



WHY AND HOW TO COMPENSATE LIVING ORGAN DONORS: ETHICAL IMPLICATIONS OF THE NEW AUSTRALIAN SCHEME

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ABSTRACT

The Australian Federal Government has announced a two-year trial scheme to compensate living organ donors. The compensation will be the equivalent of six weeks paid leave at the rate of the national minimum wage. In this article I analyse the ethics of compensating living organ donors taking the Australian scheme as a reference point. Considering the long waiting lists for organ transplantations and the related costs on the healthcare system of treating patients waiting for an organ, the 1.3 million AUD the Australian Government has committed might represent a very worthwhile investment. I argue that a scheme like the Australian one is sufficiently well designed to avoid all the ethical problems traditionally associated with attaching a monetary value to the human body or to parts of it, namely commodification, inducement, exploitation, and equality issues. Therefore, I suggest that the Australian scheme, if cost-effective, should represent a model for other countries to follow. Nonetheless, although I endorse this scheme, I will also argue that this kind of scheme raises issues of justice in regard to the distribution of organs. Thus, I propose that other policies would be needed to supplement the scheme in order to guarantee not only a higher number of organs available, but also a fair distribution.

THE AUSTRALIAN SCHEME

In early 2013 the Australian Federal Government announced¹ a two-year trial scheme to support paid leave from work for living organ donors. Living organ donation is a growing phenomenon in Australia and worldwide. According to the last estimates available, 42.5% of the more than 76,000 kidney transplantations worldwide in 2011 were from living donors.² There is also a large

black market in organs from living donors which is difficult to quantify.

In Australia the number of living kidney donations has steadily increased since the 1960s, and in recent years it has increased at a faster rate than the number of deceased kidney donations.³ Currently, there are on average 288 living donors in Australia each year, who usually donate only to family members or close friends. More than 99% of cases involve the donation of a kidney.⁴

¹ Australian Minister of Health, Parliamentary Secretary for Health and Ageing: *Joint Media Release*. 'Supporting Paid Leave for Living Organ Donors'. Canberra, ACT. 2013. Available at http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201314/healthmeasures [Accessed 14 Dec 2013].

² Global Observatory on Donation and Transplantation – WHO. *Organ Donation and Transplantation Activity*. 2011. <http://issuu.com/o-n-t/docs/2011adg?e=4461754/3988136> [Accessed 14 December 2013].

³ Australian National Health and Medical Research Council. *Organ Tissue Donation By Living Donors. Guidelines for Ethical Practice for Health Professionals*. 2007. http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e71.pdf [Accessed 14 Dec 2013] http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e71.pdf

⁴ Australian Minister of Health, Parliamentary Secretary for Health and Ageing, *op. cit.* note 1.

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So far, living donors in Australia have never received any form of compensation, either from the State or from the recipient. This trial is designed to compensate them for their time, potential health consequences and for potentially having to take leave from work (for instance in order to undergo medical evaluation before surgery). Therefore, the scheme certainly represents a significant breakthrough. As explained in the Guidelines presented by the Australian Department of Health and Ageing:

[p]rospective donors are required to undergo extensive testing to ensure they are physically and mentally able to donate. If surgery proceeds, the donor will require a significant amount of time off work to recover, with the standard recovery period being four to six weeks. Some donors may be required to take this period as leave without pay, or they may exhaust their paid leave entitlements. This can lead to financial stress and, [sic]because of this some donors may feel compelled to return to work early against medical advice.⁵

The donors would receive the equivalent of a six-week salary on the national minimum wage (about 600 AUD per week). This payment will be made to the employer, and transferred to the donor in the form of paid leave. Therefore, the actual benefit for the donor would be the fact that s/he would not need to take unpaid leave for reasons related to the donation (for instance medical follow up). The risk of financial stress and the consequent pressure to get back to work too early would thus be minimized.

In this article I am going to argue that this scheme is ethically acceptable because, while it has the potential to increase the number of living organ donations, it is well designed to avoid ethical issues concerning commodification, exploitation, inducement and equity, which are usually raised when compensation for living organ donations is proposed. However, I will also argue that – if not supplemented by other kinds of policies (of which I here propose a few examples) – the scheme is likely to increase the unfairness of the system of organ distribution. Therefore, I suggest that, if cost-effective, the Australian scheme should be taken as a model and implemented by other countries, on condition that supplementary policies aimed at increasing unrelated organ donations (in particular from dead donors) are also implemented.

