Is it time to offer financial incentives for live kidney donation?

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Abstract

With increasing rates of kidney failure in our community, the debate around offering financial incentives for both cadaveric and live organ donors continues. Like with any ethical debate there are complexities around this topic. An analysis of the literature demonstrates that there is a notion that humanity and dignity are being selectively linked to specific organs whilst blood, bone marrow, sperm and eggs are regularly sold as commodities. Although the complex issues surrounding financial incentives for organ donors are great, the need and importance of a regulated system coordinating kidney donation is worth exploring. An incentive scheme that could increase the number of donors is examined to determine the benefits and negative aspects of such a scheme.

Key words:
kidney, financial incentives, living donor, ethics

Introduction

In 2004 Australia's cadaveric organ donation rate was 11 donors per one million people, one of the lowest donation rates in the western world (Australia and New Zealand Organ Donation Registry 2006). Campaigns to increase this level have done little to increase the supply of organs (Kishore 2004). Thus, in Australia the demand for donor kidneys has outweighed supply.

Currently the average wait for a kidney transplant is close to four years and given that many individuals on the waiting list will die before a suitable donor is found the time may have come for society to explore alternative options to increase the number of organ donors. One such alternative is offering financial incentives to living kidney donors.

This paper will examine the literature and offer arguments for and against the proposal to offer living kidney donor's financial incentives as well as examining the implications that such a proposal may have on the nursing profession.

Literature Review

Articles of relevance were sought from databases including OVID, CINAHL, Blackwell Synergy and MEDLINE. Key words utilised to search these databases included "live organ donation", "organ donation", "living donors" and "financial incentives". The searches were limited to full text articles published between 2000 and 2006. This search retrieved articles on both financial incentives offered to the families of cadaveric donation as well as financial incentives offered to living donors. Several relevant articles were accessed with further articles located in hand-searched reference lists. Personal communications with experienced renal nurses was also utilised to gain information and resources relevant to the topic. Articles were evaluated which enabled a thematic approach to inform the discussion.

Arguments Against Financial Incentives

Exploitation of the poor

One argument against allowing financial incentives to living kidney donors is the potential risk that exists for those of lower socioeconomic status to be exploited. Goyal, Mehta, Schneiderman and Sehgal (2002) examined the economic and health consequences of selling kidneys in India. Their study found that almost all participants had sold a kidney in order to pay off their debts and 95 percent of participants revealed that the desire to help another in need was not a motivating factor. Thus the majority of donors were those of lower socioeconomic status. Furthermore, 79 per cent of participants would not recommend selling a kidney, although there was no further explanation as to their reasons. Many of those questioned were still in debt or experienced a worsening of their economic status post nephrectomy. This study informed the proposal of offering financial incentives to potential living donors as it provided data on the actual effects of living donation from a society where the practice has been common. However it is questionable whether these results can be applied to western societies given the variable health models.

The issue of informed consent and coercion of the poor is highly relevant. Living donors should be 'competent, willing to donate an organ and free of coercion' (Delmonico et al 2002, p. 2002). Furthermore the donor must be given 'every opportunity to change

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their mind up until the time of the surgery itself' (Israni et al 2005, p. 18). Thus, we ask "to what extent are the economically disadvantaged free from coercion?" As Kishore (2005, p. 364) states 'people surrounded by such brutal poverty and social deprivation do not have many options'. The response of one interviewee to the question of why he sold his kidney highlights the extent to which poverty influences decision making, 'I had nothing else to sell!' (Kishore 2005, p. 364). No doubt the potential financial reward provides an extremely difficult choice for someone with financial challenges (Matas 2004).

The issue of coercion is echoed by Beauchamp (2003) who suggests that voluntary donors may be forced into a non-voluntary sale of their kidney due to the constraints placed on them given their impoverished conditions of living. Furthermore it is important to consider the notion of exploitation of the poor within the right context. As Beauchamp (2003, p. 272-273) states:

> The issue here is not whether those who sell their kidneys are entirely free of manipulation or constraining influences, but whether they are sufficiently free so that they are enabled to act autonomously.'

Furthermore, the suggestion of offering compensation to living kidney donors may potentially act as a deterrent to those individuals from accepting and fully understanding the risks involved in such an action (Fox, 2006). Thus, the notion of informed consent must be examined with a level of reservation.

The issue of consent and coercion can be readily applied to the proponents' arguments as well as the opponents, as identified by Kishore (2005, p. 364);

> If the vendor is not able to give free and informed consent because of the pressures of poverty and the lure of money, the buyer is also not able to give such consent because of the pressures of illness and the urgent need to save his life.

The human body as a commodity

A further argument against offering financial incentives for organ donation is concerned with turning the human body into a commodity and thus devaluing human self-dignity. 'Selling sets a price on the organ and thereby commodifies it. With the price tag it is no longer priceless' (de Castro 2003, p. 144). The main thrust of this argument is that by offering a sum of money for a human organ, people lose their dignity as they are seen as the sum of their organs and as merely a provider of spare parts (Matas 2004).

