GSK plc

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James Gordon Analyst

Good morning. I'm James Gordon, JPMorgan European pharma and biotech analyst. And today, I've got the pleasure of introducing the GSK presentation. You're going to hear from GSK CEO, Emma Walmsley. Thanks a lot for joining us today, Emma.

I look forward to the presentation.

Emma Walmsley Executive

Thank you so much, James, and good morning. A very happy new year to you all. It is absolutely wonderful to attend today's conference and to share with everybody the progress that GSK is making. Please turn to Slide 2. This is, of course, the usual cautionary statement, and we'll comment on our performance and forward-looking statements using constant exchange rates, or CER, unless stated otherwise.

Please turn to Slide 3. GSK is a global biopharma company focused on the prevention and the treatment of disease with clear performance momentum as we head into 2024. In the first 9 months of 2023, we delivered double-digit sales and adjusted operating profit growth, with strong performance from all of our key products, including an outstanding U.S. launch of Arexvy, the world's first-ever vaccine for RSV. A vaccine that is firmly on track to be a blockbuster in its first year on the market.

Recent approvals for Apretude and HIV, together with 2 important oncology medicines Jemperli and most recently, Ojjaara have also strengthened our new product portfolio. New products launched since 2017 contributed nearly GBP 8 billion of sales in the first 9 months of 2023, reflecting our ability to bring breakthrough products to market and execute competitively. This portfolio demonstrates the delivery of the strategic choices we've made

to invest in vaccines and specialty medicines, which at Q3 now represented 70% of our business and offer meaningful sources of long-term profitable growth. Please turn to Slide 4. Our current momentum is also providing us with a strong platform to deliver on the commitments to growth we've previously set out to shareholders.

As you can see from this slide and the many green text, we are well on track to hit all of our targets that we set out for 2026. And we are increasingly confident too in our prospects for longer-term profitable growth. Next slide, please. Our first priority for capital allocation remains to invest in pipeline delivery, both organically and with continued targeted business development. Our innovation is focused on our 4 core therapy areas, and we now have a pipeline of 67 vaccines and specialty medicines, 2/3 of which is in infectious diseases and HIV.

Infectious disease affects billions of people and remains a growing burden for society, including in the developed world. Our programs are focused on seasonal respiratory viruses, bacterial and fungal infections, and these include pneumococcal and meningococcal disease and chronic viral infections such as hepatitis B. In HIV, we remain world leaders and are entering into an important period with clinical development plans for potential ultra long-acting treatments and prevention options. These spearhead the transition we expect to deliver in our HIV portfolio over the coming years. In respiratory and immunology, we're building from our decades-long respiratory heritage with next wave innovation and long-acting treatment options for asthma, COPD and refractory chronic cough.

Additionally, of course, we were very pleased to announce the agreement to acquire Aiolos Bio, providing us access to a potentially best-in-class, long-acting anti-TSLIP monoclonal antibody ready to enter Phase II for asthma. And in oncology, we are initially prioritizing development of novel medicines to treat blood and gynecologic cancers. We recently announced an exclusive licensing agreement with Hansoh for the Phase I B7-H4 targeted antibody drug conjugate that we believe has best-in-class potential in ovarian and endometrial cancer with opportunities in other solid tumors, and we've just added a second ADC for further indications. So let me briefly guide you on the significant growth opportunities we see for each of these areas. Next slide, please.

So focusing first on the opportunities in infectious disease. This is a market estimated to be worth more than GBP 100 billion. And for GSK, it's an area of extensive strength underpinned, of course, by our vaccines business. And as you can see from this slide, we have a portfolio of current and future assets with the potential to make significant peak year sales contributions. I've already referred to Arexvy.

We also continue to add to the outstanding clinical profile for Shingrix, our vaccine to prevent shingles, with results of a large post-marketing study in China demonstrating 100% efficacy. Alongside this, we announced plans to significantly expand the availability of Shingrix in China with an exclusive partnership with Zhifei, supporting our goal for Shingrix's annual sales to reach more than GBP 4 billion by 2026. We have several other vaccines of note in clinical development, including a multivalent mRNA-based flu vaccine with Phase II data expected in the first half of this year. And our 5-in-1 MenABCWY vaccine for U.S. adolescents, which we're on track to file in the first half of this year.

