A COMPETITIVE MARKET IN HUMAN ORGANS

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1. Introduction

IN THE UNITED STATES ALONE, there are thousands of people every year whose lives could be saved by means of a liver or kidney transplant but who die because organs are unavailable. Even the tens of thousands who obtain a transplant often have to wait years for an operation, during which time their quality of life and their post-operative prospects deteriorate. A sure way of increasing supply to meet the demand is to permit live donors to sell their organs in a competitive market. However, there is staunch opposition to permitting trade in human organs. It is objected that such trade would undermine altruism, coerce the poor, entice people to make decisions on inadequate information, increase inequality, degrade the people who engage in it, be analogous to slavery, compel people to pay costs that they should not have to pay, and diminish the options available to third parties. I argue that each of these objections is without merit.

The focus of this paper is sales of kidneys, livers and liver-sections; but sales of other organs will be considered explicitly in places. In section 2, I present the case for a competitive market in human organs, offering both consequentialist and deontological arguments. In section 3, I raise and rebut the main philosophical objections to a market in human organs. In large part this is a discussion of Satz 2010, which rehearses the old objections and offers some new ones. In section 4, I conclude the discussion.

2. The Case for a Market in Organs

The case for a competitive market in human organs can be made in consequentialist and in deontological terms. I present each argument in turn.

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2.1 The Consequentialist Argument

The argument of this sub-section is largely a summary of the case presented in Becker and Elias (2007). In recent decades it has become possible to save human lives by transplanting livers, liver-sections and kidneys. Most transplanted organs come from recently deceased persons; but some liver-section transplants and many kidney transplants come from live donors, usually family members. However, people who need a replacement organ often have to wait several years to get one; and, while they are waiting, most are unable to work, their quality of life diminishes substantially, their prospects for post-operation survival deteriorate, and many of them die or become too ill for a transplant. The persistent gap between the demand for, and the supply of, kidneys, livers and liver-sections is a consequence of the fact that, except in Iran (and, at one time, India), it is forbidden for donors to sell organs to recipients.

The demand for kidney and liver transplants varies inversely with cost. This is easily seen where recipients bear the full cost of the transplant directly since, the higher the cost, the fewer the number of people who can afford it. But it is also the case where the costs of the operation are borne either by governments or by private health insurance companies, since the willingness of these agencies to qualify individuals for this expensive surgery increases as the cost of the surgery falls.

At the moment, the supply of these organs depends upon altruism or family pressure. Some people arrange that when they die their organs may be used for transplants. Some people offer themselves as a living donor for a family member. People who are sufficiently altruistic to want to offer an organ to a non-relative may be prevented from doing so because of official suspicion that money might be changing hands. But if those in need of transplants could pay donors for kidneys, livers or liver-sections, the monetary incentive would call forth a greater supply, in two ways.

First, more people would be expected to donate their organs after death, since the payment received could be passed on to their heirs. However, this would not by itself be likely to increase substantially the supply of organs or their quality. For, many dead donors do not have healthy, well-functioning organs free of infection; and the relatives of the deceased often resist the removal of the organs, which causes delay which can make the organs unusable. Further, the need to transfer an organ quickly from a dead donor to a recipient makes it difficult to secure a very good match.

Second, many people would be induced to sell a kidney or a part of their liver while alive. The potential supply from live donors is huge relative to the demand for organs. Further, since live donation facilitates matching,

and since organs from live donors are normally of better quality than cadaveric organs, the organs donated would generally be of greater benefit to the recipient. Since the liver can regenerate itself and a person needs only one functioning kidney, the risks to the donors are normally small, provided there is good surgery and after-care. In the advanced countries, the risk of a donor dying seems to be no more that a tenth of one percent for a kidney donor and a third of one percent for a liver-section donor; and the vast majority of kidney donors report an excellent post-operative quality of life, with less than five percent saying that they regretted the decision. On the basis of the risks to the donor, and of lost time and earnings, it has been calculated that, in the United States, a fee of about $15,000 for a kidney donor and $38,000 for a liver-section donor would be enough to secure a supply of organs sufficient to meet demand. And, as this would represent an addition of only about ten percent to the cost for the purchaser, it would not significantly reduce demand, especially since the demand is likely to be inelastic and since the waiting time for operations will be substantially reduced.

In the less developed countries, the risks to organ donors are likely to be greater due to lower levels of hygiene and nutrition and to poorer quality of surgery, pre- and post-operative care. Surveys indicate that almost half of Indian and nearly two-thirds of Iranian kidney donors suffered bad health experiences afterwards, and almost four-fifths regretted the decision. Some of the dissatisfaction may be due to donors being given poor or misleading information about risks, especially since the Indian figures include some black-market organ sales. The situation would be improved by better regulation to ensure that donors are properly informed about risks and a "cooling off" period of a few weeks to reduce the likelihood of impulsive decisions. Even though the risks would remain greater than in the advanced countries, donors would be able to decide for themselves whether the payment is sufficient to compensate for the risks.

