PPTA

POSITION PAPER

Sustainable Access to Plasma-Derived Medicinal Products: A Resilience-Informed Approach to Cost-Containment

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EXECUTIVE SUMMARY

For patients who depend on plasma-derived medicinal products (PDMPs), sustainable access is not an abstract supply-chain objective. It determines whether infections are prevented, bleeding is controlled, neurological deterioration is avoided, treatment can continue at home or in hospital, and patients can maintain independence, live, function, work, study and participate in family and societal life with dignity.

PDMPs are essential therapies made from donated human plasma and are often life-sustaining for patients with primary and secondary immunodeficiencies, rare bleeding disorders, dysimmune inflammatory neuropathies, alpha-1 antitrypsin deficiency and other serious diseases. Their value is clinical, humanistic, socio-economic and strategic: they reduce avoidable morbidity, hospitalisations, disability and mortality, while supporting patient autonomy, labour-market participation, carer capacity, health-system resilience, thus generating around EUR 14 billion in total economic impact in Europe.[4,5,11,13,16,17]

PDMPs have unique economics. Their supply begins with a scarce human biological starting material, depends on donor recruitment and safety systems, requires highly specialised fractionation and purification, involves stringent quality and regulatory requirements, and operates within a donor-to-patient cycle that can take up to 12 months. Unlike conventional pharmaceuticals, PDMPs cannot be rapidly scaled, synthetically manufactured, genericised, biosimilarised or easily substituted when medically driven demand rises or when policy shocks disrupt market viability. This makes PDMPs a critical health infrastructure rather than ordinary commodities: disruption in supply can create systemic vulnerability for health systems that depend on reliable access to essential plasma-derived therapies.[5,17,18]

The European PDMP ecosystem is already under major cumulative pressure. Mechanistic external and internal reference pricing, price-only procurement, confidential rebates, market-specific packaging, regulatory duplication, inflation, currency fluctuations and supply-chain obligations already compress the economic conditions needed to maintain plasma collection, fractionation capacity, supplier diversity and resilience. Europe also faces scarcity of domestically collected plasma and remains structurally dependent on plasma collected outside the region. Systemic stockpiling requirements can further lock scarce product into national inventories, diverting vital supply from routine patient use and from countries or pathways where the medical unmet need is highest.[2,3,4,5]

Cost-containment measures add compounding layers of pressure. These include clawbacks and paybacks linked to budget caps or revenue growth, statutory discounts, special taxes, mandatory rebates, procurement discounts, prices exceeding local thresholds, and other automatic or retrospective deductions. Each instrument may appear administratively rational in isolation, but when aggregated with reference pricing, tenders, stockpiling, inflation and regulatory costs, they fail to recognise complexity and uniqueness of the plasma value chain and thus can erode the economic viability of a sustainable supply chain.[2,4]

For PDMPs, cost-containment is not neutral. Because PDMP use is medically driven and often inelastic, clawbacks and paybacks can punish necessary treatment growth. Because production is high-fixed-cost and difficult to scale, linear discounts can undermine the very resources needed for plasma procurement, fractionation, quality assurance, cold-chain logistics, batch release, donor and patient safety, supply redundancy and long-term investment. Because products and routes are not always clinically interchangeable, price-driven or single-supplier approaches can narrow treatment choice and disrupt continuity of care. For patients, these risks are experienced not as abstract market instability, but as uncertainty about whether the right treatment will be available at the right time, in the right formulation and setting of care.[4,5,17]

This paper argues that cost-containment measures, when applied mechanically and without assessing patient impact, medically driven demand, supply resilience and cumulative economic pressure, can undermine sustainable access and ultimately increase costs elsewhere in the health system. Nominal savings from cost-containment may translate into constrained allocation, shortages, treatment interruption, forced or medically unjustified switching, emergency procurement, avoidable hospitalisations, disability and productivity loss — ultimately increasing patient and carer burden and deepening access inequity. A low expenditure line is not a policy success if patients cannot obtain the therapy they need. For PDMPs, affordability must be understood through sustainability: the ability to fund treatment today without undermining supply, access and resilience tomorrow.[5,7,8,17]

Many European countries already recognise this logic and exempt PDMPs from cost-containment. Current PPTA research identifies 9 countries where PDMPs are exempt from selected cost-containment measures, including Belgium, Croatia, Denmark, Greece, Ireland, the Netherlands, Poland, Romania and Spain. This exemption logic mirrors emerging PDMP-specific tailoring in stockpiling and reference-pricing policy: it does not reject cost control; it recognises that one-size-fits-all rules can be disproportionate for critical, plasma-derived therapies whose supply, value and economics differ fundamentally from conventional medicines.[2]

PDMP cost-containment policy should therefore become proportionate, patient-centred and resilience-informed. PDMP policy must be understood as a matter of health security and preparedness. As Europe seeks to strengthen resilience across critical medicines and biologics, policies should be assessed not only for their budget impact but also for their effect on long-term security of supply. Therefore, a fit-for-purpose framework should assess the cumulative effect of all price-reducing and supply-locking mechanisms, protect availability and appropriate use, preserve patient and clinician choice, enable transparent exemption or adjustment pathways, and align national budget policy with European objectives on critical medicines, the implementation of the Regulation on substances of human origin (SoHO), strategic autonomy, competitiveness and supply resilience.[7,9,18,19]

