THE NEW ZEALAND INITIATIVE

Financial Assistance for Live Organ Donors

Submission to the Health Select Committee, 5 October 2015

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1. Introduction

1.1 Thank you for this opportunity to offer suggestions and advice regarding Chris Bishop's Member's Bill, "Financial Assistance for Live Organ Donors".

1.2 I am Head of Research with The New Zealand Initiative, a Wellington-based think-tank supported by New Zealand's leading businesses. The Initiative engages in public policy research for a free and prosperous New Zealand. Previously I served as Senior Lecturer in Economics at the University of Canterbury; I am currently Adjunct Senior Fellow with the Department. I can be reached at 04 499 0790 and at eric.crampton@nzinitiative.org.nz. I wish to appear before the committee to speak to my submission.

1.3 At the University of Canterbury, I taught on the economics of organ transplantation as part of an intermediate-level course in economic policy. I supervised an Honours thesis on the topic which became Elizabeth Prasad's Masters thesis, which I co-supervised after I left Canterbury to join the Initiative. Her thesis formed the basis for the attached report from The New Zealand Initiative, *Compensation for Live Organ Donors*. I have followed the economics of different organ transplant regimes as a matter of personal and academic interest for at least a decade, and have frequently commented on the topic on my blog, *Offsetting Behaviour*, and in popular media. I have reasonable knowledge of the topic.

1.4 I support the intent of this Bill as it will save and improve many people's lives at little to no net cost to the government. Better compensating donors for their lost wages and incurred costs will make it easier for more people to donate. If the Bill allows even only three more people to donate annually, the government saves money on net despite the increased compensation paid to each donor. Further, it is not right that we currently ask donors to bear these costs in order to benefit the public health system and transplant recipients.

1.5 To summarise: the Bill as it stands would be a dramatic improvement over the status quo, but can be strengthened at low cost to be far more effective.

- 1.5.1 Donors should be compensated to 100% of lost earnings, to a cap of no more than a reasonable multiple of average earnings.
- 1.5.2 Compensation for donors should be provided through the Ministry of Health rather than through Work & Income.
- 1.5.3 Donors not in employment should be compensated as though they worked full time at the minimum wage for the duration of their recovery, if they have not recently been in employment, or on the basis of their last reported earnings if they have been.
- 1.5.4 Live organ donors who go on to need an organ transplant should be guaranteed priority access.

2. Recommendations

2.1 Compensation for lost earnings should be enhanced to 100% of lost earnings, to a cap of no more than a reasonable multiple of average earnings.

2.1.1 The Bill recommends compensating donors at 80% of lost earnings. While this is an improvement on current compensation, donors will continue to bear a real cost from donating. Even with compensation at 100%, time out of the workforce incurred by donors will affect salary progression and promotion opportunities.

2.1.2 For any given number of live donors, there is little difference in the cost to the government of compensation at 80% as compared to compensation at 100% of lost earnings, subject to a reasonable maximum cap on compensation for high earners. If seventy people donate a kidney in a year, and on average earn the average wage, and each take a full twelve weeks' compensation, shifting to 100% compensation from 80% only costs the government, in total, $166,500.

2.1.3 Where the main margin on which the government may stand to save money depends on greater numbers of donors being willing to donate, compensation at 80% instead of 100% may prove more expensive for the government if it deters donation. If two more donors were able to donate were compensated at 100% rather than 80%, the government would *save* money by paying more to each donor, with savings that increase from that point. And more lives would be saved and improved.

2.1.4 The figures above overstate the costs of compensation if the government implements a cap on maximum weekly compensation at a multiple of average weekly earnings. Compensating a very high earner could otherwise prove expensive.

2.1.5 Kidney Health New Zealand's submission highlights patient reticence to approach potential donors where they know that donation would prove a financial burden. Compensation at 100% rather than 80% could remove that barrier.

2.1.6 I also support Kidney Health New Zealand's recommendation that all donor costs be reimbursed.

2.2 Compensation for donors should be provided through the Ministry of Health rather than through Work & Income.

2.2.1 Many donors will have had no experience with Work & Income.

2.2.2 It is inconvenient for potential donors to navigate Work & Income systems when they could alternatively make arrangements directly with the Ministry of Health facilitated by the transplantation teams.

2.2.3 Work & Income has an admirable focus on shifting clients from income support into work as quickly as possible. It is not clear that strong pressure to resume work is desirable.

2.2.4 As live donors are rare, it would be difficult for Work & Income to develop and specific expertise in managing those clients' cases. That expertise is better built within the Ministry of Health. In this, we endorse the recommendation made by Kidney Health New Zealand.

2.3 Donors not in employment should be compensated as though they worked full time at the minimum wage for the duration of their recovery, if they have not recently been in employment, or on the basis of their last reported earnings if they have recently been in employment. However, if compensation would be higher under the Bill's current provisions, the higher of the two should prevail.

2.3.1 Donors currently jobseeking may forgo the opportunity to continue their job search while recovering from surgery.

2.3.2 Donors who recently left one job may delay the start of a new job to allow time for recuperation and would consequently be strongly out-of-pocket if compensated at benefit rates.

2.3.3 Compensation at the minimum wage rather than at benefit rates would prove a trivial cost to the government but could remove a barrier to donation.

2.3.4 Donors who are the non-working partner of a primary earner provide important household services that may be unavailable during the period of recuperation. Compensation may allow hiring in assistance, removing a barrier to donation.

2.3.5 If a primary wage earner needs to drop from the workforce during the period of recuperation, Kidney Health New Zealand's proposed compensation regime has merit.

2.4 Live organ donors who go on to need an organ transplant should be guaranteed priority access.

2.4.1 Every live organ donor has already shortened the transplant queue by one place. Guaranteeing them a priority place in the queue should they need it does not worsen the position of those currently in the queue relative to the situation where the donor chose not to donate.

2.4.2 If a live donor needs an organ, it would seem perverse that that donor wait at the back of the queue. Basic fairness suggests that the gift that donor provided be reciprocated quickly.

2.4.3 Israel achieved substantial increases in live organ donation rates after implementing a combination of compensation for lost earnings and a guarantee that donors would receive priority access to transplant should they ever need one. While prioritization does not shift a live donor ahead of those in much greater medical need, donors receive priority over others of similar medical need.

2.4.4 Prioritising live donors over others has several effects. It signals how much we value the gift provided by live organ donors, encouraging donation. It overcomes a potential barrier to donation, where donors weigh too heavily the risk of their remaining kidney's failing. And, it overcomes a potential barrier preventing those in end-stage renal failure from asking others to donate.

2.4.5 Paula Marie Martin's PhD Thesis (University of Victoria at Wellington, 2013) surveys those in end-stage kidney failure and finds they are reluctant to ask others to donate because of fears of health impacts on donors, financial burdens for donors, and fears of effects on their relationship with the potential donor. Compensation of live donors alleviates the second concern; prioritization of live donors assists with the first.