International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Interlinking Organ Scarcirty to Human Rights

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ABSTRACT

Organ failure is a medical emergency that causes immense suffering and a life-threatening situation. Organ transplant is the only treatment for organ failures other than renal failure. Even in cases of kidney failure, transplant is the most cost effective treatment for organ failure to prolong the lives of sufferers. The advancement of medical science in the field of transplants has improved human longevity and on an average life could be prolonged by ten- eleven years. Organ procurement from a donor is the first stage in a transplant. As in the case of blood, the organ is required to be healthy and must match. However, there is an inadequacy of organs across the world and patients who could be given a new life, die during the wait. The connection with human rights has been least explicit in the context of organ scarcity.

Globally, two consent systems for organ donation can be found. The opt- in system also known as the explicit consent system requisites an express consent of either the person when alive for organ donation or their relatives after death. By contrast, opt-out systems presume everyone to be a donor and people are required to express their objection. It is generally seen that countries with presumed consent system have higher rates of organ donation in comparison to countries with opt- in system. India has opted- in system and despite having the highest population is donor rate is among the lowest in the world.

This essay has two distinct objectives: First, it seeks to interlink organ scarcity to human rights. For this purpose it draws upon International Human Rights Framework. Second, it looks into the Indian law and analyses the lessons India needs to learn to improve its organ donation rate. Technological developments in the field have opened up the possibility of transplanting an increasing number of human organs, including the non vital ones like uterus, to those in need. However, the focus of the present research is limited to vital organs and does not extend to tissues and non- vital organs. Though there are human rights issues involved with allocation of organs and organ trafficking, those fall beyond the scope of the Article.

INTRODUCTION

Organ failure is a medical emergency that causes immense suffering and a life-threatening situation. Organ transplant is the only treatment for organ failures other than renal failure. Even in cases of kidney failure, transplant is the most cost effective treatment for organ failure to prolong the lives of sufferers. The advancement of medical science in the field of transplants has improved human longevity and on an average life could be prolonged by ten- eleven years. Organ procurement from a donor is the first stage in a transplant. As in the case of blood, the organ is required to be healthy and must match. However, there is an inadequacy of organs across the world and patients who could be given a new life, die during the wait. The connection with human rights has been least explicit in the context of organ scarcity.

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I. INTERLINKING ORGAN SCARCITY TO HUMAN RIGHTS

Everyone has a right to emergency care and health goods for the purpose of treatment. The researcher argues that organs for the purpose of transplant constitute health goods and hence, access to them for therapeutic purposes can be affirmed as a human right, in so far as it is a component of the right to health, enshrined under Article 12 of the International Covenant on Economic, Social and Cultural Rights.[1]

RIGHT TO HEALTH

Although relatively young, the Right to health is prominently placed among the internationally recognized rights. The WHO Constitution 1946 was the first international legal instrument to recognize the enjoyment of highest attainable standard of health as one of the fundamental rights of every human being without distinction.[2] The right to health resurfaced after two years in the Universal Declaration of Human Rights under Article 25 which states that "everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services". Right to health was recognized as a component of right to adequate standard of living by UDHR. The incorporation of the right to health in the ICESCR under Article 12 made it legally effective and this is the most authoritative international text on right to health. Paragraph 1 reads as 'States recognize the right of everyone to the highest attainable standard of physical and mental health.' Paragraph 2 enlists the elements which constitute right to health and requires the States to take necessary steps towards their full realization. "Prevention, treatment and control of epidemic, endemic, occupational and other diseases" have been recognized under Article 12(2) (c). This means the states are required to take necessary steps towards treating organ failures. This Article reflects a public health element in the right to health. [3]State parties must take all possible deliberate, concrete and targeted steps towards the treatment and full realization of the right to health. The right to health has also been recognized by International Convention on the Elimination of All Forms of Racial Discrimination[4],

[1] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966 993 UNTS 3) (ICESCR) Art 12.
[2] UN General Assembly, *Entry into force of the constitution of the World Health Organization*, 17 November 1947, A/RES/131, Preamble.
[3] John Tobin, *The Meaning of the Highest Attainable Standard of Health (*Oxford University Press 2011) p 26.
[4]International Convention on the Elimination of All Forms of Racial Discrimination, 660 UNTS 195 (21 December 1965) (CERD) art 5 (e) (iv).

the Convention on the Elimination of All Forms of Discrimination against Women[5] and the Convention on the Rights of the Child[6].

