T R A N S C R I P T

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into increasing the number of registered organ and tissue donors

Melbourne—Monday 24 July 2023

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Meng Heang Tak

WITNESS

Dr Julian Koplin, Lecturer, Monash Bioethics Centre.

The CHAIR: Good morning. We will now recommence public hearings into the Legislative Assembly's Legal and Social Issues Committee's Inquiry into increasing the number of registered organ and tissue donors. I welcome our next witness from the Monash Bioethics Centre, Julian Koplin, Lecturer in Bioethics. Thank you so much for joining us today.

All evidence being given today is being recorded by Hansard and broadcast live.

While all evidence taken by the Committee is protected by parliamentary privilege, comments repeated outside this hearing may not be protected by this privilege.

I now invite you to make a brief opening statement of up to 10 minutes. This will be followed by questions from Members. Thank you.

Julian KOPLIN: Great, and thank you very much for the opportunity to speak here. I guess I just wanted to begin by introducing myself and the group that I collaborated on the submission with. I am obviously Dr Julian Koplin, Lecturer in the Monash Bioethics Centre, and I am one of the handful of people working at the centre that are really interested in the ethical issues connected with, I guess, trade involving the human body and parts of the human body—kind of commerce and body parts. This is obviously just a very small facet of this debate and issue around organ and tissue donation and increasing donation rates, but I think it is a really important one and a really philosophically interesting one.

Bioethics is concerned with ethics of health care and health policy. I just want to kind of clarify that I am a philosopher—my background is in philosophy and my colleagues are trained in philosophy. When it comes to the legal side of things, that may be a little outside of remit, but I can definitely help you to speak through the kind of moral and philosophical reasoning that we have used in our submission and how we are thinking through these kinds of questions.

I guess in that spirit I wanted to start from what a good thing it is to recognise at the outset any increase in organ and tissue donation. There is one really good, really powerful moral reason in favour of anything that can increase the supply of transplantable organs, being that this would save lives. Saving lives is, for very obvious reasons that do not really need to be articulated, very morally important, which means that anything that can increase supply will then at least in one respect do something really morally significant and good. Now, this does not mean that any proposal to increase supply ought to be accepted; obviously proposing to drag people off the street, kill them and harvest their organs would save some lives, but it is something we would rightly reject. But it does mean there is at least a case to be answered in favour of anything that looks like it would likely increase the supply of transplantable organs. That means that even when it comes to the kinds of proposals that my office and I have rejected in our submission, something like financial incentives or financial inducements, there is a legitimate and powerful reason in favour of them and a case that needs to be answered. I want to just sort of briefly try to answer that here.

Our focus in our submission was on a set of proposals to increase supply of both living and deceased organ donation through mechanisms that involve money in some sense, whether that is rewards, compensation or financial inducements. A big part of our motivation was to try to, I guess, provide a conceptual framework for thinking through these different things and the different kinds of ethical issues that they raise because, in our view, the terms are often used in different ways, sometimes incompatible ways and sometimes, arguably, a bit sloppily. So people might propose to pay living donors, like the deceased donors' families—they could use any kind of terminology, sometimes it is referred to as reward and gifting, sometimes it is referred to as compensation, sometimes it is referred to as an reimbursement, sometimes it is referred to as financial incentives—and we want to clarify exactly what we think these terms mean and should mean, and the issues that they raise.

The first category is financial inducements. An inducement involves trying to get somebody to do something they would not otherwise be inclined to do, if not for the inducement. So here are the kinds of things we have in mind, things like cash incentives to become a living overseas donor, or maybe something with financial value—an indirect financial incentive, like tax breaks for instance, to become an organ donor, or significant financial contributions to funeral costs. While this is discussed in the transplant ethics literature, some of the arguments were discussed in other submissions to this inquiry. This is a category of intervention that we reject. We reject it because we think it is inconsistent with the gift paradigm that underpins organ and tissue donation

in Victoria at the moment, as well as Australia as a whole, as well as almost every country in the world. We think there are two kinds of reasons why the gift paradigm is important. Some are principled reasons; so here you will see concerns about treating body parts as property and here you will see concerns about exploiting the poor. The concern that I hold most strongly is that if you have money being exchanged for bits of the body, it can create pressures to take up the options where you are being offered the money. It can create a sense of expectation or make you vulnerable to your brother saying, 'Hey, you owe me money, you should go sell your kidney to pay me back', or something along those lines. We value bodily autonomy very highly in our society, quite greatly, I think, and opening up financial inducement sort of threatens that. Beyond this we have got a pragmatic worry, which is that departing from the gift paradigm, for whatever shortcomings it has, could be very risky because it would involve reconceptualising everything we are doing around promoting the gift of life and encouraging people to do something altruistic and morally really important and sort of reframing that organ and tissue donation into a way of making money, and that might turn out to be a much less effective motivator. So financial inducements could potentially backfire.

