

# Incentivised Donation as a Solution to the Kidney Shortage

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## **Abstract**

There is a shortage of kidney donations in the United Kingdom, which leads to the deaths of 300 people each year. I propose an incentivised donation system to increase the supply of kidneys from anonymous donors. I argue that non-monetary donor incentives can strengthen the existing motivations for giving, and persuade sufficient numbers of donors in order to alleviate the transplant shortfall. Importantly, an incentivised donation system is preferable to a market solution and avoids the harmful effects that can accompany cash payments for kidneys.

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## **I. Introduction**

The shortage of kidney donations in the United Kingdom leads to the deaths of 300 people each year (GiveAKidney, 2015), despite the many millions of potential donors who have a spare kidney. One prominent solution to this problem is to create some form of a market in kidneys. In this essay I propose an alternative which is an incentivised donation system. Such a system aims at increasing the supply of kidneys from anonymous donors by way of non-monetary *donor incentives* that strengthen the existing motivations for anonymous giv-

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ing. Importantly, an incentivised donation system ought to alleviate the kidney shortage without the egregious effects that a market may have.

I begin this essay by considering the motives for anonymous donations and explain why these are weak in the case of kidney donation. I then go on to describe how non-monetary *donor incentives* would work and how they could alleviate the kidney supply shortfall. Next, I consider why an incentivised donation system is preferable to a market solution. Finally, I defend my proposal against potential objections.

## **II. Motives for Anonymous Donating**

A donation seemingly makes the donor worse off and the recipient better off. This is something of a puzzle since many theories of behaviour posit that people always act in their own self-interest. In this section I explore two categories of reasons for the general act of donating: moral duty and personal psychological motivation, and explain why each of these are weak when it comes to kidney donation specifically.

### *Donating out of a sense of moral duty*

Whether there is in fact a moral duty to donate is a subject of much debate. However, for these purposes I will assume that a moral duty to donate exists when a donor's particular donation prevents a very serious harm to the recipient at a very low cost to the donor.<sup>1</sup> For example, if I happen to have many bottles of water with me in my car and I drive past someone who I know has been without water for two days and is close to dying from thirst, then I would have a moral duty to give this person one of my water bottles. I would not, however, have a moral duty to give this bottle if it was my last one or if this person was not in great need.

The question is then whether such a moral duty to donate extends to the case of a kidney donation. Certainly a kidney donor prevents the very serious harm of death to the transplantee. And since the health risks from living with one

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<sup>1</sup> Singer (2010, p.15) has a similar formulation.

kidney (rather than two) are statistically low, it might be argued that the costs to the donor are low (see Kelly and Morrison, 2014). However, there are three important factors that increase the cost to the donor considerably. Firstly, people tend to place a high value on having both of their own kidneys. Secondly, people tend to find the prospect of a transplant operation and of living with one kidney psychologically distressing. Thirdly, people are often highly risk averse when it comes to the outcomes of an operation or the risk of living with only one kidney in later life. As a result, the donation of a kidney is a sacrifice and comes at a significant cost to the donor. Consequently, I consider that there is no moral duty to donate a kidney whilst living.

When deceased, however, the cost of donating falls (possibly to zero). It would seem, then, that after ones death there is a moral duty to give ones kidney. Unfortunately, this is like giving rags to a charity shop since most people die when they are old and with their kidney effectively used up. Even countries with high deceased donor rates, such as Spain and Austria, still have transplant shortages (The Economist, 2008).

*Donating because of personal psychological motivations*

In the absence of moral duty, people still make donations to strangers. One can propose three possible personal psychological motives. One motive would be *empathy*, meaning that the donor cares directly about the recipient. Even if the recipient is unknown to them, the donor might care generally about other people. Another motive would be *pure altruism*, meaning that the giver genuinely wants to do some good and considers that the best way to do good is by making donations. A final reason would be *psychological egoism*, meaning that the donor gives in order to increase his own wellbeing, either from the praise he receives from other people or for the internal satisfaction of having done something good. Importantly, for the *psychological egoist*, his wellbeing comes from his image (or self-image) as an altruist. It is therefore necessary that there is a cost to him in material terms he loses something of material value so that he appears (or believes himself) to have made a sacrifice, even though in actual fact making this material sacrifice leaves him better off.

