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THE USE OF FINANCIAL INCENTIVES IN MEDICAL CARE: THE CASE OF COMMERCE IN TRANSPLANTABLE ORGANS†

James F. Blumstein‡

INTRODUCTION

As a relative newcomer to organ transplant issues, I liken my experience in the field to an anthropologist’s exposure to a new culture, a new way of thinking. There are, I have learned, holy totems and sacred cows that permeate the thinking and have profoundly influenced the development of public policy in the organ transplant arena. Perhaps pushing the anthropological simile to the breaking point, I find my role to be that of the constructive archaeologist, investigating the existing landscape of values by uncovering layers of buried values that have been deemed fundamental but whose wisdom has been assumed and uncontested. These traditional values have achieved a sacrosanct status and have undergirded policy formulation in this field. It is important to subject these entrenched ways of thinking to careful scrutiny, to question whether some of these values are as self-evident as has been assumed, and to determine whether they are in need of reexamination and reevaluation given the evolution of organ transplantation into the status of mainstream, therapeutic medical care. This is particu-

† An earlier version of this article appeared in 24 TRANSPLANTATION PROCEEDINGS 2190 (1992).
larly the case as society is forced to confront the specific set of problems associated with producing a better balance between the expanding demand for transplantable organs and the currently existing inadequate level of supply.

There is widespread agreement that a shortfall exists in the number of organs made available for purposes of organ transplantation and that the supply-side constraint is a major inhibition in the further utilization of therapeutically promising organ transplantation techniques. "For those with failing hearts or livers, transplantation . . . is the only therapy that can replace imminent certain death with the hope of new life. But as its benefits have become increasingly apparent and the medical barriers have fallen, the demand for transplantation has grown rapidly, far outstripping the supply of organs."1 For example, the United Network for Organ Sharing reports that, as of May 31, 1992, 27,120 people were on waiting lists for organ transplants in the United States.2 These waiting lists have gotten longer over time, with estimates suggesting that about 200 people are added to the lists each month for kidneys alone.3 From 1986-89, while kidney dialysis patients increased by 25,000,4 kidney transplants did not increase in number and even declined slightly from 8976 to 8899.5 Yet, evidence suggests that transplantation is a more successful and cost effective procedure for many dialysis patients with end-stage renal disease.6 It has been estimated that thirty percent of patients on dialysis are candidates for transplantation.7

Despite this fundamental supply-side problem, those in leadership roles in the organ transplant movement have been strikingly hostile to markets and to the use of financial incentives as a tool for increasing the availability of transplantable organs. There is a

2. United Network for Organ Sharing, Patients Waiting for Transplants: Number of Patient Registrations on the National Waitlist, 8(6) UNOS UPDATE 35 (1992) (containing the following breakdown, by organ, of the 27,120 people on the waiting list as of May 31, 1992: kidneys (20,741); hearts (2560); livers (2113); lungs (811); pancreases (726); and heart-lungs (169)).
5. Id.
strong, visceral, adverse reaction to the introduction of commerce in the field of transplantable organs. This weltanschauung reflects a worldview more characteristic of an earlier era in medical care when the role of markets in health care was hotly contested. Shibboleth and shamanism have thrived at the expense of rigorous analysis. It is now time to frame the issues clearly and to distill and understand the nature of the deep-seated beliefs in the field.

I. ORGAN TRANSPLANTATION POLICY WITHIN THE BROADER HEALTH POLICY CONTEXT

The role of financial incentives in organ transplantation should be considered within the broader context of health policy. Ideology, as much as technology, has driven organ transplantation policy. An intellectual orthodoxy has permeated the field. The 1986 Report of the United States Department of Health and Human Services Task Force on Organ Transplantation (OTTF Report) has set the tone. It has had remarkable influence on the development of thinking and the evolution of policy. Although many officials of the Department of Health and Human Services (DHHS) vigorously disagreed with the analysis and recommendations of the Task Force, and no evidence exists that the Department has ever adopted the recommendations of the Task Force as official departmental policy, it is clear that the OTTF Report has been extremely influential in the evolution of policy thinking of important constituencies within DHHS. The OTTF Report has clearly driven the policy of the United Network for Organ Sharing (UNOS), the organization that holds the federal contract to administer the Organ Procurement and Transplant Network (OPTN) mandated by federal law.

And the OTTF Report has been an extremely important document in framing thinking about organ transplantation issues in the organ transplant community generally. From my initial exposure to organ transplantation issues, I concluded that another viewpoint and frame of reference needed expression.

A. Organ Transplantation Policy Values

If ideology, as much as technology, has driven organ transplantation policy, it is appropriate to inquire what values have under-

girded organ transplantation policy in the United States. I have identified at least five.

1. The Ethical Foundation of Altruism

Even a superficial exposure to this field reveals an intense commitment to altruism. This is deemed a moral imperative. For example, the OTTF Report stated that a core value shaping organ transplantation policy was the goal of “[p]romoting a sense of community through acts of generosity.”

Despite the widespread recognition of the shortage of transplantable organs, there persists an insistence on the exclusion or elimination of commercial incentives from all facets of the organ transplant system of organ supply, acquisition or distribution. Yet, by reasonable hypothesis, one might expect a system of financial incentives to augment the supply of available organs for transplantation.

2. The Role of the Potential Donor’s Family

The focus of the organ transplant community is on the family of the dying patient, who is the potential donor. There is a great concern expressed for the psychological well-being of family members of the potential organ donor as well as an emphasis on community-spirited commitment by the family through organ donation. There is a sense that families of a dying patient can be self-fulfilled by reaffirming their commitment to community solidarity through the donation of a loved one’s organ for transplantation. This type of psychological fulfillment is “a demonstration of the principle that from a loved one’s death may come some silver lining.”

A concomitant of this focus on the family is that there is an emphasis on the bedside of the dying patient (and potential organ donor) as the locus of decisionmaking for organ donation. It is questionable whether the bedside is an optimal place for serious

10. OTTF Report, supra note 8, at 28.

11. There is clearly an empirical question whether commercial incentives will result in an increase in the supply of transplantable organs. Since such transactions have been illegal in the United States since 1984, there is no reliable data on the question from the United States. Some critics claim that the introduction of commercial incentives could result in reduced altruistic donating. Although experiences from abroad suggest that commercial incentives do work, the empirical issue is a serious and legitimate one. Where empirical, not ethical, disagreements split policy analysts, the appropriate resolution of the debate is to run an experiment to secure evidence on the matter. For a proposal to perform a pilot study of the effect on organ supply of a $1000 death benefit for organ donation, see Thomas G. Peters, Life or Death: The Issue of Payment in Cadaveric Organ Donation, 265 JAMA 1302 (1991).

12. Blumstein, supra note 9, at 468.
consideration of the complex set of issues that surround organ donation decisions. The family is facing the possible death of a loved one and is concentrating on efforts to save his or her life. It is quite natural for family members to feel ill at ease thinking about organ donation at a time when the grieving process has not yet commenced and the preferred focus of attention is on lifesaving not organ donation.

