A Regulated Market for Living Donor Kidneys Defended and Recanted

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Abstract

Since the first successful renal transplant in 1954, many kidney patients saw their hopes for a better future dashed by the continuous lack of donor kidneys. A regulated market for living donor kidneys has been proposed in order to match supply to demand and to stop illegal and immoral practices of kidney acquisition. This paper presents an elaborated version of a regulated market for kidneys, discusses its advantages and defends it against the criticisms of lack of altruism, lack of free consent and overrepresentation of poor vendors. Next, the appealing commodification counter-argument is discussed but seems to fail on grounds of particularism and paternalism. Finally, both a communitarian and a contractarian argument are developed which I deem fatal for the moral legitimacy of a regulated kidney market.

Key Words: organ transplantation, human organ sales, kidney market, ethics, capitalism
1. INTRODUCTION

By continuously improving the technique of transplanting kidneys from living or dead donors, medical science has since the first successful renal transplant in 1954 come to the rescue of many people suffering from kidney deficiencies which would otherwise have been confined to tedious renal dialysis or even condemned to a certain death. Unfortunately, the bottleneck of this practice is the shortage of voluntary kidney donors. In 2006 an estimated 7000 individuals died in the U.S. alone while on the waiting list for a kidney transplant and definitely some of them could have been saved if they would have had earlier access to a donor kidney\(^1\). However, this shocking fact is overshadowed by the appalling practices of patients going to immense lengths to get a transplant kidney including buying kidneys in less developed (and/or less regulated) countries\(^2\), organ theft from deceased ‘donors’ in mortuaries\(^3\), brokers selling organs from (executed) prisoners\(^4\) or poor people lured or even forced into ‘donation’\(^5\).

National and international governments have stepped up their efforts to forbid most of these practices. An international body such as the Council of Europe states in its Convention on Biomedicine that “the human body and its parts shall not, as such, give rise to financial gain” although only few countries have ratified this treaty yet\(^6\). The World Health Organisation [1991] expresses the substantial consensus in the medical community against the commercialization of organs. Also the World Health Assembly, the World Medical Association, the Transplantation Society among many other international bodies have joined

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\(^1\) U.S. data were retrieved from the website of the Organ Procurement and Transplantation Network (www.optn.org/data). The number of deaths is stable since 1999 and could be compared with the total number of people on the waiting list which increased to over 75.000 in 2008 (April 18). In 2006, there were 10.659 transplants with a deceased donor and 6.434 from a living donor. The annual number of brain-dead potential organ donors in the U.S. is estimated between around 14.000 – 15.000 (Sheehy et al. [2003]).

\(^2\) Examples of transplantation centres in China: www.zoukiishoku.com; www.bek-transplant.com. The latter website does not provide any indication to wherefrom the donor kidneys come. Countries allegedly involved in ‘transplantation tourism’ are Bangladesh, Pakistan, and Turkey among other.

\(^3\) On January 28, 2006, the Washington Post reported on a number of funeral homes which were allegedly involved in a ‘body-parts-for-money’ scheme in which body parts from the recently deceased were ‘harvested’ illegally and sold to various buyers.

\(^4\) Human rights activists Matas and Kilgour [2006, 2007] collected evidence that there has been and continues today to be large scale organ seizures from prisoners on death row in China, especially from Falung Gong practitioners. Their reports and other evidence are available at www.organharvestinvestigation.net. However, the use of executed prisoners as donors has been defended by Cameron and Hoffenberg [1999].

\(^5\) This is extensively documented by the NGO Organs Watch and by one of its founders anthropologist Nancy Scheper-Hughes [2000; 2001a,b; 2003a,b; 2005]. See also Delmonico and Scheper-Hughes [2002], Delmonico et al. [2002], Bakhdash and Scheper-Hughes [2006].

\(^6\) See Council of Europe [1997], Article 21 and from the added Protocol to the Treaty [2002], see Article 22: “Organ and tissue trafficking shall be prohibited”.

the opposition. National legislation in many developed countries banned the commoditisation of body parts following Italy’s ban in 1969. Belgium currently considers a legislative proposal for an extraterritorial criminal law which would penalize transplant tourists who purchase organs abroad where the donors are prisoners or missing persons.

Apart from worries about the enforceability one might have, passing criminal laws tackles the problem of revolting practices but does not relieve the existing shortage of donor kidneys. Therefore some governments have used their legislative power to positively tackle the shortage problem by introducing a presumed consent legislation, which classifies each deceased individual as a potential donor in absence of explicit opposition to donation before death. In a recent paper based on a dataset on organ donation rates for 22 countries over a ten year period, Abadie and Gay [2006] found that presumed consent legislation has a positive and sizeable effect on organ donation rates. Other governments propose a system of mandated choice which would require all citizens to register their preference with regard to organ donation. Some countries create a legal framework to facilitate kidney exchanges which involves two donor-patient pairs such that each living donor cannot give a kidney to the intended recipient because of immunological incompatibility, but each patient can receive a kidney from the other donor. However, the gap between the demand and the supply of human organs for transplantation remains wide open. Even in countries with presumed consent legislation, physicians still seek the consent of the deceased person’s family which under the distress of grief and loss are often reluctant to let go the deceased’s organs (Cohen and Wight [1999]). Some countries, such as Iran and the Philippines, take a step further and allow financially rewarded kidney donation under certain conditions. Data collected by Anbarci and Caglayan [2005] show that cadaveric donors are almost inexistent in those countries since physicians and recipients prefer a ‘fresh’ organ from a living donor for better results.