The Committee on Economic, Social and Cultural Rights, the fundamental UN body that looks into the realization of the Covenant, published a General Comment No 14.[7] It elucidated "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."[8] Organ transplantation is an essential treatment for end stage organ failures that can enhance people's health and life. Organ transplant is only possible if there is an organ to transport to the body of the patient. The researcher asserts in so far as organs are indispensable for organ transplant, [9]they are medical goods and all those in need of transplant have a right to them as a part of their right to enjoy the highest possible standard of health.

Organ scarcity has a cumulative effect on life- expectancy, mental and physical health, quality of life, and economic life. The researcher argues that in context of organ transplant, non availability of organ results is denial to organ transplant and therefore constitutes degrading treatment. In fact, irregular availability of organs for transplant, undermines the right to health of the patient and is equivalent of sentencing him to painful death, in the sense that failing to provide the requisite organ puts the life of the done at risk.

For justiciability of access to organs, analogy may be drawn from cases concerning Access to medicines. Litigation in the later 1990's lead to interpretation by numerous supranational and national courts that access to HIV treatment was a part of right to life and health.[10]Moreover, the ECHR has quashed deportation orders in cases where life- saving treatment could not be received in the home country on the grounds that same would amount to inhuman and degrading treatment.[11] The researcher asserts that likewise access to organs for organ transplant is a fundamental right and access to organs for the critical element of this right. These medicines are very expensive and hardly prolong life but the courts have recognized access to them as a fundamental right of all affected due to the socio- economic aspects of the disease triggered success in the cases. Though not a stigmatized disease, patients with organ failure have to suffer tremendously on the financial front as the deterioration in health makes them incompetent and wait for organs also causes them and their family mental agony. Arguably, failure to access organs and proceed with transplant amounts to inhuman treatment and violation of the right to highest standard of health and human dignity.

The researcher submits that the Constitutional Court of South Africa erred in holding that chronic renal failure was merely an ongoing chronic illness and did not qualify as an emergency. It is asserted that end stage organ failure does qualify as an emergency because treatment at that stage can save life and failure

[5] Convention on the Elimination of All Forms of Discrimination against Women, 1249 UNTS 13; 19 ILM 33, (18 December 1979) (CEDAW) arts 11(f) and 12.
[6] Convention on the Rights of the Child, 1577 UNTS 3; 28 ILM 1456 (20 November 1989) art 24(1).
[7] CESCR, General Comment No. 14, 22nd Sess, E/C.12/2000/4 (4 July 2000) .
[8] IBID, para 9.
[9]The researcher uses the term in so far as to exclude from the scope medical institutes and hospitals that seek organs for research.
[10]Treatment Action Campaign v Minister of Health 2002 5 SA 721 (CC).; Mary Ann Torres, 'The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela' citing Cruz Bermudez et al. v. Ministerio de Sanidad y Asistencia Social, Supreme Court of Justice of Venezuela, Case No. 15.789, Decision No. 916 (1999) (Venez.), (2002) 3 Chi J Int'l L 105, 106;N v Government of Republic of South Africa & Others (No 1) 2006 (6) SA 543 (D) at 544 (S. Afr.)
[11] D. v. United Kingdom, 24 Eur. H.R. Rep. 423 (1997); B.B. v. France, App. No. 30930/96, 89 Eur. Ct. H.R. 2595 (1998).