WHY THIS MATTERS NOW

Cost-containment of PDMPs is an access and resilience issue, not only a budget-management issue. Medical need for PDMPs continues to grow because of improved diagnosis, broader recognised indications, better survival and growing appropriate use in severe immune-mediated and rare diseases. At the same time, Europe remains exposed to constrained plasma availability, long manufacturing lead times, geopolitical dependency, inflation, regulatory burden, mechanistic ERP/IRP pricing and fragmented stockpiling obligations.[5,7,9,17,18]

Adding broad clawbacks, statutory discounts, taxes or paybacks without assessing cumulative impact risks turning cost-containment into access failure. For PDMPs, the key policy question is not whether expenditure should be managed, but whether expenditure is managed in a way that preserves future supply.[2,4,17]

KEY POINTS FOR POLICYMAKERS

1. **PDMPs are not conventional pharmaceuticals:** they rely on donated human plasma, a finite biological starting material that cannot be manufactured synthetically or scaled rapidly in response to growing medical need and clinically driven utilisation or policy-driven supply shocks.[5,17,18]

2. **PDMP value is clinical, humanistic and socio-economic:** these therapies prevent infections, bleeding, disability, hospitalisations and premature mortality while preserving functioning, autonomy, carer capacity and labour-market participation.[4,5,16]

3. **PDMP economics are structurally different:** plasma collection, donor safety, testing, fractionation, purification, batch release, pharmacovigilance, cold-chain logistics and market-specific obligations create high fixed costs and limited surge capacity.[5,17]

4. **PDMPs are already subject to cumulative economic pressure:** mechanistic ERP/IRP, price-driven tenders, confidential rebates, procurement discounts, inflation, new regulations implementation costs, regulatory duplication and stockpiling requirements can each reduce viability; together they can threaten sustainable access.[2,3,4]

5. **Cost-containment can penalise medically necessary demand:** PDMP use is clinically driven and inelastic, so clawbacks based on expenditure growth or revenue growth may punish supply of essential therapy rather than inappropriate commercial expansion.[2,17]

6. **Linear discounts and taxes are disproportionate for high-fixed-cost products:** flat percentage cuts ignore plasma procurement, fractionation costs, quality systems, logistics, supply obligations and reinvestment needs.

7. **Cost-containment can become cost-generating:** shortages and constrained supply can trigger emergency procurement, treatment delays, hospitalisations, productivity loss, informal care burden and deeper inequity.[7,8,17]

8. **Exemptions are safeguards, not concessions:** countries that exempt or tailor PDMPs from cost-containment recognise the clinical, economic and ethical need to protect critical therapies with fragile supply chains.

9. **Affordability must be tested through the 4As:** availability, accessibility, affordability and appropriate use. A low unit price is not equitable if products become unavailable or if patients are forced into unsuitable alternatives.[4,16]

10. **PDMP policy must become cost-forward:** national cost-control measures should be aligned with EU objectives on critical medicines, SoHO implementation, medicine shortages, strategic autonomy, competitiveness and resilient supply.[7,9,18,19]

1 BACKGROUND - WHY PDMP SUPPLY AND ECONOMICS BEHAVE DIFFERENTLY

PDMPs start with human plasma donation. This makes their supply and economics structurally different from small molecules, conventional off-patent medicines and most biologics. The binding constraints are not only manufacturing capacity, but also the availability of suitable plasma, donor recruitment and retention, donor safety systems, collection infrastructure, testing, storage, transport and regulatory conditions governing plasma movement and product release.[5,17,18]

Manufacturing is complex, specialised and capital-intensive. Fractionation and purification require dedicated facilities, validated viral inactivation and removal steps, quality assurance, batch release, pharmacovigilance and compliance across multiple overlapping regulatory frameworks. These safeguards are indispensable, but they also create cost structures that cannot be compressed like ordinary manufacturing costs.[5,17] Where raw materials and manufacturing account for only 14 percent of the overall costs of traditional pharmaceuticals, they account for 57 percent of costs for PDMPs.[5] As a result, PDMPs are much more sensitive to resource constraints and are less able to absorb fluctuations in pricing.

The donor-to-patient cycle can take up to 12 months. This matters for cost-containment policy because sudden price cuts, retrospective paybacks, or cumulative tender discounts cannot be offset by rapid production adjustments. A market shock today can affect allocation, investment and availability over a much longer time horizon.[1,3,17]

The product model is also different. **A litre of plasma can generate multiple plasma-derived proteins,** and the economic viability of the entire fractionation portfolio depends on efficient use of that litre. Where national policy focuses narrowly on one product, imposes unsustainable discounts, or weakens the viability of other derived proteins, the economics of the plasma pool can be distorted. This “last-litre” challenge is rarely visible in conventional price-control methodologies.[4,5]

THE “LAST LITRE” CHALLENGE

The "last-litre" challenge is a unique feature of plasma-derived medicines. Each litre of donated plasma contains multiple proteins that are separated during fractionation to produce different therapies. The product with the highest medically driven demand - currently, immunoglobulins – ultimately determines how much plasma must be collected and processed. Once demand for this "last-litre" product is met, fractionation stops, even if demand for other plasma proteins has not been satisfied. This means that the need for one critical therapy can drive the economics of the entire plasma ecosystem, making PDMP supply planning fundamentally different from conventional pharmaceutical manufacturing.[5]

PDMPs are not fully interchangeable in clinical practice. Patients may require different formulations, concentrations and routes of administration, including IVIg (Intravenous Immunoglobulin) and SCIg (Subcutaneous Immunoglobulin). Individual tolerability, venous access, comorbidities, infusion burden, home-care suitability and patient preference may all matter. Policies that treat products as commodity-like substitutes may therefore undermine appropriate use, patient-centred care and continuity of treatment.[11,12,13]

THE CORE COST-CONTAINMENT PROBLEM

The problem is not that cost control is unimportant. The problem is that cost control is often pursued through instruments that do not ask whether the resulting net price still supports continuous, diversified and equitable PDMP supply.