Further compounding this argument is the notion that by paying for, or providing financial incentives for organ donation, society is in fact undermining our morality as attitudes shift from an altruistic stance to one of personal enrichment (Kahn & Delmonico 2004). A fear exists that people will no longer donate due to a moral obligation and will adopt a 'what's in it for me?' mentality (Rothman & Rothman 2006). Therefore, if a market in human organs is established a potential exists for a reduction in the number of cadaver and altruistic donations (Rothman & Rothman 2006). Overall 'the symbol of altruism in organ donation continues to represent powerful notions about the use of human body parts' (Delmonico et al 2002, p. 2006).

Donor maleficence

The final major argument inherent in the literature against offering financial incentives for live kidney donation is that there exists a real potential for the donor to be medically harmed, and 'the end of an increased supply of organs cannot justify using any means available' (Kahn & Delmonico 2004, p. 178). In knowingly exposing an individual to these procedures and the complications inherent in a nephrectomy, there is a view that we are breaking the ethical principle of non-maleficence (Kishore 2004).

Arguments for Financial Incentives

The driving force initiating discussion within this field is that increasing the number of live kidney donations will save hundreds of lives in Australia alone. Not only will lives be saved but the recipients' quality of life will be dramatically improved when compared to the quality and longevity of a life spent on dialysis (Gaston et al 2006).

Economic Benefits

There are economic benefits of a kidney transplant over long-term dialysis. According to Gaston et al (2006) a single living donor transplant could potentially save taxpayers US$94,000 per patient when compared to the costs of maintenance of dialysis. This figure is given conservatively as further savings may be generated when the recipient returns to work.

An important question in initiating government policy change, is the question of what is a feasible amount to pay a living kidney donor? Matas and Schnitzler attempted to answer this question and is useful in providing "a numeric figure that can. . .facilitate the debate" (2003, p. 219). This study found that a significant payment of US$90 000 could be paid to live kidney donors and still allow society to break even. However, as identified earlier, such a sum of money may in fact prove to be more attractive to people of lower economic status. Thus a potential exists for this group to be exploited (Matas and Schnitzler, 2003).

Further enhancing this debate Israni et al (2004) examined four financial incentive models; the market compensation model, the

fixed compensation model, the no compensation model and the expense reimbursement model. From their research they concluded that the expense reimbursement model whereby 'the donor should not make a financial profit through donation, but also should not incur financial loss by virtue of their contribution' (p. 16) is the favoured approach to increase kidney donation. This model is effective in reducing the ethical concerns of coercion, because altruism is likely to remain a significant motivator (Israni et al 2004). Today, as altruism remains the strongest driving force for kidney donation, it is important to question whether this model will have any impact on increasing the number of live donors.

Adopting a similar standpoint Gaston et al (2006, p. 3) present a proposal encompassing benefits that would not enrich anyone rather leaving 'the donor as well off. . .as before donation'. Their proposal includes a one year life insurance policy, the provision of health insurance and a compensation payment covering any personal costs. Once again the authors acknowledged that a potential exists for the proposal to be more attractive to individuals of lower socio economic status.

It is the rich (medical profession) deciding that the poor will be exploited

The risk of exploitation of the poor is of real concern to many objectors of financial incentives for organ donation. However, it is interesting to note the sentiments of Radin, quoted in Matas (2004, p. 2010);

> It is unclear why engaging in market transactions with the poor constitutes the use of coercive power, while in doing so with the middle class or the wealthy is an appropriate expression of personal freedom.

Opponents claiming that the poor are more likely to undergo a nephrectomy if financial reward is to be gained, are in effect undermining the ethical principle of autonomy (Matas 2004). Whilst, it is clear that the potential rewards will make the offer more attractive to people of lower economic status, it is also clear that they are individuals capable of making their own decisions based on the information given to them. Equally, it is important to ask what the impact might be on those individuals of other socioeconomic groups who may be dealing with debt due to a business failure or someone addicted to poker machines be? Would the offer of financial gain be more attractive to a university student than a teacher? It is not only the 'poor' that may find financial incentives attractive and be tempted.

Further counter arguments against the risk of exploitation are based on reflections of society itself. Society has done little to aid those of poorer economic conditions. As summarised by Veatch in Matas (2004, p. 2011);

> If we are a society that deliberately and systematically turns its back on the poor, we must confess our indifference to the poor and lift the prohibition on the one means they have to address their problems themselves.

Likewise Kishore (2005, p. 364) writes;

> If the sale of organs amounts to exploitation of the poor it is no more than a continuum of long drawn out process of their exploitation which has been watched by society for centuries. . .Why this sudden concern for the poor?