Further, it can be rather awkward for professional personnel to develop a sensitive conversation with the family of a potential donor because the family can perceive the very topic of organ donation as reflective of a certain prognostic pessimism. The so-called required request procedure, adopted in legislation at the federal level and imposed on all hospitals that participate in Medicare or Medicaid, mandates that hospitals institutionalize a policy of routinely asking families of potential donors whether or not they wish to donate the organs of their dying kin for purposes of transplantation. Several assumptions underlie the policy of “required request” or “routine inquiry.” Pragmatically, it was premised on the view that families would agree to donate organs of their next of kin if only asked by trained organ procurement personnel. Public opinion surveys showed strong support for organ donation, so the objective was to make sure that the families of potential donors were actually asked about organ donation. At the same time, institutionalization was needed “because individual professionals typically feel squeamish about raising these sensitive issues with family members in such delicate circumstances. An institutional rule is needed to make the organ donation inquiry an obligation.” Ideologically, “required request” of families of potential donors is a communitarian act that promotes altruism. It allows families of potential donors to “exercise . . . the virtue of generosity,” performing an act that “strengthen[s] altruism and our sense of community.”

Disappointment with the pragmatic effects of routine inquiry policies has led some to seek out alternatives. Those alternatives, however, will be evaluated in terms of their ideological impact and propriety, with traditionalists likely to press for maintaining the role of the family at the potential donor’s bedside as a means of

14. Blumstein, supra note 9, at 467.
16. OTTF Report, supra note 8, at 28 (quoting a report from the Hastings Center).
promoting altruism and communitarianism.17

Focusing on the bedside seems at odds with the legal regime set up under the Uniform Anatomical Gift Act (UAGA), which emphasizes control of donation by the patient himself or herself and a determination regarding organ donation before that patient becomes ill. The revised (1987) UAGA explicitly states that a gift of an organ “does not require the consent or concurrence of any other person after the death of the donor . . . ”18 This authority of the patient/donor to control the organ donation decision had been provided for in the original (1968) version, but subsequently was restated specifically for emphasis and for certainty.19

Despite this legal regime under the UAGA, apparently the fact is that family approval is always, or almost always, sought for organ donation.20 This is the so-called family veto.21 Opponents of shifting the locus away from the bedside worry that it de-emphasizes next-of-kin consent. That, in turn, deprives the family of an opportunity for “[p]romoting a sense of community through acts of generosity.”22 The DHHS Task Force Report clearly places in the value balance lifesaving that can come from transplantation, on the one hand, and “the value of social practices that enhance and

17. Disappointment with required request has led some to revisit the more drastic proposal of presumed consent — i.e., presuming that consent for organ donation exists in the absence of specific evidence on the question of intent. See, e.g., Spital, supra note 1. The proposal for presumed consent was made as early as 1968 by Professors Dukeminier and Sanders. See Jesse Dukeminier, Jr. & David Sanders, Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs, 279 New Eng. J. Med. 413 (1968). At least part of the rationale for presumed consent, even in its earliest iteration, was a sense of discomfort associated with asking for next-of-kin consent for organ donation. See id. at 416 (noting that “[t]o someone whose relative is about to die, asking for the kidneys may seem a ghoulish request”).


19. The commentary to the 1987 UAGA makes it clear that the explicit language adopted in § 2(h) of the 1987 UAGA was designed to codify expressly the intention of § 2(f) (now § 2(h)) of the 1968 UAGA. What led to the explicit language in § 2(h) of the 1987 UAGA was that family approval was routinely required by organ procurement agencies, despite the provisions of the UAGA. Section 2(f) was designed to “remove any uncertainty.” UAGA, 8A U.L.A. 35, cmt. at 36 (cmt.).


21. The authors of the original (1968) UAGA intended to eliminate this family veto. The Comments to the 1968 UAGA stated that the UAGA “recognizes and gives legal effect to the right of the individual to dispose of his own body without subsequent veto by others.” Refusal by the transplant community to honor the decision of an individual to donate his or her own organs for transplantation without express family approval is, therefore, essentially lawless. UAGA, 8A U.L.A. 35, cmt. at 36 (1987).

22. OTTF Report, supra note 8, at 28.
strengthen altruism and our sense of community," on the other hand. Note that this value has nothing to do, strictly speaking, with transplants. Instead, it concerns itself with a vision of society, of community and solidarity, and deems it necessary and appropriate to balance lifesaving against this communal vision of the good society.

3. Elimination of Donor/Family Control Over Organ Distribution

Since the organ for transplant is deemed a "national resource" under the DHHS Task Force Report and under controlling federal organ transplantation policies and principles, it is argued that the elimination of control by the patient/donor, or the family of the patient/donor, over the distribution of organs donated for transplant is an ethical imperative. Under this ideal, the donor and the family cannot assign an organ because it is simply not "theirs" to assign. The UAGA, the state-adopted legal regime in this area, gives the donor and the family the right to assign the organ to a designated beneficiary. In fact, the UAGA creates a legally enforceable right in the beneficiary, if one is designated. So, the legal structure set up in the late 1960's and early 1970's created quite a different legal regime from the currently prevailing ethic in the field.

4. Centralized Criteria for Organ Distribution

The fourth organ transplantation policy value that I have identified — mandating that a centralized set of criteria govern the system of organ distribution — follows naturally from the notion that the organ, once donated, is a "national resource" that society is responsible for distributing. Once the family decides to donate the deceased's organ for the benefit of society, it is the duty of society to formulate criteria for the distribution of organs as a "national resource", thereby substituting collective decisionmaking for patient or family determination. The approach of the DHHS Task Force

23. Id. (quoting The Hastings Center, Ethical, Legal and Policy Issues in Transplantation," 2 (Oct. 1985)).
24. Id. at 86.
25. Under the recommendations of the 1986 Department of Health and Human Services Task Force Report, OTTF Report, id., donated organs are to be considered "a national resource to be used for the public good." In such a regime, "[o]rgans would become socialized, with individual donors stripped of power to control the destiny of their donated organs or to designate specific beneficiaries." See Blumstein, supra note 9, at 486.
26. See Blumstein, supra note 9, at 486-90.
and the prevailing view of the Organ Procurement and Transplantation Network are in direct tension with the patient/family control provisions of the UAGA.

5. An Organized, Unified, Integrated System of Organ Procurement and Distribution

As set forth in the DHHS Task Force Report, and as implemented by the Organ Procurement and Transplantation Network, the vision of appropriate public policy calls for centralized control and nationally uniform guidelines governing organ procurement and distribution, organ transplantation activities at the transplantation centers themselves, and histocompatibility laboratories. The notion is that a social services delivery network, organized and controlled by professionals, should dictate how organs are procured and transplanted.

B. Organ Transplantation Values Within the Broader Health Policy Context

The values undergirding organ transplant policy are in distinct tension with the values that have emerged in the larger health policy context. They also seem strangely at odds with a policy of encouraging an increased supply of transplantable organs.

A fundamental element of health policy over the last ten years has been competition and the role of markets. "Perhaps the most striking characteristic of the health care industry as it has developed in the last decade has been the recognition that competition and markets have an important role to play in the health policy arena." What are the market-oriented values that so strikingly contrast with the values undergirding organ transplant policy?