Before tackling the ethical considerations of this new policy, it might be useful to give a brief overview of the current state of play regarding transplantations and donations in Australia.

⁵ Australian Department of Health and Ageing. *Supporting Leave for Living Organ Donors Guideline*, 2013. <http://www.health.gov.au/internet/main/publishing.nsf/Content/RPGD-BORP-Leave-for-living-organ-donors-guidelines#Supporting> [Accessed 14 December 2013].

CONTEXT, PROSPECTS AND ETHICAL ISSUES

Currently in Australia patients are put on a transplant waiting list by their doctors on the basis of medical criteria. The priority order on this list is established according to the protocols developed by the Transplantation Society of Australia and New Zealand and the Australasian Transplant Coordinators Association. The main criteria for allocation of organs include the length of time a patient has been waiting for a transplant, tissue matching between the potential recipient and the available organ, the likely deterioration of the health status of the patient without the transplant, and also logistical factors in making a certain organ available to a certain recipient in a timely manner. As explicitly stated by the Australian Government, the allocation of organs is governed by principles of *utility*, *equity*, and *fairness*.⁶

At the end of 2012 there were 1080 Australians on the waiting list for kidney transplantation.⁷ In the same year 354 deceased organ donors made transplantation possible for 606 kidney recipients.⁸ These figures clearly show that, even considering the sum of kidneys available from living and dead donors, the supply at the moment is simply not enough. Following the current trend, the cost of treating Australians with end stage kidney disease has been predicted to be 1.1 billions dollars per year by 2020.⁹ For this reason, the decision of the Australian Government to invest 1.3 million AUD over the next two years on the living organ donor scheme is most certainly a wise one. Any increase in the number of organs available from living donors would contribute to reducing the long waiting lists and to improving the quality of life, or even saving the lives, of those currently on the list. Whether or not there will be such an increase is an empirical issue. At the end of the trial, in 2015, it will be possible to assess the value of the investment both financially and in terms of health benefits. However, what warrants investigation are the ethical implications of such a plan.

⁶ Australian Government. *How the waiting lists operate*. Canberra, ACT; 2009. http://www.transplant.org.au/ignitionSuite/uploads/docs/waiting_list.pdf. [Accessed 14 December 2013].

⁷ Minister of Health, Parliamentary Secretary for Health and Ageing, *op. cit.* note 1.

⁸ ANZOD (Australian and New Zealand Organ Donation Registry). *Monthly Report on Deceased Organ Donation in Australia. December 2012*. <http://www.anzdata.org.au/anzod/updates/anzod2012summary.pdf>. [Accessed 14 Dec 2013].

⁹ A. Cass et al. *The economic impact of end-stage kidney disease in Australia. Projections to 2020*. Melbourne, VIC: Kidney Health Australia; 2010. <http://www.kidney.org.au/LinkClick.aspx?fileticket=i759hVXpJI0%3D&tabid=635&mid=1837> [Accessed 14 Dec 2013].

As is the case with policies regulating the placement of patients on waiting lists, the system through which organs are procured from living donors raises issues not only about utility, but also about equal treatment of different categories of possible donors, and about fairness in the eventual organ distribution.

As for the problem of equal treatment, since the poor are more likely to decide to give away an organ if there are financial incentives, such incentives for organ donations could bring about an imbalance whereby the poor would become a source of organs for the rich.

These kinds of concerns stem from the ethical issues specifically associated with attaching a monetary value to the human body or to parts thereof. Some of these issues principally concern the prospect of the commodification of the human body. As a provisional, working definition (which will be further discussed in the next section), this form of commodification occurs when the human body or parts thereof are treated as mere objects that can be exchanged in return for money, like any other item of private property. Some of the concerns have to do with the idea that commodification of the human body is intrinsically wrong,¹⁰ others with the possible consequences of commodification.¹¹

Besides, commodification is by its very nature susceptible to corruption and so raises concerns about inducement and exploitation of the economically or socially least advantaged members of a community. The concern is that these members might feel pressured into 'donating' organs in return for financial benefits in spite of the potential harms involved.¹²

As for the problem of organ distribution, the way organ procurement is regulated, I propose, may have implications for the way organs are distributed to those on the waiting list, not only in terms of efficiency, but also in terms of fairness in organ allocation. As I will show, the Australian scheme is an example where the proposed system of living organ donations might affect fairness in organ distribution unless additional measures are also implemented.