Since voluntary donations of kidneys clearly do not suffice, arguments in favour of a regulated market for kidney donors have come to the fore. The positive experience with organized ‘money-for-kidney’ programs in Iran and the Philippines adds empirical validity to those arguments. In Iran, the waiting list was eliminated less than 2 years after the legislation.

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7 For economic studies on efficiency and incentive compatibility of such schemes, see Roth et al. [2004, 2005a, b], Sönmez and Ünver [2006].

8 Mandal et al. [2003] determine the medical conditions under which a living donor is preferred to a cadaveric donor and vice versa. Meier-Kriesche and Kaplan [2002] show that transplants with kidneys from living donors have a much better success rate than cadaveric kidneys.

9 See Hippen [2005] for a recent overview.
was passed (Bagheri [2006]). A free kidney market attracts a lot of criticisms. However, many objections lose their force when a regulated market is presented. Especially the medical profession – a major stakeholder in the debate though – seems to have strong opposing feelings which should not be dismissed lightly. This paper aims at expanding on economic and ethical arguments both pro and contra a regulated market and introducing new lines of argument.

First, the scope of the paper has to be circumscribed. The medical transplantation technique is now so refined that the nephrectomy or kidney removal represents only a very small health risk for the living donor – who otherwise can perfectly live on with a single kidney (Allen et al. [1997]). Not being a physician, I cannot assess this risk and, therefore, assume it to be very small for the remaining. I also restrict my analysis to kidney donation rather than to other bodily parts since a kidney is the only complete organ which can be donated during life without serious consequences for the donor. I also restrict the discussion to a kidney market for living donors, not cadaveric donors, although many arguments hold in the cadaveric donor situation too.

Secondly, the discussion in the literature is flawed by failing to distinguish properly between the separate concepts of compensation for donation, rewarded gifting and donation for payment. Compensation for donation refers to the financial compensation of the incurred costs (also the opportunity costs) of a donation which further stems from a pure and altruistic motive. Compensation reimburses the donor for time taken from work, travel, loss of earnings incurred and all justifiable expenses caused by the preceding medical examinations, the removal itself, the recovery and future check-ups. The idea of rewarded gifting, developed by Daar [1992], refers to a lump sum of money which accompanies the donation and which should make up for the costs (i.e. compensation) and additionally expresses appreciation from the society for the deed of altruism (i.e. reward). The Iranian model is a prime example of rewarded gifting: upon sufficient proof of donation, the Charity Foundation of Special Diseases pays the donor a fixed amount of ten million Rials (about $1,000 in 2005 U.S. dollars) (Bagheri [2006]). The direct match between the incurred costs and the transferred amount of money – as in compensation for donation – is broken. The reward or recognition

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10 Most of the arguments also hold for other living donor organs which do not regenerate (half a liver and lobe of one lung). Most other live donations of bodily parts regenerate over time in the donor (such as blood, semen, skin, bone marrow, …).
could also be non-monetary in nature (a medal or commemorative plate) (Delmonico et al. [2002]). Donation for payment (i.e. selling for a price) implies agreeing with the removal of a kidney for transplantation in exchange for financial gain or comparable advantage. The amount of money involved exceeds the compensation for incurred costs and the symbolic reward as in rewarded gifting. The financial gain is recognized as the sole and self-containing motive for donation. One is selling for the sole purpose of gaining an amount of money and, linguistically, one should label such person a vendor rather than a donor.

The three separate concepts, however, have definitely not the same moral standing. There seems to be consensus about the fact that compensation for donation is morally acceptable. For instance, the Council of Europe\textsuperscript{11} and the World Health Organization\textsuperscript{12} allow compensation. The case for ethical acceptance of rewarded gifting has been made persuasively by Bagheri [2006] although some express serious doubts (Veatch [2000]). Finally, the ethical standing of donation for payment is highly controversial. The Council of Europe and the World Health Organization vehemently reject donation for payment. In this paper, I restrict the discussion to donation for payment.

The paper is structured as follows. Section 2 presents a detailed proposal of a regulated market for donor kidneys, its advantages and a number of practical objections and popular counter-arguments which are all rejected. Section 3, however, moves on to discuss at length the commodification argument which has much stronger appeal and cannot be easily dismissed. The next section introduces two new arguments to the discussion – a communitarian and a contractarian one – which I believe are fatal for the proposal of a regulated market solution. Section 5 concludes.

2. A REGULATED MARKET SOLUTION DEFENDED

Is a free market a solution to overcome the gap between demand and supply of kidneys for transplantation as a number of laissez-faire economists and libertarians believe? Most authors however agree that an unregulated market implying financial negotiation between recipient (buyer) and donor/vendor (seller), prices depending on variations in quality, involvement of brokers or middlemen, is not the appropriate way forward (see e.g. Monaco

\textsuperscript{11} Council of Europe [2002], Article 21: Prohibition of financial gain.
\textsuperscript{12} World Health Organisation [1991], Guiding Principle 5 and Commentary on Guiding Principle 5.
Gary Becker is probably the fiercest defender of an *unrestricted free market* for organs (Becker [2006], Becker and Ellias [2003]). Critics of this approach point to the lack of complete information, imperfect markets worldwide, almost perfect price inelastic demand (desperate patients) and supply (poor people)\(^{13}\) which are all elements which could distort the free market mechanism. Critics also express a number of ethical objections. The illegal free marketplace out there now shows clearly some of the adverse effects: an insufficient amount of transplants are performed, involving huge health risks, favouring the wealthy and exploiting both donors and recipients.

Most authors however insist on the introduction of a *regulated* or *ethical market* including various degrees of built-in safeguards against wrongful exploitation and taking into account considerations of justice. Combining elements from different proposals\(^ {14}\), I believe the following sketch of an ethical market has the strongest appeal.

