After three decades of research and development, advances in cancer therapy are at last rekindling the hope that swelled in 1972 when U.S. President Richard Nixon declared a war on the scourge of cancer. He predicted, “...there will not be any single cure, it will not come suddenly...but whenever and wherever the answers come, they are going to represent the final steps of a long journey.”¹ We may still be many steps from the end of that journey, but recent scientific breakthroughs in targeted agents, oral delivery and even cancer vaccines have propelled us a great distance along the path. This revolution — and the accompanying surge in new product development — are creating a treatment landscape that will fundamentally change the economics of the oncology marketplace.

The crux of the matter is that targeted therapies are splintering the market into narrower segments. Thus, even for cancers causing significant mortality and morbidity, new products target relatively small numbers of patients. And in order to expand a product’s indication to other types of patients or other tumor types, companies must make substantial investments in additional clinical trials. It is therefore not surprising that research companies should seek a premium price that reflects not only the innovation quotient of the molecule, but also the investment cost of multiple clinical studies with uncertain outcomes.

It is ironic that just as the clinical battle against cancer is being won, companies must now fight a fresh battle on the commercial front.

That said, new molecules introduced over the past seven years have more than realized their initial clinical potential and also addressed new segments and tumor types. Demand has, therefore, expanded faster than predicted, making it increasingly difficult for payers to finance the growth. However, relief may be on the way for payers. As more molecules come to the market (and seven new oncology products are predicted for 2007) payers will eventually have alternatives from which to choose, leading to more competitive pricing. And, over the next five years, four current oncology blockbusters will go off patent, easing payers’ extremely difficult task of developing cost/benefit parameters to guide their spending. Another option for payers is to demand higher levels of performance in terms of remission and survival in order for a drug to qualify for reimbursement, or even to sustain the launch price over time.

¹U.S. President Richard M. Nixon remarks to a National Cancer Conference in Los Angeles, CA, September 28, 1972.
Thus, the oncology class is finally reaching the same inflection point already seen in other classes. Oncology products now face commercial risks that are separate from their clinical risks, and companies will find it vastly more challenging to make the economics work. Manufacturers’ success in this market will depend upon how they set their indication strategy, determine and support their price and manage the needs of the various stakeholders involved.

It is ironic that just as the clinical battle against cancer is being won, companies must now fight a fresh battle on the commercial front.

**FACING A DRASTIC REAPPRAISAL**

The economic evolution within the oncology market is provoking a debate that strikes at the heart of societal ethics…the fundamental constructs that govern a State’s commitment to providing healthcare…and the value propositions making a consensus between the pharmaceutical industry and other stakeholders in healthcare possible. And as seen in HIV/AIDS, patients will be instrumental in shaping the consensus which must be sought.

The ethical issue concerns whether a payer — increasingly the State (even in the U.S.) — has the right to restrict access to life-saving or life-extending medications, and whether the criteria for determining access are rational and defensible. This question has been faced before, but not in connection with a range of potentially lethal diseases such as cancer.

The fundamental construct around access to healthcare, first embedded in the Beveridge Report published in the U.K. just after WWII and adopted to some extent by most democracies, demands equality of access. It has been abused frequently, but the question now is whether cancer represents the tipping point at which the “contract” between the payer (usually the State) and society will have to be rewritten. Karol Sikora, Professor of Cancer Medicine at Imperial College London, has recently commented that cancer may become a chronic disease by 2020. As cancer predominantly afflicts the elderly, this achievement would extend life expectancy, increasing the total healthcare burden and amplifying the debate over the nature and extent of a payer’s financial commitment.

The pharmaceutical industry’s concern is that artificial constraints on the uptake of innovative medicines will diminish returns and hinder further investment in intractable diseases where the risks of R&D failure are especially high. Consider stroke, for example — a devastating and frequently lethal event with a significant cost for rehabilitating survivors. For the past 30 years, the industry has persevered with expensive research in the hope of a breakthrough and not had a single success. It is hardly surprising that the industry should feel aggrieved when payers respond to breakthroughs (such as those in several of the most prevalent cancers) by restricting patient access.

