Lessons from a Pandemic:

Holistic strategy in the time of coronavirus

Introduction

Even before COVID-19, in the days when we talked and worked together face to face, implementing a holistic strategy in a large and complex organisation could be frustrating or impossible. COVID-19 has delivered a scenario for which any strategic plan would have been a challenge. Truly, it is tempting to quote Helmuth von Moltke, who was chief of staff of the Prussian army for 30 years 150 years ago. "No plan of operations extends with certainty beyond the first encounter with the enemy's main strength" (or "no plan survives contact with the enemy").

A group of marketing friends, with a strong leaning towards healthcare, shared the ether for a conversation about holistic strategy in the wake of the pandemic. Not everything has been negative, there are clear opportunities to improve how we plan, based on changes in how we are using technology we had already. We just must make permanent change to our working practices.

The group was convened by Janice MacLennan, one of the best connected and most admired strategic planners in the business.

The Problem

Strategy is very resource intensive

Strategic planning takes a lot of time and resource. It is difficult to implement a Holistic plan, when the chain of command is long and complex, with global, regional and national command centres often pulling in different directions, and when the component countries are as diverse and complicated as India and the USA, or Canada and the Cameroon.

The drive towards smaller, orphan or niche products, puts additional pressure on companies to find new ways of achieving commercial success, requiring a holistic platform in order to reach enough patients to justify the development costs.

Right at the time when major companies are beginning to plan for the year after this one, our organisations have been shut down, forced into isolation and social distance by a pandemic virus.

Our headquarters buildings have been vacated by all the staff who could possibly work from home. Face to face communication is stripped down to video screens. So, it is even more difficult to design, test and communicate strategy.

Patients have been traumatised by COVID-19

We have emptied our hospitals of all the elderly and the ambulatory, to clear beds. As a result, hospitals have become places of contagion, ghost towns for all except the critical COVID-19 patients. Everyone has reassessed their illness, with the dimension of potential contagion overwhelming the desire for treatment. Our Primary Care offices have imposed hurdles to protect their staff, removing the option of personal consultations for hundreds and thousands of patients, delaying thousands of operations, and to our perspective, delaying enrolment in clinical studies, and delaying access to the patients who should be the target of our strategy.

The customer is becoming much more unpredictable. We do not really know how they are going to behave. The retailers that have succeeded have tended to be the smaller ones, that are vested in the business and have brought their customer much more front and centre.

Reimbursement has hit the limelight, as countries have struggled to resource personal protection equipment, with moves to bundle orders, simplifying ordering and increasing centralised purchasing power.

The design and implementation of global strategy was never easy, now it is even more difficult. Is there a 'light at the end of the tunnel,' can we 'seize the day,' and adapt to 'a new normal,' with a new way of producing global strategy?

The Solution

Patients at the heart of strategy

Probably not the first time you have read this! More than ever, in this time of COVID-19, we need to make the customer the focus of our strategy, and align our operations selflessly to satisfying their needs, if we want to move our businesses forward. We must bring the outside in much earlier, we must be agile, iterative, experimental. We cannot make assumptions based on the past.

We need to re-draw the patient journey, as some of the new touchpoints will be permanent changes.

We need to consolidate the communication changes that have been forced upon us.

COVID-19 proves patient need does not have a nationality. We have seen that the clinical unmet need is almost identical around the world. Applying this to our business model for pharmaceuticals, we can see that although there are differences in the standard of care these are shrinking. And in the case of rarer conditions, that standard of care difference is shrinking even faster.

Today's world is more about patient access than market access. We can all get into the market. It does not mean that the product will get the ease of use that we anticipate. If we want to get the product used with the minimal barriers possible for the patient, a more complete way of thinking than market access will be needed. Although this will require certain functional capabilities, we do not need the organisational layers that dilute our effectiveness, and slow down the speed of response. Particularly in rare and orphan diseases where the standard of care is almost identical around the world.

Beyond the consolidation we have witnessed within the COVID-19 crisis, we can add the relentless drive towards rational prescribing, and the adoption of health technology appraisal, whether NICE in the UK, or ICER in the USA, placing the margins on pharmaceuticals under increasing pressure. With this, it is not difficult to see further consolidation of the payor structure in the USA; other countries begin to look more attractive. The sharing of information between HTA countries reduces the variance even further.

