

MONEY AS A MOTIVATOR: THE CURE TO OUR NATION'S ORGAN SHORTAGE

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"Paying for organs is morally odious, mainly to those who are not dying to get one."¹

I. INTRODUCTION

In 2010, 7,000 individuals died while on an organ transplant waiting list.² This occurred despite the fact that every year there are 12,000 individuals who die that are eligible donors.³ Yet, less than half of these individuals choose to become donors so that other precious lives can be saved.⁴ In the United States, the availability of organs from deceased donors is almost non-existent—only twenty-five out of a million people.⁵ Further complicating the issue is the fact

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¹ Robert Berman, *Selling Organs Should Be Legal*, JERUSALEM POST, Aug. 10, 2005, at 15.

² Organ Procurement & Transplantation Network, *National Data Reports*, U.S. DEPT. OF HEALTH & HUMAN SERVS., <http://optn.transplant.hrsa.gov/data/> (select "View Data Reports"; "National Data"; "Waiting List Removals"; and "Removal Reasons by Year") (last visited Apr. 4, 2011); See Ronald Bailey, *Should I be Allowed to Buy Your Kidney?*, FORBES, May 28, 1990, at 365.

³ 25 *Facts About Organ Donation and Transplantation*, NAT'L KIDNEY FOUND., http://www.kidney.org/news/newsroom/fs_new/25factsorgdon&trans.cfm [hereinafter 25 *Facts*] (last visited Apr. 4, 2011).

⁴ *Id.*

⁵ Sally Satel, *Kidney Mitzvah: Israel's Remarkable New Steps to Solve Its Organ Shortage*, SLATE,

that modern medicine is now prolonging lives so that the numbers of individuals on the transplant waiting lists are expanding.⁶ As we continue to head down this slippery slope, it is easy to see how current organ procurement laws and regulations in the United States have failed to alleviate the organ shortfall.⁷ The result: thousands of individuals wait patiently for death to arrive. The failure of our current laws to meet the ever-increasing organ demand calls for aggressive exploration of alternative means of procurement, including financial incentives.⁸ But thus far, the concerns voiced by opponents to financial incentives have persuaded lawmakers that legalizing organ markets is too risky.⁹ As emphasized by Judge Posner, it appears as though the conduct of selling organs is “highly offensive to nonparticipants.”¹⁰

Opponents argue, albeit incorrectly, that financial incentives will result in the poor not being able to have access to the donor pool, the poor being coerced into giving organs out of financial necessity, families and physicians terminating care too early in order to harvest much needed organs, the potential of organ quality to decrease, and the overall concern of transforming the body into a commodity.¹¹ In

Jan. 27, 2010, <http://www.slate.com/id/2242791/>.

⁶ Andrew C. MacDonald, *Organ Donation: The Time Has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL'Y REV. 177, 179 (1997).

⁷ David L. Kaserman, *Fifty Years of Organ Transplants: The Successes and the Failures*, 23 ISSUES L. & MED. 45, 46 (2007).

⁸ Julia D. Mahoney, *Altruism, Markets, and Organ Procurement*, 72 LAW & CONTEMP. PROBS. 17, 18 (2009), available at [http://www.law.duke.edu/shell/cite.pl?72+Law+&+Contemp.+Probs.+17+\(summer+2009\)+pdf](http://www.law.duke.edu/shell/cite.pl?72+Law+&+Contemp.+Probs.+17+(summer+2009)+pdf) (discussing how the lack of success of “‘required request’ laws mandating that families of potential organ providers be approached about donation, public-information campaigns, and other policy initiatives designed to remedy the organ shortage militate for aggressive exploration of all options, including financial rewards”); see Bailey, *supra* note 2 (quoting the late Brian Broznick, executive director of the Pittsburgh Organ Transplant Foundation, as stating “[r]equired request laws are a joke”).

⁹ Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America’s Organ Shortage*, 13 GEO. MASON L. REV. 69, 91 (2004); see R. R. Kishore, *Human Organs, Scarcities, and Sale: Morality Revisited*, 31 J. MED. ETHICS 362, 363 (2005).

¹⁰ Richard A. Posner, *Organ Sales*, BECKER-POSNER BLOG, Jan. 1, 2006, <http://www.becker-posner-blog.com/2006/01/organ-sales—posners-comment.html>.

¹¹ See *infra* Part III.A.

addition, many individuals are beginning to question the current system that allows hospitals, doctors, and other organizations to profit handsomely from organ transplantation while the organ donor isn't paid one penny.¹²

Part II of this paper will discuss our current legislative framework, its inability to meet the growing need for organs, and two recent initiatives aimed at increasing organ supply. Part III will discuss financial incentives to organ procurement and how incorporating those incentives will alleviate the death toll continually being realized. Part IV will urge Congress to take further action in implementing legislation that would allow financial incentives via a regulated organ spot market.

II. THE CURRENT STATE OF ORGAN DONATION

A. Historical Legislative Framework

In the late 1960s, the National Conference of Commissioners on Uniform State Laws (NCCUSL) drafted the Uniform Anatomical Gift Act (UAGA) in an attempt to increase organ donations and reduce the organ shortage in the United States.¹³ Unfortunately, the UAGA did not work as intended as the demand for organs continued to increase faster than organs could be supplied.¹⁴

Thus, Congress passed the National Organ Transplant Act (NOTA) in 1984 authorizing funding for qualified organ procurement organizations (OPOs).¹⁵ Through the enactment of NOTA it was "recommended that all hospitals adopt a system of routine inquiry

¹² Mahoney, *supra* note 8, at 17; see MICHELE GOODWIN, BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS 18–20 (2006); Julia D. Mahoney, *The Market for Human Tissue*, 86 VA. L. REV. 163, 176–86 (2000).

¹³ Daniel T. Stimson, *Private Solicitation of Organ Donors: A Threat to the Fairness of the U.S. Organ Transplant System, or a Solution to the National Organ Shortage?*, 10 MICH. ST. J. MED. & L. 349, 352 (2006).

¹⁴ *Id.* at 353.

¹⁵ See 42 U.S.C.A. § 273 (2010) (A qualified OPO is a nonprofit entity that must carry out defined functions as mandated by the Secretary of Health and Human Services). See 42 U.S.C.A. § 273(b) (2010).

and 'required request' concerning organ donation."¹⁶ Pursuant to NOTA, Congress created the Organ Procurement and Transplantation Network (OPTN) to streamline the allocation of organs throughout the country¹⁷ and chose the United Network for Organ Sharing (UNOS) to administer the OPTN.¹⁸ UNOS is a nonprofit organization tasked with the operation and continual upkeep of the national organ transplant waiting list.¹⁹

Congress, in passing NOTA, included language that would prove detrimental to needy organ recipients. Specifically, Congress forbid the exchange of transplantable organs for "valuable consideration" and imposed heavy fines and/or jail time for those that didn't abide by the law.²⁰ A report from the House of Representatives stated, "[T]here is strong evidence to suggest that permitting the sale of human organs might result in the collapse of the nation's system of voluntary organ donation."²¹ During deliberations within the House Committee on Science and Technology, former Congressman Al Gore, Jr. stated that paying for organs "blurs the distinction between people and things, as human organs become simply another commodity to be bought and sold in the marketplace."²²

¹⁶ Stimson, *supra* note 13, at 353 (discussing the requirements for written protocols and mandates on hospital staff to discuss the possibility of organ donation with dying patients and their families).

