

## **Measuring marketing**

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### **Introduction**

It has been said that there is only one way to test marketing: wait and see what happens. However, there can be few scenarios where a ‘watchful waiting’ approach would ultimately be considered an appropriate risk. This observation highlights an unmet need in the pharmaceutical industry: whilst it is possible to predict and measure the effects of sales promotion by direct measures, or by modelling using surrogate measures, there are no *a posteriori* measures of the effectiveness of strategic marketing that can be used to judge effectiveness. As strategic marketing, or commercialisation, is significantly more powerful as a lever for success (or failure) than promotional marketing (strategic decisions have been responsible for all major successes and failures in the pharmaceutical industry in recent years), the lack of measures that can be used to predict the success or failure of strategic decisions represents a significant area of uncertainty for the pharma industry. One issue that may contribute to the sense that strategic decisions have unpredictable results, is the perception that strategic marketing is significantly more complex than sales promotion in terms of input-output measurement. Most senior industry figures have developed the view that it is impossible to measure ‘input’ to strategic marketing in terms of its cost: good decision making costs the same as poor decision making, rendering invalid the hypothesis that the level of up-front investment is a predictor of success.

In an industry, therefore, which typically lives within 20–30 year investment horizons, and where billions of dollars are invested in R&D with the expectation of a significant return on investment, it is unsustainable that strategic marketing (distinct from sales promotion) continues without a measure of effectiveness. Commercial decisions including choice of therapeutic area, candidate selection, Target Product Profile, Target Patient Profile, definition and measures of efficacy and positioning all need to be made as early as Phase I, however until now there has been no way to test the strategy or the plans that inform these decisions. This has led to a situation where, analyses suggest, only 1 in 4 pharmaceutical brands ever repays its investment. The launch of a new Industry-Standard measure of marketing effectiveness, therefore, addresses one of the most fundamental challenges facing pharmaceutical companies in the 21<sup>st</sup> century.

### **Measures of marketing**

The increasing noise surrounding ‘return on investment’ (RoI) in the pharmaceutical industry reflects a basic tenet: you can only measure parameters where you have a yardstick available. However, the essential premise underlying RoI is that ‘investment’ is a single parameter, and that ‘return’ is measurable on the same scale as ‘investment’. Furthermore, it is clear that ‘investment’ is modified by the way in which that investment is conducted; that is ‘return’ = ‘x’ x ‘investment’ for a given activity, where ‘x’ is the factor or factors that modify the relationship between investment and return: the ‘x’ factor that determines whether RoI is high or low. Overwhelmingly therefore, the equation has been considered as a financial calculation, and various measures have attempted to translate non-financial surrogates into a financial value, to

determine the 'x' factor. This approach, however, is analogous to trying to determine what a forest looks like by examining individual trees. Furthermore, in this equation, investment is always a positive value: this assumes that any degree of investment has a positive effect, whilst in reality, the level of investment has to be compared with others in the market to ascertain whether it is above or below industry-standard. Furthermore, if the hypothesis is written as 'altering a financial investment produces a causative increase or decrease in financial return,' and is applied to *strategic* marketing, it immediately and evidently becomes invalid – spending '\$z' behind a poor decision has a significantly different outcome than spending '\$z' behind the right decision. Once stated this way, the fallacy that all marketing is measurable using a single financial scale is evident. Strategic marketing is primarily a quality-based parameter, where financial inputs are decoupled from quality outputs. Therefore, a measure of quality is essential as an end in itself. Such a quality measure, like an investment measure, can be above or below industry standard, and can therefore modify the RoI downwards as well as upwards.

Written simply, therefore: *Outcome = quality (of marketing or strategic marketing) x benchmarked investment*

Once this self-evident assertion is accepted, the goal of defining a quality measure, and the importance to pharmaceutical companies of doing so, overrides the issues of complexity in deriving the measure. In simple terms, a brand with an average or below-benchmark quality measure will never compete with a brand spending as much but with a marketing programme of superior quality.

In effect, all pre-launch marketing and a great deal of post-launch strategic marketing falls into this category: a systematically derived Target Product Profile may not pay back for 15 years. However, the cost of a poorly developed TPP may never be measurable or even calculated. Many recent examples suggest that the increasing number of failures at regulatory submission directly resulted from failures of strategic marketing. This has a substantial effect on the top line, bottom line and, perhaps most importantly, on patients.

