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Kidney Vouchers and Inequity in Transplantation

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A new “voucher” program aims to shrink the US waiting list for kidney transplants (Veale, 2016). The waiting list is long, hovering in 2017 at around 95,000 (United Network for Organ Sharing, 2017). During 2016, approximately 19,000 kidney transplants took place, meeting only approximately one fifth of the demand. For patients with end stage renal disease (ESRD), transplantation has greater health benefits than dialysis, both in terms of length and quality of life (Tonelli et al, 2011). Transplantation from living donors is optimal: it tops both dialysis and transplantation from deceased donors in terms of health outcomes and cost-effectiveness (LaPointe Rudow et al, 2015, 914). The new voucher program involves live donation.

The National Kidney Registry, a non-profit organization that aims to increase the quality and quantity of living donor transplants, administers the program. Launched in 2014, the program falls under the category of “paired exchange,” where a live donor gives one of her kidneys to a stranger in exchange for a compatible kidney for a particular intended recipient (e.g., a loved one). In the voucher program, the exchange does not take place at the time of donation. At that time, the donor’s intended recipient is not in need of a kidney transplant, and he might never require transplantation. But the intended recipient receives a voucher for a kidney from a live donor, redeemable if/when he needs one, perhaps a decade after someone donated to obtain the voucher for him. The voucher program might, for example, enable a grandfather to donate a kidney to someone in the

paired exchange program now, before he becomes too old to donate, in exchange for a voucher that his grandson, who has kidney disease, might redeem in the future for a kidney from a live donor if/when the grandson ends up needing one. Or the voucher program might allow a mother, whose son already has a kidney transplant, to donate to a stranger now, enabling him to get a voucher for another kidney, if the exigency arises.

This article probes the voucher program from an ethical perspective. It focuses mainly on an issue of inequity. A disparity exists in US kidney transplantation. While African-Americans suffer far higher rates of ESRD than whites, African-Americans are much less likely than whites to get a transplant (Ilori et al, 2015, 1). The article explores the voucher program in light of this disparity. It motivates the view that at least in the short term, more whites than African-Americans are likely to take advantage of the voucher program. The program is thus likely to increase the gap in transplantation rates between the two groups. If this is correct, what impact does it have on the moral acceptability of the program?

The article unfolds as follows: Section 1 examines the voucher program in more detail, highlighting some of the rules that govern it. Section 2 explores briefly some of the program's probable benefits as well as features that might trigger ethical worries—worries that turn out not to be particularly pressing. Section 3 develops a weightier ethical concern, namely the one regarding inequity, while Section 4 responds to this concern.

1: Voucher Program Rules

Before investigating the voucher program in an ethical light, we need to gain a more complete picture of how it works. Among the particular rules regulating it are the following

(National Kidney Registry, 2017b). Both the donor and his intended recipient (or the recipient's parent or guardian, if she is a child) must indicate in informed consent documents their awareness that a transplant for the intended recipient is not guaranteed. It is possible, for example, that no compatible organ can be found. Moreover, a voucher program donor may identify just one intended recipient, "unless multiple immediate family members have renal function impairment." If a donor identifies more than one, the first candidate suitable for a transplant receives the voucher kidney. After signing consent documents, the donor cannot alter his designation of voucher recipient. All intended voucher recipients must either already be transplant recipients (and thus possibly be in need in the future of another transplantation), or have or be expected to have some kidney problem. An intended recipient can redeem a voucher only if transplantation is medically indicated as a therapy for ESRD. If the intended recipient or recipients die before receiving a transplant, the voucher expires; it is not transferable to someone else. The donor cannot withdraw a voucher from an intended recipient once he has donated. Currently, there are around twenty transplant centers across the country that participate in the voucher program. A donor can undergo nephrectomy at a different center from the one at which the intended recipient ends up receiving a transplant.

When a donor in the voucher program undergoes nephrectomy, who, among compatible patients, receives the kidney? Available information suggests that top priority for the kidney would go to someone involved with paired exchange in one of the transplant

centers associated with the National Kidney Registry (National Kidney Registry, 2017a).¹ Good Samaritan donors (non-directed donors) in need of a transplant would, it seems, come first. (Good Samaritan donors give one of their kidneys to a stranger, but not in order to receive a voucher for anyone in the future.) Next in line, it appears, is a patient on behalf of whom someone has donated with the expectation that the patient would immediately receive a compatible kidney, but who has not received one. Patients with vouchers would be third in line, it seems, followed by “Children’s Health Insurance Program” patients. In any case, the person who receives the kidney would, I gather, in some way be associated with one of the centers involved in the voucher program.