¹⁷ Organ Procurement & Transplantation Network (OPTN) Charter art. 2, available at http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_CHARTER_II_-_NOV_04.pdf (last visited Aug. 21, 2010).

¹⁸ OPTN: Organ Donation & Transplantation, UNITED NETWORK FOR ORGAN SHARING <http://www.unos.org/donation/index.php?topic=optn> (last visited Aug. 21, 2010).

¹⁹ Stimson, *supra* note 13, at 355.

²⁰ 42 U.S.C.A. § 274(a)-(b) (West 2010) ("It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce. Any person who violates [the Act] shall be fined not more than \$50,000 or imprisoned not more than five years, or both.").

²¹ Mahoney, *supra* note 8, at 22 (citing H.R. REP. NO. 98-575, at 22-23 (1983)).

²² Calandrillo, *supra* note 9, at 91 n.112 (2004).

B. Continuing Organ Shortage

As of April 4, 2011, over 15 years since the passage of NOTA, the U.S. waiting list for organs was 110,594.²³ This included approximately 88,000 people waiting for kidneys, about 16,000 waiting for livers, and over 3,100 waiting for hearts.²⁴ From 1995 – 2010, approximately 105,000 individuals in the United States have died while waiting on an organ to become available.²⁵ This is equivalent to the entire population of either Bismarck, North Dakota or Meridian, Mississippi.²⁶ With these daunting figures in mind, it is no surprise that Dr. Scott Halpern, a senior fellow at the University of Pennsylvania’s Center for Bioethics, stated, “[i]f someone were to design an [organ donation] system, they would never design a system [like the current one] that allowed thousands to die each year while costing the government \$33 billion in medical costs.”²⁷

However, opponents of financial incentives continually reiterate the age-old arguments that were expressed prior to the passage of NOTA that compensation would eliminate altruistic donations and decrease the supply of organs.²⁸ This fails to recognize that transplantable organs are currently bought and sold for large sums of money within the medical community.²⁹ As such, there is little or no

²³ Data, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/data/> (last visited Apr. 4, 2011).

²⁴ *Id.*

²⁵ *National Data Reports*, *supra* note 2.

²⁶ *Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2000 to July 1, 2008 (CBSA-EST2008-01)*, U.S. CENSUS BUREAU, <http://www.census.gov/popest/metro/tables/2008/CBSA-EST2008-01.xls> (last visited Apr. 4, 2011) (showing the estimated populations on July 1, 2008 to be 104,944 for Bismarck and 105,525 for Meridian).

²⁷ Courtney Hutchison, *Organs in the American Marketplace: Paying for Kidneys Increases the Supply, But at What Cost?*, ABC NEWS, Apr. 2, 2010, available at <http://abcnews.go.com/print?id=10260801>.

²⁸ Mahoney, *supra* note 8, at 22.

²⁹ See *Financing a Transplant*, TRANSPLANT LIVING, <http://www.transplantliving.org/beforethetransplant/finance/costs.aspx> (last visited Aug. 21, 2010) (information retrieved from the “Estimated U.S. Average 2008 First-Year Billed Charges Per Transplant” table showing the procurement costs of organs ranging from approximately \$54,000 for a lung to \$152,000 for a Heart and Lung).

evidence to substantiate or justify a claim that payments for organs either directly to donors or to the donors' families would eliminate altruistic donations.³⁰

C. Altruistic Motivation

In today's world, the current framework that relies upon altruism only simply doesn't provide the quantity of organs needed.³¹ The disconnect between organ supply and demand can be attributed to several issues. For example, when a family is grieving immediately after the loss of a loved one, it is common for family members to forget about the possibility of donating the organs for others to use.³² In addition, medical professionals are hesitant to talk with grieving families about donations due to the belief that the subject will inflict additional stress in an already tumultuous situation.³³ This failure to talk with the family about donation results in many usable organs going uncollected.³⁴ This is tragic given that hearts, livers, lungs, intestinal organs, and pancreata come largely from deceased donors.³⁵ Furthermore, not all hospitals have the facilities or medical capabilities to harvest organs. Thus, when a potential donor dies, a hospital that cannot benefit financially from the harvest will likely not broach the subject of altruistic donation with the families and will allow the organs to be discarded.³⁶ It is

³⁰ See Mahoney, *supra* note 8, at 23.

³¹ *Id.* at 24; President's Council on Bioethics, *Staff Background Paper: Organ Transplantation: Ethical Dilemmas and Policy Choices*, BIOETHICS RES. LIBR. GEORGETOWN UNIV. http://bioethics.georgetown.edu/pcbe/background/org_transplant.html (last visited Aug. 21, 2010).

³² Chad D. Naylor, Note, *The Role of the Family in Cadaveric Organ Procurement*, 65 IND. L.J. 167, 184 (1989).

³³ *Id.* at 185.

³⁴ Phyllis Coleman, "Brother, Can You Spare a Liver?" *Five Ways to Increase Organ Donation*, 31 VAL. U. L. REV. 1, 9 (1996).

³⁵ Peter A. Clark, *Financial Incentives for Cadaveric Organ Donation: An Ethical Analysis*, 4 INTERNET J.L., HEALTHCARE & ETHICS (2006), <http://www.ispub.com/ostia/index.php?xmlFilePath=journals/ijlhe/vol4n1/organ.xml> (estimating that 22,000 die each year of cardiac arrest that could be potential donors).

³⁶ DAVID L. KASERMAN & A.H. BARNETT, *THE U.S. ORGAN PROCUREMENT SYSTEM, A PRESCRIPTION FOR REFORM* 29 (Marvin H. Kusters ed., American Enterprise Institute for

apparent that our current altruistic system is failing our society and drastic changes are needed to procure usable organs.

D. The Black Market and Other Illegal Payments

It is not surprising that with long wait times for life-saving organs, transplant tourism to black markets are viable solutions for individuals facing imminent death.³⁷ One article suggests that “one fifth of the 70,000 kidneys transplanted worldwide every year come from the black market.”³⁸ The troubling aspect of donors undergoing surgery in the black market is that, by definition, the market is unregulated and patients may not receive the same postoperative care that a regulated United States hospital could have provided.³⁹

In addition to the sales occurring in black markets, a Dallas doctor has stated that “many [living donors] are getting compensated under the table” and [doctors and healthcare providers] “don’t want to know about [illegal payments].”⁴⁰ Another Washington, D.C. doctor estimates that between 15 to 20 percent of living donor cases involve some type of compensation being received by the donor.⁴¹

If the laws in the United States are unable to provide the organs needed and our own citizens are being forced to take extreme measures to stay alive, it’s time to re-think our policies and consider an open market.⁴² Our leaders must realize that organ trafficking and illegal payments will continue as long as the demand exceeds the

Public Policy Research 2002).

³⁷ Alex Tabarrok, *Essay: The Meat Market*, WALL ST. J. (Jan. 9, 2010), <http://online.wsj.com/article/SB10001424052748703481004574646233272990474.html> (stating that the black market for organs may account for 5 to 10 percent of transplants worldwide).

