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Policy Analysis

The Ethics of Compensated Living Kidney Donation

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ABSTRACT

Kidney waiting lists continue to grow in nearly every country, and living donors remain the intervention that best relieves them, yet paying donors beyond reimbursement of direct costs is prohibited almost everywhere.

This policy analysis examines the case for and against regulated compensation for living kidney donors, drawing on cost-benefit assessments, empirical donor-welfare data from Iran's decades-old compensation program, and survey evidence on public attitudes toward payment.

It weighs the leading objections -- commodification of the body, coercion of financially vulnerable donors, and the risk that any legal payment scheme undermines the global fight against organ trafficking -- against the mortality and cost burden of the current altruism-only regime.

We argue that the empirical record from Iran demonstrates both the supply-side promise and the donor-protection failures of a poorly scaffolded compensation model, and that recent proposals for publicly administered, fixed, non-negotiable payment paired with independent donor advocacy represent the most defensible way to test compensation without repeating those failures.

We conclude that neither an unregulated organ market nor an indefinite continuation of the status quo is ethically or empirically satisfactory, and that policy attention should shift toward the specific safeguards a compensation system would need.

Keywords: organ donation; kidney transplantation; commodification; organ trafficking; health policy

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INTRODUCTION

Every major transplant system in the world runs on a paradox: kidney failure is treatable, the treatment works best when the organ comes from a living donor,

and yet in nearly every country it remains illegal to pay that donor anything beyond reimbursement of direct costs. Waiting lists lengthen every year, dialysis absorbs an outsized share of health budgets, and

thousands of patients die annually before a compatible organ becomes available, while the one intervention that could most directly close the gap -- offering donors real compensation -- is treated in most jurisdictions as morally off-limits rather than as a policy option to be weighed on its merits [1]. This asymmetry has produced one of bioethics' longest-running live debates, and it has not gone away; if anything, the last decade of empirical work on donor welfare, public attitudes, and the closest real-world analogue -- Iran's regulated compensation program -- has sharpened rather than resolved the disagreement [2].

This review asks a narrower question than "should organs be for sale." Almost no serious participant in the debate defends an unregulated market in which a buyer purchases a kidney directly from whoever will sell one at the lowest price. The live question is whether some regulated, publicly administered system of compensation for living donors -- distinct from a spot market and bounded by oversight, standardized payment, and donor protections -- can be structured to respect donor autonomy and improve donor welfare rather than exploit it. The two poles of the argument are: the case that compensation, done well, expands options for donors and recipients without violating anyone's dignity, and the case that any price on a kidney degrades the meaning of donation, commodifies the body, and predictably concentrates its harms on people already made vulnerable by poverty.

THE CASE FOR REGULATED COMPENSATION

The argument for compensation begins from a fact rarely disputed by either side: unpaid donation has not come close to closing the gap between organ supply and need. In the United States alone, tens of thousands of patients are added to kidney waitlists annually, and a substantial share die or are removed from the list before a transplant becomes available. Proponents of regulated incentive programs argue that a modest, standardized payment -- structured as, say, a tax credit, a lifetime health insurance benefit, or a fixed government stipend rather than a negotiable price -- could meaningfully increase the supply of living donors without requiring donors to negotiate individually with buyers, which is the feature of an unregulated market that most clearly enables exploitation [3]. Under this model, compensation is uniform, paid by a public or quasi-public body rather than the recipient, and donors are still screened, counseled, and followed up exactly as they are today; what changes is only that altruism is no longer the sole permissible motive.

A cost-benefit case reinforces the ethical one. Analyses comparing the cost of dialysis maintenance against the cost of transplantation plus a compensation payment have found that even a payment in the range of tens of thousands of dollars per donor would likely be cost-saving to the health system compared with

years of additional dialysis, since transplantation is both cheaper per year and produces substantially better outcomes than remaining on the waitlist [4]. This argument does not by itself settle the ethics -- a policy can be fiscally attractive and still be wrong -- but it does undercut the assumption that opposition to compensation is costless to the patients who die waiting.

Empirical work on donor welfare under a real, working compensation system offers the most direct evidence available. Iran has operated a government-regulated, single-payment compensation model since the late 1980s, structured explicitly to eliminate the waiting list for kidney transplantation domestically and to route payment through a public foundation rather than through direct buyer-seller negotiation [5]. Assessments of the program are genuinely mixed rather than uniformly damning: it appears to have eliminated the formal waiting list, but field studies of donor experience have also documented donors who felt pressured by financial desperation, received less follow-up care than promised, and in some cases regretted the decision once the immediate financial need had passed [6]. A 2024 field study of donor behavior in the Iranian system likewise found donor motivation to be predominantly financial rather than altruistic, and follow-up outcomes to be uneven across regions and hospitals, complicating any simple claim that the model "works" [7].