Beyond this, we looked at compensation and reimbursement. This is quite different to financial incentives. Even if money changes hands, the aim with compensation and reimbursement is to, I guess, redress or counteract the costs and disadvantages associated with donation. Particularly in relation to living donation, we think there are really, really strong reasons to try to make donation a financially neutral act and to not be financially disadvantaged by becoming a living organ donor, because it something that saves lives, it is something that people should be facilitated and enabled to do, and there may be moral reasons based on fairness and recognition of what donors have given up to not leave them worse off on the other side of this. With living organ donation we do have some reimbursement for some expenses, but in our submission we argue that this could and indeed should go further.

The final category is rewards. Rewards are different again. Rewards exist to try to recognise service, effort or achievement or maybe to honour something praiseworthy that somebody has done. Some interventions I think are rewards. Proposals to create a certificate of appreciation for organ donors or their family constitute a kind of reward. To register the organ donation status on the death certificate, to have a kind of ceremony—these are symbolic rewards. They are potentially valuable. They are I think potentially appropriate. In our submission we endorse these strategies, with the caveat that there can be a kind of grey area where it can be unclear whether something is a reward or a financial inducement. So you could say, 'Let's compensate some of the costs for a funeral.' And then the question would be: is this a symbolic recognition of what the donor and their family have given up and the good that they have done, or is this a financial inducement trying to get them to do something that they might otherwise not be motivated to do? At least at the level of rhetoric, you can kind of spin it both ways. I think the key question here has got to be whether somebody would become a donor or consent to their loved one becoming a donor if not for the so-called reward. And if it is what is motivating them to become a donor, then it would start slipping into the category of inducement, away from the kind of intervention that we endorse in our submission and into a category that we do not. So that is, I guess, what we have done in the submission and a little bit of background, and I am very happy to answer questions.

The CHAIR: Fantastic. Thank you for that excellent opening statement. It is certainly going to give us a lot to think about. This is a very different approach to the evidence we have heard so far. I will hand over to Chris for some questions. Thank you.

Chris CREWTHER: Thank you, Chair. Firstly, thank you very much for your submission and your time today and the work that you are doing. Firstly, I was interested to read about the comparisons between financial inducement, reimbursement, compensation and reward and different incentives and disincentives and so on. Can you explain further your views on compensating for travel costs, lost wages and expenses incurred while donating and recovering and why you think that would be beneficial or not beneficial?

Julian KOPLIN: Okay. I think it would be beneficial. As I mentioned before, there is a program that will reimburse some costs associated with donation, so some lost wages and some expenses. But by international standards there are countries that are, I guess, significantly more generous and will reimburse more costs than Australia does or additional categories. In some cases we reimburse lost wages at the minimum wage. I believe there are some jurisdictions that go a bit beyond that. We do not have provision to reimburse childcare costs or elder care costs, and there are some jurisdictions that do in fact do this. It seems like these costs can create a kind of disincentive to donate. I might be motivated to donate, but I might be worried that I and/or my family might not be able to swing it financially. I think that would be a tragedy—if whenever there is somebody in that

position who is motivated to do something that could be life saving decides not to because it would be setting them back financially. So we have argued that trying to make donation a financially neutral act by reimbursing expenses does not raise any moral concerns that we can see, and it seems like it would just be often an advantage from the perspective of donors, from the perspective of recipients and just from the perspective of lives being saved.

Chris CREWTHER: What is an example of some of the other jurisdictions that have implemented reimbursements or similar ways to make it financially neutral?

Julian KOPLIN: Yes, absolutely. I know that different jurisdictions will do different things, and they have all blurred together a little bit in my mind. I know that Israel has some components to their program that are different to what we have in Australia. I know that New Zealand does as well. I am trying to remember off the top of my head which jurisdictions allow reimbursement for childcare and elder care costs, but for some reason there is just an inconvenient blank spot. I am very happy to get back to you on that. I apologise.