This article will explain why we have reached this tipping point, bring the current commercial issues to light and suggest in broad terms what manufacturers must now consider as they develop oncology products and bring them to market in a very uncertain environment.

**ENTERING A GOLDEN AGE OF ONCOLOGY**

In 2005, the President of the American Society of Clinical Oncology (ASCO) announced that cancer therapy was entering a “golden age.” The past 30 years of research and development, which had yielded only a few breakthroughs until the late 1990’s, have finally started to pay off.

In the past eight years, three specific breakthroughs have done more than change the way cancer is treated — they have changed the way we think of the disease itself. In 1998, Genentech introduced Herceptin® to treat metastatic breast cancer. The first targeted therapy supported by a specific diagnostic test, Herceptin has revolutionized treatment of the 20-25% of breast cancers that are HER2-positive.

The second was Gleevec®, an oral therapy for chronic myeloid leukemia, launched in 2001 by Novartis. Gleevec opened the possibility of treating the disease through long-term maintenance therapy. “Gleevec allowed us to think of a cancer as a chronic illness, rather than a life-ending one,” remarks Dr. Pierre Anhoury, IMS Director, Pricing and Market Access. “It thus has significance far beyond the scope of just treating leukemia.”

And the latest development embraces a key principle of public health, i.e., vaccination. With the HPV vaccines, Gardasil®, which launched in 2006, and Cervarix®, which should launch in 2007, the industry has attacked the root cause of a disease in the cancer spectrum for the first time, making a form of cancer preventable. Anhoury continues,
“Preventing the disease itself has been the ‘holy grail’ of medical science, and now it’s achievable.”

The result here is a dramatic consensus among all stakeholders: through the industry’s innovation, scientific advances are indeed winning individual battles against the disease. Medical experts suggest that this is just the beginning, with science poised for a huge leap forward in bringing continued improvement in treatment outcomes. Specifically, optimism springs from our understanding of genetic factors and sub-cellular biology as well as improvements in diagnostic technology and chemoprevention.

A PROFILE OF THE ONCOLOGY MARKET TODAY AND TOMORROW

A few facts suffice to paint the oncology market as complex, dynamic and positively burgeoning with growth:

• Cancer consists of more than 200 different diseases and ultimately affects one in three persons. The most commonly occurring cancers are those of the lung, breast and colon (See Figure 1) and it is these tumors that recent product launches have addressed.

• The global incidence of cancer is forecast to grow by 50 percent between 2000 and 2020 due to the priority that government healthcare policies give to cancer detection and treatment.

• The size of the oncology market has more than doubled in the past five years, reaching $31 billion in 2006.

• Seventy-seven percent of today’s oncology sales are derived from products launched in the past 10 years. Recent growth is largely driven by targeted therapies such as Herceptin in breast cancer, Avastin® and Erbitux® in colon cancer, and Gleevec in chronic myeloid leukemia, while Tarceva® is driving growth in non-small cell lung cancer. Apart from advances such as these in major tumor types, drugs like Alimta®, Sutent® and Nexavar® are broadening the range of tumors responsive to chemotherapy, thus promoting further growth. The HPV vaccines, Cervarix and Gardasil, will help to drive growth still further.

• Globally, the oncology class is now growing three times faster than the pharmaceutical market as a whole and is forecast to become the dominant pharmaceutical business sector by 2010. (See Figures 2 and 3)

• Ten major pharmaceutical companies currently account for about 75 percent of global oncology sales. As many other companies are about to enter the market with exciting new compounds, it is very unlikely that the cancer market will remain as concentrated.

