Creating An Ethical Framework For A Financial Market in Organs

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Abstract

This dissertation aims to create an ethical framework in the market for organs. We look at proposed theoretical models of organ donation as well as examine case studies of where a paid market is in operation. We also look at the historical context examining whether there are any lessons we can draw from the slave trade, the other great market upon which humanity was bought and sold. Marxist and more contemporary critiques of the market will be examined before we attempt to formulate an ethical framework of our own.

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Section 1 - Introduction

For the first time in a decade we have seen the number of donated organs fall (NHSBT, 2015). In part, the fall can be attributed to the fact that fewer people now die in circumstances that lend themselves to organ donation e.g. road traffic accidents. Yet consent and authorisation rates have remained stubbornly at 60% and unless more people can be induced to sign onto the register, the number dying for want of an organ seems set to rise (NHSBT, 2015). Various strategies have been proposed to counter the fall; from the end of this year Wales is changing their system so that donors have to opt out rather than opt in (Organ Donation Wales, 2015) in the hope that this will increase the numbers registered to donate an organ.

Whether an opt in strategy will sufficiently raise the number of donors remains to be seen[1]. Another idea often advocated is that of a compensated market for organs. Such a proposal has been the scene of heated debate in the academic press and the subject of numerous news stories detailing exploitation of the poor. In 2010, a large international black market came to light when wealthy Israelis were found to be buying kidneys on the South African black market from poor migrant children (Smith D, 2010). Movies such as *Dirty Pretty Things* (2002) show how those most vulnerable may be forced into selling their kidneys simply to survive.

Understandably the idea of a trade in body parts[2] can provoke a visceral antipathy; however the different types of transactions available in both the types of body part and the differing trading models offered by the financial market would allow us to introduce subtleties that may help counter the antipathy. One of the breakthrough treatments in recent years has been that of faecal microbiota transplantation (FMT) where faeces from a healthy donor are transplanted to patients suffering from *C. Difficile* infection of inflammatory bowel disease. High quality faeces[3] is a sought after product and some labs are willing to pay donors for their product (Open Biome, 2015). Being paid for faecal donation seems to have provoked none of the antipathy that selling hearts or kidneys might; this is no doubt in part due to the fact that faeces is regarded as excreta rather than a life affirming force. However, blood too looks to become a commodity for which there will be an increased demand; recent studies are starting to demonstrate how blood from younger people can slow down cognitive decline when transfused into the elderly (Villeda S et al, 2014). Given the increasing demands we are likely to have, it seems almost inevitable that financial inducements will be considered to help promote the donation and sale of body products.

Only one country at present has instituted a limited legal market where organs can be bought and sold. The Islamic Republic of Iran allows for the (restricted) trade in kidneys and has successfully eliminated its kidney waiting list as a result (Becker & Elias, 2014). The Iranian model is not without its ethical pitfalls (which will be discussed in Section 4a) but has shown that in practice, a financial

[1] The Nobel Prize winning economist Gary Becker in advocating to a move towards a compensated system of organ donation notes that an opt in strategy has had mixed results with some countries seeing little difference after making the change (Becker & Elias, 2014). In some countries, such as Brazil and France, it has been felt that the presumed consent model in fact led to a backlash against organ donation (Bramhall, 2011).

[2] When the term body part is used it refers to the general sale of body matter whether that be an organ such as a kidney, or excreta like urine.

[3] For example, antibiotics can dramatically affect the gut flora changing the microbiota of faeces and hence undesirable for the purposes of transplantation.

market can help in eliminating the mismatch between the supply and demand for organs. But straight forward buying and selling covers only the most rudimentary actions of the market. Many trades now a day are derivatives also known as options. Here a trader purchases an option to buy a product, e.g. next year's wheat crop at a particular price. When next year arrives the trader then has the option to exercise the option and buy the wheat at the agreed upon price. Similarly with organs could we not envisage a situation where donors could sell options on their kidneys that could only be excised after their death? The donor is not forced into selling organs whilst alive through desperation but instead is able to reap a financial benefit whilst alive and donate an organ only when they no longer need it.

Yet another financial transaction is that of leasing. To a certain extent surrogacy agreements already use this method; it is however not inconceivable that medical technology will advance enough so that one day you could lease a kidney for a number of years and then have it returned to you. All these different transactions of body parts have their own ethical dilemmas. During the course of this paper we will be examining the different financial transactions that can be undertaken with different body parts.

The debate around selling organs ethically has received much coverage in the academic press and we will be considering the different frameworks put forward by commentators. We will also examine in more detail the Iranian model and the safeguards in place for it and other organ trading systems. We will also expand the discussion looking at the ethics of more complex trading systems as well as whether a financial market for organs can ever be ethical.

For some the selling of human organs will never be accepted practice. As the philosopher Cynthia Cohen writes:

"[human beings] are of incomparable ethical worth and admit of no equivalent. Each has value that is beyond the contingencies of supply and demand or of any other relative estimation. They are priceless. Consequently, to sell an integral human body part is to corrupt the very meaning of human dignity" (Cohen, 1999, p292).

Opposition to the sale of body parts is a valid position and the purpose of this paper is not to convince those that feel differently. This paper will instead try and focus on the question of whether (for those that accept selling and organ is not an absolute wrong) there can ever be an ethical way to sell body parts.

Section 2 - Organ Economics – Trading Organs on the Financial Markets

"It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest. We address ourselves, not to their humanity but to their self-love, and never talk to them of our own necessities but of their advantages. Nobody but a beggar chooses to depend chiefly upon the benevolence of his fellow-citizens." (Smith, 1776)

Markets are used on a daily basis for the distribution of goods. We are dependent on their existence in obtaining essential items such as food and housing; yet organs have on the whole not been subjected to market forces and rely on an altruistic distribution network. In this section we consider in more detail the different financial transactions we can use to trade in organs as well as consider the basic economic principles which may affect the financial market in organs.

Section 2a - The Barter Market

One of the simplest transactions is that of buying and selling organs. Buyers can either approach an individual seller, or an organisation that sells the items they want. According to traditional economic theory a free market will find an equilibrium price as shown by the diagram below (where arbitrary figures have been used).

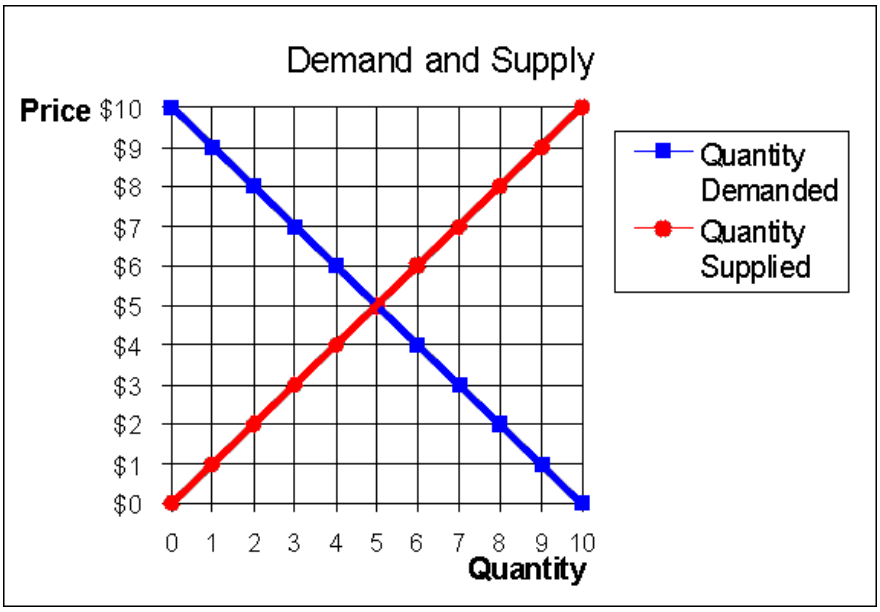

Figure 1 – Demand and Supply Curve (Danby, 2007)

The blue line represents the quantity demanded curve; we can see that as the price rises the amount people want falls (people may not be able to afford organs at high prices for example). The red curve represents the quantity supplied; as the price falls, the quantity supplied also falls (fewer people are prepared to sell their organs at such low prices). At a low price demand will rise (people are more likely to try to buy an organ as the commodity is cheap). Conversely as the price rises, the supply of the product also rises (selling an organ provides a more meaningful return). However, if supply outstrips demand (or vice versa) then we have a mismatch in the market. In the diagram above we can see that when the quantity supplied is nine units, the price consumers are willing to pay is only

$1 (known to economists as 'oversupply'). On the other end of the spectrum, when supply cannot meet demand then the prices rises, for example when the quantity available for supply is one unit, the corresponding market price is $9 (too much money chasing too few goods is known to economists as 'demand-pull inflation'). Eventually the market finds an equilibrium price (in the diagram above at $5) where supply and demand match each other.

Clearly whilst the above representation is a simplification it does raise a number of concerns that any ethical framework would need to address. For a starving individual the price at which they would be willing to sell their organs would be very low. If the rich world were to be allowed to trade with the developing world we may have a situation, where those in rich countries are able to buy organs for relatively low prices from people in desperate need of money (there would likely be an oversupply with many poor people desperate to sell their organs). The difference in wealth between two countries has the potential to therefore lead to exploitation of the poor by the rich.

The model we discuss above has a number of assumptions built into it. One such assumption is that no single individual has the power to affect the market price. However, if there were to be only a single buyer (monopsony) of organs, for example the government regulates that only the NHS can buy organs, then that buyer would essentially be a "price-setter" (Begg, 2005, p133). In other words regardless of how much individuals wanted to sell their product for, they would only have one buyer to sell it to and so would either have to sell at the price offered or not sell at all.

