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The missing link in oncology portfolio strategies

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Many pharmaceutical companies want to be a leader in oncology—but what does that really mean? Today, most pharma companies define their oncology portfolio strategy by a mix of tumor types and treatment modalities or pathways. What is missing from this latticework is an important third link: the customer. Oncology companies think about leadership as a share of market within a patient population or product class, but they are actually fighting a share-of-mind battle for a customer.

Therapy area focus adds value for pharma companies

Last year, we published a cross-therapeutic area (TA) analysis of the top 20 pharma companies that showed achieving focus and leadership in a TA led to outsized shareholder return. Companies with above-average focus and leadership in their top three TAs returned more than double the value to shareholders than their peers.

For this analysis, we used American Medical Association specialties to define TAs and measure a pharma company's focus and leadership. This framework helps explain why some product portfolios are greater than the sum of their parts: A company with the leading portfolio for a specific physician community also benefits from deeper customer relationships, more connections in the scientific community, scale in payer and provider contracting, and synergies in commercial infrastructure investments.

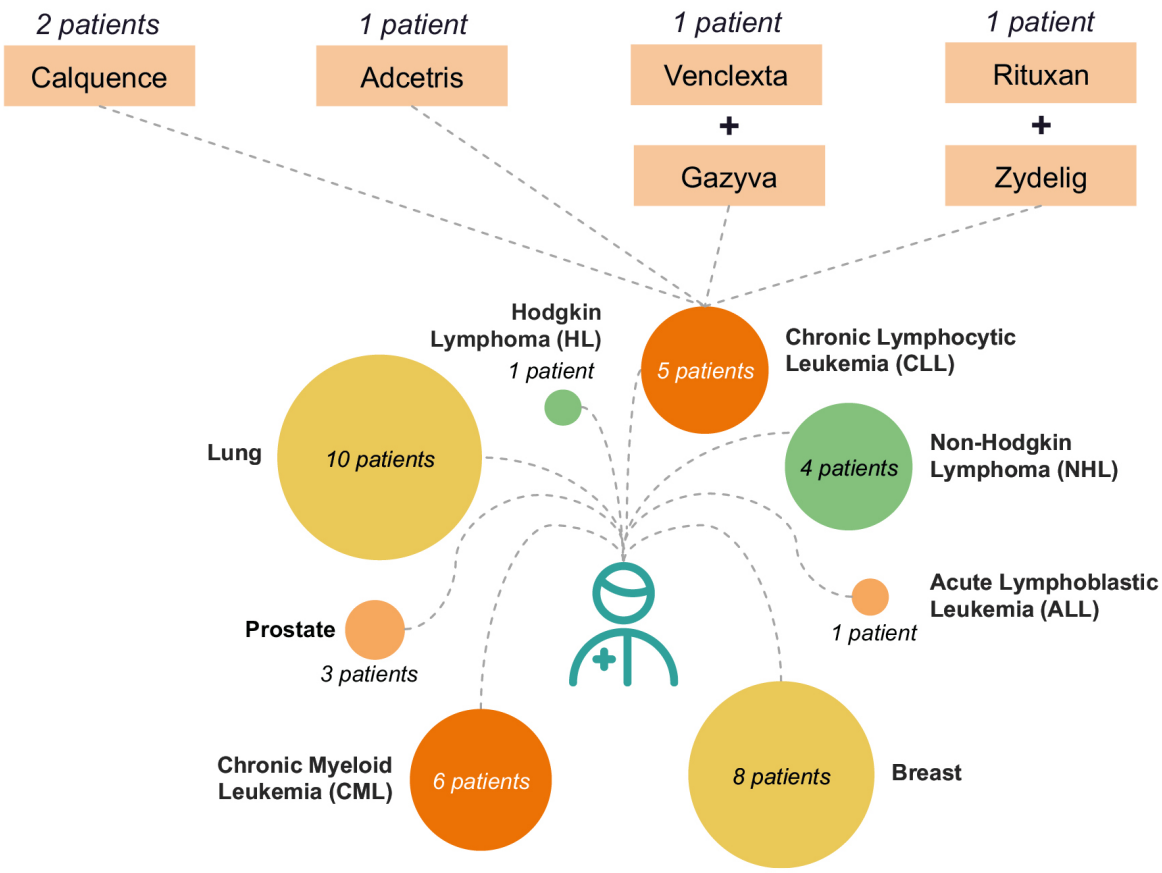
What it takes to be a leader in the ultra-competitive oncology market

