EJW
A JOURNAL OF THE AMERICAN INSTITUTE FOR ECONOMIC RESEARCH

Econ Journal Watch
Volume 7, Number 3
September 2010, pp 320-336

Do Economists Reach a Conclusion on Organ Liberalization?

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ABSTRACT

The first successful human kidney transplant was performed in 1954. The advent of immunosuppressant medications greatly expanded the possibilities in matching donors and recipients. Cadavers (the recently deceased) could now serve as a source for organs and tissues. Improved surgical techniques have also increased the quality of life and survival rate for transplant recipients (Kaserman and Barnett 2002, 1-2).

In 1968 the United States began regulating the market to establish a system of altruistic giving under the Uniform Anatomical Gift Act (UAGA). Subsequent events led to fears of peddling organs for profit, resulting in the National Organ Transplant Act (NOTA) of 1984. NOTA bans payment for bodily organs intended for transplantation. It also establishes systems of organ procurement and distribution. Beard, Kaserman, and Saba describe the cadaveric organ procurement system as, "a set of nonprofit monopsonists that are constrained to pay a zero price for this essential input" (2006, 14). Cadaveric organs are harvested by Organ Procurement Organizations, which are paid to harvest organs from recently deceased individuals. But the families of the deceased cannot be compensated (Beard, Kaserman, and Saba 2006, 14). The organs then go into the Organ Procurement and Transplantation Network, the system mandated by NOTA to facilitate the conveyance of organs to recipients. It is administered by

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Acknowledgments: I am grateful to David Hedengren for setting up the organ policy webpage used in soliciting leads on relevant sources. For valuable comments, I thank five anonymous referees.

the United Network of Organ Sharing, which runs a national database designed to find matches between organs and donors. Organs are allocated using a combination of medical and non-medical criteria (Weimer 2007, 18-19). Examples of non-medical characteristics are time on the waiting list and whether the recipient had previously donated an organ (Tabarrok 2002, 109-110).

The 1984 legislation was enacted prior to transplantation becoming common. There is a growing list of patients in need (Kaserman and Barnett 2002, 9). The shortage drew the attention of economists. Since the 1980s economists have been offering policy analysis, but they debate the role that markets should play. Do economists reach a consensus on organ liberalization? I perform a survey of published judgments to find out. An Excel file (**link**) contains passages to justify my treatment.

The Current System

The issues surrounding cadaverous organs involve multiple parties—the person recently deceased, that person's heirs or next of kin, governmental authorities, health organizations, and possibly designated beneficiaries. Actual practice in the United States varies considerably by state and on the spot often without clear legal demarcations and boundaries.

The current systems for organ donation and allocation are governed by UAGA and NOTA, which prohibit compensation, but they do not prohibit donation or gifting to a designated beneficiary[2] (Cohen 1989, 6-8). Some economists describe the situation as a fixed price of zero resulting in a shortage, reduced quantity transacted, and a significant loss in life and health (see Barney and Reynolds 1989, 16; Schwindt and Vining 1986, 491; Kaserman and Barnett 2002, 93; Cohen 1989, 1).

The legislation sets rules that create confusion, making contract and execution difficult. The rights to disposition of one's body rests with the individual; upon death the rights go to the next of kin (Cohen 1989, 7). The confusion lies in the many steps involved in procuring an organ. If the deceased's intentions are known, then the procurement agency may execute those wishes with or without the families consent. Procurement agencies often defer to the wishes of the family to avoid situations that would portray the agency negatively (Howard 2007, 26). Also, there have been examples of certain types of organs, such as corneas, that were harvested regardless of the deceased or the family's wishes (Tabarrok 2010b). In 1987 the federal government passed into law a form

2. Donors may specify an individual, but cannot specify or exclude a group of individuals.

of required request, meaning that hospital funding of Medicare and Medicaid is tied to a mandatory request to the next of kin for donations (Cohen 1989, 21). In this way, the next of kin have been empowered to veto the donor intent of the deceased.

Lloyd Cohen describes the system as gravely suboptimal. The donor, or donor's family, receive no positive monetary incentives for donating. The hospital and doctors face negative incentives, in the form of monetary punishment, for not requesting donation from the family. The negative incentives also impose the burden of making requests for donation to grieving families onto medical professionals, potentially reducing the likelihood of donating (1989, 23).

