

**Blood Products and the Commodification Debate:  
The Blurry Concept of Altruism and the ‘Implicit Price’ of Readily  
Available Body Parts**

*Annette Dufner*

There is a widespread consensus that a commodification of body parts is to be prevented. Numerous policy papers by international organizations (most recently WHO 2013) extend this view to the blood supply and recommend a system of uncompensated volunteers in this area—often, however, without making the arguments for this view explicit. This situation seems to indicate that a relevant source of worry or unease about the blood supply system has to do with the issue of commodification. As a result, the current health minister of Ontario is proposing a ban on compensation even for blood plasma—despite the fact that Canada can already only generate 30 percent of the plasma needed for fractionation into important plasma protein products, rather than transfusions, and has to purchase the rest abroad (Canadian Blood Services 2013, 42), and despite the fact that the donation of plasma is more time consuming<sup>1</sup> and intrusive<sup>2</sup> for donors than the donation of whole blood. Moreover, not all plasma that is needed is used in transfusions. Some of it is used for the production of pharmaceutical products by ordinary profit-oriented pharmaceutical companies, and it remains unclear why donors should not participate in these profits.

As many commentators have already observed, prohibiting compensation for blood donors in Canada might inevitably lead to a dependency on blood products from paid donors from the United States. A brief look at some numbers seems to confirm this worry. Out of 193 WHO countries, only 62 report to have achieved self-sufficiency in whole blood on the basis

---

<sup>1</sup> In written explanations and in videos on its website, Canadian Blood Services claims that the donation process for whole blood takes about an hour in total, including 5 to 10 minutes for the actual extraction process, while the donation process for plasma takes about an hour and a half in total, with 35 to 45 minutes for the actual extraction process. ([http://www.blood.ca/centreapps/internet/uw\\_v502\\_mainengine.nsf/page/Blood](http://www.blood.ca/centreapps/internet/uw_v502_mainengine.nsf/page/Blood), July 14, 2014; [http://www.blood.ca/centreapps/internet/uw\\_v502\\_mainengine.nsf/page/Plasma-frequently-asked-questions?OpenDocument&CloseMenu](http://www.blood.ca/centreapps/internet/uw_v502_mainengine.nsf/page/Plasma-frequently-asked-questions?OpenDocument&CloseMenu), July 14, 2014.)

<sup>2</sup> When donating plasma only, an anticoagulant has to be added to the remaining blood parts that are being returned into the donor's vein during the donation process of about 35 to 45 minutes in order to prevent blood clots. The length of time of being attached to a machine, the added substance, as well as the fact that this substance can be below body temperature and feel a bit chilly can be seen as more intrusive than the donation of whole blood.

of voluntary, non-remunerated blood donation (WHO 2014, Dhingra 2013). Moreover, out of 156 countries reporting on this issue further, 113 have to import blood plasma from abroad for plasma-derived medicinal products (WHO 2014). This means that self-sufficiency can and is being achieved, but the numbers also show that most countries fail. Countries wanting to achieve self-sufficiency, especially for blood plasma, on the basis of a system of unremunerated volunteers have to undertake very considerable efforts in order to find enough donors. Unless Ontario presents a clear and efficient campaign plan for the recruitment of uncompensated donors and successfully implements this plan—a task at which most WHO countries have failed—the chance of being able to rely exclusively on blood plasma from uncompensated donors will remain low. Prohibiting compensation and achieving self-sufficiency with a system of uncompensated volunteers are two entirely different goals, requiring entirely different strategies, and so far the health minister has mostly been active with regard to the former.

Tossing the ethical hot potato across the national border is a well-known and often-used strategy when it comes to bioethical controversies. It is particularly troublesome in countries like Canada, in which most people live within a 100 km range from the next border, or in areas like Europe, where a significant portion of the population could cross the next national border by means of a little determination and a bicycle. However, it has also often been observed that this strategy comes at a cost. The risk for Canadians is of course the loss of control over the system where the blood plasma comes from. The concern about blood or blood plasma of low quality from financially desperate “skid row” inhabitants that some commentators have worried about might of course be based on racist and classist inclinations, rather than mere facts alone. To the extent to which it is based on facts, the issue would, however, become worse for Canadians in case of an increasing reliance on foreign sources. The screening of donors and the handling of the donated substances would move beyond regulative reach. For example, Canadian collection centers offer the possibility of an anonymous exclusion of one’s own donation after the donation process in case of a risk factor in one’s life that one did not think of or did not want to admit during the screening and donation process. The means of ensuring such a protocol for compensated donors in other countries will naturally remain comparatively limited. In the following I am going to suggest

a number of alternative perspectives on the commodification debate in order to facilitate a less dogmatic and more differentiated debate about the matter.

