

## Medical tourism and organ trafficking

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### Abstract

The growth of medical tourism in developing nations has not only helped the local economies but also has assisted patients from the developed world to seek treatment at a lower cost. However, the expansion of the sector has been stigmatized by the growth of organ trafficking that facilitates organ transplantation to those who can afford it. Although developing countries have been taking measures to prohibit the sale of organs, the large gap between demand and supply has fuelled a black market that involves the “brokers”, the medical personnel and the poor whose abuse and exploitation is fuelled by the expansion of the sector and the illegitimate opportunities it creates on the side. The problem is exacerbated by the low supply in developed countries, where living potential donors appear to be misinformed about the process and hesitate to register as donors. The need for a nationwide campaign of awareness is urgently needed as the expansion of medical tourism has the potential of encouraging a further rise in organ trafficking.

**Key words:** medical tourism organ trafficking transplantation

### Introduction

Medical tourism refers to the practice of travelling to foreign countries with the purpose of obtaining medical services ranging from complicate organ transplants to cosmetic procedures, dental implants and even burial services. It is an ancient idea dating to 4,000 BC, with Sumerians offering treatments in their hot mineral springs (Bristow, 2008). From 500 BC, the popular Ayurvedic medicine of India attracted Chinese and Arab pilgrims who discussed it extensively (Wujastyk, 2003), whereas British physicians traveled to India to see rhinoplasty being performed by native methods (Lock, 2001). Around 300 BC, Greek pilgrims traveled to the Mediterranean town of Epidauria in the Saronic Gulf, considered to be the

sanctuary of Asclepius, the God of healing, to indulge in the hot baths, pray in the temples and train in the gymnasiums (Swain and Sahu, 2008). In the thirteenth century,

Cairo oversaw the building of an advanced institute, the Mansuri hospital that attracted patients from around the world (US National Library of Medicine, 2011).

The powerful history behind it helped the sector expand and diverse. The purpose of medical tourism can be threefold: people from countries with less advanced medicine may travel overseas for advanced health care, especially in cancer treatments, rare diseases and complicated surgeries, either covering the cost themselves or pressing their national health care system for coverage. Secondly, people from advanced

countries may travel to developing countries which have created a few hubs of advanced medical centers for lower cost treatment. Finally, people from all countries who can afford the cost may travel to specific destinations for faster organ transplants whose method of acquisition may remain murky.

It is the organ transplantation as practiced through medical tourism that will be the focus of this paper. Specifically, the author will present the abuses of this kind of medical tourism stemming from organ trafficking and will discuss the consequences and potential changes that could alleviate the ethical issues surrounding the practice.

### **Demand and Supply**

The demand for human organs outstrips the supply around the world. In 1991, the World Health Assembly adopted a set of Guiding Principles emphasizing voluntary donation, non-commercialization, a preference for cadavers over living donors as well as preference for genetically related over non-related donors. As non-related donors have contributed heavily to organ trafficking and commercialization, experts on the field have warned that the safety concerns cannot be adequately addressed. Given the unresolved safety concerns and the long list of patients who die waiting for a donor, a number of physicians have offered support to the legalization of "incentives" that could increase the numbers of donated organs (WHO, 2012). The need for more organs is indeed dramatic. According to the World Health Organization (WHO), approximately 66,000 kidney transplants, 21,000 liver transplants, and 6,000 heart transplants were performed worldwide in 2005, whereas a global increase in kidney diseases and a diminishing supply of kidneys have contributed to a spike in illegal kidney trade. The National Kidney Foundation (2012) reported that in the US, 104,748 U.S. patients are currently waiting for an organ

transplant whereas more than 4,000 new patients are added to the waiting list each month. In 2008 fewer than 28,000 patients received the organ they needed. Because of the lack of available donors, every day 18 people die while waiting for a transplant of a vital organ. Furthermore, nearly 10% of the patients currently waiting for heart transplants are younger than 18 years of age.

In Europe the kidney waiting list in 2006 included more than 11,000 patients, while the number of transplants approached 4,400. Donation rates vary widely between the member states, ranging from 33.8 deceased donors per million of population in Spain to one deceased donor per million population in Romania. Also there are considerable differences in the attitude towards donation, with the most positive predisposition recorded in the Nordic countries and the lowest in Austria, Latvia and Italy (Directorate General for Health and Consumers, 2007).