Further, a market in organs from live donors would enable the risks and burdens of donation to be accepted by people who are better-placed to accept them than the relatives of the organ recipient may be. For example, a professional basketball player who earns millions of dollars a year could jeopardise his career by donating a kidney to his sister. No such problem would be faced by a kidney donor who does not engage in activities that involve considerable physical contact which could risk damaging his remaining kidney. A market in organs would permit the latter to sell his organ to the sister of the basketball player.

However, it is important that the market in organs should be competitive, with no significant barriers to entry. A monopolistic agency involved in the purchase or sale of organs, with little serious competition

from rivals, would lack incentives to keep costs down and to improve quality of service, which would lead to inefficiency, waste and poorer services to organ donors and recipients.

Thus, a competitive market for human organs would bring demand and supply closer to equilibrium mainly by substantially increasing the supply from living donors. This would mean that many more people who need a transplant would get one, length of waiting times and the number of deaths while waiting would be substantially reduced, the quality of matches would be improved, prospects of survival after transplant would be enhanced, quality of life of recipients would be substantially improved, donors would have the benefit of financial payment, and the risks and burdens of donorship could be reallocated to where they are most easily borne. In contrast, prohibiting organ sales not only prevents the realisation of all these goods, it also generates a black market in live or cadaveric organs, in which transplants are available only to wealthier individuals who usually bear the total cost themselves, and are also often much riskier, for donor as well as recipient, because organs are not screened as carefully for disease and are not matched as closely to recipients, operating conditions and the quality of surgeons tend to be inferior, information provided to donors is poor and contracts are not always enforceable. Black markets also tend to provide revenue for criminals and engender corruption of public officials.

2.2 The Deontological Argument

The deontological argument is based simply on what it means to be a normal adult person ("a person," for short). A person is not only able, but is entitled, to take decisions for himself. There is perhaps no one who would deny that, so long as a person fulfils all his duties, he is at liberty to do as he pleases. This implies that a person has rights, which exclude others from controlling him, and liberties, which permit him to control himself. The most important rights and liberties a person has concern the use of his own body, since it is through the use of his body that a person does other things. Each person has each of the following entitlements, *so long as he has no duty which conflicts with it*:

- the right to exclude others from using his body;
- the liberty to waive that right by giving specified others permission to use his body in specified ways;
- the liberty to use his body in any way he pleases.

A right of one person entails a duty on others to respect that right or, failing that, to compensate the victim. But liberties do not entail

corresponding duties on others. If someone has a liberty to do something, he simply lacks a duty *not* to do that thing. This entails that others have no *right* that he not do it (for then he would have a duty not to do it), which means that he does not need others' permission to do it. However, others may still have a liberty to prevent him from doing it in ways that do not violate his rights (Hohfeld 1919, especially 35–50 and 101–2, though he calls liberties "privileges"). For example, I have the right to exclude other people from using my own telephone, so they have a duty not to use it without my permission. But I have the liberty (not a right) to use a public telephone, along with everyone else. If someone else is exercising his liberty to use the telephone just when I want to use it, then my liberty to use that telephone is frustrated, though no right of mine has been violated and I am not due compensation from the person who is using the telephone, even though his action is disadvantageous to me. Of course, I can negotiate with him to let me use the telephone first, perhaps by pleading, perhaps by explaining its importance to me, or perhaps by offering to pay him. If he accepts payment, he gives me a right to use the telephone before him, which entails a duty on him to let me use it first, which in turn means that he has bartered away his liberty to use that telephone before me without compensating me.

A person's rights and liberties regarding his body straightforwardly imply that he is entitled to offer parts of his body to others, either freely or in return for payment, unless he has some duty not to do so. There may be special circumstances in which one has such a duty, for example, if through some freak circumstance such a donation would cause the death of a million people. But there is no general duty not to donate a body part. In particular, persons are normally at liberty to donate kidneys or liver-sections. This is generally recognised: few people object to altruistic donations. Thus, a person is normally entitled to donate a kidney or liver-section to another person. Consequently, so long as he does not have a duty not to accept payment, he is entitled to sell the organ. How could the donor have a duty not to accept payment? There seem to be only two ways. The first is where the donor has made a prior agreement not to accept payment, though even then he is at liberty to break the agreement so long as he compensates the other party to it. The second is where the consequences of the donor accepting payment would be so bad (a million innocent deaths, for example) that the duty to avoid them circumscribes his liberty. But in sub-section 2.1 it was argued that the consequences of kidney or liver-section sales are generally beneficial. So, a duty not to sell an organ could arise only in special circumstances. Thus, a person is normally entitled not only to donate a kidney or liver-section to another but also to accept payment for it. A parallel argument shows that a person is normally entitled not only to accept a kidney or liver-section for transplant into his own body but also to make a payment for it

3. Objections Rebutted

In spite of the benefits of a competitive market in human kidneys, livers and liver-sections, and in spite of the fact that (barring special duties) a person is entitled to participate in such a market as buyer or seller, there is entrenched opposition to such a market. However, the main philosophical arguments offered by the opponents are egregiously invalid, unsound, confused or irrelevant. I will state and rebut them in turn.

