

**How new
technologies
are affecting
launch**

**What makes
a good pharma
leader?**

**Finding the
right value
proposition**

Sales & Marketing Innovation

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September 2019

Sales & Marketing Innovation

Sales and marketing teams are at the forefront of crafting pharma's public-facing messages, and as such are under immense pressure to adapt to a world that is rapidly embracing innovations like big data, social media and AI. But at the same time, companies savvy enough to shift through the noise about technology to identify real opportunities are poised to capitalise on these trends.

In this issue of Deep Dive, with the help of experts from across the industry, we take a look at how sales and marketing teams can navigate this complex new world and harness the full potential of innovations in the sector.

Aurora's Siân Hurst and Chris Bath tell us why they have started using data and insights to measure the success of comms strategies and design more impactful programmes. And Rosanne Campbell and Andrew Thomas from Syneos Health discuss the importance of preparing a value proposition as early in drug development as possible.

We also have interviews with two agency leaders – Healthware's Roberto Ascione and Havas Health & You's David Hunt – about their journeys through the industry and their reflections on where things are heading.

Elsewhere in the issue, IQVIA's Sarah Rickwood looks at how new, game-changing drugs are affecting launch strategies and Professor Brian D Smith shares some of his findings on what makes a good pharma leader – always an important position when it comes to driving innovation forward.

I hope you enjoy the issue.

Kind regards,



George Underwood
Editor, Deep Dive

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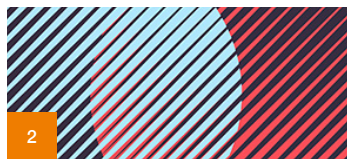
[R&D Innovation](#) – Meeting patient needs in rare diseases,
– February 2019

[Disruptive Technologies](#)
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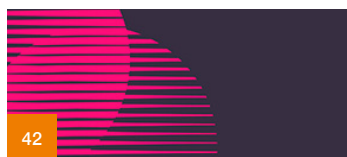
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Measuring and celebrating making a difference

Aurora's Siân Hurst and Chris Bath explain how using data-driven insights to build comms programmes can lead to more impactful outcomes for clients and patients

Although creativity is a huge part of pharma comms, it is meaningless if it does not lead to a demonstrable impact for clients and, ultimately, patients.

Aurora's digital insights lead, Chris Bath, says he has noted a tendency in the industry to focus on creativity rather than outcomes, especially among industry award bodies.

"Sometimes communications can feel quite intangible," he explains. "But actually, success in pharma comms can be measured and it can be proven."

This is the line of thinking that has led Aurora to take a more data-driven approach to their comms strategies, using insights to measure the success of their programmes then adjust them to optimise impact.

Bath, who led the implementation of Aurora's insights framework, highlights the importance of knowing that communications are actually "making a difference". He says that this can be achieved by both designing an insightful strategy based on data and then measuring its impact.



“It’s about ensuring nothing is left to chance. If you strive to make an impact with the work you do, you need to have certainty at every stage in your campaign.”

An ‘insightful strategy’, he says, is about ensuring you’re working with facts not assumptions.

“We don’t develop programmes based solely on gut feeling. We want to be confident our strategy is reflective of what people want and need. We want to know we’ve done the due diligence by speaking to patients and healthcare professionals, and that we’ve drawn out the insights that are most important.

“As communicators, all the work we do is scrutinised. We’re providing a voice for pharma, and with so many channels available to us to talk about what we’re doing, we need to find the value in the work we do more than ever.”

Aurora’s managing director Siân Hurst adds that committing to the value of data-driven communications is a matter of reputation. Good use of data and budgets will increase trust between all stakeholders, particularly patients who are pharma’s customers of the future.

“How pharma can work directly with patients in the future is something we’re thinking about now. Advancing technology and pay-as-you-go healthcare mean that patients know more, want more and expect more from their healthcare and importantly, they’re generating more data than ever before that can help shape decisions and guide our programmes of work.



“It’s really exciting right now to be in a position where we can learn from this growing pool of data because of the heritage agencies like Aurora have in working with patients and patient groups.”

Methods of measuring

In order to gather such insights and get accurate measurements of success, Aurora developed a dedicated framework, Acumen, and applied it across the entire agency.

Acumen is based on existing tools – such as the AMEC Integrated Evaluation Framework, which was developed to introduce standards for evaluation across the communications industry – but tailored to be bespoke to healthcare. It follows five stages:

- Input – strategic insights developed from data
- Action – the strategy based on these insights
- Reaction – the immediate reception, perception and reaction for the programme
- Result – longer term strategic aims including changes in behaviour and attitude
- Impact – the quantifiable impact on businesses, patients or customers.

The main sources used for these measurements are HCPs, social media, search, and patient intelligence panels through the agency's partnership with PIP Health. "These panels help ensure that our programmes are truly patient intelligent," explains Bath.

"Meanwhile, we can use social media to analyse what people are talking about and who's talking about it. We'll also analyse search engine data, which is important because there's always a disparity between what people are talking about publicly on social media and what people are searching in private.



“These channels allow us to benchmark what people want. We’ll go back to retest them all later to prove that our programmes have made a difference.”



Gathering meaningful data from social media might sound difficult, but Bath says that following certain principles can help.

“You always have to create and test a hypothesis; if you have a particular question you can go on to social media to prove or disprove that. You look at conversation topics and volumes, as well as where people have those conversations – is it Twitter, is it blogs, is it more visual conversation using Instagram? You can then analyse those conversations.

“Not every conversation is analysed, but ultimately you get to a point where you’ve got lots of rich data that can prove or disprove your hypothesis and lead you to uncovering that insight that is special to your campaign.”



Meeting challenges in implementation

Implementing a new framework like this in an established agency is no small task, and Hurst says it required a lot of research and testing.

“To make that possible we created a dedicated team, which Chris heads up, who became experts along the way and could then train the rest of our team, and in turn our clients as well.”

She says that it took longer to embed across the company than they had anticipated.

“This is because it required a behaviour change across the agency at every level – from myself down to graduate account coordinators.

“You’ve got to be realistic, because this kind of thing doesn’t happen overnight, and the biggest challenge has been finding the time to embed it across our team and to do that really well. Getting 30 people upskilled to the same level, while they’re all delivering their usual client work, is quite an undertaking. Especially if you want it to be something they think about all the time. We don’t want it to just happen at the end of a campaign creation, we want people to think about it right from the beginning.



“To do that we’ve had to test it again and again, and encourage people to sit down with the core team and think about how we can measure something and why we’re doing it.”

“We have been profiling when we’ve made a positive difference. It’s something to commend when we really make a difference.”

There are also challenges from the client side, with some clients being more proactive in harnessing insights like this while others are resistant to change.

“Many clients still don’t want to pay for measurement or invest the time to work it out with us in the planning stages of a project. I get that it’s a different way of thinking but it’s something we believe is essential to prove the value of the work we do together with and for our clients.

“Clients that want to make a difference equally get a buzz out of seeing the real impact of the work we do.”



Impacts

Hurst says that taking this approach has forced Aurora to think more critically about what they are doing and why they are doing it.

“That might sound obvious, but comms can be so fast-paced that it’s actually a good way to consciously pause, reflect and help us think.

“If you’re going to do this right with clients, you’ve got to have face time with them, so you can thrash out the details of what you’re trying to measure. Then you’ve got to sit down with them and assess and reassess the direction of the programme as new data comes in and you learn more and more. It makes us think more critically as teams with our clients. I think that’s a brilliant thing.”

Many might have assumed the opposite – that increasing digitisation would mean less face time with clients, and Hurst says there is still a risk of that.

“You could just look at the surface level of the data, and tell the client what you’re going to do without discussion. That’s not where we want to go. We want to use the framework as a starting point to look at why we are taking the approach we’re taking and then seeing how it evolves. It’s a constant negotiation.”



Negotiation is key as the insights gathered during the creation of a programme can have some surprising results. Bath points to one campaign where market research showed that digital would not actually be helpful at all for the patient population in question.

“It was for families living with an ultra rare condition where, prior to treatment being available, patients only lived for two or three years. The advent of treatment meant that children could go to school for the first time, but the unmet need was that schools weren’t equipped with the right information or resources and families weren’t equipped with the right knowledge to apply for grants.

