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Routing

A Gift of Life Deserves Compensation How to Increase Living Kidney Donation with Realistic Incentives

by Arthur J. Matas

Executive Summary

Treatment for end-stage renal (kidney) disease (ESRD) is the only government-funded health care in the United States that has no financial need- or age-based criteria; inclusion in the program (Medicare) is solely based on diagnosis. If a person has ESRD, treatment is covered by Medicare. No other criteria must be met, but the best treatment option, a transplant, is not available for most patients. Compared with dialysis, a kidney transplant significantly prolongs life and improves quality of life, but kidneys are scarce in large part because federal law prohibits the buying and selling of organs. The average waiting time for a kidney transplant in the United States approaches 5 years; in some parts of the country, it is closer to 10 years. A significant number of transplant candidates die while waiting for an altruistic donation that never comes. Allowing the sale of kidneys from living donors would greatly increase the supply of kidneys and thereby save lives and minimize the number of patients suffering on dialysis.

The National Organ Transplant Act of 1984 was passed to, among other things, prohibit the sale of

organs in the face of apprehension that the growing commercialization of medicine would result in human beings being treated as commodities rather than individuals. Whether such concerns were well founded or not, the act was clearly overbroad in its prohibition of the sale of organs. It's time to loosen those restrictions in order to save lives. The best way to increase the supply of kidneys without drastically changing the existing allocation system is to legalize a regulated system of compensation for living kidney donors. Such a system could be established using the infrastructure already in place for evaluating deceased donors and allocating their organs. The only change required to ease and probably even solve the organ shortage is some form of payment for donors.

The potential practical and theoretical concerns with compensated donation can be overcome, and alternative proposals will not do enough to solve the shortage. Upon careful analysis, it is clear that the benefits of a regulated system of compensated donation (chiefly, increasing the number of donated kidneys) outweigh any risks.

Arthur J. Matas, MD, is professor of surgery and director of the kidney transplant program at the University of Minnesota. Dr. Matas has been a practicing transplant surgeon for more than 25 years and is the immediate past president of the American Society of Transplant Surgeons.

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Introduction: The Kidney Shortage (Realities and Possible Solutions)

Patients with end-stage renal (kidney) disease (ESRD) have three options: no treatment (in which case they will die), dialysis, or a kidney transplant. Dialysis and a transplant are not mutually exclusive. A patient may be on dialysis before receiving a transplant, and, if the transplant fails, may begin dialysis again. However, a successful transplant (as compared with dialysis) significantly prolongs life and improves quality of life.¹ As a consequence, as transplant technology evolves, more patients with ESRD are opting for transplants.

Survival after a transplant is better for patients who undergo a transplant before a prolonged interval of dialysis. In fact, a transplant done before dialysis even starts (called a “preemptive transplant”) has better results than a transplant done after dialysis starts.² For each additional year that a patient is on dialysis before a transplant, the posttransplant results are significantly poorer. Thus, a preemptive, or at least a fairly early transplant, provides significant advantages.

Because of the advantages (longer survival, better quality of life) of a preemptive transplant over dialysis and of an early transplant over a late transplant, most programs now encourage the use of living kidney donors. As long as donors are available, living donation allows transplants to take place sooner and is clearly associated with better recipient survival rates than deceased donor transplants. Transplant candidates without a potential living donor must go on the waiting list for a deceased donor kidney.

Each region of the United States has a list of transplant candidates. When a deceased donor kidney becomes available, it is allocated according to a predefined algorithm designed to balance the principles of utility (that is, to maximize results) and equity (that

is, to be as fair as possible to all the transplant candidates on the list).

As transplantation becomes an ever better option than staying on dialysis, the demand for transplants has increased, as has the number of patients each year going on the waiting list for a deceased donor transplant. At the same time, the supply of donated kidneys has not kept up, and in fact, has barely increased. As a consequence of this increased demand in the face of a static supply, the waiting list and the resultant waiting time for a kidney transplant are getting longer. As recently as 25 years ago, the average wait for a deceased donor kidney in the United States was about 1 year; currently, the average wait is approaching 5 years (and, in many parts of the country, is approaching 10 years).

This significant increase in waiting time for a deceased donor has already had dire consequences for transplant candidates. As described above, the quality of life for kidney transplant recipients is significantly better than the quality of life on dialysis; thus, increased waiting time on dialysis results in more years with impaired quality of life. In addition, more people on the waiting list are dying: in 2001, in the United States, over 6 percent of waiting candidates died;³ by 2005, this figure had increased to over 8 percent.⁴ Thus, with an average wait of more than 5 years, over 40 percent of listed candidates may die before ever undergoing a transplant. And as the waiting time approaches 10 years, the majority of patients will die without an opportunity for a transplant. Remember, these patients were acceptable candidates when listed, but as time passes, the chance that a transplant will be successful decreases. A review of University of Minnesota data showed that the average (plus or minus standard error) age of patients who died while waiting for a kidney was 53 (plus or minus 11) years. Seventy percent of those patients were waiting for a first transplant and 70 percent had a panel-reactive antibody (PRA) level of less than 10 percent (that is, they would be easy to match with a donor if there were a sufficient supply).⁵

Some opponents of compensation for organs have argued that many of the waiting list deaths have occurred in patients who were “inactivated” on the list because they were too sick for a transplant, that is, they argue that such patients are not realistic transplant candidates and that worrying about these deaths is not an adequate justification for concern about a shortage of organs. These arguments miss the point. Each candidate who dies while waiting for an organ was an acceptable candidate when first listed; all were inactivated when their health deteriorated on dialysis but stayed on the list in the hope that they could recover enough to once again be viable transplant candidates.

In addition to candidates on “temporary inactivation” there are others who deteriorate and are permanently removed from the list without being transplanted. These previously acceptable and now “removed from the list” candidates do not show up in the “death on the waiting list” statistics. A logical extension of the specious argument that many deaths occur in inactivated patients is that we could eliminate all deaths on the waiting list by taking each patient off the waiting list just before they die.

Because the number of waiting transplant candidates is growing steadily, and because the number of deceased donors has barely increased (in North America) in the last decade, the waiting list and waiting time are projected to continue to increase.⁶ So it is inevitable that in the future even more transplant candidates will suffer and die while waiting for an organ that never becomes available.

Band-Aid Solutions

The obvious solution to this dilemma is to increase the number of donated kidneys. In recent years, the number of living donor kidney transplants has increased, particularly the number of living unrelated donor transplants. Yet that increase has not matched the markedly increased demand. And, in spite of decades of effort, donation of deceased donor kidneys has only moderately increased.

Recently, a national effort to increase donation of deceased donor organs called the

Breakthrough Collaborative has had some impact; however, the number of donated kidneys continues to fall far short of the need. Moreover, it has recently been estimated that, in the United States, even if all potential deceased kidney donors became actual donors, there would still be a shortage.⁷ The United Network for Organ Sharing—the nonprofit organization established by the U.S. Congress in 1984 to administer the nation’s organ procurement and transplantation network (OPTN)—has proposed new goals for deceased donor organ recovery for 2013.⁸ According to UNOS projections, even if numerous initiatives such as the Breakthrough Collaborative and acceptance of deceased donation after cardiac death are totally successful, the profound organ shortage and the prolonged waiting times for a kidney will continue. Furthermore, the need for organs (as defined by the number of patients on the waiting list) probably markedly underestimates the actual demand (as defined by the number of patients who would benefit from a kidney transplant). There are tens of thousands of patients with ESRD who are not listed for a transplant who needlessly suffer on dialysis without adding their names to the organ waiting list because the chances of receiving an organ are so low.⁹

Several novel attempts are now being made to increase the number of available living donor kidneys. Studies are finding ways to allow donations from people who don’t share the recipient’s blood type.¹⁰ More and more institutions are allowing paired exchanges, a system in which a recipient who has a willing donor who is not a match exchanges that donor with a recipient in a similar situation so that each ends up with a donor who is a match.¹¹ And, some transplant programs are experimenting with allowing nondirected donations, in other words, allowing donations from altruistic donors willing to donate to anyone on the waiting list.¹² However, these approaches will only provide a relatively small number of new donors. In combination, they will not solve the shortage.

