FINANCIAL INCENTIVES FOR ORGAN DONATION IN THE UNITED STATES

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ABSTRACT

Like most countries, the United States faces a shortage of organ donors, and the need for donations continues to exceed the number of organs available for transplantation. Patients die every day while waiting for a new heart, liver, kidney, lungs, bone marrow, or other organs/tissues. While few can argue against the need for initiatives aimed at increasing the rates of organ donations in the United States, debates persist among policymakers, stakeholders, and the public about whether programs allowing financial incentives for organ donations should be implemented in the United States. This thesis explores current laws in the United States as they relate to organ donation and transplantation, noting prohibitions against financial incentives and what the current law terms as “valuable consideration,” and studies positions of various stakeholders and scholars on incentives in general and on proposed laws written with the purpose of increasing organ donations in the United States.

The thesis focuses in part on the topics of economics and ethics as they relate to organ donations, and, more specifically, as these topics relate to financial incentives for organ donations. The thesis examines arguments both for and against the concept of financial incentives, ultimately proposing that there are sound ethical and economic reasons to support financial incentive programs in the United States. Using examples of
policies implemented in other countries to increase organ donations, particularly a compensation program implemented in Iran, as well as policies implemented and considered in China and Israel, the thesis argues that similar policies can be implemented safely and ethically in the United States. The thesis also examines specific financial incentive proposals set forth by scholars in the United States which detail programs that would use many components that are already in place, such as proper screening of donors, while adding the provision of payments by a third party (for example, the federal government).

Finally, the thesis concludes by setting forth a detailed proposal for a financial incentive program that could be implemented in the United States, using some of the concepts set forth by others. The thesis determines that some stakeholders (the same stakeholders who have spoken out against financial incentive programs in general) would likely have concerns over the financial incentive program proposed at the conclusion of this paper; however, the thesis proposes that the financial incentive program would likely have such a drastic impact on increasing the number of organ donors in the United States, that the benefits to patients’ lives far outweigh other ethical and moral concerns. Opponents of financial incentive programs for donors should realize the number of lives that could be saved through such programs, and should support, at the very least, pilot programs in the United States.
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CHAPTER ONE
ORGAN DONATION AND TRANSPLANTATION LAWS

Introduction

Debates about organ donation for the use of transplantation in the United States often involve ways to increase organ donation while safely and ethically regulating the practice. As of September 24, 2011, there were 112,308 people on a waiting list for organ transplantation in the United States, according to the United Network for Organ Sharing’s website (http://www.unos.com). Most agree that the need for organ donors is great, and that organ donation is necessary for saving and/or improving lives, but not all policymakers, stakeholders, and members of the public agree on the methods for increasing the occurrence of organ donation from both living donors and deceased donors, in the United States and abroad. This thesis will seek to discover whether a model of providing compensation or other incentives for living organ donors and/or deceased organ donors’ families can be implemented safely and ethically in the United States to increase organ donation, and will analyze proposed models of such incentive policies in the United States and abroad to determine which would offer a solution that would align most closely with common values in the United States (or will propose a combination of certain models).

First, this thesis will review pertinent U.S. laws related to organ donation, and noted particulars regarding laws prohibiting the compensation of donors and their families. An overview of U.S. laws pertinent to organ transplantation and donation, with
a particular focus on the portions of the laws regarding the provision of compensation or other incentives to donors and/or their families, provides a basis for understanding the views of policymakers and the potential for revisions to current laws. This chapter will use these laws as a backdrop against which to study issues as they relate to laws covering organ donation and the concept of providing compensation or other incentives to donors and/or their families. An overview of pertinent laws related to organ transplantation in the U.S. is provided below.

**Overview of U.S. Laws and Regulations: Uniform Anatomical Gift Act**

The Uniform Anatomical Gift Act (UAGA) was the first law governing organ and tissue donation in the United States, originally enacted in 1968 and adopted by fifty states and the District of Columbia to allow people to donate organs, tissue, and eyes (also known as “anatomical gifts”). By adopting the UAGA, the states were provided with a basic text, or template, that they could then change for their own adaption of the law through their respective state legislatures (Markmann 2005).

The UAGA has been revised several times. In 1972, the law was updated to require that uniform donor cards be recognized as legally binding documents in all states in the U.S. In 1987, the law was revised further, making it unlawful for a person to “knowingly, for valuable consideration,” buy or sell a body part “if removal of the part is intended to occur after death of decedent” (The National Conference of Commissioners on Uniform State Laws 2006). This iteration of the UAGA left some gray areas, however, and the 1987 UAGA was only adopted by twenty-six states. The section
forbidding the sale of organs appears to omit living donors, by specifically stating that the ban would apply if the physical removal of the organ were to take place after the organ donor’s death. Further, the authors of the UAGA did not define what constitutes “valuable consideration” for purposes of the Act. Because each state was permitted to adopt the law with its own variations, concerns developed regarding uniformity across jurisdictions, and the UAGA was revised again in 2006 to provide consistency for all states. (In the meantime, the National Organ Transplant Act, or “NOTA,” was passed in 1984, partly to regulate organ transfer consistently among states. NOTA, which is discussed further below, is fundamental to the discussion of organ donation and incentives).

The Revised UAGA of 2006, as drafted by the National Conference of Commissioners on Uniform State Laws, incorporated several changes, to include clarifying the list of people who are able to make an organ donation decision on behalf of a deceased person (Ibid.). According to its website, the National Conference of Commissioners on Uniform State Laws drafted the UAGA of 2006 to make updates to the UAGA in accordance with federal laws and regulations that would make the Act more consistent with the current system for allocating cadaver organs for the purposes of a transplant, and that would further make organs available for use in transplantation. The basic tenets of the Revised UAGA of 2006 include: allowing a person to document that he or she wishes to make an anatomical gift by donating his or her organs upon death, for example, on a driver's license; allowing certain people to authorize donation of organs for
another in the event that the person is incapacitated, before death; expanding the list of those persons who may authorize the donation of organs after a person's death, in the event that the deceased has not executed documents to that effect; and allowing for a document of refusal if a person does not want his or her organs donated upon death (Ibid.). The Act also sets forth penalties for anyone who forges a document with intentions of selling one’s organs. Section 16(a) of the UAGA of 2006 prohibits anyone from “knowingly” purchasing or selling organs or tissue for transplantation for valuable consideration, noting that committing such an act would be considered a felony and would be punished as such (Ibid.). Section 16(b) of the Act allows the organ procurement organizations (OPOs) to charge a “reasonable amount for the removal, processing, preservation, quality control, storage, transportation, implantation, or disposal of a part” (Ibid.).

**Overview of U.S. Laws and Regulations: The National Organ Transplant Act**

The National Organ Transplant Act (NOTA), Public Law 98-507, was enacted on October 19, 1984, with several stated purposes, to include establishing the Task Force on Organ Transplantation (Task Force), establishing the Organ Procurement and Transplantation Network (OPTN), and authorizing financial assistance for organ procurement organizations (National Organ Transplant Act of 1984). NOTA is a significant law governing transplantation in the United States, enacted after a period of time during which organ transplantation had proven to be successful, and with the government and the public finding a need to ensure that organs were fairly allocated and
that the practice was closely monitored to ensure the health and welfare of citizens (Petechuck 2006, 31). Under the UAGA, each state had the right to regulate who could donate their organs (and how, and when), and the federal government became concerned about the inconsistencies among states and the effects these inconsistencies could have on the practice of organ donation. For one, there was the possibility that residents of a state that prohibited the sale of organs under its adoption of the UAGA could travel to another state which did not prohibit the sale of organs, where they could receive “valuable consideration” for donating organs. Under this scenario, the residents of the state that prohibited organ sales would then be disadvantaged because the state would not be able to secure as many donor organs for those who needed them (Markmann 2005). Therefore, the authors of NOTA set out to standardize and regulate the way organ donations were handled in the United States.

NOTA required the creation of the Task Force on Organ Transplantation (Task Force), made up of twenty-five members who were charged with examining various issues related to organ donation and transplantation, to include medical, ethical, economic, and legal issues (Petechuck 2006, 31). The Task Force was also to examine possible reasons that there was a shortage of organs to be used for transplants. In 1985, the Task Force submitted a report to the Secretary of the Department of Health and Human Services, which included several recommendations. Two notable recommendations made were to adopt uniform standards for the procurement of donor organs, and for states in the United States to ban the sale of organs from both cadavers
and living donors (Markmann 2005). The Task Force also made efforts to increase organ
donation by recommending laws to require hospitals to develop procedures for asking
patients and their families whether they were interested in becoming organ donors
(Petechuk 2006, 31).

NOTA gave the Secretary of the Department of Health and Human Services the
responsibility for establishing Organ Procurement Organizations (OPOs) – private, non-
profit organizations set up to supervise the allocation and procurement of organs within
“geographic regions,” and for establishing the Organ Procurement and Transplantation
Network (OPTN), to manage a national list of people who need organ transplants, set up
criteria and processes to ensure the equitable distribution of organs, educate the public
about organ donation, and provide ongoing oversight of procedures for organ donation
and transplantation in the United States (Markmann 2005).

NOTA declared that the OPTN would be operated by a private, not-for-profit
organization through a federal contract, with the purpose of increasing “the effectiveness
and efficiency of organ sharing and equity” and increasing “the supply of donated organs
available for transplantation” (National Organ Transplant Act of 1984). The United
Network for Organ Sharing (UNOS) is under contract with the United States Department
of Health and Human Services, Health Resources and Services Administration (HRSA),
to operate the OPTN and to implement recommendations of the Task Force. The
Department of Health and Human Services oversaw a project to divide the United States
into eleven geographic regions, and UNOS was responsible for ensuring that organ
procurement agencies and transplant centers followed common standards of practice for
the allocation of organs (Markmann 2005). UNOS also created, and now maintains, a
nationwide transplant “waiting list” for organ recipients.

**Valuable consideration**

NOTA also directly addressed the issue of buying and selling organs for
transplantation – a tenet of the law that has enormous impact on policy for financial
incentives. Title III of NOTA is particularly important for the topic of compensation, as
it discusses mandates for the prohibition of organ purchases. Section 301(a) of Title III
forbids anyone to “knowingly acquire, receive, or otherwise transfer any human organ for
valuable consideration for use in human transplantation if the transfer affects interstate
commerce” (National Organ Transplant Act of 1984). The phrase “valuable
consideration” is a key concept in this topic; it has been defined specifically in the
context of transplantation by the Advisory Committee on Organ Transplantation (ACOT)
as “anything having worth, whether monetary or intrinsic, which induces or motivates an
agreement or contract” (U.S. Department of Health and Human Services 2004). Section
301(c)(2) of Title III of NOTA discusses “valuable consideration” and defines it for the
purposes of organ transplantation by declaring what types of compensation shall *not* be
considered as such: “reasonable payments associated with the removal, transportation,
for processing of organ and for expenses of travel, housing, lost wages” (National Organ
Transplant Act of 1984). While NOTA provides clarity on what might and might not be
considered as “valuable consideration,” it also uses the term “reasonable,” and

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interpretations of what might be considered to be “reasonable” can vary from person to person. As will be discussed later in this thesis, NOTA and its terminology are the subject of much debate among scholars, policymakers, and the public when it comes to discussing the provision of incentives for organ donation.

**Advisory Committee on Organ Transplantation**

NOTA granted powers to the Secretary of the Department of Health and Human Services to create the Advisory Committee on Organ Transplantation (ACOT) in 2000, to advise the Department on ways to increase organ donation, on ways to assure the public that the organ donation system is fair, and on ways to instill confidence in the public in relation to the overall practice of organ transplantation in the United States (Markmann 2005). The ACOT and its findings and recommendations are important for this paper because the committee has historically looked into ways to increase organ donation while not violating NOTA’s prohibition of organ purchases. As of October 15, 2011, the ACOT has published fifty-one (51) recommendations. Recommendation # 36, approved by the ACOT in November 2004, suggested that NOTA be amended to allow for additional exclusions from the definition of “valuable consideration” in the context of organ donation, to permit forms of reimbursement other than those for the actual processing of the organ and for donors’ travel, lodging, and lost wages expenses (U.S. Department of Health and Human Services 2004). The ACOT also recommended that the Secretary request that another party, such as the President’s Council on Bioethics, evaluate any proposed exceptions to NOTA’s definition of “valuable consideration” to
ensure that they are deemed to be ethical (Ibid.). In spite of this recommendation, however, there have yet to be any further exceptions to NOTA approved for the purposes of providing reimbursement for organ donation.

The Organ Donation and Recovery Improvement Act

The Organ Donation and Recovery Improvement Act (ODRIA), Public Law 108-216, was passed on April 5, 2004, to amend the Public Health Service Act to promote organ donation, and for other purposes (Organ Donation Recovery and Improvement Act 2004). ODRIA amended the Public Health Service Act to include a Section 377 titled “Reimbursement of Travel and Subsistence Expenses Incurred Toward Living Organ Donation.” The revised section permitted the Secretary of the Department of Health and Human Services to award grants to states, transplant centers, and other organizations, to include approved organ procurement organizations, for the purpose of reimbursing living donors for travel and other expenses incurred related to donating the organ, and for the purpose of reimbursing living donors for “incidental nonmedical expenses” that the Secretary determines are appropriate by regulation (Ibid.). ODRIA also allowed for donors’ relatives to be reimbursed for expenses incurred as they accompany donors and assist them through the donation process (Markmann 2005). ODRIA requires that the Secretary give preference in providing funds to those donors who might not otherwise be able to afford such expenses without assistance from the government.