Thus society must reflect on itself before passing judgement on others and remember that 'morality is always contextual' (Kishore 2005, p. 362).

de Castro (2003) has identified that in the current system donors are the only party that play a part in organ donation but do not receive any gain, financial or otherwise. Matas (2004, p. 2009) echoing these sentiments 'currently everyone but the donor already benefits financially from the transplant (physicians, coordinators, hospitals, recipients)'. Similarly, this issue is highlighted by Gaston et al (2006, p. 7);

> Well-intentioned attempts to preserve a pure altruism, while noble, fail to recognise the true cost to donors and our responsibility to ensure donor safety, not to mention the scope of unmet needs in desperately ill patients, even as they have all increased over time.

In summary, it is clear that the decision to not explore the views of potential donors by well-meaning patriarchal health professionals may need challenging.

Government regulation model may decrease the current black market

There is certainly the need for a regulated system (Brennan 2006; Gaston et al 2006; Steinberg 2006; Kishore 2005; Israni et al 2005; Kahn & Delmonico 2005; de Castro 2004; Matas 2004; Matas & Schnitzler 2003). The need for an appropriately regulated system of financial incentives for organ donation is not only important in reducing the potential risk for exploitation of the poor, it is also vital to monitor developments and to ensure that organs are sourced legitimately (de Castro 2004). A regulated system is also likely to assist in curbing the current illegal trade in human organs that operates around the world as;

> Although the underground economy is illegitimate, the demand that drives the market underground is founded on the legitimate hopes and aspirations of patients needing replacement organs (de Castro 2004, p. 145).

This could be countered by 'establishing a regulated system may well eliminate or minimise the ongoing unregulated markets' (Matas 2004, p. 2009).

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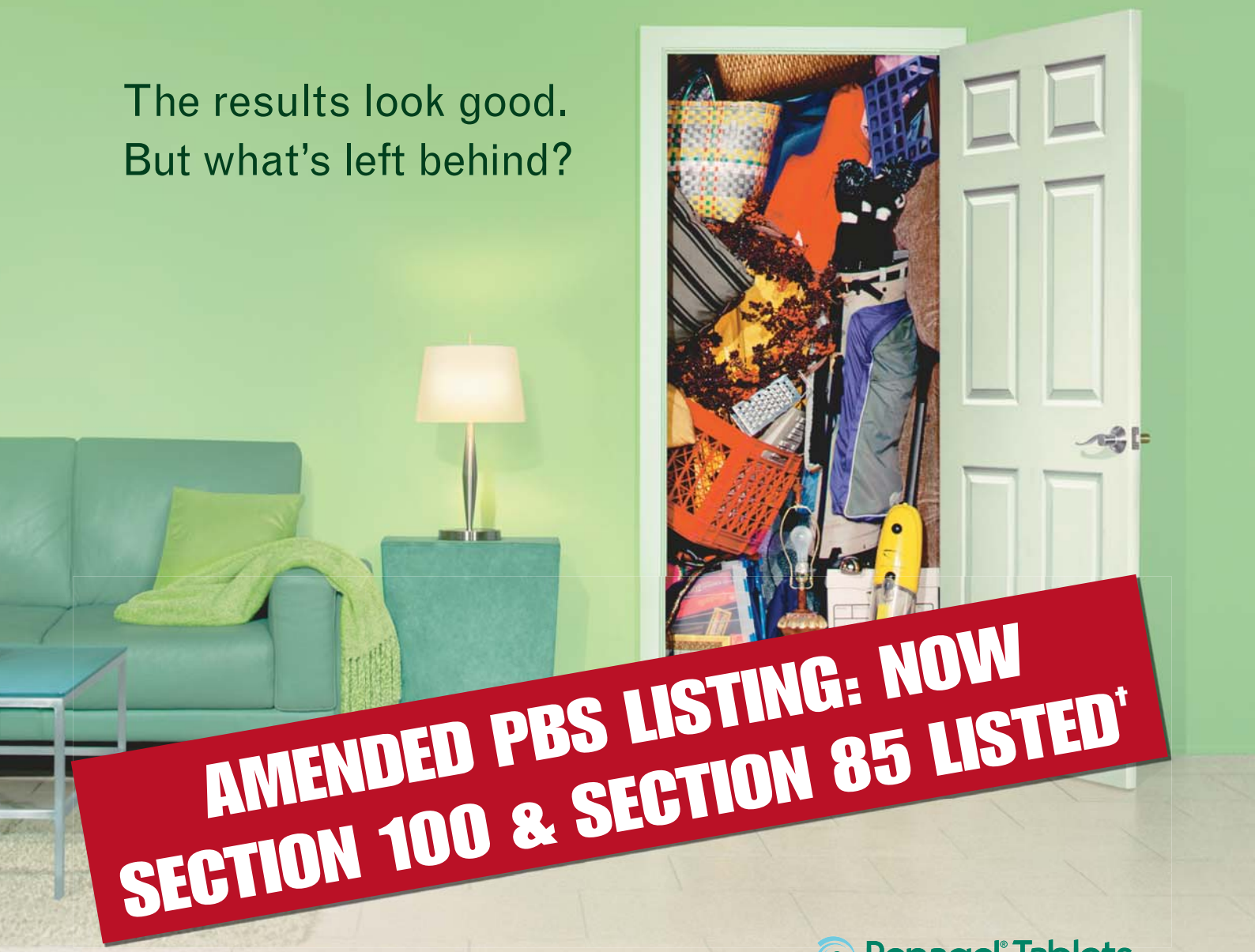