³⁸ See Jeneen Interlandi, *Not Just Urban Legend*, NEWSWEEK (Jan. 19 2009), <http://www.newsweek.com/id/178873/page/1>.

³⁹ Tabarrok, *supra* note 37.

⁴⁰ Bailey, *supra* note 2, at 368.

⁴¹ *Id.*

⁴² Gary S. Becker, *Should the Purchase and Sale of Organs for Transplant Surgery be Permitted?*, BECKER-POSNER BLOG, Jan. 1, 2006, <http://www.becker-posner-blog.com/2006/01/should-the-purchase-and-sale-of-organs-for-transplant-surgery-be-permitted-becker.html> (arguing that an open market would diminish black markets).

supply.⁴³ To meet this demand, the United States must, with proper governmental controls, allow donors to be financially compensated so that patients can obtain transplants and receive adequate postoperative care and medication.⁴⁴

E. A Recent Legislative Proposal

Only a few members of Congress have taken note of the massive organ shortage and circulated a bill to address the problem. The Organ Trafficking Prohibition Act (OTPA) of 2009 (formerly known as the Organ Donation Clarification Act of 2008⁴⁵) was an attempt by former Senator Arlen Specter to increase the number of organs collected by providing donors with noncash benefits.⁴⁶ The bill stated, "[t]he sovereign's provision of a gratuitous benefit to organ donors is not commercial in nature and does not constitute a commercial sales transaction."⁴⁷ Although cash payments were not contemplated or allowed by the proposed legislation, other benefits such as burial costs, health insurance, life insurance, and tax credits are all possible.⁴⁸ In addition, the bill would have increased oversight to monitor and police the trafficking of human organs.⁴⁹ Specter's proposed bill won the support and endorsement of some major institutions, including the American Medical Association.⁵⁰ There is

⁴³ Sally Satel, *The Case for Paying Organ Donors*, WALL ST. J. (Oct. 18, 2009), <http://online.wsj.com/article/SB10001424052748704322004574477840120222788.html>.

⁴⁴ *Id.*; Michele Goodwin, *Altruism's Limits: Law, Capacity, and Organ Commodification*, 56 RUTGERS L. REV. 305, 404 (2004).

⁴⁵ Debra Budiani-Saberi & Deborah M. Golden, *Advancing Organ Donation Without Commercialization: Maintaining the Integrity of the National Organ Transplant Act*, AM. CONST. SOCIETY FOR L. & POL'Y, 1, 7, (June 2009), <http://www.acslaw.org/files/Budiani%20Saberi%20and%20Golden%20Issue%20Brief.pdf>.

⁴⁶ Nathan Guttman, *Kidney Donation Scandal Sparks New Debate Over Specter's Organ Legislation*, FORWARD (Aug. 14, 2009), <http://www.forward.com/articles/111473/>; Sally Satel, *About That New Jersey Organ Scandal*, WALL ST. J., July 26, 2009, <http://online.wsj.com/article/SB10001424052970204886304574307932274150934.html> (The bill is cosponsored by Senators Bob Casey, Jr. and Tom Harkin).

⁴⁷ Guttman, *supra* note 46.

⁴⁸ *Id.*; Satel, *supra* note 46; Budiani-Saberi & Golden, *supra* note 45, at 6.

⁴⁹ Guttman, *supra* note 46.

⁵⁰ *Id.*; John J. Pitney, Jr., *Providing Legal Incentives and Rewards for Organ Donation: A Firsthand*

no doubt that legislation like Specter's will have a positive impact on the huge organ deficit; however, it's still unclear if noncash benefits alone will be enough.

F. National Kidney Foundation's "END THE WAIT" Plan

In January 2009, the National Kidney Foundation rolled out a new plan (END THE WAIT!) to raise awareness and help increase the number of donor organs available.⁵¹ The plan calls to end the wait for kidney transplants within 10 years by working with Congress to enact new legislation.⁵² The plan will focus on four problem areas: (1) Improving first transplants, (2) Increasing deceased donation, (3) Increasing the number of living donors, and (4) Improving the system of donation and transplantation.⁵³ However, the plan has not, for good reason, convinced the public that it will work due to its lack of clarity regarding how the problem areas targeted will be addressed. Dr. Sally Satel, a noted author on the failures of altruistic donations and a kidney donee, stated that "the plan is not serious about reducing the wait."⁵⁴ She continued, "[m]ore of the same old strategies won't recruit enough new donors."⁵⁵

III. FINANCIAL INCENTIVES

A basic fundamental element is missing from the economic organ equation – price paid to the donors. Economists generally believe that

Look at the Issue, ENCYCLOPEDIA BRITANNICA BLOG, Dec. 4, 2008, <http://www.britannica.com/blogs/2008/12/providing-legal-incentives-for-organ-donation-a-firsthand-look-at-the-issue>.

⁵¹ *Organ Shortage Needs Multi-Faceted Approach: National Kidney Foundation Issues Call to Action and Unveils Comprehensive Plan to END THE WAIT!*, NAT'L KIDNEY FOUND., <http://www.kidney.org/news/newsroom/newsitem.cfm?id=114&&cid=89> (last visited Aug. 21, 2010).

⁵² *Id.*

⁵³ *Id.*

⁵⁴ Jim Warren, *NKF rolls out "END THE WAIT" initiative with goal of ending wait for a kidney transplant in next 10 years*, TRANSPLANT NEWS (Feb. 2009), http://findarticles.com/p/articles/mi_m0YUG/is_2_19/ai_n31437718/.

⁵⁵ *Id.*

a free market maximizes the value of goods in the marketplace.⁵⁶ Thus, a complete prohibition of the price mechanism in the free market negatively impacts the ability to harvest organs and transfer them to those in need.⁵⁷ With demand far outpacing supply, it is time to introduce financial motivators into the current system to garner additional organs and alleviate the pain being suffered by so many.

Our current laws are not just failing our waitlisted patients, but also those that altruistically donate their organs. For example, after Susan Sutton was declared brain dead, her parents donated her organs.⁵⁸ Her bones were used for reconstructive surgery, her skin helped burn victims, her liver saved a life, and her corneas went to eye transplants.⁵⁹ With the exception of Susan's estate, every party involved in the collection and redistribution of Susan's gifts reaped a financial reward.⁶⁰ Susan's parents were forced to bury Susan in a pine box without a chapel service and with no grave marker.⁶¹

A simple illustration demonstrates why our current reliance on altruistic donations for organs is failing so miserably: if altruism and a feeling of doing what is noble is the ultimate motivator, then why aren't more services provided for free?⁶² The answer is that far more people would demand free service than the number of those that would be willing to supply it.⁶³ So, in order to ensure that we receive the quality services we need and expect, we willingly pay.⁶⁴ In the case of our national organ shortage, the patients on the waiting list

⁵⁶ Gregory S. Crespi, *Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs*, 55 OHIO ST. L.J. 1, 18-19 (1994).

⁵⁷ *Id.* at 19.

⁵⁸ Coleman, *supra* note 34, at 16; *Mother Protests Pauper Burial for Organ Donor*, LA TIMES (Feb. 21, 1990), http://articles.latimes.com/1990-02-21/news/mn-1259_1_organ-removal.