The reason why the ratio of patients to donors remains quite large in all countries is the limited supply. Predictably, illegal market forces have entered the equation to benefit those who can afford the purchase of an organ through illegal means. Usually, such wealthy patients are westerners and mostly come from the US, Australia, Canada, Israel, Japan, Oman and Saudi Arabia. The donor countries appear to be Turkey, Moldova, Romania, Egypt, Brazil, Bolivia, Peru, Israel, India, Philippines, Iran and China (Scheper-Hughes, 2005).

### **Process**

The transplant process can appear legal through a maze of vague prerequisites. The search usually embarks through a website such as *www.placidway.com* that will assist the patient by explaining the treatment package and offering the comparative prices. The website explains that a kidney transplant in India and Jordan costs

\$20,000, in Mexico \$47,000, in the Philippines \$24,000 and in Turkey \$34,500. The illegal acceleration of the process is enhanced by the involvement of doctors, embassy personnel, police, local mafias and former organ sellers in foreign countries (Bos, 2007).

For example, in Turkey, organ transplantation can only be performed from a living donor who is a documented relative of 1st to 4th degree, for international patients (placidway.com). This could be easily "proven" due to the high level of corruption while forced marriages are common to facilitate the process (Turner, 2011). Indeed in Turkey every year, there are two to three major 'kidney rackets' uncovered by the media and sometimes the police, that demonstrate the power and involvement of middlemen and clinicians alike (Shroff, 2009).

Similarly, in India, a thriving black market facilitates the expansion of transplantation tourism. In 2008, the police arrested one of the masterminds of a black market organ transplant ring that had been harvesting kidneys from poor Indian laborers for more than a decade, sometimes against their wishes, and using them in foreign patients. According to the police, the doctors paid \$1,000 for the kidneys and then sold them for \$37,500 while the number of illegal transplants approached 500. The Indian who ran the operation and oversaw the surgery did not have any medical training (Robinson, 2008). Although the Indian government made organ selling illegal in 1997, the whole process went underground and fell under the control of crime gangs. There are also reports of organ theft, where people are misled to believe they are in need of a small operation, only to wake up with a kidney missing.

In the Philippines organ trafficking has acquired worrisome proportions. In 2005, the World Health Organization identified the country as one of the top hot spots for organ trafficking together with India and Pakistan.

Wealthy patients bought kidney organs from poor locals for a price ranging from \$30,000-60,000. The donor received \$3,000 or less. Most of the money went to the doctors and brokers. The typical seller in the Philippines was a male, 29 years of age, with an education of less than 7 years and an annual income of \$480. The typical buyer was usually Israeli, aged 48, a university graduate and with an income of more than \$53,000 (Scheper-Hughes).

Kosovo in the meantime evolved into an international center for organ trafficking with a ring of criminals selling kidneys and other organs from impoverished victims for up to \$200,000 to patients from as far away as Israel and Canada. It was reported that the traffickers lured people from slums in Istanbul, Moscow, Moldova and Kazakhstan promising them a fee of \$20,000 for their organs. Many however were never paid a cent. The transplant operations were performed at a private clinic in Pristina. Among those implicated were the Kosovo Health Minister, a Turkish doctor and an Israeli financier (Bilefsky, 2010). At the same time another investigation implicated the prime minister himself, Mr. Hashim Thaci, who has allegedly led a criminal network that sold organs of civilian captives during the 1998-99 Kosovo war. Classified U.N. documents showed that the U.N. mission in Kosovo was aware of the organ trafficking allegations as early as 2003, but chose to ignore them, although the claims had been made public by former U.N. war crimes prosecutor Carla del Ponte (Qena, 2011).

Even developed countries have been implicated with live donors entering the US with the sole purpose of selling their organs. In October 2011, Levy Izhak Rosenbaum admitted in federal court that he had brokered three illegal kidney transplants from donors from Israel for U.S.-based patients in exchange for payments of \$120,000 or more (Freeman, 2011). Nancy Scheper-Hughes believes that organ trafficking in the US is underreported and

that US surgeons have been transplanting black-market kidneys from poor donors of the world's most impoverished nations to rich patients from Israel, Europe and the United States. She believes that an elaborate network of criminals who charge \$150,000 per transplant, network globally to connect buyers and sellers, whom they then direct to "broker-friendly" hospitals in the United States where the surgeons have been either complicit in the scheme or willing to turn a blind eye. Scheper-Hughes asserts that the brokers have often posed as or hired clergy to accompany their clients into the hospital and ensure the proper execution of the process. The sellers received only a few thousand dollars plus the chance to see an American city (Interlandi, 2009).

