There were about 50,000 persons on the waiting list for kidney transplants in the United States in the year 2000, but only about 15,000 kidney transplant operations were performed. This implies an average wait of almost four years before a person on the waiting list could receive a kidney transplant. In addition, the cumulative gap between demand and supply for livers was over 10,000, which implies an average wait for a liver transplant of a couple of years.

In 2000, almost 3,000 Americans died while waiting for a kidney transplant, and half that number died while waiting for a liver transplant. Many also died in other countries while in the queue for an organ transplant. Some of these people would have died anyway from other causes, but there is little doubt that most died too early because they were unable to replace their defective organs quickly enough.

If altruism were sufficiently powerful, the supply of organs would be large enough to satisfy the demand, and there would be no need to change the present system. But this is not the case in any country that does a significant number of transplants. While the per-capita number of organs donated has grown over time, demand has grown even faster. As a result, the length of the queue for organ transplants has increased.
grown significantly over time in most countries, despite exhortations and other attempts to encourage greater giving of organs.

In recent years the United States has taken several steps to improve the allocation of available organs among those needing them, such as giving greater priority to those who could benefit the most. These steps have helped, but they have not stopped the queues from growing, nor have they prevented large numbers of persons from dying while waiting for transplants. Some countries use an "opt out" system for organs, which means that cadaveric organs can be used for transplants unless persons who died had indicated that they did not want their organs to be so used. A study by Sebastian Gay of the University of Chicago's Department of Economics shows that opt-out systems may yield somewhat more organs for transplants than the "opt in" systems used by the United States and many other nations, but they do not eliminate the long queues for transplants.

Organ markets are the best available way to enable persons with potentially usable organs to get transplants much more quickly than under the present system.—Gary Becker

Balancing Supply and Demand

To an economist, the major reason for the imbalance between demand and supply of organs is that the United States, and practically all other countries, forbid the purchase and sale of organs. This means that under present laws, people give their organs to be used after they die (or, with kidneys and livers, also while they are alive) only out of altruism and similar motives. In fact, practically all transplants of kidneys and livers are from one family member to another. Although this is not an exact analogy, predictions of recipients. 

An open market in organs would sharply curtail the present black market where some persons in need of transplants in effect buy organs by having organs in poorer countries like Turkey, where enforcement against selling organs is slack. Since the quality of the surgeons and hospitals in these countries is much lower than in developed countries, this often greatly reduces the quality of the organs used and how well they are matched to the organ types of recipients.

What the Critics Say

Still, despite these strong arguments in favor of allowing commercial markets in organs, I do not expect such markets to be permitted any time in the near future because the opposition is fierce. Some critics simply dismiss markets as "commodification" of body parts and deem it immoral. More thoughtful critics suggest that allowing organs to be bought and sold might actually reduce the total number of organs available for transplants because the number of organs donated by altruistic motives would decline by more than the organs provided because of the pay. That scenario, however, is extremely unlikely since presently only a small fraction of potentially usable organs are available for transplants. Compensating persons either for allowing their organs to be used after their death, or for kidneys and livers to be used while they are alive, would enormously widen the scope of the potential organ market.

Another set of critics agree that the effect on the total supply of organs from allowing them to be purchased and sold would be large and positive, but they object to markets because of a belief that the commercially motivated part of the organ supply would mainly come from the poor. In effect, they believe the poor would be induced to sell their organs to the middle classes and the rich. It is hard to see any reasons to complain if organs of poor persons were sold with their permission after they died, and the proceeds went as bequests to their parents or children. The complaints would be louder if, for example, mainly poor persons sold one of their kidneys for live kidney transplants. But why would poor donors be better off if this option were taken away from them? If so desired, a quota could be placed on the fraction of organs that could be supplied by persons with incomes below a certain level, but would that improve the welfare of poor persons?

Moreover, it is far from certain that a dominant fraction of the organs would come from the poor in a free market. Many of the organs used for live liver or kidney transplants are still likely to be supplied by relatives. In addition, many middle-class persons would be willing to have their organs sold after they died if the proceeds went to children, parents, and other relatives. Although this is not an exact analogy, predictions that a voluntary army would be filled mainly with poor persons have turned out to be wrong. Many of the poor do not have the education and other qualifications to be acceptable to the armed forces. In the same way, many poor persons in the United States would have organs that would not be acceptable in a market system because of organ damage due to drug use or various diseases.

Still another criticism of markets in organs is that people would be kidnapped for their organs, and that totalitarian governments would sell organs of prisoners. This would happen, but not likely on a significant scale since the source of organs offered for sale could be determined in most cases without great difficulty.

A criticism specific to a commercial market for live transplants is that some persons would act impulsively out of short-run financial needs, and that they would regret their decision to sell a kidney or allow their liver to be used for a transplant if they had taken more time. I do not know how important such impulsive behavior would be, but it could be sharply reduced by having a month or longer waiting period between the time someone agrees to supply an organ and the time it can be used. They would be allowed to change their mind during the interim.

The ability to sell one’s organs for a price, however, does not mean that anyone with a diseased organ should do so. It is the responsibility of the state and its doctors to ensure that no one is induced to sell an organ to support an institution such as a hospital.

Gay of the University of Chicago’s Department of Economics shows that opt-out systems may yield somewhat more organs for transplants than the “opt in” systems used by the United States and many other nations, but they do not eliminate the long queues for transplants.