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October 2026

IMMUNOGLOBULIN SUSTAINABILITY IN THE UNITED KINGDOM

Characterising the challenge and identifying solutions

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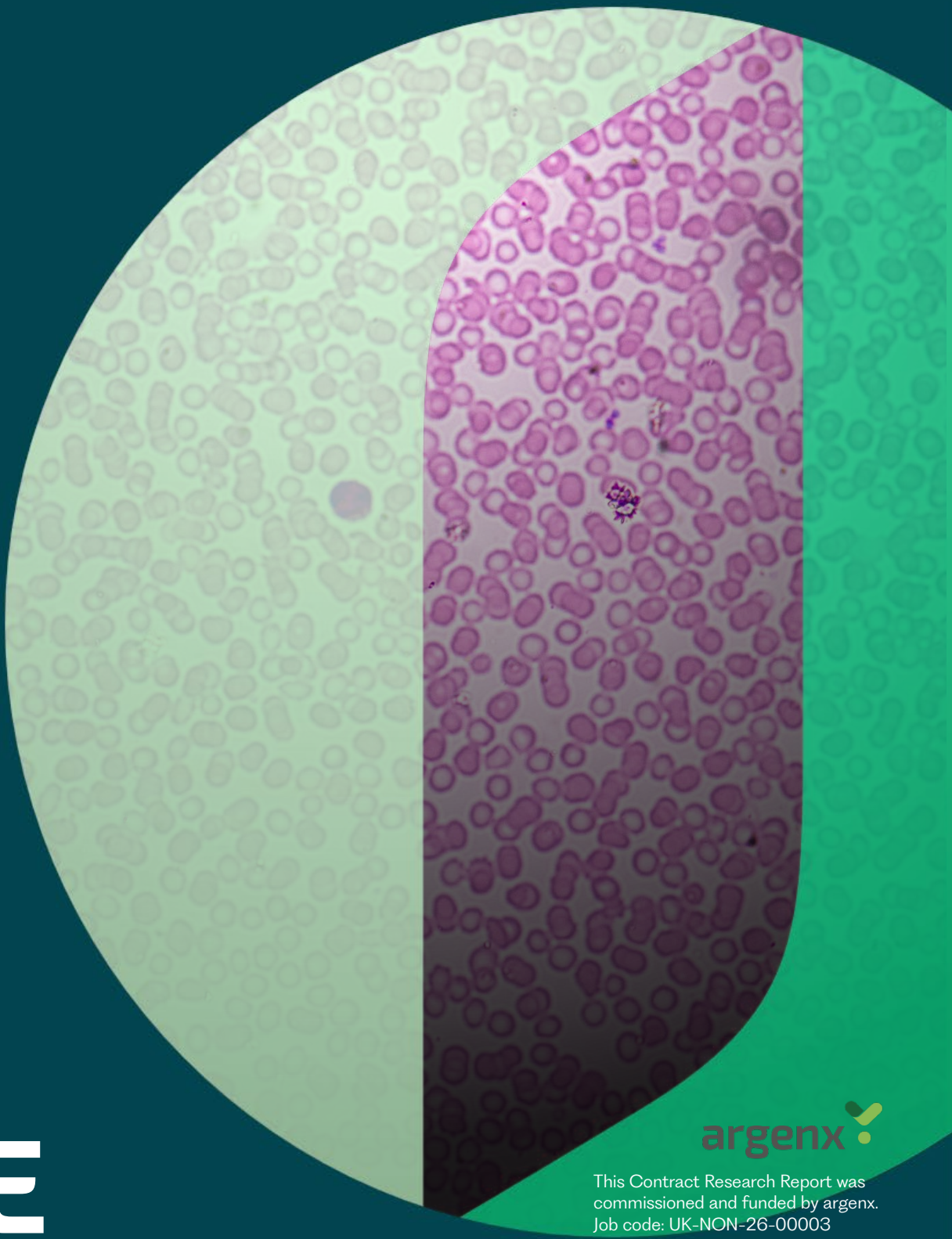

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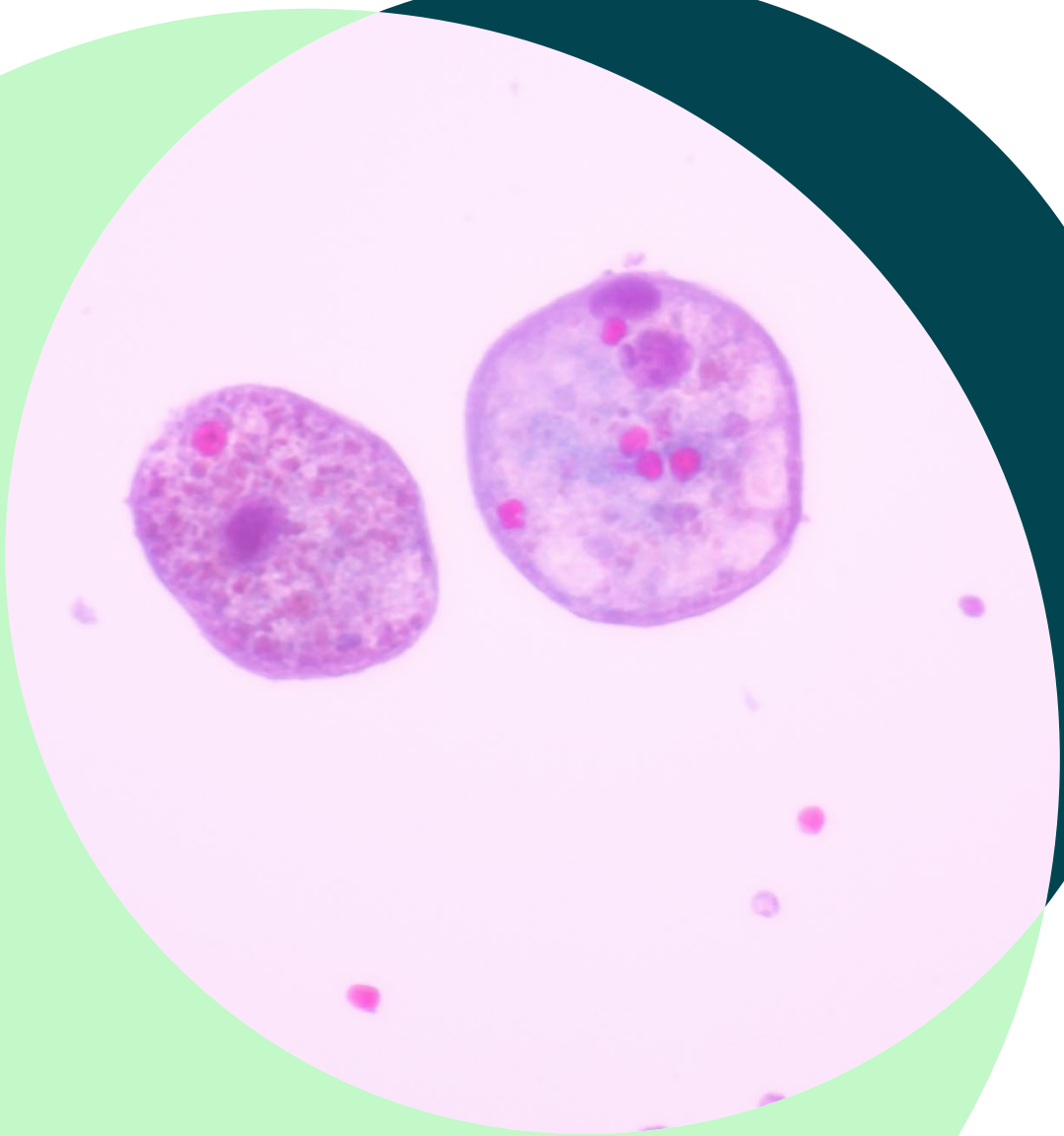


Key messages

- Immunoglobulin (Ig) is a plasma-derived medicinal product used across more than fifty clinical indications.
- The UK currently secures access to Ig at a controlled cost, but this position is under increasing pressure by increases in demand, a supply system heavily reliant on imports, and rising Ig care costs.
- Four solutions to these Ig sustainability challenges have been identified. NHS Procurement and stewardship are quick wins that are operational today but offer limited further headroom. Expanding domestic supply and alternative therapies are strategic long-term solutions that require sustained investment but offer greater potential impact.
- No single solution can resolve the identified challenges. A sustainable Ig system in the UK is likely to require progress across all four solutions.

Executive summary

This report characterises the current and future challenges to immunoglobulin (Ig) sustainability in the UK, assesses the implications for patients, services and cost, and sets out prioritised policy responses. The findings draw on a targeted literature review, economic modelling and a multi-stakeholder expert roundtable.

What is Ig sustainability?

Ig sustainability refers to the ability of the UK health system to secure long-term patient access to Ig while also managing affordability and avoiding unsustainable pressure on NHS capacity. The UK currently secures reliable access to Ig at a controlled cost, but this position is under increasing pressure.

Why Ig sustainability matters?

Ig is a plasma-derived medicinal product used across more than 50 clinical indications. For a substantial proportion of patients there is no therapeutic substitute. Around half of total use is accounted for by immunology conditions requiring lifelong replacement therapy.

What are the Ig sustainability challenges?

Three interrelated pressures will intensify over the next decade.