ODRIA also mandated that the Secretary of the Department of Health and Human Services report to Congress on various ethical implications of proposals for increasing
organ donation from deceased, some of which involve providing incentives. ODRIA did not, however, sanction conducting projects to determine whether incentives would increase organ donation from the deceased (Organ Donation Recovery and Improvement Act 2004). (A Senate version of legislation had proposed such projects, lobbied for by organizations that support the provision of incentives to donors and/or their families for providing organ transplants.)

A review of current laws in the United States regarding organ donation in general, and specifically the sections of those laws related to providing compensation or other forms of incentives for organ donors and/or their families, allows for an assessment of what principles and values are important to U.S. citizens, stakeholders, and lawmakers. Considering the major principles and values allows us to reflect on what might be preventing the adoption of laws allowing for the compensation of organ donors and/or their families.

Values

Some of the values to be considered when studying current transplant laws include: respect for human dignity; equality; autonomy; altruism; protection of the vulnerable; and the concept that the body is not a commodity. In the following chapters, I will consider these values while studying the opinions of various stakeholders involved in organ donation in the United States and other countries, policymaking for organ donation here and abroad, others’ proposals for incentivizing organ donation in the United States, and a proposal for a method that would most closely align with values
intrinsic to citizens of the United States.
CHAPTER TWO

POSITIONS OF STAKEHOLDERS

Introduction

This chapter will consider the opinions and positions of various stakeholders who are for or against the concept of providing compensation or other types of incentives to organ donors and/or their families. First, there will be a review of several bills that were debated by Congress on the topic of organ donation and the provision of such incentives, with each bill proposing a different type of incentive. Second, the chapter will study articles published in journals or other publications that represent views of certain stakeholders, and will consider briefings or articles published by stakeholders such as the World Health Organization and not-for-profit organizations that have a vested interest in organ donation and the topic of compensation or other incentives. Third, we will assess values represented by certain stakeholders on both sides of the debate, and will discuss possible reasons for why certain stakeholders maintain their positions on organ donation and compensation/incentives. The purpose of this chapter is to allow for a better understanding of what bills have already been put forth by legislators, and of the views and intentions of stakeholders when it comes to the topic of providing compensation/incentives for organ donation.

There have been various bills debated by Congress which were written with the purpose of increasing the number of qualified organ donors in the United States through the use of compensation, tax rewards, credits, and other incentives that are not directly
financial in nature. The purpose of these bills is often to encourage people to agree to
donate their organs upon death, if the organs are viable for transplant, and/or to
courage living donation, which is applicable mainly to kidney transplants (as a donor
can live with one healthy kidney). Most of the bills discussed in this chapter did not
become laws. Studying these bills allows for an understanding of what types of
incentives for organ donations have already been proposed in Congress, as well as the
views and possible values of stakeholders on both sides of the debate regarding
incentives for organ donations. A summary of some of the bills is set forth in the
following paragraphs.

**The Gift of Life Congressional Medal Act**

During the first session of the 107th Congress, on February 14, 2001, H.R. 708,
the Gift of Life Congressional Medal Act of 2001, was introduced in the House of
Representatives. The purpose of this bill was to establish a program that would provide
commemorative medals for organ donors and/or their families. Representative Fortney
Pete Stark (D-CA) sponsored this bill, which set forth a plan to have bronze medals
designed, produced, and given to organ donors (in the case of living donations) and/or to
the families of deceased donors.

The Gift of Life Congressional Medal Act of 2001 proposed that the regional
Organ Procurement Organization (OPO) would coordinate the program, and that the
Organ Procurement and Transplantation Network (OPTN) contractor would manage it,
with the organizations receiving an initial loan of $55,000 to design and produce the
medals (U.S. House 2001, E190). The bill also stipulated that the OPO and OPTN would repay the loan of $55,000 within three years with funds received under subsection (a) of the bill, which dictated that the Treasury Secretary could enter into an agreement with the OPTN contractor to collect donations for the program (Ibid.). After the OPO and OPTN repaid the loan of $55,000, the organizations would be fully responsible for funding the medal program. Once designed and produced, the Secretary of the Treasury was to give the medals to the Secretary of Health and Human Services, who would then direct the OPTN contractor to first determine which individuals were eligible to receive the medals, and then to arrange for the presentation to the appropriate organ procurement organization for distribution to the individuals (Ibid.). The bill required the Secretary of the Treasury to make efforts to ensure that the federal government would not have to pay any costs for the issuance of medals under the Gift of Life Congressional Medal Act of 2001. This Act is an example of legislation written with the intent of increasing organ donations while not offering direct financial incentives, but rather “rewarding” organ donors and/or their families with a type of recognition. The bill included fairly wide eligibility requirements, basically proposing to allow anyone who donated an organ, or the family members of a deceased person who donated an organ, to be eligible to receive a medal, provided the person submitted appropriate documentation through an application system and was deemed eligible by the OPTN.

Writing about the bill on his official website, Representative Stark said that for people who took the “generous step” of donating an organ, the legislation would “honor
the efforts of organ donors while also improving critical public awareness of organ
donation” (Representative Stark). Also on his website, Representative Stark noted that
Tommy Thompson, the Secretary of Health and Human Services at the time, had made
the topic of organ donation one of the top priorities for his administration.
Representative Stark called on his fellow members of Congress to pass legislation for this
incentive program, implying that it would reward organ donors and their families while
calling attention to the need to increase organ donations.

While no financial compensation or credits would be provided, The Gift of Life
Congressional Medal Act of 2001 would have honored and provided recognition to organ
donors as reward for their donations. In his remarks about the bill, Representative Stark
noted the altruistic nature of the act of donating an organ, and proposed that recognizing
these acts would encourage others to become organ donors. Among those to show
support for the Gift of Life Congressional Medal Act of 2001 was the American
Association of Kidney Patients (AAKP), whose Executive Director and CEO published a
sample letter to a Representative on the Association’s website, encouraging supporters to
use the letter as a template for sending correspondence to their Representatives asking
them to support the bill. The AAKP letter noted that the Gift of Life Congressional
Medal Act of 2001 would create a program to “recognize the selfless act of organ
donation” without imposing any costs to the federal government (AAKP).

An article published in The New England Journal of Medicine written by a group
of doctors and scholars who generally oppose a financial market or financial
incentives for organ donation – Francis Delmonico, M.D., Robert Arnold, M.D., Nancy Scheper-Hughes, Ph.D., Laura Siminoff, Ph.D., Jeffrey Kahn, Ph.D., M.P.H., and Stuart Younger, M.D. – showed support for the Gift of Life Congressional Medal Act of 2001, calling the proposed program an “ethically acceptable” way of encouraging organ donation because the program would not provide money to organ donors or their families, but would still provide recognition and appreciation (Delmonico et al. 2002, 2003).

While the article proclaimed the Gift of Life Congressional Medal Act of 2001 to be acceptable, the authors at the same time urged Congress to preserve the section of the National Organ Transplant Act (NOTA) that prohibits any form of payment for the provision of organs in the United States (Ibid.).

The Gift of Life Congressional Medal Act of 2001 could be viewed as one of the least controversial proposals for incentivizing organ donation, as the concept behind the program was not to provide incentives that would result in financial gain for donors. However, there was at least one stakeholder who spoke out against a later version of the bill (the William H. Frist Gift of Life Congressional Medal Act of 2007): Alex Tabarrok, Associate Professor of Economics at George Mason University. Professor Tabarrok has a special interest in health economics, and has written several papers detailing his opinions about instituting programs of incentives for organ donations. Tabarrok wrote a very short statement on his blog, “Marginal Revolution,” on April 2, 2007, declaring that the bill proposed “millions for medals but not a cent for compensation” (entry posted April 2, 2007, on the Marginal Revolution Blog). Succinctly, Professor Tabarrok implied
that in passing the bill, Congress would be spending money on commemorative medals instead of on direct compensation or other financial incentives, which Tabarrok believed would have more of an impact on increasing organ donation.

Stephen J. Dubner, a journalist and one of the authors of the book “Freakonomics,” posted an article on his own blog on April 2, 2007 about The William H. Frist Gift of Life Congressional Medal Act of 2007, in essence, echoing Tabarrok’s opinion. Dubner suggested that if a potential donor is considering becoming an organ donor, he or she would not be encouraged to move forward with the act based on the promise of a commemorative medal (entry posted April 2, 2007, on the Freakonomics Blog). Essentially, both Tabarrok and Dubner are proclaiming that while the intentions behind the proposed medal programs are good, a medal program is simply not enough to make a notable impact towards increasing the number of organ donations in the United States.

As uncontroversial as the Gift of Life Congressional Medal Act of 2001 might have been (even its opponents probably would not have been vehemently against it passing – they just hoped for a bill that included financial compensation), it still did not pass into law. If it had, the Gift of Life Congressional Medal Act of 2001 might have paved the way for the passage of other legislation for programs to provide incentives to organ donors – and eventually, for financial incentives. Since the program would only provide a commemorative token to organ donors and/or their families, it would seem that stakeholders who are against allowing compensation for organ donors would not have
reason to protest this bill. On the other hand, stakeholders who are proponents of providing compensation for organ donors believed that the commemorative medal program would not provide enough of an incentive to make a noticeable impact on the number of organ donors.

**The Gift of Life Tax Credit Act**

On May 16, 2001, the Gift of Life Tax Credit Act of 2001 (H.R. 1872) was introduced in the House of Representatives by Representative James V. Hansen (UT-R), with the purpose of amending the Internal Revenue Code of 1986 to allow a refundable credit to people who declare that they will donate their organs upon death. The bill dictated that in order to be considered eligible for the tax credit, a person must meet the following criteria: the donor must be at least eighteen years of age, the donor must have made the declaration of his or her intent to donate organs for transplantation before his or her death, and while legally competent, the donor must not have committed suicide, and one or more of the person’s organs must be donated at death for transplantation through a program approved by the Secretary of the Department of Health and Human Services (U.S. House 2001). If a person met all of these criteria, there would be allowed a $10,000 tax credit for the taxable year which included the day the donor died.

Peter A. Clark, Ph.D., a Professor in the Department of Theology and Religious Studies at St. Joseph’s University in Philadelphia, Pennsylvania who teaches courses on ethics, wrote an article titled “Financial Incentives for Cadaveric Organ Donation: An Ethical Analysis,” in which he sets forth several ideas for financial incentives related to
cadaveric organ donation. In the article, Dr. Clark concludes that it is imperative that financial incentives be implemented in order to increase organ donations (Clark 2006). Dr. Clark also suggests that the provision of financial incentives to organ donors could not only benefit the organ recipient by saving his or her life or increasing the quality of life, but could also greatly benefit the organ donor and/or his or her family (Ibid.). As basis for his conclusion that incentives are medically, socially, and ethically justified, Dr. Clark cites an average five- to ten-year waiting list for organs in the United States, and states that the supply of organs for donation, if we are going to rely on altruism, will not meet the increasing demand for organs to be used for transplantation (Ibid.). Dr. Clark’s study did not include the provision of incentives to living donors.

The American Medical Association (AMA) was asked to support the Gift of Life Tax Credit Act of 2000, which was also introduced by Representative Hansen, but in 2000. (The bill that was introduced in 2000 was practically identical to the bill introduced in 2001.) As part of its review process, the AMA sent the request to its Council on Ethical and Judicial Affairs (CEJA) for an opinion on whether it complied with AMA policy. In response to the request, Herbert Rakatansky, MD, Chair of CEJA, wrote CEJA Report 7-I-00, which opined that the bill was not specific in regards to who may give consent on behalf of a donor in order to be eligible for the tax credit, and therefore, the CEJA did not recommend that the AMA support the legislation as written (Rakatansky 2000). The CEJA’s report did note, however, that the basic tenets of the Gift of Life Tax Credit Act of 2000 were in line with the AMA’s wish to promote organ
donation, though the Act was not fully compatible with the AMA’s ethical standards (Ibid.). The AMA’s “Code of Medical Ethics,” which sets forth the Association’s ethical standards and opinions on various medical topics, is considered to be the ethical protocol for physicians to follow in the United States. Therefore, it might be considered controversial for a physician to practice medicine in a manner, or support a practice, that contradicts the ethical standards set forth by the AMA. This would include the practice of organ donation and transplantation.

The article mentioned above in reference to the Gift of Life Congressional Medal Act of 2001, published in *The New England Journal of Medicine* on June 20, 2002, also presented an opinion from the authors (Francis Delmonico, M.D., Robert Arnold, M.D., Nancy Scheper-Hughes, Ph.D., Laura Siminoff, Ph.D., Jeffrey Kahn, Ph.D., M.P.H., and Stuart Younger, M.D.) on the Gift of Life Tax Credit Act of 2001 (Delmonico et al. 2002, 2003). The group proposed that The Gift of Life Tax Credit Act of 2001 would place “an arbitrary monetary value on an organ,” and also defined a tax credit as simply another form of payment (Ibid.). These physicians and scholars have historically not supported the provision of any type of financial incentives for organ donors. They did support a pilot program for the reimbursement of funeral expenses to families of organ donors, because they considered the program to be “an expression of society’s appreciation for the donation” (Ibid.). With their support of the funeral expense reimbursement program, the authors showed how they value the act of organ donation, as they showed with their support of The Gift of Life Congressional Medal Act of 2001, but they seem to be more
interested in ensuring that NOTA’s ban on allowing valuable consideration in exchange for organs be preserved. Their ethical concerns consistently prevent them from voicing approval of any proposals allowing financial incentives for organ donations.

