Transcript Details
This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/focus-on-global-medicine/financial-incentives-for-organ-donation-could-it-work-in-the-us/3991/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Financial Incentives for Organ Donation: Could It Work in the US?

GLOBAL PERSPECTIVES ON ORGAN DONATION

Our system for procuring organs in the United States is based on altruism, but unfortunately this system continues to fall short of demands, creating a shortage in transplantable organs that causes unnecessary deaths. As a means to meet the demands in other countries around the world various forms of payment have been considered and some are in use today. How would the concept of financial incentives work here in the United States.

You are listening to ReachMD, the Channel for Medical Professionals. Welcome to a special segment - Focus On Global Medicine. I am your host, Dr. Mark Nolan Hill, Professor of Surgery and Practicing General Surgeon and our guest is Dr. Arthur Matas, Professor of Surgery and Director of the Renal Transplant Service at the University of Minnesota Medical School.

DR. MARK NOLAN HILL:

Welcome Dr. Matas.

DR. ARTHUR MATAS:

Thank you.

DR. MARK NOLAN HILL:

Dr. Matas, of patients who wait 5 years for a kidney, I believe only about 35% is the survival rate and others who wait frequently accumulate comorbidities while waiting, how frustrating is this?

DR. ARTHUR MATAS:

I think it is a huge problem. The survival on dialysis for diabetic patient in this country is 30% at 5 years and so to not have organs for these patients when you know it is both life saving and a quality of life improving operation is frustrating and it is particularly frustrating because the situation is getting worse.

DR. MARK NOLAN HILL:

Well 1 avenue which you expressed support for, involves financial incentives. What do you mean by that?

DR. ARTHUR MATAS:

We have thought about trying a policy or change in policy to try and remove some of the disincentives from donating and even considering providing incentives for people to proceed with donation, some people don't donate because they don't have health insurance and obviously as you know there is over 45 million people in this country without health insurance, some people don't donate because they may change jobs and they are worried they will lose insurance, some people don't donate because they can't afford being off work for 6 weeks and losing the income. We could eliminate all those disincentives and perhaps increase donation and perhaps again increase it further by providing some small incentives.

DR. MARK NOLAN HILL:

But who would incentives come from?

DR. ARTHUR MATAS:

In the system that I proposed, it would from the government. The government pays for dialysis and transplantation in this country and dialysis is extraordinarily more costly than transplantation, so the government could actually provide these incentives or removal of disincentive without increasing the cost of health care.

DR. MARK NOLAN HILL:

Just generally what would be an amount that would be a reasonable financial incentive?

DR. ARTHUR MATAS:

It's hard to know what would be a reasonable financial incentive, but we have done a model of outcomes and what the cost would be to the insurer, in this case the government or a private insurance

company and concluded that it would save the payer about $100,000 per transplant over a 20-year model. So that would give you about $100,000 per transplant to pay for the infrastructure involved in a program like this plus the incentives for the donor, and the incentives could you know be a 1-year term life insurance policy which has a specific price, access to Medicare or the VA system which has a specific value, a college tuition benefit, tax benefit, any number of things.

DR. MARK NOLAN HILL:

Now when you have presented this model to other physicians, administrators, insurance companies, what is generally their responses?

DR. ARTHUR MATAS:

I think that everybody's first reaction to something like this is that it just doesn't feel right. If it is the first time you have really heard about it or thought about it to actually try and provide incentives for donors to come forward, but when people start thinking about it in a little more detail and realizing that our current altruistic or gifts model system is resulting in patients dying while waiting and others suffering on dialysis. Then, people's reaction changes a little bit and they sort of start thinking about it a little more and favoring it a little bit more.

DR. MARK NOLAN HILL:

Now, I have read that Iran actually has a regulated legal system of remuneration and it is also legal in the Philippine, is that correct?

DR. ARTHUR MATAS:

I think it is very important to state very specifically what were talking about and in the Philippines they

have a market system, really an unregulated system, it is legal, but it is unregulated and in those kinds of situations the donors don't get the care that we expect donors to get, there is no followup, there is no guarantee that the donor gets whatever they have been promised. So I think we need to totally stay away from consideration of market or unregulated systems. The Iranian model is a little bit more complicated, in that that there is a payment from the government, but it also expected that the recipient makes a payment to the donor. So I think it may be a little bit closer to what I am proposing, but it is not something we would want to emulate. What we have proposed to the United States, is a government incentive that is paid directly to the donor, the donor and recipient for all practical purposes should not meet, there should be no opportunity for the donor to ask for anything else from the recipient and the kidney is allocated to the #1 person on the list so that all the recipients on the list have the opportunity to be transplanted.

DR. MARK NOLAN HILL:

Why would Iran be the only country in the world that has a regulated system?

DR. ARTHUR MATAS:

I can't answer the question for sure, what they say is that with the first Iran-Iraq wars that they basically had no dialysis and no transplant and they were trying to find a way to save the lives of the people with renal failure and it was cost effective for them to move towards a system like this because dialysis is so expensive, it is not a country that you to get a lot of information from, so it is hard to sort it out.

DR. MARK NOLAN HILL:

And the altruistic donations what will happen to them if we have this new system?

DR. ARTHUR MATAS:

I think there are 2 possibilities, one is that they will continue because even with this new system, there will still be lots of reasons to have altruistic donation. A recipient may want to know who the donor is or they may get transplanted sooner with an altruistic donor. So there may be lots of reasons to continue, but the reality is altruistic donations go down, but the total number of donations go up that is good. I don't see that as a problem, the results of kidney donation from the stranger down the street is exactly the same as the results of kidney donation from a relative assuming that all the tests and everything are okay.