3.1 The Gift Argument

Titmuss (1970) claimed that a system of freely donated blood is superior in quality to a system that also uses purchased blood. His first reason for this was that blood sellers have a reason to conceal their illnesses while altruistic blood donors do not. His second reason was that, if blood is treated as a commodity with a price, then some people who would have donated when doing so bestowed the "gift of life" will decline to donate. What is true of blood should also be true of organs.

Neither of the reasons offered seems cogent. For there are medical tests that can help to identify whether or not an organ is suitable for transplant; indeed, a donor will be less knowledgeable about the state of his organs than will a person with access to the test results. Further, donors could be held legally liable for damage to recipients resulting from diseased organ donations. And even if it is true that altruistically motivated people would initially be less inclined to donate an organ if payment were made to them, it should be easy to circumvent this by permitting donors to decline the payment, or by advertising the fact that the payment could be donated to charity, which would enable donors to do a double good. Further, even if payment for organs *did* reduce altruistic donations, this reduction would be made irrelevant by the substantial supply from people donating organs for gain. For, we know there is a thriving black market in human organs (Finkel 2001; Scheper-Hughes 2003); and, as we saw in sub-section 2.1, a payment to donors equal approximately to ten percent of the current cost of transplants should be sufficient to call forth a supply to meet demand.

3.2 The Desperation Argument

Some claim that organ sales are objectionable because a live donor would not sell one of his organs unless he was desperate, faced with no reasonable alternative; and a sale made under such "coercive circumstances" is no more voluntary than is the action of a man handing over his wallet to an armed thief. This is particularly so where the donor is under pressure from

more powerful others, as with many women in third-world countries (see Sandel 1998, 94; Scheper-Hughes 2003; Satz 2010, 195–97).

The concept of coercive circumstances is contentious; but we do not need to enter that controversy since we can talk instead simply of desperate circumstances. The claim that organ sellers can only be people in desperate circumstances seems plainly false. *First*, if it is possible for someone who is not in desperate circumstances to donate an organ altruistically, then why could not the same person, or a different person in similar circumstances, not volunteer an organ for money? *Second*, people are inherently aspirational: whatever their level of wealth, there are usually things they want which are beyond their current pecuniary means. If money is needed for a special occasion, like a wedding, or a special treat, like a "dream holiday," the possibility of selling an organ may offer the most acceptable way of raising the cash, especially where the risks for the donor are low. Similarly, an organ may be sold as a way of raising money for investment, for instance, in a superior education for one's child, or in an asset required for an expanding business, or for a change of occupation. For example, a Turkish man sold a kidney to buy a taxi-cab (Finkel 2001).

Of course, one would expect that *some* organ sales would be made as a way of escaping a desperate situation. But it surely is a good thing that a person in a desperate situation has some means of escape. Admittedly, it would be better if there were no desperate situations; and surely we could all do more to try to reduce the number and severity of desperate situations in which people find themselves. But desperate situations will always be a recurring fact of life. Prohibiting organ sales simply makes it less likely that people will be able to escape from desperate situations. Insofar as organ sellers are poor or desperate (and this will not always be so), prohibition of organ sales simply makes the poor or desperate worse off, which frustrates the aims of those who propose it (this point is acknowledged, more or less, by Sandel 1998, 95–96, and Satz 2010, footnote 27).

In cases of actual coercion, people act because they are literally forced or threatened. The problem there is the coercion, not necessarily the activities that people are coerced into, since people can be coerced into activities which are otherwise perfectly legitimate. Coercion of women in some third world countries is a serious problem; but it should be addressed directly rather than by trying to outlaw activities that many people engage in freely.

3.3 The Weak-Agency Argument

Satz (2010, 195–97) presents, but does not fully endorse, the following argument. A market participant who is not fully informed of the

consequences of his transaction is to that extent a weak agent. Kidney transplants involve risks. The risks are likely to be greater in places where people have little access to clean water or adequate nutrition and are often engaged in difficult manual labour. Organ donors, especially those in poorer countries, cannot be sure that the outcome will not be bad. Indeed, evidence from India suggests that many organ donors later regretted their decision. The situation could be improved if potential donors were provided with better information on the risks. But poor people might still sell a kidney after receiving this information because they are in desperate need of the money. Therefore, people should not be allowed to sell their organs.

There are a number of serious problems with this argument. First (as Satz to some extent acknowledges), all decisions involve some risks, since things can always go wrong, and all of us from time to time take decisions that involve risks of significant adverse consequences to ourselves, often extending far into the future, such as decisions to take out a mortgage, buy a car, get married or choose an occupation (especially one of the more risky occupations, such as the armed forces, fire-fighting, mining, law enforcement, or even fishing or cab-driving). If the existence of such risks were a reason for prohibiting the decisions, we would be unable to take many of the most important life-decisions, which is absurd.

