



Organ Transplant Expert Answers Our Viewers Questions About Kidney Sales

Answers to Inquiries About the Controversial Idea of Selling Kidneys

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Dr. Arthur Matas is a professor of surgery and director of the Renal Transplant Program at the University of Minnesota. Matas is also a former president of the American Society of Transplant Surgeons.

You submitted your questions about kidney sales. Read Matas' answers below:

Question: How can I participate in kidney sales? *Shelly, Harrisburg, Pa.*

Matas:

Currently, compensation for donation is against the law. Congress would have to change the law before we could establish a program like this. It is possible that there would not be a complete change, so that programs of compensation could be started everywhere. But, at first, there might be a change in the law so that a trial could be done.

Question:

Would you have to have led a very healthy lifestyle to qualify to donate, or sell, a kidney? How would living with one kidney effect my quality of life? *Suzanne, Ramsey, Minn.*

Matas:

The major tests that one has to undergo to be a donor are blood and X-ray tests. The prospective donor would also have to have a complete physical and psychological evaluation. The tests are designed to make sure that the prospective donor has two good kidneys, is healthy enough to tolerate the operation, and has no diseases that would affect the kidney or be transmitted with the transplant.

The major risk to the donor is the surgery itself. If all goes well, the recovery time is about six weeks and after that there should no impact on lifestyle. Donors can return to doing anything that they were doing before donation. When we have done quality-of-life studies in donors, we find that, on average, donors have a better quality of life than the age-matched general population.

Question:

Is there a particular age at which a healthy person's kidney would no longer be considered as viable for using in a transplant? *Barbara, Newport Beach, Calif.*

Matas:

There is no absolute age cutoff at which we would turn a donor down. But we also have to worry about the risk of the surgery to the donor. As one gets older the risks are higher. We have done donor operations on donors in their late 60s and early 70s.

Question:

What about people living with HIV or other diseases which can be spread through blood? Are they eligible to donate to other people who have the same disease? *Mark, Atlanta*

Matas:

In general, people living with HIV or other similar diseases cannot give kidneys to others with the same disease. Part of the concern is that there are many different types of the same viruses. The kidney may transmit a different virus type and make the recipient sicker.

Question: Who will pay the \$60-70,000 that my kidney is worth? The government or the insurance company? *Patti, Austin, Texas*

Matas:

If the system were set up, it would be the recipient's insurance or the government that would provide the donor compensation. Currently, private insurance or the government (Medicare) pays for dialysis, and dialysis is much more expensive than transplantation. Thus, in the long run it would be cost-saving or cost-neutral to pay the donor. In fact, for the altruistic donations that we do today, the recipient's insurance company (or Medicare) pays for all of the medical costs of the donor evaluation and the donor surgery.

It may be that the actual "payment" is less than \$60,000. I believe that there should be a number of choices so the donor receives something of value to them. For example, some might prefer direct payment, others a tax deduction. Some may prefer lifetime health insurance as part of the package; others who already have health insurance might prefer something else.

Question: What kind of short- and long-term risks and medical care is involved after you give your kidney? *Campbell, E-Town, Ky.*

Matas:

The donor operation has risks, just like any other operation. Our biggest concern is the risk of dying which, for this operation, has been calculated at 3 in 10,000. In addition, the donor is at risk for any of the complications that can occur with any major operation such as bleeding requiring reoperation, infection requiring reoperation, infection or hernia at the site of the cut, bowel obstruction, pneumonia, bladder infection, blood clots in the legs (and many more). However, the risk of each of these complications is low.

Studies to date suggest that donors are not at increased long-term risk (but we are continuing to do additional long-term studies). Just like people with 2 kidneys, donors can get kidney disease. But it does not appear that donors have any increased risk of getting kidney disease or kidney failure.

Question:

Would the insurance companies be responsible for allocating organs to patients in need, or will the harvested organs be available only for patients who are able to pay for them? *Mayla, Valencia, Calif.*

Matas:

If this system were established, anyone on the waiting list would be eligible. The patient would not be paying for the kidneys; the government or insurance companies (who currently pay for dialysis) would be the payors. The kidneys would be allocated in the same way that we allocate kidneys from deceased donors today, so that everyone would have a chance to be transplanted.

Question:

It seems more cost-effective to stay on dialysis. Dialysis costs are covered by insurance, while transplant anti-rejection drugs are covered for only one year. Is this going to change anytime soon? *Linn, Lagrange, Ohio*

Matas:

This is a different issue (although related). For insurance companies or the government, a transplant is cost-effective compared to dialysis. If one looks at transplant costs (including the costs of the medications and follow-up care) over 10 years, and compares those to dialysis costs over 10 years, transplantation is significantly cheaper.

Yet the government (Medicare) and insurance companies will pay for dialysis indefinitely. But if the patient has a transplant, Medicare (the government) will only pay for three years of the (expensive) anti-rejection medications (most private insurance companies will pay for the medications for as long as the transplant is working). So for an individual patient it may be cost effective to stay on dialysis (even though length of live would be longer, and quality

of life better, with a transplant). (Older patients, who have long-term Medicare, receive long-term payment for the medications.)

Most of us in transplantation believe that Medicare should pay for the anti-rejection drugs for as long as the transplant is functioning.

Question:

Someone recently advised me that there is a simple solution to the kidney shortage: Change the law so when anyone who dies in a hospital or under other suitable circumstances, all their organs are harvested for donation, without charge. This simple change in the law would make far more organs of all types available than are needed. What do you think? *Stockton, Pacific Palisades, Calif.*

Matas:

It has been determined that if every potential donor in the United States became a donor, there would still be a tremendous shortage of kidneys. I agree that we should do everything possible to increase deceased, as well as living, donation. But the reality is that, to date, every proposed solution to this problem would not (in total) provide a sufficient number of kidneys for all of our patients. In contrast, compensation for living donation has the potential to provide all of the needed kidneys.

Question:

What do you think about paying an individual tax credits or cash when family members donate organs upon his death? Each state could create organ donation registry that could be quickly accessed in the event of death. A registry could solve resolve some of the legal problems and delays associate with organ donation at death, as well as quick identification of health and blood compatibility issues. *Stephen, San Francisco*

Matas:

The answer to the comment about tax credits for deceased donation is really the same as the answer to the previous question. I see nothing wrong with this idea (there are some practical issues e.g., if there are multiple family members, who gets the tax credits; and for families that do not pay taxes, tax credits are not an incentive), but the major concern is that, even if successful, this approach would not solve the problem.

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