Americans Are Dying Needlessly Because of the Current Liver Transplant Allocation System

Where you live should not determine if you live or die while waiting for an organ.

The demand for transplantable organs in the United States has long outpaced the supply. Right now, more than 16,000 Americans are waiting for liver transplants. California has one of the highest rates of liver disease while also having one of the lower donation rates.*

Unfortunately, America’s flawed organ allocation system continues to make an already dire situation far worse by ensuring vast geographic disparities in access to liver transplants—regardless of severity of illness. Consequently, hundreds of Americans in California, among other states, are dying needlessly while waiting for livers.

This can and must change.

Fortunately, a new concept document called Redesigning Liver Distribution to Reduce Variation in Access to Liver Transplantation offers a set of sensible, lifesaving recommendations. The goal of the proposed changes is to reduce the substantial geographic inequity in liver transplant with patients in some regions of the country transplanted 10 times more quickly than other regions while the delayed patients are as much as 70% sicker as measured by the “MELD at transplant” scoring system.

Below is an overview of the current liver allocation system and the recommendations to make it more equitable.

Geographic Inequalities in the Liver Distribution System

The nation’s organ transplant system is overseen by the United Network for Organ Sharing (UNOS), a private, not-for-profit organization chartered by the US Department of Health and Human Services to oversee the national transplant system. Largely for administrative purposes, UNOS long ago divided the country into 11 regions. California is currently in Region 5 with Nevada, Arizona, New Mexico and Utah.

Under the current rules, the sickest liver patients are ranked at the top of local waiting lists within their UNOS region. Organs from a deceased donor are given to the sickest person in that region, even if there are sicker patients in greater need elsewhere in the nation. California receives far fewer organs than other UNOS regions—and far more Californians waiting for livers die unnecessarily. The current system also enables those patients needing liver transplants with the personal resources to travel quickly and independently to other states can get on shorter waiting lists in places like Tennessee or Texas, while Californians of more modest means wait in vain.

A more just and equitable system—using modern organ preservation technology—would permit organs to cross regional borders and be given to patients with the greatest medical need.

Changes Under Consideration Would Reduce Inequities—and Save Lives

In response to the recommendations of an Institute of Medicine Committee directed by Congress to address this issue 15 years ago, and under the belief that “geographic disparities in candidate access to liver transplants are unacceptable high,” the UNOS Board of Directors asked its Liver Committee to
explore a solution. The Liver Committee, in turn, produced a paper, *Redesigning Liver Distribution to Reduce Variation in Access to Liver Transplantation*, which calls for reducing the number of liver donation regions from the 11 that exist today to either four or eight larger ones.

The Liver Committee’s full set of recommendations are rooted in comprehensive research and data. Its models suggest that sharing livers within four broader zones would save *at least* 554 lives over five years. Total costs would decline by 4.3%, or about $246 million, “due to the decrease in the cost of pre-transplant care.”

The concept document also states that there is no relationship between poor organ procurement performance in a given area and geographical differences in access to livers—and under a revised system of four or eight liver donation regions, there would still be no relationship. Finally, reducing the number of regions would not reduce organ donations. In a 2013 survey, 82% of respondents said they would prefer that organs go to the person in greatest medical need, regardless of location.

The UNOS paper will now undergo a public comment period. Advocates for transplant centers in the Midwest and South, which would be required to share their organs more equitably, have already mounted a campaign against it. After the public comment period, the Liver Committee will submit a final proposal to the UNOS Board for consideration and further public comment in the spring of 2015 or thereafter.

**CHA Position**
The nation’s organ allocation system must be reformed to correct significant geographic disparities. Under the current system, individuals waiting for livers in New York, California, and other areas have substantially longer waiting times and higher waitlist mortality rates. CHA is grateful that UNOS has undertaken this long-overdue examination of the current, deeply flawed liver allocation system. CHA urges the committee to continue its work to examine the benefits of even fewer transplant regions. While moving to four regions will not be a significant benefit to California, it is an import step in the right direction. It would lower costs, reduce waiting lists, and—most important—save lives.

**ACTION**
Please sign on to the Nunes-Engel letter to HRSA administrator Wakefield.

Contact Andrew House (<andrew.house@mail.house.gov>) or Heidi Ross (<Heidi.Ross@mail.house.gov>) to sign on.

*Liver disease rates in CA are higher due to a large Hispanic population with a genetic predisposition to liver disease along with other populations with higher than average Hepatitis C. Donor rates are low in large part due to the significantly lower death rate in CA compared to the rest of the nation and due to the large number of recent immigrants who tend to be more reluctant to sign up for donation.*