We're also pressing forward with clinical development of candidate pneumococcal vaccines, using MAPS, a highly innovated multiple antigen presenting system designed to allow the highest serotype coverage and robust immune responses, these would open up significant new U.S. market opportunities for us. Beyond vaccines, I'm going to highlight Bepirovirsen, an antisense oligonucleotide, which has the potential to establish a new standard of care for chronic Hep B. This is a disease which impacts an estimated 300 million people and causes close to 1 million deaths annually. We also have a portfolio addressing several resistant bacterial infections.

Our most advanced asset is gepotidacin, which has the potential to be the first novel antibiotic for uncomplicated urinary tract infections in more than 20 years. And also in earlier stages of development, we have a potential suppressive therapeutic intervention for herpes simplex virus. The unmet need in HSV is also very significant, with lifelong incurable infections impacting around 500 million people globally. Turning to Slide 7. In HIV, we are pioneering innovation for treatment and again, the prevention of disease.

As a result of strong commercial execution with our current portfolio, we've upgraded our '21 to '26 sales CAGR from mid-single digits to a higher range of 6% to 8%. And as we move into the second half of the decade, we are confident in cabotegravir, the world's first and only approved long-acting integrase inhibitor, becoming the foundational medicine in our HIV portfolio. Registrational chart trials for the selective dose of cabotegravir every 4-month dosing are expected to start in the prep setting in 2024 with regulatory submission and potential launch plan for 2026 and pivotal work on a 4-monthly treatment regimen is expected to begin in '25 with submission and launch planned for '27. Please turn to Slide 8. And turning to Respiratory.

Well, here, we have 3 key late-stage growth opportunities. Firstly, Nucala launched to treat severe asthma. This first-in-class biologic medicine is now on a path to support clinical remission there, helping patients who suffer from asthma to be exacerbation and oral steroid-free and to live with symptom control and stabilized lung function. Our ultimate goal is to change the course of disease by slowing it down, stopping progression and even reversing previous damage. But later this year, we'll get the results from the pivotal study of Nucala in chronic obstructive pulmonary disease, COPD, where 40% of patients still experience exacerbations.

And then building on Nucala, we are developing depemokimab. This is a potential new medicine with anticipated peak year sales of more than GBP 3 billion with more potent pharmacology and the longer half-life and ultimately, an improved twice-yearly dosing interval. We progressed straight to Phase III from Phase I in 4 indications, and we have our first readouts in severe asthma in the first half of 2024. And then thirdly, camlipixant for refractory chronic cough with 28 million patients diagnosed globally and nearly half of them having suffered for over a year. RCC is one of the last common areas of respiratory medicine without treatment, and it is a true area of unmet need.

Camlipixant provides potential efficacy and tolerability benefits and could be a first and best-in-class medicine. The Phase IIb SOOTHE trial showed a greater than 40% reduction in 24-hour cough frequency with low rates of taste related adverse events, which is an important

differentiation versus the competition. Pivotal data from our development program is expected in the second half of 2025. Based on the high prevalence unmet need and the potential for a differentiated profile, we see peak year sales potential for camlipixant more than GBP 2.5 billion. Now please move to Slide 9.

And lastly, oncology. Well, here, our initial focus is on hematologic malignancies, gynecologic cancers and with options in other solid tumors. Jemperli is a backbone for our research in both monotherapy and in combination with standard of care and future novel agents, particularly in patients with limited treatment options. Data from the RUBY study demonstrated the potential of Jemperli plus chemotherapy to redefine the treatment of primary advanced or recurrent endometrial cancer versus chemotherapy alone, and we anticipate data in monotherapy endometrial cancer and non-small cell lung cancer and rectal cancer in 2027. Ojjaara was approved and launched in the U.S.

late last year as the first and only treatment indicated for myelofibrosis patients with anemia. A key unmet need, again, with limited treatment options, and we expect EU marketing authorization also early this year. Combinations and future indications are currently under evaluation. Zejula is a once-daily oral PARP inhibitor for ovarian cancer, and we're also assessing activity across multiple tumor types and in combination with other therapeutics. So given the number of key oncology readouts expected this year, we do expect to update on the portfolio approach during 2024.