Chris CREWTHER: I am happy for you to take that on notice.

Julian KOPLIN: Yes, absolutely.

Chris CREWTHER: Is there anything more we can do around the current sick leave or carers leave? Is that sufficient as it stands to allow for donors to donate and then recover from donations at the moment, or do you think things need to be tweaked within the current leave arrangements that we have?

Julian KOPLIN: Very roughly, I think, be more generous for as long as somebody is continuing to incur costs associated with donation. That should be compensated for. I do think that reimbursing just at minimum wage is something where you could still end up having a financial disincentive to donation. Even if you will get some of the lost income back, I think it does make sense to consider being more generous and going beyond this. In terms of time frames for recovery, I am probably not the best person to talk to there, but it does seem to me that any kind of cost associated with recovery seems at least in principle kind of fair to cover. I believe it is Israel that will even compensate for, I guess, psychological treatments associated with the aftermath of donation, and that is something else that would feel appropriate as a way of again compensating for the disadvantages and drawbacks of donating without providing this kind of –

Chris CREWTHER: Inducement.

Julian KOPLIN: inducement, yes.

Chris CREWTHER: You talked about donor compensation and the need to avoid being too generous. Can you give us some examples of where it might straddle that situation of being generous and too generous and an example where you might be too generous?

Julian KOPLIN: Yes, absolutely. So I guess part of the kind of conceptual mess that I did not get into in the opening statement is that there is this subtle distinction between reimbursement and compensation. With reimbursement, the way that we use the terms and the way we think they should be understood, you are merely giving somebody back money that they have lost. You are merely sort of reimbursing financial costs, and if you are reimbursing financial costs, you are capped at financial neutrality. You cannot get ahead through reimbursement. You cannot get ahead financially.

We argue compensation is a more difficult category. Here, if you are compensating somebody for something, you are not trying to give them a new reason to do something. But not all of the costs associated with donation are financial—there is short-term pain, there is short-term disability and there are all kinds of inconveniences. The idea when it comes to compensation is that you could go some way toward counteracting these disadvantages that might bring you above financial neutrality, but it still would not be an inducement because the money still would not be enough to make you do that otherwise. But it can still kind of defray the drawbacks. So that is the compensation idea.

Again there is this kind of distinction between what is good in principle and what is good in practice. We think in principle compensation is morally benign. Compensation is morally appropriate because you are not inducing anyone, and it seems fair, it seems, you know, reasonable. The question is that when you start looking

at something that could bring somebody quite far financially above where they started it can be very difficult to be really certain that it is just compensation and that that ability to get financially ahead is not actually inducing someone. It is not actually the reason that someone has chosen to become the donor. Exact monetary value, I am not completely sure, but I guess I am very, very cautious about compensating above financial neutrality. But there is a long way to go without even needing to worry about any of that by trying to make living donation a financially neutral act.

Chris CREWTHER: With funeral expenses, do you think there is a risk there that even if you are covering moderate funeral expenses, there might be an incentive for either that person or the relatives of that person that an elder abuse type situation could arise because it might trigger an inducement?

Julian KOPLIN: Yes. Again this is something where we cash it out as in principle it could be okay, but as soon as there is a significant amount of money on the line it could mean that there is—well, it gives people a reason to do something with the body of their loved one that their loved one might not have agreed to. It gives, I guess, family members reason to put pressure on each other to try to go win acceptance of donation. Even though donation is life-saving, even though it is the right thing to do, it seems like we value bodily autonomy in this way where we should be really, really worried about that happening. So yes, I am quite concerned personally, but I cannot speak for my co-office about that.

Chris CREWTHER: Yes, yes. Last question: I said I would talk about opt-out, your views on an opt-out mechanism. What are your views on an opt-out mechanism and it being introduced here like there is in Spain, and do you see any links between potentially compensating people or people being more eased into an opt-out system where there is compensation for expenses and so on?

Julian KOPLIN: I do think that the opt-in, opt-out debate is quite separate to the compensation, reimbursement and financial incentive debate, and I just want to clarify that what I am saying here is not representing consensus within my discipline and it is not necessarily representing what my co-authors in the submission believe. But personally my views on an opt-out system are: in principle I have got no objection to it. It seems like organ donation is the right thing to do; making the right thing to do the default—that seems appropriate, that seems good. I know that there is a worry that you might end up having donations in situations where the person would have preferred not to be a donor. But it seems to me that there is a perfectly inverse worry with an opt-in system where there might be people who would have wished to be a donor that do not get to, and in both cases we have these wishes about how one's body is treated after death that are not being met. So in principle it seems like a great idea to me.