We have seen a surge in Telehealth in response to the barriers on face to face appointments, with patients prepared to engage openly with physicians over web-based consultation platforms, treating the camera as a trusted partner in the sharing of intimate details. As we come out of lockdown, the blend of touchpoints in the patient journey will include both physical and virtual physician contacts.

Being in their living rooms, patients and consumers will be much more accessible. Instead of market research, we will be able to explore markets in more detail. Instead of bringing people to one central place and getting around the table, there is a willingness for access in their own settings. We move from market research to market exploration.

Re-set the organisation to reflect the new world

When the organisation is riven by global, regional and local power plays strategy is the first casualty. Which happens even if the global and local markets are only divided by a ceiling. It may not be the failure to work together, it may be suspicion and doubt and perhaps a little bit of arrogance rather than anything else. It is a failure to grasp that the people who are taking the medicines are the people who matter. A patient in one jurisdiction is experiencing much the same as a patient in another. Someone in Ontario with Haemophilia does not really care where they are living; they may have more in common with the young person in Edinburgh than they have with the general manager in Quebec.

If we start with the patient and the clinical need, these do not differ massively between countries. In rare diseases, these communities talk to each other across the world; and now because we are not all going to congresses and meeting up that type of connectivity is being amplified. The patient at the centre of it is aware of what's happening in Japan, what's happening in India, what's happening in the US and all of these patients are able to collaborate, if they choose, either through social media or through their Regional/national or international disease based societies. Ultimately, this is more likely to drive us forward rather than specific geographies that we aggregate depending on where our offices are. Traditionally we have considered different patients in different countries, but if you could get people all over the world contributing to that discussion around patient unmet need etc, you would probably find more common than different.

Take advantage of the similarities, not the differences.

Trimming down the organisational layers would help improve the embedding of the patient. It is not a giant step to suggest that the communication windows which provide us with a different type of intimacy and insight can also open new ways of recruiting and monitoring studies. This is going to

impact the way that we make decisions and the way we formulate clinical strategy, because we can reach out and be with patients in such an easy and fluid way. Traditionally, we say “here’s the protocol, this is the patient we want”. Our trials are constrained by the countries that say, “sorry that can’t be done”, because those patients are not coming into the clinic. They will not take the risk. Setting a series of guide rails which describe broadly the type of patient that you are interested in and offering a list of drop-down menus for an individual country to access may be a better way of doing this. Physicians are saying “ with telemedicine I can access a completely different set of patients, still within your target, but they are all staying at home; I can send a nurse out to those that I need to, I’m going to ship their medicine to them via Amazon and no need for a pharmacy”. We can see a lot more dependence on what the patients and the local physicians are telling us, and they are offering secure alternatives for patient contact.

We need to speed up the whole process, making it more agile and more collaborative and co-creative. One interesting way through this, is a concept called HealthVault, where you set the broad parameters of the disease that you’re attempting to treat and you allow into the vault a certain criterion of patient that is very reflective of the broad disease and you recruit the control trial from within the vault. So your clinical trial is recruited from a vault which already meets several of the entry criteria, with no screen failures to slow recruitment. That allows you to meet the regulatory hurdle of your randomised control trial. But the core part of the vault gives you a controlled group of patients that you still follow as a comparison of real-world practice. All your data is compliant because the patients were screened and consented before they entered the ‘vault’. So, the vault enables you to tell a patient’s story of the benefit of your therapy versus the standard of care. The Health Vault is blurring the boundary between the Randomised Clinical Trial and real-world evidence.

New challenges create common focus

The response to COVID-19 from regulators has been interesting. In the rush to accelerate clinical trials that test existing or new therapies, there has been remarkable cooperation between public regulators and private researchers. The lessons learned will advise future relationships. It will be difficult to revert to the more guarded approach that pre-dates this pandemic. The regulatory bodies are interested and supportive of remote monitoring, but the technology must enable calibration to ensure the evidence gathered electronically is objective, repeatable and differentiating to a standard that equates to more invasive approaches.