An alternative solution would be to limit transplant candidates’ access to the waiting

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list. In fact, some researchers have argued that the organ shortage is an artificial situation created by those who have a vested interest in promoting transplants.¹³ But, in reality, patients with ESRD when given a choice between dialysis and a transplant generally opt for a transplant, since a successful transplant significantly prolongs survival and improves quality of life. Still, the transplant community could develop stricter acceptance criteria in order to limit access to the waiting list—thus decreasing the average waiting time and improving outcomes for those candidates fortunate enough to be listed and then undergo a transplant. The most likely criterion would be to limit access based on a patient’s potential for long-term success after a transplant. In fact, such a criterion is the basis of a proposal to change the allocation of available deceased donor kidneys to a system based on maximizing life-years of survival.¹⁴ This criterion would minimize access for older candidates and for candidates with significant nonkidney-related disease (for example, heart disease) by not allowing them access to standard-criteria kidneys (that is, ideal kidneys) and drive them to accept the less good “expanded-criteria donor kidneys” (that is, kidneys from less than ideal donors). Such recipients do not survive as long as younger recipients or those who have no additional disease. But the logical extension of this argument would be to limit access to diabetics, to women, to children, and to blacks (who have worse long-term results than nondiabetics, men, adults, and whites).

A Realistic Solution

The most practical solution to the organ shortage would be a system of compensation for living kidney donors that requires minimal change in the existing system.¹⁵ The procedural framework would be virtually identical to the system currently used to evaluate altruistic living donor organs, but the allocation system used would be the one currently used for altruistic deceased donor organs. The deceased donor model for allocation is appropriate because there currently is no official allocation system in place for living organ donations. At

this point almost all living donor organ donations are directed to family or friends. Thus, by combining current existing models for living and deceased organ procurement and allocation, a system can be developed that provides the following: a predefined algorithm, such as the one used by UNOS, to assure that everyone on the waiting list has the same opportunity to undergo a transplant, full evaluation of potential donors, informed consent, careful oversight, long-term follow-up, and treatment of donors with dignity, including offering them recognition for providing a lifesaving gift. The added element proposed here is a fixed payment to donors by the government or a government-approved agency (hereafter I will use the term compensated donation). Existing prohibitions on private sales would remain in place.

Compensation for donors could take many forms. Options include a fixed payment, long-term health insurance, college tuition, tax deductions, or some combination of these alternatives or other equally valuable forms of compensation.¹⁶ Such a system would likely not be feasible in all countries, but would work only in countries such as the United States or geographic areas such as Europe where long-term donor health care and long-term follow-up care can be guaranteed.

Furthermore, donors could not come from other countries in order to be compensated donors unless there is a way to ensure long-term health care and long-term follow-up when they return to their own countries.

Each component of the proposed system of compensation for living kidney donors is critical to the overall package. First, an algorithm for allocation would be developed so that all recipients on the list have the same opportunity for a transplant. This algorithm could be identical to the current (UNOS-derived) algorithm for allocating deceased donor kidneys. The current UNOS algorithm was designed to balance the principles of utility and equity. Under the current system, some deceased donor kidneys are, after removal, shipped from one region or part of the country to another. For obvious reasons, we might not want

to do that with living donor kidneys. Importantly, with our current screening criteria, success rates would be equivalent for all living donor transplants except perfectly matched siblings. That is, differences in donor characteristics, such as age, would not significantly affect results. (With deceased donation, older donor kidneys are associated with inferior long-term results, but this is not so with living donation because, unlike with deceased donation, there is ample time to effectively screen potential living donors.)

Second, the compensated donor evaluation, at a minimum, must be as complete as the current conventional living donor evaluation. We may want to include additional testing, such as viral testing done twice (at six-month intervals), or psychosocial testing to study the motivation and the stability of potential compensated donors.

Third, informed consent is critical. Each step of the evaluation, allocation, follow-up, and compensation must be transparent. Early in the process, the risks of the evaluation and surgery would have to be clearly explained. A “cooling-off period” should be required, allowing the donor time to evaluate whether the benefits warrant the risks. (Mandatory viral testing at six-month intervals would provide adequate time for this cooling-off period.)

Fourth, careful oversight of the process would assure the safety and health of both donors and recipients. Today in the United States, UNOS and the Center for Medicare and Medicaid Services provide oversight of deceased donor kidney use and allocation, including studies of short-term and long-term results for recipients. In the compensatory system presented here we would continue the same type of oversight but also include studies of donor outcomes. It will be important to determine if there are any differences in short-term or long-term results for conventional versus compensated donors. Numerous studies of conventional donors suggest no increased risk as compared with the age-matched nondonor population, and kidney failure in donors occurs at the same rate as would be expected in the age-matched general population.¹⁷ In fact, studies from Sweden suggest that donors live longer than the

general population.¹⁸ Although this benefit may be due to selection bias, these studies at least show that donors’ lives are not shorter.

Fifth, it will be our responsibility to create a “culture of dignity” for compensated donation. Our conventional living donors are heroes—even though we realize their motivations are complex. Likewise, compensated donors should be treated as heroes.

And finally, there would be a regulated system of compensation. Compensation to all donors would be similar, but perhaps not identical. A menu of options would provide each donor with something that has personal value. For example, health insurance may be of value to those who do not have work-related health insurance but not to others. A tax break may be of value to some, direct compensation to others. Under the system advocated here, no other commercialization would be allowed. All legal allocation of organs and payment for organs would take place through the government or a government-determined contractor. Currently existing prohibitions on private brokers and contact between the donor and recipient would remain in place.

None of the initiatives to increase living or deceased donation mentioned here are mutually exclusive. It would be reasonable to move forward with compensation for donation while simultaneously pursuing initiatives to study cross-blood-type matches, to allow paired donations, and to increase deceased donation.

Consequences

Allowing Realistic Incentives for Organs Would Save Lives

Compensated donation would increase the number of kidneys available for transplants, thereby shortening waiting time, improving patient survival rates, and minimizing suffering on dialysis.

Unfortunately, until there is a clinical trial of a system of compensated donation, we will not know whether its potential can be fulfilled. Given the absence of this knowledge, where is the burden of proof? Many of those

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who argue against such a system point to the lack of evidence that a system that allows financial incentives will work and, therefore, say that such a system should not be tried. But the opposite is true.¹⁹ Because patients are dying while waiting for a kidney, we should lift the ban on compensated donation, unless opponents can provide any reasonable arguments justifying its continuation.²⁰ After all, currently everyone but the donor already benefits financially from a transplant (physicians, coordinators, hospitals, recipients). Moreover, ample legal precedent already exists for compensated donation of body parts (such as sperm or eggs) and for payments to surrogate mothers.