“After speaking to families and nurses at Great Ormond Street Hospital, we designed a resource pack that helps families learn what they need to talk to the school about and helps equip schools with the right documents to apply for grants from the government and local authorities.”

Families did not need to download the pack off the internet. Instead, the programme was paper-based and led by the nurses.

“You might assume that in 2019 you need to do something digitally,” Bath says. “But we didn’t need to do that. It wouldn’t have worked for these patients because it’s focused on a very specific population and was co-created with them.

“In terms of success there is something to celebrate here. All the families who received the pack secured a meaningful and worthwhile education – something that hadn’t been seen before.

“That’s still using data, of course. When you say data, people think zero and ones, numbers and charts, but actually you can still get the richest data from having a conversation with families that have a child with a condition, instead of trying to find some form of insight using social media.

“If you lose the voice of the customer, you lose the data at the end to prove you’ve made a difference.”



Eye to the future

Bath notes that it can take extra time to nurture insights like these to work out what's important to brands or campaigns. This, he says, points towards a changing skillset in communications teams.

"Big networks often have insight teams which healthcare practices can access. We see it differently. Integrating the skills amongst the team is really important so we can all deliver the work that can successfully make a difference."

Bath says that agencies like Aurora will also need to make sure they keep pace with new roles that appear with emerging channels. To do this, he says that it's important to keep speaking to patients and healthcare professionals to ask them where they find their information and where they go to talk about it.

Meanwhile, Hurst notes that the agency's own framework will continue to evolve:



"We want to keep making adjustments to make sure that we're always doing the very best that we can. It's going to be an ongoing piece of work."

And going forward, she says she would like to see both Aurora and their clients being "braver and more ambitious" about knowing the impact they can make.

"We've just got to recognise that it's going to take a little extra time to plan. Over the next few years we'd like all of our clients to invest in knowing they've made a difference and help patients have better lives.

"Change is happening and that's something to applaud."



About the Interviewees



Siân Hurst is managing director of Aurora, a specialist independent healthcare communications agency helping patients access medical innovations. With over 20 years' experience working in healthcare agencies, her strengths lie in team leadership and client relationships, both of which are helping to drive evolution of the agency in response to the needs of Industry and, most importantly, patients.



Chris Bath is a director and digital insights lead at Aurora, responsible for establishing an insights and measurement framework that is central to the agency's ambition to be the leading evidence-based agency, specialised in health. With ten years' experience working with pharmaceutical companies, he specialises in understanding how to help clients solve their biggest problems, and how to use digital channels and insight to do it.





Finding the right value proposition

With health technology assessment organisations becoming more powerful in Europe, and huge public scrutiny on drug prices in the US, it's vitally important that pharma companies start thinking about the value of their product early in development. Richard Staines spoke with Rosanne Campbell and Andrew Thomas from Syneos Health to find out more.

Getting drugs to market has never been easy, with regulators rightly demanding high standards in terms of clinical effectiveness, safety and the value proposition. But the influence of health technology assessment (HTA) bodies in Europe, such as NICE in the UK and Germany's AMNOG pricing system, mean that pharma companies have several barriers to overcome before they are able to launch.

And on the other side of the Atlantic, US payers are becoming concerned about the high price tags for drugs – which can also be a barrier to access as prescription costs will often be funded in part or entirely by the patient.

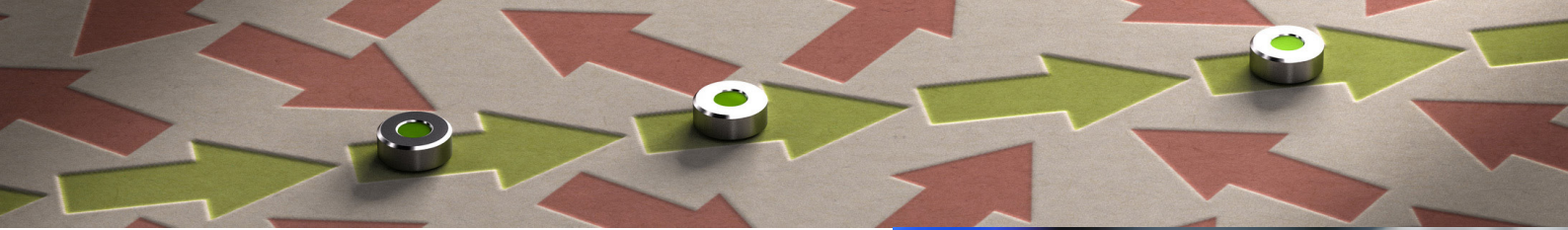
According to Rosanne Campbell, senior project leader for value, access and HEOR, and Andrew Thomas, managing director for PR UK, pharma companies must start thinking about matters relating to price early on in drug development to maximise their chances of getting the product to market at a good price.

They added that it's not always as simple as NICE being intransigent, or pharma companies being greedy – often it's a case of miscommunication that occurs because of a drug development culture where companies are rewarded on the basis of clinical milestones.

Thomas said: "We see this a lot when we work with smaller companies, like biotechs, who are very clinical-focused. They'll have one product that they, understandably, put their heart and soul into, and they're so focused on getting regulatory approval that they're not thinking about the commercial side and getting access soon enough in the strategic planning process."

This also does not fit well with NICE, which is increasingly looking for engagement with drug developers early in the clinical development process.





Much of early clinical development is overseen by smaller biotechs because of big pharma's tendency to outsource this stage of research or get involved much later on in the clinical development process.

Consequently, the needs of HTA bodies are still often overlooked in the early stages.

Campbell said: "HTA bodies really want early engagement. If we look at NICE, they're set up in such a way to encourage that. They have the Office of Market Access and Early Scientific Advice.

"They want you working with them early on so that you are developing the right evidence that's going to help you to get access."



According to Campbell, HTA bodies are becoming more confident and are clear in their demands about what they will and will not accept from pharma.

Their goal is to guide development so that drugs come in at the right price and come to the market as soon as possible.

While NICE is accommodating in terms of providing feedback during the clinical development process, it is rigid when it comes to enforcing its cost-effectiveness threshold.

"They're saying, 'Don't mess us around. Don't come to us with a QALY of £32,000, come to us with a QALY of £30,000'," Campbell said.

Technical challenges in value

Unfortunately, NICE's approach is at odds with a trend towards clinical development where drugs are approved on the basis of earlier data.

Regulators in both the US and Europe are willing to accept findings from phase 2 trials and grant conditional licences if manufacturers commit to providing confirmatory data from large-scale studies.

But bodies such as NICE and Germany's G-BA and IQWiG often rely on phase 3 data to measure how newly approved drugs perform compared with standard care.

NICE struggles with data from phase 2 trials which may often have a single arm, resulting in uncertainties following its number-crunching.

Thomas said: "It's trying to get pharma companies to look beyond the regulatory stage, and towards the commercial end of things."

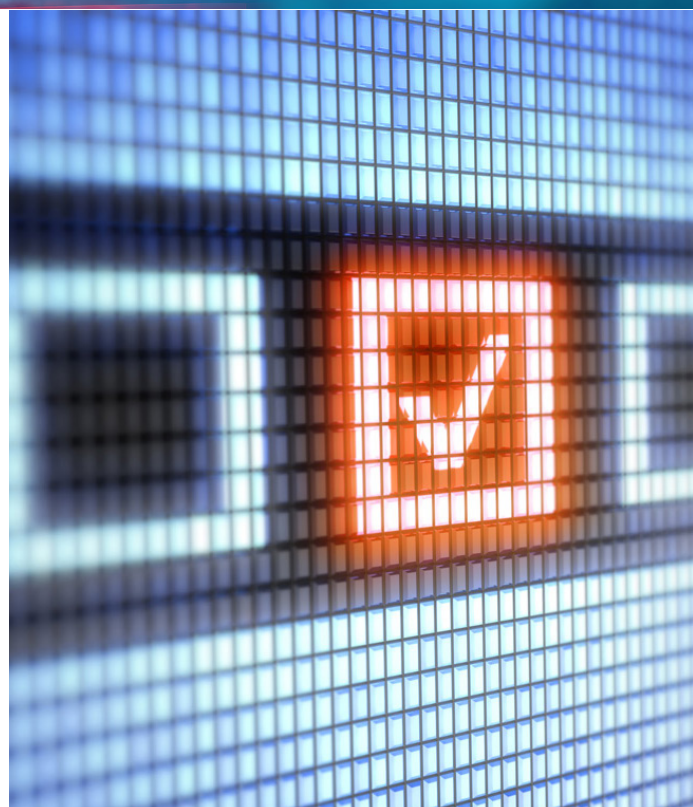
Another challenge is to convince payers about the value of the innovative products. With so many companies trying to argue that higher prices are justified because of innovation, payers want to see hard evidence of any benefits.