An example of this is the failure to adequately power studies to examine sub-groups of patients who may accrue greater benefits from a particular agent (responder/non-responder analyses). Although the influenza agent RELENZA was shown to confer benefits in a heterogeneous patient population, the lack of robust evidence in those at most risk, where payors perceived the benefit of RELENZA to lie, prevented a smooth approval; one from which RELENZA has never recovered. The chemotherapy agent IRESSA is another example: although the overall patient populations examined showed no significant benefit for IRESSA in later trials, it is evident that there are sub-populations of patients who do benefit. However, the studies were not formally designed to test this hypothesis, and so the opportunity to appropriately position in a population with a favourable risk/benefit profile was missed. Conversely, there is no doubt that the drivers behind the considerable success of LIPITOR were qualitative (positioning, brand message, redefinition of efficacy, aggressive trial programme), multiplied by significant investment.

Even at a mundane level, a well-organised and objective-led advisory meeting will cost the same as one with no clear objectives. There is, it seems, little alternative but for the industry to attempt to rate quality independently of cost.

### **Measuring quality**

Given the lack of ‘hard’ endpoints, it is tempting to say ‘it is impossible to measure quality’ in strategic marketing, and that the ‘x’ factor or factors are beyond the definable. To be content with this conclusion, however, ignores the truth behind the powerful statement, ‘hope is not a strategy.’ As we have seen, many billions of dollars of investors’ money lie on laboratory floors as a result of this ‘impossible’ task.

However, lessons from many industries point towards a way to overcome the difficulties in defining a quality measure. Some industries struggle with a harder task: knowing what ‘good’ looks like is often based upon collective, subjective judgements (for example, in the entertainment industry, wine making, or tea production). In the pharmaceutical industry, however, drawing conclusions from success or failure is a much more objective prospect. Forensic case studies of disruptively successful compounds, or unpredicted failures, as well as moderate performers, yield many lessons for the experienced investigator.

The obfuscating factor in forensic examination of pharmaceutical case studies is the contingent nature of strategic marketing – a compound’s positioning is contingent upon the quality of the market research, advisory meetings, and assumptions about the probable attributes, as well as the quality of the process of deriving the positioning.

However, that key insight provides the first guide: looking for a single ‘metric’ or template that works across all brands would be impossible – like attempting to tune a piano by tightening or loosening all the strings at the same time. So, the first imperative is defined: a measuring scale must allow for each brand to be measured against its own objectives.

It is also essential to look beyond the binary: for example, ‘having’ a positioning is not predictive of success or failure; having a systematically-derived positioning (i.e., with properly-tested premises and assumptions, and a best practice-based approach), however, is a component of successful brands and one that is lacking in unsuccessful brands. That is, positioning quality is a robust, causative and predictive component of success.

Building up a ‘quality construct’ or qualitative index from such components, therefore, produces a more specific picture of ‘quality’ than was previously available. Developing a robust qualitative index is then a function of identifying an exhaustive set of components, all of which must be present, and of testable individual quality. This approach results in an objective yardstick, that has both validity and reproducibility.

### **Measuring investment**

Constructing an investment, or quantitative, index, is relatively more straightforward, although still complex. It begins with a hypothesis that no two brands face the same challenge: therefore a valid quantitative index must be built upon elements that are

standardised against objectives and historical parameters. For example, an undifferentiated ‘me-too’ brand in Phase III, launching into in a primary care market, has different imperatives than a novel transplant immunosuppressant in Phase I. There are many historical analogs and financial models that provide benchmarks for investment in each case.

### **A standardised measurement scale**

There are two ways to apply measurement to a marketing plan: with complex feedback, or with reference to a standardised scale. Many internal processes have relied upon ‘experts’ to provide complex and constructive feedback on strategic marketing, however such processes are typically limited by time, which then limits a full audit of the premises, assumptions and testable components within any plan. Furthermore, such review struggles to make reference to the competitive landscape. A self-referential review, which does not apply the same scale used to rate competitors, yields less valuable information for senior management, analysts and the brand team itself. Yet many measures of marketing excellence employed within the pharma industry compare one brand with others from the same company. Such an approach may provide a ranking of compounds, but provides no information on how they stand within the all-important competitor environment. There is little point being a first brand among equals if all the brands are equally poor.

