



*Econ Journal Watch,  
Volume 1, Number 1,  
April 2004, pp 11-18.*

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## How to Get Real About Organs

ALEXANDER TABARROK\*

**A COMMENT ON:** BYRNE, M. M., AND P. THOMPSON. 2001. A POSITIVE ANALYSIS OF FINANCIAL INCENTIVES FOR CADAVERIC ORGAN DONATION. *JOURNAL OF HEALTH ECONOMICS* 20: 69-83.

[ABSTRACT, KEYWORDS, JEL CODES](#)

**MORE THAN 80,000 AMERICANS ARE WAITING FOR ORGAN DONATIONS.** Due to lack of available organs at least 6000 of them will die this year.<sup>1</sup> These deaths could be prevented if more cadaveric organs were conferred. Efforts to encourage organ donation have included a prominent advertising campaign featuring Michael Jordan, support for workplace programs, new driver's ed programs, and organ registries.<sup>2</sup> Economists and others have contributed to the cause by pointing to the price control on human organs. Given the prohibition of financial compensation for organ donation, the maximum price allowed by law is zero. At a price of zero, quantity demanded exceeds quantity supplied. Many have argued that by lifting the control, or by finding other ways to increase the incentive to sign

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\* DEPARTMENT OF ECONOMICS, GEORGE MASON UNIVERSITY

<sup>1</sup> As of March 7, 2003 there were 80,602 people on the waiting list for a transplant. In 2002, when there were a similar number on the waiting list, 6,386 died while waiting for a transplant and another 1,866 became too sick for an operation to be possible. The most recent data can be obtained from the United Network for Organ Sharing, online at <http://www.unos.org/data/>.

<sup>2</sup> Tommy Thompson, the secretary of the U.S. Department of Health and Human Services, has launched a series of initiatives to increase organ donation. For more details see: <http://www.hhs.gov/news/press/2001pres/20010417.html>.

an organ donor card, more organs would become available (Cohen 1989, Epstein 1983, Becker 1997, Barnett, Blair, and Kaserman 1996, Tabarrok 2002).

The typical counter-argument to the market approach maintains that, for one reason or another, it is wrong to “traffic” in human organs. The debate has foundered on whether it is more wrong to traffic in human organs or to let people die from the shortage.<sup>3</sup> Byrne and Thompson (2001) take the debate in a different direction by suggesting that financial incentives to sign a donor card might actually *decrease* the supply of organs. Byrne and Thompson point out that, even if a person has signed his organ donor card, i.e., registered as a donor, it is his next of kin who decides whether to permit the harvesting of organs. (As I describe later, this is not accurate in every state.) They explain that current practice gives the relatives the authority to decided ‘yes’ or ‘no’ to donation even though the letter of the law would make the signer’s signing an authoritative ‘yes’ (Byrne and Thompson 2001: 72-73). In practice then, signing an organ donor card simply signals to relatives the donor’s intent.

The central idea in Byrne and Thompson's model is that a donor has two kinds of preferences: ‘authentic’ or ‘true’ preferences and preferences for the incentive good (such as cash payments). According to their model, when the donor's relatives make their donation decision they try to estimate the donor’s ‘true’ preference for donation and factor out whatever role financial or other incentives played in the decision to donate. Under the right assumptions, money-for-signing or money-for-donation will lead to fewer actualized donations. Imagine that very few people currently sign their organ donor card. Bill Gates then offers \$500 to anyone who signs and, as a result, virtually everyone signs. When asked to follow through on the donation, the relatives reason that without the incentive the donor would not have signed, and they refuse. Even the relatives of people who would have signed without any incentive might refuse because they aren’t sure

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<sup>3</sup> Most of the plans offered by economists use pecuniary incentives. Tabarrok (2002) argues that a “no-give no-take plan” (signers of organ donor cards would receive priority in receiving organ) establishes appropriate incentives without commodifying the body. See also Schwindt and Vining (1998). Recently, [Lifesharers.com](http://Lifesharers.com) has begun to implement a “club” approach similar to that suggested by Tabarrok. Members of Lifesharers agree that in the event of their death any usable organs are conferred first to other Lifesharers members. As more members join the Lifesharers club the benefits of being a member increase. Since being a member means being a potential organ donor, Lifesharers increases the incentive to be an organ donor.

whether the deceased donated out of the ‘good of his heart’ or because his decision was ‘distorted’ by the incentive.