1. The Use of Incentives

Not so long ago, the consideration of the use of incentives in the health policy arena was deemed inappropriate, a taboo, a subject not for polite company. The use of incentives in medical care was rejected on the related grounds of ethics and effectiveness. Ethically, the objection stemmed from the ideological commitment in

some quarters that unrestricted access to medical care on the basis of medical need was the appropriate normative benchmark. This was a component of the rhetorical espousal of medical care as a right.\(^{28}\) If one believes that access to medical care should be costless to users, the imposition of financial disincentives is directly in conflict with that principle. Obviously, if one starts from the premise that an individual’s utilization of medical services should bear no economic consequences for the beneficiary of the treatment, the use of financial disincentives will have unacceptable distributive effects.\(^{29}\)

In terms of effectiveness, financial incentives were questioned because of the prevailing medical view that money did not affect how patients were treated. It was assumed that there was a correct course of treatment, and that was a professionally determined decision. Science not economic incentives drove medical care diagnosis and treatment decisions. Therefore, financial incentives could not be effective because they did not influence medical care decision-making. And, implicitly, to the extent that scientific and professional judgments might indeed be influenced by financial considerations, that was an inappropriate deviation from the clinically correct scientific pathway.

The ethical issue is now seen as more richly textured than it once was. The rhetoric of rights and equality has been deemphasized, replaced in responsible circles by concern about the role of government in providing for an adequate level of services to individuals unable to afford medical care.\(^{30}\) Further, there is now a broader understanding that establishing a relationship between utilization of medical resources and expenditures by patients as consumers is not always inappropriate. Medical care is not monolithic; in some areas, it may be troublesome to use financial incentives, but with respect to other types of care use of incentives to shape behavior might be acceptable.

With respect to effectiveness, it is now commonplace for ana-


\(^{29}\) See, e.g., T. R. Marmor et al., *Medical Care and Procompetitive Reform*, 34 Vand. L. Rev. 1003, 1014 (1981) (stating that “[c]ost sharing amounts to a tax or user fee imposed on the sick and is a de facto transfer of wealth from the sick to the healthy”).

lysts to examine the effects of incentives on conduct in the health arena. This is no longer an oddity. It is quite mainstream. And there is a recognition that economically unrestrained decisionmaking in medical care, as in other areas, has consequences in terms of resource utilization. Thus, the ideological commitment to unrestricted access has run into a hitherto unrecognized economic reality. Not only are distributive values at issue when financial incentives are under consideration. Elimination of financial considerations from medical care resource allocation decisions has the consequence of increasing the aggregate levels of resource utilization. This links the ethical and the effectiveness grounds for objecting to the use of financial disincentives. The cost of maintaining the ethical case against incentives is elevated once one accepts the position that overall patterns of utilization are affected (upwardly biased) by the absence of financial considerations in the medical care decisionmaking process. Moreover, there is now greater recognition of the broad range of medical services; not all medical treatment fits the model of life-or-death treatment. Much care is palliative in character, and much expense in medical care involves careful consideration of the value of buying incremental levels of reduced uncertainty. The existence of clinical uncertainty, reflected in the widely divergent and unexplained procedure rates across providers in seemingly similar circumstances, further suggests an appropriate role for incentives. The evidence about divergent procedure rates undermines the assumption of a monolithically correct mode of treatment. In this world of uncertainty, it should no longer be inappropriate to allow financial considerations to enter into decisionmaking. The assumption can no longer be indulged that consideration of financial incentives undermines scientifically clear-cut clinical pathways. These factors — the many faces of medical care services and the existence of clinical uncertainty — lend further legitimacy to the use of incentives in many areas of medical care.

Now recognized to have an effect in influencing behavior, financial disincentives are widely in use, despite the earlier ideological objections. DRGs (diagnostic related groups), just to take one ex-
ample, have shaped behavior. There has been an increasing empha-
sis on ambulatory care, and that is a direct result of the financial
incentives created by DRGs. Hospitals downsized staffs, shortened
lengths of stay, built outpatient clinics and outpatient surgery cen-
ters. At many medical centers, new construction emphasizes ex-
pansion of outpatient services. These are clearly supply-side
responses to incentives. 34

2. Enhanced Respect for Pluralism and Decentralization

At one time in the broader health policy arena, commentators
asked or inquired about the preferred way to organize the health
care delivery system. In the early 1970's, Health Maintenance Or-
ganizations (HMOs) were promoted by some because they were
seen as the good monolithic model by which to deliver health care.
The mindset was that a consensus would form on the question of
what is the single best way of organizing the system of health care
delivery. The current trend, however, is toward pluralism and de-
centralization, that is toward diversity as in other segments of the
economy. Much of this thinking has been influenced by the findings
of Jack Wennberg 35 and others 36 concerning the existence of clinical
uncertainty and the existence of striking, unexplained diversity in
practice patterns. We now recognize that we do not have a mono-
lithic system, and perhaps such a monolithic system is not a desira-
ble objective.

In summary, then, the foregoing principles — competition and
incentives, and pluralism and decentralization — have seemed to
influence the rest of the health policy arena in the past decade.
These principles appear to be strikingly at odds with the strongly
held, fundamental principles that are so widespread in the organ
transplantation arena. The logical next question is whether there
might be some appropriate extrapolation from the broader health
care context to the world of organ transplantation policy.

C. Mainstreaming Organ Transplantation Policy

What would organ transplantation policy look like if it were
more compatible with these other, mainstream trends in health pol-

34. Incentives have also played an augmented role on the demand side. For example,
increased attention to competition and markets has resulted in a focus on individual con-
sumer choice and patient involvement in decision-making.
35. See, e.g., Wennberg & Gittelsohn, supra note 33.
36. See, e.g., Mark R. Chassin et al., Variations in the Use of Medical and Surgical
icy? First, it would allow the introduction of incentives; that is, it would permit commerce in organ transplantation. Eliminating the exclusive reliance on altruism would recognize and acknowledge the priority of overcoming organ supply shortages and yet retain fidelity to principles of autonomy and individual choice of donors or their families.

Second, it would shift the exclusive focus from the family of the dying patient to the patient himself or herself. This, of course, is returning to the UAGA regime. It would shift decision-making to a circumstance and time when the donor is capable of making competent choices regarding organ donation. It would restore patient and donor autonomy and basically restore the regime of the UAGA. Such a policy would undertake to make the organ donation vision of the UAGA work well rather than disregarding the philosophical underpinnings of the UAGA.

Third, it would vest control over organ disposition with the donor or the donor's family. This would give the donor or the donor's family the psychological satisfaction of benefiting a human being. This has the ancillary benefit of allowing designated beneficiaries, persons or institutions, to have enforceable legal rights to the donated organs. This is an important potential counterforce to the present custom of requiring family consent, even though family consent is not now legally necessary.

