PLASMA SUPPLY FOR SELF SUFFICIENCY IN BLOOD PRODUCTS

Analysis of options by H.H. Gunson
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My conclusion following a survey of RTC's was that it was unwise to assume at the present time that a sufficient quantity of plasma will be available for the successful operation of the new B.P.L. I therefore gave consideration to the options which may be available in order to attempt to ensure this supply. These are listed below:

(1) Pursue the present policies of encouraging RTD's to apply to their R.H.A.'s for finance for the increase in plasma supply with the assistance of Dr. Lane and Mr. Armour where this is appropriate. During the past year this approach towards the definition of a three year programme has not been successful uniformly throughout the Country, largely due to the policy of considering proposals on a yearly basis and the large number of competing priorities which R.H.A.'s have to determine for the allocation of their finance for developing specialities.

This approach could be supplemented by additional advice from the D.H.S.S. However, this has already been tried and although most R.H.A.'s agreed in principle, few have actually allocated finance for the purpose of the additional supply of plasma.

(2) The C.B.L.A. should assume managerial responsibility for the entire work of the RTC's. This option has considerable merit which could lead to a truly national service with a greater degree of standardisation which is now possible. Regions with potential would be able to supplement those with needs greater than the RTC is able to provide for reasons beyond their control, e.g. inadequacy of premises, shortages of blood donors, excessive demands for blood products from large specialised institutions.

From a practical point of view, however, I have concluded that the necessary administrative infra-structure could not be achieved by 1986 when the new B.P.L. is due to be in full production.

For the time being, I think that this must remain a long term objective.

(3) The C.B.L.A. should finance the collection of plasma in excess of that harvested by Regional Transfusion Centres (RTC's) in 1983/4. This would require funding for the collection of approximately 300,000 litres plasma annually.

This could be a promising option. Each RTC would be assessed with respect to its potential for producing plasma and the necessary financing agreed. Regional Health Authorities could purchase from the C.B.L.A. the products which they require, the decision with respect to quantities purchased depending on the priorities which they assign to the various specialities within the Region. This will allow R.H.A.'s to have a choice with espect to the expenditure on blood products; the only difference from current practice is that the products will be purchased from the N.H.S. fractionation laboratory instead of from commercial companies which applies at present. As feasibility studies have shown in the past this could result in a considerable financial advantage.

could be argued that the whole of the plasma supply for fractionated products should become the responsibility of the C.B.L.A. My reason for suggesting that this responsibility should be restricted to those in excess of the current supply is to simplify negotiations since, otherwise, the supply of red cells and other components prepared at RTC's would become involved in the financial transactions.

I do not underestimate the difficulties involved, thus:

(a) RTC's would be acting on an agency basis for the C.B.L.A. and there would have to be accountability for the investment provided.

(b) A proportion of the plasma would have been paid for by the R.H.A.'s and the products derived from these would have to be supplied on a different basis from those derived from plasma financed by the C.B.L.A. However, this could be resolved by the present pro-rata system with an additional charge for fractionation if this method of financing is agreed.

(c) A number of clinical consultants reserve the right to prescribe for their patients the product of their choice. This may result in the continuation of purchases of blood products from commercial firms. This, I contend, is largely a matter for local resolution.

Despite the problems I submit that this option is worthy of consideration since it could secure the necessary plasma supply, allow regions to determine their own priorities, the system can be self-financing once the initial investment has been made and, finally, by accountability to the C.B.L.A., both financially and with respect to quality of plasma a degree of standardisation could be achieved which is not possible with the present devolvment of plasma collection to Regional Services.

A further option, which I have not included in the above is the purchase of plasma from the U.S.A. to fill the gap left by the national supply. The reasons for this are that such plasma would almost certainly come from professional donors and this would be against the declared aims of the World Health Organisation, the Council of Europe and the International Society of Blood Transfusion which are to attain national self-sufficiency of plasma supply from voluntary, non-remunerated donors. The British Government has agreed to these principles and such purchases, therefore, could be politically unacceptable. Moreover, the present concern with regard to the transmission of AIDS by the transfusion of blood products and the fact that enquiry has determined that collection of the necessary quantity of plasma is feasible from voluntary blood donors in England and Wales, any move to purchase plasma from the U.S.A. would invite severe criticism and unfavourable publicity.

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