Given that oncology is the largest TA by revenue and also the most competitive, attracting approximately 40% of R&D dollars, the pharma industry needs to begin applying the same thinking to its portfolio strategy for that area. Focusing the innovation pipeline to achieve leadership, rather than looking for revenue opportunities anywhere, will become increasingly critical to the numerous pharma companies that aspire to be an oncology leader.

So, what does it mean to be a leader? Today, most oncology companies define their portfolio strategy by a mix of tumor types and heme malignancies (i.e., patients), and mechanisms of action or treatment modalities (i.e., product classes). In the practice of medicine, however, the relationship between patients and products is mediated by the doctor making treatment selections for their patients. Oncology companies thinking about leadership as a share of market within a modality, pathway or tumor are actually fighting a share of mind battle for a customer. Leadership requires an audience, but the customer is missing from the portfolio strategy latticework.

FIGURE 1:

Typical oncologists treat multiple tumor types



Does the tumor-focused oncologist exist?

Imagine you are an oncologist. In a given month, you will see patients with a variety of primary tumor sites and specific histologies for those tumors (Figure 1). Many of these patients will have cancer of the lung or breast. About one in eight will have chronic lymphocytic leukemia (CLL). Now imagine you are an aspiring leader in oncology therapeutics with a novel approach to drugging a target in CLL. Even if your company entirely displaces Calquence in this doctor's CLL armamentarium, where will you fall on her mental list of top oncology companies? She may still turn to AstraZeneca solutions far more often than your company's solutions because of AstraZeneca's broader portfolio of Tagrisso, Imfinzi, Lynparza and Enhertu with indications in lung cancer and breast cancer.

Many more oncologists' practices look like this than not. The tumor-focused oncologist is not mythical, but only one in ten oncologists spends 80% of her time treating only one type of tumor. There isn't a single tumor for which the top half of treaters focus even 50% of their time. This makes it challenging to identify discrete physician communities in oncology.

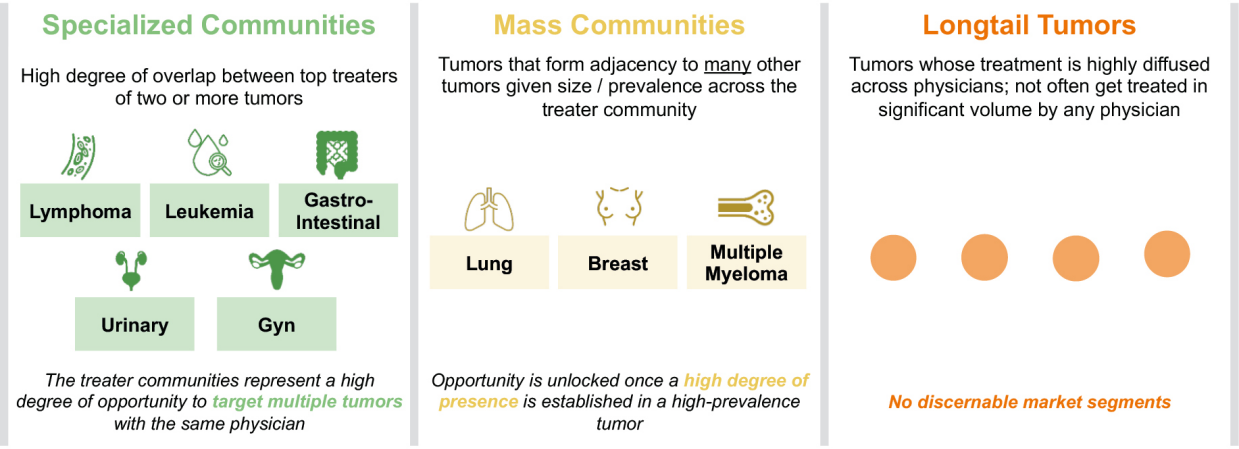
What communities of oncologists actually look like

