ORGANS WITHOUT BORDERS? ALLOCATING TRANSPLANT ORGANS, FOREIGNERS, AND THE IMPORTANCE OF THE NATION-STATE (?)

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I
INTRODUCTION

Most of the discussion of market or nonmarket forms of allocating and procuring organs takes as its unit of analysis the nation-state, or, less commonly, a particular state or province, and asks what should the system look like as to this framework. In this article, the second of two articles that I contribute to this issue of *Law and Contemporary Problems*,[1] I want to expand the viewfinder and examine an issue that has received peculiarly little attention in the scholarly and policy discourse: the desirability of treating the nation-state (or its subdivisions) as the right level of distribution for organs, whether through market systems or nonmarket allocation systems. I show that when we flirt with using a more global viewfinder, a series of difficult (and thus far largely unexplored) ethical and regulatory questions arise relating the inclusion of "outsiders." In part V of this article I explore what relevance this analysis may have to allocation within the nation-state as well.

A large number of questions could be discussed under this title, but for this article I largely limit myself to two related questions. In analyzing both questions I use the United States as the "home country" for rhetorical clarity, but the basic issues are the same for any home country. The first issue is: Should the United States allow "foreigners" to be on the list of those eligible to receive organs in the United States when they become available and, if so, at what level of priority? Second: Should the United States maintain its own organ

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1. The other article is I. Glenn Cohen, *Regulating the Organ Market: From Normative Arguments to Regulation*, 77 LAW & CONTEMP. PROBS., no. 3, 2014 at 71.

distribution network that is limited to the nation-state instead of participating in a more globalized system? I should emphasize that my interest here is organs that come to recipients through typical government-run (or at least government-approved) organ-allocation systems rather than through foreigners who come to U.S. centers and bring their own living donor.[2]

I first describe the two issues and then offer a normative analysis of each. This cluster of issues applies equally to the current U.S. distribution system, with its hostility to markets, and any of the potential alterations discussed in this issue of *Law & Contemporary Problems*. That is, even if we introduce market elements of one form or another to the U.S. organ-allocation system—as I discuss in my companion article in this issue and as do other authors in the issue[3]—we still have to answer the two questions that I contemplate in this article: Should non-U.S citizens who are nonresidents be allowed to have access to U.S. organs in the domestic system, and should the United States as a whole join larger inter-country organ-allocation systems? In part V of this article, I make some comments about what this analysis implies as to organ sharing *within* a nation-state, for example between U.S. states or geographic regions.

Let me emphasize a terminological point here. I use the term "foreigner" in a specific sense to refer to someone who is a non-U.S. resident *and* a non-U.S. citizen. There are several intermediate cases between "foreigner" and citizen–resident, particularly the non-U.S. citizen who *is* a U.S. resident (like this author at the present moment!), citizen nonresidents (for example, expatriates), legal versus illegal residents (sometimes referred to as documented versus undocumented aliens) as well as various degrees of residency (visa versus permanent resident versus asylum seeker). A full ethical analysis would pick out each of these possibilities and run the analysis for each, but doing so would require a fuller theory of the importance of citizenship versus residency for benefits and burdens of home-country law and policy than I intend to tackle in this article.[4] Parts of the analysis I offer below suggests resident noncitizens, whether in the United States legally or illegally, should be treated quite differently for this analysis, but those implications (and resident noncitizens more generally) are not my main concern in this article. Instead, in this article I am interested in the relative priority for home-country organ allocation of two groups: "insiders" to the nation-state (residents and citizens) and "foreigners" (nonresident–noncitizens).

2. This is not to say that this other practice is unproblematic. In particular, there may be risks that the voluntary donor they bring with them is paid in violation of the law of the destination country. For an analysis of this kind of problem, see I. Glenn Cohen, *Transplant Tourism: The Ethics and Regulation of International Markets for Organs,* 41 J.L. MED. & ETHICS 269 (2013).

3. *See* Cohen, *supra* note 1.

4. I have made some tentative gestures towards such theories in the very different context of criminal law and circumvention medical tourism. *See* I. Glenn Cohen, *Circumvention Tourism*, 97 CORNELL L. REV. 1309 (2012).

II

ORGANS BEYOND BORDERS: AN INTRODUCTION TO TWO POLICY QUESTIONS

A. Should Non-Resident Non-Citizen of the U.S. Be Eligible for U.S. Organs?

Although not widely publicized, the U.S. organ distribution system allows non-U.S. citizens to be considered for receiving an organ procured in the United States from a U.S. organ donor. In a 2012 publication aimed at the general public, the United Network for Organ Sharing (UNOS) writes that

> [p]atients can travel from other countries to the U.S. to receive transplants. Once a transplant center lists them, non-resident aliens are considered based on the same factors as U.S. citizens. Non-resident aliens comprise roughly 0.8% of the U.S. waiting list. They also comprise 0.4% of deceased donors and 1.8% of living donors in the U.S.[5]

Writing for the Hastings Center in 2008, Arthur Caplan writes that "[t]hough American transplant centers can list foreigners, they can make up no more than 5% of any center's list. Most of non-U.S. citizens listed have substantial financial resources and pay in cash."[6] In fact, this slightly misstates the relevant guidance, which indicates only that a center for which foreigners comprise more than five percent of its list is subject to an audit.[7] In June 2012, noting confusion about the old five-percent rule, the Organ Procurement and Transplantation Network (OPTN), a part of the U.S. Department of Health and Human Services, and the UNOS moved to a newer policy that does away with the five-percent threshold but instead collects data on non-citizen/non-residents transplants and will report the numbers as part of its annual reporting.[8] The OPTN specified in its policies that

> [a]ny member transplant center that places a non-US citizen/non-US resident on its waiting list shall adhere to the following guidelines . . . Nondiscrimination in Organ Allocation. Deceased donor organ allocation to candidates for transplantation shall not differ on the basis of a candidate's citizenship or residency status in the US. Allocation shall not be influenced by favoritism or discrimination based on political influence, national origin, race, sex, religion, or financial status.[9]

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5. UNITED NETWORK FOR ORGAN SHARING, TALKING ABOUT TRANSPLANTATION: WHAT EVERY PATIENT NEEDS TO KNOW 8 (2012).

6. Arthur Caplan, *Organ Transplantation*, *in* FROM BIRTH TO DEATH AND BENCH TO CLINIC: THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICYMAKERS, AND CAMPAIGNS 129, 130 (Mary Crowley ed., 2008), *available at* http://www.thehastingscenter.org/uploadedFiles/Publications/Briefing_Book/organ%20transplantation%20chapter.pdf.

7. Alexandra K. Glazier, Gabriel M. Danovitch, Francis L. Delmonico, *Organ Transplantation for Non-Residents of the United States: A Policy for Transparency*, 14 AM. J. TRANSPLANTATION 1740, 1740–41 (2014).

8. *Id.*

9. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, *Old Policies*, 6-1, http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Policies_Old.pdf. This policy is relatively new, and collecting data on these groups as well as catching acts of discrimination is difficult, but at least, on paper, the OPTN is taking steps to adopt an anti-discrimination approach. One subtle distinction in the way this is worded is worth emphasizing. This policy pertains to nondiscrimination by the OPTN, not a listing center. A center deciding whom to list can discriminate against foreigners in its

Should the United States allow nonresident, non-U.S. citizens (from now on I will use the simpler term "foreigners")[10] to be eligible to be put on waiting lists for U.S. organs at all? Even if so, is the OPTN justified in mandating that transplant centers taking foreigners and allowing them on waiting lists not discriminate against foreigners in the allocation phase by granting them less priority because of their citizenship or residency?[11] The term "discriminate," as used in this context, after all, connotes that it would be wrongful to take into account nationality, which is the very question in which I am interested.

B. Should Organ Distribution Systems Extend Beyond the Borders of the Nation-State?

Because there are significant differences between the organ-procurement systems of different countries, there are numerous opportunities for collaboration of various forms. In this article, I want to examine one particular question regarding potential collaboration: Should distribution systems be (at least partially) globalized such that they extend beyond the borders of the nation-state? As Watkins observes, different systems have come to quite different conclusions on the matter:

> Organ trading systems differ substantially throughout the world regarding centralization (working together with other countries in a regulated organ exchange effort). Some reasons for these variations include the following factors: (1) scope (such as regional, national, or supranational); (2) number of people served; (3) type of management (such as by professionals, health administrators, or a mixture of both); (4) structure (such as non-profit foundations, state agencies, or private agencies); (5) a centralized or decentralized organization; (6) responsibilities and objectives (such as organ sharing, exchange, and procurement); and (7) activities (such as organs, tissues, bone marrow, or some combination). Centralization is a key issue in a country's optimal goals for organ procurement. Eurotransplant, a highly centralized organization, consists of Austria, Belgium, Germany, Luxemburg, Slovenia, and the Netherlands. This international collaborative foundation oversees more than 118 million inhabitants. More than 75 transplant hospitals are participating, and the joint international wait list is approximately 15,000 patients. Eurotransplant's goal is to optimize the use of available organs by combining the countries' efforts. Spain, on the other hand, features a decentralized system that procures and transplants most organs locally.[12]

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listing practices, but the OPTN has never had policies directly on listing practices, in part because of concerns about intruding on the practice of medicine and the proper scope of federal regulation.

10. The OPTN policies split the world into U.S. citizens who are U.S. residents and non-U.S. citizens who are non-U.S. residents. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, *Policies*, http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Policies.pdf. Again, let me emphasize that in this article I follow suit using the term "foreigner" to refer to a non-U.S. resident, non-U.S. citizen.

11. What do other countries do? Marie-Chantal Fortin and Bryn Williams-Jones claim that Canada has no policy on this issue, that in the United Kingdom a foreigner can only receive a transplant if there is no U.K. citizen available, and that France empowers the medical team to decide whether to list a foreigner with a few mandatory conductions. Marie-Chantal Fortin & Bryn Williams-Jones, *Should We Perform Kidney Transplants on Foreign Nationals?,* 39 J. MED. ETHICS 703 (2013), *available at* http://jme.bmj.com.

12. Christy M. Watkins, *A Deadly Dilemma: The Failure of Nations' Organ Procurement Systems and Potential Reform Alternatives*, 5 CHI.-KENT J. INT'L & COMP. L. 1, 16 (2005).

According to Nora Machado, as part of the Eurotransplant system (at least at the time of her writing in 1998), a transplantation center in any of the countries covered by the system could propose a transplantable patient to the system with allocation based on a point system relating to blood type, HLA data, mismatch probability, distance and time to transport organ to patient, effective waiting time, and national import–export balance.[13] This last criterion is the most significant for this discussion, and it is calculated as the "net exchange between [the country requesting the transplant] and all other countries," with "export" being a net negative exchange wherein "the number of kidney transplants performed in a country is less than the number of kidneys procured," and "import" being the opposite situation.[14] "[N]o points are assigned" in cases where "the candidate has his/her residence outside the Eurotransplant area."[15]

Similarly, the Nordic countries have also engaged in significant efforts to share organs and waiting lists. In 1969, they founded Scandiatransplant "to pool Nordic resources and to find matches for rare tissue types."[16] Before Cyclosporine became widely available in 1982 and tissue-type matching became less important, more than fifty percent of all kidneys available for transplant were shipped to another Nordic country for use rather than used in the Nordic country where the organ was recovered.[17] In more recent years, that number has dropped and Nordic countries ship only five percent of organs procured at home to another Nordic country in a given year, and usually only in cases in which a recipient in another Nordic country is a perfect tissue match. Annually, ten percent of all organs in the system are shipped internationally.[18] Apparently, at least as of 1998, Scandiatransplant has "reciprocity rules," wherein "a kidney received by one centre from another must be paid back within a 6 month period with a kidney of the same type."[19]

Should the United States (or other home countries) copy the Eurotransplant or Scandiatransplant model and participate in more centralized waiting lists and distribution systems that share organs with other nations?

To be sure, apart from the overall normative evaluation, there are important facts that shape the normative assessment of a truly globalized organ-sharing system and that act as limitations on how far sharing can go. Medical considerations, for example, present significant concerns when sharing organs. Although "the length of time that an organ can survive outside a body without compromising transplant success is ultimately determined on a case-by-case

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13. NORA MACHADO, USING THE BODIES OF THE DEAD: LEGAL, ETHICAL AND ORGANISATIONAL DIMENSIONS OF ORGAN TRANSPLANTATION 67 (1998).

14. *Id*. at 72 n.90.

15. *Id*.

16. Salla Lötjönen & Nils H. Persson, *Kidney Donations: Lessons from the Nordic Countries*, *in* ORGAN SHORTAGE: ETHICS, LAW AND PRAGMATISM 171, 171 (Anne-Maree Farrell et al. eds., 2011).

17. *Id*.

18. *Id*. at 172.

