NEW ZEALAND'S ORGAN TRANSPLANT LAWS: ANY HINTS FOR IMPROVEMENT FROM SINGAPORE?

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Introduction

For people with end-stage organ failure, transplantation offers the only effective treatment.[1] Not only does it improve medical outcomes for the individual, it also reduces the healthcare burden on society as a whole.[2] However, almost invariably, need for organs will far exceed availability, and most measures to increase supply in any healthcare system are fraught with controversy.

This paper explores the laws governing organ donation in New Zealand and Singapore and considers the strategies implemented by the two governments to increase organ donation rates. Singapore has changed to an opt-out system which has increased the rate of donation[3] whereas New Zealand has retained an opt-in system but with enhanced recognition of the donor's wishes. Because of certain features that cause difficulty in implementation of organ donation at the individual level, it is likely that New Zealand will remain unable to significantly increase organ availability. This paper explores the two systems, and asks if adopting certain aspects of the Singaporean system might possibly increase organ donation rates in New Zealand.

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[1] World Health Organization "Human Organ Transplantation" (2010) <www.who.int>.

[2] Ingvar Karlberg and Gudrun Nyberg "Cost-Effectiveness Studies of Renal Transplantation" (1995) 11 International Journal of Technology Assessment in Health Care 611.

[3] (16 March 1989) 53 Singapore Parliamentary Debates 297.

I.
1. New Zealand

New Zealand is a country located in the south-western Pacific Ocean with two main islands (North and South) that cover approximately 255 200km^2. With a population of 4.37 million people,[4] New Zealand's distinct culture has been described as a complex mixture of "human and physical geography…developed historically through the iterative interplay of beliefs and behaviour in reaction to events."[5] A series of key moments in New Zealand's history has shaped the constitutional culture of the country.

As a representative democracy, the move from a First-Past-the-Post to a Mixed-Member Proportional (MMP) Voting System in 1993 has created a Parliament where no single party holds the majority of seats in the House. The MMP system gives smaller parties greater say,[6] which has made the legislative process more complex; creating new law now requires extensive inter-party negotiation in order to secure enough votes to pass a Bill.[7] In effect, getting adequate support on controversial topics is made more difficult by the need to seek consensus across cultures.

The culture of New Zealand is shaped by the different ethnicities that inhabit the country. As the indigenous people of New Zealand, the Māori play a significant role in influencing the culture and norms of New Zealand. In addition, a steady stream of immigrants has changed the population's ethnic mix.

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[4] Statistics New Zealand "National Population Estimates: June 2010 quarter" (2010) <www.stats.govt.nz>.
[5] Matthew Palmer "New Zealand Constitutional Culture" (2007) 22 NZULR 565 at 568.
[6] Andrew Geddis *Electoral Law in New Zealand: Practice and Policy* (LexisNexis, Wellington, 2007) at 34.
[7] Ibid, at 40.

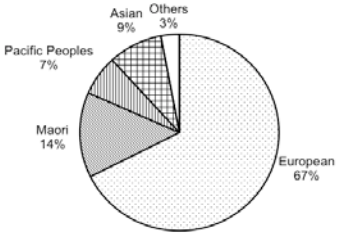

Figure 1.Ethnic Mix of Population from New Zealand Census 2006.[8]

Like other developed countries, New Zealand struggles with a high prevalence of diseases such as diabetes and hypertension. Type 2 diabetes incidence is attributed to the prevalence of obesity which most severely affects the Māori and Pacific ethnic groups.[9] Diabetes incidence is expected to double between 2006-2011,[10] and the number of deaths attributed to diabetes in 2011 is forecasted to exceed 2100.[11] As many diabetes and hypertension sufferers eventually experience kidney failure, the demand for these organs for the purposes of transplant will increase.

Unfortunately, as in many other countries, the supply of organs for transplant in New Zealand outstrips the population's requirement. The Ministry of Health reported that "even if organs were retrieved from every potential deceased donor, the supply of organs (especially kidneys) would still fall well short of the demand for them."[12] In 2007, New Zealand's organ donation rate stood at 9 donors per million people, well below Britain (13.2), the United States (24.6), France

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[8] Statistics New Zealand "2006 Census" (2006) <www.stats.govt.nz>.
[9] Ministry of Health *Diabetes in New Zealand: Models and Forecasts 1996-2011* (2002) at 3.
[10] Diabetes New Zealand "Diabetes Awareness Week 2008 Fact Sheet" (2008) <www.diabetes.org.nz>
[11] Ministry of Health, above n 9, at 7.
[12] Cabinet Paper "Review of the Regulation of Human Tissue and Tissue-based Therapies: Paper Two" (March, 2006) at 2.

(24.7) and Spain (34.3).[13]

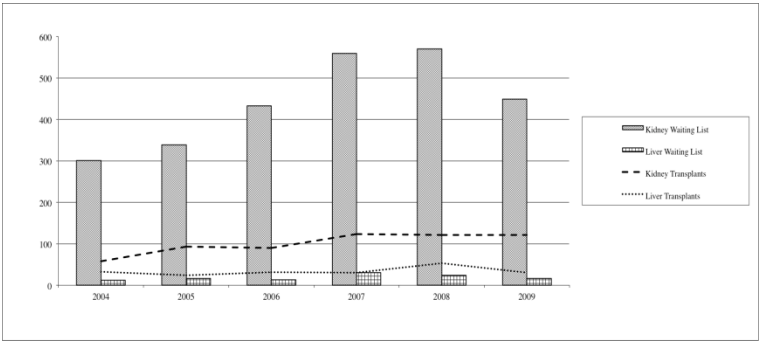

Figure 2. Live and cadaveric organ supply and demand in years 2004-2009.[14]

In New Zealand, organs usually transplanted include the heart, lungs, liver, kidney, and pancreas.[15] Of these organs, the kidney and liver are the only ones that can be obtained from both living donors and cadavers. In addition, tissue donors within the Auckland region are able to donate their heart valves and skin; and anyone in New Zealand may donate corneas and sclera (of their eyes).[16] All living organ donations are regulated according to the provisions of the Code of Health and Disability Services Consumers' Rights 1996. Cadaveric organ donations fall under the Human Tissue Act 2008, which replaced the Human Tissue Act 1964.

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[13] Organ Donation New Zealand "International Donor Rates" Organ Donation New Zealand <www.donor.co.nz>

[14] Compiled from: Australia and New Zealand Organ Donation Registry Annual Reports 2005-2010.

[15] Organ Donation New Zealand *Annual Report 2009* (2009) at 12.

[16] Ibid.

A. Living donor transplants

1. Informed consent

The removal of organs from living donors is a health care procedure in New Zealand and thus governed by the provisions of the Code of Health and Disability Services Consumers' Rights 1996 (the "Code"). Right 7(10) of the Code specifically forbids "any body part[s] or bodily substance[s] removed or obtained in the course of a health care procedure" from being "stored, preserved or used" without the informed consent of the consumer.[17] "Informed consent", according to the Health and Disability Commissioner Act 1994 is consent that "is freely given" and in accordance with the requirements under the Code.[18] The expectations of informed consent under the Code comprise three elements: the right to effective communication (Right 5); the right to be fully informed (Right 6); and the right to make an Informed Choice and give Informed Consent (Right 7).[19] In addition, Right 7(7) states that every consumer has the right to refuse services and to withdraw consent to services. This is consistent with s 11 of the New Zealand Bill of Rights that states that "everyone has the right to refuse to undergo any medical treatment."[20]

Thus, under the Code, every patient has the right to be informed of all the risks and benefits of a living organ donation before giving consent. The Code demands a high standard of communication to ensure that all risks and benefits of the procedure are fully understood by the donor.

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[17] The Code of Health and Disability Services Consumers' Rights 1996.
[18] Health and Disability Commissioner Act 1994, s 2
[19] The Code of Health and Disability Services Consumers' Rights 1996.
[20] New Zealand Bill of Rights Act 1990, s 11.

2. Payment for organs

Given the demand for organs, and the difference they make to the recipient, it would be easy to imagine a market for them. However, trading in human tissue is an offence under the Human Tissue Act 2008[21] except where an exemption has been given by the Minister.[22] No person is permitted to "require or accept, or offer or provide, financial or other consideration for human tissue."[23] Similarly, advertisements relating to the sale or purchase of human tissue are forbidden.[24] This rule upholds the generally favoured view that the "gift" status of human tissue and blood be recognised[25] and that organ and tissue donation by deceased donors is an unconditional and anonymous act.[26]

The prohibition on trade does not preclude the payment of compensation to living donors. The government, through Work and Income New Zealand, offers financial assistance to living donors to assist with loss of income or extra childcare costs incurred.[27] The age and marital status of the donor determine the size of "loss of income" assistance and the maximum amount ranges from approximately $130 to 320 per week for up to 12 weeks as well as childcare costs.[28]
However, in actual practice, living donations are a very limited source of organs because living donors have substantial risk to life and health. Thus, significant increase in donations is more likely to come from deceased persons.

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[21] Human Tissue Act 2008, s 56.
[22] Ibid, s 60.
[23] Ibid, s 56.
[24] Ibid, s 61.
[25] Cabinet Paper "Review of the Regulation of Human Tissue and Tissue-based Therapies: Paper Three" (2004) at 11 – 12.
[26] Ministry of Health *Review of Human Tissue and Tissue-based Therapies: Submissions Summary* (Ministry of Health 2004) at 93.
[27] Work and Income New Zealand "Financial Assistance for Live Organ Donors" <www.workandincome.govt.nz>.
[28] See Appendix 1

B. Cadaveric organ transplants

1. Human Tissue Act 1964: a historical perspective

The 1964 Act dealt solely with the post-mortem use of bodies and body parts and gave statutory status to the "no property" common law rule that dated back to the 18th century.[29] While no person can own a corpse, certain persons have limited property rights in the body, such as executors for purposes of burial and coroners for the purposes of autopsies.[30] The Human Tissue Act 1964 introduced the concept of a "person lawfully in possession" of a body and authorised that person to determine whether bodies could be used for anatomical examination or organ transplantation.[31] This paper will address only the parts of the Act relating to organ donation.