to get treatment puts the person's life at risk. Though the case involved dialysis which is more expensive than transplant, the researcher submits that, the refusal of the court was an opportunity missed and moreover the denial of the opportunity to prolong life was unjust. [12]

ESSENTIAL ELEMENTS OF HEALTH-AAAQ

The GC has enlisted four inter- related and essential elements of the right to health- AAAQ i.e. "availability", "accessibility", "acceptability" and "quality". Availability means functioning public health and health care facilities, goods and services. In terms, of organ transplant this would mean sufficient facilities and donated organs for the purpose of transplant. Both these are unavailable to the extent desired. Accessibility: Accessibility to facilities, goods and services has four components: nondiscrimination, physical accessibility, affordability and access to information. In case of transplant all the four goals are a distant dream and the states have not acted sufficiently. Physical access especially is not sufficient as there is a shortage of organs and treatment centers are also few. Since organ procurement needs special facilities and due to their dearth many organs than could be utilized go waste even in the most advanced countries. It may also be mentioned that transplants are expensive and the rates vary across public and private sectors. However, due to shortage of kidneys, many patients have to take up dialysis which is more costly and does not eliminate the disease. Acceptability: Health facilities, goods and services must respect medical ethics and be culturally appropriate and sensitive to gender and life-cycle requirements. The WHO guiding principles must be followed but many states have adopted policies that run against the medical ethics. Quality: Health facilities, goods and services must be scientifically and medically appropriate and of good quality. Due to shortage of supply many patients are forced to look for organs from the outside market. Since states are unable to curb the illegal market, diseased organs are transplanted in numerous cases. Henceforth, there is a failure in all four elements and realization of the right to health.

The States have an obligation to fulfill which requires Governments to adopt all legal, administrative and budgetary measures that are necessary. It is quite paradoxical that Governments, particularly in opt- out systems, have a right to procure organ, the patient does not have an express right. The researcher argues that obligation requisites a comprehensive policy on organ transplant that guarantees right to health and a separate budget allocation for transplant sector. The lack of resources argument does not apply in case of organs because they do not involve costs unless Governments choose to incentivize donation. The states, however, do have an obligation to use maximum resources to ensure the facilities for the realization of the right to organ transplant. States must take all necessary steps to realize the right, failure to do so would be a violation of the duty to fulfill. There is a need for the issue to be discussed at the international level.

II. ORGAN SCARCITY IN INDIA: LESSONS FROM COUNTRIES WITH THE PRESUMED CONSENT MODEL.

India's tryst with organ transplantation dates back to May 1965, when the first renal transplant was carried out in King Edward VII Memorial Hospital at Bombay (Mumbai). Through the years thousands have benefitted from organ transplants which have improved significantly due to advancements of medical science.[13]Over the years changes in laws and policies have been made to cater the demand for

[12] Soobramoney v Minister of Health Kwazulu Natal 1998 (1) SA 430, para 11 and 21.
13 VN Acharya, '*Status of Renal Transplant in India'* [1994] 40(3), p158.

organs but results have not been satisfactory. In India, the Supreme Court has held that right to life encompasses the right to health.[14] Moreover India has ratified all major human rights instruments and is henceforth, bound to ensure self- sufficiency. The researcher in this part proposes the changes that can help India cater the demand for organs.

DOCUMENTING ORGAN SCARCITY -The magnitude of the scarcity is indicated by the fact that nearly 500 billion patients die every year due to the shortage of organs, while 1,50,000 wait for an organ[15]. Since 2005 nearly 3 million Indians have lost their life waiting for an organ.[16] As per the official data, only 6, too kidneys, 1500 livers, and 15 hearts are available, though the desired number is 2, 00, 00, 30,000 and 50,000 respectively.[17] In spite of having a population of **1,028,737,436** [18] and approximately 26,789 people dying day after day[19], the organ donation rate at 0.8 per person per million is among the lowest in the world and cadaver donations only constitute 27% of all donations. If we take into account the fact that one deceased can make twenty-five different organs and save up to nine lives, it can be concluded that the scarcity of organs can be easily met.