The question is whether it would actually successfully increase organ donation rates, and I know that this is controversial. I know that Spain, from what I understand, has on paper an opt-out system, but the actual opt-out process is rarely, if ever, utilised. I know that there is some literature suggesting that opt out tends to increase donation rates, but then you have some people saying, 'Well, potentially that's just because it thrusts the topic of organ donation into the public consciousness to the point that people are talking about it and more likely to opt in.' And I know that people worry about the risk of some sort of scandal, because it would be quite galling if your loved one is sort of wheeled out before someone gets to have the say-so to override it, or they are worried that somebody that they know or somebody that they love will have this done without their consent. So when you put all of that together, for me, it is just 'Would it be effective?' And if it would be effective, it sounds like a great idea. Whether it would be effective—I am a philosopher and I am not fully across the opt-out literature, so I guess personally that is what everything turns on. I am ambivalent, but I have got no in-principle objection to it.

Chris CREWTHER: Thank you, Chair, and you, Julian.

The CHAIR: Thank you. Heang, would you like to ask some questions?

Meng Heang TAK: Yes. Thank you, Chair. Thank you, Doctor. Some people from migrant backgrounds may have different experiences in terms of donations or receiving donations from country of origin—for example, human organ trafficking and all of that. So in terms of compensation or reimbursement, what do you think is culturally acceptable or appropriate in this context?

Julian KOPLIN: Okay. So I guess there are two parts to the question. I just want to make sure I am following along.

Meng Heang TAK: Yes, that is right.

Julian KOPLIN: Yes. There are some jurisdictions where there is an unregulated black market or grey market trade in human body parts. I think even within those countries there tends to be a lot of opposition. I mean, sometimes it is patchy, but there tends to be a lot of opposition to this trade. When it comes to bodies like the World Health Organization, there is a lot of vehement opposition to this trade. When it comes to medical professional bodies and bioethicists and philosophers, including philosophers who argue in favour of paying donors, they tend to argue that this black-market trade is morally reprehensible, people are frequently defrauded and people frequently receive poor care. Most kidney sellers on these markets suffer quite horribly, end up financially worse off, are unable to work, end up in a worse position to the position they started in, suffer from shame, stigma or whatever else.

So I think when it comes to organ trafficking, there is no alternative to really, really strong condemnation. What happens in organ trafficking is that somebody is offered an inducement to sell a kidney, and they will take that inducement. In most cases they are offered an inducement, and that is how it operates. Non-consensual organ trafficking, from what I understand, is quite rare. It does happen, but in most cases they will be offered a payment and they will accept it. Sometimes they will receive what they were promised, sometimes they will not receive what they were promised or sometimes they will receive part of what they were promised. It seems like, regardless of what happens, they end up worse off and they regret it, and many of them think that this trade should be illegal.

When it comes to reimbursing expenses, I think that is very different, because there is no inducement on the table here. When it comes to well-designed compensation that does not sneak into inducement, then I think none of those ethical issues apply here. I do not know for sure if this would require stakeholder engagement, but I would assume that you would not see the same kind of opposition or the same kinds of worries about commodifying the body that you would if someone was being paid for it directly. What I think experience with organ trafficking does show, though, is that we do need to be very careful about inducements, just because the experience of kidney sellers is so uniformly horrible. I mean, I wrote a literature review on the literature on organ trafficking back in 2014, and it was a very unpleasant slog sifting through these medical accounts of I guess the victims' long-term wellbeing and these first-person accounts of what they had experienced. And I think that should really make us worried about financial inducements and payments, but not about reimbursement. Sorry, did that answer your question?

Meng Heang TAK: Yes. And then I wonder in terms of culturally appropriate ways to overcome these associations—back in the country of origin and here—how do we improve that understanding?

Julian KOPLIN: Do you mean how do we improve the understanding that what Australia is doing is very different to –

Meng Heang TAK: Yes.

Julian KOPLIN: Look, as a moral philosopher I guess all I can say is I think it would be great if we could overcome that misunderstanding as to how we do it. Somebody else would be better positioned to speak about that—yes, maybe someone who has done more of that kind of stakeholder engagement.