⁵⁹ *Mother Protests Pauper Burial for Organ Donor*, *supra* note 58.

⁶⁰ *Id.*; Coleman, *supra* note 34, at 16.

⁶¹ Coleman, *supra* note 34, at 16; *Mother Protests Pauper Burial for Organ Donor*, *supra* note 58.

⁶² See Steve Chapman, *Dying People Shouldn't Be Beggars: Altruism as a Failing Medical Strategy*, CHI. TRIB., Mar. 14, 2010, at C21, available at http://articles.chicagotribune.com/2010-03-14/news/ct-oped-0314-chapman-20100314_1_marrow-donors-marrow-transplant-fatal-blood-disease.

⁶³ *Id.*

⁶⁴ *Id.*

may be willing to pay, however, our own laws have criminalized such payments.⁶⁵ But compensation has been paid to individuals that perform honorable deeds for as long as we can remember.⁶⁶ For example, the services provided by firefighters, military personnel, and social workers are righteous and it's widely accepted that the people performing in those roles should be paid.⁶⁷ One must ask, "why shouldn't [a donor] be able to accept a reward for saving the life of another human being?"⁶⁸ In the end, it's the donor that bears all the risk in order to save another life and our society should be willing to compensate a donor for providing such a service.⁶⁹

Although the legal restrictions against providing valuable consideration for organs have been in place since NOTA's passage in 1984, people are ready to entertain a change that will benefit the greater good of society.⁷⁰ As evidenced by a UNOS survey, fifty-two percent of United States citizens were in favor of providing compensation to those that donate their organs.⁷¹ As one points out, "[i]f public opinion is in favor of some form of financial incentives, then it seems odd that we are so timid in examining this idea realistically."⁷² Offering financial incentives in addition to our existing altruistic system will help persuade individuals that might otherwise be unwilling to part with their organs.⁷³

Allowing financial incentives to be paid to organ donors will

⁶⁵ 42 U.S.C.A. § 274e.

⁶⁶ See Sally Satel, *A 'Gift of Life' with Money Attached*, N.Y. TIMES, Dec. 22, 2009, at D5, available at <http://www.nytimes.com/2009/12/22/health/22essa.html>.

⁶⁷ *Id.*

⁶⁸ Satel, *supra* note 43.

⁶⁹ *Id.*

⁷⁰ 42 U.S.C.A. § 274e.

⁷¹ Christy M. Watkins, *A Deadly Dilemma: The Failure of Nations' Organ Procurement Systems and Potential Reform Alternatives*, 5 CHI.-KENT J. INT'L & COMP. L. 1, 24 (2005), available at http://www.kentlaw.edu/jicl/articles/spring2005/s2005_christy_watkins.pdf; see also David E. Jefferies, *The Body as Commodity: The Use of Markets to Cure the Organ Deficit*, 5 IND. J. GLOBAL LEGAL STUD. 621, 653 (1998) ("[The] free market system enjoys its greatest popularity in the United States. Americans accept the market as an alternative to altruistic systems and the coercive power of the state.").

⁷² Clark, *supra* note 35.

⁷³ Crespi, *supra* note 56, at 21.

increase the number of transplants performed thereby reducing the number of people that die on the transplant waiting lists and will also decrease the overall cost to society.⁷⁴ Even if the policy changes come at an expense, it will be considerably less costly than life-sustaining methods, such as dialysis, used on patients while they wait for an organ to become available.⁷⁵

The question remains, however, as to how much it would take to encourage people, that would otherwise be unwilling to donate, to part with their organs.⁷⁶ For example, the amount provided “must be adequate to induce individuals to overcome psychological barriers, religious and ethical concerns, and the inconvenience and time taken to enter into [a] contract.”⁷⁷ How much of a financial incentive that would be required to increase the organ supply is currently unknown and will likely take time to learn as the market equilibrium process works.⁷⁸

Money is a method of financial compensation that would likely yield the highest increase in usable organs.⁷⁹ It allows donors complete flexibility on how to dispose of it after the organs are harvested.⁸⁰ “A donor can use the payment in any way he or she pleases; it can be invested, used to purchase insurance, freely spent,

⁷⁴ Kaserman, *supra* note 7, at 54.

⁷⁵ *Id.* at 54–55; Kishore, *supra* note 9, at 364 (stating the sale of organs will only slightly impact the overall cost of an organ transplant because the majority of the costs are the high fees associated with surgeons and other medical professionals); See 2 UNITED STATES RENAL DATA SYSTEM, *Costs of ESRD*, 2009 ANNUAL DATA REPORT 336–42, http://www.usrds.org/2009/pdf/V2_11_09.PDF (In 2007, the costs for End-Stage Renal Disease (ESRD) rose 6.1 percent, to \$23.9 billion representing 5.8 percent of the Medicare budget); Sally Satel & Mark J. Perry, *Allowing Informed Donors to Sell Organs Will Save Thousands of Lives Each Year*, JEWISH WORLD REV., Mar. 5, 2010, http://jewishworldreview.com/0310/organ_sell.php3 (stating that “[d]ialysis costs about \$72,000 per year whereas the anti-rejection medication that kidney recipients need costs between \$12,000–\$15,000 annually”).

⁷⁶ Andrew J. Love, *Replacing Our Current System of Organ Procurement with a Futures Market: Will Organ Supply be Maximized?*, 37 JURIMETRICS J. 167, 183 (1997).

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.* at 184.

⁸⁰ *Id.*

or donated to charity.”⁸¹ However, using money as the only form of financial compensation would likely be cost prohibitive. In addition to money, there are other compensation schemes that may be more acceptable due to the fact that “some good consequences are guaranteed to flow from the transactions.”⁸² These schemes can include different types of incentives, such as estate tax deductions, funeral expense allowances, college education benefits, or even charitable donations.⁸³ In order to increase options and yield the highest number of organs possible, there could even be a “menu approach” that allows donors or their families to choose from different compensation mechanisms.⁸⁴

A. Arguments Against Organ Donor Compensation

Common arguments made by opponents of organ compensation are (1) inability of the poor to receive transplants, (2) economic coercion of the poor, (3) premature termination of care, (4) decrease in organ quality, and (5) commodification of the human body.⁸⁵

1. Denial of Access by the Poor

The use of financial incentives to procure usable organs will not prohibit the poor from having access to those organs.⁸⁶ As one article explains:

The most obvious fallacy of this argument is that it fails to

⁸¹ Love, *supra* note 76, at 184

⁸² Mahoney, *supra* note 8, at 32.

⁸³ MacDonald, *supra* note 6, at 182 (citing John A. Sten, Comment, *Rethinking the National Organ Transplant Program: When Push Comes to Shove*, 11 J. CONTEMP. HEALTH L. & POL’Y 197, 214 (1994)); See L.A. Siminoff & M.D. Leonard, *Financial Incentives: Alternatives to the Altruistic Model of Organ Donation*, 9 J. TRANSPLANT COORDINATION 250, 253 (1999); See 20 PA. CONST. STAT § 8622 (1994) (Pennsylvania’s *Organ Donation Trust Fund* authorizes the state to pay up to \$3,000 to the donor’s hospital or funeral home to cover donor associated expenses.); Bailey, *supra* note 2, at 366; Clark, *supra* note 35.