A prima facie case for compensated kidney donation can be made on the basis of two claims: the “good donor claim” and the “sale-of-tissue claim.”²¹ The good donor claim stems from the fact that it is already legal for a living person to donate a kidney, as it should be. If donating a kidney is legal, and if the only difference between donating a kidney and selling one is the motive of monetary self-interest, and if the motive of monetary self-interest does not on its own warrant legal prohibition, then it follows that compensated kidney donation should be allowed. The sale-of-tissue claim stems from the fact that it is legal (and rightfully so) for living persons to sell parts of their bodies (blood, sperm, eggs). Thus, it is clear that monetary self-interest does not on its own warrant legal prohibition. If we oppose compensated kidney donation (as opposed to the sale of sperm or eggs) because nephrectomy is more dangerous, then we should also oppose uncompensated kidney donation; if we oppose compensated kidney donation because people should not sell body parts, then we should also oppose the compensated donation of sperm or eggs.²²

Another argument in favor of compensated donation relates to autonomy. The ban on compensated donation is paternalistic and ignores the need to respect individual autonomy. In general, with “few constraints, people make personal decisions on what they wish to buy and sell based on their own values,” and should be allowed to do so.²³

Finally, we cannot ignore the fact that although most countries have laws against the sale of organs, a growing black market for compensated donation already exists—a market in which donors are often poorly evaluated and cared for and most of the payment goes to a broker.²⁴ Many ESRD patients, desperate for a transplant, travel to take advantage of such opportunities. Development of a regulated system will help limit this phenomenon of “transplant tourism.” Eliminating the legislative ban on compensated donation and establishing a regulated system may also eliminate or minimize the ongoing growth of black market organ dealing. Thus, those people who sell a kidney will be better compensated and better cared for.²⁵ As conceded by the International Congress on Ethics in Organ Transplantation in December 2002:

The well established position of transplantation societies against commerce in organs has not been effective in stopping the rapid growth of such transplants around the world. Individual countries will need to study alternative, locally relevant models, considered ethical in their societies, which would increase the number of transplants, protect and respect the donor, and reduce the likelihood of rampant, unregulated commerce.²⁶

Allowing Compensation for Kidneys Could Save Taxpayers Money

It is important to recognize that, because dialysis is so much more expensive than a transplant, compensation for donors could be cost-effective.²⁷ Dr. M. Schnitzler and I have estimated that each living unrelated donor kidney transplant saves Medicare about \$95,000. It is difficult to quantify the value transplant recipients place on their improved quality of life, but the actual dollar savings to the federal government because transplant recipients, unlike most dialysis patients, lead normal productive lives can be estimated.²⁸ Once recovered from surgery, transplant recipients can resume normal work schedules and care for themselves

and their households as they did before they were diagnosed with kidney disease. They no longer, or never, need to spend 9 to 15 hours a week hooked up to a dialysis machine, and they won't be debilitated by fatigue, bloating, and thirst as dialysis patients often are. We estimate that these quality-of-life differences would save the federal government an additional \$75,000 in lost income taxes and nonmedical services commonly needed by dialysis patients. In light of a total federal savings of around \$270,000 (including putting a value on improved quality-of-life), it would be cost-neutral, on top of saving taxpayers money, for the government to spend as much as \$95,000 per transplant to pay for infrastructure and donor compensation.²⁹

Recently, the Congressional Budget Office evaluated the financial implications of paired donation (defined above). With a paired donor transplant, two individuals who would otherwise have remained on long-term dialysis undergo transplants. When "scoring" this proposal, the CBO recognized the long-term financial savings associated with transplants (as compared with dialysis); they credited paired donation with long-term savings for both recipients, sparing the Medicare program from spending thousands of dollars for numerous years of dialysis. Similar savings could come from compensated donation.³⁰

The Current System for Distributing Organs Can Easily be Adapted to Handle Compensated Living Organ Donation

In the United States, each transplant center currently has clinical transplant coordinators and a protocol for evaluating living donors. In addition, each center belongs to an organ procurement organization (OPO), whose coordinators are responsible for recovering and allocating deceased donor organs. UNOS, which oversees the overall allocation of deceased donor organs, and each OPO have an algorithm for deceased donor organ allocation. Similar mechanisms exist in other countries. A system of donor compensation could use existing facilities and existing administrative structures. In fact, a precedent has already been set: in some regions of the

United States, OPO coordinators are responsible for evaluating and allocating living donor organs from altruistic donors who are not specifically donating to a relative or friend.³¹ Such donations are commonly referred to as "nondirected organ donations."

National criteria could be established regarding what tests and results should be required in compensated donor evaluations. Evaluations could be coordinated by the OPO and then reviewed at the OPO by a panel consisting of a transplant surgeon, transplant physician, social worker, OPO coordinator, and donor advocate.³² If the donor is accepted, then a regional crossmatched list would be generated and the kidney would be offered to the highest-ranked candidate on the waiting list in accordance with UNOS criteria. If the center or the potential recipient accepts the offer, the detailed evaluation would be sent to the center (which, again, would have the opportunity to accept or reject the offer). If the center or potential recipient rejects the offer, the next candidate on the list would be offered the kidney. All bills generated by the donor evaluation, donor surgery, and donor follow-up would be sent to the OPO. Administration, including payment to the donor and long-term follow-up, would be done at the OPO level. When a transplant was finally scheduled and done, the center would be charged an acquisition fee by the OPO, which would be compensated by the government (Medicare) or the recipient's insurance (if the transplant were done before ESRD). Having the evaluation, allocation, and follow-up coordinated by the OPO would allow national reporting and oversight.

From a practical perspective, setting up a national computer database of donor evaluations would be useful. Thus, a donor rejected in one OPO would not go to another OPO and again incur the costs of evaluation. Such a registry could also be used for long-term follow-up of accepted donors.

The Realities of Who Donates

There is no doubt that creating additional incentives for living organ donation will

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increase the availability of organs for transplantation, but estimating how much such incentives are likely to increase the pool of available donors requires an understanding of why people donate.

It is naive to believe in a clear dichotomy between prospective donors, that is, between those purely motivated by altruism and those purely motivated by incentives. Instead, a continuum between these extremes is more probable. Transplant teams recognize that current conventional donors (family members and friends) often donate for multiple reasons. For example, whereas altruism certainly plays a role, there is often a component of family pressure or of secondary gain.

As the recent Institute of Medicine report states:

Confusion has marred much of the discussion [of organ donation] . . . perhaps because of an assumption that a donation or a gift system . . . is necessarily grounded in altruism. However, the ordinary experience of gift-giving among families or friends should be sufficient to dispel that notion—the motives of gift givers are often quite complex and may reflect a combination of generosity, perceived obligation, and a desire to be regarded with favor.³³

At the same time, many potential conventional donors whose major motivation is altruism cannot afford to take off time for the surgery (because of their lack of disability insurance or of compensated vacation from work); others are concerned about long-term health care (because they do not have health insurance).³⁴ Thirty-nine percent of surveyed transplant programs in the United States reported potential living donors declining donation because of future insurance fears.³⁵ Such individuals might be willing to proceed with donation if a package of incentives (including long-term health insurance) were available.