LAW ON ORGAN DONATION IN INDIA

Transplantation of Human Organs Act [20]which came into force on 4th February 1995 is the primary law relating to organ transplant. It aimed to tackle the rampant commercial transactions in organs by criminalizing them and to regulate the removal storage and transplantation of human organs for therapeutic purposes.[21] This Act was subsequently amended by Transplantation of Human Organs (Amendment) Act, 2011 and supplemented by The Transplantation of Human Organ Rules in 1995 which were amended in 2008 and 2014.

ORGAN DONATION-

The legislation provides for an ***Opt-in system of consent*** for both deceased and live donations. Recognizing the potential of retrieval from brain dead, the Act takes a big leap by authoring the procurement of organs from the brain dead. Any person can pledge to donate his organs after death by filling the form 7[22] either with NOTTO, Non- Governmental Organisations or societies authorized by the State Governments. Lately, the applicants of driving licenses are given a choice to opt-in and the same is then reflected on the license. Consents are not legally binding and the person can withdraw any- time.

In cases of cadaver donations, irrespective of the wishes of the deceased, informed consent of the family is mandatory for retrieval of organs. It will not be wrong to say that the law presupposes that the next of kin consider the wishes of the deceased. Besides, in case of brain-dead donors, certification of brain-stem death is mandatory. It is to be made by a board of medical experts consisting of the medical

[14]Paschim Banga Khet Mazdoor Samiti v State of West Bengal (1996)4 SCC 37
[15] National Health Portal. "*Organ Donation Day*". Available at: http://www.nhp.gov.in/organdonation-day_pg. Accessed on December 29, 2018.
[16] Amarnath K. Menon**, "**Body blow" (India Today, July 30, 2018) <https://www.indiatoday.in/magazine/the-big-story/story/20180730-body-blow-1289809-2018-07-24> accessed on 28th November 2018.
[17] Lok Sabha Unstarred Question, 04. 03. 2018
[18]T 00-005: Total Population, Population of Scheduled Castes and Scheduled Tribes and their proportions to the total population, "Census of India 2011" <http://censusindia.gov.in/Tables_Published/A-Series/A-Series_links/t_00_005.aspx> accessed on 9th December 2018.
[19]Indian Population Clock <https://www.medindia.net/patients/calculators/pop_clock.asp> accessed on 9th December 2018.
[20] The Transplantation of Human Organ Act (42 of 1994).
[21] Ibid, Preamble.
[22]The Transplantation of Human Organs and Tissues Rules, 2014.

administrator of the hospital where death occurred; an independent registered medical practitioner from a panel of names approved by the Appropriate Authority; a neurologist or a neurosurgeon and if they are not available then either an anaesthetic; or intensivts; and the medical practitioner treating the deceased. [23]

In case of living donation, the close relatives like spouse, mother, father, brother, sister, son, daughter, grandfather, grandmother, and grandchildren may donate after approval the Director or Medical Superintendent or in-charge of a hospital gives the approval. In case any other known person wishes to donate a sanction from the by the ―Authorization Committee of the hospital, district or state as the case may be, is needed. For living donations, the law is really strict and establishes the check- system in order to avoid commercial dealings under the guise of altruism and to check the motivation of the donor. The Act prohibits Minors[24] and mentally challenged from be living organ donors. The Amended Act has also permitted organ swap for the first time. However, an altruistic donation from strangers is absolutely prohibited. The strictness is to avoid commercial transactions.

The National Organ and Tissue Transplant Organisation (NOTTO) is the apex body in the country to coordinate and network the procurement and distribution of organs as also to fill up the gap between their demand and supply in the country. The Regional and State bodies have also been established to function under NOTTO. The Union Government has launched the National Organ and Tissue Programme under which national helpline and green corridors for the speedy delivery of organs to ensure timely utilisation have been started.