I will argue in this article that the principles of utility, equity and fairness, if extended to living donors policies, both 1) ethically justify the new Australian scheme with regard to utility and equity and 2) demand that the scheme integrate complementary policies aimed at improving fairness in organ distribution.

COMMODIFICATION

Broadly speaking, 'commodification' is the process of 'making something an object of exchange'.¹³ As such, the term itself is morally neutral and of course commodification occurs in many of our everyday commercial transactions. When used in a morally loaded sense, however, the notion of commodification is taken to mean something like 'making something an object of exchange, *when it ought not to be*'.

It *might* be claimed that the Australian scheme involves commodification of the human body and organs in the neutral sense. The situation might be read as follows: the organs are made into objects of exchange, because donors would receive paid leave in return for their kidneys or other organs. Even *if* we concede – for the sake of argument – that this interpretation is correct, it remains to be demonstrated that the Australian scheme does involve 'commodification' of the impermissible kind. I am going to show that this is not the case. Before doing this, however, the stakes in the debate need to be ascertained.

There are two possible argumentative strategies that can be used to argue for the wrongness of commodification of the human body: a non-consequentialist and a consequentialist one. According to the non-consequentialist view, the human body and its parts are the kinds of objects that have value in themselves, and are not 'the sort[s] of objects on which a financial value can be set'; any kind of financial value would be 'demeaning of human dignity, treating the person like a thing'.¹⁴ *If* this is the reason why commodification is morally wrong, then the kind of commodification involved by the Australian scheme is not morally wrong. According to the Australian scheme, donors would not receive money from the recipients for their organs, but from the state merely as a compensation for their time and the potential health risks. This consideration allows us to draw a distinction between the Australian scheme and a regulated 'market' in organs (advocated by some philosophers).¹⁵ The entity of the compensation will not be determined by the demand for organs or by what is deemed to be an adequate or affordable price for such a beneficial good, as would be the case in a proper 'market' (whether free or controlled by the State); rather, it will only be determined by what is deemed to be enough to cover the costs for potential health consequences and the expenses for a period in which the workers might have to take unpaid

¹⁰ S. Holland. Contested Commodities at Both Ends of Life: Buying and Selling Gametes, Embryos and Body Tissues. *Kennedy Inst Eth J* 2001; 11: 263–284.

¹¹ P. Singer. Altruism and Commerce: a Defence of Titmuss Against Arrow. *Philos Public Aff* 1973; 2: 312–320.

¹² N. Scheper-Hughes. The Global Traffic in Human Organs. *Curr Anthropol* 2000; 41: 191–224; T.L. Zutlevics. Markets and the Needy: Organ Sales or Aid? *J Appl Philos* 2001; 18: 297–302.

¹³ D. Dickenson. *Body Shopping. The Economy Fuelled by Flesh and Blood*. Oxford: Oneworld; 2008. p. 11.

¹⁴ *Ibid*: 12.

¹⁵ G. Dworkin. 1994. Markets and Morals: the Case for Organ Sales. In Dworkin, G. editor. *Morality, Harm, and the Law*. Boulder, CO: Westview Press: 155–161; J. Radcliffe-Richards et al. The Case for Allowing Kidney Sales. *Lancet* 1998; 351: 1950–1952; C.A. Erin & J. Harris. An Ethical Market in Organs. *J Med Ethics* 2003; 29: 137–138.

leave from work. Therefore, no financial value would be set on the organs themselves. It follows that human dignity – if such a thing exists and whatever the concept is taken to mean – would not be violated by the implementation of this scheme, at least no more than it is violated by pure *donations* of organs, blood or any other body tissues that are already accepted and, indeed, often encouraged.

