

Financial Incentives for Living Kidney Donors: Are They Necessary?

Dominique E. Martin, PhD,¹ and Sarah L. White, PhD²

In the face of the perceived failure of altruistic organ donation programs to generate sufficient kidneys to meet demand, introducing financial incentives for living donors is sometimes argued as the only effective strategy by which lives currently lost while awaiting kidney transplantation might be saved. This argument from life-saving necessity is implicit in many incentive proposals, but rarely challenged by opponents. The core empirical claims on which it rests are thus rarely interrogated: that the gap between supply of and demand for donor kidneys is large and growing, the current system cannot meet demand, and financial incentives would increase the overall supply of kidneys and thus save lives. We consider these claims in the context of the United States. While we acknowledge the plausibility of claims that incentives, if sufficiently large, may successfully recruit greater numbers of living donors, we argue that strategies compatible with the existing altruistic system may also increase the supply of kidneys and save lives otherwise lost to kidney failure. We conclude that current appeals to the life-saving necessity argument have yet to establish sufficient grounds to justify trials of incentives.

Am J Kidney Dis. ■(■):■-■. © 2015 by the National Kidney Foundation, Inc.

INDEX WORDS: Kidney transplantation; end-stage renal disease (ESRD); living donors; transplant waiting list; organ procurement; altruistic organ donation; financial incentives; medical ethics.

INTRODUCTION

“Altruistic” organ donation, in which donors (or their families) do not materially gain from donation,¹ is the prevailing international norm in organ procurement programs. However, in the face of the perceived failure of current altruistic donation programs to generate a sufficient supply of kidneys to meet demand, the introduction of a regulated market that offers payment in return for living provision of a kidney is sometimes held to be the only effective strategy by which the lives currently lost while awaiting kidney transplantation might be saved.²⁻⁷ For some, financial incentives or other benefits representing a material gain for living kidney donation thus become a moral “imperative.”^{5,8} This argument from life-saving necessity (necessity argument) is implicit in many proposals for the introduction of markets in human kidneys, but is rarely challenged by market opponents.

Proponents and opponents of financial incentives agree that efforts to reduce the premature loss of lives from end-stage renal disease (ESRD), including optimization of organ donation, are ethically warranted. Removal or reimbursement of the financial costs incurred by living kidney donors is also widely regarded as ethically acceptable.^{1,9,10} Debate instead habitually centers on differing evaluations of the consequences of financial incentives, especially regarding their impact on kidney vendors. Although we hold serious concerns regarding risks of impaired autonomy, exploitation, and harm to kidney vendors,¹¹ in this article, we set aside these familiar components of the incentives debate and

focus solely on examining the necessity argument and the rarely contested empirical assumptions it contains (Box 1). Examining data from the United States, in which context the necessity argument is usually invoked, we consider the claims that the current system of altruistic donation cannot meet current and future demand, and that conversely, financial incentives would produce a substantial increase in, if not sufficiency of, kidneys for transplantation. We consider the donor potential within the existing altruistic system and discuss alternative uncontroversial strategies by which society might meet its ethical obligation to prevent the premature loss of human life from ESRD.

EVALUATING THE PROBLEM

The supply-demand gap between the number of waitlisted candidates and the number of kidney transplantations performed each year in the United States is invoked to support the claim that unmet needs for transplantation constitute a “disaster,”¹² costing thousands of lives and requiring immediate

From the ¹Centre for Health Equity, School of Population and Global Health, The University of Melbourne; and ²Charles Perkin Centre, Sydney Medical School, The University of Sydney, Sydney, Australia.

Received October 22, 2014. Accepted in revised form March 6, 2015.

Address correspondence to Dominique E. Martin, PhD, Level 4, 207 Bouverie Street, The University of Melbourne, 3010, Australia. E-mail: dominique.martin@unimelb.edu.au

© 2015 by the National Kidney Foundation, Inc.
0272-6386

<http://dx.doi.org/10.1053/j.ajkd.2015.03.041>

Box 1. Premises of the Argument From Life-Saving Necessity

1. Society has an ethical obligation to prevent the premature loss of human life when possible through the provision of necessary health care resources and services.
2. A large number of lives are currently lost prematurely as a result of end-stage renal disease; a proportion of these could be saved through timely provision of a kidney transplant if more kidneys were available.
3. Existing organ procurement systems based on altruistic donation are unable to meet current and anticipated future demand for kidney transplants.
4. Financial incentives for living provision of kidneys will increase the overall number of kidneys available for transplantation.
5. Potential ethical concerns about payment for living kidney provision can largely be addressed through market regulation; regardless, these concerns are insufficient to outweigh the overriding ethical obligation to maximize the saving of lives when possible.
6. Therefore, society has an ethical obligation to introduce financial incentives for living provision of kidneys.

intervention in the form of incentives for living kidney provision. We therefore begin by considering the scale of this gap.

