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# The rise and decline of Israel's participation in the global organ trade: causes and lessons

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**Abstract** Why would a country choose to actively take part in the illicit organ trade, and later reverse course and cease that participation? The article answers this question with respect to Israel, where patients in need of a transplant received public funds to allow them to purchase organs abroad. I argue that the Israeli policy of financing "transplant tourism" resulted from the pleas of desperate patients facing a local organ shortage, combined with cost-saving considerations. Yet pressures from the Israeli and international medical community, together with media reports, led to a legislative prohibition on the trade in organs—a prohibition that has sharply reduced the outflow of patients. The article highlights the main influences that motivated Israel's policy change, including concerns for the country's international reputation, and offers lessons for other countries where organ trafficking flourishes.

Organ trafficking—the sale and purchase of human organs for transplantation—is a widespread medical crime. Estimates put the worldwide number of commercial transplantations—those involving payment for the organ—at about 10,000 annually: roughly 10 % of all transplantations [77]. In most cases, the organ in question is a kidney, sold by a living donor. The paid donation and subsequent transplantation often break local laws that prohibit the provision or acceptance of monetary compensation in exchange for an organ; this practice also violates the international standards in the area of transplantation, as promulgated by the World Health Organization (WHO) [75, 76]. Underlying the prohibition on organ trafficking and the requirement of *altruistic* organ donation is the view that human organs are not a commodity to be traded. Furthermore, the trade in organs is inherently exploitative and unjust, since it is the poor and vulnerable members of society who are driven to sell their organs to the rich.

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Notwithstanding such prohibitions, the organ trade has flourished, given the powerful incentives of sellers and buyers to engage in it. For the paid donors, selling a kidney often offers the only hope of escaping miserable poverty or paying off debt. In some cases, donors come under heavy pressure to elicit their consent, or are coerced outright [12]. For the patients, the purchase of an organ offers the promise of regaining their health and, at times, avoiding imminent death. Given the global problem of organ shortage and the increasingly lengthier waiting lists [1], some patients see no other choice but to obtain an organ through a commercial transaction. Yet such a transaction is far from a satisfying solution, either for the donor's economic hardship or for the patient's medical problem; in fact, it could leave the two worse off. Paid donors often experience a deterioration of their health—as a result of inferior donor assessment and selection as well as poor postoperative care. Many donors also face psychological problems, such as a sense of shame and social isolation. Moreover, the hoped-for economic improvement rarely occurs. Donors often spend the money quickly to pay off debt without enhancing the quality of their lives; their worsening health could actually lead to a reduction of income. Many end up regretting the donation [22, 50, 51, 54, 80]. Nor is commercial transplantation a panacea for the patient. Given the often-inadequate pre-transplant evaluation of donors and recipients, as well as substandard medical treatment, commercial transplantations may yield inferior outcomes, compared with transplantations that meet ethical requirements. Commercially transplanted patients face a higher risk of surgical complications, infections such as HIV and hepatitis, and acute organ rejection, which might lead to major morbidity and mortality [2, 30, 33, 34, 60, 70].

The trade in organs may take place within national boundaries. Patients obtain kidneys from fellow citizens or from vulnerable individuals who are in the country temporarily: migrant workers and refugees. Yet the sale and purchase of organs may also take place across borders; in such case, the practice is known as *transplant tourism*. Transplant tourism has several forms. Most commonly, patients from rich countries travel to poorer countries, where the donors and transplant centers are located. Soon after the transplantation, the patients return to their home country, where they will be in need of continuing care.[1] As in other sectors of illicit trade, organ trafficking thus involves "exporting countries"—typically poor countries whose citizens are the source of organs—and "importing countries"—rich countries whose citizens obtain the organs. The identity of the exporting countries has varied over the years. Once-popular destinations have seen a reduction in the inflow of patients after local authorities took action to curb the organ trade (e.g., India in the mid-1990s) or when the broader environment changed (e.g., the Iraq war and the end of Saddam Hussein's regime in 2003). In 2007, a study commissioned by the WHO identified China, the Philippines, Pakistan, Egypt, and Colombia as major organ-exporting countries [65, p. 957]. The major organ-importing countries include the rich countries of East Asia (Japan, Taiwan, South Korea, Malaysia, and Singapore) as well as the Persian Gulf countries (especially Saudi Arabia, Kuwait, and Oman). Yet

[1] In another form of transplant tourism, the paid donor travels to the country where the patient and transplant center are. Alternatively, the donor and the patient—from the same country or from different countries—may travel to a third country that has less stringent ethical requirements and allows commercial transplantations [64].

among the importing countries, it was Israel that was singled out for criticism by the international medical community.

One reason was Israel's major involvement in the organ trade, especially given the small size of its population. From Turkey to Bulgaria to South Africa to Azerbaijan to China to the Philippines, Israeli patients roamed the globe in pursuit of organs. However, it was another aspect of Israeli transplant tourism that made it exceptional: this practice was state-sponsored. With authorization from the Ministry of Health, the Israeli Health Maintenance Organizations (HMOs) reimbursed patients for commercial transplantations performed abroad. In other words, public funds turned organ purchasing from a prohibitively expensive exercise into an affordable option that was within reach even for patients of modest means. Unsurprisingly, the reimbursement served as fuel that encouraged and facilitated transplant tourism, resulting in a rapidly growing outflow of patients. And yet, in March 2008 Israel sharply reversed course and redeemed its reputation with the enactment of the Organ Transplantation Law, which established a set of prohibitions aimed at eliminating organ trafficking and transplant tourism, while at the same time putting in place measures to encourage altruistic organ donation within Israel. By enacting the law, Israel became a positive example of the pursuit of national self-sufficiency in transplantation, consistent with the principles of the international medical community. Those principles were reinforced by the Declaration of Istanbul on Organ Trafficking and Transplant Tourism [69], which was adopted by the Transplantation Society and the International Society of Nephrology 1 month after the enactment of the Israeli law.

Why did Israel choose to sponsor its patients' purchasing of organs abroad? What later induced it to eliminate this practice? Applying a framework for the analysis of cooperation against illicit trade, the article sheds light on the origins of Israel's policy and its transformation. I argue that Israel's funding of transplant tourism resulted from the pressure of desperate patients, combined with considerations of cost-effectiveness and cost-saving: in the case of kidney failure, a one-off transplantation abroad is much cheaper than long-term dialysis and improves the patients' health outcomes. Yet advocacy by the local and international medical community convinced Israeli politicians and bureaucrats that transplant tourism is morally wrong, potentially harmful to the donors and patients, and damaging to Israel's international reputation. I conclude with the broader implications of the Israeli experience for fighting organ trafficking in other countries.

## Theoretical framework

To understand Israel's policy on organ trafficking, this article applies a theoretical framework for the analysis of international cooperation against illicit trade [16]. While conventional approaches to transnational crime focus on criminals, this framework suggests that the politics of illicit trade is shaped by the *legitimate* actors involved, such as museums that acquire looted antiquities, banks that launder money, and arms manufacturers that sell guns indiscriminately. These actors put pressure on governments to allow their unscrupulous practices; they also seek to undermine national and international regulatory initiatives that threaten their business. In many cases, governments indeed choose to protect the interests of these actors and overlook

the negative effects of illicit trade—especially when those effects are felt abroad. Such governments refuse to put in place laws and regulations to eliminate illicit trade, or establish laws but do little to enforce them. For decades, up until the 1970s, the U.S. government allowed the import of looted antiquities into the country—antiquities that ended up in the collections of major museums; a number of countries—from Russia to the Philippines—have been hesitant to curb the involvement of their financial institutions in money laundering; and China and Pakistan, protecting the interests of their state-owned arms industries, have resisted the international efforts against the illicit trade in small arms [7, 16, 18].

