

## **Adrian Towse Remarks for the blog version**

### **Introduction**

Welcome to OHE's launch as a Charity. I am Professor Adrian Towse the Director of OHE. I am joined by my colleagues Professor Paula Lorgelly Deputy Director, Professor Nancy Devlin Research Director and Professor Mike Drummond, the Chair of the OHE Board of Trustees.

In the next five minutes I am going to take you through the first 55 years of OHE's history before handing over to Nancy Devlin who will give you a flavour of our research themes for 2017 and beyond.

By the way, you can access *all* of OHE's work over the last 55 years via our website. <https://www.ohe.org/publications>  
It is well worth a look.

### **Let's go back to 1962 when OHE was established**

1. The industry and the NHS had faced the tragedy of Thalidomide, which led to the 1968 Medicines Act introducing more effective drug safety regulation;
2. There was a VPRS rather than a PPRS pricing agreement in place between industry and government, (the V stood for "voluntary" not "value") yet the government was

threatening four companies with compulsory licensing of broad spectrum antibiotic drugs to force down prices.

3. We knew very little about how to achieve the right balance between prices and investment – indeed little about how much it cost to develop a drug or the size and importance of public sector investment in science.
4. Measuring patient quality of life or health status to understand benefit for drug regulation or drug pricing was not even considered.
5. The NHS was about to embark on a massive hospital building programme and primary care was to be revitalised with a new GP contract in the 1960s.
6. Yet we knew very little about:
  - a. how much anything cost that the NHS did? or
  - b. how to measure the output (in terms of outcomes for patients) it achieved? or
  - c. how to incentivise better performance by doctors or hospitals?
7. And we knew little about the costs of diseases and whether medicines represented good value in tackling them.

Into this mix OHE began its work. OHE was the first, I repeat the first, health economics group to be formed anywhere in the world. 1962 was a year before Kenneth Arrow published his seminal American Economics Review paper *Uncertainty and the Welfare Economics of Medical Care*, which is usually taken to represent the intellectual birth of health economics.

I now highlight one or two pieces of work per decade:

**In the 1960s** : OHE sought to shine a light on hospital costings (for example <https://www.ohe.org/publications/hospital-costs-perspective> ) and on the economic burden of disease (for example <https://www.ohe.org/publications/progress-against-tuberculosis> )

In the **early 1970s** OHE held a symposium at the Imperial College on The Pharmaceutical Industry and Society (<https://www.ohe.org/publications/pharmaceutical-industry-and-society-study-changing-environment-and-economics> ).

The issues seem to be very similar to today:

- the industry facing a challenge about trust;
- a concern about rising costs of R&D linked to regulatory requirements, caution in uptake, and
- a lack of understanding about the nature and extent of price competition between medicines;
- the challenge for the UK government as to whether pushing for lower prices will risk the biomedical investment base in the UK.

**In the early 1980s** OHE held a symposium on “**Measuring the Social Benefits of Medicines**”

(<https://www.ohe.org/publications/measuring-social-benefits-medicine> )in which DH economist Jeremy Hurst speculated on the ability to generate “health status yield per £ for selected treatment provided by the NHS” and George Teeling-Smith, OHE’s first Director, speculated that

“The Quality Adjusted Life Year (QALY) devised by Weinstein and Stason seems to be a useful example of a longitudinal unit of account.” and also that

“Despite the scepticism expressed by some.. it seems highly probable that, within a decade or so, major therapeutic innovations will often be routinely subjected to an economic assessment of their social value, in the same way as their clinical value is usually systematically assessed at present.”

In **1985** OHE held a symposium on Health, Education and General Practice (<https://www.ohe.org/publications/health-education-and-general-practice> ) in which **Alan Maynard led a discussion on introducing GP fundholding, GP commissioning, and prescribing budgets.** All of which came to pass within a little over 5 years of that meeting.