(a) Who could give consent?

The 1964 Act gave the "person lawfully in possession" of a body (PLPB)[32] the power to make decisions about the use of a corpse. Section 2(2) defined the PLPB to include the person in charge of a hospital if a person died within the facility,[33] the person in charge of a mental health facility if the deceased's body was on its premises,[34] and the prison manager of a deceased's prisoner.[35] Generally speaking, because organ donation is only possible from individuals that have passed away in hospital, the PLPB of potential organ donors – by virtue of s 2(2)(a) – was the person "for the time being in charge" of

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[29] See generally P.D.G. Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Thomson Brookers, 2006) at 574.
[30] Peter Skegg "The Removal and Retention of Cadaveric Body Parts: does the Law Require Parental Consent?" (2003)Otago Law Review 10(3) 425 at 428.
[31] Human Tissue Act 1964, s 3(1).
[32] Ibid, s 2(2).
[33] Ibid, s 2(2)(a).
[34] Ibid, s 2(2)(b).
[35] Ibid, s 2(2)(c).

the hospital.[36]

Under s 3(1), a PLPB could authorise the removal of body parts for therapeutic purposes if the deceased had expressed such a request "either in writing at any time or orally in the presence of 2 or more witnesses during his last illness"[37] and that request had not subsequently been withdrawn.[38] The PLPB was not obligated to consult or gain the approval of family members. In practice, however, medical practitioners would consult family members and not proceed against their wishes.[39]

If the deceased had not consented, under s 3(2) the PLPB could authorise the removal of body parts if "having made such reasonable inquiry as may be practicable", the PLPB had no reason to believe that neither the deceased nor the "surviving spouse, civil union partner, de facto partner, or any surviving relative of the deceased" objected to such use of the deceased's body.[40] This "lack of objection" threshold meant that rather than gaining consent, all that was required was an enquiry into whether there was objection before the proposed tissue harvest could proceed. Problematically, "any surviving relative" was extremely broad and meant that any relative – no matter how far removed – had the power of veto.[41] In contrast to the potentially large number of relatives to whom such an enquiry had to be addressed, the time following death that any organ could be harvested as donated

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[36] Human Tissue Act 1964, s 2(2)(a) and P D G Skegg "The Removal and Retention of Cadaveric Body Parts: Does the Law Required Parental Consent?" (2003) 10(3) Otago L. Rev. 426 at 429.
[37] Human Tissue Act 1964.
[38] Ibid, s 3(1).
[39] Jennifer Ngahooro & Grant Gillett "Over my dead body: the ethics of organ donation in New Zealand" (2004) 117 New Zeal Med J 1051, at 1053. This practice was validated by the official website for organ donation in New Zealand: Organ Donation New Zealand "Talk to your family" (2008) <www.donor.co.nz>.
[40] Human Tissue Act 1964.
[41] Ibid, s 3(2)(b).

tissue, is extremely limited.

(b) Repealing the Human Tissue Act 1964

The limited scope of the Act proved insufficient to address issues that arose relating to the use of human tissue, particularly that of organ donation.[42] In the meantime, waiting lists of potential recipients continued to grow[43] with donor rates plummeting in 2006.[44]

The dire shortage of organs led to the presentation of the 2002 petition of Andy Tookey and 1, 169 others to Parliament.[45] At the time, there were many concerns with the current system such as the lack of public education or advertising regarding organ donation; the failure of some doctors to approach potential donor families; the ability of families to override the wishes of a potential donor; and problems created by tying the driver licence system to organ donation such as the driver licence not meeting accepted requirements for obtaining informed consent.[46] The Health Committee had similar concerns and recommended that the government take proactive steps" by creating an environment that facilitates donation."[47] Specifically, with respect to "DONOR" indications on a driver licence, the Health Committee reported in 2003 that the introduction of synthetic paper licences severely limited the ability of holders to update information on organ donation because licences did not need to be renewed until the holder's 71st birthday. Even after the switch to the current 10-yearly cycles of licence renewal, it was still risky to rely on a licence as an accurate reflection of the holder's current wishes.

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[42] Cabinet Paper "Review of the Regulation of Human Tissue and Tissue-based Therapies: Paper One" (2004) at 1.
[43] The waiting list for organ donations (Campbell Live, 20 February 2007).
[44] Organ Donation New Zealand "Number of deceased organ donors in New Zealand" (2008) <www.donor.co.nz>.
[45] Petition 2002/25 of Andy Tookey and 1,169 others (26 November 2003).
[46] Ibid, at 3 and 7.
[47] Ibid, at 8.

In May 2006, Dr Jackie Blue introduced a Member's Bill to the House.[48] The Human Tissue (Organ Donation) Amendment Bill sought to establish a register on which people could register legally binding wishes to be organ donors or state their desire not to.[49] Despite the pressure to reform human tissue laws in New Zealand, the Bill did not pass its second reading. The Select Committee did not support the establishment of a register, because it would be costly[50] and there was no evidence that it would improve the rate of donation.[51]

A national consultation process conducted in 2004 revealed a widely held belief that tissue and tissue donors should be treated with respect; the importance of individual consent and individual autonomy; the need for respect for families/whānau and cultural differences; and the need for legislation that was practical to implement.[52] In November 2006, the government introduced the long-awaited Human Tissue Bill to the House[53] which received royal assent in April 2008 and became the Human Tissue Act 2008.

2. Human Tissue Act 2008

The Human Tissue Act 2008 (HTA) regulates the use of human cadaveric tissue and tissue-based therapies. The Ministry of Health's objective was to streamline legislation relating to tissue which was

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48 (3 May 2006) 630 NZPD 2748.
49 Human Tissue (Organ Donation) Amendment Bill 2006 (33-1).
50 Cabinet Paper, above n 12, at 9
51 Human Tissue (Organ Donation) Amendment Bill 2006 (33-1) (Health Committee Report) at 2. Note also that while the Committee felt it was unnecessary at this time, it recommended an amendment to the Human Tissue Bill so as to allow for the set up of a register at a later time. This amendment was accepted and is s 78 of the Act.
52 Ministry of Health *Review of Human Tissue and Tissue-based Therapies: Submissions Summary* (2004) at 10 – 13.
53 (14 November 2006) 635 NZPD 6467.

"comprehensive", "easily understood", but still flexible enough to respond to future as-yet-unpredicted advances in science.[54] While the Act may be comprehensive, it is unlikely to be easily understood or practical to implement against the realities of clinical practice settings. This paper will address only the parts of the Act relating to organ donation.

The "lack of objection" threshold in the 1964 Act was replaced by the requirement of informed consent, which is consistent with the Code. However, the consent process in the HTA is very complex. When an individual has passed away, the following scenarios may arise: prior to death, the deceased consented or objected to the removal of organs; alternatively, the deceased expressed neither objection nor consent.

(a) Informed consent/objection by the deceased

The 2008 Act recognises far greater autonomy of the deceased and permits a physician to act on the deceased's consent even if it does not accord with the wishes of the family. Consent is valid only if it was "informed" which the Act defines as "given freely" and "in light of all information that a reasonable person, in that person's circumstances" needs.[55] "Informed objection" is similarly defined.[56] Unlike living organ donations, "informed consent" and "informed objection" for cadaveric organ donation is completely different. There are no risks to the deceased; rather, a potential donor requires information such as the process for determining brain death, how a recipient is matched to donor organs and how donation will affect funeral arrangements.[57] Consent and objection must either be "in writing (with or without witnesses)",[58] or "orally and in the presence of 2 or more witnesses

[54] Cabinet Paper, above n 42, at 3.
[55] Human Tissue Act 2008, s 9(1).
[56] Ibid, s 9(2).
[57] Organ Donation New Zealand "What happens? – Organ Donation" (2008) <www.donor.co.nz>.
[58] Human Tissue Act 2008, s 43(1)(a).

present at the same time."[59]

Under the old Act, the PLPB could not authorise organ removal if the deceased had expressed objection.[60] The new requirement of "informed objection" under the HTA means that objection based on the grounds of misinformation cannot qualify as "informed objection." This is significant as unless people are educated and misinformation is clarified, an objection may be disregarded because it was not informed. Misinformed beliefs include the inability of organ donors to have an open casket, the fear that the medical team will not try their best to save lives of potential donors, and delays in funeral arrangements.[61]

Both informed consent and objection can be stated in a person's will,[62] even if the will is invalid.[63] However, a significant obstacle to consent or objection in a will is that organ procurement takes place in the limited time after brain death but before heart death. This is a serious impracticality as the will reading of a person will usually occur long past organ viability.[64] Contrary to popular belief, an agreement to be a donor on one's driver licence is merely indicative and not legally binding because it does not constitute informed consent.[65] This is because it is considered too difficult to prove if a person had full information of what they were agreeing to and whether agreement was given willingly.[66] The different standards for consent given in a will as compared to one given on a driver licence highlights a significant discrepancy in the law of informed consent as a will – which may be

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[59] Ibid, s 43(1)(b).
[60] Human Tissue Act 1964, s 3(2)(a).
[61] Organ Donation New Zealand "Questions about donation" (2008) <www.donor.co.nz>.
[62] Human Tissue Act 2008, s 43(2).
[63] Ibid, s 43(3)(a).
[64] Jennifer Ngahooro & Grant Gillett, above n 39.
[65] Human Tissue Act 2008, s 9(1)(a).
[66] NZ Transport Agency "Organ and tissue donation" (2010) <www.nzta.govt.nz>.

no better informed than a driver licence indication – is taken as valid informed consent for organ donation while the driver licence is not.

Section 14 imposes a duty on any person proposing to collect tissue (in this instance, the "physician") to ascertain whether relevant informed consent has been given.[67] In addition, the physician must consult the "responsible person"[68] who is legally obliged to help establish informed consent (or lack thereof).[69] The "responsible person" is defined in s 12 as "the person lawfully in possession of the body" and often, in the case of potential organ donors lying in hospital, this "responsible person" is "the person for the time being in charge of a hospital."[70] Unlike the 1964 Act that armed a PLPB with power to authorise organ donations, the 2008 Act merely requires the PLPB to assist the physician in ascertaining informed consent.