Now turn to Slide 10. And lastly, for ESG, we do continue to make excellent progress on delivering impact across our 6 key areas that we prioritize. We note on this slide some recent highlights on how we're using our science and technology to improve our sustainability. And we were delighted to announce last quarter that we're starting Phase III trials of a low-carbon version of Ventolin, using a next-generation propellant this year. If successful, it has the potential to reduce greenhouse gas emissions from the use of this inhaler by about 90%, and it will significantly contribute to our net 0 climate targets.

Next slide, please. So as shown on this slide, we have undoubtedly made great progress on our investor road map, and we are well-positioned heading into 2024 with several late-stage pipeline events anticipated. We continue to focus together on execution, our pipeline, capital allocation and investor engagement, and we'll keep investors updated on the progress that we're making, of course. And final slide, please. So to summarize.

We are delivering strong and sustained momentum as we head into 2024. We are confident in delivering on our growth commitments and we continue to progress with the development of meaningful innovation in our core therapy areas. All of this underscores our confidence to sustain profitable growth through this decade, delivering scale, health impact and attractive returns for shareholders, combining science, technology and the talent of GSK's people and partners to get ahead of disease together. Thank you very much. And now Tony and Luke are going to come and join me for Q&A with James.

Thank you.

James Gordon Analyst

[Operator Instructions] So maybe to start, you mentioned Arexvy, had a very strong start in

Q3. And it looks like it may even be doing better than your guidance for the full year '23. I think you might have even commented on that. How are you thinking about Arexvy? Is that be one-off in Q3?

Can we extrapolate that? And how do we think about Arexvy for '24?

Emma Walmsley Executive

Well, I'll ask Luke to add color because he's been responsible with the team for a launch that we're absolutely delighted with. Now we'll be surprised to know that we're not about to bring any new information around '23 or outlooks for '24 today, but delighted with the launch, delighted with the market share and very confident in that ambition of more than GBP 3 billion around the world. This is an enormous disease. There's never been a solution to it before, and we welcome the fact it's a competitive arena. But Luke, perhaps do you want to...

Luke Miels Executive

Sure. I mean it's always difficult to project a new product, particularly in a new area. But yes, the uptake has been encouraging. The profile of the patients that have elected to get a shot was what we thought. So 85% of those people are 64 and above as you would expect.

Yes, and I think we're now lining up for the contracting process this year. And over time, we feel very confident in the GBP 3 billion peak sales that we've indicated.

Emma Walmsley Executive

Looking forward to adding that 50 to 59 cohort, hopefully, which is another scale opportunity.

James Gordon Analyst

Because in terms of moving parts, you could have an extra competitor because you could have Moderna as well. But then as you say, you could also have a different age demographic in terms of contracting as well. Did you get lucky in Q3 last year and -- yes. Should we worry about that? Or are you confident that we could have strong growth even with more competition?

Luke Miels Executive

Look, I think ultimately, this is a very large segment. If you -- the best correlate is the high-dose flu market, which is several orders higher. It's the same patient population, essentially. But yes, we have another competitor. I'm sure the competition will reflect on as we are on what we learned last year, but higher activity is going to also expand the pie itself.

Remember, we had ACIP approval in June and essentially entered the flu season a couple of months later. So it all had to happen quite quickly. We've got more time to prepare. We've got -- I mean, 2/3 of physicians recognize Arexvy by name. So yes, let's see.

I mean, we try and make our own luck as much as possible.

Emma Walmsley Executive

I think this point about creating a market is absolutely fundamental. 3 years ago, I don't know

how broadly the awareness was of the general public about RSV for older adults, even though it's a scale disease that hospitalizes tens of thousands of Americans that were on, sadly 15,000 [indiscernible] . So we're at very early stages of penetration of the market. I think competition and awareness is a good thing, and we're really pleased with the market share so far, and we'll keep going.

James Gordon Analyst

And how do you think about the build to GBP 3 billion plus? Is the vaccines launch very slowly? Could this be 10 years to build there? Or could this be quite a rapid one?

