

We Favor a *Freer* Market in Kidneys



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According to Michael Brooks in his article “A Free Market in Kidneys Would Be Efficient and Equitable: A Case of Too Much Romance” in this issue of *The Independent Review*, our case for a free market in kidneys founders on an overly romantic view of government. Our analysis, however, was not intended to justify the government’s acting as a payer-of-last-resort for those who might benefit from a kidney transplant. Nor did we presume that government subsidies lead to efficient and equitable outcomes. We stated (Barnett, Saliba, and Walker 2001) that our primary purpose was to refute two arguments used to support the current prohibition on the purchase and sale of kidneys: (1) that “wealthy people . . . would bid up the price. . . . Therefore, the ‘poor’ would be priced out of the market” and (2) that “only poor individuals would sell kidneys, and such sales would be coercive in nature” (374). We made our proposal to repeal the prohibition on sales and purchases of kidneys in the context of the *reality* of the current situation, in which the government *does* act as the third-party payer-of-last-resort—a reality unlikely to change anytime soon.

Brooks does not disagree that, regarding the first issue, we established our point that the poor would not be priced out of the market. Instead, he makes the point that in his opinion some people should be priced out of the market. He does not consider

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the second issue, that only the poor would sell kidneys and that they would do so under coercive situations, which we also refute.¹ Our analysis shows that a “freer” market in kidneys would lead to greater efficiency and equity than is the case where the sale and purchase of kidneys are prohibited by law.

Under the current system, only donated kidneys are available for transplant, resulting in a shortage of transplantable kidneys. Moreover, in the current bureaucratic processes, these artificially scarce kidneys almost certainly are misallocated. Both of these factors result in inefficiencies. Our analysis indicates that permitting kidneys to be sold and purchased in markets would eliminate the current *economic* shortage of kidneys. Further, as long as the government continues to serve as payer-of-last-resort, the *medical* shortage of kidneys also would be eliminated, so anyone who could benefit physically from a kidney transplant would have access to one. The latter result may not be efficient, as Brooks notes. On the other hand, it may be! Given the increased supply of kidneys, the increased competition for sales of complementary transplant services would bid down these expenses so that the total expense of a transplant would decline. The government’s expense of subsidizing a transplant currently includes not only excessively high expenses for complementary services because of many other government interventions,² *but also* a monopoly price for the kidneys themselves. Therefore, as long as *any* government intervention occurs, the efficiency of the markets for kidneys and for transplants thereof is indeterminate. Given that such intervention occurs and will continue to occur, the relevant question is: Is it better to have too few transplants, which the current system of prohibited sales and purchases indubitably yields, or too many, which *might* occur but, *contra* Brooks, *might not occur*³ where kidney sales and purchases are not prohibited and the government remains as the payer-of-last-resort?

We show that a freer market in kidneys also promotes greater equity than exists in the current situation. The first principle of a free society must be self-ownership of

1. One minor point: Brooks misstates the nature of our D_2 curve (his D_E curve). Our D_2 curve represents the *combined* demand of all parties, including the government as payer-of-last-resort. Therefore, it is incorrect to sum our D_1 (his D_M curve) and D_2 curves vertically to arrive at the “marginal social benefit” curve; our D_2 curve *is* the marginal social benefit curve.

2. These interventions include subsidization both of the education of health care professionals and of medical research; interference in the markets for medicines, including Food and Drug Administration regulation of the licensing process for medicines and medical devices; the licensing of those who may practice as medical professionals and of those who may prescribe restricted medicines; and the regulation of hospitals.