I envision a scheme in which a single purchaser such as a health insurance trust (e.g. NHS or Medicare) has been mandated by the relevant government to buy and distribute kidneys within a confined geopolitical area (such as a nation state or grouping of states such as the European Union). To prevent exploitation of low income countries, only citizens resident within the geographical area could sell into the system. Any unregulated sale of kidneys outside the health insurance trust is legally prohibited to protect people (especially the poor) from going to a free (black) market. Typically, the health insurance trust acts as a clearing house, attracting and informing potential donors, screening and selecting them on medical and psychological grounds according to the rules set out by the government, checking for free and informed consent, providing counselling before and after the nephroctomy, rating the quality of the kidney, performing correct tissue typing to minimize graft rejection, and matching the kidney independently to a recipient. The health insurance trust has for that reason full access to the complete database of people on the waiting list. Likewise, the government sets out rules for how the organs are processed and distributed to ensure organ quality, safety, and fair access. Sufficient strict controls and penalties are in place to prevent abuse. The health insurance trust organizes and pays for the surgical intervention. It also reimburses all the incurred costs since no one should have to incur a personal expense for

\(^{13}\) See Aumann and Gaertner [2004] for a graphical analysis.

\(^{14}\) A number of recent defences of an ethical market are (in chronological order): Radcliffe-Richards et al. [1998], Harris and Erin [2002], Rapoport et al. [2002], Erin and Harris [2003], Aumann and Gaertner [2004], Matas [2004], Roth et al. [2004], Hippen [2005], Friedman and Friedman [2006], Monaco [2006].
donating an organ and transfers the non-negotiated payment after the donation. The payment is set depending on quality and availability\textsuperscript{15}. The recipient receives the kidney for free. Eventually, this scheme ensures the donors that they would be equally eligible to receive organs but now the chances of receiving an organ in the case of need have increased by the existence of a market – which is the main justification of a market after all\textsuperscript{16}.

The advantages of this scheme are numerous. First of all, surgery is performed under optimal clinical circumstances within authorized hospitals and by experienced medical staff. Donor and recipient could be checked carefully before surgery and adequately cared for after it. Also a number of justice considerations are carefully dealt with: allocation of the kidney is decided on fair grounds of medical priority; poor people and rich people are treated alike; a number of safeguards protect against uninformed, impulsive decisions or donation under coercion; anonymity can be assured. Also the black market with its unethical practices is cut out as are (greedy) middlemen.

Interestingly, the scheme is also cost-effective. It makes enough savings generated by reduced dialysis costs to render the system self-sustaining (Monaco [2006]). Matas and Schnitzler [2004] have calculated that society could break even while paying $90,000 per kidney vendor. A study from Laupacis et al. [1996] showed that the cost of dialysis treatment and transplantation in the first year after transplantation was similar, but thereafter the care of a transplant patient costs less than 50\% that of a dialysis patient.

Since only the health insurance trust is legally handed the right to buy kidneys a monopsony is created: a market with a single buyer for the products of several sellers. It has the advantage that direct interpersonal trade is excluded and price negotiations are cut down (since there is a single buyer). Neither the monopsonist which has the obligation to supply kidneys nor the would-be vendors have absolute control over the price which makes Harris and Erin [2002] to state that a pricing mechanism as in a free market is possible.

\textsuperscript{15} Monaco [2006] suggests a payment of $40,000 to $80,000. Also Matas and Schnitzler [2004] and Becker and Elias [2003] established a market price for a living donor kidney. Assuming that an American earning a mean of $40,000 annually has a life valued at $3 million, faces a risk of death from nephrectomy of 1\%, a decrease of 5\% in quality of life, and will lose $7,000 of income due to convalescence room surgery, the latter calculated a kidney purchase price of $45,000. Prices on the black market vary significantly: an Indian or African kidney ($1,000), a Filipino kidney ($1,300), a Moldovan or Romanian kidney ($2,700), a Turkish or urban Peruvian kidney ($10,000) and sellers in the USA can receive up to $30,000 (Scheper-Hughes [2003a, p 1647]).

\textsuperscript{16} This procedure could be adopted to include living donors who want to sell their kidneys after death (i.e. a futures market). See e.g. L. Cohen [1989].
Nevertheless, a number of objections to a regulated market for kidneys have been raised\(^{17}\). The objections range from some *practical considerations* such as determining criteria for vendors, handling logistics and designating a price, over *weaker arguments* such as objections of organized religions and fears of abuse of the system, to a number of *stronger arguments*. Fall of the number of altruistic donations, lack of genuine consent, exploitation of the poor and commoditisation of the body are strong and widely appealing objections aiming directly at the core assumptions of the proposed market: the recognition of the individual as sovereign over his own body and of the right to increase one’s well-being through freely engaged contracts of exchange (Dworkin [1993]). Since these strong arguments cannot be dismissed as easily as the practical and weaker arguments (see for instance Matas [2004]) a thorough examination of each of them is needed.

A first widespread objection states that an organized kidney market would lower the number of organs available for transplants donated from altruistic motives. I however buy the counter-arguments of Radcliffe-Richards et al. [1998, p1951-2]: “It is frequently asserted that organ donation must be altruistic to be acceptable, and that this rules out payment. However, there are two problems with this claim. First, altruism does not distinguish donors from vendors. If a father who saves his daughter’s life by giving her a kidney is altruistic, it is difficult to see why his selling a kidney to pay for some other operation to save her life should be thought less so. Second, nobody believes in general that unless some useful action is altruistic it is better to forbid it at all.” And after all, the presence of markets does not generally drive out altruistic motives. Dworkin [1993] refers to hospital workers who are paid which does not expel volunteer workers.