2: Some Advantages and Drawbacks of the Program

Potential advantages of the voucher program are evident. A person who redeems a voucher (perhaps after several years) gets an organ from a live donor, instead, presumably, of going on the deceased donor waitlist. Kidneys from live donors tend to last longer than ones from deceased donors (LaPointe Rudow et al, 2015). Moreover, the deceased donor waitlist is lengthy. While on it, many people undergo dialysis, which tends to yield worse health outcomes than transplantation (Tonelli et al, 2011). And some on the waitlist die before obtaining a kidney (Organ Procurement and Transplantation Network, 2017b). A person’s redeeming the voucher may well enable him to have a higher quality of life or a

¹ I state priorities for voucher program kidney recipients tentatively because the National Kidney Registry website does not to my knowledge offer a transparent account of these priorities, and my efforts to gain clarification through contacting the Registry have been unsuccessful.

longer lifespan than he would if he did not have this option. Second, the donor who earns a voucher by undergoing nephrectomy can enable paired exchange transplants to occur. To construct a simple example, suppose that, outside of the voucher program, a husband wishes to donate to his wife who has end stage renal failure. But he cannot; as a result of her having blood type O, his kidney is not a match for her. However, a donor in the voucher program has blood type O, and it turns out that his kidney is suitable for her. At the same time his wife receives a kidney from the donor in the voucher program, the husband donates to an appropriate candidate for his kidney in the paired exchange program. The voucher donor thus facilitates the wife and a third party's acquisition of well-matched kidneys. In short, the voucher program can recruit live donors who would otherwise not have donated. Such recruitment seems especially important now, since live kidney donations have over the past decade or so been decreasing in the US (LaPointe Rudow et al, 2015, 915). The program can aid not only those who redeem vouchers (designated recipients), but also others who participate in paired kidney exchanges.²

A few possible drawbacks of the voucher program are also easy to identify. First, it is illegal to purchase organs for transplantation in the US. Some might argue that the voucher program is open to misuse in the form of unlawful payments. For example, a wealthy individual who suffers from chronic kidney disease and expects after a number of years to need a transplant might offer a large financial reward to someone, a stranger, to

² Of course, this discussion of advantages is not exhaustive. For example, an additional advantage might accrue to the donor: the moral pleasure arising from the expectation that his action will help his designated recipient as well as strangers participating in paired donation.

become a voucher program donor and list her as his sole voucher recipient. The voucher program does not limit intended recipients to family members. Whether one finds such unlawful payments unethical depends, of course, on several factors, including whether one holds there to be a moral obligation to obey the law and whether one judges the purchase or sale of a kidney to be intrinsically wrong. In any case, a risk for illegal (and perhaps unethical) behavior such as this does exist in connection to the voucher program. But such a risk also exists in connection to live kidney donation to strangers. If the risk is acceptable in the latter case, why would it not be in the former? The risk is acceptable in both cases, I believe, in light of the life preserving and enhancing benefits provided to recipients from live donation.

Second, one might be concerned that donors will be unduly pressured into participating in the voucher program. Their donation might not be fully voluntary, say, because it is the result of coercive family pushing and prodding. We assume here that full voluntariness in donation, which is morally preferable to a lesser degree of voluntariness or no voluntariness at all, requires that it not result from coercive pressure, that is, that it not, for example, take place against the background of a family threat to make a potential donor who opts against it worse off than he would be if the question of donation never arose. Take, for example, a forty-year-old man who has a fraught relationship with his sister, but who is financially dependent on her. Invoking her generosity, she might pressure him to enter the voucher program and donate on behalf of her teenage son who has kidney disease and will probably need a transplant. Of course, similar worries apply to directed live donation outside of the voucher program. To vary our example, the brother might be

pressured into a directed donation to his nephew, if the nephew needed a transplant right away.