![Figure 1: Innovation in the past 10 years has focused on cancers with the highest morbidities](source: GLOBOSCAN 2002, published September 2005)

![Figure 2: Global oncology sales growing at more than three times the global pharma rate](source: IMS MIDAS, MAT JUNE 2006)
THE UNSTOPPABLE MARCH OF PROGRESS

Given recent scientific advances, there is an inexorable process at work: established players and new entrants are investing heavily in new product development, especially in biologically-led, targeted therapy. The oncology pipeline is the richest in number and potential of any therapeutic category. (See Figures 4 and 5) Up to 55 New Chemical Entities (NCEs) could enter the market within the next five years, some of which will lack clear differentiation in terms of efficacy, toxicity and convenience.

Thus, the oncology market, which could never have been described as crowded or competitive in the past, is about to become so.

FIGURE 4: THE ONCOLOGY SECTOR IS WITNESSING A PERIOD OF UNPRECEDENTED R&D INVESTMENT

R&D Activity in Main Therapeutic Areas

Size of bubbles = forecast sales 2009
Note: * = Growth of value sales
Source: IMS Health Consulting

FIGURE 3: GLOBAL GROWTH FORECAST IS TWICE THE RATE OF THE OVERALL PHARMA MARKET: $66 BILLION IN 2010

LEADING THERAPY CLASSES, 2005-2010

Source: IMS MIDAS, IMS Therapy Forecaster 2006 and IMS Health Consulting

FIGURE 5: SEVERAL MANUFACTURERS ARE MAKING A SIGNIFICANT INVESTMENT IN ONCOLOGY

NUMBER OF ONCOLOGY NCEs* IN LATE STAGE DEVELOPMENT BY COMPANY

Note: *Includes vaccines
Source: IMS R&D Focus; IMS Knowledge Link; IMS Health Consulting
Through a confluence of market conditions occurring globally, the historical method for product valuation is about to be turned on its head.

**THE UNINTENDED CONSEQUENCES OF PROGRESS**
Because the conquest of cancer has been an elusive goal of inestimable value, payers have allowed manufacturers more pricing freedom than in other classes. To date, the industry’s ability to charge a premium price for its oncology products has correlated strongly with its ability to innovate. This has been fortuitous because development costs have been escalating with the need for more clinical trials to validate product efficacy.

Graham Lewis, Vice President, IMS Global Pharma Strategy, comments, “The industry has always assumed that oncology drugs would be able to command high prices at launch and would remain relatively protected throughout their lifecycles.” However, through a confluence of market conditions occurring globally, the historical method for product valuation is about to be turned on its head.

Targeted therapies were designed to treat more finite segments of the oncology population. However, empirical experience is demonstrating that, when used in combination with more systemic drugs, targeted therapies produce benefits across a wider range of patients within the first tumor type approved, and subsequently in other tumor types. The use of these drugs is shifting more quickly from advanced to early-stage treatment, while the expansion to other tumor types continues as before.

This “shift” has put more pressure on payers, so they have begun to scrutinize the benefits derived from innovative therapies more rigorously and to compare these benefits to those gained in treating other diseases. Payers are making the comparison not because the diseases are similar, but because they are urgently seeking a new value paradigm that will help them distribute their budgets more rationally in an inherently irrational situation.

In retrospect, it is clear that all stakeholders miscalculated the consequences of recent rapid progress in extending remission and survival. This had nothing to do with an or inadequate intellect; it had everything to do with an assumption drawn from real-time experience. The assumption was that new drugs would mimic their predecessors, bringing marginal improvements to limited population subsets. On the basis of this assumption, pharmaceutical companies set their pricing strategies and payers accepted them. Subsequent clinical experience has confounded empirical reasoning.

**IMPLICATIONS FOR MANUFACTURERS**
Of course, increased competition will heighten the importance of manufacturers’ marketing competence. This is especially true since the key stakeholders are not increasing numerically, so that only the best products will be accessible. But perhaps less obvious — it will also affect decisions made long before a product enters the market, beginning with what indication to target first. Companies must choose the right point of entry for a molecule, given that some indications will be shared with competitors sooner rather than later.