A second criticism points to the presence of conditions which are pre-emptying informed consent. Fully informed and specific consent of a competent living donor which is free of coercion and willing to donate are essential prerequisites for any living donation. However, there are at least two central principal-agent issues. First of all, are donors fully informed and capable of making a rational decision? Bardhan [2005] states that poor people (and people in poor countries) have often less access to public information of which many are uneducated and superstitious. In general, access to information but also the ability to make

\(^{17}\) See discussions by Rapoport et al. [2002], Matas [2004], and Hippen [2005].
sound informed decisions is more often problematic for less educated people. I do not believe that lacking education or wealth *a priori* forestalls making a sensible decision. In any case, sufficient safeguards such as providing objective and comprehensible information and preceding counselling should be made available to avoid potential donors to fall into this trap.

A second central principal-agent issue relates to the question whether the decision to donate was made under circumstances free of coercion and duress. Truog [2005] for instance describes the ethical pitfalls of living donation – both paid-for donations and altruistic donations. Even Good Samaritan or altruistic donations could be the subject of immense pressure or even coercion (within the family i.e.). Some people might have psychologically suspect motivations (e.g. to become involved in the life of the recipient), or put racist conditions as additional clause (e.g. the recipient should be a white male). Obviously, many of these problems are rendered less relevant under a regulated market scheme which includes sufficient screening and counselling of the potential donors: one donates unconditionally to an anonymous pool and safeguards are in place to check free and informed consent. Also group or family pressure evaporates if one donates to an anonymous pool.

Many people however are more concerned that financial pressure or poverty might force people into donation. Poverty not only induces unequal bargaining power leaving the poor often pulling the shortest end (although regulation or minimum prices could prevent this), it also makes free and autonomous consent problematic. Scheper-Hughes [2003] for instance describes situations in which destitute people consider selling part of themselves as the one and only way out of misery. It is undoubtedly true that poor people will be overrepresented in the pool of vendors for such a radical sale which entails health risks, psychological burdens, disfigurement and scars, pain, discomfort and incapacitation, and, as Scheper-Hughes points out, in some cultures ridicule, blame, social isolation, stigma or even eviction from family and community. However, I agree with Dworkin [1993], who is one of the fiercest defenders of the ethics of a regulated market, that the fact that the risks will fall disproportionately by income class does not imply that the choices of the poor are involuntary.

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18 Evidently, this problem should not be underestimated since it touches the individual world of motivations, desires, wishes, cravings, wants which in any case are difficult to discern. Impossibility should not restrain one to do what is reasonably possible.

19 As are e.g. Olbourne (2001), Dworkin [1993], Wight [1991], Taylor [2002, 2005, 2006].
Dworkin further asserts that if one would accept that poverty alone pre-empts voluntary choices, it does not necessarily imply that organs should not be sold. It would suggest “that poor people should not be allowed to enter the army, to engage in hazardous occupations such as high-steel construction, to become paid subjects for medical experimentation” (Dworkin [1993, 67]). Considering poverty as coercive would make every sale in which a poor person is involved an illegitimate one which is not common sense. Dworkin defends the right of poor people to engage in contracts which improve their standard of living. Bakdash even asserts that it would be ethically unjustifiable to deprive the poor of the chance of a better life (Bakdash et al. [2006]).

Zutlevics [2001, p 299] however argues that Dworkin’s “argument is problematic as it justifies a great deal more than allowing the poor to sell their organs”. It justifies any kind of self-inflicted harm which would alleviate hardships including for instance self-mutilation in order to beg more effectively, engage in unprotected sexual intercourse in return for money, or accepting to work in hazardous conditions way below safety standards. Zutlevics’s reaction points at two further issues. First, he appeals at our intuition to accept that there are situations where self-chosen extreme harm – even if it would constitute an improvement in their situation – is ethically unacceptable. This is especially the case when the vulnerability of poor people is used for others advantage and the line of human exploitation is crossed. But this does not seem to be an argument against a market for kidneys but rather one in favour of more regulation within the market. It pleads for better regulation and control, not for prohibition. Secondly, if some people are so desperate to sell their bodily organs then they should not only be protected against exploitation but, according to Zutlevics, they are also entitled to (financial) help. It is obvious that we must address the causes of poverty and work out poverty-alleviating policies. But I do not consider an ethical market as one of those policies. Some scholars like Radcliffe-Richards et al. [1998] defend kidney sales as a way to give deprived people an additional option in their fight against poverty. I find this argument inappropriate since it also opens the door to many other ‘additional options’ – irrespective of their ethical acceptability or factual efficacy.

In sum, the fact that poverty brings people to sell the valuable goods they possess – even bodily parts – is an argument for poverty-alleviation programs and regulation of markets

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20 Also Friedman and Friedman [2006] explicitly defend this right.
21 See also Arneson [1992] in the context of commercial surrogacy.
to protect the vulnerable from being exploited, not for the abolition of markets. None of the objections discussed above – the fall in altruistic donations, the lack of free and informed consent and the strains of poverty – are convincing enough to prohibit a well-regulated market for kidneys. I believe that people under the right conditions have the personal autonomy to improve their well-being through freely engaged contracts, within the constraints of moral permissibility. However, this conclusion hinges on a couple of assumptions. First, personal autonomy is limited by the personal autonomy of others who are represented by the community one belongs to. Whether and to what extent the community plays a role in this context are issues I will expand on in section 4. Secondly, until now we have been assuming that kidneys are commodities that could be bought and sold neglecting the fundamental question whether kidneys should be a tradable commodity after all? The matter of the moral permissibility of kidney sales is scrutinized in the next section.