CHANGE TO PRESUMED CONSENT MODEL

The current regime, despite amendments, has failed to cure the deficiency. While other countries have evolved innovative approaches to deal with organ scarcity, India has lagged behind.[25] The presumed consent system is the most common response to organ scarcity and the researcher asserts that in light of the shortage of organs, India must follow the ensemble after Wales, Netherlands, and England.

Increasing the consent for organ donation of the deceased is the key to eradicate insufficiency of organs and the prima facie evidence shows that the countries with presumed consent model witness higher rates of donation.[26] Given that opt-out system presumes donation, the masses are likely to perceive that the legislators are recommending donation.[27] Moreover, it is likely to facilitate a transition from intention to action.[28]In simple words, it taps the prospective donors who refrain from signing up under the current regime because of lethargy, unawareness, inertia or denial to think about death. Moreover, the change in law can create a culture of organ donation as the withdrawal would mean standing out as an exceptional misanthrope who fails to fulfill the duty of a good citizen. [29]**The increase**

[23]Ibid, Section 3.
[24]Minors can donate in case of exceptional medical grounds.
[25]Dr. Anju Vali Tikoo, *Transplantation of Human Organs: the Indian Scenario*, (Summer Issue 2017 ILI Law Review, Vol. 1, pp153).
[26] Amber Rithalia and others, 'impact of Presumed Consent for Organ Donation on donation rates: A Systematic Review,' (2009) BMJ 338(7689), p 284.
[27] CRM McKenzie and others, '*Recommendations implicit in policy defaults*.' Psychol Sch (2006) 17(414) pp 415- 417.
[28] Shepherd Lee and others, "*Awareness of Legislation Moderates the Effect of Opt-Out Consent on Organ Donation Intentions."* Journal of Health Psychology (2013) 19(2) p 1058–1063.
[29]Davidai, S and other, '*The meaning of default options for potential organ donors*.Proceedings of the National Academy of Sciences',(2012).*https://stanford.app.box.com/s/yohfziywajw3nmwxo7d3ammndihibe7g accessed online on 15th December 2018.*

in consent from 44% in 2014 to 65% in 2018 Wales is the latest demonstration of the success of presumed consent model.[30] Countries with highest rates in the world Spain, Croatia have opt- out system. Considering the high likelihood of rise in consent, India must transition to opt- out system.

SOFT OPT OUT SYSTEM vs. HARD OPT OUT SYSTEM

Denial of the family has been a major reason for low deceased organ rates in India.[31] Adoption of hard law eliminates the power of the family to veto but the same involves the question of morality and experimenting with such a system can be extremely risky. For example, in 1997, Brazil switched to a hard opt-out system where the family was not given the power to veto. The law was received with mistrust and the unpopularity compelled abolishment of the system the very next year.[32] Likewise, change to the hard opt-out system in 2010 had backfired for Chile which witness drop 8.31 per million during 2001- 2009 to 5.95 p.m. in 2010-11.[33] In all possibility, implementing such a system would have deleterious consequences in India. Besides, India must respect the rights of the family and hence must adopt the liberal approach.

LESSONS FROM COUNTRIES WITH THE PRESUMED CONSENT SYSTEM

Countries which have achieved high rates adopted other measures along with the legislation, which are equally relevant to the Indian context and could be applied if the Union and the States make a commitment. Spain which is the global leader in this field attributes its success to the various measures it took and this is attested by the fact that donation rates only increased 10 years after the legislation, when extensive measures were taken.[34] The researcher underlines certain measures which ought to be adopted with the change in legislation to harness high rates.