3. It is necessary to recognize the possibility that if no government intervention of any type occurred, then: (1) kidneys would be relatively inexpensive (Adams, Barnett, and Kaserman 1999, 154); (2) competition among suppliers of complementary services would increase; and (3) the expense of transplants therefore probably would fall sharply. In such circumstances, charitable contributions for the purpose of financing transplants might increase so that they, in combination with insurance benefits, would allow everyone who might benefit medically from a transplant (and who wanted one) to receive one. Thus, the private demand curve would truncate at the relevant quantity and at a price equal to (or perhaps slightly greater than) the expense of providing the marginal transplant. Put another way, the demand curve would intersect (or exceed) the supply curve at the relevant quantity. Because no government intervention would occur on the demand or the supply side, this arrangement would be efficient and equitable. No excessive transplants would occur, nor would either a medical or an economic shortage exist.

one's body; otherwise, we have slavery, or, alternatively, a situation in which one's body is a commons. Therefore, eliminating the restriction on the sale and purchase of body parts, with informed consent and exclusion of children and the mentally incompetent, is unarguably a move in the direction of equity. That the purchase might be subsidized through the use of taxes does not alter this outcome. Moreover, it is unclear that increased taxation would be required. As we note in footnote 3, lifting the prohibition of the sale and purchase of kidneys and eliminating other government interventions might so reduce the expense of a transplant that private insurance and charity would obviate the need for the government to act as a payer-of-last-resort.

Moreover, given that the government does act as payer-of-last-resort, deaths and needless pain and suffering take place not because individuals have insufficient means to afford a transplant, but because the prohibition of the sale and purchase of kidneys causes a shortage of kidneys.⁴ Furthermore, were this prohibition to be lifted, the bureaucratic process that currently misallocates the artificially scarce kidneys would vanish.

One might argue that the government has assumed the role of payer-of-last-resort in order to reduce the inequities that would result if poor individuals had to forgo the receipt of a kidney because they could not pay for the transplant operation and the postoperative care.⁵ The government subsidy plays an important part in our analysis not because we defend it per se, but because it becomes the vehicle by which to eliminate the medical shortage of kidneys. Given the other actual restrictions in the market for transplants, the medical shortage would not be eliminated in the absence of government subsidies, leading to cries of inequity when higher-income individuals with the capacity to pay for both the kidney and the transplant operation receive the increasing supply of kidneys made possible by the free market.

We do not argue that efficiency dictates that all who might benefit physically from a kidney transplant should receive one. We merely note that as long as government remains the payer-of-last-resort—a fact of the current situation—this outcome would occur provided that the prohibition on sales and purchase of kidneys were lifted. We agree that such a situation may be neither efficient according to conventional welfare economics nor equitable from the standpoint of taxpayers who are forced to pay taxes, some of whom may place greater value on alternative uses of their tax dollars.

Our analysis shows that as long as current policy regarding subsidies for kidney transplants remains in place, a free market in kidneys would be *more* efficient and *more* equitable than the current situation, in which a price ceiling of zero in the market for

4. The effects of this shortage are compounded because the bureaucratic process that rations the relatively few donated kidneys almost certainly misallocates them.

5. As many scholars have shown, the results of one government intervention often lead to additional intervention(s) in an attempt to rectify new problems created by the original intervention. In this case, the original prohibition of the sale and purchase of kidneys and the government's restrictions on competition for complementary resources is responsible, at least in part, for the medical shortage.

kidneys precludes many who might benefit physically from a kidney transplant and who have the economic wherewithal from obtaining a transplant. We do not propose that our “mixed case of private and public provision will . . . resolve all equity and efficiency concerns relating to kidneys,” as Brooks suggests. Our analysis does show, however, that it is inefficient and inequitable for the government to prohibit the sale and purchase of kidneys.

A totally free market in kidneys—one without government subsidies and without the prohibition of the sale and purchase of kidneys, but also without other currently imposed supply-restricting interventions—would meet Brooks’s efficiency concerns. Furthermore, because a totally free market would permit all voluntary transactions (including selling and purchasing kidneys) between consenting adults, it also would be more equitable.

In sum, we continue to view our proposal as conducive to an outcome more equitable and more efficient than the current one. We agree, however, that we might have given—nay, should have given—our article a more accurate title, something along the lines of “A Freer Market in Kidneys: *More* Efficient and *More* Equitable.”

References

- Adams, A. F., A. H. Barnett, and D. L. Kaserman. 1999. Markets for Organs: The Question of Supply. *Contemporary Economic Policy* 17, no. 2: 147–55.
- Barnett, William II, Michael Saliba, and Deborah Walker. 2001. A Free Market in Kidneys: Efficient and Equitable. *The Independent Review* 5, no. 3: 373–85.

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