Second, our ignorance of the consequences of actions we are about to take derives not only from risks but also from uncertainty and from gaping holes in our information. We are all *irremediably* "weak agents" (in Satz's sense) all of the time, either in markets or out of them (this is, indeed, guaranteed by the problem of induction, but the larger problem is our lack of information rather than the reliability of the information we have). So if "weak agents" were not permitted to take decisions for themselves, then none of us would be permitted to take decisions for ourselves; which is absurd.

Third (as Satz acknowledges), the same risks to health are incurred whether an organ is sold or donated altruistically. So if this argument were valid, it would also commend prohibition of altruistic donations.

Fourth, as reported in sub-section 2.1 (and as Satz acknowledges on p.196 and in footnote 32), in the advanced countries the risks to donors are low and the vast majority of donors are happy with their decision. It is perhaps inevitable that the risks of donation in poorer countries will be greater; but all reasonable steps should be taken to ensure that potential donors are provided with the available information about the risks they are taking (this is presumably an area where real improvements can be made).

Fifth, from the fact that poor people may sell their organs even after they have been given the current available information on risks, it does not follow that those people should therefore be prohibited from taking the risks. That would follow only on the *assumption* that those people should not be permitted to decide for themselves which risks are worth taking for which benefits; but that is the *conclusion* of the argument, which is therefore circular.

Satz (2010, 202–3) says that perfect information is assumed by the efficiency theorems of welfare economics and she describes an agent's lack of perfect information about consequences as a market failure. But the perfectly competitive market of welfare economics is not a description of a possible state of affairs: at most, it is a tool for analysing real markets (see Hayek 1949, particularly Essays II, IV and V; Hayek 1978; Kirzner 1963). In real life there is not, and cannot be, any market transaction, or any other kind of decision, where all (or any) of the participants have perfect information. If this were to count as a market failure, then it would be logically impossible for any market to succeed.

3.4 The Inequality Argument

Satz (2010, 197–99) fears that the introduction of organ markets will increase inequality by including body parts in the scope of things to which money gives a person access. A kidney market might mean that kidneys go to the highest bidders. The donors would be mostly poor people; the recipients mostly well-off. She asks: shouldn't kidneys be allocated to people on the basis of need, length of time waiting, medical suitability, and not on the basis of ability to pay?

It seems true that the sellers of organs are on the average likely to be poorer than the recipients. But (as Satz acknowledges) this is no more sinister than the fact that the sellers of domestic services are on the whole likely to be poorer than the buyers. In each case, there is a mutually beneficial trade. Besides, the *poorest* people might not be eligible to be sellers if they have infectious diseases, serious illnesses or use drugs. And, in any case, the membership of the categories *rich* and *poor* changes over time: in market economies most people are relatively poor when young but relatively well-off by the time they are middle-aged; indeed, a person might sell a kidney when young to invest in a career which makes him rich, thereby enabling him to buy a kidney in old age. Further, a market in organs would substantially increase the number of transplants. This could bring down the costs of transplants over the long term through scale economies in the production of instruments and the encouragement of technological innovations which enable less-skilled (and thus cheaper) surgeons to perform operations of a

standard that only better-skilled surgeons could perform in the past. This, in turn, could mean that poorer people are more able to afford organ transplants. And the substantial reduction in waiting times would benefit all transplant recipients, whether rich or poor. In all these ways, markets in organs will benefit the poor. Of course, none of this will eliminate the distinction between rich and poor. But to the extent that financial inequality is considered to be a problem, it can be rectified by redistribution through the tax system. There is no need to prohibit the trade in organs, thereby making potential organ-sellers financially worse off and causing avoidable suffering and death by reducing supply.

Furthermore, the allocation of organs on the basis of need, length of time waiting, and medical suitability has pernicious consequences. It means that all organ transfers pass through a bureaucracy which decides how many organs are needed and who gets them, instead of these matters being decided by the willingness of donors to sell and recipients to buy. As a consequence, one may be refused a transplant for which one is willing to pay because a bureaucrat deems one's need is not a priority, even though there is an available donor who is willing to sell; or one may find oneself allocated an organ even though one would prefer to forego the organ and have instead a tax rebate to invest in a child's education. The costs of the bureaucracy (salaries, offices, equipment, supplies, energy and so on) will have to be recovered, either from recipients of organs or from the general taxpayer. And since the bureaucracy will be a monopolistic agency, it will have inadequate incentives to keep costs down. Rationing by professionals will also put the poor at a disadvantage to the extent that it will favour educated people who are sufficiently articulate, assertive and informed to communicate productively with the professionals and to work the system to get what they want (for this last point see Le Grand 1982 and Green 1982). If the aim of this arrangement is to help the poor, it would be much better served by giving the poor more money.