⁸⁴ KASERMAN & BARNETT, *supra* note 36, at 50 n.33.

⁸⁵ T. Randolph Beard & David L. Kaserman, *On the Ethics of Paying Organ Donors: An Economics Perspective*, 55 DEPAUL L. REV. 827, 830-40 (2006); KASERMAN & BARNETT, *supra* note 36, at 75-76.

⁸⁶ Beard & Kaserman, *supra* note 85, at 831.

distinguish between the use of money to *acquire* organs from donors and the use of money to *allocate* organs to waiting recipients. Obviously, the price system can be used for both, but its use for one does not necessitate its use for the other. Consequently, financial incentives can be incorporated readily within the current system without any alteration in the manner through which transplantable organs are distributed to patients. The only difference would be that more organs would become available for distribution.⁸⁷

Thus, the fact that the supply of organs could increase drastically, all individuals, both wealthy and poor, would benefit greatly! In addition, "the costs of transplantation are generally paid by third parties" such as insurance companies or government healthcare entities.⁸⁸ Hence, adding the price for organs to the total bill for transplantation would in no way exclude low income patients from receiving transplants.⁸⁹

2. Economic Coercion of the Poor

Opponents to offering financial incentives for organs are worried that the poor will be induced into selling their organs out of desperation.⁹⁰ This extreme argument insinuates that poor individuals will allow themselves to be exploited by a system that offers consideration for performing a noble deed.⁹¹ Opponents fail to realize, however, that market prices motivate individuals to do unpleasant things all the time.⁹² Offering an individual compensation

⁸⁷ *Id.*

⁸⁸ A.H. Barnett & David L. Kaserman, *The Shortage of Organs for Transplantation: Exploring the Alternatives*, 9 ISSUES L. & MED. 117, 125 (1993).

⁸⁹ Beard & Kaserman, *supra* note 85 at 831. See Roger D. Blair & David L. Kaserman, *The Economics and Ethics of Alternative Cadaveric Organ Procurement Policies*, 8 YALE J. REG. 403, 446-49 (1991) (stating, in part, most economists who have addressed the subject conclude that market-clearing organ prices would be relatively low); Gary S. Becker, *Response on Whether Organs Should be Purchased and Sold*, BECKER-POSNER BLOG (Jan. 14, 2006), <http://www.becker-posner-blog.com/2006/01/response-on-whether-organs-should-be-purchased-and-sold-becker.html>.

⁹⁰ Satel, *supra* note 43.

⁹¹ Clark, *supra* note 35.

⁹² Beard & Kaserman, *supra* note 85, at 832.

to donate an organ is “no more coercive than paying a coal miner to work in [a] mine, a professor to teach, or a surgeon to provide medical services.”⁹³ Furthermore, studies have shown that poorer persons are generally more willing to donate their organs than wealthier individuals, and the introduction of consideration for organs did not influence the poor or the wealthy any differently.⁹⁴

However, although the poor would not be coerced anymore than the wealthy, there are still safeguards that can be implemented for those isolated incidents in which the poor may require protection. For example, non-cash payments and benefits could be offered such as “contributions to a retirement fund, an income tax credit, or tuition vouchers for. . .children.”⁹⁵ Incentives such as these would circumvent any concerns about money-hungry individuals selling off their body parts to the highest bidder.⁹⁶ Another way to completely eliminate this concern is to allow financial incentives for only the collection of cadaver organs. “No one will be forced by the desperation of poverty to sacrifice their dignity or health. . .” if a restriction were put into place that only allowed for compensation of usable cadaver organs.⁹⁷

3. Premature Termination of Care by Medical Facilities

In a system that disallows living donations, but allows financial compensation for cadaver organs only, any “incentives [would be] paid to the families of the deceased, not the attending physician.”⁹⁸ Opponents to financial compensation for organs must remember that

⁹³ KASERMAN & BARNETT, *supra* note 36, at 76.

⁹⁴ Scott D. Halpern et al., *Regulated Payments for Living Kidney Donation: An Empirical Assessment of the Ethical Concerns*, 152 ANNALS INTERNAL MED. 358, 363 (2010).

⁹⁵ Satel, *supra* note 43; see also Frederick R. Parker, Jr. et al., *Organ Procurement and Tax Policy*, 2 HOUS. J. HEALTH L. & POL'Y 173 (2002) (describing a proposal of how tax credits could be implemented).

⁹⁶ Satel, *supra* note 43.

⁹⁷ Shelby E. Robinson, Comment, *Organs for Sale? An Analysis of Proposed Systems for Compensating Organ Providers*, 70 U. COLO. L. REV. 1019, 1045 (1999); Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 30 (1990).

⁹⁸ Beard & Kaserman, *supra* note 85, at 833.

doctors are held to high standards of conduct by their professional community and the decisions they make or recommend regarding life or death are not taken lightly.⁹⁹

Further, if a doctor believes a family is financially motivated to the point where they will request premature termination of care by the attending physician, there are long-standing legal safeguards which can be enabled.¹⁰⁰ In addition, those arguing that organ payments will result in the purposeful withholding of care wrongfully assume that payments will be substantial enough to cause families to “pull the plug” too soon.¹⁰¹ To the contrary, data shows that the “size of the financial incentive required to eliminate the organ shortage is rather modest—probably on the order of \$1,000 to \$5,000 per donor.”¹⁰²

4. *Substandard Organs*

Opponents have argued that introducing payments into the altruistic system for organ procurement could negatively impact the quantity of organs obtained from wealthier individuals, thus reducing the overall quality of organs received.¹⁰³ In addition, opponents argue that the use of financial payments will encourage family members to not disclose important medical conditions of the deceased out of fear of being rejected and not receiving the payment.¹⁰⁴

However, payments would actually result in higher quality

⁹⁹ Clark, *supra* note 35; See *Code of Medical Ethics*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml> (last visited Oct. 21, 2010) (The first principle of medical ethics states, “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights”).

¹⁰⁰ Clark, *supra* note 35 (mentioning legal guardianship as a mechanism that can be used to protect a patient from their family members).

¹⁰¹ Beard & Kaserman, *supra* note 85, at 833.

¹⁰² *Id.* at 833–34 (citing A. Frank Adams III et al., *Markets for Organs: The Question of Supply*, 17 CONTEMP. ECON. POL'Y 147, 154 (1999)).

¹⁰³ *Id.* at 837 (referencing Susan Rose-Ackerman, *Inalienability and the Theory of Property Rights*, 85 COLUM. L. REV. 931 (1985)).

