Should financial compensation be given for living kidney donation?

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**Introduction**

Living kidney donation has taken place in the Netherlands since 1966 and has increased compared with post-mortem donation [1]. There are different types of donors: donations after brain death and donations after circulatory death, better known as heart beating and non-heart beating donors, and living organ donation. The numbers of living kidney donations is increasing and there is a stabilization in the numbers of organs from deceased donors. 18,712 kidney donations have taken place in Europe in 2011, of these donations were 20.6% (0-61%) living kidney donations [2,3]. In the Netherlands, the number of living kidney donations was 26.3% [2]. Living donation has a major impact on the life of the donor, physically, psychologically and financially [1,4,5] and often gives a better outcome/prognosis for the receiver compared with post-mortem donation [5,6].

**Question**

A person can donate a kidney with anonymous, altruistic intentions, known as the Samaritan donors or because they know someone who needs a new kidney. When a person decides to donate a kidney, they go through the living donation process. This consists of screening, surgery and the postoperative period [1]. The donor is confronted with both physical and psychological challenges associated with the operation, the risks it entails, and the long-term risks of living with one kidney. They also face the financial burden of medical expenses and will be temporarily in the Health Insurance Act. In the Netherlands, the medical costs that are incurred by the donor are reimbursed by health insurance and they are entitled to a benefit of the Health Insurance Act, the “UWV”. In addition, they are eligible for an allowance, which was introduced in January 1, 2011 by the Dutch Transplant Foundation [1].

Therefore the direct expenses of the donation should be covered for the donor. The Center for Ethics and Health (CEG) has suggested an additional financial stimulation, for example in the form of a lifetime exemption of health insurance premiums [7]. Through this stimulus the Centre for Ethics and Health expects more people would be willing to donate a kidney [7]. However, the Netherlands has a prohibition on the provision of financial compensations for donation [8]. The question is whether this is reasonable for the donor. Donors help a patient with chronic kidney failure, but are then exposed to the risks of the surgery and will have to continue living with one kidney. Should kidney donors receive compensation in exchange for their kidney donation?

**Medical situation**

Living donation brings risks for the donor during and after the surgery. Of these living donations, the risk of death during and immediately following surgery is the greatest. However, this risk is minimal [9-11]. In the short term there is a small risk of spleen injury, thrombosis, wound infection, bleeding and pneumonia [9,10]. It is hypothesized that long term effects are seen with declining kidney function, but the available research is inconclusive [9-11]. Some of the latest studies show that kidney donors have an increased long-term risk for end-stage renal disease (ESRD) compared with people who did not donated a kidney [12]. Studies have shown there is a minimal increased risk of hypertension and proteinuria [9,10]. Also, female donors have an increased risk of developing preeclampsia during pregnancy, compared with women who have not donated a kidney [9,11]. In addition to the physical issues, living donation could psychologically affect the donor as well [9,13].

**Ethical situation**

Beside the financial and medical aspects, living donation also involves ethical aspects. The surgeon must consider whether the improved health of the recipient can be seen as a greater benefit compared to the attendant risks faced by the donor [14]. Another ethical issue is autonomy. An individual in the Netherlands may, free of pressure and coercion from others, voluntarily register as a living kidney donor based on his or her own values. Similarly, the individual has the opportunity to withdraw at any time as a donor [1]. A third issue to consider is that of justice. Equals should be treated as equals and unequals as unequals according to Rawls’ principle of justice [15]. Therefore all people should be treated equally, also in terms of access to health care. Factors such as gender, social status or race, should not be considered when it comes to organ donation.
Argumentation
A compensation for living donation can be viewed in different ways. The compensation can be viewed as a payment for goods, which is a donated kidney in this case. It could be seen as a compensation for the lost time and the costs incurred, and it could be seen as a gift which stands for appreciation [16]. Paying non-medical expenses associated with the transplant is a possibility of paying off debt, an option which is preferred in the study of Gordon et al. [17] which investigated the change of willingness to donate in case of a financial compensation [17]. The Dutch government prohibits any form of compensation that is a direct consequence of the removal of an organ [8]. As long as there is no solution to the growing waiting lists and the associated cost from morbidity and mortality, a compensation for ethical living donation should be considered to increase the numbers of living donations!

In my opinion there should be further compensation for living donation, in addition to the compensation which already exists in the Netherlands. This compensation should be provided because of the risks to which the donor is exposed. The donor indirectly promotes the welfare of the recipient and acts using the principle of beneficence. The principle of beneficence should in my view be the reason for remuneration and not the delivered organ itself. However this distinction may not be allowed under current European law. [8]

It is expected that with the introduction of a compensation system the numbers of (anonymous) donations will increase and the waiting period will decrease. Ethical screening would be required as the autonomy of a donor may be compromised when an individual is financially uncertain. The form of the compensation could vary. Donors could opt for an one-time payment for their organs, they could opt for a small lifetime discount on the premium. The indirect compensation is the best option as it ensures the donor is not rewarded directly or temporarily. Therefore the autonomy of the donor is less at risk.

The principle of justice, which stands for division and equality, would be jeopardized if the compensation for living donation should be paid by the receiver himself. This would have the effect that only the wealthy could afford a kidney transplant. To prevent this, it should be paid by a multidisciplinary authority like the Dutch Transplant Foundation [7,18]. The costs of a kidney transplant are lower than the costs incurred annually by the chronic kidney patients on hemodialysis and peritoneal dialysis [19]. Therefore these funds could be redirected toward reimbursement of donors’ annual insurance premium. There is little evidence that shows the number of (anonymous) donations will actually increase after the introduction of a compensation. One of the reasons is that organ compensation is prohibited in many countries [8,14]. Only in Iran such a reimbursement is permitted. In 2006, there was no waiting list in Iran for kidney donation [14,20]. The data from the Iranian model do not provide sufficient evidence that compensation for living donation in the Netherlands will help shorten the waiting list. Further research is necessary [14].

Conclusion
A compensation available to living kidney donors should certainly be considered in the Netherlands mainly, because it is expected that the number of (anonymous) donors will increase. This could be verified through a pilot project, where a compensation is offered temporarily during the duration of the pilot. The introduction of compensation does not cause a conflict with the ethical principles. Individuals remain free to choose to register as donors, whether they will receive compensation or not. By choosing an indirect compensation, such as a discount on the premium for health insurance, the principle of justice will be prevented from being jeopardized. This can also be prevented by making the financial compensation paid by a multidisciplinary authority, so rich and poor have equal chance of receiving a new kidney.

Also, the medical costs, which are made in the current situation due to chronic kidney patients, can be reduced by an increase in the number of kidney transplants as a result of the increased number of donor kidneys. This could offset the costs of a compensation system. Thus compensation for living donors of kidneys should be considered.

References

Opinion
18. Friedman A.L. Payment for living organ donation should be legalised. Bmj. 2006; 333: 746-748.