Measures that lower short-term expenditure while increasing the risk of shortages, non-clinical switching, treatment interruption or emergency procurement do not protect affordability; they shift costs and risks to patients, carers and health systems.

A cost-forward framework must therefore protect affordability by preserving the conditions for tomorrow's availability, appropriate use and resilience.

2 PDMP VALUE - FUNDAMENTAL, INCREMENTAL, MACROECONOMIC AND HUMANISTIC

A balanced cost-containment framework must begin with value. PDMPs should not be reduced to short-term pharmaceutical expenditure or unit acquisition cost. Their value includes clinical outcomes, humanistic outcomes, avoided downstream costs, broader socio-economic contribution and the continuous innovation required to maintain a safe and resilient plasma-to-patient system.

Fundamental, patient-centred value lies in preventing infection, bleeding, disability, functional decline, hospitalisation and premature death. In primary immunodeficiency, immunoglobulin replacement can be life-sustaining and may represent the only effective long-term treatment. In secondary immunodeficiencies, rare bleeding disorders and dysimmune inflammatory neuropathies such as chronic inflammatory demyelinating polyneuropathy (CIDP) or multifocal motor neuropathy (MMN), timely and sustained PDMP therapy can preserve functioning, prevent irreversible deterioration and reduce the burden on carers and health services.[4,11,13,16]

Socio-economic, psycho-social and humanistic elements of value are inseparable from the therapeutic value. For many patients, PDMPs determine whether they can attend school, work, live independently, avoid repeated hospitalisation, participate in family and social life, and maintain dignity and autonomy. Additionally, route of administration, treatment setting, tolerability, infusion burden and continuity of therapy all influence real-world outcomes, patient experience and health-system economics. Recent studies from Spain and Italy show that home-based subcutaneous immunoglobulin can be cost-saving compared with hospital-based intravenous immunoglobulin, largely because it reduces administration-related resource use, hospital attendance, transport burden and productivity loss. This means that route and setting are not secondary attributes or mere patient preferences; they are value-relevant features of PDMP care that affect system capacity, continuity of access and patient-centred outcomes.[15,20,21]

Macroeconomic value is also material. Plasma-derived therapies can reduce avoidable healthcare resource utilisation, hospital admissions, intensive care episodes, rehabilitation needs, social-care dependency and informal caregiving burden. They preserve productivity, reduce absenteeism and presenteeism, and support the European health economy. Copenhagen Economics estimates that plasma-derived therapies in Europe generate approximately EUR 6.6 billion in direct economic impact and around EUR 14 billion in total economic impact when indirect and induced effects are included.[5]

Incremental value is continuous rather than patent-dependent. PDMP research, development and innovation occurs across donor screening and monitoring, plasma collection models, pathogen safety, fractionation yields, purification technologies, quality assurance, cold-chain and supply-security measures, formulation optimisation, routes of administration, home-based care models and patient support. Cost-containment that treats PDMPs as mature commodities risks undermining the reinvestment ecosystem that sustains this value.[5,17]

FUNDAMENTAL VALUE VS COST-MYOPIC POLICY

Fundamental value: survival, disease control, reduced infections, reduced bleeding, preserved function, avoided disability, avoided hospitalisations, social participation, labour-market participation and improved patient and carer quality of life.

Cost-myopic policy: expenditure reduction measured in isolation from availability, continuity of care, shortage risk, downstream costs, patient choice and the economic conditions required for continuous supply.