Luke Miels Executive

I mean I think our expectation is that we'll get high-risk 50 to 59 population. I think it's more of a slower build classically because it takes time for people to become comfortable. We've used -- we've said multiple times of PCV, Analog is probably the most appropriate. I think COVID was and outline -- I mean even if you look at Shingrix, we're about 1/3 penetration, and this is a product that launched in 2017. So it does take time, but it's very durable once it's established.

Our working assumption is it's in every second year shot, and so once people get into the habit in their 60s and 70s of presenting for a regular RSV vaccine and this population is going to be very compliant over time.

James Gordon Analyst

And how do you think about combos, like, for instance, Astra recently licensed to vaccine combined with MPV. Do you think it's going to be a combo market? And is that something you need to do?

Tony Wood Executive

Yes. I think again, the sensible combos are with viruses, which has similar plasticity, if you like, or stability in that context. So human metapneumovirus, clearly on parainfluenza virus and others.

Emma Walmsley Executive

I mean the other thing to remember is -- in pediatric vaccines, and we've got many decades of experience of combos are a good idea, but efficacy will always jump convenience. And you also have to be thoughtful about what the frequency of whatever that dosing is required. And as Luke said, we have data on 2 years. So that needs to be brought in mind.

James Gordon Analyst

Makes sense. But maybe switching to another vaccine. So Shingrix, is Arexvy going to take up where Shingrix stops growing? I know the U.S. has been growing more slowly.

Do you still see a long growth runway for Shingrix, maybe from outside the U.S?

Emma Walmsley Executive

Luke should comment. Again, we've -- as I said in my opening remarks, we still see growth ahead for Shingrix, and he did a very exciting deal with Zhifei in China. More of the growth is ex U.S. But this is just part, and you should talk more Shingrix, but we -- one of the most important things to understand if betting on GSK is that we have a very strong portfolio and pipeline of adult vaccination. It's an extremely strategic choice to commit meaningfully more investment in R&D, but also in manufacturing, technology platforms know-how.

So you've got Shingrix with growth. We're adding RSV. We've got the MenABCWY to work with that, then you have mRNA, then we should add pneumococcal, we are exploring HSP. So there's this whole portfolio of something which is fundamentally, and I will allow Luke to then get back to Shingrix. But you just stepped back and governments around the world are under huge pressure for their healthcare budgets.

There is -- and healthcare systems are squeaking with workforce and overloading and you've got the demographic imperative. The reality is there is no better return on healthcare budget investments than investing in vaccines that stop disease before it starts. And that's why you're seeing a regulatory environment that and the IRA has been removing co-pays. That's why you're seeing governments approved RSV around the world, at least for private access at a faster pace. And so I think it's a really exciting time for the growth of the full portfolio, but still [indiscernible] Shingrix.

Luke, if you want to comment on that.

Luke Miels Executive

I mean, we're following the strategy that we outlined a couple of years ago with Shingrix, which is essentially to maximize the U.S. If you look typically at an adult population, 60% of the present for a regular vaccine each year. So that's probably the peak penetration under the current label. We have around 33%. We had 1% a quarter.

So there is still growth. Obviously, the first half is harder than the second half, but there's still potential there. But as we've said, there's a 3-phase process for Shingrix that the next phase was Europe, and we're picking up contracts there and access expanding. And then entry into emerging markets, of which the deal with Zhifei was very important. As everyone knows in this room, I mean, Zhifei has done a brilliant job with Gardasil in China, and we have very high confidence with our partnership with that company.

And then you've got the life cycle elements. So next -- this year, we get the 12-year data for Shingrix. That will provide some insight as to when you can expect a potential for a booster. And there's also some interesting emerging data in terms of the relationship potentially between zoster vaccination and dimension that needs more exploration. Either one of those could also propel growth for a number of years beyond that, back in the U.S.

population once we reach that saturation point.

James Gordon Analyst

One other thing mentioned in the presentation with the targets, and so you previously set targets out to '26 and also '31. Yes. Well, there's been a lot of things have happened since

then, some things that worked in the pipeline. Some haven't you've upgraded the guidance for some constituents like HIV recently? Are those targets still accurate?

It might be time to update some of those?