- Volume pressure: UK demand grew by around 30% between 2015 and 2024 and is projected to continue to grow. Growth is driven by improved diagnosis, widening eligibility and secondary antibody deficiency arising from bispecific antibody and CAR-T therapies. Approximately 80% of supply is imported, manufactured predominantly from US-sourced plasma, exposing the UK to global competition and external shocks. National shortage alerts occurred in 2010/11, in the late 2010s and in 2020/21.

- Economic pressure: Ig ex-factory price has grown by 14% after accounting for inflation during the period between 2007 to 2025. NHS procurement practices help in deferring exposure to international price growth, but rising costs will influence future negotiations.

- Health system pressure: Intravenous administration of Ig dominates in the UK and is associated with substantial delivery costs and resource use. Infusion and workforce capacity are already constrained.

These combined effects are likely to impact patients in the future through delayed or reduced treatment, changes of Ig product or changes to alternative therapies, with potential clinical and psychological risks, especially where such changes are not medically driven.

What are available policy responses?

Four solutions were assessed, spanning levers that increase the volume of Ig available, secure access to existing volume, and/or reduce the volume required. Their effects are complementary rather than interchangeable.

1. NHS procurement secures price and supply for a defined term. Protection is limited by contract duration, but this policy solution has achieved stable prices and secure supply.

2. Clinical stewardship has been implemented successfully and is internationally regarded as a UK strength. It has inherent limits too, and changes to dose or therapy can also lead to patient and system harm if evidence-based guidance is applied inconsistently. Patient equity can be a concern if there are uneven standards of clinical stewardship across the UK and patient subgroups.

3. Alternative therapies have the potential to reduce Ig demand and release Ig volume for indications where no alternative exists. There is a need to invest in clinical research, development, and access of such therapies in the long term.

4. Domestic Ig supply is a well-established response to import dependence. There is a need to invest in raising domestic supply in line with NHSBT targets through donor retention and plasma collection capacity.

Which solutions should be prioritised?

Procurement and stewardship are quick wins: operational, funded from existing budgets, and capable of immediate benefit, but with limited remaining headroom given the success that has already been achieved via these means. Alternative therapies and domestic supply expansion are strategic responses requiring sustained investment and longer lead times, with correspondingly greater potential impact. The preference of multi-stakeholder experts for a focus on alternative therapies and domestic supply expansion therefore reinforces the case for shifting attention towards these longer-term levers, where the greatest potential for additional impact lies.

In conclusion, each of the policy tools at our disposal can support a different component of a sustainable Ig system, with their effects complementary rather than interchangeable. **A resilient and sustainable UK Ig system will therefore require a coordinated approach across all four.**

Short term policy recommendation:

- Recognise the growing Ig sustainability challenge and monitor demand, supply and cost outcomes.
- Strengthen NHS procurement practices, including for SCIg, to stabilise prices and mitigate supply risk as volume pressure increases.
- Evolve stewardship guidance to keep Ig use clinically appropriate and equitable, protecting access without unnecessarily restricting treatment.
- Invest in research into, and translation of, effective and clinically appropriate alternatives to Ig.

Long term policy recommendation:

- Support wider adoption of alternative therapies, where clinically suitable, to reduce demand and reliance on imported Ig.
- Invest in domestic plasma self-sufficiency to build a more resilient Ig supply chain and reduce exposure to external shocks.

1 Background

Plasma is the liquid in our blood. It is rich in proteins and immune cells which can be used for various medical therapies and treatments (Pant, Bagha and McGill, 2021). Plasma is used to manufacture plasma-derived medicinal products (PDMPs) such as clotting factors, albumin and immunoglobulins (Ig), which play a critical role in the treatment of many rare and severe conditions (Premnath, Sankar and Khalil, 2026). PDMPs are manufactured by extracting antibody proteins from plasma through a process called fractionation; plasma is collected via whole blood or plasmapheresis donation (Foster, 2026; Pant, Bagha and McGill, 2021). Ig in particular is used to treat primary and secondary immunodeficiencies, immune thrombocytopenic purpura, Guillain—Barré syndrome, chronic inflammatory demyelinating polyneuropathy (CIDP) and many other conditions (Foster, 2026). Global plasma supply is highly concentrated, with the US supplying approximately 70% of the world's plasma for fractionation, most of which is collected from compensated donors at private collection centres (Belmonte et al., 2025). Fractionation of PDMPs takes place at manufacturing plants across North America, Europe and Asia, however the plasma in these plants is largely of US origin (von Bonsdorff et al., 2025). Most of the finished Ig used outside the US, including in the UK, is therefore manufactured from US-collected plasma.

According to the latest Immunoglobulin Database Annual Report, Ig use in England and Northern Ireland reached 5.9 million grams in 2024/25 (Foster, 2026). Of these, neurological indications accounted for 52% of total Ig use by volume, with immunology accounting for a further 42%. CIDP (neurology), primary immunodeficiencies and secondary antibody deficiencies (immunology) represent the largest indications by volume of Ig used at 26%, 22% and 18% respectively (Foster, 2026).

The UK Ig supply chain depends on centralised procurement of international immunoglobulin, alongside a growing but limited domestic collection programme (Belmonte et al., 2025; NHSBT, 2024b). 80% of Ig supply is imported as finished product, procured centrally by NHS England through a national framework agreement, with hospitals expected to use framework-approved products (Foster, 2026). The remaining 20% of supply is generated domestically through NHS Blood and Transplant (NHSBT), which collects plasma via its donor network and contracts a European fractionator to process plasma into finished products for NHS use, including Ig products (DHSC, NHS England and NHSBT, 2025).

The UK's progress towards domestic PDMPs over the past five years has been a real success story. A two-decade ban on using UK-collected plasma for fractionation, introduced as a precaution against Creutzfeldt—Jakob disease (CJD), was lifted in 2021 (NHSBT, 2021b). NHS England subsequently appointed a single fractionator and began shipping UK-collected plasma to their European manufacturing sites in summer 2024, and the first Ig products manufactured from UK plasma reached NHS patients in early 2025 (DHSC, NHS England and NHSBT, 2025). Domestic collection has grown from a standing start to supplying 20% of national Ig demand by the end of 2025, with NHSBT targeting 30—35% by 2030 (Foster, 2026; DHSC, NHS England and NHSBT, 2025). Growth at this pace is a notable achievement. However, the UK remains less self-sufficient than comparable countries with an estimated 4.4L of plasma per 1,000 inhabitants compared to the European average of 14L per 1,000 inhabitants, likely a by-product of the relatively delayed start to domestic plasma collection (Kluszczynski, Rohr and Ernst, 2020).

With such a reliance on imported Ig, multi-year procurement arrangements have supported cost control and supply security (DHSC, 2021; DHSC, NHS England and NHSBT, 2025). Both the domestic collection programme and these procurement arrangements were driven by the need to reduce reliance on imported plasma and the supply vulnerabilities exposed during the COVID-19 pandemic and subsequent stock

alerts, and have strengthened the resilience and security of the UK's PDMP supply (DHSC, NHS England and NHSBT, 2025). However, maintaining this position will become increasingly challenging due to several interrelated challenges which threaten the sustainability of Ig supply.

2 About this report

Motivation

The term 'sustainability' in this report refers to the ability of the UK health system to secure long-term patient access to Ig while managing affordability and avoiding unsustainable pressures on NHS capacity. The UK's current position on Ig sustainability is encouraging, but it is not secure. The factors that have supported Ig supply to date, including central procurement, strong stewardship and a growing domestic plasma collection programme, are operating against a backdrop of rising demand and constrained global plasma availability. Although concerns about Ig supply are widely recognised by stakeholders, there is not yet a shared understanding across the system of the nature and scale of the challenge. This lack of alignment risks hindering the development and implementation of effective solutions.

Objective

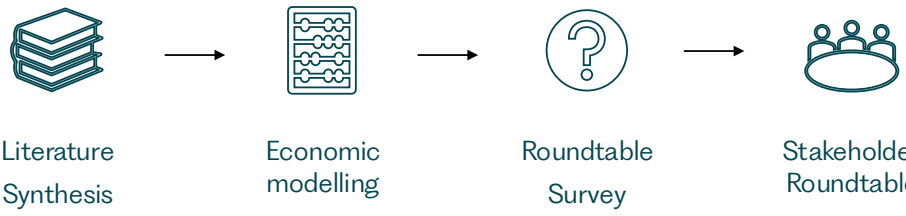
This report aims to: (1) characterise the current and future challenges to Ig system sustainability in the UK, considering availability, cost and system capacity; (2) assess the clinical, economic and operational implications of these challenges; and (3) identify and prioritise potential policy responses to support sustainable access to Ig therapies, optimise patient care and maximise societal value.

Approach

This report draws on work developed in two stages. Literature reviews and economic models were originally produced for argenx by third-party consultancies, named in the Acknowledgements. OHE was commissioned to review that material critically, to develop it further, and to interpret and apply it to the UK context.

We conducted a critical review of the existing literature and supplemented it with our own targeted reviews of peer-reviewed and grey literature, covering current Ig use in the UK, the pressures affecting sustainability, and the solutions available to address them.

Figure 1: Overview of methodological approach



We critically reviewed existing economic models and adapted them to::

1) Project Ig demand under a range of growth scenarios;

2) Compare historical price and cost trends, and test whether real-terms price growth is likely to persist;

3) Estimate the demand impact of alternative therapies;

4) Translate domestic supply targets into the collection infrastructure required and the resulting reduction in imports.

