

Paid donors: a contradiction in terms and contraindicated in practice

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It is tempting to offer a few remarks about Titmuss when discussing how commercial interests might influence what has traditionally been regarded as an exclusively altruistic endeavor. This editorialist is not going to resist the temptation. In his book, *The Gift Relationship*,¹ Titmuss was unrestrained in his criticism of commercialization as a contributor to, among other misdeeds, impairment of transfusion safety, suppression of altruism, increased costs, and exploitation of “low-income groups.” Although Titmuss’s work was, by and large, favorably reviewed, it was not the only analysis of the tensions between the paid and unpaid market segments. A book by Hagen,² published 10 years after *The Gift Relationship*, while not earning as much attention, deserves mention. The title, *Blood: Gift or Merchandise*, is still a relevant question today, and Hagen’s comments about Titmuss succinctly identified why *The Gift Relationship* was not universally endorsed. “It is not always clear when the moral philosopher is speaking and when the social scientist.” Although Hagen did share some of Titmuss’s preferences, such as nonremuneration of blood donors, he disputed others, for example, the notion that payment is unethical.

What is sobering about Hagen’s 1982 publication is that even then he lamented that “a further increase in the commercial collection of plasma may appear to be counter productive to the increase of voluntary donations.” Titmuss had hinted at crowding out, but Hagen was unambiguous in his concern. Against this background, what deserves attention today is the very real possibility that volunteer blood and component programs at not-for-profit blood centers will face competition for donors, not only from source plasma programs, but also from volunteer blood programs deciding to offer cash incentives to donors. Before addressing the paid versus unpaid dispute, one earlier criticism of cash incentives deserves closure. Both Titmuss and Hagen were concerned that payment jeopardized transfusion safety, a relationship that was revisited during the grim recognition that HIV transmission was a risk, especially for concentration-dependent people with hemophilia. Subsequent experience, however, requires reappraisal of those authors’ opinions. There is evidence that paid apheresis donors at the University of Iowa and the Mayo Clinic were no riskier than unpaid donors.^{3,4} Furthermore, serologic testing for infectious disease markers

in donors has progressed to the point that infectious complications in transfusion recipients, while not absent, have been minimized. As for derivatives prepared from source plasma, many aggressive pathogen reduction steps during manufacture have promoted safety significantly.

While there has been a relative eclipse of transfusion-transmitted infection as a preeminent concern for recipients of blood or components, as well as for recipients of plasma-derived medicinal products (PDMPs), it is now the availability of blood and components, from the perspective of the blood collector, that has moved to center stage. Product availability has also drawn comment from the source plasma industry as it confronts an inexorable increase in demand for PDMPs. Contributing to this demand is the industry’s recognition that one of their challenges is also “the ability to continue identifying valuable new uses of plasma-derived medicines.”⁵ A solution to meeting the need for more raw material for PDMPs was suggested in a recent publication funded by a company involved in source plasma collection in the United States.⁶ The authors insisted that ensuring an adequate supply of PDMPs is a “compelling moral duty.” Any suspicion on the part of the reader that the industry believed it enjoyed exclusive residence on moral high ground was confirmed with the authors’ follow-up suggestion that blood programs consider, as an “ethical imperative,” payment of plasma donors. With payment at source plasma centers escalating, “... donors can earn up to \$400 in a month, ...”⁷ the term *donor* becomes increasingly anomalous. An individual who is paid for plasma would

ABBREVIATIONS: PDMPs = plasma-derived medicinal products; PPTA = Plasma Protein Therapeutics Association.

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Received for publication November 13, 2019; and accepted November 13, 2019.

doi:10.1111/trf.15612

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TRANSFUSION 2020;60;S138–S141

better be described as a vendor, rather than be mischaracterized by the oxymoron *paid donor*.

There is no denying, however, that some form of compensation in the volunteer blood and component donation setting is an established practice. Folléa,⁸ in a recent review of compensation and remuneration, asked, “Is There Really a Difference?” Noncash incentives, despite having to abide by the Food and Drug Administration instruction that they are not redeemable for money, have been enriched: out with coffee mugs and T-shirts, in with theater tickets and passes to sporting events. Although many organizations, including the World Health Organization and Council of Europe, recommend voluntary nonremunerated donations, there is debate about how best to abide by that stipulation, but still ensure that volunteers have some token of appreciation for their donation. A valuable tool in this regard has been developed by the Nuffield Council on Bioethics.⁹ Interventions to promote donation are ranked according to whether they are altruistically or nonaltruistically focused. A letter of appreciation is altruistic. An intervention sufficiently appealing to encourage donation from someone not originally inclined to do so is nonaltruistic. Time off work, in excess of that needed for donation, would fall in the same category.

The troubling risk to availability of product that the source plasma industry foresees is a risk shared by the volunteer donor programs. Despite patient blood management and the decreased demands for transfusion support, it is indisputable that blood programs find it increasingly difficult to maintain certain inventories, especially for Group O D-blood and for apheresis platelets. A proposal for relief from shortfalls of the latter, attributed to an aging of the donor base, was offered at a session at the recent AABB meeting entitled “Can Platelet Availability and Safety Be Improved by Using Paid Donors and Pathogen Reduction Technologies?” The session was moderated by the chief medical officer for Secure Transfusion Services (STS),¹⁰ a company that has grown out of an affiliation between a Florida community independent blood program and a manufacturer of a licensed pathogen reduction technology for platelets. Pathogen reduction here has a twofold purpose: allaying the entrenched convictions of a residual few who believe that payment promotes transfusion infectious risk, and addressing the Food and Drug Administration’s concern for bacterial contamination. Pathogen reduction, however, while a contributor to transfusion safety, is not a guarantor.¹⁰ Viral inactivation may not apply to nonenveloped viruses such as hepatitis A, hepatitis E, and parvovirus, where there is evidence of transfusion transmission from pathogen-reduced products.¹¹⁻¹³

Review of the STS Web site could leave a reader impressed that their “best practices in operational excellence” justify the commitment that the company “provides its customers with an economical and stable supply of pathogen-reduced single-donor platelets.” However, they present no evidence for their claim that payment of apheresis platelet donors would offer customers a “scalable supply” of product. Without evidence, assurances ring hollow.