Meng Heang TAK: Okay. Thank you. Thank you, Chair.

The CHAIR: Thank you. Cindy, would you like to ask some questions?

Cindy McLEISH: Thank you. It sounds as though, just listening to you, that you have thought about a lot of stuff, and that we have got the balance okay. You have said that we could do things a little bit better in some of the rewards or recognitions perhaps, like other countries, or the compensations.

Julian KOPLIN: Yes.

Cindy McLEISH: Do you think we are going okay in this space, regardless of the numbers that are coming through?

Julian KOPLIN: I think we could and should be doing more in the sense that I really think that financial neutrality or close to financial neutrality to being a donor is—I would hope it would be—somewhat effective in

increasing donation rates. Again, that is an empirical claim. I would assume that it would, although that obviously is going to depend, but it is also what I think is fair and reasonable. I think there is something unfair about somebody saving a life, doing something that is good for the Australian healthcare system and something that is altruistic and generous, and being left worse off financially, so I do think further reimbursement would be excellent and definitely weigh in favour of it.

In terms of rewards, that seems like a good idea, although personally I am a little bit less riled up about it, but it seems like that could be appropriate and worth exploring. As I said at the beginning, anything that can increase donation rates and save lives is worth at least exploring, but it is something, as you know, really crucial to get right. But having said that, I am not sort of sitting in the ivory tower, pointing and condemning the people who are doing the actual work of promoting organ and tissue donation in the practical space that I am not in personally.

Cindy McLEISH: And I am sure that there are a lot of people out there who are not looking for any sort of reimbursement.

Julian KOPLIN: Yes, definitely.

Cindy McLEISH: And that is okay?

Julian KOPLIN: Yes. Absolutely.

Cindy McLEISH: How do you I guess come up with the things to talk about? Do health authorities or different practitioner groups come and raise issues with you that they would like you to think about, or do you find an area that you find is interesting and then perhaps do a lot of work in that space?

Julian KOPLIN: Do you mean in bioethics?

Cindy McLEISH: Yes. In your faculty.

Julian KOPLIN: Yes, in my faculty. I guess it is largely driven by the interests of the researchers, and it is something where we, I guess, try to develop expertise on the topic matter, where we will try to consult with people who are working in these spaces when we can, write peer-reviewed publications and look for opportunities to contribute to policy development in exactly the way that led me here today. But it very much is a matter of gathering, clarifying and ordering thoughts, writing about them and submitting to journals, submitting to public submissions and working in this way. I guess work as a philosopher is a very strange, unique thing where you do spend a lot of time in your office surrounded by books.

Cindy McLEISH: Do you have a relationship with the hospital, Monash Medical Centre?

Julian KOPLIN: I do not personally. Some of my colleagues I believe do.

Cindy McLEISH: And just finally, with some of the philosophising that you do, do you spend time looking at the post-life donations and also the live, as we have talked about—say, the kidney donation or something like that? Do you look at both of those in equal time?

Julian KOPLIN: Yes. My entry into the transplant ethics space was via living donation, and I guess payments and organ trafficking. I am interested in both. Did you have, sorry, a specific something you wanted to put to me about the deceased side of things?

Cindy McLEISH: No, not particularly. I was just wondering if there were any issues in either of those that really stood out that you think we need to make sure are considered? You have covered a lot but I just sort of –

Julian KOPLIN: Definitely living donor reimbursement and thinking through rewards for deceased organ donation are the two kinds of key takeaways from the submission.

Cindy McLEISH: That is all. Thanks.

Julian KOPLIN: Great. Thanks.

The CHAIR: Thank you. Annabelle.

Annabelle CLEELAND: Thank you, Dr Koplin. I was a bit nervous actually, before when I was reading your submission, about how this would go, so well done. Are you on the organ donor registration?

Julian KOPLIN: Yes.

Annabelle CLEELAND: Yes, cool. Give me a little creative licence for a minute. One thing that has cropped up a few times is around people who are on the organ donor registration and then the family have not supported that decision. So leaning on your ethics background—I guess we are grappling with how to navigate that and from a consent perspective what that might look like—what do you see in that little scenario?

