Payment for Kidneys: A Government-Regulated System Is Not Ethically Achievable

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n this issue of CJASN, Dr. Ahad Ghods, along with Dr. Shekoufeh Savaj, presents the most comprehensive review to date of the Iranian model of kidney transplantation. It is an excellent report given by a colleague for whom we have high personal regard and with whom we have interacted at several international transplant meetings in recent years. His contribution to the Amsterdam Forum was substantial and well received. Nearly 20,000 kidney transplants have been performed in Iran since the inception of the program in 1988.

The Iranian model is to be commended for its intent to provide care for the kidney vendor by lifelong health insurance, especially since 80% of the vendor population is categorized as poor. The Iranian system also provides an important example for the international transplant community to preclude the abuse of transplant tourism, which is now evident in many parts of the world.

The report by Ghods and Savaj presents important data from the total Iranian experience. The widely known success of kidney transplantation has made it the preferred approach of renal replacement therapy for Iranian patients and for all patients around the world. Certainly, the most striking measure of the total Iranian experience is the assertion that “...the renal transplant waiting list in the country was successfully eliminated.”

However, it is important to examine more closely this assertion and the data used to support it. We reach a different conclusion. There were 19,609 kidney transplants performed in Iran between 1988 and 2005, or about 1090 per year. With a population of 68 million inhabitants, this amounts to 16 kidney transplants per million base population per year (pmpy), although the authors suggest that this number is closer to 25 to 28 pmpy, which might reflect more recent activity. How does this compare with the rest of the international transplant community? The date shown in Table 1 were obtained from The Organizacion Nacional de Trasplantes and refer to annual deceased donor (DD), living donor (LD) and Total (Tot) kidney transplant rates in 2005, shown as pmpy. The accuracy and completeness of these data vary by location, but they do provide important perspective. The combination of the highest DD

transplant rates (48 pmpy) and LD transplant rates (22) would yield 70 kidney transplants pmpy, and this has been achieved in countries without any current financial incentives. Indeed, these data clearly indicate that considerable organ donation could be achieved by maximizing the potential of both voluntary living and deceased organ donation under current principles in every part of the world.

Therefore, it appears that the Iranian transplant programs could have achieved similar outcomes without resorting to a “regulated” market. Moreover, the elimination of the waiting list has as much to do with limitations on listing candidates as it does with providing donors. Thus, the interpretation of this important issue provides all of us with the challenge to reconsider our own current attempts to maximize donation as well as our standards for listing and allocation.

The Iranian model also makes evident what has long been anticipated would occur in a regulated market. There is a fundamental unethical construct that cannot be overlooked despite the attributes that we have cited regarding the Iranian system. It is the poor person who bears the burden of being the kidney source for transplantation. That exploitation becomes real in Iran (>80%) as it does in any other regulated market. The poor person is coerced to make this donation decision, as there are no other means available to obtain money for what becomes temporary personal or family support. This coercion violates the dignity of the human person who is used by those who are highly advantaged to undergo transplantation within the same society.

Furthermore, the contention that a market can be regulated comes into question as Ghods and Savaj acknowledge that additional monies are furnished by the recipient families to vendors. These additional rewards are clearly unregulated and subject to the abuses of brokers that again exploit recipients and vendors. There is no oversight of these transactions in the Iranian system, nor could such oversight be assured or verified in any other regulated market. If the vendor is paid, why shouldn’t market forces seek the highest price possible? Under-the-table exploitation in any proposed regulated market becomes an economic reality for individual transactions. The Iranian experience shows that government cannot police these reward components, nor does it provide a justification that government should, as this transaction is made by economic forces as opposed to social principles.

The Transplantation Society, the American Society of Trans-
plantation, the American Society of Transplant Surgeons, the European Union, Eurotransplant, the National Kidney Foundation, the World Health Organization, and more have long recognized the unethical realities regarding a regulated market, and each organization has consistently opposed it. The concept of a regulated market is not ethically achievable and the evidence for that perspective is given by the report on the Iranian model.

We appreciate the authors’ attempts to maximize the benefits of transplantation for their patients while addressing the ethical problems of paid organ donation. We clearly conclude that this system does not currently meet ethical standards and we encourage the authors and their colleagues to consider our concerns. We challenge all members of the transplant community to redouble efforts to increase opportunities for transplant candidates to receive the “gift of life” while simultaneously honoring and respecting the humanity of the donor.

Table 1. Kidney transplant rates from deceased and living donors by geographic regiona

<table>
<thead>
<tr>
<th>Location</th>
<th>DD Tx^b</th>
<th>LD Tx^b</th>
<th>Tot Tx^b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
<td>30.7 (22 to 48)</td>
<td>4.9 (0.5 to 19)</td>
<td>35.6 (31 to 50)</td>
</tr>
<tr>
<td>North America</td>
<td>31.9 (19 to 33)</td>
<td>21.2 (14 to 22)</td>
<td>53.1 (33 to 55)</td>
</tr>
<tr>
<td>Latin America</td>
<td>7 (4 to 36)</td>
<td>5.2 (0.9 to 7.2)</td>
<td>12.2 (5 to 37)</td>
</tr>
<tr>
<td>Middle East</td>
<td>4 (4 to 13)</td>
<td>9.7</td>
<td>13.7 (14 to 22)</td>
</tr>
<tr>
<td>Australia/New Zealand</td>
<td>17.4</td>
<td>12</td>
<td>29.4</td>
</tr>
</tbody>
</table>

^aDD, deceased donor; LD, living donor; Tot, total; Tx, transplant.
^bMean transplants per million base population per year (range).