A review of 35 studies from 12 countries on direct and indirect costs incurred by living donors showed that altruistic donation is not

cheap.³⁶ Travel or accommodation costs were incurred by 9 to 99 percent of donors and were higher in countries with larger land mass; 14 to 30 percent incurred costs for lost income; 9 to 44 percent incurred costs for dependent care; 8 percent incurred costs for domestic help.³⁷ There are also some concerns regarding costs for analgesics after the surgery. A review of studies done internationally from 1972 through 2006 on donors' insurability found 2 to 14 percent of donors were concerned about insurability and 3 to 11 percent actually encountered difficulties with their insurance.³⁸

Some Practical Considerations

Many practical considerations are involved in establishing a system of compensation for organ donation. Each of the following questions will require considerable discussion.

1. Should there be a minimum age restriction? In North America, 18-year-olds can join the military, vote, and be conventional kidney donors. However, in most states, young adults cannot legally drink until age 21. Car rental companies, recognizing the typical poor driving record of so many young drivers, have different restrictions and rates for those under age 25. Given such concerns regarding the judgment of young adults, it might be reasonable to set a higher minimum age for compensated donors than the current minimum of 18 used for conventional donors.

2. Should all living donors be compensated? That is, should conventional donors to family members or friends also be compensated? As discussed above, many conventional donors have concerns about long-term health care. A system could be established where all living donors receive equal compensation. Alternatively, there could be a two-tiered system of incentives, as mentioned above, one for conventional donors who give a kidney to a specific family member or friend (incentives could include health and life insurance as well as reimbursement for expenses and lost wages) and one for compensated donors who give a kidney for allocation to a waiting list (incentives could similarly include health and life

insurance as well as reimbursement for expenses and lost wages, along with other options such as a tax break or direct payment).

3. How would payment be distributed? A study conducted at the University of Minnesota suggests that, in the United States, a living donor transplant saves taxpayers more than \$95,000, compared with maintaining a patient on long-term dialysis.³⁹ Some of the available savings could be used to support the donation infrastructure, to fund long-term follow-up studies, and to pay for donor incentives such as life, health, or long-term care insurance. If direct payment to donors is an option, it would have to be decided if such payments would be in a lump sum or parceled out in installments at follow-up visits. In addition, policies would have to be developed regarding whether or not payment would affect welfare benefits or taxes or would be subject to attachment by other concerned parties (such as creditors or ex-spouses).

4. How would the health status of potential compensated donors be verified? Verification is both a practical and an ethical issue. From a practical perspective, potential compensated donors could be evaluated twice (as with viral studies), at six-month intervals. Doing so would not guarantee safety, but it would minimize the risk. Potential recipients could be informed about the limitations of the evaluation process (similarly, some limitations apply to the current conventional donor pool) and sign an appropriately developed “informed consent” form.

5. How would logistics be handled? Some logistical issues would have to be resolved before a system of compensated donation could be implemented. For example, would only local recipients be considered or could organs go to a national list? Would compensated donors have to travel to a recipient’s center?

6. Would the line be drawn at kidneys? If we establish a system for compensated kidney donation, should we also have a system for compensated donation of a liver lobe, a lung lobe, or a partial pancreas? Could a compensated donor return repeatedly for sale of more body parts? Living donor liver, lung, and pan-

creas transplants have all been done successfully. But for each, the donor morbidity rate is higher than after kidney donation. In addition, considerably more information is available on long-term follow-up after kidney donation than after living liver, lung, or pancreas donation. For these reasons, perhaps a compensated donor system should at first be limited to kidneys, but once such a system is established and running well, other organ donors could also be considered.

So Why Doesn’t the United States Already Allow the Sale of Kidneys?

There is little doubt that a regulated system of incentives for live organ donation is feasible and would increase the supply of much needed organs, yet the United States does not have such a system. Why not?

First, policymakers confuse a system like the one being advocated here with what happens when there is a black market in organs, as exists in some countries.⁴⁰

Second, it is important to note there are historical reasons for not having a system of compensated organ donation in the United States. As the recent Institute of Medicine report clarified, “According to the chair of the Uniform Anatomical Gift Act draft committee, the drafters did not intend to encourage or discourage payment for organs; ‘it is possible,’ he states, ‘that abuses may occur if payment could customarily be demanded, but every payment is not necessarily unethical.’”⁴¹ The Uniform Anatomical Gift Act, passed in 1968, and recently revised in 2006, provides a uniform legal framework for organ donation and gives adults the right to donate their bodies or organs upon their death without subsequent “veto by others.”⁴²

Twenty-five years ago, a kidney transplant was seen as a quality-of-life operation rather than an operation that prolonged survival. In addition, the average waiting time for a deceased donor kidney was about 1 year. Living *unrelated* donor transplants were rare because at that time

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medical professionals believed that the results would be similar to deceased donor transplants, and, therefore, the risk to the donor was not justified. It was in this context that compensated donation was first proposed and rejected. In 1987 the World Medical Association declared, "The purchase and sale of human organs for transplantation is condemned."⁴³ The International Transplantation Society stated in 1986, "No transplant surgeon/team shall be involved directly or indirectly in the buying or selling of organs/tissues or in any transplant activity aimed at commercial gain."⁴⁴ And, in 1991 the World Health Organization recommended that physicians not transplant organs "if they have reason to believe that the organs concerned have been the subject of commercial transactions."⁴⁵

In the United States, the ban on sales was established with passage of the National Organ Transplant Act in 1984. This act made it a federal crime to "knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce."⁴⁶ This ban was, in part, in direct response to one individual's attempt to establish a brokerage service in which he would purchase organs, particularly in developing countries, for transplants in the United States.⁴⁷

However, dramatic changes in the last 20 years have led to a reexamination of many of the policies established two or more decades ago. For example, it is now widely accepted that an unrelated living donor transplant (which a compensated donor transplant would likely be) has results equivalent to those of a related living donor transplant.⁴⁸ Also, as discussed above, because of the improvement in transplant outcomes, more patients with ESRD are opting for a transplant, and waiting lists and resultant waiting times are getting markedly longer. It is in this context that compensated donation must be reconsidered.

In the mid-1990s, when the shortage of organs was not as severe as it is today, two separate groups discussed the possibility of financial incentives for donation. The Bellagio Task Force Report on Transplantation, Body Integrity, and

the International Traffic in Organs (convened under the auspices of the Center for the Study of Society and Medicine of the College of Physicians and Surgeons of Columbia University) found no ethical principle that would justify a ban on compensated donation under all circumstances.⁴⁹ The International Forum for Transplant Ethics concluded that the discussion of compensated organ donation needs to be reopened.⁵⁰

In addition, the general public favors financial incentives. In fact, two national surveys (done when the waiting list was less of a problem) reported that the general public is much more willing than the medical community to accept the idea of compensation for organ donation.⁵¹ In 1991, a study found that 52 percent of the general public favored compensation.⁵² A subsequent study found that 70 percent of the general public and 51 percent of medical students, but only 25 percent of surveyed physicians and nurses, favored compensation.⁵³ Medical attitudes may be changing in response to the long waiting lists: at a recent meeting of the American Society of Transplant Surgeons (January 2007), the majority of attendees voiced approval of a trial of compensation for donation. Similarly, the vast majority of attendees at an international meeting on living donation (held in Essen, Germany, in June 2007) favored a trial of compensated donation.