Unfortunately, Byrne and Thompson spend an inordinate amount of time deducing conclusions from their premises and very little time arguing for the relevance or plausibility of those premises.<sup>4</sup> They do not provide empirical evidence for their assumptions or develop an intuitive argument. On examination, their key premises appear doubtful.

Byrne and Thompson's assumptions are questionable in respect to both donors and donor relatives. Absent extraordinary circumstances, it is unlikely that the relatives would readily override the actual evidence of donor intent (a signed organ donor card) in favor of a theory about ‘true’ intentions. Donor intent is currently one of the best predictors of family choice. Siminoff et al. (2001) find that when the deceased's family knew that the deceased had a donor card 89.3% agreed to donate.<sup>5</sup> Although this does not rule out lower donation rates when financial incentives are put into play, it does suggest that relatives take donor intent seriously. Moreover, it is not true that family consent is always required for organ donation. As of January 2003, twenty-seven states had passed “donor-designation”/“first person consent” laws that state clearly that the intent of the donor is legally binding, even absent family agreement.<sup>6</sup> Naturally, no organ procurement organization wants to override family wishes during a difficult time, and, as a result, in some states family wishes can still override donor intent regardless of the law. In recent years, however, a number of organ

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<sup>4</sup> Milton Friedman (1953) argued that what matters is not premises but predictions. Thus, a theory with unrealistic, even absurd, premises is okay so long as it leads to good predictions. Byrne and Thompson, however, do not attempt to test their model. Indeed, the central question here is precisely whether we *should* test a system of financial incentives for organ donation. To the extent that Byrne and Thompson's model convinces readers that financial compensation is a bad idea it precludes the test that is supposed to justify the model. Realism and appropriateness of assumptions are valid criteria for judging an argument whenever testing is expensive or otherwise unlikely to occur and is especially vital whenever testing is the very question at debate.

<sup>5</sup> This compares with 65% who agreed to donate if they knew that the deceased did not have a card and 44.4% who agreed to donate if they knew that the deceased had not signed an organ donor card.

<sup>6</sup> States with first-person consent laws are Alaska, Arkansas, Arizona, California, Colorado, Delaware, Idaho, Indiana, Iowa, Louisiana, Maryland, Minnesota, Missouri, Montana, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Virginia, Washington, Wisconsin, and West Virginia. Florida is currently considering such a bill. The list is from a UNOS provided table “Donor Designation (First Person Consent) Status by State as of January 2003.” A number of these laws passed after publication of Byrne and Thompson.

procurement organizations have become more aggressive in seeing that the wishes of the donor are followed. In Maryland, for example, the approach has shifted from asking the family about donation to informing the family that the person will be an organ donor. As an empirical matter, therefore, the assumptions of the Byrne and Thompson model are likely to be false both as they regard the preferences of donor-families and their rights. Thus, the signaling problem that Byrne and Thompson identify is unlikely to be significant. In any case, Byrne and Thompson do not offer any evidence, direct or indirect, that financial compensation would reduce family agreement to donate.

With regard to donor preferences, Byrne and Thompson's model is unrealistic because it ignores meta-preferences for honesty and personal autonomy, and, most importantly, it misunderstands what is being exchanged when someone signs an organ donor card in response to an incentive. The state of Georgia, for example, gives an \$8 discount on driver's licenses for those who sign their organ donor cards. Byrne and Thompson require that many of the people who sign their donor cards in response to such an incentive actually think themselves fortunate when they realize that their families will refuse harvesting should that contingency arise. But most people have a preference for following through on their agreements. Few people like to think of themselves as the sort of person who makes a bargain only to go back on that bargain at the first opportunity (especially when someone's life depends on it). Even fewer people want their loved ones to think of themselves this way. By overriding the choices of their loved ones, even (perhaps especially) if done on paternalistic grounds, donor families could well be insulting their loved one's perceptions of personal autonomy.

Byrne and Thompson model the decision to sign an organ donor card as if the exchange were a conventional contingent contract—the donor gets a payment today in return for giving up something of value in the future. Yet, the contingency is the donor's death, and what the donor gives up at that time isn't worth anything to the donor. Certainly, the donor could have strong preferences about what happens to his organs in the future in which he is dead. But in modern, Western society most people don't worry about needing their organs in the after-life—all the major religions support organ donation. It is more plausible that what the incentive buys is the time

and attention that it takes to sign one's organ donor card *today*—and the unpleasantness of pondering one's own death.<sup>8</sup>

If the costs of signing the donor card are incurred when the card is signed, and not when the organs are harvested, then the relatives cannot make the donor better-off (even ex-ante) by refusing donation. Indeed, the reverse would seem to be the case. Once the organ donor card is signed the costs are sunk, but the benefits of giving life to someone else remain in the future. In short, Byrne and Thompson assume that giving up your organs when you are dead is a cost of signing your organ donor card—but it seems more plausible to view this as the benefit of having signed your donor card. Indeed, this is precisely why people sign their organ donor cards today.