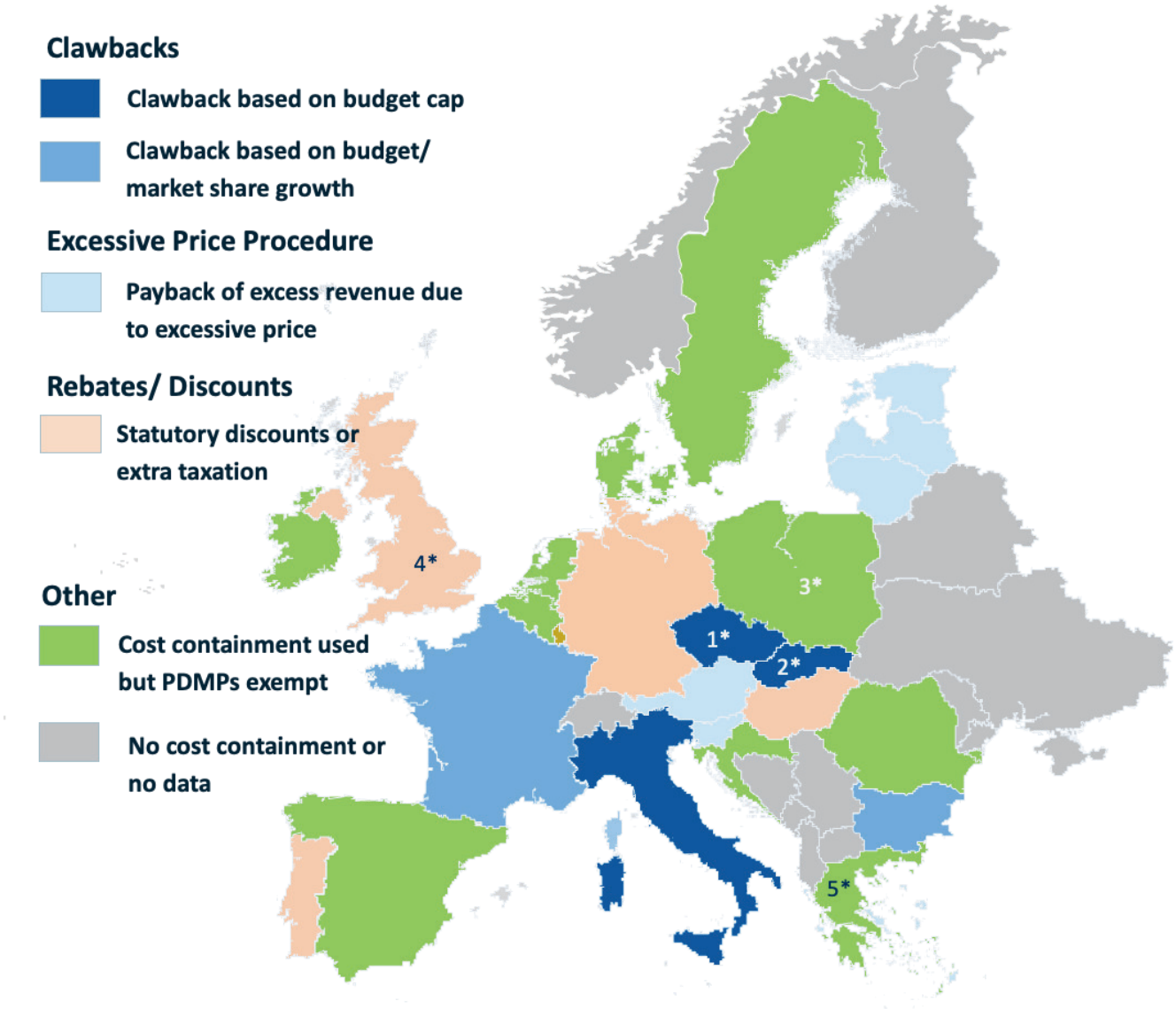
Cost-forward policy: affordability achieved through proportionality, sustainability safeguards, patient access monitoring and alignment with supply resilience.

3 THE COST-CONTAINMENT LANDSCAPE AFFECTING PDMPS

Cost-containment measures vary across Europe, but they share a common logic: they reduce, recover or cap expenditure after or alongside price-setting and procurement decisions. For conventional medicines, some of these mechanisms may function as broad expenditure-management tools. For PDMPs, however, they can become a third or fourth layer of economic pressure, added on top of ERP/IRP, tender discounts, confidential rebates, stockpiling obligations and rising supply-chain costs.

PPTA has consulted experts and key opinion leaders across all EU countries to identify and map countries using cost-containment and the key categories of cost-containment measures affecting PDMPs. These include clawbacks and paybacks linked to budget caps or revenue growth, statutory discounts, special taxes, mandatory rebates, procurement discounts, prices exceeding local thresholds, and other automatic or retrospective deductions. The key policy issue is not the existence of any single instrument, but their cumulative and often uncoordinated application to a class of medicines whose supply cannot be rapidly expanded and whose value is not captured by unit price.[2,4]

Cost-containment	Core logic	PDMP-specific concern
Budget-cap clawback	Manufacturers or suppliers repay expenditure above a defined public or payer budget ceiling.	Can penalise clinically necessary growth in PDMP use, especially where medically driven demand rises because of better diagnosis, broader appropriate use or improved survival.
Revenue / market-share growth clawback	Payback triggered by revenue growth, sales growth or market-share expansion.	May punish manufacturers for meeting unmet medical need rather than for excessive promotion, because PDMP utilisation is predominantly clinically driven and supply-constrained.
Statutory discount or extra taxation	Automatic percentage deduction or tax applied to reimbursed medicines or select product groups.	Flat cuts ignore plasma collection, fractionation, quality, cold-chain and market-specific costs; they disproportionately affect high-fixed-cost and resilience-dependent products.
Payback of excess revenue / excessive-price procedure	Retrospective recovery or intervention where price or revenue is deemed excessive based on national threshold or technical/fiscal determination.	If applied mechanically, can misread necessary PDMP price levels as excessive because it does not account for plasma economics, last-litre economics and shortage risk.
Mandatory rebate / procurement discount	Negotiated or imposed discount layered on top of reimbursement price or tender price.	Creates hidden cumulative erosion when added to ERP/IRP-driven price caps and price-driven tenders.
Other expenditure-control measures	Caps, paybacks, managed entry agreements, tender-linked penalties and other deductions.	May interact unpredictably with procurement, outpatient reimbursement, stockholding obligations and supply allocation decisions.



