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HELPING HAND

As healthcare innovation evolves, the industry is beginning to look beyond its own four walls to embrace collaboration

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INTERVIEW
Pierre Chancel, head of Sanofi Diabetes, on the escalating threat from diabetes in emerging markets

ROHIT KHANNA
IT'S A BEAUTIFUL DAY IN THE NEIGHBOURHOOD

Clinical trial data is vital for clinicians practicing evidence-based medicine, but even more compelling can be real-world data gathered from local real-world patients

As pharmaceutical marketers, we rely on data to make a persuasive argument for the use of our drug versus a competitor's. Data, we have been conditioned to learn, is what 'sells' our products. Without data, one can't possibly achieve any meaningful market penetration. Or can one?

Let's be clear about what we mean when we say 'data'. By 'data', we mean the typical peer-reviewed literature that has been published in reputable journals using results from an RCT or other type of 'Level 1' evidence showing a statistically significant difference in some meaningful primary endpoint that is clinically relevant to your target audience. Data might also constitute the content in the product monograph that is used to achieve market registration, authorisation or approval with the regulatory agencies (FDA, EMA, etc).

Apart from the fact that the data in the product monograph is needed to achieve regulatory approval and demonstrate efficacy, safety and the incidence of adverse events, this information is also used, to some extent, in our marketing efforts. This definition of data is what I call 'cost-of-entry data'. Simply put, this is the minimum amount of data required to achieve both regulatory approval and to gain the confidence of the clinician that your product is no worse than the current gold standard of care for a particular therapeutic category.

> ***"When data is at the heart of your brand's promotional efforts, success lies in your own backyard"***

The other type of data that we long for as marketers is what I describe as 'disruptive data'. Disruptive data is data that changes treatment paradigms and shifts thinking towards novel approaches to treatment intervention. We can probably all count on less than two hands the data that meets this criterion – think Framingham or West of Scotland (WOSCOPS), ISIS, the Women's Health Initiative (WHI) or the HOPE Trial. As marketers, we cannot plan for disruptive data. It simply cannot be built into an annual strategic plan. If it happens, it happens.

So is anybody paying attention to cost-of-entry data? Clinician feedback seems to suggest that cost-of-entry data is becoming less relevant as a driver of product adoption. There are two basic camps into which we can divide clinicians on this issue: those who practice evidence-based medicine and those who do not. For those who do not, cost-of-entry data is largely meaningless since it requires an embracing of evidence. For those who do, the familiar echo is that 'my patients don't look like the patients in your clinical trials'.

Clinicians who practice evidence-based medicine complain that the protocol design of trials is such that only pristine patients are being selected due to rigorous inclusion and exclusion criteria and that this does not truly mimic their waiting rooms. They have a point. The world is one big co-morbidity, except in pharmaceutical trials where only the healthiest of the healthy are selected for participation. Other common complaints of cost-of-entry data include small sample sizes, inadequate follow-up, lack of statistical power and length of time from protocol design to publication (which can take on the order of 36-48 months by which time the results may not be clinically meaningful).

What clinicians are most interested in is 'neighbourhood data'. Demonstrate to a clinician who exactly is using the product in his neighbourhood. Studies have shown that consumers are more likely to purchase a product if they have been exposed to it on a prior occasion by a friend or family member who has been pleased with the product's performance (it is conventionally assumed that friends and family members live in close geographic proximity to each other). The same is also true of clinicians. Peer-to-peer influence, which forms the basis of the concept of neighbourhood data, is one of the greatest drivers of product adoption.

By using credible peers from within the customer's geographic neighbourhood, we show the clinician how their peers 'down the street' are using the product, in what types of patients and with what types of results. Intuitively, pharmaceutical marketers understand the importance of this but we simply don't do it enough. Yes, we organise local dinner events with local speakers; but not nearly often enough. We don't fund local investigator originated proposals (IOPs) or investigator initiated trials (IITs) nearly enough. We don't encourage the transfer of knowledge through the use of local preceptorships nearly enough. And the list goes on.

Let's go back to our two main camps of clinician on the data issue: the clinician who practices evidence-based medicine (but is becoming increasingly sceptical about the data and evidence being presented from big pharmaceutical companies) is going to embrace neighbourhood data simply because no one can challenge real-world outcomes.

Sure, there was no ethics review board approval or any well designed protocol surrounding these patients. But they're real patients with real results and real co-morbidities. The clinician who doesn't practice evidence-based medicine is going to embrace neighbourhood data as well because it's the way he/she has always practiced medicine for the most part anyway.

As strategic marketers, remind yourselves that when data is at the heart of your brand's promotional efforts, success lies in your own backyard.

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