choice and "the welfare state"

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SOCIALISM AFFLUENCE

fabian tract 370
choice and "the welfare state"

contents

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1. introduction

For those of us who are still socialists the development of socialist social policies in the next few years will represent one of the cardinal tests on which the Labour Government will be judged—and sternly judged—in the early 1970's. Economic growth, productivity and change are essential; about this there can be no dispute. But as we—as a society—become richer shall we become more equal in social, educational and material terms? What does the rise of "affluence" spell to the values embodied in the notion of social welfare?

For the purposes of this pamphlet I have, in asking these questions, to take a long view and disregard our immediate economic and social problems. One assumption I have to make is that over the next ten years (and thereafter) British society will be substantially richer; that, on average, the population of Britain will be living at a higher standard than today. In his pamphlet *Labour's social plans* (Fabian tract 369) Professor Abel-Smith dealt with what he called the "ugly imbalance between private affluence and public squalor," and went on to direct a searching attack on the social policy content of the Government's *National plan* (Cmnd 2764, HMSO, September 1965)

He assumed (as I do) that over the period of the *National plan* we may expect to be (in company with other highly industrialised countries of the West) a richer society in the 1970's. Now that the Government has begun to lay a sounder basis for a higher rate of growth in the future after inheriting a decade or more of incompetence and dereliction it is, I think, more rather than less likely that our economic targets will be broadly attained.

But, at the present time, economic and industrial policies are involving much hardship for a minority of workers; whether this was or was not inevitable is a matter on which a great deal more could be said, and no doubt will be said. The acid test will come, however, in the next few years; there will be many who will want to know by the time the life of this Government comes to its natural end whether those who are making sacrifices now in the general interest will be more than justly compensated.

The role of social policy

This question of who should bear the social and economic costs of change is relevant to the larger issue of the future role of the social services in a more affluent society. First, however, let us remember the general thesis about "freedom of choice" now being forcefully presented by various schools of "liberal" economists in Britain, Western Germany and the United States—notably in the writings of Professor Friedman of Chicago and his friends and followers in London and elsewhere (M. Friedman, *Capitalism and Freedom*, University of Chicago Press,

1962) Broadly, their argument is that as large-scale industrialised societies get richer the vast majority of their populations will have incomes and assets large enough to satisfy their own social welfare needs in the private market without help from the State. They should have the right and the freedom to decide their own individual resource preferences and priorities and to buy from the private market their own preferred quantities of medical care, education, social security, housing and other services.

Unlike their distinguished predecessors in the nineteenth century, these economic analysts and politicians do not now condemn such instruments of social policy (in the form of social services) as politically irrelevant or mistaken in the past. They were needed then as temporary, *ad hoc* political mechanisms to ameliorate and reduce social conflict; to protect the rights of property, and to avoid resort to violence by the dispossessed and the deprived. This contemporary redefinition of the past role of social policy thus represents it as a form of social control; as a temporary short-term process of State intervention to buttress and legitimate industrial capitalism during its early, faltering but formative years of growth. We are now told that those who in the past were critical of State intervention in the guise of free social services were misguided and short-sighted. The Bourbons of today disavow the Bourbons of yesterday. The times, the concepts, the working classes, and the market have all changed. They have been changed by affluence, by technology, and by the development of more sophisticated, anonymous and flexible mechanisms of the market to meet social needs, to enlarge the freedom of consumer choice, and to provide not only more but better quality medical care, education, social security and housing.

In abbreviated form, these are some of the theories of private social policy and consumer choice now being advanced in Britain and other countries. Like other conceptions of social policy presented in large and all embracing terms, these theories make a number of basic assumptions about the working of the market, about the nature of social needs, and about the future social and economic characteristics of our societies. These assumptions require examination. (See, for example, D. S. Lees, "Health Through Choice" in R. Harris, *Freedom or free-for-all?* Hobart papers vol 3, The Institute of Economic Affairs, 1965 and E. G. West, *Education and the State*, The Institute of Economic Affairs, 1965)

I cannot, however, discuss them all in as much detail as I would like in this pamphlet. I propose, therefore, to make more explicit four important assumptions and, in respect of each, to raise some questions and add some comments.

