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Translation of the Spanish model to Australia: pros and cons

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The national organ donation management scheme developed by Dr Rafael Matesanz, implemented as the «Organización Nacional de Trasplantes» (ONT), is known internationally as «the Spanish model».

The impact on cadaveric donation rates in Spain, following establishment of ONT in 1989, was immediate and dramatic. Using the international measure of donor rates (donors per million of population), Spain's donation rate climbed from 14.3 dpmp (1989)[1] to 17.8 dpmp (1990)[1], to its current rate of 33.6 dpmp (1999)[2]. In some provinces, donation rates exceed 50 dpmp[3]. Comparative cadaveric donation rates in Australia were 14 dpmp (1989)[4], 12 dmp (1990)[4] and 9 dpmp (1999)[5].

Noting the linear improvement in Spain's cadaveric donation rate, when Australia's rate was steadily declining, the initiative to translate elements of «the Spanish model» to Australia was taken by South Australian Health Minister-Hon Dr Michael Armitage. Establishment of the South Australian Organ Donation Agency (SAODA) in 1996 presaged the establishment of agencies in all other States of Australia, adopting elements of the model deemed appropriate for their circumstances.

This paper examines the extent to which elements of «the Spanish model» have been adopted in Australia, and the preliminary impact of such adoption on cadaveric donation rates.

BACKGROUND-AUSTRALIA'S POLITICAL LANDSCAPE

Since the presence of a powerful and well-funded national donation agency (ONT) is central to «the Spanish model», it is important to understand the extent to which Australia's federated system of Government restricts its ability to replicate the model.

Founded as a penal colony by England in 1788, Australia's first move to self-Government occurred in 1855-6, in New South Wales. South Australia followed in 1856, Tasmania in 1887, and Western Australia in 1890. The Northern Territory achieved limited self-Government in 1978, the Australian Capital Territory in 1988. The States did not form a collaborating Federation until 1901.

The Commonwealth and all States and Territories operate their own Constitutions, which are not necessarily complementary. In fact there are significant differences, which despite Federation are maintained to the present. States need not be similarly constituted even with regard to what might be termed «national» interests. Nor, beyond sharing national tax benefits, is there commonality between the Commonwealth, States and Territories.

While support for national Health schemes is contained within «block» funding from the Commonwealth to the States and Territories, recently the Commonwealth has shifted away from any notion of «tied» grants.

This financial independence is reflected in variations in Government, administration and even social attitudes, nearly 150 years after the first State achieved self-Government.

While there may be strength in diversity, attempts to implement national programs —especially when they depend on shared funding arrangements— are guaranteed to be prolonged, frustrating and frequently acrimonious.

Empowered, nationally-funded agencies such as the ONT in Spain, or the Etablissement Français des Greffes in France, could never function within Australia's political landscape. A major funding consideration is the tax base available to support national programs —some 40 million people in Spain, but only 18 million in Australia.

CHRONOLOGY OF ADOPTION BY STATES OF ELEMENTS OF THE SPANISH MODEL

The «Spanish model» comprises a number of elements, at national, regional and local levels, forming

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a cohesive national structure. The principal element is its establishment of a strong, adequately funded national authority (the ONT), which for reasons discussed above is unlikely to be either favoured or politically possible in Australia.

At the national level, Australia has a collaborating network organisation called Australians Donate Inc (AD), which comprises representatives of a broad cross-section of the national donation and transplantation infrastructure. AD has no power to direct or control State agencies, nor does it actively coordinate the retrieval, transport, storage and allocation of organs and tissue.

There are organisations which manage the tissue matching and allocation of available organs to recipients (the National Organ Matching Service), and the implementation of nationally consistent practices for the management and care of donors and their families (guidelines produced by the Australia & New Zealand Intensive Care Society —ANZICS— and the Australasian Transplant Coordinators Association-ATCA).

At the regional level, the adoption of elements of «the Spanish model» has therefore been the province of State agencies. These are responsible for managing the identification and management of donors, the care of their families, and for notifying transplant units of the availability of donated organs.