It is plausible that if donors are motivated for personal psychological reasons, there is a mixture of these three motives at play (with different weights for

different individuals). A person is therefore likely to make a gift to a stranger if the cost to them personally is outweighed by the combination of how much they value benefitting the recipient (empathy), doing good (pure altruism), or receiving praise and an internal satisfaction (psychological egoism).

This weighing up of the costs of giving compared with the various psychological benefits makes it apparent why anonymous kidney donation is currently unappealing. As discussed earlier, the cost of donating a kidney is high because of the value of having both kidneys, the burden of the operation and the high degree of risk aversion towards the dangers of living with one kidney. What is additionally important here is that the various psychological benefits are also low. The *anonymity* means that the empathy motive is probably weak, since people tend to care more about people they know well and less about unspecific, general people. The *lack of recognition* from donating a kidney is a problem for the psychological egoist. He might tell his friends about it or post on a website, but his gift is not praised in any meaningful way. Lastly, *bystander effects* further dissuade empathisers and pure altruists: there are many healthy potential donors for every kidney sufferer, reducing the need for an individual to give their particular kidney. A potential donor might reason that their kidney is not needed because someone else will give in their place.

Given these factors, it is no surprise that anonymous kidney donations are low. In 2014 there were only 118 anonymous donors in the United Kingdom (GiveAKidney, 2015). This is from a pool of likely millions of potential living donors who have both of their kidneys.<sup>2</sup>

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<sup>2</sup> Very rough calculations based on the number of non-elderly adults in the United Kingdom with no health complications easily reaches into the millions. There will, of course, be fewer people if the kidney required is of a rare blood and tissue type in order to ensure a viable match between donor and recipient. However, the ratio of the number of potential donors per recipient is likely to be similar across different blood and tissue types (in all but extremely rare cases), such that my general argument that there is a substantial potential donor pool still holds.

### III. An Incentivised Donor System

In light of this fact, I propose that *donor incentives* could increase supply. Such incentives have two distinguishing features:

They are *non-monetary* and *non-exchangeable* for money. This means that donors do not benefit in an explicitly material way, which is important for maintaining the appearance of sacrifice that is needed for the psychological egoist.

They are *non-vital* to having an adequate standard of living. Importantly, this (together with the first condition) means that donors are not motivated unethically by vulnerability or desperation.

*Donor incentives* could take the form of public honours, priority healthcare, in-kind vouchers or donation multipliers. Such incentives are commonplace in society: public honours range from a sticker for a charity-box donation, to plaques, OBEs, and other award ceremonies; and in-kind vouchers are provided through the Recognition Card to war veterans. I am not aware of donation multipliers being used but they would take the form of the State giving the money saved from a transplant (in avoiding future dialysis costs) to a donors charity or social cause of choice. This is a substantial sum, estimated at c.241,000 per transplant, providing a significant motivation (Kidney, 2015).

*Donor incentives* encourage the psychological motivations for giving. Donation multipliers strengthen peoples empathetic and altruistic motives by helping more people and doing more good. Honours provide the psychological egoist with the recognition he desires. Vouchers act in a similar way, by providing a reward or other form of recognition to the egoist, whilst at the same time providing other valuable benefits. Clearly, the vouchers need to be carefully constructed to meet the two stated conditions. Whilst they will provide a benefit, this should not be so large or material that it removes the appearance of sacrifice. They should also be non-exchangeable and unrelated to the basic costs of living. Examples might include enhanced insurance, supplementary education, or special discounts as per the veterans Recognition Card. Priority healthcare lowers the

donors costs by reducing future health risks.<sup>3</sup> Lastly, the bystander effect is mitigated (although not removed) since the recognition of a donors contribution gives them a particular reason to help, instead of relying on others to do so in their place.