The tight requirements for donor candidacy reduce the pool of likely donors to about one percent of all deaths. The person must have been healthy, free of diseases or infections, within a preferable age range, and have a cause of death that does not eliminate their candidacy (Kaserman and Barnett 2002, 9). The growing waiting list for cadaveric organs has led to an expansion of organs considered viable for transplant. The use of expanded criteria organs has made little progress in providing the desired amount of organs (Tabarrok 2010b). The process required to elicit donations further reduces the number of cadaveric organs donated. Insincerity or ineptitude at such a traumatic time reduces the likelihood of families consenting to donation. It is estimated that of the medically viable *donors* only 25-50 percent are harvested (Kaserman and Barnett 2002, 10-11).

Organs are entered into the national database to search for matches. Local recipients are given priority due to the small window of opportunity for transplant. Patients are ranked using a points system. The highest points are awarded to patient most likely to have a successful transplant. The doctor of that patient is contacted, and the organ is offered to him. If the physician refuses, then the organ is offered to any other local recipients first, then the organ becomes available to matches in a wider region. The criteria differ by organ type. Some require blood type matches or other idiosyncrasies that limit availability (Kuznik 2004, 7-11).

What Should Be Done?

Some economists focus on improving the workings of the current system. Exhortation activities are directed at potential donors, surviving family members, and medical professionals (Thorne 1998, 249). The proponents of more exhortation believe that procurement agencies under-invest in procurement activities because they fail to capture all of the returns on their investments (Thorne 1998, 253). Some proponents of exhortation feel the increased effort in

securing more donations would be cheaper than implementing a market oriented system (Thorne 1998, 256).

Barter famously suffers the "double-coincidence of wants" problem. The government's prohibiting of the mediating of wants by resort to the medium of exchange—money—has spurred the pursuit of workarounds. People strive to mitigate the transaction costs of government-imposed barter.

One method for overcoming the current legal constraints is donor pools. As Tabarrok puts it, "the policy of the United Network for Organ Sharing (UNOS) is that organs are a 'national resource'" (2002, 108). Donor pools restrict access to organs to individuals whom have shown a commitment to donate their own organs, which solves the commons problems (Tabarrok 2002, 109). Donor pools can and do operate under the current system; Lifesharers is an example of a private organ sharing club (Tabarrok 2010b). Donor pools provide a signal of willingness to participate, and a credible commitment that ameliorates the commons problems (Tietzel 2001, 169). Willing donors are given preference on recipient lists or organs are restricted to members of the group (Tabarrok 2010b). Donor pools have been criticized as discriminating against those unaware that access to organs would be contingent on membership. According to David Howard, donor pools may introduce non-medical variables into the allocation process that break with egalitarian principles (2007, 34).

For living donation of kidneys, Alvin Roth, Tayfun Sonmez, and M. Uktu Unver tackle the concept of a clearinghouse to facilitate swaps among four individuals, two donors and two recipients. An inoperative pair does not have the needed matches in biological characteristics, but each may be operative when crisscrossed with another inoperative pair (Roth, Sonmez, and Unver 2004, 459). There is a national database for donors waiting for cadaveric kidneys, but to date, there is not a national database for patients having a willing, live donor that does not match the recipient (Roth, Sonmez, and Unver 2004, 460). Roth et al's clearinghouse is an example of reducing transaction costs in a barter system: a necessity given the current legislation.

If liberalization were to repeal the government prohibition on using money, markets would develop. Economists have proposed a litany of market-oriented reforms ranging from minor compensation to donors all the way to an open market for organs. One of the first reforms proposed by economists was a futures market that targeted the supplier's (donor's) incentives to induce greater organ supply. Compensation in futures markets can take many forms, and involve a wide array of groups as procurement agencies. Organs could be sold by the individual and procured by private parties (Brams 1986, 13), insurance companies (Hansmann 1989 64), or the government as a monopsonist (Schwindt and Vining 1986, 489). The payment could be made when the contract is created or when the

individual dies. Suggested payments have varied from cash payments to the individual (Adams, Barnett, and Kaserman 1999, 154), cash payments to a designated beneficiary (Cohen 1989, 2), or non-liquid reimbursement such as covering funeral services (Hansmann 1989, 62) or tuition assistance (Schwindt and Vining 1986, 496). The individual would knowingly, and freely, enter into a contract while having property rights over his body. The individual passes those rights to the procurement agency. Futures markets would reduce the confusion caused by the next of kin being involved (Cohen 1989, 2).

