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From: Richard Darling, DDS, President & CEO: FAIR Foundation
Sent: Sunday, April 20, 2008 11:18 AM
To: PC, DB & Gov't incentives OD Template Letter Contact List
Cc: Tom Mone
Subject: Tom Mone's public support for incentivizing kidney donation

Thomas Mone is Chief Executive Officer of OneLegacy, the largest non-profit organ procurement organization in the USA serving L.A. and six neighboring counties. He is also President of the Association of Organ Procurement Organizations, and is a director of the United Network for Organ Sharing.

I am extremely pleased to send the article below by Tom (written on behalf of himself and not the expressed views of any of the organizations he serves) that was published in the Los Angeles Business Journal. In it he states,

["Well aware of all of the questions and issues involved in this matter, most of us in the field of organ donation and transplantation are reluctant to call for a nationwide effort to pay for kidney donation. \(However,\) I believe the best way to proceed would be with small-scale pilot programs that offer donors lifetime insurance coverage and see what the effect would be.....If such programs do not indicate that there would be any negative effect on the national organ donation process, then the practice of paying for kidneys through insurance coverage and similar non-cash incentives should be allowed."](#)

Tom states in an email to me that he "wrote this commentary in order to offer common ground in the ongoing debate between those vigorously proposing a 'free market' solution and those doggedly defending purely altruistic donation."

I met with Tom and we discussed various aspects of his recommendation to be considered in the future, including the following:

- Providing this benefit to living donors and to a deceased donor family member; recognizing that it may be more difficult to address NOTA limitations with deceased donor cases since insurance may be seen as a tangible consideration in those cases versus a protection against future complications in the case of living donors.
- The pros and cons of making the pilot project national from the onset, desirable from my perspective to negate the possibility of one State's residents being angered by their not being offered the same incentive; undesirable in Tom's view that pilot projects should be small scale to provide experience and data for assessment of net positive or negative effects of the idea.
- Providing a health insurance policy is much more politically palatable and ethically defensible than including cash payments into the incentive. In addition, navigating NOTA, as was done with paired donations, may be more likely with the incentive limited to health insurance coverage.
- Limiting the health insurance benefit to a set term, perhaps 20 years, may be necessary to ensure the benefit is not excessive. Or, providing the insurance benefit as a secondary coverage, which would limit the number of years of coverage needed and total dollar cost to the federal government (assuming the coverage was a form of Medicare).

- Additionally, subsidization of lost wages for living donors should be considered, as is now being instituted in Canada as seen here: [http://fairfoundation.org/organdonation/LKD\\$.pdf](http://fairfoundation.org/organdonation/LKD$.pdf). Also, all costs of surgery, etc. should be covered, i.e. there should not be any out of pocket expenses to the donor or his/her family. It would be feasible for OPOs or transplant centers to provide this lost wage offset, though the cost would ultimately have to be passed on to insurers or Medicare and this would require substantial political support.

It is my opinion that with over 40 million US citizens without health insurance coverage and millions of others potentially not covered for complications that might result from living donation, at risk, Tom's laudable recommendation, if applied nationally, would eliminate the 74,000 kidney waiting list within 5-10 years. In addition, it would provide kidneys for all new renal patients as well as those who are not listed due to the 5-6 year waiting list but could be transplanted if kidneys were available.

Richard Darling, DDS

Founder: FAIR Foundation with its [template letter](#) by many MD's & OD advocates in support of incentivizing kidney donations

Financial Incentives Might Expand Organ Donor Pool

By - 3/31/2008

Los Angeles Business Journal Staff

By THOMAS MONE

In Los Angeles County and six neighboring counties, more than 6,000 people await donated kidneys to replace their own failing organs. Nationally, the waiting list for those precious organs has nearly 75,000 names on it. Unfortunately, only a little more than one-fourth of that number will have their needs met. The others face an uncertain future that for many will end in death.

This doesn't have to happen. There are literally millions of people in this country who could make up that shortfall of 56,000 kidneys. Tests have long shown that healthy human beings can function normally with just one of the two kidneys they were born with. So how can more of those healthy people be motivated to give up a kidney?

At present, the satisfaction of helping others to survive is the only reward that exists for organ donation in the United States. But living donors are providing only about 6,000 kidneys a year (the rest come from deceased donors). So it's quite apparent that a stronger incentive is needed.

It isn't difficult to identify a stronger incentive. If potential donors were offered cold, hard cash and made aware that they can lead a normal life with a single kidney, there's little doubt that the donation rate would be much higher.

The United States wouldn't be breaking any new ground if it started authorizing the purchase of kidneys. In at least three countries – Iran, Pakistan and the Philippines – paying cash for kidneys has been a standard practice for many years.

But to do so in this country would raise a number of concerns.

How much should be paid for a kidney – and who should pay it? The recipient, or the government, via Medicare? A payment of \$5,000 would probably be sufficient to attract more than enough donors to erase the current shortage of 45,000 kidneys a year.

Or, instead of a fixed amount for the kidney itself, should the payment also cover expenses for hospitalization and recovery? And what about wages lost by the donor during the donation and recovery period? Should donors get guaranteed insurance coverage rather than cash?

But these technical questions pale in comparison to other issues that would be involved in paying for kidney donations.

A major concern is whether this country would be creating an organ-growing class. In Iran, according to a recent study, 81 percent of those who were paid for kidney donations are illiterate. They use the money they make from selling their kidneys to eke out a living.

In India, the literacy rate among kidney donors is a little higher but most are very poor. A recently published study of kidney donation in that country found that although donors might receive \$5,000 to \$10,000 for a kidney, little if any of that sum was used to improve their lot or that of their families; 70 percent to 80 percent went to repay debts.

Medical underclass?

This is not to suggest that paying for kidneys in America would create a new layer of economic stratification. Few in this country are as poor as in the countries that allow and encourage kidney donation. But there is little doubt that if payment for donation were permitted in this country, a huge percentage of the donors would be poor people. And if the recipients of kidneys, and not the government, were paying for them, the practice would be viewed by many Americans as allowing the rich to take advantage of the poor.

Such a perception would indeed be unfortunate. But it would not be the worst-case scenario. It is possible that potential donors of other organs – livers, hearts, lungs, pancreases and small intestines – would react negatively upon learning that people were being paid for their kidneys. It might be that fewer drivers would sign up as potential donors when getting or renewing their licenses because they assumed that paid donors were filling the need.

Well aware of all of the questions and issues involved in this matter, most of us in the field of organ donation and transplantation are reluctant to call for a nationwide effort to pay for kidney donation. I believe the best way to proceed would be with small-scale pilot programs that offer donors lifetime insurance coverage and see what the effect would be.

If such programs do not indicate that there would be any negative effect on the national organ donation process, then the practice of paying for kidneys through insurance coverage and similar non-cash incentives should be allowed.

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