The same kind of reply can be used to address the consequentialist argument against commodification. From a consequentialist perspective, it has been claimed that unpaid donations increase the supply available by fostering a sense of community and mutual interdependence that motivates people to donate more. Titmuss and Singer,¹⁶ who famously made this point with regard to blood donation, cited in support of their claims evidence comparing different systems of blood ‘donation’ (with versus without payment) in different countries (US and Japan versus Britain); this evidence was interpreted as suggesting that a system based on pure donations was more effective. The same point might be extended to organ sales by arguing that monetary value put on organs would not encourage people to think deeply enough about, for instance, how it is to live with kidney failure. The point has been clearly expressed by Anne Phillips as follows:

Donation encourages people to think more explicitly about their moral equality. It encourages the person with two good kidneys to think about what her life would have been like had she suffered kidney failure; and the person with kidney failure to think about what she would have been willing to do had she had two healthy kidneys. A market in kidneys encourages purchasers and sellers to think of themselves as beings apart.¹⁷

I do not want to discuss whether this kind of argument is convincing or not, and whether or not the existing evidence supporting the consequentialist opposition to commodification is conclusive. I simply want to point out that the aim of the Australian scheme is exactly to help people to demonstrate their willingness to help others. While Singer and Titmuss were (perhaps rightly) concerned about ‘payments’, what is entailed by the Australian scheme is better described as ‘compensation’ for possible negative consequences that donors would not have had, had they not decided to donate the organ in the first place. Surely, both payments and compensations can be seen as forms of incentives. But what is relevantly different – for the purpose of the present discussion – is the different effect they have on potential living donors’

¹⁶ R. Titmuss. *The Gift Relationship: from Human Blood to Social Policy*. London: LSE Books; 1997; P. Singer *op. cit.* note 11.

¹⁷ A. Phillips. It’s My Body and I’ll Do What I Like with It; Bodies as Objects and Properties. *Polit Theory* 2011; 39: 724–748.

motivations. As pointed out by the Parliamentary Secretary for Health and Ageing, living donors in Australia usually donate kidneys to family members or close friends, out of a sentiment of love or concern for the dearest ones.¹⁸ It is safe to assume that a minimum wage compensation would not be sufficient to turn this motivation into a mere desire for financial advantage and therefore into a materialistic consideration. However, what is appealing about this scheme is that it can guarantee that low-income workers who want to help their loved ones can afford to do so, which is presumably already the case for high-income workers.

EQUITY

This last consideration of equity can also be deployed to address another concern associated with introducing paid leave in organ donations. The guidelines of the pilot scheme clearly state that the scheme ‘is not an incentive to donate, but is designed to help support those people who wish to donate but cannot afford to due to loss of income and to offset the financial stress on the family of the donor’.¹⁹ However, it remains true that this form of compensation – being based on the national minimum wage – is more appealing to a low-income worker than to a high-income one. Therefore, it is safe to predict that any increase in living organ donations in Australia following the trial scheme will likely be due to new low-income rather than high-income donors. So it might be thought that equity between different social classes is thereby compromised. However, this conclusion is based on a misinterpretation of the prediction.

In fact, the scheme would give the same opportunities – to take paid leave before or after the surgery – to everybody, and in particular to those who would donate if they had the financial means to do so. In this way, the scheme would guarantee that everybody, regardless of wealth or income, could afford putting into effect the desire to help a dear one. Equity would actually be improved, rather than weakened.

INDUCEMENT AND EXPLOITATION

The Australian scheme might be accused of encouraging exploitation. It might be argued that even within a developed country, people in dire financial situations might be tempted to put their health at risk when there is any compensation involved, even when the compensating agent is a state which acts according to strict regulations. In other words, compensation can be seen as a form of inducement. So, for instance, it is plausible that

¹⁸ Australian Minister of Health, *op. cit.* note 1.

¹⁹ Australian Department of Health and Ageing, *op. cit.* note 5.

low-income Australians may be likely to see the six-week minimum wage compensation as an additional reason for donating organs. Could the Australian scheme lead to the exploitation of those most vulnerable? I am going to argue that there is no such risk.