### **The Source of the Unease: Commodification or Guaranteed Access to Body Parts?**

Before looking at some further issues, it might be important to point out that there are a number of possible sources for the unease that people seem to experience when confronted with the question of monetary compensation for blood and plasma donors. Not all of them have to do with the commodification of body parts that many commentators worry about. For example, it might be the case that, at least on a very subliminal level, we still have not gotten used to the idea that internal body liquids or tissues and even solid organs can get excavated from one person and transferred to another one. If this is a relevant factor, then the unease might have to do with the peculiar relationship that humans tend to have with their own physical inside, which they never tend to see other than in emergency situations, as well as with the idea that one's body, which one generally takes to be one's very own, can literally be partly transferred over to others. It might be a rather natural impulse to believe that these still somehow astonishing transfers should remain limited and occur only under utterly controlled and highly regulated circumstances.

A further possibility about the source of the unease, which seems to apply to blood products in particular, is the fact that in a health care system, which wants to guarantee a reliable supply of blood products for its population, what one is aiming for is literally a *constant availability* of body parts. This is likewise a point quite separate from the worry about commodification. The idea that certain body parts, especially blood products, should be available on a constant basis, and should be "up for grabs" whenever a physician requests any, is still a novel thought in and of itself. The very project of guaranteed availability of blood seems to turn the substance into a public resource like the water flowing out of a tap. The term "public resource" is indeed often used to refer to blood, especially by commodification critics. The idea, of course, is that donated blood should not belong to anybody in particular; that it is a public resource that should, at least in principle, be available to everyone. This idea is similar to general attitudes regarding the life-sustaining substance of water, which we take out of lakes and not out of bodies. When it comes to water, you pay for the service of having

water supplied to your house and for having it cleaned afterwards; the water as such, however, tends to be thought of as a “public resource” that is thought to belong to everyone and that everyone has an equal claim on. The idea that blood is in the process of turning into a public resource that belongs to everyone and that everyone has an equal claim to can well be thought of as still having an unusual or even intrusive character.

Of course it is not quite the case that nowadays *your very own* blood is a public resource; the thought is that it only becomes one if you donate it. Especially commodification critics tend to emphasize, however, that it is not exactly *your own* either, because it may not be appropriate to think of people as having literal property rights over their own body parts. While you are of course granted privileged use of your own blood as long as you want, those who voluntarily give some away are supposed to have turned human blood into a “public resource” which can then be requested and distributed like commonly owned water. Arguably though, blood should *not* be seen a public resource. Quite to the contrary, donors might see it as a very *private* resource that they intend to donate specifically for the *private* use of other individuals.<sup>3</sup> The peculiar and intimate relationship that people tend to have toward their own blood might in fact be more conducive to seeing the substance as a private matter – at least in terms of its *use* – and this might in turn contribute to the unease when confronted with the thought of a system providing a general and readily available supply of body parts.

These thoughts are not supposed to suggest that we should give up the idea of a more or less guaranteed availability of blood products in a public or in another kind of just healthcare system. They are supposed to suggest that the source of the unease when it comes to the right way of handling the blood supply might not merely be the worry about a commodification of body parts, but also the still-peculiar fact that the insides of human bodies can be transferred and can even become of guaranteed public availability in a large-scale distribution system. We live in a world in which certain “human resources” are being stored in fridges and can be made use of upon request. The commodification of inner human body parts might be a worrisome thought, but their regular transfer on the basis of more or less guaranteed public availability can be perceived as rather novel as well. Again, none of this is meant to question the project of ensuring a guaranteed blood supply. It is also not meant to

---

<sup>3</sup> This point is owed to an anonymous referee.

question the search for uncompensated volunteers. What is in fact required, though, is greater care about the exact sources of the unease about the right way of handling the matter.