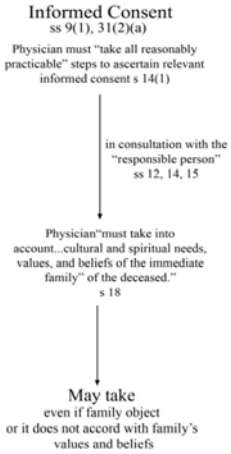

Figure 3. Process of ascertaining informed consent.

[67] Human Tissue Act 2008, s 14(1).
[68] Ibid, s 14(2).
[69] Ibid, s 15.
[70] Human Tissue Act 2008.

The physician must take into account the "cultural and spiritual needs, values, and beliefs of the immediate family" of the deceased.[71] "Immediate family" includes members of the "individual's family, whānau, or other culturally recognised family group" who were either "in a close relationship with the individual" or had "responsibility for the individual's welfare and best interests" in accordance with the customs and traditions of the community the deceased identified with.[72] While the physician must seek information regarding the values and needs of the immediate family, that information does not need to be obtained from family members. Provided the physician has obtained reliable information regarding the needs of the immediate family and taken them into account, the duty will be deemed to have been satisfied. This means that family members do not have a right under the Act to object to organ donation where the deceased gave informed consent. In practice, while organ donation may proceed even with the objection of family members, it is highly unlikely to happen against the wishes of grieving family members because current practice emphasises the importance of the best interests of grieving families, even if it means ignoring the Act and the deceased's express wishes. This practice is validated by the official website for organ donation in New Zealand that states that "the family's wishes will always be respected and organs and tissues will not be retrieved if the family has any objection."[73]

Thus, recognition of a deceased's informed consent has been granted under the HTA. A physician can take the organs of a deceased even if it does not accord with the spiritual beliefs and needs or a family. This is an exception to the general rule and a clear departure from the old Act. While the beliefs and needs of a family may weaken consent, nobody – not even family or the PLPB – can override a deceased's

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[71] Human Tissue Act 2008, s 18.

[72] Ibid, s 6.

[73] Organ Donation New Zealand "Talk to your family" (2008) <www.donor.co.nz>.

informed consent once it has been established. However, giving informed consent does require a person to consider the subject of death and take positive steps to give valid informed consent. When enforced, this new system has the potential to raise organ donation rates.

(b) No informed consent or objection from the deceased

The process of acquiring informed consent becomes most complicated when there is no informed consent or objection from the deceased. This is not uncommon for reasons including the fact that there is no established organ donor register in New Zealand, the often mistaken belief that having "DONOR" on one's driver licence is informed consent and the practical difficulties of checking for consent in a person's will immediately after death and before organs become non-viable. These issues persist in the new Act and are obstacles to increasing organ donation rates in New Zealand.

(i) Nominees

The law permits a person prior to death to delegate decision-making to one or more nominees who are then able to give consent or raise objection to organ donation on behalf of the deceased.[74] Where there are two or more nominees, informed consent or objection must be given collectively by all nominees who are available and willing to give them. [75] Anyone may be a nominee and little formality is required on the part of the person delegating decision-making to another; nominations need only be made with the nominee's written consent and this is revocable with a written notice by the nominee to the nominator.[76] A nomination may also be made in a person's will,[77] even

[74] Human Tissue Act 2008, s 31(2)(b).
[75] Ibid, s 39(5).
[76] Ibid, s 39(4).
[77] Ibid, s 43(2).

if the will is not valid.[78]

The Act permits anyone to be a nominee. The nominee does not have to be the executor or a member of the family who would ordinarily be responsible for disposal of the body. However, a nomination may be "made, amended, revoked, or revoked and replaced" by persons authorised by other laws to give consent on a person's behalf.[79] For example, before a person's death, nominations may be revoked by the person's welfare guardian or by someone with power of attorney.[80] After a child's death, nominations may be revoked by the parent or legal guardian of the child.[81] Thus, the nominees of a deceased are armed with decision-making powers and, subject to certain persons overriding their status, may give binding informed consent or objection on behalf of the donor. In giving informed consent or raising objection, the only obligation a nominee(s) has is to take into account the cultural and spiritual needs, values and beliefs.[82] However, the nominee(s) is given the discretion to "decide what weight…to give to" such wishes and is not obligated to give effect to them.[83]

By permitting a person to have nominees, the Act allows people to elevate the decision-making status of specific people who are able to give binding consent or objection. The potential – through nominations – to reduce the scope of persons able to have a say on the issue simplifies the decision-making process and may increase organ donation rates.

(ii) "Immediate family"

If there are no nominees or if they have not consented or objected

[78] Ibid, s 43(3)(b).
[79] Ibid, s 39(2).
[80] Ibid, s 38(3)(b)-(c).
[81] Ibid, s 38(3)(a)
[82] Ibid, s 42.
[83] Ibid, s 42.

after some time,[84] the decision falls upon a member of the deceased's "immediate family."[85] "Immediate family" is given a very broad definition under the HTA and includes – at its most broad – "culturally recognised family."[86] Section 40 obliges the family member giving informed consent or raising informed objection to take "all reasonably practicable steps to consult members" of the individual's "immediate family" where all of the different interests within the family are represented.[87] However, the Act does not cloak any specific persons with the responsibility of representing the family. Thus, with complex family structures rife in New Zealand, time may be wasted choosing the representative and conflict may arise.

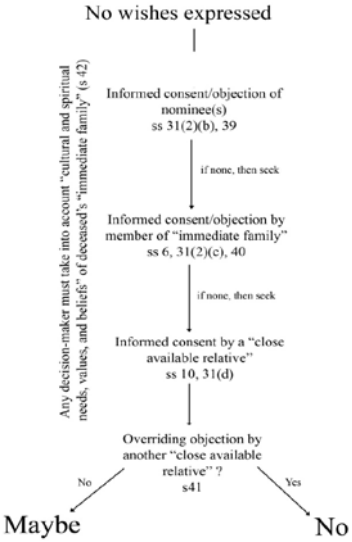

Figure 4. Process of obtaining consent from family.

[84] Ibid, s 35.
[85] Ibid, s 31(2)(c).
[86] Ibid, s 6.
[87] Ibid, s 40(a).

Under the old Act, the PLPB was required to make "such reasonable inquiry as … practicable" to ensure that the deceased, "surviving spouse, civil union partner, de facto partner, or any surviving relative of the deceased" did not object.[88] This has now been replaced with a new obligation to consult the deceased's "immediate family" with the "view to achieving general agreement on the matter."[89] Notably, "immediate family" is much larger in scope than "any surviving relative."

At this stage in the decision-making process, there are 3 possible outcomes: first, everyone in the family consents to organ donation and the removal of organs proceeds; second, everyone in the family object to organ donation and organs cannot be removed; and third, the immediate family is divided. In the first two instances, informed consent or objection given on behalf of the immediate family is deemed not to have been given if the physician is uncertain as to its unanimity.[90] This is because s 40 requires that the member of the immediate family believe "on reasonable grounds that *all* capable members" would give the consent/objection if personally consulted.[91] The decision falls upon a "close available relative" where the immediate family is divided.[92]

(iii) "Close available relative" and overriding objection

For a child under the age of 16 who has died, a "close available relative" is considered in this order of availability: a parent of the child, the guardian of the child immediately before death, or a sibling of the child if the sibling is over 16 years.[93] If the deceased was over 16 years old, the "close available relative" is considered in this order of

[88] Human Tissue Act 1964, s 3(2).
[89] Human Tissue Act 2008, s 40.
[90] Ibid, s 36.
[91] Ibid, s 40(c) (emphasis added).
[92] Human Tissue Act 2008, s 31(2)(d) and 36.
[93] Human Tissue Act 2008, s 10(2).

availability: a "spouse, civil union partner, or de facto partner of the individual immediately before" death; any child of the deceased if he or she is over 16 years; the parent of a deceased; or the sibling of the deceased if he or she is over 16 years.[94] A person who is dead, unknown, missing or not capable is deemed to be "not available" under the Act.[95] While the Act is silent on how much effort must be undertaken to locate family members, it appears that unless they are considered unavailable under the Act, all attempts must be made to find relatives before the person next in hierarchy may step in to make the decision. However, the expectation to exhaust every option before the next available relative is sought seems impracticable against clinical realities.

The HTA gives first priority to "immediate family" to come to a "general agreement" before close relatives are sought. However, because a close relative falls within the definition of "immediate family", a close relative who is available and who objects can negate the consent of the immediate family and can override the consent of any other close relatives. [96] Conversely, if all close available relatives consent, the immediate family's objection will only prevail if there is general agreement to the objection.[97]

(iv) Respect for families/whānau and cultural differences

The person giving the consent or raising an objection must also take into account the cultural and spiritual needs, values and beliefs of the deceased's immediate family and weight them accordingly.[98] This is consistent with the principles of the Treaty of Waitangi and the expectation that the Crown will actively protect the treaty rights of

[94] Ibid, s 10(1).
[95] Ibid, s 11.
[96] Ibid, s 41(2).
[97] Ibid, s 40(b).
[98] Ibid, s 42.

Māori.[99] This obligation "guarantees the right of Māori to determine how body parts are treated… [ensuring they are in accordance] with Māori values, customs and cultural practices."[100] The holistic approach in obtaining consent or objection accords with Māori culture that places important emphasis on the collective process of whānau decision-making.

The support of Māori and the public in general is vital to the success of this Act. Although there are many provisions that impose duties to take into account the immediate family's cultural and spiritual needs, values and beliefs, this was felt to be insufficient by the Māori Party. As noted in the opposition of the Bill by the co-leader of the Māori Party during its Third Reading in Parliament, the Bill (and now, the law) "is by no means sufficient to accommodate the views of whānau decision-making processes."[101]

Despite having such a strong cultural presence, a survey commissioned by the Ministry of Health found that there is no universally recognised cultural authority within the Māori or Pacific communities from whom a ruling or pronouncement as to the acceptability of transplantation and the donation of organs would settle the matter.[102] This lack of authority within the communities distinguishes it from other religions (such as Islam) that recognise religious figureheads as capable of making religious rulings by which believers then live.