Section 2b - The Leasehold Market

Another form of trade is through borrowing. As previously stated, this already happens in surrogacy agreements where a third party's womb may be used by a couple to host their embryo. In the UK it is illegal to pay the surrogate anything but expenses (UK Government, 2015). On an international level commercial surrogacy is legal, notably in some states of the USA and in India (Cheung, 2014). Commercial surrogacy has been fraught with controversy, whether it has been the refusing of homosexual couples' access to surrogacy services in India (Bindel, 2015) or allegations of "[w]omen [being] pimped by husbands and criminal gangs into renting their wombs to rich western couples" (Bindel, 2015).

Surrogacy is a unique transaction and it is difficult to think of another biological function to which it compares. However the principle of renting out an organ may become a technical reality. Case studies show that the same organ can be transplanted successfully more than once (Kadambi et al, 2012). This could potentially lead to a situation where someone may lease out a kidney for ten years, only to have it re-transplanted back into themselves after the agreed time period had lapsed. Clearly such a position would be ethically fraught, but medical science is reaching a point where this could become a technical reality.

Section 2c - The Futures Market

Another trading mechanism is that of futures. These financial instruments are often used in commodity markets, as an example to illustrate how the futures market works we will consider the agricultural market. A buyer may purchase next year's crop from a farmer in one of two ways. He may either purchase the crop outright in advance (e.g. I will pay you £10 for every kilogram you produce next year) or he may purchase an option to buy next year's crop (e.g. I will pay you £100

now for the option to buy every kilogram you produce next year for a price of £10 a kilogram. The down payment of £100 in this second scenario is the price of the option; it may be that by next year a kilogram is selling for considerably less than £10, if so the buyer may not want to exercise the option).

The futures model could be used to trade organs. Some organs like kidneys can only be donated if the donor dies in a certain manner e.g. patient cannot die outside of a hospital setting. For other organs such as cornea and skin this is much less of an issue. Therefore a donor could potentially sell some organs in advance e.g. I will take £100 now for my corneas which can be harvested upon my demise. Other organs can be sold as an option e.g. I will pay you £10 now for the option to buy your kidney for £100 towards your estate should you die in the right circumstances.

We can add a further layer of complexity to this type of transaction. Often these options are bought and sold by financial companies. If we take the above example further and assume that I have purchased the option from Donor A of £10 to buy his kidney for £100 upon his death; a financial company may then want to buy the option from me. They may predict that in twenty years' time (the point at which actuarial tables estimate Donor A is likely to die) kidneys will be worth £150 on the open market. As a result they buy the option from me for £12 and speculate on their future return.

This type of trading in body parts takes us beyond the simple buying of an organ for someone in need of it for their own health. Here organs have become a financial commodity and bring in parties with no primary interest in the organ and see it merely as a means of making a profit. As we progress further we will need to consider the ethics of such a position and whether it can be incorporated within our ethical framework.

Section 3 - Current Ethical Frameworks in Organ Trading

Professor John Harris of the University of Manchester has consistently advocated for the use of financial incentives in order to increase the availability of organs. Recognising the potential ethical pitfalls he puts forward a framework (hereafter referred to as The Harris Model) which we discuss and critique below.

Section 3a - The Harris Model and its Critique

Professor Harris puts forward several principles[4] that would make up his organ market. These consist of:

1. "The market would be confined to a self governing geopolitical area such as a nation state or indeed the European Union. Only citizens resident within the union or state could sell into the system and they and their families would be equally eligible to receive organs" (Errin & Harris, 2003, p138).
2. Organs could not be bought from low income countries to prevent their being exploited (Errin & Harris, 2003).
3. There would be only one purchaser of organs who would also decide on how they were distributed. Distribution would be determined on a prioritisation system based on medical need (Errin & Harris, 2003).
4. Safe guards would need to be enacted to prevent wrongful exploitation of vulnerable people (Harris & Errin, 2002).
5. Organs cannot be seen to be capital and therefore cannot count as wealth to those being assessed for benefits (Harris & Errin, 2002). Similarly money raised from the selling of an organ should be exempt from overall benefit payments or tax so that there is no welfare loss to the seller (Harris & Errin, 2002).
6. "People who sell their organs and tissues into the marketplace should perhaps be afforded greater priority in the allocation of organs if they become patients in need of organs than people who do not" (Harris & Errin, 2002, p114).
7. The organs would be tested for disease such as HIV, viral hepatitis etc… (Errin & Harris, 2003)

His last principle (7) is perhaps the least controversial of all. Few would object to the requirement that organs traded for transplant should be as safe as possible. Similarly point (4) is also uncontroversial, in that vulnerable people, e.g. those with learning disabilities, should have additional protections to prevent them from being exploited.

Whilst advocating in favour of a market Professor Harris in fact puts forward a very restricted market. His first two principles confine the sale of organs to a limited geographical area. His justification for doing so is to prevent the exploitation of people in developing countries. Furthermore he feels that close geographical proximity is important so that:

[4] The Harris model discussed below takes points from several of his papers and presents them as a unified framework. Harris is also not the sole contributor to the papers, however for the sake of convenience it is his name that is taken.

"…organ vendors would know they were contributing to a system which would benefit them and their families and friends since their chances of receiving an organ in case of need would be increased by the existence of the market. (If this were not the case the main justification for the market would be defeated") (Errin & Harris, 2003, p138).

Here Professor Harris appears to suggest that a self-contained market is needed for people to feel motivated enough to sell into it; he postulates that by limiting the area donors feel that they have a greater chance of receiving an organ should they ever be in need themselves[5]. We could however argue that the larger the available market the more likely it is that an organ can be found and by restricting the supply of donors by geography we also limit the supply of organs.

A further restriction Professor Harris places on his proposed market is the sole use of a monopsony as a buyer of organs. He feels by having a monopsony we are better able to "prevent the rich using their purchasing power to exploit the market at the expense of the poor" (Harris, 2002, p114). Furthermore, he argues that the monopsony could regulate the trade better by for example making sure organs are healthy and ensuring there was a fair mechanism of distribution in place (Harris, 2002). For advocates of neoclassical economics a monopsony has the potential to lead to market failure (Penner, 2004, p26). As the sole buyer a monopsony has the ability to set the price, if this is too low many may feel it not worth their while to sell their organs and the supply falls. This is illustrated in the diagram below:

[5] Within welfare theory it is often argued that we expect recipients to share similar cultural and social values (Anderson, 2002, p95) one of which might be reciprocity. We essentially limit ourselves to what the sociologist Benedict Anderson terms an "imagined community" which he defines as:

> "[An imagined community] is imagined because the members of even the smallest nation will never know most of their fellow-members, meet them, or even hear of them, yet in the minds of each lives the image of their communion.... Communities are to be distinguished, not by their falsity/genuineness, but by the style in which they are imagined.... Finally, [the nation] is imagined as a community, because, regardless of the actual inequality and exploitation that may prevail in each, the nation is conceived as a deep, horizontal comradeship. Ultimately, it is this fraternity that makes it possible, over the past two centuries for so many millions of people, not so much to kill, as willing to die for such limited imaginings (Anderson, 2006, p6)."

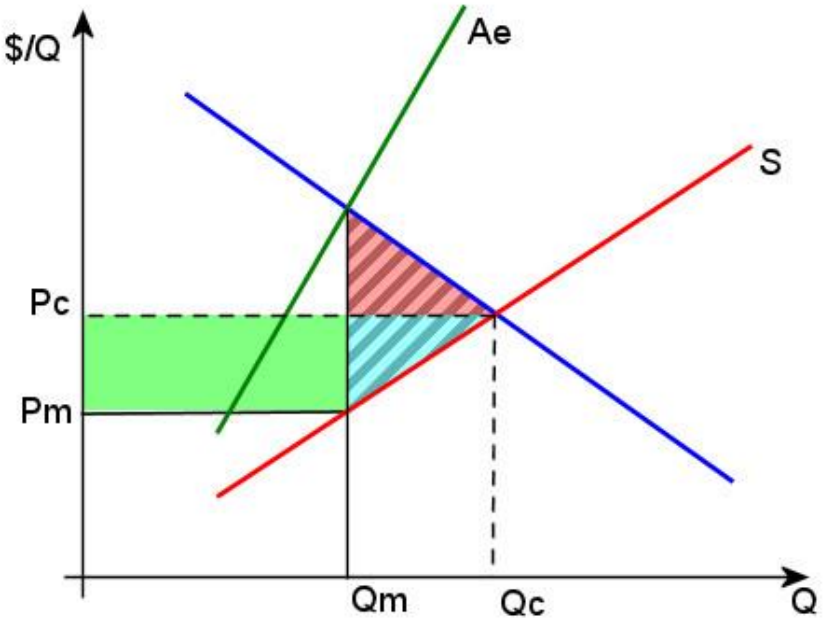

Figure 2 – A Monopsony Leading to Market Failure (Jiminez, 2012)

Similar to *figure 1* we have our demand and supply lines. If we look at just the supply and demand curves, we can see that the price of the good would be Pc and quantity supplied of the good would be Qc at the market equilibrium position. Due to its position a monopsonist can move the market to its Average Expenditure (Ae) curve[6]. By doing so it reduces the quantity supplied to position Qm but being a monopsony they can set the price at Pm (as they are the sole buyer sellers have no option but to the take the price given). As a result, the monopsony makes a price saving (as shown by the area shaded green). However due to the reduced price, the monopsony loses a certain quantity of product as indicated by the area shaded in red (as for some suppliers the price they are being offered will not be worth it and they will exit the market). For the monopsony this is still economically beneficial, the savings they make are offset by the quantity they lose (this can be seen on the diagram as the green area is greater than the red area). The blue shaded area indicates the financial loss to the suppliers as they are being forced to take a set price rather than one determined by market forces. Thus the overall loss to society (the combination of reduced supply and less money going to those who sell their products) is represented by the red and blue areas added together.

