Medical Xpress

Three ethical ways to increase organ donation in Australia

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Australia's organ donation levels are low by international standards. At least twenty countries achieve better donation rates than Australia's 16.1 donors per million population (DPMP), including Belgium (29.9

DPMP), the United States (25.9), France (25.5) and the United Kingdom (20.8).

The review of Australia's tissue and organ transplantation systems, announced last week, aims to increase organ donation rates by focusing on the role of the national Organ and Tissue Authority, which helps coordinate donation services. However, many of the key policy settings are in the hands of state and territory governments.

It's time to go beyond improving the mechanisms for implementing existing laws, and to consider more fundamental changes to organ procurement in Australia. We previously argued for an opt-out policy on The Conversation. We also need to consider proposals that are frequently sidelined due to supposed moral objections.

1. Changing the veto rules

Currently, a decision to sign up to the Australian Organ Donor Register is largely meaningless. Unless an objection is noted on the register, the decision about whether a deceased's organs will be donated is left to family members. Last year, family refusal prevented 38% of potential donations proceeding (see page 27).

Under current law, there is nothing an individual can do to ensure a relative will not override their wish to donate after their death. But there should be.

Generally, individuals are allowed to decide for themselves what happens to their bodies, or their property, after they lose mental capacity or die. This is part of respecting a person's autonomy. For instance, individuals can make advance care directives that require treatment to be discontinued. Or they can make wills to allocate their property.

The only plausible argument in favour of allowing family members a veto on donation is that it would cause them distress. But distress isn't sufficient to set aside a care directive or will. It should not set aside organ donation either.

The moral case for protecting a decision to donate is bolstered by the fact that up to ten people can benefit by receiving organs or tissue from a single deceased donor.

We legally require autopsies to be conducted in some circumstances, regardless of objections from family members. This is done for good public interest reasons (to ascertain the cause of death). The public interest in upholding donation decisions is at least as strong.

2. Financial incentives

We should also consider trialling the use of incentives to encourage individuals to sign up as potential donors, or for family members to donate on behalf of a deceased relative where they did not express a preference.

In Australia, kidneys are the most sought-after organ for transplantation. The ongoing cost of dialysis for someone with renal failure is estimated to be between around A$53,000 to A$79,000 per year. As a result, it could make economic sense for governments to offer incentives of quite significant financial value in some cases.

One proposal is for governments to contribute to the funeral expenses of donors. The Nuffield Council on Bioethics has proposed that the UK's National Health Service adopt this approach. This would be similar to the free funeral or cremation services that universities regularly offer in return for the donation of cadavers. The likely effectiveness of such an approach is supported by the latest empirical evidence on financial

incentives for blood donation.

The federal government has already begun to trial such incentives, after it introduced financial assistance in 2013 for those who take time off work to make live organ donations.

An extension of this approach could be to provide a small measure of financial assistance to those who sign up as candidate donors (preferably without the possibility of family veto). This could be a small reduction in tax, for instance. The amount would probably be nominal (because only a small number of deceased individuals are eligible donors), but it would recognise the good that potential donors contribute, and may work to increase the number of such individuals.

Although it is regularly objected that paying people for organs involves exploitation, the objection loses its force in the context of deceased donations. Exploitation involves harm – but offering people something in return for organs which can no longer benefit them (after their death), does them no harm. They (or their families) would simply receive something instead of nothing, as they currently do.

3. Non-financial incentives

An example of a non-financial incentive to encourage donation is prioritisation. Under the current system, being unwilling to contribute does not lessen your chances of receiving a transplant. This encourages free riding.

Those who are willing to be donors should receive some priority in the receipt of organs, should they ever need one. Such an approach has been adopted in the US (for those who have been living donors), and for would-be donors in Singapore and Israel.

Israel was the most recent country to adopt such a policy, which came into effect in April 2012. There is preliminary evidence to suggest the change has increased donation rates there (and the number of willing donors).

It might be objected that this would unfairly penalise those who object to donation. However, if the incentive structure worked to increase the supply of organs, then even those who objected to donation may have a better chance of receiving an organ. A rising tide could lift all boats.

Regardless, individuals should wear the costs of their beliefs, and it is not fair to impose those costs on others. The incentive scheme should be considered as analogous to insurance. If you pay the premium, you can receive the benefit.

Saving lives

As the population ages, and as diseases such as type 2 diabetes become more prevalent, we desperately need to consider new measures to increase the supply of transplantable organs.

Crucially, we need to make changes to the framework in which people make their choices. As British philosopher Bertrand Russell wrote, "the desired result is not likely to be achieved by moral exhortation," but rather, by making it "to each person's interest to act as the general interest demands."

Spurious moral arguments have ruled out many promising options for the procurement of organs. For this reason, the philosophical scalpel, as much as the medical one, is necessary to save lives.

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