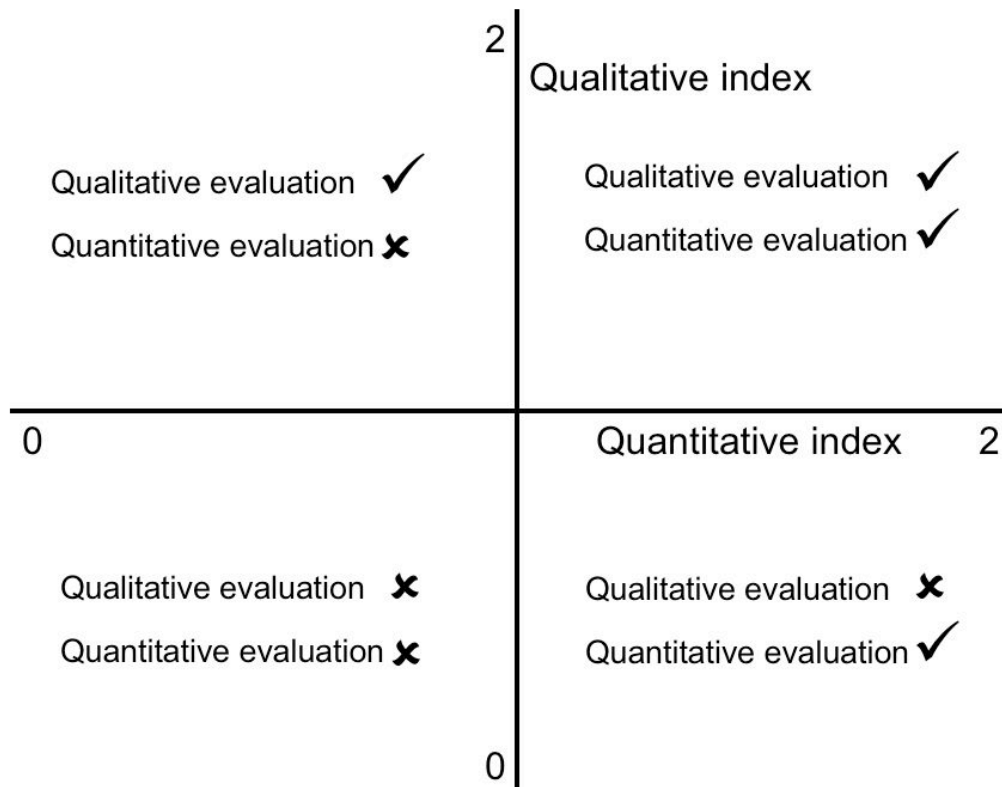
Therefore, there are two requirements: a full independent audit (to fully investigate the strategic marketing plans and other testable components) and a rating scale

triangulated across the whole industry, measuring qualitative and quantitative components against a 'benchmark' score.

### **The Q2 Audit**

The Q2 audit applies new industry-standard rating scales to individual brand audits, rating qualitative and quantitative components on an index of 0–2, where 1 is a 'benchmark' rating for each. The individual Q scores are then multiplied to produce the Q2 score, so a brand which scores at benchmark (1) on each scale, produces an overall score of 1 (i.e, a brand which is expected to be market-neutral).

The Q2 rating has an important opacity. A brand scoring 1.8, for example, may be very well supported by a large budget (scoring 1.8 on a quantitative assessment), but with a 1.0 qualitative rating. A small increase in the qualitative rating would produce a non-linear improvement in the Q2 score (for example,  $1.2 \times 1.8 = 2.16$ ), signifying a brand that would be expected to outperform its market. However, none of this detail would be apparent to a viewer who sees only the Q2 score (for example a pharmaceutical analyst).



This is an important consideration in an era where analysts and senior management need to know more than the clinical data to make a judgement about a brand’s prospects. Many recent high-profile compounds that have delivered against their clinical objectives have spectacularly underperformed in the market (predictably, when a Q2 rating is applied retrospectively). A ‘positive’ Q2 rating made public is a more effective guarantor of success, without revealing strategic details to competitors.

**Conclusions**

Q2 Audit is the new industry-standard measure of strategic marketing; the first independent, objective predictor of commercial performance.

By applying latest benchmark planning, best practice and investment indices to pharmaceutical commercialisation plans, Q2 is the only rational approach to the significant unmet need within the pharmaceutical industry to de-risk the strategic marketing element of commercialisation.

Most commentators agree that commercialisation is, historically, a greater lever of success than R&D, yet to date companies have had to rely entirely upon internal standards. Q2 now provides a timely, independent audit of the qualitative and quantitative components of the commercialisation plans.