“R&D companies may find that it is advantageous to take the ‘road less traveled’ to enjoy some exclusivity in the market,” suggests Dr. Simone Seiter, Principal, IMS Consulting. “They may be more interested in first entering smaller, niche markets where the competition is less fierce, and saving additional indications in the larger markets for later. The marketing activities to support a niche product launch are far less intense than those needed in a major market where competition already exists.”

In any event, companies must now think about where they launch, the sequence of successive launches and how their products will be differentiated from others to command and sustain a premium price.
If this could have been foreseen, pharmaceutical companies may have opted for a different pricing model and payers may have set alternative cost/benefit parameters. Now, the various stakeholders are pausing for thought and attempting to find a business model that is acceptable to all. Pharmaceutical companies are widely employing compassionate use programs, payers are erecting barriers to access (which, unfortunately, has brought the legal profession into the fray) and providers are caught between their budget-holding masters, their patients’ desire for the most effective treatments, and their intellectual conviction that the pharmaceutical industry actually is delivering. The dilemma was summed up by an expert Oncologist at the recent European Society for Medical Oncology (ESMO) meeting in Turkey:

“This is not a straightforward cost containment issue. There are discrepancies in cancer treatment outcomes both within and between different EU states in terms of access to top quality surgery, radiotherapy, drugs and information.”

Professor Roberto Labianca
Chair, ESMO MOSES Task Force

PAYERS FLEX THEIR MUSCLE

The coffers are being emptied everywhere as payers struggle to meet the growth in oncology sales with limited budgets. “We are reaching a point,” states Lewis, “when even the most liberal and sympathetic payers will have to apply price or access controls in order to make ends meet.” To illuminate the challenge that payers will face, consider that if the two new HPV vaccines are adopted successfully, their peak sales will exceed the value of all vaccine sales in the U.S. today!

In the E.U., health authorities have already been restricting access to certain populations as a means of controlling their drug budgets. Figure 6 lists the type of access restrictions in place within the E.U. for just four leading oncology treatments.

And the situation is bound to get worse. At a 2006 conference held by Cambridge Pharma Consultancy, a Unit of IMS, Dr. McCabe, former Director of the National Institute for Health and Clinical Excellence (NICE) Decision Support Unit in the UK, said, “Drug budgets will have to increase markedly if the oncology market is to continue expanding with new products and new medications. This is at a time

FIGURE 6: IN PARTS OF EUROPE, PAYERS HAVE ALREADY TAKEN STEPS TO MANAGE ACCESS OF CERTAIN AGENTS

<table>
<thead>
<tr>
<th></th>
<th>France</th>
<th>Italy</th>
<th>Germany</th>
<th>Spain</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gleevec</strong></td>
<td>Repeat Rx can only be made by certain specialists</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>NICE has minor restrictions beyond label Uneven take up despite NICE approval</td>
</tr>
<tr>
<td><strong>Herceptin</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Late stage BC - positive NICE review took 2 yrs</td>
</tr>
<tr>
<td><strong>Avastin (in CRC)</strong></td>
<td>None</td>
<td>&gt; 6 month delay between EMEA approval &amp; launch</td>
<td>None</td>
<td>None</td>
<td>Rejected by both NICE &amp; the Scottish Medicines Consortium</td>
</tr>
<tr>
<td><strong>Erbitux (in CRC)</strong></td>
<td>None</td>
<td>Price vol agreement, observational studies &amp; prior authorization</td>
<td>None</td>
<td>None</td>
<td>Rejected by both NICE &amp; the Scottish Medicines Consortium</td>
</tr>
</tbody>
</table>
when the National Health Service (NHS) budget is widely expected to plateau after 2007, which raises the distinct possibility of market access restrictions and/or price reductions in response to growing demand.”