Concerns about lack of full voluntariness in directed donation are reasonable. But a couple of points seem salient in response. Live donor transplantation in the US is governed by rules set forth by the Organ Procurement and Transplantation Network (OPTN). OPTN rules require not only that each live donor candidate undergo psychosocial evaluation, including “an assessment of whether the decision to donate is free of inducement, coercion, and other undue pressure,” but also that each candidate be represented by an “independent living donor advocate,” someone outside of the transplant team tasked with advocating for the donor’s rights (Organ Procurement and Transplantation Network, 2017a, 181-182). These OPTN required measures should diminish risk of insufficiently voluntary donation, whether the live donation takes place within or without the voucher program. A second point regarding the voluntariness of donation in the voucher program takes shape against the observation that a person feels more pressure to donate to a sibling when she witnesses the sibling’s suffering (e.g., by being in geographical proximity to him when he is in end stage renal failure) than if she does not witness it (Franklin & Crombie, 2003, 1251). It seems reasonable to assume that families as a whole feel more pressure to get a loved one a transplant when they witness his suffering. Of course, such feelings are consistent with fully voluntary donation. A person might reflectively endorse the idea that donation to make her sibling’s suffering cease expresses her deepest values. And none of her relatives might encourage the notion that they will make her suffer if she fails to donate. Nevertheless, the possibility of coercive pressure to donate would seem to increase when potential donors and their kin witness the suffering of a relative in need of a kidney.

Potential voucher program donors may well avoid witnessing their intended recipients suffering due to failing kidneys, even if they are nearby; for their kidneys might not fail for many years to come. Therefore, it seems reasonable to hypothesize, potential voucher program donors would tend to get less exposure than other potential directed donors to one sort of pressure that might contribute to diminishing the voluntariness of donation.

A third possible concern regarding the voucher program stems from one of the program's rules: if a donor lists only one intended recipient and that person dies before redeeming the voucher, the donor cannot transfer the voucher to someone else. Some might object that this provision gives the donor insufficient ability to ensure that her donation will do good for someone she cares about. She gives a kidney, but does not get one for someone of her choice. Granted, a donor in the voucher program can designate more than one possible voucher recipient, as long as the additional possible recipients are immediate family members with kidney disease. When a donor lists multiple intended recipients, one dying would not prevent another, namely, the first person on the list for whom a transplant is medically indicated, from getting a voucher for a kidney. But in cases where a donor does not have multiple possible voucher recipients (e.g., because she does not happen to have any immediate family members with kidney problems), the death of her intended recipient would indeed prevent her from using her donation to benefit someone she cares about.

Perhaps there is some reason to change the rule in question on the grounds that the program aims to give donors a chance to help particular individuals of their choosing. Might not a regulation stipulate that voucher program donors get the option of designating another recipient in case their (one and only) intended recipient has died? Would such a rule cause an undue administrative burden? The other intended recipient would be able to

redeem the voucher, of course, only if transplantation was medically indicated. In any case, it would be precipitate to conclude that voucher program participants, even those (if any) whose designated recipient has died, are thereby treated unfairly. The rules of the voucher program are presumably made known to prospective participants in advance of their giving their consent to join.

3: An Equity Concern

Another concern about the voucher program deserves more attention. In brief, the concern is that the program will exacerbate inequities in the practice of kidney transplantation in the US. In discussing this concern, I focus on kidney transplantation among African-Americans as opposed to whites. African-Americans in the US are well over three times more likely than whites to suffer from ESRD (Kucirka et al, 2011, 620); but they are approximately half as likely receive a kidney (Ilori et al, 2015, 1). Moreover, younger (18-30 years old) African Americans on dialysis die at almost twice the rate of younger whites on dialysis (Kucirka et al, 2011, 624). While some of the difference in transplantation rates seems to have a basis in a larger proportion of African-Americans than white ESRD patients being medically unsuitable for transplantation, evidence indicates that medical reasons fall far short of accounting for the difference as a whole (Epstein et al, 2000). The large difference in transplantation rates between African-Americans and whites in the US amounts to an inequity, or, equivalently in my usage, a

disparity: it is both avoidable and unfair or unjust to African-Americans, I believe.³ Other things being equal, fairness dictates that the difference should diminish; the rate of kidney transplantations among African-Americans should increase.