19. MACHADO, *supra* note 13, at 70.

basis by the transplant surgeon or team at hand," because it "takes more time to travel greater distances, an organ's medically acceptable ischemic time limits how geographically far from the donor an organ can be transported without sacrificing organ and patient outcome."[20] The geographical spans involved in existing systems like Eurotransplant and Scandiatransplant are much smaller than even the continental United States, let alone the United States and some of its potential trading partners. There are also administrative costs and difficulties involved with expanding the geographic scope of waiting lists.[21] Finally, one might worry that increased organ sharing across borders increases the prevalence of organ trafficking or other undesirable practices.[22]

Moreover, some of the "crowding out" concerns that I discuss in the companion article that I wrote for this issue—the notion that applying some rules to the organ-allocation system, such as permitting individuals to sell their organs, will reduce the overall supply or supply of quality organs, or will otherwise alter supply in a morally problematic way—are relevant in this context, too.[23] This presents at least the theoretical possibility that if we join a multinational organ-sharing network, some Americans may be less likely to donate an organ if they believe that a foreigner is more likely to be the ultimate recipient. It is also possible that donation professionals may be less apt to press families into donation of the organ of their kin if they believe the organs may be available for foreigners. Without empirical data, however, these are just "possibilities," and we have no reason to believe they will or will not occur. In part III, I discuss a parallel set of issues in greater depth, including some available (though imperfect) evidence relating to the crowding out that might be associated with the inclusion of foreigners on the waiting list for U.S. organs.

These technological, administrative, and motivational issues are all serious obstacles, but are not the principal questions that interest me in this article, in which I instead focus more directly on the normative questions. Thus, let me simplify the road to the primary normative question by bracketing some of those issues through stipulation. For now, imagine that there is no motivational crowding out such that the number of organs available for allocation is static whether or not we include foreigners as potential recipients. Further, imagine that technology or administration or cooperation were to develop to such a degree that there would be no administrative or medical costs in expanding waiting lists for organs to large geographies beyond the nation-state. In this

20. Eric F. Galen, *Organ Transplantation at the Millennium: Regulatory Framework, Allocation Prerogatives, and Political Interests*, 9 S. CAL. INTERDISC. L.J. 335, 359 (1999).

21. *See* Douglas J. Norman, *The Kidney Transplant Wait-List: Allocation of Patients to a Limited Supply of Organs*, 18 SEMINARS IN DIALYSIS 456, 458 (2005) (noting "[d]ual listing [at multiple transplant centers] requires resources to travel and pay for lodging in a distant city. Not all centers are willing to dual list patients who come from geographically distant cities because of the added expense to examine and maintain these patients on their list. Maintaining patients on a local list is becoming more difficult and drains financial and nurse coordinator resources.").

22. For a discussion of organ trafficking, transplant tourism, and potential regulatory responses, see generally Cohen, *supra* note 2.

23. Cohen, *supra* note 1.

context, would it be normatively desirable to do so? That is the question I attempt to answer.[24]

III
SHOULD WE INCLUDE FOREIGNERS ON U.S. WAITING LISTS FOR ORGANS? A NORMATIVE ANALYSIS

Although the two policy questions that are my focus are quite different, my answers to both depend on a common set of normative issues relating to whether nation-states are the proper boundaries for organ-distribution policies. Or, to put matters slightly differently, both policy questions force us to decide whether a nation is justified in giving (or obligated to give) its citizen–residents priority in access to organs procured in the nation-state. Though I start with the question of including foreigners on U.S. waiting lists, that analysis is also a good springboard for the second, related policy question.

To state the conclusion I reach up front, I argue for a revision of the current U.S. policy promulgated by the OPTN: as long as the United States is not part of a multinational organ-allocation system, the current state of affairs, there should be no obligation to list foreigners on U.S. waiting lists for organs procured in the United States by U.S. organ donors, except in cases where those organs would otherwise truly go to waste. Indeed, not only do I think there is no obligation to list foreigners, I think several good moral reasons may exist not to list them, though my conclusion on this latter point is more tentative. Now let me explain my analysis leading to that end point.

A. Distinguishing a Few Cases

In spite of the volume of work on the ethics of organ allocation, the question of including foreigners has received surprisingly little discussion. One of the few significant discussions in the literature pertains to ethics of localization versus nationalization *within* a nation-state's organ-distribution system, and even here not much is written from the bioethics perspective. In her 1998 book on comparative organ-allocation systems, Machado notes that in the Spanish system some

> advocates [of] a dencentralised system argu[e] that organ priority should be given to the area procuring organs. This makes for "geographical fairness" in organ sharing, in the sense that the local transplant center serves the interests of its community, ensuring legitimacy and effective commitment of members of the community to continue donating organs that are transplanted to their neighbours. This is for them an obvious moral imperative.
>
> However, it's generally recognised that there is a need to also share organs across the borders of communities and regions, not only to avoid wastage (organs unused

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24. Although conceptually I think it is helpful to bracket these other issues in this way to get to the normative heart of the matter, in practice one need not do so: transport time, and its implicated effects on organ quality and transaction costs when organ sharing crosses borders, can be factored into the rationing system much as transport time is currently factored into allocation decisions within the nation-state.

> because of lack of a suitable recipient) but to assure the most suitable match of organ procured and recipient is the objective (the larger the pools of procured organs and potential recipients, the greater the likelihood of a good match). But also to avoid privileges and a sense of unfairness.[25]

Machado also notes that, in the U.S. context, one argument in favor of localization as against national centralization has been "the importance of 'local altruism' and the evidence from the USA of the inverse relationship between the size of [Organ Procurement Organizations] and the donation rates achieved."[26] Beyond that, little is written on this issue.

I think the right approach to thinking about this problem is to distinguish a few (admittedly stylized) cases.

In the first case, which I call "domestic true waste," imagine that a U.S. procurement organization recovers a kidney from a U.S. citizen-resident for whom no other U.S. citizen-resident is a suitable match, such that if the organ is not made available for use by a foreign recipient, it will be discarded. One way such a situation may arise is when the organ does not meet the quality requirements of the donor's home country but does meet the standards of another country that are lower (or at least different).

Contrast this with a case I call "foreigner better match," whereby the home country's *own* diagnostic and allocative criteria (involving waiting-list time, tissue match, etc.) designates a foreigner as a superior candidate if we entirely ignore citizenship or residency status.

The third case is "foreigner equally good match," whereby the home country's own diagnostic and allocative criteria would designate the foreign recipient as an equally good match for the organ as a U.S. citizen–resident. To be sure, the idea of an "equally good" match is more useful as a stylized thought experiment than as a description of reality. Rarely, if ever, are two candidates for transplant, one domestic and one foreign, truly equal matches. At most, in some cases there is a zone of uncertainty around which of two candidates is a better match wherein reasonable people might disagree. In any event, in what follows I use the idea of an "equally good" match as a simplifying theoretical case that helps us clarify our normative judgments; I do not mean to claim it as more than that.

We can also imagine a fourth case, "foreigner worse match," where the foreign potential recipient is a *worse* match than the U.S. citizen–resident. But I put that case to the side, since I do not think anyone plausibly supports favoring the foreigner in such a case.

B. The Easier Case

Of the three other cases, I think domestic true waste is fairly straightforward and can be dispensed with fairly quickly. If there is an organ that becomes available that no U.S. citizen-residentcan use, but can be used by a foreign

25. MACHADO, *supra* note 13, at 69.
26. *Id*. at 76–77.

recipient, what justifies failing to make it available?[27] Why not improve the lives of those abroad by sharing an organ of which our home-country citizens can make no use?

One possible reason why is that the amount of organs donated domestically in the United States will change based on whether foreigners are given access to those organs. This is again a kind of "crowding out" argument of the type that is discussed in my other article in this symposium.[28] Machado suggests such an effect might stem from the psychological phenomenon of "local altruism,"[29] and Volk presents some evidence that Americans (at least) are less likely to donate an organ if they know that foreigners might receive their organs.[30] It is interesting that there currently appears to be some "acoustic separation,"[31] such that most Americans remain unaware that foreigners may be eligible for organs that Americans donate (indeed I was myself unaware until I started researching this article!). Perhaps this unawareness can be maintained to dampen potential crowding out concerns—which raise their own set of ethical issues—or perhaps we can use public education or "libertarian paternalist" forms of choice architecture to avoid crowding out, even if the practice of foreign recipients becomes well-publicized.[32] It is also at least theoretically possible that introducing foreigners into the potential allocative pool—a kind of "We Are the World" moment—can actually increase the supply of donated organs domestically.

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27. For present purposes, I gloss over the distinction between a variant of this case, where the transplant occurs in the United States, and a variant where the organ is shipped abroad for transplant. The latter looks more like the organ-sharing networks discussed later in this article. One key difference pertains to the amount of U.S. resources directed towards the transplant in each case.

28. Cohen, *supra* note 1.

29. MACHADO, *supra* note 13, at 76–77. Here, I am discussing general crowding out of supply. If the effect were specific to certain kinds of organs or donors, we would face additional complications in terms of distributive justice if the negative effects were borne by particular sub-populations (such as African Americans or other racial groups).

30. From December 2008 to January 2009, Volk and others recruited 1049 American participants greater than eighteen years of age and asked them whether "people should be allowed to travel to the United States to receive a transplant, and whether this practice would discourage the respondents from becoming an organ donor." M. L. Volk et al., *Foreigners Traveling to the U.S. for Transplantation May Adversely Affect Organ Donation: A National Survey*, 10 AM. J. TRANSPLANTATION 1468, 1468 (2010). They reported that "30% (95% CI 25–34%) felt that people should not be allowed to travel to the United States to receive a deceased donor transplant, whereas 28% felt this would be acceptable in some cases" and "thirty-eight percent (95% CI 33–42%) indicated that this practice might prevent them from becoming an organ donor." *Id*. The authors' analysis of this data was that "deceased-donor transplantation of foreigners is opposed by many Americans" and that "[m]edia coverage of this practice has the potential to adversely affect organ donation." *Id*. Of course, it is very hard to move from the results of this survey data to predicting actual behavior given a rule change that is publicized, but this is the one data point I know of on the subject, however limited.

31. *See* Meir Dan-Cohen, *Decision Rules and Conduct Rules: On Acoustic Separation in Criminal Law*, 97 HARV. L. REV. 625, 630 (1984) (describing a model of acoustic separation whereby the law sets "conduct rules" for the general public and "decision rules" for public officials).

32. *See, e.g.*, Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1159 (2003) (describing libertarian paternalism interventions capable of "steer[ing] people's choices in welfare-promoting directions without eliminating freedom of choice").

Although some suggestive data points to the possibility of crowding out organ supply when foreigners are included, I do not think we know enough yet about the likelihood of the effect, the effect size, and whether other measures can counteract the crowding-out effect to rest an argument for the exclusion of foreigners from U.S. transplant waiting lists on this possibility.[33] Moreover, even if the total supply of organs decreases due to crowding out by the inclusion of foreigners, whether that is morally problematic cannot be ascertained without first assessing whether we have obligations of justice to include foreigners in the first place, an issue this article addresses. If we do not, then crowding out concerns only buttress the exclusion of foreigners. If such obligations do exist, we then have to reach considered judgments about how to trade off reductions in the number of available organs against the avoidance of injustice in the allocation system.[34]

With this in mind, in the analysis that follows I assume that the *supply* of organs available for transplant from U.S. donors (or, if nonmarket elements are introduced, "providers") remains constant regardless of the policy adopted as to organ sharing with foreigners. If evidence suggests this assumption is untrue, then a full analysis would further need to factor in potential diminutions (or increases) in organ supply.

There is a second way in which the seemingly simple case of domestic true waste is possibly harder than it first appears. To say that no home-country citizen can use an organ is not to say that the organ sharing is *costless* to the home country; there are costs involved in procuring the organ, transporting it, and, if the transplant is performed in the United States, in transplanting it as well. If such costs are significant and *not* covered by the home country of the foreigner (or the foreigner him or herself, or his or her insurer), then perhaps there is an argument that the sharing is problematic if it means that the costs involved are borne by U.S. taxpayers. In many ways that case would more resemble ones where the foreigner is a better match but there is no true waste, which I discuss next.

In fact, I am told informally by transplant professionals that most hospitals that allow foreign patients on their waiting lists are incentivized to do so partially because the foreigners are "full pay" and therefore actually reimburse at a higher rate than do most domestic patients. This fact may help explain the reason why hospitals wait list foreign patients, but it also raises new concerns. Although the home-country hospital and surgeons may get fully paid (and then some compared to what they get from many domestic patients!), that does not mean the *system* gets fully compensated. There are costs borne by the system

33. For one thing, it is possible that Volk's respondents are reacting to concerns about transplant tourism, of the kind discussed in Cohen, *supra* note 2, rather than to the inclusion of foreigners in U.S. allocation systems.

34. Another way of thinking about this issue from a normative or political-theoretical perspective is as between an analysis in the context of ideal and nonideal justice. *See* JOHN RAWLS, A THEORY OF JUSTICE § 39, at 244–46 (1971).

for procuring and allocating the organ that the payment to the hospital does not cover—for example, the infrastructure costs involved in setting up a transplant program and managing waiting lists. If there are costs involved, however, these costs are of a scale similar to what the law already requires the health care system to spend on foreigners: for individuals who are lawfully in the United States (and indeed, albeit more controversially, for those who are here illegally), the Emergency Medical Treatment and Active Labor Act (EMTALA) requires that U.S. hospitals provide emergency services regardless of patients' insurance status or ability to pay.[35] Thus, the costs borne by the system (or, in the rare case, the hospital) for foreign patients getting U.S. transplants seem not to diverge too much from the current accepted practice of providing care under EMTALA to foreigners in need of emergency treatment. Finally, it is worth emphasizing that many of these costs are "lumpy." We cannot reduce them by excluding foreigners from our waiting lists; they are the cost of having the system we have in place and have fewer variable costs associated with adding foreigners as potential recipients. They are also "untimely": many of the costs accrue before we know whether the organ in question goes to a foreigner rather than a domestic person because no domestic match exists. This unpredictable nature of the costs is another reason not to allow these costs to alter our willingness to grant foreigners access to organs in the true domestic waste case.