The Gift of Life Tax Credit Act of 2001 did not pass into law. To opponents of the bill, the provision of tax credits for organ donors seemed to be too similar to allowing direct financial payments to donors, which leads many to think about possibilities of a market that would allow the buying and selling of organs. Some who were in favor of the bill believed that it would have been a step towards impacting an increase in the number of organ donors, without providing direct financial compensation or the outright purchase of an organ.

The Help Organ Procurement Expand Act

On June 6, 2001, Representative Christopher H. Smith (NJ-R) introduced the Help Organ Procurement Expand Act of 2001 (H.R. 2090) in the House of Representatives, with the purpose of amending the Internal Revenue Code of 1986 to allow a credit against gross income for organ donation. The bill detailed a plan that would provide a tax credit in the amount of $2,500 for a qualified organ donor, to be permitted as long as the donor met certain criteria, to include having provided legal consent to donate the organ(s). In accordance with this bill, the beneficiary of the tax credit would be the organ donor himself or herself, in cases of live organ donation, or, for deceased donors, the person to receive the tax credit would be the designated beneficiary or the estate of the deceased organ donor (U.S. Congress, House 2001).
The Help Organ Procurement Expand Act of 2001 was fairly similar in concept to The Gift of Life Tax Credit Act of 2001, and the same proponents of the latter bill did not object to the former. Opponents of The Help Organ Procurement Expand Act of 2001 included an ethics panel formed in 2002 and sponsored by the American Society of Transplant Surgeons, made up of doctors, surgeons, ethicists, and representatives of organ procurement organizations. The panel was charged with considering whether they would recommend convening a pilot trial for implementing financial incentives for families to authorize the donation of organs from a deceased relative. The findings of the panel were unanimous against allowing exchanges of money via payments or tax incentives for organ donations from cadavers, with the representatives believing that such incentives would “violate the ideal standard of altruism in organ donation and unacceptably commercialize the value of human life by commodifying donated organs” (Arnold, et al. 2002, 1361). The panel, which included Francis L. Delmonico, a medical doctor who has historically spoken out against the concept of incentivizing organ donations, likened the provision of tax credits that would be permitted under The Help Organ Procurement Expand Act of 2001 to direct payments, which was equated with commercialization and therefore deemed to be ethically unacceptable (Ibid.). The Help Organ Procurement Expand Act of 2001 did not pass into law.

**The Organ Donation Improvement Act**

The Organ Donation Improvement Act of 2001 (H.R. 624) was introduced in the House of Representatives on February 14, 2001, by Representative Michael Bilirakis
This bill was written with the purpose of amending the Public Health Service Act to allow the Secretary of the Department of Health and Human Services to award grants or contracts to states, transplant centers, qualified organ procurement organizations, or other qualified public/private entities to provide reimbursements to organ donors for travel and related expenses incurred during the process of donating an organ, and to provide reimbursements for other “incidental nonmedical expenses” that the donor incurs and that the Secretary of the Department of Health and Human Services determines are appropriate (U.S. Congress, House 2001). The Organ Donation Improvement Act of 2001 included limitations on what expenses could be granted; reimbursements would only be permitted for donors who lived in a different state from the recipient of the organ, and would only be permitted if the annual income of the recipient did not exceed $35,000. The bill also authorized the Secretary of the Department of Health and Human Services to carry out public education programs about organ donation and the need for donations, and to award grants to non-profit organizations for studies and projects encouraging organ donation (Ibid.).

On March 6, 2001, the Committee on Energy and Commerce, to whom H.R. 624 was referred, recommended that the bill be passed, and submitted Report 107-11 to accompany the bill. Report 107-11 mentions that research has found that there are people who are willing to become living organ donors who decline because of financial hardships that discourage them from donating (for example, travel expenses and time the
donor would have to take off of work for the surgery and recovery) (Tauzin 2001). This bill would have allowed qualified donors to be reimbursed for a portion of these expenses, therefore creating more of an incentive to donate while not providing direct compensation for the organ itself.

On June 28, 2002, the OPTN and UNOS Board issued a news release supporting legislation that would study the success of incentives to increase organ donation. The President of OPTN/UNOS, Jeremiah Turcotte, M.D., noted that the organizations believed that volunteerism should be the basis for organ donation, but because of the increased shortage of organs for donation, the OPTN/UNOS believed that it was time to consider the use of incentives to increase organ donation (Turcotte 2002). Among the financial incentives that the OPTN/UNOS recommended be studied was the reimbursement of donors’ medical expenses. In the news release, the OPTN/UNOS acknowledged that the allowance of such incentives would require that NOTA be amended, since the federal law does not permit the provision of “valuable consideration” for organ donation (Ibid.). The release further stated that the OPTN/UNOS would support such amendment of NOTA, which is an important note, since amendment of the law would be an important step towards enacting programs that permit financial incentives for organ donations.

President George W. Bush’s administration endorsed The Organ Donation Improvement Act of 2001 as part of its support for increasing the number of organ donors and providing “public awareness” about the need for organ donations (Peters and Wooley
The American Society of Transplant Surgeons (AST) published its support for The Organ Donation Improvement Act of 2001 in the March/April 2001 issue of its newsletter published online, noting that the bill included many “positive donation initiatives” that had been included in other larger bills that were not passed (American Society of Transplantation 2001, 17). In spite of the support, the bill did not become law.

The Living Organ Donor Job Security Act

The Living Organ Donor Job Security Act of 2009 (H.R. 2776) was presented in the House on June 9, 2009, introduced by Ruben Hinojosa (D-TX). This bill intended to amend the Family and Medical Leave Act of 1993 by allowing leave from work for individuals who provide living organ donations (for example, kidney and bone marrow donations). Under this Act, a donor would be granted leave from his or her job for the following: to undergo testing to determine whether he or she is qualified to donate, to receive other pre-transplant outpatient services, to undergo postoperative transplantation services, to have the actual surgery performed, for travel required to undergo testing, evaluations, and other related services, and for time to recover as required by the type of transplant surgery (U.S. Congress, House 2009).

The National Kidney Foundation (NKF) pronounced its support of the Living Organ Donor Job Security Act of 2009 as part of its “End the Wait” campaign (National Kidney Foundation). Historically, the NKF has not been supportive of allowing financial incentives for organ donation. Because the Living Organ Donor Job Security Act of 2009 would not be allowing direct financial compensation, but instead would be assuring
living donors that they were guaranteed leave from work as long as they provided the appropriate documentation and followed other required procedures, the NKF did not object to the Act. In essence, the bill attempted to remove a disincentive for potential living organ donors, rather than to provide an incentive. There are undoubtedly many people who have thought about donating a kidney or bone marrow but were dissuaded by the idea of taking time off of work and possibly being fired or losing income. The Living Organ Donor Job Security Act of 2009 set out to alleviate such fears and encourage living organ donation. While the proposal was fairly uncontroversial, and it is difficult to find opponents, the bill did not become law.

The Organ Donation Recovery and Improvement Act

The Organ Donation Recovery and Improvement Act (ODRIA), H.R. 3926, was introduced in the House of Representatives by Representative Michael Bilirakis (R-FL) on March 10, 2004. ODRIA was written with the purpose of increasing organ donations, and included provisions for reimbursing organ donors for travel and other expenses related to donating an organ by amending the Public Health Service Act to award grants to entities that would include states and qualified organ procurement organizations that they would in turn use to reimburse donors for travel and other incidental expenses needed while going through the process of donating an organ (U.S. Congress, House 2004). President Bush signed H.R. 3926 on April 5, 2004, at which point it became Public Law 108-216.

Many stakeholders were in favor of ODRIA. The NKF worked with the sponsors
of the bill to help finalize the legislation, in an effort to increase organ donation and to make donating an organ less of a financial hardship for donors. However, the NKF campaigned to make sure that NOTA was kept intact even in the passing of ODRIA. Some stakeholders interpreted the bill to support pilot studies for incentives in such a way that would supersede the prohibition against providing “valuable consideration” as set forth in NOTA (Joralemon and Cox, 27).

Now that this thesis has considered bills that were put forth with the intent of increasing organ donations, and set forth a summary of which stakeholders spoke out either for or against these bills, we will review some publications that represent general views of organizations that are stakeholders in the broad community of organ donation and transplantation, so we can better understand the positions of those organizations as they relate to compensation/incentives for organ donation.

**Stakeholder views: The World Health Organization**

The World Health Organization (WHO) published its revised “WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation” on May 26, 2008, which includes Guiding Principle 5, which dictates that organs, cells, and tissues should be donated “without any monetary payment or other reward of monetary value” (World Health Organization, 229). The document clarifies that Guiding Principle 5 does not prohibit the reimbursement of “reasonable and verifiable” expenses for the donor; the WHO maintains that its intent is to protect those who are considered to be vulnerable, who could potentially be taken advantage of if recipients were allowed to purchase
organs from donors, and to preserve the concept of altruistic donations (Ibid.). While the reimbursement of “reasonable and verifiable” expenses (such as lost wages and incidental medical expenses) would be permitted under the WHO Guiding Principles, even the purchase of health insurance coverage for a donor by a recipient would be prohibited, on the basis that access to such coverage is not something that should be purchased in exchange for a body part (Ibid.). While the WHO is interested in increasing organ donations, it is also committed to ensuring that the dignity of the donor is respected, and that the altruistic act of donating is recognized. The WHO maintains that each country’s own “legal framework” should be specific to the country’s circumstances, but that regardless, the ban on payment for organs and tissues should apply to everyone, regardless of their national origin or current residence. We should keep in mind that the WHO, an organization acting as the public health arm of the United Nations, is concerned about citizens of countries all over the world, and is therefore naturally anticipating how to protect some of the more disadvantaged. The stakeholders who were referenced in connection with U.S. proposed bills in the first part of this chapter are mainly concerned with the citizens of the United States, though of course they also care about protecting those who are vulnerable. Given its responsibilities and perspective, it is understandable that the WHO is going to take a stand against any type of financial market for organs.

**Stakeholder views: transplant surgeons**

Reviewing commentary from a transplant surgeon is also worthwhile in this study, as transplant surgeons are part of a stakeholder group dealing specifically with
organ donations. Amy L. Friedman, Director of the Transplant Program and Professor of Surgery at SUNY Upstate, and previously at the Yale University School of Medicine, wrote an article that was published in the *British Medical Journal* (November 2006) titled “Payment for Living Organ Donation Should be Legalised.” In the article, Dr. Friedman argues that a system that allows compensation for organ donation could ultimately improve shortages of organs for donation and at the same time be a safe solution. Dr. Friedman likens the prospect of compensating organ donors to the practice of paying egg and sperm donors, or to paying volunteers who participate in medical studies – both of which are permitted and regulated by the government (Friedman 2006). Dr. Friedman proposes that if these practices are allowed, then the provision of compensation for the donation of one’s organ should also be allowed.

**Stakeholder views: The American Nephrology Nurses’ Association**

The American Nephrology Nurses’ Association (ANNA) published its support for research of financial incentives for donors as a way to increase organ donation in the Nephrology Nursing Journal with its listing of position statements in 2007. While ANNA is interested in working towards decreasing the gap between those who need organ transplants and the number of viable donors, ANNA is also concerned about protecting organ donors’ interests. ANNA states its position that as an organization, it is against the use of coercion when it comes to increasing organ donation, both for living donors and cadaver donors (ANNA 2007). The meaning of the term “coercion” in this context is not entirely clear. Does the Association believe that the provision of financial
incentives would be equal to coercion? Or is the association merely stating its concern that a potential donor who might otherwise not be at all interested in donating an organ would be unreasonably swayed by the promise of a payment of some sort? Based on the published position statements, one cannot tell, but it is obvious that ANNA has hesitations regarding approving policy allowing financial incentives for organ donations.

Stakeholder views: The American Medical Association

At its annual meeting in 2002, the American Medical Association (AMA) shifted its opinion on incentives, and its House of Delegates voted to support studies to determine whether the use of financial incentives would increase organ donation from cadavers (Josefson 2002). Previously, the AMA had not supported such studies, instead wanting to rely on the altruism of donors to increase the supply. However, because the AMA recognized that altruism alone was perhaps not having a significant impact on the number of organ donors, the AMA decided to endorse studies on using incentives. Such incentives would potentially include small sums of money to be spent on funeral costs and other incidental expenses (Ibid.).

Stakeholder views: transplant professionals in general

A study with details published in the book Altruism, Incentives, and Organ Donation: Attitudes of the Transplant Community demonstrates some general attitudes of transplant professionals towards the use of financial incentives to increase organ donations, based on a survey. Questionnaires were sent to all three of the following transplant professionals to obtain feedback on organ donation and the use of incentives:
transplant surgeons, transplant coordinators, and transplant nurses. All three professions reported that they believed that the system that encourages donations based on altruism is morally appropriate, that they believed non-financial incentives or, for example, costs toward funeral expenses, to be morally appropriate or “morally neutral,” and that they believed policies that would provide direct financial incentives or incentives such as reductions of health insurance costs to be morally inappropriate (Jasper et. al. 2004). Of course, this study only represents a portion of people in these professions, and there are individual transplant surgeons, transplant nurses, and transplant coordinators who are in favor of establishing incentive programs (to include direct compensation) for organ donation, but this study provides an overall view of those in the referenced professions.

