

STATEMENT ON THE GLOBAL KIDNEY EXCHANGE CONCEPT

as adopted at the 21st meeting of the Council of Europe European Committee on Organ Transplantation (CD-P-TO) on 10 April 2018 (document PA/PH/TO (18) 3 DEF)

With the support of the Council of Europe Committee on Bioethics (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.¹ Living kidney donation, based on universally accepted ethical and professional standards, is therefore assuming increasing importance.^{2,3,4,5} 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.⁶ 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).⁷ 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.⁷

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.**^{2,3,4,5,8} 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.^{9,10} This would seem consistent with the definition of trafficking in human organs.¹¹
- 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).¹²
- 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.¹³ 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.^{14,15}

* The Committee of Ministers of the Council of Europe held on 9 July 2014 reiterated in the Statement by the Committee of Ministers the prohibition of any form of commercialisation of human organs. The Committee emphasised: “the fundamental importance of that established principle for the protection of human dignity, which must be strictly respected in any regulation and procedures concerning the transplantation of human organs”.

- 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,^{4,5,8,15,16} 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.¹⁷

Taking all these arguments into consideration, the CD-P-TO, with the support of the DH-BIO and in agreement with many others,^{9,10,14} 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).

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