### **The Worry about Crowding out Altruism and the Habits of Defining Altruism**

A common worry in the commodification debate is the possibility that many altruistic donors will get “crowded out” of the system when introducing compensation. As some studies seem to indicate, the motivation of most donors is altruism (e.g. Hupfer et al. 2005, Sojka/Sojka 2008). Moreover, further studies even seem to indicate that people are actually *more* willing to help, donate, or make sacrifices, if one does *not* offer them any money but appeals to their sense of altruism instead (e.g. Frey/Oberholzer-Gee 1997, Gneezy/Rustichini 2000). The surprisingly widespread motivation of altruism as well as the crowding-out effect seem to raise the worry that participation in blood donation might actually drop rather than increase, if one were to introduce compensation. However, it is worth pointing out that these kinds of studies are often designed on the basis of an overly broad understanding of altruism. This feature seems to question the significance of the results.

Among the allegedly *altruistic* motivations of donors that many studies report, there are often such broad motivations as “feeling good about oneself,” “acting out of duty,” “having received donated blood oneself in the past and wanting to give back,” or “a relative having received donated blood in the past.” For example, a study about the motivation of Canadian students donating blood comes to the conclusion that altruism dominates (Hupfer et al. 2005). However, the researchers used test statements such as “I enjoy helping others,” “It is a moral and personal obligation,” and “If my physician recommended a transfusion to speed my recovery from illness, I would agree to that course of action.” It should be needless to say such statements can be understood as altruistic only under a strong extension of an informed ethical understanding of the term. “I enjoy helping others,” for instance, could just as well be described as “self-interested” rather than “altruistic.” Also, acting out of “moral obligation” or duty, as Immanuel Kant wrote, is something entirely different from acting out of philanthropic inclination. Acting out of duty, according to Kant, means that you are acting out of a rational conviction that the categorical imperative requires this, and that under such circumstances your will could not be otherwise. In fact, he even goes as far as saying that actions that are

done merely out of philanthropic inclination are morally worthless; they only possess moral worth if they are done out of duty (Kant 1998 [1785], bk.1). Acting out of duty—or out of “obligation” as the tested students reported—might hence be something entirely different from acting on the basis of an altruistic inclination. Furthermore, the statement “If my physician recommended a transfusion to speed my recovery from illness, I would agree to that course of action” can be seen as implying a reciprocal motivational element. Far from being based on the idea of an entirely selfless wish to give, students moved by this belief might be trying to find an appropriate way of giving back or even compensating the community for what the community is prepared to give to them in the event of an illness.

Of course the researchers who conducted this study are to some extent aware of the problem when writing that “humanitarian reasons” can either be “genuine or more indicative of ego enhancement and self-esteem needs.” Nonetheless, if the definition of altruism that underlies the study is this broad, then no wonder they have to conclude that the “importance of altruism as motivator of donors in our sample is consistent with decades of research” (Hupfer et al. 2005, 155). And no wonder that this situation in turn often raises the worry that undermining altruism by the introduction of money or other forms of compensation and reciprocity could lead to a massive backlash. The truth is that many of the motives that the surveyed people reported seem to be partly altruistic and partly self-interested at the same time or feature reciprocal elements. Studies aiming more explicitly for a result on the issue of altruism and self-interest in donors’ motivations (rather than on motivational patterns in regard to sex and donation experience in case of the study discussed) have confirmed this common sense belief about human motivation for a long time (e.g. Oswald 1977, Trimmel et al. 2005, Schlumpf et al. 2008, Steele et al. 2008). The assumption of a substantial crowding-out effect of the allegedly altruistic, non-remunerated blood and plasma donors in case of the introduction of compensation is thus questionable. Moreover, some of the most well-known studies supporting the crowding-out effect were not about blood donations, but about other kinds of sacrifices (Frey et al. 1996, Frey/Oberholzer-Gee 1997, Frey 1997, Gneezy/Rustichini 2000).<sup>4</sup> If these results were fully extendable to blood donations, there would have to be considerably lower donation rates in countries allowing for compensation than in other places.

---

<sup>4</sup> For an accessible and influential description of the issue see Sandel 2012, 113-120.

Studies such as the one discussed and especially studies supporting the crowding-out effect are usually cited by *critics* of compensated donation systems. The *proponents* of compensated donation systems have also made claims about the notion of altruism and its function. Unfortunately, these claims have often been no more differentiated than the ones they meant to rebut. Kenneth Arrow, for example, in his well-known initial response to Titmuss argued that altruism is a limited resource that should not be depleted through overly strong exploitation (Titmuss 1997 [1970], Arrow 1972, 354-55).<sup>5</sup> This strangely metaphorical thinking of a human motive as a resource at risk of depletion like natural oil or gas is obviously vulnerable to the charge that more altruism might produce more, rather than less, altruism in response.

