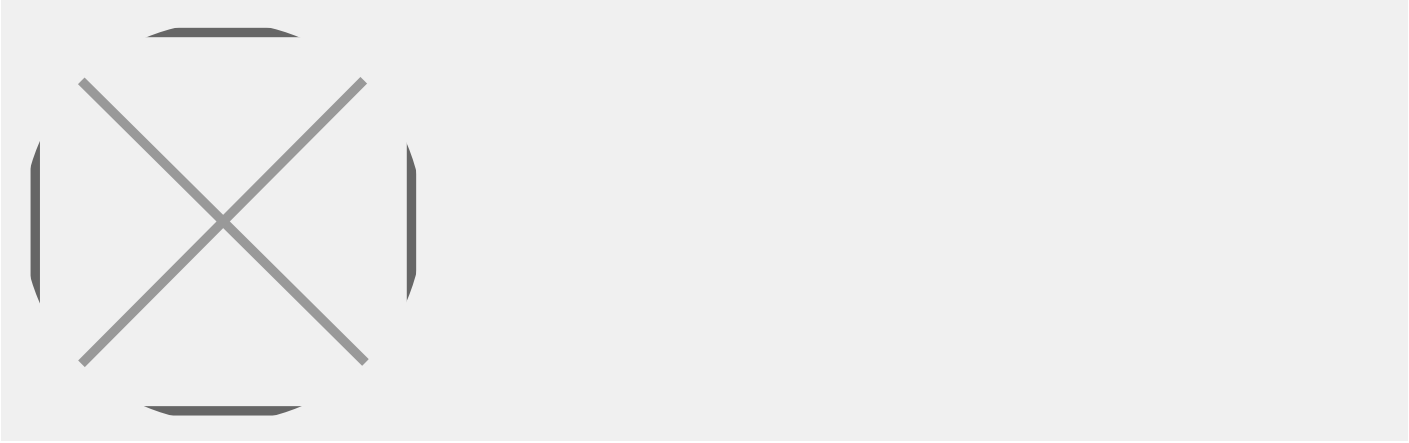
Interview with Martin Olovsson, Managing Director, AstraZeneca, Nordic-Baltic



20.05.2013

Tags: Baltic, Nordic, AstraZeneca

martin-olovsson-1.jpg

You refer to AstraZeneca as the locomotive of bioscience in Sweden. Can you elaborate on what you mean by that, and the role that you see for AstraZeneca in pushing this development forward?

AstraZeneca has a significant R&D presence in Sweden. We currently have more than 2,300 researchers at our site in Mölndal, which include 30 professors, 560 PhD's and 250 researchers from 30 different countries. The Mölndal site is responsible for 22% of the company's R&D spend, and is chosen as one of three key hubs, alongside Cambridge (UK) and Gaithersburg (US). In addition to R&D, AZ have in Sweden a major manufacturing site, responsible for over US$6 billion in export in 2012, thereby representing a significant portion of Sweden's total trade surplus. Sweden represents ~1% of AstraZeneca's total sales turnover, but in the added value we bring to the country within R&D and manufacturing by far exceeds these 1% – that's why I feel the term the locomotive of Sweden life science industry is well grounded.

This commitment to R&D investment in Sweden comes at a time when we see clinical trial numbers dropping in the country, yet rising in neighbouring Denmark. How would you rate the climate for conducting clinical trials in Sweden today?

The primary reason for us conducting clinical trials in Sweden the last few years is that our regulatory authority plays an important role in Europe. The issue is that incentives for Sweden's healthcare to contribute to research are not as strong as it needs to be. The output of clinics and hospitals are not measured at all by the amount of clinical research they produce, so unfortunately clinical research has ceased to be a high priority within the healthcare. Basically, the drive for efficiency and productivity squeezes clinical trials out of the system. In order to ensure that Sweden has stronger motivation to do clinical research in the future, the country needs to build positive incentives for the healthcare system to not only provide care, but also produce research for tomorrow's medicines and treatments.

Do you think that Sweden, a successful and developed market and a country with high quality of life, has a certain level of complacency with regard to reforming sectors such as healthcare?

There are signs of some complacency at the political level in, my view. Even when issues in today's healthcare are debated, many tend to take a position that Swedish healthcare is world class, now and forever. What is worrying is the level of implementation of new treatments; expenditures on new medicines last year were extremely low. Ten years ago, Sweden would have been considered a country where new medicines were introduced relatively quickly, but today this process is much slower compared to countries like for instance Denmark, which might see the introduction of new products as much as 2 years earlier than Sweden.