Professor Harris disagrees with the idea of a monopsony being a cause of market failure, instead he states that:

"It might be thought that in a monopsonistic market there is no possibility for a pricing mechanism as in the free market. But the monopsonist is under pressure to purchase, this pressure resulting from the need for organs: if the purchaser is responsible for supplying patients with organs, and if demand from the public for such provision exists, the purchaser will have an obligation to provide organs and a powerful motive for discharging the obligation. This affords the would be vendor a degree of bargaining power over the price he or she can demand for his or her organ. There is an analogy here with the NHS purchasing drugs and other equipment in the current system: in the United Kingdom, even before the growth of private health care, the position of the NHS as the lone major purchaser of

[6] For an explanation of this assumption please consult Appendix A

pharmaceuticals did not afford it the power to dictate the prices of the drugs it purchased" (Harris, 2002, p114-115).

What Harris fails to point out is that a difference exists between large pharmaceutical companies and individual sellers of organs. Pharmaceutical companies often act as a monopoly (some classes of drug will be patented to certain firms) where as individuals have much less power, thereby reduced their ability to negotiate a price. The price offered by a monopsony (as shown in *figure 2*) is likely to be lower than that offered by a free competitive market and as result sellers of organs will receive less income from their sale. Professor Harris however rightly states that there are advantages that a monopsony can bring, and in theory there is nothing to stop a government backed monopsony purchasing organs for a premium. However both neoclassical economic theory and everyday reality (Noll, 2005) serve to illustrate that with a monopsony it is the individual sellers that lose out. An additional concern is that those likely that those willing to sell their kidneys would belong to lower socioeconomic classes[7]. By forcing them to accept lower prices a monopsony may contribute to the exploitation of the poor.

As well as creating an economic injustice, the establishment of a monopsony infringes upon the autonomy of the donor. Beauchamp and Childress provide two components to the definition of autonomy; a negative obligation which states that "autonomous actions should not be subjected to controlling states by others" (Beauchamp and Childress, 2001, p64) and a positive obligation which "requires respectful treatment in disclosing information and fostering autonomous decision making" (Beauchamp and Childress, 2001, p64). A monopsony conflicts with the negative obligation one has towards the donor.

Professor Harris also suggests (in point (6) listed above) that those that are prepared to sell into the system should receive a higher priority for receiving an organ should they ever be in need. Yet arguably this rewards them twice, once when they are compensated for their organ and again when they are given a higher priority. Whilst Harris terms it as being only just that they are given a higher priority in reality it maybe a necessity as fewer people would likely be willing to take part in such a market without such a safe guard.

[7] This data is certainly seen in the Iranian Model where approximately 80% of donors are from the lower socioeconomic classes (Ghods & Savaj, 2006,p1140

Section 4 - Trading Frameworks in Practice

Whilst one cannot buy an organ on the open market trade in body parts takes place in a limited capacity under various jurisdictions. Some examples include the Iranian kidney market and the paid surrogacy market, both of which we consider below. In this section we examine the regulatory framework put in place, along with the ethical controversies that each market has generated. We will also consider one of the pioneering works in the field of paid organ donations, that of the late Professor Richard Titmuss, who's seminal book *The Gift Relationship* has shaped much of the work carried out in this field.

Section 4a(i) - The Iranian Model

In 1988, following the aftermath of the Iran-Iraq war the Iranian government instituted a system of compensated kidney donation. In less than a decade the market had eliminated the waiting list for kidney transplants (Ghods & Savaj, 2006). If a patient requires a kidney and is unable to obtain one from a living relative for free, then they are able to be referred to the Dialysis and Transplant Patient's Association (DATPA), an organisation that can obtain a kidney from living unrelated donors (Ghods & Savaj, 2006, p1137). DATPA acts as the sole broker of exchange between unrelated donors and recipients; the staff at DATPA receive no incentives for brokering a match (Ghods & Savaj, 2006, p1137). As an added safety measure, not only does the donor have to consent but so to do their next of kin (Tober, 2007).

Donors can receive both a government reward for donating[8] (typically around £600 (Griffin, 2007, p503)) as well as a reward from the recipient, or if the recipient is poor from a charitable organisation on behalf of the recipient (Ghods & Savaj, 2006, p1138). Both the Iranian government and the charitable sector help subsidise the cost of the aftercare such as the immunosuppressive medication needed by recipients.

Foreign patients are not permitted to either donate of receive a kidney from an Iranian national. They are allowed to participate in the scheme, but can only do so with an individual who shares their nationality and only after seeking special permission of the Ministry of Health (Ghods & Savaj, 2006, p1138). The ethics of the entire process is scrutinised by the Iranian Society for Organ Transplantation as well as the transplant teams themselves (who are not directly incentivised in any way by DATPA or the recipient) (Ghods & Savaj, 2006, p1138).

Section 4a(ii) - The Iranian Model Analysed

The Iranian Model bears some similarities with Harris' proposed model. Most notably, both models place a constraint on who can access the services and both use a central authority to control the process. For all its success in eliminating the waiting list the Iranian Model has not been without controversy. Critics say one of the reasons behind Iran managing to eliminate its waiting list is due to the large disparities in its health care provision. Many of those living in the rural areas of Iran lack access to adequate healthcare facilities, and often do not realise they are in renal failure till it is too late to take any action (Ghods & Savaj, 2006, p1138). As a result the incidence of renal

[8] The government reward takes the form of *Diyeh* or blood money, refer to Appendix B for more details

transplantation is significantly lower in Iran than in the developed world[9]; there is a fear that if the incidence were to rise, then the Iranian organ market would be unable to cope.

The social demographics of those choosing to donate have been studied in some detail. As might be expected, those individuals who are considered to be financially well off were significantly less likely to sell their organs. Statistics reveal that 84% of donors were classed as being poor, with only 6% having a university degree (Ghods & Savaj, 2006, p1141). It is worth pointing out that a majority of the kidney recipients (50.4%) are also classed as being poor (Ghods & Savaj, 2006, p1141) so it is by no means the case that the market has locked out the impoverished (Ghods & Savaj, 2006, p1141). There also appears to be a gender disparity with donors from the lower socioeconomic class; most are women who have decided to donate to "help supplement the family income and that they did not want their husbands to sell their kidneys because of the potential lost income" (Tober, 2007, p166). Whilst the statistics do point towards financial need being the strongest motivator for kidney donation, prior to the introduction of the market there was evidence of living relatives being coerced into being donors, a situation which now appears to have resolved (Ghods & Savaj, 2006, p1140).

With the donors having lower levels of education than the general population, there is a fear that they may not always understand the implications of kidney donation. Research in India suggests that donors do not always realise the function of the kidney, or that having more than one kidney did not simply mean you had a spare (Goyal et al, 2002). Similarly, in Iran "[m]ost male donors, who worked as day laborers, reported they were not able to work as well after transplantation because they were 'weak and tired', and are thus financially worse off than they were before transplantation" (Tober, 2007, p161).

Studies that have followed up Iranian kidney donors in the short term (i.e. straight after hospital discharge) find that 95% of donors express satisfaction with their decision (Griffin, 2007, p504). Over the short to medium term (in this study from 6 to 132 months), researchers found that "76% of donors agreed that kidney sales should be banned and if there was another chance they would prefer to beg (39%) or get a loan (60%) instead of selling a kidney" (Griffin, 2007, 504-5). Generally, the money given to donors tends not to be enough to make a significant long term difference to their life which may be one of the reasons for their dissatisfaction. Whether larger financial incentives would change the levels of longer term satisfaction remains to be seen.

Whilst many donors are happy to receive only the government reward for donation, many will also enter into private arrangements with the recipients. It is not unheard of for donors to write their blood type and telephone number on clinic walls or pin notices to trees. The photograph below shows the wall outside a clinic where a prospective donor has placed their advertisement.

[9] Unfortunately there is a paucity of data to show whether Iran truly has less end-stage renal disease (ESRD) than other countries. While most epidemiological studies show a rise in ESRD it seems to have lower levels of prevalence than in the developed world (Mousavi et al, 2014).

Figure 3 – An O +ve kidney for sale with the vendors telephone number (Sinapour, 2012)

Often there is a haggling over the price of a kidney with the donors sometimes feeling that the recipients "want it practically for free. They think I'm selling meat" (Sarvestani, 2006).

Despite the financial incentives involved, all donors expressed an altruistic desire for their donation. In Diane Tober's ethnographic study looking into motivations behind paid kidney donations she noted the high value placed on charity by both Islamic and Iranian societies:

"I gave my kidney for God. I always wanted to do this in my life. . . . I'm giving another life to this lady – another life" – An extract from an interview with a twenty one year old mal" (Tober, 2007, p165)

However she also notes:

"[donors] did not express a desire to 'get anything' from the recipients yet; in Iranian culture this desire would probably not be directly expressed anyway. Further probing did demonstrate a need for money among the donors" (Tober, 2007, p165)

When the motivations of kidney donors were looked into by Javaad Zargooshi he found "motivations for donating were purely financial in 43% of cases and mainly financial with a minor altruistic component in another 40%" (Zargooshi, 2001, p386). Additionally, despite the high value placed on charity in Iranian society there is evidence emerging that those who donate to strangers are also the victims of stigma (Zargooshi, 2001).

The availability of organs has led to a change in medical practice. For the nephrology teams in Iran "the preferred source of organs is first from cadaveric donors, second from living related donors, and third from living unrelated donors, in practice, the actual sources for organs are the reverse: living unrelated donors and living related donors are the primary sources for organs, while cadaveric donors fall far behind" (Tober, 2007, p162). Furthermore, the number of young patients in Iran is much higher than the international average (Haghighi et al, 2002, p28); whilst neither the epidemiology nor the source of organs are do not necessarily a point to organs being used inappropriately; they do show how the use of market incentives is changing the delivery of medical care.