2. the economic growth solution

Assumption no 1—That economic growth without the intervention of comprehensive and deliberately redistributive social policies can, by itself alone, solve the problem of poverty.

None of the evidence for Britain and the United States over the past twenty years during which the average standard of living in real terms rose by fifty per cent or more supports this assumption. The most recent evidence for Britain has been examined by Professors Abel-Smith and Townsend in their study *The poor and the poorest* (Occasional papers on social administration, no 17, Bell and sons, 1965). Had private markets in education, medical care and social security been substituted for public policies during the past twenty years of economic growth their conclusions, in both absolute and relative terms, as to the extent of poverty in Britain today would, I suggest, have been even more striking.

economic growth and poverty in the United States

For the United States the evidence is no less conclusive and can be found in the recent studies of Orshansky, Brady, S. M. Miller and Rein, Moynihan, Schorr, Herman Miller and Richard Elman whose book *The poorhouse state: The American way of life on public assistance* (Pantheon Books, New York, 1966) provides a grim picture of degradation in the richest country the world has ever known.

Yet, in 1951, the first chairman of the Council of Economic Advisors under the Eisenhower administration said, before his appointment to the Council " . . . the transformation in the distribution of our national income . . . may already be counted as one of the great social revolutions in history." (Quoted in H. T. Miller ' Is the income gap closed ? ' No ' ? " *New York Times Magazine*, 11 November 962)

Economic growth spelt progress; an evolutionary and inevitable faith that social growth would accompany economic growth. Automatically, therefore, poverty would gracefully succumb to the diffusion of the choices of private market abundance. All this heralded, as Daniel Bell and others were later to argue, the end of ideological conflict. (D. Bell, *The end of ideology: on the exhaustion of political ideas in the fifties*, New York, Collier Books, 1961)

One is led to wonder what liberal economists would have said fifteen to twenty years ago had they had foreknowledge of the growth in American wealth and had they then been asked to comment on the following facts for the year 1966: that one American child in four would be regarded as living in poverty and that three elderly persons in ten would also be living in poverty (M. Orshansky in *Social*

security bulletin, July 1963, January 1965 and July 1965, Social security administration, US department of health, education and welfare); that the United States would be moving towards a more unequal distribution of income, wealth and command-over-resources (D. S. Brady, *Age and the income distribution*, Research report no 8, Social security administration, department of health, education, and welfare, 1965. For other evidence of recent trends see S. M. Miller and M. Rein, "Poverty, inequality and policy" in H. S. Becker (ed), *Social problems*, John Wiley and Son, New York); that many grey areas would have become ghettoes (see D. R. Hunter, *The slums: challenge and response*, New York, Glencoe Free Press, 1964; H. Gans, *The Urban Villagers*. New York, Glencoe Free Press, 1962; K. E. Taeuber, *Scientific American*, 1965, vol 213, no 2; and K. E. and F. Alma Taeuber, *Negroes in cities: residential segregation and neighbourhood change*, Chicago, Aldine, 1965); that a nationwide civil rights' challenge of explosive magnitude would have to be faced—a challenge for freedom of choice, for the right to work, for a non-rat infested home, for medical care and against stigma (*The Negro family: the case for national action*, Office of policy planning and Research, US Department of Labour, 1965); that, as a nation, the United States would be seriously short of doctors, scientists, teachers, social workers, nurses, welfare aids and professional workers in almost all categories of personal service; and that American agencies would be deliberately recruiting and organising the import of doctors, nurses and other categories of human capital from less affluent nations of the world.

shortage of doctors in Britain

Britain, we should remember, is also relying heavily on the skills of doctors from poorer countries—due in part to the belief less than five to ten years ago among Conservative Ministers and leaders of the medical profession that we were in danger of training too many doctors. And, we should add, the belief among liberal economists and sections of the medical profession that Britain was spending too much on the Health Service which was in danger of bankrupting the nation.