The focus on the *legitimate* actors involved in illicit trade, rather than the criminals, is particularly appropriate for organ trafficking. The organ trade may indeed involve "professional" criminals who act as brokers; yet the majority of those involved in this trade are legitimate actors, rather than outlaws. The patient in need of a transplant; the paid donor; the medical team that performs the commercial transplantation, led by the transplant surgeon; the hospital administration; labs that conduct tests and evaluations prior to the transplantation; and medical insurers—while all of these directly or indirectly contribute to an illegal practice, they are otherwise legal actors whose interests and concerns may affect governments' calculations. In the context of Israel—an organ-importing country—the relevant actors are the patients and their insurers: the HMOs. The patients engaged in transplant tourism and the HMOs funded it, with the approval of the state's health authorities.

Yet government authorities that tolerate illicit trade may ultimately take action to stop it. Such a policy change may come about through two channels. One is interstate coercion: powerful governments—first and foremost, the U.S. government—may threaten or impose sanctions on weaker governments in order to compel them to suppress illicit trade. Coercion has indeed been at the heart of the international efforts against illicit drugs and counterfeit goods. The United States issues annual condemnations of countries involved in these trades, accompanied by threats of aid suspension or trade sanctions [8, 62]. A second mechanism whereby governments may be induced to combat illicit trade involves moral entrepreneurs, that is, civil society groups committed to the suppression of trade that they consider harmful and repugnant [49]. These groups place the trade on the political agenda and call on governments to take action against it. Using their knowledge and expertise, they educate policymakers by providing information that exposes the trade's negative effects. In addition to making a moral and normative case in favor of suppressing the trade, the entrepreneurs may also offer instrumental reasons—for example, warning that tolerance of illicit trade may stain the country's reputation. An example is the advocacy of archaeologists against the American and British involvement in the illicit antiquities trade. In the early 1970s, lobbying by archaeologists—reinforced by media scandals that exposed the unethical practices of the art market—prompted the U.S. government to take measures for preventing the import of looted antiquities. In the early 2000s, a similar combination of archaeologists' advocacy and public scandals motivated the British government to curb the London art market's participation in the illicit antiquities trade [16].

In the case of organ trafficking, the first mechanism of policy change—U.S. coercion—is absent. While the United States has been leading an international campaign against human trafficking since 2000 [71], the issue of organ trafficking

has received little attention in that campaign. It has focused on trafficking in persons for the purpose of sexual or labor services, to the neglect of trafficking for organ removal. It is therefore the second mechanism—moral entrepreneurs—that is at work here. A group of physicians, committed to the elimination of the organ trade, convinced the Israeli government to tackle this problem. The group applied two-pronged pressure: from below—that is, through local Israeli physicians—and from above, that is, through representatives of the international medical community, with the blessing of the World Health Organization. Like the archaeologists' campaign against the illicit antiquities trade, the physicians' advocacy efforts received a boost from media reports that exposed the Israeli involvement in the organ trade.

Based on the above framework, the following analysis highlights several key influences on the Israeli policy. In the 1990s and early 2000s, it was the Israeli patients and the HMOs that identified transplant tourism as a remedy for the acute problem of organ shortage. Unaware of the full ramifications of this practice, the Israeli health authorities went along with it. Yet the advocacy efforts of the medical community—bolstered by media coverage—managed to redirect the Israeli policy from tolerance and support of transplant tourism to a prohibition.

## Israeli transplant tourism: background

The practice of transplant tourism emerged in Israel in the early 1990s. Soon enough, the trickle of patients undergoing commercial transplantations abroad became a flood. In the peak year—2006—at least 155 Israelis obtained kidneys overseas [37]. In some cases, the source of the kidney was a paid donor who was Israeli as well. Ministry of Health regulations allow Israeli hospitals to transplant organs from living donors only if the donation was altruistic[2]; if an Israeli patient found a fellow Israeli willing to sell his kidney, the procurement and transplantation of the organ had to take place in a third country. In the majority of cases, however, Israeli transplant tourists obtained kidneys from foreign paid-donors. The surgery took place in the donor's home country (for example, the Philippines or Colombia), or in a third country (for example, Israeli patients and Brazilian donors arriving for a transplantation in South Africa; Israeli patients and Moldovan donors traveling to Turkey; kidneys from Eastern European donors transplanted in Azerbaijan and Kosovo). The surgeries were often performed late at night or in the early morning hours, when few of the hospital staff were present [47, 72, pp. 76–77].

Over time, Israeli transplant tourism saw several developments. First, the practice grew in scale. As patients suffering kidney failure came to learn of the option of buying a kidney—a solution that would relieve them of the suffering of dialysis—demand soared. Second, the rising demand and the possibility of making an easy profit brought brokers into the picture and made transplant tourism an industry. The brokers' involvement led to a steep price increase. Initially hovering at around $40,000, the price of a transplantation abroad rose to $70,000, ultimately reaching $100,000–$120,000 and in some cases exceeding $200,000. Third, the places where

[2] Circulatory letter of the director general of the Ministry of Health no. 10/98, Transplantation of Organs from Living Donors—Updated Procedure, July 20, 1998.

the transplants are performed changed over time, as countries started closing their doors to transplant tourism. Media exposure of this practice led governments to take action against it; when one destination closed, Israeli patients moved on to the next.

Transplant tourism is not a uniquely Israeli phenomenon. Patients from Japan, Taiwan, and Saudi Arabia, among others, have also undergone commercial transplantations abroad. American participation in the kidney trade has been observed as well [42]. Yet the international medical community has seen Israel as the initiator and "leader" of transplant tourism. Israel's rate of transplant tourists per capita was one of the highest among organ-importing countries. Moreover, the growing reach and sophistication of Israeli transplant tourism set an example soon followed by brokers and patients in other countries. What led to the thriving of transplant tourism in Israel?

What lies in the background to this phenomenon is the severe organ shortage in Israel. Among Western countries, Israel has one of the lowest rates of organ donation from the dead: 9.86 deceased donors per million inhabitants in 2008, compared with 26.26 in the United States, 25.31 in France and 14.59 in Germany [21]. One cause of Israel's low donation rate is cultural practices and religious beliefs that favor leaving the dead intact; another is Orthodox Jews' objection to the concept of brain death [53]. The result of the paucity of donations has been a severe organ shortage, which further escalated in the early 1990s with the influx of Jews who migrated to Israel from the former Soviet Union. The dramatic and sudden increase of the Israeli population—by roughly 20 %—raised the demand for organs; furthermore, many of the migrants had received poor healthcare in the former Soviet Union, resulting in a higher rate of disease than that of the native population [6]. The result was ever-growing waiting lists. As of January 2008, 864 patients were waitlisted for organs, mostly kidneys; in the preceding year, only 231 patients underwent transplantation in Israel, with organs from deceased or living donors (Israel's National Transplant Center data). Inevitably, some patients died while waiting.

