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India's Organ Donation System Fails Its Own Ideals

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India's organ donation law is grounded in altruism, but the system fails to create the institutional conditions that are needed to sustain it. Reform requires mandated medical care, harmonised legal definitions, and sustained public education-not abandoning altruism, but honouring it.

On 10 February 2026, Dr Thankam Subramonian, a consultant in foetal medicine and obstetrics and gynaecology at Manipal Hospital, Bengaluru, became the first anonymous kidney donor in Karnataka. Despite the dominant organ donation legislation in the country-the Transplantation of Human Organs and Tissues Act, 1994 (THOTA)-expressly allowing for unrelated (non-near relative) living organ donation, she underwent a long-drawn struggle to make a willing donation.

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Her more than decade-long arduous journey is documented on her website. It included prolonged waits for approval from the relevant hospital authorisation committee, which kept deferring or rejecting her case due to unfamiliarity with anonymous living donation, and ultimately required her to seek legal recourse before her donation could proceed. Her case has brought forth, once again, the plethora of obstacles surrounding organ donation and its altruistic underpinnings in India.

Organ donation, in all its forms, is founded on the pillars of supererogatory altruism and utilitarianism. Supererogatory altruism refers to acts that exceed the demands of moral duty-actions that are praiseworthy and morally significant precisely because they are freely chosen rather than obligatory, representing a voluntary commitment to the welfare of others that goes beyond what any ethical framework requires (Dalal 2015). Utilitarianism is a branch of normative ethics that deems an act right if it maximises good consequences for the greatest number of people in society (Morris and Holt 2021). This philosophical architecture has formed the basis of transplant legislation across most jurisdictions, and India's THOTA is no exception.

THOTA regulates all forms of organ donation in the country-whether from living donors, near relative or otherwise, or from deceased donors-on the principle that organs must be given freely and without commercial motive. Under the Act, living donations by those other than near relatives are permitted only by reason of affection or attachment towards the recipient, or for any other special reason, and require authorisation committee approval to verify the absence of commercial transaction (THOTA 1994, sec. 9[3]). Commercial dealings in human organs are criminalised under Section 19 of the same Act.

The legislation is therefore grounded in altruism-assumed in the case of living related donations, and expected in the case of living unrelated and deceased donations. Altruism is not merely a value the Act aspires to; it is the legal and philosophical foundation of the entire system, despite only the unrelated living donation route being colloquially described as "altruistic donation".

Taking Dr Subramonian's case as an entry point, this article engages in a broader inquiry: how does altruism actually function across the full range of donation under THOTA, and what conditions does the system currently create for it? Her prolonged struggle raises questions that extend well beyond unrelated living donation and into how deceased donation and living related donation are organised and supported in India. The article examines each form of donation in turn, attending to the ethical, structural, and policy dimensions of altruism as it operates in practice, and asks what a more sustained commitment to the Act's own principles might require.

Altruism in India's Transplant System

India recorded its first successful kidney transplant in the 1970s at Christian Medical College, Vellore-17 years after the procedure had first been performed in the United States (Kher et al. 2024). The clinical milestone was quickly followed by a troubling social consequence: rising instances of commercial organ sales, documented most extensively in studies of poor and indebted donors. This led to the introduction of THOTA in 1994, which banned organ commerce and permitted transplants only between close family members or, in exceptional circumstances, non-related strangers for genuinely altruistic reasons.

> India records at least 200,000 new cases of end-stage kidney disease every year, yet only 13,642 kidney transplants were performed in 2023-of which 11,791 came from living donors and 1,851 from deceased donors.

The Act was not designed to resolve India's organ shortage entirely. Demand has structurally outpaced supply in every transplant system globally, regardless of the policy architecture in place (Caplan 2014). What the Act sought to establish was a framework within which people could donate freely-motivated by generosity rather than financial desperation-and within which some patients, often those known or related to the donor, could receive the organs they needed.

While donation following cardiac death was practised before 1994, the Act's legal recognition of brain stem death substantially expanded the possibilities for deceased donation, enabling retrieval of vital organs such as the heart, liver, and lungs from patients on ventilator support -organs that cannot be retrieved after cardiac death (Lancet Regional Health 2024). It was a framework built on trust in human generosity, and one that, in recognising brain stem death, opened a new frontier for donation in India.

For context, India records at least 200,000 new cases of end-stage kidney disease every year, yet only 13,642 kidney transplants were performed in 2023-of which 11,791 came from living donors and 1,851 from deceased donors (Kher et al. 2024). That gap is striking, but the more important question it raises is not one of supply alone. It is whether the system has built the institutional conditions under which voluntary donation-across all the forms the Act envisions-can actually be sustained.

Ambition and Reality

The rift between an organ as a "gift" and an organ as a "commodity" lies at the heart of the ethical architecture of transplant policy. Political philosopher Debra Satz, in *Why Some Things Should Not Be for Sale* (2010), includes kidney markets in her analysis of "noxious markets"-those that are especially harmful because they capitalise on human desperation, thrive on informational asymmetry, unequal distribution of risk, and weak agency, and, in her words, turn "desperate poor people into spare parts for the rich" (Satz 2010: 198).