In summary, when there is no informed consent or objection from the deceased, reaching a general agreement on organ donation can be an

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[99] Treaty of Waitangi Act 1975.

[100] Ministry of Māori Development *Hauora o te tinana me ōna tikanga : a guide for the removal, retention, return and disposal of Māori body parts and organ donation* (1999) at 10.

[101] (8 April 2008) 545 NZPD 15428.

[102] Mauri Ora Associates *Maori Pacific Attitudes Towards Transplantation: Professional Perspectives*(prepared for the Ministry of Health for Renal Services) at 9.

extremely time-consuming and stressful process involving a large number of parties who often base their decision on little or no background information. When brain death occurs, the optimal organ procurement period is highly time-sensitive and requires the co-ordination of a number of critical care experts.[103] Hugely impractical and oftentimes impossible when balanced against clinical realities, such a lengthy consultation process does little to encourage organ donation rates in New Zealand.

C. New Zealand Conclusion

At present, organ demand and supply is supported by an organ sharing agreement with Australia. The Trans Tasman Arrangements for the Exchange of Organs and Blood Products is the organ sharing agreement of the Transplant Society of Australia and New Zealand. With this informal inter-governmental agreement, it is hoped that organ availability will be maximised in and between both countries with a distribution of organs that is "equitable and affords transplant candidates in both countries equal consideration and opportunity."[104] This agreement is similar – although less extensive – to other existing exchange programs such as the Eurotransplant Kidney Allocation System.[105] While it appears in Figure 5 that there are more organs going to Australia than those entering New Zealand, the significance of this difference is lessened by the small number of organs available for exchange and complicated by the huge number of clinical factors that must be taken into account when matching donor organs with recipients. Organs from New Zealand are only sent to Australia where

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[103] O'Connor K.J., Wood, K.E. & Lord, K. "Intensive Management of Organ Donors to Maximize Transplantation" (2006) 26 Critical Care Nurse at 94.

[104] Members of the Standing Committee of TSANZ "Trans Tasman Exchange Principles" (2002) The Transplantation Society of Australia and New Zealand <www.tsanz.com.au>.

[105] Eurotransplant International Foundation "About Eurotransplant" <www.eurotransplant.org>.

there are no suitable recipients[106] and through this agreement, New Zealand has access to a wider pool of organs and there is efficient use of organs.

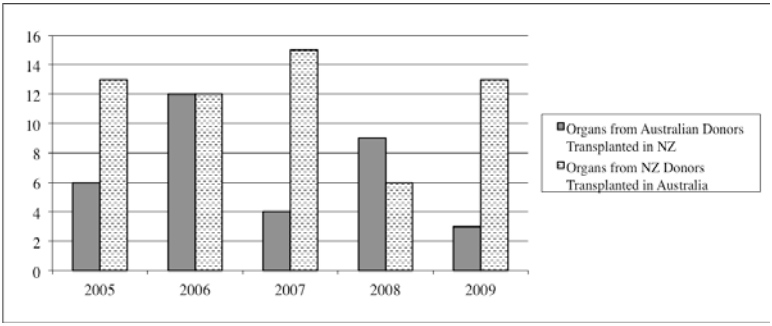

Figure 5.Total number of organs (liver, heart, lungs and kidneys) donated under the trans-Tasman organ sharing agreement.[107]

Despite the long gestation period of the present Act, consent for organ donation under the HTA is more confusing than it used it to be and certainly a far cry from the original goal of being "easily understood."[108] Legislature's attempt to create a more comprehensive Act has led to a highly complex Act that is likely to reduce the organ donation rate than increase it.

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[106] Australia and New Zealand Organ Donation Registry Annual Report 2010 at 25.

[107] Organ Donation New Zealand *Annual Report 2009* (2010), at 9.

[108] Cabinet Paper "Review of the Regulation of Human Tissue and Tissue-based Therapies: Paper One" (2004) at 4.

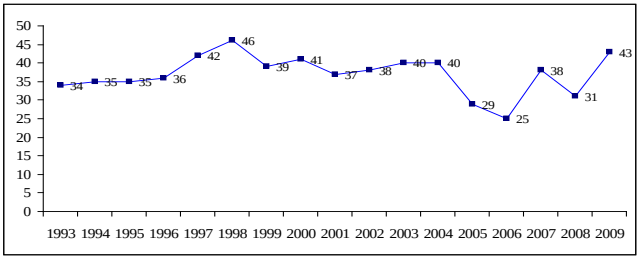

Figure 6. Number of Cadaveric New Zealand Donors 1993-2009.[109]

From Figure 6, there has been an increase in organ donors since the HTA came into force on 1 November 2008. However, this increase is still less than the donor peak in 1998. New Zealand now has an Act with multiple hurdles to organ donation and is so complicated it could even discourage potential donors – thus also defeating another objective of promoting "public good."[110] The reason for this compromise could be due to the influence of Māori in Parliament, and the need for the government to strike a balance between the two extreme positions of family decision-making and individual autonomy lest it loses public favour. The need to sift through numerous subparts to establish consent under the Act has not only made the job of physicians much harder, it has also made organ donation laws inaccessible to the ordinary New Zealander.

Thus, organ demand is a global issue and many countries have had to implement various strategies to more effectively address this public health burden. If New Zealand is serious about increasing its rate of organ donation, it may have to look to a different system. One possibility worth considering is the opt-out system recommended by the Council of Europe[111] and adopted by Singapore.[112]

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[109] Australia and New Zealand Organ Donor Registry *Annual Report 2010 Appendix II* (2010) at 2.

[110] Ministry of Health *Review of the Regulation of Human Tissue and Tissue-based Therapies: Discussion document.* (Ministry of Health 2004) at 1.

[111] Council of Europe *Resolution 78(29) on Harmonisation of legislation of member states to removal, grafting and transplantation of human substances. Adopted by the Committee of Ministers of the Council of Europe* (11 May 1978).

II.

Singapore

Singapore is a 710km² island with a population of nearly 5 million people.[113] Since its independence from Malaysia in 1965, Singapore's politics has been dominated by the People's Action Party – the state's ruling political party since 1959.[114] This party has been central to Singapore's rapid political, social and economic development, but it has also come under heavy criticism by observers who have described its politics as "paternalistic."[115] However, despite any disgruntled feelings one may have towards tight political control by the government, it is hard to ignore the economic successes that Singapore has enjoyed despite its limited resource. This is attributed by many to the "overwhelming emphasis" placed on efficiency-based policies and economic fundamentals on all facets of its government.[116]

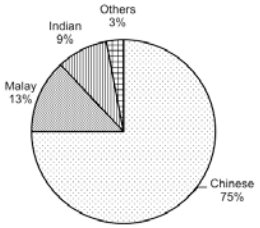

Figure 7. Singapore resident pop by ethnic group as of June 2009.[117]

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112 (9 December 1986) 48 Singapore Parliamentary Debates 866.

113 National Population Secretariat, Prime Minister's Office and others. *Population In Brief 2010* (2010) at 1.

114 People's Action Party "Party Milestones" (2010) People's Action Party <www.pap.org.sg>.

115 RS Milne and DK Mauzy *Singapore: The Legacy of Lee Kuan Yew* (Westview Press, Boulder (Colorado) 1990) at 90.

116 Ho Khai Leong "Citizen Participation and Policy Making in Singapore: Conditions and Predicaments" (2000) 40(3) 436 at 438.

117 Singapore Department of Statistics *Monthly Digest of Statistics Singapore, July 2010* (2010) at 2.2.

With an estimated 7.3 people aged 15-64 years old per elderly person aged 65 years and over,[118] Singapore is considered one of the fastest ageing societies in the Asia-Pacific region[119] with the current 8.5% of residents aged 65 years or older projected to increase to 19% by 2030.[120] A significant need of a country with increased life expectancy is a corresponding demand for transplants from organ failure. Quality healthcare and life-preserving treatment has meant that people can be sustained for longer while awaiting an organ transplant, but ultimately organs are still needed unless death occurs first.

Singapore has the fifth highest incidence of kidney failure in the world[121] and the National Kidney Foundation is responsible for the management of 24 different dialysis centres across the island to meet the needs of kidney patients.[122] Organ demand has continually outstripped supply and in 2006, twenty-two patients died while waiting for an organ in Singapore.[123] In 2009, there were 460 kidney patients with end-stage organ failure in Singapore awaiting a transplant, and only 66 patients received new kidneys.[124] It can be said that Singapore, with its vision to "increase the yield of cadaveric organs as well as to facilitate living organ donation",[125] takes a very utilitarian approach in addressing the need for organs. At present, two separate Acts govern

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118 Ibid at 1.

119 S Vasoo, T Ngiam and P Cheung "Singapore's ageing population" in DR Phillips (ed) *Ageing in the Asia-Pacific Region: Issues, policies and future trends* (Routledge, New York, 2000) 174 at 174.

120 WHO *Western Pacific Country Health Information Profiles 2009 Revision* (WHO Regional Office for the Western Pacific, Manila, 2009) at 394.

121 National Kidney Foundation Singapore "Did you know…?" (2009) National Kidney Foundation Singapore <www.nkfs.org> .

122 National Kidney Foundation Singapore "NKF Dialysis Centre Location" (2009) National Kidney Foundation Singapore <www.nkfs.org> .

123 Ministry of Health *Public Consultation Paper on Proposed Amendments to the Human Organ Transplant Act* (2008) at 5.

124 National Organ Transplant Unit from Chin Kwong Cheong.

125 Ministry of Health *Public Consultation Paper on Proposed Amendments to the Human Organ Transplant Act* (2008) at 5.

the procurement of organs to address this demand: the Medical (Therapy, Research and Education) Act 1972 and the Human Organ Transplant Act 1987.