What led to Denmark developing in such a different way to Sweden in recent years?

The attitude towards innovation is more positive in Denmark. And the debate on patient health is stronger. Attitudes towards pharmaceutical spending in Sweden have taken a very negative turn. Budgets are delegated to a very low level in the hierarchy. Fears of an ever expanding medicines bill have imposed management systems, which has gone to the extreme. This fear does not match the reality of the situation; last years, there have been more funds left in the budget than anticipated. This is not commonly known.

Do you think that as a part Swedish company, AstraZeneca has a special responsibility to change that attitude towards innovation?

It is in my view our responsibility to voice concerns if we see things that are blocking adequate implementation of innovative medicines that improve patient health. At the end of the day we should put the health of patients first. Our mission is to provide great medicines that improve patients' health. If that becomes difficult due to choices made over healthcare policy, then it is our job to voice our concerns. We do that mainly through discussion and collaboration. People in Sweden and the Nordics tend to be collaborative, so we try to discuss our way around potential difference of views, but we don't shy away from taking a stronger stands when needed.

Do you believe that Sweden can be a frontrunner in a consensus-based healthcare model?

I believe that it can, if we with consensus-based mean that stakeholders work together to implement treatment to promote better outcomes with joint efforts. There are ongoing pilots and projects to trial 'structured introduction': The idea is to enter into discussions early on with payers about new products, and discuss the best way to bring this new medicine to patients in a way that promotes best outcomes, cost-effectiveness and correct utilization. Through this model we are in dialogue on a more holistic view on care-related infections, looking not just at anti-infectives, but working with other stakeholders and partners to take steps towards total prevention. Thanks to initiatives like this, and the further introduction of technology to monitor patient outcomes, we can focus not just on providing medicines, but also on delivering outcomes together with key stakeholders. However, today, we are in danger of losing our cutting edge position because of the delay in embracing new medicines. This is one example. Initiatives like these are ongoing in diabetes, respiratory disease and so on.

We met with xxx on behalf of Biogen, formerly of Pfizer, and discussed with him the role of sales representatives. He said that traditional sales models no longer work in Sweden and the roles of reps are no longer just to differentiate from competitors, but to identify any barriers in the identification and diagnosis of patients in order to bring better compliance. How does AstraZeneca approach this new model?

It depends first on the therapy area. The situation varies. But generally, we approach it through better understanding of what criteria and objectives are driving the decision-making process across several stakeholders. This requires an "account oriented" representative that understand the needs of the different decision makers, and brings to the table not only an understanding of the

disease and medicine itself, but also how decisions are taken and implemented. Ultimately, we should offer to facilitate efficient implementation in order to achieve the best outcomes.

How challenging is it to find that person for AstraZeneca?

It is not too difficult because we have been accustomed to this approach for a while; you need project leader skills, a strong scientific base, a collaborative approach and a sense of negotiation or commercial thinking. But most importantly, you need cross functionality. This is not a matter of finding one person doing it all, but rather leading to bring in the correct resources where they are needed, and allocating them in the right places.

You were appointed 3 years ago to lead the Nordic and recently the Baltic countries. What are your key ambitions with regards to growing the operations in the coming years?

There are some areas where we have very high aspirations, such as making Brilique a leading treatment in ACS; it has the evidence to support it and it makes a big difference to patients. AstraZeneca also have an important collaboration with BMS in the area of diabetes. We aspire to be leaders in this disease area, knowing that competition is fierce and specialised companies such as Novo Nordisk are there. Together with BMS, we are the first to offer a great medicine in each of the innovative classes of diabetes treatment. Moreover, AstraZeneca has a very strong respiratory and inflammation pipeline; we have novel treatments in gout and collaboration with Amgen in inflammatory diseases. We are also accelerating assets in our oncology pipeline; oncology is an area where we have a great heritage but also a few disappointments a few years back. But what we see from for example ASCO this year, illustrates clear ambitions to accelerate exciting medicines in our oncology pipeline. We also have an exciting infection portfolio, but in my opinion it requires a go-to market or collaborative model that is different, not naturally existing today.

I can imagine that this is an exciting time to be working for AstraZeneca, having had a few tough years behind it but now looking ahead to the future.

We have a more focused strategy and there is a sense of new oxygen in the air. Yes, there’s a clear direction, clear sense of meaning and clear sense of belonging. We are selective in what we do,

but we have the intention to become leaders in the areas where we choose to engage.

See more interviews