Seven of the eleven-man committee which drew up the Ministry of Health and Department of Health for Scotland's *Report of the Committee to consider the future numbers of medical practitioners and the appropriate intake of medical students* (HMSO, 1957), were eminent members of the medical profession and the chairman was an ex-Minister of Health, Sir Henry Willink. In May 1962 a special committee set up by the British Medical Association to consider recruitment to the medical profession concluded in its report that in spite of certain obvious indications of a shortage of doctors it was not prepared to commit itself on the need for more medical students. (*The Times*, 11 May 1962) Dr. R. G. Gibson, chairman of this committee (and now Chairman of the Council),

said two months later that the profession had recently experienced a "glut of doctors. At present there seemed to be a shortage, but care must be taken not to create unemployment in the profession a few years from now." (*British medical journal*, supplement, ii, 26, 28 July 1962).

Guilty as we have been and are in our treatment of doctors from overseas, at least it cannot be said that we are deliberately organising recruitment campaigns in India, Pakistan and other developing countries.

3. the private markets solution

Assumption no 2: That private markets in welfare can solve the problem of discrimination and stigma.

This assumption takes us to the centre of all speculations about choice in welfare and the conflict between universalist social services and selective means-tested systems for the poor. It is basically the problem of stigma or "spoiled identity" in Goffman's phrase (E. Goffman, *Stigma: notes on the management of spoiled identity*, Prentice Hall, NJ 1963); of felt and experienced discrimination and disapproval on grounds of poverty, ethnic group, class, mental fitness and other criteria of "bad risks" in all the complex processes of selection-rejection in our societies.

How does the private market in education, social security, industrial injuries insurance, rehabilitation, mental health services and medical care, operating on the basis of ability to pay and profitability, treat poor minority groups? All the evidence, particularly from the United States and Canada, suggests that they are categorised as "bad risks," treated as second class consumers, and excluded from the middle-class world of welfare. If they are excluded because they cannot pay or are likely to have above-average needs—and are offered second-class standards in a refurbished public assistance or panel system—who can blame them if they come to think that they have been discriminated against on grounds of colour and other criteria of rejection? Civil rights legislation in Britain to police the commercial insurance companies, the British United Provident Association, and the BMA's Independent Medical Services Ltd. would be a poor and ineffective substitute for the National Health Service.

Already there is evidence from recently established independent fee-paying medical practices that the "bad risks" are being excluded, and that the chronic sick are being advised to stay (if they can) with the National Health Service. (S. Mencher, *Private practice and the National Health Service*, pp 130-6, to be published). They are not offered the choice though they may be able to pay. In point of fact, their ability to choose a local doctor under the Health Service is being narrowed. This is a consequence, I suppose, of what Mr. Arthur Seldon of the Institute of Economic Affairs in his most recent essay on "choice in welfare" describes as "a new stirring in medical insurance and a new class of doctors with a grain of entrepreneurial determination to supplement or abandon the NHS and to find salvation in the market." ("Which way to welfare," *Lloyds Bank Review*, October 1966).

The essential issue here of discrimination is not the problem of choice in private welfare markets for the upper and middle classes but how to channel proportionately more economic and social resources to aid the poor, the handicapped, the

educationally deprived and other minority groups, and to compensate them for bearing part of the costs of other people's progress. We cannot now, just because we are getting richer, disengage ourselves from the fundamental challenge of distributing social rights without stigma; too many unfulfilled expectations have been created, and we can no longer fall back on the *rationale* that our economies are too poor to avoid hurting people. Nor can we solve the problems of discrimination and stigma by re-creating poor law or panel systems of welfare in the belief that we should thereby be able to concentrate state help on those whose needs are greatest. Separate state systems for the poor, operating in the context of powerful private welfare markets, tend to become poor standard systems. Insofar as they are able to recruit at all for education, medical care and other services, they tend to recruit the worst rather than the best teachers, doctors, nurses, administrators and other categories of staff upon whom the quality of service so much depends. And if the quality of personal service is low, there will be less freedom of choice and more felt discrimination.

4. do private markets offer more choice?

Assumption no 3: That private markets in welfare would offer consumers more choice.

As I have said, the growth of private markets in medical care, education and other welfare services, based on ability to pay and not on criteria of need, has the effects of limiting and narrowing choice for those who depend on or who prefer to use the public services.