Of course, some might deny that the difference in transplantation rates constitutes an inequity. They might argue, for example, that the gap derives wholly from behavior for which individuals are morally responsible. Among such behavior, they might assert, is African-American's failing to inform themselves regarding the health advantages of transplantation over dialysis. If this gap stems from such behavior it constitutes a difference, but not an inequity, they might conclude. But I believe and will here assume that such arguments are flawed.⁴

To mention one salient point, evidence indicates that a basis of the disparity lies in the behavior of medical professionals themselves. According to one study, among patients considered by independent experts to be appropriate candidates for transplantation, African-Americans were less likely than whites to be referred for evaluation for transplantation and less likely to be placed on a waiting list. Moreover, whites whom

³ A new system for allocating kidneys to patients on the deceased donor waiting list was implemented in December 2014. According to a recent report, data gathered after the change gives "no evidence of systematic bias in this system with respect to kidney transplant access by ethnicity" (Organ Procurement and Transplantation Network/United Network for Organ Sharing, 2016, 55). However, as the report itself suggests (55), this finding is consistent with there being ethnicity-related bias regarding who gets on the waiting list.

⁴ For helpful discussion of these issues see Daniels, N. (2008) *Just Health: Meeting Health Needs Fairly*. Cambridge: Cambridge University Press.

experts judged to be *inappropriate* candidates for transplantation were more likely than African-Americans whom experts so judged to be referred for evaluation and more likely to be placed on a waiting list (Epstein et al, 2000, 1537).

As discussed in some detail below, another basis for the difference in transplantation rates seems to be African-Americans' distrust of the US medical system. Since African-Americans have less trust in the system than whites, they are less willing to participate in transplantation (Goodwin, 2006). This distrust is longstanding, and it stems from a long history of medical abuse and betrayal, including experimentation on slaves, eugenics-inspired sterilization, and the Tuskegee syphilis study (Goodwin, 2006). Are African-Americans morally responsible for allowing this distrust to diminish their willingness to participate in kidney transplantation in a way that reduces the extent that the difference in transplantation rates constitutes an inequity? I doubt that very much.

Let me now explain why we might be concerned that the voucher program would exacerbate disparities in US transplantation. At least upon first sight, it seems reasonable to react to the program as one whose main beneficiaries are likely to be people of high socio-economic status. According to a *Wall Street Journal* article describing the program (Veale, 2016), a retired judge developed the idea for it. The judge's grandson was born with one kidney, which was not working well. But by the time the boy would need a transplant, the grandfather would be too old to donate. This judge is well-educated and, presumably, well-insured. But how many people who are unlike him in these respects would take part in this program? The good fortune involved in the grandson receiving from his grandfather a kidney voucher (as he apparently has) seems somewhat akin to the good fortune he would have in receiving from the grandfather a fund to pay for college. In the case of both of these

bequests, it is good fortune that stems in part from the grandfather's relatively lofty socio-economic position.

The idea that African-Americans are less likely to participate in the voucher program than whites gains support, albeit indirect, from studies of African-American participation in and attitudes towards live kidney donation in general. A study of African-American and white living kidney donors in the US registered in the United Network for Organ Sharing (UNOS) between 1998 and 2010 found the incidence of living donation to be lower among African-Americans than among whites in zip codes with the lowest median household income (Gill et al, 2013, 3). It is in these zip codes where the greatest number of African-Americans with ESRD reside, according to the study. A recent questionnaire-based study finds that willingness to donate kidneys to relatives in need was lower among African-Americans than among Hispanics or whites (Purnell et al, 2013, 677). The authors hypothesize that greater distrust of doctors and hospitals among African-Americans than among whites contributed to this result. As mentioned above, the voucher program is a kind of kidney paired exchange, where a live donor gives one of her kidneys to a stranger in exchange for a compatible kidney for a particular intended receipt (e.g., a loved one). Transplant experts have written recently that kidney paired exchange "is very complex and characterized by many moving parts, which require exquisite coordination for seamless and successful execution. It is challenging even for transplant professionals . . . to have unwavering trust and faith in the process" (Rodrigue et al, 2015b, 239). In their study of former potential living donors and recipients in paired exchange, they find distrust (e.g., regarding whether the intended recipient would actually receive a kidney in exchange for the donor's kidney) to be a prominent concern. Moreover, they find African-Americans to

have more overall concern with kidney paired donation than whites. These studies do not, of course, demonstrate that fewer African-Americans than whites will participate in the voucher program. But it makes sense to hypothesize that they would. The voucher program seems to require an especially high level of trust in the medical establishment. Years or even decades might go by before an intended recipient would receive a kidney in exchange for the donor's giving one to a stranger. Participation in the program appears to involve considerable confidence in the reliability of medical institutions—confidence that, evidence indicates, may be absent in the African-American community.

