

Evidence doesn't create access on its own

In my previous article <https://www.linkedin.com/pulse/can-heor-really-become-generic-jasmin-cecilie-tiedemann-kivie/>, I wrote about what happens when the market moves faster than the evidence package built around it. Disease definitions change, patient populations evolve and treatment landscapes develop. Sometimes, the question we originally set out to answer is simply no longer the question that matters most.

But what happens when we have managed to ask the right question and generate the right evidence?

Because even then, evidence does not create access on its own.

NICE is often used as a benchmark when developing evidence for HTA submissions, and looking at how NICE itself describes the evaluation process, I think this becomes quite clear. NICE does not assess evidence in isolation. The current manual states that the importance given to different types of evidence depends on the evaluation context, including the technology, population and decision problem. It also considers clinical and patient experience, uncertainty, the position in the care pathway, and whether the economic model actually reflects the decision problem at hand. Implementation issues such as workforce, training and changes in clinical practice are also part of the process <https://www.nice.org.uk/process/pmg36>.

For me, this is an important distinction. A strong evidence package can demonstrate clinical benefit and value for money, but access still depends on what happens around that evidence. Does it address the question that matters to the decision-maker? Does the value proposition make sense within the healthcare system? Can the change actually be implemented in clinical practice? And what would need to happen for the evidence to influence behaviour?

This is something I have experienced across global HEOR, Market Access and market development in both Pharma and MedTech. The work does not stop when the model is finished or the submission is ready. Often, that is where a different type of work begins: understanding how the evidence fits into the healthcare system, how different stakeholders perceive value, and what needs to happen for a decision to translate into real-world change.

I found this particularly interesting in EASYHTA's reflection on my previous article https://www.linkedin.com/posts/analysts-should-not-have-to-be-programmers-ugcPost-7508214545304182786-4EnP/?utm_source=share&utm_medium=member_desktop&rcm=ACoAAAo8RPMBN dne0DMzUMj7_NN LGGg3JuGT_Oc. They connected the discussion around increasingly generic analyses with the importance of knowing what to model, why to model it, and whether we can trust the answer. I think that same principle applies one step further: we need to understand not only whether the evidence is right, but what it needs to achieve.

And perhaps this brings me back to the question I asked in my very first article: **If AI can do the analysis, what should HEOR professionals become exceptionally good at?**

Maybe the answer is becoming clearer.

Not simply analysing evidence, but understanding the context around it. Not simply generating the answer, but recognising which question is worth answering. And not simply demonstrating value, but connecting evidence to decisions, healthcare systems and ultimately patient access.

ISPOR's 2026–2027 Top 10 HEOR Trends places AI at #1, RWE at #2 and Value-Based Healthcare at #3, while also identifying the relevance of HEOR itself as a growing priority. ISPOR describes AI as accelerating how evidence is generated and analysed, while emphasising that human oversight remains essential <https://www.ispor.org/heor-resources/top-10-heor-trends>.

So perhaps the future HEOR professional is not the person who can produce the most evidence.

It is the person who understands **what the evidence is for, whose decision it needs to inform, and what needs to happen next.**

Because evidence can support access. **But it does not create access on its own.**