We also convened a multi-stakeholder roundtable with experts from across the Ig ecosystem to validate the literature findings and modelled evidence, and to discuss solutions. We circulated a survey in advance with key questions and discussion topics to gather insights to enrich the subsequent roundtable discussion. Expert participants were from NHS Blood and Transplant, the NHS Immunoglobulin Policy Working Group, clinicians in immunology, neurology and nursing, patient organisations (Inflammatory Neuropathies UK and Immunodeficiency UK), and argenx industry observers.

Our findings across these data sources and analyses formed the evidence base for this report. Interpretation of the modelled results and the literature is OHE's own, informed by the roundtable discussion. Chapter 3 characterises the supply and demand, financial and system capacity pressures on the UK Ig system and their clinical, economic and operational consequences. Chapter 4 examines four groups of solutions and enablers, and how each could alter the trajectory of the UK Ig system. Chapter 5 sets out conclusions and policy recommendations.

3 Ig sustainability challenges

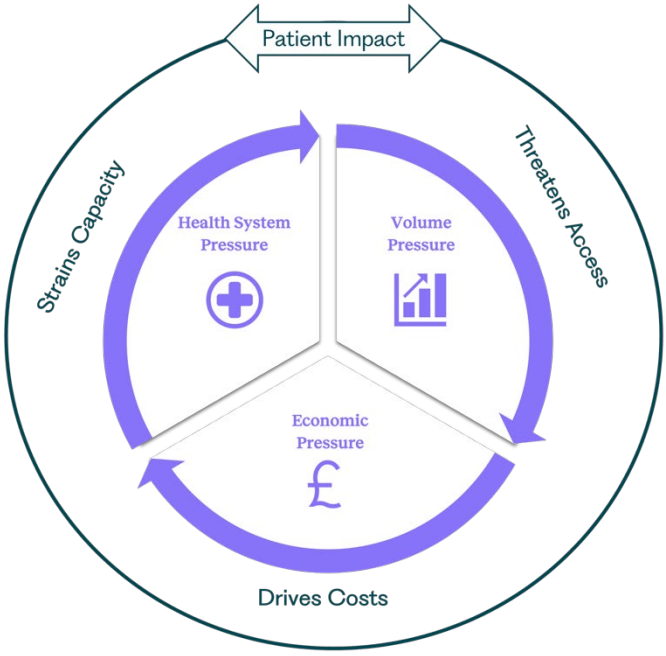
This chapter characterises the UK's Ig sustainability challenges and pressures, their likely trajectory over the next decade, and their consequences for patients, health services and cost.

Future sustainability is influenced by three types of pressure:

1. Volume pressure: continued growth in Ig use alongside constraints in plasma availability.
2. Economic pressure: increasing acquisition costs and the complexity of securing domestic and imported supply in a competitive global market with rising demand and limited supply.
3. Health system pressure: workforce, infrastructure and service delivery requirements associated with Ig administration and stewardship, which manages the appropriate use of Ig through clinical guidance, prioritisation of indications and monitoring of Ig use.

These pressures are interrelated: volume pressure is driven by the underlying growth in need; economic pressure influences the cost at which that need can be met; and health system pressure governs the capacity to deliver treatment, with the combined effect falling on patients through delayed or reduced treatment, changes of Ig product, or changes to therapy (Figure 2). The pressures are expected to intensify over the next decade and together may compromise the NHS's ability to maintain equitable and sustainable access to Ig therapies. In the remainder of this section, we discuss each of these pressures in turn.

Figure 2 The Ig sustainability pressure framework with impact on patients in the UK



3.1 Volume pressure

Demand growth

Demand for Ig has been increasing steadily both in the UK and internationally, and this trend is expected to continue. Between 2015 and 2024, UK Ig use grew by around 30%, from 4.6 million grams to 6.0 million grams (NHSBT, 2025). There was a notable dip during the COVID-19 pandemic, reflecting Ig supply disruption rather than being indicative of a reduction in clinical need or demand. Global plasma collection fell due to social distancing, donor reluctance and reduced collection centre capacity; between 2019 and 2021 the US and the EU saw a 20% and 9% reduction in plasma collections respectively (Belmonte et al., 2025). Because PDMP manufacturing takes 7-12 months, this shortfall continued to impact Ig supply in subsequent years (Kluszczynski, Rohr and Ernst, 2020). Ig us has since rebounded above its pre-pandemic level, indicating that the underlying structural growth trend remains intact.

The number of individuals eligible for Ig therapy is increasing steadily, supported by improved diagnosis and expanding indications (Belmonte et al., 2025; Foster, 2026). The number of clinical uses has grown to over 50 across multiple therapeutic areas, including immunology, haematology, neurology, and infectious diseases (Goubran et al., 2024). New indications are particularly concentrated in secondary antibody deficiency arising from modern haematology, including oncology therapies such as CAR-T cell therapies (Foster, 2026). Demand is also concentrated in a few high-volume indications, and many of the largest indications require long-term maintenance therapy with a significant and growing proportion of patients remaining on continuous treatment (Foster, 2024; IDF, 2026).

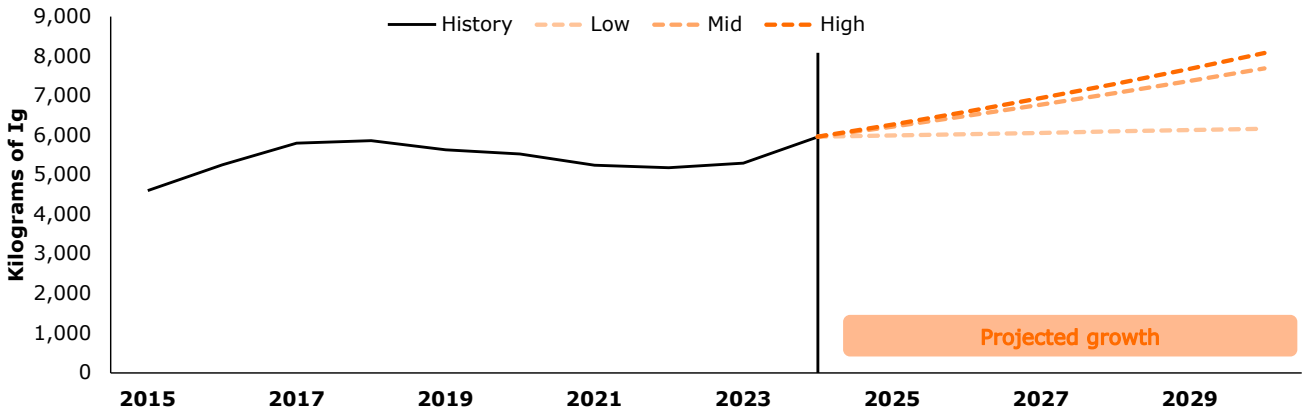
Looking ahead, modelling estimates for this report suggest that without any intervention, UK demand for Ig could increase by between 3% and 35% between 2024 and 2030 — a wide range that reflects the considerable uncertainty involved in projecting future demand (Table 1 and Figure 3). It is precisely because of this uncertainty that a range of scenarios were modelled, each based on a different annual growth assumption: 0.55% in the low scenario, drawn from World Bank population projections; 4.33% in the base case, drawn from the Marketing Research Bureau forecast (MRB, 2024); and 5.19% in the high scenario, which maintains the 2015—2019 pace. A summary of these results is presented in Table 1. In volume terms, this equates to a rise from 5.96 million grams in 2024 to between 6.16 million grams under the low scenario and 8.08 million grams under the high scenario by 2030, with the base case reaching 7.69 million grams. For full modelling details see Appendix A.

Table 1 Projected UK Ig demand by scenario, 2024-2030

SCENARIO	ANNUAL GROWTH ASSUMPTION	BASIS / INTERPRETATION OF ASSUMPTION	2024 DEMAND (MILLION GRAMS)	2030 DEMAND (MILLION GRAMS)	TOTAL GROWTH 2024—2030 (%)	ABSOLUTE INCREASE (MILLION GRAMS)
Low	0.55%	Population growth only (World Bank projections). No new indications, no change in diagnosis rates or prevalence.	5.96	6.16	3.34%	0.20
Base (MRB)	4.33%	Marketing Research Bureau country forecast (MRB, 2024). Reflects expected uptake: broader use in existing indications, new indications and improved diagnosis.	5.96	7.69	28.96%	1.73
High	5.19%	Continues the 2015—2019 historical UK growth pace (pre-COVID trend). Assumes recent expansion of use is sustained.	5.96	8.08	35.47%	2.11

Growth rates are applied to reported NHS Ig use in 2024 (5.96 million grams) and held constant to 2030; total growth is compound growth over the period. Modelling by AppEco, see more detail in Appendix A.

Figure 3 Ig demand in the UK



Sources: NHS Annual report data; NHS National Immunoglobulin Database Annual Reports data. Low projection: 0.55% ((World Bank, 2026), Population estimates and projections); Medium projection: 4.33% (MRB forecast); High projection: 5.19% (Keeps 2015-2019 pace). Growth rates are applied to reported NHS Ig use in 2024, the latest complete year of data, and held constant to 2030. Projections apply an average growth rate to total Ig demand and are not adjusted for individual indications. Modelling by AppEco, see more detail in Appendix A.

Supply and self-sufficiency

In the UK, demand is met through a combination of imported product (80%) mainly from the US reliant on a paid donor system, alongside a growing domestic contribution (Foster, 2026; Pant, Bagha and McGill, 2021; NHSBT, 2024a). Since UK plasma collection resumed in 2021, the UK has made significant progress towards self-sufficiency, with domestically sourced plasma now meeting 20% of national Ig demand (DHSC, 2021; DHSC, NHS England and NHSBT, 2025; Foster, 2026). Yet, the scale of growth required to meet

demand is likely to exceed what domestic collection alone can deliver, even as UK domestic supply and self-sufficiency continues to improve.