Section 4b - Paid surrogacy

Paid surrogacy came to international notice in the summer of 2014 with the case of Baby Gammy, a boy born to a paid surrogate in Thailand who was allegedly abandoned by his adopted parents when he was found to have Down's syndrome (Jabour, 2014). Surrogacy can be seen as the leasing of organs, or renting them out to others. At present surrogacy is the only form of organ renting[10] but as medical science advances the field may potentially grow[11]. Commercial surrogacy is prohibited in the UK, however altruistic surrogacy agreements are allowed. Regulation tends to be stringent with the courts looking for the surrogacy to be (Brilliant Beginnings, 2015):

- In the child's best interest.
- The child being born through surrogacy and for conception to have taken artificially.
- That the applying couple be in a marriage/civil partnership or stable cohabiting relationship, and are both over 18.
- That at least one of the applicants is child's biological parent.
- At least one of the applicants is domiciled in the UK, Channel Islands or Isle of Man.
- That the child is in the care of the applicant when they apply.
- That the surrogate mother and her husband or civil partner (if she has one) fully and freely consent to the order. The surrogate cannot validly give her consent until the child is six weeks old.
- That the court is satisfied that no more has been paid to the surrogate or any agency involved, other than what it deems to be reasonable expenses.

Not all countries have adopted non-commercial surrogacy as their framework. In India the commercial surrogacy sector is expanding, with it currently estimated to be worth $2 billion US dollars (Choudhry, 2014, p2). Surrogacy cases have become wide spread and (in a case that predates but mirrored the Baby Gammy story) have even spread to the big screen. Mala Aai Vhhaychy! (I want to be a Mother!) tells the story of a woman who becomes a surrogate to relieve her poverty but then finds herself looking after the child when the adoptive parents decide they do not want a child with disabilities (Mala Aai Vhhaychy! 2011). The movie (based on a real court case) then witnesses the battle between the surrogate and the biological parents when they return and try to adopt their child back.

Whilst Bollywood movies invariably end with happy endings the reality of the situation in India is quite different. Surrogate mothers in India tend to be poor and unaware of their rights (Roy, 2011). Still a surrogacy agreement can pay them multiples of their yearly income (Roy, 2011). As one participant put it "any fool can have a baby, it takes a smart woman to get paid for it" (Roy, 2011). Scott Carney, in his investigative reporting of the markets in body parts (which he terms the 'Red Market') spent time examining the surrogacy market in India and reports:

[10] The UK has recently approved uterus transplantation where a women receives a donor womb which is then removed after she has finished having her children (to prevent her from having to be on lifelong immunosuppressive drugs) (Johnston, 2015). It is not inconceivable to one day imagine that the same uterus could be used for more than one woman.

[11] In 1997 a Florida man made the news when he offered a 99 year lease on his kidneys. At the time it was dismissed as being potentially illegal and beyond the remit of current medical ability (CNN, 1997). Whilst the former assertion is still held to be true the latter is not.

"Like every other market in human tissue, surrogacy blends notions of altruism and humanistic donation with the bottom line of medical profitability. Before India, only the American upper classes could afford a surrogate, now it's almost within reach of the middle class. While surrogacy has always raised ethical questions, the increasing scale of the industry makes the issue far more urgent. With hundreds of new clinics poised to open, the economics of surrogate pregnancy are moving faster than our understanding of its implications" (Carney, 2011a).

The Indian government, recognising the dangers of commercial surrogacy has tried to mitigate some of the risks involved with the introduction of The Assisted Reproductive Technology (Regulation) Bill 2008. However the bill has generated controversy and been accused of being mainly enacted to "protect clinics from complaints in social disputes such as who the "real parent" of the child is… [and] does not protect women from dangerous technologies" (Shah, 2009, p32). The surrogacy legislation in India has also given rise to some controversial legal situations such the case of the Japanese surrogacy arrangement in 2008. In this case a Japanese man (who had contributed 50% of the genetic material required) was unable to adopt his baby after he divorced from his wife during the gestational period (BBC News, 2008). Neither his wife nor the surrogate wanted to adopt the baby, and Indian law prohibits single men from adopting children (BBC News, 2008).

Aside from the legal peculiarities particular to India there are broader criticisms levelled against its commercial surrogacy market:

"Acknowledging surrogacy as legitimate labour and permitting a market in surrogacy could push women back into their role as reproducers, thus endangering the hard-won gains that women have made to be more than mere reproducers. There is also the argument that surrogacy will encourage exploitation of poor women as cheap labour, available to all and sundry, especially for foreigners. Also, women's bodies will continue to be exploited through commercial control over their reproduction as they are already exploited through control over their sexuality (Shah, 2009, p35)."

Here we see similar criticisms to those directed towards the trade of organs in Iran. The introduction of money leads to the commodification of the human body. Countries such as France have made it illegal for surrogacy (both altruistic and commercial) with the Court of Cassation[12] stating that "the human body is not lent out, is not rented out, is not sold" (Greenhouse, 1991)[13]. The French government in arguing bringing the case felt that it should be illegal "to arrange for a child to be abandoned, to reduce a woman to be merely an incubating womb" (Greenhouse, 1991) as that may lead to situation similar to that of the USA, where surrogates are chosen according to their looks (Greenhouse, 1991).

Whilst commercial surrogacy has raised the fear of eugenics, (Bindel, 2015) the broader context of renting organs throws up many other ethical issues. Despite altruistic surrogacy being legal[14] in the UK, many are turning to commercial surrogates abroad due to the convenience the commercial market brings (Campbell, 2015). And so, rather than those that need it the most being able to access

[12] France's highest domestic court.

[13] Many of the arguments put forward to the court also concerned that surrogacy may undermine adoption (Greenhouse, 1991)

[14] The paying of expenses (like taking time off work) may be required and can be as much as £15,000 (Campbell, 2015) making it sometimes cheaper to pursue a commercial option abroad.

surrogacy it is those that can afford it that are better able to gain access. Furthermore, surrogacy agreements have thrown up issues surrounding ownership and contract. This can be illustrated by the regulations in New Hampshire where surrogates have the right to sue for damages for breach of contract, and legislation that requires the commissioning parents are to pay for support should they not adopt the child (Choudhry, 2014, p45). Whilst these afford invaluable protections for the surrogate, they also contribute to the sense that surrogacy is a purely commercial transaction.

Section 4c - The Gift Relationship

In his pioneering work on social policy, Professor Richard Titmuss examined the different ways in which blood was donated comparing in particular the American model, which used market incentives, with the UK model, which relied on altruism (Titmuss, 1971). Titmuss' findings were ground-breaking and challenged conventional economic theory. Instead of incentivising more donations, financial reward seemed instead to decrease it. As well as a reduction in the quantity supplied Titumss was scathing of the effects that the market had on blood donation and found that:

"…the commercialization of blood and donor relationships represses the expression of altruism, erodes the sense of community, lowers scientific standards, limits both personal and professional freedoms, sanctions the making of profits in hospitals and clinical laboratories, legalizes hostility between doctor and patient, subjects critical areas of medicine to laws of the marketplace, places immense social costs on those least able to bear them-the poor, the sick, and the inept-increases the danger of unethical behaviour in various sectors of medical science and practice, and results in situations in which proportionately more and more blood is supplied by the poor, the unskilled, the unemployed, ….Redistribution in terms of blood and blood products from the poor to the rich appears to be one of the dominant effects of the American blood-banking systems… And, finally, in terms of quality, commercial markets are much more likely to distribute the contaminated blood; the risks for the patient of disease and death are substantially greater." (Titmuss, 1970, p245-246)

The reduction in quantity has come in modern day economic terms to be known as "crowding out" (Mellström & Johannesson, 2008, p2) or by psychologists as "over justification (Leper et al, 1973)". Essentially the theory states:

"…a person's intrinsic interest in an activity may be undermined by engaging him to induce in an activity as an explicit means to some extrinsic goal. If the external justification provided to induce a person to engage in an activity is unnecessarily high and psychologically "oversufficient", the person might come to confer that his actions were basically motivated by the external contingencies of the situation, rather than any intrinsic interest in the activity itself. In short, a person induced to undertake an inherently desirable activity as a means to some ulterior end should cease to see the activity as an end in itself" (Leper et al, 1973, p129).

Titmuss illustrates this by using the example of Japan, which went from a system of voluntary donation to compensated donation in the 1950s[15]. Following the move, Japan had an acute shortage of donors[16] and the rates of blood borne virus (BBV) also increased (with the American ambassador

[15] As Titmuss points out this coincided with Japanese blood stocks being used for American soldiers stationed in Korea which may also have prompted the decrease in blood donations.

[16] It must be also noted that as the level of invasive surgery increased the demand for blood also increased. Titmuss unfortunately does not factor this into his analysis.

contracting hepatitis following transfusion in a Tokyo hospital) *(Titmuss, 1970, p245-246)*. Titmuss speculates that the cause of this increasing level of infection (both in Japan and the USA) is from the fact that those from more disadvantaged groups such as the poor and homeless (both of whom tend towards more risky lifestyle behaviour such as intravenous drug use and hence higher rates of BBV) began to constitute a larger proportion of the donor class[17].