The scarcity of organ donations in Israel and the resulting long waiting lists were the necessary cause and motivation for the emergence of transplant tourism as a means of overcoming the organ shortage. Another factor, however, served as fuel that encouraged and facilitated this practice: an official policy of reimbursing patients for transplantations performed abroad. The reimbursement removed the financial barrier that otherwise might have prevented the pursuit of organs overseas. The result was a growing outflow of patients, who preferred obtaining an organ from a stranger abroad to the other, less attractive options: continued waiting, perhaps in vain, or asking a loved-one to donate. For the State of Israel, however, the policy of reimbursement meant funding an activity abroad that typically violated foreign laws prohibiting paid organ-donation. I now turn to examining why Israel chose to support and sponsor such an activity, and how the country's pariah status within the medical community generated pressures for reform.

## Israel's policy of funding transplant tourism

The Israeli healthcare system is largely a public system. The 1994 National Health Insurance Law guarantees universal, unconditional coverage to all residents of Israel.

This coverage entitles them to a uniform "healthcare basket" of services which is determined by law and funded by the state. The primary vehicles for the provision of health services are four public, nonprofit HMOs: Clalit (the largest HMO, covering 53 % of the population), Maccabi, Meuhedet, and Leumit. The state funds the HMOs from two sources: a health insurance tax, collected by the National Insurance Institute (Israel's Social Security); and the government budget. The funds are allocated among the four HMOs based on the number and age of individuals covered by each [9].

In terms of the legal landscape, until 2008 Israeli law was largely silent on the issue of organ trafficking and transplant tourism. In fact, the entire area of organ transplantation existed in a legislative vacuum: it was regulated mainly through directives—"circulatory letters"—issued by the Ministry of Health. The only ban relating to organ trafficking appeared in a 1997 directive to physicians. That directive prohibited physicians from performing a transplantation procedure if the organ was paid for; a physician who violated that ban could be subject to disciplinary action and criminal prosecution.[3] By contrast, there was no prohibition—legislative or other—on the selling or buying of organs, nor was there a ban on organ brokering. It was this silence of the law that allowed Israeli transplant tourism to thrive.

In 1994 Clalit received the first reimbursement claim for $40,000 from a patient who had received a transplant in Turkey. The HMO was initially reluctant to reimburse that patient and those who followed. First, it was clear that the transplantations were illegal in the countries where they had been performed. Second, Clalit indeed had no legal obligation to pay. By law, an HMO should fund a medical service abroad only if the insured individual faces a "life-threatening danger" unless provided that service.[4] In the case of kidney failure, such a danger presumably did not exist, as the patient could still survive on dialysis. A kidney transplantation abroad was thus not seen as a life-saving treatment, but as one that would merely enhance the patient's quality of life—such a medical service did not entitle the patient to a reimbursement. Nevertheless, within a short time, Clalit made the decision to reimburse patients who had received a transplant abroad for an amount equivalent to the cost of a transplantation in Israel (roughly $35,000 in the mid-1990s; this amount grew over time to $50,000). In late 1996, Clalit's policy received official approval from the Ministry of Health. In a letter to all HMOs, the ministry authorized them to reimburse transplant tourists in the amount it would cost to have the procedure performed in Israel.

Why did the HMOs and the Ministry of Health choose to fund overseas transplantations that violated foreign laws? The policy of reimbursement was the product of several considerations and influences [83]. One of them was patients' pleas. When kidney patients came to see transplantations abroad as a lifeline and rescue—a way to escape the torment of dialysis and regain health—they applied heavy pressure on the HMOs and the Ministry of Health to fund those transplantations. Facing desperate patients, the HMOs and the ministry decided to provide reimbursement for overseas transplantations, although they were not legally required to do so. Their reasoning was that, in principle, the statutory health insurance covers transplantation: the HMOs

[3] Circulatory letter of the Medical Administration no. 68/97, Prohibition on Trafficking in Organs for Transplantation, October 29, 1997.

[4] National Health Insurance Regulations (Health Services in Foreign Countries), 5755–1995, Art. 3(A)(2).

are obligated to bear the full costs associated with this surgery [see 91]. Had the transplantation been performed in Israel, the HMOs would have had to fund it. Refusal to pay for a transplant only because it was done abroad would thus be profiting off of patients' suffering: the patients would be paying out-of-pocket for an expensive medical service, and the HMOs would be keeping the money they would otherwise have spent. Based on this fairness argument, the HMOs justified their funding of transplant tourism.

Second, financial support for transplant tourism made sense as a matter of cost-effectiveness and cost-saving: compared with the alternative—dialysis—a kidney transplantation is cheaper and also produces better health outcomes for patients. Indeed, funding kidney transplants abroad meant significant savings for the state and the HMOs, given the threefold cost of dialysis: 1. the cost of the dialysis treatment itself, which is very high: in 1996, the annual cost of treatment for a single patient was 160,000 shekels (approximately $50,000) [66, p. 231]. This is a *recurring* cost, borne throughout the patient's life. 2. Dialysis patients face a high risk of additional medical complications, such as infections, resulting in added costs of hospitalization and medications. 3. Dialysis entails further social costs: lower workforce productivity (as patients typically cannot work fulltime or at all) and disability benefits. Compared with the very expensive option of long-term dialysis, transplantation offers a much cheaper solution, as it is, in principle, a one-time treatment. Furthermore, following a successful transplant, the patient is again a fully functioning, productive member of society, with a longer life expectancy. Indeed, transplantation does entail the additional cost of immunosuppressive medications to prevent the rejection of the transplanted kidney. Yet while immunosuppressants are quite expensive, they are still cheaper than dialysis treatment [see 31, 55]. It should be noted, however, that a *commercial* transplantation abroad may *not* be cost-saving if, as is often the case, the kidney is of poor quality or the surgery is performed in suboptimal conditions. In such case, the need for hospitalization and possibly a retransplantation would escalate the costs. Yet the HMOs' decision to fund overseas transplantations was based on the assumption that they would indeed reduce costs and improve patients' health compared with dialysis [83].

Finally, transplant tourism offered the HMOs yet another economic benefit: the ability to market a complementary insurance that entitled patients to *additional* funds for a transplantation abroad, beyond those provided on the basis of the statutory healthcare basket. As indicated above, Israeli transplant tourists received approximately $50,000 through the healthcare-basket coverage. Those patients with a complementary HMO insurance could receive additional funding for overseas transplantations in the amount of roughly $15,000. This complementary insurance has become an important source of revenue for the HMOs.

In summary, pressure from patients, coupled with considerations of cost-effectiveness and cost-saving, led the state and the HMOs to fund transplant tourism. This meant adopting a no-questions-asked approach, that is, reimbursing patients without inquiring about the identity of the foreign donor or the way in which the donation was obtained. A specific dilemma arose with respect to transplantations performed in China, given that the source of organs was executed prisoners [14, 63]. In that case, the Israeli patients and HMOs reasoned that the prisoners on death row would die anyway; transplanting their organs at least could save the lives of other people.

It should be noted that the HMOs were not the only source of funding for commercial transplants abroad. Patients who had *private* medical insurance could receive insurance benefits to cover the cost of an overseas transplantation. Like the HMOs, private insurers found the funding of such transplantations preferable to paying long-term disability benefits. My analysis focuses on the HMOs, however, as the primary providers of health insurance in Israel.

## Sources of policy change

Beginning in the mid-1990s, the State of Israel—through the HMOs—used public funds to allow Israeli patients to undergo transplantation abroad, in violation of the foreign countries' laws. This status quo was convenient to all the Israeli actors involved, yet it came to an end with the passage of the Organ Transplantation Law of 2008. This law was intended, on the one hand, to eliminate Israeli transplant tourism, but, on the other hand, to offer an alternative by encouraging living and deceased organ donation in Israel.

