Liver Allocation

In the United States, organ transplants, including liver transplants, are coordinated by a non-profit called the United Network for Organ Sharing. Given that donated organs have a limited time frame for their viability, the U.S. is divided into 11 geographic areas for liver-donation purposes.[1] Within these regions, patients receive donated livers in order of need. However, there is a wide disparity in donated livers across these 11 regions. For example, in Region 9, which includes New York, 327 livers were donated in 2016, whereas in Region 3, which includes the Deep South and Puerto Rico, 1336 livers were donated. This disparity is due to many factors, including prevalent causes of death; some causes of death, like heart attack, usually leave livers intact, whereas others, like liver disease, do not. In Region 3, for instance, strokes are a frequent cause of death, leading to many more viable livers for donation.[2]

A new policy change will work to mitigate this geographic disparity. Regardless of membership in a transplant Region, someone in need will be eligible for any livers that become available within 150 nautical miles of the hospital where the transplant would occur. Approved by the Organ Procurement and Transplantation Network, this policy "will make more livers available in some places—including cities such as New York and Chicago—where the shortage is more severe than it is in regions such as the southeastern United States."[3] Many view this change as an acceptable improvement in addressing disparities, but not totally satisfying—partly because this would not entirely eliminate those disparities, but also because it does not address one of its key causes, which is the difference in rates of organ donation in different communities.

Additionally, these changes will leave in place another feature of the current system which has received some criticism: it will still be possible for people to join multiple regional liver registries if they can afford it. Such people need to be able to pay for travel and accommodations in the new Region, in addition to covering the costs of a second testing. These patients also need to be able to cover the cost of returning to this Region should a liver become available for them. This clearly is prohibitively expensive for many. However, those who support maintaining the possibility of patients joining multiple registries emphasize the autonomy of patients: "When it's come up for a vote, patient advocacy groups have argued that while things like test results and blood types are out of the patients' control, determining whether to obtain a second listing and where to do it allows the patient to be proactive."[4]

Despite the change to regional allocation, discussion continues about how to make liver transplants—and organ transplants in general—more equitably accessible to those who need them. In 2016 more than 7,000 candidates died while on an organ transplant wait list, or within 30 days of leaving the list for personal or medical reasons, without receiving an organ transplant.[5]

STUDY QUESTIONS

1. Is it fair to distribute organs by geographic availability?
2. What should we use as the primary criteria for determining how to distribute livers and other vital organs?
3. Should joining multiple regional registries for liver transplants be allowed?

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[1] https://optn.transplant.hrsa.gov/learn/about-transplantation/how-organ-allocation-works/
[2] https://www.washingtonpost.com/national/health-science/liver-transplant-distribution-changed-after-years-of-debate/2017/12/04/fedefc0e-d92c-11e7-b859-fb0995360725_story.html?utm_term=.f88be9266d31
[3] https://www.npr.org/sections/health-shots/2017/09/26/549224583/searching-for-a-fairer-way-to-distribute-donor-livers
[4] https://news.vice.com/article/good-luck-getting-an-organ-transplant-if-youre-poor-in-america
[5] https://unos.org/data/