1. MEDICAL TRUST-

Organ transplant depends on the participation and donation from the public.[35] Opt out legislation works best in countries where the medical mistrust is low.[36] Medical mistrust is currently very high due to the frequent scandals associated with organ transplant and apprehension that doctors under treat and declared brain dead to procure organs. Despite large scale campaigns, out of nine crore, only 5 lakh applicants for driving license consented to be organ donors[37]. A transition to presumed consent would

[30] James Niven, Natalie Chalmers, '*Opt-out organ donation: a rapid evidence review'*, 20 July 2018https://www.gov.scot/publications/opt-out-organ-donation-rapid-evidence-review/pages/11/ accessed online on 15th December 2018.
[31] AK Seth and others, '.*First prospective study on brain stem death and attitudes toward organ donation in India* ' (2009)Liver Transpl 15(11) pp 1443-1447.
[32] Parsons Jordan Alexander, *'Welsh 2013 Deemed Consent Legislation Falls short of Expectations', (*2018) Health Policy Review 122(9) p 943.
[33] Zuniga- Fajuri Alejandra, *'Increasing Organ Donation by Presumed Consent and Allocation Priority:* Chile' bulletin of the World Health Organisation, (2015) 93(3),pp 199- 200.
[34] Navarro-Michel, "*Institutional Organisation and Transplanting the 'Spanish Model'*" in Anne-Maree Farrell, David Price and Muireann Quigley (eds), Organ Shortage: Ethics, Law, and Pragmatism (Cambridge University Press 2011) p 170.
[35] Ibid.
[36] ibid (n 29).
[37] Dipak Dash, ' Govt steers drive: Pledge your organs when seeking licence' (Times of India, 5 May 2018)<http://timesofindia.indiatimes.com/articleshow/64037005.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst> accessed online on 1st January 2019.

only increase the fears of the population [38]and mistrust would manifest itself in the form of high levels of refusal rates and opting out, as seen in the cases of Brazil and Chile. India needs to imitate Singapore and Spain by sending letter to target the youth who turn major each year. During the transiting period these should be sent to all citizens explaining the need for donation and change in law. The timing of these letters must be coupled with educational campaigns. Furthermore, India must intensify its organ donation campaigns to counter all myths and misperceptions revolving around organ donation.

2. FAMILY CONSENT

The cadaveric donation, particularly from the brain-dead, is essential to attain self-sufficiency. Researchers have concluded that the need for organs can be easily fulfilled by procuring organs from victims of head injury resulting from road fatalities, which are rapidly increasing.[39] It is suggesting that procuring organs from 5- 10% of the victims could supply to the entire demand for organs.[40]It is extremely important to detect donors prior to brain death and counsel the family, but due to insufficient coordinators, many potential donors are not being utilized. Moreover, India is lagging behind Spain and UK where Physicians independent of the doctors taking care of the patient, act as Transplant Coordinators.[41] It is recommended that the Spanish mandatory training for Doctors in critical care be replicated by either the Indian Society of Critical Care Medicine or Medical Council of India and the NOTTO.[42]

3. AUDIT

India should try to replicate the Spanish Quality Program on Organ Donation which involves self-auditing of performance internally by the coordinator and externally by regional coordinator of another region. This provides very useful information about the number of deaths, brain deaths and organ donors for every ICU. By acknowledging the cases where consent could not be obtained, the audit helps improve performance. Moreover, it helps the Government identify the weak centers and focus on them so that their results improve. This is a reform India must take if the cadaver donation rates are to be improved.

4. INFRASTRUCTURE

The biggest shortcoming of India is the lack of medical infrastructure. Across the state, only 301 hospitals perform organ transplants and out of them, only 148 are registered with the NOTTO. The law has set up minimum requirements for registration and arguably reduced the hospitals. Going by the number it means that there is only one organ transplant center for about 43 lakh people.[43] Moreover, there is no universal healthcare system in India and of the 29 states, only ten states have advanced

