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Committee on Social Affairs, Health and Sustainable Development

Global Kidney Exchange concept

Background

On 10 April 2018, the European Committee on Organ Transplantation (CD-P-TO) adopted a position statement on the Global Kidney Exchange concept, with the support of the Committee on Bioethics (DH-BIO). The two Committees stressed that this new concept raised ethical and legal issues and called upon Council of Europe member states not to engage in Global Kidney Exchange programmes involving the inclusion of "financially incompatible" donor-recipient pairs (see Appendix).

On 26 June 2018, Ms Marta López Fraga, Secretary to the CD-P-TO, presented this position statement to the members of the Sub-Committee on Public Health and Sustainable Development. Following an exchange of views, the Sub-Committee agreed to consider a draft statement on the Global Kidney Exchange concept at its next meeting, with a view to its adoption by the plenary Committee.

Having in mind the Parliamentary Assembly recommendations and resolutions on the fight against trafficking in human organs as well as the declaration of the Committee on Social Affairs, Health and Sustainable Development on "Prohibition of any form of commercialisation of human organs" adopted on 24 June 2014, the Sub-Committee is invited to consider the draft declaration below and invite the plenary Committee to adopt it, with a view to joining its voice to that of the CD-P-TO and DH-BIO.

Declaration adopted by the Committee on 17 September 2018

The Committee on Social Affairs, Health and Sustainable Development of the Parliamentary Assembly of the Council of Europe shares the concerns expressed by the European Committee on Organ Transplantation and the Council of Europe Committee on Bioethics with regard to the Global Kidney Exchange concept.[1]

According to this new concept, potential living donor-recipient pairs from low- and middle-income countries who cannot afford the transplant procedure in their health-care system would be offered travel to high-income countries. There, the recipient would be given access to a kidney transplant, provided that their donor is able to facilitate a chain of transplants in patients from that high-income country.

The Committee recalls that the human body and its parts shall not, as such, give rise to financial gain. This fundamental principle is asserted in the Council of Europe's Convention on Human Rights and Biomedicine and in its Additional Protocol concerning Transplantation of Organs and Tissues of Human Origin.[2] Accordingly, human organs must not be bought or sold or give rise to financial gain or comparable advantages for the person from whom they have been removed or for a third party.[3] The Council of Europe Convention against trafficking in human organs establishes as a criminal offence any removal of organs performed in violation of this principle.

[1] Rees MA, Dunn TB, Kuhr CS, Marsh CL, Rogers J, Rees SE, et al. Kidney Exchange to Overcome Financial Barriers to Kidney Transplantation. Am J Transplant 2017; 17(3): 782-790.
[2] See also the European Union Charter of Fundamental Rights.
[3] See also World Health Organization's Guiding Principles on Human Cell, Tissue and Organ Transplantation.

The Committee notes that the Global Kidney Exchange concept provides for a payment in kind for patients in low- and middle-income countries - in the form of surgery and medical treatment - in exchange for making a kidney available to a patient in a high-income country. The Committee notes that this may amount to a violation of the principle of non-commercialisation. It also notes that such a concept is likely to take unfair advantage of the poorest and most vulnerable patients and could lead to their exploitation.

The Committee therefore calls on the Council of Europe member states and their health authorities not to engage in the Global Kidney Exchange concept as currently defined, and hence not to consider the inclusion of “financially incompatible” donor-recipient pairs in any kidney exchange programme. The Committee calls on member States to instead support the development of equitable kidney paired exchange programmes that do not exploit financial inequalities between pairs (or countries).

Appendix

Statement on the Global Kidney Exchange concept adopted by CD-P-TO, with the support of DH-BIO

In view of the large deficit of kidneys for transplantation compared with demand, many countries are also facilitating transplants from living donors to complement the supply of organs made available from deceased donor programmes. Living kidney donation, based on universally accepted ethical and professional standards, is therefore assuming increasing importance. Donation between a living donor and their intended recipient was originally only possible in approximately 40% of potential pairings who presented for living donor transplantation since, after initial investigation, pairings could not proceed because of blood group differences or tissue typing antibody barriers, making the pair biologically incompatible. Kidney exchange programmes have emerged as a strategy to overcome these biological incompatibilities between patients in need of a kidney transplant and their genetically or emotionally related living donors. Kidney exchange programmes allow incompatible pairs to swap donors (kidneys) and thus form new compatible donor-recipient pairs. In such schemes each pairing has a symmetrical benefit with no imbalance, either financial or otherwise.