Julian KOPLIN: A lot. I can ramble a little bit, but it is going to be a ramble thinking on my feet. There is a handful of different considerations there. One is the risk of a backlash against the donation system as a whole if somebody's family's wishes are overwritten, particularly in a situation where maybe the family believes that they knew the person's wishes quite well. I signed up to the organ donor registry at age 18, I think it was, and I am now mid-30s. A lot could have changed in the meantime, and it has not for me personally, but I can imagine somebody who knows me now or somebody else where there is this big time lag between signing up and the point at which they die where they might think they have a better understanding of their wishes of how their body should be treated after death. In those cases, I think there is both this pragmatic worry when it comes to the risk of a backlash and the risk of a scandal that could then reduce trust in the system, reduce donation rates and end up being self-defeating if you are wanting to make sure that everybody who is registered as an organ donor can donate in order to have access to life-saving organs. There is a risk of a kind of backlash and that would go against the very purpose that you would be taking them in the first place. How large that risk is, I not sure. That is an empirical question, but that does worry me personally.

Then there is the question of how much control you should have over parts of your body after you die, and that is a really controversial thing within philosophy. Do we have any posthumous interest after we are dead? Do we have any interest in what happens to our body? Or once we are no longer conscious, once we are no longer there, does it not really matter anymore because we are not around to experience what happens to bits and parts of our bodies? I have not thought this through fully, but my instincts are very much the second view. I very much feel like once you are no longer around, what matters are the interests of the people around you. I would not feel comfortable suggesting my gut instinct as a good basis for policymaking, but that is my kind of feeling.

Annabelle CLEELAND: Sorry, that was curly. I was just interested because it has cropped up and it is the first time we have had a chance to speak to someone around the ethics of things. So by all means if you have interesting thoughts later down the track, then send them through because we are interested in that.

With your submission, I am interested to know if there is any example of a country or state that is doing this form of reimbursement and navigating reimbursement—compensation, pardon—well?

Julian KOPLIN: Okay. Israel came up as a very interesting model. There are a few facets of it where it is a little bit unclear whether it would straddle the line into an inducement or not, but Israel I think is doing some very, very interesting things in this space. New Zealand has an interesting living organ donor program. Again, this is a very inconvenient, fuzzy, lax blank spot, but I am very happy to, for example, find examples of jurisdictions that are providing reimbursement for eldercare and childcare expenses as well.

Annabelle CLEELAND: With all of your background and research in this space, what would be your advice on Victoria navigating that compensation line? I know this is the entirety of your submission, but what would be your advice for the next step of navigating that compensation?

Julian KOPLIN: I think the very first step is to see how far you can go getting up to the point of financial neutrality for living donors, and I believe there is going to be a long way that you can go. I believe that there are going to be extra categories of expenses that can be reimbursed, and I believe there is going to be more generous reimbursement of existing expenses that will not end up spilling over into somebody ending up financially better off. That seems like the starting point, and as long as you are within that range it seems like there are from my perspective no ethical worries; there are only benefits. Then, past that point, the difficult questions start coming up, but there is a lot that we can do before any difficult questions or trade-offs even begin to emerge.

Annabelle CLEELAND: Can I have more time?

The CHAIR: Yes.

Annabelle CLEELAND: Can you go into a little more detail about Israel as an example of doing it well? What does the financial compensation look like for a 30-year-old with two children—I do not know—that is able to be a living donor?

Julian KOPLIN: Okay. I guess the aspects of the model that stood out to me—I believe that there is compensation for life insurance, private health insurance. There are some interesting, I guess, things that have a very small amount of financial value that fit in my mind much more as a kind of symbolic reward. There is, for example, free entry into national parks. I do not think anyone is going to be undergoing nephrectomy in order to get that lavish free entry into national parks, but it is something that I think has this really nice kind of symbolic aspect to it, that it is this symbol of appreciation. I think when it comes to something like the insurance reimbursement, I guess the idea there would be that even though living organ donation is very, very safe, it still does entail some small degree of risk. And it does seem like it is a potentially appropriate compensation to take that into account and to try to sort of compensate for those drawbacks through insurance systems. I find that really, really interesting as a strategy and worth thinking through further.

Annabelle CLEELAND: And finally, do you know the organ donation rates in Israel since this compensation model has been introduced, and does it compare dramatically with beforehand?

Julian KOPLIN: Israel has done a lot of different things, a lot in quick succession. Their cultural situation is quite different to Australia's, so the baseline is quite different. I have read work that suggests that it has been at least somewhat effective or that it has been effective. I think that is what I would be comfortable saying, not being, you know, completely across it and not wanting to sort of over –

Annabelle CLEELAND: No worries. That is fascinating. Thank you so much for your time.