3. A REGULATED MARKET SOLUTION DOUBTED.

Another widespread argument against paid living-unrelated donors for renal transplantation which, when well-understood, has much more appeal is the commodification argument. In fact, a myriad of arguments show concern over the proposal that human organs enter the marketplace and could be bought and sold as an ordinary commodity. The question is obviously not whether a kidney can be sold. Of course, it is technically possible to sell bodily parts as opposed to friendship, love or received honours where trade corrupt the good itself or at least transforms it into something else (Sandel [1998]; Wight [1991]). The question should be: Should kidneys be sold for money?

The commodification arguments fall basically apart into three major categories but each argument is deemed so grave by their proponents that it in any case commands the prohibition of a commercial kidney market. A first line of attack focuses on the nature of the transaction and how the introduction of money substitutes the altruism inherent to donation for less noble motives as greed thereby corrupting the moral permissibility of the transaction. A second group of arguments asserts that a paid transaction alters the nature of the relationship between the good and the vendor as is illustrated by a famous quote from Charles Fried [1978, p 142]: “When a man sells his body he does not sell what is his, he sells himself.

22 The standard reference is the detailed analysis by Radin [1987]. For recent research see Wilkinson [2000].
People become alienated from their body and for that very reason sales should be forbidden. The third and most important chain of commodification arguments claim that a kidney sale alters the nature of the vendor itself. Paid donation, they argue in vibrant rhetoric, affects bodily integrity, diminishes human dignity, devalues the personhood, profanes the sacredness of the body, undermines self-respect, depersonalises oneself, creates dehumanization, infringes on the inalienable values of life and liberty, or reduces a person’s worth to the sum of its body parts.

In any case, this kind of commodification arguments have to show convincingly that (A) the human trait one defends – be it dignity, personhood, humanity, self-respect, or whatever – is valuable in itself; (B) the sale of a kidney reduces or corrupts the human trait one considers valuable; (C) the reduction or corruption is severe enough to ban kidney sales thereby overriding the right to personal autonomy and, finally, (D) the argument does not simultaneously condemn unpaid donation which is widely considered morally praiseworthy.

Commentators often refer to an analogy between kidney sales and what they believe are similar markets to derive a conclusion about the moral standing of a kidney market. Once the analogy between, for instance, selling babies and selling kidneys is established, then, some argue, since baby-selling is impermissible, the sale of kidneys should be declared immoral as well. Or the other way around: since there does not seem to be a factual difference between the market of blood, which is widely accepted, and the kidney market, the latter should not be morally opposed. The force of the analogy argument hinges on the correspondence of the commodities under comparison. However, scholars do not always carefully establish the similarities and the differences between the commodities under scrutiny.

In my opinion, the special status of kidneys as a commodity derives from four aspects at least. (i) Kidneys are non-regenerative or irreproducible: kidneys are not renewable and once removed they will not grow back as is the case with a lob of liver, semen, blood, or some

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24 Gill and Sade [2002] e.g. ground their analogy solely on the claim that blood and kidneys are both necessary to preserve life and the only significant difference between removing blood and removing a kidney is ‘the seriousness of the procedure’. C. Cohen [2002] sees at least five relevant differences between blood and kidney removal: 1) discrete object versus stream; 2) different importance with respect to the donor’s bodily functioning; 3) difference in long-term physical drawbacks for the donor, call it non-renewability; 4) difference of degree of intrusiveness; 5) difference in potential (life-saving) impact for the recipient.
other types of tissue. In this sense, kidney donation is a removal which is one of the most disruptive to the donor’s physical condition of all bodily parts donations. Although individuals can live with one kidney, the lack of backup should the remaining kidney fail might add lifelong uncertainty and psychological burden. (ii) The transaction is irreversible: one can not buy the kidney back as is possible for a number of other goods (semen, eggs, and babies e.g.). Of course, one could technically buy the removed kidney back but what is meant is that the removed kidney cannot be re-installed again. (iii) Removed kidneys are irreplaceable: once the organ has been removed it cannot be replaced neither by the own kidney nor by another one. This makes it factually different from the removal of other body parts such as blood for instance. (iv) Kidneys are organs which are integral to the functioning of human beings: the simple medical observation of the life-sustaining characteristics of human organs, especially of those integral to the functioning of human beings, makes them significantly different from other bodily parts such as hair, nails, or semen.

Kidney provision is not relevantly similar to any other sort of body part provision, so it cannot be claimed that selling one morally justifies selling the other (or vice versa). In sum, any analogy argument should only be invoked with great care. I am not keen on the analogy argument anyway, since it derives moral conclusions from factual similarities without examining the arguments underlying the moral status of the similar market. The ailing analogy argument is not pointless at all. It points into the direction of content arguments.

