Could Greater Diversity and Inclusion Improve Innovation in Pharma?

The past few weeks, and the response to the COVID-19 crisis, have shown not only how vital the pharmaceuticals (pharma) industry is to the global economy and society, but also the amazing collaboration and results it can achieve when it really puts its mind to it.

There can be no doubt pharma executives are committed to bringing drugs to market to improve the lives of patients, but when the pharma industry lacks diversity within, it underserves patients outside. A lack of diversity in decision-making leads to lack of insight that could otherwise contribute to improving and saving lives. Whilst the industry is certainly diverse, in terms of nationality and culture at least, there is no doubt it could be more inclusive. The problem stems in part from the industry's hiring practices: these tend to be too insular and there's also an over-confidence in the industry's own abilities.

The big question is whether the industry can really meet diverse, new patient and customer needs if it hasn't yet fully embraced inclusion amongst its own staff base. Innovation is about new ideas, or creative or different applications of existing knowledge or methods. It usually happens incrementally, using or redeploying existing technology, science and systems in pre-existing market conditions.

Incremental, disruptive and architectural innovation are probably already on the watching brief of pharma CEOs. However, Covid-19 has accelerated a new possibility – radical innovation. This is where the market and technology change fundamentally at the same time. The variables are many more to compute. The risks and the opportunities are beyond the capability of any one leader, any one company, to compute. This is where inclusion comes in.

Radical Innovation

Recently, AstraZeneca announced a partnership with Oxford University to combat Covid-19 infection from SARS-CoV-2. In a move away from the usual linear process of bringing drugs to market, various workstreams and pathways will instead run alongside each other in parallel, enabled by the radical innovation circumstances we now find ourselves in. The university brings the vaccine, the pharma company brings the development, manufacturing and distribution machine. It's a creative and different application of academia, science and business partnering together in real time. The potential vaccine entered Phase I clinical trials in late April. Data could be available in June with advancement to late-stage trials occurring by late summer.

This didn't just happen overnight. Two months prior, during China's Covid-19 peak, AstraZeneca established a different approach in its China operations. Whilst not linked to the Covid-19 vaccine development, it highlights the importance of inclusion enabling innovation. Breaking down the usual hierarchy, over 20 online town halls were hosted across the organisation, where participants were encouraged to speak up on three dimensions: protecting employees, finding new ways to drive the business and supporting customers. This flat hierarchy and inclusive crowd-sourcing of ideas contributed to a fast and agile response. Over 220,000 masks and 40,000 vitamin C tablets were delivered to employees, online opportunities were captured through digital channels and there were no stock-outs.

In 2011, an AstraZeneca cancer drug programme was set to close after results from a Phase II trial. Susan Galbraith, SVP Early TDE in Oncology R&D, argued for further analysis of a particular genetic status. She had noted the multiple stories where patients had seen positive results from the cancer drug. Further analysis demonstrated the cancer drug substantially improved progression-free survival in a subset of patients with this mutation. The data subsequently led to approval, ensuring the cancer drug reached patients. Had Susan not spoken up, and had she not been heard, this opportunity to benefit patient lives would have been lost.

It is clear that there is a correlation between inclusive cultures and innovative outputs. We know that inclusive teams gain new perspectives, better avoid group think, and can be significantly more productive. When Pascal Soriot spearheaded an inclusive leadership culture change, he was aiming to improve psychological safety and encourage people to challenge the status quo. This had direct results in terms of innovation. For example, staff working on Calquence, a leukaemia drug, challenged norms and implemented a novel supply change design which resulted in a 70% reduction in batch cycle time and a 90% > 0% batch failure rate. In August 2017, Calquence was granted BTD and priority review for MCL by US FDA, and the overall development time was reduced from five years to 15 months.

How Diverse is Pharma?

The pharmaceuticals industry is certainly diverse, in terms of nationality and culture, but this masks two problems that need addressing. A lack of other types of diversity, and proactively including different perspectives. When Reshma Kewalramani was appointed Chief Executive of Vertex Pharmaceuticals, she become one of just two female CEOs in the top 25 pharma companies worldwide. Of the top 35 we have worked with, Emma Walmsley at GSK, Marie France Tschudin at Novartis and Heather Bresch at Mylan stand out joining Reshma as the only four female leaders. Compared with any other major industry, that level of gender diversity is low. Kenneth Frazier, CEO of Merck, is the only African American CEO in the top 35.

Cynthia Challener pointed out that the pharma industry features less gender and ethnic diversity than other industries in the Fortune 500, with one-third of the top 50 pharma companies having

no women on their boards, and only 8% of board seats held by ethnically diverse directors, compared with 14% for the Fortune 500 overall. The board diversity that exists often relies on non-executive positions. The problem is the pipeline. Graduate programmes and lower management levels display more diversity but from middle management onwards it becomes a male game. If the industry still lacks diversity in its decision-making positions, can it truly claim to be inclusive?