One of the reasons why holistic strategy was important, particularly with rare diseases, was that the key secondary or tertiary care physicians know each other. It is not unusual for a physician in France to have spent time in California being trained, or vice versa. Or for the physician in China to have had a sabbatical in Paris. The connections they have are deep and maintained by touches when they meet at conventions, or increasingly virtual meetings.

We have all been on the receiving end of global strategies, and we have written global strategies, and, on both sides, no-one was really satisfied.

Although different countries have fared differently, the same types of resource have been engaged, and the outcomes have been similar. Germany has managed significantly better than the UK, but the variables are only about the absolute numbers. There has been no outlier country, in terms of the type of people infected or dying. Health systems are converging, this pandemic has shown the similarities to be greater than the differences. For the purposes of holistic strategic planning, the alignment of approach has been remarkable. If a pandemic speeds communication within and

between countries desperate to find a cure, then we see countries that may be on the same path but just at different steps along the way.

Of course, our product it has core truths and certain things are fundamental and we must work on them together and then make sure that we are aligned.

Collaboration does not mean slavish alignment

Unfortunately, it is not practical to leave strategy to each individual country and hope that the similar circumstances will lead to a common plan. The financial commitment from organisational inefficiency would kill any business. Instead, perhaps it would be better to identify some immutable truths and offer the possibility of weighting elements of the strategy, according to where the country is in their evolution. Viewing the different countries as travellers on different stages of progression towards the long-term vision for the Brand.

Allowing countries to weight the relative importance of the strategic elements empowers everybody. There will be countries who have more similarities than differences, who with small compromises become clusters. These clusters create the critical mass for enabling the strategy. It does not matter if there are only six countries in cluster A, and 400 in cluster B and 20 in C. They will be more committed and more effective together than if they had been offered only one route, that they could not relate to.

It is unlikely that countries cluster as regions or around geography. And of course, with the technology at hand it does not matter; put a sunrise behind you and you could be in Singapore, St. Tropez, Florida, or Reykjavik. So, what used to be the language, the territorial, the distance barrier, has gone. Different countries may be at different points in their evolution. It is more important to align countries according to their stage in development, than their geographical location, in order to realise the vision.

Seek out the best, wherever they are

Turning to how the various routes are built, and how the immutable truths are agreed, certain leadership is often presented as the aspirational target for all of us. As a result, senior managers apply knowledge from previous situations, engineer their own perceptions and their own experience onto that strategy, and this is reinforced through committee layers which can sometimes seem just to obstruct the pursuit of clarity. When this happens, the clean and exciting aspects of strategy can be smoothed off, leaving a strategy that looks like any other.

There is a growing appetite to devolve the ability to test and learn and experiment throughout the organisation. It requires input from the smartest thinkers in the organisation. It also requires transparency, so that the route to a strategy is understood and challenged appropriately. Version control may be the best thing to come out of PowerPoint and Word documents!

if you think about the key elements of any strategy, you should start with the idea of ‘what does winning look like’, rather than vision. This should be clearly grounded in the experience of the patient. When we do this, we work out the unmet need, and work around which stakeholders we are going to engage, and what behaviours we are going to drive. We win by getting our positioning right, with clear imperatives and objectives which may change along the way. Nothing unusual, expect perhaps the complete grounding in the patient.

The issues and the strategic imperatives would be identical globally, the options for change are influenced at a market level, through the setting of alternative strategies. Some of the alternative

strategies might just reflect that different countries are at different places on the arc of development. Back to ‘A’, ‘B’ and ‘C’.

No more straight-line thinking!

Through technology, which is already available, there is no requirement for anything to be linear. We can shape anything in any way. People can share stimulus material, collaborate, set different roles for different stakeholders, all of which will encourage then to share that information and move towards alignment. Allowing the process to be entered at an infinite number of points, frees people to dip in at several different places wherever they feel comfortable and to amend things.

The macro journey would be one of preparation of input stimulus material, selection of groups of stakeholders that we are going to engage with that stimulus material, then facilitation of that process and allow those groups of people to come together online.

The stimulus material would be accessible at all levels, whether that is at a global level, regional level, local level or in whichever grouping is preferred. There will be an opportunity for those groups to review and to approve so that the strategy can then go and be executed with whatever stakeholder approval is needed.