Arguments against Compensated Donation

Numerous arguments have been made against compensated donation. Yet, it is noteworthy that the discussion of compensated donation is occurring in an environment in which we accept "altruistic" living donation. Any effective argument against compensated donation must justify the ban on compensation while simultaneously permitting altruistic donation.⁵⁴

As discussed above, the ban on compensation for organ donation has significant detrimental consequences for patients with ESRD. In reviewing the individual arguments against

compensated donation (or a combination of them), one must ask this overriding question: Is this argument (or, are these arguments) sufficient to allow patients to continue to suffer and die on dialysis when something can be done to increase their quality of life and chances of survival? Tom Beauchamp and James Childress, the authors of the definitive textbook on bioethics, defined four principles to apply in bioethics discussions: a) respect for autonomy; b) beneficence, including both the obligation to benefit others (positive beneficence) and to maximize good (utility); c) justice (fair and equitable distribution of benefits and burdens); and d) nonmaleficence, the obligation not to inflict harm.⁵⁵ They argue that when these principles conflict (as with kidney donation), they must be balanced. Our society accepts that the advantages of conventional living donation (which respects donors' autonomy and maximizes outcome for patients with ESRD) outweigh potential harms (risks to donors). The question still undecided in the political realm, although not in the eyes of the public at large, is whether the advantages of compensated donation would also outweigh potential harms.

The arguments that have been made against compensated donation (and some counterarguments) are briefly outlined below.⁵⁶

Arguments that Do Not Distinguish between Conventional Donation and Compensation

The compensated donor would be harmed. Some researchers argue that the surgery for compensated donors could be associated with death and complications. Currently, the mortality rate associated with altruistic living kidney donation is 0.03 percent.⁵⁷ If compensated donors are screened as thoroughly as today's altruistic living donors, the mortality rate would likely remain about 0.03 percent; the surgical and long-term risks for compensated donors would be identical to the risks for altruistic living donors.⁵⁸ As discussed above, if these risks alone are sufficient to justify the ban on compensated donation, they should also justify a ban on altruistic donation. One novel form of the argument about potential donor harm is

that compensated donors may be less healthy (because of, say, poorer nutrition) than altruistic donors and that their surgical and long-term risks may therefore be higher. But no evidence supports this contention. Assuming we develop and maintain adequate screening standards, complications after compensated donation should be no different from complications after altruistic donation.

Genuine consent would be impossible. Some bioethicists argue that, because incentives are involved, a potential compensated donor cannot ever truly provide genuine consent. But, this argument rests on a paternalistic attitude that someone other than the individuals involved are best able to weigh the risks and benefits and ignores a fundamental tenet of current medical practice and philosophy—autonomy. Others argue that some potential compensated donors may be unable to fully understand the risks; but this objection also applies to altruistic living donors, whom we feel capable of screening and educating. The information on risks provided to a compensated donor would be identical to that provided to an altruistic donor. If a ban is justified on the grounds that some potential compensated donors may not understand the risks, then that should justify a ban on altruistic donations as well.

Not enough is known about long-term risk to donors. Another argument in this category is that not enough is known about long-term risk to donors. Yet we know enough to state that there is little increased long-term risk.⁵⁹ Again, if our screening practices are similar for altruistic and compensated donors, long-term risks should be the same.

Arguments with No Supporting Data

Donation should be altruistic. Historically, bioethicists, among others, have argued that donation should be altruistic. But there is no reason it must be this way. There are many reasons beyond pure altruism why individuals donate.⁶⁰ In addition, our current practice of altruistic donation is not working. The waiting list and resultant waiting time are getting longer every year.

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Medicine report, in discussing altruism as the sole motive for donation, states that “the motives of gift givers are often quite complex and may reflect a combination of generosity, perceived obligation, and a desire to be regarded with favor.”⁶¹ Studies have shown that a significant percentage of current altruistic donors feel pressure (external or internal) to donate.⁶²

Altruistic donation would decrease. Some detractors fear that if a system of compensated donation were established, altruistic living donation might decrease. But no evidence supports this concern. In fact, there are many reasons to believe that altruistic donation would continue at close to the same rate as takes place today. First, some recipients would continue to want to know their donor. As discussed below, they may have concerns about the “quality” of compensated donor kidneys. Families with these concerns might opt for altruistic donation. Second, with the system of compensated donation described here, waiting time is likely to be reduced but not eliminated. Outcome for kidney transplant recipients is better with a preemptive transplant (discussed above), so many recipients would still opt for preemptive transplants from altruistic donors rather than waiting until they are on dialysis.⁶³ Third, potential compensated donors may turn out to be demographically different (for example, older) from potential altruistic donors, providing another reason to possibly prefer an altruistic donor kidney, even though adequate screening should eliminate any concerns typically associated with age.

In addition, if altruistic donation decreased and the total number of available organs increased, the end result would still be positive. As noted above, living unrelated and living related transplants have equivalent results.⁶⁴ So if a system of compensated donation increased the total number of available kidneys, more patients would be provided a successful transplant. Nevertheless, in some situations, a family might rather turn to a compensated donor than to a family member or an altruistic friend. If so, there could be some decrease in altruistic donation (probably related to how long the waiting list is, once a compensated donor sys-

tem is established). Some of that decrease may be good. First, we do not know how much family pressure is involved in related donation; presumably a compensated donor system could reduce that sort of pressure. Second, currently in the United States, the criteria for acceptance of living donors are being expanded (for example, donors with single-drug hypertension or obese donors are now allowed in some centers). An expanded-criteria donor is usually accepted only if he or she is the sole available donor for an individual recipient. The argument made is that the risk to the recipient of having a long wait on dialysis is greater than the risk to the expanded-criteria donor. A large compensated donor system might eliminate the need to use expanded-criteria donors. Clearly, whether compensated donation would result in a significant decrease in altruistic donation cannot be known for sure without trying a compensated donation system and studying its effects on altruistic donation.

One practical question is whether it would be better to provide incentives to all living donors or only to some. Currently, about 49 million Americans do not have health insurance. Concerns about short- or long-term health issues prevent many potential donors from donating.⁶⁵ If incentives such as health and life insurance are provided to all donors, donation may increase. It would be wrong to provide health coverage for compensated donors but not for altruistic donors. As mentioned earlier, a two-tiered system of incentives could be developed, one for altruistic donors who give their kidney to a specific family member or friend (incentives could include health and life insurance as well as reimbursement for expenses and lost wages) and one for compensated donors who give their kidney to be allocated to the waiting list (incentives could similarly include health and life insurance as well as reimbursement for expenses and lost wages, along with other options such as a tax break or direct payment).

Deceased donation would decrease. Another question is whether allowing compensation for living donors will cause a decrease in the supply of deceased organs. This is unlikely because

only kidneys, and perhaps partial livers, lungs, and pancreases are currently suitable for living donation and there will continue to be a great need for organs such as hearts, which could never be supplied by living donors. But eliminating the ban on payment to living donors may result in the families of deceased donors lobbying for payment as well. As discussed above, the arguments for and against compensation for living and deceased donors differ. For example, living donors will experience pain and will require time for recuperation; and with compensated living donation, the compensation would go directly to the donor. Although the potential for providing compensation for deceased organs is not precluded by what is argued here, the arguments are different and would need separate analysis from what is provided here.