DR. MARK NOLAN HILL:

Dr. Matas, what about black market troubles, what about people trying to pay exorbitant amounts to get someone's kidney or another organ?

DR. ARTHUR MATAS:

I think all of us who are in support of a regulated system of incentives are totally opposed to black markets and if you think about it, the black markets exist in the current environment of the organ shortage and all the laws against commercialization or sales of organs. So I would argue that if we developed a regulated system and increased number of organs available, it would significantly decrease this black market, remember a big difference between the black market is that it is only going to be available for the rich whereas a regulated system's compensation will allow allocation of the kidneys to everyone.

DR. MARK NOLAN HILL:

You have made a push for some clinical trails to investigate our options here. Could you expand upon these, please?

DR. ARTHUR MATAS:

Well first of all, one needs to change the law to allow any trial of incentives, but once that law is changed, then I have not argued for any specific incentive. I think that different areas of the country ought to be allowed to try whatever policy that they think might work, incentives for living donations, incentives for deceased donations, or any combination of incentives and I think that these trial is ought to be done in a way in which we follow the donors, make sure the donors do okay, and we can see whether organ donation goes up or goes down and we will learn whether or not incentives can really make a difference.

DR. MARK NOLAN HILL:

Are there are any trials to date here in the United States?

DR. ARTHUR MATAS:

No and it would be illegal to do one under the current North American Transplant Act.

DR. MARK NOLAN HILL:

Well Dr. Matas, how are you going to initiate this whole process?

DR. ARTHUR MATAS:

Well, my role is to talk about it and try and convince people that it is a good idea, but the ultimate initiation is going have to come from a change in the law in Congress and our hope is that someone

from the Senate or Congress will initiate this change recognizing the tremendous need for organs.

DR. MARK NOLAN HILL:

It has also been said that diseases, they get much better funding when someone in the legislature has a family member and such who contracts that disease. Do you think that something like that will have to happen?

DR. ARTHUR MATAS:

Well it certainly won't hurt if someone in the legislature has a family member who needs to go on the list for organ donation and understands what that tremendous wait time on the list does in terms of deterioration in health and in quality of life, but my hope is that we can move this forward without something like that happening. It is not something you want to wish for.

DR. MARK NOLAN HILL:

Are there other systems in other countries that we can learn from?

DR. ARTHUR MATAS:

There are no systems, you mentioned the Iranian system, but there are really no systems that were regulated systems of compensations and again the regulated I think is a key word with the appropriate oversight in controls and I think the only way we are going to be able to learn about this is by doing the trials in the United States.

DR. MARK NOLAN HILL:

What if we combined presumed consent with monetary incentives, kind of a hybrid plan, is that something that you might find acceptable?

DR. ARTHUR MATAS:

I will find acceptable anything at works that allows protection of the donor and maintenance of both dignity and respect of the donor. I mean, in our current system donors are heroes and I really believe that we have to in any system we initiate or develop continue to treat the donors as the heroes that they are, but I don't think that our attempts should be limited to any one thing. I think anything that adds a few kidneys to the system or livers or hearts, and again following the respect of the donor etc. as part of it is worth pursuing.

DR. MARK NOLAN HILL:

Now, you of course are a renal transplant surgeon, are other surgeons who transplant livers and hearts and lungs, do they feel similarly as you do?

DR. ARTHUR MATAS:

I think there is a spectrum of how people feel about this, again to some extent it is related to how long people have thought about it, but certainly the American Society of Transplant Surgeons which is my professional organization has shifted to cue over the last few years and I would say that based on a relatively my first informal call and then more recently a more formal call the majority of the members are in favor of trials of incentives. I don't think anyone, there is not a lot of people who would say we should just jump into this and do it, but the majority of people would say we should do trials.

DR. MARK NOLAN HILL:

Now the United States has the best transplant outcomes in the world, is that correct?

DR. ARTHUR MATAS:

Well they are certainly among the best; I can't tell you for sure that they are the best.

DR. MARK NOLAN HILL:

If we can create a working system of some of the things you just talked about, perhaps we can set an example for the rest of world, yes?

DR. ARTHUR MATAS:

That is one of the arguments that we have made because one of the counter arguments to our proposal is that if we make this a legal system in the United States people use an example of how to develop unregulated systems elsewhere and I find that argument kind of silly. It seems to me exactly as you say, if we can develop a model in the United States to show that this increases donation and at the same time, the donors can be protected, followed up and shown to be doing well, then that could service a model for other countries, particularly in the western world. It is hard to image how this could be applied to third world countries, but certainly it could be a model for the western world.

DR. MARK NOLAN HILL:

I want to thank our guest, Dr. Arthur Matas. We have been discussing global lessons towards reducing the organ shortage in the United States.

I am Dr. Mark Nolan Hill and you have been listening to a special segment, Focus on Global Medicine on ReachMD, the Channel for Medical Professionals. Be sure to visit our web site at www.reachmd.com, featuring on-demand pod casts of our entire library and thank you for listening.

Thank you for listening to our special series, Focus on Global Medicine as we celebrate this annual holiday season. Everyone at ReachMD wishes you and your family a happy holiday and a successful New Year.

Free CME on ReachMD is now easier. Link to ReachMD's free custom application for your iPhone at www.reachmd.com.