Attempts to establish legislation to govern transplantation in Israel had been made as early as the late 1970s. These attempts stalled, however, due to the complexity of the ethical, legal, and religious questions at stake. As a result, transplantation rules and procedures were set mainly by the Ministry of Health's internal directives. What, then, led the Ministry in 2003 to launch a legislative effort that would culminate 5 years later in the passage of the Organ Transplantation Law?

One factor, though not the most decisive, was the exposure of the practice of transplant tourism by the Israeli and foreign press [82]. As mentioned above, media scandals revealed the involvement of the U.S. and British art markets in the illicit antiquities trade; the resulting embarrassment convinced policymakers that this practice had to be stopped.[5] Media exposure of transplant tourism had a similar effect in Israel. In 2000, the popular daily *Yedioth Ahronoth* reported that "every year hundreds [of Israelis] are buying organs abroad for enormous sums of money;" "according to rumors, the transplantations are performed in Turkey, Moldova, Georgia, and Estonia; the donors come from Romania, India, and the Far East, among others" [58]. A 2002 article revealed that Israeli donors and patients used to fly to South Africa, where the kidneys were removed and transplanted. The donors were recruited through ads in local Israeli newspapers; they received $15,000 at best, out of $100,000–$250,000 paid by the patients. Some donors suffered medical complications following the removal of their kidney [3]. Yet another scandal broke in 2003: brokers had preyed on the economic hardship of Russian immigrants in Israel, luring them to sell their kidneys while providing "reassurance" that the missing kidney would grow again. Prospective donors who backed down before the surgery faced heavy pressure, threats of violence, and imprisonment by the brokers—until they submitted and were flown abroad for kidney removal [79]. Additional stories broke

[5] In the United States, one of the most notable scandals followed the Metropolitan Museum of Art's acquisition of a Greek vase in 1972. The vase—the "Euphronios Krater"—turned out to be looted from Italy. Only in 2008 did the Met return the vase to Italy [43, pp. 86–100]. In Britain, a major scandal broke in 1997 after a journalist revealed that many of the antiquities sold by the reputable auction house *Sotheby's* had been smuggled from Italy [see 74].

occasionally throughout the process of legislating the Organ Transplantation Law. One of them revealed that dozens of Israelis, having despaired of waiting for an organ, "are flying each month to China, where they get the organ that will save their lives—straight from the bodies of executed Chinese criminals" [25]. According to another story, "after discovering Colombia, South Africa, and China, Israeli transplant tourists have arrived at Bulgaria," where they buy kidneys from the very poor, including the Roma people (Gypsies) [59].

Internationally, the *New York Times* exposed Israeli transplant tourism in a feature story of the Sunday Magazine in 2001. The article followed the journey of a 43-year-old kidney patient from Jerusalem to Turkey—a journey that ended with a failed transplantation. An Israeli nephrologist interviewed for that article suggested that "Airplanes are leaving every week. In the last few years, I've seen 300 of my patients go abroad and come back with new kidneys. Some are fine, some are not—it's a free-for-all" [19]. In another *New York Times* article, the same nephrologist explained that patients who go abroad "save the country a lot of money, not only in terms of what doesn't have to be spent on dialysis, but also by opening places for other people who are on the list." According to the article, the Israeli "government says it has no obligation to monitor operations done abroad" [57]. Another catalyst of international attention was anthropologist Nancy Scheper-Hughes of the University of California, Berkeley, a leading expert on the organ trade. Scheper-Hughes's publications highlighted the key role of Israel in that trade—a role that made the country "something of a pariah in the international transplant world" [61, p. 73].

In fact, it was that pariah status within the world medical community that proved to be the most effective motivator of action, prompting the Ministry of Health to prepare a legislative proposal and push for its enactment. The medical community's pressure was, in fact, two-pronged: from both above and below. The pressure from above was the result of the activities of the World Health Organization and the Transplantation Society (TTS), the latter being an international association of healthcare professionals in the field of transplantation. In 2004, the WHO resolved to take action against organ trafficking and transplant tourism [75], and asked the TTS to collaborate in that endeavor. The WHO/TTS joint effort devoted much attention to Israel as one of the primary engines of the global organ trade. That attention was manifested in the efforts of Dr. Francis Delmonico, a senior transplant surgeon and Harvard Medical School professor who was among the leaders of the Transplantation Society. As part of the collaboration between the TTS and the WHO, Delmonico was appointed as WHO consultant on organ donation and transplantation. In meetings and correspondence with Israeli officials, Delmonico conveyed a clear message: Israel should not allow organ trafficking—either in the form of transplant tourism overseas or in the shape of paid organ donation at home. These advocacy efforts had a significant impact on the Ministry of Health. Not only did Delmonico make a compelling ethical case, but he was perceived as expressing the consensus view of civilized, enlightened countries. His involvement was also seen as carrying an implicit threat: Israel's noncompliance with the WHO standards could lead to an official condemnation and imposition of countermeasures by the organization. The Ministry of Health took this threat seriously [85].

The international medical community's consensus and efforts against organ trafficking also resulted in pressures from below, that is, domestic calls for action from

Israeli physicians. Most importantly, Israel's leading transplant surgeons—Professor Jay Lavee and Professor Eytan Mor[6]—alerted the Ministry of Health to the fact that Israel had become a target of criticism and condemnation in medical circles: in any discussion of transplantation ethics in international conferences, Israel occupied pride of place as a country that was fueling the organ trade. For Lavee and Mor, invalidating Israel's pariah status and rehabilitating its good name were important motivations for advocating against transplant tourism. The two physicians were also propelled by moral sentiments: the belief that human organs are not a commodity to be traded and that the organ trade is an inherently exploitative practice. In their view, the most vivid illustration of the venality of that trade was the Chinese practice of transplanting organs obtained from executed prisoners. Lavee and Mor thought that the Israeli healthcare system should not participate in an illegal and unethical practice —either by way of financial reimbursement or through the performance of medical checks and assessments in preparation for a transplantation abroad. They were also concerned about the potential corrupting influence of this practice on the Israeli healthcare system itself [84, 86].

Moral entrepreneurs who advocate the elimination of illicit trade are motivated not only by moral principles, but by the negative material consequences of the trade, with which they often come in close contact. The archaeologists who called on the U.S. and British governments to curb the illicit antiquities trade were motivated by the destruction of archaeological sites and monuments which they had seen with their own eyes.[7] Similarly, the Israeli physicians' concern was also the result of their firsthand experience with and understanding of the negative consequences of transplant tourism. Some of the negative consequences were direct. Financial incentives and absence of monitoring and regulation resulted in poor screening of candidates for transplantation; while some foreign transplant centers offered high-quality care, others provided substandard treatment; adding to the already-large burden on the Israeli medical system, returning patients often checked into the Israeli transplant centers with severe rejection, infection or surgical complications, but the local teams had little information about the transplant procedure itself and no information on the donor. In addition, the flourishing of transplant tourism had broader indirect effects. Most significantly, it has been suggested that this practice was among the causes of the stagnant rate of living and deceased organ donation in Israel [47]. Patients preferred to obtain a kidney from a stranger abroad, rather that ask a loved-one to donate; and the Israeli government had little incentive to make the effort and investment necessary for increasing deceased organ donations, given the option of overseas transplantations.[8] This posed a serious problem to non-renal patients: while kidneys could be bought from a living donor abroad, patients in need of a heart or a lung were still largely dependent on cadaveric donations at home.