In sum, even in the seemingly easy case of true domestic waste there are some reasons not to list foreign patients on U.S. waiting lists for organs procured in the United States and not to allow them to receive an organ when there is no U.S. citizen-resident who can use the organ. Given the existing state of our knowledge on things like crowding out, my own sense is that these reasons do not themselves outweigh the strong rationale we have for allowing wait-listing in this instance: the ability to save someone's life, albeit someone from another nation, without denying any of our citizens an organ they can use.

C. The Harder Cases: When the Foreigner is an Equally Good or Better Match or "Judging the Indifference Principle"

Instances of domestic true waste, however, will be very few and far between. The more common and more difficult question is what to do in the other two cases where the foreigner is a *better or equally good* match. Let me emphasize

35. EMTALA requires such facilities to "screen[]" any patient that presents herself to determine "whether or not an emergency medical condition (within the meaning of the statute) exists," and if it does, then the hospital must either stabilize (give "treatment as may be required to stabilize the medical condition") or transfer the patient to another facility, which can be done only if the patient requests the transfer in writing after being informed or if a health care provider certifies that "the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual." 42 U.S.C. § 1395dd(a)–(d) (2006); *see, e.g.*, Burditt v. U.S. Dep't. of Health & Human Servs., 934 F.2d 1362, 1368–73 (5th Cir. 1991) (holding EMTALA requires emergency departments to "provide for an *appropriate* medical screening examination *within the capability of the hospital's emergency department*" and finding transfers appropriate if the patient has been stabilized and the medical risks of the transfer have been weighed).

again that by "better" and "equally good" here I mean by whatever system of allocation the home country has settled on domestically, which might involve "best outcomes," "age weighting," and many other systems of prioritization.[36] In such a case, giving the organ to the foreigner means denying it to a home-country citizen and setting back his or her interest. Is the home country justified or even mandated to do so in either case?

Let us begin with the instance of an equally good match. Here, the question becomes can we use citizenship or residency status as a tiebreaker in our organ-allocation systems? To operationalize, we can potentially allow foreigners to be listed on our U.S. waiting lists, but can also specify that, in determining who gets priority for transplantation, U.S. citizen–residents will get a tiebreaking point in cases of true ties. Recall from our earlier discussion of the OPTN policy that, for U.S. transplant centers that *do* accept foreign patients (it appears to be optional), the rule is that "the allocation to candidates for transplantation shall not differ on the basis of a candidate's citizenship or residency status in the US. Allocation shall not be influenced by favoritism or discrimination based on political influence, national origin, race, sex, religion, or financial status."[37] Giving a tiebreaker to U.S. citizens or residents thus requires an alteration to the OPTN's stated policy. It may also require alterations to the U.S. National Organ Transplant Act (NOTA). A tiebreaker is only the de minimis form of intervention; one could give weighted priority to the citizen or otherwise favor them.

Let us put aside the questions of crowding out and costs raised above and discuss what is *new* about this case. Unlike the easy case of true domestic waste, the debate about whether to favor our own citizen–residents over foreigners in organ allocation when the other priority indicia are exactly equal requires us to decide on the validity of a particular kind of principle. The argument against favoring our own citizens–residents is essentially a claim that we should be indifferent as between the welfare of our own citizen–residents and foreigners in terms of organ allocation; that is, a successful organ transplant to a foreign patient is just as good an outcome for our system as a transplant to a U.S. citizen–resident. Call this the "indifference principle."

Whether to give the organ to the foreigner in the case of an equally good match, then, turns on whether, as a normative matter, we should support or reject the indifference principle. I have already tipped my hand that I think the indifference principle is problematic, but it requires a fair amount of analysis—in particular unpacking why some tempting argumentative directions turn out to be wrong turns—to explain why.

1. Reciprocity of Donors and Recipients

One argument against the indifference principle that clearly applies to the

36. *See, e.g.*, I. Glenn Cohen, *Rationing Legal Services*, 5 J. LEGAL ANALYSIS 221, 244–84 (2013) (describing six families of rationing principles).

37. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, *supra* note 9.

policy of adding foreigners to waiting lists relates to reciprocity between donors and recipients.[38] If a foreigner is added to a waiting list for an organ procured from a U.S. patient, U.S. citizens are not necessarily able to be listed as eligible organ-recipients by (and given the same priority as someone from) the foreign patient's country of origin. This means that U.S. patients may end up donating organs to a common pool to which both U.S. and foreign patients have a claim, but the same is not true for the foreign patient. Why should U.S. citizens diminish their own priority by adding foreign patients to the organ-transplant pool when foreigners' home countries are unwilling to reciprocate with U.S. citizens?[39] Is that not a strong reason to reject the indifference principle?

I think it is not. First, the argument only applies if we resolve our second policy question (whether organ-sharing networks should cross borders and be larger than the nation-state) in a certain way. As I discuss below, the Eurotransplant and Scandiatransplant systems have reciprocity rules weighting the net import–export of the various players, and theoretically we can do the same if the United States becomes part of a larger organ-sharing partnership. Another way of doing this is to allow foreign patients to list themselves on U.S. waiting lists only if their home countries offer the same privilege to U.S. patients. That is a kind of quid pro quo requirement short of establishing an organ-sharing network, and it results in different distributions of organs depending on how many patients from each country avail themselves of this option.[40]

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38. *See* Volk, *supra* note 30, at 1468 ("[O]thers argue that because foreigners are not members of the community that donates the organs, it is not fair for them to be recipients.").

39. There is an additional complication in that Americans may end up receiving foreign organs outside the foreign allocation system, for example on the black market through transplant tourism. *See generally* Cohen, *supra* note 2. Whether that kind of access should "count" in this analysis is unclear to me, and depends (among other things) on knowing whether the home country of a patient seeking a transplant facilitates (or potentially at least does nothing to stop) this kind of transplant tourism.

40. One might wonder why transplant centers are willing to list foreign patients on their waiting lists in the first place. I have not seen a definitive explanation for hospitals' motivation for putting foreigners on transplant waiting lists in the literature, or even a discussion of how widespread this practice is, but Arthur Caplan suggests that "[m]ost of [the] non-U.S. citizens listed have substantial financial resources and pay in cash." CAPLAN, *supra* note 6, at 130. At one time this was clearly the case. *See* ARTHUR CAPLAN, MORTAL MATTERS: ETHICAL ISSUES IN MEDICINE AND THE LIFE SCIENCES 142 (1995) ("In the early '80s it was not uncommon for wealthy foreigners to pay big bucks to push their way to the head of the line for a transplant. This trade got so out of hand that Congress insisted a national system be created to ensure that Americans got first crack at the organs that became available and that organs be distributed in an equitable manner.").

No one has good data on how true this is of the current state of the world, but transplant professionals I know, when asked, tell me the main incentive for a center to list a foreign patient is that the foreign patient is "full pay" and thus the reimbursement to the hospital is more generous than that of a typical domestic patient on public or private health insurance. Some transplant centers may also have a second financial incentive to list foreign patients because it means a higher probability of future charitable donations to the center.

Now it is possible that *favoring* foreign patients, or at least indifference to their being foreign, is better for the *transplant center* and potentially some of *that transplant center or hospital's other patients*, but the distributional consequences are complex. Some patients may be net losers because they now have reduced priority for organ transplants, whereas other patients may be net gainers because their

A second, and I think deeper, objection is that this argument against the indifference principle misrepresents the existence of reciprocity. As I discuss in greater depth in my companion article in this issue, the United States (unlike Israel and Singapore) does not have a system wherein those who *agree* to donate organs get increased priority for receiving organs.[41] This means that there is already a deep failure of reciprocity in the system: some recipients "take out" organs, or at least have the potential for doing so, but do not "pay in" by agreeing to either live or cadaverous donations. If we are willing to tolerate the failure to participate in reciprocity *between citizens within a nation-state*, why should we not tolerate it when the individuals happen to be part of *different nation-states*?

In other words, invoking the reciprocity norm suggests that when citizens and residents of Canada, for example, list themselves on the U.S. waiting list, but U.S. citizens are not able to list themselves on the Canadian allocation system, there is a failure of reciprocity between the United States and Canada. But this conclusion assumes that the right framework for analysis is at the level of the nation-state rather than at the individual level, for at this latter level of analysis the problem cannot be distinguished from that in the more typical case of lack of reciprocity between donors and recipients *within* the nation-state.

That is, if reciprocity is what matters, there are at least two possible ways to think about bisecting the world: (1) it consists of those who agree to donate (and thus deserve reciprocity-oriented priority) and those who do not agree to donate, independent of their countries of citizenship or residency; or (2) it consists of citizen–residents of the country where the organ is procured and foreigners, and the former deserve priority independent of whether members of either group themselves agree to donate. The first bisection is a much more plausible account of a reciprocity-based system of obligation and entitlement than the latter, but only in the latter does citizenship or residency matter in a way that counts against the indifference principle. Accordingly, the reciprocity argument against the indifference principle fails.

One might try to refute this point by saying that we *should* implement a system to give organ donors priority. Of course, as I discuss in my companion

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priority remains unchanged (no foreigner listed needs a particular type of organ, or they do not need an organ transplant at all) and they continue to benefit from the hospital or center receiving additional resources. What seems more problematic, for those who oppose markets in organs, is that an element of willingness-to-pay allocation has now essentially been reintroduced as the method of distribution without transparency into an allocation system that is depicted as nonmarket. *See* Cohen, *supra* note 1. Moreover, particular transplant centers that are willing and able to list foreigners end up making a private gain (for their center or hospital) while imposing an externalized cost (in the form of more competing potential recipients for the existing pool of organs) on others.

Again, I have no hard evidence that any center currently lists foreign patients for this reason, and some of the wording of the new OPTN rules seems to suggest doing so is problematic. If in fact private gain *is* the motivation for the listing, however, the ethical problem with the practice may run deeper still. For this reason, I put this *additional* concern with listing foreign patients largely to one side and argue that the practice is problematic even if this additional, fairly weighty reason does not apply.

41. Cohen, *supra* note 1.

article in this issue, actually enforcing such a system (especially with specific performance) would be quite difficult.[42] In such a system, however, giving otherwise equally deserving foreigners less priority for transplants would follow not from the fact that they are foreign, but from a more general policy of giving less priority to individuals who do not "pay in" to the system, and nothing would follow from the fact that the foreigner is not a U.S. citizen–resident. On this argument, foreigners should receive no more and no less priority than others who fail to "pay in" through reciprocity. Being a foreigner would become largely orthogonal to one's entitlement to be put on a waiting list, with the requisite level of priority instead dictated by the home country's allocation system.[43]

For these reasons, reciprocity—at least as we thus far conceive it[44]—does not seem to be a strong argument for rejecting the indifference principle.

2. Common Ownership of "Our" Organs

Is there a stronger argument that justifies rejecting the indifference principle? A different argument against the indifference principle might reconceptualize organs available for donation as a kind of national resource that "belongs" to the fellow citizen–residents of those donors' home country but not to foreigners. No country currently allows foreigners to claim a share of its domestic oil deposit or hydroelectric energy stores, and certainly not a share equal to the claim of its own citizen-residents.[45] Why should organs be any

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42. *See* Cohen, *supra* note 1.

43. One complication would involve whether foreigners can or cannot "pay in" by themselves, agreeing to become donors in the U.S. system, and the worry that it is unjust to exclude them from doing so if paying in is a precondition to being eligible for priority. In the OPTN system, true foreigners (non-U.S. resident, non-U.S. citizens) can and do donate—a recent study of the first twenty-two months where data was available (March 2012 to December 2013) suggests that "47 or 0.3% of deceased donors in the United States were categorized as non-U[.]S[.] citizens/non-U[.]S[.] residents although there are concerns of under-reporting in this category as neither residency [n]or citizenship is consistently collected as a routine part of the donation process." Glazier, *supra* note 7, at 1743. There are, however, several complications. Here are two: first, although all such priority systems suffer from credible commitment problems and default, *see, e.g.*, Cohen, *supra* note 1, the situation would be even worse for foreign donors who do not face even social opprobrium for their families if they were to default. Second, if foreign donors themselves come from countries where they may earn priority for receiving organs for themselves or a loved one by agreeing to be a donor, they may want to agree to donate in more than one country and the system would have to determine which country gets to claim their organs upon death.

44. I suggest a variant related to reciprocal *investment or contribution* below.

45. Of course, we do often *sell* these resources to other countries. The current prohibition of a market in organs, discussed throughout the articles in this issue, prohibits selling organs to potential recipients *within* the home country. Ironically, though, because the U.S. National Organ Transplant Act (NOTA) does not (as currently written and based on the interpretative methodology endorsed by the U.S. Supreme Court) have extraterritorial prescriptive jurisdiction, it *is* legal (under *U.S.* law) to sell one's kidney abroad or indeed to buy one (though the law of the country where the organ donor comes from or where the transplantation takes place may still render the system illegal). *See* Cohen, *supra* note 2, at 282 (discussing NOTA's failure to criminalize transplant tourism and suggesting its prohibition should be made extraterritorial); Cohen, *supra* note 4, at 1338 (discussing the Supreme Court's approach to determining the extraterritoriality reach of an ambiguous statute).

There are some theorists on global justice, especially as it relates to poverty, who put pressure

different?

