

VIEWPOINTS

Should governments offer financial compensation to organ donors and their families as a strategy to increase donation rates?

doi: 10.35493/medu.40.12

INTRODUCTION

The heightened incidence of organ failure and recent technological developments of organ transplants have conjunctly led to a greater demand for donors.¹ By the end of 2020, 4129 Canadians remained on the organ transplant list, with 805 withdrawing that year due to either clinical improvement, voluntary withdrawal, deteriorating patient condition, or death.² This organ shortage has increased the cost of medical care worldwide, deprived organ recipients of a standard quality of life, and led to thousands of deaths.¹ One proposed solution to address the increasing demand for organ donors is donor compensation.³ The topic is of high ethical and financial debate, and would impact not only the lives of those on the transplant waiting list, but also the healthcare system and how society views individual rights as a whole.

IN FAVOR OF FINANCIAL COMPENSATION

Major obstacles for living organ donors include the financial costs associated with travel, board, recovery, and medical treatment postoperation.¹ The removal of such disincentives for organ donors is legal under the National Organ Transplant Act (NOTA), but has demonstrated variable results with regards to increasing organ supply.³ Compensation has thus been proposed as an alternate solution. Currently, NOTA prohibits the profitization of any organ transplants, calling for donations to be motivated by altruism. Donor compensation, however, would have benefits for both individuals and the healthcare system as a whole.

Regulated compensation by the government would incentivize organ donors and lead to an increase in organ supply. As a result, the stress placed on the organ transplant list would diminish, thereby improving the quality of life of

AUTHORS: ALLISON FANG & AISLING ZENG
ARTISTS: ASEEL ABONOWARA & RYAN TSO

hundreds of thousands of patients.⁴ Additionally, a study by Meier-Kriesche et al. found that in end-stage renal failure patients, longer transplant wait times are a risk factor for decreased survival post-transplant.⁵ Increased organ supply would thus decrease the average wait time of patients on the waitlist, promoting patient survival rates. Furthermore, the implementation of organ compensation programs in other countries have modeled the success of such a solution. Iran adopted a compensated organ donor system in 1988, and by 1999, completely eliminated the renal transplant waiting list.⁶ 78% of Iranian donors were unrelated to the recipients, and as of recently, Iran has doubled annual kidney transplants from 1186 in 1999 to approximately 2600.^{6,7}

Additionally, an organ compensation donor model would provide financial benefit to the healthcare system.^{3,8} A cost-benefit analysis conducted in the United States by Held et al. found that taxpayers would save \$12 billion annually, under the assumption that living and deceased donors receive \$45 000 and \$10 000 in compensation, respectively.⁸ In the case of renal failure specifically, the high costs of dialysis, averaging about \$121 000 annually, coupled with long transplant wait times, led to an estimated lifetime cost of \$735 000.⁸ In comparison, the total cost of a transplant, including recovery procedures and medication, is estimated to be \$395 000—approximately half the previously calculated cost.⁸

Furthermore, the associated health consequences and costs of long wait times on transplant lists are a major contributor to transplant tourism.⁹ The implementation of a regulated

organ compensation program would help eliminate this pattern. Patients with the financial means often travel to countries with fewer regulations to undergo illegal and dangerous transplant procedures, then return to their home country for follow-up care.⁹ In a 2011 British Columbia study by Gill et al., all patients of ethnic minority elected to travel for unregulated transplantation after a median wait time of two years and a completed transplant evaluation.¹⁰ Since the procedure is illegal, medical records and important procedure notes are often not recorded, hindering the ability of the patient's physician to perform follow-up care afterwards. Moreover, patients that undergo unregulated procedures are at a higher risk of infection, organ failure, and death.¹¹

AGAINST FINANCIAL COMPENSATION

While the potential benefits of a donor compensation program may appeal to healthcare systems with a high demand for organs, there are ethical and practical concerns that must be considered. Offering financial incentives for organ donation would disproportionately affect those in the lower socioeconomic bracket.¹² Financially vulnerable individuals may turn to donating their organs as a source of income, which could compromise the integrity of the transplant system as a whole. Additionally, donor candidates might be inclined to falsify medical records and information to increase their chances of being selected as an organ donor, putting both their own and the recipient's health at risk.^{13,14}

As the demand for organs outpaces supply, the organ-desperate patient and the economically struggling individual both present as easy targets for those involved in illegal organ markets. This calls into question the ethical implications of a financial compensation program for organ donation. This calls into question the ethical implications of a financial compensation program and whether it would open the door for human exploitation.¹⁴ While arguments in favor of compensation programs highlight laws and policies that protect against the abuse of the system, it will be impossible to distinguish which donations were financially motivated; a truly ethical system may thus never be feasible.¹²

Dr. Lainie Ross, a physician and bioethicist at the University of Chicago, says that in order to understand the argument against financial compensation for organ donation, the principle of autonomy must be examined.¹⁵ While people have the right to make their own decisions about their body from a moral standpoint, limits can be placed on autonomy to protect individuals from misguided decisions.¹⁶ Thus, someone's choice to donate organs should be challenged if there is an element of coercion due to hardships such as economic status. Additionally, Ross states that organ donation is unique in that it involves a third party: the medical staff responsible for the transplantation. The surgeon also has the right to refuse to operate based on their moral stance if they believe the patient has elected to donate organs solely for monetary gain.¹⁵ These ethical barriers make financial compensation for organ donation a difficult program to implement.