Exploitation occurs when someone takes unfair advantage of someone else who is in a weaker position.²⁰ Someone is in a weaker position when, for instance, she cannot reasonably refuse to engage in a transaction given the circumstances, but would have refused in different circumstances. On some interpretations, the idea of exploitation is centered on the unfairness of the transaction, rather than on the outcomes.²¹ It has therefore been suggested that exploitation may occur even if none of the parties is harmed or left worse off. For this reason, some people talk of ‘non-harmful exploitation’²² (for instance it might make sense to say that I am ‘exploited’ if I pay too much or if I am not paid enough for some good, even if the good I buy or the money I get do benefit me). When exploitation is applied to organ transactions, however, the relevant concept seems to be that of ‘harmful exploitation’; there is evidence – I am going to present some below – suggesting that vendors are significantly harmed where a black or even a legal market is in place. Anyway, whichever notion of exploitation we want to settle for, I argue that neither is entailed by the Australian scheme, because – as already suggested in the previous sections – the Australian scheme does not involve any form of inducement.

Consider first what happens in the current black market of organs, where unquestionably ‘harmful exploitation’ frequently occurs. People, particularly from developing countries, often sell organs to recipients in wealthy countries, because this is the only option they have to make the money they desperately need. It is very likely that people would have refused had they found themselves in better financial circumstances, for at least three reasons. First, the donation of a kidney, unlike the donation of, say, blood, is a surgical procedure, and therefore much more invasive and stressful; second, kidney donation is risky because it might have serious health consequences, for instance the donor may develop some disease involving failure of the remaining kidney; third, often the risks are increased by the lack of adequate medical follow up, which obviously a system centered on a black market cannot guarantee. Thus, for instance, 86% of donors in the Indian black market reported a deterior-

ation of their health status as a consequence of the nephrectomy, and 79% of them would not recommend that others sell organs.²³

These poor outcomes of organ sales might be explained by the simple fact that the black market is a ‘market’, i.e. that putting monetary value on body parts inevitably leads to coercion or exploitation of the poor. Others may argue,²⁴ however, that the reason is that the black market is ‘black’; accordingly, a regulated market, rather than prohibition on sales, would be the best solution. As pointed out by Radcliffe Richards, for instance, ‘nearly all the harms alleged – cheating, careless medical practice, and a lack of screening, counseling, information and follow up – are exactly the ones you would expect of a black market’.²⁵ In this view, well-designed regulations to prevent exploitation while allowing people to benefit financially from organ sales could be used to retain the benefits of the market while getting rid of the shortcomings of a black market. For instance, the problem might be addressed by setting limits to the price for organs (so as to avoid inducement) and by guaranteeing by law adequate medical follow up.

It is also true, however, that the idea that legalizing organ sales would be the best solution is questionable on both empirical and ethical grounds. The empirical grounds can be found in the studies on the health consequences for ‘donors’ in Iran, where there is a regulated market in which the State sets limits to the amount of money that can be paid for an organ. One study has shown that vending had negative effects on the physical abilities of 60% of vendors, and more than 70% of vendors experienced *de novo* post-operative depression; most notably, Iranian vendors regretted their choice: 85% of them said they would not make the same choice again, and half of them would rather lose more than 10 years of life and 76% to 100% of their property to regain their kidneys.²⁶ Such data, of course, do not prove that any kind of financial compensation would necessarily entail exploitation. Different kinds of restrictions might work better than the ones in place in Iran. There are, however, also ethical reservations in regard to the argument that the best way to address concerns about potential donors’ wellbeing is a regulated market. For instance, one might argue that, if we are really concerned about improving autonomy and wellbeing of those who are so desperate to be willing to sell organs, we should help them through

²⁰ A. Wertheimer & M. Zwolinski. Exploitation. In Zalta E.N., editor. *The Stanford Encyclopedia of Philosophy*. 2013. Available at [http://plato.stanford.edu/archives/spr2013/entries/exploitation/0](http://plato.stanford.edu/archives/spr2013/entries/exploitation/). [Accessed Dec 14 2013].

²¹ R. Goodin. Exploiting a Situation and Exploiting a Person. In Reeve A., editor. *Modern Theories of Exploitation*, London: Sage; 1987, pp. 167–200.