This argument, I believe, fails because it demands too strong an analogy between organs and natural resources. Government-owned waterfalls that generate hydroelectricity are a collective good, whereas we do not ordinarily think that others have claims of ownership to their fellow citizens' organs, especially given that organ provision is optional.[46] Moreover, one can take her organs with her if she chooses to move abroad or become a citizen of another country without paying a sort of "exit tax," and indeed it may be possible for a U.S. citizen–resident, as a matter of law, to direct that her organs be made available to a particular foreigner, such as a foreign blood relative. This seems to count against the idea of one's organs "belonging" to one's nation-state. In this way, it seems much more plausible to conceive of organs as a kind of thing "owned" (even if not currently sellable, and with other restrictions on use)[47] by individual Americans *as individuals* rather than resources owned by that individual's *home country*.

Thus, an argument against the indifference principle premised on either

on the question of whether we deserve the wealth that comes from the (they would say arbitrary) fact that one is born into a country with such resources. For example, Charles Beitz stresses that Rawlsian distributive justice principles should be extended globally to the international sphere because of "(1) the desire to avoid moral arbitrariness in the distribution of primary goods—that is, 'we should not view national boundaries as having fundamental moral significance'—and (2) that a limitation of Rawlsian redistribution to the domestic sphere is only justifiable on an account of nations as self-sufficient cooperative schemes, a position he views as untenable in today's world of international interdependence, where those regulating trade (World Trade Organization) and capital (International Monetary Fund and World Bank) 'impose[ ] burdens on poor and economically weak countries that they cannot practically avoid.'" *See* I. Glenn Cohen, *Medical Tourism, Access to Health Care, and Global Justice*, 52 VA. J. INT'L L. 1, 20 (2011) [hereinafter *Medical Tourism*] (quoting CHARLES R. BEITZ, POLITICAL THEORY AND INTERNATIONAL RELATIONS 151 (1979) and Charles R. Beitz, *Justice and International Relations*, 4 PHIL. & PUB. AFF. 360, 374 (1975)). Whether such strong cosmopolitan views are right or wrong is not something I try to fully resolve here, though I discuss it in more depth in other work, *see generally id.*, and I offer a few observations on the subject below. Here, I want to make the simpler point that *if* organs are thought of to be like natural resources, then the argument for organ sharing based on that analogy also suggests foreign entitlement to our national resources itself. Whether that makes perfect sense or constitutes a reductio ad absurdum depends on one's views of global justice, but to argue for organ sharing on this analogy requires a much more extreme departure from current practices.

46. *But see* CÉCILE FABRE, WHOSE BODY IS IT ANYWAY 96, 72–123 (2006) (concluding that under some conditions "the sick have a right to the organs of the dead if they need them in order to lead" a minimally decent life, and that confiscation of not only cadaverous organs, but in some cases even the organs of live individuals, may be justified). Fabre's controversial analysis, though, suggests that organs should be subject to cadaverous conscription, but does not suggest organs belong to the deceased's home country. Her arguments about conscription are thus just as compatible with making organs derived in this way available to foreigners by enabling them to be wait listed in the home country where the organ is procured, so they do not appear to answer the questions I struggle with in this article one way or another.

47. The appropriate metaphor here is the ubiquitous one from property that analogizes a compilation of various rights to a bundle of sticks, wherein the individual retains the right to donate—indeed, in the United States, in some cases, to make a directed donation—but not the right to sell the organ. There are also other sticks in the bundle that are limited; for example, limiting the right to use a gifted organ for something other than transplant, therapy, education, or research. *See* REVISED UNIF. ANATOMICAL GIFT ACT § 4 (amended 2009).

common ownership of one's organs by one's fellow home-country citizens or by the home country itself fails. In a moment, I consider a different argument against the indifference principle premised on investment. Before I do so, however, let me briefly divert the discussion to the question of whether it matters where the foreign patient seeking an organ comes from.

3. Does the Home Country of the Foreign Patient Matter? Global Justice and Organs as Compensation

In my prior example of a Canadian citizen-resident seeking an organ from the U.S. allocation system the two countries are relative equals in terms of how well-off they are. When I first started writing this article I had only that instance in mind, and it remains the focus of this work. Suppose, however, that the foreign patient is from a much less well-off country, such as Malawi. Does the analysis change?[48] My answer is: it depends. One argument for treating this example differently is that access to U.S. organs is a kind of "compensation" for the Malawian. Such a view may justify not only the indifference principle, but also the notion of giving foreigners *more* priority for U.S. organs. This argument would not justify a *general* policy of allowing foreigners such access, but instead suggest a country-by-country analysis wherein we determine if the United States owes that particular country compensation or not, and based on that decision, grant the foreigner appropriate priority.

Is that plausible? In practice it seems unlikely to occur, but it is worth inquiring into whether it is persuasive even as an ethical goal. To be clear, in the instance of equal or near-equal partners, the situation is as I lay it out above, whether the pair be near equally well-off or near equally poorly off. Such an instance is my focus in this article. Here, however, I want to more briefly and tentatively examine whether the analysis should change for instances where there is a significant mismatch between the two countries. Although I do not resolve this question, I aim to show that, in order to claim that the identity of the two countries under consideration should matter in this way, one needs to take a specific position on four fairly contentious and complex philosophical debates.

The first debate is over whether there are "separate spheres" for the allocation of benefits, or, otherwise put, the fungibility of the currency for redistribution.[49] On one extreme is the view that treats organs as a self-contained set of goods for which international exchanges should be made. The other extreme, which raises some of the commodification concerns discussed in

48. I am indebted to Nir Eyal for pressing me on this question. A very different set of concerns with this example deals with how various potential policies in this domain inflect the incentives of developing countries to build self-sustainable donation and transplant systems. I bracket that question here.

49. *See, e.g.*, Dan W. Brock, *Separate Spheres and Indirect Benefits*, 1 COST EFFECTIVENESS & RES. ALLOCATION 4 (2003), *available at* http://www.resource-allocation.com/content/1/1/4; Cohen, *supra* note 36, at 248–50.

my companion article,[50] treats organs as one of a series of resources to be traded between poor and rich countries.

The second debate is whether the nation-state or the individual "owns" organs for transplantation, a question touched upon earlier in this article.[51] From one view, it is proper to think of organs for transplantation as among the collective goods of one country versus another, such that they "belong" to a nation-state and can be traded or given away by that nation-state. The alternative view is to reject national collective ownership in favor of individual control over one's body and its parts.

Third, as I have discussed in much greater depth elsewhere, there are ongoing debates within the philosophy of global justice, as between (1) cosmopolitans, who hold citizens of one country to have duties of distributive justice to foreigners in other countries that are equal to those duties they bear to their co-citizens; (2) statists, who limit duties of distributive justice to within the nation-state but may recognize duties of humanitarian aid or duties to assist burdened states; and (3) intermediate positions, which recognize lesser duties of inclusion requiring consideration to some extent the welfare of those outside the nation-state in some circumstances (such as coercive relationships or shared institutions), or duties to rectify harm that is done.[52]

Fourth, to sum up a huge swath of philosophy in a tiny nutshell, there are debates about what the proper principle of distributive justice is, even *within* a nation-state. Rival views include (1) libertarians, who reject redistribution; (2) utilitarians, who are "committed to maximizing aggregated social welfare," and for whom the fact of diminishing marginal utility from health care gives a good prima facie argument "to favor interventions for the worst-off over the better-off, even if each group is a similarly sized population"; (3) "[p]rioritarians, who do 'not give equal weight to equal benefits, whoever receives them,' but instead give more weight to 'benefits to the worse off'"; and (4) "[s]ufficientarians, according to whom justice is not concerned with improving the lot of the least well-off (Prioritarianism) or achieving equality per se (Egalitarianism), but instead with ensuring that individuals do not fall below a particular threshold of whatever is the 'currency' of distribution."[53] Although emanating from a more Aristotelian starting point, one influential sufficientarian account (though I am not sure she would classify it as such) has been put forth by Martha Nussbaum,

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50. *See* Cohen, *supra* note 1.

51. *See id.*

52. *See generally Medical Tourism*, *supra* note 45, at 14–45.

53. *See id.* (citing JOHN STUART MILL, UTILITARIANISM (1863), *reprinted in* UTILITARIANISM AND OTHER ESSAYS 272, 336 (Alan Ryan ed., 1987); Roger Crisp, *Equality, Priority, and Compassion*, 113 ETHICS 745, 756–63 (2003); William W. Fisher & Talha Syed, *Global Justice in Health Care: Developing Drugs for the Developing World*, 40 U.C. DAVIS L. REV. 581, 602–05 (2007); Harry G. Frankfurt, *Equality as a Moral Ideal*, 98 ETHICS 21, 21–25 (1987); Alexander Rosenberg, *Equality, Sufficiency, and Opportunity in the Just Society*, 12 SOC. PHIL. & POL'Y 54 (1995); and quoting Derek Parfit, *Lindley Lecture at the University of Kansas: Equality or Priority?* (Nov. 21, 1999), *reprinted in* 10 RATIO 202, at 213 (Dec. 1997)).

who argues that what matters is making sure that individuals are raised to "threshold" in ten "capabilities," including "[l]ife[—b]eing able to live to the end of the human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living" and "[b]odily [h]ealth[—b]eing able to have good health, including reproductive health . . . ."[54]

If one believes that organs are not part of a separate sphere but instead are part of a general "currency" of redistribution, *and* one believes that organs in some sense belong to the nation-state, *and* one believes in a cosmopolitan conception of global justice (or perhaps some forms of the intermediate position), then on some but not other (especially libertarian) theories of distributive justice, it may be that the better-off nation-state might owe the citizen–residents of the worse-off nation-state access to its organ-allocation system on equal or more favorable terms as compared to that better-off nation-state's own citizen–residents. If one accepts all of these positions in these debates, then it may make a difference whether the foreigner and home-country resident are from equally well-off as opposed to very mismatched countries; on this view, allowing organ access is a way of making up for other debts that the well-off countries owe the less well-off.

Although I do not intend to resolve fully this matter here—my focus is on the simpler case of relatively equally well-off states—I acknowledge some uncertainty with several of the assumptions one has to make to reach a resolution; two in particular strike me as worrisome. First, I have some doubts as to whether it makes sense to assume a view of organs as being part of a general currency of distribution rather than a self-contained channel, especially because, for those who need them, these organs are often (more on that in a moment) life-preserving, such that it seems less fungible with other things that make a life go well or badly. Second, it is questionable whether the nation-state can properly treat the organs of its donating citizens as belonging to it, such that it is right to say that one country owes another country organs. For reasons I suggest earlier,[55] one should be skeptical about collective national ownership of organs themselves—as opposed to collective ownership over organ transplantation and allocation infrastructure, which I discuss below. As I mention above,[56] that individuals get to take their organs with them when they become citizens of another country is one argument against common national ownership. Perhaps it might be open to someone in favor of collective ownership to suggest that collective ownership is bonded to citizenship, such that if one alters one's citizenship, one then owes one's organs to one's new nation-state. That seems unconvincing to me and introduces difficulties for dual

54. *See Medical Tourism*, *supra* note 45, at 21–22 (citing MARTHA NUSSBAUM, FRONTIERS OF JUSTICE 155–216, 273–315 (2006); MARTHA NUSSBAUM, WOMEN AND HUMAN DEVELOPMENT: THE CAPABILITIES APPROACH 4–14 (2002) (describing the Capabilities approach similarly); and quoting NUSSBAUM, FRONTIERS OF JUSTICE, *supra*, at 76–78).

55. *See supra* p. 175–81.

56. *See infra* p. 204–10.

citizens, among other individuals. In any event, I think there is a still greater problem with the common-ownership view, which is that organ donation is voluntary. If organs are really commonly owned by our country, then our country should be free to conscript our organs (especially cadaverously) in the name of life preservation. Although a few philosophers defend organ conscription in some instances,[57] if this collective ownership argument has that implication, I think many may find it problematic.

For these reasons, I am skeptical that, even in mismatch instances, the identity of the foreigner matters much for the analysis, but I do not purport to fully resolve this issue here.[58] In any event, in what follows I assume that the countries are relatively well-matched such that the possibility of organs as compensation does not present itself.

4. Investment/Contribution?

Above I suggest that collective national ownership of organs, building off the natural resources idea, is problematic. Natural resources, however, are not the only possible analogy. It is helpful to think about which resources we *do* give priority to citizen–residents over foreigners; that is, situations in which we reject equivalents of the indifference principle as to that resource. One example is that in many countries citizen–residents get to attend museums, operas, or universities for free or at a reduced rate while foreigners do not. Why is the state justified in drawing this distinction?

Let us focus on universities. Although I do not want to disparage museums or operas, the opportunity offered by universities in terms of bettering one's life seems more on par with health care opportunities, and indeed in many theories of why we ought to offer universal access to health care, analogies are often made between education and health care as two important inputs to the larger goal of equality of opportunity.[59] For universities, scarcity no doubt plays a role in the "citizen first" rule, in that there are only so many possible slots available

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57. *E.g.*, FABRE, *supra* note 46, at 72–123.

58. One additional complication relates to who needs an organ even within a group of foreign potential claimants. In many wealthy countries, dialysis, although extremely unpleasant, remains a life-preserving (and—for the home country or individual payer—very costly) alternative to organ transplant for that country's citizens. In some developing countries, dialysis is not an option. For one who makes all of the aforementioned assumptions on some theories of redistribution and the more cosmopolitan theories of global justice, this may lead to the following intriguing conclusion: in a case of mismatch, where the better-off country can afford dialysis for its citizens but the less well-off country cannot, the better-off country ought to give all of its organs to the worse-off country and put its own patients on dialysis, or at least provide dialysis technology to the worse-off country (or fund it) directly as recompense. I do not dwell on this intriguing possibility, except to note that for some this is a necessary corollary of these assumptions that makes good sense, whereas for others it may constitute a reductio ad absurdum of those assumptions.