It is also unexplained why it is thought that organs should be allocated on the basis of need, length of time waiting, and medical suitability, when some other health services are not; and why some health services should be allocated on this basis when food is not, or when risky occupations are not. All may be matters of life and death. Consistency would seem to demand that all goods and services necessary to life, or to a good life, should be allocated on the basis of need, suitability and waiting time. But that seems to entail socialism, which we know leads to stark inequality (between the rulers and the rest), the collapse of the economy, the spoliation of the environment and gross human rights abuses.

As a means of reducing inequality, therefore, the prohibition of a market in organs is quite ineffective: it makes the poor worse off, as well as the rich; it produces a wasteful bureaucracy; and the end can be achieved effectively by redistributing money.

3.5 The Degradation Objection

Many people claim that market valuation and exchange degrades certain goods and practices. In particular, the sale of human body parts is claimed to be intrinsically degrading, and thus wrong, even if conducted under the most propitious circumstances, because it is a violation of bodily integrity, of the sanctity of the human body (Sandel 1998, 94–95; Scheper-Hughes 2003).

This is plainly a strict deontological view: it maintains that organ sales are wrong intrinsically, not because they have adverse consequences. Indeed, as we have seen, organ sales will generally have beneficial consequences: the recipients avoid death, suffering and reduced quality of life; and the donors receive payment and perhaps the satisfaction of having helped another. So the view deprecates organ sales *despite* their beneficial consequences. However, those who hold the view seem committed to a dubiously coherent, or plainly incoherent, position, for a number of reasons.

First, deontologists are rarely absolutists: they typically recognise that there can be exceptional circumstances in which deontological principles may legitimately be over-ridden, as when we are entitled to kill an innocent person in order to save the lives of many others, or to kill an innocent person to avoid being killed by him (see, for example, Thomson 1985, 1991). But, in the United States alone, tens of thousands of people per year suffer while on the waiting list for a transplant, more than a thousand of them become too sick for a transplant and many more of them die while waiting; and all who wait for a transplant have less chance of a successful outcome. One might have thought that such circumstances enjoined waiving the deontological principle.

Second, violations of bodily integrity are commonplace and unproblematic, such as the removal of an appendix, the amputation of a gangrenous limb, the excision of a malignant growth, and so on. Further, altruistic donation of an organ to a relative is usually lavished with moral approval. Thus, violations of bodily integrity are not held to be intrinsically wrong, even by the people who oppose markets in organs on this ground. Their cant about "the sanctity of the human body" is inconsistent with their other views.

Third, market valuation and exchange are involved even in altruistic transfers of organs, and in other operations. For, the surgeons and other

medical and administrative staff receive payment. Those who object to organ sales do not object to this market valuation and exchange. So how can it be wrong that the donor gets paid?

Fourth, if donating an organ for free is (or can be) morally commendable, why is it intrinsically wrong to donate an organ for money? Admittedly, the latter is a different kind of act and is not as morally valuable as the former; but why does it become morally wrong? How can payment make such a difference? Clearly, it is held that some activities just should not be done for money. But which activities are of this nature? A simple list of such activities will be arbitrary, unless there is some principle for grouping these activities together and separating them from other activities. But there appears to be no such principle. It is not the intimate nature of the activities. For a wide range of intimate services are provided for money without moral objections being made: a doctor examines the bodies of his patients, a surgeon tampers with the internal workings of a patient's body, a dentist examines the recesses of a patient's mouth, a counsellor or therapist listens to details of his clients' personal lives and tries to help them to solve personal and relationship problems, the nurse or other attendant helps an old person to wash, or cleans up that person's bodily wastes. If it is not degrading to buy or sell these intimate personal services, why is it degrading to buy or sell organs? And it is not the fact that organ donation involves risks to the provider. Members of the armed forces, fire-fighters, police officers, miners, and so on, put their bodies and lives at risk in the course of their paid work. If it is not degrading to incur such personal physical risks and sacrifices in return for payment, why is it degrading to sell organs for money? It seems that one who holds to the deontological principle will hold a coherent view only if he also abjures as degrading a wide range of commonplace and very beneficial practices. The principle seems either incoherent or perverse.

It should be noticed that I am not saying that anything that one is morally permitted to do is something that one is morally permitted to do for payment. As noted in section 2.2, there may be specific circumstances in which making or accepting payment for a particular activity has significant adverse consequences. My argument is that, if it is not wrong to perform a specific act, then it is difficult to see how it can be *inherently* wrong to perform that act for money. The strict deontological principle against organ sales is baffling.

If the deontological principle is held as a personal moral view, the holder will refuse to sell his organs and refuse to accept an organ for transplant unless it had been given without payment. If he is not an absolutist about the principle, he will recognise the possibility that the principle may be over-ridden in some circumstances; and perhaps if his life is at stake he may

waive the principle (though he need not, since it depends on how firmly he holds it). However, while many people do seem to hold this deontological principle, many others do not. And it seems inequitable that people who do hold the principle should demand that the law, which affects everyone, should be fashioned in their moral image, so that sales of human organs would be prohibited. Indeed, given the death and suffering consequent upon prohibition, it seems iniquitous that prohibition should be instituted on the basis of a deontological view that is not generally shared.