[38] De Looze, K. and Shroff, S.,"*Can presumed consent overcome organ shortage in India? Lessons from the Belgian experience*" (2012) The National Medical Journal of India 25 (3) p169.
[39]Aneesh Srivastava, Anil Mani,'*Deceased organ donation and transplantation in India: Promises and challenges'* (2018) Neurology India 66(2) pp 316—322.
[40] M Rajmohan and others, 'Facility Location of Organ Procurement Organisations in Indian Health Care Supply Chain Management', (2017) SA Journal of Industrial Engineering, 28(1), p 91.
[41]Pandit, Rahul Anil. *'Brain Death and Organ Donation in India'*, Indian Journal of Anaesthesia, vol. 61/no. 12, (2017), pp. 950.
[42]Palaniswamy V, Sadhasivam S, Selvakumaran C, Jayabal P, Ananth SR. *Organ donation after brain death in India: A trained intensives is the key to success*. Indian J Crit Care Med 2016; pp 593.
[43] Savika khera, 'A Dismal Setting For Organ Donations In India' (NDTV, 22 August 2017) https://sites.ndtv.com/moretogive/a-dismal-setting-for-organ-donations-in-india-1368/ accessed online on 1st January 2019.

facilities. The lack of the facility in remaining part of the country means the majority of organs that could be retrieved with facilities in place, are going waste. Dr. Sunil Shroff from the Mohan Foundation which is the most prominent NGO in this field in India recently underlined the fact that the problem is no longer about people's acceptance but the lack of infrastructure to retrieve organs which are causing organs to get wasted in a country facing an acute shortage. [44] Presumed consent model without adequate infrastructure will not be effective as donors would serve no purpose without retrieval facilities. Presumed consent rates are highest in countries that have a well- equipped health system, like for example Spain, Portugal, and Belgium. In contrast, Bulgaria, Latvia, Greece, Turkey despite the presumed consent model has the lowest rates in Europe, due to underdeveloped infrastructure. Spain witnessed a rise from 14.3 per million populations in 1989[45] to 46.9 per million in 2017 has 40% of the contribution being made from the small hospitals.

The researcher argues that providing adequate infrastructure and funding is not only necessary; it is a legal obligation of the state. Scaling up transplant infrastructure will not prove to be extremely burdensome as a transplant is less expensive in comparison to dialysis.[46]. The Government is looking into giving incentives of Rs 5 lakh to the family of the donor and 50000 to reimburse the hospital. It is submitted that such a policy would be violative of Guiding Principle 5 and India must resist the pressure. Though giving incentives or adopting the priority rule that exists in Singapore, Israel and Chile are luring, India must respect human rights and ethics. The researcher submits that the Government should invest this money in advancing infrastructure rather than treating bodies like commodities.

CONCLUSION

Organ transplant is an essential treatment, which has not been acknowledged as a component of right to health. The researcher has applied the human rights framework to organ transplant generally and organ scarcity specifically. Application of human rights framework can strengthen recognition of access to organ transplant, ensure more attention on the issue of organ scarcity at the International level, and can be a powerful tool to advance towards organ sufficiency. Countries at present follow two different systems of organ procurement, opt- in and opt- out. In presumed consent some states have opted for a strict approach where consent of the family in case of deceased donors is not considered. Though the system gives high rates, it's questionable as the states cannot transgress on the rights of the family.

India which has the highest population in the world has adopted opt- in system. Even though there is high potential to reach self- sufficiency, India has a rate of 0.8 per person, which is seven hundred times lesser than Spain. The researcher argues that India should switch to opt- out system to witness an increase in the rates. However, legislation cannot be effective till adequate infrastructure and public trust is there. It is hoped that in future organ sufficiency would be attained and, history will not judge the international community for the neglect in recognizing the right to health of those in need of transplant, many of whom have been compelled by scarcity of organ, facilities or finances to suffer and die in pain.

[44]Organ donation up 4-fold in India, but still a long way to go' (Times of India,1 August 2001) .

[45]Spital A,, '*Conscription of cadaveric organs for transplantation: a stimulating idea* whose time has not yet come' (2005) Cambridge Q Healthc Ethics. 14(1), p 109.

[46] Delmonico L Francis and others, *'Organ Transplantation: A call for Government accountability to achieve national self sufficiency in organ donation and Transplantation,'* (2011) The Lancet 37(9800), p1414.