59. *See, e.g.*, NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 46–63 (2008) (discussing the extension of Rawls' theory of justice as fairness to protect health and address issues in health care as being rooted in equality of opportunity). If university seems too bourgeois to map onto an important need for an individual like an organ transplant, feel free to substitute trade school, or welfare, the latter a matter that I discuss below.

in the university system—although we could add more. This scarcity element, however, seems necessary, not sufficient, since many goods are permanently or at least temporarily scarce. What justifies privileging our own citizens for education is, I think, the governmental investment in the university system. In the United States, this investment is pervasive both among public universities and among private schools more indirectly via funding from the National Institute of Health (NIH), the National Science Foundation (NSF), and the National Endowment for the Humanities (NEH), among other grantors.[60] These investments are even larger in other countries.

Unemployment assistance and welfare benefits are a second useful analogy. Americans who meet certain criteria can qualify for this privilege, whereas foreigners (again in the sense of nonresidents and noncitizens) do not.[61] Indeed, as I emphasize again below, if the argument for providing organs to foreigners requires extending them welfare as well, for many that would be a knock-down argument against doing so. If forced to articulate why it is not unjust to deny foreigners welfare payments, I suspect many would say it is because Americans "pay in" to this system when working through taxable wages, and these benefits serve a purpose connected to the interests of the home state—such as enabling individuals and families to survive when times are rough and maintaining social order—that would not be served if such assistance were given to true foreigners.[62] I argue that much the same can be said about organs. For every American who does not get a kidney, at least, there is a high price to pay[63]—the costs of dialysis for private and public insurers as well as the cost to the patients who must remain on dialysis are extremely high. When an American is denied an organ in favor of a foreigner, other Americans must continue to pay those

60. *See, e.g.*, NAT'L CONFERENCE ON STATE LEGISLATURES FISCAL AFFAIRS PROGRAM, STATE FUNDING FOR HIGHER EDUCATION IN FY 2009 AND FY 2010 (2010), *available at* http://www.ncsl.org/documents/fiscal/HigherEdFundingFINAL.pdf (providing data on state and federal government funding of universities in the United States).

61. Although I have not done a comprehensive comparison of other countries, I am unaware of any country that provides these kinds of benefits to true foreigners (in the case of noncitizen nonresidents either).

62. One should be careful here about this purpose-driven argument. The claim is that helping *American* individuals survive and maintaining *American* social order is not served by giving these things to foreigners (or at least not served quite as much). But why not think about the goal as helping *other* human beings survive and maintaining the social order of *other communities*, wherever the individuals involved might live, where such aid would be helpful? One answer is that we do already contribute towards this goal through foreign aid, but that explanation is not entirely satisfying, for one might suggest we ought not to distinguish *foreign* aid from other aid and should instead provide aid to everyone regardless of where they live. One reason to resist this move can be framed in game-theory terms: we ought not to do this if we have fears that other countries will defect and not return the favor. A different response, which I discuss in the main text, comes at the level of political theory and suggests that such an argument can only be sustained on very strong cosmopolitan theories of global justice, and thus evaluating this move will depend on evaluating that bigger debate. In any event, I think it is the investment argument, more than the purpose proviso, which does most of the work for me in justifying why it is not unjust to deny welfare benefits to foreigners.

63. UNITED STATES RENAL DATA SYSTEM, COSTS OF ESRD 332 (2012) (suggesting 2010 per patient per year average cost of $87,561 for hemodialysis and $66,751 for peritoneal dialysis), *available at* http://www.usrds.org/2012/pdf/v2_ch11_12.pdf.

costs either from tax revenue or cross-subsidization through insurance.

I want to be clear that although I speak of "investment" and "paying in," I do not mean to restrict this to financial contributions, so calling this "contribution" or "participation" instead might be preferable. Take the analogy of university price-setting or welfare and the question of who should qualify for the state assistance. Wealthy individuals who are taxed at a higher rate might arguably be said to have "paid in" more, yet no one thinks that one's entitlement to welfare should depend on how *much* money one contributed to the system at an earlier, more fecund time.[64] That is not to say that there are no resource-allocation systems in our society that function that way; 401(k) plans and pensions come to mind. But welfare, education, and—I would add—the kind of functional health that is enabled by access to organs are the more basic goods needed to make a life go well. For these kinds of goods, the logic of distribution is not pro rata on the basis of how much one paid in; the logic is instead to ask at a more basic level: did someone contribute her fair share when asked by the state, even if the share that may be fair for her is much smaller than for another person? Are the people being discussed here part of a cooperative enterprise of the state as to this good wherein they both govern and are governed? Does society sink or swim together? This is more of the sense of "investment" I have in mind when I think of the analogy.

On these analogies (to museums, university education, or welfare), it is *not* that the organs available for transplant come from U.S. citizen–residents that justifies a preference for U.S. citizen–residents as recipients, but instead that U.S. domestic resources are the ones that are invested in developing the U.S. organ procurement and allocation system, as well as training transplant physicians and other health care providers and their facilities.[65] This domestic investment is the result of tax revenue (as well as other kinds of contributions) raised from U.S. citizen–residents but ordinarily not from foreigners. I say "ordinarily" because it is possible that some foreigners pay U.S. taxes on some of their income when it arises from income earned or expenditures in the United States. This might require a more sophisticated description of who the "insider" versus "outsider" is, then. Thus, if this is the argument that succeeds

64. Indeed, many beneficiaries of the welfare state are unable to contribute financially at all (such as those with profound intellectual or physical disabilities), yet we often think of them as most in need of assistance from the state, whereas to focus too crudely on financial investment would perversely exclude those most in need. One might ask, why prefer *our* fellow Americans with intellectual or physical disabilities over those individuals with disabilities in India or Barbados and not include all of them in our social support program? One answer is to point to the investment of their citizen parents or friends that justifies their receiving aid. A different answer, at least in sound but perhaps not in substance, is that they are part of our community, that they are the ones who have agreed to sink or swim with the rest of us, and that they are the ones who deserve special priority for our collective resources when such resources are scarce.

65. On training of physicians and other health care workers, as I have noted elsewhere, the situation is somewhat more complex since a large number of U.S. medical providers were trained outside the United States and recruited as part of medical migration and also because they send remittances back to their home countries. *See* I. Glenn Cohen, *Introduction*, *in* THE GLOBALIZATION OF HEALTH CARE: LEGAL AND ETHICAL ISSUES xv (I. Glenn Cohen ed., 2013).

against the indifference principle, the relevant cleavage between "insider" and "outsider" may not be all citizen–residents versus all foreigners, but rather citizen–residents plus foreigners who pay substantial U.S. taxes or otherwise substantially contribute to the United States as compared to other foreigners.[66]

Another different but complementary way of putting this is to ask: To whom does our organ allocation system answer? OPTN and the HHS are not, by any means, directly elected by the populace. They are, however, indisputably ultimately responsible to the executive branch and Congress and, through them, to the people. Not just any people, but the people of the United States. These are the people who both govern and are governed by these policies, and thus they represent a special community of interest that deserves a special priority in accessing the good in question.

On this analysis, reciprocity matters, but the key reciprocity is *not* between organ donation and receiving (which, as we see above, proves too much and excludes many U.S. citizen–residents as well) but instead is between investment in the infrastructure of organ procurement and allocation and shared decision-making as organs *vel non*. It is this reciprocity that U.S. citizen–residents share but that foreigners ordinarily lack, and thus this form of reciprocity justifies U.S. citizen–residents' priority, at least in the case of equally matched foreigners and U.S. citizen–residents.

One interesting implication of this approach is that the strength of the argument varies with the amount that the home country's citizen–residents (as against foreigners) have invested in or contributed to their country's organ procurement and allocation system. [67] It might seem as though the United States is a much more difficult case for this argument, since its health care system is more private than many of the others in the world. I do think the argument is more straightforward for a country like Sweden or Canada where the notion of sinking of swimming together as part of a health care system is more deeply rooted in the system's design. Still, I think even in the U.S. citizen–resident's case,[68] investment in organ procurement and allocation is significant.[69]

66. That said, even foreigners who do pay substantial taxes may not have some of the other indicia of contribution discussed above. They may not sink or swim together with us, or govern and be governed by our laws. I think there are hard questions on which reasonable minds can differ as to whether financial investment is necessary or sufficient and how much a role these other indicia can justifiably play.

67. To the extent the shared governance piece seems particularly salient to one's conception here, it may also depend on how much the country's people get to govern and be governed by the organ allocation and procurement system.

68. I am deliberate in my choice of words here. I think public versus private investment is the wrong division, and instead the right division is between citizen-resident investment (through public or private means) versus foreign investment in the procurement system. For example, citizen-residents with private health insurance who cross-subsidize the organ procurement and allocation costs through higher premiums would have made an investment on par with public investment.

69. Of course, how significant must the U.S. government's investment be to meet the threshold is a question on which some will disagree. For those who think that investment matters but that the United Statess does not invest enough, one possibility would be to give U.S. citizens additional priority over foreigners in organ allocation while not completely barring foreigners from receiving the organs.

a. Resonances of the argument in global justice theory. The justification for prioritizing home-country citizens can be somewhat fitted into the landscape of more general theorizing on global justice, although the fit is not perfect in that such theories are usually concerned with the distribution of resources *in general*, rather than the allocation of specific goods like organs. I would describe this more as a "resonance" of certain global justice theories rather than something more. Elsewhere, I review the leading statist, cosmopolitan, and intermediate theories of global justice and their application to the globalization of health care, with a focus on medical tourism,[70] so here I am more brief. Whereas more cosmopolitan theories of global justice may lead us to conclude that national borders are arbitrary and that the right relationship is donor to recipient, wherever they may be located, more statist or intermediate theories of global justice yield conceptions of what we owe each other that are more in tune with the idea of investment in organ procurement and allocation that I focus on.

As I note elsewhere:

> Statists limit justice-based duties of redistribution to the nation-state because "[w]hat lets citizens make redistributive claims on each other is not so much the fact that they share a cooperative structure," but that societal rules establishing a sovereign state's basic structure are "coercively imposed." Nagel clarifies that this is because for Rawls (and contra the Cosmopolitans), the "moral presumption against arbitrary inequalities is not a principle of universal application;" rather "[w]hat is objectionable is that we should be fellow participants in a collective enterprise of coercively imposed legal and political institutions that generates such arbitrary inequalities." It is the "complex fact" that in societal rules establishing a sovereign state's basic structure "we are both putative joint authors of the coercively imposed system, and subject to its norms, i.e., expected to accept their authority even when the collective decision diverges from our personal preferences—that creates the special presumption against arbitrary inequalities in our treatment by the system."
>
> Increasing globalization does not change the picture, say Nagel and Rawls, because "it is not enough that a number of individuals or groups be engaged in collective activity that serves their mutual advantage"; that is, "mere economic interaction does not trigger the heightened standards of socioeconomic justice."[71]

The argument I offer is resonant with the statist view insofar as that U.S. citizen–residents collectively invest in the U.S. organ-distribution system and are bound by its rules. Thus, the duty to share organs is limited to sharing with those who are citizen–residents of that nation-state.[72]

More intermediate theories of global justice, such as the one espoused by Joshua Cohen and Charles Sabel and applied to health by Norman Daniels, might also echo the grounds I offer for limiting who can list themselves on U.S.

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70. *Medical Tourism*, *supra* note 45.

71. *Id*. at 27 (quoting and citing JOHN RAWLS, THE LAW OF PEOPLES 115–19 (1999); Michael Blake, *Distributive Justice, State Coercion, and Autonomy*, 30 PHIL. & PUB. AFF. 257, 265, 285–89 (2001) (emphasis omitted); Thomas Nagel, *The Problem of Global Justice*, 33 PHIL. & PUB. AFF. 113, 127, 128–29, 138 (2005)).

72. One might wonder whether it is appropriate to use these global justice theories in determining the correct allocation rules for a specific good rather than using them to think about distributive justice more generally. I discuss this issue, in particular in relation to Rawls' concept of "basic structure," elsewhere. *See id*. at 20 n.78.

organ waiting lists.[73] These theories focus on the institutions that mediate the relationships between citizens of various countries, and suggest that the demands of justice are not all-or-nothing when it comes to the treatment of foreigners versus citizens; rather, they recognize duties of "inclusion" internationally, which fall short of full-blown distributive justice but require the state to treat those outside of the coercive structure of the nation-state as individuals whose good "counts for something," not nothing, even if it falls short of the full consideration a state gives its own citizens.[74] As I note elsewhere:

> The authors are self-admittedly somewhat vague about the contours of these kinds of duties, telling us that it is not a duty of "equal concern" or redistributive justice on the one hand, but that it requires more than mere humanitarian duties on the other, and that it requires treating individuals abroad as individuals whose good "counts for something" (not nothing) while making decisions that will impact their life.
>
> That leaves a fair amount of room to maneuver. One could imagine the duties mandating something like "notice and comment rulemaking" in administrative law—which would merely require acknowledging that these interests were considered, but found to be outweighed—to something approaching a weighting formula in which the welfare of those abroad is counted as .8 while those in the nation state are counted as 1 (to use purely fictional discounting factors).[75]

In the context of organ transplantation, one possibility inspired by these duties of inclusion is to impose a penalty in terms of priority for foreigners on the waiting list for organs procured in the United States, but not to exclude foreigners altogether, such that their good "counts for something." This is again contrary to the OPTN policy, which is at once too weak—giving individual institutions the decision whether to list foreigners or not—and too strong—forbidding foreigners who are listed (if they are listed) from receiving any less priority than similarly situated U.S. citizen–residents.