But let us be more specific, remembering that the essential question is: *whose* freedom of choice. Let us consider this question of choice in the one field—private pension schemes—where the insurance market already operates to a substantial extent and where the philosophy of "free pensions for free men" holds sway. (A. Seldon, *Pensions in a free society*, Institute of Economic Affairs, 1957). It is, for example, maintained by the insurance industry that private schemes "are arrangements made voluntarily by individual employers with their own workers." (Life Offices' Association, *The pension problem: a statement of principle and a review of the Labour Party's proposals*, 1957, p3); that they are tailor-made and shaped to meet individual (consumer) requirements. This is, *par excellence*, the model of consumer choice in the private welfare market.

What are the facts? For the vast majority of workers covered by such private schemes there is no choice. Private schemes are compulsory. Workers are not offered the choice of deferred pay or higher wages; funded schemes or pay-as-you-go schemes. They are not asked to choose between contributory or non-contributory schemes; between flat-rate systems or earnings related systems. Despite consumer evidence of a widespread wish for the provision of widows' benefits, employees are not asked to choose. There is virtually no consultation with employees or their representatives. They have no control whatsoever over the investment of funds in the hands of private insurance companies which now total some £2,500 millions (W. G. Nursaw, *Principles of pension fund investment*, p19, 1966) And, most important of all, they are rarely offered on redundancy or if they freely wish to change their jobs the choice of full preservation of pension rights. (See Report of a committee of the National Joint Advisory Council, *Preservation of pension rights*, Ministry of Labour, HMSO, 1966; the Government Actuary, *Occupational pension schemes: a new survey*, HMSO, 1966, and two forthcoming studies by T. A. Lynes, *Pensions and democracy*, and *Pensions in France*, occasional papers in social administration).

These issues of transferability and the full preservation of pension rights underline strongly the urgency and importance of the Government's current review of social security. We have now been talking for over ten years about the need for freedom of industrial movement, full transferability, and adequate, value-protected pensions

as " of right ' in old age; it is time the Government's proposals were made known. But they cannot now help with the immediate problem of the redundant workers in the Midlands and other parts of the country. Have these workers forfeited their full occupational pension expectations ? What choices have been concretely offered to them by the private pension market ? I have seen no statements or surveys or reports from the insurance industry or from the Institute of Economic Affairs. Surely, here was a situation in which one might have expected the protagonists of private welfare markets to have assembled the facts, and to have demonstrated the superiority of practice as well as theory in the matter of consumer choice. But it looks as though they failed in 1966 as they failed in 1956 when the British Motor Corporation announced on the 27 June that 6,000 employees would be sacked on the 29 June. (H. R. Kahn, *Repercussions of redundancy*, Allen and Unwin, 1965) They were not offered the choice of full preservation of accrued-pension rights.

5. should medical care be bought?

Assumption no 4: That social services in kind, particularly medical care, have no characteristics which differentiate them from goods in the private market.

I propose to consider this last assumption in relation to medical care, and to pursue a little more intensively some of the central issues which I raised in "Ethics and economics of medical care" (*Medical care*, vol 1, no 1, 1963, p16. See also criticisms of this article by Professor Lees, Professor Jewkes and others in *Medical care*, vol 1, no 4, 1963, pp 234-44, and D. S. Lees, "Health through choice" in *Freedom or free-for-all?* (Ed R. Harris), Hobart Papers vol 3, the Institute of Economic Affairs, 1965). This article was written in response to the thesis advanced by certain "liberal" economists in Britain and the United States who, after applying neo-classical economic theory to Western-type systems of medical care, concluded that "medical care would appear to have no characteristics which differentiate it sharply from other goods in the market." (D. S. Lees, *ibid*, pp 37-9 and 86-7). It should, therefore, be treated as a personal consumption good indistinguishable in principle from other goods. Consequently, and in terms of political action, private markets in medical care should be substituted for public markets. In support of this conclusion it is argued that the "delicate, anonymous, continuous and pervasive" mechanism of the private market (D. S. Lees, *ibid*, p64) not only makes more consumer choice possible but provides better services for a more discriminating public. Choice stimulates discrimination which, in turn, enlarges choice.