Trust in government and/or doctors would erode. Some authors on this topic are concerned that, if a government-sponsored system of compensation is established, society's trust in the government or in doctors would erode. If the government (or its appointed agency) were the sole buyer of kidneys as suggested here, there is concern that the government would be seen as preying on the poor rather than providing a safety net.⁶⁶ Some authors argue that the government would then have less incentive to provide social benefits, because the poor could go out and sell a kidney (which would save Medicare money). But no evidence supports this claim. The government function of providing for the needy would not be in direct conflict with its other function of buying and providing kidneys for patients on the organ waiting list. But, even if such conflicts existed, government agencies often have competing priorities (for example, consumer advocacy vs. environmental protection, developing the economy vs. raising the minimum wage, minimizing dependence on foreign oil vs. preserving the country's wilderness). The goal of purchasing kidneys would be to save lives—certainly an acceptable goal for the government. A system that allows for compensated donation, with appropriate screening, good postoperative follow-up, and a substantial pay-

ment to the compensated donor, could be managed with care and dignity so that respect for neither the government nor the medical profession would diminish.

Another argument is that allowing compensated organ donation would damage the traditional doctor-patient relationship.⁶⁷ But, no evidence suggests that compensated donation would have any negative impact on either patient care or compensated donors' expectations of doctors. No evidence suggests that medical care for surrogate mothers (analogous to compensated donors) or egg donors (who also undergo an operative procedure) has differed in any way from the current standard of practice. Presumably, compensated donors would be given the same care as altruistic living donors (and much better care than compensated donors currently receive in black markets). In addition, if long-term health care were one of the benefits, many compensated donors would likely have access to both more and better health care than they did before donation.

A system of compensation would be abused. There is no reason to assume that individuals involved in compensated donation would have any more or less reason to lie than those involved in altruistic donation. In each situation there may be much to gain or to lose. An altruistic donor may lie about health status and risks in order to help someone they very much want to help or, on the other hand, someone being pressured to donate who really doesn't want to do so may lie in order to be disqualified from donation. The argument that physicians or transplant personnel might relax acceptance criteria is equally suspect; there is no reason for a physician (who receives the same compensation whether the donor is a compensated donor or an altruistic donor) to be more prone to misrepresent acceptance criteria for compensated donors. Abuse by potential donors could be minimized by appropriate screening and oversight; for example, as mentioned earlier, potential compensated donors might be required to undergo viral screening twice, at six-month intervals. Furthermore, is the mere potential for abuse a sufficient reason to allow waiting transplant candidates to die? We don't allow the pos-

No evidence suggests that compensated donation would have any negative impact on either patient care or compensated donors' expectations of doctors.

Life insurance is now common, yet at one time it was maligned as improper commodification.

sibility of abuse to justify bans on numerous other priorities. Even though some people speed, we do not ban fast cars.

Illogical Arguments

Unregulated systems have failed elsewhere.

This is an argument against allowing the black market to thrive as it does in some countries, not against establishing a system such as the one suggested here.

Congress and various professional societies have already voted to prohibit compensation, so that ends the discussion. Those votes occurred in an era when the waiting time for a deceased donor kidney was short, and the likelihood of dying while waiting was low. As discussed above, the situation for today's patients and donors is quite different. We already accept that any number of previous congressional or societal decisions (for example, on slavery or on women's rights) can be changed as public standards evolve. Life insurance is now common, yet at one time it was maligned as improper commodification. Placing a financial value on human life as done by the life insurance industry was initially thought an affront to human dignity and a form of "putting death on the market" that devalued the sanctity of human life.⁶⁸ The notion of compensation for organs is closely analogous to how Americans previously felt about life insurance.

Some researchers argue that, because compensated donation is currently a contentious issue, politicians (always concerned about reelection) would be reluctant to propose and fight for a change in the law. Whether or not this is true, it is not an argument either for or against compensated donation. Certainly, it was difficult to change the law to allow emancipation of women and blacks. Presumably, since there are surveys (see earlier discussion) that show the public generally supports a system of compensated donation, politicians should be willing to eliminate the ban, at least if what was found in the surveys is confirmed through polling.

The sale of blood has failed. The failure referred to in such arguments occurred before

effective testing was available for human immunodeficiency virus (HIV) and hepatitis. Our blood screening tests are now much better, so today we are comfortable that we can effectively screen the blood of potential donors, both altruistic ones and those compensated for their donations.

Organized religions would object. Actually, almost all organized religions currently support conventional organ donation. And all Western religions give priority to saving a life. In Judeo-Christian culture, saving lives takes precedence over other religious laws and customs. Where individual religious authorities fail to take a formal stand for or against compensated donation,⁶⁹ individual religious donors can choose on their own whether to be compensated or not. Furthermore, in a country that prides itself on maintaining the separation of church and state, religious belief should not determine law and public policy.⁷⁰

Financial incentives would constitute coercion. Some philosophers define the word "coercion" as "persuasion [of an unwilling person] to do something by using force or threats."⁷¹ No potential compensated donor can be coerced by the opportunity to be compensated for donation. The term "coercion" is often misused when authors invoke it to suggest that payment might "manipulate the victim's preferences, even if it would be rational to accept"⁷² or that "the intent of the offer is to elicit behavior that contradicts the individual's normal operative goals."⁷³ The fact of payment does not indicate that the compensated donor's choice isn't free and voluntary.⁷⁴ As noted by one theorist, "it is unclear why engaging in market transactions with the poor constitutes the use of coercive power, while doing so with the middle class or the wealthy is an appropriate expression of personal freedom."⁷⁵ Moreover, if this "financial pressure" is sufficient to justify a ban on compensated donation, then psychological or emotional pressure that may occur in related donation should justify a ban on altruistic donation. Furthermore, a ban on compensated donation is clearly overbroad because it also stops potential donors who are not financially vulnerable.⁷⁶

“Coercion” is different from “peaceful persuasion.” Coercion violates the free choice of persons, whereas peaceful persuasion “grounds the very process of negotiation through which individuals fashion consensual agreements.”⁷⁷ As succinctly put in an article by Mark J. Cherry: “To be coercive, rather than peaceably manipulative, requires showing that making such an offer places potential compensated donors into unjustified, disadvantaged circumstances. Financial offers may be ‘seductive,’ but they are not subtle threats.”⁷⁸

The coercive argument can be phrased differently.⁷⁹ Some observers who are concerned about “coercion” do not see the poor as being coerced by the offer itself. Instead, they believe that “a market in human kidneys would enable the poverty of destitute people to coerce them into selling their kidneys and would provide the necessary conditions for the poor to suffer from impaired autonomy in a way that they would not otherwise suffer.”⁸⁰ Therefore, the argument goes, prohibiting compensation protects the poor from a limitation of their autonomy.

But poverty in and of itself cannot coerce.⁸¹ Coercion requires an “agent” trying to control the potential seller. James S. Taylor, in his book *Stakes and Kidneys: Why Markets in Human Body Parts Are a Moral Imperative*, points out that “a person’s economic situation is not an intentional entity, and so it makes no sense to claim that it intends to exercise control over the persons who find themselves within it. Impoverished people thus cannot give up any degree of control over their actions to that which is already allegedly coercing them, that is, their economic situation.”⁸²

We should do more preventive medicine. Of course this is true, yet we still have a shortage of organs. And given what we know of the causes of ESRD, it is not preventable, as some once thought it might be.⁸³

Other current initiatives are working. As discussed above, even if all new initiatives succeed, there would still not be sufficient kidneys to meet the need. More needs to be done than simply encourage an increase in altruistic donation.

Once we allow compensated donation, we cannot return to altruistic donation. Some opponents argue that a regulated system of organ donation that allows compensation would fail. They argue that, once we start a trial of compensated donation, we could never return to the conventional altruistic system. But there is no reason why we could not have a temporary clinical trial of compensated donation. For example, the ban could be lifted for three years so that trials could be done; then there could be a planned one-year moratorium thereafter, in order to evaluate results and reach conclusions. Such trials could also be limited in their regional scope and not be done in every part of the country. After evidence from these trials is available, there could be open discussion as to whether or not to permanently lift the ban.