Further, prohibition involves a form of degradation. For an adult person is normally entitled to make his own decisions about the use of his own body, so long as doing so does not violate any duties he has. Indeed, to prevent a person from executing such decisions is to assume a position of moral superiority over him. And this degrades him by treating him as a non-person or a sub-standard person who is incapable of making his own decisions. Thus, when the deontological principle against organ sales is elevated from a moral rule to a legal one, it avoids something that *some people* regard as a form of degradation engaged in by *some people*, only by imposing on *everyone* something that *people generally* regard as a form of degradation.

3.6 The Slavery Argument

It may be contended that a person who thinks that all of his parts have prices might think that it is acceptable to sell off all of himself or to buy all of the parts of others. So, a desire for a ban on organ sales may be an extension of our revulsion to slavery. (This argument was mentioned by Satz in a footnote to a draft of her 2010 for an Aristotelian Society meeting on 30 June 2008; for an earlier version of the argument see Abouna et al. 1991, 169).

The argument is fallacious. First, if it is acceptable for a live donor to sell a kidney or a liver-section, which has minimal or small negative impacts on his health, it does not follow that it is acceptable for him to sell other parts of his body, such as his heart or brain, which raise additional issues. Heart transplants from live donors raise the issue of assisted suicide, since the surgeons who remove the heart would be knowingly killing the donor. Selling one's brain raises issues about personal identity: there appears to be an intimate connection between personality or personhood and the brain; so someone who donates his brain to another may be acquiring a new body rather than the recipient acquiring a new brain. A flourishing market in human brain transplants therefore seems unlikely, but a market in human brains is still possible since it seems there will always be a demand for brains for research. But live donation of one's brain for research amounts to assisted suicide. It is of course arguable that live donations of hearts or brains is

morally permissible, at least under some circumstances; and it even seems likely that some parents might want to make such a sacrifice to raise money for their children. But one could consistently accept a market in kidneys and liver-sections while rejecting a market in hearts or brains, because the issues involved are different.

Second, a person could sell *every* part of his body without becoming a slave, or anything like a slave, if the transfer of his body, either in whole or in separate parts, happens after his death. Even hard-core materialists must acknowledge a distinction between a person and his body since, when a person dies, he ceases to exist, but his body still exists. Selling one's body is not the same as selling oneself; owning a person's body does not amount to owning the person.

Third, the main reason we feel revulsion at slavery is that the slave is denied his independence: even a slave who is happy being a slave does not have the option of running his own life. But the sale of an organ is an exchange between independent agents who make their own decisions. The difference between a market in organs and slavery is thus categorial, not merely a matter of degree. In the former, rights and liberties to use organs are owned and exchanged; in the latter, persons are owned and exchanged. In a contract for organ donation, the donor and the recipient *agree* to the transplant; and either is entitled to break the agreement at any time up to the transplant; though, if he does so, he may then be liable to pay compensation to the other party (a refund of payments made or perhaps compensation for costs or damages incurred). In slavery, by contrast, the slave cannot opt out.

Whatever appeal the slavery argument has may derive from the fact that an unrestricted market in body parts or bodies permits agreements which *mimic* slavery in various ways. In a contract of employment, the employee sells to his employer some of his rights and liberties to use his body: during working hours he has to do what his employer says, within the terms of the employment contract. In the armed services, employees even sell part of their right to life, in that it is legal for other people to kill them under specified circumstances. Where assisted suicide is legal, a person may pay another to kill him: he thus gives his right to life to that other. In some medical experiments people give or sell rights and liberties to use their bodies in quite invasive ways (similarly in prostitution). It really is a short step from such agreements to one in which a person agrees to be another's permanent servant, obeying the other's orders and even accepting physical punishment from, and confinement by, the other, and perhaps even permitting the other to take the servant's life. This could be done in return for payment (which the servant might hand over to a third party, either as a gift or for safekeeping), or it could be done for fun, as seems to happen in some sado-masochistic

sexual relationships. But this is only an imitation of slavery, for two reasons: first, the agreement is entered into voluntarily by both parties; and, second, either party may terminate the agreement at any time. If it is important to one or both parties to the agreement that the servant sometimes tries to escape and is forcibly recaptured, a special form of words will be needed to distinguish *termination* of the agreement from the escape and recapture which is *within* the terms of the agreement (the coercion specified in the agreement is only a phoney coercion). As things stand, agreements of this sort are not legally enforceable; but I think they should be. This would not mean that the servant could not terminate the agreement: legally enforceable contracts can be terminated. So, it does not mean that the servant (any more than an employee, a contractor, or a paid volunteer for medical experiments) can be legally forced to perform the duties described in the agreement. But it would mean that the party who terminates the agreement would be bound to pay any compensation due to the other party. Thus, if the servant entered the agreement for money which was paid upfront, he should have to repay some, or perhaps all, of the money; or, if the master invested in equipment, such as custom-made restraints tailored to the body of the servant, then the servant could be liable for at least part of the costs (indeed, such compensation arrangements could be spelt out in the agreement). What the servant is giving or selling in such agreements is not himself (he does not own himself), but extensive rights and liberties to use his own body, perhaps even including his right to life.