> The medical principle of primum non nocere (first, do no harm) is violated not by the Act's text but by the distance between what the Act imagines and what occurs on the ground.

Most of the empirical studies which Satz drew on were in fact conducted in India (Satz 2010). Donors in these transactions were overwhelmingly poor, frequently below the poverty line, donating not out of altruism but to repay personal debt. These concerns also informed the altruistic framework of THOTA.

Yet the persistence of a black market for kidneys in India, despite the Act's altruistic and anti-trafficking structure, raises questions the Act alone cannot answer. The costs of this existing reality are borne disproportionately by the most vulnerable. Documented harms among paid donors include wound infections, chronic pain, psychological distress, and declining kidney function that frequently goes undetected-in part because these operations occur outside formal medical oversight and accountability.

The medical principle of *primum non nocere* (first, do no harm) is violated not by the Act's text but by the distance between what the Act imagines and what occurs on the ground (Sever et al. 2022; Adair and Wigmore 2011).

Living Related Donation

For donors who operate within the law, the picture is hardly more encouraging. Living donors have been denied health insurance, despite such denial being illegal. Post-surgery follow-up care is inconsistent, structured counselling is rarely the norm, and there is no systematic compensation for lost wages, travel costs, or recovery time-even though the Act already permits reimbursement of such unavoidable expenses (THOTA 1994, sec. 2[k]).

An examination of who these donors are adds a further dimension. According to a report by the MOHAN Foundation, based on National Organ and Tissue Transplant Organisation (NOTTO) data spanning 1995 to 2021, 80% of living organ donors in India are women, while women constitute only 18.9% of recipients (MOHAN Foundation 2022). NOTTO's own 2021 statistics confirm this: 80% of recipients were male, while 75% of donors were female (NOTTO 2021).

The MOHAN Foundation attributes this to what it terms the "breadwinner dilemma": men's perceived economic indispensability within families makes them reluctant donors, while women are socially conditioned to assume altruistic caregiving roles even at personal risk. Among spousal donors specifically, nearly 87% are wives, and 36% of wives who qualify as acceptable donors proceed to donate, compared to only 6.5% of husbands (MOHAN Foundation 2022).

The system's dependence on living related donation is therefore, in significant measure, a dependence on women's generosity within families-generosity that the existing institutional framework does not protect, compensate, or even formally acknowledge. This dynamic is documented with striking detail in The Quint's investigative multimedia report "Patriarchy's Silent Hand", which draws on interviews with donors and clinicians to show how guilt, familial duty, and economic dependency converge to make donation feel, for many women, less like a choice than an obligation (Ramesh and Sasikumar 2024).

Living Unrelated Donation

Dr Subramonian's case illustrates a different but structurally related set of concerns. Anonymous living donation is a form of giving that has been growing in visibility in other contexts. In October 2025, American actor Jesse Eisenberg announced on the Today show that he would donate a kidney to a complete stranger, describing it as "essentially risk-free and so needed". He subsequently donated on 30 December 2025 and was named to the TIME 100 Health 2026 list (Eisenberg 2026).

Reflecting on the low rates of anonymous donation despite a waitlist of approximately 90,000 people in the US, Eisenberg observed: "It feels like it's almost an advertising problem rather than an empathy problem" (2026). In India, the problem is not merely one of awareness-it is one of active institutional unpreparedness.

Where the system Eisenberg navigated offered clear pathways, professional support, and public recognition, Dr Subramonian encountered a decade of bureaucratic obstruction that required High Court intervention to resolve. What her case makes visible is not the rarity of anonymous donation but the absence of the institutional conditions that would allow a growing community of such donors to exist and be supported.

Deceased Donation

Deceased donation presents a differently configured but structurally related set of concerns. The concept of brain stem death is poorly understood by most families, generating mistrust that is not irrational but is the product of inadequate communication and legal incoherence.

India has three separate frameworks that define death differently: the Indian Penal Code, 1860; the Registration of Births and Deaths Act, 1969; and THOTA itself (Suriyamoorthi et al. 2018). Families from lower socioeconomic backgrounds navigate this confusion at the most difficult moments, with cultural and religious concerns compounding the difficulty further (Sasidharan et al. 2025).

The system requires an act of profound generosity from families at the worst possible moment and provides minimal institutional support for navigating that decision. The absence of trained hospital-based counsellors, standardised communication protocols, and harmonised legal definitions means that the conditions under which a family might say yes are rarely created. This is not a failure of willingness-studies consistently show that most families who refuse consent do so because of uncertainty rather than objection (Sasidharan et al. 2025). It is a failure of institutional design.

Across all three forms of donation, a common thread emerges: the Act creates the legal conditions for altruistic voluntary giving but not the institutional conditions that sustain it. This is where the work of Robert Axelrod becomes theoretically significant. In *The Evolution of Cooperation* (1984), Axelrod demonstrated that cooperation can emerge and sustain itself even among self-interested actors-but only when institutional design enables it.