The system proposed here is a blanket legalization of black market practices. As discussed above, for a system of compensated donation to work, certain precautions must be taken:

- Allocation of kidneys by a predefined algorithm so that everyone on the list has an opportunity to undergo a transplant;
- Full evaluation of potential donors;
- Informed consent;
- Careful oversight;
- Long-term follow-up;
- Treatment of the donor with dignity, including recognition for providing a lifesaving gift; and
- A fixed payment to the donor by the government or government-approved agency and no one else.

Approval of such a system should in no way be seen as giving license to currently existing black markets. It is purely alarmist and illogical to accuse those who advocate one thing of in fact advocating something else. The United States operates under a well-established rule of law, and nothing in this proposal suggests abandoning that system in favor of a free-for-all where the government protects neither the rights of recipients nor of donors.

No potential compensated donor can be coerced by the opportunity to be compensated. Poverty in and of itself cannot coerce.

“I am advocating not that people be treated by others as property, but only that they have the autonomy to treat their own parts as property.”

Arguments that Equate Compensation with Wrongful Commodification of the Body

Some authors argue that putting a monetary value on a body part would result in a loss of human dignity. Even in cases where this is arguably true, as with slavery, it does not follow that compensation for the donation of body parts is wrong. As outlined by several authors, there are numerous differences between slavery and compensated donation.⁸⁴ For example, Michele Goodwin, in her book *Black Markets*, points out that in slavery there was no choice—it was compulsory, state enforced and protected, with no opt-out provisions.⁸⁵ Therefore, arguments that slavery is wrong do not lead to the conclusion that incentives for organ donation are wrong.⁸⁶ Furthermore, unlike slavery, there are many forms of “commodification” that are clearly not dehumanizing. For example, there is no evidence that sperm or egg donors or surrogate mothers have diminished self-dignity or self-worth. There is also no necessary connection between the commodification of bodies or body parts and the commodification of persons. Stephen Wilkinson, in his article “Commodification Arguments for the Legal Prohibition of Organ Sales,” points out that there is no indication that organ sales are any more likely to cause the commodification of persons than other widely accepted practices, such as altruistic organ donation and compensated labor.⁸⁷ The anti-commodification argument may have tremendous emotional impact, but lacks supporting data. As Michael Gill and Robert Sade put it in their well-known Kennedy Institute of Ethics article, “My Kidney Is Not My Humanity,”⁸⁸ “humanity—what gives us dignity and intrinsic value—is our ability to make rational decisions, and a person can continue to make rational decisions with only one kidney.”⁸⁹

No doubt, some of the concern regarding commodification comes from our own (industrialized Western civilization) history. Lori Andrews, in an article in the *Hastings Center Report* (one of the oldest and most renowned bioethics journals), notes that “some of the finest advances in society have resulted from a refusal to characterize human beings (blacks,

women, children) as property,” but elaborates, “I am advocating not that people be treated by others as property, but only that they have the autonomy to treat their own parts as property.”⁹⁰ Just as attitudes and laws have changed regarding characterization of blacks, women, and children as property, societal attitudes are critical to the dignity of compensated donors. If compensated donors are treated as heroes who receive compensation for their pain and have their rights and interests protected, they can sell their kidneys without any loss of dignity.⁹¹ Heroism does not preclude payment: many other heroes (such as police officers and firefighters) are compensated for their heroic work.

In part, dignity is something we convey by our behavior and attitudes. If we establish a system of compensation, it is our responsibility to create a culture of dignity for compensated donors. Some thoughtful authors on these topics suggest using the term “compensated donation” or “rewarded gifting” to confer dignity to the procedure.⁹²

Some detractors argue that body integrity is and should be more highly valued than allowing compensation for organs would indicate.⁹³ They argue that compensated donors are likely to have longstanding emotional or psychological damage because of the breaks in their bodily integrity. For example, Stephen Wigmore and colleagues in their article “Defending the Indefensible?” argue that “violation of this integrity is not well compensated for, other than by spiritual/philosophical gains such as acting in an altruistic fashion.”⁹⁴

But, again, little evidence supports this concept of negative violation. Surgical procedures, a direct violation of bodily integrity, do not usually lead to long-term psychological harm or damage to human dignity. One could argue that surgical procedures are necessary for the curing of disease, so their violation of bodily integrity is thus justified. But, for example, the entire field of plastic surgery requires a break in bodily integrity. In addition, numerous occupations and recreational activities are associated with risks to bodily integrity, yet we do not prevent people’s involvement in these activities. And many cultures and religions throughout the world violate bodily

integrity as part of their beliefs (for example, through piercings or male circumcision). Furthermore, individuals who see receiving compensation for organs as offensive can offer to donate without compensation. The “commodification” argument simply does not justify a total ban on compensated donation.

An extension of this argument is the concept that a system of compensation would harm society, because an individual’s value would shrink to be the sum value of his or her body parts. In reality, the court system (for example, through damage claims) regularly establishes monetary values for loss of or damage to various body parts or functions; this assignment of value has not resulted in a loss of appreciation for the overall, intangible value of an individual human being. Similarly, establishment of a system of sperm or egg donation or surrogate motherhood has not harmed society. There are many other situations in which we give rewards or incentives to community members—outstanding citizens, dedicated teachers, families left behind by soldiers killed in battle—without commodifying or diminishing the value of their gift to society.⁹⁵ Similarly, money is often given to others—presents, baptismal gifts, condolences to the bereaved—without any loss of dignity.⁹⁶ None of these practices diminish the value of the individual.

Arguments that Assume Compensation Would Exploit the Poor

The core of this argument is that kidney donation is risky, and, because the poor are more likely to sell a kidney than the rich, the financial offer will override a donor’s better judgment. In a broader context, the concern is that the citizens of Third World countries would become donors for citizens of industrialized countries. It is easy to dismiss this concern, because the system being discussed here would prohibit such a situation.

The system advocated here is constructed to prevent exploitation. In the Third World there is little (if any) pre- or posttransplant care of donors, and donors often do not receive the promised payment. The system described here is specifically designed to prevent such abuse of donors.

The fact that kidney donation has risks plays an important role in the exploitation argument. However, the risks of kidney donation cannot justify a ban on compensated donation. As discussed above, if surgical risk alone were sufficient to justify a ban on compensated donation, it should also be sufficient to justify a ban on altruistic donation. In addition, our society allows the less wealthy to take many high-risk jobs that the rich are unlikely to take (such as police officers, deep-sea divers, firefighters, military “volunteers,” and North Sea oil rig workers). And we allow both rich and poor to engage in recreational activities that have considerably greater risk than kidney donation, such as smoking, mountain climbing, skydiving, and bungee jumping.