The situation in China is equally dire. The China Daily (2011) reported that the police in Bazhou, raided a clinic on suspicions of illegal kidney transplants and arrested three doctors. However, Amnesty International has accused the Chinese government of double standards because of the 1984 enactment of the "Rules Concerning the Utilization of Corpses or Organs for the Corpses of Executed Prisoners" (Bellagio Task Force Report on Transplantation, 1997). The law provided "that corpses or organs of executed prisoners could be harvested if no one claimed the body, if the executed prisoner volunteered to have his corpse so used, or if the family consented." Amnesty International asserts that the Chinese government is performing executions for minimal offences to capitalize on the organ trade while they cite the testimony of witnesses who assert that criminals are regularly examined to select matches for waiting patients. "One prisoner, during his seven year jail term, told how he saw numerous prisoners being medically prepared for organ removal. On the night before the execution, the prison staff would take blood samples." (Craig, 1998).

One million Chinese need a transplant every year, but less than 10,000 receive

organs. The gap between supply and demand has boosted the black market, with 'organ dealers' advertising openly on the web, promising the perfect match between patients and donors willing to sell their organs. A dealer claimed in his site that he had found transplant kidneys for more than 200 patients. Under international pressure over the abuse of organs, the Chinese government finally admitted the use of inmates for organ harvesting and promised to fight the black market, where a single kidney can sell for \$80,000. Acknowledging that prisoners were not the proper source of organs, the government and the Red Cross Society of China have initiated campaigns to encourage people to become donors, creating a database of potential donors and offering financial support to needy families of those who volunteer (Foster, 2009). Although in 2007 the government banned foreigners from receiving transplants in China, medical tourism to that purpose is still taking place. In February 2009, the government was investigating whether 17 Japanese tourists had received illegal kidney and liver transplants spending \$87,000 each (McDonald, 2009). The suspicions of a thriving black market are further supported by a report in the Yangzi Evening News concerning the Nanjing City Organ Donation Pilot Program (2011). This pilot program received no organ donations for the whole year since Nanjing became one of the ten organ donation pilot cities. Strangely enough over the past twenty years there had been only three organ donations reported in that city whose population exceeds 10 million. Therefore one has to wonder where the organs used in organ transplant operations came from (Yu, 2011).

### **Effects**

In a number of instances deaths or serious complications including HIV infection have been recorded. Inston (2005) reported that a number of patients among the large Indo-Asian population in the UK who had had a

limited chance of receiving a transplant for several reasons, resorted to traveling abroad to obtain an unrelated donor kidney transplant. The authors identified 23 patients who had undergone transplantation abroad against medical advice. Mortality from causes directly related to transplantation approached 35% with an overall rate of successful transplants approaching 44% in the short term. Furthermore, there was very limited information on both donors and recipients. The authors underscored the risks associated with organ trading. They emphasized the monetary basis for this trade and refused to endorse this practice that involved unacceptable risks.

Dr. Jafar (2009) has also reported that transplant surgeries based on organ trafficking are performed at private for-profit hospitals in cities where most units are not accredited to adhere to practice standards for safety and quality of care. In addition, services are outdated and since the market is price driven, the international rates exceed the local bids. He states that two thirds of the 2,500 paid kidney transplants in Pakistan in 2007 were reported to have been for patients from overseas. Data on short- or long-term complications and graft and patient survival for both donor and patient were scarce. Yet, high rates of transmission of infections, including HIV and hepatitis, and recipient mortality have been observed after transplant of purchased kidneys from these regions which indicate the existence of substandard safety standards.

The effects on the victims are serious and multidimensional. The World Health Organization has published the consequences of paid kidney donation in Egypt, India and Iran (Shimazono, 2007). Upon assessing the data one sees certain common denominators emerging: poverty of donors, deterioration of health after donation, negative effects on their employment status and overall financial situation. Similar results emerged from

studies in Pakistan and the Philippines, with the vast majority of the donors regretting their act, experiencing serious health problems and re-occurring financial problems. Furthermore the donors expressed feelings of social rejection, discrimination and depression (Budiani-Saberi, 2008).