In sum, the equity concern regarding the voucher program is the following. There are already disparities in the practice of kidney transplantation in the US. Among patients with ESRD, African-Americans are far less likely than whites to get a transplant. If the voucher program attracts significant numbers of participants, it will probably make the gap in transplantation rates even wider. More white people than black people will take advantage of it, thereby augmenting unfairness.⁵

4: Responding to the Equity Concern

In response, let us suppose that the voucher program will amplify unfairness; it will widen the gap between the likelihood of an African-American person getting a transplant

⁵ Of course, this kind of equity concern is not unique to the voucher program or to kidney transplantation. It arises whenever there is a disparity (i.e., unjust difference) in the rate at which different groups (e.g., regarding ethnicity or income) get a health resource, and an augmentation in the availability of the resource increases the disparity.

and that of a white person getting one. According to many of us, it does not thereby follow that the voucher program should, morally speaking, be rejected. This does not follow because, many of us believe, it can be permissible, all things considered, to distribute health benefits in a way that aggravates inequities if it also increases overall health benefits.

This point will become clearer against the background of two scenarios. In describing them, I suppose, as studies have shown, that live donors of a particular race tend overwhelmingly to donate to members of the same race (Lentine & Segev, 2013, 862). In the first scenario, let us assume that the voucher program has no net effect on the number of African-Americans who get transplantations, but increases the number of whites who receive them. Inequity increases. But no one is worse off in terms of health than she would be in the absence of the voucher program.⁶ Some are significantly better off, namely, those white individuals who get transplants instead of remaining on dialysis.

In this scenario, some would judge the voucher program to be morally acceptable, all things considered. First, the program does not seem to violate at least some commonly embraced moral constraints that are salient in this context. By a moral constraint let us understand an all-things-considered prohibition on performing a certain type of action in

⁶ It is an idealization to specify that no one is worse off in terms of her health than she would be in the absence of the voucher program. If, as a result of the program, some transplants take place that would not have otherwise, the program might lead to an ESRD patient who receives a transplant suffering from surgical complications and thereby dying sooner than she would have had she remained on dialysis. I adopt this idealization for the sake of simplicity; it does not, in my view, affect substantively any of the article's ethical claims.

some cases in which doing so would bring about the best consequences overall (Kagan, 1998).

An example of such a constraint is that against treating others merely as means. Many people think that it can be wrong to use another merely as a means, for example, by extracting her vital organs to save seven other people (and in the process killing her), even if doing so produces better results (e.g., six people surviving who would not have otherwise) than any other available action. The voucher program does not appear to treat donors merely as means, at least not on one Kantian account of doing so (Kerstein, 2013). Suppose a person uses another. On this account, she uses him merely as a means roughly if the other can neither consent to her use of him nor share the proximate end(s) she is pursuing in using him. A person cannot consent to be used in some way if he cannot avert the use simply by dissenting from it. And a person being treated as a means to some end cannot share this end roughly if it would be prudentially irrational for her to pursue it. Administrators of the voucher program do, of course, use donors to get kidneys for transplantation. But, assuming the program respects informed consent procedures, potential donors can avert administrators' use of them simply by dissenting from it. So the administrators' use of donors in the program does not fulfill the account's jointly sufficient conditions for treating them merely as means. Of course, program administrators do not treat potential participants who refrain from entering the program merely as means. In order to treat them merely as means, they would have to treat them as means, that is, use them. But they do not do so.

Even if the voucher program does not run afoul of a constraint against treating others merely as means, does it not violate a different one, say, a constraint against

foreseeably augmenting inequities? This is not the occasion to argue in detail for there being such a constraint. But the notion that there is has some plausibility. The constraint would hold that it is sometimes wrong, all things considered, to do something that, one foresees, will increase inequity even when doing it will have the best consequences overall. Here is one kind of case that provides intuitive support for such a constraint. Suppose that three people on a camping trip have cooperated equally in making a meal (e.g., they have contributed groceries of the same value and worked just as hard by the campfire). Two of them have left the third with a lesser portion, though, as they realize, he would prefer a full one. It would be all-things-considered wrong, it seems, for the two to *further* cut this person's portion, thus augmenting an existent inequity, even if their doing so would maximize overall good. (Their doing so might maximize overall good if, say, the two would get immense enjoyment from the dish, but the one would not.)