This thesis is usually presented as applying universally and in terms of the past as well as the present. It is presumed to apply to contemporary India and Tanzania as well as nineteenth-century Britain. It is, therefore, as a theoretical construct "culture free." It is also said to be value free. Medical care is a utility and all utilities are good things. But as we cannot measure the satisfactions of utilities—or compare individual satisfactions derived from different utilities—we should rely on "revealed preferences." Observable market behaviour will show what an individual chooses. Preference is what individuals prefer; no collective value judgment is consequently said to be involved.

In applying this body of doctrine to medical care we have to consider a large number of characteristics (or factors) which may or may not be said to differentiate medical care from personal consumption goods in the market. I want to concentrate discussion on two of these factors, chiefly because I believe that one of them is central to the whole debate about medical care, and because both of them tend to be either ignored or treated superficially by most writers on the subject. Broadly, they centre around the problems of uncertainty and unpredictability in medical

care and, secondly, the difficulty, in theory as well as in practice, of treating medical care as a conceptual entity.

Consider first the problems of uncertainty which confront the consumer of medical care. Then contrast them with the problems of the consumer of, say, cars; there is clearly a risk to life in both situations if wrong choices are made. It is argued, for example, by Professor Lees and others that the market for consumer durables is affected both by unpredictability of personal demand and consumer ignorance about needs. (D. S. Lees, *ibid*, p87). The more significant differentiating characteristics in the area of medical care would appear to be (though this is by no means an exhaustive list) :

1. Many consumers do not desire medical care.

2. Many consumers do not know they need medical care.

3. Consumers who want medical care do not know in advance how much medical care they need and what it will cost.

4. Consumers do not know and can rarely estimate in advance what particular categories of medical care they are purchasing (such as surgical procedures, diagnostic tests, drugs, and so on).

5. Consumers can seldom learn from experience of previous episodes of medical care consumption (not only do illnesses, or "needs," vary greatly but utility variability in medical care is generally far greater than is the case with consumer durables).

6. Most consumers cannot assess the value of medical care (before, during or after consumption) as an independent variable. They cannot be sure, therefore, whether they have received "good" or "bad" medical care. Moreover, the time-scale needed for assessment may be the total life duration.

7. Most consumers of medical care enter the doctor-patient relationship on an unequal basis; they believe that the doctor or surgeon knows best. Unlike market relationships in the case of consumer durables, they know that this special inequality in knowledge and techniques cannot for all practical purposes be reversed.

8. Medical care can seldom be returned to the seller, exchanged for durable goods or discarded. For many people the consequences of consuming medical care are irreversible.

9. Medical care knowledge is not at present a marketable advertised commodity. Nor can consumers exchange comparable valid information about the consumption of " good " or " bad " medical care.

10. Consumers of medical care experience greater difficulties in changing their minds in the course of consuming care than do consumers of durable goods.

11. Consumers of medical care may, knowingly or unknowingly, take part in or be the subject of research, teaching and controlled experiments which may affect the outcome.

12. The concept of " normal " or " average " economic behaviour on the part of adult consumers, built into private enterprise medical care models, cannot be applied automatically to the mentally ill, the mentally retarded, the seriously disabled and other categories of consumer-patients.

13. Similarly, this concept of " normal " behaviour cannot be applied automatically to immigrant populations or peoples with non-Western cultures and different beliefs and value systems.

These thirteen characteristics are indicative of the many subtle aspects of uncertainty and unpredictability which pervade modern medical care systems. " I hold " wrote Professor K. J. Arrow in an article entitled " Uncertainty and the welfare economics of medical care " in the *American economic review* (vol LIII, no 5, December 1963) " that virtually all the special features of this (medical care) industry, in fact, stem from the prevalence of uncertainty."

To grasp fully the significance of these differentiating characteristics, each one of them should be contrasted with the situation of the consumer of cars or other consumption goods; an exercise which I cheerfully leave to the reader.

I turn now to my second set of questions. Many economists who attempt to apply theories and construct models in this particular area conduct their analyses on the assumption that " medical care " is (or can be treated as) an entity. Historically, perhaps this may once have been marginally valid when it consisted almost wholly of the personal doctor-patient relationship. Medical cure, we would now say, was more a matter fifty years ago of spontaneous biological response or random chance.