Report from Institute for Medicine

The Wall Street Journal published a commentary by Richard Epstein, a law professor at the University of Chicago, on May 15, 2006 (“Kidney Beancounters”), in which Epstein criticizes a report from the Institute of Medicine titled “Organ Donation: Opportunities for Action” for its lack of scope and imagination in regards to ideas for increasing organ donations. Epstein notes the increasing number of people on waiting lists for organs, and claims that only financial incentives will make any sort of notable impact on decreasing the number (Epstein 2008). Epstein’s commentary notes that according to the Institute for Medicine report published in 2006, law should continue to ban direct financial payments as well as reimbursement of funeral expenses, and “experimental programs” should also be precluded, hence they cause people to see organs
as commodities and decrease the number of altruistic organ donations (Ibid.). In the article, Epstein noted that the Institute of Medicine and its public stances often have an impact on the making of health care policy in the United States, and in the case of organ donation, Epstein is concerned about the impact the Institute's opinion will have on policy for organ donation (Ibid.).

The NKF chose to support the same Institute of Medicine report that Richard Epstein criticized as noted in the above paragraph. In a position statement published on its website (http://www.kidney.org/news/newsroom/newsitemArchive.cfm?id=323), Charles B. Fruit, chairman of the NKF and a transplant recipient himself, references NOTA and its prohibition on “valuable consideration” for organ donation. Fruit writes that the allowance of payments is “an affront” to those who have already donated organs for altruistic reasons (National Kidney Foundation). Fruit even goes so far as to compare Epstein’s proposal to implement a market for organs, which would be based on supply and demand, with the United States’ then-current market for gasoline (Ibid.).

Stakeholders on both sides of the debate for allowing incentives for organ donation seem to have a common goal – to increase the number of organ donations from living and cadaveric donors, and, ultimately, to save lives. Yet stakeholders who are in support of providing various types of incentives, financial and otherwise, seem to be more intent on increasing the number of donors and less convinced that such incentives, especially financial incentives, would cause harm. Stakeholders who are generally opposed to allowing financial incentives (indirect and direct), seem to be more concerned
with protecting the vulnerable and preventing a slippery slope, avoiding the commodification of body parts. This is not to say that those who oppose the provision of financial incentives do not wish to save lives, but they seem to place more importance on focusing on the altruistic nature of organ donation, whether it is proving to be successful or not.
CHAPTER THREE

POLICIES FOR ORGAN DONATION/TRANSPLANTATION IN THE UNITED STATES AND OTHER NATIONS

Introduction

In this chapter, the thesis will first briefly review current laws and policies in the United States regarding organ donation and transplantation, or, more specifically, the United States government’s role and interest in creating policy for organ donation and transplantation. Next, it will focus on the topics of ethics and economics as they relate to organ donation and donor compensation issues, outlining ethical and economic arguments in favor of allowing incentives for living organ donors and/or the immediate families of deceased donors. Finally, the chapter will review current policies for organ donation and the provision of incentives in several other countries, considering strategies that have been proven to work outside of the United States, to begin setting up an argument for implementing similar incentive programs for donors in the United States.

The subject of organ donation for use in transplants can be an emotional one, and much of the policymaking on the topic is based on a wish to ensure that those who are in dire health situations are able to get the help they need. In some ways, policymaking for organ donation and transplantation is directly linked to the broader topic of the government’s role in ensuring adequate access to health care. Some policymakers and citizens are of the belief that government has the fundamental responsibility to ensure that citizens have access to medical care without requiring that they spend a great amount of money on such care. For those who agree that government should be responsible for
ensuring healthcare for all, it might naturally follow that, when considering the topic of organ donation and transplantation, the government should enact policy that allows for an increase in organ donation and transplantation in an effort to provide better care to citizens, and, ultimately, to save lives.

**Role of the United States Federal Government**

In the United States, the federal government is a key player in the field of organ donation and transplantation, and has an integral role in monitoring and creating policy for the practice. For one, the United States Department of Health and Human Services (DHHS) handles the contracting for the United Network for Organ Sharing (UNOS), performs oversight of the organization, and ultimately has the authority to modify UNOS’s role if it feels that would be appropriate. The federal government is also primarily responsible for providing funding for patients with end-stage renal disease (ESRD), through Medicare, which covers costs for ESRD patients once they begin dialysis, or if they undergo kidney transplantation. (ESRD patients are those with kidney disease who are in the final and most severe stage of kidney failure, thus requiring dialysis and/or a kidney transplant.) For those patients who have Medicare coverage only because of ESRD, the Medicare coverage would end twelve months after stopping dialysis, or thirty-six months after the patient undergoes kidney transplantation and no longer needs dialysis (California Health Advocates).

As a major stakeholder with not only financial responsibility, but responsibility for ensuring standards of care for patients, it follows that the federal government would
be most interested in policymaking for organ donation and transplantation. Medicare spent approximately 8.6 billion dollars on care for dialysis patients, including dialysis treatments and related medications, in 2007 (Rubin 2009). Because dialysis patients also tend to suffer from other health problems, such as heart ailments and infections, they are often required to be hospitalized throughout their treatment, and they sometimes require advanced and repeat medical treatment that is covered by Medicare. While patients who receive kidney transplants often have some related medical issues or complications, and might be hospitalized at one point or another after the transplant, the cost of covering medical care for a kidney transplant patient for three years after his or her transplant pales in comparison of covering a lifetime of dialysis for another ESRD patient, as the cost per year for a patient on dialysis is estimated at about $30,000.

In 1984, Congress enacted the National Organ Transplant Act (NOTA) and thus laid the “framework” for organ transplantation policy to be further developed (Blumstein and Sloan 1989, 12). As discussed in previous chapters of this thesis, NOTA established the Task Force on Organ Transplantation and the Organ Procurement and Transplantation Network (OPTN), and provided funds for grants to qualified organ procurement organizations. NOTA’s purpose was not to be regulatory in nature, but instead to provide a foundation for a “rational” and “fair” policy for the United States in dealing with organ transplantation (Ibid.). Even though NOTA was not intended to regulate organ transplantation and donation, we know by now that the Act included a ban against the provision of organs in exchange for “valuable consideration,” and we also know by now
that this ban has affected the institution of related policy on the subject of organ donation. As a result, many can argue, as do I, that NOTA’s ban on allowing organs to be donated for “valuable consideration” has had a direct and lasting impact on a continued shortage of viable organs for transplantation in the United States.

As noted above, DHHS administers the contract with UNOS to manage the United States’ system for organ donation and transplantation. According to UNOS’s website (http://www.unos.org/about/index.php), the organization manages the national transplant waiting list, maintains a database which includes pertinent information related to each organ transplant and/or donation that occurs in the U.S., and coordinates its member organizations in order to develop policies that will work to “make the best use of the limited supply of organs and give all patients a fair chance at receiving the organ they need, regardless of age, sex, ethnicity, religion, lifestyle or financial/social status” (http://www.unos.org/about/index.php). To that end, UNOS wishes to ensure that the number of organs available for transplant increases, but also wishes to ensure that those in need of transplants are given fair opportunities to receive them.

The development of policy for organ transplantation and donation can be viewed in a different category from other types of policy, even for healthcare in general, because it is intended to help those with a “catastrophic disease” (Blumstein and Sloan 1989, 11). The idea that policy enacted by government could potentially save lives is an important concept to note in the context of organ transplantation policy, because policymakers would presumably recognize certain values linked with government assistance for those
who are in grave health. We assume that policymakers realize that if they deny
government payment or funding to help those dealing with “catastrophic” illnesses, they
would knowingly be turning their backs on those whose lives they could help save, which
could have negative effects (Ibid.). While helping those with illnesses is important to
policymakers and the government, we cannot ignore the responsibilities of the
government to protect the vulnerable and treat patients fairly and ethically.

**Ethical concerns**

The subject of ethics comes up often throughout the discourse on organ donation
and transplantation. There are several ethical topics to be considered in the broader
context of organ transplantation policy. Ethical considerations enter the debate on a
myriad of topics related to organ donation, such as: whether physicians should risk the
lives of healthy living organ donors in order to save the life of another (the recipient);
whether prison inmates in need of an organ transplant should be included on waiting lists;
whether a determination of the definition of “death” for cadaveric organ donors is
ethically sound; and whether paired kidney exchange programs violate the current ban on
valuable consideration in exchange for organs.

For the purpose of this paper, ethical questions will be considered as they relate
specifically to the provision of compensation or other incentives for organ donors, and we
will begin to formulate arguments in favor of allowing financial incentives for organ
donors and their families for ethical reasons. In these cases, we are mainly discussing
living donors who would be donating kidneys or bone marrow, though incentives for families of deceased donors is also recommended, as discussed in the final chapter. The most common ethical concerns about allowing the provision of financial incentives to organ donors include: a market for organs would exploit the poor; the set-up of an organ market is unfair, because only the richer people would be able to afford to purchase organs; it is wrong to permit a practice that would, in essence, commodify the human body; and those who choose to donate organs should be making the decision based solely on altruistic intentions. I will make the argument that these common ethical concerns can be overcome in the interest of increasing organ donations.

Many opponents to financial incentive programs for organ donors and/or their families in the United States believe that such programs have the potential to exploit poorer populations, and that the more fortunate would be taking advantage of the less fortunate. In a case where the organ recipient had enough finances to, for example, purchase a kidney from the organ donor, and the potential organ donor was in need of money to feed or otherwise care for his family, but was not interested in donating a kidney and was in fact afraid of the surgery, one could understand that the potential donor would be somewhat vulnerable and could be coerced into the process. This might be a scenario that would be “penalizing the weakest” (Marino et al. 2002). There is also the potential for cases in which an organ “broker” misleads the organ donor about the sum of money that he or she will be awarded upon the donation, and ultimately does not provide
the promised amount, thus stealing the recipient’s money meant for the donor. Even proponents of a system for incentives for organ donation are concerned about cases like these and wish to ensure that they are avoided.

However, I would argue that a balanced and well-regulated system of incentives for organ donation, proposals for which will be discussed in the next chapter of this thesis, could work to rule out instances of coercion. I also argue that in the cases of living donors, if there are methods in place to ensure that the donor is informed by the medical community, and fully understands all risks involved, and if the donor asserts his or her willingness to undergo surgery to donate, it is unlikely that the organ donor is being exploited. A sound policy would also ensure that reputable medical professionals provide thorough screening of the donor to ensure that he or she is physically healthy enough to donate and undergo the transplant surgery, as well as to ensure that the donor is mentally sound enough to fully understand any risks involved. These are steps that already occur in qualified transplant centers in the United States, even without the provision of financial incentives. Ultimately, I would argue that if a financial incentive, either in the form of a direct payment, or, for example, a health or life insurance policy for the donor, would benefit the donor and improve his or her quality of life, he or she (and the family) would be better off for donating the organ, as would the recipient. If such a transaction were monitored and regulated and would, in the end, improve the life of the donor and the recipient, I do not believe there are many reasons to argue against it. Both opponents and proponents of a financial incentive system for organ donation have
concerns about the black market for organs, and about an unregulated system of incentives. I am arguing for a regulated system of allowing financial incentives that could be controlled to prevent corruption and abuse.

Another ethical concern of opponents of financial incentive programs for organ donation is that such programs are, on their foundation, not fair because only people with more money would have the means to provide financial incentives for the organs, and would thus be favored over the less fortunate. I will argue for a system, as will be discussed during the following chapters, that would allow for the government or a third, neutral party to put forth payment of some sort for organ donations, rather than the actual organ recipient paying for the organ directly out of his or her pocket. In cases such as these, it would not matter whether a person could afford to “buy” a kidney from a living donor, for example. Instead, the third party would be providing the financial incentive, thus eliminating the fear that the wealthier will be shown favoritism over the less wealthy. The government-controlled and regulated incentive program would allow for the existing organ waiting list system to remain intact (based on set medical criteria and time spent on the waiting list). Some note that if people are buying organs on the black market, that is unfair as well as unsafe, so let us regulate the system and institute a safe program for financial incentives.

A commonly discussed concern about allowing incentives for organ donation is the fear that incentives will commodify the human body by allowing humans to trade or sell body parts. In a letter to the British Medical Journal about J. Harris and C. Erin’s
article titled “An Ethically Defensible Market in Organs,” the authors claim that “any financial incentive to organ procurement…dangerously undermines human dignity by obscuring the difference between being human and marketing” (Marino et al. 2002). There is an ethical concern that body parts should not be bought and sold, just as actual people should not be bought and sold, as it is an assault to human dignity. While I would argue that humans should absolutely not be bought and sold, I would also argue that if a person wishes to donate a kidney (for example), either based solely on altruistic reasons, or based solely on a need to reap financial reward, or based on a combination of the two reasons, there should not be concern that an actual person is being “commodified.” A person who donates an organ can then go on to live a normal, free life, once the transaction (surgery) is complete. The organ recipient will not own the donor from that point forward. Further, if donating an organ in exchange for some sort of “valuable consideration” (incentive) is defined as commodifying part of the human body, then I would argue that the commodification is for the benefit of saving a person’s life, and I see no reason for the practice to be banned based on that concern, as long as the practice is regulated and fair in all aspects. In addition, others have noted that the U.S. federal government has permitted other practices that both exploit and “commodify” human beings, such as providing unfair low wages to certain types of workers (Wilkinson et al. 1996). Organ donation and incentives for such is providing a benefit to humans that could mean the difference between living and dying.
Lastly, opponents of financial incentives for organ donations often base their arguments on the concern that organ donations should be based solely on altruistic intentions, and that such motivations should be encouraged at all costs. Some fear that if financial incentives for organ donors are allowed, the numbers of altruistic donors will decline, and that eventually all organ donors will offer to donate while expecting compensation of some kind instead of volunteering to donate organs without reward. Others argue that most of those who would donate an organ for purely altruistic reasons in the first place would still donate based on a wish to help others.