The slavery argument is therefore mistaken: it assimilates sales of kidneys and liver-sections to sales of other body parts which raise broader issues; and it confuses sales of rights and liberties with sales of persons.

3.7 The Argument from Cost of Preferences

The argument of this sub-section seems to be implicit in the argument to be considered in the following sub-section (see, particularly, Satz 2010, 200–201, 203), but it is worth stating and debunking it separately. The argument runs as follows. Once there is a market in organs, someone who does not sell his organs foregoes the price he could receive from the sale; and he thus pays a cost (the money foregone) by not selling. But the preference a person has for not selling an organ is not a preference he should have to pay a cost for.

However, abolishing the market price does not abolish the cost of the preference for retaining the organ. All scarce resources have alternative uses and the cost of using them is simply the most valuable alternative use foregone. And healthy organs are scarce. Thus, the cost to a person of

retaining an organ is what that person loses by not giving the organ to the person who would give him most in return for it. In a market, this cost can be measured objectively by the price he would get for selling it, though what value he puts upon that amount of money is a subjective matter. However, without a market the person still bears the cost of retaining the organ, but he does not know how large that cost is (because there is no market price) and he does not have the option of avoiding that cost by making a trade (because such trades are prohibited). The ban on sales simply makes people worse off. Since the aim of those who urge the ban is to make people better off, they are frustrating their own purpose.

It might be objected that, if there is no market in organs, people will not know that they are giving up something by retaining their organs. Since the possibility of such alternative uses of their organs will be unknown to them, subjectively they lose nothing by retaining their organs, so they do not pay a cost of retention. As Buchanan (1999, 41) says:

> Cost is that which the decision-taker sacrifices or gives up when he makes a choice. It consists in his own evaluation of the enjoyment or utility that he anticipates having to forego as a result of selection among alternative courses of action.

However, even with no market for organs, it would be a particularly ignorant or stupid person who did not realise that there is a demand for organs, especially if organ donation is permitted. The vast majority of people will be aware that people are dying for want of organs and would be prepared to pay significant sums to get them. The fact that there is no market price for a person's organ means that it is inherently vague what he could get for it if he were able to sell it. He will therefore know that there is a significant cost of retaining his organ and that he is being legally compelled to bear that cost, even though he has only a vague idea of its monetary value.

3.8 The Argument from Impaired Choice Sets

Satz (2008, 199–202) argues that allowing organ sales as a widespread practice would have effects on the nature of the choices that are available to people. For example: where organs are viewed as potential collateral, moneylenders may acquire incentives to seek out additional borrowers as well as to change the terms of loans. (She could have added that potential borrowers may acquire incentives to seek out moneylenders to obtain loans or more favourable terms for loans.) A poor person who did not want to sell her kidney would probably find it harder to obtain a loan and may have to pay a higher rate of interest. So, while a market in organs will expand a single individual's set of choices, if adopted in the aggregate, other people may be

worse off, having their choice set restricted, since they will no longer be able to find reasonable loan rates without mortgaging their organs. (This argument is a development of the argument from higher-level preferences discussed inconclusively in Radcliffe Richards 1996, 394–97.)

It is not clear that the effects that Satz hypothesises would actually follow. For, once organ sales are allowed, many people will sell an organ instead of taking out a loan, thus reducing the demand for loans, leading to improved terms for borrowers. But let us accept for the sake of argument that the consequences would be as Satz says. Her argument seems confused. *First*, her reference to poor people is another instance of the confusion we noted in the desperation and inequality arguments: poverty should be addressed separately from the matter of organ sales. *Second*, there is nothing in the argument about impaired choice sets that is specific to permitting trade in body parts. For reduced third-party choice sets result *whenever* people are permitted to trade anything; indeed it is an inevitable consequence of liberty, as we saw in section 2.2, where someone exercising his liberty to use a public telephone prevented me from using it. Consider some examples. If black people have the liberty to use the bus, the demand for seats on the bus will be greater than otherwise and, as a consequence, the bus may often be full, which will mean that some white people will sometimes be unable to get on the bus and thus have their choice sets restricted. If women have the liberty to enter the professions, then many jobs that would previously have been available to men will be taken by women, so men will have their choice sets reduced. People's liberty to produce and sell compact discs put an end to the mass production of vinyl records thus impairing the choice sets of record consumers (particularly those who preferred vinyl). If people have the liberty to promote new fashions, this will impair the choice sets of those people who preferred the old styles, which will become unobtainable unless made to order. If someone produces a new widget which is much better and cheaper than the older widgets, then many of those who produce the older widgets may no longer have the option of continuing in their current occupation. If I ask a woman to dance and she accepts, I remove the option of having that dance with that woman from everyone else who might be interested. If impaired third-party choice sets really impugned the legitimacy of organ sales, it would impugn the legitimacy of virtually all our liberties, whether or not they involve sales.