THE CASE AGAINST: COMMODIFICATION, COERCION, AND EXPLOITATION

Opponents of compensation do not typically argue that the current unpaid-donation system is working well; they argue that the specific harm of paying for organs outweighs the benefit of a larger donor pool. Several distinct objections recur in this literature, and they are worth separating because they support different policy conclusions.

The first is a dignity-based commodification objection: treating a kidney as something with a price transforms the body, and by extension the person, into a good that can be bought and sold, in a way that damages how we understand human worth even for people who never sell an organ [8]. This objection does not depend on any donor actually being harmed; it holds that permitting the transaction corrodes a social norm worth protecting regardless of outcomes. Critics of the commodification argument reply that we already permit compensation for other risky uses of the body -- clinical trial participation, surrogacy in many jurisdictions, hazardous employment -- and that singling out kidney donation for special protection needs a better account of what makes it different [9].

The second objection is about coercion and exploitation rather than dignity in the abstract: a payment large enough to motivate donation from people with real financial need will function, in practice,

less like an offer and more like a form of duress, because refusing it is not a realistic option for someone facing eviction or unpayable debt [10]. This is the objection with the most empirical traction, because it is testable. Analyses that have modeled the likely donor pool under a compensation system consistently find that donors would disproportionately come from lower-income groups, since the payment matters more to someone with fewer resources -- exactly the population a policy aiming to avoid exploitation would need to protect [11]. Whether this constitutes exploitation depends on what happens to those donors afterward: if a regulated payment genuinely improves a donor's situation and the medical risk is well-managed, the "exploitation" framing is harder to sustain than if the donor ends up worse off, health complications included, once the money is spent.

A third objection, empirically informed rather than purely conceptual, concerns whether the public itself would find a compensation system acceptable, since a policy that most citizens regard as illegitimate is unlikely to be durable regardless of its theoretical merits. Survey work asking members of the public about their attitudes toward compensated donation finds a more permissive picture than commonly assumed, with a meaningful share of respondents supportive of at least non-cash forms of compensation (funeral costs, lost-wage reimbursement, health insurance), even while cash payment specifically draws more resistance [12]. This suggests the debate inside bioethics may be running somewhat ahead of -- or in a different direction from -- actual public sentiment, which appears more comfortable with compensation structured to look like cost-neutralization than with anything resembling a purchase price.

ORGAN TRAFFICKING AND THE GLOBAL CONTEXT

Any serious discussion of compensation has to reckon with the fact that illegal organ markets already exist, operating without the safeguards a regulated system would build in, and that transplant tourism moves patients from wealthier countries to obtain organs from vendors in poorer ones under conditions the vendors rarely control [13]. The Declaration of Istanbul, first issued in 2008 and subsequently strengthened, represents the transplant community's dominant institutional response: a global condemnation of organ trafficking and transplant commercialism, paired with a call for countries to develop their own domestic living and deceased donation programs so that patients are not driven abroad [14]. A 2019 assessment of the Declaration's implementation found real progress in national policy adoption but also persistent gaps in enforcement, particularly around identifying and protecting trafficked donors after the fact rather than only prosecuting brokers [15].

This context complicates the compensation debate in both directions. Advocates of regulated payment argue

that a well-designed domestic system is precisely what would reduce the incentive for patients to seek organs through trafficking networks, since desperate patients turn to illegal markets partly because legal supply is so constrained [3]. Opponents counter that legitimizing payment anywhere makes it harder to maintain a bright moral and legal line against organ markets everywhere, and that trafficking networks have shown themselves adept at operating in the gray zones any partial-legalization scheme would create [16]. A 2023 case analysis of a UK organ-trafficking prosecution illustrated how thin that line already is in practice, with brokers exploiting ambiguity about what counts as "reimbursement" versus payment to move a donor and recipient through a transaction that skirted, without clearly crossing, existing legal categories [16].

Table 1. Main policy positions on compensated living kidney donation, their core empirical claims, and the strongest objection each faces.

Position	Core claim	Strongest objection	Representative source
Unregulated market	Price signals would rapidly close the supply-demand gap	Concentrates risk on the poorest sellers with no oversight	Radcliffe-Richards-style libertarian arguments
Iranian-style fixed payment	A single, government-set payment has eliminated the domestic waiting list	Documented cases of donor regret and uneven follow-up care	Ghods & Savaj (2006); Fry-Revere (2014)
Regulated public compensation	Standardized, publicly administered payment can expand supply without buyer-seller negotiation	Donor pool would still skew toward lower-income participants	Gill et al. (2017); Semrau et al. (2022)
Altruism-only (status quo)	Preserves the non-commodification of the body as an unqualified norm	Has not closed the supply gap; patients die waiting	Delmonico & Ethics Committee (2002)

Figure 1. Schematic comparison of four donation/compensation models on two illustrative dimensions -- how far each departs from an altruism-only norm, and how much donor-protection infrastructure each would require to operate responsibly. Values are illustrative rankings for discussion, not measurements from a single empirical study.