¹⁰⁴ *Id.*

organs being available for transplantation.¹⁰⁵ Opponents have failed to realize that financial incentives are designed to increase the number of individuals willing to supply organs and by increasing the pool of organs available medical professionals can be selective in only choosing the highest quality organs to use during surgery. Due to the current inability to meet the demand of organs needed, transplant centers have been forced to use marginal or even substandard organs.¹⁰⁶ An article states that “[k]idneys donated from people over the age of 60 or from people who had various medical problems are more likely to fail than organs from younger, healthier donors.”¹⁰⁷ However, due to the inadequate supply of organs to choose from, these higher risk donor organs are now being used.¹⁰⁸

For example, Eugene Steele, after having considerable coronary issues, needed a new heart.¹⁰⁹ However, in Steele’s situation there was only one heart available and it had belonged to an elderly stroke patient.¹¹⁰ The donated heart was not in satisfactory condition and doctors had to perform a bypass just so that it would work correctly once transplanted into Steele’s body.¹¹¹ When asked about “extended criteria” kidneys, Jimmy Light, director of transplant services at Washington Hospital Center, stated, “[i]f you’ve got a patient who’s already between 60 and 70 years old, waiting five years on dialysis means they’re not going to be a very good candidate when their time comes.”¹¹² He continued, “[o]ne way to shorten the wait is to trade

¹⁰⁵ *Id.*

¹⁰⁶ Lisa E. Douglass, *Organ Donation, Procurement and Transplantation: The Process, the Problems, the Law*, 65 UMKC L. REV. 201, 202 (1996) (stating that “[w]hile in a majority of cases the donated organ truly is the ‘gift of life,’ many recipients have been transplanted with deadly organs resulting from pitfalls in the organ donation process. By 1993, 6,798 patients were documented as recipients of cancerous organs, and it is estimated that the cancer incidence in patients who undergo transplantation ranges from 4% to 18%.”).

¹⁰⁷ Tabarrok, *supra* note 37.

¹⁰⁸ *Id.*

¹⁰⁹ Paul Engstrom, *Damaged Goods*, WASH. POST, June 26, 2001, at HE08.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

off donor quality.”¹¹³

The continual use of these substandard organs proves that the organ shortage is actually worse than the transplant waiting list numbers reflect. While the waiting list numbers grow, society must be reminded that those lucky enough to receive transplants may not be receiving quality organs.¹¹⁴ Therefore, the need to quickly implement financial incentives to increase the number of available organs is paramount to not only help eliminate the shortage, but to also ensure that only the best organs are used in transplantation surgeries.¹¹⁵

5. *The Body as a Commodity*

In a 1993 report, UNOS argued that purely economic approaches to organ donation may start “the ultimate slide down the slippery slope.”¹¹⁶ However, as evidenced by the legality of “men to sell their sperm, for women to ‘rent’ their wombs as surrogate mothers or sell their limited number of reproductive eggs, and for people to sell their blood and hair,” the human body is already a commodity that allows for the donor to reap payment.¹¹⁷ It is baffling as to why our government and the zealous opponents to financial incentives view payments for organ donations differently than payments for other parts of the body.¹¹⁸

While opponents to financial incentives attempt to draw distinctions between body fluids and hair versus organs, they have a much more difficult time justifying why female reproductive eggs,

¹¹³ *Id.*

¹¹⁴ Tabarrok, *supra* note 37.

¹¹⁵ Beard & Kaserman, *supra* note 85, at 837–38.

¹¹⁶ Organ Procurement & Transplantation Network, *Financial Incentives for Organ Donation: A Report of the Payment Subcommittee OPTN/UNOS Ethics Committee*, U.S. DEPT. OF HEALTH & HUMAN SERVS. (Jun. 30, 1993), <http://optn.transplant.hrsa.gov/resources/bioethics.asp?index=4>.

¹¹⁷ Berman, *supra* note 1.

¹¹⁸ *Id.* (arguing that donations of a kidney and part of a liver are not high risk for the donor and should be treated the same other as other body parts that are currently being traded in the marketplace).

which, like most organs, do not regenerate, can be sold.¹¹⁹ “There are over two hundred private oocyte donation agencies in the United States, many of these with databases of over three hundred women willing to donate.”¹²⁰

When commercial blood banks were first introduced, “[o]pponents claimed [the] banks would repress altruism, increase the risks of unethical medical practice, and exploit the poor to provide for the rich.”¹²¹ Yet, commercial blood banks are now widely accepted as commonplace and viewed as a necessary tool for our hospitals.¹²² Similarly, in the 19th century, life insurance was highly scrutinized because the body was reduced to a mere object that could be broken down into monetary terms and values.¹²³ The United States has even become a huge exporter of plasma.¹²⁴ As early as 1990, the U.S. commercial plasma industry was supplying “60% of the world’s \$2 billion per year plasma market.”¹²⁵

In effect, by classifying the organ as a gratuitous transfer, NOTA has unfairly forced the organ donor to be the only one in the distribution chain that does not gain any financial incentive.¹²⁶ All other parties to the transplantation process are able to collect a

¹¹⁹ Peter Aziz, Note, *Establishing a Free Market in Human Organs: Economic Reasoning and the Perfectly Competitive Model*, 31 U. LA VERNE L. REV. 67, 102-03 (2009) (citing EMILY JACKSON, REGULATING REPRODUCTION: LAW, TECHNOLOGY AND AUTONOMY 165-66 (Hart Publishing 2001)).

¹²⁰ Curtis E. Harris & Stephen P. Alcorn, *To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation*, 16 ISSUES L. & MED. 213, 218 (2001) (women receive between \$5,000-\$8,000 per donation for their eggs).

¹²¹ Gail L. Daubert, *Politics, Policies, and Problems with Organ Transplantation: Government Regulation Needed to Ration Organs Equitably*, 50 ADMIN. L. REV. 459, 481 (1998) (citing Gloria J. Banks, *Legal and Ethical Safeguards: Protection of Society’s Most Vulnerable Participants in a Commercialized Organ Transplantation System*, 21 AM. J.L. & MED. 45, 49-50 (1995)).

¹²² *Id.*

¹²³ *Issues, THE ALLIANCE FOR ORGAN DONOR INCENTIVES, ISSUES*, <http://organdonorincentives.org/wordpress/answers-to-common-objections-to-payment-for-organs/> (last visited Apr. 4, 2010).

¹²⁴ Bailey, *supra* note 2.

¹²⁵ *Id.*

¹²⁶ Mahoney, *supra* note 8, at 23.

handsome fee for their participation.¹²⁷ In addition, the fact that donors rarely know “how lucrative the transplant business is only compounds the unattractiveness of denying organ sources compensation while neither urging nor expecting similar generosity from the others involved.”¹²⁸ Professor Fred Cate of Indiana University stated, “We sell body parts all the time; we just don’t call it that . . . What the advocates are saying is, ‘Let’s call a spade a spade. And let’s not exclude the donor or the donor’s family from a market that everyone else is participating in.’”¹²⁹ Opponents of financial incentives argue that any payments made during the donation process are not for the organ itself, but only for the services of the professional staff necessary to coordinate and complete the transplantation procedures.¹³⁰ However, this argument is flawed because the organ is the most integral piece to the entire transplant puzzle.¹³¹ Without the organ, the expensive services would not be needed!¹³²

B. Payments in Foreign Countries

In November 2009, a man in Singapore became the country’s first-ever paid organ donor.¹³³ Singapore is planning to compensate as much as US\$36,000 to individuals that are willing to donate their organs.¹³⁴ Israel is implementing an aggressive “no give, no take” system whereby individuals who choose not to participate in the donor system will be adversely impacted by being forced to the back of the waiting list line should they ever have the need for a donated

¹²⁷ *Id.* at 29.