The concept of altruism is a bit more straightforward and clear-cut when considering cadaveric donations, because we can assume that a person who has already died and donated his or her organs cannot directly reap any financial rewards or benefits. With living organ donations, it seems quite natural for family members to donate to other family members, and even for close friends to donate to other close friends. But, as Epstein notes in his article “The Human and Economic Dimensions of Altruism: The Case of Organ Transplantation,” we are often surprised and perhaps even slightly suspicious when strangers are willing to act as living donors to those for whom they do not share blood or relationships, as we might assume that there must be some type of hidden financial motivation involved (Epstein 2008).

I will note here, however, that I have personal experience with organ donation and the need for donors, as my husband was the recipient of a donated kidney through transplant two years ago. While I was willing to serve as the donor for my husband, our
blood types are not a match, and he eventually received a kidney from his mother as the donor. Going through that experience with my family has made me utterly aware of the desperate need for more organ donors, and the way in which a donor can positively impact a person’s life. If I did not need to reserve my kidneys for a future time when my husband might need another transplant (when we might be able to participate in a paired exchange program, since I am not a match for my husband), I would seriously consider donating an organ to someone whom I barely know (or even do not know at all). I would also argue that in the consideration of a financial incentive program for organ donors, we should not be concerned with intentions – altruistic or otherwise. More than likely, family members will still donate to other family members without the provision of financial incentives. By introducing a program of incentives, we would be offering rewards to donors, and if such a program increases the rates of viable organ donations, then policymakers and stakeholders should not be concerned if the number of altruistic donors decreases.

**Economics**

The subject of economics plays an important role in the debate over whether to allow financial incentives for organ donors. There are several economists who have contributed to the discussion on financial incentives. Next, the chapter will review some opinions of economists and scholars on incentive programs and I will argue that, from an economics perspective, it follows that the United States should support the institution of a program that will allow financial incentives for organ donors.
The fundamental economic concept of supply and demand can be applied to organ donations, where demand far exceeds supply, and continues to do so, despite other initiatives and proposals put forth by the government as discussed in previous chapters. Gary S. Becker and Julio Jorge Elías are economics professors who wrote an article in *The Journal of Economic Perspectives* that focuses on using financial incentives to increase living organ donations. Becker and Elías measure the severity of the gap between supply and demand for organs to be used for transplantation by looking at the annual number of transplants in the U.S. and comparing it with the number of people who are added to the waiting list for an organ transplant annually (Becker and Elías 2007). Becker and Elías also pose an interesting and important question: How do we calculate the price of an organ? The economists propose that in order to come up with an answer to this question, we should consider the following: compensation for the donor’s risk of dying during surgery; compensation for the donor’s time spent recovering from the surgery; and compensation for the possibility that the donor’s quality of life would be negatively affected after the surgery (Ibid.). Using certain formulas and assumptions for each of these factors, Becker and Elías arrived at an amount of approximately $15,200.00 as an appropriate payment to a living organ donor in the United States in 2007 for a kidney transplant (Ibid., 11). Becker and Elías had a different formula to determine what an appropriate payment would be to a living partial liver donor, which can be considered more risky for the donor, and came up with an approximate price of $37,600 (Ibid., 14). Becker and Elías point out that the provision of financial incentives would increase the
cost of transplants, of course, since the amount of the incentive would be added to the existing cost, but they suggest that the incentives would also increase the number of viable organ transplants, therefore increasing the supply and closing the gap on supply and demand (Ibid., 9).

Few can argue against the point that organ transplants most often improve the quality of life for the organ recipient. In the cases of kidney transplants, many ESRD patients must begin dialysis treatments when their kidney function decreases to the point that they require treatment in order to live. For many patients, dialysis treatments can be exhausting and debilitating, rendering them unable to work or unable to work at the capacity to which they were formerly working, at which point they may be receiving disability payments from the federal government. A kidney transplant, more often than not, allows a recipient to return to a more normal life, with better health and productivity than the recipient was experiencing immediately before the transplant. If we consider the figure that Becker and Elías provide as an example of what might be an appropriate incentive payment for a kidney transplant, in the neighborhood of $15,000, it seems a small price to pay when we compare the potential costs of federal disability payments for the rest of an end-stage renal disease patient’s life. Also, with the average cost per year for one patient to undergo dialysis treatments at approximately $30,000, paying half that amount for the incentive to a kidney donor (in addition to the cost of the surgery and related expenses) will save money in the long run, considering that many end-stage renal disease patients remain on dialysis treatments for many years.
While we can use the $15,000 to $16,000 figure as a basis for an estimate for a financial incentive to a live kidney donor and I believe we can justify that payment in the interest of economics, there is also merit to the idea that a legal financial incentive system for organs in the United States would drive the actual prices for donated organs down by increasing the supply, with more people being motivated and willing to donate. If this scenario were to occur, and if recipients were permitted to pay the donors, even more of those in need of organs would be able to afford any financial incentives. In such cases, there might be less of a concern about disparities between the poor and the wealthy, as discussed earlier in this paper.

**Policies and programs in other nations**

In considering the argument for implementing financial incentive programs for organ donation in the United States, it is valuable to consider laws and policies in other nations regarding organ donation and incentives for donors and/or their families. Next, the chapter will examine current policies for incentivizing organ donation that have been implemented in countries outside of the U.S., as well as proposals that are being considered for implementation, so we can garner ideas for our own country’s policies, review the positive and negative impacts such policies have had on organ donation and transplantation for those nations, and consider the societal contexts of those countries and how they might differ from the society in the United States.

Iran was one of the first countries in which the government instituted a system allowing the provision of financial incentives to organ donors, and is also known as the
first country to legalize a system in which the government provides the actual compensation to living organ donors, though in some cases, the organ recipient provides additional funds to the donor (Griffin 2007). Iran has claimed that the incentive programs have basically eliminated the country’s waiting list for kidney donations.

In Iran, the first kidney transplant was performed in 1967, but because the kidney transplant program had limited capabilities, only 100 kidney transplants were performed in Iran between 1967 and 1980 (Ghods and Savaj 2006, 1137). As a result, most ESRD patients had no choice but to remain on dialysis, and the number of patients on the waiting list increased. In order to facilitate more organ transplant for its citizens who needed them, Iran’s Ministry of Health enacted a program which provided government funds to patients who were accepted into a transplant program in another country, and the government paid expenses related to travel and the transplant surgery (Ibid.). Most of the kidney donors in these situations were living donors, related to the recipient. Eventually, however, the cost to the Iranian government of funding the living donor transplants abroad became prohibitive, and in 1985, Iran established two kidney transplant teams inside the country, to handle renal transplants for citizens from living donors (Ibid.).

In 1988, with a lengthy waiting list for renal transplants, some with no willing living donors, Iran instituted a program in which the government provided compensation to living donors, and deceased donors’ families, for organ transplants (Ibid.). The country reported in 1999 that the number of those on its waiting list had been reduced to zero, though some scholars dispute that claim.
As is the case for most transplant programs, a neutral party serves to facilitate organ donations in Iran, where the Dialysis and Transplant Patients Association (DATPA), a non-profit organization made up of transplant and dialysis patients who volunteer their time to match living donors to recipients, handles the financial incentive payments to the donor, ensures that the donor and recipient are healthy enough to undergo the surgeries, and ensures that the required consent forms are obtained (Griffin 2007). There are approximately seventy-nine (79) DATPA offices throughout Iran. All of the kidney transplant teams are associated directly with university hospitals, and the Iranian government funds the hospital-related costs of kidney transplants (Ghods and Savaj 2006, 1137). Iran requires that the donor and the recipient be of the same nationality, and that the donors are healthy, between the ages of 20 and 35, and that they have written consent from a living relative, typically a spouse or parent (Griffin 2007). In Iran, there are no financial incentives allowed for families of cadaveric organ donors; the program for organ donation from the deceased is solely dependent on altruism.

After the transplant surgery is completed, DATPA distributes a monetary reward from and the provision of health insurance to the donor, both from the Iranian government (Ghods and Savaj 2006, 1137). In many cases, the transplant recipient also contributes a financial reward to the donor out of his or her own pocket, in addition to the reward provided by the government. One of the key components of Iran’s transplant program is the provision of pharmaceuticals to transplant recipients, most of whom will need to take the drugs for the remainder of their lives, at a much lower cost compared to
what prescriptions would cost without government assistance.

Iran is also concerned with preventing transplant tourism in its country, as it should be, considering its more radical incentivized program. To that end, non-Iranians are not permitted to travel to Iran and receive an organ from an Iranian living donor who is not related to the recipient, nor are such non-Iranians permitted to serve as a kidney donor to an Iranian recipient (Ibid.). An exception might be made for some in especially dire circumstances, but the End-Stage Renal Disease Office of the Ministry of Health would have to approve such instances (Ibid.).

The Iranian model can be viewed as one of the more forward-thinking policies for a government-regulated system for providing incentives to organ donors. The nation found a way to include safeguards to prevent issues such as transplant tourism, while managing to dramatically decrease the waiting list for transplants, if not eliminate it. Because the government funds the incentives, a wealthier patient who is in need of an organ transplant would not be favored over another who is less financially well-off, even though the recipient is permitted to pay the donor additional funds out of his or her own pocket. I believe that the principles of the Iranian model could have enormous positive impact if implemented in the United States, provided the federal government and policymakers ensure that regulations include safeguards similar to those set forth in the Iranian model.

Israel is an important country in the study of organ donations, as it has had several issues in the area of organ transplantation and transplantation tourism over the past
several years. In some cases, Israelis have been identified by authorities as having brokered deals for patients who are in need of kidney transplants. Many of those in the U.S. are familiar with the story of a man from Brooklyn, New York named Levy-Izhak Rosenbaum, who was charged with arranging organ donor deals for three Americans with Israeli donors. In addition to troubles that these illegal activities have caused, historically, Israel has had a low record number of organ donors, with only ten percent of the adult population having completed donor cards (Brunner, Medical News Today).

With low numbers of donors, and those in need of transplants often going abroad to purchase organs on the black market, the Israeli government ultimately realized it was important to develop programs to encourage organ donation for its citizens.

In 2006, the Israel National Transplant Council (INTC) formed a committee that included transplant doctors and surgeons, transplant coordinators, ethicists, attorneys, and religious leaders to consider ways of increasing organ donation in the country. The committee’s report included a proposal that a person who holds a donor card for at least three years who is put on the waiting list for a transplant would be given top priority in the allocation process (Ibid.). Also, those on the waiting list who have a first-degree relative (sibling, child, parent) who served as an organ donor after death or a living donor would be given the same type of priority. This recommendation set the stage for policy to be enacted years later.

In 2008, Israel enacted the 2008 Organ Transplant Act to govern transplants performed in the country; the Act also banned the buying and selling of organs in Israel.
(Verger, The Daily Beast). Israel’s 2008 Organ Transplant Act required that if Israeli citizens went to another country to receive or donate an organ, the transplant must be performed in accordance with that country’s transplant laws as well as the laws of Israel. One important piece of the Act was to require that insurance companies were only permitted to provide reimbursements for transplants performed within such laws (Ibid.). With Israeli patients reportedly going to other countries such as China to buy organs on the black market, and with Israeli transplant recipients’ insurance companies covering some of the costs in addition to the recipient paying out of his or her pocket for the organ, Israel was giving the impression that it was sanctioning a system that took advantage of the less fortunate (Ibid.).

In January 2010, the Israeli government amended its Public Health Law to allow that an Israeli citizen who donates an organ to another Israeli citizen in accordance with the law – for living donations, mostly kidneys – would have his or her health insurance coverages paid by the government for a time as set by the Israeli Minister of Health. While this is not an incentive in which direct financial payment could be given to the donor, it does allow an indirect financial incentive, and is a step in the right direction towards encouraging people to become living donors. For those who might not have health insurance, or who are hesitant to donate an organ because they are afraid that the health insurance coverage they do have would not be enough to take care of them, the law might convince a potential donor to become one.

In 2012, the Israeli government enacted law that allowed for those who agree to
become organ donors at time of death (or living donors) to receive priority on the waiting list if they were ever in need of an organ transplant. The law also gave priority to first-degree relatives of those who have volunteered to be organ donors, of those who have donated organs after death, and to living organ donors (Brunner, Medical News Today). In essence, the law introduces non-medical criteria for ranking patients on the waiting list, but those who are most in need of a transplant will still be given priority over those with a less critical need at that time. The Israeli law assigns various levels of priority, with the highest level of non-medical priority given to a person who has a first-degree relative who was a cadaveric donor or who was a living organ donor; next priority would be given to a person who has signed his or her own donor card, expressing intent to donate; and lastly, priority would be given to a first-degree relative of someone who signed a donor card (Ibid.).

One of the major challenges for organ donation programs and laws in Israel has to do with the varying religious beliefs among different sects of the Hebrew religion. The organ transplant laws enacted in Israel in 2012 have been controversial in that some believe that assigning non-medical criteria to priorities on the waiting list penalizes those who choose not to become organ donors for religious purposes.

At its core, Jewish law requires that bodies remain intact after death, though it also prioritizes efforts to save lives, and the law demands that when a life is at stake, anything should be done in order to save that life (Shabtai 2012). Therefore, when
considering organ donation and how its ideals fit into Jewish law and religion, few could argue against organ donation in the context of how it saves lives. However, there are disagreements among religious sects about how to define death, and whether brain death equals death. Israel’s chief rabbi defines brain death as death, but not all Jewish leaders agree, and for those who disagree with the chief rabbi, removing organs from the brain dead is not permitted (Ibid.)

China is another country which has historically experienced a severe shortage of organs for transplantation, which was likely a contributing factor to the country’s illegal organ trafficking problem. To combat these issues, in 2011, China began to consider instituting a financial incentive program for organ donors (Blanchard 2011). Many Chinese believe in the custom that the body must remain intact after death, thus discouraging many Chinese from donating their organs upon death – let alone while they are living.