Table 1 compares current supply and demand, noting that demand may be enumerated as: (1) the total number of candidates on the kidney transplant waiting list, active and inactive (94,183 as of December 31, 2012); (2) the number of candidates on the active waiting list (57,903 as of December 31, 2012); or (3) the number of new candidates added to the waiting list in 2012 (31,157).¹³ On the one hand, it is argued that the organ shortage should be defined in terms of the total waiting list on the basis that many inactive candidates were once healthy enough to receive a transplant but become ineligible due to delayed transplantation.¹⁴ On the other hand, deceased donor kidneys can only be allocated to active candidates; thus, effective demand is confined to the active waitlist.¹⁵ At a minimum, meeting the demand for kidney transplantation would require that the annual number of kidney transplants exceed the number

Table 1. Kidney Transplant Waiting List Dynamics in 2012

	Adults	Children
Total (active and inactive) patients as of December 31, 2012	92,885	1,298
Active patients as of December 31, 2012	57,378	525
Patients added to the waiting list during 2012	30,274	883
Removed from waiting list: underwent transplantation	16,025	776
Removed from the waiting list: died	5,209	27
Removed from the waiting list: too sick to undergo transplantation & other ^a	5,029	57

^aOther reasons include patient refused transplant, patient improved (transplant not needed), and "other."

Data from: OPTN/SRTR 2012 Annual Data Report.¹³

of new additions. In 2012, a total of 31,157 candidates were added to the kidney transplant waiting list and 16,801 were removed due to transplantation: a shortfall of 14,356 transplants.¹³ However, >30% of adult waiting list additions in 2012 were inactive within 7 days of listing (n = 10,587).¹³ Approximately 50% of initially inactive adult candidates will be activated within 12 months of listing; approximately one-third of initially inactive candidates will remain inactive, with these continuously inactive candidates tending to be older, obese, and other marginal candidates with poorer expected posttransplantation survival.^{16,17} Further, a large proportion (~40%) of candidates who die while inactive do so within 2 years of listing.¹⁵ These observations suggest that up to one-third of candidates listed initially as inactive may not be suitable for transplantation. The increased use of inactive status since the amendment to Organ Procurement and Transplantation Network policy 3.5.11 in 2003 (Fig 1) and the complexity of wait list dynamics¹⁶ may therefore result in overstatement of the gap between supply and effective demand for kidneys, particularly when cited in public commentaries on incentive proposals.¹⁸

Nevertheless, it is important to recognize that waiting lists, while an indicator of demand, are a poor reflection of true population need for kidney transplantation. A significant proportion of the population that might benefit from kidney transplantation is never wait-listed, either as active or inactive candidates. Schold et al¹⁹ estimate that successful efforts to increase access to transplantation for all candidates with a good prognosis (defined in their study as life expectancy > 5 years) would approximately double the existing waiting list.²⁰ However, what this and other studies also report is that the reasons for non-listing relate primarily to structural, geographic, and socioeconomic barriers to waiting list access, such as

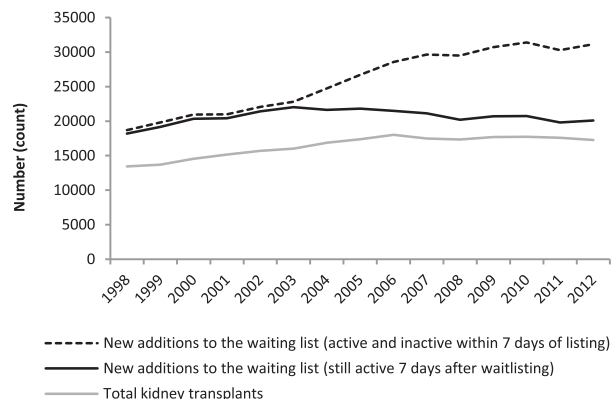


Figure 1. New additions to the kidney transplant waiting list (adult and pediatric candidates) in each calendar year by patient status (active/inactive within 7 days of listing) compared to the total number of kidney transplantations performed in adult and pediatric patients in the same year. Data from OPTN/SRTR 2012 Annual Data Report.¹³

Download English Version:

<https://daneshyari.com/en/article/6157108>

Download Persian Version:

<https://daneshyari.com/article/6157108>

[Daneshyari.com](https://daneshyari.com)