SUSTAINABLE ORGAN DONATION SYSTEMS AND GLOBALISATION: ORGAN TRADE, ORGAN TOURISM OR ORGAN TRAFFICKING?

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“Social sustainability occurs when the formal and informal processes, systems, structures, and relationships actively support the capacity of current and future generations to create healthy and liveable communities. Socially sustainable communities are equitable, diverse, connected and democratic and provide a good quality of life.”

What society do we want to maintain?

Whose health do we want to maintain?
Health & Sustainability

- Health & safety (of workers worldwide)
- Environment & health (ecological sustainability)
- Public health (river toxicity = population health).

- Events happening in our community are often the result of global as well as local activities.
Health Sustainability & Globalisation

- Social Equity/ Justice
- Social responsibility
- From local to global
Organ Donation & Transplantation: From Local to Global

- The problem:

  - Increased Technological Advances in Transplantation
  - Increased Demand of Organs Worldwide
What’s in a name?

- Organ Trade
- Organ Tourism (Transplant Tourism)
- Organ Trafficking

Two Standpoints

Trafficking

Trade

‘A moral outrage; a gross exploitation of the poor by the rich, who are now taking the very bodies of those from whom there was nothing else left to take’ Radcliffe- Richards 1996. Emphasis on: Fairness and justice.

‘The rich in question here are dying [...] Radcliffe- Richards 1996. Emphasis on: autonomy, the right of persons to sell their body parts, free of paternalism.'
“The idea of establishing a market for organs, although certainly not new, is now attracting unprecedented support. Much of the enthusiasm comes from members of the transplant community, but it is also favoured by a growing number of economists and bioethicists who believe that the sale of body parts has become ‘morally imperative’. To be sure, the practice is explicitly prohibited by U.S. law, rejected by the guidelines of almost every national and international transplant society and opposed by many commentators. But never before has a market solution been so vigorously endorsed” (Rothman & Rothman, 2006. American Journal of Transplantation)
There is always a Third Way to disguise Neoliberal ideas....

Transplant Tourism
The practice of travelling to another country—especially India, China, or the Philippines—for solid organ transplantation. While transplant tourism is typically cheaper, transplant tourists may be subject to sub-standard surgical care, poor organ matching, unhealthy donors, and post transplant infection, prompting some institutions in the US to refuse to treat the tourists who return needing post-op care or even a new organ, should their ‘tourist’ organ fail.

http://medical-dictionary.thefreedictionary.com/Transplant+Tourism
In the same bag as...

- Cosmetic and other cross-border health tourism (dental, IVF, stem cell...)
- “Cosmetic surgery tourism can be thought of specifically as a tourist experience. Whilst essentially involving travel for the purpose of undertaking painful surgery, cosmetic surgery tourism has a particular resonance with the holiday, most usually constructed as relaxing and restorative.” (Bell et al 2011)
- It is also marketed like that: http://www.placidway.com
How can ‘organ trafficking’ be deterred?

- 2 realist evaluation/synthesis projects. Based on health sustainability principles:
  - 1: By improving donation systems in richer (buyer) countries: UK/Spain comparison
  - 2: By exploring ‘who buys and in what circumstances, where’...
Biology & Geography: Inequalities and Redistribution

- In the UK, organ allocation systems are sustained by a national registry for organ matching and selection criteria (concerning who gets on to the transplant list).
- Allocation policies (who is prioritised to receive organs) are decided according to geographical and clinical principles.
- Distribution policies follow diverse demand management models (based upon need and/or outcome) which are supposed to ensure equity of access, justice and fairness (Neuberger, 2012).
- However, black and minority ethnic groups are at greater risk of developing organ failure and they also experience differential access to transplantation lists and organs (Randhawa, 2011).
- Some structural factors that offer a deeper insight than the lower organ donation rates from non-whites follow. These factors highlight the importance of biology and geography in organ matching procedures, demonstrating that increasing the numbers of transplanted organs must not be based only in notions of abstract altruism.
NHS Blood & Transplant:

- People from South Asian, African and Afro-Caribbean communities living in the UK are more likely to need a kidney transplant than the rest of the population:
- Black people are three times as likely as the general population to develop kidney failure
- The need for organs in the Asian community is three to four times higher.
- This is because people from these communities are more likely to develop diabetes or high blood pressure, both of which are major causes of kidney failure.
- Unfortunately, while the need for donor organs is three to four times higher than among the general population, donation rates are relatively low among black and South Asian communities, thus reducing the chance of a successful match being found.
Once a potential donor is identified, they need to determine suitability for donation through a process of donor assessment. This consists of a thorough medical and social history, physical examination and blood testing.

Organ allocation protocols in the UK are based on matching two principal immunological characteristics between donor and recipient: blood groups and genetic type.
Blood and Genes

- There are four main blood types in human populations: O, A, B and AB.
- In the UK, O is the most common blood group and A, B and AB, are rare.
- B and AB are particularly concentrated amongst South Asian, Chinese and Japanese communities, and these rare blood groups in the UK are also geographically concentrated (Davies, 2006).
- A ‘same blood group’ rule matching donors and recipients is usually maintained. The distribution of HLA antigens also differs between ethnic groups, and given that most organs are donated from the majority white population, it is clear to see how inequalities of opportunities soon emerge amongst groups of potential receivers.
- These biological differences are not simple boundaries. In 2006, a new Kidney Allocation Scheme was introduced aiming to prioritise ‘difficult to match’ patients in the UK. The South Asian populations were potentially disadvantaged under the previous allocation scheme because they share fewer HLA antigens with the donor population than Caucasians. The effect of the new calculations - designed to reduce the importance of HLA matching - in addressing inequalities will take several years to be assessed (Perera and Mamode, 2011).
The Geography

The spatial organisation of organ transplantation has potential implications for inequality for black and ethnic minority groups (Davies, 2006).

Time constraints restrict donation procedures. Organs that cannot be stored using cryogenicisation have to be transplanted promptly after removal for them to retain their functional qualities. This period is variable (approximately 40 hours for a kidney, and four hours for a heart) but, as a general rule, the shorter the amount of time, the better the outcomes.

There is a complex relationship between local and national scales in the geography of organ transplantation, but in a nutshell: geographical distribution promotes inequality (the less donors in one area, the less organs are allocated for that area).

Not only is it logistically easier to transplant organs locally but organs not used locally are felt to be ‘stolen’ from local transplant units (Roudot-Thoraval et al, 2003, p 1388), and institutions operate under the rule that the effort of achieving consent and retrieving organs should be ‘rewarded’ by the local use of the organ (Rudge et al, 2003, p 1398).

Significant variation exists in demand for, access to, and waiting times for organs between ethnic groups in the UK (Roderick et al, 2011). There are currently a disproportionately greater number of people from minority ethnic backgrounds waiting for transplants. Mostly they are waiting for kidney transplants, but there are also long waiting lists for heart, lung and liver transplants (Randhawa, 2011). The biological and geographical examples above demonstrate how national macro-structures create internal health inequalities for organ donation and transplantation (Rudge et al, 2007; Randhawa, 2011).
In Europe, Ethnic Minorities are buying from countries of origin (Khrisanan et al, 201b, Ambagtsheer et al. 2012)

UK:

- 40 patients received transplants overseas; 38 of these were of Indoasian ethnicity, one was Chinese, and the other was white.
- All assessed for waiting list, 20 were not placed on waiting list. Only 16 were on the waiting list at the time of travel. 7 had been on the waiting list for more than 2 years at the time of travel.
Think ‘mechanisms’...

- Ethnicity...
- Familiarity of the trip (It’s not ‘tourism’)...
- Accessibility of the health services (local community-family-support and knowledge of process in the country of transplantation make this treatment a more viable option)
- Not on the waiting list: Risk has a different meaning...
- The outcomes of transplant tourists were poor, more than 30% of cases resulted in either patient death or graft loss(14).