Diversity Must be Accompanied by Inclusion

Every major pharma company undertakes some form of diversity and inclusion work. Inclusion can be measured by analysing those behaviours that contribute to or detract from inclusion. The majority of pharma companies are still reliant on 'pulse surveys' that are a poor indicator of inclusion. Instead, we have used an inclusion diagnostic in several organisations to do this. For example, if we measure psychological safety by asking whether employees feel they can speak up and challenge their boss without fear of retribution, we get an insight into whether pharma is cultivating an inclusive culture or not. Asking questions such as 'am I proud to work for the company?' offers very little actionable insight.

Inclusion diagnostics, on the other hand, have revealed poorer levels of psychological safety among those groups that are still under-represented in pharma. To increase inclusion, we need to improve their psychological safety and perceptions of fairness over a range of indicators. This is not only a moral question; it is directly related to the effectiveness of decision-making.

Take, for example, the Bank of England. Decision-making is core to the central bank's mission of mitigating risk in its decisions and the economy overall. Similarly, decision-making is core to pharma's ability to bring drugs to market to improve the lives of patients. However, the Bank of England instituted a policy of 'Author in the Room' in order to increase inclusion. It challenged the hierarchy by mandating that the most qualified person, of whatever level, should be in the senior meetings to inform the discussion, rather than the members relying on 'papers' that had passed up through the ranks. Many pharma companies would not even be aware of this because they haven't measured inclusion and they rarely look outside pharma for good practice.

Old Habits Die Hard

I recently spoke to 14 colleagues in diversity and inclusion roles in six European-based pharma companies and asked, "How much would you say the pharma industry is insular in its hiring practices?" 13 out of 14 said 'somewhat' to 'very'. Outside industry churn is a good measure of openness to new people and ideas. When compared to almost any other sector, pharma does not recruit from outside.

Perhaps more worrying than just the internal work, many pharma companies are not properly considering inclusion in their consumer work. Seven of our colleagues said their organisation considered the diversity of its customer

base when discussing how best to meet consumer needs. However, six said the opposite. When a new pharma CEO was appointed, he privately acknowledged he wanted to use inclusion and diversity to provoke the executive team. In his view the executive was too comfortable, too insular and too resistant to change.

In my years working alongside executives in the industry I have personally witnessed brilliant innovation, excellent people management and the highest ethical standards. However, is its success part of the problem? When you have such an abundance of resources within, might you be less inclined to look elsewhere?

With an obvious scientific bias, there is less credence given to people's 'lived experience' because it's harder to quantify. This can result in an empathy deficit. When the diversity business case only offers correlation, not causation, many executives may dismiss its contribution to business and scientific outcomes. When many executives are working hard on complex briefs, there may be limited additional cognitive capacity available for empathy. When their companies are doing well, they may rely on their own view, rather than inviting challenge from the outside.

Change is often driven by under-performance. Many cash-rich, high-margin pharma businesses simply lack the external pressures many other sectors experience. This might go some way to explaining a reluctance to really address insularity and make the necessary changes.

Making Progress

Of the 14 diversity and inclusion professionals we surveyed, all of them said their work had been at least somewhat effective in changing culture. Examples included employee resource groups and internal communications, participation in external benchmarks, celebrating dates, for example raising the Pride flag on IDAHO day and training, specifically unconscious bias training. Others went further, to have diversity strands in the core business (e.g. research policy) and work closely with patient advocacy groups and have diversity-focussed clinical trials. However, all admitted there was much still to do, especially going beyond gender, including disabled people, and more customer segmentation.

Collaboration around Covid-19 has shown what the industry is capable of: opening up labs for rapid testing, co-operation between firms, and release of staff for medical duties. Diversity is now featuring in clinical trials. The next challenge is to move from diversity to inclusion. The industry needs to start measuring inclusion and start embedding it throughout. Inclusion offers insight leading to innovation and multiple benefits. The scientific bias needs to be challenged head on, with an appreciation that inclusion is more than technical; it's a behavioural methodology. The fact is without it the industry misses out on insights that would help it save lives.

The good news is diversity is now high on the agenda. We just need to progress to more inclusion. The future of medication is individualisation – without realising the "diversity" of people/patients, pharma companies will not be able to provide future medication. Without being inclusive, pharma would only provide medication of the "standard male person". It is not an exaggeration to conclude that tackling insularity in pharma would lead to fewer Covid-19 deaths, better drugs, and better lives for patients.

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