The concept of Global Kidney Exchange (GKE) has been recently proposed as a means to increase the number of pairs that can benefit from kidney exchange programmes in high-income countries (HIC). First, a potential living donor pairing must be identified in a low/middle-income country (LMIC). They may be biologically compatible, but the transplant cannot take place because the pair cannot afford the procedure under their healthcare system. GKE proponents have coined a new term for this – "financial incompatibility". Through the GKE programmes, this pair would travel to the HIC and the recipient would be given access to a transplant, but only provided that their donor was able to facilitate a chain of transplants in patients from that HIC country. The proponents of these GKE programmes suggest the associated costs (pre-donation and pre-transplantation screening, travel, lodging, a lump sum of money for post-transplantation care costs in the LMIC, etc.) could be covered by the cost savings of transplantation as compared with dialysis in the HIC. A fixed lump sum would be made available for the care of the recipient and possibly for any problems the donor could experience once they returned to their country. However, this sum would only last for a limited time and there is no surety that it would be increased should there be any complications or recurrent problems in the pairing.

A pilot GKE programme has started in the United States, using donor-recipient pairs coming from Mexico and the Philippines.

The Council of Europe Committee on Organ Transplantation (CD-P-TO) has carefully studied the GKE proposal and, with the support of the Council of Europe Committee on Bioethics (DH-BIO), concluded that:

1. Access to kidney exchange programmes on the basis of "financial incompatibilities" is inconsistent with the fundamental principle *that "the human body and its parts shall not give rise, as such, to financial gain or comparable advantage*", a principle enshrined in a number of international standards. In this scenario, highly vulnerable patients in LMIC are given access to transplantation services only if they are able to provide a suitable donor kidney to the pool in the HIC, i.e. in exchange for making a kidney available, they receive substantial payment in kind, in the form of the cost of a procedure and medical therapy. This would seem consistent with the definition of trafficking in human organs.

2. GKE involves the commodification or alienation of donor-recipient pairs from LMIC. The selection and acceptance criteria into the programme is not based on humanitarian criteria, but on the usefulness of the donor from the LMIC for a recipient in the HIC, involving the minimum expense for the programme (e.g. financially incompatible pairs from HIC are not accepted in the programme as their post-transplantation costs would be higher than those of pairs in LMIC).

3. GKE programmes entail severe risks of exploitation of individuals in LMIC. Patients in need of a transplant and not able to access it due to financial and other reasons are highly vulnerable. This position may be abused (pressuring them to accept unfavourable offers) or prompt them to exploit their potential donors (who, for many reasons, may be vulnerable themselves). Although it is accepted that the supporters of GKE wish to put in place good governance to prevent abuse of the system, in reality, that guarantee would be difficult if not impossible to deliver, especially as the number of cases increased. In addition, for several reasons, the detection of possible cases of human trafficking for the purpose of organ removal and/or trafficking in human organs may be particularly difficult when evaluating and accepting non-resident living donors.

4. GKE does not guarantee appropriate long-term care of living donors and transplant recipients in LMIC. There is significant disparity in the long-term care provisions for the LMIC pairing and any of the HIC couples. While multiple international legal instruments and scientific recommendations emphasise the need to provide appropriate long-term follow-up of donors after the donation procedure. GKE programmes foresee a lump sum of money to address the medical needs of the recipient from the LMIC once back in their country of origin. It is unclear whether these funds would also be made available to donors in the case of unexpected medical or psychosocial complications. Whatever the case, follow-up care is only guaranteed until this money runs out. This carries severe risks for both the recipient (who will lose the graft in the absence of immunosuppression and appropriate follow-up) and the donor (who may end up suffering from serious medical complications and even losing their remaining kidney). GKE proponents also do not address who will be responsible or finance the treatment if either the donor or the recipient in the LMIC need a (re)transplantation. On the contrary, couples from HIC are guaranteed their long-term follow-up according to the standards of the health system of their HIC.

5. The GKE programmes may undermine local efforts to develop ethically sound transplant programmes in both the LMIC and the HIC, jeopardising their ability to strive for self-sufficiency in transplantation.

Taking all these arguments into consideration, the CD-P-TO, with the support of the DH-BIO and in agreement with many others, recommends member States of the Council of Europe, Health Authorities, hospitals and professionals not to engage in GKE as currently described, and hence not to consider the inclusion of “financially incompatible” donor-recipient pairs in any kidney exchange programme. To assist in addressing barriers to transplantation that arise from the difficulties in finding biologically compatible donors for certain recipients, member States should support the development of equitable kidney paired exchange programmes that do not exploit financial inequalities between pairs (or countries).