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On the Issues

Edwards and Organ Transplants

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Although John Edwards is no longer a presidential candidate, his attacks on the U.S. health care system will continue to resonate. As a candidate, he used the tragic case of Nataline Sarkisyan, who died while awaiting a liver transplant, as an indictment of the U.S. medical system and an argument for a European-style single-payer system. But AEI's Scott Gottlieb, M.D., argues that there is little support for Edwards's argument that a single-payer system would be better for people who need transplants. The data show, he says, that organ access in the United States, our willingness to transplant the sickest patients, and U.S. medical outcomes are among the best in the world.

Campaigning in the primaries, former senator John Edwards leveraged the tragic story of Nataline Sarkisyan—the seventeen-year-old California woman who recently died awaiting a liver transplant—to press his political attack on insurance companies and argue for European-style, single-payer health care. But the former trial lawyer, accustomed to using anecdotes of human suffering to frame his rhetoric, twisted the facts. Organ transplantation, like many areas of medicine, provides a poor basis for his political thesis that single-payer health care offers a more equitable allocation of scarce resources or better clinical outcomes.

Late last year, Sarkisyan developed liver failure, apparently a result of blood clotting that stemmed from the high doses of chemotherapy and a bone marrow transplant she had received to treat relapsed leukemia. She was put on life support as her doctors at the University of California, Los Angeles (UCLA) tried to get her a new liver and asked CIGNA, the insurer that was acting as administrator to her father's employer-provided, self-insured health plan, to pay for the transplant. CIGNA deemed the transplant unproven in its medical benefit and ineffective as a treatment. It recommended that her father's employer not cover the procedure.

After an appeal, CIGNA hired an oncologist and transplant surgeon to review the case. According to CIGNA, these experts agreed that the transplant exceeded appropriate risk-taking, with little support from existing medical literature.

CIGNA never reversed its administrative decision. But after significant pressure from the California Nurses Association, a powerful union lobby—and legal threats—it made a clumsily announced concession, a one time "exception" to pay for the transplant itself, despite sticking to its judgment that the procedure constituted an experimental use of a scarce organ. But CIGNA's concession came too late. The same day it was made, Sarkisyan was taken off life support and died.

From here, facts are in dispute. Her family says a liver became available while CIGNA wrung its hands over the matter. Some news accounts question this turn, since institutions like UCLA would typically proceed with transplants, even before insurance plans are settled, once an organ becomes available.

Edwards seized on the case. "We're gonna take their power away and we're not gonna have this kind of problem again," he said on December 21, 2007. "These are living and breathing examples of

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what I'm talking about, and there are millions more just like them," Edwards told reporters on January 6, 2008. An edited video of his attacks on CIGNA has been posted on YouTube.

Research provides little support to Edwards's underlying premise that single-payer health-care systems would do better. On balance, data suggest that in the United States, transplant patients do quite well compared to their European counterparts, with significantly more opportunities to undergo transplant procedures, survive the surgery, and benefit from new organs.

Some of the best data pit the United States against the United Kingdom and its National Health Service. A study published in 2004 in the journal *Liver Transplantation* compared the relative severity of liver disease in transplant recipients in the United States and the U.K. The results were striking. No patient in the U.K. was in intensive care before transplantation, one marker for how sick patients are, compared with 19.3 percent of recipients in the United States. Additionally, the median for a score used to assess how advanced someone's liver disease is, the "MELD" score, was 10.9 in the U.K. compared with 16.1 in the United States—a marked gap, with higher scores for more severe conditions. Both facts suggest even the sickest patients are getting access to new organs in the United States.

On the whole, the United States also performs more transplants per capita, giving patients better odds of getting new organs. Doctors here do far more partial liver transplants from living, related donors but also more cadaveric transplants (where the organ comes from a deceased donor). In 2002—a year comparative data are available—U.S. doctors performed 18.5 liver transplants per one million Americans. This is significantly more than in the U.K. or in single-payer France, which performed 4.6 per million citizens, or in Canada, which performed ten per million.

What about the differences in outcomes between ours and single-payer systems? One recent study found that patients' five-year mortality after transplants for acute liver failure, the type from which Sarkisyan presumably suffered, was about 5 percent higher in the U.K. and Ireland than the United States. The same study also found that in the period right after surgery, death rates were as much as 27 percent higher in the U.K. and Ireland than in the United States, although differences in longer-term outcomes equilibrated once patients survived the first year of their transplant.

These findings are not confined to transplanted livers. A study in the *Journal of Heart and Lung Transplantation* compared statistics on heart transplants over the mid-1990s. It found patients were more likely to receive hearts in the United States, even when they were older and sicker. The rate was 8.8 transplants per one million people, compared to 5.4 in the U.K. Over the same period, about 15 percent of patients died while waiting for new hearts in the U.K., compared to 12 percent in the United States. In 2006, there were 28,931 transplants of all organ types in the United States, 96.8 transplants for every one million Americans. There were 2,999 total organ transplants in the U.K., 49.5 transplants for every one million British citizens.

What about Edwards's implicit thesis, that U.S. organ allocation is dictated by someone's ability to pay? When it comes to livers, the majority of U.S. transplants are for chronic liver disease, usually resulting from hepatitis C or alcoholism. These are diseases disproportionately affecting lower-income Americans who predictably comprise a comparatively higher number of people getting new organs.

Ideally, everyone who can benefit from an organ transplant would receive one, especially a young patient like Sarkisyan. But with more patients than available organs, some form of allocation procedure involving administrative judgments is inevitable. In Sarkisyan's case, that judgment was made by CIGNA, in an advisory capacity to her father's employer, interpreting the terms of the employer's health insurance contract. In the U.K. and other European systems—and in the U.S. single-payer system favored by Edwards—those judgments are made solely by a government agency. The available data suggest that the government allocation procedures do a somewhat worse job, as far as health outcomes are concerned, than private allocation procedures in the United States.

As in all events, the inevitable trade-offs and ethical dilemmas cannot be wished away. Our system in the United States for allocating scarce resources remains imperfect. But taken as a whole, statistics show that organ access, our willingness to transplant the sickest patients, and our medical outcomes are among the best in the world—probably superior to the single-payer systems that Edwards would have Americans emulate and certainly better than the facts that Edwards wants us to believe.