Combining donor or family control over organ disposition with a forward contract of sale for the use of organs at death would alter the entire nature and perception of the transaction. Transplant procurement and surgical teams would have to defer to what is essentially a commercial judgment effectuated while the donor was alive and of sound mind. This would create a new calculus. At the present time the players are the procurement people, the physician of the potential donor, and the family. If the family objects, the prudent lawyer would advise the client, "look, the family members are the only ones around who can sue; they're the only ones who can cause trouble; they're the only ones who can go to the newspaper — so, defer to the family." With an enforceable contract, other players enter the game, and their interests must be taken into account. There is the patient/donor speaking not by means of an abstract donor card but specifically and compellingly through a commercial transaction. There is also the other party to the contract — the buyer/broker — who says "we did a deal and it's important to respect the contract." And third, and perhaps most importantly, there is an identified donee, a beneficiary who is lying in a hospital
waiting to have his or her life saved. The beneficiary would say "the family may be finicky about this and I respect the family's judgment, but a deal was done, reliance on the transaction has been established, and the financial benefit has accrued or will accrue to the donor/seller or his or her beneficiary. My life and health are in the balance, and by enforcing the provisions of the contract I am respecting the autonomy of the donor, who made the choice to save lives by allowing use of his or her organs for transplantation."

Moreover, while one can understand the concerns of the family, those concerns must be put in context. The balance must appropriately consider not only the squeamishness of the family of the potential organ supplier but must also examine the priority of saving an identified life and fulfilling a commitment made by the potential "donor" when he or she was competent to choose. The representative of the donee or of the contracting party would be facing a very different calculus on the evening news than currently exists. The public relations climate would inevitably concentrate on the primacy of lifesaving, especially when to save a life would be to fulfill the terms of a freely and fairly negotiated agreement and to honor the autonomy of the patient/donor/organ seller. So the introduction of commerce changes the legal advice, the public relations, the politics, and the whole nature of the transaction. The existence of a legally enforceable contract and the existence of enormous lifesaving stakes once there is an identified beneficiary create a tremendous counterforce to the current system.

Fourth, public policy would recognize a value to pluralism and diversity. It would allow for experimentation and innovation. There would be a substitution for the monolithic, national system of control that we currently have in the United Network for Organ Sharing (UNOS). The Organ Procurement and Transplantation Network (OPTN), administered by UNOS, still could be retained for education, for information, for the smooth transfer of organs, for matching of organs and so forth, but the OPTN would not have a regulatory, command-and-control function. It would recognize local and regional differences. It would respond to the need for clinical experimentation. In short, it would facilitate the smooth functioning of organ transplantation procedures and help to improve quality, but it would not seek to govern or control the process. Instead, the OPTN would respect pluralism and diversity.

Fifth, under a more mainstream policy orientation, there would be concern regarding the restrictive features of the current national system. There is considerable risk associated with the professional
dominance that has characterized the medical care industry historically, and that risk is particularly acute when the profession is in a position to exert control over potential competitors who seek to enter the market. The organ transplantation field has been characterized by professional control, and the OPTN provides a vehicle by which the professionals can impose their vision on potential competitors. The authority exercised by UNOS as administrator of the OPTN, if unconstrained, poses a considerable threat to the evolution of pluralism and competition in the organ transplantation marketplace.

At present, it is unclear who actually controls the OPTN policy-making process. Elsewhere, I have criticized the regulatory authority exercised by UNOS as administrator of the OPTN. Partly in response to such criticism, DHHS has asserted its power to review and approve of all OPTN regulatory policies. Whether DHHS will rubber-stamp the regulatory vision of the OPTN embraced by UNOS, or whether it will strike out in a different direction is still unclear. It is within the power of DHHS, however, to alter the vision of the network so as to allow competition and encourage the promotion and preservation of different views on an array of organ transplantation issues. A particularly important objective, in this regard, would be to hold in check barriers to entry by new programs and to encourage young Turks to enter the field of organ transplantation.

II. DOES ORGAN TRANSPLANTATION WARRANT A DIFFERENT POLICY APPROACH FROM THAT OF MAINSTREAM MEDICAL CARE?

I have described mainstream public policy in the overall health care arena, explained how organ transplantation policy does not coincide with the mainstream, and analyzed what organ transplantation policy might look if it did coincide. Apart from different ideological perspectives, does the field of organ transplantation warrant such a different policy approach from that of mainstream medical care? I now want to present an approach toward consideration of that question.

38. See Blumstein, supra note 9, at 478.
39. See id. at 496 n.245.
A. The Presumption for Incentives in a Market System

I would start with the assumption that organ transplantation policies should allow for financial incentives in the absence of convincing arguments to the contrary. Evidence from elsewhere in the health arena shows that incentives affect behavior. Evidence from abroad shows that financial incentives dramatically increase levels of transplantable organ supply. The issue is increasingly being raised and discussed favorably in professional meetings and forums. And a recent survey performed under the auspices of UNOS and published in The Lancet demonstrates that a majority of the respondents believed that some form of compensation should be offered in the United States to donors of transplantable organs; only two percent of those surveyed commented that use of financial incentives would be immoral or unethical. I would require that those seeking to outlaw incentives in the area of organ transplantation persuasively make the case against commerce empirically or ethically. "In a nation whose institutions have relied on market mechanisms for making basic economic choices," governmental action that prohibits the use of incentives, which constitute a fundamental component of the market system, "bears a burden of persuasion."

B. Organ Procurement Is a Form of "Commerce" and Transplantable Organs Can Be a Form of "Property" Under the United States Constitution

In interesting ways, some courts have reinforced the case for allowing financial incentives to be introduced into the organ transplantation arena. A federal district court has found that organ procurement is "commerce" and is therefore protected by the commerce clause of the United States Constitution. Also, a fed-
eral appeals court has held that a transplantable organ can be considered a form of "property" protected against deprivation under the due process clause of the Fourteenth Amendment.\textsuperscript{46}

In \textit{Delaware Valley Transplant Program v. Coye},\textsuperscript{47} the State of New Jersey forbade New Jersey hospitals from using an out-of-state organ procurement organization (OPO). A Philadelphia-based OPO that operated in southern New Jersey challenged the regulation as a violation of the commerce clause,\textsuperscript{48} which prohibits state discrimination against interstate commerce.\textsuperscript{49} The court found for the Philadelphia OPO and issued an injunction against New Jersey. Under commerce clause principles, New Jersey could not bar the interstate shipment of transplantable organs and could not ban the Philadelphia OPO from operating in New Jersey.\textsuperscript{50}

In order to reach its decision, the court had to find that organ procurement and distribution constitute a form of commerce.\textsuperscript{51} The court in \textit{Delaware Valley Transplant Program} relied upon \textit{Philadelphia v. New Jersey},\textsuperscript{52} a constitutional challenge under the commerce clause to New Jersey's banning of the dumping of garbage from Philadelphia in New Jersey landfills. The Supreme Court in \textit{Philadelphia v. New Jersey} held that the traffic in garbage was a form of commerce and struck down New Jersey's ban on the importation of garbage as impermissible discrimination.\textsuperscript{53} Just as the state in \textit{Philadelphia v. New Jersey} could not ban the importation of an article of commerce (garbage), it could not ban the exportation of an article of commerce (transplantable organs) in \textit{Delaware Val-
ley Transplant Program.\textsuperscript{54}

In \textit{Brotherton v. Cleveland},\textsuperscript{55} a “pulseless” person was found in an automobile, was taken to a hospital, and was pronounced dead on arrival. Because the death was considered a possible suicide, the body was taken to the county coroner’s office for an autopsy. After the autopsy, the coroner permitted the decedent’s corneas to be removed and used as “anatomical gifts.” No approval for the anatomical gift was sought or received from the decedent’s wife. The wife sued alleging that the county coroner had unconstitutionally deprived her of “property” (her husband’s corneas) without due process of law.