Thomas said: "We have to innovate. We need to bring new products through, but it's about specificity. Innovation for what purpose, for who and when? It now needs to be more quantifiable and qualifiable innovation."

Campbell added: "You have to tick certain boxes, which can have advantages and disadvantages. Obviously, the advantage is that it can help you focus, in terms of you as a company and what you need to be working towards to really demonstrate the value.

"But then if your product is innovative, the rules may be restrictive, or it may be difficult for you to really demonstrate its value.

"That can cause problems and lead to undervaluation of your product. That's not such a positive thing for pharma."



Patients' perspective on value

In many cases the missing link can be the patients' perspectives. They have the insight that can allow companies to make the case for their product and help to convince payers about its value. Campbell cites the example of cystic fibrosis drugs in Ireland, which were eventually funded as a result of campaigning by patients.

Campbell said: "It's a super expensive drug. It was taking up a lot of the healthcare budget, but patients had a big voice there and it got in on the floor of Parliament. Then suddenly they were reassessing things. I do think the patient is getting more powerful. They're a lot more informed now. They have a stronger voice."

It's worth noting that campaigning by patients in the UK has not been able to resolve the differences between health technology assessment bodies and Vertex for their expensive cystic fibrosis drug Orkambi – but there have been some notable successes.

The Scottish Medicines Consortium (SMC) earlier this month used its Patient and Clinician Engagement (PACE) in a process that ended with a funding recommendation for Akcea's Tegsedi for the rare muscle wasting disease spinal muscular atrophy (SMA).

Although the SMC rejected Vertex's latest cystic fibrosis combination Symkevi using the same process, this demonstrates that patient input can be a deciding factor when it comes to health technology assessment and market access.

Campbell said: "It's the same in NICE committee meetings as well. The patients are there, they are represented, they have a place at the table."



A compelling case

Making a compelling case about the value of the product will therefore require pharma companies and biotechs to be well coordinated internally, and to begin dialogues with organisations such as NICE as early as possible in the development process.

Thomas said: “Oftentimes you’ll still find people working within silos in a pharmaceutical organisation. We would always argue that there are huge advantages to be realised from greater integration – both in terms of resource allocation and intellectual efficiency.”

Campbell concluded that the key to success with organisations such as NICE is to be willing to accept advice from outside sources, and to start thinking about arguments on value as early in clinical development as possible.



“You need to have that back-of-mind when you’re preparing your clinical trial, when you’re getting ready for market access, when it’s approaching the commercialising stage.

“You have a better chance of getting your story across with a clear strategy in place.”

About the Interviewees



Rosanne Campbell is senior project leader for value, access and HEOR of Syneos Health Consulting, based in London. Rosanne brings more than eight years of experience in HEOR and PMA consulting to Syneos Health’s Pricing and Market Access practice in Europe. She has worked on a wide range of projects including economic models, literature reviews, reimbursement dossiers and market access strategy across Europe, Asia and the US. Rosanne studied in Ireland and London with degrees in Business, Economics and Health Economics.



Andrew Thomas is managing director of Syneos Health PR UK, based in London. He has more than 18 years’ experience of running national, regional and global communications campaigns for pharmaceutical and biotech clients as well as disease awareness initiatives for large NGOs such as the World Health Organization. He also has considerable client-side experience having held senior roles in Pfizer with responsibility for some of the organisation’s biggest brands and product launches.



About Syneos

Syneos Health is the only fully integrated biopharmaceutical solutions organisation. The company, including a contract research organisation (CRO) and contract commercial organisation (CCO), is purpose-built to accelerate customer performance to address modern market realities. Created through the merger of two industry-leading companies – INC Research and inVentiv Health – it brings together approximately 24,000 clinical and commercial minds to help its biopharmaceutical customers shorten the distance from lab to life. Learn more at syneoshealth.com



A close-up photograph of a hand holding a smartphone. The background is heavily blurred, showing colorful bokeh lights in shades of orange, yellow, and blue. The hand is positioned in the upper right, with fingers gripping the phone. The phone's screen is visible in the lower right, showing some indistinct blue and white patterns.

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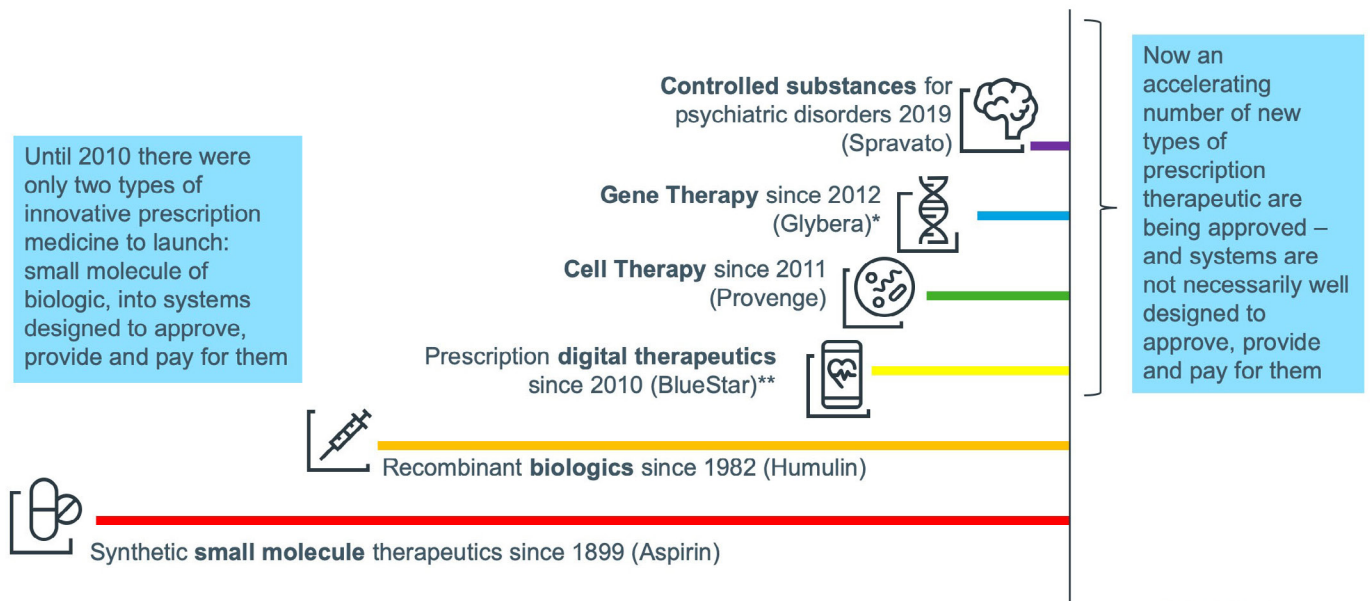
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How new technologies are creating new markets

Sarah Rickwood looks at why the next frontier for pharmaceutical innovation may not be a pharmaceutical at all, and how this will affect launch

The prescription medicines industry has always been driven by innovation, and that innovation has, until very recently, focused almost exclusively on the molecules of one of two basic types – small or biologic. This is changing rapidly, as Graphic 1 shows. The future of innovative prescription launch will now include therapies made from genetic material, a patient's own cells (or someone else's) or even more beyond molecular innovation entirely, for example moving into the digital realm. As this happens, it will not be business as usual for launch.