¹²⁸ *Id.*

¹²⁹ Peter S. Young, *Moving to Compensate Families in Human-Organ Market*, N.Y. TIMES, July 8, 1994, at B7.

¹³⁰ Mahoney, *supra* note 8, at 23.

¹³¹ *Id.*

¹³² *Id.* (“No one would pay for organ transportation or transplant services that fail to include an organ, just as there is no market for ‘dining services’ that do not include food.”).

¹³³ Neo Chai Chin, *Husband Urges Wife to go for Surgery, Donates Kidney*, CHANNELNEWSASIA.COM (Nov. 26, 2009) <http://www.channelnewsasia.com/stories/singaporelocalnews/view/1020633/1/.html>.

¹³⁴ Tabarrok, *supra* note 37.

organ.¹³⁵ Israel is the first country to reward deceased organ donors by giving money to the deceased's family in order to help "memorialize" the deceased.¹³⁶ Iran has completely eradicated its kidney shortfall by offering financial payment to donors.¹³⁷

The Dialysis and Transplant Patients Association (DATPA) is a nonprofit organization in Iran that helps individuals in need of a kidney by identifying potential donors from a pre-determined pool of applicants.¹³⁸ If the donors meet the government's criteria for eligibility the donors can receive \$1,200 plus a year's worth of health insurance.¹³⁹ Organ recipients, or charitable organizations, then contribute an additional \$2,000-\$5,000 to compensate the kidney donor.¹⁴⁰ With this system in place, the Iranian waiting list for kidneys was completely eliminated only 11 short years after the legalization of financial incentives.¹⁴¹ With foreign nations proactively addressing their organ shortages, the United States needs to take note of other countries' successes and failures and enact aggressive measures to protect our citizens.

C. Ways to Implement Financial Incentives

"The waiting list for transplants grows by approximately 300

¹³⁵ *Id.*

¹³⁶ Satel, *supra* note 5.

¹³⁷ Tabarrok, *supra* note 37.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*; *Contra* Debra A. Budiani-Saberi & Francis L. Delmonico, *Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities*, 8 AM. J. TRANSPLANTATION 925, 928 (2008) (noting the Iranian model "lack[s] medical coverage for the donor beyond one year following transplantation" and "unregulated payments may be imposed upon the recipient"); *Contra* Budiani-Saberi & Golden, *supra* note 46, at 10 (noting study results on living kidney donors in Iran that indicates the donors are "poorly educated, unemployed, and uninsured"; kidney vending caused negative financial effects; and "half the [donors] would have preferred to lose more than 10 years of their lives and to lose 76-100 percent of their personal possessions in return for their preoperative condition").

¹⁴¹ *Compare* Benjamin E. Hippen, *Policy Analysis No. 614, Organ Sales and Moral Travails: Lessons from the Living Kidney Vendor Program in Iran*, CATO INSTITUTE (Mar. 20, 2008), <http://www.cato.org/pubs/pas/pa-614.pdf>, with *Data, supra* note 23 (showing approximately 86,000 candidates on the kidney waiting list in the U.S. as of Aug. 21, 2010).

people each month.”¹⁴² A free market in human organs would increase the total amount of organs available for transplantations thereby saving thousands of suffering Americans.¹⁴³ In 2010, there were over 28,000 transplants performed in the United States, 77 percent of which were made possible from donors that were already deceased.¹⁴⁴ Many proponents of financial incentives for organs rightfully believe that harvesting organs from only the deceased will increase the number of organs collected thereby decreasing the number of individuals on the waiting list and reducing the need for living donors.¹⁴⁵ In addition, focusing on only cadaver organs eliminates many of the ethical/moral issues in the organ debate. For example, the concern of a poor individual being financially induced out of desperation is lessened.¹⁴⁶

1. Public Compensation System

Under a public compensation system, the government would establish, irrespective of fluctuations to supply and demand, the amount of payment to be made for a particular organ.¹⁴⁷ Proponents of the public compensation system argue that “the compensation would be public, not private, and thus would represent the appreciation of the entire community rather than a private contract between parties.”¹⁴⁸

The public compensation system operates precisely like the current altruistic system:

[T]he families of the deceased are approached by the organ procurement personnel regarding permission to remove the

¹⁴² Mayo Clinic, Organ Donation, <http://www.mayoclinic.org/transplant/organ-donation.html> (last visited Aug. 21, 2010).

¹⁴³ Aziz, *supra* note 119, at 106–07.

¹⁴⁴ *National Data Reports*, *supra* note 2 (select “View Data Reports,” “National Data,” “Transplant,” and “Transplants by Donor Type”) (last visited Apr. 4, 2011).

¹⁴⁵ Blair & Kaserman, *supra* note 85, at 430; Gary S. Becker & Julio Jorge Elias, *Introducing Incentives in the Market for Live and Cadaveric Organ Donations*, 21 J. ECON. PERSP., 3, 3 (2007); KASERMAN & BARNETT, *supra* note 36, at 123–24; Naylor, *supra* note 32, at 167.

¹⁴⁶ See *supra* Part III.A.2.

¹⁴⁷ KASERMAN & BARNETT, *supra* note 36, at 53–54.

¹⁴⁸ President’s Council on Bioethics, *supra* note 31.

organs. . . Similar appeals to altruism and human kindness can be made. In addition, however, some financial payment or other form of compensation is offered under this system to provide additional encouragement to grant permission to remove the organs of the deceased. It is argued, then, that such payments will lead to an increased rate of organ collection as fewer families decline the request to donate.¹⁴⁹

As society becomes more educated about the public compensation system it is believed that the compensation established by the government will motivate families to independently ask about donating organs.¹⁵⁰ The public compensation system, while better than our current altruistic model, doesn't go far enough. A true market-balancing system needs to be invoked in order to cure our chronic organ shortage.

2. *Market System*

Organ markets "would allow individuals before death or surviving family members after death to sell their own or their loved one's organs in private contracts."¹⁵¹

[O]rgan suppliers. . . would be offered a market-determined price (that is, a price that would be allowed to fluctuate with changes in demand and supply) by organ procurement firms for permission to remove the transplantable organs at death. Those firms would then sell the harvested organs to transplant center that have placed orders with them for needed organs. The center, in turn, would include the price paid to those firms in the bills for transplant operations, just as all other inputs are currently billed. In a competitive environment, this resale price would equal the price paid to the donor (or donor's family) plus the marginal cost to the firm of collecting and distributing the organs.¹⁵²

After payments have been made, the organs would be allocated

¹⁴⁹ KASERMAN & BARNETT, *supra* note 36, at 50.

¹⁵⁰ *Id.*

¹⁵¹ President's Council on Bioethics, *supra* note 31.