²² Wertheimer & Zwolinski. *op. cit.* note 20.

²³ M. Goyal et al. Economic and Health Consequences of Selling a Kidney in India. *JAMA* 2002; 288: 1589–1593.

²⁴ J. Radcliffe-Richards. *The Ethics of Transplants: Why Careless Thought Costs Lives*, Oxford: Oxford University Press; 2012; J.S. Taylor. 2005. *Stakes and Kidneys: Why Markets in Human Body Parts Are Imperative*. Burlington: Ashgate; Dworkin, *op. cit.* note 15.

²⁵ Radcliffe-Richards, *op. cit.* note 24: 55.

²⁶ J. Zargooshi. Quality of Life of Iranian Kidney Donors. *J Urol* 2001; 166: 1790–1799.

means that do not put their health at risk, for instance extensive aid programs.²⁷

Once again, whether any of these arguments are convincing and any of the supportive evidence is conclusive is not what I want to focus on. What I want to point out here is that, *if* these are the kinds of concerns about exploitation, whether or not well grounded, then they are all avoided by the Australian scheme. The reason is that there are two important constraints in the Australian scheme, namely:

- 1) only people who already have an at least minimum wage, i.e. that are not unemployed, are eligible for the scheme, and
- 2) the compensation would be calculated on the national minimum wage.

Although at a first glance these might appear discriminatory and unfair, such constraints are actually reasonable, as they will prevent inducement and exploitation of, respectively:

- a) the unemployed, who would otherwise see the prospect of receiving the equivalent of a six-week payment as a definitive reason for donating an organ and would therefore be induced into 'donating', and
- b) low-income workers, who would be tempted to donate organs if they were to receive a compensation worthy more than the minimum they already earn.

The Australian scheme would therefore be different from a system like the legal market of organs in Iran, where living-unrelated donors are allowed to make a financial gain (although within limitations posed by the Ministry of Health) out of kidney 'donations'; the gain usually consists of an award (circa 1,200 USD) and health insurance provided by the Government, plus a 'gift' from the recipient or, in case the recipient cannot afford it, from some charitable organization.²⁸ In a system like the Iranian one, it might be argued that people are easily induced into 'donating' when in a poor financial situation. In light of the aforementioned data about the post-operation health and financial status of Iranian living donors, this consideration seems to suggest that the practice actually is harmful exploitation.

So, if we think that the harms of exploitation occur because there is a black market, rather than a regulated market, then the Australian scheme is obviously immune from this criticism, because the exchange is strictly regulated. But even *if* we think – *contra* Radcliffe Richards – that the harms occur simply because there is a market (even a regulated one), the Australian scheme remains untouched by this objection also because the aspects that

make this market problematic and exploitative (inducement, low income of the donors) are not present.

What about 'mutually advantageous' exploitation? Let us assume, for the sake of argument, that the use of the word 'exploitation' is appropriate when both parties benefit, or at least when neither is left worse off, but the transaction is unfair because one of the two is in a significantly weaker position. The same argument I have just provided should also dismiss concerns about 'non-harmful exploitation'. Since the Australian scheme would not introduce any motivation related to financial gain in the potential donor's decision-making process, there would be no inducement. Potential donors would not be put in a weaker position, i.e. in a position where they cannot reasonably refuse to take part in a transaction that they would otherwise have refused. The point is that the donation is exactly the choice they would have made if they had the financial means. The means-ends relationship is therefore the opposite of that in place in exploitative transactions: whereas a transaction is exploitative because – among other things – the organ 'donation' (or selling) is the means used to get the desired financial reward, the Australian scheme would make the financial compensation a means to enable people to make the desired organ donation.

POSSIBLE SCENARIOS

I have argued so far that the Australian scheme is likely 1) to be effective, because it would encourage more people to donate out of a desire to help; and 2) to promote equity, because it would give everybody, regardless of their income, the same opportunity to help someone in need, if so desired. When the trial period is over, it will be possible to assess whether the predictions are accurate or whether, instead, it is necessary to adjust the policy or to abandon the idea. It is worth mentioning at this point that a law similar to the Australian scheme was enacted in 2008 in Israel. The law includes a variety of measures which remove disincentives to living donation; for instance, it grants – among other things – earning loss reimbursement, transportation reimbursement to cover all commuting to and from the hospital, insurances reimbursement for five years and reimbursement of psychological consultations and treatments.²⁹ A recent study has shown that this scheme has produced a significant increase in living kidney transplantations, risen from 71 in 2010 to 117 in 2011.³⁰

²⁷ Zutlevics, *op. cit.* note 12.