Emma Walmsley Executive

Well, first of all, I want to just be -- clarify that we've laid out guidance for '26, and we've given some vision and ambition around '31, I think that's an important distinction. And we are, as I said, absolutely thrilled with the momentum and the progress to date. Remember 2023 is the first full year that GSK has been a focused pure biopharma company. And even through the seismic structural change of the demerger in '22, we had the great '22. You've seen our results '23, and the upgraded guidance again there.

So we feel very good about the, if I can say, more than 5 and more than 10 top line and operating margin CAGRs. Obviously, join us on 31st of January, I think it is for our Q4 results. And we've also said that we will reflect on what we laid out and our progress against those goals that we talked about in 2021. I think the other -- where you're absolutely right, is an enormous amount has gone on, and we've made tremendous progress since that '21 update also on the pipeline. Actually, the majority of the key assets, whether it's the approval of RSV or the approval of Apretude long acting, the progress we've made on Jemperli, the Hep B progress, the antibiotics.

We've also had some disappointments. So otilimab, we stopped, and that's the reality of our business. We've had some ups and downs, and we're very conservative on our outlook for Blenrep as well. But then we've added BD is absolutely core to the way we now do our R&D. And we've added Affinivax.

We've added camlipixant. We've added Sierra Oncology. We've added this morning another very exciting addition to our, I mean, early-stage respiratory portfolio. And there's a whole bunch, the [indiscernible] early. There's -- we've been really -- none of that was part of where we were 2 years ago.

So I think what we've achieved in 2 years in progress, we're just going to keep doing together. And we'll keep you updated along the way through the roadmap and through the data that comes through.

James Gordon Analyst

And in this 2026 and 2031 still the years you're focused on it. If you were to uptake the target, would it be those use? Are you looking even further out now?

Emma Walmsley Executive

Yes. Yes. The periods that we're focused on -- I mean, like all big companies in our industry, it's a long-term industry. You want to make sure you deliver the quarters. We guide for the year.

We think it's really important to have had that 5-year outlook, which was really demonstrating a step change in performance for this company, and we haven't delivered like we're delivering now for a very long time.

And we have the next period simply because the question that people have asked for as we always do and such as what happens when dolutegravir comes off patent. And so that's why we think it's important to lay out that ambition, which is a snapshot of our risk-adjusted outlook. That's probably where people are more focused in terms of what's coming. So we want to make sure we bring visibility to those building blocks. And that's why you've seen both [indiscernible] for HIV and these 2 guys do the series of meet the management meetings, not some big grand Investor Day on all of R&D, but meet the management meetings by core therapy area.

So we did one at the beginning of the year on infectious diseases. We did HIV, we did respiratory. This year, we'll do one on oncology to give people just a sense of those building blocks of what's coming for later in the decade. Now of course, in Tony's research work looks beyond that again, but I don't know how far the models run, James, but we're conscious on what's going to be done a bit nearer than the mid-30s now.

James Gordon Analyst

Makes sense. And if you did have some upside to the revenue number, might Tony get some more to spend on R&D. Would you -- would that necessarily drop down and might you reinvest more on all the pipeline?

Emma Walmsley Executive

Look, our job is to grow competitively and profitably to impact patients at scale around the world. And the core of what we do is to prioritize innovation and capital allocation to innovation. We want to make sure we're also delivering returns for shareholders. I think it's very important as we have a really clear capital allocation framework, and we've set our guidance and our outlooks on a more than basis to retain some flexibility. But there are no surprises coming from this company in terms of maintaining the commitments that we've laid out.

James Gordon Analyst

And you mentioned the different meet the management events, and I believe we have an oncology one this year. So what will we learn there?

Emma Walmsley Executive

Well, I think you guys can -- I mean you'll learn more as I laid out in the interim, perhaps Tony, you can pick up? We've got quite a lot of data coming this year. So...

Tony Wood Executive

Yes. And I think, look, the way to look at it is we'll continue to embroider the pathway that we have for Jemperli on top of the women's cancer indications, and Emma mentioned some of the exciting results that we've seen for RUBY in the Part 1 study in the dMMR setting. We'll see the ITT results for that group as well.