Risk of supply-demand imbalance and shortages

The UK's stewardship of Ig demand is internationally recognised as strong, but with demand still rising, it is unlikely that this alone can continue to deliver sustainable access as its scope for further gains is largely exhausted. However, continued rigorous stewardship is essential if evidence-based access to Ig is to be preserved.

Reliance on imports exposes the UK, like many other countries dependent on global plasma supply, to global competition, price volatility, and external disruptions (Belmonte et al., 2025; NHSBT, 2024a). The UK has experienced periodic shortages of Ig over the past decade, with national alerts recorded in 2010/2011, again in the late 2010s, and most recently in 2020/2021 (O'Shaughnessy et al., 2013; Foster, 2019, 2026). These were triggered by external shocks including global regulatory and manufacturing disruptions, and the COVID-19 pandemic (O'Shaughnessy et al., 2013; Foster, 2019; ESHT, 2021).

Internationally, poorly managed Ig supply issues have been linked to worse clinical and system-level outcomes. Enforced treatment changes due to supply constraints can lead to disease deterioration, while disruptions in access have been associated with treatment cancellations, exacerbations, and even mortality in patients with PID outside the UK (N'kaoua et al., 2022; Strengers, 2023). Furthermore, shortages can exacerbate inequities in access, with treatment availability varying by institution rather than clinical need, and in some cases increasing out-of-pocket costs for patients (Boulis, Goold and Ubel, 2002; Bolcato and Jommi, 2024). A national demand-management plan is in place for catastrophic shortages, and is designed to prioritise Ig for patients with conditions exclusively dependent on Ig therapy. Other patients would have to be managed through dose reduction or a change to alternative therapies (OHE Roundtable, 2026). Recurring shortages of Ig can place increasing pressure on acquisition costs.

3.2 Economic pressure

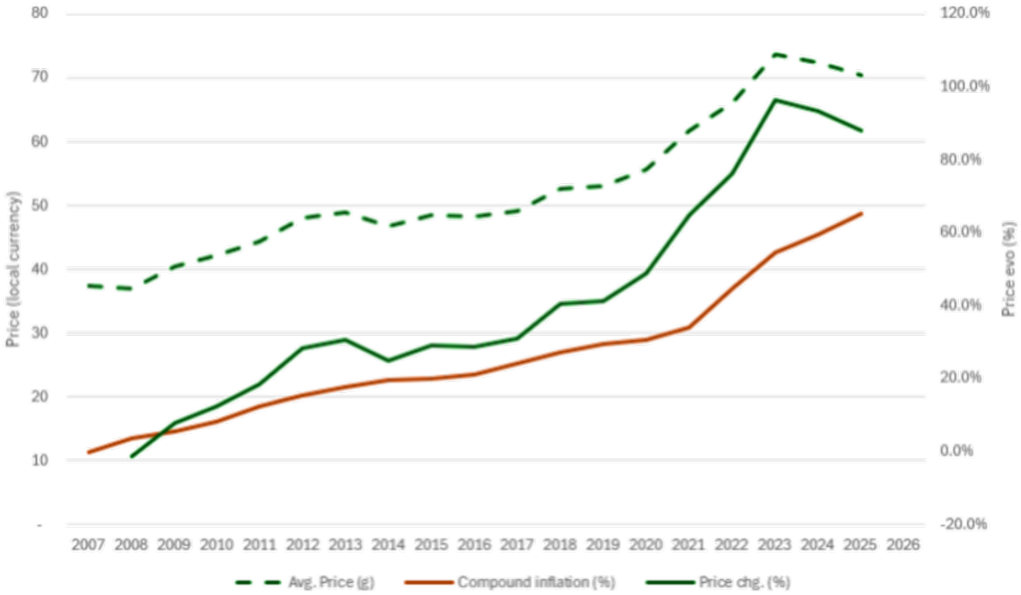
International price trends

The natural supply constraints associated with PDMPs translate into sustained upward pressure on pricing and system costs for imported Ig. In the UK, Ig ex-factory price has grown by 14% after accounting for inflation (price-inflation difference was 23%) during the period between 2007 to 2025. The steepest acceleration in ex-factory price occurred after 2020, followed by a slight softening in 2024-2025 (see Table A.3 and Figure 4). This price growth trend is mirrored across other major markets, including the United States, France, Germany, Italy and Spain, as growing strain on global supply chains pushes up acquisition costs (internal data). .

Ig also sits outside the conventional pharmaceutical price lifecycle: as a fractionated derivative of donated human plasma, its production depends on access to donated human plasma and specialised fractionation capacity, rather than on synthesis of a patented molecule. It therefore does not face the same conventional loss-of-exclusivity dynamic as a typical pharmaceutical product, with competition instead shaped by access to the scarce plasma input, donor recruitment, collection and fractionation capacity, and global competition for these resources (von Bonsdorff et al., 2025).

Considering historical trends and the current pricing structure of Ig, ex-factory pricing is expected to increase over time (Figure 4).

Figure 4 Ig price trajectory. Average ex-factory price of IG per gram and price change vs compound inflation (UK)



Sources: Extracted annual ex-factory prices for IVIg and SCIg, Comparison of compound and annualised Ig price growth with inflation, extrapolation methods to assess whether trends may continue over time. Modelling by Prescient, see more detail in Appendix B.

Procurement contract prices

The NHS obtains Ig for England, Scotland and Northern Ireland under a single national contract which is retendered every 3-4 years, while Wales holds separate arrangements with suppliers (Immunodeficiency UK, 2025). This procurement contract defines the Ig framework which sets out which products are available to the NHS, and at what price, for the duration of the agreement; each new contract changes which products are able to be prescribed (NHSFT, 2025). The previous contract ran from 2021 until March 2025, the current one runs from April 2025 until December 2027, with the option to extend it into 2029 (Immunodeficiency UK, 2025).

Centralised procurement at this scale has successfully contained cost and secured continuity of supply, with buffer stock requirements written into the tender specification to reduce exposure to global shortages (NHS England, 2026; OHE Roundtable, 2026). The protection this affords, however, is only for as long as the contract duration. A fixed price shields the NHS from international price growth for the duration of the agreement but does not alter the trajectory of the underlying market: each renewal is negotiated against the prevailing international baseline, which has continued to rise. Central procurement therefore defers exposure to global price growth rather than removing it, and the scale of the eventual adjustment depends on how far international prices have moved during the contracted period.

Furthermore, headline savings reflect unit price alone and exclude the delivery costs that fall on clinical services rather than the procurement budget when patients are moved between Ig products due to procurement-constrained product availability. Ig products are regarded as clinically equivalent, but best practice is not to switch without a clinical

reason, with a high proportion of switches requiring an observed first infusion in hospital. This process requires additional appointments, along with associated clinical and administrative burden, and travel costs — especially for patients established on SC administrations at home who would not otherwise be in the hospital for Ig treatment (Bethune and Herriot, 2019; Immunodeficiency UK, 2026). Separately, the volumes procured may not reflect longer-term ambitions to reduce the total cost of delivery. Where a lower unit price for IVIg is secured in preference to SCIg volume, delivery costs remain high because patients continue to be treated in hospital. Roundtable participants noted that the current contractual framework secures insufficient SCIg, which limits the shift to home administration and leaves demand concentrated in higher-cost hospital infusions (OHE Roundtable, 2026). If these costs are excluded from procurement decisions, the true saving to the system may be overstated.

Cost of expanding supply

Scaling supply is costly because PDMPs do not benefit from economies of scale (i.e. do not become cheaper with additional units produced). Manufacturing costs are higher than for biologics, and harder to reduce due to strict safety requirements (Grifols, 2024; JPAC, 2026). Additionally, plasma contains multiple proteins that are extracted together during fractionation, but the quantities of these proteins differ. To produce enough of the most in-demand components, plasma must continue to be processed, even after demand for other components has been met, which leads to wastage of surplus proteins (Galduf et al., 2023). As a result, the first litre of plasma yields far more usable product — and revenue — than the last (Galduf et al., 2023).

Expanding domestic supply of Ig carries its own cost. NHSBT estimate that an additional 200,000 donors would be needed each year to keep pace with rising demand, a substantial increase from existing targets of 15,000, which are already not being met (NHSBT, 2025, 2021a). Achieving this would require overcoming significant awareness barriers by investing in public education and engagement, alongside associated costs of loyalty programmes and donor retention initiatives (Berger et al., 2023). Furthermore, research is needed to assess potential health risks and to develop robust medical guidelines that can ensure donor safety while enabling higher collection output (NHSHRA, 2026).

Increasing domestic supply further would also require investment in infrastructure. As of 2024, England had only three dedicated plasma donor centres, and just 7% of total plasma was collected via plasmapheresis, well below the European average of approximately 40% (NHSBT, 2026a; Hunter and Jones, 2025). Expanding collection would require substantial investment in donation centres, apheresis capacity and trained staff (NHSBT, 2026b).