The United States Court of Appeals for the Sixth Circuit noted that the wife’s claim was “dependent upon her having a constitutionally protected property interest in her husband’s corneas.”\textsuperscript{56} Upon an analysis of Ohio’s laws, the Court of Appeals held that the wife had such a constitutionally protected property interest in her husband’s corneas.\textsuperscript{57}

The invocation of the commerce clause in \textit{Delaware Valley Transplant Program} and the concept of property in \textit{Brotherton} suggest that courts are not uncomfortable with the use of traditional commercial paradigms in considering organ transplantation issues. By analogy, these decisions lend support to the growing acceptance of adopting some form of a commercial paradigm in the organ transplantation context.

C. The Advantages of a Market Approach

What are the advantages of the market approach, an approach that would allow individuals (or parents on behalf of their children) to enter into forward contracts while alive and in good health for the use of their organs for transplantation after their death?\textsuperscript{58} I

\textsuperscript{54} The Supreme Court has held that bans on importation and on exportation of articles of commerce are presumptively unconstitutional. \textit{See}, e.g., Hughes v. Oklahoma, 441 U.S. 322 (1979).

\textsuperscript{55} \textit{Brotherton}, \textit{supra} note 46.

\textsuperscript{56} \textit{Id.} at 479.

\textsuperscript{57} For a discussion of the \textit{Brotherton} case in the context of considering whether a presumed consent statute would constitute an unconstitutional taking of property, \textit{see} Mehman, \textit{supra} note 13, at 53-59. On the general issue of body parts as property, \textit{see} Guido Calabresi, \textit{Do We Own Our Bodies?}, 1 \textit{HEALTH MATRIX} 5 (1991).

\textsuperscript{58} In this article, I want to avoid specifying a specific market-based approach. My objective is to argue the general case. In practice, I would allow the market to function in developing effective strategies for inducing an increase in the supply of transplantable organs. The UNOS-sponsored article published in \textit{THE LANCET} identified the following as “[s]ome of the more popular potential financial donor compensations” covered in the UNOS survey:
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want to set forth two rationales simply and succinctly and then examine, at greater length, criticisms leveled at the use of markets.

First, there is the libertarian argument in support of the use of incentives and markets. This position emphasizes respect for the autonomy of the donor (and the ability of the donor to choose), deemphasizes paternalism, and strengthens the hand of the individual rather than the family.\textsuperscript{59} Payment to "donate"\textsuperscript{60} allows a person to determine his or her own organs' fate, respects the right of the buyer to contract, and recognizes the ability of the medically needy donee beneficiary to benefit from the transaction.

In addition to the libertarian argument, there is also the utilitarian argument. That is, would or could incentives increase organ supply? Permitting contracts for the sale of organs and making provision for a registry of potential donors would provide pressure to pursue transplants aggressively. A source of potential suppliers could be expected to come forward,\textsuperscript{61} and, once a contract had been entered into, the purchaser and the ultimate beneficiary would be

\textsuperscript{59} See Kittur et al., supra note 43. Professor Henry Hansmann has proposed a reduction in medical insurance premiums for those who sign up to donate their organs at death. See Henry Hansmann, The Economics and Ethics of Markets for Human Organs, in ORGAN TRANSPLANTATION POLICY: ISSUES AND PROSPECTS 57 (James F. Blumstein & Frank A. Sloan eds., 1989). Dr. Thomas Peters has proposed a death benefit of $1000, analogous to a social insurance payment, for those whose organs are used in transplantation. See Peters, supra note 11. There have been numerous proposals for specific market-based systems designed to increase the supply of transplantable organs. I would like now to acknowledge those other proposals, although this is not designed to be a comprehensive listing. See, e.g., Roger D. Blair & David L. Kaserman, The Economics and Ethics of Alternative Cadaveric Organ Procurement Policies, 8 YALE J. ON REG. 403 (1991); Lloyd R. Cohen, Increasing the Supply of Transplant Organs: The Virtues of a Futures Market, 58 GEO. WASH. L. REV. 1 (1989); Richard Schwindt & Aidan R. Vining, Proposal for a Future Delivery Market for Transplant Organs, 11 J. HEALTH POL., POL'Y & LAW 483 (1986); Aidan R. Vining & Richard Schwindt, Have a Heart: Increasing the Supply of Transplant Organs for Infants and Children, 7 J. POL'Y ANALYSIS & MGMT. 706 (1988). See also Erik S. Jaffe, Note, "She's Got Bette Davis's Eyes": Assessing the Nonconsensual Removal of Cadaver Organs under the Takings and Due Process Clauses, 90 COLUM. L. REV. 528 (1990). For critiques of these proposals, see, e.g., Kass, supra note 42; Richard D. Guttmann, The Meaning of "The Economics and Ethics of Alternative Cadaveric Organ Procurement Policies," 8 YALE J. ON REG. 453 (1991).

\textsuperscript{60} The term "donate" is a bit of an oxymoron in this context. It is noteworthy, however, that we are so imbued with the language of altruism that the term donor comes naturally, even when the proposal under consideration involves a mixture of altruism and the use of financial incentives rather than pure altruism through donation.

\textsuperscript{61} See Chengappa, supra note 41 and accompanying text.
forceful advocates for the effective use of transplantable organs to save lives.

D. Criticisms of Markets

Criticisms leveled at the use of markets for increasing the supply of transplantable organs can be either empirical or ethical in character. In understanding and evaluating the criticisms of markets for transplantable organs, the analyst must bear in mind the framework within which to consider objections to market-based proposals. In that context, it is worth reiterating that the burden of persuasion should lie with those advocating making market transactions illegal. Ultimately, the assignment of the burden of persuasion may well be outcome determinative, at least with regard to some portions of the argument.

1. Empirical Criticisms

It is noteworthy that many critics of the use of markets and incentives have focused on an empirical claim. Their argument is that the use of financial incentives — allowing the market to function in this area — will not result in an increase in the supply of transplantable organs. The same claim was made ten to fifteen years ago regarding financial incentives in medicine generally. But the empirical evidence from the experience of the last ten years in the medical arena refutes this. Incentives work. Objectors raise various concerns about the state of mind of potential donors — fears, uncertainty and ignorance. These deal not with the feasibility of a system of incentives but with the price that would be needed to induce supply. Concerns concentrated on this type of donor frame of mind do not address the question whether or not incentives would work. If people are not inclined to donate, then that means they will require more in the way of an inducement. Prospective buyers would have to raise the price. This focuses, as an economist would say, on the nature or characteristics of the supply curve, on its price elasticity, not on whether inducements would ultimately work. It is artificial to think in terms of absolutes — yes, people will contract for anatomical “gifts,” or no, they will not enter into such contracts. It is better to think of what inducements are needed to encourage sufficient supply so as to satisfy the demand. That is, the issue is one of degree not one of absolutes.62

62. Quality, which is a concern, arguably could be monitored where there is a contract and where patients have agreed to allow their organ to be used for transplant at their death.
If the issue concerning commerce in transplantable organs is really an empirical argument — i.e., would it work to increase the supply of transplantable organs —, then the scientist's view should come into operation: if in doubt, do a controlled experiment. Define a region, repeal the federal ban on the purchase and sale of organs for transplant in that area, and, with proper controls and monitoring, let us see what happens.