To handle the organ trafficking issue, in 2007, China enacted law for voluntary organ donation that prohibited organ transplants from living donors except from donors who are spouses, blood relatives, and other immediate family members, to include stepparents and stepchildren, and adopted/adoptive family members (Ibid.). China has been criticized by human rights activists for taking organs from executed prisoners and using them for transplantation – a highly controversial practice for ethical and moral reasons. One of the concerns among those opposing this practice was that there would be incentive to execute prisoners, and perhaps sell the organs, and another concern was that
families of the prisoners were not asked permission to donate the organs (Bradsher 2012). In 2012, the Chinese government announced its plans to abolish the practice of using executed prisoners’ organs for transplantation, citing high rates of infection occurring with organs taken from the prisoners – purportedly resulting in lower success rates in transplantation (Ibid.). It is not known whether China caved to pressure from those citing ethical and moral concerns, or whether China plans to eliminate the program for the reasons stated above, but the nation realized that it was time to pursue other options for increasing organ donations.

In 2011, China finally enacted a system through which citizens could register to become organ donors upon applying for a driver’s license. However, in spite of these efforts and those cited above, according to reports, there is still an organ shortage in China, as well as an organ trafficking problem. China’s Vice Health Minister, Huang Jiefu, has been quoted in Chinese news outlets as proposing various ideas for incentives for organ donation, to include offering reimbursements for medical costs related to a donor’s stay in the hospital and for funeral expenses, as well as offering medical insurance, waivers of tuition, and tax refunds (Blanchard 2011). To date, however, China has not enacted laws to allow for such incentives.

While the current laws and policies in the United States do not allow for the provision of financial incentives to organ donors and/or their families, the ethical and economic concerns can be addressed in ways that should convince lawmakers to modify NOTA to allow for such provisions. Further, we have seen some evidence from laws and
policies for financial incentives that have already been enacted in at least one other
country – Iran – to prove that policies for incentives can vastly improve the rates of organ
donations in the U.S. Though Iran is the only country known at this point to permit direct
financial payments to organ donors in return for their donated organs, since Iran has
claimed to basically eliminate its waiting lists for organs through this program, it is worth
the consideration of a program in the U.S. for financial incentives.

Many studies on the rates of organ donation in developed countries have shown
that the numbers of organ donors most likely depend on several factors. Spain, for
example, has high rates of deceased organ donors (thirty-two deceased donors per million
people – nearly twice as many as those in Great Britain), which some have attributed to
Spain’s presumed consent program, whereby citizens are assumed to be organ donors
upon their death unless they specify otherwise (The Economist 2012). However, there are
other countries with presumed consent programs, such as Greece, where organ donation
rates are low (about four deceased donors per million people). The U.S., which has
relatively high rates of organ donations (about twenty-six deceased donors per million
people), does not have a presumed consent program (Ibid.). We could surmise that
presumed consent programs alone might not have enough of an impact on increasing the
rates of organ donations. Some studies have noted Spain’s excellent public awareness
campaigns, screening and referral processes, and management systems for retrieving and
allocating organs as possible reasons for the country’s high rates of organ donations
(Ibid.). All in all, there are many elements to be considered as part of efforts to increase organ transplantation in the U.S. and in other nations, but a financial incentive program should be considered as one that would provide the greatest impact.
CHAPTER FOUR

PROPOSALS FOR FINANCIAL INCENTIVE PROGRAMS

Introduction

In recent years, several scholars and stakeholders have spoken out in support of instituting incentive programs for organ donors in the United States, putting forth their own detailed proposals for such programs. Most of the proposals discussed in this chapter focus on the provision of financial incentives, considering the potentially great impact such programs would have on the current organ shortage, though this chapter also considers a proposal that sets forth a non-financial incentive program (a reciprocity program). While non-financial incentive programs should not be dismissed, and could offer some value in increasing organ donations, programs allowing direct financial incentives would offer a more effective way of increasing the number of viable organs for transplantation in the United States. This chapter reviews several proposals for incentive programs, which include the provision of direct financial payments, life insurance payments for donors, health insurance coverage for donors and/or their families, tuition waivers, and tax credits, discussing positive and negative components, and sets up an argument that the provision of financial incentives is an ethical and moral solution to the organ shortage.

Proposal from Arthur Matas, M.D.

Dr. Arthur Matas is a professor of surgery and the Director of the Renal Transplant Program at the University of Minnesota, as well as a former president of the
American Society of Transplant Surgeons. As discussed in a previous chapter of this thesis, the American Society of Transplant Surgeons, as an organization, has not supported the implementation of financial incentive programs for organ donors, but its leadership of late has publicly recognized the urgent need for a more radical solution to the organ shortage. As do many proponents of incentives for organ donors, Dr. Matas focuses on compensation for living donors – specifically, for living kidney donors, since a healthy person with two functioning kidneys can donate one kidney and then go on to lead a normal life with just one remaining kidney, though there are some risks involved, as there are with any major surgery. The major risks associated with the actual surgery are possibilities of infection and bleeding, though it is very rare for a donor to die as the result of the actual surgery. Long-term risks include the possibility of the donor’s remaining kidney suffering injury or infection. Dr. Matas proposes a system of compensation for living kidney donors that would utilize the current system in the United States for evaluating altruistic living donors and their organs, but the system for allocating organs from paid donors would be the one currently in place for altruistic deceased donor organs (Matas 2007). This is an important detail in Dr. Matas’s proposal, because at the present time, the United States does not have an allocation system for living organ donations. Most living donors essentially decide to donate to a particular family member or friend, (or, in some less common cases, to a stranger).

Dr. Matas has set forth specific parameters for living donor incentives that, for the most part, consist of many procedures that are already in place in the United States.
These include: a set of rules for ensuring that patients on the waiting list for a transplant have fair and equal opportunity to receive a transplanted organ, such as the one currently in place, mandated by the United Network for Organ Sharing (UNOS); complete and thorough medical evaluations of potential living donors to ensure that they are physically and mentally healthy enough to donate an organ; a legal requirement for obtaining informed consent (whereby a fully informed patient is capable of making his or her own healthcare decisions), in a written format, from the donor; and attentive oversight and follow-up services for both the donor and recipient (Ibid.). As part of acknowledging that financial incentives would be untested when first put into effect, Dr. Matas also proposes that the program include additional, comprehensive follow-up services in order to closely evaluate donor outcomes and further ensure that donors are not adversely affected, and he also proposes that “psychosocial” testing be implemented for donors, in an attempt to better understand the donors’ motivations once financial incentives are involved (Ibid.).

In his proposal, Dr. Matas stresses the importance of the transparency of informed consent in the context of providing financial incentives to donors, noting that a transplant team must ensure that the prospective living donor fully understands the risks of undergoing surgery to donate an organ (e.g., a kidney), and his proposal recommends that this happen early in the process, followed by a period of time in which the prospective donor is allowed time to consider the risks and make an informed decision (Ibid.). The premise is that one must be permitted enough time to weigh his or her options, after receiving pertinent information, and to ask questions and consider the answers before
making a final decision on whether to donate his or her organs. This would help to avoid someone from being pressured into serving as a donor, would allow for discussion with family and other counsel, and would also allow a potential donor to change his or her mind before it is too late.

In Dr. Matas’s proposal, the federal government, or a central organization named/approved by the government, would provide payment of a financial incentive to the living donor. Dr. Matas’s proposal acknowledges that financial incentives could be in one, or a combination of, several forms, to include a monetary payment, health insurance for the donor for a long period of time after the transplant surgery, tax credits, or even benefits such as waived college tuition (Ibid.). It seems that most, if not all, sound financial incentive proposals for organ donors in the United States include regulations to guard against abuse, and Dr. Matas’s proposal is no different, noting that bans on “private sales” of organs would remain, and organ donors and recipients would not be permitted to arrange their own exchanges of money for transplant, nor would a broker be permitted to arrange these exchanges for the patient. Dr. Matas also recommends that the United States not permit organ donors to travel to the country from other nations to receive compensation and donate an organ, due to concerns about follow-up care and long-term health provisions when they return to their country of origin (Ibid.).

With the possibility of a direct payment to the organ donor, we must consider what would be deemed an appropriate amount for such a payment. In Chapter Three of this thesis, it is noted that economists Becker and Elías have come up with a formula to
propose an amount of approximately $15,200.00 as an appropriate payment to a live organ donor in the United States in 2007 for a kidney to transplant. Whatever the amount might be, Dr. Matas suggests that policymakers would have to decide whether any type of direct payment to a donor would be made in one sum, or whether it would be made in installments, some of which would be paid in periods of time after the transplant surgery takes place (Ibid.).

In Dr. Matas’s proposal, he acknowledges that perhaps it is not feasible to have a “one size fits all” approach with the exact type of compensation provided to an organ donor, and instead suggests a “menu of options” from which a donor could choose his or her form of compensation (Ibid.). Indeed, one organ donor might put more value on the provision of paid health insurance for his or her children; another might need or value cash payment(s) more than another person does.

To support his cause, Dr. Matas discusses studies performed in 1991 that showed that seventy percent (70%) of the general public surveyed were in favor of allowing financial compensation to organ donors, while only twenty-five percent (25%) of doctors and nurses surveyed were in favor of such programs (Ibid.). As discussed in a previous chapter of this thesis, historically, many in the medical profession (physicians, transplant surgeons, and so on) have spoken out against proposals for, and the concept of, providing compensation to organ donors. However, many medical professionals have witnessed first-hand that the waiting lists for organs have only increased, and most in the medical profession have to admit that something more drastic needs to be done in order to
increase the availability of viable organs for transplant. Dr. Matas notes that in January 2007, at a meeting of the American Society of Transplant Surgeons, most of the meeting participants spoke out in favor of conducting trials in which proposals for financial incentives for donation would be studied (Ibid.).

Dr. Matas’s proposal contains many valuable components, some of which are already in place in the United States, with organization and oversight by UNOS, and therefore to implement Dr. Matas’s proposal would not require a complete system overhaul. The only proposed regulation of Dr. Matas’s with which I do not agree is the recommendation that the United States not permit organ donors to travel here from other nations to donate organs in exchange for financial incentives. Dr. Matas claims that his concern is that another country (the donor’s country of origin) might not be able to provide adequate follow-up healthcare for the donor when he or she returns home. I contend that the organ recipient’s transplant center in the United States could make efforts to coordinate with a transplant center or other healthcare provider in the donor’s country of origin in an attempt to track the donor and make referrals as appropriate. While it might not be possible to control the quality and level of care for a donor who travels home to another country after the transplant, it is also not possible to control the exact level of care for a donor who remains in the United States. Donors are not forced by law to attend regular doctor’s visits or receive regular health care after a transplant. While a certain course of care is recommended by the transplant center, if a living organ donor does not attend the recommended follow-up appointments, the donor is not forced
into complying with the recommendations.

**Proposal from Sarah Krieger Kahan**

Sarah Krieger Kahan is an attorney who published an article in the Hofstra Law Review detailing her position in favor of the federal government allowing policies for financial incentives for organ donations as a way to increase the organ supply for transplants. Kahan proposes that the government institute an agency that would be allowed to provide compensation to live organ donors or to the families of deceased donors, with the financial amount dictated by the market at the particular time of the transaction (Kahan 2010). Kahan proposes that the OPTN would provide oversight of the agency, and that organs would be “purchased” by the agency and then allocated to organ recipient patients in the same way that they are allocated today on the transplant waiting list managed by UNOS (considering scientific compatibility, a person’s time spent on the waiting list, severity of the transplant recipient’s medical condition, and so on, and assigning a score with a number of total points when combining the factors). Under Kahan’s scenario, it would be necessary for transplant recipients to be registered on the transplant waiting list in order to be afforded an organ, and organs would be offered first to a patient in need who is medically compatible with the donor and who lives in the same “Donation Service Area” as the donor (laid out by geographic region) (Ibid.). If there were no matching donors and recipients who lived in the same Donation Service Area at the time, the geographic area would be expanded until an organ recipient is found who is a match for the donor (Ibid.).
Under Kahan’s proposal, only a friend or family member could direct an organ donation to a recipient (whereby the waiting list would not apply); strangers would not be permitted to donate organs to strangers and receive financial compensation for such donations. If a person wishes to donate an organ to a stranger, he or she must donate through the channels mentioned in the previous paragraph, with his or her organ being donated to the next compatible person on the UNOS waiting list (Ibid.). I believe this is an important component to Kahan’s proposal, as it offers a logical measure to prevent organ recipients from negotiating with donors, which might present itself as an opportunity for an organ recipient with more financial means to take an organ when someone else with less money would not be able to afford it. Critics might be less inclined to argue against Kahan’s proposal with this prohibition included, as it offers some protection against exploitation of donors. Kahan offers additional protections in her proposal, noting that the government could put minimum and maximum limits on the prices for each organ to ensure that the incentives are reasonable, and to ensure that both donors and recipients are treated fairly.

Kahan focuses on financial incentives in her paper, but she suggests that if the government will not approve a program allowing direct payments for organ donors, the government should approve the provision of other types of incentives, such as the reimbursement of expenses related to medical care and funerals, and the provision of tax credits (Ibid.). In all, I believe that Kahan presents a logical proposal for financial incentives for organ donors, laying out the steps that would be taken to ensure that organs
are distributed fairly to recipients and including some components to attempt to combat exploitation of poorer donors.