Are the aforementioned four distinguishing characteristics of kidney removal ethically significant? At least the attributes show that kidney donation is a serious transaction of a significant organ with ever-lasting, irreversible physical and psychological consequences which should not be dismissed lightly. But does the seriousness of kidney provision also invoke ethical consequences? I am inclined to believe it does. To me, not being a dualist, a person is the intimate connection between the body and what the body is and does (actions, beliefs, choices, preferences, rationality, …). I am well aware that a person bears a complex relationship to its body. We like, adore, train, use, improve, feed, or care for our body but we almost all identify with it. Ordinary expressions like ‘I am ill’ and not ‘My body is ill’ or ‘I will undergo surgery’ and not ‘My body will undergo surgery’ corroborate the observation of a person-body identification.
I do, however, not insist on a ‘natural’ identity between body and humanity, no more than on an identity between body parts and humanity, as Kant appears to assert. Chadwick [1989, p 136] explains that to Kant one’s body does not only belong to the person but that it is the person25. In short: “The body is not mine, it is me”. Nor do I follow Kant in claiming that the value of the whole body implies that each piece of the body has a trace of personhood in it. It would mean that amputees or self-mutilators have a reduced personhood which is not widely accepted. Nor do we accept that people who want healthy body parts to be removed, as is the case in a medical condition called Body Integrity Identity Disorder (BIID)26, are considered less person. In my view, the value of the body for the person is in the identification. Apart from some (pathological) deviations, all of us identify with our bodies since without it a person could not exist. And it is the person, for which the body is a conditio sine qua non, that has value, carries dignity and is worthy of respect. Most of us not only identify with our body as such but, on reflection, also with the bodily parts which are integral part of our functioning. Kidneys which are non-generative and ordinarily required for normal biological functioning are expected to be one of those pivotal body parts crucial for the body. In short: Kidneys are not mine, I consider them to be (fundamental constituents of) me.

What are now the moral consequences of this point of view? Since most persons identify with body parts which are integral part of their functioning, such as kidneys, they consider that those body parts in some way are them, and so deserve respect just as they do. Selling one’s kidney, then, cannot be done without impairing one’s self-respect and dignity. One simply does not grant oneself what one deserves. A stronger reading of the relationship between body parts and the person, asserts that actions towards organs cannot be distinguished from actions towards its respective persons (Fried [1978], Shapiro [2003]). In this view, selling kidneys cannot be separated from selling people and so a prohibition of kidney sales follows logically from the prohibition of selling people.

Anyway, selling a kidney is morally rejectable since it undermines self-respect and alters the person-body relationship. But what about unpaid donation? The idea that the value of body parts is in the identification and not a ‘natural’ fact, allows people to attach meaning to organ removal. The person-body identification is subject to moral reasoning thereby

26 Similar disorders are Body Dismorphic Disorder and Anorexia Nervosa (dissatisfaction with body size and shape).
allowing the option that morally praiseworthy deeds transform the ‘self-respectless’ act of kidney removal. In the symbolic self-giving act of a kidney donation – a gift of life – I exemplify through my body who I am, what kind of person I am: a loving person caring for others with all I have and can give. In short: Altruistic donation makes you a better person; selling for money does not.

There is another twist to the commodification argument. A pitfall many want to avoid is that persons are treated as property by others. For Kant and Radin [1987], for instance, people and their integral parts cannot become the property of others. There seems to be a danger entailed in accepting a regulated market of sliding into some sort of commodification attitude: the mere fact that kidneys are tradable, adds them to the list of personal alienable assets. Kidneys are then regarded as commodities which, just like all other commodities, come with property rights which can be transferred, put down, or claimed. The attitude of treating kidneys like other alienable commodities may result in situations where kidneys are used as a collateral guaranteeing economic contracts or where court bailiffs or other creditors lay claim upon kidneys of debtors (with or without the use of force). Since I believe that there is an intimate person-body identification, attaching property rights to kidneys is entering a slippery slope along which persons might be treated ever more as property by others.

Is this all enough to prohibit a regulated kidney market? I am convinced that there is a close person-body identity, that the person, his body and its parts are worthy of respect, that selling kidneys compromises one’s self-respect, and that a slippery slope lurks around the corner. But I hesitate to assert that this calls for a prohibition of a regulated market. First of all, I appeal to a particular conception of the personhood on which other people might maintain quite divergent views. Secondly, a prohibition based on these arguments could invoke the criticism of paternalism. Paternalism in this context denies people the freedom to sell a kidney on the grounds that it is better for their overall well-being not to engage in such contracts. To avoid the criticism of paternalism one has to show convincingly that the state knows better what is good for the citizens than the citizens themselves and that it allows the state to limit personal autonomy. Cohen is exactly trying to do this: “Autonomy is an important ethical limit, but is itself limited in scope and weight. It meets one of its limits when

27 See Wilkinson [2002] with reference to Radin [1987, p 1859]: “Commodification includes not only actual buying and selling, but also market rhetoric, the practice of thinking about interactions as if they were sale transactions, and market methodology, the use of monetary cost-benefit analysis to judge these interactions.”
28 I share this hesitation with Arneson [1992] and Wilkinson [2002].
the sale of human body parts is at issue. Even though we respect the freedom of individuals to do what they want with their lives, we draw certain lines based on human dignity beyond which we do not give effect to their free choices.” (C. Cohen [1999, p 295]) However, if society finds consensus over the concept of personhood invoked above and if it considers the loss of self-respect and dignity involved in selling kidneys an ethical limit to personal autonomy not to be trespassed, then, nothing stands in the way of a state prohibition of kidney sales.  

In sum, my qualified commodification argument starts from the observation of an intimate person-body identification. I then assert (A) that the person and consequently the body and its parts which are integral to its functioning are worthy of respect; (B) that selling kidneys compromises self-respect and is therefore morally rejectable; (C) that prohibition would face the criticisms of particularism and paternalism which lose force if there is a societal consensus and, finally, (D) that the argument allows for a moral difference between gift and sale or in the terminology of Radin: market-inalienability is compatible with other forms of alienability such as unpaid donation or gift.

4. A REGULATED MARKET SOLUTION RECANTED.

If personal choice and autonomy were all that matters, then, I believe, a regulated market solution would be appealing or, at least, would be difficult to contradict. However, a puzzling fact remains. Why find so many people, when asked for their intuition, the idea of kidney sales repellent? And more specific, why is the medical world including medical ethicists so vehemently condemning a regulated market given that personal autonomy is the pre-eminent value in medical ethics (Taylor [2002])?