A. The Medical (Therapy, Research and Education) Act 1972

The common law rule of *Williams v Williams,*[126] stating that a property right cannot exist in the dead body of a human being, applied fully and without exception, in Singapore.[127] The adoption of the Medical (Therapy, Research and Education) Act 1972 (MTERA) created the legal right for persons to, during their lifetimes, donate parts of their body to any approved hospital, medical or dental school, college or university for "medical or dental education, research, advancement of medical or dental science, therapy or transplantation" or to "any specified individual for therapy or transplantation needed by him."[128] This Act is more similar to New Zealand's Human Tissue Act 1964 than it is to the 2008 Act and this paper will address only the parts of the MTERA relating to organ donation.

1. Consent

Revised in 1985 with amendments in 1998, 2008 and 2010, the MTERA permits any person over the age of 18 years and of sound mind to donate any part of their body for therapeutic purposes after his or her death.[129] If a person has not expressed any clear wish to donate his organs, relatives may consent to their removal after death or immediately before death.[130] However, this may only proceed if there is no contrary indication expressed by the deceased and if family members in an identical class or in a class with higher priority have not

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126 *Williams v Williams* (1882) 20 Ch D 659

127 KSH Terry "Rights, Ethics and the Commercialisation of the Human Body" (2000) Sing. J. Legal Stud. 483 at 497.

128 Medical (Therapy, Education and Research) Act 1972, s 7.

129 Ibid, s 3.

130 Ibid, s 4.

lodged opposition.[131] Unlike New Zealand law that has a fairly broad definition of family, relatives under the MTERA are restricted to a small number and prioritised in this order: the spouse, an adult son or daughter, either parent, an adult brother or sister, a guardian of the deceased at the time of death, and any person authorised or under obligation to dispose of the deceased's body.[132]

Similar to the old law in New Zealand under the HTA 1964, written consent can be given at any time, but oral consent is valid only if given in the presence of two or more witnesses and *during a last illness*.[133] The donor may revoke consent at any time either in writing or by an oral statement in the presence of at least two other people.[134]

Finally, consent under the MTERA is not given a definition. The Act merely states that a person "may give all or any part of his body" with no reference to how much information the donor possessed at the time of giving consent. In contrast, the law in New Zealand for living and cadaveric organ donations require that "informed consent" – and nothing less – be given before organ removal may take place.

2. Lack of donations and the need for change

Despite "favourable legal provisions"[135] designed to facilitate the donation and use of organs for transplant and other medical purposes, organ supply remained deficient and the MTERA was considered a "dismal failure."[136] Between 1970 and 1987, there were only 85 cadaveric kidney transplants[137] with none performed between 1979

131 Ibid, The Schedule of Authorised Persons.
132 Ibid, The Schedule of Authorised Persons.
133 Ibid, s 8 (emphasis added).
134 Ibid, s 9.
135 (2 June 1972) 31 Singapore Parliamentary Debates 1343.
136 (9 December 1986) 48 Singapore Parliamentary Debates 865.
137 Eugene Shum and Arthur Chern "Amendment of HOTA" (2006) 35 Ann Acad Med Singapore 428 at 429.

and 1981.[138] In 1986, 14 years after its introduction, only 27 000 organ pledges had been received – about 3% of Singapore's needs – and not a single kidney had been available from the pledges.[139] Thus, encouraged by the recommendation of the Council of Europe in 1976 to its member states to modify organ donation laws towards the presumed consent system,[140] the Singapore government passed the Human Organ Transplant Act in an attempt to meet the demand for kidney donations. Kidney transplants had become routine and successful treatment for kidney failure. The passing of this Act created two separate parts to the Singaporean law governing organ transplantation: one an opt-out system for kidney donation under the Human Organ Transplant Act 1987 and, for all other organs, an opt-in system under the MTERA.

B. Human Organ Transplant Act 1987

1. Introduction

The HOTA provides an opt-out system that presumes the consent of an individual with respect to organ removal. This is in contrast to New Zealand that has an opt-in system. A deceased is presumed to have consented to organ donation unless he or she registered an objection with the National Organ Transplant Unit prior to death.[141] Unlike New Zealand law that respects the objection of family where no consent or objection has been received, family members in Singapore have no right to object.

The opt-out system applied to all Singaporean citizens and permanent residents other than Muslims. From 1987 to 2004, Singaporeans and

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138 Valerie Chew "Human Organ Transplant Act (HOTA)" (2008) Singapore Pages/Singapore Infopedia, National Library Board Singapore <infopedia.nl.sg >

139 (9 December 1986) 48 Singapore Parliamentary Debates 873.

140 (9 December 1986) 48 Singapore Parliamentary Debates 866.

141 See Appendix 3.

permanent residents of the Muslim faith were automatically considered objectors to the HOTA because of the religious belief that the removal of organs after death was a desecration of the deceased and that consent of the *waris* (paternal next-of-kin) is necessary in culture before organs could be donated.[142] However, Muslims were still able to opt-in under the HOTA or pledge their organs under MTERA with no right of next-of-kin to override the pledge.[143]

When first introduced, any Singapore citizen or permanent resident who was of sound mind, between twenty-one and sixty years of age, and not Muslim was presumed to be a donor unless he or she had registered dissent prior to death.[144] The removal of organs cannot be authorised if the circumstances surrounding a death are suspicious and within the jurisdiction of a coroner,[145] or if there is reason to believe that the deceased was "mentally disordered" and consent has not been given from the parent or guardian of the individual concerned.[146]

As presumed consent was a relatively new concept, the government was rigorous in its public education so as to ensure widespread understanding, ease fears and overcome reluctance. Public concerns included fears that organs would be removed before a person was truly dead, a reluctance to donate because of superstition as well as suspicion of the government.[147] However, despite these concerns, only a small number of people chose to opt-out under the Act once it was passed in 1987.[148] The small number of objections could be due to the

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142 Ministry of Health "Summary of Feedback Received" (2007) Ministry of Health <www.moh.gov.sg>.

143 Revocation of such a gift was limited to statements made by the donor only. See: Medical (Therapy, Education and Research) Act 1972, s 9.

144 To opt-out of the HOTA, a person must fill out an opt-out form and send it to the National Organ Transplant Unit. See Appendix 3.

145 Human Organ Transplant Act 1987, s 6(1).

146 Ibid, s 5(2)(e).

147 (9 December 1986) 48 Singapore Parliamentary Debates 868 and 874.

148 Khaw Boon Wan, Minister for Health "MOH Budget Speech (Part 2) – Transforming Healthcare" (speech to Parliament, Singapore, 6 March 2007).

social disincentive introduced alongside the HOTA – those who opted out of the system were immediately placed low in priority for an organ donation together with Muslims who had not opted in, with foreigners seeking an organ transplant placed last in the queue.

The impact of the HOTA on organ supply in Singapore was seen rapidly. Organ procurement was initially confined to the kidneys of those who had died accidental deaths. In 1988, there were 16 kidneys acquired and a further 15 kidneys in 1989.[149] Together with organ pledges under the MTERA, kidney transplants increased from 15 and 16 transplants in 1986 and 1987, respectively, to a total of 23 transplants in 1988 and 26 in 1989. However, this increase in organs coincided with an increase in the number of patients diagnosed with end-stage kidney failure. In 2003, only 34 of 675 end-stage kidney failure patients received new kidneys; in general, only 5-10% of kidney failure patients were receiving a kidney transplant annually in Singapore.[150]

[149] Bernard Teo "Organs for Transplantation The Singapore Experience" 21(6) The Hastings Center Report 10 at 10.

[150] A Vasthsala "Twenty-five facts about kidney disease in Singapore: A remembrance of World Kidney Day" (2007) 36 Ann Acad Med Singapore 157 at 159.

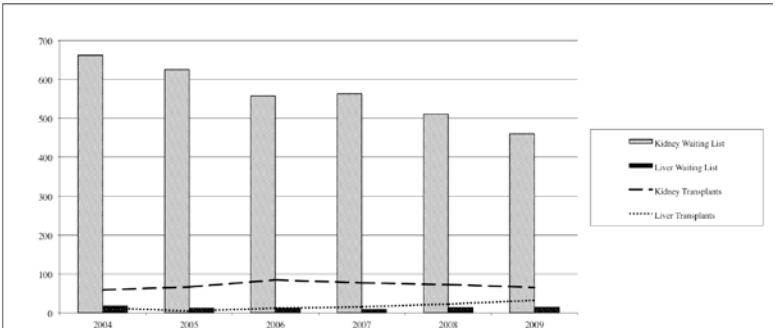

Figure 8. Live and cadaveric organ supply and demand in years 2004-2009.[151]

2. Living donor transplants

In 2004, provision was made for living donor organ transplants in the Act. Prior to that, laws governing organ donation related wholly to cadaveric donors. Unlike New Zealand, where the only requirement is informed consent, all living donor transplants in Singapore – whether related or not –[152] require the written authorisation of a hospital ethics committee. Every hospital that performs transplants has an ethics committee that screens the eligibility of living donor organ transplants under the Act.[153] This is intended to protect donors from exploitation and ensure that organs are not obtained illegally.

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[151] National Organ Transplant Unit from Chin Kwong Cheong.

[152] Under the draft Amendment Bill, written authorisation from the ethics committee was only required for living unrelated organ transplants. However, pursuant to a recommendation by the Singapore Academy of Law, the requirement for a written authorisation was extended to include living related organ transplants as it was felt that the risk of pressure and undue influence was possibly even greater in living related organ transplant scenarios. (see Ministry of Health "Public Consultation on the Human Organ Transplant (Amendment) Bill – Summary of feedback received" (2003) Ministry of Health <www.moh.gov.sg>).

[153] Human Organ Transplant Act 1987, s 15A(2).