Serious objections have never been raised about permitting financial incentives to encourage middle- and upper-class people to be compensated donors.⁹⁷ The “exploitation” argument against compensated donation becomes, in part, the argument that the poor are more likely to be compensated donors than the rich. The dictionary definition of exploitation is “utilization of another selfishly,”⁹⁸ that is, deriving wrongful advantage from the calamity of others. It is not clear that compensated donation would take wrongful advantage of anyone. First, it would benefit a subset of the population, namely, patients, whether poor or rich, with ESRD who are waiting for a transplant. Second, if the donor makes an autonomous decision and, in return, receives substantial compensation that may significantly improve his or her quality of life, we must ask, is this truly exploitation? Or, all things considered, is the notion of “exploitation” even of moral importance in this context? As one scholar points out, “In reality, any financial transaction would seem to have effects that differentiate based on income level.”⁹⁹ With compensated donation, “in a surprising contravention of our usual ideas about individual liberty, we prevent adults from entering freely into contracts from which both sides expect to benefit, and with no obvious harm to anyone else.”¹⁰⁰ By prohibiting the poor from being compensated donors, we

The court system through damage claims regularly establishes monetary values for loss of or damage to various body parts; this assignment of value has not resulted in a loss of appreciation for the overall, intangible value of an individual human being.

**Compensated
kidney donation
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of life.**

remove one opportunity for them to better their lives.

Some detractors erroneously equate economic opportunity with an unacceptable form of inequality that they see as exploitative of the poor. This type of argument was discussed in a recent *Kennedy Institute of Ethics Journal* article where the authors state, “if paying for kidneys is legalized, the ratio of poor people with only one kidney to rich people with only one kidney probably will increase.”¹⁰¹ This result could be seen as not being equal. But, the authors emphasize, “The kind of equality that matters to egalitarians, however, concerns not the presence of one kidney vs. two but economic and political power. There is no reason to believe that allowing payment for kidneys will worsen the economic or political status of kidney sellers in particular or of poor people in general.”¹⁰²

Most importantly, the “exploitation” argument centers on whether a system of compensated organ donation would take wrongful advantage of the calamity of others and on whether the financial offer would override the better judgment of individuals in desperate need. No doubt, a significant financial offer would provide hard choices for people in need. But there is a difference between a “hard choice” and “no choice.” I do not think we are willing to say that being poor removes the ability to make rational decisions (if we believed that, we would need legal guardians to vet any decision an impoverished person makes). A system that allows compensation for organs is not necessarily exploitative if it provides significant incentives (an amount that has the potential to make a positive impact on the compensated donor’s life) and if it includes procedural safeguards to ensure that donors know what they are doing and are acting voluntarily to seek their individual best. In the case of compensated kidney donation, the system would not be seeking the typical exploiter’s “wrongful gain,” but would be established to help both patients and donors experience a better quality of life.

Supporters of compensation for organ donation often counter the “exploitation”

argument by suggesting that the ban on compensated donation removes potential options for the poor, and leaves them poor; whereas if they could sell a kidney, it would give them the possibility to better their lives.¹⁰³ One author notes, “Banning payment on ethical grounds to prevent [exploitation] overlooks one important fact: to the person who needs money to feed his children or to purchase medical care for her parent, the option of not selling a body part is worse than the option of selling it.”¹⁰⁴

The ideal solution to the problem of the poor being more likely to be compensated donors would be to end poverty. Tamara Zutlevics suggests in her article “Markets and the Needy: Organ Sales or Aid?” that, rather than allowing compensated donation, we should provide additional aid to the poor.¹⁰⁵ The reality, however, is that no evidence suggests that poverty will disappear in the near future, no matter how much financial aid is provided. Forbidding compensated donation does nothing to eradicate poverty and has no effect on whether or not additional aid might be forthcoming. One prominent bioethicist, Robert Veatch, once suggested that, rather than permit compensated donation, we should prompt social change to end poverty, but he has become pessimistic about the possibility of social change and now favors compensated donation.¹⁰⁶ Veatch now offers a different perspective, noting that “irresistibly attractive” financial offers are not usually felt to be unethical. He asks why offers (to induce consent to procure organs) that are irresistible because of the amount of compensation being offered are deemed unethical, while offers of jobs and offers of basic necessities are not. Further, he suggests that the ethical problem is not that the offer is attractive to its recipient, as compared with the alternatives available, but “must be understood in terms of the options available to the one making the offer.”¹⁰⁷ Veatch’s original concern about compensated donation was that the (political) decisionmakers could, in effect, force the poor to sell their organs by withholding alternative means of addressing their problems. Reexamining the issue 20 years later, he now concludes that our society has

done little to help the poor, and with “shame and bitterness” proposes that it is time to lift the ban on compensated donation, “If we are a society that deliberately and systematically turns its back on the poor, we must confess our indifference to the poor and lift the prohibition on the one means they have to address their problems themselves.”¹⁰⁸

Finally, it is argued that in a government-controlled single-payer system there would be pressure to lower the price compensated for each kidney, that is, institutionalized “exploitation” would occur (as described above by Veatch). But this is unlikely because the price offered for a kidney would need to be sufficient to “encourage” potential donors to step forward. In a welfare state like the United States, where the most basic of needs are met by society, the poor will not step forward simply to meet those basic needs. The compensation offered must increase their standard of living beyond what is otherwise available through state and private aid, or they won’t donate.

A Balance of Principles

Opponents of a system of compensation for any of the reasons detailed above imply that they are taking the moral high ground by protecting the potential compensated donor (supposedly from exploitation or from the harm of surgery) or by protecting society (supposedly from loss of human dignity). The end result, however, is that they are sentencing many transplant candidates to death or to ongoing suffering on dialysis and denying many potential donors an opportunity to improve their lives.

There is no avoiding the ethical dilemma: yes, kidney donation has risks, albeit small; yes, the poor are more likely to become compensated donors. But the prohibition of financial incentives now results in the (preventable) death of many transplant candidates and the languishing of many on dialysis. And prohibition prevents potential compensated donors from receiving a payment that will benefit them as well. Even those who oppose compen-

sation recognize this dilemma and waffle when discussing the issue. Some propose an “ethical incentive”—payment of \$300 to consenting families of potential deceased donors for funeral expenses.¹⁰⁹ Others propose a gold medal—but the medal would have significant value (\$10,000) and could be sold.¹¹⁰

As described above, the four principles defined by Beauchamp and Childress¹¹¹ (respect for autonomy; beneficence; justice; and nonmaleficence) conflict not only when applied to compensated donation but also when applied to altruistic donation. Balancing the advantages against the harms is similar in both situations. And in each case, the benefits of permitting donation outweigh the harms.

At the end of the day, one must cut through all the passion and rhetoric and ask this very simple question: What is the better option—establishing a system of compensation (even if doing so might not be easy) or maintaining the status quo (under which transplant candidates are suffering and dying on dialysis)?

The better option is to eliminate the ban on financial incentives so that we can increase the number of transplants, significantly decrease or eliminate deaths on the waiting list, and improve the overall survival rates and quality of life for patients with ESRD. It is time to eliminate the 1984 National Organ Transplant Act prohibition against “valuable consideration” for organs. Once the ban on incentives is lifted, we can initiate pilot trials to determine how best to preserve the rights and improve the lives of both kidney donors and kidney recipients.

The issue of compensated kidney donation is not a hypothetical ethical fine point; it affects the lives of people worldwide. Leon Kass, former chairman of the President’s Council on Bioethics and a staunch opponent of compensation, writes, “I suspect that regardless of all my arguments to the contrary, I would probably make every effort and spare no expense to obtain a suitable life-saving kidney for my child—if my own were unusable. . . . I think I would readily sell one of my own kidneys, were its practice legal, if it were the only

At the end of the day, one must ask this simple question: Which is the better option—establishing a system of compensation (even though it might not be easy) or maintaining the status quo (while transplant candidates suffer and die)?

way to pay for a life-saving operation for my children or my wife.”¹¹²

Notes

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