[6] Lavee is director of the Heart Transplantation Unit at the Sheba Medical Center; Mor is director of the Department of Transplantation at the Rabin Medical Center.

[7] See, for example, the Congressional testimony of an archaeologist discussing the archaeological destruction he had witnessed in Turkey and Iran—destruction fueled by the art market's demand for antiquities [73, pp. 68–69].

[8] Increasing deceased donations entails various investments, such as public awareness campaigns, hospital and organizational infrastructure, and so forth [see 78].

## The process of policy change: enacting an organ-trafficking prohibition

The pressures from the local and international medical community had a significant effect on the Ministry of Health. Ministry officials came to recognize that there is a compelling moral case for stopping Israelis from buying organs abroad, and that Israel should tackle the problem of organ shortage by encouraging living and deceased donations at home. Another reason for curbing transplant tourism was its negative implications for Israel's international reputation: inevitably there was tension between Israel's aspiration to be seen as an enlightened country, on the one hand, and its participation in the global organ trade, on the other. In the ministry's words:

> [T]he State of Israel should be extremely cautious regarding the involvement of public entities such as the HMOs in funding transplantations [abroad]. This is so because of the fundamental normative reason of avoiding acts that involve trade in organs, as well as the fact that the funding could make the state complicit in acts that the enlightened world considers unethical and immoral; it could undermine the state's status as a member of equal rights and values in the international community; and it could damage the state's ability to obtain international cooperation on different aspects of the issue [of transplantation]. … It is important to note that the state is aware of the patients' hardship … yet this consideration, important as it may be, does not relieve the HMOs of the need to ensure that they are not involved in acts that violate fundamental ethical norms. Alongside the patient's obvious interest, there is also a public and universal interest in preventing all forms of exploitation of people, who typically belong to the poorest and most vulnerable groups of society … [there is an interest] in not using public funds to encourage inappropriate norms that the international community abhors.[9]

On the basis of this view, in 2003 the Ministry of Health proposed a comprehensive legislative bill to govern transplantation in Israel. Aimed at "combating the phenomenon of organ trafficking and reducing the shortage of organ donations,"[10] the bill prohibited the giving or receiving of monetary compensation for an organ, as well as brokering in organs—for transplantation in Israel *or abroad*. The bill also established the National Transplant Center to manage and coordinate organ donation and transplantation[11] and set rules for living and deceased donation.

The proposed prohibition on commercial transactions in organs received strong support from several Members of the Knesset (MKs), especially from left-leaning parties. It also received the blessing of the medical establishment: the Israeli Medical Association expressed strong opposition to any commercialism in transplantation [87]. While acknowledging the need to tackle the shortage of organs, the association argued that "organ donation should be purely altruistic" and that "it is impossible to accept the idea that human organs and tissues could be traded": "trade in organs from living donors creates class discrimination, is unethical, and as such is unacceptable."

[9] The Ministry of Health's position in [88], paras. 29, 35.
[10] Organ Transplantation Bill, 5764–2003 (November 24, 2003).
[11] The center, a unit of the Ministry of Health, had operated since 1994, based on the ministry's internal regulations. The bill meant to formalize the center's status and authority through primary legislation.

On these grounds, the association opposed any monetary compensation to living donors in Israel; it also called for the elimination of transplant tourism [27–29].

Yet not everyone shared these views, and the proposed bill quickly became the subject of a fierce battle in the Knesset. The bill's fundamental premise—a prohibition on monetary compensation for organs—met resistance from several legislators led by MK Avraham Ravitz, who had undergone a kidney transplant himself. Whereas the bill sought to eliminate transplant commercialism, this group of legislators envisioned a regulated market as a solution for the problem of organ shortage, and payment of about 100,000 shekels ($25,000) for a kidney as an incentive for living donations. The group also expressed alarm about the intention to eliminate transplant tourism and close down the option of buying organs abroad. By stopping this practice and cutting off the HMO funding for it, the MKs argued, the bill might "prevent saving the lives of patients who need transplantation but have no recourse in Israel, given the low supply of and high demand for organs."[12] In their view, a transplantation procedure abroad should meet the legal requirements of the foreign country where it is performed, but should not be subject to Israeli legal restrictions. In taking this position, the MKs were expressing the view of the patients, who saw the bill's prohibition on compensated donation and its goal of eliminating transplant tourism as closing their only window of hope. The patients' representatives also participated in the legislative debate directly and expressed their plight and concerns, but to no avail. They possessed little political influence and could not gather enough MKs on their side, nor could they convince the Ministry of Health to relax the prohibitions on the trade in organs [81].

The issue of compensation for living donors in Israel lay at the heart of the deliberations of the Knesset subcommittee that considered the transplantation bill. The idea of a regulated market allowing individuals to sell their organs was quickly ruled out; the debate thus revolved around the reimbursement of donors' expenses, such as lost wages and psychological treatment, and ways of preventing that reimbursement from becoming an incentive for donation. The controversy over this issue delayed the passage of the legislation. The Ministry of Health, however, felt an urgent need to curb transplant tourism, even before the bill became law: Israel could not engage in the process of enacting a prohibition on organ trafficking, and at the same time sponsor the organ trade through public funds [85]. The increasing numbers of Israeli transplant tourists—with China becoming a popular destination—reinforced the sense of urgency. To reduce the outflow of patients seeking organs abroad, the ministry decided in 2006 to eliminate a primary driver of that flow: the HMO funding. In a directive to the HMOs, the ministry's director general emphasized that

> the State of Israel shares the approach of enlightened countries, according to which any trafficking in organs is prohibited. The HMOs must conform to this approach … A situation in which the state prohibits organ trafficking within its boundaries, yet the HMOs fund transplantations abroad that result from trafficking or coercion, is inappropriate, sends a dual message, and raises problems

[12] Letter from MK Lia Shemtov et al. to MK Arie Eldad, chair of the Knesset Subcommittee on the Organ Transplantation Bill, June 13, 2007.

for Israel's commitment to the normative and moral principles underlying the universal prohibition on organ trafficking.[13]

According to the directive, transplantations performed abroad naturally raise a suspicion that the donor was compensated, especially when brokers are involved and when the patient cannot prove a prior acquaintance with the donor (whose identity, in many cases, he doesn't even know). Indeed, the regulatory framework at the time—prior to the passage of the Organ Transplantation Law—did not require the HMOs to ensure that the overseas transplantations they funded were free of organ trafficking; but according to the directive, that requirement arose from "fundamental legal and ethical norms accepted by all enlightened countries." In operative terms, the directive instructed the HMOs, as a condition for reimbursement, to ask the patient for detailed information that would negate any concern about trafficking. This information should include the donor's identity and nationality; the way in which the donation was obtained; an affidavit by the donor and the patient confirming the absence of monetary compensation; details about the donor and patient's prior acquaintance that would indicate the altruistic nature of the donation; and any checks performed by the foreign hospital to make sure that neither trafficking nor coercion was involved.[14] Ultimately, the most important requirement was that of a previous acquaintance: the vast majority of Israelis could not prove a prior relationship with the donor, thus revealing the true nature of the donation and voiding any entitlement to reimbursement.