1 Czechia has budget cap in their legislative framework, but it is not applied (though not an explicit exemption)*

2 Slovakia has budget cap in their legislative framework, but it is not applied (though not an explicit exemption)*

3 Poland does not apply standard cost-containment but does require confidential risk-sharing agreements for PDMPs*

4 UK exempts one subclass of PDMPs (IgGs) from Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) by tender framework and annual inflation price adjustments*

5 Greece exempts PDMP subclasses (IgGs and Albumins), but remaining PDMPs are still subject to statutory clawback*

COST-CONTAINMENT IS NOT NEUTRAL WHEN APPLIED TO PDMPS

Clawbacks, statutory discounts, taxes and ERP caps can destabilise therapies whose supply chains are already fragile, costly and difficult to scale.

Because PDMP use is medically driven and often inelastic, cost-containment can penalise manufacturers for meeting expanding patient needs rather than for avoidable expenditure growth.

Because PDMPs require continuous reinvestment, cost-containment can remove the resources needed to maintain plasma collection, fractionation, quality systems, logistics and supply-chain resilience.

4 EXEMPTIONS AND TAILORED POLICIES - A SIGN OF MATURITY, NOT INCONSISTENCY

Many European countries have already recognised that broad pharmaceutical cost-containment tools should not always be applied mechanically to PDMPs. Current PPTA research identifies 9 countries where PDMPs are exempt from selected cost-containment measures, including Belgium, Croatia, Denmark, Greece, Ireland, the Netherlands, Poland, Romania and Spain. This is more than a technical exception; it is an important policy trend.[2]

The exemption rationale is clinical, economic and ethical. Clinically, uninterrupted access prevents deterioration, hospitalisation, disability and loss of quality of life. Economically, exemptions can prevent shortages, emergency procurement, supplier exit and downstream costs. In exceptional circumstances, such as material increases in plasma-collection, manufacturing, quality, or supply-chain costs, manufacturers are also allowed upward price adjustments. Ethically, such exemptions and allowances protect patients who depend on therapies that cannot be substituted or rapidly scaled.[2,4,5,17]

This logic mirrors other areas of PDMP policy. In stockpiling, countries such as Austria and Denmark exempt PDMPs from general obligations, while France, the Netherlands and the UK use more tailored approaches. In reference pricing, Spain has moved to exclude medicines derived from human plasma from reference-price group formation. These examples point in the same direction: PDMP-specific policy is not a concession to the industry, but a proportional response to distinctive value, supply constraints and economics, necessary to sustain access to these essential medicines.[1,3,4]

Exemptions should not be framed as abandoning cost control. They should be framed as applying cost control intelligently. The objective is not unrestricted pricing or limited accountability. The objective is to prevent mechanistic, undifferentiated, linear and retrospective measures from undermining availability, appropriate use and long-term supply sustainability.

Country	Cost-control exemption policy	Policy meaning for PDMPs
Belgium, Croatia, Denmark, Ireland, Poland	PDMPs or selected PDMP subclasses are exempt from selected cost-containment measures, including automatic deductions, clawbacks, rebates or similar expenditure-recovery tools.	Recognises that broad cost-containment may be disproportionate for therapies with finite plasma supply, long production timelines, high fixed costs and high and growing medical need/demand.
Greece	PDMP subclasses (IgGs and Albumins) exempted on annual or bi-annual basis from selected cost-containment measures.	Shows that exemptions can be designed as managed, reviewable safeguards for critical therapies rather than permanent measures.
Netherlands	PDMPs exempt from selected cost-containment measures together with tailored coordination in stockpiling to avoid cumulative overstocking.	A more integrated approach that protects critical supply while avoiding unnecessary inventory and downward cost pressures.
Romania	PDMPs exempt from selected cost-containment measures.	Shows that exemption logic is not confined to high-income markets; it can support equity and continuity where access is already fragile.
Spain	Recent reform excludes medicines derived from human plasma from reference-price group formation.	Illustrates proportionality logic in reference-pricing policy: PDMPs should not be forced into downward price convergence where supply, value and interchangeability differ materially.

EXEMPTIONS ARE PATIENT-ACCESS SAFEGUARDS, NOT CONCESSIONS TO THE INDUSTRY

PDMP exemptions should be understood as proportionate safeguards for critical therapies with finite biological supply, high fixed costs, long manufacturing timelines and limited substitutability.

The purpose of exemptions is to preserve continuity of care, treatment choice and supply resilience where broad cost-containment measures would otherwise increase the risk of disruption or shortages.

5 THE CUMULATIVE EROSION PROBLEM - COMPOUNDING THREAT TO PDMP SUSTAINABILITY

The central risk is cumulative pressure, not any single measure. Stockpiling, restrictive reference pricing, clawbacks, statutory discounts, price-only procurement, regulatory duplication and inflation may each appear manageable in isolation. Together they create a compounding threat to PDMP sustainability; eroding supply resilience, weakening market viability and multiplying health-security risks.

