*PROC. R.S.E. (B), 71, (Supplement), 6, 1971/72*

# VI.—**The Blood Donor.** By **Richard M. Titmuss,** C.B.E., Professor of Social Administration, The London School of Economics and Political Science

When one has spent—or mis-spent—substantial fractions of many years in gathering materials for a study and has eventually seen the results published in book form one is strongly conscious of a need to forget; at the very least there is a wish not to live in repetitious ways. An ancient Arab proverb, possibly relevant here, runs something like this: the word you have spoken is your master; the word you have not spoken is your slave. And so it is with my book *The Gift Relationship* which I sub-titled *From Human Blood to Social Policy.*

Nevertheless, I accepted the invitation to take part in this symposium for a number of reasons. First, because it offered me an opportunity to express again my gratitude to those who educated a layman (both orally and in writing) in many of the scientific and technical aspects of blood and blood products and their procurement, processing, distribution, use, misuse, benefit and harm. Secondly, because I would now wish to apologise to the Scottish Blood Transfusion Services for not including them in my field studies and in the questionnaire enquiry I undertook of the characteristics and motivations of 3813 blood donors. But I had to draw the line somewhere if I was not to embark on a lifetime study at great expense (and with no consumer-contractor relationship in operation, Lord Rothschild might have had something to say about that).

A third reason for accepting was to report to you something of the response I have had since the book was published. I have had from many countries in the world hundreds of letters from individuals who have contracted serum hepatitis following blood transfusions; masses of additional statistical material about blood donor (or supplier) numbers and characteristics—especially from the USA, the USSR and India, and much interesting testimony ranging from reports on the British National Blood Transfusion Services being printed in Washington's *Congressional Record* to requests from the State Central Scientific Medical Library (International Book Exchange Section) in Moscow for free copies of the book because of an inability among haematologists in the Soviet Union to obtain foreign exchange to buy such apparently unscientific publications (a request I gladly acceded to).

From this new material I have selected a few facts to report. Despite developments in the last few years in methods and techniques of plasma fractionation, component therapy, storage, computer programs and so forth—some of which were reported on this morning—the demand for the supply of whole blood continues to increase all over the world. Apart from rising medical and surgical demands, a more ultra-violent, nationalistic, overcrowded and accident-prone world needs more donor blood if death is to be delayed and disability prevented. From the evidence I have received it seems that there is a more widespread awareness among responsible authorities of shortages of supplies, chronic and acute, in the United States, Japan, South Africa, Sweden, East Germany, the Soviet Union and other countries.

For example: it appears that I underestimated in my book the number of units of

blood obtained in the United States from various groups I classified (in an eight-fold typology of donors and suppliers) as 'Captive Donors'—paid and unpaid. More use is being made of prisoners (partly because statistically more crimes are being committed and there are more prisoners). It seems that this trend has had the effect of lowering the proportionate share in the USA of blood supplies from voluntary and other categories of donors in relation to demand. Or it could mean that proportionately more whole blood is being wasted through out-dating. But the statistics are inadequate to check these interpretations.

In other countries with different political and economic systems more inducements and privileges are being offered to popularise and attract donors and suppliers. In some of the Republics of the Soviet Union those donating blood are being given preferences in service at trading establishments, cinemas, postal and other public services. In the German Democratic Republic, where 75–80 per cent. of all donors are paid (a higher proportion than in the Soviet Union), similar preferences are being given to those who volunteer to give blood without a direct cash payment.

My main impression in studying this new and additional material that has reached me is that in many modern industrialised societies blood transfusion agencies are finding it harder to attract and recruit the voluntary donor and, perhaps even more important, to maintain repeated and continuous contributions from such donors. Given the hard facts of rising demands, the changing pattern of seasonal, emergency and geographical needs for whole blood of different groups, and other medical and social variables, it is becoming clearer to those responsible for organising recruitment programmes that effective transfusion services cannot be run on the basis of dramatic and 'crises' appeals to transient or sporadic givers or suppliers of blood.

This was one of the lessons I learnt, aided by the computer, from my study of the National Blood Transfusion Service in England. The 3616 donors who had all given at least one previous donation had contributed over more than 15 years of giving, a total of 43 391 pints. Of this total, 7 per cent. had come from relatively new donors (1 to 4 pints), 34 per cent. from those with a record of 5–14 previous donations, 34 per cent. from those with 15–29 previous donations and 25 per cent from those who had given over 30 previous donations. What surprised me—though perhaps it should not have done so—was that the pattern of giving was broadly the same for women as for men. Both sexes exhibited these characteristics of regularity, reliability and consistency in their voluntary contributions.

I shall not speculate here—nor did I do so in my book—how and why this had come about; to what extent this pattern was attributable to effective and humane 'management' of donor panels; to an allegiance to the principles of the National Health Service; to a relative absence in modern society of other forms or channels of giving something unique (or thought to be unique) by one individual to other individuals and groups, or attributable to other complex factors in human attitudes, behaviour and relationships.

In the typology of donors and suppliers I developed I described the primary characteristics of the voluntary donor in the following terms: the absence of tangible immediate rewards in monetary or non-monetary forms; the absence of penalties, financial or otherwise, for not donating; and the knowledge among donors that their donations were for unnamed strangers without distinction of age, sex, medical condition, income, class, religion or ethnic group.