The method of procurement and compensation within traditional markets can vary as much as in futures markets. Markets would consist of buyers and sellers. There are only two organs that can be sold while living. A person can survive after donating a kidney or a portion of the liver (Kaserman and Barnett 2002, 6). Becker and Elias estimate the compensation for a kidney in the US would be in the ballpark of $15,000 (2007, 14). Others have proposed a regulated market in which organs are procured from individuals by the government and allocated using something like the current system (Matas and Schnitzler 2004, 216). Proponents of markets suggest that living donors are preferable to cadaveric donors, because cadaveric kidneys have a short window for use. Living donors provide opportunities to find better matches reducing the likelihood of the organ being rejected (Becker and Elias 2007, 16-17). But for organs such as hearts, lungs, intestines, or corneas, the only source is cadavers (Kaserman and Barnett 2002, 1-2).

Markets are criticized for potentially crowding out altruistic donors. Most economists cite Bruno Frey (1993) on altruism and pricing. He shows that in some cases pricing can have a negative effect on participation rates when participants perceive that accepting payment degrades their sense of virtue (Frey 1993, 654). Some worry that financial incentives will reduce the total number of donations, because the altruists will no longer donate. Richard Epstein[3] offers a rebuttal. An individual could preserve his self-image of "altruist" by declining payment or donating the payment to a charity of his choosing. And even if some "altruists" are inhibited, they may be replaced by individuals seeking compensation. Moreover, a high price signals the humane significance of the act of supplying the organ. Epstein contends that markets with crowding out could do no worse than the current system (Epstein 2008, 475-77). The issue is addressed extensively in Taylor (2005), *Stakes and Kidneys*: *Why Markets in Human Body Parts Are Morally Imperative*.

3. I opted to include Epstein as an economist. Although he does not have a degree in economics, such activities as being the director of the Law and Economics Program at the University of Chicago Law School, editor of the *Journal of Law and Economics*, and so on, would seem to qualify him as "economist."

Presumed Consent and Mandated Choice

I categorize each economist by the reforms he or she seems to favor. The categorization is rooted in the status quo, and then asks the primary question: Does the economist seem to be favoring liberalization, greater restriction, or simply the status quo? The concept of "liberalizing" from the status quo is synonymous with the liberty principle: Does the endorsed reform represent an augmentation or a reduction in liberty?

Two kinds of reforms are tricky to parse. One is called *presumed consent* (or implicit consent), which would change the default to universal organ donation at death (Abadie and Gay 2006, 600). Under the reform, a person who objects to donating his organs must explicitly state his objections during life or his organs will be subject to harvesting (Cohen 1989, 14). Abadie and Gay investigate the impact of presumed consent and conclude that, "once other determinants of organ donation are accounted for, cadaveric donation rates are 25-30% higher on average in presumed consent countries" (Abadie and Gay 2006, 613). Becker and Elias argue that presumed consent would not completely solve the shortage of organs (2007, 16).

Cohen suggests that presumed consent laws confiscate property (body parts) upon death (1989, 14-15). There is no evidence that the wishes of families are ignored within countries that have presumed consent rules. The body is still considered the property of the deceased's family. Many argue that presumed consent orients the status quo in a way that facilitates more donations (Tabarrok 2010a). Those arguing in favor of presumed consent have not addressed the implications of the policy on the presumption of liberty. Presumed consent is a contravention of the liberty principle, because Smithian natural liberty, it seems to me, would hold that upon death one's things become the property of one's heirs or next of kin, not the government. Indeed, the very labels "presumed consent" and "implicit consent" tell of taking people's stuff without their consent. Imagine a law that confiscated half an individual's income upon their death unless he or she filled out a set of paperwork. Regardless of the ease in filling out said paperwork, I argue that the law would be a liberty violation. That organ harvesting is a much better cause is beside the point, in terms of parsing the liberty principle.

Presumed consent's incursion on liberty might seem minor, for one need only to opt out of organ donation. Becker and Elias, however, caution against the precedent set by presumed consent (2007, 16). If collectivists became more emboldened in their claims that the government owns all organs upon death, they

might start charging individuals for opting out of organ donation—although, to my knowledge, this has never occurred in presumed-consent countries.

Another tricky reform is called *mandated choice*. It would hold that individuals must decide whether to release their organs. By mandating choice, it would eliminate any default position. Supporters say it creates a binding contractual obligation between the individual and the state well before imminent death. The universal establishment of a decision during life would, it is hoped, eliminate the need to deal with family members during the emotional period just after death (Byrne and Thompson 2004, 23). Again, I am inclined to count this as a contravention of the liberty principle, although it depends somewhat on how the "mandate" is implemented and enforced. It would not seem to be a large incursion on liberty, and it would not seem to pose some of the indirect threats to liberty that presumed consent does.

