Is the role of the health economist an academic and scientific one, or is their job essentially to support product sales as an extension of the commercial and marketing departments?
A central issue concerns the audience for health economic communications. The conventional audience has been the Health Technology Assessment Agency (HTAA) or its equivalent—for example, the UK’s NICE or Australia’s Pharmaceutical Benefits Advisory Committee (PBAC). Typically, these bodies are mandated to assess the cost effectiveness of new medical technologies. Since they employ people with professional qualifications in health economics, complex models and weighty dossiers have been an excellent way of communicating with them. However, recently there has been a growing realization within pharmaceutical companies that HTAAs and similar top-level decision-makers are only one of many audiences for health economic messages. In most healthcare systems there are many other stakeholders who make decisions as to whether a particular product should be used, based on its perceived value. They include pharmacists, insurance plan managers, members of formulary committees, clinicians, clinical directors, hospital managers, public health officials and employers, to name but a few. Even in a monolithic system such as the UK’s National Health Service, a positive decision from NICE (or its Scottish equivalent, the Scottish Medicines Consortium) does not mean a product will actually be used in eligible patients at a local level. In an effort to stamp out ‘postcode prescribing’, NICE has announced that its decisions carry statutory weight and must be implemented within six months. However, local decision-makers have budgets to balance and targets to meet, regardless of whether a new technology has been judged by others to be cost-effective or not. Hence, value-based decisions are continually being made throughout the healthcare system—for example, whether the use of an expensive drug should be restricted, or whether disposable equipment should be used in a hospital’s operating theatres.

It is this reality that underlies the gradual commercialization of the health economist’s role within the healthcare industry. Sales and marketing departments were quick to realize that they had to reach people making value-related decisions about their products. After all, there is little point in spending millions of dollars on persuading doctors to write prescriptions for a product if, elsewhere in the system, someone has decided that those prescriptions will not be honored because the product is deemed to be too expensive. Over the past few years, most major pharmaceutical companies have set up specialized sales forces tasked with reaching these decision-makers and influencers, wherever they might live within the healthcare system. Health economists are generally required to support these sales forces through the development of messages and sales materials. In many cases, budgets have migrated as well. Where once, health economics departments had substantial budgets of their own, funds are often now controlled by commercial or marketing departments. While some health economists have relished the challenge of a commercial environment, others have felt uneasy about an apparent erosion of their academic independence and scientific status.

One of the biggest challenges has been the development of materials to communicate health economic messages to a disparate audience of non-health economists. While it is technically possible to add a user-friendly ‘front end’ to a complex model originally intended for HTAAs, this approach is unsatisfactory for several reasons. First, the model may still be too difficult for the audience to understand because of the health economic concepts it relies on, such as probabilistic sensitivity analysis or the discounting of costs and benefits. Second, the front end will have the effect of hiding inputs and calculations, creating ‘black box’ results that are difficult to accept. Third, the perspective may not be relevant—for example, a model encompassing the healthcare system as a whole may be of little interest to someone whose
job is to balance a budget locally. And finally, the results of the model may be expressed in terms that are alien and unhelpful—for example, very few decision-makers below HTAA/health ministry level are likely to be interested in the incremental cost per QALY gained.

The key to successful communication is to address the audience in terms of its own agenda and preoccupations. The basic components in the value argument will be the same as for HTAAs—for example, establishing unmet medical need, presenting clinical data showing the benefits of the product and estimating the economic implications of its use. However, the language and landscape will be strikingly different. The value story may be framed in terms of targets or guidelines known to be important to the audience. Presenting clinical arguments with clarity and impact will be of paramount importance, so that the decision-maker has a clear idea of the bang he will get for his buck. The economic case will be made in straightforward, meaningful manner. Usually this will be in terms of budget impact, though cost-effectiveness arguments are possible if the measurement of benefits is practical and relevant—for example, the cost per event avoided rather than the cost per QALY.

So what does all this mean for health economists working in the pharmaceutical and medical devices industries? The good news is that the importance of health economics to these industries seems certain to grow. In an era of modest product pipelines and escalating regulatory demands, there will be growing pressure to obtain premium prices for new products. At the same time, the pressure on healthcare systems to control costs will surely increase as well. The ageing of the population in most major industrial countries will simultaneously reduce government tax revenues and increase the demand for healthcare. Not only will a greater quantity of healthcare be required—there will also be an added demand for better treatments for the diseases of old age, such as macular degeneration, osteoarthritis and cancer. It will fall to health economists to justify the cost of these new treatments, ensuring the continuing prosperity and success of the companies that employ them.

The creeping commercialization of the health economist’s role is probably irreversible. Like it or not, commercial and marketing departments will continue to call the tune. Value arguments will need to be increasingly sophisticated and effective, and are likely to be tested with customer panels and focus groups to ensure optimal return on investment. Product value may need to be communicated not only to HTAAs and other decision-makers within the healthcare system, but also to external influencers such as patient pressure groups, politicians, employers and the media. The cost, quality and availability of healthcare is already a hot topic for public debate in most Western countries. The ageing of their populations will intensify the debate, as has already been demonstrated with recent Medicare reforms in the United States. Healthcare companies may have to justify their prices not just to professional decision-makers within the healthcare system, but to society as a whole.

When the marketing manager quoted at the beginning of this paper said that “health economics is much too important to be left to health economists”, he was no doubt referring to the traditional quasi-academic role of the health economist within the pharmaceutical industry. The tone of his remarks may have been unnecessarily provocative; however, from the perspective of his employer, there is more than a grain of truth in what he said.

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