PDMPs are first exposed to reimbursement price-setting, often through mechanistic ERP or IRP methodologies that ignore plasma economics, net prices, market-specific obligations, regulatory burden and shortage risk. They may then face procurement discounts, price-only tenders, single-winner awards, confidential rebates, statutory discounts, taxes, paybacks or clawbacks. Stockpiling requirements may add further inventory cost while locking scarce product away from continuous clinical use. These pressures can undermine the economic predictability required for long-term fractionation contracts, capacity planning and investment in plasma collection, fractionation, quality systems and supply redundancy.[2,3,4,6,17]

This means the real economic constraint faced by the PDMP supplier is not the list price, and not even the reimbursement price. It is the cumulative net effect of reimbursement caps, procurement discounts, rebates, paybacks, clawbacks, stockholding requirements, market-specific costs, and regulatory obligations. Formal price decisions may therefore look broadly sustainable, while the actual supply economics may become materially unsustainable.

For PDMPs, this cumulative erosion can reduce the ability to maintain buffer inventories, preserve multiple supply options, support smaller markets, invest in yield improvement, expand plasma collection, modernise manufacturing, absorb inflation, or respond to shocks. The system may appear efficient on paper while becoming structurally brittle in practice. Over time, these pressures may also weaken Europe's competitiveness as a destination for PDMP supply, investment and innovation. In this sense, mechanistic cost-containment does not only create access risks for patients today; it may also shift future plasma-derived capacity, investment and strategic attention away from Europe, undermining the very resilience objectives that EU critical-medicines policy seeks to advance.[5,9,17]

REFERENCE PRICING + PRICE-DRIVEN PROCUREMENT + STOCKPILING + CLAWBACKS = CUMULATIVE EROSION

List price is not net price. Reimbursement price is not tender price. Tender price is not necessarily a sustainable price. Stockpiled product is not accessible product. Clawback-adjusted revenue is not investment capacity.

A sustainable PDMP framework must assess the combined effect of all mechanisms that reduce price, recover revenue, lock inventory or increase market-specific obligations.

6 PERVERSE CONSEQUENCES FOR PATIENTS, HEALTH SYSTEMS AND EUROPEAN RESILIENCE

6.1 Reduced availability and delayed access

The clearest risk of excessive cost-containment is reduced availability. Where cumulative net prices fall below sustainable levels, multiple risks compound, including limited allocation, reduced participation in tenders, product withdrawal and, in extreme cases, market exit. For PDMPs, this risk is amplified because additional volumes cannot be rapidly generated and products are not always interchangeable across patients, routes and formulations. Anti-D immunoglobulin, for which there is no substitute, provides a concrete warning case: it depends on plasma collected from a small and declining pool of immunised donors, yet no anti-D plasma collection program currently exists in the EU/EEA and production is concentrated in a limited number of countries. This shows how fragile specialised plasma-derived supply can become when collection and manufacturing are not supported by predictable, economically viable conditions. Once such programs disappear, they cannot be rapidly rebuilt, and patients become dependent on narrow and non-secure external supply chains.[7,8,18,22]

Patients may experience delayed treatment initiation, dose spacing, reduced treatment frequency, forced switching or treatment interruption. In severe primary immunodeficiency, prolonged IgG shortage may increase serious infection risk and mortality. In conditions such as chronic inflammatory demyelinating polyneuropathy (CIDP) or multifocal motor neuropathy (MMN), interruption may contribute to irreversible neurological deterioration, disability and loss of independence.[11,12,16,17]

6.2 Low expenditure can create false affordability

Affordability is not the same as a low unit price or a low expenditure line. A product may be nominally reimbursed and priced, yet practically unavailable because supply is constrained, tender design is fragile, eligibility criteria are restrictive, or the market has become unattractive.

If cost-containment leads to emergency procurement, hospitalisations, avoidable deterioration, productivity loss, carer burden or out-of-pocket expenditure, nominal savings become real-world unaffordability. For PDMPs, low price should therefore never be treated as a sufficient indicator of equitable access. [4,7,8,17]

6.3 Penalising medically necessary demand

Many cost-containment tools implicitly assume that expenditure growth reflects excessive prices, excessive promotion or inappropriate volume growth. This assumption does not hold well for PDMPs. Medically driven demand for immunoglobulins and other PDMPs is frequently driven by better diagnosis, increased survival, expanding recognised indications and legitimate unmet needs.

Clawbacks linked to budget caps, revenue growth or market-share growth may therefore penalise manufacturers precisely when they supply more therapy to patients who need it. This reverses the logic of value-based healthcare: the system punishes provision of high-value critical treatment rather than rewarding continuity, resilience and patient benefit.[2,4,17]

6.4 Narrowing patient and clinician choice

Cost-containment measures often interact with price-only procurement and formulary restriction. For IgG, for instance, this can reduce choice between IVIg and SCIg, limit formulation options, increase non-clinical switching and weaken shared decision-making between clinicians and patients.

For PDMPs, therapeutic choice is not a luxury. It is a component of appropriate use. Patients differ in tolerability, venous access, infusion burden, comorbidities, home-care suitability and treatment preferences. Policies that reduce all products to the lowest net price risk compromising adherence, medical and patient outcomes, quality of life and continuity of care.[2,4,11,12,15,16]

6.5 Weakening European resilience and competitiveness

PDMP resilience depends on a viable industrial ecosystem: plasma collection networks, donor infrastructure, testing and storage, transport, research and development, fractionation capacity, quality assurance, batch release, pharmacovigilance, cold-chain logistics and country-specific market access operations.