That said, as Cohen, Sabel, and Daniels make clear, there needs to be a certain threshold of institutional interdependency or coercion between the institution and the foreign citizen to justify even these lesser duties of inclusion. The relationship of a foreign citizen to U.S. organ-allocation institutions does not neatly map onto the kinds of relationships present in the authors' other examples, which Cohen, Sabel, and Daniels claim should generate these duties. This is not like the World Trade Organization (WTO), on which the authors foist duties of inclusion because they are of the view that

> "[o]pting out is not a real option" because no country in the developed or developing world could really survive without participation in the WTO, and once one is in for a penny, one is in for a pound; a member country cannot pick and choose which parts of the WTO's demands to comply with, such that "there is a direct rule-making

73. *See* Joshua Cohen & Charles Sabel, *Extra Rempublicam Nulla Justitia*, 34 PHIL. & PUB. AFF. 147 (2006); DANIELS, *supra* note 59, at 333–55.

74. Cohen, *supra* note 73, at 154–55; *see also* DANIELS, *supra* note 59.

75. *Medical Tourism*, *supra* note 45, at 41 (quoting and citing Cohen & Sabel, *supra* note 73, at 154–55); *see also* Administrative Procedure Act, 5 U.S.C. § 553 (2000); DANIELS, *supra* note 59, at 351; JOHN F. MANNING & MATTHEW C. STEPHENSON, LEGISLATION AND REGULATION 604–40 (2010).

> relationship between the global bodies and the citizens of different states."[76]

Nor is this a case where there is "consequential rulemaking by international bodies 'with distinct responsibilities' such as the International Labor Organization (ILO)," (the authors' example), which has taken on the responsibility for significant rule making in the area affecting the lives of those abroad as well.[77]

The only example given by Cohen, Sabel, and Daniels of an institutional arrangement giving rise to duties of inclusion that at all resembles the question of the organ waiting list is the case of medical migration, the "brain drain." The very rough resemblance between the two is that in both instances a medical good in which one country is invested to produce (health care providers in one case and organs successfully procured in the other) ends up moving across borders in a way that deprives the sending country of its investment. Here, Daniels argues that

> the International Monetary Fund (IMF)'s historical requirement that countries like Cameroon make severe cutbacks in their publicly-funded health care systems in order to reduce deficits that result in poorer working conditions for medical personnel (a "push" factor), combined with the attempt by the United Kingdom and other OECD countries to recruit medical personnel from developing countries (a "pull" factor), gives rise to a duty on the part of Western countries and the IMF to address the ill effects of this migration.[78]

The United States, however, is not responsible for the availability of organs in foreign countries the same way it is (at least partially) responsible for medical migration from those countries: it does not demand that foreign countries alter their procurement strategies or investment therein, nor does it attempt to directly siphon organs from foreign country's internal supplies.[79] Thus, even in

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76. *Medical Tourism*, *supra* note 45, at 34–35 (quoting Cohen & Sabel, *supra* note 73*,* at 168). Of course, whether these authors are right to think that the WTO example itself involves this kind of coercion is another matter on which I leave to the international trade specialists.

77. *Id*. at 35 (quoting Cohen & Sabel, *supra* note 73*,* at 170–71).

78. *See id*. (citing DANIELS, *supra* note 59, at 337–39).

79. One might push back here that, by prohibiting the sale of organs, the United States causes an undersupply and thus increases the market for transplant tourism. *See generally* Cohen, *supra* note 2 (discussing transplant tourism). The argument would be that an undersupply of organs is as much the United States' responsibility as is a failure to supply sufficient health care professionals. I think there are a few reasons to resist this analogy. First, no country currently meets the goal of satisfying the full demand for organs, which is why the Declaration of Istanbul treats self-sufficiency as a goal but one that almost every country is far off from achieving at the present moment. *See The Declaration of Istanbul on Organ Tracking and Transplant Tourism,* 23 NEPHROLOGY DIALYSIS TRANSPLANTATION 3375, 3376 (2008) (noting countries "should strive to achieve self-sufficiency in organ donation," but that "collaboration between countries is not inconsistent with national self-sufficiency"). Therefore, if this failure to supply organs imposes an obligation on the United States, it likely also does so for many (if not all) other countries in a way that such obligations are counter-balanced. Second, some express worries that allowing the sale of organs will reduce rather than increase the sale of organs. Cohen, *supra* note 1. Elsewhere I have suggested, however, that the existing empirical evidence does not particularly support this fear. *See* I. GLENN COHEN, PATIENTS WITH PASSPORTS (forthcoming in 2014) (on file with author). Third, the United States has taken some steps to crack down on transplant tourism and could take several other steps I outline elsewhere. *See* Cohen, *supra* note 2, at 281–82 (suggesting, for example, countries apply their prohibitions on organ sale and purchase to the extraterritorial activities of their citizens). Finally, it seems to me that the United States' contribution to

the institution-focused intermediate approach urged by Cohen, Sabel, and Daniels, there is no strong argument for a duty of inclusion giving rise to an obligation to consider potential foreign organ recipients on U.S. organ waiting lists for organs that are procured in the United States from U.S. citizen–residents.

To be sure, strong cosmopolitan views of global justice may still find the investment- and contribution-based argument for limiting foreigners' access to the U.S. waiting list unpersuasive, adopting (as they tend to do) a view that refashions justice obligations as being individual-to-individual and not mediated by nation-states. Moreover, as I argue elsewhere, strong cosmopolitan views have very radical implications for what we owe others, including massive taxation on the developed world to fund health initiatives in the developing world, open borders, etc.[80] Some may find such implications troubling.

At least among statist and intermediate views of global justice, I think the investment and contribution argument is the strongest one for rejecting the indifference principle. If my argument succeeds, it suggests that, contrary to the OPTN's policy, no duty exists to provide foreign patients, who are equally good matches for organs as their U.S. citizen-resident counterparts, equal priority on waiting lists for organs procured in the United States.

Can we take the argument one step further and suggest that not only does this argument suggest a lack of a duty to include foreigners, but also implies that it is *wrong* to include them on U.S. transplant lists, except in cases of true domestic waste? Foreigners do not make investments in or contributions to our domestic organ procurement or allocation infrastructure and are essentially "free riders" whose presence on lists diminishes the priority of those who make such investments and present stronger claims of entitlement for the organ. They also are not the ones governing the system or bound by the rules, but are instead interlopers outside of the system in both directions.

I am somewhat ambivalent about whether this stronger argument is justified. For me it would turn, in part, on the magnitude of the contributions and investments made by the home-country citizen–residents in the country's organ procurement and allocation system. The more citizen–residents invest in that system at the expense of other kinds of investments they might make that

transplant tourism is much more mediated, smaller, and indirect than the medical migration case that Daniels has in mind. It might be different if, like Israel's prior practice, *see* Jacob Lavee & Avraham Stoler, *Reciprocal Altruism—The Impact Of Resurrecting An Old Moral Imperative On The National Organ Donation Rate In Israel*, 77 LAW & CONTEMP. PROBS., no. 3, 2014 at 323, the United States were to actually pay for the transplants of those who engage in transplant tourism and buy organs illegally; that would be a stronger demonstration of complicity. In any event, it may actually be the case that accepting foreigners into the U.S. allocation system reduces transplant tourism by incentivizing those with means to travel to the United States to seek lawful organ allocation.

80. *Cf. Medical Tourism*, *supra* note 45, at 26 ("[A]ddressing the harms caused by medical tourism is a small drop in the bucket in terms of what these [strong Cosmopolitan] theories would call upon us to do to right the balance between developed and developing countries. For starters, they would further demand that we radically increase taxes for all strata in our nation to fund large-scale water purification, housing, and other interventions in Less Developed Countries (LDCs).").

further their own welfare, the more I think one can argue that it is wrong to include foreigners, as opposed to this being a case of moral prerogative (i.e., one where home countries would not be wrong to include nor exclude foreigners).

b. Some objections and responses. That is the positive argument against the indifference principle. Now let me consider objections to it.

(1) Emergency and Health Care. One might object that the argument proves too much in terms of limiting foreigner access to other goods. In particular, to stay within the health sphere for a moment, one might worry the argument implies that, when a foreigner requires emergency care in the United States and cannot pay for it, it is wrong for U.S. doctors to provide that care—or at least that it is not wrong to fail to provide that care. This result is contrary both to the legal rule under EMTALA, noted above, and to many people's moral intuition that it is wrong to let foreigners die on our streets if they are unwilling to pay for their health care.

I do not think my argument implies that result for several reasons. First, and to some this will sound crass while to others honest, it may be in our national self-interest, thereby furthering our citizens' public health interests, (especially in the realm of communicable diseases), to provide this care to foreigners even though they are free riding.[81] This is, in part, one of the reasons why EMTALA requires most hospitals to provide care to U.S. citizens who need emergency care but who are without insurance and cannot pay. Moreover, EMTALA's obligations are limited to stabilization of individuals in emergency need. It is less plausible to think that foreigners will come to the United States *in order to get* EMTALA care and thus suffer both the costs to their health resulting from the travel itself as well as the risks of being given inadequate emergency care, as compared to the limited transaction costs and risks (if any) for foreigners in getting themselves on U.S. organ waiting lists.

Second, the EMTALA case is different because the good in question, emergency health care, is not scarce in quite the same way as organs for transplantation are. Giving an organ to a foreigner, except in the case of true domestic waste, means denying that organ to a U.S. citizen who is also desperately in need of it. Although, ultimately, the care offered to foreigners in emergency situations is paid for indirectly by U.S. citizens (through taxation and higher health care costs), that sacrifice is more attenuated and broadly shared, though some may find that to be a difference in degree more than in

81. *Cf. Medical Tourism*, *supra* note 45, at 14–17 (evaluating the United States' self-interest arguments for regulating medical tourism, including the risk of disease transmission). I think this self-interest argument also helps distinguish what might be thought of as ways my argument threatens to even more radically prove too much. If investment is key to justify access to domestic goods, why not, for example, limit foreigners from accessing our roads or shopping malls as well? The answer is that providing this form of access to foreigners improves the well-being of our citizens in a way that access to our already far-too-limited supply of organs seems not to.

kind.

Third, and this is a point some make in defense of favoring identified over statistical lives in resources more generally,[82] there is a psychological cost to observing someone, citizen or noncitizen, dying in the street in an emergency situation when help could be administered. Though it no doubt sounds cynical, those needing organs who live abroad are much more "invisible" in their suffering and need for organs, and whatever psychological cost we experience in observing their plight is counterbalanced by suffering we experience in observing the much more immediate and visible plight of a similarly situated American who could be helped.

Fourth, emergency care is just that: an emergency, for which the thought of examining someone's papers and determining his or her residency or citizenship may be impracticable (especially in the case of someone who is unconscious) or deleterious to the patient's health in that it delays care, as well as a poor fit for the medical ethics training of most physicians to treat all in need. By contrast, getting registered on a U.S. organ waiting list is a highly regulated administrative process done in advance, and determining residency and citizenship is fairly easy to do and can more easily be handled by an administrative system divorced from the day-to-day practice of medicine.[83] Finally, one benefit for providing EMTALA care to foreigners arises from the desire to stimulate reciprocal provision of emergency care for our citizens when they travel abroad, as well as a desire to maintain good international relations.[84] It is less clear to me that the decision whether to list foreign patients on U.S. organ waiting lists or not will have major effects on either of those axes. Of course, if it does, and we think it is in our interest to have our own patients listed on foreign waiting lists, one intermediate policy possibility is for OPTN to permit U.S. transplant centers to list only foreign patients from countries who list our citizens as well—which would essentially instantiate an organ-sharing program across borders of the kind I discuss below. For all of these reasons, I do not think a claim about implications for emergency care for foreign patients is a strong reason to reject the argument I offer.

All that said, perhaps the argument I offer may imply that the United States does not owe robust duties to provide free health care outside of the emergency setting to foreigners—as opposed to undocumented immigrants, for example—who neither take up residency in the United States nor contribute to the funding of its health care system in the way that American citizens and residents

82. *See, e.g.*, Cohen, *supra* note 36, at 251–54 (discussing this problem in the context of rationing: people are more prepared to expend resources to save the lives of known or individuated, "identified" persons rather than the lives of persons unknown, so called "statistical" persons).

83. In practice, of course, some transplant professionals might be uncomfortable asking questions about residency and demanding documents. Even if that were true, it is not clear exactly how to weigh causing them discomfort in this analysis if the result was a system that more closely tracked our considered judgments about what justice requires.