Science, technology and economic growth have now, however, transformed medical care into a group process : a matter of the organised application of an immense range of specialised skills, techniques, resources and systems. If, therefore, we

now wish to examine medical care from the standpoint of economic theory we need to break down this vague and generalised concept "medical care" into precise and distinctive components.

To illustrate the importance of doing so let us consider one example; probably one of the more critical components in curative medicine today, namely, the procurement, processing, matching, distribution, financing and transfusion of whole human blood. Is human blood a consumption good?

With the data now available relating to different blood procurement programs in various countries, organised on private market principles and community welfare principles, it is now possible to consider these economic theories relating to choice and revealed preferences in respect of this particular component of medical care. Consider, first, the thesis that the "delicate mechanism" of the market works better if left by government to get on with the job: that it is more efficient; provides higher quality services; by allowing choice it generates more demand; and that it results in proportionately higher national expenditures on medical care than socialised systems like the National Health Service. Economists in Britain, West Germany and other countries who advance this thesis support it by drawing on American macro-economic data.

the New York blood transfusion services

It is appropriate, therefore, to examine the blood transfusion services in New York City and contrast them with the National Blood Transfusion Service in England and Wales. National statistics for the USA are fragmentary and defective in many respects. One reason is the great variety from area to area in the programs of the American Red Cross, community, hospital and commercial blood banks and services. More information is, however, available for particular cities and areas. It must not be assumed that what obtains in New York is generally applicable in the USA. For a community of some 8,000,000 people, New York uses about 330,000 pints of blood a year. (The New York Blood Center, *Progress report for* 1965, Community Blood Council of Greater New York, Inc, 1965). In England and Wales in 1965 the number of blood donations totalled approximately 1,300,000. (*Annual report of the Ministry of Health for* 1965, Cmnd 3039, 1966, table 75). It is variously guessed for the USA as a whole that some 6,000,000 pints of blood are collected annually. (American Medical Association, *Directory of blood banking and transfusion facilities and services*, Chicago)

Figures of this order indicate the indispensable and increasingly vital part played by blood transfusion services in modern medicine. The transfer of blood from one human being to another represents one of the greatest therapeutic instruments in

the hands of the doctor. It has made possible the saving of life on a scale undreamt of a few decades ago and for conditions which would then have been considered hopeless. The demand for blood increases yearly in every Western country as new uses are developed ; as more radical surgical techniques are adopted which are associated with the loss of massive amounts of blood ; as road accidents continue to rise ; and with the increasingly widespread use of artificial heart-lung machines in open heart surgery (first developed in Britain in 1950) and for numerous other reasons. It is a precious commodity yet in Britain (with a wholly voluntary program of blood donations) without price. If carelessly or wrongly used it can be more lethal than many drugs. Because of the risks of transmitting the virus of infective hepatitis (homologous serum hepatiitis) and other diseases the most rigorous standards are set in Britain in the selection of blood donors, and in the cross-matching, testing and transfusion of blood.

Not only is human blood potentially lethal to the recipient but it has the critical characteristic of " 21-day perishability." Its value rapidly expires. This particular characteristic presents great administrative and technical problems in the operation of blood transfusion services ; in the estimation of demand for blood of different groups ; in the organisation, planning and execution of blood donor programs ; in the technical organisation of compatibility tests and cross-matching ; and in the distribution of supplies of whole blood in the right quantities and categories, at the right times, and to the right hospitals and the right patients.

After this brief explanation of some of the important factors to bear in mind, I want now to present some information about the present situation in New York. Despite the fact that there are over 150 independent agencies handling blood in New York, some operating on a profit basis and many buying blood from so-called " professional " donors, there is an acute and chronic shortage of blood. (The New York Blood Center, *ibid*, pp 2-11). Operations are postponed daily because of the shortage. " Professional " donors from " Skid row denizens," drug addicts and others who live by selling their blood (at $10 to $25 or more a pint) are often bled more frequently than accepted international standards recommend, and far more frequently than the much higher standard set in Britain. (R. F. Norris, *et al*, *Transfusion*, 3 pp 202-9, 1963, and *Medical World News* 15 March 1963). There is evidence from a number of American cities in which studies have been made that something like 30 to 40 per cent of paid blood donors are unemployed and predominantly unskilled workers. In Chicago, the Blood Donor Service reported a figure of 40.6 per cent for 1965 (personal correspondence with Medical Director, July-August 1966). In 1964, the latest year available, 60 per cent of all donors bled by this Service were paid.