“At the moment, pricing and market access limitations are a country-by-country affair,” explains Anhoury. “But in the future they will take the form of a Europe-wide effort that is centrally coordinated. This will start with oncology and then move to other therapeutic categories.”

In the U.S., payers are still recommending “appropriate use,” rather than applying restrictions, but they may well follow the E.U.’s lead in time. Traditionally, U.S. health plans had neither the motivation nor the means to manage oncology pricing. Almost all expenditures were administered through Medicare Part B, with most oncology patients being elderly and receiving therapy closely linked to physician services. Today, there are two shifts in the U.S. that will cause additional scrutiny of oncology costs: first, the implementation of Medicare Part D, and second, the influx of oral therapies covered under this part of the Medicare plan. What was previously a more stable situation — with most therapies being reimbursed under Medicare Part B — is now becoming more complex — with greater demand on payers to cover oral therapies under Medicare Part D. With new and innovative therapies helping to turn cancer into a chronic disease, patients are living longer, but they are also increasing the cost of therapy and the pressure on plans to pay.

The budget drain is giving payers ample incentive to change the way they manage their oncology expenses. And the growing number of therapy options presented by competition will support payers’ cost savings goals, giving them the leverage to insist on the least expensive alternative, or to force patients to pay the difference.

**IMPLICATIONS FOR MANUFACTURERS**

The biggest challenge for manufacturers operating in this new environment will be to get the price right at launch. “If you come out with a price that is higher than the market will bear, you’ll be hit with access restrictions,” asserts Pamela Santoni, IMS Senior Principal for Pricing. “Conversely, if you start with a price that is too low, you’ll have to live with it. If you increase your price later, you’ll risk alienating physicians. In the U.S., physicians are subsidizing price increases for products covered under Medicare Part B.”

It is probable that a high unmet need will no longer be sufficient on its own to command a high price, and companies that base their pricing decisions on analogues from the past — even the recent past — will make a strategic mistake. To justify premium pricing or achieve unfettered access, companies will need to demonstrate that their products deliver improved outcomes relative to competing products using metrics that matter most to each stakeholder.

“Typically, these would be proof of extended time to relapse or increased survival,” says Mike Aristides, IMS Principal, Health Economic and Outcomes. “Surrogate endpoints, such as tumor response will not be sufficient for pricing and reimbursement negotiations. If NICE is the bellwether, then health economics will also be important to justify access and uptake.” Indeed a meta-analysis across NICE deliberations and across all disease areas strongly suggests that the organization is using financial benchmarks in its decisions. (See Figure 7)

**FIGURE 7: NICE DECISIONS BY COST/QALY**

![NICE DECISIONS BY COST/QALY](image)

* QALY = Quality Adjusted Life Years
Source: Presentation by Professor Sir Michael Rawlins, Chair, National Institute for Health and Clinical Excellence. *A NICE time at NICE.*
Although economic issues are still second to clinical ones in reimbursement decisions, the balance between the two will shift towards equilibrium. The proverbial writing appears to be on the wall. Payers will come to use the same rationale for determining payment with oncology drugs that they currently use in other therapy areas. We can expect that payers’ new philosophy will manifest itself in:

• Pricing limits, even in free-pricing markets.

• Restrictions on treatment initiation. Payers may require evidence that a patient has failed to respond to existing treatment before authorizing reimbursement for another more expensive therapy. Or, payers could make reimbursement dependent upon the results of specific tests verifying that a patient will respond to a given treatment. They could also limit reimbursement for off-label use of drugs.

• Restrictions on therapy continuation. Payers may require clinical evidence that a product is actually reducing the size of a tumor or insist that continued treatment be dependent on certain biological tests. Their decision criteria will increasingly depend on the availability of survival as well as remission data.