You should expect by that point in time, we'll also have a clearer view of how we're positioning Jemperli and the CD226 access agents into lung relative to a competitive environment at

that point, and perhaps they are looking at other cancer types in colorectal as we continue to expand again, the transformational results that we've seen in ISS studies for Jemperli and rectal cancer into colorectal. So a clearer position on the IO portfolio. Obviously, by that point in time as well, we'll also be able to be giving you a firmer foundation of our interpretation and regulatory feedback on the results that we're now generating for Blenrep. So I suspect that will be the major component of what we talk about. We may also have early updates on the 2 exciting ADC programs that were the subject of business development deals at the end of last year.

James Gordon Analyst

And how are you thinking about Blenrep? So we had a negative study but then more recently, DREAMM-7 was positive. Is there a scenario where you've got approval on that study and come back to market? Or do you wait for the DREAMM-8 study?

Tony Wood Executive

Well, I think it all depends on the continued maturation of the data in the DREAMM-7 study and in particular, are reaching statistical significance for OS data. As I'm sure you're aware, DREAMM-7 and DREAMM-8 have slightly different designs. They're looking at different comparators, DREAMM-7 was head-to-head with daratumumab and chemo DREAMM-8 will be against VELCADE. But I think, look, at this stage, it's important to recognize that we're very pleased with the results but we need to see static on OS and there's a journey to be traveled this year in terms of regulatory interactions on the DREAMM-8 package.

James Gordon Analyst

Blenrep really one ADC, but you mentioned other ADCs. So where is GSK in ADCs?

Tony Wood Executive

Yes. So -- well, first of all, of course, because of Blenrep, we've established a pretty sophisticated development in supply chain. Proposition for ADCs and that is going to be an important factor in determining penetration. So I'm very pleased in terms of the capabilities that we've built there, particularly in partnership with Regis and his team. And then you should look at the 2 R&D B7-H3 and H4 deals is, first of all, being about building out in women's cancers.

The way to think about these in general terms is they're increasingly particularly the new generation of Topo based ADCs. They're occupying a position which is coming subsequent to or in partnership with IO. So we have 2 assets: one is certainly in our focus in women's, particularly gynecological cancers and then the broader opportunity presented by the recent deal with B7-H3 that again will probably be focused initially in colorectal, but let's see how the IO landscape that I described earlier shapes up this year first.

James Gordon Analyst

And then quite a lot going on in the respiratory pipeline as well, and I saw a deal today. So it looks like you've got potentially a 6-month's t-slip. So how does the data? And I know it's early, but the early day to look versus existing t slips like [indiscernible]?

Tony Wood Executive

Yes. I mean, look, let me just sort of remind you if you're in the Respiratory Meet the Management event, what we said was we were looking for a low T2 option. Obviously, we cover the high T2 population extremely effectively, and that's about 60% of severe asthmatics. The low T2 option gives us access to 40%. We know from the work that we've done with that, Luke, you might comment on this, if I don't do justice that both patients and healthcare providers tell us they want longer-acting agents and they want earlier treatment as well.

So I very much see this as being something that is a relatively straightforward fit with our portfolio. And just like depe as well, the advantage of -- in the area is one can model out from early data from PK/PD and have pretty good confidence in terms of translation of oncology, and that's what we've got going on with the deal that we've just announced, it's really not more complex than that.

Emma Walmsley Executive

I think it would be good for you to comment on the sort of patient and physician demand for long acting, whether it's on depe or on [indiscernible]. This is another way of keeping people out of hospital.

Luke Miels Executive

There's no argument that biologics are a superior solution for the severe spectrum of asthmatics. Access is excellent, yet we've only seen around with less than 1/3 of patients who are eligible being treated for biologics. So that is a combination of factors. I mean, in contrast to say, TNS or RA, where you're looking at 2/3 of patients. So one of the elements is shot frequency.

And what attracted us to that the deal that we announced this morning is clearly, it's the most competitive profile in terms of being 2 shots a year. And physician preference, patient preference is very compelling. Either in naive patients, and there's a proportion of physicians that are comfortable doing that straight off the back. Or as we've developed in the depemokimab program patients who have stabilized on existing therapy in that class and IL-5 in the case of depemokimab, then switching those patients off. And we think that 75% of those patients are likely to come from other antibodies apart from Nucala.