The HMOs opposed the new directive, arguing that the rules governing transplantation should be established by primary legislation and that the directive banned organ trafficking without offering a viable legal alternative. Ultimately, they failed to comply with the directive and continued the policy of reimbursement no-questions-asked [85]. The noncompliance was the result of the HMOs' continued incentives to fund transplantations abroad, as well as the fact that the ministry's directive did not impose sanctions on violators. Furthermore, the disregard of the directive received the blessing of the judicial system. In those cases in which the HMOs indeed denied funding of overseas transplantations, in compliance with the directive, patients challenged the refusal in the courts. Feeling sympathy for the patients, and despite strong evidence suggesting that trafficking was involved, the courts ordered that reimbursement be provided (see, for example, [93]). One of those challenges to the directive ultimately reached the Supreme Court. The court approved the directive, expressed support for the prohibition on funding in case of concern about trafficking, and urged that it be established in primary legislation [92].

That primary legislation—the Organ Transplantation Law (hereafter the law)[15]—was enacted in March 2008, six months after the Supreme Court's decision. Following that decision, another provision was added to the Prohibitions section of the law, specifically addressing the funding of overseas transplantations. The law allows their funding on two cumulative conditions: 1. the procurement and transplantation of the organ conform to the laws of the foreign country in which they are

[13] Circulatory letter of the director general of the Ministry of Health no. 7/06, Funding Organ Transplantations in Foreign Countries, March 13, 2006.
[14] Ibid.
[15] Organ Transplantation Law, 5768–2008.

performed; 2. the provisions of the law that prohibit organ trafficking are complied with.[16] The second condition constitutes, in effect, an extraterritorial application of Israeli legislation: to qualify for funding by an Israeli medical insurer, a transplantation procedure abroad must involve no compensation, as required by the Organ Transplantation Law. Since nearly all transplantations abroad involve such prohibited compensation, the law effectively ended the practice of funding them. The law's prohibitions on organ trafficking and brokering are backed by criminal sanctions, which apply to all those involved in the transplantation, with the exception of the donor and the patient themselves.[17] As the following section will demonstrate, the threat of criminal punishment proved effective, leading the HMOs and the private insurers to stop reimbursing transplant tourists.

While effectively closing the door on commercial transplantations abroad, the Organ Transplantation Law also seeks to offer patients a local solution by increasing the rate of organ donations in Israel. For that purpose, the law removes disincentives for living donation by guaranteeing the donor reimbursement for relevant expenses. The law also attempts to incentivize donation through the establishment of nonmedical criteria for organ allocation. Most importantly, it awards priority to transplant candidates who, prior to being listed as candidates, signed a donor card expressing willingness to donate their organs after death [36]. The law's architects were well aware, however, that the mechanisms aimed at encouraging donations did not offer an immediate solution, but only offer the hope of raising donation rates in the long run. In the short term, it was clear that the law would negatively affect patients by closing down the route of transplantation abroad, before a viable domestic alternative is in place. And yet, the ethical considerations and the concern for Israel's international image prevailed [82, 85].

## Consequences of the legislative prohibition

The efforts against illicit trade—in drugs, arms, and other goods—are based on criminal prohibitions and civil-regulatory measures that seek to prevent and eliminate certain illegal transactions. Yet accurately assessing the effectiveness of these means is an extremely challenging task. Given the clandestine nature of the transactions, we typically lack reliable quantitative data on the participants in illicit trade and its volume [4]. It is therefore very difficult to judge whether measures against illicit trade indeed lead to any substantial reduction. In that sense, organ trafficking is different from other illicit trades, as some of its dimensions and participants are more exposed. There is no way to identify and record all illicit drug users or illegal gun holders; by contrast, it is easier to track transplant tourists who buy organs illegally.

[16] Article 5 of the Organ Transplantation Law.

[17] Article 36 of the Organ Transplantation Law. While the Law prohibits the donor and the patient from selling or buying organs, they will not be punished for doing so. Underlying this exclusion were several reasons: the sense that the donor and the patient are not offenders but victims, pushed into the prohibited transaction by economic hardship or a severe medical problem; the belief that the two are so desperate that a criminal sanction would have little deterrent effect on them; and the view that the state should not use criminal law to stop a person from doing everything to save their life. While no public funds should be used for the purpose of buying an organ, the state cannot bar patients from doing so with their own money.

They appear in official statistics: as dialysis patients or transplant candidates on the waiting list prior to the transplantation, and as recipients of medical care and immunosuppressants following the transplantation. The availability of data makes it fairly straightforward to assess the effectiveness of the prohibition on transplant tourism.

As Fig. 1 shows, since 2008 there has been a significant drop in the number of Israelis undergoing transplant procedures abroad: from a peak of 155 in 2006 to 35 in 2011. The cutoff of transplant-tourism funding from HMOs and private insurers has thus clearly been effective. In the absence of that funding, the patients who undergo transplantations abroad are those able to buy a kidney illegally by their own means. In addition, a small number of patients receive HMO funding for *legal* transplantations using organs from deceased donors, especially in the United States and Russia.

As expected, the curbing of transplant tourism had immediate adverse effects on patients in need of transplants. The number of patients waiting for a kidney grew from 540 in January 2008 (immediately prior to the law's passage) to 733 in January 2011; the number of patients who died while on the waiting list for a kidney rose from 22 in 2008 to 39 in 2010. On the positive side, there are some early signs that the law may have resulted in increased donations, especially from living donors. Unable to purchase a kidney abroad, patients have had to turn to their loved-ones for a donation; this may explain why the number of kidney donations from living donors leapt from 56 in 2008 to 117 in 2011. The number of deceased kidney donations showed a more modest increase over the same period: from 100 to 123 [37, 67, pp. 357–361].

These encouraging trends, however, do not amount to an immediate solution to the organ shortage, resulting in growing pressure from patients, which has been directed, first and foremost, at the HMOs. The HMOs had long facilitated transplant tourism, choosing to overlook the commercial nature of the transplantations and the violation of the foreign laws prohibiting them. That approach persisted even after the 2006 Ministry of Health directive that instructed the HMOs to verify the absence of trafficking. The 2008 law, however, established a legislative prohibition accompanied by criminal sanctions, which the HMOs could no longer ignore. They have started asking for detailed information to confirm the altruistic motivation of the foreign donor; since such information could not usually be supplied, the vast majority of reimbursement claims have been denied. This has resulted in patients' frustration, anger, and pressure on the HMOs. Patients have also challenged the rejection of their claims in the courts, but to no avail: the courts have found that the HMOs had a

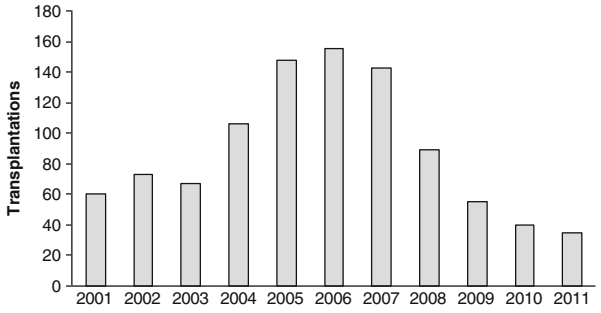


**Fig. 1** Kidney transplantations of Israeli patients abroad. Source: [37]

reasonable cause to suspect that the transplantation abroad involved trafficking [89, 90, 94]. At the same time, patients have been calling for a revision of the Organ Transplantation Law. They have received support from media reports describing their plight following the funding prohibition [17, 38, 45].

Besides curbing the outflow of patients abroad, the Organ Transplantation Law has achieved one additional goal: the improvement of Israel's image and rehabilitation of its good name within the international medical community. Prior to the law, Israel had been condemned for fueling the organ trade. Following the legislation, Israel came to be seen as a positive example—a country committed to eradicating the organ trade and fulfilling the transplantation needs of its patients through resources from within the country [13, p. 360].