International experience suggests that expansion on this scale is achievable, but that it depends on sustained investment and a clear national ambition rather than on the donor model (OHE Roundtable, 2026). Australia, the Netherlands, Belgium and Italy have all achieved substantial growth in voluntary, non-remunerated models; only Germany, Austria, Hungary and the Czech Republic compensate donors, and Canada operates a mixed model that remains predominantly voluntary (OHE Roundtable, 2026; Pant, Bagha and McGill, 2021). The UK's voluntary, non-remunerated donor model is therefore not a barrier to growth. Importantly, most established plasma programmes have developed over several decades, with continuous collection since the 1970s, whereas the UK restarted plasma collection from a standing start in 2021 (Pant, Bagha and McGill, 2021; DHSC, 2021).

Despite the growth achieved, international experience shows that self-sufficiency can remain difficult to achieve and sustain. Canada has substantially expanded domestic plasma collection, yet Ig self-sufficiency remains around 27%, while Japan's Ig self-sufficiency fell from around 95—96% historically to 68.1% in FY2024 as demand outpaced domestic supply capacity (Canadian Blood Services, 2025; MHLW, 2025). Table

2 presents current levels of self-sufficiency and associated targets for the UK, Belgium, Canada, Italy, the Netherlands and Spain. Levels range from around 20% in the UK to approximately 61% in Italy, and where long-term targets exist, they remain distant, with Italy aiming for 80% self-sufficiency and Canada for 50%. Against this backdrop, the UK's target of 30-35% self-sufficiency by 2030 is a substantial increase from a base of around 20%, but a modest end point because it would still leave roughly two-thirds of demand met by imports. Furthermore, it remains below what Belgium and the Netherlands already achieve, and well short of the targets set by Italy and Canada. Whether a more ambitious target is deliverable depends on the scale of collection infrastructure, donor recruitment and investment required.

Table 2 International experiences regarding domestic Ig supply and self-sufficiency targets

COUNTRY	IG SELF-SUFFICIENCY	SELF-SUFFICIENCY TARGET	KEY VULNERABILITY	SOURCE
UNITED KINGDOM	~20% (2025)	~30—35% by 2030	Requires sustained growth in donor base, and implies continued ~65—70% import reliance	(Foster, 2026; DHSC, NHS England and NHSBT, 2025)
BELGIUM	~46% (2025)	Unknown	>50% of requirements remain dependent on external supply	(Rode Kruis Vlaanderen, 2025)
CANADA	27% (2023/24)	50% long term target	Domestic target still leaves structural reliance on global supply	(Canadian Blood Services, 2024)
ITALY	~61% (2025)	80%	Significant regional disparities; some regions <50% self-sufficient currently	(Gazzetta Ufficiale, 2017, 2026; Candura et al., 2023)
NETHERLANDS	~55% (2025)	Unknown	Domestic collection remains insufficient despite ~23% growth in apheresis donations since 2020	(Sanquin, 2025)
SPAIN	~29% (2024)	Unknown	High import dependence despite initiatives to increase domestic plasma collection	(Ministerio de Sanidad, 2024)

Note: self-sufficiency is the share of Ig demand which is met from domestically sourced Ig. It is a relative measure, the underlying demand differs between countries, so 30% self-sufficiency in one country does not represent the same volume of domestically sourced Ig as 30% self-sufficiency in another country.

3.3 Health system pressure

Service delivery

Beyond the product itself, Ig therapy places substantial demands on the healthcare system. The resources required to deliver Ig are already under pressure, so health system capacity is itself a major constraint on the system's ability to absorb future Ig demand.

In the UK, IVIg remains the dominant mode of delivery with 76% of Ig administered in this way (Foster, 2026). IVIg incurs substantial costs requiring infusion capacity, hospital resources and transport costs (Chaudry, Culpin and Elshazly, 2026). Furthermore, IVIg administration incurs a patient burden. Long-term Ig therapy can require regular hospital

attendance or ongoing home administration, creating time commitments, disruption to work, education and daily routines, and reliance on caregiver support (Jones et al., 2020).

Ig can also be self-administered subcutaneously (SCIg) at home, which avoids the need for infusion capacity but still requires input from clinicians, pharmacists and nurses to train and monitor patients and carers (Foster, 2020). Lack of availability of SCIg in suitable formats (e.g., pre-filled syringes) limits the shift to home administration (OHE Roundtable, 2026).

New Ig use cases

Rising demand is increasingly driven by haematology advances, for example B-cell depleting therapies including bispecific and trispecific antibodies and CAR-T therapies, which can lead to secondary antibody deficiency and require supplementary Ig (OHE Roundtable, 2026; Foster, 2026). This growing demand places additional pressure on Ig services that are already operating at infusion and workforce capacity and rely on effective collaboration across specialties. The challenge is compounded by the fact that many haematology units do not have access to a dedicated immunology service (OHE Roundtable, 2026). In centres where immunology teams have absorbed this work, increasing demand and nursing workforce constraints have limited their ability to accept additional patients. Roundtable participants also noted that existing capacity is not always used optimally, and that efforts to shift care outside traditional hospital settings can be constrained by patient uptake. For example, one centre trialled weekend opening of its day unit to increase capacity, but lack of patient awareness meant it was subsequently discontinued because of low utilisation (OHE Roundtable, 2026).

Stewardship burden

Stewardship of Ig manages the appropriate use of Ig through clinical guidance, prioritisation of indications and monitoring of Ig use. It is an important mechanism to optimise the use of Ig as a limited resource and direct it to those with the highest need. That said, this is not without cost.

Managing supply and stewardship also adds administrative burden, with European evidence suggesting that pharmacy staff spend a substantial proportion of their time addressing and managing supply issues (Napier, Berdud and Cole, 2024). In Canada, the introduction of a stewardship programme required the establishment of four dedicated roles to carry out core activities, along with remuneration for committee participation, amounting to annual costs of approximately 495,000 CAD (2021 prices); although these costs were offset by savings made from reducing inappropriate Ig use (Sarker et al., 2024). Rising demand is also increasingly driven by advances in haematology, adding pressure to Ig services that are already operating at capacity and that depend on cross-specialty collaboration.

3.4 Patient impact

The pressures described above are ultimately felt by patients. Constrained supply, tightening prioritisation and procurement-driven changes in product availability all translate into changes to individual treatment, whether in dose, frequency, product, route of administration or the therapy itself. This section considers the consequences of those changes for patient health, for the psychological burden carried by patients and their caregivers, and for equity of access across the UK.

Health impact

Operational constraints, particularly limited infusion capacity may mean that some patients may not be on an optimal dose or frequency, and some may be switched to alternative therapies to prioritise Ig resources for the patients most in need. Where such changes are clinically appropriate, the evidence is encouraging, for example studies where patients are switched from IVIg to SCIg, or a controlled reduction in dose report no significant deterioration in observed clinical outcomes (Cowan et al., 2025; Moral Moral et al., 2025; Stump et al., 2017; Lababidi, Theocharides and Gonzalez, 2025). By contrast, non-medically driven changes in treatment during shortages which involve treatment interruptions or changing to less effective therapies (for example switching from Ig to corticosteroids or plasma exchange), can lead to deterioration in patients' conditions, sometimes significantly (N'kaoua et al., 2022; Strengers, 2023).

Critically, for a substantial proportion of patients, viable alternatives to Ig do not exist or are not available. Approximately 21% of total Ig use is accounted for by patients with primary immune deficiencies, many of whom rely on lifelong Ig replacement therapy with no equivalent substitute (Foster, 2026; IDF, 2026). Similarly, for certain neurological conditions, such as multifocal motor neuropathy, Ig remains the only evidence-based treatment option. Alternative interventions such as corticosteroids or plasmapheresis are not suitable in these cases and may even worsen disease progression (Perez et al., 2017; Kimyongur, Hywel and Holt, 2019). With this in mind Ig displacement can generate substantial value: if Ig use can safely be avoided in indications that do have alternatives, the volume released can support patients who do not have a viable substitute.

Psychological burden

Beyond clinical risks, patients and caregivers may experience a significant psychological burden when treatment regimens change, including uncertainty about effectiveness and increased stress associated with managing new therapies (Immunodeficiency UK, 2017). The greatest fear for many patients is that changing their treatment regimen may lead to increased symptoms if the alternative treatment is less effective (OHE Roundtable, 2026).