Commencing with the South Australian Organ Donation Agency (SAODA) in 1996, all Australian States now have agencies. South Australia is additionally responsible for the Northern Territory; NSW is responsible for the Australian Capital Territory; and Victoria is responsible for Tasmania. There are therefore 5 State agencies.

Elements of «the Spanish model» available for adoption by State agencies include:

1. *the location of donation teams in every donating hospital;*
2. *the inclusion on teams of at least one member who is medically qualified;*
3. *the establishment of nationally consistent «best practices» in identification, management and care of donors and their families;*
4. *national management of media relations, emphasising consistent messages.*

Observations on the uptake by State agencies of these elements follow:

1. *The location of donation teams in every donating hospital - (The adoption of this element by Australian State agencies is highly variable).*

South Australia/NT (est 1996): 5 donor coordinators (3 full-time, 2 part-time), a fulltime Manager and a part-time Medical Director, all centrally located in a «shop front» office in central Adelaide. Donor coordinators have nominal responsibility for donations at designated hospitals in Adelaide and the Northern Territory.

New South Wales/ACT (est 1997): 3 full-time donor coordinators, full-time Manager, full-time Grief Counsellor, and full-time Media Manager, located in Sydney. No Medical Director. Supported by 8 part-time «area coordinators» located in hospitals in regional centres, but not empowered to manage donations beyond the identification of potential donors.

Queensland (est 1999): 3 full-time donor coordinators and full-time Manager, in centrally located office within the Princess Alexandra Hospital in Brisbane. No Medical Director. Donor coordinators have nominal responsibility for donations at designated hospitals in Brisbane. Supported by 8 part-time link nurses» located chiefly beyond the metro area, and who facilitate local donations.

Western Australia (est 2000): 3 full-time donor coordinators, full-time Manager and full-time Medical Director (a former practising intensivist). 3 part-time medical coordinators each responsible for donor management in principal donating hospitals. Donor coordinators responsible for donations at designated hospitals.

Victoria/Tas (est 2001): 3 full-time donor coordinators, full-time Manager and part-time Medical Director (a practising intensivist). Donor coordinators cover all donating hospitals for the purposes of facilitating donation.

2. *The inclusion on teams of at least one member who is medically qualified.*

Only South Australia, Western Australia and Victoria include in their State agency structures provision for a Medical Director. Only in South Australia and Western Australia is the staff of the agency augmented by part-time engagement of intensivists working in donating hospitals.

3. *The establishment of nationally consistent «best practices» in identification, management and care of donors and their families.*

Since, as noted above, the national agency (AD) has no power to direct or control, adoption of national «best practices» is a voluntary process, which by virtue of the wide disparity in agency structures mitigates against national consistency.

4. *National management of media relations, emphasising consistent messages.*

For the same reasons as in (3) above, there is no provision for national media management; should that situation change, there would be no guarantee that State agencies need abide by national media management strategies. Only New South Wales employs a media officer.

There is growing recognition of the need for centrally-managed, professional media liaison services

for the national network. AD is currently lobbying for the engagement of such services -in whatever guise.

IMPACT OF THE ADOPTION OF ELEMENTS OF «THE SPANISH MODEL» ON DONATION RATES IN AUSTRALIA

Tabla. Australia and New Zealand. Number of Donors 1995-1999

	1995	1996	1997	1998	1999
Queensland	34 (10)	35 (10)	37 (11)	40 (12)	20 (6)
New South Wales/ACT	67 (10)	69 (11)	69 (10)	65 (10)	50 (7)
Victoria	38 (8)	49 (11)	42 (9)	40 (9)	42 (9)
Tasmania	4 (8)	1 (2)	5 (11)	0 (0)	6 (13)
South Australia	23 (16)	25 (17)	25 (17)	35 (24)	30 (20)
Northern Territory	1 (6)	3 (17)	4 (21)	3 (16)	3 (16)
Western Australia	17 (10)	12 (7)	8 (4)	13 (7)	13 (7)
Australia	184 (10)	194 (11)	190 (10)	196 (10)	164 (9)
New Zealand	35 (10)	36 (10)	42 (11)	46 (12)	39 (10)

Donors Per Million of Population.
Source: ANZDATA 2000 Report, page 2.