It suggests that personal choice and autonomy are most probably not the only values that matter. Just like there is a morally significant person-body relationship, there is a much underestimated and complex relationship between the person and the community one belongs to. The identity of a person – who one is – is built upon a myriad of relationships and interactions that person has (had) with other persons. Caring relationships a person maintains throughout his life with parents, family, friends, lovers, neighbours, not only come to define

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29 C. Cohen [2002, 59-61] refers to Rawls as one of the liberal theorists who recognizes that limits on individual freedom are needed to support certain fundamental values.
who he is, but are an indispensable necessity for his mere existence. One depends on others for food, care, education, and on the wider community for language, culture, traditions, social customs, institutions, and a multitude of other benefits. A person cannot form an understanding of who and what he is, cannot even exist, in isolation from a caring community. Consequently, the value of a person ultimately derives from the value of the relationships which define and establish the person and, therefore, these relationships must have value and should be preserved and maintained.

In this way of reasoning, often called communitarianism, the preservation of caring communal relationships precedes over the fulfilment of idiosyncratic interests of the isolated individual. Based on the importance of the broad web of caring relationships which constitutes a particular community and the more limited interpersonal relationships, communitarian ethics then derives moral standards the members should hold in order to maintain and nurture the communal relationships. A fundamental and widespread requirement is the inalienability of personal characteristics which constitute who one is such as one’s identity, nationality, criminal record, or obtained school and university degrees. One can neither donate nor bequest it, neither abandon nor sell it. In modern democratic societies, the right to vote could be delegated but never be sold. It all demonstrates that in this view the community retains the right to prevent actions both for the maintenance of communal relationships and the protection of the personal identity which is pivotal in the broad web of relationships. Communitarian ethics definitely objects to the idea that individuals are unidentified particles in an anonymous community but instead preserves and respects each individual person’s dignity and fosters personal development.

This approach implies that caring relationships are protected, nurtured and aided by the community if failing. In the context of a kidney market, two groups in society are in danger of missing out on sufficient care: on the one hand, all those waiting for a kidney transplant and, on the other hand, the poor who will be overrepresented in the pool of kidney vendors. Proponents of a regulated market point out that a market would solve both problems simultaneously: the kidney patients would acquire a graft and the willing poor would reach a higher standard of living.

However, this is not how I see it. A market solution negates and endangers the caring relationships persons need and allows vendors to engage in a transaction which impairs one’s
self-respect (see above). It is difficult to see how a caring community could uphold a proposal in which people are offered the option to sell parts of themselves to function decently within it. Do we want to live in a community where people (you as well as me) could find themselves in a situation where they are forced by circumstances to sell a kidney in order to take part in that community in an acceptable manner? Does one of us really want to live in a society where selling one’s kidney is the ultimate way out of poverty? Not only should a caring community come up with other purpose-built poverty-alleviating options, it should also find ways to enable citizens to keep their self-respect in all circumstances. If not, it is endangering and potentially damaging the essence of a community and the interpersonal relationships on which it is built. Entering a slippery slope of commodification of care is only one potential danger for a caring community. A society allowing its members to undermine self-respect and altering the person-body relationship, erodes its own raison d’être which is to protect and encourage the development of each individual person. This is not paternalism since a community unable to guarantee the bodily integrity of its members basically fails to fulfil one of its fundamental duties. Therefore, kidneys should be restrained from market-alienability in a similar way as one’s identity or voting rights are. Let us turn on, and not negate, existing caring relationships to find alternative ways out of the pressing kidney shortage. Fortunately, many proposals to tackle the shortage have found their way to the literature but, surprisingly enough, spark much less interest than the regulated market solution. Anyway, a summary is presented below.

I am rather confident to claim that kidneys should not be market-alienable quite irrespective of the concept of the good society one holds. The legitimacy of the arguments derives from its association with the same values which bestow high moral status and praise to voluntary kidney donations such as altruism, care, and solidarity. A further - contractarian - argument is characterized by the fact that it does not require to identify the common good at all. The argument runs as follows. Assume that the technology of transplantation comes to perfection and that we as a community are urged to form judgements on the just acquisition and allocation of kidneys for that matter. Contractarian theory, as presented by John Rawls [1971], states that the ideal state for forming such judgements is an ‘original position’ in which self-interested individuals are hypothetically placed behind a ‘veil of ignorance’ which hides them from specific information related to themselves. Rawls argued that, under such circumstances, the individuals would reach a high level of consensus regarding the principles of justice which should guide the basic structure of society. He further claimed that the
principles of justice agreed upon would protect the interests of the worst-off people in society. A similar thought experiment could be carried out to discover principles to guide kidney transplants. Behind a veil of ignorance, self-interested individuals only know the overall probabilities of relevant characteristics such as ever being in need of a kidney or ever being poor. Thus, an individual knows neither whether he is currently waiting for a transplant nor whether he will need a transplant in the future. They do know the medical risks involved and their respective probabilities. Those individuals are then asked to try to find agreement on the guiding principles for a system of kidney provision. I believe at least three guiding principles will come to the fore:

1) The system should improve the well-being in the long run of all those involved.
2) The (new) system should minimize the negative effects which come with the transition from the existing system to the new one.
3) The system should comply with human rights and principles of justice.