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An additional argument in favour of offering financial incentives for live kidney donation is in fact a counter argument to the notion that financial incentives are contrary to human dignity. Human dignity, or the attributes that are uniquely human, include the ten virtues of love, trust, righteousness, compassion, tolerance, fairness, forgiveness, beneficence, sacrifice and concern for the weak (Kishore 2005). Thus as stated by Gill and Sade in Matas (2004, p. 2011);

> my kidney is not my humanity… humanity – what gives us dignity and intrinsic value – is our ability to make rational decisions, and a person can continue to make rational decisions with only one kidney.

Moreover it is significant to note that the notion of humanity and dignity is being selectively applied to organs such as kidneys. Blood, bone marrow, sperm and eggs are regularly sold as commodities yet society does not feel that this violates dignity (Kishore 2005). Therefore, the attitudes of society are critical in protecting and maintaining the dignity of the donor (Matas 2004).

Implications for Nursing

The issue of organ donation alone is complex and multifaceted and this ethical debate and moral dilemma present very worthwhile concerns and arguments. The likelihood that the poor will be at risk of exploitation is a real concern however, if any system is introduced, it must be introduced with safeguards and adequate regulation to protect those at risk of exploitation.

Of importance perhaps is the fact that this debate is occurring in an environment where live kidney donation is deemed an acceptable practice. According to the ANZOD Annual Report (2006) of the 623 kidneys transplanted in 2005, 246 or 39 per cent were donated by living donors. Thus the Australian society accepts live kidney donations. Therefore, the main issue in objecting to offering financial incentives to increase this rate and save even more lives comes from a moral concern. In addition, while 'discussing organ sales simply does not feel right; but letting candidates die on the waiting list (when this could be prevented) also does not feel right' (Matas 2004, p. 2008). Thus any change in policy that will permit donor reimbursement will require a change in the attitudes of society as a whole. This change can only come about by societal education and robust discussion. This area of education and a change in attitudes leads into highlighting the importance of this issue to practicing professionals, including nurses, and those health professionals that are soon to graduate.

Nurses are at the forefront of providing care to patients and their families. This care is all-inclusive of the physical, mental, spiritual and emotional needs of the patient and their family. Part of the provision of adequate care, is the provision of adequate information and education. Nursing is in a unique position, one in which we are able to build rapport and trust with a patient and their family. In our role as a nurse, many patients and their families 'may turn to you for assistance and explanation' (Brennan 2006, p. 192).

For these reasons, nurses can be aware of what is happening within their field.

- What policy affects them and their practice?
- What technological advances are occurring in their speciality?
- What will the impact be of these changes to the care they give and the care their patients receive?

Medical developments have allowed for live kidney donations to become an every day phenomenon. Thus nurses must be able to facilitate questions that a potential donor may ask and to do so nurses must possess current information.

The possibility of financial incentives aimed at increasing the number live kidney donors will not happen in Australia until society accepts the need for this change. Nurses are a strong driving force when it comes to initiating change. Thus it is essential that, if Australia embraces an incentive scheme, nurses are a driving force as a patient advocate, both for the donor and recipient, within that debate. To do so we must keep an open mind and be aware of any new arguments that arise.

Conclusion

Arguments against introducing financial incentives to increase live kidney donation are based on the ethical principles of non-maleficence and autonomy and include the risk of exploitation, the potential harm to the donor and the notion that receiving monetary reward for donating a kidney is contrary to humanity. Alternately, arguments in favour of living donor reimbursement include an increased number of lives saved. Additionally, studies show that incentives are more cost effective than long term dialysis and proponents draw on the ethical principles of autonomy and beneficence to counteract the arguments against.

Finally, all parties involved in the area of organ donation, be it live or cadaver donation, must be aware of and stimulate debate within the area. In doing so they are spreading knowledge about the issues at hand and getting more people involved. As summarised by Friedman and Friedman (2006, p. 962);

> At the least, debating the controlled initiation and study of potential regimens that may increase donor kidney supply in the future in a scientifically and ethically responsible manner, is better than doing nothing more productive than complaining about the current system's failure.

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