

Can HEOR really become generic?

In my previous article, I asked what HEOR professionals should become exceptionally good at if AI can increasingly take over parts of the analytical work. Since then, I have been thinking about a related question: can HEOR really become generic in the first place?

There is no doubt that AI will make parts of evidence generation faster, more scalable and potentially more standardized. ISPOR's 2026–2027 Top 10 HEOR Trends report puts Artificial Intelligence at the top of the list and highlights its growing ability to accelerate literature reviews, structure complex datasets and speed up analysis, while emphasizing that human oversight remains essential. <https://www.ispor.org/heor-resources/top-10-heor-trends>. And as I described in my previous article, we may increasingly start from a generic foundation and then add the product-, market- and decision-specific elements on top. But what if the challenge is not always to adapt the evidence to the market? What if the market itself is changing?

Having worked across Pharma & MedTech in global HEOR, Market Access and market development, I have experienced this from quite different angles. In some launch projects, the challenge was not simply to enter an established market with a well-defined disease category and patient population. Sometimes, there was no established category to enter. I have worked with situations where the disease area and the relevant patient population had to be reconsidered because the way the disease was understood was changing. Obesity is a good example. What was historically often viewed primarily as a lifestyle issue has increasingly been recognized as a chronic disease area requiring medical management. In that situation, the challenge is not simply to generate evidence for a new treatment. It is also to rethink the patient population, the unmet need and, ultimately, the context in which the value of that treatment is being assessed.

And these challenges are not limited to launch. I have also experienced them in market expansion projects where access had already been achieved, but where the market had moved on. New treatment options, new evidence or changes in clinical practice can create opportunities that did not exist when the original access strategy was developed. That can mean going back to the patient population. Does it still make sense as originally defined? Should it be more precisely specified? Are there patients who were previously not considered relevant? Could the population potentially be broader than originally anticipated? In these situations, the challenge is not simply to maintain the access that has already been achieved, but to understand what has changed and what that means for the opportunity ahead.

This is where I see an important part of the human aspect of HEOR and Market Access. Not simply in interpreting the evidence, but in keeping an eye on the market and recognizing when something is changing. Some developments will eventually appear in guidelines, datasets or HTA decisions. But the signals often emerge earlier: through conversations with local teams, healthcare professionals, patient organisations and other important key stakeholders, through changes in clinical practice, or through a growing recognition that the current definition of a disease or patient population no longer fully reflects reality. This is not something I see as being easily replaced by AI. AI can help us identify patterns and process enormous amounts of information, but someone still needs to understand which changes actually matter, connect the dots and ask whether the question we are trying to answer is still the right one. Interestingly, this is also reflected in emerging HEOR research: an ISPOR 2026 review of AI applications presented at ISPOR Europe 2025 found that the largest efficiency gains were

concentrated in high-volume, repetitive tasks, while hybrid AI-human workflows consistently outperformed fully automated approaches. <https://www.ispor.org/publications/journals/value-outcomes-spotlight/vos-archives/issue/view/artificial-intelligence-in-healthcare/reflections-on-the-past--present--and-future-of-ai-in-heor-and-healthcare-decision-making>

Because the challenge is not always to optimise the existing evidence package. Sometimes, it is to recognize that the market has changed enough that the evidence package - and perhaps even the patient population it is built around - needs to change with it. This is also why I think the discussion about making HEOR more generic needs some nuance. There are certainly parts of evidence generation that can and should become more standardized. But the context in which that evidence is used is not static. Healthcare systems change. Treatment landscapes change. Disease definitions change. Patient populations change. And access opportunities can change even after access has already been achieved. As ISPOR CEO Rob Abbott recently reflected, AI can accelerate evidence synthesis and support economic modelling, but human oversight remains important for interpreting HTA requirements, challenging causal assumptions and ensuring transparency and validity. <https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2026/poster-session-5-3/the-current-landscape-of-artificial-intelligence-ai-methodology-in-health-economics-and-outcomes-research-heor--a-review-of-ispor-europe-2025-abstracts>

For me, that is where the future role of HEOR and Market Access becomes particularly interesting. AI may increasingly help us produce the evidence. But we still need to understand when the market has changed, what that means for patients, and whether we are still asking the right question. Because perhaps the future of HEOR is not about choosing between generic and bespoke. It is about knowing **when generic is no longer good enough.**

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#PatientAccess #HealthTechnologyAssessment #RealWorldEvidence