¹⁵² KASERMAN & BARNETT, *supra* note 36, at 52.

according to the same UNOS guidelines used today.¹⁵³ Discussed below are three variants of a potential market system: a cash market, a futures market, and a spot market.

a. Cash Market

A cash market system allows potential donors to enter into contractual arrangements for the future harvesting, either during their life or at death, of their organs for payments to be received immediately.¹⁵⁴ While money would almost certainly yield the greatest increase in usable organs, the cash market system doesn't address or alleviate the concerns that have been raised by opponents of financial incentives.¹⁵⁵ Therefore, this cash market would not pose any advantages over the futures market.¹⁵⁶

b. Futures Market

A futures market would allow a donor, during his lifetime, to contract with an organ collection firm in order to dispose of his organs at his death.¹⁵⁷ It would drastically reduce or eliminate the organ shortage and would avoid the major concerns outlined by opponents of commercialization.¹⁵⁸ The contract would allow for the posthumous payment of an organ only after the organ was evaluated and deemed usable.¹⁵⁹ This would prevent individuals from signing contracts, receiving payment, and then at some future date being unable to donate due to their organs being damaged or unfit for transplantation.¹⁶⁰ At death, the organs would be immediately

¹⁵³ *Id.*

¹⁵⁴ Crespi, *supra* note 56, at 54.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 6.

¹⁵⁸ *Id.* at 7; *See supra* Part III.A.

¹⁵⁹ Harris & Alcorn, *supra* note 120, at 232 ("A medical center would not have to pay for a liver that was, subsequent to the contract, destroyed by alcohol or incident to the donor's death.").

¹⁶⁰ *Id.*

harvested and a suitable donee would be found.¹⁶¹ There are many safeguards that could be implemented with this system such as requiring prior consent of the donor before allowing the family to sell the organs, mental health evaluations of the donor at the time of contracting, prohibition of minors from executing contracts, and contractual provisions that nullified the contract in the event the death of the donor occurred by murder or suicide.¹⁶²

c. Spot Market

After the death of a potential donor, a spot market would allow families to decide whether or not to sell “their loved one’s organs for cash payment or some other valuable consideration.”¹⁶³ The spot market would actually provide the family with the equivalent to a life insurance policy in that they would be able to collect payment after the death of the donor and would be free to dispose of the payment as they saw fit.¹⁶⁴ Like the futures market, the spot market also addresses the major concerns articulated by opponents to financial incentives.¹⁶⁵

The transaction costs for a spot market will be drastically less than those for a futures market.¹⁶⁶ For example, in the futures market a contract is signed and the chance of actually collecting an organ from the potential donor, for a variety of reasons, is unlikely.¹⁶⁷ In addition, a futures contract could be signed years before a person’s death, resulting in time and effort to monitor the contract in order to determine when, where, and under what conditions the donor will die.¹⁶⁸

A spot market also maintains the status quo in that it continues

¹⁶¹ Watkins, *supra* note 71, at 37.

¹⁶² Harris & Alcorn, *supra* note 120, at 232-33.

¹⁶³ President’s Council on Bioethics, *supra* note 31.

¹⁶⁴ KASERMAN & BARNETT, *supra* note 36, at 52-53, & 150 n.49.

¹⁶⁵ See *supra* Part III.A.

¹⁶⁶ KASERMAN & BARNETT, *supra* note 36, at 129.

¹⁶⁷ *Id.* at 130.

¹⁶⁸ *Id.*

to involve families in the decision making process.¹⁶⁹ Currently, even if a donor has an express declaration regarding organ donation, the family is still consulted for permission to harvest the organs.¹⁷⁰

3. *Difference Between the Public Compensation and Market Systems*

The first difference between public compensation systems and market systems is how the amount of financial incentive is determined.¹⁷¹ Under public compensation, the form and amount of payment to organ suppliers is largely arbitrary and set by the government at a fixed amount.¹⁷² The market system allows the prices of organs to naturally adjust themselves depending upon the supply and demand of the marketplace.¹⁷³ This price flexibility, unlike the fixed rates in the public compensation system, will allow the organ market to equalize between the number of organs demanded and the number of organs supplied.¹⁷⁴

The second difference between the two systems deals with profit.¹⁷⁵ The market system uses profit and competition to incentivize the organ procurement firms to operate more efficiently and effectively in "identifying potential donors and encouraging potential donors and their families to agree to supply the needed organs."¹⁷⁶ The public compensation system, however, does not offer incentives to organ procurement firms to more effectively identify potential donors and tactfully ask them to donate.¹⁷⁷

Finally, the market system, by changing the current organ collection environment from a structure of one buyer facing many sellers to one where multiple buyers will be introduced into the

¹⁶⁹ *Id.* at 129.

¹⁷⁰ *Id.* at 131.

¹⁷¹ KASERMAN & BARNETT, *supra* note 36, at 53-54, 126.

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Id.* at 53-54.

¹⁷⁵ *Id.* at 54.

¹⁷⁶ KASERMAN & BARNETT, *supra* note 36, at 54.

¹⁷⁷ Barnett & Kaserman, *supra* note 88, at 127.

marketplace, will result in greater efficiencies in procurement.¹⁷⁸ The public compensation system merely maintains the current nonprofit status where a seller in a particular region would only have access to one buyer.¹⁷⁹

IV. CONCLUSION

“Every day, 18 people die while waiting for a transplant of a vital organ.”¹⁸⁰ Allowing the inadequate altruistic model of procurement to continue without enacting additional financial measures to increase the number of organs available shows that “we would rather accept the deaths resulting from the failure to supply an adequate number of organs than offer compensation to donors.”¹⁸¹ Even opponents of offering financial incentives for organs must ask themselves: “Is it not worse for hundreds of people to die each year for want of an organ many people would have been willing and able to safely contribute?”¹⁸²

Congressional action is long overdue. While the actual impacts of financial incentives are unknown, Congress must enact legislation offering relief to those suffering slow, horrible deaths on the transplant waiting lists. As noted previously, thousands of usable cadaver organs go uncollected each year.¹⁸³ In addition to appealing to a family’s sense of altruism to save another human being’s life, procurement personnel should also be authorized to use financial compensation as a means to offer something in return to the grieving family. The most obvious, least burdensome way to accomplish this

¹⁷⁸ KASERMAN & BARNETT, *supra* note 36, at 126.

¹⁷⁹ *Id.* at 126–27.

¹⁸⁰ 25 *Facts*, *supra* note 3.

¹⁸¹ Robert Steinbuch, *Kidneys, Cash, and Kashrut: A Legal, Economic, and Religious Analysis of Selling Kidneys*, 45 HOUS. L. REV. 1529, 1579 (2009).

¹⁸² Berman, *supra* note 1; Bailey, *supra* note 2, at 372 (quoting Dr. J. Wesley Alexander, a transplant surgeon who chairs the UNOS donations committee: “I think that when push comes to shove, the public has to make a decision as to whether they would rather see people die on dialysis while leading a fairly unsatisfactory life . . . or to allow the buying and selling of human organs.”).

¹⁸³ See *supra* Part II.C.

would be to utilize the spot market system. This system would thrive only off of the collection of cadaver organs and would continue to include the family of the deceased in the decision-making process. Families could be offered a menu type approach that would allow them the flexibility to choose cash or other financial incentives as payment for the organs harvested. The administrative overhead and overall sophistication of organ procurement firms would be less than that of a futures market since the tracking of long-term contracts, individuals, the place of death, and whether the cause of death would allow harvesting would all be eliminated. Firms would be forced to engage the organ marketplace in a competitive fashion, resulting in organ harvesting proposals being presented to families in the most respectable manner possible while maximizing the incentives offered to the families for their loved one's much-needed organs.