Satz (2010, 201) partly concedes this and also that the losses experienced by people who do not sell their organs, through impaired choice sets, may be outweighed by the gains to organ buyers (she should also have mentioned the monetary gains to organ sellers). But she maintains that people should not have to pay a cost for refusing to sell their organs. This is

poorly expressed. As we noted in the last sub-section, people bear a cost for not selling their organs whether or not a market in organs is permitted: forbidding the trade in organs does not take away the costs; rather, it makes them unclear and it prevents people from avoiding them even if they wish to do so. But we can express Satz's point here by saying that, while some people may be made worse off by the legitimate exercise of the liberty of others, they should not be made worse off simply because they refuse to sell their organs. The obvious question is why people should not be worse off for a refusal to sell their organs when they would be worse off by a refusal to sell another scarce resource which has just become marketable. Why are organs different? Here is her tentative answer (2010, 201):

> If we view kidneys as resources analogous to other resources we have, whether money or apples, it is unclear why we should not have to part with that resource if we wish to secure credit. But many people resist this analogy. They seem to tacitly believe, following Ronald Dworkin, that we have good reason to draw a "prophylactic line" around the body, a line "that comes close to making [it] inviolate, that is, making body parts not part of social resources at all."

This is not much of an answer: it amounts to saying that organs should not be treated as marketable assets because many people believe they should not be. But this is question-begging because it is precisely that belief that is at issue. Although Satz says that people believe we have good reason for this belief, she provides no good reason; and, as I have tried to show in detail in this paper, the belief does not survive criticism. It is also questionable how many people hold the belief, given the existence of thriving black markets. Of course, it is true that the belief is held by many people *in some circles*; but I suggest that the explanation for this may be that these people have had a largely religious or quasi-religious upbringing (Christian or Marxist, for example) in which a general repugnance for buying and selling was inculcated and induced, so the belief is an unthinking one (see Haidt 2001 for a psychological appraisal of this phenomenon, though there is much to dispute in his analysis).

4. Conclusion

I have argued that a competitive market in human organs would be a great improvement over the current situation in which organ sales are almost universally prohibited. It would do away with the evils of the black market. It would substantially increase the supply of organs, the quality of matches, the number of transplants and the likelihood of their success, thereby saving lives, reducing suffering and improving the quality of lives. It would permit

people to trade an organ, or part of an organ, for things they value more highly. And it would allow the burdens of donation to fall where they do least damage (indeed, create most value). It might even bring down the cost of transplants in the long term. And it would treat people with the respect that is due to them as persons who are entitled to make their own decisions about their own bodies.

Yet despite these substantial benefits there is, in influential circles, entrenched opposition to a market in human organs. I have considered the main philosophical objections to a market in organs and shown that none of them has merit. The gift argument depends upon false premises about altruistic donation and upon ignoring the substantial new supply of organs from people responding to financial incentives. The desperation argument depends upon the false claim that organ sales are made only by people in desperate circumstances; but even prohibiting organ sales in desperate circumstances would simply make the desperate worse off. The argument from weak agency would abolish all our liberties, since it uses a notion of weak agency that makes everyone a weak agent. The inequality argument confuses redistribution with bureaucratic control; and the type of non-market arrangements it favours would be wasteful, diminish autonomy and, if applied consistently, would lead to the horrors and abuses of socialism. The degradation objection offers an apparently arbitrary deontological principle to be held despite the suffering and death it engenders. Further, as a rule of personal morality the principle seems incoherent; and as a rule of law it is inequitable, iniquitous and imposes upon everyone something that is generally acknowledged to be a degradation. The slavery argument is fallacious, assimilating simple cases of organ sales to more complex cases and confusing sales of rights and liberties with sales of persons. The argument from the cost of preferences and the argument from impaired choice sets confuse the absence of a price with the absence of a cost: prohibiting sales does not abolish the cost; it obscures it and prevents people from avoiding it. Further, if the argument from reduced choice sets were valid, it would entail the general suppression of our liberties. What appeal that argument has seems to be borrowed from the untenable degradation objection.

People who oppose a market in organs usually do so out of a concern for human welfare and, in particular, the well-being of the poor. But a competitive market in human organs would be generally beneficial; and its prohibition makes the poor worse off. The arguments offered for prohibition are unsound, invalid, confused and often involve principles which consistently applied would result in the wholesale suppression of ordinary liberties. The absence of a cogent reason for the opposition to markets in organs, and the fact that such opposition means death, suffering and the

suppression of freedom, makes the existence and obstinacy of such opposition, amongst many people who are both intelligent and educated, not only puzzling but also distressing.

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