During the public consultation period, several people expressed a preference for a central ethics committee over hospital-specific committees to ensure "uniformity in standard" as well as independence of the committee.[154] However, the Ministry of Health felt that leaving ethics committees responsible for individual assessments and decisions was "more appropriate" since the final responsibility for the care and well-being of the donor and recipient lay with the transplant team. Additionally, the Ministry felt that the rules and procedures laid out under the HOTA were sufficient in safeguarding the interests of all involved.[155] Finally, while statutory declarations are not mandatory for potential recipients, the court has recently alluded to the fact that such a requirement would be "prudent" and would "better equip [transplant ethics committees] to carry out their tasks."[156]

Thus, Singapore takes a very serious approach in governing living donor organ transplants. While there is no standard requirement of "informed consent" like in New Zealand, the rigorous process of interviews with ethics committees ensures that anyone wanting to donate his or her organs is fully aware of the risks and benefits of the procedure, and consent when given, is fully informed This standard imposed by the HOTA arguably affords more protection for the donor as safeguards are in place to ensure that such transplants are completely altruistic in nature and not a result of coercion or duress.

3. Increasing the pool of donors

Over the years, Singapore has introduced several amendments to increase the organ donation rate. These include widening the type of organs available for donation; the removal of the Muslim exemption

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[154] Ministry of Health "Public Consultation on the Human Organ Transplant (Amendment) Bill – Summary of feedback received" (2003) Ministry of Health <www.moh.gov.sg>.
[155] Ibid.
[156] *Public Prosecutor v Tang Wee Sung* [2008] SGDC 262 [45]

under the HOTA; and the removal of the upper age limit for donation. These amendments successfully increased organ donation rate in Singapore.

(a) 2004 Amendment to widen the pool of organs

In 2004, the HOTA (Amendment) Act was passed by Parliament introducing provisions to extend the donation of organs to include not just the kidneys but also the liver, heart and corneas. Lungs have not been brought under the HOTA as it is felt that lung transplants are not yet fully established.[157] In addition, HOTA's confinement to accidental causes of death was extended to include all causes of death. The success of the 2004 Amendment is reflected in the numbers: in 2007 alone, cadaveric organs were used to perform 46 kidney transplants, 12 liver transplants, 4 heart transplants and 253 cornea transplants.[158]

(b) The removal of the exemption for Muslims

In 2007, the Ministry of Health revealed that 21% of the patients on the kidney waiting list were Malay despite them making up only 14% of the total resident population.[159] This disproportionate burden did not bode well for Muslims who, as non-organ pledgers under MTERA and presumed objectors under HOTA, were low in priority for an organ under the HOTA allocation scheme. Following discussions with the Muslim Kidney Action Committee and the Ministry of Health, the Fatwa Committee of the Islamic Religious Council of Singapore[160] issued a religious ruling permitting Muslims to come under the HOTA. The HOTA was amended to remove the Muslim exclusion[161] and the "vast majority" of Muslims has since chosen to remain under the

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[157] Ministry of Health, above, n 154.
[158] National Organ Transplant Unit from Chin Kwong Cheong.
[159] Ministry of Health "Public Consultation on the Human Organ Transplant (Amendment) 2007" (2007) Ministry of Health <www.moh.gov.sg>.
[160] *Majlis Ugama Islam Singapura* – Islamic Religious Council of Singapore
[161] Human Organ Transplant Act 1987, s 5(2)(f) prior to amendment.

HOTA, with reports stating that four Muslim donors have since donated organs to benefit 15 people.[162]

Organ donation was a very sensitive topic that was avoided amongst Muslims because of belief that it did not align with religious and cultural beliefs that place value on an intact body. While there was significant potential for many Muslims to be offended by including them under the opt-out system, this obstacle was overcome through thoughtful process between religious leaders, health professionals and policy-makers. Through awareness of the need for organs and teaching by Islamic leaders, Muslims have grown to accept organ donation and the organ donation rate has increased.

(c) Removal of the upper age limit

Previously, the HOTA did not apply to deceased persons over 60 years old. Any person over 60 years who wished to donate his organs needed to have pledged them under the MTERA. However, the Health Ministry removed Singapore's upper age limit in 2009 so as to further increase the pool of organs. By removing this limit, Singapore now shares similar practice with Norway, Spain, United Kingdom and the United States that assess transplantable organs for medical suitability and do not impose an upper age limit for cadaveric organ donation.[163] In addition, the removal of the upper age limit more than 20 years after the adoption of the HOTA gave many older Chinese Singaporeans, whose beliefs are steeped in Confucian ethics that place value on upholding the integrity of one's body,[164] time to warm to the

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162 "More muslims get transplants since organ donor law change" *The Straits Times* (Singapore, 11 February 2009).

163 Ministry of Health *Public Consultation Paper on Proposed Amendments to the Human Organ Transplant Act* (2008) at 6.

164 John Gilman "Religious Perspectives on Organ Donation" (1999) 22(3) Critical Care Nursing Quarterly 19.

common goal of saving lives through organ donation.[165]

4. Payment for organs

Like New Zealand, it is strictly forbidden for anyone to enter into a contract to supply or receive an organ for monetary consideration in Singapore. However, the laws were amended in 2009 to allow donor reimbursement. Beyond that, trade is prohibited and the penalties for organ trading have become more severe to discourage the activities of middlemen and organ syndicates.

(a) Donor Reimbursement

Donor reimbursement was introduced to "better protect…welfare and ensure that [live donors] do not suffer…because of their altruistic acts."[166] Prior to the Amendment in 2009, donors bore any losses incurred from missed work or lost insurance coverage. This view was considered "outdated", "unfair to the donors" and irregular against current accepted practices overseas.[167]

Thus, in light of the significant risks undertaken by altruistic donors for the benefit of others,[168] the government permitted reimbursements to "defray" any costs incurred relating to such a living organ donation.[169] The National Kidney Foundation is responsible for the 'Donor Support Programme' which offers several benefits including a reimbursement to donors for loss of income of up to $5 000.[170]

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165 Email from Pheng Soon Lee to Joanne Lee regarding Chinese culture towards organ donation (9 September 2010).
166 (23 March 2009) 85 Singapore Parliamentary Debates 3426.
167 Ibid.
168 Ministry of Health *Public Consultation Paper on Proposed Amendments to the Human Organ Transplant Act* (2008) at 8.
169 Human Organ Transplant Act 1987, s 14(3)(c).
170 National Kidney Foundation "Kidney Live Donor Support Programme" (2009) <www.nkfs.org>.

However, unlike New Zealand that limits financial assistance to those received from Work and Income New Zealand, reimbursements over and above any reimbursements received from the 'Donor Support Programme' is permitted and is at the discretion of organ recipients who wish to assist organ donors with expenses incurred as a result of their altruistic act.[171]

(b) Increased penalties for syndicated organ trading and the case of Tang Wee Sung

In September 2008, retail magnate Tang Wee Sung was found guilty of attempting to buy a kidney from Indonesian Sulaiman Damanik and making a false declaration under the Oaths and Declarations Act 2000 confirming that no money or financial gain had been paid to procure the organ and that the prospective donor, Sulaiman Damanik, was a relation.[172]

Mr Tang, who had been given one to two years to live without a transplant from a live donor, sought to procure the kidney through a "middle-man" and was prepared to fork out $300,000 to see the deal through. However, suspicions were raised and the illegal contract was eventually discovered and reported. When deciding on an appropriate sentence, the district court judge highlighted that society's main disapproval is "focused on the middlemen who profit from illicit organ trading and not the dying patient in need of a transplant or the poor"[173] as seen by the stance of the Ministry of Health to "take a sympathetic approach to the plight of the exploited donors and the basic instinct of kidney failure patients to try to live."[174]

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171 Ministry of Health "Amending HOTA to save more lives" *Health Scope* (Singapore, April 2009).
172 *Public Prosecutor P v Tang Wee Sung* [2008] SGDC 262
173 Ibid, at [20].
174 (21 July 2008) 84 Singapore Parliamentary Debates 17.

Despite the fact that criminal culpability for offenders under the HOTA is not distinguished between the different roles played by offenders under the Act, the district court judge took a sympathetic approach towards the plight of Tang and, in recognising that an extended jail term would cause a disproportionate toll on Tang's health,[175] found it appropriate to invoke the doctrine of judicial mercy.[176] Tang was sentenced to a mandatory penalty of one day's imprisonment and a $10 000 fine under the Oaths and Declarations Act 2000 and a $7 000 fine under the HOTA. At the time of sentencing and prior to the 2009 Amendment, the maximum penalty under the HOTA for entering into such a contract was $10 000 fine and/or 12 months imprisonment.[177]

Indonesian Sulaiman Damanik was similarly given a relatively light sentence of 2 weeks imprisonment and a fine of $1 000 for illegal organ supply in contravention of s 14(2) of the HOTA as well as making a similar false statutory declaration under the Oaths and Declarations Act 2000. The district court judge took sympathy towards the dire financial situation of the accused and agreed with the view that a person in such a vulnerable position receiving a similar sentence to that of the "ringleader" would "undoubtedly offend the innate sense of justice of the reasonable man."[178]

Conversely, the High Court upheld the sentence of 14 months imprisonment imposed by the District Court for Wang Chin Sing's role as middleman for two kidney transplants.[179] In March 2008, Wang successfully brokered the sale of a kidney from an Indonesian to another Singaporean, Juliana Soh, for a fee of $8 000.[180] In May 2008, Wang began the process of procuring an organ on behalf of Tang.

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175 *Public Prosecutor P v Tang Wee Sung*, above n 172, at [51

176 Ibid, at [49].

177 Human Organ Transplant Act 1987, s 14(2), prior to amendment in 2004.

178 *Public Prosecutor v Sulaiman Damanik and Another* [2008] SGDC 175 at [28].

179 *Wang Chin Sing v Public Prosecutor* [2008] SGHC 215

180 *Public Prosecutor v Wang Chin Sing* [2008] SGDC 268 at [13].

Aware of his wealth, Wang quoted a fee five times the amount paid by Juliana Soh.[181] For his elaborate role in orchestrating the illegal supply of an organ, exacerbated by his 'cavalier manner in…fabricating several overlaying shrouds of deceit to ensure the success of his "trade"',[182] the High Court found him "fixed with the lion's share of the stigma of culpability."[183] Two months after this event, the HOTA was amended with the intention to impose heavier penalties – a fine not exceeding $100,000 or up to 10 years imprisonment or both – [184]on "middlemen" and organ trading syndicates.