The problem is that this scientific approach of experimentalism is not satisfactory to many of the market critics. They worry that the altruistic system will be undermined and that the damage will be irreversible. The thought seems to be that the use of incentives is like an incurable infectious disease — once it is unleashed, it will deal a fateful and fatal blow to the altruistic underpinnings of the existing system of organ donation, a blow from which the existing system would not recover.

This is a hard position to counter because neither side has firm data. The evidence from India and Egypt indicates that inducements do work. Evidence from other areas of health care suggest the same thing. It is not reasonable to maintain an empirically-based criticism of financial incentives and simultaneously deny society the opportunity at least to have an experiment, even if only in a region and not in the whole nation.

In appraising the empirical criticism, the analyst must return to first principles so as assess the argument within the appropriate analytical framework: the burden of persuasion is on those seeking to outlaw market-oriented behavior in our democratic society. In the absence of firm evidence, or an experiment, we should legalize com-

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The purchaser would have an incentive to keep the seller's organ healthy, and in most scenarios the seller would have the same incentive. This makes the organ market distinguishable from the blood sale market, where quality is a serious concern.

63. Section 301(a) of the National Organ Transplant Act, enacted in 1984, bans the use of any "valuable consideration" for inducing potential donors to allow their organs to be used for transplantation. 42 U.S.C. § 274e(a) (1988).

64. The proposal for a controlled experiment accords, in broad brush, with the death-benefit idea recently advanced by Dr. Thomas Peters, although the contours of his proposal seem more narrowly drawn than the controlled experiment proposed in text. See Peters, supra note 11.

65. See Chengappa, supra note 41.

66. The empirical argument becomes linked to the ethical argument to some extent. Part of the concern about irreversibility is a concern that altruism will be eroded in practice. Critics of markets decry this, finding it lamentable as a policy development. Perhaps altruism has some immeasurable independent virtue worthy of some positive evaluation in the policymaking process, but that virtue is hardly confined to the organ transplantation arena. When measured against the benefits of saving lives and improving health, the independent value of altruism surely must play second fiddle.
merce in organs for transplant, as other commerce in medical care is now permitted.

2. Ethical Criticisms

I now consider the ethical criticisms of commerce in transplantable organs. I deal with these in specific contexts, taking on the harder claims first.

The Effect of Markets on the Distribution of Organs. Much of the ethical concern regarding commerce in transplantable organs focuses on the issue of distribution. That is, who gets the organ available for transplantation? What is the effect of a market in transplantable organs on the distribution of organs? This set of questions focuses on the demand side of the market.

The ethical thesis is that organs are different from other commodities or services that are distributed by the market system. Organs, argue critics of markets, should be allocated by medical criteria, not by financial considerations. This claim needs to be taken seriously. I would note, however, that some make the same claim for all medical care.\(^6^7\) We know that financial considerations are taken into account in medical care generally, so the issue regarding transplantable organs would have to be argued on the basis that organ transplantation is different from other forms of medical care — not only from medical care generally but also from comparable lifesaving therapies.\(^6^8\)

In my view, the original banning of market transactions in transplantable organs stemmed from an understandable yet ultimately unsophisticated linkage of issues surrounding the demand and the supply sides of the market. A market in transplantable organs can function on the supply side and, if desired on ethical grounds. Society can leave the demand side to a non-market form of distribution.

The concern by ethical critics of commerce in transplantable organs is with the effect of wealth inequality on the distribution of available organs. There is a special claim that while wealth inequal-

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\(^{67}\). Ten years ago I was involved in a debate on rationing medical care in which the claim was made that medical care should be allocated purely on the basis of medical criteria. For opposing viewpoints on the debate, see James F. Blumstein, Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis, 59 Texas L. Rev. 1345 (1981); James F. Blumstein, Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources, 60 Texas L. Rev. 899 (1982); and Rand E. Rosenblatt, Rationing "Normal" Health Care: The Hidden Legal Issues, 59 Texas L. Rev. 1401 (1981).

\(^{68}\). On the question of government's role in paying for organ transplantation, see Blumstein, supra note 9, at 453-60.
ity is acceptable as a general matter, it is unacceptable as a basis for deciding which persons are to be recipients of organ transplants.69 This is the notion that organ transplants constitute a "merit good."70

The problem, however, can be resolved by public subsidy for those whose inadequate level of wealth bars access. The kidney program is an example of a publicly financed program for a specific illness and a specific set of procedures. To establish a principled basis for this type of categorical public support for kidney transplantation, however, advocates must be prepared to justify a kidney transplant program in comparison to other transplant therapies, such as heart or liver transplants, which are more likely to deal with life-threatening situations and which are not funded as generously by the federal government.71 Also, those who make claims of special consideration for transplant programs must be prepared to demonstrate that the justification for special status for organ transplantation does not apply as persuasively to non-transplant treatments of other life-threatening illnesses (e.g., public financing of drugs such as AZT for AIDS patients). Does society have an obligation to provide a public subsidy to make available and distribute this type of life-enhancing or life-prolonging drug? And if so, must the drug be made available without a fee, so that commerce is completely eliminated in the allocation of the scarce resource? If wealth can make a difference with regard to AZT, for example, why is it unacceptable for financial considerations to enter into organ allocation decisions?

Special consideration for organ transplants must also distinguish not only other lifesaving but also other quality-of-life-enhancing procedures. Dialysis, after all, is an alternative to kidney transplantation, albeit less desirable therapeutically.72 Thus, since an alternative treatment regimen exists, kidney transplantation is not necessarily a lifesaving procedure. Other parts of the kidney trans-

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69. Presumably, the life-or-death character of many transplants, coupled with the supply constraints on transplantable organs, distinguish organ transplantation from other areas of medical care. Of course, this is an incomplete basis for distinction since there are other lifesaving therapies and since not all transplants (e.g., kidneys) are of a lifesaving character given the availability of alternative therapies (e.g., dialysis).


72. See Eggers, supra note 6.
plantation process require a fee. Whereas kidneys cannot be paid for by the patient, and kidney donors cannot receive compensation for their beneficence, organ procurement organizations can be paid for their organ procurement efforts by hospitals. Drugs are paid for, hospital stays are paid for, physicians are compensated. Money matters in every dimension of organ transplantation. It is not so clear why ethical critics become so fastidious, so squeamish, about paying for the lifegiving organ itself.