The shortage of blood in New York and other cities is in part due to a large amount

of wasted blood (resulting from blood-hoarding by hospitals and other agencies) and to the hazardous quality of "professional" blood. In consequence, blood charges and blood bills remitted to patients are high. Some commercial blood banks in New York import blood from Tennessee, and such banks in the USA have attempted to import blood from England and Australia.

The New York Academy of Medicine reported in 1956 that the city was relying on "professional" donors to the extent of about 42 per cent for its blood supplies. (*Human blood in New York City*, (privately circulated), New York Academy of Medicine, Committee on Public Health, 1956) In 1965 the estimated figure was 55 per cent. (New York Blood Center, private communication from Dr. A. Kellner, June 1966) "Professional" donors cannot be expected to be as truthful in clinical history-taking as unpaid volunteers. Studies at the University of Chicago and elsewhere have demonstrated that the chances of the "professional" donor being a carrier of hepatitis "are essentially six times greater than those of the volunteer or family donor." (J. Garrott Allen and W. A. Sayman, JAMA, 180: 1079, 1962) The virus cannot be detected in the laboratory. The patient is the test. The doctor is thus faced with the choice of withholding blood or transfusing blood which may have been obtained from a "professional" donor—if he knows, which he rarely does, the source of the blood.

the contrasting situation in Britain

In Britain, the situation is incomparably different. There is no shortage of blood. It is freely donated by the community for the community. It is a free gift from the healthy to the sick irrespective of income, class, ethnic group, religion, private patient or public patient. Since the National Health Service was established the quantity of blood issued to hospitals has risen by 265 per cent. (*Annual Reports of the Ministry of Health*)

The question I have raised whether human blood is a trading commodity, a market good like aspirins or cars, or a service rendered by the community for the community, is no idle academic question asked in a philosophical mood. In the last few years it has become in the USA a battle ground for lawyers and economists. The costs incurred by respondents in debating this question in one case alone (involving the Federal Trade Commission and a blood bank in Kansas City) have amounted to $250,000 (*Transfusion*, 5, 2: 207, March-April 1963) Dr. R. L. Mainwaring, President-elect in 1964 of the American Association of Blood Banks, has said that if blood is legally designated as a commodity (thus endorsing commercial practise) "Hospital insurance rates would go sky high. The laboratory director would not be able to rely on anyone else to screen his blood; he would have to do it himself. And, even with perfect cross-matches he could expect that

one out of every 200 pints he provided would carry hepatitis virus." (*Transfusion*, 4 : 68, 1964)

less choice for the consumer

There is much more that I could say (and shall hope to say elsewhere) on these complex issues. But I find no support here for the model of choice in the private market; on criteria of efficiency, of efficacy, of quality, or of safety. No consumer can estimate, in advance, the nature of these and other hazards; few, in any event, will know that they are to be the recipient of someone else's blood. In this private market in New York and other American cities the consumer is not sovereign. He has less choice; he is simultaneously exposed to greater hazards; he pays a far higher price for a more hazardous service; he pays, in addition, for all the waste in the system; and he further pays for an immense and swollen bureaucracy required to administer a complex banking system of credits, deposits, charges, transfers and so forth. Above all, it is a system which neglects and punishes the indigent, the coloured, the dispossessed and the deviant.

The characteristics of uncertainty and unpredictability are the dominating ones in this particular component of medical care. They are the product of scientific advances accentuated, as this study shows, by the application of inapplicable economic theories to the procurement and distribution of human blood.

I draw one other conclusion from this discussion. Socialism is about community as well as equality. It is about what we contribute without price to the community and how we act and live as socialists—and not just about how we debate socialism.

fabian society

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Enquiries about membership should be sent to the General Secretary, Fabian Society, 11 Dartmouth Street, London, SW1 ; telephone Whitehall 3077.

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