**Proposal from Sally Satel, M.D.**

Sally Satel, M.D., has become an outspoken proponent of the U.S. government allowing financial incentives for organ donors since a friend donated a kidney to Dr. Satel several years ago. Dr. Satel advocates for permitting “regulated exchange involving valuable consideration,” though she acknowledges opponents’ moral concerns and therefore outlines a plan for allowing valuable consideration while paying attention to each side’s “moral commitments” (Satel 2006). Dr. Satel suggests a plan for allowing financial incentives for organ donations while at the same time encouraging people to become organ donors based on altruistic intentions – perhaps through public education. By way of acknowledging that some physicians and other members of the transplant community might have moral concerns about programs that allow financial compensation for donors, under Dr. Satel’s proposal, a transplant center or doctor who is not in favor of allowing financial incentives for donors would have the right to decline to perform transplants that would involve such compensation (Ibid.). Furthermore, if a potential transplant recipient does not agree with policies for compensating organ donors, the recipient would have the option to decline an organ from a donor who would be provided with a financial incentive, and wait for an altruistic donor to provide the organ (Ibid.). Dr. Satel sets forth a plan that allows for donors, recipients, and medical professionals to operate in accordance with their own moral guidelines and beliefs. Dr. Satel also emphasizes the need
for proper education for living organ donors, to make efforts to protect them from exploitation, as that is a common concern among opponents of policies for financial incentives. All potential living organ donors must fully understand all risks involved in such a surgery, and Dr. Satel stresses that they must be medically and psychologically screened to ensure that they are well enough to undergo the surgery, and they should receive quality care after the surgery (Ibid.). Dr. Satel claims that many opponents of the financial incentive programs speak of the black market and related issues when denouncing potential compensation programs, but what proponents are pushing are “above-board,” properly regulated systems that include quality education and medical care (Ibid.).

For the specific financial incentive programs, Dr. Satel proposes that one, several, or a combination of the following options would make a positive impact on the number of living organ donors. The federal government or an agency selected by the federal government would be designated as the authority to allocate organs from living donors, similar to the way that cadaver organs are allocated currently, via a national waiting list. The federal government or the designated agency would be the only authority permitted to distribute the financial compensation to the donor (Ibid.). Dr. Satel’s plan includes a proposal that Medicare would fund financial incentives for donors, made possible through cost savings that would be achieved through conducting more life-saving kidney transplants, as opposed to funding years of dialysis for patients (Ibid.). While Dr. Satel is offering a concrete method for financing the incentives, and this is an important
piece of the plan, Medicare alone might not be capable of providing all funding for such incentives. To that end, Dr. Satel suggests that a financial incentive program for organ donors could include multiple providers of compensation, instead of a program funded solely by Medicare. Under this type of program, an intermediary would be responsible for arranging the donor, the hospital that would perform the transplant, and the organization funding the transplant. It is possible that Medicare would be one of the agencies to pay the incentive, but would do so in coordination with, perhaps, a non-profit foundation for organ incentives, and/or private insurance companies. This plan, of course, would require the cooperation of multiple entities. Similar to the way that more organ transplants could mean financial savings for Medicare, it could also mean savings for private insurance companies. As it currently stands, private insurance companies pay the myriad of medical bills that are part of treating a person who is experiencing organ failure, to include medication, hospital stays, countless visits to doctors, and so on. Therefore, private insurance companies could have a vested interest in increasing the number of organ donations through the provision of financial incentives.

Dr. Satel considers the various types of compensation that could be offered to living donors if NOTA’s ban against “valuable consideration” were revised or lifted, and she proposes allowing a living organ donor to select his or her type of incentive/compensation from among several options, most of which have also been suggested by other advocates of such plans: funds for the donor’s retirement plan; school tuition waivers; health insurance; life insurance; tax credits; a contribution made to a charity of the donor’s
choosing, in his or her name; or payments of cash made in installments (Ibid.).

Whether for or against the idea of allowing financial incentives for organ donors, most could not argue with the notion that a way to increase the number of living organ donors would be to permit a recipient and a donor to enter into a private contract, through which the organ recipient would provide direct compensation to the donor. Dr. Satel notes what I consider to be a logical comparison to a contract between an organ donor and recipient – a contract between a surrogate mother/gestational carrier and a single parent or couple who wishes to have a child – which is a legally acceptable arrangement in the United States (Ibid.).

Acknowledging a common concern among policymakers, stakeholders, and the public about private arrangements between organ donors and recipients – that such policies would give the wealthier patients advantages over the less well-off patients in need of organ transplants – Dr. Satel makes what I believe is a valid argument for ways that private contracts could actually help those who are less affluent. If those who could afford it were allowed to purchase their kidneys outright, those patients would receive transplants and would then be removed from the waiting list. Those still on the waiting list for organs would then move up on the list, and would be closer to receiving a transplant than before (Ibid.). Private contracts for organ donations would also include government regulation, thorough psychological and medical evaluations, and counseling to ensure informed consent. Furthermore, Dr. Satel proposes that in order to prevent the poor from being “coerced” into selling their organs to make money, the government could ban anyone
with an income of less than $35,000 from being an organ donor (Ibid.). I do not believe this idea has much merit; what if someone who makes less than $35,000 (or whatever amount is set by the government as part of the regulation) truly wishes to be a living organ donor, and could benefit from the compensation or other type of financial incentive that becoming a donor would provide? Why should the government or anyone else assume that a person who makes less money is not capable of making his or her own rational decisions and could be taken advantage of? Instead, I propose that policymakers and the government focus on requiring appropriate and thorough screening of potential donors by qualified, experienced transplant professionals to ensure that the donor fully understands all risks and possible circumstances. In addition, perhaps the transplant professionals can be trained to make a reasonable determination about the potential donors circumstances and to make a recommendation as to whether or not the potential donor is feeling coerced into donating an organ.

**Reciprocity proposals**

For some time, scholars in the U.S. and abroad have put forth “reciprocity proposals” for organ donation. Under this scheme, if a person formally agrees to be an organ donor upon death (assuming, for cadaveric donation), it would increase that person’s likelihood of receiving an organ if he or she ever required a transplant. For example, a non-profit organization called “LifeSharers” was created with the purpose of building a membership of people who commit to being cadaveric organ donors, and other
members would have first “rights” to receive other members’ organs. One of the purposes of LifeSharers is to encourage more people to register as organ donors, with a reciprocity approach.

Mark S. Nadel, J.D., and Carolina Nadel, M.D., published an article that outlines a proposal for using reciprocity to encourage organ donation in the U.S. The basic concept of the Nadels’ plan is to provide committed organ donors with priority in the allocation process if organ donors ever need a transplant. The current national waiting list for organ transplants would be used, but organ donors would receive priority over non-organ donors on the waiting list. The Nadels propose that the priority would be given in the form of additional points, awarded based partly on how long the patient had been registered as a donor (Nadel and Nadel 2005). (This is a logical component to the plan, given the prospect that a person could essentially wait until he or she finds out that a transplant is needed, and could then register as a donor. A scenario like this one would be slightly unfair to those who have agreed to be organ donors without ever knowing whether they would need transplants themselves.) Under this plan, people are not committed for life; if anyone who had registered as a donor ever changed his or her mind, he or she could then change their status as an organ donor.

The organ donor registration system currently in place would remain as-is, with donors being permitted to register when renewing driver’s licenses, at voter registration facilities, and so on (Ibid.). Under this proposal, in order for an organ donor to receive
preference on the waiting list, the donor would have to be listed on either a national registry or an individual state’s registry – which would be linked to a national registry (Ibid.). For donors who are HIV positive or have other medical histories which prevent them from serving as organ donors under the current system, the Nadels’ proposal includes a provision that would allow them to receive priority points if they agree to donate their organs/bodies for medical research on the topic of transplantation (Ibid.).

A reciprocity proposal like the one the Nadels have outlined would most likely increase the number of registered organ donors, and I do believe it is a logical step in the direction of attempting to increase the number of organ donors. While I am not confident that a reciprocity proposal will make a drastic impact on increasing the number of organ donors in the United States, I do not see any moral or ethical issues with its implementation. For the most part, reciprocity proposals appear to be an attempt to take steps in the right direction for increasing organ donation without upsetting those who have moral and ethical concerns about incentives for organ donors.

Summary

The proposals referenced in this chapter support an argument for allowing the provision of some form of compensation for organ donors. Though the proposals vary somewhat in the methods that would be used to implement the program, to include the types of incentives to be provided and the controls to be used to prevent exploitation of donors, each proposal has some merit and provides further detail on exactly how an incentive program would be organized to increase organ donations. Most of the proposals
build from parameters for organ donation and transplantation that are already in place in the United States, such as rules for ensuring equal opportunities for those on waiting lists, medical evaluations and other types of screenings of potential donors and transplant recipients, and requirements for obtaining informed consent from donors.

While I am proposing that the United States implements financial incentive programs for organ donations, I also believe that controls are necessary to prevent exploitation of potential donors, and the proposals outlined above all include some form of such important measures. Dr. Matas believes that any new program should include a ban on private sales of organs, to include brokered sales, while Dr. Satel believes that private contracts could be permitted, likening them to private contracts that are permitted now with gestational carriers for people who are unable to conceive children on their own. I propose that if a ban on private sales of organs would move legislation for financial incentives forward more quickly, then this is what should be included in the legislation.

In order for any of the proposals for financial incentives to be instituted in the United States, Congress would have to amend the National Organ Transplant Act of 1984 (NOTA) to allow for “valuable consideration.” By studying the proposals discussed above, one can see that as long as certain protections are in place as part of the regulation, to prevent exploitation and to ensure the success of the transplant, financial incentive proposals are a reasonable way of increasing the number of organ donors in the United States. Such proposals could have a strong impact on the lives of those in need of organ
transplants, and could be implemented in a manner that addresses ethical and moral concerns. Above all, proponents of such plans are attempting to save lives with a regulated system for organ donations, while avoiding a black market and health and safety issues that come with such a market.
CHAPTER FIVE
CONCLUSION

This thesis is focused on the topic of incentives for organ donation through the following: an overview of relevant laws in the United States regarding organ donation, including particulars related to laws prohibiting compensation of donors and their families; an analysis of bills debated by Congress on the topic of organ donation and incentives; an overview of opinions and positions of various stakeholders on the topic of organ donation and incentives; a review of policymaking and policies in the United States as they relate to organ donation and incentives; a consideration of ethical and economic arguments for and against incentives for organ donations; a study of policies in countries outside of the United States that have instituted incentive programs; and analyses of proposals for incentive programs for organ donations inside of the United States. As the result of this study, the thesis concludes with the determination that it is not only possible to establish a financial incentive program for organ donation in the United States, but it is necessary in order to increase organ donations and save lives.

This final chapter will outline a proposed program for the provision of financial incentives in the United States, based on a combination of concepts put forth by experts on the topic of organ donation and incentives, will discuss which stakeholders might be for and against such a program, will consider why the stakeholders might have such objections, and will review opponents’ ethical objections to financial incentive programs for organ donors. As discussed in previous chapters of this thesis, and as is prevalent in
general in policymaking in the U.S. and abroad, not all policymakers, stakeholders, and the public agree on which methods for increasing the rates of organ donations are best for constituents. This chapter will consider potential values issues inherent for stakeholders who would likely be for or against the policy proposed here. Ultimately, this final chapter sets forth how the proposed policy can be implemented safely and ethically.

The main focus for the financial incentive proposal set forth in this chapter is on living organ donors – namely, kidney donors – but as I believe that incentives should apply to those who may donate their organs upon death as well, in which case the families might reap most of the benefits, cadaver donors are included also. A financial incentive program could make a drastic difference in the number of people willing to become living organ donors and therefore not only dramatically affect patients’ lives for the better, but save lives. Further, a regulated program allowing financial incentives for organs would safely control a market that, in some instances, might operate as an illegal black market.

**Compensation for living donors**

The proposal I am suggesting in this chapter begins with a system for compensating living donors. Under this proposal, a system would be implemented that allows the federal government, or a third, neutral party identified by the federal government, to distribute financial payments to these donors. The entity responsible for distributing the payments would also be responsible for ensuring that the proper procedures had been followed to medically and psychologically screen the donor, and
that the organ donor was therefore indeed qualified to receive the funds. This proposal
would not allow for direct payments to be made from the organ recipient, under any
circumstances, nor would it allow for any third party to broker such a deal. Only the
entity named by the federal government would be approved to pay financial incentives to
donors. Because the organ recipient would not be paying the organ donor directly, and
the organ recipient would not be funding the payment, the financial status of the recipient
should not give the recipient priority or affect the chances of the patient receiving an
organ in any way. The possibility that a wealthier person would be favored for an organ
donation over a less well-off person would be less of a concern under such a proposal.

The program I am proposing in this thesis to provide financial incentives for
living donors includes methods for ensuring safety for all patients, on the donating and
the receiving side. It is critical that qualified, licensed transplant centers conduct the
procedures that follow in this chapter. Transplant centers would, as they are now, be
required to employ qualified and experienced transplant physicians, nurses, and
coordinators to conduct extensive physical and psychological medical evaluations of
potential living donors to ensure that they are fit to donate an organ. As is protocol now,
all necessary tests would be performed to ensure that the potential donor is a blood and
tissue typing match for the recipient. The transplant center would screen donors for
medical conditions such as cancer and severe high blood pressure. A potential kidney
donor would be evaluated to make sure that he or she has two kidneys that work to their
optimum levels, thus verifying that the donor would be able to live with one kidney after the transplant. Under this proposed program, a qualified, licensed transplant nurse or social worker would conduct thorough evaluations and discussions with the donor to form an opinion on whether the donor was being coerced into donating the organ. This type of evaluation would involve several visits, interviews, and possible discussions with family members, at a minimum. The transplant center must also fully educate the donor and his or her family on all risks involved in the transplant surgery, and must conduct further interviews and evaluations after such education sessions are held, to ascertain whether the sessions resulted in a change in the donor’s decision to donate. At all times during these situations, the transplant team must assure the donor that he or she is not obligated in any way to continue through to the surgery. Enough time (as much as the donor needs) must be given to the donor to make an informed decision; it would be recommended that at least one month pass between the transplant center interviews and education session and the time that the donor confirm whether he or she wishes to be an organ donor.