Titmuss' book provoked controversy with the American economist Kenneth Arrow who took issue with Titumuss' proposition of the introduction that the market reduces the likelihood that people would give. Arrow instead argued that:

> *"…the creation of a market increases the individual's area of choice it therefore leads to higher benefits. Thus, if to a voluntary blood donor system we add the possibility of selling blood, we have only expanded the individual's range of alternatives. If he derives satisfaction from giving, it is argued, he can still give, and nothing has been done to impair that right". (Arrow, 1972, p313-314)*

In reply to Arrow the philosopher Peter Singer felt that this was an over-justification as "…a voluntary system fosters attitudes of altruism…a desire to help others in the community….The laws of the marketplace discourage altruism and fellow feeling" (Singer,1973, p313-314).

As well as receiving strong criticism for his ideas, Titmuss' data collection methods have also been challenged with some critics feeling that "the survey was slapdash and [committed] the cardinal sin of "selection on the dependent variable" – i.e., of failing to survey non-donor" (McLean, 2010). However recent replication of his work, via controlled psychological experiments, found that the use of incentives reduced donation rates by almost by a half[18] (Mellström & Johannesson, 2008).

[17] Titmuss wrote his book before the HIV epidemic; current practice stipulates that blood products undergo routine screening regardless of their source. However the legacy of the BBV epidemic lives on with the European Court of Justice which as recently as April 2015, allowed for the refusal to accept the blood of gay men under certain circumstances (Geoffrey Léger v Ministre des Affaires sociales, de la Santé et des Droits des femmes and Établissement français du sang C-528/13)

[18] The reduction was seen in women only. In men there was no change (Mellström & Johannesson, 2008)

Section 5 - Can an Organ Market Be Ethical

In 2008 at a meeting of the World Health Organisation (WHO) the Declaration of Istanbul was born. Whilst recognising the great achievements that transplant surgery have brought, the delegates were fearful that these "accomplishments have been tarnished by numerous reports of trafficking in human beings who are used as sources of organs and of patient-tourists from rich countries who travel abroad to purchase organs from poor people"(WHO, 2008). The Declaration did not prohibit financial incentives for organ donors explicitly it contained proposals as to what adequate reimbursement should be:

6. Comprehensive reimbursement of the actual, documented costs of donating an organ does not constitute a payment for an organ, but is rather part of the legitimate costs of treating the recipient.

- **A. Such cost-reimbursement would usually be made by the party responsible for the costs of treating the transplant recipient (such as a government health department or a health insurer);**
- **B. Relevant costs and expenses should be calculated and administered using transparent methodology, consistent with national norms;**
- **C. Reimbursement of approved costs should be made directly to the party supplying the service (such as to the hospital that provided the donor's medical care);**
- **D. Reimbursement of the donor's lost income and out-of-pockets expenses should be administered by the agency handling the transplant rather than paid directly from the recipient to the donor.**

Proposal 6 from the Declaration of Istanbul (World Health Organisation, 2008)

Whilst recognising the global shortage in organs the Declaration of Istanbul did little to provide a solution other than to state "[t]he act of donation should be regarded as heroic and honored as such by representatives of the government and civil society organizations" (World Health Organisation, 2008).

Whilst in this paper we accept the premise that financial incentives are one way to solve the shortage of organs available for transplant, we do still need to ask if the market mechanism is the best way of achieving our goals. For this we turn to Adam Smith, a man often lauded as being the father of economics. Smith's doctrine of the 'invisible hand' is celebrated as the inspiration for the free market. Smith first mentions the 'invisible hand' in his book *The Theory of Moral Sentiments* where he writes:

"It is to no purpose, that the proud and unfeeling landlord views his extensive fields, and without a thought for the wants of his brethren, in imagination consumes himself the whole harvest that grows upon them. The homely and vulgar proverb, that the eye is larger than the belly, never was more fully verified than with regard to him. The capacity of his stomach bears no proportion to the immensity of his desires, and will receive no more than that of the meanest peasant. The rest he is obliged to distribute among those, who prepare, in the nicest manner, that little which he himself makes use of, among those who fit up the palace in which this little is to be consumed, among those who provide and keep in order all the different baubles and trinkets... [The rich] consume little more than the poor, and in spite of their natural selfishness and rapacity... They are led by an invisible hand to make nearly the same distribution of the necessaries of life, which would have been made, had the earth been divided into equal portions among all its inhabitants, and thus without intending it, without

knowing it, advance the interest of the society, and afford means to the multiplication of the species. When Providence divided the earth among a few lordly masters, it neither forgot nor abandoned those who seemed to have been left out in the partition. These last too enjoy their share of all that it produces (Smith, 1759, p215)."

Smith therefore states a market would lead to a fair distribution of goods amongst all levels of society. Yet to read Adam Smith's doctrine as a call to free market economics is to read it out of context. Smith understood that the market could abuse the worker and felt regulation in favour of the labourer was just (Smith, 1759). Nevertheless, it is this 'invisible hand' he proposed that allows the market to find its equilibrium, where the demand for organs rises to meet the supply[19].

The market has not been without its critics, the most eloquent of whom is perhaps the philosopher Karl Marx and it is with him we will turn to for our first critique of the market. We will examine the problems that Marx felt the market created, and look at modern critiques of the market by philosophers such as Michael Sandel so that we can better understand what problems a financial market in organs may create. We also consider two important legal cases set in the seventeenth century which concern the trade in human beings as slaves rather than the trade in organs, but from which we can nevertheless draw some interesting parallels.

Section 5a – Marx and his Critic of the Market

At present the UK is dependent on altruism for the acquisition of blood and other body parts. As such people are treated equally regardless of whether people have money or not[20]. The introduction of the market has the potential to change that. As Marx writes:

"The extent of the power of money is the extent of my power. Money's properties are my – the possessor's – properties and essential powers. Thus, what I am and am capable of is by no means determined by my individuality. I am ugly, but I can buy for myself the most beautiful *of women. Therefore I am not ugly, for the effect of ugliness – its deterrent power – is nullified by money" (Marx, 1844).*

Marx argues that in a market it is money, not need that determines where resources go. Perhaps today we can better regulate this; Harris' monopsony is one way of doing so. That money may prove a corrupting influence is hardly profound; instead Marx's most powerful critique comes from his theories of what money does to us, how it fundamentally changes the relationship between men:

"Money is the estranged essence of man's work and man's existence, and this alien essence dominates him, and he worships it" (Marx, 1844)

For Marx money was seen to be used by the capitalist employer to "alienate and dehumanise" (Churchich, 1990) their workers. Introducing money into the relationship between organ donor and recipient risks belittling the sacrifice the donor makes. Instead of being a gift for which one should feel profoundly grateful for, the organ becomes an item for which the recipient has paid a fair price.

[19] As seen in Figure 1.

[20] Admittedly people with strong social networks and extended families are more likely to be recipients of living organ donation.

Marx's writing in his *Das Capital* perhaps still serves as the best analysis of how money can transform the products of labour into mere commodities (termed 'commodity fetishism'):

"The relation of the producers to the sum total of their own labour is presented to them as a social relation of objects which exists outside them.... It is a particular social relation between men themselves which in their eyes assumes a phantasmagorical form of a relation between things. ... This is what I call fetishism; it attaches itself to the products of labour as soon as they are produced as commodities, and it is therefore inseparable from the production of commodities." (Marx, 1867)

There is a real worry that money may not only corrupt the process of organ donation but also the social relationship between donor and recipient. Already commentators in the US write critically of the almost industrial way in which cadavers are stripped of body parts for their organs in mortuaries. Even though these body parts may not be sold, excessive handling charges provide handsome profits for those doing the organ harvesting (Scheper-Hughes, 2002, p64) and leading to the current state of practice being described as "neocannibalism"(Scheper-Hughes, 2002, p65).

Marx's criticisms find earlier resonance in Aristotle's theory of ethics. If we want to encourage altruistic behaviour than altruistic behaviour needs to be practised. As Aristotle says "we learn by doing them, e.g. men become builders by building and lyre players by playing the lyre; so too we become just by doing just acts, temperate by doing temperate acts, brave by doing brave acts (Aristotle, 350BC)." Rousseau too shared similar sentiments:

"The better the constitution of a State is, the more do public affairs encroach on private in the minds of the citizens. Private affairs are even of much less importance, because the aggregate of the common happiness furnishes a greater proportion of that of each individual, so that there is less for him to seek in particular cares. In a well-ordered city every man flies to the assemblies: under a bad government no one cares to stir a step to get to them, because no one is interested in what happens there…" (Rousseau, 1762)

Whilst Rousseau was writing on the state there are lessons that can be taken with regards to civic responsibility. There are a few greater asks that a state can make on its citizens than to give their blood or body parts for the benefit of their fellow citizens and states that ask more of their citizens may get more back in return. In an experiment run by psychologists at Northwestern University, two groups of people were asked to complete a survey. On the front of one survey was written 'Consumer Reaction Study', and on the other 'Citizen Reaction Study[21].' Those who filled out the consumer study appeared far less likely to care about society or the environment and were found to be more competitive and selfish[22] (Bauer et al, 2012).

If simply changing words on a survey can have such a profound effect on an individual's sense of civic duty and altruistic tendencies, it is arguable that the potential effect money may have on the situation is likely to be even more dramatic. Few commentators in favour of the compensated organ trade have provided an adequate response to Marx's critique. Ultimately commodification of the human body may be the price that we pay, so that we can save the lives of those who would otherwise die without the gift of an organ.

[21] No mention of this difference in title was made to the participants, they were simply asked to fill out the forms in front of them.

[22] Interestingly the consumer group revealed higher levels of anxious affect and dissatisfaction with life (Bauer et al, 2012).