**In the 1990s**, i.e. *20 years ago*, OHE was working on genomics and the implications for medicines (which we now call stratified medicine) with a publication at the beginning of the decade by David Weatherall, then Regius Professor of Medicine at Oxford, and at the end of the decade a symposium on Genomics, Healthcare and Public Policy (<https://www.ohe.org/publications/genomics-healthcare-and-public-policy> )at which Patricia Danzon presented a paper on the health economics of targeting treatment.

We also began the OHE Annual Lecture series **in the 1990s** with the inaugural lecture being given by Sir Douglas Black on Health Inequality **in 1994**

(<https://www.ohe.org/publications/doctor-looks-health-economics> ). Subsequent lecturers have included nobel prize winner Daniel Kahneman (<https://www.ohe.org/publications/galys-versus-experience-perspective-experimental-economics> ), leading economists Kenneth Arrow (<https://www.ohe.org/publications/saving-lives-buying-time-economics-malaria-drugs-age-resistance> ) and William Baumol (<https://www.ohe.org/publications/health-care-handicraft-industry> ), and, most recently, Professor Dame Sally Davies talking about the achievements of 10 years of NIHR, a lecture that will be published shortly.

**In the 21<sup>st</sup> century** I highlight two pieces of work on NHS reform:

- OHE's Commission on Competition, published 2012 (<https://www.ohe.org/publications/report-office-health-economics-commission-competition-nhs>), which concluded that:

“..although competition in the NHS is controversial, in the right circumstances it can be used to stimulate the provision of better health care than is achieved without competition. .... The issue is not whether to have competition for all NHS services or for none; the question is for where and for which services competition would produce benefit for patients.”  
We set out a template for assessing its potential value in relation to a particular service.

- OHE's Commission on NHS Outcomes, Performance and Productivity, published in 2008 (<https://www.ohe.org/publications/nhs-outcomes-performance-and-productivity>) which concluded that:

“...the collection and use of outcomes measures in the NHS is both practical and essential. It can be expected to lead to improved outcomes, performance and productivity, thereby providing significant benefits to patients.” A timetable to develop comprehensive Patient Reported Outcome Measures within a decade for most NHS activity was set out.

Before I turn to Nancy to talk about the future, I want to say a few words about the change in OHE's structure.

### **Evolution of OHE's ownership**

It is quite remarkable that OHE exists at all, let alone that it has survived for 55 years.

It is an organisation owned by the ABPI on behalf of the pharmaceutical industry in the UK which has credibility within academic and policy circles including within government, not only within the UK but internationally.

That is a tribute to the ABPI who have continued to provide research funding to the OHE over this 55 year period. It is of course strategic self-interest as well. Industry can only ultimately meet society's needs if there is an understanding as to how we have an efficient health care system, and as

part of being an efficient health system, the NHS uses drugs cost-effectively, paying prices that represent value for money and are able to reward R&D investment, and that the UK invests in an effective university system and clinical and data research infrastructure when it is evident that this brings benefits to patients as well as a return on investment to UK plc.

It is also a tribute to the robustness of OHE's governance arrangements designed to ensure that it has always operated at arm's length from the ABPI - in particular to the role of the Research and Policy Board and the Editorial Board and to all of those people who have served on these bodies over the years.

It is also a tribute to the quality of the work that OHE does. If it wasn't topic relevant and of good quality interest in OHE would long have disappeared.

Yet it is essential that OHE evolve, and, as Professor Mike Drummond has indicated, the move in January 2016 to set OHE up as an ABPI owned not-for-profit research company with a for-profit consultancy subsidiary and the subsequent obtaining of charitable status at the end of December 2016 has introduced further transparency and clarity into both our ownership and governance arrangements, and our objectives, which are unambiguously to serve the public interest by providing research and analysis that will increase understanding of health, health care and biomedical research

issues and the public policy challenges that result. We hope as Mike said that this move will also increase opportunities for funding and for joint work with organisations who hitherto have not been able to support us.

I pass you over now to my colleague Nancy Devlin who will say a little about our research agenda for the future.