The real question to be asked would have been whether ensuring the blood supply is *the right kind of project* to be based on altruistic donor motives alone. We do not believe that the food supply, care for the elderly, or schooling should be based exclusively on altruistic individual providers—despite the fact that some of these projects have life-sustaining functions as well. What exactly is it that turns some projects into plausible candidates for such a setup and others not? What seems to speak against altruistic providers in many cases is the fact that certain processes require trained professionals. These people spend years in education in order to later make a living off of their services. Relying on altruistic volunteers might produce a sharp decline in quality and reliability in these areas. The burden of donating blood plasma, and moreso even in case of whole blood, seems to be comparatively low, though. Spending an hour at the collection center once or twice a year seems to be a minor, rather than a lifetime, commitment and does not require any special skills. However, as especially some feminists have observed, entirely altruistic, non-reciprocal, and selfless ways of handling problems should possibly be reserved for emergency situations, or situations in which another satisfactory solution cannot be found (Mongoven 2003). Of course, the donation of blood in hope of helping someone out of dire need by doing so does seem to feature an emergency component, but trying to ensure a guaranteed supply on a regular basis might go beyond the exceptional cases in which one-sided help without any thought of social recognition for this help is morally appropriate. Making entire social subsystems dependent on pure forms of altruism on a permanent basis might be a violation of the idea that altruistic

---

<sup>5</sup> For an accessible description of this issue see Sandel 2012, 122-30.

help is calling for social recognition. Compensation, for example in the form of monetary payments or other, more nuanced kinds of rewards (Buyx 2009, Swanson 2014), can be a form of such recognition.

### **On Exploitation in the Context of Renewable Body Parts and Low Extraction Risks**

A further issue usually raised when it comes to the right way of handling transfers of body parts concerns the threat of exploitation, especially of the poor. For the poor even a small monetary compensation might represent such a strong incentive that it might have to be viewed as a coercive factor raising the question of whether they can really be thought of as consenting *freely* to a compensated body donation. The issue is particularly pressing in case some of the poor have few other options, or even none at all, to meet their basic needs. In this case it would be wrong to speak of a literal *choice* to donate. Moreover, it is often perceived to be immoral to compel the poor to sell their body parts, while the benefactors could be largely richer members of society who could then be seen as benefiting from an instrumentalization of the poor.

It has long been observed by opponents of this argument that it can appear odd that giving money to the poor is viewed as an additional problem rather than a part of the solution, at least if the amount of money they receive is fair and the circumstances are just. This condition should hopefully be fulfilled in a country like Canada that provides a welfare system in order to alleviate the situation of the poor. If this system is made to work correctly, then it should be impossible for there to be people in Canada who literally have to rely on something like blood or plasma donations in order to meet their basic needs on a regular basis. One can also insist that the question of whether the supply with blood products really runs mostly from the poor to the wealthy is an empirical question requiring empirical data. For example, if it is the poor who are more likely to have to undergo dangerous emergency surgeries, then much of the blood and plasma supply might in fact run in the other direction.<sup>6</sup>

With regard to the exploitation controversy the special nature of blood and blood components might also be relevant. In contrast to most “solid” organs, blood is a *renewable* body part. Moreover, in comparison to the donation of a renewable portion of one’s liver, the

---

<sup>6</sup> This point is owed to an anonymous referee..

*intrusiveness* and the *riskiness* of the donation procedure are comparatively low. If you give some blood plasma away, or even sell some, your body will produce more, and the risk to your health is rather moderate. This fact is often handled very briefly by compensation critics, even though it seems to have an impact on the extent of the problem of exploitation.