²⁸ A. Ghods & S. Shekoufeh. Iranian Model of Paid and Regulated Living-Unrelated Kidney Donation. *Clin J Am Soc Nephrol* 2006; 1: 1136–1145.

²⁹ B. Padilla, G.M. Danovitch & J. Lavee. Impact of Legal Measures Prevent Transplant Tourism: the Interrelated Experience of The Philippines and Israel. *Med Health Care Philos* 2013; 16: 915–919: 916.

³⁰ J. Lavee et al. Preliminary Marked Increase in the National Organ Donation Rate in Israel Following Implementation of a New Organ Transplantation Law. *Am J Transplant* 2013; 13: 780–785: 782.

These results, although promising, are of course no guarantee that the Australian scheme will be successful. The same kind of policy might have different outcomes in different societies and cultures. In the case of the Australian scheme, the possibility does exist that the compensation will turn out to be ineffective in enticing more people into donating or in compensating living donors in a way that is commensurate with the economic or other kinds of costs (for instance psychological, or in terms of medical follow up). At that point, two alternative options might be considered: increasing the compensation or giving up the scheme entirely. The first option might be problematic because it might raise all the issues concerning commodification, inducement and exploitation discussed above. Further analysis and discussion would then be needed as to whether the best alternative would be a modification or a total abandonment of the scheme.

FAIRNESS

Even if successful in terms of utility and equity, however, the Australian scheme would not solve all the practical and moral problems related to organ procurement and to long waiting lists. Issues of fairness about access to organs and prioritization on the waiting list would not be satisfactorily addressed – and indeed may be aggravated – by a scheme of this kind. The reason has to do with the imbalance this scheme risks of bringing about in regard to the ratio between living related and non-related organ donors. Whereas the latter benefit those who more urgently need an organ (according to the priority order on the waiting list), the former only benefit those who have relatives and friends willing to donate an organ. It is very likely that the Australian scheme would increase, if anything, only related donations.

In principle, the scheme does not distinguish between, and targets both, living related and non-related organ donors (where ‘related’ can indicate either a genetic link – e.g. donation to a family member – or an emotional link – e.g. donation to a close friend). The distinction is not even mentioned in the guidelines for the implementation of the scheme; besides, both forms of donations are permitted in Australia. However, as one would expect, unrelated (or ‘good Samaritan’) kidney donations are extremely uncommon.³¹

The motivations in the two types of donations are profoundly different. In case of related donations, the

motivation cannot be considered purely altruistic. We should rather call it a ‘personal’ donation. Altruism is about disinterestedly benefiting others, but one’s own interests play an important role in the decision to donate organs to a dear one while still alive, even if these interests take the form of love and concern for the beloved ones or of benefits deriving from a loved one’s improved health. As a matter of fact, people usually do not simply donate to the healthcare system for whoever might need their organs. The motivation for impersonal, i.e. unrelated, donations is, on the other hand, more significantly ‘altruistic’ (unless motivations like increased self-esteem or feeling of moral duties, which might both be present in the case of unrelated donations, are factored into the notion of ‘self-interest’). Being so strictly altruistic, this motivation is much rarer.

The Australian scheme is not designed to induce people to make this kind of ‘impersonal’, strictly altruistic donation, *if they are not already predisposed to do so*. As argued in the previous sections, the worth of the compensation is not enough to significantly alter the motivation and the scope of one’s donations; it is only enough to allow those who could not otherwise afford to donate to stick to their motivation and put this into practice. Even without a similar scheme, the number of living kidney transplantations from related donors has constantly increased since the 1960s;³² in contrast, unrelated donations are practically non-existent. Since the compensation of the scheme is not likely to shift the motivation for the former into a motivation for the latter, there is no reason to expect that it would have a significant impact on the number of unrelated donations. On the other hand, the constant increase in the number of related living donations suggests that trend could continue and thus make an increasingly more significant impact on the supply of organs. Any attempt to facilitate this trend is therefore very likely to be significant even if it could not affect the number of unrelated donations.