Patient equity

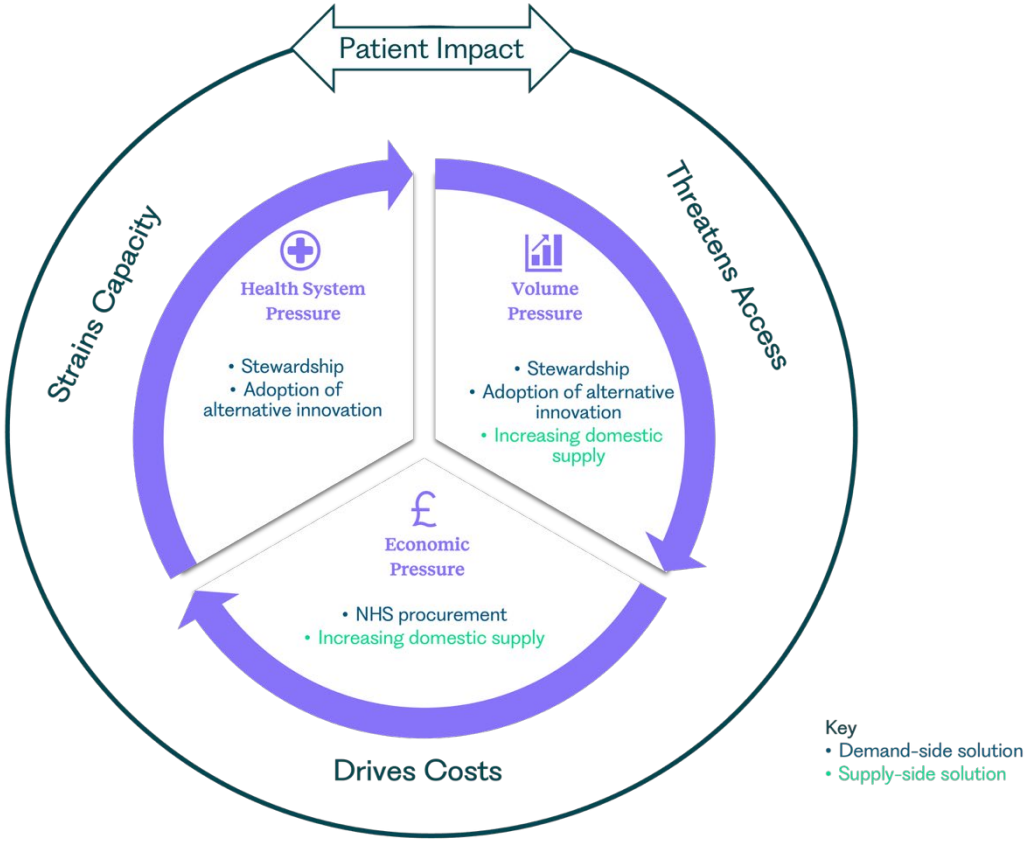
Care can also vary by treatment location rather than by clinical need alone, with access to specialist review shaping whether a patient's treatment is optimised or safely adjusted. This can lead to differences in disease management, Ig stewardship, and patient outcomes (OHE Roundtable, 2026).

4 Solutions to Ig sustainability challenges

Roundtable participants agreed that no single intervention can resolve the pressures discussed previously, and complementary action across both the supply- and demand-side strategies is required, for which we consider four. Figure 5 maps these solutions onto the related challenges.

On the demand side, NHS procurement seeks to optimise how Ig products are contracted and purchased, clinical stewardship seeks to optimise appropriate use of Ig through guidance, prioritisation and monitoring, and alternative therapies seek to leverage alternative treatment options and new technologies, where clinically appropriate, to reduce pressure on Ig demand. On the supply side, domestic Ig supply seeks to strengthen plasma collection capacity in order to reduce reliance on imports.

Figure 5 Solutions to the Ig sustainability challenge in the UK



Drawing on the evidence reviewed in this report, the modelling undertaken for it, and expert views expressed before and during the roundtable, we completed SWOT analyses for each solution. They are then compared with one another in a prioritisation matrix at the end of the section.

4.1 NHS procurement

NHS procurement seeks to optimise how Ig products are contracted and purchased on behalf of the health system. It is an effective tool for securing supply and holding cost for a defined period but rising international Ig prices and the difficulty of forecasting future demand limit the additional protection it can offer.

Strengths: National, multi-year contracting is regarded internationally as a well-managed model. Fixing the price of contracted Ig for the term of the contract insulates the NHS from international price increases over that period, while supply guarantees prevent suppliers from diverting product to higher-paying markets. Contracts also include headroom above forecast demand, providing some capacity to absorb short-term fluctuation, and iterative review between contract rounds has allowed the approach to be refined over time.

Weaknesses: The principal weakness of the current approach is that it is not commissioning-focused: it addresses the direct price per gram of Ig rather than patient impact or the wider costs of delivery. Furthermore, contracts must be priced and sized years in advance against demand that is inherently difficult to forecast. Contracts have not secured sufficient subcutaneous supply, which has contributed to regional disparities in access and affects equity between patients. Roundtable participants noted that, while historically a diverse range of stakeholders, including consultants, specialist nurses, pharmacists and patient groups have been involved in procurement discussions, more recent contracting iterations have involved a narrower group of participants.

Opportunities: A shift towards a strategic commissioning model would build patient and wider system value into the specification, with contract volumes and review points set against demand forecasts rather than historical use. Early and structured engagement with clinicians, nurses, pharmacists and patient groups would improve the quality of specifications and their acceptability in practice. Securing sufficient subcutaneous supply would in turn support greater home administration, aligning Ig services with the NHS 10-year plan ambition to shift care into community settings.

Threats: Against this, three threats emerge. Fixed prices hold only for the contract term, with renewals re-priced against a rising international market. Exponential demand growth could outstrip the forecasts on which fixed-term contracts are based, leaving the NHS exposed once volume ceilings are reached. While the import procurement framework relies on multiple sources and suppliers, the domestic Ig supply comes from a single contracted manufacturer/fractionator. This can be seen as high reliance on a single supplier and may limit the NHS's ability to negotiate lower prices or more favourable contractual terms.

4.2 Stewardship

Clinical stewardship seeks to optimise the appropriate use of Ig through clinical guidance, prioritisation of indications and monitoring of Ig use. It is effective at reducing consumption, but it now offers diminishing returns and inconsistent implementation risks variation in patient outcomes.

Strengths: The UK is widely regarded as a global gold standard in this respect, and measurable reductions in Ig use have been achieved through dose reduction and the narrowing of commissioned indications (Misbah et al., 2020). Ig use is restricted to the indications and doses set out in a single national clinical commissioning policy, and prescribing for any non-emergency indication requires approval by a local or sub-regional

Immunoglobulin Assessment Panel before the hospital pharmacy will release the product. Table 3 compares stewardship programmes across a range of countries.

Table 3 International experiences regarding Ig stewardship

COUNTRY	DEMAND-MANAGEMENT MATURITY	ROUTINE DEMAND MANAGEMENT / STEWARDSHIP	SOURCES
UNITED KINGDOM	●●●● Advanced	**Highly structured national demand-management and stewardship. NHS England commissioning policy restricts Ig use to defined routinely commissioned indications, supported by Sub-Regional Immunoglobulin Assessment Panel (SRIAP) oversight and prioritisation when supply is constrained. Routine stewardship includes indication-specific pathways, dose optimisation to the minimum effective dose, structured product switching and use of clinically appropriate non-Ig alternatives.**	NHS England Clinical Commissioning Policy (2025);
AUSTRALIA	●●●● Advanced	**Highly structured national stewardship.** Government-funded Ig access is controlled through national eligibility criteria and **BloodSTAR authorisation**, with treatment reviews and an emphasis on the lowest effective dose and use where alternatives are limited.	(National Blood Authority, 2024, 2026)
BELGIUM	●●●○ Moderately advanced	**Centralised access controls through reimbursement and hospital dispensing. Polyvalent IVIg/SCIg must be prescribed by a specialist and, for reimbursement, dispensed through a hospital pharmacy. Belgium is also actively reassessing Ig utilisation: a 2026 KCE study is examining demand, reimbursed and off-label use, utilisation trends and current monitoring mechanisms.**	(NIHDI, 2026)
FRANCE	●●●○ Moderately advanced	Use is managed through authorised/reimbursed indications and clinical guidance, with increasing emphasis on **appropriate ("juste") prescribing**, reassessment and avoiding poorly supported use.	(ANSM, 2019; AVIS 146, 2024)
ITALY	●●○○ Moderate	AIFA, CNS and regional authorities monitor Ig demand/availability and promote appropriate therapeutic use, although implementation is **decentralised and regionally variable**.	(Di Giorgio et al., 2022; Candura et al., 2023)
NETHERLANDS	●●○○ Moderate	**More decentralised stewardship.** Prescribing and utilisation management are largely driven by specialty and hospital-level protocols rather than a comprehensive national Ig authorisation system. National work includes monitoring and forecasting demand.	(Kuipers, 2022; So-Osman et al., 2024)

Improving the appropriateness of prescribing manages expenditure while protecting access for patients with evidence-based need, and systematic monitoring of Ig use allows the NHS to track prescribing patterns, identify unwarranted variation and target areas for improvement.

Weaknesses: The national commissioning policy defines the indications and doses for which Ig is commissioned; it does not direct treatment — that is the role of clinical guidelines. Where the commissioning policy is understood as a recommendation to treat, rather than a broader boundary of what may be funded, prescribing practice can vary, creating uncertainty about what constitutes appropriate use and leading to inconsistent stewardship decisions and inequitable access. Where stewardship is applied inappropriately it can cause patient harm and generate additional costs elsewhere in the system. Stewardship initiatives also carry a management burden since they must adapt continually to a changing clinical and commissioning environment.

Opportunities: Opportunities lie principally at the sub-national level. Strengthening stewardship below the national tier would improve patient access and realise further efficiency gains, supported by better data registries capable of identifying and resolving sub-national variation. Reframing stewardship messaging around patient wellbeing, rather than cost containment, could also improve patient engagement with and acceptance of dose optimisation.

Threats: The main threat to stewardship is diminishing returns. Existing measures have largely addressed inappropriate Ig use and ensured optimised dosing, so the remaining scope for efficiency is limited. Increased Ig requirements associated with evolving treatment pathways, including bispecific antibodies and CAR-T therapies, may create demand pressures that stewardship alone cannot mitigate, and the need for rapid access in acute situations limits the application of standard stewardship controls. Differences between clinicians in the acceptance and interpretation of evidence, and in willingness to adopt stewardship recommendations, are constrained by panel approval which is required for all non-emergency indications and enforced in practice by hospital pharmacies. This means that Ig use outside national commissioning guidance is not routinely funded.