For example, Keown dismisses any potential impact of the renewable nature of blood by simply asserting that blood has more in common with kidneys than with “waste products” such as hair or urine (Keown 1997, 99). This comparison brushes over the fact that blood has a very interesting hybrid character that lies in between non-renewable solid organs on the one hand, and renewable substances such as hair or urine, which do not have to get extracted out of a person’s body by any technical means, on the other. (Moreover, the claim that hair is a “waste product” seems rather insensitive to the situation of women who are poor. Long, healthy, and thick hair might in fact be the only natural status symbol for some of them.) Arguably, even Kant, one of central proponents of the idea that organs should not be for sale, might have thought that it makes a large difference whether a body part is renewable or not. Hair, for example, which is renewable, may have a price, according to him, while teeth, which he presumably still took to be both non-renewable and irreplaceable, should not have a price (Kant 1991 [1797], 219). Given the current state of medical technology, this means that even one of the most central classic critics of markets for body parts could arguably have been permissive with regard to blood.

Even though blood is renewable, there are indeed some moderate risks in donating too much, or in intervals that are too short, or both. Among other things, your iron levels might decline. However, there seems to be a natural limit to this risk: the interest in avoiding adverse health effects (which the poor might be under danger to disregard) seems to coincide with the public interest in having blood conserves of good quality in the system. “Milking” poor donors whose iron levels have become too low as a result of over-donating is certainly not a possibility if one wants to ensure proper standards in the supply system. In fact, if one sets high-quality standards for the blood in the blood banks, then the potentially exploitative risk of over-donating among the poor might cease to be a serious danger. In other words, authors who are seriously worried about exploitation of the poor should not only consider a prohibition of compensation, but also the further possibility of strengthening the system of quality checks, for example of the iron levels in the donated blood.

A further point about exploitation which leads in the opposite direction is the question of whether nudging people into altruistic and uncompensated donations, which is obviously required in order to achieve a stable national supply of non-remunerated donations, might not amount to a form of over-exploitation of the altruistically inclined as a population group. With regard to living organ donation it is, for example, well known that the majority of donors is female (Biller-Andorno 2002, Kayler et al. 2003, Khajehdehi 1999, Ojo/Port 1993, Zimmerman et al. 2000). Given the traditional role of being the giving (and especially in light of child bearing also physically giving) part of the family, this might not be surprising (Scheper-Hughes 2007, 508). There is evidence that blood donation campaigns can have similar effects (Bani/Giussani 2010).

On the one hand, one might be inclined to think that there is no problem of individual exploitation, if traditionally over-altruistic groups of individuals donate truly voluntarily. On the other hand, it can be argued that there is such a thing as mutually advantageous exploitation, in which consent on both sides is valid and the agreement is not harmful to anyone, but in which one side nonetheless exploits the other (Wertheimer 1996). In both cases, though, it could at least be viewed as a form of statistical injustice and as an unfair reinforcement of pre-existing social behavior patterns that have in turn led to injustices. If the majority of donors are naturally more altruistically inclined than others, it is also possible that these donors have on average lower incomes, lower retirement payments, less property, and fewer savings as a direct consequence of their altruistic nature. Again, this is not necessarily a problem of exploitation or lack of autonomy on behalf of individual donors, but nudging the altruistic into giving even more might be inappropriate in a country trying to decrease gender imbalances and other biases, and does nothing to improve social reciprocity. For example, if targeting younger females as non-remunerated plasma donors generates particularly successful campaign results and improves the self-sufficiency of the country, there does seem to be something the matter, even if these females donate for free on a truly voluntary basis.

What is being said here does not imply that one should not campaign for uncompensated donations. But one should hope that these campaigns do not operate on the basis of biases in terms of gender, race, or social and financial status. Living in a world in which a steady number of altruistically inclined give even more, while others continue to give little (and might even dominate on the receiving end), is not the kind of development a

donation campaign should give rise to. Unless this can be ensured, members of traditionally over-altruistic groups who want to leave the world to their children in a more reciprocal and less biased condition should possibly make a point of insisting upon a form of explicit social recognition for their behavior. This would be an instance of “self-interest” that would be “altruistically” motivated.

### **The Ever-present Commodity of *Usable* Blood and Blood Plasma**

A further remark about the often too undifferentiated commodification debate concerns the fact that we do have and will continue to have a commodity of *usable* blood and especially also a market for usable medicines containing blood plasma products as they are produced by commercial pharmaceutical companies. Even the raw blood or the raw plasma donated specifically for the purpose of transfusion will never be used in an attempt to save anybody’s life. As we all know, it first has to be screened, prepared, and sent to the right place. This process requires highly trained professionals, materials such as blood bags, as well as an entire logistics system—all of which cost money. As a result, the places that use these products have to account for those costs. Of course one can argue that the raw material is still not a commodity, even if the end product is being paid for, but a screened and conserved blood bag sent to the right place certainly is and will remain a commodity, irrespective of how the respective jurisdictions regulate the donation process.