As mentioned above, in order to maintain proper controls on the financial incentive system for organ donors, I recommend that organ recipients not be permitted to pay the organ donors directly. Allowing money to exchange hands in that manner has the potential to cause many problems; for example, a prospective donor could demand money from a prospective recipient and then fail to donate the organ, or a prospective recipient could somehow coerce or blackmail the prospective donor into donating an
organ. Instead, the federal government should name an agency that would be responsible for handling the disbursement of all financial incentives to donors, either in one lump sum after the surgery, or partial payments made before and after the surgery. While others have put forth proposals that include options for various types of incentives, such as health insurance for the donor after the transplant surgery, financial scholarships to colleges/universities, and tax credits, I propose a system in which the government agency would provide a financial payment to the donor. As discussed in Chapter Three of this thesis, there must be a method for determining a reasonable and viable amount for each type of living donation, whether it is a kidney or bone marrow. The set payment amounts would likely increase by a certain percentage each year, perhaps in accordance with the Cost-of-Living Adjustment (COLA), determined by the Consumer Price Index. It would be likely that each state would have a different determination for the cost to be paid to a donor, partly affected by the cost of living in that particular state. I suggest that the determination be based on the place of residence for the donor, and not necessarily the state where the transplant takes place.

As mentioned in a previous chapter, dialysis treatments, which are required for End-Stage Renal Disease (ESRD) patients when their kidneys cease to function at a rate that allows them to live without treatment, and funding for which is provided through Medicare, could cost upwards of $30,000 per year. Further, an ESRD patient might remain on dialysis for many years, since in the majority of cases, kidneys do not regain function from dialysis. In the long run, more kidney transplants should mean a cost
savings for Medicare, since the transplant recipient is usually able to go on to live a relatively normal life, aside from daily medications and a suppressed immune system (making the patient susceptible to illnesses such as colds, viruses, and so on). While transplant patients are likely to have medical complications to some degree, those complications usually do not compare to the myriad health problems that come with dialysis treatments, required several times per week, for hours at a time. Further, many dialysis patients are weakened from treatments to the point that they are unable to work, often receiving disability benefits under the Social Security Administration – an additional cost to the federal government. Dialysis patients also have to take daily medications to control blood pressure and potassium and phosphorous levels, at minimum. Kidney transplants typically afford ESRD patients an opportunity to return to a fairly normal, productive life, without dialysis. As Sally Satel, M.D., proposes, and as discussed in this thesis, I believe the federal government would be able to fund the direct financial incentives to organ donors, based on the savings that would be achieved through an increase in the number of kidney transplants (Satel 2006).

In order for any program of incentives for organ donations to be instituted in the United States, first, the National Organ Transplant Act (NOTA) would have to be amended. NOTA was enacted, in part, to ensure the fair allocation of donated organs and a sound monitoring policy to ensure the health and welfare of donors and recipients, and it also specifically addressed regulations surrounding the exchange of “valuable consideration” for organs. To proceed with plans for allowing financial incentives for
organ donations, Section 301(a) of NOTA, which forbids anyone to “knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce,” should be deleted in its entirety (National Organ Transplant Act of 1984). Instead, a revision to NOTA should be made to set forth a clear program for financial incentives, with rules such as those discussed herein, to protect all parties involved.

The U.S. federal government should make efforts to push for NOTA to be amended to allow for financial incentives to organ donors, considering not only the fact that more organ donations means more lives saved, but that more organ donations should realize a financial savings, in the long run, for the federal government. The federal government is responsible not only for ensuring standards of care for the treatment of patients (in this case, organ donors and recipients), but for financing much of the treatment for ESRD patients on dialysis, through Medicare. Few can argue with the notion that organ transplants save lives. The topic of economics also cannot be ignored when it comes to the discussion of allowing financial incentives for organ donors, and I argue that it makes sense from an economics perspective for the U.S. to implement a program that will allow financial incentives for organ donors.

With organ donations in the U.S., as in most other countries, there is simply not enough supply to meet the demand. The provision of financial incentives would, in all likelihood, drastically increase the supply of organs available for donation. Economists who have studied the issue of organ donations and incentives make a case that the cost of
financial incentives will eventually be driven down when the supply is increased. For example, we will take the estimate of $15,200 proposed by Becker and Elías, cited in a previous chapter of this thesis as an appropriate payment to a living kidney donor, and inflate the number by fifteen percent (15%) to take into account a three percent (3%) increase per year since that number was proposed in 2007, coming up with a revised estimate of $17,480 as payment to a living kidney donor. Of course, we must factor in this additional cost of the financial incentive to the actual cost of the transplant surgery and related expenses, but as financial incentives would most likely increase the number of organ donors, thereby increasing supply, it would follow that the price for incentives could be driven down.

**Incentives to donate organs upon death**

As discussed in this thesis, there are have been several proposals put forth that outline non-financial incentive programs (tax credits, reimbursement of funeral expenses for cadaveric donors, and medals). While these proposals are certainly a step in the right direction, I propose that they be implemented for cadaveric donations, and not necessarily for living organ donations. While I believe that they would not have the direct, lasting impact on increasing the number of organ donors in the United States that a direct financial incentive program would have, I believe these types of incentives could greatly benefit a donor’s family if he or she donates organs upon death. The provision of a direct financial payment to a donor’s family could have unintended consequences. For example, a donor might not want his or her direct relatives to benefit financially from the
organ donation, but perhaps a reimbursement of the donor’s funeral expenses would help defray costs of a funeral for the family. In these cases, the organ donor could designate which type of non-direct financial compensation incentive the donor wishes to be provided to the family upon the donation. If the deceased donor is leaving children behind, college tuition waivers could be of great value to the family. Such programs for cadaveric donations would likely be less controversial, as even those who have spoken out against financial compensation programs have voiced approval of pilot programs for funeral expense reimbursements and similar programs.

Further, there are some programs that I propose should be instituted but not viewed as incentive programs. For example, The Living Organ Donor Job Security Act of 2009 (H.R. 2776) was written with the intention of amending the Family and Medical Leave Act of 1993 to provide leave from work for those who serve as living organ donors (for example, kidney and bone marrow donations). The law would have ensured that employers would allow leave from a living organ donor’s job for certain activities related to the transplant, to include testing, surgery, and post-operative care. Programs such as The Living Organ Donor Job Security Act of 2009 are not truly incentive programs, necessarily, but are more so programs to remove disincentives. If a person were interested in becoming a living organ donor, but was concerned that his or her employer would not grant time off for the surgery and for activities related to the surgery, or was even concerned about being fired from the job, then a law like the Living Donor Job Security Act might have persuaded the donor to go through with the surgery. However, it
is highly unlikely that a potential donor would see the job protection act as an incentive, meaning that it alone would not be motivation for the person to go through with the surgery. Instead, I believe that job security for living organ donors should be standard, and should not be considered an incentive program. Also to be considered standardized would be programs to allow the organ recipient to reimburse the living donor for expenses related to ongoing medical care, if necessary, and to allow the organ recipient to purchase life insurance or health insurance for his or her donor.

As discussed in this thesis, many opponents to programs of financial incentives for organs have voiced ethical concerns about the practice. However, it is the position of this writer that the United States has the capability to institute financial incentive programs in an ethical manner, with safeguards for all patients. To those concerned about programs exploiting the poorer populations, I say that financial incentives for organ donors could actually *help* the poorer populations. As long as the appropriate procedures were put in place and followed by all parties, to include qualified transplant centers and the patients, as discussed in previous paragraphs, and as long as the government or a government-mandated organization were coordinating the transaction, the risk of a potential donor being coerced into donating the organ is low. Provided that the donor was making an informed decision, had ample time to think about it, and so on, I see no reason not to support the financial incentive program. The donor could save a life, and also have enough money to, for example, send his child to college (or partly pay for college tuition). Further, as long as the government monitors the process and funds the
payments, there should not be an ethical concern about an imbalanced system that favors those patients in need of transplants who can afford to pay incentives over those who cannot, because the money would not be coming from the recipient. Another common ethical concern about financial incentives for organs is that such programs would “commodify” the human body. I argue that the proposed incentive program would allow a donor to be reimbursed for his or her efforts, which may include loss of income from being out of work during the surgery and recovery, at minimum. I do not believe that a program of financial incentives would then lead to the unregulated buying and selling of body parts. Organ donation and incentive programs for such has little to do with buying and selling organs, and more to do with saving lives. Opponents to incentive programs have also voiced concerns that such programs would decrease, if not eliminate, the number of altruistic donors – those who donate organs solely for the benefit of others. I believe that family members would still be willing to donate organs to other family members without any financial reward. For example, many mothers and fathers would be more than willing to donate a kidney to their child, and presumably would not expect a financial incentive, unless it was needed for healthcare or other expenses. The incentive programs would more so motivate strangers to become organ donors for the benefit of people they do not know. In the end, we should not be concerned about altruistic donors decreasing, as long as the provision of financial incentives results in more lives being saved.

This thesis has noted incentive programs that are being considered, or already
implemented, in countries outside of the United States, and has found that several
countries have been able to introduce laws allowing incentives of some kind for organ
donors. Of course, each country has its own culture and societal norms, and what might
be permitted in Iran, for example, where financial incentives are allowed for organ
donors, might take longer to be accepted in the United States. However, we can see from
Iran’s policies that they have had a great impact on increasing organ donations, and
perhaps it encourages United States policymakers to consider such laws in our country.

Based on a study of articles and position papers written by various stakeholders in
reaction to proposals for organ donor financial incentive programs, we can speculate
about which stakeholders would likely be opposed to the proposal for incentives outlined
at the beginning of this chapter. A particular group of physicians and academics has been
very outspoken in its opposition for many types of incentive programs for organ donors.
The group, which includes Francis Delmonico, M.D., Robert Arnold, M.D., Nancy
Scheper-Hughes, Ph.D., Laura Siminoff, Ph.D., Jeffrey Kahn, Ph.D., M.P.H., and Stuart
Younger, M.D., has published articles outlining its stance on preserving NOTA’s ban
against the provision of “valuable consideration” and its position against any type of
incentive program, aside from the Gift of Life Congressional Medal Act and another
program that would allow the reimbursement of funeral expenses to the families of
donors. Unless their opinions have drastically changed of late, it is fairly certain that this
group of professionals would oppose a program of direct financial incentives, since they
believe that organs should not be given in exchange for any type of financial reward. They are very concerned about exploiting organ donors, and fear a slippery slope that might lead to more unregulated behavior (Delmonico et al. 2002, 2003).

The above referenced professionals might be following the opinions of the American Medical Association (AMA), a stakeholder that would likely be another opponent to the financial incentive program set forth in this chapter. The AMA, through its Council on Ethical and Judicial Affairs (CEJA), has considered and voiced opinions against various proposals for incentives, to include the Gift of Life Tax Credit Act of 2000. The AMA specifically contemplates whether certain proposals align with AMA policy on ethics and other topics, as applicable. While the AMA wishes to promote organ donation, and will consider programs that might encourage people to donate, the AMA will not recommend a program that is not wholly compatible with the published ethical standards of the association. The AMA’s “Code of Medical Ethics” sets forth these standards, and medical professionals are expected to follow them. Therefore, it would be assumed that physicians and transplant surgeons would follow suit and would support or not support financial incentive programs as the AMA does. As a national association for the medical profession, the AMA is concerned with practicing medicine in a way that is fair for all involved, and is not in support of programs that allow for body parts to be bought and sold. Thus, the AMA is not quick to support programs of financial incentives for organ donors (Rakatansky 2000).

The National Kidney Foundation (NKF) would also likely be opposed to the
financial incentive program ideas set forth in this chapter, as the foundation has historically spoken out in favor of preserving the ban against “valuable consideration” in NOTA, and is against most proposals for financial incentives (National Kidney Foundation). As an organization that lists the promotion of organ donation among its goals, I have been surprised at the opposition shown by the NKF against financial incentive programs for organ donors. We could speculate that the NKF Board of Directors, which is made up of physicians (nephrologists) and other healthcare workers, in addition to members who have been affected by kidney disease, is strongly leading the foundation’s stance on financial incentive programs. Since many medical professionals are concerned about ensuring equality in medical care, and the protection of the vulnerable, it follows that many in the medical profession might be against programs of financial incentives for donors.

While the debate about these programs is still very much ongoing, with stakeholders both for and against financial incentives continuing to voice their concerns, it is time to amend NOTA and implement a program in an effort to dramatically increase organ donations in the United States. The program would include safeguards and strict procedures, and the federal government would provide oversight of the program to ensure that all protocols were being followed by transplant centers, patients, and their families. Many cannot truly understand the helplessness felt by those in need of organ transplants, and their families, as they wait for an organ on a transplant list. For patients in need of a kidney transplant, they can be kept alive by dialysis treatments, but those treatments take
a toll on the heart and other organs, and some patients do not fare well during dialysis. Many kidney patients wait on a transplant list for a deceased donor’s kidney, when a living donor would be even more ideal. Financial incentive payments to living donors could shorten the wait time for these patients immensely, and could ultimately save lives.
REFERENCE LIST


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