4.3 Alternative therapies

Alternative therapies to Ig can offer effective and evidence-based alternatives and new technologies, where clinically appropriate, to reduce pressure on Ig demand. Encouraging access to alternative therapies with demonstrated clinical benefit can support Ig sustainability by reducing demand, freeing Ig for indications in which no alternative exists, and offering potential long-term cost-effectiveness gains. For example, in other disease areas like haemophilia, alternative therapies were able to reduce the need for PDMPs (Belmonte et al., 2025).

Strengths: Its principal strength is that it expands clinical choice, providing additional treatment options and supporting more individualised care. Approved alternative therapies that are already licensed in relevant indications can displace Ig use, and emerging innovations with trials in progress could extend that displacement further, subject to regulatory approval and demonstrated benefit. Modelling undertaken for this report captures the potential for clinically appropriate substitution to reduce Ig demand, and to offset projected demand increases. We presented low, medium and high substitution scenarios with 10%, 20% and 30% reductions in total demand to experts in the roundtable. The high substitution scenario suggests that alternative therapies could fully offset the increase in demand projected under the high-growth scenario by 2030. While participants agreed strongly that alternative therapies could make a substantial difference to demand, they could not quantify the size of the expected impact.

Weaknesses: Therapeutic innovation in indications dependent on Ig remains limited, with few existing alternatives to date. Clinical evidence is limited and variable across patient populations, creating uncertainty about the role and positioning of alternatives. Furthermore, the impact of alternative therapies on Ig demand is unclear and not yet evidenced.

Opportunities: Several opportunities would strengthen the case for alternatives. Increased investment in clinical trials for alternative therapies would build the evidence base for adoption. Broadening the perspective taken by NICE in their health technology assessment to capture system and societal costs, of the type described in Section 3.3, would allow the broader value of alternatives to be recognised. The innovation lifecycle is also relevant. Conventional cost-effectiveness analysis assumes constant real prices for both the intervention and its comparator. This could either overstate or understate the cost-effectiveness of the new intervention, depending on its price trajectory relative to the comparator's. [1] Ig is unusual in having no loss of exclusivity and therefore no generic or biosimilar entry to reduce its price; as described in this report, its price trajectory has in fact been upward. Competition, by contrast, will bring the price of alternative therapies down once exclusivity ends. Standard static-price methods therefore understate the long-run cost-effectiveness of alternative innovative therapies in this case, where Ig is the comparator.

Ig displacement also carries a second-order benefit. Because Ig supply is bounded by plasma availability rather than by price, volume released in indications where an alternative therapy is clinically appropriate becomes available for those in which no alternative exists. This 'innovation dividend' accrues to patients beyond those treated with the alternative itself but is currently not captured where cost-effectiveness appraisals consider each indication in isolation.

Threats: The threats to innovative alternatives are largely institutional. Health technology appraisal frameworks and NHS procurement may underrepresent the broader benefits of alternatives and thereby delay adoption. It is also important to note that even if a non-Ig alternative exists, it may not fully solve the sustainability problem if the alternative itself is difficult to access, expensive, or itself has supply constraints. Newer, innovative treatments can be more expensive than those they replace, so displacing Ig volume could also increase overall treatment costs even where it eases supply pressure. Also, while alternative treatments will not be dependent on plasma donation volumes, they still carry their own risk of supply disruption. Finally, if they still require hospital resources to administer or monitor, the service capacity pressures set out above may persist. Nevertheless, to be approved they would have to be cost-effective compared to the standard of care (i.e. Ig), so value for money is established at the point of adoption, and unlike Ig, they also sit within the conventional pharmaceutical lifecycle, so competition and loss of exclusivity should bring prices down over time.

4.4 Domestic Ig supply

Expanding domestic Ig supply means strengthening domestic plasma collection capacity in order to reduce reliance on imports. Domestic supply is the main structural strategy against import dependence, but it is capital-intensive, slow to scale, and no established international programme has yet reached full self-sufficiency.

Strengths: Significant progress has been achieved from a standing start in 2021, establishing proof of concept and providing a platform for further scale-up. Domestic supply reduces exposure to global price and supply shocks, and advances in plasma collection technologies are already improving yields and collection efficiency.

Weaknesses: The weaknesses of this solution are those of scale and cost. Domestic supply still meets only a minority of Ig demand, leaving heavy continued reliance on imports. Furthermore, it currently depends on a single contracted fractionator,

[1] *If the comparator is a standard of care whose cost is expected to remain stable (e.g. no therapeutic intervention, or a therapy already at its post-exclusivity price floor), accounting for the new intervention's price falling on loss of exclusivity would improve its estimated cost-effectiveness. If the comparator is a branded therapy that launched earlier and loses exclusivity first, accounting accurately for lifecycle pricing would have the opposite effect.*

concentrating delivery risk. Expanding collection requires significant capital investment in collection infrastructure, processing capability and supporting services, and depends on sustained growth in voluntary plasma donation, which in turn requires continued donor recruitment, retention and engagement.

Opportunities: Further expansion of domestic plasma collection, combined with technology advances that accelerate collection efficiency and maximise plasma yields, would raise the domestic share of supply materially. Innovative approaches to donor engagement, including partnerships with employers, charities and patient organisations, mobilisation of the UK's charity networks, and the deployment of mobile plasma collection units, offer routes to the donor growth on which expansion depends.

Modelling undertaken for this report captures the potential reduction in imported Ig, and the potential to offset increases in imported Ig demand, as domestic supply expands. Under a scenario in which the UK achieves 30% self-sufficiency by 2030, approximately 15% of the import volume that would otherwise be required under the high-demand scenario could be avoided.

Threats: Three threats temper this. Expansion of domestic Ig production competes with other public spending priorities, so without political advocacy the funds may not be made available. Continued growth in Ig demand may outpace domestic scale-up, increasing the difficulty of achieving meaningful self-sufficiency. And established international plasma programmes have themselves yet to reach self-sufficiency, suggesting that high levels of domestic self-sufficiency remain challenging even with sustained investment. Additional modelling suggests that under a high-growth scenario, in which Ig demand grows by 5.2% per year and domestic supply grows at 9% per year, and 18 new collection centres would need to be established to meet the 30% self-sufficiency target by 2030, requiring up-front capital investment before any reduction in import cost is realised.

4.5 Prioritisation matrix

Because no single solution can mitigate all of the pressures identified, the four options above are best understood as complementary rather than competing. To support prioritisation, each solution was scored based on potential future impact and feasibility (encompassing cost of implementation and speed at which benefits could be realised), drawing on expert opinion collected in the pre-roundtable survey and subsequently discussed at the roundtable. Together these dimensions separate the four options into quick wins that are readily achievable but offer limited further headroom, and strategic, long-term solutions that require sustained investment but carry greater potential impact (Figure 6).

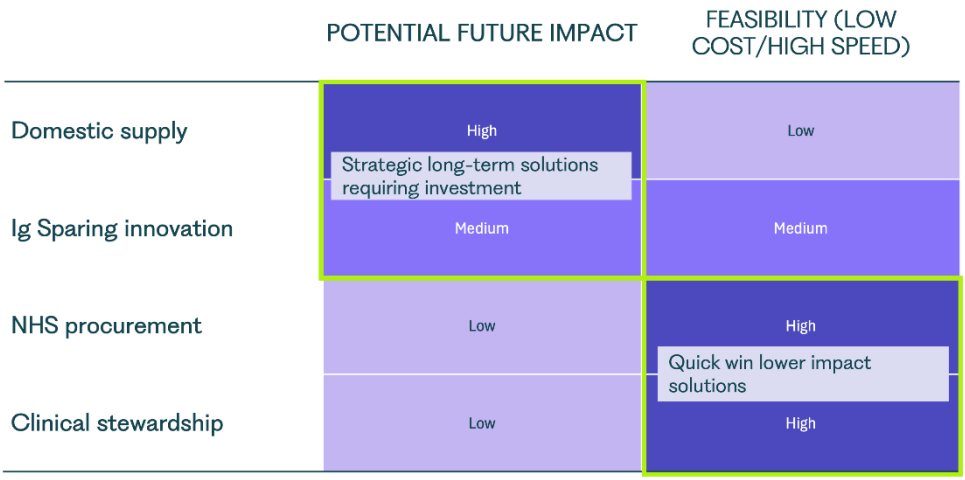
Quick wins: Procurement and stewardship represent the quick wins. Both are already operational and funded from existing budgets so require no implementation lead time and can therefore deliver benefit immediately and at low marginal capital cost, although stewardship carries a recurring administrative and workforce cost. Their limitation is headroom because both have already been implemented successfully; existing stewardship measures have largely addressed inappropriate use and the protection procurement affords is bounded by the contract term, so the scope for further gain from either is limited.

Strategic solutions: Expanding domestic supply and alternative therapies are strategic, long-term solutions. Both require sustained investment and more time to realise the benefits. New collection capacity depends on multi-year infrastructure builds and significant up-front capital, while adoption of alternatives is constrained by clinical trial timelines, regulatory and HTA approval, further evidence generation in some disease areas, and higher unit prices than Ig. Their potential impact is correspondingly greater though:

expanding domestic supply could substantially alleviate growing demand pressures, and clinical experts considered the potential of alternatives to be high, subject to the evidence base and the breadth of relevant indications expanding. While a strategy for domestic supply is in place, it should be noted that no policy or strategy is in place to foster the development or adoption of alternative therapies to Ig.