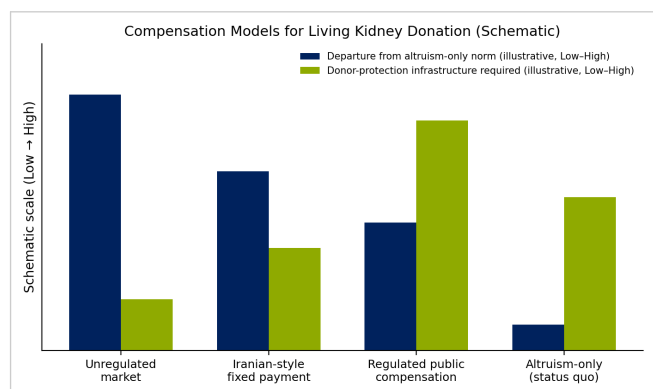


Table 1 summarizes the main policy positions surveyed here alongside their core empirical claims and the strongest objection each faces. Figure 1 presents a schematic comparison of how far each proposed model departs from the status quo of purely altruistic, unpaid donation, set against how much donor-protection infrastructure each requires to operate responsibly -- illustrating why the debate is not simply "pay or don't pay" but a question of how much regulatory scaffolding any departure from altruism-only donation would need.

TOWARD A DEFENSIBLE MIDDLE GROUND

Much of the recent literature has moved away from an all-or-nothing framing and toward asking what a compensation system would need to include to avoid its predictable failure modes. Several recurring design features appear across proposals: compensation paid by a public body rather than negotiated between donor and recipient, so no financially desperate patient can simply outbid another for an organ; payment structured as a fixed, non-negotiable amount (or as in-kind benefits like health insurance) rather than an escalating price, to limit incentives toward risk-taking or repeat donation; independent donor advocacy and long-term medical follow-up funded separately from the transplant itself; and a waiting period or counseling requirement designed to screen out donation motivated by acute financial crisis rather than considered judgment [17]. Proposals along these lines, sometimes packaged as a refundable tax credit rather than a direct cash payment, have circulated in U.S. legislative discussions without so far becoming law, reflecting how far the political consensus still lags behind the empirical and philosophical case that has accumulated on both sides [18].

None of this resolves the deeper disagreement about whether payment for organs is wrong in principle, independent of its consequences. What the empirical turn in this literature has done is narrow the terrain on

which that disagreement plays out: fewer serious commentators now defend either a wholly unregulated market or an indefinite continuation of a status quo that is failing thousands of patients each year, and more of the argument concerns exactly how much regulatory protection a compensation system would need before its risks to vulnerable donors became acceptable, if they ever could.

CONCLUSION

Compensated living kidney donation sits at the intersection of two things bioethics is generally good at holding apart and bad at holding together: a consequentialist case grounded in donor welfare, patient mortality, and system cost, and a deontological worry about dignity, commodification, and the particular vulnerability that money can create. The empirical record from Iran's decades-old program is instructive precisely because it is not one-sided -- it demonstrates both that compensation can expand the donor pool substantially and that doing so without robust donor protections produces real, documented harms to the donors it was meant to help [6]. The most defensible position emerging from the recent literature is neither an unregulated market nor an indefinite moral veto, but a heavily scaffolded system of public, fixed compensation paired with independent donor advocacy, long-term follow-up, and safeguards against acute financial coercion -- a position that takes seriously both the patients dying on waiting lists and the donors a poorly designed system would put at risk.

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Conflict of Interest

The authors declare no conflicts of interest relevant to this work.

Author Contributions

Camille Brenner conceived the review and drafted the sections on the case for regulated compensation and the global trafficking context. Renate Radcliffe performed the literature synthesis on donor welfare, public attitudes, and the Iranian model, and critically revised the manuscript. Lars Whitmore drafted the sections on commodification and coercion objections and on policy design, and provided final approval of the submitted version. All authors read and approved the final manuscript.

Ethics Statement

As a literature review synthesizing previously

published, publicly available research and policy analysis, this article did not involve new data collection from human participants and did not require institutional ethics committee approval.

Data Availability

No new data were generated or analyzed for this review. All sources discussed are cited in the reference list and are publicly available through their respective publishers.

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