The first guiding principle states that the well-being of all those involved (donor, recipient, family, those bearing the costs, community, medical staff …) should be taken into account. If anyone’s well-being is damaged in the long run, than the proposed system is not an acceptable one. Note that neither short-run nor maximum improvement is required. Therefore, a regulated market-solution seems to comply with this first normative principle: patients get their transplants, society saves costs and donors gain money. But whether the well-being of the vendor is well-served in the long run given the impairment of self-respect remains to be proven. Nor does the community seem to gain since huge pressure falls on care and caring relationships. The second guiding principle focuses on the negative externalities involved in the transition from the existing system to the new system. Again, the regulated market system does not seem to survive this test undamaged. Introducing the rationale of the market into intimate caring relationships might be seen as a serious adverse effect. Finally, human rights and general principles of justice should be complied with. However, the fact that the worst-off people in society – the poor who need a kidney – will obviously not be able to sell a kidney might be considered by some as an unnecessary and grave injustice of the market system.

For all these reasons, a regulated kidney market does not seem to be the evident, first best solution for the problems at hand. However, this does not mean that those in desperate
need for a kidney are left in dire straits. Alternative solutions maintaining and even thriving upon caring relationships and at the same time preserving the dignity of each person should first be scrutinized according to the guiding principles discussed above and the best ones should be put into practice, offered government support and public backing. It suggests that society should first exhaust other morally legitimate, legal and economic incentive schemes to alleviate the kidney shortage before implementing a regulated organ market.

Fortunately, the list of alternatives to a market is impressive. First of all, prevention should try to keep demand under control by for instance decreasing the renal failure associated with hypertension, atherosclerosis, obesity, or type II diabetes (Delmonico et al. [2002]). Second, government and social actors such as churches or unions could step up their efforts of informing and convincing citizens to donate their organs after death and medics could request donation routinely. Third, Sade et al. [2002] propose to increase the number of procurement coordinators and enhancing bereavement counselling. Fourth, legal systems could be adopted to alleviate the kidney shortage. The success of a presumed consent legislation has already been stressed in the introduction. Also mandated choice or an opt-in system, where those who opt-in for organ donation would go to the head of the waiting list if they themselves or their immediate family needed an organ, could be considered. Fifth, efforts could be made to reduce the search and exchange costs of living donation. Epstein [2006] defends various devices that seek to take advantage of lower search costs in order to expand the supply of organs: directed donations, matchingdonors.com, donor-recipient pairs, and LifeSharers. Roth, Sönmez and Ünver (2005a, b) suggest a centralized clearinghouse in the context of kidney exchange without a medium of exchange, say money.

Also economic solutions involving money other than a regulated market should be scrutinized. We already mentioned better financial compensation and rewarded gifting in the introduction. Other proposals could include incentive schemes through taxation, a futures market famously introduced by L. Cohen [1989], health insurance premium credits proposed by Hansmann [1989], Peter’s [1991] death benefit payment to families of cadaver organs, a mutual insurance pool (Schwindt and Vining [1986, 1998]) or a lump-sum of money to be

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30 Reviews of alternative organ procurement policies can be found in Hou [2002], Kaserman and Barnett [2002].
31 Science-fiction author Larry Niven - who also coined the word organlegger to describe the criminals who traffic in human organs - sketched in ‘The Jigsaw Man’ [1967] a world in which the government imposed organ donation as a penalty for recidivist misdemeanour criminals.
32 See e.g. Dosseter [1992], Byrne and Thompson [2001].
33 See also Crespi [1994].
donated to a fund for organ transplants (Aumann and Gaertner [2004]) or, in my opinion, to any other good cause of the donor’s choice.

Finally, the issue might be solved in the future by stem cell research leading to the ability to ‘grow’ human organs from organ cells, by tissue engineering or even by xenotransplantation (organ transplants from other animal species) although a number of tricky ethical issues will definitely crop up. Anyway, all proposals should be examined carefully and the results weighted against the merits of a market solution.

5. CONCLUSIONS

Since the introduction of kidney transplantations, the kidney acquisition process has never been freed from moral, legal and medical obstacles. Not only is immunological incompatibility often hindering donation, also legal restrictions render a gift of life in certain cases impossible. From a moral point of view, kidney donation touches upon important but at times conflicting moral values such as altruism, self-respect, dignity, integrity of the body, care, solidarity and many other. A regulated market for living donor kidneys has been proposed as a solution to overcome many of these problems and to close the gap between the supply and the pressing need for kidneys. Many critics – often members of the medical profession – stood up fiercely against kidney sales thereby distinguishing between the moral status of a kidney gift and a kidney sale – deeming the former heroic, the latter demonic. The former makes you a saint, the latter turns you into a sinner. My defence of a regulated market shows that the moral justification is much more complicated and less unambiguous than that. In the end, I plead for a prohibition of kidney sales neither on the basis of individualistic reasoning nor on paternalistic grounds but based on a notion of a caring community – which we all need to exist – which I believe is incompatible with the idea that people could find themselves in a situation in which they have to sell a kidney to function within that society. This communitarian argument has further been supported by a contractarian one. A kidney market as such does not seem to be the first-best solution and should, just as the sale of votes, be forbidden.

Further research should in the first place focus on examining the ethical merits and the practical feasibility of the many proposals to adapt supply to demand. Examining whether the arguments apply to cadaveric kidney sales and other markets of generative and non-generative
body parts is another obvious way forward. The proposal of a kidney market turns on the view of markets as fair and efficient institutions for producing and distributing goods. I have not dealt explicitly with distributive aspects well-aware of the dilemmas the allocation of an indivisible good might cause. Nonetheless, the distributive features of market and non-market kidney acquisition systems should be carefully looked at. In sum, there is no easy way to solve the kidney shortage and until consensus is reached within a community on a better system of kidney provision, the hope of kidney patients on the waiting list is that campaigners find enough Good Samaritans responding to their slogan: Show your heart, bestow a kidney!

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