## Lessons and implications

Within a relatively short time, Israeli policy went through a radical change: from sponsoring the participation of the country's citizens in the organ trade to near-elimination of that participation. This section distills and highlights the main influences that motivated and facilitated Israel's policy change on transplant tourism, so as to glean lessons for other countries involved in organ trafficking.

1. *State involvement*. Ironically, it was the public funding of transplant tourism that made it easier to eliminate this practice. That funding brought attention to the Israeli role in the global organ trade, making the country a target of international criticism and pressure. Due to the state's involvement, Israeli officials also felt a greater responsibility to take action. The pursuit of organs abroad could not be dismissed as simply the private actions of individuals, over which the state had no control; rather, it was the result of an official policy that was within the state's power to change. Indeed, as Israeli transplant tourism was, to a large degree, the result of state financing through the HMOs, it was easy to substantially reduce this practice by cutting off the official funding. State funding of organ trafficking, however, was unique to Israel: transplant tourists from other countries typically pay for the transplantation out-of-pocket. By contrast, the influences examined below may apply to other countries confronting the organ trade.
2. *Media coverage*. News stories about Israelis buying organs from poor people in remote countries drew public attention to this phenomenon, giving rise to embarrassment and a feeling that something had to be done.[18] This role of the media in raising awareness of illicit trade is not unique to Israel, nor is it limited to organ trafficking. I have noted above the role of media scandals in motivating American and British action against the illicit antiquities trade: once it was publicly revealed that art dealers, museums, and collectors had been acquiring looted objects, policymakers sensed that government regulation of the art market

[18] For example, the Knesset Committee on Labor, Welfare, and Health convened for an urgent meeting following a newspaper article on Israeli patients who had received organs from executed Chinese prisoners, with HMO funding [23]. Protocol no. 102 of the meeting of the Labor, Welfare, and Health Committee, November 27, 2006. This newspaper article was published following Jay Lavee's call for stopping the Israeli participation in China's organ trade [35].

was necessary. At roughly the same time that Israel's participation in the organ trade was being exposed, Israelis also learned of their county's role in the global sex industry: young women from the former Soviet Union had been trafficked into prostitution in Israel in the 1990s and early 2000s. Growing media coverage of this phenomenon—coupled with the activities of local NGOs and American pressure—alarmed Israeli officials and prompted them to curb the sex trade [16]. Overall, this experience suggests that media coverage and the exposure of organ trafficking can be a strong motivating influence. Once this issue comes into the limelight and becomes a matter of public interest and debate, the authorities come under pressure to take action.

3. *Physicians' advocacy.* Ultimately, the most decisive influence on the Israeli policy shift was the combined pressures of Israeli physicians and representatives of the international medical community. Based on ethical principles and on the negative material effects of transplant tourism, the physicians made a strong case in favor of eliminating this practice. They also made it clear that the norm against organ trafficking and transplant tourism had gained a worldwide consensus and that Israel was suffering a heavy blow to its reputation for violating that norm. As discussed above, the Israeli physicians and their foreign colleagues acted as moral entrepreneurs—an important force in campaigns against illicit trade. Not all moral entrepreneurs, however, are capable of influencing policy: governments may choose to dismiss entrepreneurs' calls for the elimination of illicit trade. What, then, made the physicians' advocacy efforts so effective? How did they manage to convince the Israeli authorities to eliminate transplant tourism?

One of the keys to the physicians' success was the combination of pressures from both above and below. The local physicians' experience with and understanding of organ donation and transplantation in Israel gave their urgings the necessary credibility. At the same time, the representatives of the international medical community, under the auspices of the WHO, argued that organ trafficking is anathema to all civilized countries, which address the organ shortage they face differently. These intertwining local and international pressures followed a pattern that is common in morally inspired advocacy campaigns, especially those demanding respect for human rights. In such campaigns, domestic and transnational advocacy groups—with support from international organizations and Western governments—challenge norm-violating governments, urging them to change their behavior [32, 56]. Yet even such a combination of pressures does not guarantee the success of an advocacy campaign: governments may still disregard activists' demands. The physicians' efforts against organ trafficking, however, enjoyed an important advantage that other campaigns often lack: highly respected, authoritative messengers. As various studies have noted, actors are more persuasive when their audience considers them to have expertise or seniority or otherwise holds them in high regard [11, p. 168; 40]. Among the public and policymakers, physicians command respect as holders of professional authority and expertise; furthermore, they are often seen as *moral* authorities [26]. The professional and ethical reputation of physicians was key to their advocacy against organ trafficking. It lent the necessary credibility and force to their assertion that transplant tourism is immoral and detrimental and as such should be eliminated.

4. *Shaming and reputational concerns*. Shaming is an important tool in the hands of advocacy networks that promote human rights: rights-violating countries are denounced as pariahs that do not belong to the community of civilized nations [56, p. 15]. Shaming, however, is often ineffective. Whereas some governments ascribe importance to enjoying a positive international reputation, others are less sensitive to criticism, and publicizing their bad behavior does not induce them to change it [24]. In the case examined here, however, shaming was successfully employed to motivate policy reform. The physicians argued that all civilized nations repudiate the organ trade, and that Israel had earned a pariah status due to its involvement in that trade. This argument strongly resonated with the Israeli authorities. The Ministry of Health justified its opposition to organ trafficking on the basis, among other things, of the ethical norms accepted by enlightened countries—norms to which Israel also should conform: "All the countries of the enlightened world agree that organ trafficking is an abhorrent phenomenon that must be completely eliminated. In each of these countries, organ trafficking violates ethical and legal norms."[19]

The shaming strategy was highly effective not only because the condemnation came from a highly respected source—the medical community—but because of the great sensitivity of Israeli officials to their country's international reputation and their desire to establish Israel's image as an enlightened, law-abiding country, committed to high moral standards. The desire to enjoy international respectability is obviously not unique to Israel, but Israeli officials are especially concerned for their country's international image [5, 16, chap. 5]. Given Israel's isolation in its own region, and the heavy criticism it often faces in international forums, the country's acceptance by the international community is considered a foreign-policy priority. The perception of Israel as civilized and law-abiding is seen as crucial to its international relations, especially with the United States and Europe. Against this background, it is understandable why Israel's pariah status within the international medical community was of great concern to Israeli officials. Israel's participation in the organ trade, contrary to international norms, undercut its claim of being a rule-of-law country and undermined its efforts to establish a positive reputation.

5. *Weak counterforces*. As the theoretical framework has suggested, efforts to eliminate illicit trade might threaten the actors that are involved in it: from arms manufacturers to banks that launder criminal proceeds to art dealers and museums that trade in looted antiquities. These actors seek to delay or obstruct the regulatory efforts against illicit trade and to minimize any governmental interference with their business. However, their ability to do so depends on their political organization and influence. Actors who represent a large constituency, those whose business is considered vital to a country's national interest, or those with close ties to politicians through legitimate contributions or bribes are better able to weaken regulation or prevent its establishment altogether. In the case of the organ trade, there are several identifiable counterforces with an interest in

[19] The Ministry of Health's position in [88]. See also a paper by the Knesset's research center that examined the legal regulation of organ donation in several Western countries and concluded that all of them prohibit the trade in organs [39].

hindering anti-trafficking efforts: paid donors, patients, physicians and hospital administrators who are involved in commercial transplantations, and brokers. What influence did such actors have on the Israeli policy?