To appreciate the potential benefits of financial inducements to signing, consider the preferences of people today who have not signed their donor card. Given the costs of signing, and low expected benefits, many don't bother to sign. With greater reflection, however, surely a number of these people would experience regret at not having taken the opportunity to save someone else's life. Had these people known of and already faced their death (thus having incurred the costs of signing) many of them would have had their utility *increased* by the knowledge that their gift would give life to another person. If this is a plausible description of many people's preferences then it is clear that Byne and Thompson have modeled donor decisions incorrectly. Moreover, their assumptions have artificially eliminated the scope for trading partners to use cash incentives to prompt people to reflect on the matter. In Byrne and Thompson's model, people's initial attitudes are their eternal attitudes. But an individual's attitude about such a decision clearly depends on social influences, the promises he makes, and the depth of his reflection about the matter—factors all of which can be affected by the financial compensation that induces initial signing.

In some settings the Byrne and Thompson assumptions could be valid. Consider a country in which there are strong, perhaps religion-based, fears concerning organ donation. Suppose foreign firms enter the market and offer a financial incentive to sign an organ donor card. Despite misgivings, some of the destitute sign donor cards. It is possible that, when asked to permit harvesting, many families refuse. It is also possible that such refusal might decrease the total number of donations—although this is less likely, as by hypothesis there would have been few donations irrespective of financial incentives.

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<sup>8</sup> On the view of various religions see: Cooper-Hammon and Taylor (2000).

In the United States and other Western countries, however, the plausibility of the above scenario is much decreased. A 1993 Gallup survey representative of the U.S. adult population found that most people in the United States [78%] do not think it important that they be literally buried or burned with all their organs (Gallup 1993).<sup>9</sup> Support for organ donation was overwhelming, with 85% in support and only 6% opposed. Despite large measures of support, it is estimated that only 14% to 28% of adults have signed organ donor cards (Gallup 1993, Manninen and Evans 1985). What prevents organ donation in the United States is probably indifference and institutional incompetence. When those people who previously indicated that they were unlikely to donate an organ were asked why, 47% said “No reason/don't know/haven't given much thought.” This was by far the most common response—the next highest response, at 13%, was “medical reasons” (i.e., they thought the organs would not be wanted).<sup>10</sup>

What the Gallup Poll results indicate is that a large majority of people support organ donation, but because of indifference, or perhaps a superficial reluctance, they do not sign their organ donor cards. As a matter of mathematics, it follows that any large increase in organ donor card signatories brought about by financial incentives must come predominantly from organ donation *supporters*. Thus, there is little possibility of the perverse response showcased in Byrne and Thompson's article. Financial or other incentives are ideally suited to enable interested parties to overcome the sort of indifference or reluctance that precludes most supporters of organ donation from signing their organ donor cards.

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<sup>9</sup> The poll can be accessed online at:

[http://www.transweb.org/reference/articles/gallup\\_survey/gallup\\_index.html](http://www.transweb.org/reference/articles/gallup_survey/gallup_index.html).

<sup>10</sup> The possible responses to this question and answers were: Medical reasons (13%), Too old (10%), Don't want body cut up/want to be buried as whole person (9%), Don't feel right about it (6%), Against religion (5%), Other (10%), No reason/don't know/haven't given much thought (47%) (Gallup 1993).

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### ABOUT THE AUTHOR



[Alexander Tabarrok](#) is associate professor of economics at George Mason University, Research Director for [The Independent Institute](#), and Assistant Editor of [The Independent Review](#). His papers have appeared in the Journal of Law and Economics, Public Choice, Economic Inquiry, Journal of Health Economics, Journal of Theoretical Politics, The American Law and Economics Review and many other journals. Co-author of the web site, [FDAREview.org](#), Dr. Tabarrok is also the editor of [Entrepreneurial Economics: Bright Ideas from the Dismal Science](#) (Oxford University Press), [The Voluntary City: Choice, Community, and Civil Society](#) (with David Beito and Peter Gordon, University of Michigan Press), and *Changing the Guard: Private Prisons and the Control of Crime*. His email address is: [Tabarrok@gmu.edu](mailto:Tabarrok@gmu.edu).