Prescription launch offering types have multiplied since 2010- as will launch challenges

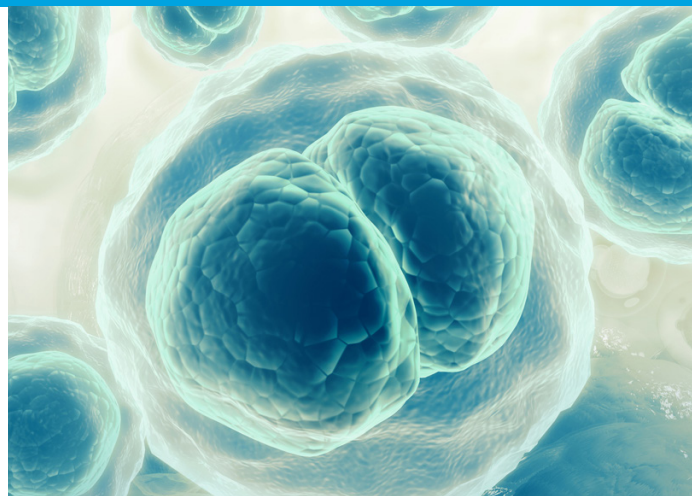


*Gendicine was approved in China in 2003, but Glybera was first gene therapy approved by EMA and FDA
**First standalone prescription digital therapeutic (re-Set) approved by FDA November 2018

IQVIA™

Launch of the first advanced therapy medicinal products: cell and gene therapies

From 2010, with Provenge (sipuleucel-T), pharmacotherapies involving modified cells launched commercially. Subsequent launches of Kymriah, (tisagenlecleucel) for acute lymphoblastic leukaemia and diffuse large B-cell lymphoma, and Yescarta (axicabtagene ciloleucel), also for large B-cell lymphoma from 2017 onwards have proven successful and laid the foundations for a sustainable commercially successful sector in cell therapies.



Gene therapies had been performed experimentally since the 1980s, with patchy and partial success, until the 2012 approval of the first gene therapy treatment by a major regulatory agency, the European Medicines Agency, with Glybera (alipogene tiparvovec). This pioneer therapy was subsequently withdrawn in the EU, and it was a subsequent gene therapy launch in 2016, Spinraza (nusinersen) for spinal muscular atrophy, which became the first truly commercially successful gene therapy launch¹.

For these launches, solving manufacturing and logistics questions moves from background and support very much into the foreground.

Location of manufacturing facilities choices must be made early and carefully.

The cell therapy area has many restrictions on the testing and export of human cells which means that international launch could be complicated and slowed by where manufacturing is allowed. Unsurprisingly, both Kymriah and Yescarta started with manufacturing facilities in the US, and serviced their initial European use out of those facilities, although European facilities will come online. Other countries require earlier planning – for example if they do not permit the export of human cells and cell therapies must be manufactured locally. Novartis announced in 2H 2018 it would be partnering in China with a local Chinese Biotech, Cellular BioMedicine Group.

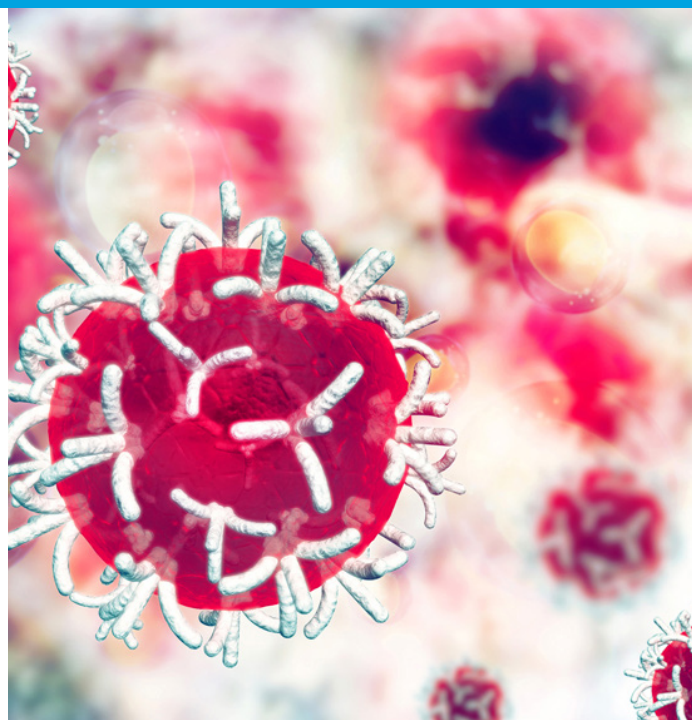
Cost of goods is significant and cost reduction a challenge. The companies which most successfully address this challenge will also be most successful in long term launch.

Compared to the processes for manufacturing conventional biologic medicines, cell therapy manufacturing is labour intensive and, initially, unautomated. Estimates (not by IQVIA) of manufacturing cost using the original, manual processes have been in the order of \$100k per patient². Full or partial automation of cell therapy manufacturing processes will be pursued, and may successfully address the cost challenge, although as patient numbers ramp up from hundreds to thousands, other formidable challenges of consistent quality, demand management and capacity will come to the fore. What's clear is manufacturing strategy is a key element of autologous cell therapy launch success.



Launch into markets defined by biomarker

The FDA has, as of mid-2019, approved three tissue agnostic treatments, the first being the already marketed Keytruda (pembrolizumab) for any tumour in the body which has a molecular alteration called microsatellite instability-high (MSI-H) or DNA mismatch repair deficiency (dMMR). This alteration results in a high level of DNA mutations, resulting in high levels of abnormal protein expression acting as a target for the immune system. More recently, the FDA approved larotrectinib, (Vitrakvi) to treat adults and children with solid tumours that have a gene alteration known as a neurotrophic receptor tyrosine kinase (NTRK) gene fusion, and Rozlytrek (Roche), applicable in 10 solid tumours.



Medicines launched alongside companion diagnostics which identify the patients appropriate for that pharmacotherapy have existed for decades – HER-2 diagnostics for Herceptin were a prominent early example. However, these diagnostics identify appropriate patients within an existing indication, conventionally defined. Genetic or other biomarkers can define patient segments in a completely different way, cutting across conventional diagnoses. While technologically cutting edge, this creates significant launch challenges – the patient journey must involve routine genetic testing, which must be both available and paid for. Responsibilities of diagnosing and treating healthcare professionals may be unclear, reimbursement codes may not exist or be disputed, health technology assessments and pricing/market access discussions more complex because comparators could be from multiple indications.

These types of products also face unique structural difficulties because they challenge the way healthcare systems are organised, which is by indication, and not mutation. That applies to treating oncologists (typically specialised by tumour type) and importantly payers' budgets and the way health technology assessors compare products. Companies launching these types of products cannot assume that payers and health technology assessors will immediately adjust their structures and processes to accommodate these new approaches – early evidence is that this will be resisted, and the responsibility to adjust will be pushed back to the launching companies.

Value added medicines (VAM)

For over a decade the market for value added medicines (VAM) – that is, pharmacotherapeutics where the active agent is off patent and multi-source, but the product has had value and differentiation added by, for example, novel delivery systems – has quietly grown to become a global market worth, in total, \$44 billion.

These products can address unmet needs – for example, of convenience, better delivery, reduced side effects, and can provide real benefit to individual patients and to healthcare systems. They are therefore differentiated from generics and, as branded products, seek a value above the generic level, and need launch investment that is more significant as well.



VAM launches face significant payer and market access challenges, because it can suit healthcare systems to treat them as generics on pricing, overlooking the investment made in generating useful differentiation. Prices tend to be higher than generics but lower than new active substance launches.

Health technology assessment and market access is structured to compare VAMs to their generic actives and price according, ignoring the often patient-centred advantages they bring. Industry level campaigning will be the best lever to persuade health technology assessors and payers to modify their policies to encompass a true valuation of VAMs. Companies launching VAMs must be extremely cost effective in managing market access and promotional investments, running lean promotional campaigns with a strong digital element.