To support this strategic shift in oncology portfolio strategy, ZS analyzed a comprehensive database of Symphony Health oncology claims to identify underlying treater communities in the U.S. What we found differs substantially from commonly held assumptions across the industry.

There are eight definable treater communities in oncology: three that we describe as Mass Communities and five Specialized Communities. On average, tumors in one of these communities represent more than a third of the total patients treated by the top half of treaters in the community. That means if you build a portfolio that is relevant to a quarter of patients treated by one of these communities, treaters in that community will be thinking about your products on a weekly or even daily basis.

FIGURE 2:

5 Specialized Communities and 3 Mass Communities in Oncology



Mass Communities vs. Specialized Communities of oncologists

Three tumor types each represent a high proportion of patients treated by physicians whose practice has a focus on one of these cancers. They also overlap with many other tumor types, but they do not fit into a discernable, unique multi-tumor community. These are the Mass Communities: lung cancer (LC), breast cancer (BC) and multiple myeloma (MM). The top half of treaters for each of these tumors spends a third or more of their time treating just that tumor.

Contrast this with prostate cancer (PC), which has the second highest incidence rate and is the fourth leading cause of cancer-related death in the U.S. Despite the significant patient volume, the top half of PC treaters spend only 7% of their time with PC patients. The only clear tumor adjacency to PC comes from renal cell carcinoma (RCC). Oncologists who treat PC and RCC together form a urinary-focused treater community. Ironically, only one in ten treaters with bladder cancer as a focus also has PC as a focus, and they only loosely overlap with treaters who have RCC as focus.

While many oncology companies think about hematologic malignancies as a market segment, this is not reflected in the actual distribution of patients across practices. Hematologic malignancies are subdivided into communities focused on lymphomas, leukemias and MM, respectively. Only one in five treaters for whom Non-Hodgkin lymphoma (NHL) is a top focus also has a focus in CLL. In fact, an oncology manufacturer would get more commercial synergy extending its NHL customer-facing resources to LC than CLL. MM, which represents about 2% of all cancer patients but 8% of all cancer drug sales according to EvaluatePharma and SEER, overlaps as much with the lymphoma and leukemia communities as it does with LC and BC treaters.

There is no community of treaters focused on women's cancer when BC is included in the definition. Oncology manufacturers should instead think about gynecological cancers as a community whose treaters have significant cross-tumor overlap and among the highest degree of focus on their respective tumors of any Specialized Community.

A cluster of gastro-intestinal tract tumors form the fifth Specialized Community. Treaters for whom colon cancer is common in their practice also spend significant time on esophageal and hepatocellular carcinoma.