Collectively, incentives tilt the balance so that the benefits are higher and the costs lower, which ought to provide an extra push towards donating. For people who have already considered giving a kidney, incentives provide further reason to do so and should motivate some non-donors to become donors. How responsive the supply of kidneys will be to *donor incentives* is an empirical question, but there is good reason to be optimistic about this. There are numerous examples of such incentives motivating altruistic acts the ceremonies and honours awarded to veterans is one example. There is also related evidence from studies on blood donation that supply increases with non-monetary rewards (Costa-i-Font, Jofre-Bonet and Yen, 2012).

As an aside, although *donor incentives* increase the benefits and reduce the costs of donating, there is still no moral duty to donate. This is because the sacrifice of giving a kidney remains significant in and of itself and this is the important factor in assessing the moral duty. Although *donor incentives* mean that some people will consider that the overall cost of donating is reduced, it cannot be assumed that the cost has been reduced sufficiently for everyone. Many people will continue to consider giving a kidney is a significant sacrifice, no matter what the compensatory incentives. Since a moral duty needs to apply to everyone universally, it seems that the *donor incentives* do not result in there being a moral duty to donate.

#### IV. Evaluation Against the Market

An incentivised donor system ought to increase supply without any harmful effects. At the very least, *donor incentives* are an improvement on the current unincentivised donor system. However, an improvement is a poor achievement if there exists a better alternative arrangement. The main alternative is a regu-

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<sup>3</sup> Priority would need to be balanced against other healthcare triage principles, such as urgency of need.

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lated market, for which two main arguments are often made: a market respects the rights of self-ownership and autonomy by allowing people to sell their body parts; and a market has the beneficial consequence of increasing supply and saving lives (Erin and Harris, 2003).

I think that two propositions jointly favour an incentivised donor system over a market system: firstly, a market is likely to have harmful consequences and an incentivised donor system will not. Secondly, an incentivised donor system can eliminate the shortage whilst a market might not. I consider each of these in turn.

*Proposition 1: A market is likely to have harmful consequences, whereas an incentivised donor system will not.*

Since donating a kidney is a significant sacrifice, at low prices it is likely that only those who are financially desperate will sell their kidney. This is of moral concern because if people are forced to sell their kidney to make ends meet, their ability to make a rational choice is impaired or their bargaining power is so weakened that they are unfairly remunerated.<sup>4</sup> In order to avoid this risk, the price would need to be suitably high to incentivise sellers who are in a comfortable financial position. Proposals of 10,000 are, to my mind, inadequate to avoid this risk.<sup>5</sup> It is therefore likely that many of the sellers would be financially desperate and harmfully affected. By contrast, the conditions imposed on donor incentives avoid these harmful effects.

These harmful effects partially undermine the argument that a market respects the right to sell a kidney. This is the case if one is a pluralist, balancing the impact on rights against the consequences for wellbeing, or if the right is itself an instrument to achieve optimal consequences. (Clearly, the right still stands if it has separate, deontological foundations).

*Proposition 2: An incentivised donor system can eliminate the shortage whilst a market might not.*

One of the striking features of relying on anonymous donors is that their numbers

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<sup>4</sup> There is evidence of these harmful effects from sellers in India who subsequently regret their decision (Satz, 2010, p.196).

<sup>5</sup> Becker & Elias (2007) propose a price of \$15,000/£10,000.

are vast (many millions) when compared to the 300 people who die annually on the kidney waiting list. Moreover, anonymous donors already exist, and their numbers are increasing each year. If 118 people already gave a kidney anonymously last year, it is plausible that there are more potential donors whose decision not to donate was marginal and could be persuaded to donate.