Prescription digital therapeutics

In November 2018, Pear therapeutics' prescription digital therapeutic reSET, was approved by the FDA for patients with substance use disorders in the US. This FDA-approved prescription treatment consists of a 12-week series of interactive treatment modules delivering cognitive behavioural therapy, to be used in conjunction with outpatient care. This launch was rapidly (January 2019) followed by the US launch of Pear's reSET-O for opioid use disorder. Digital therapeutics are a broad and evolving group of treatments, but Pear Therapeutics' offerings mark a new stage, where prescription digital therapeutics (PDTs) have the potential for genuine equivalence to molecular therapeutics.



The first digital therapeutic to receive FDA approval was WellDoc's BlueStar digital support system for diabetes management. In 2010 it was approved for prescription use to track blood glucose and support patient self-management, and in January 2017 it gained further approval for non-prescription use. Proteus Digital Health's Digital Feedback Device, a miniaturised, wearable sensor and Proteus/Otsuka's Abilify MyCite, a drug/device combination to track ingestion of Otsuka's atypical neuroleptic for schizophrenia, have also received multiple FDA clearances since 2012. However, what has been approved and by which pathway differs – Pear Therapeutics' reSET is indeed the first prescribable software claiming specific therapeutic benefits, supported by clinical trial results.

Substantial barriers remain before PDTs are routinely prescribed and reimbursed. Prescription cannot automatically follow the well-established path of molecular therapeutics. The prescription element of PDT infrastructure is in its infancy. Reimbursement, the next challenge to successful launch, is also developing.

WellDoc secured reimbursed access to BlueStar for employees of several major companies, emphasising the savings that use of the programme bring to the management of diabetics. In the UK, digital therapeutics delivered via AppScript can already be funded by parts of the UK's National Health Service (for some this is free, for others this is as a one-time fee set at the level of the prescription charge – i.e. £9, and for a third category costs are individually priced).



However, debate on appropriate price points for digital therapeutics is in its infancy. The UK's health technology assessor, NICE, has undertaken a technology evaluation for Sleepio, a sleep improvement digital programme, and published the first evidence standard framework for digital health technologies in March 2019 – the start of a more explicit discussion on how to evaluate investment and return.

Digital therapeutics, and PDTs within them, also exemplify the challenges of creating new types of therapeutic launch. The market is not a global one – different countries are at quite different stages of development. New infrastructures for prescription, pricing, reimbursement and delivery of molecular therapeutics must be developed – existing ones may not be ideal or may not work at all. In short, creating new markets is a lengthy process, requiring activities and investments over and above the established challenges of Excellent Launch.

The future of launch: launching while creating a new market

Value-added medicines, cell and gene therapies, prescription digital therapeutics, and even biosimilars are all areas of the prescription medicine market which have one thing in common – they are, to a greater or lesser extent, creating a new market, with structural, cultural and perceptual barriers that ‘mainstream Rx’ – whether specialty, orphan or other – do not have to address.

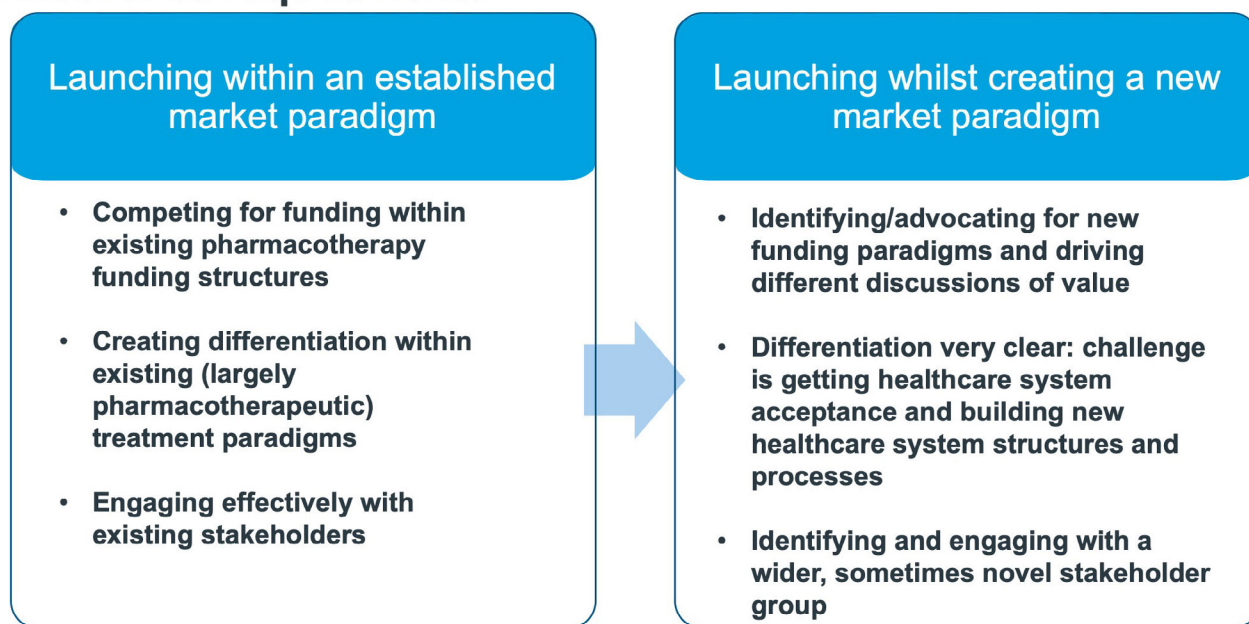
It is worth reflecting on how long it takes to create new markets. The modern market for small molecule generic Rx medicines, for example, originates in the 1984 Hatch-Waxman Act in the US. In the US, it was not until 1998, over a decade later, that generic volume as a share of the unprotected US market exceeded 50%. A decade after that, in 2008, generic volume as a share of the unprotected market had still not reached 50% in France, Spain, Italy and Japan.



The modern biosimilar market was initiated in 2006 in the EU, with the launch of Omnitrope, a version of Human Growth Hormone, by Sandoz. A decade later, in 2016 the global market for biosimilars approved by a dedicated regulatory pathway was only \$2.1 billion and had barely started in the US, the largest market (the Q1 2019 current global value is \$8.5 billion so progress is finally being made). This was not for lack of major biologics losing exclusivity; the challenge of creating a new area of the market which did not fit neatly into the existing infrastructure, culture and perceptions in healthcare systems was the bigger barrier.



With new types of Launch, we are seeing an evolution of Excellence requirements



IQVIA™

As outlined in figure 2, companies with novel types of launch must address incremental issues to those which launch within an established market paradigm. They will need to identify and advocate for new funding paradigms, gain healthcare system acceptance, and probably be involved in the building of new healthcare system structures for provision, as well as identifying and engaging with an expanded stakeholder audience. In the end, successfully accomplished, this expands the frontiers of pharmaceutical innovation further and faster than ever before – as such, it's true innovation.

About the Author



Sarah Rickwood has 26 years' experience as a consultant to the pharmaceutical industry, having worked in Accenture's pharmaceutical strategy practice prior to joining IQVIA. She has wide experience of international pharmaceutical industry issues, having worked in most of the world's leading pharmaceutical companies on issues in the US, Europe, Japan and leading emerging markets, and is now vice president, European thought leadership at IQVIA, a team she has run for eight years.

Exceptional leadership for an exceptional industry

Professor Brian D Smith dives into findings from his research to see what makes a good pharma leader



Few subjects consume as much bandwidth as leadership. From banal LinkedIn posts to weighty academic tomes, to those airport books with sexy, over-promising titles, we're overwhelmed with prescriptions about how to lead. But look carefully and you will see that this huge edifice is built on one, dubious assumption: leadership is leadership, whatever business you're in.

This is an extraordinary claim for which, to echo Carl Sagan, there is no evidence. Further, it is counter-intuitive: do we really believe that leading, say, Novartis is the same as leading Wal-Mart? Aside from obvious, basic competencies, is the skill-set of a CEO in pharmaceuticals or medical technology really the same as one in retail or consumer goods? These thoughts drove my latest research, in which I asked 23 industry leaders two questions: Is leading in our industry different and how do those differences influence how you lead? Their surprisingly frank answers, based on seven hundred years cumulative experience, make essential reading for those who work in the industry and perhaps aspire to leadership.