What this means for pharma's pipeline strategies

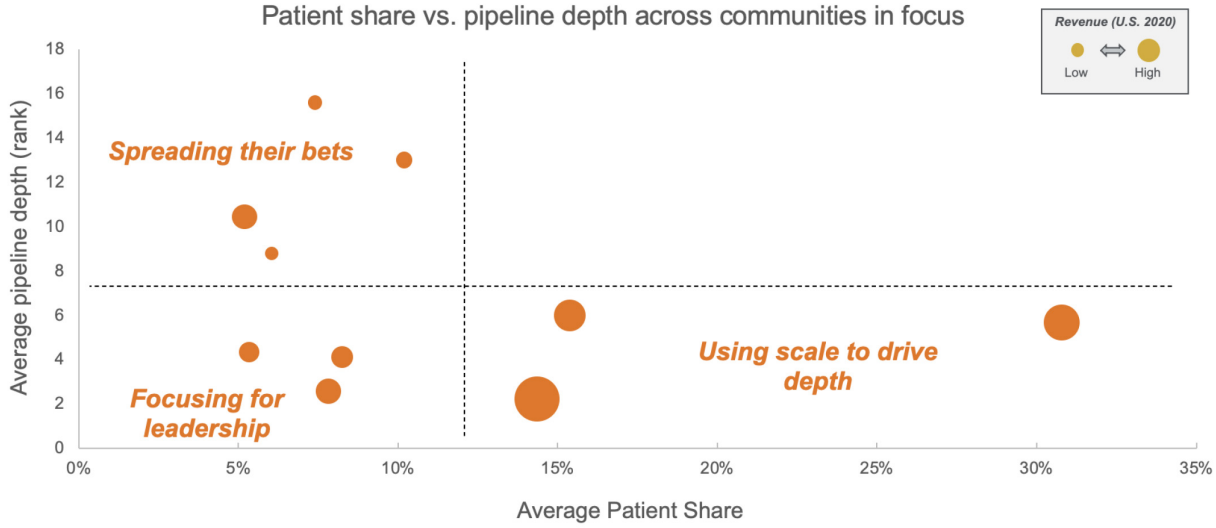
Many tumors are treated by a broad cross-section of physicians with very little aggregation of patients among specialists. These tumors, of course, deserve the attention of innovators as they are often rare and represent relatively high unmet need. But individually, they are unlikely to propel an oncology company to leadership in the eyes of a customer. Many of these tumors are also being addressed by the same MOAs being used to address much more common tumors (e.g., two thirds of the MOAs in clinical development for thyroid cancer are also in clinical development

for LC). This means many companies building a deep pipeline around one of the three Mass Communities or five Specialized Communities will have organic scientific adjacencies to support the fight against these other tumors as well.

Looking at the pipelines of the 10 largest oncology manufacturers by revenue today (see Figure 3), they are employing a variety of portfolio strategies. We examined each company's average rank of pipeline depth across the oncology communities for which the company has multiple indications under development, relative to their average market share across these communities today. Some companies are using their scale to drive depth, some are applying their resources in a focused way to generate a smaller number of leadership positions and others are spreading their bets while looking for revenue across communities. To achieve the benefits of leadership, these companies and others with the ambition to be included among the top ten should focus on specific communities to concentrate their bets and build for scale.

FIGURE 3:

Using scale to drive depth



Of course, treater communities alone should not drive how oncology manufacturers think about portfolio strategy. Portfolio strategy is an optimization problem that should include many dimensions bearing importance to the company and ecosystem into which that portfolio will be sold. In oncology, institutional decision-makers in integrated hospital systems are increasingly centralizing some of the decision autonomy that individual oncologists have enjoyed in the past. Payers and the role of utilization management also need to be considered in a forward-looking oncology portfolio strategy.

The future of leadership in oncology must include the customer

The nature of scientific discovery is challenging to contain to a few tumors, particularly given the industry's focus on immuno-oncology, onco-genetic targets and platforms with novel approaches to attacking cancer cells (e.g., engineered cell therapies like CAR-T). These modalities are inherently applicable to multiple tumors. As of 2021, approximately 60% of MOAs with an approved product in oncology had indications in at least two tumors. Yet only one in five MOAs is currently used across five or more tumors. And there is significant correlation between tumors that are being addressed by the same MOA and tumors that are being managed by the same treaters. Creating focus in a company's oncology pipeline is not easy, but it is also false to claim that it is impossible to consider treater communities in discovery and development decisions.

We propose that oncology manufacturers should incorporate the customer in the form of eight defined treater communities as a new dimension in their portfolio strategies with the goal of building leadership positions in a focused set of treater communities. This shift in how new opportunities should be identified and development programs should be prioritized will deliver clear advantages that will benefit those who adopt

this framework. Taking this approach will help you define a clear vision for who you want to perceive your company as a leader, clarity on portfolio adjacencies and the ability to capture commercial synergies in an increasingly competitive market.

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