Where national cost-containment removes the economic conditions needed for investment, it undermines European objectives on critical medicines, strategic autonomy, biomanufacturing, medicines security and shortage prevention. Pricing, procurement and cost-containment reform are therefore not separate from the Critical Medicines Act agenda; they are enabling conditions for its success.[7,9,17,18,19]

PATIENT PERSPECTIVE: EQUITY IS NOT THE LOWEST PRICE

Equitable PDMP access requires continuous availability, sufficiently broad reimbursement, clinically appropriate product choice, route and formulation options, protection from non-clinical switching, and access pathways that allow the right patient to receive the right therapy at the right time.

From the patient perspective, a policy that lowers the price but increases treatment disruption, uncertainty or forced switching is not equitable cost-containment. It is cost shifting from the payer budget to patients, carers and society.

7 ROOT CAUSES - WHAT COST-CONTAINMENT DOES NOT FIX

- **Plasma collection capacity:** Sustainable supply depends on adequate plasma collection, donor recruitment, donor safety, donor retention and fit-for-purpose donor policies. Clawbacks and discounts do not increase plasma availability; if excessive, they reduce the ability to invest in collection.

- **Manufacturing and fractionation capacity:** Expanding capacity requires long lead times, capital investment, technical expertise, validated quality systems and regulatory approvals. Retrospective revenue recovery does not build capacity; it can weaken the case for investment.

- **Plasma utilisation and last-litre economics:** PDMP sustainability depends on efficient use of each litre of plasma across the full product portfolio. Cost-containment applied product by product rarely considers cost absorption across the fractionation chain.

- **Continuous innovation:** Safety, yield, formulation, route-of-administration, home-care, real-world evidence (RWE), and supply-chain innovation require reinvestment. Treating PDMPs as mature commodities undermines this incremental value.

- **Market-specific obligations:** Packaging, labelling, pharmacovigilance, distribution, cold-chain, regulatory fees and stockholding vary by country. Mechanical cost-containment ignores these costs even though they directly influence market viability.

- **Supply-chain resilience:** Resilience requires supplier diversity, redundancy, qualified logistics, inventory rotation, shortage monitoring and fallback options. These capabilities cannot be built on continuously declining and retrospectively reduced revenues.

- **Equitable access:** Cost-containment does not guarantee that the right patient receives the right therapy at the right time. In PDMPs, access depends on availability, reimbursement breadth, clinical protocols, route choice, supply continuity and appropriate use.

- **European coordination:** EU-level objectives on critical medicines, SoHO, shortages, strategic autonomy and competitiveness can be undermined if national measures remove the economic conditions required for resilient supply.

8 TOWARDS A COST-FORWARD PDMP FRAMEWORK

A tailored PDMP cost-forward framework must be structured, transparent, proportionate and value-informed; balancing affordability with availability, and accessibility with appropriate use and resilience. Cost-containment should be one policy input, not an automatic override of clinical value, supply-chain economics, health security and patient access.

The framework should assess the cumulative effect of all relevant measures before applying additional deductions. This means asking not only whether the clawback, discount or tax reduces expenditure, but whether the combined system still supports sustainable supply, multiple treatment options, patient choice, market participation, plasma collection, fractionation investment, manufacturing capacity, shortage prevention and resilience to external shocks. Patient organisations should help define the access, continuity-of-care and treatment-burden indicators used to assess whether cost-containment measures remain proportionate in practice.[2,4,5,17]

Dimension	What should be assessed	Why it matters for PDMPs
Therapeutic and humanistic value	Survival, function, infection prevention, bleeding prevention, disability prevention, health-related quality of life (HRQoL), carer burden, and patient preference.	Prevents cost-containment from reducing PDMPs to commodity-like unit costs.
Socio-economic value	Avoided hospitalisation and disability; productivity and broader economic contribution.	Captures value beyond the pharmaceutical budget line.
PDMP cost structure	Plasma collection, testing, storage, transport, fractionation, quality systems, cold chain, and market-specific packaging.	Aligns cost-control decisions with the real economics of continuous supply.
Cumulative economic pressure	ERP/IRP, tender discounts, rebates, statutory discounts, taxes, clawbacks, stockpiling, inflation, and regulatory costs.	Prevents each measure from appearing harmless in isolation while combined effect becomes unsustainable.
Supply-risk assessment	Shortage indicators, supplier diversity, allocation risk, fallback supply options, and reinvestment capacity.	Ensures cost-containment does not increase the probability of shortages or emergency procurement.
Clinical choice and appropriate use	Route, formulation, tolerability, home-care feasibility, non-clinical switching, and shared decision-making.	Protects patient-centred care and avoids price-only treatment substitution.
Exemption / adjustment pathway	Transparent criteria for exempting, suspending or recalibrating cost-containment where sustainability is at risk.	Makes proportionality operational rather than rhetorical.
4A access monitoring	Availability, accessibility, affordability and appropriate use.	Makes real patient access the final test of policy success.