It is still very early days in the adoption, by some State agencies, of elements of «the Spanish model». [The most recent State agency (Victoria) commenced early in 2001].

Of those, the first (South Australia) has adopted more elements of the model than others, and enjoys the greatest improvement in donation rates. The Table «Number of Donors 1995-1999»[6] shows that, before adopting elements of «the Spanish model», South Australia's donation rate was 16 dpmp; upon its establishment, the rate rose to 17 dpmp, repeated in 1997; lifted to 24 dpmp in 1998; settling to 20 dpmp in 1999; with a repeat of that rate (not shown on this table) in 2000[7]. These rates —modest alongside those achieved in Spain— are still better than double the national donation rate.

The New South Wales experience has been less satisfactory, and may reflect that State agency's adoption of very little of «the Spanish model». The rate actually fell (to 7 dpmp) in the year following the agency's commencement, and in year 2000 returned to 9 dpmp[7] only with strong support from the Australian Capital Territory.

Queensland's agency only commenced in 1999, but enjoyed an immediate lift in its rate from an unusually poor 6 dpmp in 1999, to 10.4 dpmp[6] in 2000.

Both the Western Australian and Victorian agencies have been operating for less than a year, but in WA a vigorous campaign to lift rates, before establishment of their agency, saw their previously poor rate of 7 dpmp (1999) lift to 11.7 dpmp[6] in 2000.

OTHER FACTORS AFFECTING DONATION RATES IN AUSTRALIA

Some recent developments, other than adoption by State agencies of elements of «the Spanish model», are expected to impact positively on donation rates in Australia.

- The establishment of a nationally accessible register of intending donors —the Australian Organ Donor Register— with direct and frequent contact with every Australian registered with the national health service, «Medicare». «Authorised medical personnel» from anywhere in Australia may access the Register, posted on the Internet, 24 hrs daily/365 days annually. Launched in november 2000, the Register has yet to reach its full operating potential, when it will be possible to monitor its ability to reduce the incidence of family refusals to allow donation, where the potential donors' wishes have been unknown;
- The completion of an in-service training program —the ADAPT Medical Module— for assisting intensivists and others charged with the responsibility to request donation. The program has been developed with the active participation of the Australia and New Zealand Intensive Care Society, and holds promise of regularising «best practice» in the request process nationally;
- Improved vehicle safety requirements, stronger enforcement of statutory speed limits, better roads and driver education programs have caused a 40% decrease in Australia's deaths through road trauma. But it is noted that a similar drop was experienced in Spain, during which time their donation rates climbed steadily; and
- Independent surveys indicate that 90% of Australians support the principle of organ donation[8], and 46.3% of Australians have already taken some step or steps to record their wish to donate[9].

CONCLUSIONS

1. The State agency which has replicated most elements of «the Spanish model» (South Australia) enjoys the greatest improvement in cadaveric donation rates;
2. The agency (New South Wales) adopting fewest elements of the model continues to suffer poor cadaveric donation rates. Despite a recent Review of

its first years of operation, it shows no inclination to adopt further elements;

3. Two States (Queensland and Western Australia) have adopted some key elements of the model, and their rates of cadaveric donation have shown immediate improvements;

4. The Victorian agency commenced in 2001 —outcomes yet to be measured;

5. Two National Forums on Organ & Tissue Donation produced calls for national consistency in the adoption of «best practices» in the identification, management and care of donors and their families, which will encourage State agencies to adopt voluntarily those processes and codes which may be possible to implement by decree from an organisation like the ONT in Spain;

6. The national coverage now afforded by the establishment of State agencies, the implementation of new national programs in the fields of professional and public education, and the enlistment of intending donors, offer new opportunities for lifting the rate of cadaveric donation in Australia. It should be possible to report more comprehensively on the continuing impact of «the Spanish model» on Australia's donation rates, over the next 3 to 5 years.

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