There is an irony at work here. Advocates for funding of organ transplants by third-party payers claim that organ transplantation is in fact ordinary and necessary medical care — mainstream, non-experimental medicine indistinguishable from other lifesaving and life-enhancing treatments for purposes of third-party reimbursement. The claim that organ transplantation be covered by insurance requires that organ transplantation be viewed as just another effective therapy, like many others covered and paid for under traditional medical insurance policies and programs. The claim for third-party coverage rests on the mainstream status, the lack of specialness of organ transplants. Yet that very specialness serves as the ethical foundation of the underlying hostility to commerce in transplantable organs. There is a clear tension between these two positions.

Further, for these ethical objections to commerce in organs to make sense, there must be a willingness on the part of the objectors to exalt these distributive values above overall lifesaving and quality-of-life-enhancing objectives. This is true because, for the ethical discussion, we must assume that, as an empirical matter, commerce in transplantable organs will result in an increased supply of such organs and, consequently, more saved and quality-of-life-enhanced lives from transplantation procedures.

Some have made the forthright argument that it is better not to save lives in order to maintain distributional equity. I find that argument troubling. If one assumes that a price induces more supply, and that a wealthy person's life is thereby saved, how is the poor person harmed as compared with the status quo? One must take the position that it is better to deprive the wealthy person of a transplant, which by hypothesis would not otherwise be available, in order to preserve some sense of egalitarian justice. This is a difficult outcome to impose on a person in the name of fairness since the economically disadvantaged person is not benefited in any tangible way by prohibiting the wealthier person from using his or her resources to pay for a transplantable organ.
This is a genuinely troubling ethical dilemma that, as an intellectual matter, is worthy of further investigation, debate and discussion. As a pragmatic matter, however, the issue can be finessed in the name of incremental reform. For the time being, at least, market-oriented reformist efforts can be concentrated on the introduction of commercial incentives on the supply side of the marketplace, leaving intact a non-market-driven system for the distribution of transplantable organs on the demand side.

The Effect of Markets on Live Donors. A second difficult question is whether a prospective system of commerce in transplantable organs should permit payment for use of organs provided by (i.e., sold by) live donors. At least for the present, this ethically serious and troubling issue also can be finessed. Market-oriented reforms can focus, at least at the initial stage, on the use of markets exclusively for the sale of cadaveric organs, preferably by a forward contract.

The ethical concern with live donors is coercion, but the coercion claim may not be as much of a problem as some would argue. While there is an increase in choice, it is coercion only if we equate coercion with hard choices.

We do allow people to choose risk for a price. Life with one kidney is risky. But the question is whether this is a socially acceptable level of risk that should be subject to private choice and decisionmaking or whether the risk should be banned by collective action through paternalistic governmental regulation. Professor Henry Hansmann, for example, has argued that the risk of living with one kidney is quite moderate, equivalent to driving back and forth to work sixteen miles a day. Society tolerates that level of risk in other areas, he argues, why not in the transplant area as well? Clearly there is a benefit for the recipient/purchaser, whose health is improved. Arguably, there are also considerable benefits for the “donor”/seller, who can use the funds received in the transaction for other advantageous purposes.

One must hasten to add that, if any system of commerce is established involving live-“donor” organs, safeguards are necessary to assure voluntarism and to bar other uses of body parts via coerced, not induced sale. Still, despite any safeguards that one might develop, the paternalism concern regarding live-“donor” organ sales is real and pervasive.

Also, there is worry about what some view as organ imperialism

73. Hansmann, supra note 58, at 72-74.
— the sale of organs by poor or third-world persons to provide organs for wealthy people. Rationally, the analyst may note that the sellers deem themselves better off, do not consider the risk to be excessive, and deem organ donation to be an avenue of opportunity. The skeptic may even call paternalistic objections to this activity elitist or illustrative of a certain "feel-good" morality. Yet a typical reaction is one, perhaps, of revulsion. And although this may be irrational, non-rational, or exercising a form of symbolic hypocrisy, the objections exist and persist.

The Effect of a Market for Cadaveric Organ Sale on the "Donor's" Family and on Society. It is now appropriate to address the issue of cadaveric organ sale. There are essentially two concerns here — the potential effect of a market in cadaveric organs on the family of the "donor" and the potentially dehumanizing effect of organ sales on society.74

The family issue is a legitimate concern. By selling his or her organs during life by forward contracting for transplantation at the time of death, an individual takes charge of the disposition of his or her organs at death. In the world of estate planning, this is not unusual, rather it is the norm. By allowing sales and by enforcing these forward contracts for organ transplantation, society validates the autonomy of the individual. At the same time, society takes away the ability of the family to veto the decedent's decision to allow use of his or her organs for transplantation purposes. This undoubtedly detracts from the "silver lining" phenomenon through which family members, in the exercise of altruism, feel good about giving the organs of a loved one to save the life of another human being.

The psychological satisfaction of the family in this circumstance can be considerable, but the autonomy of the patient, if it is to be adequately respected, must outweigh the family's concern. This is, of course, the normal pattern with respect to inheritance, and it is the clear determination of the existing legal regime under the UAGA, which already vests legal authority in the individual to donate his or her organs for transplantation irrespective of the wishes of the family. The family veto recognized in the transplant community is an extralegal custom not validated by existing law. Indeed, the UAGA was expressly drafted to overcome the family veto, giving primacy to the autonomy of the individual donor.75 Given the

74. For a forceful statement of this perspective, see Guttmann, supra note 58.
75. See supra notes 18-23 and accompanying text.
existing legal framework, which does not recognize the family veto, the supposed loss of the family’s psychological well-being is a weak claim. Ultimately, the autonomy of the donor and the welfare of the beneficiaries who receive the transplantable organs must outweigh the claims of the family.\textsuperscript{76} In any event, the establishment of a market for cadaveric organs will take nothing from families to which they are currently legally entitled.\textsuperscript{77}

The potentially adverse effect on society of a market in cadaveric organs stems from a concern about the commodification of human body parts (HBPs).\textsuperscript{78} This is an abstract, hazy issue. For example, Dr. Leon R. Kass, who objects to the use of markets in transplantable organs, recognizes that his objections “appeal . . . largely to certain hard-to-articulate intuitions and sensibilities that . . . belong intimately to the human experience of our own humanity.”\textsuperscript{79}

One set of objections to commodification of HBPs focuses on the value of communitarianism. There is the belief that the establishment of a market in cadaveric organs poses a threat to the value of altruism. I just do not see this as a transplant issue. It is an issue that deals with other, broader philosophical issues about how society should be organized and about how people should be motivated to live their lives. Advocates of communitarianism generally are suspicious of what they regard as the atomization of society that stems from reliance on markets for making economic allocation decisions. They are hostile to market transactions, and they worry that commodification of HBPs places yet another set of decisions into an economic context with which they are none-too-pleased to

\textsuperscript{76} Rejection of the family veto was one of the recommendations stemming from a joint forum of the American Medical Association, the Annenberg Washington Program of Northwestern University, and the Annenberg Center for Health Sciences at Eisenhower: “An individual’s decision to donate should in every case be respected; health care professionals and relatives should act in accordance with that decision, thus, respecting the donor’s right and fulfilling the donor’s desires.” \textit{Transplantation and Communications in the ’90s and Beyond, supra} note 42, at 2.

