentioned earlier—they lead to outcomes that are Pareto-efficient or Pareto-optimal, to use the technical term. That means that the final situation is such that no physically feasible shift of resources could make everyone better off (or at least make some people better off without making anyone worse off). “Better off” means better off in one’s own estimation.

Inefficient situations are clearly bad in the sense that some physically feasible efficient situation can be found in which everyone is better off. It would be better to be in that efficient situation. Any efficient situation is certainly better than certain inefficient situations, namely, those in which everyone is worse off. But it is definitely not true that any efficient situation is better than any inefficient situation. *A* may be an efficient situation and *B* an inefficient one; but some people may be better off in *B* than they would be in *A*, though others must be better off in *A*. We would say that the distribution of income differs between *A* and *B*. The economist has no technical right to recommend a move from *B* to *A*. He can recommend a move from *B* to one of the efficient situations that is clearly superior to *B*, say *C*; or, which comes to the same thing, he could recommend a move from *B* to *A* accompanied by a redistribution of income that would be, in effect, a move from *A* to *C*. Without the redistribution, there is no sense in which *A* is economically better than *B*.

This is old stuff in welfare economics, but it is sometimes forgotten in the heat of advocacy. Suppose some scarce resource is being distributed free or at some artificially low (or high) price that does not adequately reflect the cost of making it available. If economic motives predominate, the resource will be over-used (or under-used) in the sense that everyone could be made better off if less (or more) of this resource were produced and consumed and the production and consumption of other things were increased (or decreased). This is Cooper and Culyer’s case for pricing blood, except that they merely assume that only economic motives can matter. Going over to rational pricing will almost always have distributional effects as well as efficiency effects; in fact there is usually a sense in which the distributional effects are first-order and the efficiency effects second-order. Suppose I protest that the introduction of rational pricing will hurt the poor or the innocent or the worthy and help the rich or the slick or the unworthy. The marketer’s response is that the right way to help the poor is directly through transfers of purchasing power; there is no virtue in generating wasteful misallocation of resources in order to bring about a desirable

distribution of income when direct non-distorting methods are available. He is right about that. Well, then, he goes on, you think about what to do next, and in the meanwhile let's have rational pricing of whatever-it-is and get rid of the inefficiency. But there he is wrong. An improvement in efficiency accompanied by adverse distributional effects is not a good thing pending corrective redistribution. It is a good thing only when it is accompanied by corrective redistribution.

This proposition cuts both ways. I have alluded to the unattractiveness of a system in which the poor sell their blood to the rich. The marketer replies: to eliminate that possibility will do harm to the poor as well as to the rich, perhaps more harm to the poor than to the rich. Leaving aside addicts, alcoholics, and other incompetents, those who sell blood receive something in exchange of greater value to them, else they wouldn't do as they do. Now it is my turn to say that there are better ways of increasing the income of the poor to the point where they would cease supplying blood for money even if the opportunity remained. But it is not enough to say that there are better ways. Unless they are actually effective, to cut off the option of selling blood is to satisfy my moral judgments at the expense of those who would voluntarily choose that option.

In summary, some of Timuss's complaints about the enthusiasts of the market are valid. But they are valid complaints about invalid overextensions of economic reasoning, not about economic reasoning itself. The dichotomy between efficiency and distribution is a necessary analytical distinction, not a justification for regressive policy measures.

V.

There is another side to the coin. Efficiency in the use of scarce resources is a worthwhile goal. If you believe that, and if you believe, in addition, that autonomy of the individual decision-making person is a good thing, then you ought to find the free competitive market an attractive way to organize a lot of activities, *provided the distribution of income is fair*. In a society of equals or near-equals, one might even look more kindly on the sale of blood, though I can easily understand and share the feeling that might make one wish to prevent it as one would wish to prevent people from selling their eyes or kidneys or votes or selling themselves into slavery.

Titmuss, on the contrary, is rather down on buying and selling, sometimes for defensible reasons, sometimes for poor reasons, sometimes for reasons of taste on which right-thinking people need not agree. For

example, there are some things or services that are best kept from the market, not because it would be technically difficult or inefficient to market them, but because the "social" consequences would be bad even if the narrowly "economic" consequences were good. I would rather say that if, in total, the social consequences are bad then the economic consequences are bad too, and only appear to be good because the accounting is incomplete. But that is a quibble about words; the point is that it may well be socially destructive to admit the routine exchangeability of certain things. We would prefer to maintain that they are beyond price (although this sometimes means only that we would prefer not to know what the price really is).

I have already mentioned Titmuss's argument that the economist's attempts to economize on altruism merely destroy more altruism than they save. There is no intellectual difficulty here; anyone, economist or other, would recognize that as false economy. But Titmuss makes a very weak case for this belief; it can hardly be regarded as established in general, or even in the specific instance of blood donation.

A less legitimate argument occasionally crops up in this book and elsewhere. It is an old thought that to put something in correspondence with "money" is to dirty or demean it. But there is a confusion here. Money itself is surely more or less irrelevant; a return to barter would not eliminate the moral problems connected with buying and selling. Whenever people must choose among alternatives, they must somehow reduce their preferences to some kind of common denominator, if only the intensity of desire itself: I want *X* more than *Y* and *Y* more than *Z*, so that if presented with a choice I will choose *X*. If people must exchange with one another, they will certainly have to represent and discuss the terms on which they are prepared to exchange units of *X* for *Y* and units of *Y* for *Z*. I can see no special moral problem that arises when relative prices are expressed in money terms. Quite the contrary, though it has become less fashionable to say so, there are real *moral* as well as economic advantages in having an impersonal, universalistic way for people to express and exhibit the strength of their preferences. Prescription by authority or ascription by custom and status are not always attractive alternatives to the market registration of the sum of individual wishes.

Allocation through a market will work only where autonomous individuals must exchange resources, each trying to do the best for himself according to his own preferences. Allocation through a market will seem morally right only in spheres in which self-interest is an approved motive and it is felt to be right that individual preferences should count. It

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would be a grim world if that covered everything. But it would be a very difficult world to organize in a decentralized way if that covered nothing. *Given rough equality*, I should think the free market provides a tolerable and even preferable way of organizing a fairly large area of economic activity. One of the reasons Professor Titmuss disagrees—if, as I think, he does disagree—is that he seems to attribute somewhat less importance to the notion that individual preferences should count. There is a slight, rather typically Fabian, authoritarian streak in Titmuss; he seems to believe that ordinary people ought to be happy to have many decisions made for them by professional experts who will, fortunately, often turn out to be moderately well-born Englishmen.