While the HOTA may appear draconian, it seems that in practice it is administered with due regard to the needs and interests of grieving families. Recognising that good relationships between healthcare workers, the general public and the government are vital to the common goal of saving lives through organ donation, the transplant unit places an emphasis on education over the exercise of enforcement powers. In addition, it is highly unlikely that the government will make it a statutory duty to harvest organs as this can create zeal amongst doctors and create a conflict of interest that can potentially jeopardize doctor-patient relationships. Thus, understanding the importance of the roles of the multiple stakeholders in this highly sensitive arena ensures that there is good balance struck between increasing organ donation to save lives and ensuring the best possible process for the donor family.[185]

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[181] Ibid, at [39].
[182] *Wang Chin Sing v Public Prosecutor*, above n 179, at [4].
[183] Ibid, at [5].
[184] Human Organ Transplant Act 1987, s14(2A).

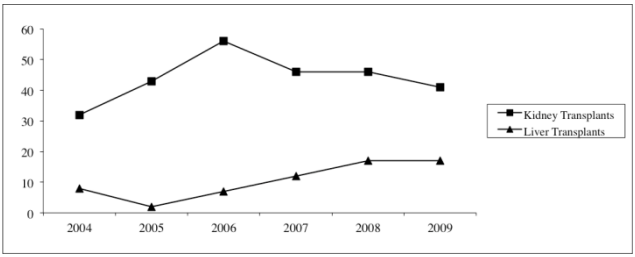

Figure 9. Number of Cadaveric Singaporean Donors 2004-2009.[186]

III.

Would an opt-out system be a better option for New Zealand?

Organ donation laws have continuously evolved in Singapore. Driven by a desire to maximise self-sufficiency in kidney donation,[187] Singapore is constantly hunting for ways to increase organ donation rates. Since 2004, the law has been repeatedly amended to accommodate the perceived needs of Singapore, namely the rising demand for organs as a result of organ failure. The success of such a policy may be judged in several ways including clinical outcomes, the increase in donor rates and public acceptance of the law.

When assessed purely on improved clinical outcomes for organ failure patients, the HOTA is a success. By taking steps to increase donation rates, more patients have been able to receive organs. However, as seen in Figure 9, the success of HOTA is not necessarily reflected in increased numbers. This could be due to many factors – both clinical and social – including the number of deaths that vary annually[188] and the viability of organs for transplantation. On the other hand, if success of the HOTA is assessed by the measure of public acceptance

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[186] National Organ Transplant Unit from Chin Kwong Cheong.
[187] Ministry of Health *Public Consultation Paper on Proposed Amendments to the Human Organ Transplant Act* (2008) at 3.
[188] "Deaths from Non-Natural Causes" *Singapore Statistics Newsletter* (Singapore, September 2002) at 21.

of the law, it is undoubtedly a success. This is largely attributed to the Singapore's staged implementation of the HOTA and the pro-active steps taken by the government to increase awareness. By initially excluding groups that were most likely to object to organ donation (namely Muslims and older Chinese), the government allowed them time to warm to the idea of organ donation for the greater public good. In addition, there have been many active steps towards the widespread dissemination of educational material through various media so as to increase awareness.

All things considered, it can be said that Singapore has successfully implemented a law that can only improve organ donor rates. However, this approach is not extraordinary – Singapore's move to an opt-out system was triggered in part by a recommendation by the Council of Europe to its member states, many of which are similar in culture to New Zealand.[189] Regardless, whether such bold utilitarian moves by a country to address organ demand should be lauded and replicated in New Zealand is not as straightforward. This is so for many reasons including the emphasis on Māori and Treaty principles, the emphasis on the 'gift' status of organs, and the strong culture of informed consent in healthcare.

First, death and grieving are highly significant events amongst Māori and there is deep familial interest in the sanctity of an intact body. It is likely that any law that deprives a family of the right to contribute to such a significant decision will offend their identity as *tangata whenua* ("people of the land").

Second, because of cultural beliefs, there are few Māori donors despite a disproportionate number of Māori on organ waiting lists. Singapore's allocation scheme that prioritises by donation status and medical need

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[189] Council of Europe *Resolution 78(29) on Harmonisation of legislation of member states to removal, grafting and transplantation of human substances. Adopted by the Committee of Ministers of the Council of Europe* (11 May 1978).

is likely to stir up controversy in New Zealand. This is because many Māori will find themselves low in the priority queue because of their beliefs and regardless of medical need. Such an arrangement also conflicts with many New Zealanders who believe that donated organs are an "unconditional gift" that should "be allocated to those with the greatest need for them" and that alternatives would "raise serious distributive issues."[190]

The political structure within New Zealand is such that minority parties now have a larger say than ever before. As such, any political party that attempts to advance a policy that is unfavourable towards the beliefs and values of any group is likely to suffer significant political repercussions. This is even more so when the Crown is obliged under the Treaty of Waitangi to protect the well-being of Māori.[191] This commitment is reflected in the Ministry of Health that emphasised the importance of ensuring Māori are "given the opportunity to experience the same health status as non-Māori."[192]

Third, informed consent is so entrenched in the New Zealand healthcare system that a move to introduce an opt-out system is unlikely to be received wholeheartedly. While the old standard of "lack of objection" is quite similar to presumed consent and thus not unfamiliar, the move from "lack of objection" to informed consent under the new Act was executed intentionally in order to align with current healthcare standards under the Code. The history of medical procedures and experiments on non-consenting patients that mars New Zealand's medical history caused public outrage. This outrage was appeased only by an inquiry and eventually a full statement of

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[190] Ministry of Health *Review of the Regulation of Human Tissue and Tissue-based Therapies: Submissions Summary* (Ministry of Health 2004) at 93.

[191] Ministry of Māori Development *Hauora o te tinana me ōna tikanga : a guide for the removal, retention, return and disposal of Māori body parts and organ donation* (1999) at 10.

[192] Ministry of Health *Review of the Regulation of Human Tissue and Tissue-based Therapies: Discussion document.* (Ministry of Health 2004) at 5.

patient rights that enshrined informed consent in New Zealand. Thus, a law change essentially reversing the standard from that of the widely-accepted informed consent to presumed consent is likely to confuse people, cause great unease and also raise suspicion.

Finally, there is no guarantee that organ donation rates in New Zealand will improve significantly enough to make the cost worthwhile for New Zealand. This is because while greater organ donation rates certainly means that fewer lives will be lost, the Singaporean approach does come with political and social costs that may not be beneficial to New Zealand in the long run. The different political and social structures of New Zealand as compared to Singapore mean that introducing such a controversial law is likely to cause public upset and have great political cost for the government.

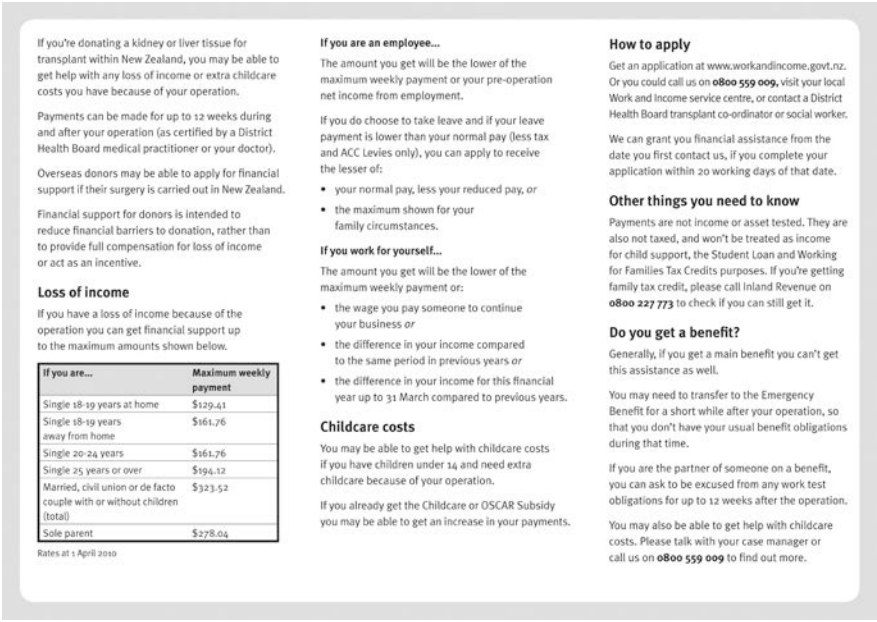
While an opt-out system may not be beneficial for New Zealand to adopt, a key strategy that has succeeded in Singapore is educating the public on organ donation and demystifying cultural and societal misconceptions surrounding it. As a multi-ethnic and multi-religious country, there are many mindsets and superstitions surrounding death and organ donation. However, these have been clarified and put at ease through extensive discussion and education targeted at different groups in society. By emphasising the greater public good of organ donation and drawing on the altruistic nature of people, Singapore's utilitarian approach has led to a greater number of organs for transplant.

Conclusion

Organ demand has always outstripped supply and both New Zealand and Singapore have taken very different approaches in their attempts to increase organ donation rates. New Zealand has an opt-in system and has enhanced recognition for the wishes of a deceased. However, it is complex and highly time-consuming, particularly where a

deceased's wishes are unknown. The law has created multiple hurdles for potential donors to overcome and it may not have the desired outcome of increasing organ donation rates. On the other hand, Singapore has an opt-out system that presumes the consent of individuals unless they have registered an objection in their lifetime. In doing so, it can be said that the government takes advantage of a donor's reluctance to broach the matter of death and organ donation and essentially decides for him or her. Through this system, Singapore has garnered public acceptance of the law and successfully increased organ donation rates.