Overall, expert views reflected a balance of solutions. When asked to select a single solution for national prioritisation, two-thirds of participants selected leveraging alternative therapies, with the remaining third prioritising increased domestic supply. This preference reflects where participants judged the greatest additional impact to be, rather than a case for diverting effort from procurement and stewardship which remain the foundation of the current position and would need to be sustained alongside any longer-term investment.

Figure 6 Prioritisation matrix



OHE assessment, informed by pre-meeting survey responses, adapted following roundtable discussion and re-scaled to low/medium/high (OHE Roundtable, 2026).

5 Conclusions and recommendations

Increasing domestic Ig supply and centralised NHS tendering have together supported reliable patient access while keeping costs under control. The future sustainability of that position, however, is increasingly under pressure. The Ig sustainability challenges set out in this report are expected to intensify over the next decade, and volume pressure in particular risks escalating costs and straining service delivery capacity.

No single solution is likely to resolve these challenges on its own. NHS procurement practices can help optimise Ig procurement, stabilising prices and mitigating supply risk. Effective stewardship, applied where clinically appropriate, can prioritise patient access to Ig without compromising health outcomes. Adoption of appropriate alternative therapies can reduce reliance on imported Ig and lower overall demand, while ensuring patients continue to be treated effectively, with the volume released available for indications in which no alternatives exist. Increased domestic supply can strengthen the resilience of the Ig supply chain, supporting stable and reliable patient access. Each acts on a different part of the system, and their effects are complementary rather than interchangeable: a sustainable Ig system in the UK is likely to require progress across all four.

We therefore set out the following policy recommendations, distinguishing between actions that can be taken in the short term and those requiring longer-term investment.

Short term policy recommendation:

- Recognise the growing Ig sustainability challenge and monitor demand, supply and cost outcomes.
- Strengthen NHS procurement practices, including for SCIg, to stabilise prices and mitigate supply risk as volume pressure increases.
- Evolve stewardship guidance to keep Ig use clinically appropriate and equitable, protecting access without unnecessarily restricting treatment.
- Invest in research into, and translation of, effective and clinically appropriate alternatives to Ig.

Long term policy recommendation:

- Support wider adoption of alternative therapies, where clinically suitable, to reduce demand and reliance on imported Ig.
- Invest in domestic plasma self-sufficiency to build a more resilient Ig supply chain and reduce exposure to external shocks.

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Appendix

Appendix A. Modelling: immunoglobulin demand

Purpose

NHS use of immunoglobulin was modelled to 2030 to estimate how demand may develop if recent patterns of use continue. The projections are used alongside a separate assessment of the volume of Ig that could be produced from UK-collected plasma.

AppEco was commissioned by argenx to conduct the modelling, which OHE built on and refined for inclusion in this report.

Data sources

The analysis draws on the following sources to establish the historical demand series, set the growth assumptions and inform the treatment-switching scenario.

Table A.1 Data sources for Ig demand model

Historical Ig use and 2024 baseline	NHS National Immunoglobulin Database annual reports	2015—2024
Share of Ig use by indication	NHS Immunoglobulin Database Annual Report 2024/25((Foster, 2026)	2024/25
Average Ig use per patient		
Central case growth rate	Marketing Research Bureau (MRB) forecast	To 2030
Low case growth rate	World Bank population projections for the UK	To 2030
Switching rates (proxy)	Published estimates of poor response to Ig: Bril et al. (2012, 2025), Alhaidar et al. (2022), Leger et al. (2013)	2012—2025

Modelling approach

Reported NHS Ig use of 5,964 kg in 2024 provides the starting point for the projection. Demand was projected to 2030 using three alternative annual growth rates. Each rate was kept constant over the projection period.

The MRB forecast of 4.3% annual growth was considered the base case scenario. The low scenario uses projected UK population growth of 0.6% a year, assuming that Ig use per person remains unchanged. The high scenario uses the average annual NHS growth of 5.2% recorded between 2015 and 2019. This pre-pandemic period was used on the assumption that the rate of growth seen before the disruption caused by COVID-19 resumes.

Under the base scenario, demand increases from 5,964 kg in 2024 to 7,690 kg in 2030, a 29% increase over six years. The low and high scenarios show how this estimate changes when we use different assumptions about the pace of demand growth, while the base scenario provides the main projection used in the report.

Key assumptions

The growth assumption of the mid scenario captures the combined effect of factors that influence Ig use, including the number of patients receiving treatment, diagnosis rates, dosing and clinical practice.

The year 2024 was used as the baseline because it is the latest complete year of NHS data. Recorded use had recovered by 2024 from the reduction seen between 2019 and 2022. We treat Ig issued as a proxy for demand, although recorded use may be below underlying clinical need where supply or access constraints have affected treatment. The distribution of Ig use between indications at its2024/25 level was kept stable throughout the forecast. CIDP, PID and the other indications therefore all grow at the same rate as total Ig demand. This is an assumption because we do not have sufficient evidence to predict how the mix of indications will change. Changes in clinical guidance, treatment eligibility or clinical practice could alter the distribution.

Limitations

The growth in demand projection is based on recorded Ig use rather than underlying clinical need. Recorded use reflects what the NHS was able to supply and fund, so where constraints limited treatment during the historical period, the recorded volumes understate true demand, and the projection carries that understatement forward. The drivers of demand are not projected separately. The projection shows the potential scale of future demand without attributing growth to any driver.

New indications are excluded from the main projection. If licensing or clinical guidance widens eligibility for Ig, demand could exceed the projected levels. The low and high scenarios show the range of demand that could result from different growth assumptions, while the central case is used as the main projection in the report.

Appendix B. Historical immunoglobulin price

Prescient was commissioned by argenx to conduct the price analysis.

Data sources

Ig price data was extracted from GlobalData's drug-pricing database in June 2026 using the platform's built-in search functionality and the search term "Human immunoglobulins". The resulting dataset comprised 2,079 product-price records across six markets: France, Germany, Italy, Spain, the United Kingdom, and the United States. The records covered the period from January 2007 to June 2026. The dataset included two price categories: ex-factory and wholesale. Consequently, the same product presentation could have appeared more than once where both price types were available. Consumer price inflation data were obtained from the World Bank Data Portal.

Price analysis

Prices were standardised to a price per gram to account for differences in product strength, pack size and number of units. For each market, price category and administration route, we calculated the unweighted mean price per gram across all eligible product presentations at each December timepoint. Price trends were expressed as cumulative percentage changes from the 2007 baseline, with 2007 set to 0%. Annual inflation rates were compounded and expressed using the same baseline approach. This allowed cumulative Ig price growth to be compared with cumulative general price inflation over the analysis period.

Table B.1 Pricing data

	UK	US	FRANCE	GERMANY	ITALY	SPAIN
Currency	GBP	USD	EUR	EUR	EUR	EUR
Price type	Ex-factory	Wholesale (WAC)	Ex- factory	Ex- factory	Ex- factory	Ex- factory
Price source	GlobalData	GlobalData	GlobalData	GlobalData	GlobalData	GlobalData
CPI source	World Bank; ONS (2025)	World Bank; Statista, Trading Economics (2025)	World Bank; Eurostat (2025)	World Bank; Eurostat (2025)	World Bank; Eurostat (2025)	World Bank; Eurostat (2025)
2007	37.5	119.0	42.2	51.7	32.2	31.0
2008	37.0	112.9	42.3	61.3	35.1	32.4
2009	40.4	124.8	42.7	64.6	35.4	37.3
2010	42.1	125.6	43.0	65.6	38.8	37.4
2011	44.4	119.7	42.3	67.0	41.2	46.8
2012	48.1	120.6	42.6	67.0	41.2	50.1
2013	49.0	131.9	42.6	67.2	42.9	48.1
2014	46.8	131.5	42.7	67.0	45.4	46.3
2015	48.4	144.0	42.8	67.3	46.4	46.1
2016	48.2	156.7	42.9	68.8	48.3	47.4

	UK	US	FRANCE	GERMANY	ITALY	SPAIN
Currency	GBP	USD	EUR	EUR	EUR	EUR
Price type	Ex-factory	Wholesale (WAC)	Ex- factory	Ex- factory	Ex- factory	Ex- factory
Price source	GlobalData	GlobalData	GlobalData	GlobalData	GlobalData	GlobalData
CPI source	World Bank; ONS (2025)	World Bank; Statista, Trading Economics (2025)	World Bank; Eurostat (2025)	World Bank; Eurostat (2025)	World Bank; Eurostat (2025)	World Bank; Eurostat (2025)
2017	49.1	159.8	42.9	67.7	48.3	48.2
2018	52.6	169.7	41.7	68.8	48.3	48.6
2019	53.0	189.6	41.7	69.6	47.4	50.8
2020	55.7	195.4	41.5	70.5	47.4	50.6
2021	61.8	203.9	54.5	72.2	50.9	51.5
2022	66.0	215.0	54.5	73.9	50.9	59.2
2023	73.6	222.4	54.6	78.9	58.1	59.2
2024	72.4	241.3	61.7	82.5	62.8	72.5
2025	70.4	252.0	61.9	85.7	n/a	75.2
Nominal change 2007-2025, market average	88%	112%	46%	66%	95%	143%
Nominal change 2007-2025, same-product index (UK)	47%					
Nominal change 2020-2023, same-product index (UK)	35%					
Cumulative CPI 2007-2025	65%	55%	33%	44%	37%	43%
Price-inflation difference	23%	56%	13%	22%	58%	100%
Real price growth	14%	36%	10%	16%	42%	70%

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