### **The Iranian Model**

Following a different approach, Iran, having legalized the commercial sale of organs, claims that there are no waiting lists for kidney transplants. The vendor of the kidney receives financial compensation from the government and health insurance for one year. The broker is a voluntary organization served by patients of kidney disease who strive to safeguard the transparency of the process. Foreigners may not receive kidneys in Iran (Ramana, 2008).

The Iranian model has offered a basis of arguments to the supporters of legalization. Given the huge gap between the supply and demand, monetary compensation under a strict control system may alleviate the situation. Legalization of selling one's organs could let patients live longer while the sellers have exercised the freedom to do as they please with their bodies while not harming others. Legalization, according to Martin Wilkinson, an ethics professor from Keele University, could increase the supply and clear the backlog on the waiting list (2010). The professor has pointed out that the outcome is not guaranteed. "Perhaps few people would want to sell; perhaps people who would have donated now would not because, for instance, they are offended by the idea of money changing hands. In theory, the supply of organs could even fall if sales were allowed." Society may indeed find this type of commerce repulsive and continue its donation habits based on altruism alone. Yet, the professor points out, a new dilemma will emerge. We cannot claim that we prefer altruism, when adherence to it increases the death rate of

patients. And although it is the poor who are more likely to sell, is it right to deprive them of an open transparent process instead of pushing them to the hands of unscrupulous brokers? Dr. Wilkinson believes that the

market should be regulated and that selling an organ should no longer be a criminal offence. Given the abuses of the black market and the high profitability of trafficking organs, a number of people have supported legalization of selling human organs. Opponents of the idea assert that legalization of organ sales will institutionalize the belief that the rich may acquire property rights to the organs of the poor.

### **Medical tourism intertwined with organ trafficking**

Developing countries have invested heavily in medical tourism especially after the Asian financial crisis of 1997. With the middle-class population in developed countries affected by the crisis, hospitals in Asia took advantage of their devalued currencies and started advertising their services overseas. Thailand's Bumrungrad Hospital was among the first to attract foreign patients, enticing hospitals in other countries to follow suit. The Malaysian government has facilitated the growth of the industry by establishing the National Committee for the Promotion of Health Tourism. Hong Kong and China have been marketing traditional Chinese medicine. The figures are impressive. According to Fox and Sullivan, by 2012, medical tourism will be a \$100-billion business, with a growth rate of 20-30%. The quality of services is excellent and famous American hospitals like Johns Hopkins or the Mayo Clinic are receiving more and more competition from facilities in places like Parkway Hospital in Turkey at or Bumrungrad in Thailand or Severance in Korea (Sullivan, 2011).

At the same time the rise of medical tourism has hurt the poor populations of these countries. Private doctors may choose the lucrative business of treating foreigners in local expensive private facilities rather than cater to the needs of the poor in run-down public hospitals. The situation is

exacerbated by the organ transplantation that may involve organ trafficking or organ harvesting against the wishes of the donor.

### **Discussion**

The evaluation of the problem has created the need for new discussions and bold perspectives on the evolution of medical tourism as it is related to organ transplantation. Two facts are indisputable. The demand outstrips the supply and the black market has intervened to profit from the gap. The ethical concerns are mounting in places like Asia where one sees very wealthy patients in need of an organ, and very poor people desperate for some money. The World Health Organization has opposed the commercial sale of organs because it sees the exploitative nature of the transaction as rich people will have no incentive to sell organs.

These ethical concerns have encouraged many Asian countries to take serious steps in an effort to prevent this exploitation. In the Philippines, India, China, Singapore, Thailand and Malaysia, governments have been taking steps to prevent organ sales. This prohibition however is grossly violated, having given rise to a thriving black market, criminal networks and unscrupulous treatment of the desperate poor.

The situation is exacerbated by the low number of registered donors in developed countries. Thomas (2009) reported that although 72% of Americans said they wanted to donate their organs, a mere 38% of licensed drivers were registered to do so, while 18 people die daily in the US waiting

for a transplant. Their reasons ranged from misconceptions as to who could become a donor to mistrust of doctors, to gross misunderstandings as to the meaning of "brain dead patient." The need for educating the public appears urgent so the number of donors will increase. Although there are some educational efforts undertaken by transplanted patients, in no way can they match the potential of a nationally designed comprehensive campaign. If this awareness

endeavor is not launched, the scourge of organ trafficking, having hijacked the vehicle of medical tourism, will only grow and metastasize.

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