In conclusion, it is not guaranteed that an opt-in system such as in Singapore will prosper in another country. In New Zealand, history as well as the difference in cultures and national opinion has created a climate unfavourable towards an opt-out system that presumes consent. However, the approach taken by Singapore demonstrates that it is possible to implement strategies to increase the organ pool while still being sensitive to the needs of different cultures. While an opt-out policy may not necessarily work in New Zealand, Singapore's success with HOTA shows that thoughtful policy making and vigorous public education can make a difference in increasing organ donation rates. If improvement in education and awareness is coupled with an effective management of an opt-in system, such that prior-registered informed donation can be verified during the period of organ viability, improvement can possibly be achieved under the current legal framework.



If you're donating a kidney or liver tissue for transplant within New Zealand, you may be able to get help with any loss of income or extra childcare costs you have because of your operation.

Payments can be made for up to 12 weeks during and after your operation (as certified by a District Health Board medical practitioner or your doctor).

Overseas donors may be able to apply for financial support if their surgery is carried out in New Zealand.

Financial support for donors is intended to reduce financial barriers to donation, rather than to provide full compensation for loss of income or act as an incentive.

Loss of income

If you have a loss of income because of the operation you can get financial support up to the maximum amounts shown below.

If you are...	Maximum weekly payment
Single 18-19 years at home	$129.41
Single 18-19 years away from home	$161.76
Single 20-24 years	$161.76
Single 25 years or over	$194.12
Married, civil union or de facto couple with or without children (total)	$323.52
Sole parent	$278.04

Rates at 1 April 2010

If you are an employee...

The amount you get will be the lower of the maximum weekly payment or your pre-operation net income from employment.

If you do choose to take leave and if your leave payment is lower than your normal pay (less tax and ACC Levies only), you can apply to receive the lesser of:

- your normal pay, less your reduced pay, *or*
- the maximum shown for your family circumstances.

If you work for yourself...

The amount you get will be the lower of the maximum weekly payment or:

- the wage you pay someone to continue your business *or*
- the difference in your income compared to the same period in previous years *or*
- the difference in your income for this financial year up to 31 March compared to previous years.

Childcare costs

You may be able to get help with childcare costs if you have children under 14 and need extra childcare because of your operation.

If you already get the Childcare or OSCAR Subsidy you may be able to get an increase in your payments.

How to apply

Get an application at www.workandincome.govt.nz. Or you could call us on **0800 559 009,** visit your local Work and Income service centre, or contact a District Health Board transplant co-ordinator or social worker.

We can grant you financial assistance from the date you first contact us, if you complete your application within 20 working days of that date.

Other things you need to know

Payments are not income or asset tested. They are also not taxed, and won't be treated as income for child support, the Student Loan and Working for Families Tax Credits purposes. If you're getting family tax credit, please call Inland Revenue on **0800 227 773** to check if you can still get it.

Do you get a benefit?

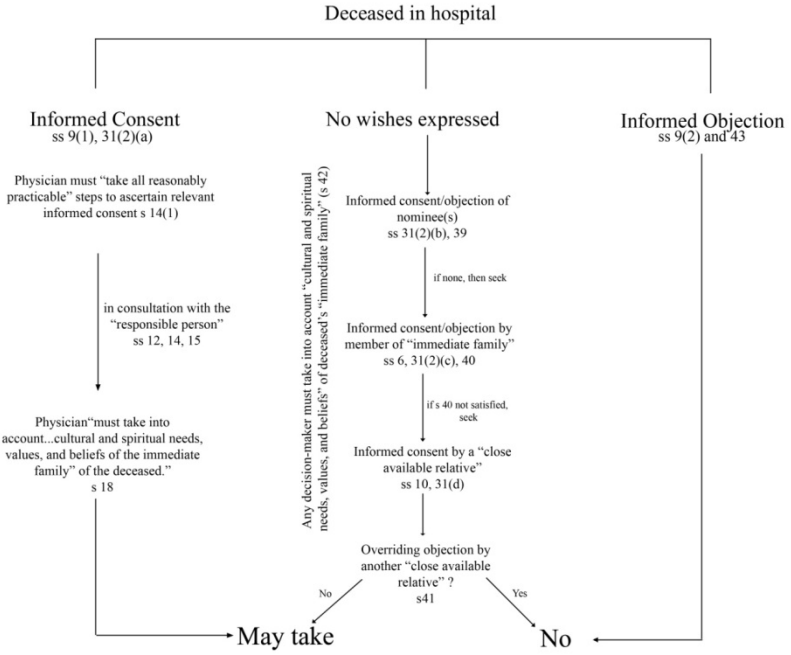
Generally, if you get a main benefit you can't get this assistance as well.

You may need to transfer to the Emergency Benefit for a short while after your operation, so that you don't have your usual benefit obligations during that time.

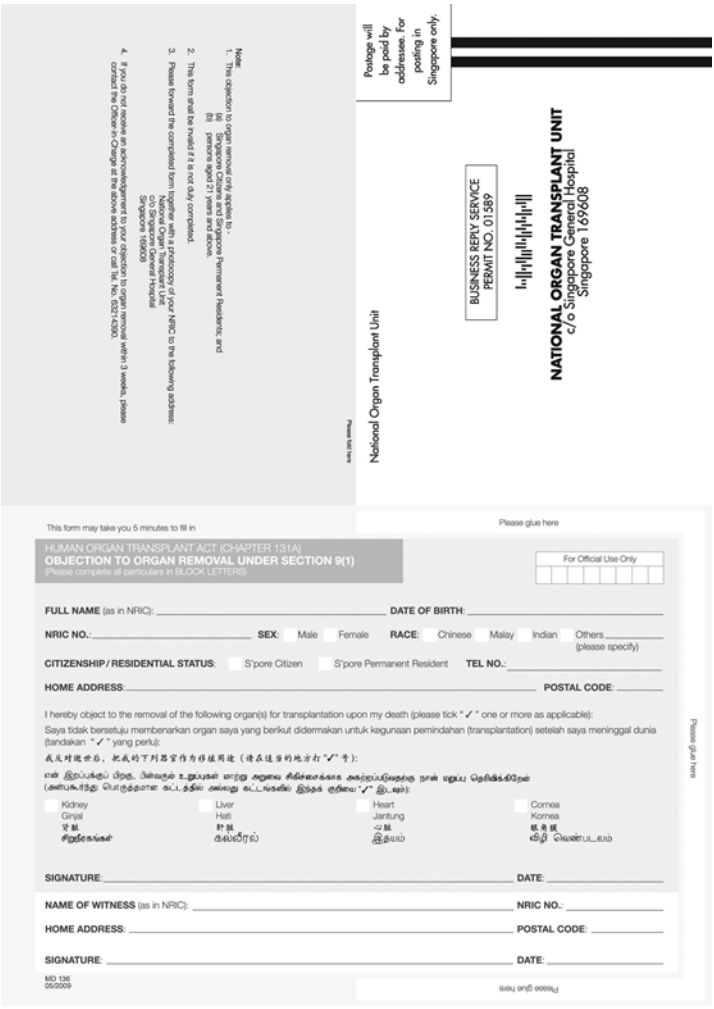
If you are the partner of someone on a benefit, you can ask to be excused from any work test obligations for up to 12 weeks after the operation.

You may also be able to get help with childcare costs. Please talk with your case manager or call us on **0800 559 009** to find out more.

Appendix 1. Work and Income New Zealand Financial Assistance for Live Organ Donors



Appendix 2. Decision-making process under the Human Tissue Act 2008



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BUSINESS REPLY SERVICE
PERMIT NO. 01589

NATIONAL ORGAN TRANSPLANT UNIT
c/o Singapore General Hospital
Singapore 169608

National Organ Transplant Unit

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Please glue here

This form may take you 5 minutes to fill in

HUMAN ORGAN TRANSPLANT ACT (CHAPTER 131A)
OBJECTION TO ORGAN REMOVAL UNDER SECTION 9(1)
(Please complete all particulars in BLOCK LETTERS)

For Official Use Only

FULL NAME (as in NRIC): _____ **DATE OF BIRTH**: _____

NRIC NO.: _____ **SEX**: Male Female **RACE**: Chinese Malay Indian Others _____ (please specify)

CITIZENSHIP / RESIDENTIAL STATUS: S'pore Citizen S'pore Permanent Resident **TEL NO.**: _____

HOME ADDRESS: _____ **POSTAL CODE**: _____

I hereby object to the removal of the following organ(s) for transplantation upon my death (please tick "✓" one or more as applicable):

Saya tidak bersetuju membenarkan organ saya yang berikut didermakan untuk kegunaan pemindahan (transplantation) setelah saya meninggal dunia (tandakan "✓" yang perlu):

我反对取出我，把我的下列器官作为移植用途（请在适当的地方打"✓"号）：

என் இறப்புக்குப் பிறகு, பின்வரும் உறுப்புகள் மாற்று அறுவை சிகிச்சைக்காக அகற்றப்படுவதற்கு நான் மறுப்பு தெரிவிக்கிறேன் (அவசுகூறிது பொருத்தமான கட்டத்தில் அல்லது கட்டங்களில் இருக்கக் குறியை "✓" இடவும்):

Kidney	Liver	Heart	Cornea
Ginjal	Hati	Jantung	Kornea
肾脏	肝脏	心脏	眼角膜
சிறுநீரகங்கள்	கல்லீரல்	இதயம்	விழி வெண்படலம்

SIGNATURE: _____ **DATE**: _____

NAME OF WITNESS (as in NRIC): _____ **NRIC NO.**: _____

HOME ADDRESS: _____ **POSTAL CODE**: _____

SIGNATURE: _____ **DATE**: _____

MD 136
05/2009

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Note:
1. This objection to organ removal only applies to -
   (a) Singapore Citizens and Singapore Permanent Residents; and
   (b) persons aged 21 years and above.
2. This form shall be invalid if it is not duly completed.
3. Please forward the completed form together with a photocopy of your NRIC to the following address:
   National Organ Transplant Unit
   c/o Singapore General Hospital
   Singapore 169608
4. If you do not receive an acknowledgement to your objection to organ removal within 3 weeks, please contact the Officer-in-Charge at the above address or call Tel. No. 6321 4380.

Appendix 3. Official opt-out form under the Human Organ Transplant Act 1987