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Eliminating Transplant Tourism in the United States as a Means to Decrease Waitlist Mortality of US Residents

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To the Editors

The liver transplant community is united in seeking to decrease the number of waitlist deaths while mitigating geographic disparities in access to transplantation. The Share 35 policy enacted in June 2013 and recent redistricting efforts have focused on broader geographic sharing of the current supply of livers in order to minimize waitlist mortality.¹ Less attention though has been paid to another mechanism to minimize waitlist mortality of US residents: eliminating transplant tourism to the US.

Although policymakers have sought to limit transplantation of nonresidents, there have never been specific penalties for ‘excess’ transplantation of nonresidents. The “5% rule” was used as a trigger for auditing a transplant program, but itself did not merit sanctions.² Although there have been estimates of the number of transplant tourists to the US, due to changes in coding since 2010, it is unknown whether travel to the US for liver transplantation has continued.

We estimated the number of foreign nationals traveling to the US for DDLT using Organ Procurement and Transplantation Network (OPTN) data from 1/1/05–12/31/13. We included all adult foreign national deceased-donor liver transplant (DDLT) recipients, excluding Status 1 (acute liver failure) patients (n=24). The primary analyses utilized a broad definition of a foreign national: a citizenship status that was not “US” or Puerto Rico, plus

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either: 1) permanent place of residence at waitlisting was ‘foreign country;’ 2) citizenship status at registration was listed as ‘non-resident alien’ (green card holders are considered a ‘resident alien’); and/or 3) primary insurer was listed as a ‘foreign government.’ Secondary analyses utilized stricter criteria, excluding non-resident aliens with “private insurance” or Medicare whose date of entry into the US was >1 year of their waitlist date.

From 1/1/05–12/31/13, there were 366 non-Status 1 adult foreign national DDLT recipients (mean yearly volume: 40.7), with only small fluctuations in the year-to-year volume. Using the more stringent criteria, there were 314 foreign transplant DDLT recipients during the study period (mean yearly volume: 34.9).

With fewer than 6,000 DDLTs each year in the US, in the face of approximately 2,500 waitlist removals for death or clinical deterioration, it is clear that the current system of liver transplantation is unable to meet the needs of the broader US population. It goes without saying that any policy that places an outright ban on travel tourism to the United States must consider the potential harm to foreign nationals in need of a lifesaving liver transplant. Thus we would not argue that foreign nationals who develop acute liver failure while in the US be denied access to a transplant.

The continued success of the organ transplant system relies on the public trust in order to promote organ donation. Continued transplantation of foreign nationals in a system where thousands of US residents are dying without a lifesaving transplant has the potential to erode the public’s trust in the US transplant system. Although the number of foreign nationals traveling to the US each year for a DDLT is small in the absolute sense, the number of waitlist lives of US residents that could be saved by restricting transplant tourism is relatively similar to more high profile proposals to re-fit the MELD score or redraw maps of organ distribution.³ The transplant community should begin a dialogue to readdress this issue given the continued focusing on minimizing waitlist mortality.

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Abbreviations

OPTN	Organ Procurement and Transplantation Network
UNOS	United Network for Organ Sharing
DDLT	Deceased-Donor Liver Transplant
MELD	Model for End-Stage Liver Disease

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