“The big question is, of course, ‘When will it change?’ It won’t happen in the blink of an eye,” reasons Santoni. “It will happen gradually. A few aggressive payers will take action and others will follow. Plans will try things and they’ll get push back from patient advocates and employers. We can expect to see many iterations without ever reaching a steady state.”

Two recent events, though, suggest that the industry is anticipating these events. Amgen has introduced its new cancer therapy, Vectibix™, at a 20 percent discount to its nearest competitor, Erbitux. Two European governments have granted GlaxoSmithKline permission to introduce two specific products at the company’s chosen price, subject to a contractual agreement that GlaxoSmithKline will undertake Phase IV studies to evaluate the agreed performance parameters. The price may subsequently be modified up or down. It is not known if the two products are in the cancer arena, but from a payer’s perspective, this modus operandi would work well in oncology because the number of patients who can be evaluated during the regulatory and pricing and reimbursement process is very small. Real-world experience can thus produce different outcomes from clinical trials, as evidenced by AstraZeneca’s Iressa® which failed to demonstrate a survival benefit and was even linked to patient deaths, following fast-track approval on the basis of tumor shrinkage.

**IMPLICATIONS FOR MANUFACTURERS**

Companies must have a respected voice in stakeholder deliberations concerning a rational access policy for innovative compounds in the cancer space. The recent growth in the market has benefited pharma players in oncology, and the short-term outlook is also positive. However, there are many major companies with a disproportionately large part of their active pipeline in oncology and they and their investors have placed bets on a continuation of significant returns.

If payers change the game, and there are signs that they are doing so already, Pharma cannot stand by and wait for third-party decisions to determine their fate. Experience in other markets shows how damaging and unpredictable that can be, making effective planning very difficult.

Some companies have already taken active steps to counter rising public criticism of oncology drug prices. ImClone/BMS announced that it was reviewing a price cap for Erbitux. Novartis announced its intent to provide Gleevec to any patient that needed it, regardless of insurance status. And Genentech is considering a charitable trust to help disadvantaged patients with the cost of oncology treatment.

Companies must remember that public opinion is fickle. That can work for and against anyone looking to the public for support.
THE UK EXPERIENCE WITH HERCEPTIN HIGHLIGHTS THE CHALLENGES

Since it affects patients, the price/access issue won’t be debated and negotiated privately between the commercial parties involved; it is going to have a very public profile. This is apparent in the media coverage given the Herceptin decisions made in 2005 in the U.K. Following a very public appeal by a patient to gain access to Herceptin, NICE issued final guidance in September 2006 recommending that Herceptin be used in early breast cancer and be paid for by the state health service. (See Figure 8)

Interestingly, the advent of targeted therapies has given the price of treatment for which there is no alternative a new level of legitimacy. When there is a clear identification of a cancer type and a proven solution, there’s a strong moral obligation to find the money to pay for treatment. European governments have not always managed to do so and have had to ration treatment to stay within their budgets, but patients have been on firmer ground in fighting rationing decisions.

The introduction of legal challenges and direct political intervention makes oncology an increasingly fraught arena for all stakeholders, including pharma.

Already in the U.S., public opinion is beginning to question the price of oncology products, but when the solution becomes to delay or deny access to life-prolonging care, the public will respond with more than questions. For the industry, being in the spotlight is a two-edged sword: manufacturers are lauded as heroes for their discovery and development, and at the same time vilified for their pricing practices in which they are held responsible for treatment denial or restricted access.

The only solution is to use health economics to define and produce consistent and comparable criteria and to conduct evaluations that can be scrutinized by all stakeholders. This would allow some patients to pay for treatment even if there is limited or no reimbursement, and however unpalatable that would at least be a rational basis for decision making.

At present this does not exist.