Section 5b – Modern Critiques of the Market

"In the depth of winter of 1913…the Vienna Bankers Club gave a Bankruptcy Ball at the opulent Blumensaal hall. Some ladies appeared as balance sheets, displaying voluptuous debits curving from slender credits. Others came as inflated collateral: faux enhancements amplified the bust or upholstered the posterior…. If you wrote your waiter an I.O.U., he would pour you a flute of Champagne. Dancing and merriment continued until 5 a.m., when, suddenly, the orchestra leader stopped his men in the middle of the "Emperor Waltz." He announced that since the musicians hadn't been paid, there would be no more music, good morning, good luck, goodbye" (Morton, 2001).

One of the constants of the market has been the regularity at it which it has crashed. Morton writes above on the first major depression which was soon followed by The Great Depression of the 1930s and numerous other downturns up until the most financial crisis of 2008. Whilst the causes of each of these crashes are too complex to examine in this paper, we shall suffice to say left to its own devices the market can at times spectacularly implode. As Robert and Edward Skidelsky write "[c]apitalism, it is now clear, has no spontaneous tendency to evolve into something nobler. Left to itself, the machinery of want-generation will carry on churning, endlessly and pointlessly" (Sidelsky & Skidelsky, 2012).

The Skidelskys argue that capitalism was founded on a Faustian pact, "the devils of avarice and usary were given free reign (Sidelsky & Skidelsky , 2012)" but were supposed to be banished when they had "lifted humanity from poverty (Sidelsky & Skidelsky, 2012)." In part this misconception lies at the centre of economics, J M Keynes writing in the early 1930s thought that:

"For many ages to come the old Adam will be so strong in us that everybody will need to do some work if he is to be contented. We shall do more things for ourselves than is usual with the rich to-day, only too glad to have small duties and tasks and routines. But beyond this, we shall endeavour to spread the bread thin on the butter-to make what work there is still to be done to be as widely shared as possible. Three-hour shifts or a fifteen-hour week may put off the problem for a great while. For three hours a day is quite enough to satisfy the old Adam in most of us!" (Keynes, 1963, p363)

The central tenant of economics is how we satisfy unlimited wants with limited resources. Keynes assumed that as workers became richer they would devote more time to leisure. Similarly it was assumed that when the NHS was first set up there would be an initial rise in demand followed by a levelling off as people's health improved (Evans, 2008, p31). This proved not to be the case[23] and demand has been steadily rising since the NHS was founded. As can be seen in case of Iran whilst the market for kidneys may have resolved the need for a waiting list it seems also that younger patients are receiving transplants, this set of patients may in other circumstances not be eligible or organs. Given their availability however, it seems there may be market distortions in the demand for organs.

Another prominent modern critique of the market comes from the Harvard philosopher Michael Sandel. In his latest book *What Money Can't Buy* Sandel questions whether there should be somethings that are just too precious to be bought and sold. Sandel draws on earlier philosophers in

[23] Nye Bevan was reported to have said "'I shudder to think of the ceaseless cascade of medicine which is pouring down British throats at this time" (Hollis, 1977, p164"

his critique; he argues against the default economic position which is that altruism is a virtue to be preserved, a position best summed by Harvard economist Larry Summers:

"We all have only so much altruism in us. Economists like me think of altruism as a valuable and rare good that needs conserving. Far better to conserve it by designing a system in which people's wants will be satisfied by individuals being selfish, and saving that altruism for our families, our friends, and the many social problems in this world that markets cannot solve. This is not just an abstraction -- the far larger degree of private charity in this country than in Western Europe, and in Western Europe than in the socialist economies, is worth some reflection" (Summers, 2003)

Instead, Sandel feels that:

"This economist view of virtue fuels the faith in markets and propels their reach into places they don't belong. But the metaphor is misleading. Altruism, generosity, solidarity and civic spirit are not like commodities that are depleted with use. They are more like muscles that develop and grow stronger with exercise. One of the defects of a market-driven society is that it lets these virtues languish (Sandel, 2012, p130)."

Any framework we produce must accept the possibility that we may lose virtue by selling organs and ideally, tries to find a way to restore it.

Section 5c – Lord Mansfield and the 17th Century Slave Cases

Imagine a situation in which a company has been granted licence to collect blood and then sell it on to hospitals for use in operations and emergencies. Because of a tremendous willingness of people to donate blood to the company the supply of blood has risen and as a result the price of blood falls[24]. The company, whilst happy to provide a social good, has to answer to its shareholders and decides that by destroying some of the blood product they will limit supply and hence the price will rise.

Such a case presented itself to Lord Mansfield in 1783; however instead of blood being jettisoned it was slaves. Lord Mansfield had a few years earlier ruled in the case of *Somerset v Stewart* (1772) 98 ER 499, which concerned a slave who absconded when his ship landed in England. His master demanded his return. Lord Mansfield aware of the political and economic implications of not returning the slave tried several times to bring the parties together but to no avail. Forced into making his judgement Lord Mansfield is reported as having famously said "let justice be done, though the heavens may fall[25]." He ultimately ruled in favour of the slave retaining his freedom saying:

"The state of slavery is of such a nature, that it is incapable of now being introduced by Courts of Justice upon mere reasoning or inferences from any principles, natural or political; it must take its

[24] See *Figure 1* for explanation of why this happens.

[25] Mansfield actually said "let justice be done, whatever the consequences". He was however translating the Latin phrase *fiat justitia, ruat coelom*. Historians and subsequent legal scholars have kindly corrected his translation to the more accurate "let justice be done, though the heavens may fall" (Finkelman, 1994, p326).

rise from positive law… we cannot say the cause set forth by this return is allowed or approved of by the laws of this kingdom, therefore the black must be discharged"
Extract from the case of Somerset v Stewart (1772) 98 ER 499.

Lord Mansfield ultimately decided the case on a technicality. The 'positive law' he refers to is law that "has been positively laid down, imposed or enacted" (Murphy, 2005, p5). Since the law of England did not specify that people could be enslaved, slaves could not be taken. More than a decade later Lord Mansfield was once again involved in a major slavery case. The case of *Gregson v Gilbert* (1783) 3 Doug KB 232 (more commonly known as the Zong massacre) concerned a slave ship which on its way from England to the West Indies found that several of the slaves were either sick or dying[26]. The ship's cargo (slaves were considered a commodity) was insured; however the insurance would not pay out were the slaves to die of ill health. It would however, pay out if part of the cargo was jettisoned overboard to in order to save the rest (Wiseboard, 1969, p562). A decision was made to discard some of the cargo and one hundred and thirty three slaves were thrown overboard[27] (Wiseboard, 1969, p562).

Upon their return to Liverpool the ships owners put in a claim with the insurance agents; their claim was however rejected. A trial was subsequently held and the central debate became whether slaves were to be regarded property or human beings. Granville Sharp, an ardent abolitionist, was rumoured to be helping advise the underwriters whose lawyers felt they were acting as "counsel for millions of mankind and the cause of humanity in general (Wiseboard, 1969, p563)[28]." Lord Mansfield in his concluding remarks sided with the ship owners saying "[t]hough it shocks one very much…the case of slaves was the same as if horses had been thrown overboard Wiseboard, 1969, p564)". There remains a great deal of speculation as to what happened at the end of the trial, it appears a retrial was ordered but whether it ever took place is still contested (Webster, 2007). Nevertheless, ultimately a change is legislation was ordered so that:

"…under such Policies of Assurance so made or to be made, no Loss or Damage shall hereafter be recoverable on Account of the Mortality of Slaves by natural Death or ill Treatment, or against Loss by throwing overboard of Slaves on any Account whatsoever" (Webster, 2007,p297).

The cases were barbaric. Slavery is now ethically unacceptable and whilst we hope to never to see such cases in the courts again[29] there are a number of key points that the cases raise that are relevant to our discussion. Firstly who owns the organs once they have been donated to an intermediary and secondly what can be done with organs. Let us return to the example of the company who buys blood from donors and sells it to hospitals. No doubt we would all find it reprehensible if the company destroyed blood product but what would happen if they were able to

[26] The exact events surrounding why so many of the slaves were unwell has never been fully established. The log book that was supposed to be carried was lost (some say conveniently so) and crew members subsequently gave differing accounts of the events on board (Webster, 2007).

[27] The last ten slaves in a gesture of defiance threw themselves overboard rather than let themselves be thrown (Wiseboard, 1969, p562)

[28] These threats to prosecute for murder were lightly dismissed by the ship owners as "madness because the blacks were property (Wiseboard, 1969, p563)."

[29] Some of the reports regarding black market organ harvesting are equally horrific but these happen outside a legislated framework. Slavery sadly did not.

make a bigger profit by selling the blood to a pharmaceutical company. Would it be fine for the company to do so?

Many who donate their body parts expect them to be used for a noble cause and understandably so. However, if one donates for financial compensation surely getting the best financial reward is also part of the equation. If the law allows a donor to sell a kidney to a recipient in need of one, than should the donor also be allowed to sell their kidney to a pharmaceutical company? Restricting them from doing so is a clear violation of their autonomy; furthermore by restricting the number of buyers in the market the sellers are likely to get a lower price[30]. Would we be happy for a financial speculator to enter the market and buy kidneys so that they can sell them on to a third party at a mark-up?

An important part of this debate centres around how we view organs. If we consider them to be ordinary commodities then selling an organ to a pharmaceutical company it would likely be allowed by law (as seen in the Zong case). Admittedly such a situation would enrage many and could be argued to violate the dignity of the human body. We could however take Professor Harris' suggestion of a central beneficent monopsony which controls the trade and only allow organs to be used for public good. If we instead wanted a legal solution we could reclassify the status of organs to be somewhere between that of a commodity and that of human being, with restrictions placed upon their use. As we have seen in the Zong case the law will not necessarily follow the most moral course, but instead obey precedent and statue.

[30] See Figure 2 for explanation of why this was so.

Section 6 - What Would An Ethical Framework Look Like?