No donor type can, of course, be said to be characterised by complete, disinterested, spontaneous altruism. There must be some sense of obligation, approval and interest; some awareness of need and of the purposes of the blood gift; perhaps some organised group rivalry in generosity; some knowledge that fellow-members of the community who are young or old or sick cannot donate, and some expectation and assurance that a return or reciprocal gift may be needed or received at some future time. Nevertheless, in terms of the free gift of blood to unnamed strangers there is no formal contract, no legal bond, no situation of power, domination, constraint or compulsion, no sense of shame or guilt, no gratitude imperative, no need for penitence, no money and no explicit guarantee of or wish for a reward or a return gift however many donations are made. They are acts of free will; of the exercise of choice; of conscience without shame.

Virtually all donors in Britain and donors in some systems in a number of other countries fall into this category. And, in Britain, as far as I was able to estimate from the analysis of the demographic and social characteristics of the donors in the survey, they closely resembled at many points the general population of the country. In relative terms, they were far more typical of the general population in respect of sex, age, civil status, social class and income group than blood donors and suppliers in the United States where something like 47 per cent. of all blood supplies in 1965–7 were paid for and only 7 per cent. was derived from the voluntary community donor as defined above.

Encouraged by the National Blood Transfusion Service in England to undertake an analysis of motives—a hazardous task—I then categorised under 14 main heads the answers given by donors to questions attempting to elicit the reasons donors had for giving blood.

Quite obviously, the decision to give blood and to continue doing so at regular intervals is a complex process. Many of those responding to the questionnaire could not, understandably therefore, distinguish a single or predominant motive. All I could do then was to categorise the donors' own statements and attempt to distinguish between primary and secondary reasons. The broad results of this exercise were that over two-fifths of all the answers in the whole sample fell into the categories 'Altruism', 'Reciprocity', 'Replacement' and 'Duty'. Nearly a third represented voluntary responses to personal and general appeals for blood. A further 6 per cent. responded to an 'Awareness of Need'. These seven categories (out of the 14 employed) accounted for nearly 80 per cent. of the answers, suggesting a high sense of social responsibility towards the needs of other members of society. This was one of the outstanding impressions which emerged from the sample survey.

What intrigued me when I embarked on this survey was the absence of any collected national data on the social and demographic characteristics of some 1 500 000 blood donors in Britain. The French and the Belgians, I learnt, were worried because they had an ageing donor population and were not recruiting the young. The Swedes were worried because, having institutionalised a cash payment some 20 years ago (though, unlike the Americans, direct to hospitals and not through commercial blood banks), they found they were relying too heavily on the transient young and such categories as students to whom a relatively small cash payment was a temporary inducement. With rising standards of living, rising demands for blood supplies and a fall in the real value of the cash inducement was there not in prospect a crisis for the Swedish

Blood Transfusion Services? In South Africa the authorities were worried because they were failing to recruit donors from the Bantu and Coloured populations. Increasingly, there was in operation a system of redistribution of blood supplies from White people to Black people in order to maintain supplies to the hospitals.

But, most explicit of all, were the worries of authorities in the United States who were uneasy about what seemed to be a heavy reliance on commercialised blood-bank systems and supplies from the unemployed, the low-paid Negro, captive donors and those (like drug addicts) desperate to obtain quickly 10–20 dollars.

Hence I embarked (because so little was known in most of these countries) on organising and collecting a mass of statistics about numbers, types, characteristics and trends. Some part of this material was published in the book, but because of the voluminous nature of the response much of the study is focused on a comparison of the pluralised American system and the national voluntary system in Britain.

All I can do here is to present in an extremely abbreviated form my main conclusions. In undertaking this comparative analysis I employed four sets of criteria. These are basic criteria which an economist—and not necessarily a haematologist—would themselves apply in attempting to assess the relative advantages and disadvantages of different systems. They exclude, therefore, the much wider and unquantifiable social, ethical and philosophical aspects which, as this study has demonstrated, extend far beyond the narrower confines of blood distribution systems judged simply in economic and financial terms.

These four criteria which to some extent overlap are, briefly stated: (1) economic efficiency; (2) administrative efficiency; (3) price—the cost per unit to the patient; (4) purity, potency and safety—or quality per unit.

Of all four criteria, the commercialised blood market fails. In terms of economic efficiency it is highly wasteful of blood; shortages, chronic and acute, characterise the demand and supply position and make illusory the concept of equilibrium; the market also involves heavy external costs. It is administratively inefficient; the so-called mixed pluralism of the American market results in more bureaucratisation, avalanches of paper and bills, and much greater administrative, accounting and computer overheads. These wastes, disequilibria and inefficiencies are reflected in the price paid by the patient (or consumer); the cost per unit of blood varying in the United States between £10 and £20 (at the official rate of exchange in 1969) compared with £1, 6s. (£2 if processing costs are included) in Britain—five to fifteen times higher. And, finally, in terms of quality, commercial markets are much more likely to distribute contaminated blood; in other words, the risks for the patient of disease and death in the form of serum hepatitis are substantially higher.*

* Richard M. Titmuss, 1971. *The Gift Relationship: From Human Blood to Social Policy*. London.

These studies, national and international, were based on evidence relating chiefly to the years 1965–69. Since then many economic, social, technical and scientific developments have taken place (for example, the accumulation of knowledge of many aspects of Australia—hepatitis associated—antigen). Moreover, large-scale unemployment has increased in Britain, the United States, Canada and other countries

and other divisive forces have been at work which may conceivably have affected donor-supplier motivations and patterns of demand and supply.

Whether or not they have done so I do not know. But I remain convinced that the voluntary system must be sustained in Britain and with it the principles of regularity and consistency in relationships between the Service and its donors.