Furthermore, there is no guarantee that financial compensation would even close the organ shortage gap. According to the motivation crowding theory, the provision of extrinsic incentives may undermine intrinsic motivation.¹⁷ In this case, payment for organ donation could reduce intrinsic motivation, decreasing the existing number of donations for which no money is given.¹⁸ In certain situations, donors may feel that financial compensation lessens the weight of altruism that is involved in the gift of donation.¹³ For example, a Swedish study by Abolghasemi et al. on blood donation found that in groups of women, the introduction of monetary incentives cut donors by nearly 50%.¹⁹

With the demand for donor organs remaining an ever-present issue, there is no doubt that the controversy surrounding financial compensation systems will be reignited. Limited by a complex debate of ethics and logistics, the topic is largely divided in public opinion. With many countries already operating under a compensation system, only time will tell whether more will follow suit.

1. Abouna GM. Organ shortage crisis: Problems and possible solutions. *Transplant Proc.* 2008;40(1):34-8. Available from: doi:10.1016/j.transproceed.2007.11.067.
2. Canadian Institute for Health Information. e-Statistics on organ transplants, waiting lists and donors [Internet]. 2020. Available from: <https://www.cihi.ca/en/e-statistics-on-organ-transplants-waiting-lists-and-donors> [cited 2021 Oct 25].
3. Harbell JW, Mathur AK. Financial compensation for organ donors. *Curr Opin Organ Transplant.* 2019;24(2):182-7. Available from: doi:10.1097/MOT.0000000000000617.
4. Hippen B, Ross LF, Sade RM. Saving lives is more important than abstract moral concerns: Financial incentives should be used to increase organ donation. *Ann Thorac Surg.* 2009;88(4):1053-61. Available from: doi:10.1016/j.athoracsur.2009.06.087.
5. Meier-Kriesche HU, Port FK, Ojo AO, Rudich SM, Hanson JA, Cibrik DM, et al. Effect of waiting time on renal transplant outcome. *Kidney Int.* 2000;58(3):1311-7. Available from: doi:10.1046/j.1523-1755.2000.00287.x.
6. Ghods AJ, Savaj S. Iranian model of paid and regulated living-unrelated kidney donation. *Clin J Am Soc Nephrol.* 2006;1(6):1136-45. Available from: doi:10.2215/CJN.00700206.
7. Malekshahi A, Morteza-Nejad HF, Taromsari MR, Gheshlagh RG, Delpasand K. An evaluation of the current status of kidney transplant in terms of the type of receipt among Iranian patients. *Ren Replace Ther.* 2020;6(1):66. Available from: doi:10.1186/s41100-020-00314-8.
8. Held PJ, McCormick F, Ojo A, Roberts JP. A cost-benefit analysis of government compensation of kidney donors. *Am J Transplant.* 2016;16(3):877-85. Available from: doi:10.1111/ajt.13490.
9. Akoh JA. Key issues in transplant tourism. *World J Transplant.* 2012;2(1):9-18. Available from: doi:10.5500/wj.v2.i1.9.
10. Gill J, Diec O, Landsberg DN, Rose C, Johnston O, Keown P, et al. Opportunities to deter transplant tourism exist before referral for transplantation and during the workup and management of transplant candidates. *Kidney Int.* 2011;79(9):1026-31. Available from: doi:10.1038/ki.2010.540.
11. Babik JM, Chin-Hong P. Transplant tourism: Understanding the risks. *Curr Infect Dis Rep.* 2015;17(4):473. Available from: doi:10.1007/s11908-015-0473-x.
12. Harbell JW, Mathur AK. Financial compensation for organ donors. *Curr Opin Organ Transplant.* 2019;24(2):182-7. Available from: doi:10.1097/MOT.0000000000000617.
13. Shaikh SS, Bruce CR. An ethical appraisal of financial incentives for organ donation. *Clin Liver Dis.* 2016;7(5):109-11. Available from: doi:10.1002/cld.548.
14. Adair A, Wigmore SJ. Paid organ donation: The case against. *Ann R Coll Surg Engl.* 2011;93(3):191-2. Available from: doi:10.1308/147870811X565061a.
15. Hippen B, Ross LF, Sade RM. Saving lives is more important than abstract moral concerns: Financial incentives should be used to increase organ donation. *Ann Thorac Surg.* 2009;88:1053-61. Available from: doi:10.1016/j.athoracsur.2009.06.087.
16. Engelbrecht SF. Can autonomy be limited - an ethical and legal perspective in a South African context? *J Forensic Odontostomatol.* 2014;32(Suppl 1):34-9. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5734815/> [cited 2021 Oct 25].
17. Frey B, Jegen R. Motivation crowding theory: A survey of empirical evidence. *J Econ Surv.* 2002;15(5):589-611. Available from: doi:10.1111/1467-6419.00150.
18. Gill S, Klarenbach S, Barnieh L, Caulfield T, Knoll G, Levin A, et al. Financial incentives to increase Canadian organ donation: Quick fix or fallacy? *Am J Kidney Dis.* 2014;63(1):133-40. Available from: doi:10.1053/j.ajkd.2013.08.029.
19. Abolghasemi H, Hosseini-Divkalyai NS, Seighali F. Blood donor incentives: A step forward or backward. *Asian J Transfus Sci.* 2010;4(1):9-13. Available from: doi:10.4103/0973-6247.59385.