There may well be other companies or blood programs considering donor payment to boost recruitment, but is there evidence to justify a switch to commercialization of donation to achieve this goal? Results of research into a role for payment of both source plasma and conventional blood and component donors are available, but evidence for efficacy is mixed. Part of the reason for this is that many of the studies have limitations. Conclusions about the influence of payment were not based on field trials, where actual donation frequencies were measured. If they had been, results would be telling. Most of the studies relied, rather, only on questionnaires or interviews, and, consequently, these results are less cogent since responses may have more to do with individuals wanting to be perceived as prosocial in their behavior rather than averse to payment.

A publication from the Retrovirus Epidemiology Donor Study Group is an example.¹⁴ They reported that “monetary cash may be detrimental to blood availability by discouraging about 7% of current volunteer donors from returning.” The results, however, reflected responses to a questionnaire that asked if a variety of incentives, including cash, would be an encouragement or discouragement. An attitude to an incentive might not necessarily predict actual donation or nondonation behavior.

A study that came close to providing suitable experimental evidence needed to conclude that cash is a justifiable recruitment tool in the volunteer donor setting came from Germany,¹⁵ where paid and unpaid blood donation opportunities are available. Investigators examined what happened if a center that had been offering payment discontinued the financial incentive. While a more valuable study would have looked at the effect of introducing a financial incentive, rather than removing one, it was revealed that there was a sustained drop in the number of donations after payment of the incentive was withdrawn. This behavior contributed to the authors’ observations that there are systematic differences between donors seeking payment and those indifferent to a financial reward. For the former, there is evidence that increasing value of the incentive increases the number of donations.¹⁶ For the latter, payment for their charitable act is a disincentive.^{14,17}

The Plasma Protein Therapeutics Association (PPTA), a trade organization representing plasma collection centers and the manufacturers of PDMPs, has commented on the different demographics of blood and plasma donors, observing that “there is no evidence that source plasma donors would be more likely to donate blood if plasma compensation did not exist.”¹⁸

In the United States, opportunities for both charitable and commercial donations have existed side by side for many years. Donors can select a reward—namely, money at the source plasma center—or the realization of intrinsic motivation at the blood center. The PPTA has concluded that opportunities for payment increase volunteer donations.¹⁹ They cite experience in the Czech Republic, where

regions with new plasma centers saw an increase in volunteer donations at neighboring blood centers. The conclusion is an example of the post hoc ergo propter hoc fallacy: a temporal association is not a causal relation. This might not have relevance to the United States, but if companies paying donors for blood or apheresis platelets decide to set up their locations independently of volunteer donor sites, to avoid the confusion that paid and unpaid individuals might experience when donating at the same premises, then it would be best not to cite PPTA's claim that paid donations encourage volunteer donations.

If blood programs decide to weigh the merits and demerits of introducing payment for blood or components, a number of issues deserve thoughtful preliminary consideration. Blood programs function in a societal context and depend on supportive relationships with businesses, service organizations, religious groups, and schools. Their opinions about continued allegiance with blood programs that pay their donors need to be heard. Cost is another issue. A recent article²⁰ on the sustainability of the US blood supply reported that about 90% of the blood provided annually in the United States is at a negative margin. This being the case, and given the challenges hospitals confront for reimbursement, a blood program's ability to recover a transfusion product's cost, which has been amplified by both pathogen reduction and financial incentive, is uncertain. The financial cost of the donor incentive is also uncertain. Given competition for volunteer donors, it is highly likely that blood programs will not shy away from increasing the cash incentive, either to sustain donors' loyalties to one program or to lure them away from a competitor.

The phrase "more research is needed" has been written often enough for the plea to lose any sense of relevance or urgency. That is not the case here. There are avenues to explore, particularly with regard to recruitment, before it is prematurely assumed that the only solution to the aging of the donor base is payment of donors. Devine,²¹ in a recent editorial, commented on the importance of psychosocial research. Such cross-disciplinary collaborations are few, but they have been explored in the past. In the 1980s, a collaborative study²² at the University of Washington between the Departments of Hematology and Psychology and what was then the Puget Sound Blood Center in Seattle looked at a role for prosocial interventions in a multicenter national study of 9,378 students and confirmed that these interventions were highly effective. A recent publication from the Australian Red Cross Blood Service²³ reveals how many disparate specialties, including neurobiology, public health, and psychology can similarly join forces.

While other programs or businesses considering paying volunteers for what had previously been an unpaid donation might express a different sentiment, STS's opinion is that the US platelet market represents a "\$1.5B market opportunity." The risk here is that this statement could be interpreted as no more than an invitation to share in a

financial windfall. Without evidence, even if only some preliminary proof of the concept that commercialization of donation is warranted, effective, and can blend seamlessly with current blood program operations, the risk of that interpretation remains.

CONFLICT OF INTEREST

The authors have disclosed no conflicts of interest.

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