Econlit and Beyond: Canvassing for Published Judgments by Economists

I began with multiple keyword searches on EconLit using *organ*(*s*), *kidney*(*s*), and *transplant* as keywords. (A screen capture of each search is available upon request.) I reviewed the abstracts of articles for relevance to organ policy. For articles found relevant, I documented the title, author(s), source, date searched, and the number coinciding with the EconLit search.

The first column of Table 1 contains the keyword used to search for articles; the second column contains the total number of articles found by EconLit; the third column is the number of articles deemed relevant to organ liberalization. If an article appears in multiple searches it will be captured in the spreadsheet for the first appearance only.

Table 1: Results of Keyword Search of EconLit

Keyword	Total Number	Relevant Articles (not in a preceding search)
Organs	143	66
Organ	155	41
Kidneys	21	6
Kidney	94	5
Transplant	138	0

I fanned out from Econlit by examining the works cited by a work from the primary Econlit searches. The same keyword process was performed using

Google to check for any non-traditional forms of media such as blogs, associated press publications, interviews, or webpages. A final method of canvassing was to search in books (notably textbooks)—I inquired with textbook authors[4] and set up a webpage (link) where leads could be entered as comments. The search for judgments, then, started systematically with Econlit and fanned out in less systematic ways. The logic behind this study is that an economist who publishes a judgment makes him- or herself accountable to colleagues and the reading public for the judgments affirmed. Ultimately, I incorporated any published judgment by an economist, regardless of the media or of how I came by it. The media include popular publications and blog entries, for they too make the economist accountable to public scrutiny. My goal has been to make the survey as comprehensive as possible. This journal welcomes letters about sources I overlooked.

I verified an author's qualifications as "economist" using any of the following as sufficient: (1) a graduate degree in economics; (2) a teaching position in an economics department of higher education; (3) a professional position with the title "economist."[5]

72 Economists Categorized, Based on Their Judgments

All of the reform judgments that I found can be classified with the following seven categories:

1. Favoring presumed consent.
2. Favoring mandated choice.
3. Favoring the status quo while frowning on liberalization.
4. Favoring the status quo without addressing liberalization.
5. Favoring the status quo while entertaining mild liberalization.
6. Favoring some but not dramatic liberalization.
7. Favoring dramatic liberalization.

I also assess how clearly the economist makes his or her reform position: A) vaguely, B) fairly clearly, or C) clearly. The appended spreadsheet includes quot-

4. I used *The Economics Network* (link) as my source for economics textbooks. Under the "Introductory" classification, I recorded all textbooks titles and authors within the categories Economic Principles and Applied Economics for the USA. Under the "Intermediate" classification, I did the same for microeconomics (USA), Health Economics (General and selected specifics), and Law and Economics (General Texts). I located author's credentials and contact information in the same manner as my other searches.

5. I recorded the first met qualification, captured in the appended Excel file, and moved on. If I could not verify a person's credentials as an economist I omitted him/her.

ations that help to justify my assessment. My goal is to provide an accurate assessment of an author's views.

There are a number of authors who have written multiple pieces on the topic. Some offered different methods for increasing the supply of organs. But I did not find any author who made highly contradictory statements. Table 2 provides the last name of each economist sorted into a cell.

Table 2: Categorization of 72 Economists by Their Published Judgments on Organ Policy

Judgment	**Is the Judgement conveyed vaguely or clearly?**				
	Vaguely	*Fairly Clearly*	*Clearly*		
Favors presumed consent		Abadie Breyer Gay Kliemt			
Favors mandated choice		Byrne Thaler Thompson			
Affirms the status quo while frowning on liberalization		Mocan Tekin Thorne Wellington	Howard Munshower Steiner Tietzel		
Affirms the status quo without addressing liberalization	Dewar Nicoló	Roth			
Stays close to the status quo while entertaining mild liberalization	Âlvarez	Gottheil Guell Sönmez Ünver			
Favors significant but not dramatic liberalization			Schnitzler		
Favors dramatic liberalization		Levitt Posner	Adams III Altinanahtar Anderson Arnold Bailey Barnett Barnett II Barney Beard Becker Benjamin Blair Boudreaux Brams	Brooks Caplan Cohen Cowen Boyes Crampton Crespi Crooker Epstein Elias Friedman Hamermesh Henderson Kaserman Kruse	Mankiw Melvin Miller North O'Sullivan Reynolds Rottenberg Saba Saliba Schiller Schwindt Sheffrin Spurr Stonebraker Tabarrok Walker