An exceptional industry

Everyone thinks their industry is special and their company unique. Management scientists like me are trained to screen out this subjectivity and identify what, if anything, is genuinely exceptional. When this technique was applied to my research, four authentically important factors emerged, as outlined below.



What makes our industry exceptional?

We have a contract with society

Society gives our industry permission to make money out of human suffering in return for longer, healthier lives. As Novo Nordisk's Lars Fruergaard Jorgensen put it, at this boundary of science, health and business there is always going to be emotion. Compared to other industries, this social contract creates higher moral expectations, which means that leadership cannot be focused on profit alone.

Ours is a risky business

Allan Hillgrove, of Boehringer Ingelheim, painted a graphic image of our industry's 40-year investment cycle, in which very large assets face both technical and commercial risk as product life cycles overlap over decades. Few other industries are required to manage risk profiles like this and this requirement inevitably shapes the leadership role.

Our value chain is complex

Both the supply and demand sides of our industry are increasingly complex. As our core science advances, so does the augmented value created by services and complementary technologies. Add to that the complexity of our global market, in which professionals, payers and patients are increasingly segmented, and our industry is not only complicated but complex, in the Chaos Theory sense of the term. As UCB's Jean-Christophe Tellier told me, the complexity of the value chain is the industry's defining characteristic.

Our workforce is knowledge-intensive

In the words of Lundbeck's Deborah Dunsire, a world-class life science company requires a very high concentration of intellectual capital across a very broad range of disciplines. From discovery scientists to health economists, our workforce operates at the frontier of knowledge. And, significantly, the knowledge intensity is not restricted to only some parts of the industry. Even roles that are semi-skilled in other industries, such as sales or customer-service, often require qualified scientists in the life science industry.

From this first part of my research, it was clear that each of these four factors differentiated our industry from others. But it is the convergence of these factors that makes pharma and other life sciences business exceptional. Whilst some other industries can claim some of these factors to some extent, no other business combines them together with the same intensity. It is this combination of unusual factors that creates the exceptional environment in which our leaders must operate and means that the 'leadership is leadership' trope is lazy thinking.





Leadership as adaptation

My research into leadership nested inside a wider set of research projects at the University of Hertfordshire, all of which are concerned with the evolution of the life sciences industry. The findings from this wider work (which can be found in my book 'Darwin's Medicine') helped us to see that our industry's leaders occupy an exceptional habitat, quite different from that of leaders in other sectors. As Darwin taught us, success is about neither intelligence nor strength but adaptation, so the next phase of our questioning sought to uncover how leaders in the life sciences industry adapted to the exceptionality of their industry context. In all, nine critical adaptations emerged as summarised below.

Nine leadership lessons from the life sciences

The mission matters

Whilst other industries pay lip service to mission statements, they are seen by our leaders as a critical tool. This is because they align the business to its social contract, they enable complex, cross-functional working, they help to mitigate some forms of risk and they motivate highly educated workforces.

Leadership is about decisive facilitation

The traditional management literature is polarised between two schools of thought. The first sees leadership in the style of Steve Jobs: dynamic, charismatic and somewhat autocratic. The second sees leaders as servants, enabling their teams. Neither style fully fits the four conditions of the life sciences. In our industry, leaders adopt the facilitation approach of servant-leaders but combine it with 'crystallising' complex choices in the style of decisive leaders.

The big issue is bicongruence

The complexity of our industry demands specialisation (known technically as macrocongruence) but specialisation makes it harder to align internally (known as microcongruence). Our leaders have learned that their key challenge is to achieve microcongruence and macrocongruence simultaneously – bicongruence in the jargon of management scientists.

Leadership is individualistic

Naïve, aspirant leaders are often misled by books and gurus into thinking that leadership can be reduced to a standardised, mechanistic process. In reality, leadership is idiosyncratic and very much shaped by each leader's personality and character. Leadership style is founded on their deeply held values and it demands that leaders both model and coach behaviours in a very personal way.



Subsidiarity is a contingent craft

A critical issue for leaders is how much to allow decisions to be made at lower levels – subsidiarity in the jargon. They have learned to ‘craft’ this decision based on two contingencies. First, by allowing discretion to sub-ordinates as much as possible, but only when guided by a clear, understood mission. Second, retaining control only where they, personally, can make a significant difference.

Words are important

The complexity of the industry, its science and its audiences mean that communication is both very important and inevitably difficult. One of the more surprising findings of the research was the way leaders prioritise the use of language. Their vocabulary and their toolbox of powerful phrases, metaphors and figures of speech were an important but often invisible adaptation to their leadership environment.

Leadership is a growth process

The final question in my study asked the leaders what they would tell their younger selves. The answers were varied but coalesced strongly around the theme of personal growth. Understanding one’s own values, following a vocation and constantly developing one’s knowledge, skills and personal attributes were the mainstay of their abilities as leaders.

Stakeholders demand transparency

All leaders are caught in a web of competing priorities between customers, owners, employees and other stakeholders. They have learned to balance to these tensions by prioritising consistency and transparency in their communications. As Andy Thompson of Proteus Health put it, he doesn’t do PR: he engages with stakeholders on the basis of science.

Protect the leadership asset

Whilst good leaders are, indisputably, an important intangible asset to any company, they are also remarkably fragile assets. The interviewees in my study all recognised that the importance of maintaining themselves – their mental and physical health, their energy levels – was equal to that of maintaining any other key asset in which the organisation had invested.



Leadership as evolution

The fundamental lesson that emerged from this research is that the traditional idea of leadership as a generic, universally-applicable talent is flawed. Like other advanced competencies, it may have a small core of transferable basics but much of it is totally situation-specific. This reminded me of Darwin's Galapagos finches, who shared their basic anatomy but who thrived because of the way they had adapted their beaks and other features to the particular habitat of each island. Leadership in the life sciences is much the same. To succeed, you must recognise and understand what makes our industry exceptional – the four factors mentioned above – and then adapt to those conditions. The nine findings discussed above are each examples of how experienced industry leaders have adapted to the exceptional environment of the life sciences industry. Leadership is not leadership, it is adaptation.

About the Author



Professor Brian D Smith is a world-recognised authority on the evolution of the life sciences industry. This article is based on his latest book *Leadership in the Life Sciences: 10 Lessons from the C-Suite of Pharmaceutical and Medical Technology Companies*. He welcomes questions at brian.smith@pragmedic.com



Comms from the ground up

David Hunt's career has taken him from painting Havas Lynx Group's offices to running the agency, and now to LA to head up the West Coast for Havas Health & You. He tells Paul Tunnah how agencies can navigate growth challenges and help pharma connect with patients



With pharma comms changing so rapidly it's rare to find someone who has stayed in the same place for more than 15 years, let alone someone who started at a company for work experience and rose to become CEO. But that's exactly the path David Hunt has taken at Havas Lynx Group.

It might be a surprise to some, then, that after spending his entire career at the same agency, Hunt has transitioned, within the network, to take up the role of CEO West at Havas Health & You, moving from the UK to California in the process.

Hunt says he "literally can't wait" to start the role.

"The agency in San Francisco is already very special, and is leading the way in search and social, which will be the foundational components of the most contemporary integrated campaigns in our industry.

"The combination of search, social, media and data represent the greatest opportunity for pharma since the first adopters embraced digital in the early 2000s with CLM and CRM."

The move marks a big change for Hunt, whose previous life at Havas Lynx Group began when he was just 18, joining what was then called Creative Lynx for a week's work experience.

"At that stage I was really considering the direction my career was going to take and I fell in love with Creative Lynx. I loved the vibe, the creativity and the ideas that were being bandied around. And at that point I thought, 'My ambition is to run this agency'.

Now, I never expected that to happen by the time I was 33 – I thought it was more realistic for it to happen when I was 53."

The big move to the US, then, makes more sense when Hunt says that in Havas Health & You he has found an even longer-term home, describing how the company culture harkens back to those first experiences at Creative Lynx.

A world-famous alarm clock

After finishing his work experience at Creative Lynx, Hunt continued with his studies in product design, which included making a 'world-famous' alarm clock for his final year project.