A commodity is usually thought of as something that has a price and can be bought and sold on the market. In order to fully judge whether something has at least an “implicit price” in the sense of something that looks like a price tag despite the absence of a market in a strict sense of the term one needs to know more about the bureaucratic subtitles of the respective system. How so? As already indicated, in most jurisdictions hospitals in some way account for the blood bags they get. And as soon as there is some kind of monetary transfer, or at least an entry on a cost record or on an inventory sheet, there will be a number in the picture that will look like a price tag. In Canada, for example, the number in question is 386\$ (Canadian Blood Services 2013, 37). This has been the average production cost of one unit of a shipped blood product in 2012/2013. It is the basis of the value of the blood products in the 2012/2013 inventory sheet of Canadian Blood Services (Canadian Blood Services 2013, 66),

and the amount that has been “charged to the statement of operations upon distribution to hospitals” (Canadian Blood Services 2013, 71).

In case you are surprised that the blood you donated for free is worth so much money (none of which you ever saw), you are, of course, wrong. 386\$ is not the value of the stuff that was running through your veins; it is the value of the “collection, production and testing” (Canadian Blood Services 2013, 71) process that had little or nothing to do with you.

However, the observation that there are these numbers should suffice to establish that the following twofold claim can be true: “We have no commodity of raw blood in our country, but we have a commodity of blood in our country.”

This observation that there might be an implicit price and, in this sense, a commodity for *usable* blood is one thing. But there might be an implicit price for *raw* blood in many places as well. In order to figure out whether this is the case, one does not just have to take a look at whether bills or checks are being handed over at collection centers; one also has to take a look at the further subtleties of the bureaucratic process. Hospitals will show a certain dollar amount for bags with usable blood on their records. If the regulatory process does not require this number to be identical in all cases, one will most likely end up with different numbers for bags with different blood groups. As we all know, some blood groups are compatible with very many other blood groups, while others are not. If demand, rather than top down regulation, is allowed to play any role regarding the size of the number on the record, then we might end up with higher numbers for bags with more widely usable, but rarer blood groups. Under the further assumption that the costs for screening and conservation are nonetheless the same across most blood groups, we would then end up with an interesting result: more or less equal costs for the handling process, but nonetheless different numbers on the cost record or on the inventory sheet of the hospital requesting the bags. How would this be compatible with the idea that raw blood is not a commodity and does not have an implicit price after all?

There is great public debate about the question of whether blood donors should be allowed to receive compensation, and people tend to believe that this is the place where blood would turn into a commodity. This assumption is overly simplistic. The place at which blood will turn into a commodity can occur later in the supply chain. Nonetheless, there is no public

debate over the question of whether the price (or at least a certain number on a cost record or inventory sheet) for blood bags may vary according to blood groups, if the production costs are the same. This might be an equally relevant issue to look at in the commodification debate. It is impossible to prevent valuable things from having a value, and preventing them from having a price is often not as simple as it looks.

A historical example might help to further prove the point. After the Second World War, Germany developed a dual system of whole blood donation, which is, in a modified form, still in place today. Hospitals usually recruited their own donors and compensated them with a certain amount of money. The Red Cross, which searched for volunteers via broad advertising campaigns, did not compensate its donors, but charged the hospitals for the blood bags. In this system, both the hospitals and the Red Cross were engaged in different forms of commodification. As many hospital physicians thought at the time, the Red Cross was engaged in a moneymaking game and overcharged the hospitals, while the Red Cross put forth versions of the familiar arguments against the compensation of donors. Let us assume for a moment that the price that the Red Cross charged was indeed above the production costs for the bags. What was the worse form of commodification here? Compensating the donors, or not compensating them while charging the hospitals prices above the production costs? These are relevant questions to ask when thinking about commodification.