FIGURE 8: THE UK EXPERIENCE WITH HERCEPTIN HIGHLIGHTS THE CHALLENGES WITH A PREMIUM-PRICED THERAPY

Herceptin portrayed in the UK popular media as a cure for breast cancer, akin to a miracle treatment
Women in the UK are denied Herceptin for use in early breast cancer and a number take this issue to the courts
Ann Marie Rogers loses her High Court battle over Swindon Primary Care Trust’s refusal to fund Herceptin treatment
The European Commission approved Herceptin for early-stage HER2-positive breast cancer in May 2006

2002
2004-2005
Oct 2005
Nov 2005
March 2006
Summer 2006

NICE recommends Herceptin be available for women with HER2-positive advanced breast cancer
North Stoke Primary Care Trust rejects Elaine Barber’s appeal to use Herceptin on the grounds that they are not convinced of the drug’s safety or cost-effectiveness
North Stoke Primary Care Trust changes ruling that rejected Elaine Barber’s appeal
Health Secretary Patricia Hewitt notes health managers should not use cost as an excuse for refusing to give patients Herceptin
Fulfilng its commitment to accelerate consideration of Herceptin, NICE issued its guidance in August 2006 (recommending Herceptin as a treatment option for early-stage HER2-positive breast cancer after surgery and chemo)

What will be the global consequences of NICE’s recommendation on Herceptin?
CONCLUSION

Ultimately — and rather perversely — the industry’s investment in oncology research and development may offer the basis for a more rational era in oncology pricing and reimbursement provision as:

• Repetitive innovation will create new benchmarks of performance.
• Oncologists will have more choice.
• Increasing competition between pharmaceutical companies will lead to keener pricing and incremental value propositions.
• The development of more sensitive diagnostic tests will allow targeted therapies to be used in the patients most likely to respond positively.

All this will occur while payers prepare for generic versions of valuable products such as Taxotere® and Gemzar®.

“For the moment, companies in the oncology market are enjoying the success that comes from their years of innovation, relatively unhampered by the influence of payers,” declares Lewis, “but in a sense, companies will become the victims of their own success. Their experience is attracting others to the market, and this competition will give payers the leverage they need to strengthen their technology assessments, clamp down on prices and create access barriers as needed. The special freedoms manufacturers have enjoyed in the oncology market will go the way of all outmoded conventions. Oncology products will be subject to the same managed care influences as products in other markets.”

Considering all the forces at work, the near future could easily become “the best of times and the worst of times” for players with an oncology franchise. It will certainly test pharma’s strategic foresight and operational savvy. Indeed, manufacturers in the cancer space must have a whole new set of questions on their radar screen. (See Figure 9)

The strongest insurance against falling prey to payers’ heavy-handed involvement and the public’s ire over pricing is for research companies to: differentiate their innovations, especially expressed in terms of health and economic value; target them precisely to population segments that will receive the most demonstrable benefits; and set and review performance parameters with payers at regular intervals.

FOR MORE ONCOLOGY INSIGHTS VISIT OUR WEB SITE:
WWW.IMSHEALTH.COM/ONCOLOGY

FIGURE 9: ONCOLOGY FRANCHISE: THE RADAR SCREEN

<table>
<thead>
<tr>
<th>Strategic</th>
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<tbody>
<tr>
<td>• How will we stand out from the crowd in oncology?</td>
</tr>
<tr>
<td>• Do we have the capability, talent and organization to win in oncology?</td>
</tr>
<tr>
<td>• How can we achieve excellence in the management of all our oncology stakeholders?</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Operational</th>
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<tbody>
<tr>
<td>• What is the right clinical development paradigm?</td>
</tr>
<tr>
<td>• Do we fully understand the national, regional and local oncology environment?</td>
</tr>
<tr>
<td>• Do we have the necessary capability in HEOR, pricing and reimbursement?</td>
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ABOUT IMS HEALTH
Operating in more than 100 countries, with $1.8 billion in 2005 revenue, IMS provides clients with evidence-based, customized intelligence about the pharmaceutical and healthcare markets — delivering critical information, analytics and consulting that drive superior client business strategies, decisions and results.

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