\textsuperscript{77} For individuals who wish to provide this form of psychic satisfaction to members of their family, the option of delegating this choice to family members would continue to exist under the UAGA. The choice for altruism as the basis for an anatomical gift at death would still be available.

\textsuperscript{78} For a general discussion of the commodification issue, see Margaret Jane Radin, \textit{Market-Inalienability}, 100 \textit{Harv. L. Rev.} 1849 (1987).

\textsuperscript{79} Kass, \textit{supra} note 42, at 84. Dr. Kass asserts that the sale of body parts comes “perilously close to selling out our souls,” \textit{id.} at 83, yet he concedes that “rational calculation” justifies further extension of the lifesaving potential of organ transplantation, presumably by sale of transplantable organs if need be. \textit{Id.} at 86. Dr. Kass laments this conflict, which he sees as posing a painful dilemma. \textit{Id.}
begin with. Again, I view this type of concern to be quite unrelated to organ transplantation issues *per se* but rather related to broader humanitarian concerns that underlie much of how market-based economies function in general.

Significantly, in the context of a market for cadaveric organs, there is no issue of coercion as there could be in the context of live-“donor” organ sales. Similarly, there is no real issue of organ imperialism, there is no concern regarding irreversibility, and there is no problem of exploitation of the poor. Professor Lloyd Cohen, who has written in support of a futures market in transplantable organs, has a wonderful statement regarding the non-risk of exploitation of the poor in the context of a market for cadaveric organs: “[I]n the cadaver market the vendors are neither rich nor poor, merely dead.”

The loss of altruism should not in itself be viewed as a problem, except if it results in reduced supply of transplantable organs. Supply is an empirical not an ethical concern. The issue is not whether or not altruism is a good thing. The question is whether market transactions should be made illegal. Advocates of markets in cadaveric organs have no desire to make altruism a felony. Altruism can co-exist peacefully with a flourishing market for cadaveric organs. The claim of market proponents is based upon principles of freedom, autonomy, and choice. Indeed, when one carefully examines the argument for preserving altruism by outlawing market transactions, one wonders whether the real fear is that legalization of market transactions will in fact work. That is, given a choice, people would choose to participate in a market and would abandon altruism. Unpacked, the argument to outlaw market exchanges to preserve altruism is in reality an argument to coerce altruism. This surely is a strange way of promoting the supposed good feeling of communitarian solidarity that comes from voluntary donations of the organs of a recently deceased loved one for the benefit of another human being.

To make out the case against market transactions in transplantable organs, advocates for that position must establish the unique features of organs and organ transplantation. Since, in a market economy, market-based transactions are the norm, those seeking to curtail the operation of a market must show that there are special

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80. When a transaction cannot be undone — e.g., the sale of an organ by a live “donor” or the sale of a human being into slavery, — there may be a stronger reason to examine the fairness and the wisdom of allowing exchange transactions.
reasons justifying the restriction. I will now argue that organs and their transplantation are not unique in this policy-relevant sense.

There are numerous other lifesaving or life-enhancing therapies for which sales are not prohibited. There is no ban on the sale of alternatives to organ transplantation, such as kidney dialysis. There is no ban on the sale of substitutes for failed body parts, such as artificial organs and other artificial body parts. Thus, we are left with a gnawing concern because the transplantable organ derives from a dead human body. This is not an objection to the use of the organs of a cadaver for transplantation purposes, since a donated organ is acceptable. It is just a question of how we induce donors or families to donate those organs. Does this, as Dr. Kass ominously warns, really "come perilously close to selling out our souls"? The UNOS-sponsored survey, which showed support for compensation for use of transplantable organs, would certainly call that predictive judgment into question.

Analysts must balance the hazy, abstract concern about the effect on society of the mechanism used to motivate individuals to supply their organs at the time of death for transplantation against other, fundamental values. When life and death are in the balance as far as recipients are concerned and when libertarian values of individual autonomy are involved as far as the "donor" is concerned, I must conclude that there is an insufficient basis to warrant a flat-out prohibition on forward contracting while an individual is alive for the use of that individual's organs for transplantation at the time of death.

CONCLUSION

I have discussed the advantages of allowing commerce in organs in the form of forward contracts for transplantable cadaveric organs. To summarize briefly, some of those advantages are:

- There is a shift in the locus of decisionmaking — away from the bedside of the dying family member to an earlier time when an individual can make a determination about organ sale or donation while he or she is healthy and can act coolly and rationally;
- Recognition of market transactions promotes and validates the autonomy of the individual donor/seller;

82. See Kass, supra note 42, at 83.
83. See Kittur et al., supra note 43.
84. As I have indicated earlier, I am not the first to advocate development of a market in cadaveric organs. See sources cited supra note 58.
Legalization of market exchanges for cadaveric organs creates a legal and public-relations counterforce at the time of a "donor's" death so that the owner/purchaser of the organ and the potential and identified recipient of the transplantable organ can counteract the extralegal influence of the reluctant family of the potential donor and possibly of the attending physician as well.\textsuperscript{85}

Use of financial incentives is likely to induce a greater supply of needed transplantable organs than the current, exclusively altruistic system. These advantages take on added significance because of the acute need for transplantable organs and the dearth of available organ supply under the current system.\textsuperscript{86} This is where the success of organ transplantation makes a difference. The squeamishness about markets could be indulged when the stakes were not so high. The lifesaving ability of organ transplantation means that organ supply shortages are costing lives. The claim by organ transplantation experts to mainstream status within the medical community, along with third-party payment for what is now considered to be ordinary and necessary medical treatment, suggest that it is now time to emphasize the similarities between organ transplantation and other forms of lifesaving and quality-of-life-enhancing medical procedures rather than emphasizing the differences. Values regarding organ transplantation fit within the mainstream. They are not unique. We have allowed this ghettoization of organ transplantation policy within the health policy arena to go on for too long. At this point I do not argue for a complete, full-scale market approach. I do not now call for creation of a market for live-"donor" organs. Nor do I now call for experimenting with a market on the demand side for the distribution of transplantable organs. But I do call for a controlled supply-side experiment with the sale of cadaveric organs. Permitting the sale of cadaveric organs in advance through forward contracts, with the concomitant establishment of a computerized donor registry, would represent a reasonable, modest, incremental experiment, one that is well worth trying. This is especially true given the lives at stake.\textsuperscript{87} This would allow for a constructive blend of altruism and self-interest and nurture the hope that that combi-

\textsuperscript{85} An important safeguard would be a requirement that the physician who certifies the death of the organ supplier be independent of the family of the decedent, of the family of the potential recipient, of the owner of the organ, and of any institution that had a stake in the transplant procedure.

\textsuperscript{86} See supra notes 1-6 and accompanying text.

\textsuperscript{87} See Peters, supra note 11.
nation would help to reduce the existing shortage of transplantable organs. Upon analysis, my reluctant conclusion is that the opposition to a proposal for experimenting with the sale of organs is based upon prejudice not reason.