In the case of blood plasma used in the production of pharmaceutical products, it is even more obvious that there is a price tag involved than when thinking about blood products for transfusion.<sup>7</sup> Blood plasma is often used for the fractionation and production of important medicinal products by ordinary pharmaceutical companies. These products are later *sold* to hospitals and pharmacies. In contrast to transfusion plasma, these products have a long shelf life and are traded internationally and purchased by facilities in countries such as Canada that do not have adequate production capacities. Since the companies producing these medicines are for-profit pharmaceutical organizations, it would arguably be rather obscene to literally prohibit all donors from participating in the profits. There is an international commercial market for medicinal plasma products, and for these products there are very *explicit* prices. In contrast to the case of transfusion plasma, the only question to be asked here is whether the donors should participate in the already-existing commercial profits or not. Against the

---

<sup>7</sup> For a related point see Marckmann 2007.

background of these facts, it can even be seen as a moral, rather than a commercial move by the companies producing these medicines, to offer monetary compensation to the donors in their supply chain. Otherwise, any explicit price for these medicines that lies above the costs for production and logistics can be seen as an exploitation and commodification of non-remunerated donors—donors who might even be oblivious to the fact that their plasma is the raw material for the commercial production process of a pharmaceutical company.

This point about the implicit price of human body parts and the explicit price of medicines containing blood plasma is not meant to suggest that body parts will always have some kind of a price after all so that there is no point in worrying about commodification, anyway. It is meant to draw attention to the fact that commodities are things that can be bought and sold on a market *irrespective* of whether they were once given away as a gift. Just as in the case of all other body parts, the metamorphosis of blood into a commodity does not become impossible once the substance has passed the doorsteps of the collection center; it can still occur thereafter. Moreover, *unlike* in the case of other body parts, this is especially likely in the case of blood plasma used for the production of medications with a long shelf life and an international production chain run by commercial pharmaceutical companies. If one wants to prevent commodification, it is neither necessary nor sufficient to insist that donors give their body parts away without any kind of compensation for their efforts. It is necessary, though, to know what happens afterward.

In light of the safety risk of tossing the issue of the blood plasma supply across the national border, in light of the more intrusive and time-consuming nature of plasma donations in comparison with whole blood donations, in light of the special hybrid status of blood plasma as a renewable body substance that can be given away at very moderate risk and that cannot easily be depleted without reducing its quality, as well as in light of the often oversimplified notions of altruism and especially commodification, it may be concluded that the debate has not conclusively established that it would be morally objectionable to provide blood plasma donors with monetary compensation, or with other forms of explicit social recognition as an incentive. Donating for free is neither automatically altruistic, nor does it necessarily prevent the commodification of blood and blood plasma. And refusing to donate unless you receive some form of compensation does not have to be self-interested.

## Literature

- Arrow, K., 1972, “Gifts and Exchanges”, *Philosophy and Public Affairs* 1: 343-62.
- Bani, M. / Giussani, B., 2010, “Gender Differences in Giving Blood: a Review of the Literature”, *Blood Transfusion* 8: 278-87.
- Biller-Andorno, N., 2002, “Gender Imbalance in Living Organ Donation”, *Medicine, Health Care and Philosophy* 5: 199-204.
- Buyx, A., 2009, “Blood Donation, Payment, and Non-Cash Incentives: Classical Questions Drawing Renewed Interest“, *Transfusion Medicine and Hemotherapy*, 36: 329-339.
- Canadian Blood Services, 2013, “Complete 2012/2013 Financial Report”, [http://video.bloodservices.ca/Annual2013/pdfs/cbs\\_ar2013\\_finreport\\_en.pdf](http://video.bloodservices.ca/Annual2013/pdfs/cbs_ar2013_finreport_en.pdf), July 14, 2014.
- Dhingra, N., 2013, “International Challenges of Self-Sufficiency in Blood Products”, *Transfusion Clinique et Biologique* 20: 148-52.
- Frey, B. / Oberholzer-Gee, F. / Eichenberger R., 1996, “The Old Lady Visits Your Backyard: A Tale of Morals and Markets”, *Journal of Political Economy*, 104:1297-313.
- Frey, B. / Oberholzer-Gee, F., 1997, “The Cost of Price Incentives: An Empirical Analysis of Motivation Crowding-Out”, *American Economic Review*, 87: 746-55.
- Frey, B., 1997, *Not Just for the Money: An Economic Theory of Personal Motivation*, Cheltenham, UK: Edward Elgar Publishing.
- Gneezy, U. / Rustichini, A., 2000, “Pay Enough or Don’t Pay at All,” *Quarterly Journal of Economics* (August 2000): 791-810.
- Hupfer, M.E. / Taylor, D.W. / Letwin, J. A., 2005, “Understanding Canadian Student Motivations and Beliefs about Giving Blood”, *Transfusion* 45: 149-61.
- Mongoven, A., 2003, “Sharing Our Body and Blood: Organ Donation and Feminist Critiques of Sacrifice”, *Journal of Medicine and Philosophy* 28: 89-114.
- Kant, I., 1998 [1785], *Groundwork of the Metaphysics of Morals*, Mary Gregor (trans.), Cambridge: Cambridge University Press.