The implication for organ donation policy is not that voluntary giving should be replaced by incentive. It is that generosity, like cooperation, is activated or undermined by the conditions surrounding it. Whether in the living related donor denied adequate post-operative care, the anonymous donor obstructed by an unprepared committee, or the family asked to consent at a moment of grief without any prior preparation, the pattern is the same: the willingness is present, and the system is not designed to meet it.

Rethinking Scale

In 2023, living donors accounted for approximately 86% of all kidney transplants performed in India, yet much of the non-governmental organisation (NGO) activity and state-level programme infrastructure has historically been oriented towards increasing deceased donation -reflecting a widespread view that cadaveric retrieval is where the greatest growth potential lies (Kher et al. 2024; MOHAN Foundation 2015). The system is sustained overwhelmingly by living donors, and the institutional conditions that support or undermine their contribution have received comparatively little policy attention. This asymmetry points to a misalignment between where policy effort is directed and where donation actually occurs.

> Where systems invest in those structures, donation rates reflect it; where they do not, latent commitment does not translate into practice.

Spain's experience is instructive, though primarily for deceased donation. Spain holds the world's highest deceased donor rate, at 49.4 per million population in 2023 (Lancet 2024)-an achievement built not on unusually altruistic citizens but on sustained institutional infrastructure: nationally coordinated systems, hospital-based transplant coordinators, standardised protocols, and decades of public education (Matesanz et al. 2011). India has not made that investment.

For living and unrelated donation, Spain offers no direct model, but the same principle applies across all three forms: where systems invest in structures of information, protection, and institutional support , donation rates reflect it; where they do not, latent commitment does not translate into practice (Matesanz et al. 2011).

The two directions for reform that follow are both responses to that gap. They are not mutually exclusive, and each reinforces the conditions necessary for the other to function.

Strengthening the System

The first direction is to take altruism seriously as a system requirement rather than merely a moral aspiration. Public awareness and education must be treated as policy infrastructure: the gap between expressed willingness to donate and actual donation rates is not a gap in generosity but in information, institutional trust, and facilitation.

Legal definitions of death must be harmonised across the three existing frameworks. Post-donation care for living donors must be mandated and monitored. The denial of health insurance to organ donors is already illegal, and the fact that it continues reflects an enforcement gap that must be addressed.

Formal recognition of donors and donor families also matters. The decision of the family of ten-month-old Aalin Sherin Abraham in Kerala to donate her organs after her death received national recognition and a state funeral in 2024. Such recognition is a communicative act by the state about what it values, and evidence suggests it contributes to the cultural normalisation of donation (Matesanz et al. 2011).

Regulated Compensation Models

The second direction is more contested. We are not arguing for a market in organs, but that the binary between pure altruism and organ commerce is analytically insufficient, and that the policy space between those two positions has not been adequately examined in India. THOTA already permits reimbursement of unavoidable expenses for living donors (THOTA 1994, sec. 2[k]), yet this provision is poorly implemented and not systematically applied. Strengthening it is not a departure from the Act's altruistic principles but a precondition for honouring them.

> Any compensation model India considers must be equity-centred, covering unavoidable costs without creating conditions in which only the poor donate and only the wealthy receive.

Two international examples are instructive. Iran operates the only legal, regulated compensation programme for kidney donation in the world. Donors receive approximately $1,200 and one year of government health insurance; no brokers are permitted, and transplant tourism is prohibited. The programme has been credited with substantially reducing Iran's kidney transplant waitlist, though its long-term sustainability and equity implications remain debated (Dalal 2015).

It is not a model for straightforward adoption, and concerns about coercion and commodification are real. But it demonstrates that regulated financial involvement does not automatically erode altruistic culture, and that visible exchange can be monitored in ways that a black market cannot.

Israel's Organ Transplantation Law of 2008 offers a different example: a priority system in which registered donors receive preference on the transplant waiting list. This is a non-monetary, reciprocal structure in which giving is rewarded with priority access, embedding the logic of reciprocity into the donation system without introducing financial exchange (Axelrod 1984).

Any compensation model India considers must be equity-centred, covering unavoidable costs without creating conditions in which only the poor donate and only the wealthy receive (Sever et al. 2022).

Conclusions

THOTA's grounding in altruism is not the problem-it is the right foundation. The question this article has tried to open up is what it would mean for the system built on that foundation to take its own principles seriously, across all forms of donation and at every point where donors and donor families encounter the state.

Reform does not require abandoning altruism. It requires building the conditions under which altruism can actually function: harmonised legal definitions, mandated post-donation care, enforcing existing protections, sustained public education, and an honest engagement with the policy space between pure volunteerism and organ commerce.

India records 200,000 new end-stage kidney disease cases every year and performs around 13,000 transplants. That gap will not be closed by goodwill alone. But a system that treats the goodwill it already receives with the seriousness it deserves would be a meaningfully different system from the one that currently exists.

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