Discussion of the Results

Rows 6 and 7 favor liberalization and account for 68 percent of the 72 economists included. As for opponents of liberalization, if we count those merely espousing presumed consent and mandated choice among them (not necessarily an appropriate thing to do), then we would say that those listed in rows 1, 2, and 3 account for 21 percent. So, by any figuring, the liberalizers greatly outnumber the opponents of liberalization, leaving 11 percent in rows 4 and 5 who seem to affirm the status quo. Given that the status quo usually carries something of presumption of rectitude, and given that presumed-consent and mandated-choice viewpoints do not necessarily imply opposition to other reforms in the direction of liberalization, it is fair to say that organ policy is one issue on which economists who are vocal take exception to status-quo restrictions in an exceptional way.[6]

Table 3: AEA members on allowing payments for organs

The U.S. should allow payments to organ donors and their families	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
	4.7%	10.9%	14.1%	45.3%	25.0%

Source: Whaples (2009)

How does the set of economists who publish judgments compare to the set of professional economists at large? While the two sets of economists have been found to differ on some issues, with the former more supportive of liberalization, on others they seem to be alike in their distributions of views.[7] In 2007 a sample of members of the American Economic Association were surveyed by Robert Whaples (2009) on whether organ donors or their families should be allowed to receive payments. Responses from 128 respondents are summarized in Table 3. The allowing of payments—a significant liberalization—was supported by 70

6. The following authors discuss organ policy in their textbooks without expressing an opinion or providing much discussion of the issue: Sean Flynn, Campbell R. McConnell, Stanley L. Brue, David C. Colander, James D. Gwartney, Richard L. Stroup, Russell S. Sobel, David MacPherson, Neva Goodwin, Julie A. Nelson, Frank Ackerman, and Thomas Weisskopf.

7. Rough likeness between the two sets of economics seems to hold also for sports subsidies (Coates and Humphreys 2008), rent-control (Jenkins 2009) and most likely agricultural subsidies (Pasour 2004, Whaples 2006), but on the U.S. Postal Services's monopoly (Geddes 2004; Whaples 2006) and the Food and Drug Administration (Klein 2008), as well as most likely occupational licensing (Svorny 2004) and rail-transit projects (Balaker and Kim 2006), the issue-expressive economists seem to be more liberal on the issue than are economists at large.

percent, and opposed by 16 percent. When it comes to organ policy, the two sets of economists seem to be rather alike.

Repugnance

Daniel Hamermesh (2009) says that, although he believes donors should be compensated, he does not approve of a person being able to purchase an organ in a market system. Alvin Roth (2007) discusses acts that are considered repugnant when involving money. He uses as examples life insurance, prostitution, addictive substances, and dwarf tossing (Roth 2007, 39). The acceptance of some repugnant activities has changed over time. Life insurance is considered a norm today, but it was considered unconscionable a hundred years ago (Roth 2007, 41). Levitt suggests that people are becoming increasingly open to markets in organs as the inadequacy of the current system becomes apparent. The number of patients dying while on transplant waiting lists continues to grow (Dubner and Levitt 2006).

Some argue that denying the right to sell an organ robs people of an opportunity to increase their income (Barnett, Saliba, and Walker 2001, 380-81). Others point out the inequity and hypocrisy of a system in which every party involved in organ transplantation is paid except the donor (Dubner and Levitt 2006). Others point out the contradiction in one's being able to give his body to science in exchange for a paid cremation, but parts of the body cannot be sold to save lives (Tabarrok 2009). Government-sanctioned "commodification" already exists in the form of surrogate mothers and the payment schedule used for soldiers in combat (Becker and Elias 2007, 21).

Some economists argue that denying individuals the right to engage in mutually beneficial exchange is unethical[8] (Boudreaux 2006b). In my view, supporting the prohibition on certain consensual life-saving activities, apparently from certain political prejudices or the impulse to signal one's allegiance to certain political communities, is repugnant.

Appendix

Supporting quotations and economist credential check (**Link to Excel file**)

8. The argument is not limited to economists. See nobably James Stacey Taylor (2005) *Stakes and Kidneys*: *Why Markets in Human Body Parts Are Morally Imperative.*

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