The problem is that without a significant parallel increase of unrelated donations, issues of fair distribution of organs are very likely to be exacerbated: someone with lower priority on the waiting list might get an organ before someone else with higher priority, simply because the former is lucky enough to have a friend or family member willing to donate the organ, and the latter is not. In other words, people who more urgently need organs might not benefit from this scheme.

Of course, this consideration is not an argument against the ethical acceptability of the Australian scheme. On the contrary, one less person on the waiting list (regardless of her position on the list) would certainly benefit not only the recipient, but also the people who

³¹ Australian National Health and Medical Research Council. 2007. *Organ Tissue Donation by Living Donors. Guidelines for Ethical Practice for Health Professionals* Canberra, ACT: 21. Available at http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e71.pdf. [Accessed 14 Dec 2013].

³² Ibid: 9.

come after her on the list and the healthcare system in general. My point is rather that the scheme only provides a partial, though significant, solution to the problem of scarcity of organs for transplantation. The scheme is only aimed at equity and utility in the procurement of organs, but not at improving fairness in the allocation of organs, in particular in allocation according to the needs.

The ideal scenario would be one in which organs from living donors are simply allocated according to the priority order on the waiting list. But such a solution would jeopardize the ‘personal’ motivation behind living donations; we would end up with even less living donors than we currently have, possibly with no living donor at all, considering the rarity of ‘good Samaritans’.

EXPLORING NEW PATHS

Other policies would be needed to supplement the scheme in order to guarantee an ‘impersonal’ source of organs. While contributing to maximizing the number of organs available, ‘impersonal’ donations would also make up for the unfair distribution that is likely to result from the ‘personal’ donations inspired by the Australian scheme.

Given what has been said so far, impersonal donations are more likely to be increased through cadaveric donations. One example of such a kind of policy aimed at impersonal donations is the opt-out, or presumed consent, system for cadaveric organs, which is currently enforced in some countries (for instance Spain and Austria). The opt-out system has the potential to increase donation rates if adequately implemented,³³ despite the fact that the actual correlation between high donation rates and presumed consent is not straightforward and questioned by

³³ A. Rithalia et al. Impact of Presumed Consent for Organ Donation on Donation Rates: a Systematic Review. *BMJ* 2009; 338: a3162.

many.³⁴ Whether or not such a policy would work in any one specific country is an empirical issue which, like the Australian scheme, might be worth testing in the form of a limited-time trial.

Other solutions have been proposed (for instance so-called ‘organ donation euthanasia’)³⁵ or enforced (for instance giving priority on the waiting lists to those who signed a card for organ donation after death, as happens in Israel)³⁶ and might be considered by policymakers. These policies might be problematic as well because, while addressing issues of efficiency and justice in the allocation of organs to those on the waiting list, they might raise other kinds of issues. For instance, there might be issues about genuine informed consent or issues of justice as to who ends up on the waiting list in the first place, and according to what criteria.

Campaigns aimed at improving people’s understanding of transplantation and at encouraging them to become after-death donors are also important and often neglected strategies for policy-makers.

For any policy, we need to make sure that the maximization of organs available for transplantation is accompanied by a distribution of organs that is as fair as possible. The Australian trial scheme, if successful, should be seen as the first, but certainly not the conclusive step in this direction.

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³⁴ R. Coppen et al. Opting-Out Systems: No Guarantee for Higher Donation Rates. *Transpl Int* 2005; 18: 1275–1279; C. Simillis. Do We Need to Change the Legislation to a System of Presumed Consent to Address Organ Shortage? *Med Sci Law* 2010; 50: 84–94.

³⁵ D. Wilkinson & J. Savulescu. Should We Allow Organ Donation Euthanasia? Alternatives for Maximizing the Number and Quality of Organs for Transplantation. *Bioethics* 2012; 26: 32–48.

³⁶ J. Lavee et al. A New Law for Allocation of Donor Organs in Israel. *Lancet* 2010; 375: 1131–1133.