84. *Cf.* Cohen, *supra* note 4 (discussing similar arguments for reciprocal legal treatments of travelers in relation to circumvention tourism).

do. Even if my argument *does* imply that result, it is not clear to me that this implication is untoward enough to count as a reason against the argument. I have not seen robust calls to include foreigners who are poor or elderly in the Medicaid or Medicare programs, for example, and I do not think most individuals are troubled by their exclusion. Indeed, I think most Americans would be troubled by the *inclusion* of foreigners in such programs, because it would mean giving these individuals benefits from a system they do not invest in and reducing the amount available for those who do invest. Of course, I am not arguing for "ethics by public opinion"; the claim is not that because most Americans unreflectively think this, then it must be correct. Instead, the claim is that even upon reflection many would conclude that the failure to include true foreigners in our social safety net is non-problematic. If we are untroubled by rejecting the indifference principle as to Medicaid and Medicare or welfare, which provide more fungible and divisible benefits than do organs, it is not clear why we should not reject the indifference principle in the case of foreigners' access to organs as well. Indeed, one might turn this argument on its head and suggest it is those who endorse the indifference principle (apparently the OPTN included!) who need to explain why they would not extend it to Medicaid and Medicare or welfare benefits. If they agree that their argument requires this extension, then I think it is incumbent on them to explain why it is not a knock against their argument.

(2) Undocumented Immigrants. One might object that the argument I offer against the indifference principle implies undocumented U.S. immigrants should also lack priority for organs or other health care goods. My argument does not have that implication for several reasons. First, undocumented immigrants frequently pay into the U.S. system through social security and other tax resources from which they do not draw, such that we can say that they in fact meet the investment prerequisites. Indeed, there are arguments that current U.S. practices and the planned treatment of undocumented aliens under the Affordable Care Act do not give them enough health care resources given how much they contribute.[85] Further, the OPTN suggests that they frequently "pay in" more directly through organ donation.[86] Second, the continued presence of undocumented aliens as residents in the United States, both with

85. For a more general discussion of health care access by undocumented immigrants with a particular focus on the Affordable Care Act rules, see Norman Daniels & Keren Ladin, *Immigration and Access to Health Care*, *in* THE ROUTLEDGE COMPANION TO BIOETHICS (John D. Arras et al. eds., 2014).

86. A recent study of the first twenty-two months where data was available (March 2012 to December 2013) suggests that during this same time period, deceased donors in the United States that were categorized as non-citizens but U.S. residents comprised approximately 3.3% of all deceased donors. Glazier, *supra* note 7, at 12. Two notes of caution are in order. First, the OPTN reports a category of non-citizen U.S. resident but does not break it down further between, for examples, undocumented immigrants versus students on visas or temporary workers, so we cannot say what percentage of that 3.3% are undocumented immigrants. Second, the OPTN's collection of the data in this form is relatively new so we cannot say whether the reports for this short period are typical or aberrant compared to historical averages.

families and as part of communities, complicates our moral relation to them in a way that is not true in the case of true foreigners.

(3) Foreigners Buying In. A third objection to my argument focuses on the investment and contribution criteria. If the key difference between foreigners and U.S. citizen–residents is their investment and contribution in procurement and allocation systems, why not allow the foreigner to remedy the situation by "buying in" after the fact? This is, indeed, the practice of some universities—one of our analogies—that allow foreign students to pay much higher fees than domestic students if admitted. Can we allow foreign patients to make comparable "catch-up payments" that would stand in for their investment in the procurement and allocation system as a condition of being listed on the waiting list?

That, it seems to me, generates several new problems. First, it exacerbates existing socioeconomic status differentials among foreigners as to who can get an organ through being on a waiting list, resulting in a preference in favor of the wealthy.[87] Second, the investment does not mirror one made by a citizen who pays into the system domestically, since the foreigner only pays in at the moment he or she needs to be waitlisted, whereas all U.S. citizens pay in regardless of their needs to be on the waiting list. Finally, mixing such payments with priority allocation may have the appearance of (if not actual) impropriety, which may lead members of the public to lose faith in the fairness of the distribution system (rightly or wrongly).[88] Given these additional problems, allowing foreigners to "buy in" after the fact does not appear to be a prudent solution to the difference in investment between foreigners and U.S. citizen–residents.

A slightly different response, but one for which I am less inclined, would be to focus on the "currency" of paying in. The more one thinks about this as participation and contribution in a more communitarian sense rather than a financial investment, one might respond that the kinds of catch-up payments made by foreigners are unacceptable because they come in the wrong currency.

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87. While in the companion article I argue that ability-to-pay is not entirely arbitrary as a moral factor and may be no more arbitrary than some forms of priority-setting—such as familial directed donation—as I stress in my other article in this symposium, ability-to-pay may still be more arbitrary than other distribution systems that ration based on best outcomes, priority to the worst off, etc. *See* Cohen, *supra* note 1.

88. This response also answers a slightly different objection one might raise if investment is what matters, which is that allocation of organs based on investment implies that a wealthy foreigner who offers a large donation to buy his way to priority should be given similar priority by virtue of his investment. I discuss in-depth whether organs should be bought and sold in my other paper in this issue, *see* Cohen, *supra* note 1, as do the other authors. Here I just want to make the point that this argument does not carry that implication. There is a difference between buying an organ and investing in a system whereby organs are procured and allocated. One may indirectly benefit from the latter form of investment (for example, more organs become available) but one is not buying the good. Indeed, as I note above regarding catch-up payments, it may be important that the investment be made before one even knows whether one needs an organ. All that said, as my discussion above of undocumented immigrants and their contributions to the system suggests that in some instances foreigners can make sufficient investments into the system to merit being treated like citizens for organ-allocation purposes.

Why not adopt this argument wholesale? While I am open to the idea that one's contribution need not be financial but can instead take other forms as the reason that justifies home-country citizen-resident priority, I am also not a strong champion of separate spheres views, and want to also be open on the other side as to what kinds of currency foreigners may contribute so as to be on par with home-country citizen–residents. Those who have more restrictive views, though, might also adopt this additional argument.

For these reasons, I do not find any of these objections sufficient to defeat the argument I offer for rejecting the indifference principle.

D. When the Foreigner Is a Better Match

The preceding discussion focuses on a case in which the foreigner and domestic individual are *equally* good matches. What of cases where the foreigner is a better match for the organ? Favoring the U.S. patient in this case results in a less beneficial use of the organ (by the allocation criteria of the country whose organ is being allocated), or, to put it another way: We can do more good (in terms of life years or quality-adjusted life years) by giving the organ to the foreigner.

Still, if the analysis I provide above is correct—that the foreigner's claim to the organ is much weaker than the claim of a citizen due to the foreigner's lack of investment in our organ procurement and allocation system—it is not clear that even a significant differential in the prognosis favoring the foreign patient over the domestic patient is enough. Exactly how much of a differential might justify directing an organ to a foreigner over a citizen may depend somewhat on how much the home-country citizen-resident contributes or invests into the home country's organ procurement and allocation system and more generally on which theory of global justice one subscribes to. As I suggest above, intermediate theorists (but not true statist theorists) are willing to recognize duties of inclusion that fall short of full-blown duties of distributive justice, and one way of understanding such duties is that they might lead you to direct an organ to a foreign recipient when the benefit that follows is much greater. However, I suggest above that there are plausible arguments that the prerequisites for such lesser duties of inclusion are not met in the organ-sharing case.[89] If this is the case, then the fact that a foreigner benefits so much more than a domestic patient (who is still herself in great need) may not be a good enough reason to grant the foreigner priority or even access to the list.

In sum, although I offer and critique what I think of as two more straightforward arguments for rejecting the indifference principle—one relating to reciprocity between donors and recipients and the other relating to common ownership of organs—I also offer a third argument that relates to investment and contribution which I think works better. If this argument is accepted, it suggests that there is no normative justification for allowing foreigners on

89. *See supra* p. 185–89.

waiting lists for U.S. organ transplants in cases where the foreigner and home-country citizen-resident are equally good matches. This theory does suggest that foreigners be allowed to access organs from home country citizen-residents in cases cases of true domestic waste, and perhaps in cases where the foreigner is a much better match, but the last will depend on more general views about global justice.

IV
SHOULD THE UNITED STATES ENTER INTO ORGAN-SHARING SYSTEMS WITH OTHER COUNTRIES AND OF WHAT TYPE?

What about our second policy question, regarding the appropriate geographical scope of organ-allocation systems and whether they should cross borders? Once again there are significant non-normative concerns related to such organ-sharing programs—for example, relating to effects of longer durations of organ transport, increased risk of organ trafficking, crowding out – which would continue to play a role in determining the optimal policy to implement, but I am bracketing them for present purposes to focus on the more normative questions. My treatment of this policy question is briefer than the prior one, in part because many of the analytical points in part III can be used here too, and in part because I believe the ratio of normative to non-normative considerations is more heavily tilted towards the latter in this case. I also emphasize that I aim here for a *normative* analysis, rather than one that attempts to examine whether the relevant nation-states have the right motivation or are likely to enter into such arrangements, a question I distinguish and address separately quite briefly at the end of this part.

Are there good normative reasons for the United States to enter into a larger organ-sharing network that extends beyond its borders? If the argument that analogizes organs to natural resources were valid, perhaps there would be some argument for "keeping what we need at home," although, even in the case of natural resources, countries routinely trade hydroelectricity and the like (albeit with forms of strategic reserves in some cases). In any event, for the same reasons I provide above, I find this analogy wanting and thus not a fruitful tool with which to examine the matter.

Instead, the key question seems to me to be, once again, one of reciprocity. As discussed in part III, when conducting a normative analysis it is useful to imagine some stylized cases about the way organ sharing across borders might work. First, we can imagine a case in which the balance of trade is roughly equal, when the importation and exportation of organs between a particular pair of countries (say between the United States and Canada) are roughly the same, at least in terms of expected values over a time frame in which both countries are committed to continue the exchange. We can contrast this scenario with cases in which there is, in expected value terms, likely to be an imbalance of trade.

A. The Case of Roughly Equal Balance of Trade

The case of a roughly equal balance of trade seems fairly easy to me and yields a strong argument for entering into organ sharing across borders. When two entities have complementary goods that are equally valuable, it is almost axiomatic that they benefit from trading them. To the extent organ sharing between the two countries is an improvement for one's home country in "bang-for-your-buck" terms of quality-adjusted life years (or whatever metric is used by the country in its allocation system), there is a net gain that should be pursued.[90]

One might object that, even in this instance, there is a problem that relates to the gap between Kaldor–Hicks and Pareto conceptions of efficiency[91] and is analogous to an argument I consider on baselines for distributional changes in my companion article to this issue.[92] Imagine the United States is faced with a policy choice: enter an organ-sharing arrangement with Canada or do not. I suggest that in the case of roughly equal balances of trade, joining the organ-sharing arrangement results in net gains for both countries (i.e., it is Kaldor–Hicks efficient), but from the perspective of individual recipients of organs things might look different. In particular, if organ sharing across borders is permitted, there will be some individuals in the United States who may have otherwise been "winners" in a sealed U.S.-only organ-sharing network but who will now "lose out" to a Canadian recipient who is a better match. Because the distribution with organ sharing is unlikely to be Pareto superior, there is likely to exist someone made worse off as compared to a world where the organ sharing does not take place.

Such an individual has a normatively valid complaint only if her claim that her entitlement to the organ is superior to a claimant's in another country is based on the organ coming from a U.S. citizen–resident. But if the argument I offer above is correct, then that claim seems to fail: it is not that the organ donor and recipient share a common country of citizenship and residency that matters, but instead, that foreigners do not make the same kinds of investments and contributions to the organ procurement and allocation systems as citizen–residents do, thus giving the citizen-resident a claim for priority. In the case of an organ-sharing network with roughly equal balance of trade, that investment is furthered by sharing across borders since those who make the investment are collectively made better off with organ sharing than without it. Therefore, organ sharing across nation-states is desirable in cases of roughly equal reciprocity when expanding the geographical scope improves outcomes under the metrics

90. My understanding is that, as of now, we do not have any good data examining whether such gains are likely or how large they would be, hence the reason why I phrased it "to the extent that." Obviously, this would be very important data to gather and it would be important to run simulations, and I hope one tangible outcome of this article is to make a case for trying to answer these questions.

91. Cohen, *supra* note 1.

92. Cohen, *supra* note 1. I do not repeat here what I say there about transition and phase-in issues, but they apply equally to this case.

used by the home country's allocation system.

B. The Case of Imbalance of Trade

Cases in which there is likely to be an imbalance of trade are harder because one country benefits more than the other from the sharing. In some instances, such imbalances temporarily favor one country in a dyad, and in others temporarily favor the other, but over the long run, it all "evens out." Such instances seem to me more like those of equal balance of trade, although if the periods of imbalance are very long perhaps there are questions of intergenerational justice that distinguish it. To illustrate this point, imagine that for 100 years Canadians take more organs than they give by a wide margin and for 100 years thereafter Americans do the same. In such a hypothetical state of the world—assuming our life spans are roughly what they are today—it does seem to me that the generation of "givers" may have a valid concern about the generation of "takers," although there may be complications relating to intra-familial benefitting that transcend the generation line. There may also be concerns relating to credible commitment over longer periods of time—perhaps one country ceases to exist as such or defects after receiving the benefit of the system, which becomes more likely the longer the periods of benefit and sacrifice.

If one is moved by such concerns, a "fix" is eminently possible: recall that the Scandiatransplant system discussed above is designed so that the "accounts" of the two countries must "balance" within a five-month period. Of course, one may conclude that five months is too short (or, less plausibly, too long), but this is just to say that there exists system-design techniques to solve such problems. I do not dwell on whether such fixes are desirable, though, for two reasons. First, such an imbalance is unlikely to occur naturally over such long periods of time. Second, these questions of intergenerational justice are largely independent of the questions of global justice upon which I focus. That is, one can imagine the same problem existing *within* a nation-state based on regional distribution or distribution as between racial groups, or other designations, such that the cross-border element is not really the issue.

