Organ Transplantation

Several recent articles by Gina Kolata (News and Comment, 1 July, p. 32; Research News, 1 July, p. 40; 8 July, p. 139) suggest that we have now entered a new era in organ transplantation. While there are many reasons for this optimism, the availability of cyclosporin (Sandimmune) is foremost. It more effectively deals with the problem of rejection than traditional immunosuppressive therapy with prednisone and azathioprine. In addition, the rate of infection among transplant recipients has declined substantially with the use of cyclosporin. Unfortunately, the side effects of this drug, primarily nephrotoxicity and neoplasia, are not minor (*1*).

Despite the availability of cyclosporin, as Kolata points out, this new era of transplantation remains "clouded" because of the extreme shortage of donor organs. A further source of concern is how organ transplants will be paid for. Few private insurers routinely pay for transplants, and only kidney transplants are currently covered under the Medicare program. Nonetheless, through various circuitous means, the Medicaid programs of some states have paid for liver transplants.

The federal government has not, however, totally ignored the reimbursement or payment issue. The Health Care Financing Administration (HCFA) of the Department of Health and Human Services is currently sponsoring a major national study on heart transplantation (*2*). HCFA has responsibility for administering the Medicare program and consequently makes what are commonly referred to as coverage determinations (what to pay for) and reimbursement decisions (how much to pay) (*3*). The major objective of the National Heart Transplantation Study is to determine whether or not heart transplants will be paid for under the Medicare program. To enable HCFA to make this determination, data are being collected to address each of the following key points: (i) the need for heart transplantation in the United States; (ii) the survival rates for heart transplant recipients as well as for persons who fail to receive transplants because a suitable donor is not identified in time; (iii) the supply of viable donor hearts; (iv) the cost of performing heart transplants as well as the cost of providing medical care for patients who do not receive transplants; (v) the quality of life of heart transplant recipients; (vi) the legal issues surrounding heart transplantation; and (vii) the ethical issues associated with heart transplantation. In short, the study is addressing the key issues omitted from consideration at the Surgeon General's Workshop on Solid Organ Procurement and at the National Institutes of Health Liver Consensus Development Conference. With regard to the latter, it should be noted that the conference statement issued by the panel is but a single ingredient in the complex process of making coverage determinations. It does not bind private insurers nor the federal government to payment for liver transplantation.

Perhaps one of the less salient conclusions arrived at during the hearings before the House Committee on Science and Technology, the Surgeon General's Workshop, and the NIH Liver Consensus Development Conference was that organ transplant procedures cannot be assessed individually, nor can they be viewed apart from other pressing health care needs (*4*). Kidney, heart, liver, pancreas, bone marrow, and other organ and tissue transplants are likely to become more prevalent over the next decade. As a result, it appears that a national strategy is required to ensure the safety and efficacy of these procedures. It is equally apparent that transplantation represents only one technology in the complex armamentarium of health care technology. Consequently, the future development and growth of all health care technologies must be subjected to careful scrutiny to ensure that they are cost-effective. Technology is not without its price, and society must be prepared to decide the price it is willing to pay for health care. Neither individuals nor society can ignore the cost associated with providing the finest health care obtainable. Some very difficult issues are yet to be confronted, and equally difficult choices remain to be made.

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References

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3. L. D. Schaeffer, in *Critical Issues in Medical Technology*, B. J. McNeil and E. G. Cravalho, Eds. (Auburn House, Boston, 1982), p. 151.
4. R. W. Evans, *J. Am. Med. Assoc.* **249**, 2047 (1983); *ibid.*, p. 2208.

Erratum: In the report "Pregnancy interception with a combination of prostaglandins: Studies in monkeys: by J. W. Wilks (30 Sept., p. 1407), figures 2 and 3 on page 1408 were interchanged.