

Guest Editorial

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Medical writing and health economics/market access: A health economist's view

Having had the pleasure of attending the one-day symposium on health economics and market access at this year's Spring EMWA conference, and of teaching a workshop on health economics at the conference, two points struck me.

First, perhaps unsurprisingly, I could not accept the caricature of health economists that was portrayed by the opening speaker, only partially in jest I fear, in her otherwise excellent introduction to health economics. Her view of health economists was not dissimilar to the view of scientists portrayed in bad 1960s B movies: nerdy men with poor social skills locked away in darkened rooms to focus solely on technical matters. Well, I protest, though I admit that this view may have some foundation, perhaps particularly in academia. The health economists who work in and for the pharmaceutical and devices industries are, however, very much in touch with the real world. Health economics is a rewarding field to work in, demanding a combination of scientific rigour and commercial acumen.

The world that health economists live in is usually predicated on the assumption that there is a fixed pot of money available for healthcare expenditure, which needs to be used as efficiently as possible in order to maximise the overall health of the nation or of insurance plan members. In this world, the 'opportunity cost' (the cost incurred by making one choice over another) is not money but health. If you choose to pay for something expensive that offers questionable clinical benefit, less money is available for others to be treated, and sooner or later people will suffer or even die as a consequence. We cannot escape the fact that expenditure on healthcare in all developed countries is increasing exponentially, and tough choices about what to pay for can no longer be avoided.

For pharmaceutical and medical device companies, demonstrating that a product represents good value for money has become a fundamental aspect of successfully bringing it to market. Further,

health technology assessment (HTA) has emerged as a coherent framework used by reimbursement agencies all over the world to assess value-for-money. Such assessments constitute the so-called 'fourth hurdle' over which companies must now leap in order to gain access to a given market (the first three hurdles being the conventional ones required for regulatory approval). HTA attempts, explicitly and coherently, to trade off the costs and benefits of a given health technology (i.e. a drug, device, diagnostic test, or public health initiative) in a particular disease area to answer the simple questions 'Is it better than what we already have?' and 'Does it represent good use of money compared with what we already have?'

Global acceptance of HTA as the gold standard reimbursement framework has also led to the emergence of market access as a distinct standalone discipline. A good market access professional understands the need to present complex concepts simply and concisely, within an overall communication strategy, to present a convincing case for the clinical and economic value of the product. The skills needed are similar to those needed by a good medical writer. Even nerdy health economists, such as myself, have rapidly come to understand the value of good communication.

This is why I see health economics and market access as an area where medical writers can add real value. The majority of health economics, like medical writing, takes place in the commercial setting and not in academia. We (the economists) need help in getting our work into top tier clinical journals rather than backwater technical journals. Our clients need a high quality, well written, single information resource covering the epidemiological, clinical, and economic literature as well as the global corporate strategy for a product in a given indication (the 'global value dossier').

Further, too often, companies have their products rejected by agencies such as the National Institute for Health and Care Excellence (NICE), not because the product is poor but because the materials they submit to the agencies are substandard. At the Manchester symposium, a current member of a

NICE committee gave examples whereby at the end of reading the economics section of a submission he did not know what sort of model had been built, and by the end of the clinical section he was unclear about what the target indication for the drug was. I have also seen submissions that say one thing in the clinical section and a contradictory thing in another (i.e. show poor editorial control).

This brings me to my second, more positive, observation, namely that the medical writing community, as represented at the EMWA meeting, seems to be well aware that their input in the

health economics field is much needed. Both the symposium and my workshop were very well attended and there was a high level of engagement in both. My hope is that the coming together of the disciplines of health economics and medical writing continues, and that we can together ensure that the technologies that are likely to be of greatest benefit to patients are adopted and/or reimbursed. We should together also try to ensure that both the public and the medical community understand the need to use only those technologies whose costs can be justified by their clinical benefits.