Importantly, *donor incentives* strengthen donation motives whereas a markets cash payments can crowd these out and reduce overall supply. Crowding out can occur when payments for previously gifted goods (be it blood, or kidneys) lead to a reduction in overall supply (Titmuss, 1970). This might occur because the psychological egoist is seen to benefit monetarily and no longer receives the praise or internal satisfaction that they desired. There is currently a debate about the likelihood and severity of crowding out, but it seems reasonable to me to assume for now that there will be some crowding out (or that there is a high probability of crowding out) if a market in kidneys is introduced.

By contrast, *donor incentives* do not alter the psychological egoists rewards in this way but provide a reason to give, as well as strengthening the motives for altruists and empathisers. The public honours and donation multipliers are clearly very different to market incentives and provide a further reason to give. In-kind vouchers have some similarities to cash payments, which might make them vulnerable to crowding out effects, but I think it is possible to construct vouchers so that they are not valued in the same way as cash payments (which are a material benefit), but rather as rewards for doing something good. Indeed, there is recent empirical evidence to support this argument. Costa-i-Font, Jofre-Bonet and Yen (2012) find that field studies of non-monetary rewards increase the supply of blood. They have also surveyed attitudes regarding donating versus selling blood. A high proportion (68%) thinks that donations ought to be rewarded non-monetarily. By contrast, the majority (83%) thinks that blood should not be sold and that the proportion of people willing to sell their blood *decreases* as the price increases. This suggests that non-cash incentives can increase supply and do have a different effect to cash payments. A separate study would be required on kidneys, but it is plausible to assume that attitudes to kidney donation are similar to those towards blood.

It is therefore reasonable to assume that these two propositions hold and an

incentivised donor system is preferable to the market.

## V. Objections

Two possible objections might be raised:

*Incentivising donors undermines the intrinsic value of human life*

One complaint might be that incentives objectify and commodify kidneys. This undermines the intrinsic value of human life and treats people (and their kidneys) as means rather than ends.

My response is twofold. Firstly, a person does not donate solely for the incentive their kidney is not a commodity that is exchanged for benefits. Rather the incentives strengthen existing motives and tilt the balance in favour of donating. Secondly, to the extent that the incentives are viewed as rewards, people are not rewarded for the object of their kidney per se, but for the generous act of donating.

*If the kidney price is set high enough, a market can deliver supply without harmful effects*

A further complaint might be that I have unfairly characterized the limitations of the market by using a low kidney price. At a higher kidney price, many people would be incentivised to sell without any harmful consequences and the numbers would be so large as to outweigh any crowding out effects. Indeed, all kidneys might be provided through a market and the market could be regulated so as to protect the most vulnerable. Moreover, this properly respects the rights to self-ownership that people hold over their body.

I think this objection may well be correct in that a high market price can clear the market without harmful effects on the sellers. However, the price is likely to be very high and very costly, far more so than the *donor incentives* which are relatively low in cost. If the costs are funded by the State (as seems reasonable), then this imposes a much higher tax burden on individuals than *donor incentives*. Moreover, although it respects peoples right to self-ownership

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and sale of their kidneys, the use of the market may crowd out the benevolent and altruistic motives of anonymous donors. If, as Singer (1973) has argued, altruism is like a muscle that needs to be exercised to be used, then weakening this sentiment will have wider, knock-on effects by reducing the prevalence of altruism in society more generally. Even if a high price means that there are no harmful effects on individual kidney sellers, a market might have a harmful effect on society through the erosion of the altruistic spirit.

## **VI. Conclusion**

Anonymous donors are the largest category of potential donors but they are often seen as the hardest people to persuade to give a kidney. I have argued that they can be incentivised by appealing to their individual motivations. It is plausible that with the right incentives, donors can be persuaded in sufficient numbers to alleviate the transplant shortfall. Importantly, if this is the case, then it is a preferable solution to the market and avoids the harmful effects that many fear from cash payments for kidneys.

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