At its best, a compensated organ market can dramatically improve the lives of the poor and save the lives of those who are sick. Yet, as we have seen, the market is no panacea and can cause as many problems as it solves. Having considered theoretical and actual regulations that surround the trade in organs we now need to establish what should constitute the ethical framework of an organ market. In doing so, we need to ask ourselves the question of which moral philosophy to adopt? Clearly a utilitarian ethic would be more permissive of a market for organs; conversely the Kantian concept of "[a]ct[ing] in such a way that you treat humanity, whether in your own person or in the person of any other, never merely as a means to an end, but always at the same time as an end (Kant, 1785, p30)" would be less permissive of the sale of organs.

Whilst academics have debated the issue of whether one moral philosophy may prove superior to another, no firm conclusion has been reached. For the philosophers Persson and Savulescu, altruism is an uncontroversial form of morality than can be adopted (Savulescu & Persson, 2012); yet such a concept sits almost in opposition to the sale of organs. In creating an ethical framework for organ selling we need to be able to balance the interests of those selling the organs with those in need. In the following sub-sections, using the real life examples and theoretical frameworks already explored, we create principles that will make up an ethical market in organs.

Section 6a – Trading Over a Geographical Area

A pint of blood in India sells for £16 whereas in the USA it closer to £217 (Carney, 2011b). Clearly with such disparities an international market would make it difficult for an America citizen to sell an organ at the national market rate when it could be purchased so much cheaper from abroad. Yet restricting the market by geography means that individuals in poorer countries are denied access to a market which has the potential to allow them to raise significant sums of capital. Furthermore supply within one country alone may not be sufficient to meet its own needs. Finally due to geography or public health policies Country A may need more blood products whilst Country B may require more kidneys. To forbid them to trading penalises those in need in both countries.

One solution around this would be to allow a transnational trade in organs where the purchaser has to buy organs at the market rate of his country of residence (this value would be ideally set by an independent health board). Therefore the poor would have access to the international and domestic market and be able to sell their organs on as well. Whilst this arrangement allows for greater flexibility towards the seller, it also gives rise to a situation where two sellers (who may even be neighbours) receive widely differing rates of return for their organs. Furthermore it may also lead to a situation where domestic sellers decide not to sell on the domestic market and instead hold out for better prices from abroad thus depriving locals in need of organs. This could however be potentially mitigated by charging a premium on international trades; this excess could then be used to subsidise the domestic market by, for example granting an extra payment for those that sell their organs domestically.

Such an arrangement helps prevent exploitation of poorer countries (as the financial costs for buyers in rich countries remain the same) whilst promoting trade. Thus, our formulation would be:

Article 1: Organs can be sold across a global network; the price paid will be determined by independent authority and will be set at the market value for an organ in the buyer's country of

permanent residence. International trades will incur an additional charge which will be used to help mitigate the effects of the transaction within the sellers own country.

Section 6b – The need for a Monopsony

Professor Harris felt that a single buyer off organs was essential to ensure ethical soundness in the trade of body parts. Whilst we have shown that a monopsony can lead to market failure, they do also offer certain advantages. As Harris points out a monopsony is better able to regulate trade and can ensure a fair mechanism of allocation (Harris & Errin, 2002). Advocates of the free market would undoubtedly lean towards individuals being able buy and sell on their own accord; yet this has the potential for the seller at risk of exploitation, as some who sell may not be aware of the market value of an organ and therefore inadvertently sell at a discounted rate.

Another advantage of a monopsony (particularly one without a profit motive) is that what can be it can be better regulated. As explored above with the introduction of an open market, it would be possible for pharmaceutical companies to outbid patients for organs. Alternatively a state monopsony could allocate the organ on the basis of need and only to an appropriate source. Such a restriction does limit the autonomy of the seller, and some would argue along the lines of John Stuart Mill that "[o]ver himself, over his own body and mind, the individual is sovereign" (Mill, 1859). Modern liberal philosophers such as Gerald Gaus echo such sentiments and feel that the "liberal tradition in moral and political philosophy maintains that each person has a moral claim to do as he wishes until some justification is offered for limiting his liberty" (Gaus, 2005, p3). For Mill too, the "only part of the conduct of anyone for which he is amenable to society is that which concerns others"(Mill, 1859). One could argue that the societal benefit of improved health would justify the restrictions on liberty, which would be created by the imposition of a monopsony. Moreover given that those individual selling an organ will be doing so from a position of need, we could also argue that they do not have true normative competency (Stoljar, 2015), their restrictive financial situation undermines their ability to distinguish the right course of action (Wolf, 1988). Admittedly this line of argument may be seen as overly paternalistic; there may be also several individual circumstances where this assumption may not apply e.g. a patient choosing to donate their organ to a medical charity for cancer rather than a person in need, as they are passionate about finding a cure for cancer. Nevertheless we argue that whilst a monopsony does not present a perfect solution, it provides protection for both donor and purchaser and can help in the regulation of the organ trade.

Article 2: Organs will be sold via a state monopsony which will determine the ultimate recipient of each organ based on clinical need. The monopsony will be in required to ensure the well-being of the donor and that those who donate are making an as informed a decision as possible.

Section 6c – Maintaining Altruism

As we have seen, many of the contemporary critics of a markets raise concerns about the effect that monetisation can have on altruism. Whilst the liberalist viewpoint supports the market (Bennett, 2008, p71) it does not take into account what might be in the best of society. As the philosopher Macintyre declares:

"[T]he best type of human life, that in which the tradition of the virtues is most adequately embodied, is lived by those engaged in constructing and sustaining forms of community directed

towards the shared achievement of those common goods without which the ultimate human good cannot be achieved" (Macintyre, 2003 pXIV)

In creating our ethical framework we need not only balance the interests of the buyer and seller, but also that of society. One such way of doing so would be to limit to trade of organs to non-replenishable organs, e.g. a kidney may be sold but blood could not[31]. Whilst advocates of the free market may feel that reducing the financial incentive may reduce the supply, we have seen, not least in the study by Titmuss, that this is not always the case. The removal of body parts that regenerate themselves cause no long term physical harm to the patient; conversely when an organ that does not replace itself is donated, then it seems only fair that the donor be compensated for their loss.

A more pertinent criticism would be as to whether we are denying a valid source of income to those who may otherwise struggle to earn a living. It is hard to conclude other than they lose out on a potential source of income, however their body parts, and hence their physical selves, will be viewed less as commodities and they will (in theory at least) live in a more altruistic society.

Article 3: Only body parts that cannot be regenerated are eligible to be traded on the financial market.

Section 6d – What kind of trades should be allowed

In this paper we have examined several different types of trading mechanisms. At present a futures market in organ trading does not exist; arguably this is the most ethical format. A futures model encourages a sign up to the organ register with the donor receiving financial benefit immediately, and the organ being relinquished only after death. We have discussed how options can be used to accomplish this task but there are methods that may be equally effective. Two Danish philosophers proposed that tax breaks be given to people who agree to donate an organ after death. They postulate that a "tax credit could be the ideal nudge that changes behaviour in a direction that most people welcome; it might help us to act in the way we think, reflectively, we should" (Peterson & Lippert-Rasmussen, 2011, p452). Interesting they also feel that the "tax credits at issue…[would be small enough to] not enrich anyone sufficiently to coerce them into making a decision that they would not otherwise make" (Peterson & Lippert-Rasmussen , 2011, p454).

The selling of organs on a futures market would be logistically complex[32], especially if financial tools such as options were to be used. Nevertheless, they have the potential to be the least exploitative of all the financial transactions as they require no immediate sacrifice from the donor. The majority of transactions are likely to come from the straightforward buying and selling of organs and it is hard to imagine a viable market where these transactions are prohibited. As we have seen in the Iranian model there are concerns regarding how informed the donors are and most worryingly how much they regret their donation later on. Whether a fairer model of transaction would help alleviate these fears remains to be seen. Better pre-donation counselling, greater financial rewards as well as more recognition of the altruistic element of the transaction all have a part to play if we allow organs to be bought and sold.

[31] This may come as some relief to people in countries such as India where it is not unknown for people to be kept captive and bled regularly so that their captors could tune a profit (Carney, 2011b).

[32] This is largely due to the inability to predict whether donors will die in circumstances that will make them suitable organ donors.

The final model we examined was that of organ leasing via the prism of the surrogacy market. In recent years it has dominated the national news agenda due to the various scandals some of which we discussed. However the controversies often stemmed from inadequate contractual and legal protections for the surrogate, and should not in themselves be a bar to this type of transaction. However, given the leasing of organs is at present mainly confined to women being able to provide the service, we have to take seriously Shah's concerns of surrogacy being a backward step for women's rights. Furthermore, commercial surrogacy has given rise to worries about eugenics and that paid surrogates may face stigma within their own community.

If we take a hypothetical scenario of a donor being able to lease out his kidney than the objections that we had when we discussed a woman leasing out her womb no longer exist. It would a rather curious situation to be in if we were to make decisions on leasing on an organ basis. Clearly some of the objections to leasing come from the reproductive functions of womb leasing and the creation of new life. Ultimately if we are to allow altruistic surrogacy than it the case for commercial surrogacy becomes stronger albeit with stronger safeguards than exist today.

Article 4: The preferred way of selling organs would be on the futures market. However both direct selling and leasing of organs would be permitted with appropriate safeguards in place to protect the donor.

Article 5: Leasing of the womb should be allowed on a commercial basis in countries where it is legal to take part in altruistic surrogacy. The agreement must be covered and enforced by a legal contract which spells out the rights and responsibilities of each party including eventualities for breach of contract.