Defenders of the notion that the voucher program is morally acceptable in the first scenario might endorse this constraint, according to which it is *sometimes* wrong, all things considered, to do something that, one foresees, will increase inequity even when doing it will have the best consequences overall. However, they might hold that the voucher program does not present us with a case in which the constraint gets violated. The goodness of more ESRD patients benefitting in terms of their health from live transplantation would clearly override both the badness, if there is any, intrinsic to the action of implementing a program that foreseeably augments inequity as well as the badness of more inequity emerging in the world, they might insist. The defenders might maintain that although in some cases it is indeed wrong, all things considered, to augment inequity when doing so has the best effects overall, this scenario does not represent such a

case. They might bolster their position by pointing out that in the scenario, the voucher program renders no ESRD patients worse off in terms of their health than they are under the current regime. Of course, that in the first scenario the voucher program would not violate either of the two constraints we have considered fails to entail that it would steer clear of violating all moral constraints.

Nevertheless, many, I venture, would judge the voucher program morally acceptable in this first scenario. Their judgment would be based in part, I believe, on an implicit assumption. This is the plausible assumption that voucher recipients such as the judge's nephew have not significantly contributed to the social practices that presumably underlie the disparity in transplantation rates between whites and African-Americans. In other words, it's not the fault of those who would profit from vouchers that relatively few African-American's receive kidneys.

Those who endorse the voucher program's moral acceptability in the first scenario might, on reflection, also judge their endorsement to be contingent on its having very significant health benefits. Let me try to illustrate this point. Suppose access to some scarce medication for a minor skin ailment differs between whites and Hispanics: whites get it more often. The medication is fairly effective, and equally so on members of each population. Moreover, the difference in access constitutes a disparity: it is unfair. It is not obvious that it would be morally permissible for a government agency to introduce a program that unintentionally but foreseeably augmented the unfair gap in access to the medication by benefitting whites but no Hispanics, even if no Hispanics would thereby be worse off in terms of their health. A key difference between this case and that of the

voucher program is that in the latter a lot more is at stake for the advantaged group than relief from a minor skin condition.

In any case, a second scenario has more verisimilitude than the first. In the second, the voucher program increases the number of whites who receive kidney transplants. Whites who would otherwise not have donated do so in order to get a voucher for a family member, for example. However, unlike in the first scenario, the program also increases the number of African-Americans who receive a transplant. It does so in part because some African-Americans who would not otherwise be donors participate in the program, thus securing a transplant for a loved-one. But it also does so indirectly. Some individuals who receive a voucher and then a kidney from participation in the program would otherwise have been on the deceased donor waiting list. Since they do not end up on the list, others move up, including African-Americans. In this second scenario, like the first, inequity increases. But, again, no one is worse off regarding her health than she would be in the absence of the voucher program. Indeed, some are significantly better off, namely, those white as well as a smaller number of African-Americans who get transplants instead of dialysis.

This second scenario approximates the impact the voucher program may well actually have, in my view. Many of us believe that in it, the voucher program's moral acceptability is clear. As in the first scenario, in this one the program does not seem to violate context-salient moral constraints, such as that against treating people merely as means. The program does exacerbate inequity, but this negative impact seems to be outweighed by an important benefit, namely, ESRD patients, including African-Americans and whites, leading healthier and longer lives than they otherwise would. A key difference

between this scenario and the first is, of course, that in the second the voucher program makes some African-American ESRD patients much better off in terms of their health than they would otherwise be.

In both of the scenarios sketched above, the voucher program makes no one worse-off regarding her health in the following sense: no individual's health is worse than it would be in the absence of the voucher program. Someone might object that the scenarios employ one notion of being worse off but overlook another notion of it, one that is morally important in this context. The program will increase the extent to which African-Americans *as a group* are worse off in terms of health than whites as a group, the objector affirms. After all, in both scenarios, the gap between African-Americans and whites in transplantation rates (and thus, presumably, in overall health) increases. It is this relative, collective notion of being worse off that the scenarios ignore. But once this notion comes to light, the objector concludes, the moral permissibility of the voucher program becomes questionable.