"At that time, to retrieve information from the internet on a domestic product you would need a hard drive, motherboard, operating system, RAM, etc., and I managed to do it with just an MCU and a modem," he explains. "The plan with my clock was that half an hour before it woke you up, it would check the local traffic information. If the traffic was heavy, it would wake you up early. If the traffic was light, it would let you sleep for a little longer.

"It was exhibited in the London Science Museum. It was reported all around the globe. I was one of the first people in the world to get a micro-controller and a modem to retrieve information from the internet. It is amazing what you can do with 30 pages of machine code."



Hunt says that this background in product design means he fully appreciates the critical importance of user experience, product development and branding, preparing him well for working with start-ups in the US.

"What excites me about the base in California is the access to Silicon Bay and Silicon Beach, the life sciences hub in San Diego and the pharmaceutical companies across the region. Those companies are creating some of the most amazing healthcare solutions and technologies in the world right now.

"Last year we launched Havas Union, the idea being to take 20 years of pharma insight and help support start-ups whilst also taking the energy and the ideas of start-ups and trying to bring them to big pharma. We felt we could be a catalyst in the middle, speaking both languages. After an amazing launch, this move is the next step in that journey."



Growing pains

The success of his alarm clock did not deviate Hunt from the passion he had for working for Creative Lynx, and after graduating he went back to join the company.

“The first thing I had to do when I joined was paint the office. For me that was a really important lesson because, there I was, a kid who's just graduated with a first, just invented an alarm clock, who one day wants to run the agency. I arrive all smart on my first day, and then I'm given some overalls and a paintbrush and literally have to paint the entire office for the first two weeks. My only break was to go and get the office sandwiches.

“It was an incredibly important experience, as I was helped by one of the partners at the time. This demonstrated that it didn't matter how senior you were in this business, everyone rolled up their sleeves and got stuck in. That's something that's really stuck with me for the last 20 years and has shaped today's culture at Havas Lynx Group.”



As it happened, it didn't take Hunt till he was 53 to start leading the company – that came in 2013 after Havas bought Creative Lynx.

He cites two things that have really influenced his beliefs as an agency leader since then.

“The first was a book by David Jones called Who Cares Wins. It's not necessarily related to healthcare, but it says that the future of advertisement, the future of communications, is about making money and doing good, and creating campaigns that do both. That really resonated with me, and I believe it's the perfect approach for pharma.

“On the back of that, in 2013 we published a white paper, Good Pharma, which was two things: it was a response to Ben Goldacre's #BadPharma but it was also taking what David Jones had written and applying it to the healthcare setting. From that we came up with our mission, which centres around 'helpful change'. The concept was really simple – it's about how we can use communications to improve the lives of patients, therefore driving the commercial success of our clients and taking pride in the work that we do and the positive impact we have on society.”

The second big influence was a talk he saw at Cannes in 2013 by R. John Fidelino.



"The talk was about 'Making pharma cool'. I thought it sounded ridiculous. I knew nothing at all. I was all wrapped up in 'good pharma' and having a significant impact on peoples' lives. I thought being cool was the domain of fashion, automotive and travel advertisers.

"Within about two minutes I was completely hooked; he was absolutely inspirational and could not have been more correct, and me more wrong. The point he made was that if pharma climbed down from its ivory tower and was a bit more empathetic, a bit more approachable, a bit cooler, it could build much stronger relationships with patients and their communities and, as such, would be better placed to influence behaviours.

"So, I was left with two thoughts. The first; that the effective use of creativity will help to improve patient lives. The second; that creativity has to be fresh, relevant and aligned to the real needs of the community. It has been these two thoughts that have driven the growth of Havas Lynx Group from 100 to 400 people, five years later."

But that growth wasn't without its challenges. Hunt says that when he became CEO five years ago the agency was "no fun".

"The agency I had fallen in love with when I joined, where people were working together with great camaraderie, had slowly disappeared.

"It was partly because we'd grown so fast into 100 people. I often get asked, what's the hardest growth point? Is it when you go from 25 to 50, 50 to 100, 100 to 400? For us it was 100 people. All our ways of working, all our operations, everything that had been foundational to making us great was now strangling the business. We were still doing okay work. I'm not saying it was poor. But it wasn't to the standards which Creative Lynx had become known for.

"The reason: we were spending all of our time haggling over resource, instead of being focused on patients, their needs, and the market. We had no continuity on accounts. A client could do four meetings with us and have four different teams."

The idea for change came from a pub conversation with his business partner Steve Nicholas.





“We were saying how we had really enjoyed it when we were an agency of 25 people, so why don’t we just divide ourselves? Divide 100 people into autonomous micro-agencies of around 25 people.

“We both agreed almost immediately it was a great idea. Then over the next eight weeks we planned it in the most minute detail you could imagine. Then we completely ripped the agency up and rebuilt it in a single day. On that morning everyone came into work and we addressed them, explaining that we were going to divide ourselves up into four different business units. Typically, with two or three account teams, a couple of medical writers, two or three planners, four or five creatives, four or five digital experts. Every team would have the same. And, as you can imagine, I asked them, very politely, for their support, as there was no ‘undo’ button.”

Havas Lynx Group has stuck to this structure since then, and as the company has grown they have increased the number of teams rather than increasing individual team sizes – they call it PRIDE.

Having learnt a huge amount during his lengthy stay at Havas Lynx Group, Hunt says the most important piece of advice he would give to somebody running an agency is to love what you do.

“I am totally passionate about using creativity to help patients, simple,” he says.

So, while at first it might seem that he is making a big change with his new role, it looks like Hunt won’t be changing his view on what makes an agency tick, whether it’s an agency in the UK or America.

About the Author



Dr Paul Tunnah founded pharmaphorum in 2009, which is a content and communications company offering industry leading publications (www.pharmaphorum.com) and a strategic consultancy (www.pharmaphorumconnect.com). He is a recognised author, speaker and industry advisor on content marketing, communications and digital innovation, having worked with many of the world’s leading pharmaceutical companies and the broader ecosystem of healthcare organisations.

Connect with Dr Tunnah at [LinkedIn](#) or email paul.tunnah@pharmaphorum.com.



Humanising healthcare through technology

An early exposure to computer science by way of the Commodore 64, combined with subsequent medical studies, set Roberto Ascione on the path to combining healthcare and software. He tells Dominic Tyler how this background led to the formation of his agency Healthware and continues to power its expansion.

Over the last two decades medicine has been hugely transformed through technology in a series of advances that show no signs of slowing. For Roberto Ascione, CEO of the Healthware Group, delivering on the possibilities of digital health is in his company's DNA and continues to drive their work.

"It is a source of excitement every single day, because all the different ways technology could add value to medicine are exactly what I had in mind when I started. Now, it's incomparable to where we were so many years ago, but there's still a lot to do."

Healthware was founded in Naples, Italy in 1997, when adding value to medicine was the end game Roberto had in mind, but it was one he wanted to be framed in terms of things like improving the circulation of data and facilitating better physician decisions.



Healthcare + software

The path towards setting up the company seems, in retrospect, a very natural one. Roberto was born into a medical family, where his grandparents were physicians and his father was a prominent hepatologist.



But perhaps a more important step towards forming Healthware actually came from Roberto's early introduction to the Commodore 64. The 8-bit computer was launched in 1982 and for most childhood users was more commonly associated with games like Boulder Dash, Maniac Mansion or Elite.

However, on receiving the computer aged 13, Roberto was immediately attracted by its coding possibilities, with his early efforts showing his family's influence as he gravitated towards medical matters, such as developing small medical questionnaires.

"I was 'polluted' early on with a passion for computer science," he says smiling, noting the PC came well before he decided to train and study as a medical doctor. "I come from a family where many family members were physicians and as a kid I was inspired by this. Then, when deciding what to study, I felt a deep connection to medicine's ability to help people."

From there the tension between his passion for computer science and his medical studies made a move into digital health a natural next step.

"At some point during my medical studies I realised that everything around me was analogue. I have a vivid memory of thinking that if I become a physician I'll need to treat patients one by one in a paper-based environment. So, even if I'm a good doctor, the impact I'll be able to have will be maybe a few thousand patients over my career. My 'a-ha' moment came when I realised that if I write software for physicians, then I can be a much more impactful physician."