Whoever is going to be either the project sponsor or the global lead would be setting that stimulus working with someone who is be able to provide that stimulus.

At the facilitation level you want to track the progress of that strategic development, you could facilitate Q & A’s around that stimulus if there’s anything that is slightly unclear, and people who can engage to resolve misalignments on any aspect of that strategy.

Two strong elements would be the inclusion of touchpoints on the patient journey, and patient segmentation. I think there are frameworks which countries or individuals can use. Presenting options at each stage is a sort of standardisation without losing the richness of the local insight.

There would be the potential for drop down cascading approaches of options, to share the potential discussion points around that strategy. They can go back to different levels within the organisation and again to have this iterative process from input to online facilitation and discussion.

If you allow people to weight their options, you can rank issues. You would also encourage people to think longer term. Gathering the overall weighting rather than cutting out choices, you can consider together which issues are most important at which stage in the journey, looking further into the strategy than just the current planning period. Which would be a much better way of looking forward, than just getting stuck in what happened before.

Now we have a way of engaging all the countries and encouraging them to identify the countries which are most similar, by looking at the responses to stimulus. Which is where you might find the UK, Canada and Australia to be in one group whereas India and the USA might be another one. Following this approach, there is no correct answer. There must be some level of review but this is a mechanism for giving people the space to discover, if you like, their ‘Facebook friends’, their internal ‘WhatsApp’ group of people whose thinking or stimuli draw them together. Over iterations, this would encourage people to look at positions that are close to where they are, and they would themselves narrow down the range of options because they would find convenience, they would be seeking to build alliances, to be able to pitch for appropriate resourcing. Which is one of the objectives of strategic planning!

In summary

COVID-19 has forced us to focus more on where we want to be, on ‘what winning looks like’. It has forced us to look more closely at the patients we want to serve, and at the optimum organisation for this purpose. It has speeded up the implementation of innovative communication technologies and it has forced us to see each other as more similar than different.

We have presented an approach to strategy which is more inclusive, less directed, less confrontational, and more likely to engage and motivate. As von Moltke also said, "Strategy is a system of expedients".

The group of marketing friends

Clare McGowne has over 20 years' experience in the pharmaceutical industry, with 15+ years small bio-pharma, commercializing rare and orphan medicines, both in the UK and Europe. She has worked across a wide range of therapeutic areas, including Pulmonary Arterial Hypertension, Idiopathic Pulmonary Fibrosis, Inherited Metabolic Diseases and Hemophilia. In her current role she is international commercial strategy lead at Vertex.

Dana Matsuzaki is currently with Takeda Pharmaceuticals, working in their Global Marketing as their Finance Head. She is Canadian, though she has been in Switzerland now for almost 20 years and become quite Swiss too as well.

Abigail Stuart has more than two decades of experience consulting with biopharma and healthcare companies to develop global brand strategies and communications. She is co-founder of an insight and research agency called Day One, a company that brings technology into the market research process to make things faster, bring more insight and more engagement.

Thomas Kolaras is a highly respected commercial leader with over 25 years of US and global experience with JNJ, Novartis, Eisai, Otsuka and Endo bio-pharmaceutical companies..

Brett Haumann recently appointed as Chief Medical Officer for ReViral having served as Chief Medical Officer and Senior Vice President of Clinical Development at Theravance Biopharma, a San Francisco-based biotechnology company focused on the discovery, development and commercialization of organ-selective therapies

John Glasspool CEO of Anthos. He has lived in Switzerland for 11 years, worked in South Africa and in Australia and worked in New Jersey. And a long while back, in the UK too.

Malcolm Allison worked in the pharmaceutical industry for something over 40 years in the UK, in Switzerland, in Germany and the US, and now runs a communications company called InterComm, which is based in Cambridge

Mat Freer founded The Culture Experiment, working with a broad range of organisations to inspire capability and behavioural change in their people. Specializing in designing and facilitating events and workshops for groups ranging from 8 to 800.

Dan Burgess is a live illustrator who produced the visuals that accompany this article.

Scott Lenik runs a digital product studio – NeverBland, the digital agency behind NMBLR - and works with a lot of entrepreneurs and take some of their ideas and turn them into tangible products across all sorts of industries.