And so that same hypothesis has held up when we look at T-slip. So entering into Phase II. We expect that T-slip as Tony said, will be dominant in about 40% of the patients that we can't access in terms of that T2 low. So the market will be prime for a conversion to a long-acting solution that we intend to provide.

James Gordon Analyst

Maybe one other respiratory. So you've got Nucala COPD coming up this year. I know there's been some mix data historically for IL-5s for COPD. So would you say that a similarly -- do you have similar high confidence there? Is that still quite high risk?

And why might the study be different to some of the other studies we've seen historically?

Tony Wood Executive

Yes. So let me deal with that in 2 different parts. First of all, I think the accumulation of data and the effectiveness of agents that address eosinophilic COPD is adding increasing confidence to that is being an important area. Within that group of patients, you can think about 2 different sets. The bronchitic who are largely eosinophilic, have reactive airways and respond most effectively to these treatments.

And that's what you see from the Sanofi data. About 30% of COPD patients have emphysema. That's a group that is more difficult to reach, but nevertheless, an important aspect of building out a broader label. So my overall confidence and the approach of reducing eosinophilia in high -- driven COPD is high. For those who haven't followed this, where we stand is, we ran 2 previous Phase III studies.

One succeeded. One was a narrow failure on the basis of hierarchy of testing stats. We had a CRL for that and the criticism that we've addressed carefully is with regards to recruitment of patients who were clearly COPD patients in that study. So if you consider that plus the powering of the study with regards to the challenge that I just mentioned and also selection of patients with high EO counts, we're increasing the confident in the outcome. And what I should add is that, although we haven't talked about this a lot, if you look at some of our earlier Phase II studies where we were able to cut patient populations by bronchitics and EO counts, and we see efficacy, which is very much in line with the results that you have seen from different Sanofi.

James Gordon Analyst

One earlier project that was mentioned in your presentation was HSV and the Phase I/II data. So what is it we're going to see this year? And how big an opportunity is that?

Tony Wood Executive

Yes. So what you'll see is a PSC readout looking at both transmission and shedding asymmetric -- sorry, asymptomatic shedding is very important for HSV. You can think about this as a logical extension of the science underpinning Shingrix with regards to the approach that we've taken in design of the antigen and an adjuvanted vaccine. It's important though to stress that although they're part of the same virus family that the nature of the virological life cycle between the 2 viruses is different. And so I'd hate anyone to come away thinking this is a slam dunk.

It's a sensible experiment for us to run, and we can talk about the outcome and I actually see it.

James Gordon Analyst

And this would be a therapeutic for people who already have the virus?

Tony Wood Executive

Correct.

Emma Walmsley Executive

Yes, which is 500 million people and not a great virus to live with and obviously a field in terms of STDs that we have quite a lot of know-how. So let's see, early days and what's come when we know.

James Gordon Analyst

Sure. Maybe one other question would be business development and you've been busy this morning already. How is GSK now thinking about business development? Is there -- are you potentially in the market for doing a very big deal? Or is the deal that you announced this morning, the sort of deal that we should think of GSK doing?

Emma Walmsley Executive

Look, we're in the market for strengthening our pipeline and delivering good returns for the capital that we invest. And yes, it's one of the most important changes that we made for this new chapter of delivery for GSK was to set ourselves up with the balance sheet, the capacity, the organization, the talent in the teams and this working governments to bring more ambition agility, competitiveness and, frankly, unbiased view across internal, external, across core TAs of what the returns could look like. And that's why you've seen us increase the percentage of our pipeline that comes externally. I would say, in general, you should expect more of the kinds of things we've been doing because we have really good growth prospects. We're interested in stuff that's going to be delivering more for the end of the decade in our core TAs, in vaccines and specialty medicines, but also technology platforms that can adds to the flywheel of development.

And that can be acquisition, it can also be partnerships because more and more we like to work on collaborative efforts and very much open for business for anybody here.

James Gordon Analyst

Great. Well, I think maybe that's a nice place to end this. We're just out of time. Thank you very much for joining us today.

Emma Walmsley Executive

Wonderful. Thanks, everybody.