Let us put aside cases in which equal balance of trade is achieved over a fixed time period and instead consider cases in which, absent any regulatory intervention—meaning organs merely go to the claimant who, under the allocation principle agreed to, is the most deserving,[93] wherever she resides—one country receives many more organs than it would give, even over the long term.

Things get a bit more complex when one recognizes that such an imbalance can occur on the demand side (how many organs are needed per capita) or the

93. Here, in an attempt to keep the level of complexity manageable, I am fudging another difficult issue: what if the two countries have radically different systems of allocation such that they disagree sharply on which claimants are deserving? For present purposes, I imagine a unitary shared set of criteria that dictate a particular patient has priority if geography is ignored.

supply side (how many organs are procured per capita) or both. In imbalanced situations, "fixes" are possible at a technical level that turn such imbalanced systems into roughly equally balanced ones. For example, as discussed above, the Eurotransplant system routinely puts in place one fix, wherein priority in allocation to a particular patient is adjusted by the import–export net exchange of his or her country and the country from which the organ is procured in order to equalize the system over time.

But just because such a fix is possible does not tell us whether it is normatively necessary or even desirable as a precondition to entering such a cross-national, organ-sharing arrangement. Again, if organs are like natural resources that "belong" to home-country citizen–residents, the argument for adopting such a fix (or, in its absence, not sharing organs across nations) is strong, since it means giving away that which belongs to the home country's waiting-list recipients. I argue above, however, that this cannot be what (if anything) gives potential home-country recipients a superior claim to the organ and instead points to home-country citizen-resident investment and contribution in the organ procurement and allocation system. In the case of cross-border, organ-sharing initiatives, however, *both* nations make investments in organ procurement and allocation. The question then becomes whether such investments and contributions are symmetrical or asymmetrical.

If the investments are symmetrical, and it is these investments that give the U.S. citizen-resident this superior claim to the U.S. organ to begin with, the investments of the two countries appear to cancel each other out and thereby eliminate the superior claim by a U.S. citizen-resident for a U.S. organ.

If the investments are not symmetrical—say that Canada invests only half as much funding or efforts in organ procurement and transport, resulting in Canada being a net importer of organs—then, as a first cut, one might think it appropriate to reduce the priority for Canadian citizens as to U.S. organs in the organ-sharing arrangement, but *not* vice versa. On this view, asymmetries in trade should mirror asymmetries in investment.

That consequent adjustment in priority is subtly different from the Eurotransplant "fix" in a way that I wish to emphasize: Eurotransplant adjusts the balance of trade based on the balance of organs "supplied," which in turn reflects the balance of organs successfully procured and maintained for transplant. Investment and supply, however, can come apart. Imagine that Canada makes investments comparable to the ones the United States makes towards procuring and maintaining organs, but for reasons unrelated to those investments, Canada has a lower per capita yield of organs. For example, imagine Canada more effectively educates the public on the dangers of motorcycle driving without a helmet and thus has fewer fatalities, consequently yielding fewer organs for transplant. In such a case, a "fix" based on supply unfairly penalizes Canada, whereas a "fix" based on investment does not. Penalizing Canada in this hypothetical seems unfair in that Canada's failure to procure more organs results from its own attempt to protect its population from

motorcycle accidents. Here, I should emphasize that law can potentially also be a source of investment in procurement and allocation. If it were the case that countries with opt-out systems of organ donation have much higher procurement rates (it is far from clear that this is the case), then it would seem fair to "penalize" the country with lower procurement rates because it maintains an opt-in system in setting the balance of trade.

There are other cases, though, in which it seems less clear that the United States would be right to ignore supply. Suppose that Canada invests the same as the United States in procurement, but that its procurement rate is worse because its doctors are (either as a matter of culture or as a matter of law) more likely to defer to familial reservations about donation of a dead individual, notwithstanding that this person signed up to be an organ donor and the law permits no such veto. In such a case, it seems fairer to "penalize" Canada for this choice, but perhaps that is in part driven by my anti-veto view in these cases? If I had more solace for allowing familial veto, perhaps I would find penalizing Canada in this instance as unfair as in the prior case.[94]

Another difficult case is one in which the difference in procurement rates is the result of imbalances in investment in general health care or sanitation in one of the two countries that is not directly related to organ procurement and distribution. That is, imagine the investment in organ procurement is symmetrical, but investment in more general health care is asymmetrical, and that this imbalance is responsible for differences in the resulting supply of organs. Whether to penalize the country with the poorer supply in this case seems to depend on specifying more thoroughly the way in which investment and contribution factors into the basis for an entitlement claim to organs—that is, how "fitted" versus "general" the investment and contribution has to be to justify priority.[95]

My conclusion is that, even in cases in which there is an imbalance of trade, there is still a strong normative argument for countries to join multinational organ-sharing networks. When the imbalance is a function of differential investments in procurement and allocation systems, it is appropriate to require a fix that "penalizes" the country that invests less by reducing the priority its citizens get for organs from the other country.[96] This reduction is justified both as a matter of justice and for the more instrumental reason that it may incentivize partner countries to improve their organ procurement and allocation

94. Trying to untangle responsibility on the "demand" side seems even more fraught and difficult. If one country in the dyad needs more organs for transplant per capita due to high diabetes rates, under what circumstances should it be penalized or not? If the diet is worse in that country, one might be tempted to penalize it, but what if that diet is the function of cultural tendencies to eat certain foods but not others? What if those cultural tendencies are themselves a product of colonialism?

95. This issue bears a family resemblance to the "separate spheres" and "indirect benefits" issues in allocation priority that I and others discuss elsewhere. *See, e.g.*, Brock, *supra* note 49; Cohen, *supra* note 36, at 248–50 (discussing separate spheres arguments and their cogency).

96. Although Eurotransplant reduces the priority of a given country for the next organ available by a fixed number per organ transplant by a fixed number per organ transplant, there are other ways of implementing this as well that are worth examining further.

efficiencies. When the imbalance is present for reasons unrelated to investment in health care goods, it is not appropriate to penalize the foreign country in this way.[97] There are also intermediate cases in which the investment is related to health but not organ procurement, for which I am less convinced there is a clear right answer.

All of this is a discussion of what is normatively justified. I have no illusion that this means that countries will use this analysis as their guide when determining whether to construct such multinational partnerships. In particular, most (if not all) countries are unlikely to join such partnerships if it means they will become net exporters of organs such that they end up being net "losers" in terms of access to organs. For this reason, it may be desirable to maintain a system of adjusting for import–export imbalances in *all* cases uniformly, rather than trying to parse out which ones are those in which the principles I discuss argue for or against making such adjustments. Sometimes the world of ideal justice has to bow to the world of nonideal justice, but it is useful at least to recognize and analyze those divergences, even when they are unavoidable in the real world.

V

FROM INTERNATIONAL TO INTRANATIONAL

My focus in this article is the sharing of organs across nation-states. But what of sharing *within* the nation-state? Should a citizen in Florida who is as good a match to an organ as a New Hampshireite have as good a claim to an organ procured in New Hampshire?

Once again, let me factor out a few reasons why the answer may be yes that are not normative claims. First, as I suggest above, the outcome one can expect for transplanting an organ may be related to ischemic time until it is used. To the extent that is the case, it can be (and is currently) factored in. Second, it is possible that there are some "local altruism" crowding-out effects, such that giving those in the same state or region priority for an organ increases the willingness of members of the community to donate. I am unaware of good evidence to this effect, but, as I suggest above with crowding-out concerns relating to foreigners, if it turns out to be a real and substantial effect, one can imagine trade-offs being made as to how many organs are lost to crowding out versus how much distributional unfairness one is willing to tolerate. Further, such localist preferences may be eliminated through education and through libertarian paternalist–type interventions.

97. There is a separate set of questions for "mismatch cases" of the kind discussed above. For example, Malawi may not have as many resources to begin with for health care such that it can spend less in total dollars? One possibility would be to adjust the measure to relative spending based on resources, but again countries that have less may need to satisfy more basic needs before they can even think about investing in organ procurement, such that this metric might be unfair. For this reason, as with the discussion above, I want to largely focus the analysis on cases of marriages of equals or near equals and not opine on organ sharing between countries with radically different resources here.

Again, though, let us factor out *these* reasons and imagine they do not apply or are already factored in. Is there a further, entitlement-based claim for why a co-citizen of a state (say New York) should have a stronger entitlement to an organ procured from his co-citizen than from the citizen of a "foreign" state (say Massachusetts)? I think the claim here is even weaker than in the international context. As I note in the context of my work on medical tourism, "[t]he identification of [] a citizen of one of a series of coequal states is a much thinner conception for social contract or communitarian purposes than is the identification as a citizen of a nation," and indeed, "too strong a notion of state citizenship might undercut national citizenship in an undesirable way for a federalist model of a country like the United States."[98]

Even if the conception of state citizenship were on all fours with the thickness of our conception of national citizenship, the argument fails. I reject the claim that states "own" their citizens' organs. Indeed, given how frequently individuals change state citizenship from one U.S. state to another, and indeed the way in which state citizenship is splintered such that one can be a state citizen for some purposes but not others (for example, diversity of citizenship jurisdiction vs. taxable income vs. eligibility for Medicaid), the claim of ownership seems much harder to make here. In addition, the contribution and investment argument I ultimately rely on at the national level to justify a preference for citizens of one's own country is also more strained here: states individually make far fewer contributions to the infrastructure for procuring and allocating organs in that state than do all U.S. citizens as a collective to the procurement and allocation of organs in the United States.

For these reasons, any favoritism of members of one's own state or region for the purpose of organ allocation, above and beyond what is relevant to transplant outcome and perhaps crowding out, seems wrong.

VI
CONCLUSION

In this article, I examine two related but separate policy questions pertaining to organ sharing across borders: whether foreigners should be listed on a country's organ waiting list and with what priority, and whether countries should join multinational organ-allocation systems like Eurotransplant or Scandiatransplant. These are issues that receive exceedingly little attention from scholars, and I consider my analysis tentative and hope my claims here may spark a conversation.

In cases in which a country is not part of a multinational organ-allocation system, as is currently the case for the United States, I argue that it is appropriate for the system to allocate organs procured in the United States from U.S. citizens to foreigners when the organs may truly go to waste if they fail to do so. By contrast, in cases in which there is a potential U.S. recipient

98. Cohen, *supra* note 4, at 1347–48.

who might benefit from the organ, I argue there is no strong normative justification for allowing foreigners on the waiting list for the organs, and that the OPTN's policy to the contrary should be revised. I am more tentative about whether this is a case of discretion, or whether it may actually be wrong to give the foreigner an organ, and I suggest it may depend in part on the magnitude of investment and contribution that the home-country citizen–residents make in the country's organ procurement and allocation system.

By contrast, there are strong arguments for countries like the United States to join multinational organ-allocation systems. Organ sharing across nation-states is clearly desirable in cases of roughly equal balance of trade in which expanding the geographic scope of organ allocation will improve outcomes. Even cases in which there is an imbalance of trade of organs, I argue that there is still a strong normative argument for countries to join multinational organ-sharing networks under certain conditions: when the imbalance is a function of different investments in procurement and allocation systems, it is appropriate to adopt a "fix" to the allocation rules that "penalizes" the country that invests less by reducing the priority of its citizens in receiving organs from the other country. By contrast, when the imbalance is present for reasons unrelated to investment in health care goods, it is not appropriate to penalize the foreign country in this way. Eurotransplant and Scandiatransplant provide potential models for how such "penalties" may be applied, except in my view both wrongly treat as the metric of the balance of trade "supply" rather than investment. There may be differences in supply that are not the fault of the country supplying fewer organs, and for that reason, in theory, I favor a metric that is more keyed to desert, such as investment. However, I also accept that, both as a matter of political motivation and also as a matter of feasibility—supply is much easier to measure than investment—a system that tracks relative supply may be more justified even if it is theoretically second-best. Sometimes theory must bow to practicalities, a point that we, as lawyers, deeply internalize; yet, it is always important to recognize that this is what is happening.

Finally, I more briefly use the analysis of the *inter*national case to shed light on the *intra*national one. I show why the same arguments support the conclusion that any favoritism of members of one's own state or region for the purpose of organ allocation—above and beyond what is relevant to transplant outcome and perhaps crowding out—is hard to justify.

Although my goal has been to get away from the nation-state in the analysis of this paper, the astute reader will notice I have not gotten all the way away from it. What I have offered is a view of organ allocation that is more international and transnational, but not quite post-national. A truly post-national organ-allocation system is a bit hard to imagine. One possibility is that it would be completely private, such that individuals would relate to one another as buyers and sellers or perhaps as members of a club, like masons, hinted at by the advent of "lifesharers" in the United States (discussed in the companion paper) wherever they might be. A public version of this system is

harder to imagine under the existing institutional configuration. In particular, because nation-states remain the key economic, social, technical, and above all "real-space" actors in the procurement of organs, as well as (in most countries) the primary payers of the medical costs for those who get and fail to get organs, it is harder to imagine them disintermediated without also disintermediating the nation-states' involvement in the health care system more generally. Still, it may be that my imagination has failed me, and others might take on the charge of designing (or at least imagining) a truly postnational system of organ allocation that is not also postnational in this other sense.