Section 6e – Other Considerations

Another factor we have to consider is whether those that sell their organs should be given a higher priority over others if they were ever in need of a transplant. Some may argue that by receiving financial compensation they have already been rewarded and it would be unfair to double compensate them by also giving them a higher priority on the transplant list. However, if selling organs is something we would like to encourage and reward as a society then giving donors a higher priority is something we should consider. Furthermore as we have seen in the case of Iran, it is primarily the lower socioeconomic groups that take sell organs and as a society it can be argued that we have a greater duty towards them.

Article 6: Those that take part in selling their organs will be given a higher priority should they ever be in need of an organ transplant themselves.

One of the points we saw in the Harris model was that of organ selling not being a substitute for welfare. It can never be acceptable that the government tell individuals that they are not eligible for state benefits as they still have organs left that they can sell. It follows that money raised by selling organs cannot be used when measuring someone's wealth e.g. the state cannot tell a donor that as they have an extra £10,000 of income this year through the sale of their kidney, they thereby no longer qualify for job seekers allowance.

Article 7: Organs cannot be viewed as a source of wealth. Donors cannot be compelled to sell their body parts in order to be eligible for state benefit. Money raised from the sale of organs cannot be

used when calculating wealth; additionally money raised from the sale of organs is exempt from tax.

Other considerations need much less justification. Few would argue against donors being well informed and free from coercion. Similarly there are few, if any, sensible objections to ensuring that organs are healthy and should be subject to strict medical testing prior to transplantation.

Article 8: All organ donors must be assessed by an independent agent to make sure that they understand the implications of their actions and to make them aware of other ways in which they can attain financial support.

Article 9: All organ donors must satisfy an independent authority that they are entering into this exchange free from coercion. Minors and those that lack capacity are prohibited from partaking in the market.

Article 10: Organs must be tested prior transplantation in order to ensure that they are healthy. Transplants take place in arenas that meet the accepted medical standards of the day

Section 7 – Concluding Remarks

Organ donation, even when not for financial reward, is a controversial issue that raises numerous ethical dilemmsa. As the philosopher Leon Kass points out, living donors force surgeons to go against a central tenement of medical ethics, namely that of *primum non nocere*. To harvest a kidney from a living donor is to subject an otherwise healthy individual to surgery that is of no clinical benefit to them (Kass, 2002). To harvest organs from the dead is to mutilate a corpse (Kass, 2002), a practice that meets with strong taboos in numerous cultures.

Outside of the clinical setting there has also been much anthropological interest in organ transplantations with anthropologists "especially interested in the psychological adjustment of organ recipients as they come to terms with the sacrifices or deaths that were necessary to provide them with organs and as they respond to the presence of an outsider in their bodies" (Ikels, 2013, p89).

Organ donation has perhaps best been describes by Leon Kass as "a noble form of cannibalism" (Kass, 2002 p186). As we have seen the introduction of the market adds only the murkiness of already unclear waters. At its best an organ market has the potential to save millions of lives. Our formulation of ten articles (listed together below for completeness) attempts to govern such a market along an ethical framework, one that strikes a balance between the interests of donors, patients in needs and society.

An Ethical Framework for a Market in Organs

Article 1: Organs can be sold across a global network; the price paid will be determined by independent authority and will be set at the market value for an organ in the buyer's home country. International trades will further attract an extra charge which will be used to help mitigate the effects of the transaction within the sellers own country. Article 1: Organs can be sold across a global network; the price paid will be determined by independent authority and will be set at the market value for an organ in the buyer's country of permanent residence. International trades will incur an additional charge which will be used to help mitigate the effects of the transaction within the sellers own country

Article 2: Organs will be sold via a state monopsony which will determine the ultimate recipient of each organ based on clinical need. The monopsony will be in required to ensure the well-being of the donor and that those who donate are making an as informed a decision as possible.

Article 3: Only body parts that cannot be regenerated are eligible to be traded on the financial market.

Article 4: The preferred way of selling organs would be on the futures market. However both direct selling and leasing of organs would be permitted with appropriate safeguards in place to protect the donor.

Article 5: Leasing of the womb should be allowed on a commercial basis in countries where it is legal to take part in altruistic surrogacy. The agreement must be covered and enforced by a legal contract which spells out the rights and responsibilities of each party including eventualities for

breach of contract.

Article 6: Those that take part in selling their organs will be given a higher priority should they ever be in need of an organ transplant themselves.

Article 7: Organs cannot be viewed as a source of wealth. Donors cannot be compelled to sell their body parts in order to be eligible for state benefit. Money raised from the sale of organs cannot be used when calculating wealth; additionally money raised from the sale of organs is exempt from tax.

Article 8: All organ donors must be assessed by an independent agent to make sure that they understand the implications of their actions and to make them aware of other ways in which they can attain financial support.

Article 9: All organ donors must satisfy an independent authority that they are entering into this exchange free from coercion. Minors and those that lack capacity are prohibited from partaking in the market.

Article 10: Organs must be tested prior transplantation in order to ensure that they are healthy. Transplants take place in arenas that meet the accepted medical standards of the day.

A framework, no matter how good, can never be all encompassing. Coercion is always a possibility; we have to ensure there are sufficient safeguards so that those selling their organ are doing so of their own accord. More importantly the use of monetary rewards for organs cannot mean that the altruistic nature of the donation be ignored. If we think the exchange of money seals us from future obligation to the donors; that the fact they are paid means the transaction is over than we undervalue what it is they donate. Whether an organ is given freely or sold for money if we fail to recognise it for the extraordinary gift that it is, then no ethical framework will ever suffice.

Appendices

Appendix A - Monopsony and Average Expenditure Curves Explained

A monopsony is able to move its average expenditure curve due to its position as sole purchaser in the market. In the diagram below we have a monopsony purchaser of labour (e.g. the NHS and doctors). The vertical axis shows the amount of wage paid and the horizontal axis shows the amount of labour demanded.

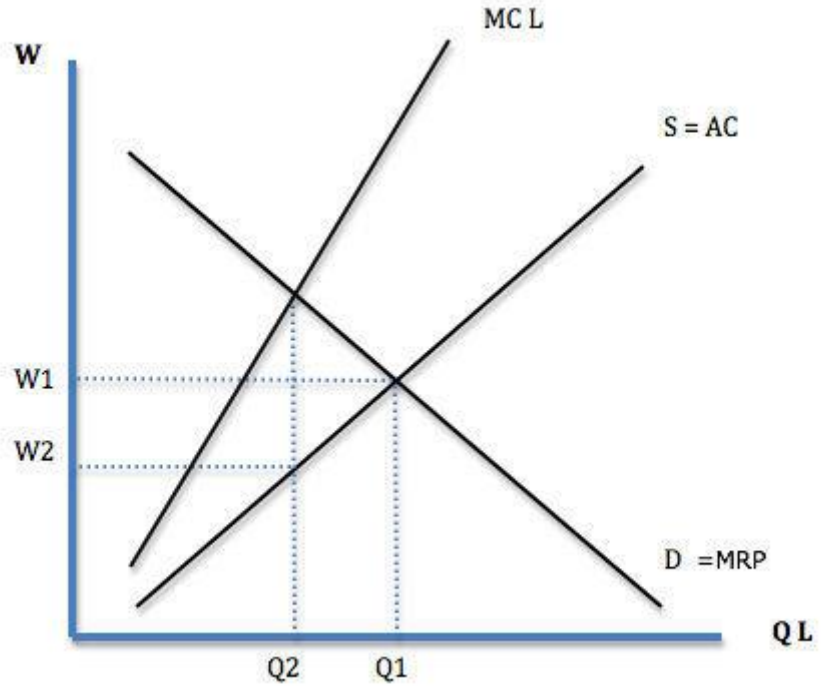

Figure A – A monopsony can use its position to pay workers less (Economics Help, 2015)

In a perfectly competitive market Q1 will be demanded and W1 will be paid i.e. where demand (D) is equal to supply (S). However a monopsony can choose to employ fewer workers and pay them less. "The marginal cost of employing one more worker will be higher than the average cost because to employ one extra worker the firm has to increase the wages of all workers. To maximise the level of profit the firm employs Q2 of workers where the Marginal cost of labour equals the Marginal Revenue Product MRP = D. In a competitive labour market, the firm would be a wage taker. If they tried to pay only W2, workers would go to other firms willing to pay a higher wage" (Economics Help, 2015). In a monopsony however the workers have no choice. They have to take the wage given or go without.

Appendix B – A Brief Description of the Theological Underpinning of the Compensated Organ Market in Iran

The Islamic Republic of Iran is a majority Muslim country whose members are largely made up of the Shi'a denomination. As a result their *fiqh* or Islamic Law is different from many other Islamic countries. As a member of the Iranian clergy reports:

> *"In Iran our jurisprudence (fegh) is more dynamic (pouya) than Sunni fegh because we use reason or intellect ('aql) and Sunni rely more on strict readings of religious texts. According to the Prophet Mohammed, intellect was the first thing created by God, so it is our responsibility to always use reason and be flexible...For Shi'a, though, the difference is we can be more flexible in using and pursuing new science and technology because we can adapt the religious texts to modern society through our own interpretations and intellect. Because Islam, and particularly Shi'a Islam, emphasizes science and new thinking, there is no challenge between religion and science (Tober, 2007, p153)."*

Within Shi'a Islamic Law, there is a long standing tradition of blood money or *diyeh*. In Iran *diyeh* is used commonly within the criminal justice system, for example in a domestic violence case a wife would we able to demand reparations from her husband in accordance with the physical damage caused e.g. a broken nose would get the equivalent of $1,000 (Tober, 2007, p159). "In Iran, then, the idea of compensation for body parts – whether through injury, labor or organ donation – is consistent with Islamic principles" (Tober, 2007, p159). It is worth pointing out that there are some clergy within the Shi'a jurists that oppose the principle of paid organ donation. For some the concept of *diyeh* does not extend to the field of organ donation.

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