Two points seem salient in response. First, it is unclear what invoking a relative, collective notion of being worse off adds of moral importance to the discussion. Both scenarios, let us recall, unfold against the background supposition that the voucher program will widen the gap between the likelihood of an African-American person getting a transplant and that of a white person getting one, thereby amplifying extant unfairness. The unfairness in question derives roughly from whites having greater access than African-Americans to a significant health-related good, namely kidney transplantation, when the difference in access is not morally warranted. Second, let us grant that the voucher program would, regarding health, make African-Americans as a group worse off relative to

whites than they would be in its absence. Many of us are nevertheless inclined to see the program as morally permissible, especially in the second scenario. We judge the benefits, which accrue to some African-Americans and a greater number of whites, of longer and healthier lives to outweigh the drawback of African-Americans as a group becoming worse off relative to whites as a group. Of course, this judgment is akin to one, mentioned above, that these benefits would outweigh the drawback of an amplification of inequity.

Some in the transplant community are cognizant of the disparity in transplantation rates between African-Americans and other groups. They are exploring its causes as well as ways to diminish it (LaPointe Rudow et al, 2015; Rodrigue et al, 2015a). As mentioned above, evidence suggests that one ground of the disparity lies in the behavior of medical professionals who, other things being equal, are less likely to refer African-Americans than whites for evaluation to get on the transplant waiting list. Evidence points to implicit bias against African-Americans in the healthcare realm as whole (Maina et al, 2017). It thus makes sense to wonder whether this lower likelihood stems in part from implicit bias. Distrust of the medical establishment among African-Americans also appears to diminish their participation in kidney transplantation, as suggested above. It is, I think, an open and pressing question how to best combat these first two bases of the disparity.

Other barriers to transplantation among African-Americans are perhaps easier to displace. One is a lack of awareness of the health advantages of transplant over dialysis in the treatment of ESRD (Ilori et al, 2015). It appears that some patients with chronic kidney disease do not seek transplantation because they do not know of its benefits. Improvement in communication between doctor and patient is an obvious response to this difficulty. Barriers to live donation in particular include the difficulty some African-American kidney

patients have of informing relatives and friends of the option of becoming live donors. Researchers are exploring some promising ways to facilitate these conversations, including “house call” interventions, during which transplant educators deliver a program describing living donation to the patient and guests (e.g., family members and friends) (Rodrigue et al, 2016). Another obstacle to live donation may be the fear that it would be too expensive in terms of travel or lost wages (Rodrigue et al, 2015a, 1691). The National Living Donor Assistance Center, supported with federal funds, offers reimbursement of travel and subsistence expenses for qualifying donors. It is also piloting a program that compensates some donors for lost wages. In any case, removing or at least diminishing the obstacles mentioned would, it appears, encourage African-American participation in the voucher program.

Despite its potential to increase disparity in transplantation rates, the voucher program is laudable as an instrument for decreasing the kidney transplant waiting list. The program promises to reduce morbidity and mortality among ESRD patients by attracting people who otherwise would not have made a live donation. But since its inception in 2014 through the first quarter of 2017, less than 20 voucher program donations have occurred across the US (National Kidney Registry, 2017c, 22). We can expect the program to gain momentum as awareness of it grows. Yet it is nevertheless difficult to see how the program could on its own result in dramatic reductions to the waiting list. In order to do that, the program would need to enroll large numbers of people who are willing to sacrifice for loved ones not yet suffering from ESRD. But intuitively, at least, it seems that potential donors would be more likely to undergo nephrectomy to combat actual or imminent

suffering than to avert misfortune that might or might not arise. And even among those people who would donate for the sake of possibly benefiting a loved-one in the future, some will not take this step. They will be ignorant, or at least not know before they become medically ineligible to donate (e.g., due to age), that their loved one will develop serious kidney disease. According to transplant surgeon Richard Veale, the voucher program “could be our only realistic shot at eliminating the waiting list for kidney transplants” (Veale, 2016). Let us hope that there are other morally permissible ways to eliminate it.⁷

⁷ I am grateful to two reviewers for this *Journal* for their helpful comments.

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