PATIENT-GENERATED EVIDENCE AS CORE INPUT INTO PDMP POLICY FRAMEWORK

Patient-reported evidence should be treated as a core input into PDMP policy, not as supplementary advocacy. Patients and patient organisations can document the real-world consequences of supply disruption: treatment delays, dose reductions, non-clinical switching, uncertainty about future access, additional hospital visits, deterioration in quality of life, and increased carer burden. The International Patient Organisation for Primary Immunodeficiencies (IPOPI) have emphasised that access to immunoglobulin therapy should be based on doctor-patient shared decision-making and not dictated by financial considerations. Both IPOPI and European Patients Organisation for Dysimmune and Inflammatory Neuropathies in Europe (EPODIN) have also expressed concerns that under compounding cost pressures and the resulting shortages patients may be restricted from accessing the most suitable therapy or compelled to switch for non-clinical reasons.[16,23,24]

RECOMMENDATIONS AND POLICY PROPOSALS

The central issue is not whether PDMPs should be affordable. They must be. The issue is whether affordability is pursued through mechanisms that preserve availability, clinical choice, supply resilience, and long-term investment in the plasma ecosystem. For PDMPs, a price that is too low to sustain supply is not an affordability success; it is an access failure deferred. A cost-containment measure that lowers expenditure but weakens availability, narrows patient choice or increases shortage risk fails the affordability test in real-world terms.

1) ONE SIZE DOES NOT FIT ALL

PDMPs should not be treated as ordinary off-patent commodities, generic small molecules or interchangeable biologics.

Cost-containment frameworks should explicitly recognise finite plasma supply, long manufacturing timelines, complex fractionation economics, regulatory burden, last-litre economics and limited surge capacity.

2) MAKE COST-CONTAINMENT PROPORTIONATE TO PDMP VALUE AND ECONOMICS

Before applying clawbacks, statutory discounts, taxes or paybacks, authorities should assess PDMP fundamental value, incremental value, macroeconomic value, supply-chain costs and shortage risk. Cost-control measures must not erase the economic conditions required to deliver that value.

3) ASSESS CUMULATIVE PRESSURE, NOT EACH MEASURE IN ISOLATION

Authorities should evaluate the combined effect of ERP/IRP, procurement discounts, rebates, statutory deductions, clawbacks, taxes, stockpiling obligations, inflation and regulatory costs.
PDMP sustainability cannot be judged by the list price alone.

4) USE PDMP-SPECIFIC SAFEGUARDS WHERE SUSTAINABILITY IS AT RISK

PDMP-specific exemptions and policy tailoring should be available where broad measures would threaten supply, patient access or reinvestment capacity. These safeguards should not only protect PDMPs against value erosion but also, when there are material increases in collection and manufacturing costs, allow proportionate upward price adjustments.

Exemptions, tailoring and adjustments should be understood as safeguards for critical therapies, not as concessions to the industry.

5) AVOID PENALISING MEDICALLY NECESSARY DEMAND

Clawbacks based on budget overruns, revenue growth or market-share growth should distinguish between inappropriate expenditure growth and legitimate treatment need.

Growth in medically driven PDMP use often reflects better diagnosis, improved survival and appropriate use in current and emerging indications across a wide range of rare and debilitating diseases.

6) ALIGN COST-CONTAINMENT WITH PRICING AND PROCUREMENT POLICY

Reimbursement bodies, procurement authorities and payback systems should not operate in silos. Tender discounts, rebates and clawbacks should not undermine the economic assumptions of reimbursement decisions or reverse value- and resilience-informed policy objectives.

7) PROTECT PATIENT AND CLINICIAN CHOICE

Cost-containment should not force non-clinical switching, eliminate route or formulation options, or concentrate access in a single product or supplier where clinical needs differ.

Appropriate use based on guidelines, clinician choice and patient need, as well as shared decision-making, should remain crucial for advancing patient-centred care.

8) USE EXEMPTION AND EARLY-WARNING MECHANISMS

Authorities should create transparent pathways to suspend, reduce or recalibrate cost-containment measures when shortage indicators, supplier withdrawal, constrained allocation or emergency procurement risks emerge.

9) MAKE THE 4As THE TEST OF COST-CONTAINMENT

Cost-containment should be assessed against availability, accessibility, affordability and appropriate use.

A policy that lowers expenditure but undermines any of these dimensions should be redesigned.

10) ALIGN NATIONAL COST-FORWARD FRAMEWORK WITH EU RESILIENCE OBJECTIVES

National cost-forward frameworks should support, not undermine, EU policy objectives on critical medicines, SoHO implementation, shortage prevention, strategic autonomy, resilient supply, health and medicines security, as well as biomanufacturing, competitiveness and equitable access across Member States.

11) ENABLE CONTINUOUS DIALOGUE WITH PATIENTS, CLINICIANS AND INDUSTRY

Structured dialogue is essential to maintain proportionality, detect sustainability risks early and understand the real-world consequences of shortages, forced switching, access delays and treatment interruptions.

Patient organisations should be recognised as policy, evidence and accountability partners in PDMP decision-making. Their role should extend beyond consultation towards structured participation in policy design.

THE SUSTAINABLE PATIENT ACCESS TEST

A proportionate cost-containment policy should ask three questions:

- Will patients retain continuous access to the therapy they need?
- Will clinicians retain the ability to choose the appropriate product, route and setting of care?
- Will the system preserve the supply resilience needed to avoid shortages, forced switching and emergency procurement?

If the answer to any of these questions is NO, the measure should be redesigned, exempted or recalibrated.

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