- Kant, I., 1991 [1797], *The Metaphysics of Morals*, Mary Gregor, (trans.), Cambridge: Cambridge University Press.
- Kayler, L. K. / Rasmussen, C. S. / Dykstra, D. M. et al., 2003, “Gender Imbalance and Outcomes in Living Donor Renal Transplantation in the United States”, *American Journal of Transplantation* 3: 452.
- Keown, J., 1997, “The Gift of Blood in Europe: An Ethical Defence of EC Directive 89/361”, *Journal of Medical Ethics* 23: 96-100.
- Khajehdehi, P., 1999, “Living Non-Related versus Related Renal Transplantation—its Relationship to the Social Status, Age and Gender of Recipients and Donors”, *Nephrology, Dialysis, Transplantation* 14: 2621-2624.
- Marckmann, G., 2007, “Human Blood: Altruistic Donation for Commercial Purposes? (in German), in: *Kommerzialisierung des menschlichen Körpers*, J. Taupitz (ed.), Berlin: Springer, p. 69-81.
- Ojo, A. / Port, F. K., 1993, “Influence of Race and Gender on Related Donor Renal Transplantation Rates”, *American Journal of Kidney Diseases* 2: 835-841.
- Oswalt, R. M., 1977, “A Review of Blood Donor Motivation and Recruitment”, *Transfusion* 17: 123-135.
- Sandel, M., 2012, *What Money Can't Buy: The Moral Limits of Markets*, London: Penguin.
- Scheper-Hughes, N., 2007, “The Tyranny of the Gift: Sacrificial Violence in Living Donor Transplants”, *American Journal of Transplantation* 7: 507-11.
- Schlumpf, K.S. / Glynn, S.A. / Schreiber, G.B. / Wright, D.J. / Randolph Steele, W. / Tu, Y. / Hermansen, S. / Higgins M.J. / Garratty, G. / Murphy, E.L., 2008, “Factors Influencing Donor Return”, *Transfusion* 48: 264-272.
- Sojka, B.N. / Sojka, P., 2008, “The Blood Donation Experience: Self-Reported Motives and Obstacles for Donating Blood”, *Vox Sanguinis* 94: 56-63.
- Steele, W.R. / Schreiber, G.B. / Guiltinan, A. / Nass C. / Glynn, S.A. / Wright D.J. / Kessler, D. / Schlumpf, K.S. / Tu, Y. / Smith, J.W. / Garratty, G., 2008, “Role of Altruistic Behavior, Empathic Concern, and Social Responsibility Motivation in Blood Donation Behavior”, *Transfusion* 48: 43-54.
- Swanson, K., 2014, *Banking on the Body. The Market in blood, Milk, and Sperm in*

*Modern America*, Cambridge, Mass.: Harvard University Press.

- Titmuss, R. M., 1997, *The Gift Relationship: From Human Blood to Social Policy*, 2<sup>nd</sup> ed., exp. and up., New York: New Press.
- Trimmel, M. / Lattacher, H. / Janda, M., 2005, “Voluntary Whole-Blood Donors, and Compensated Platelet Donors and Plasma Donors: Motivation to Donate, Altruism and Aggression“, *Transfusion Apheresis Science* 33:147-155.
- WHO, 2013, “Draft Declaration on Achieving Self-Sufficiency in Safe Blood and Blood Products, based on Voluntary Non-Remunerated Donations”, <http://www.fiods.org/main/sites/all/files/DRAFT.pdf>, July 17, 20174.
- Wertheimer, A., 1996, *Exploitation*, Princeton: Princeton University Press.
- WHO, 2014, “Blood Safety and Availability. Fact Sheet No. 279”, <http://www.who.int/mediacentre/factsheets/fs279/en/>, July 17, 2014.
- Zimmerman, D. et al., 2000, “Gender Disparity in Living Renal Transplant Donation”, *American Journal of Kidney Diseases* 36: 534-540.