Today it seems a logical observation, but in the 1990s Roberto says he was seen as "somewhere between crazy and stupid", with the consensus being that focusing on becoming a doctor was the most sensible path. "I clearly remember people saying, 'Computer science and medicine will have nothing to do with each other' and 'doctors will never use computers, will never put data into a machine', though you have to remember that this is more than 20 years ago.

"But, when I explained the idea of the impact to my father, even though he thought the chances were that this wouldn't happen, he said it was worth trying. That encouragement was very important to me in being given the permission to fail. And when I started to code medical software I quickly realised it was my real-lifetime passion, and Healthware was born in 1997."



Solving real problems

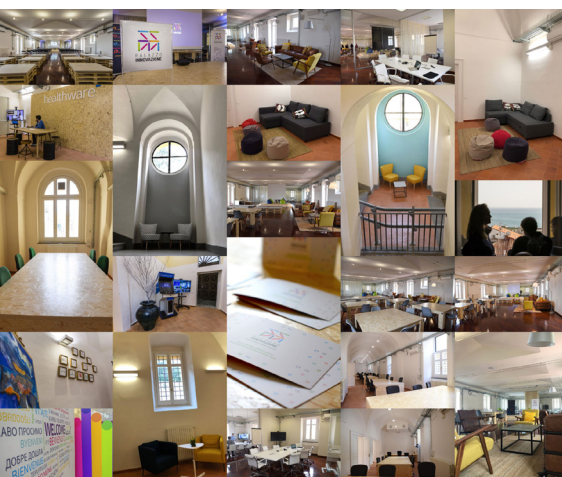
The agency began with a team that mixed people studying medicine and coding, mirroring Roberto's twin passions. Realising the importance of data and the wealth of information that was locked inside paper-based medical records, Healthware's first endeavour was an electronic medical record. But it was slow going trying to target hospitals, which were not then interested in the concept. Then a switch to linking electronic medical records to research, medical education and patient education began to get a lot of traction.

"We flexed our muscles in the first two or three years mainly on the software side, but then the software, per se, was not solving any problem. So, we realised that we needed to apply these tools to real problems that people have, which is something that the company is still largely based on. That is what brought us into communications and basically morphed us into, mainly, an agency, which we still cultivate as our core business."

As adoption of the internet spread and its uses expanded at the turn of the millennium, Healthware started looking at how the web could be harnessed to spread medical information to patients and empower them through the availability of content and the provision of services. "This led us to building some of the first disease awareness websites in late '99, early 2000. And very quickly, we became what today you would define a digital agency."

During that time the Italian agency quickly grew internationally and within four years most of its work was outside its local borders. As it did so it moved to a new base south of Naples.

During the Middle Ages, Salerno prospered under the rule of the Lombard Dukes and was renowned as a centre of medical studies and learning through its prestigious medical school. Healthware's current base at the Palazzo Innovazione is right in the city's historical centre, just a stone's throw from the terraced Minerva's Garden, has been growing medicinal plants since the 14th century.



Its work, however, continued to be right up to date, with a focus on websites and support for clinical trials, disease awareness and healthcare professional portals that saw Healthware broaden its internal capabilities, adding creative and content generational roles. Then, as search engines came to the fore, it was an early practitioner of SEO and digital media. By mid-2006, it had become a large-scale healthcare agency focusing on all varieties of digital.

Still located in its original base in Salerno on the Amalfi Coast, the agency kept expanding, first to Milan and then Rome, and then further afield to London and New York. Along the way Healthware was acquired by Publicis in 2007 and then underwent a demerger in 2015.



Innovation and collaboration

From intense early days spent coding to its subsequent development into an international digital agency, the last five years have seen Healthware “really be bold about digital health”, Roberto says.

After leaving the Publicis network, Healthware created a global joint venture with US-based pharmaceutical marketing agency Intouch Solutions. Both agencies have a digital background and a deep innovation mindset, Roberto explains.

Another key development for the agency's future began in 2009, as Healthware started developing increasingly close links with the digital health start-up ecosystem.

“We're doing this in multiple ways. One of these ways has been to start investing into early-stage digital health start-ups. Further down the road, we started discussions with VC firms and found a very strong alignment with FII Tech Growth, which is the leading Italian tech growth VC and invests in Italian-originated companies that are scaling globally.

“That was perfect for us, and so we came together to form Healthware Ventures, which is a corporate venture capital vehicle for investing in digital health start-ups, but in a more structured way than we had been doing before.”



Allied to these developments was the Healthware Life Hub, which was set up when Healthware moved into the Palazzo Innovazione in 2018. It's an innovation hub where pharmaceutical companies or medical device teams connect with Healthware, and sometimes start-ups as well, to run co-creation sessions.

"The Life Hub really allows for 'cross-contamination' between healthcare companies, designers, coders and start-ups, to come together and accelerate and boost projects and ideation. We want to keep cultivating the culture at this place."

The group's expansion has also seen it launch innovation agency Healthware Labs and digital media arm Healthware Engage. With all these expansions, Roberto says the best way to describe the Healthware of today is as "a next-gen healthcare consultancy".

"We live in a complex world where healthcare is being transformed so radically by technologies that in order to stay relevant as a service organisation to the life sciences industry, we needed to transform ourselves. That's why we took what was great and good to the core business in the agency, and amplified and augmented it."

Another important initiative for the agency is Frontiers Health. Now in its fourth year, Roberto has been chairman – and Healthware its co-host – since the digital health event's inception. This year it will return to Berlin in November, when its digital health themes will include digital therapeutics.

"We believe that digital therapeutics will truly be an entirely new wave of medicine. Frontiers Health has been covering digital therapeutics as one of the main focus areas since the first edition. And, when a few pioneers in the industry came together to form the Digital Therapeutics Alliance, I was super happy to join as a founding advisor.

"At Healthware, we want to partner with digital therapeutics companies, whether they are start-ups or large-scale pharmaceutical companies, and we are proud to be so entrenched in the digital health ecosystem and particularly the digital therapeutics one."





Humanised healthcare

When Healthware was set up medicine and technology might have been seen as separate entities by many, with little evidence that the web would come to be so dominant generally, and influential in healthcare. When it did so, Healthware – with its foundations in healthcare and software – found itself at the epicentre of that transformation. Since doing so it's remained true to its original mission.

"Our core vision is leveraging digital technologies to improve health outcomes. True to that, we believe digital technologies are the key force behind the transformation of healthcare, but we don't see a future of 'techno-medicine', it's going to be about a much more humanised healthcare, thanks to the technologies that will more and more permeate and underpin medical and healthcare practices," Roberto says.

"It's super important to everyone that works for Healthware to focus on finding solutions – whether they are creative, technological or data-driven, or a combination of all three, to improve patient outcomes. This is really our core value. And I can comfortably say that we have been true to this throughout these 20 years."

About the Interviewee



Roberto Ascione is the CEO and founder of the Healthware Group. He is very active in the digital health ecosystem in various advisor capacities, both in Europe and in the US, to companies, startups and investors. Among others, he has been recognised as Decade's Best Industry Leader by Health 2.0 Conference – 10 Year Global Retrospective Award in 2016, nominated Transformational Leader at the 2017 PM360 ELITE Awards and named among the 100 Most Inspiring People by PharmaVOICE in 2017. He is founding member of the Digital Therapeutics Alliance, past President of the Health Tech Summit and he is chairman at Frontiers Health.

About the Author



Dominic Tyler is a trained journalist and editor with 20 years of pharmaceutical and healthcare publishing experience. He serves as a contributing editor at pharmaphorum media, which facilitates productive engagement for pharma, bringing healthcare together to drive medical innovation. He is also creative and editorial director at the company's specialist healthcare content consultancy, pharmaphorum connect.



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Contacts

Editorial team

George Underwood

editorial@pharmaphorum.com

Sales team

advertising@pharmaphorum.com

Design

Mike Hammerton

Mike Smith

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www.pharmaphorum.com

pharmaphorum media ltd, Third Floor, Rosemount House,
Rosemount Avenue, West Byfleet, Surrey KT14 6LB, UK
Tel: +44 (0)1932 339 264