The CHAIR: Thank you. Just to wrap up I would like to change tack a little bit and speak about stem cell donations. We have just heard from the Leukaemia Foundation, and I think you heard that conversation that we had as well. I am just wondering if you have considered some of these compensations, rewards, reimbursements for stem cell donations, noting that it is different to an organ donation.

Julian KOPLIN: Yes. I guess in the case of the peripheral blood stem cell donation, that is on the physical level similar to blood donation in terms of how it is carried out. The norms that we have against paying organ and tissue donors extend to blood and blood products. They extend to blood donation. We do not pay blood donors. People do not end up financially ahead of the game. I believe there is a trial at the moment looking at some kind of small gifts of mostly symbolic significance in the blood donation space. I am not completely across that, but I believe it is happening.

Annabelle CLEELAND: The Nippy's.

Julian KOPLIN: Yes, I very, very, very much enjoy the Nippy's after donation. I do not think that there is anything particularly new to say here. I believe reimbursement for expenses, again, seems like a great idea. For somebody to be left financially worse off on account of this is unfair. For somebody to be disincentivised to become a stem cell donor because they are worried about the financial cost or because they cannot take the time off work, I think is a kind of tragedy. If there are medical gains and lives that could be saved that are not going ahead because of these disincentives, then for reimbursement in the space for time off work and for other kinds of various things associated with the donation process, I think, the arguments extend pretty easily. The objection to inducement and payment extends pretty similarly. There is a little more variety overseas, but given that in Australia we have this really strong gift model, with both laws and social norms that treat blood and all the tissues of the body as a gift, it seems like it could be quite risky to try and shake that in this instance.

The CHAIR: On reimbursement, I have worked in workplaces previously where you could take annual leave, essentially, for the purposes of a blood donation, so you might take one to three hours off depending on what kind of donation you were going to be giving that day. Is that something that you think is an appropriate thing to be introduced, say, across more workplaces?

Julian KOPLIN: Yes, absolutely. Again, it is not something where it is going to be an inducement where anyone is going to go out of their way to donate in order to claim back those hours that they are not getting to spend as they wish anyway.

The CHAIR: And do you think that could also be applied to stem cell donations?

Julian KOPLIN: Yes, absolutely.

The CHAIR: Along with the snacks that you get after blood donation.

Julian KOPLIN: Along with the chocolate milk, yes.

The CHAIR: Great.

Annabelle CLEELAND: That is a formal recommendation there.

The CHAIR: And one other thing that we heard from the Leukaemia Foundation was that they are really looking to target young people aged 18 to 35, because they are considered the best stem cell donors. Do you have any other thoughts around specifically targeting that cohort of younger people and also targeting ethnically diverse people with, say, reimbursement, reward or compensation?

Julian KOPLIN: On specific thoughts about targeting the demographics as opposed to doing it in general, I can see why that might sit a little bit uncomfortably, but I think that the reason that it sits uncomfortably is not actually a sort of robust one. I think the reason why there is a moment of pause is because it feels like you are targeting groups that you want to take on the burden of these particular procedures and processes. But I do not think that that is what is genuinely happening here. You are targeting them and inducing them. That worry might apply if you were trying to get some of them to do something that they otherwise would not be incentivised to do, as opposed to raising awareness of an option that they may not be aware was there or if you were trying to facilitate something that they might want to do but otherwise would not do by removing these disincentives. I do not think that worry really applies. I think that, given that there are very good reasons for targeting these groups in particular, there are good reasons independent of their demographic—because donations from them would be particularly useful—I do not personally see any moral concerns there.

The CHAIR: Great. Are there any further questions from Committee Members? No. We will wrap up then. Thank you so much for appearing before the Committee today, and thanks to you and your colleagues for preparing the written submission. The time you have taken to prepare your evidence is greatly appreciated. We have heard a very different side of issues around organ and tissue donation today, so it has given us a lot to think about. Thank you so much for that.

Julian KOPLIN: You are very welcome.

The CHAIR: You will be provided with a proof version of today's transcript to check, together with the questions taken on notice. Verified transcripts and responses to any questions taken on notice will be published on the Committee's website. We will take a short break before our next witness.

Witness withdrew.