Given that the paid donors were mostly foreign, they had no presence or voice in the Israeli transplantation debate. Furthermore, even in their own countries the donors are typically not politically active. Given their poverty and low social status, they lack the knowledge and means necessary for political action. Another type of actor missing from the Israeli debate was the broker. The brokers could, in principle, have been politically active, given their social status and background: among them were lawyers and a former military officer. Yet due to the ethically dubious nature of their business and the fact that it violated foreign laws, the brokers did not make their voice heard in the political arena. More importantly, the HMOs, which facilitated transplant tourism, were also largely absent from the debate. As primary providers of health services, the HMOs are highly involved in health policymaking in Israel. Yet they had only a minor presence in and limited influence on the legislative process that culminated in the Organ Transplantation Law. This was not the result of lack of interest. As discussed above, the HMOs had several motivations for funding transplant tourism. Yet they apparently sensed that publicly advocating the continuation of this practice would be indefensible. They accepted the change of policy—a prohibition on funding commercial transplantations—without a fight.

What about the physicians and patients? A very small number of Israeli physicians had been involved in organizing commercial transplantations abroad; at times, they traveled with the patients and participated in or oversaw the procedure.[20] These physicians, however, were also absent from the legislative process. The medical community's representatives who participated in that process were united in support of a prohibition on transplant tourism. The only actors who publicly opposed that prohibition were the patients: this ethical ban would cost them their lives, they argued. Yet with meager financial resources and little political clout, the patients could not significantly influence the legislation, let alone block it. The politicians they did have on their side were unable to prevail over the Ministry of Health, the medical community, and the MKs who vigorously opposed commercial transplantations.

In short, while the local and international medical community advocated a prohibition on organ trafficking and transplant tourism, no significant force counterbalanced that influence: the actors with a stake in transplant tourism were either absent from the legislative process or unable to influence it. The weakness of the counterforces greatly facilitated the change of policy and the establishment of a prohibition.

What lessons, then, does the Israeli experience offer to other countries? Policy changes similar to Israel's have, in fact, occurred worldwide. Recent years have seen a flurry of laws and initiatives against organ trafficking, from Pakistan[21] to the Philippines[22] to Egypt[23] to Malaysia [44]. To a large extent, these measures have

[20] The best known among those is Professor Zaki Shapira [52].
[21] Transplantation of Human Organs and Tissues Act, 2010.
[22] Rules and Regulations implementing Section 4(g) of Republic Act No. 9208, otherwise known as the Anti-Trafficking in Persons Act of 2003, in relation to Section 3(a) of the same Act, on the Trafficking of Persons for the Purpose of Removal or Sale of Organs (in force since 2009).
[23] Egypt enacted an organ transplantation law in February 2010.

come about as a result of the same influences that prompted Israel to prohibit transplant tourism: pressures from the local and international medical community, reinforced by media coverage. The international pressure has, in fact, intensified since 2008, when the Transplantation Society and the International Society of Nephrology adopted the Declaration of Istanbul on Organ Trafficking and Transplant Tourism. Through its set of principles and proposals aimed at eliminating the organ trade and increasing legitimate organ donations, the declaration expressed the consensus of the world medical community, supported by the WHO [13, 15]. This upped the pressure on governments to conform and bolstered the demands of local physicians who had been urging action against the organ trade.

Yet not all countries have put in place laws and regulations to eliminate organ trafficking. Furthermore, even where laws exist on the books, they do not always translate into laws on the ground. Official policy may prohibit organ trafficking, while enforcement authorities fail to put the prohibition into effect [20, 41, 48]. Without vigorous enforcement, the reality of a flourishing organ trade would see little change. One lesson from the Israeli case is the importance of media coverage for prompting the authorities into action. By shining a spotlight on the hidden phenomenon of trade in organs, media reports can end the official unawareness or denial of the trade's existence. Governments and law-enforcement authorities find it more difficult to remain willfully blind to the practice of organ trafficking once the public learns of it. Media coverage is therefore an essential support for the main driver of change: advocacy of the medical community. The Israeli experience highlights one of the winning arguments that the advocates made: organ trafficking and transplant tourism violate the norms of civilized, enlightened countries. Israel's aspiration to be —and be seen as—an enlightened country made that argument very effective in influencing Israeli officials. Yet the desire to enjoy the status of a "modern," "advanced," or "civilized" country is far from unique to Israel: it could be a powerful influence on developing countries, leading them to embrace and implement international norms [68]. Those calling for government action against organ trafficking should thus link such action to a country's international status and reputation; they should create the sense that elimination of the organ trade is what the international community expects of a civilized country, whereas participation in that trade turns a country into a pariah.

On a less optimistic note, it is worth emphasizing that Israel's policy shift met only weak resistance: the actors with a stake in transplant tourism either had little political influence (the patients) or chose not to exercise their influence (the HMOs). In other countries, however, initiatives aimed at eliminating the organ trade and encouraging legitimate donations face stronger resistance. For example, patients in the Gulf countries are wealthier and more well-connected than their Israeli counterparts, making it harder for their governments to establish and enforce a prohibition on transplant tourism. Healthcare professionals might also pose an obstacle. As the Pakistani experience demonstrates, physicians and hospital administrators who are directly involved in commercial transplants may try to derail the efforts against the organ trade [46]. In Egypt, efforts to increase legitimate donations must overcome physicians' religion-based skepticism toward the idea of organ procurement from the dead [10]. Despite such resistance and hesitations, both Pakistan and Egypt ultimately passed transplantation laws and committed to abolishing the organ trade. Their

endeavors in this area, however, have been less decisive than those of Israel, where the medical community rallied behind the efforts against organ trafficking.

## Conclusion

Unlike drugs and counterfeit goods, where anti-trafficking efforts have been the result of American pressure, the motivating force behind the efforts against the organ trade was nonstate moral entrepreneurs. It was the advocacy efforts of the local and international medical community, assisted by media coverage, that led to a turnabout of the Israeli policy: from official approval and funding of transplant tourism to a prohibition that has nearly eliminated that practice. The physicians made the case against the organ trade on ethical grounds, on the basis of the detrimental consequences of the trade, and by highlighting the worldwide consensus against it—a consensus whose violation was extremely injurious to Israel's international reputation. The advocacy efforts were facilitated by the unanimous position of the Israeli medical community in condemnation of organ trafficking and in favor of increasing legitimate organ donations. Another important (non)influence was the weakness or absence from the debate of the actors with a stake in transplant tourism: the patients and the medical insurers. In other countries, the efforts against organ trafficking have met a more vigorous opposition. Nevertheless, even these countries have established laws and initiatives to eliminate the trade in organs. Physicians' pressure from both above and below, under the umbrella of the WHO, spoke to these countries' concern for their international image. The experience in other sectors of illicit trade, however, teaches us that governments often establish anti-trafficking laws but do little to enforce them. Persistent pressure from the medical community and the media thus remains essential for motivating government action and enforcement against organ trafficking.

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## Author's Interviews

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83. Author's interview with an HMO official, May 2012.
84. Author's interview with Professor Jay Lavee, Ramat Gan, May 2012.
85. Author's interview with an Israeli health official, June 2012.
86. Author's interview with Professor Eytan Mor, Petach Tikva, June 2012.
87. Author's interview with Professor Avinoam Reches, chair of the Ethics Committee of the Israeli Medical Association, Ramat Gan, June 2012.

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