EphMRA

keeping members informed and involved

Post Conference news

September 2019

Reports from the Warsaw Conference 2019

Innovation

Experts

Development

Post Conference News: Sponsored by Research Partnership

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We collaborate with clients from the global pharmaceutical, medtech and biotech industries, providing research intelligence and strategic recommendations that elevate healthcare brands and power their success.

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Contents

Diary

EphMRA Switzerland Meeting – Basel 24th September 2019

EphMRA is delighted to be holding its 3rd meeting in Switzerland - Hear some inspirational papers and network with colleagues from both industry and agencies. The meeting will be held in Basel at the Hyperion Hotel, Messepl. 12, 4058 Basel. Registration open.

EphMRA London Meeting
25 February 2020

Germany One Day Meeting - Berlin
28 April 2020

2020 Annual Conference: Flanders Meeting & Convention Center Antwerp
23–25 June

Copy Deadline

December 2019 News –
copy deadline is 15th October 2019.
Send to: generalmanager@ephmra.org
www.ephmra.org

Get in touch

If you have any enquiries, suggestions or feedback, just phone or email us:
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Bernadette Rogers
General Manager

Welcome to EphMRA

Annual General Meeting (AGM) for Members

The AGM was run by EphMRA President, Karsten Trautmann who gave an overview of the Association's activities of the past 12 months.

The current Board members were thanked for their contribution over the past 12 months and the voting took place for the Board members standing for election from 1.10.19.

The Treasurer Mr Charles Tissier who is based in Basel gave a summary presentation of the Association's financial status.

Board Members

Bernadette Rogers, General Manager thanked the current Board members for their support:.

Current Board Members:

President:
Karsten Trautmann
Merck KGaA

Past President:
Thomas Hein
Thermo Fisher Scientific

Board Members:

Gabi Gross
Thermo Fisher Scientific

Manuel Guzman
bioMerieux

Fenna Gloggner
HRW

Richard Head
Research Partnership

Amr Khalil
Ripple International

Xander Raijmakers
Lilly

Nicola Friend
Astra Zeneca

Richard Hinde
Norgine

Sarah Phillips
IQVIA

Anton Richter
M3 Global Research

The following Board candidates were voted into office by the members for the term, 1 October 2019 – 30 September 2020:

President:
Karsten Trautmann,
Merck KGaA

Nicola Friend
Astra Zeneca

Manuel Guzman
bioMerieux

Xander Raijmakers
Lilly

Gabi Gross
Thermo Fisher Scientific

Marianne Fletcher
Pfizer

Past President:
Thomas Hein,
Thermo Fisher Scientific

Agency Members on the Board 2018 - 2019

Thanks to Members leaving the Board:

Richard Hinde
Norgine

Sarah Phillips
IQVIA

Anton Richter
M3 Global Research

Agency Members of the Board as of 1st October 2019:

Richard Head
Research Partnership

Amr Khalil
Ripple International

Stephen Potts
elma research

Marcel Slavenburg
SKIM

Christophe van der Linden
suAzio

President's Award 2019

Announcement of the winners of the EphMRA President's Award for Contribution to Pharmaceutical Market Research

In 2001 EphMRA initiated an award which was first presented at the Athens 2001 conference. This award is a recognition of a person's outstanding contribution to healthcare market research.

The award recipient can be from a pharmaceutical company or supplier/agency and will receive the award based upon:

- having made an outstanding/recognisable contribution to EphMRA
- having made an outstanding/recognisable contribution to healthcare market research

The below is a complete record of the President's Award winners since its inception in 2001.

Year	Winner	Runner-Up
2019	Anton Richter, M3 Global Research	Mattias Blomgren, Janssen
2018	Michel Bruguiere-Fontenille, EphMRA Treasurer	Carolyn Chamberlain, Assure Brand Panels
2017	Sarah Phillips, QuintilesIMS and Richard Head, Research Partnership (Joint Winners)	Karen Belantani, Takeda Pharmaceuticals
2016	Catherine Beauce, Sanofi David Hanlon, Kantar Health (Joint Winners)	Bernd Heinrichs, Gruenenthal
2015	Sarah Phillips, Prescient Healthcare Group and Alexander Rummel, Aurum Research (Joint Winners)	Georgina Butcher, Astellas Pharma Europe Bob Douglas, PSL
2014	Bob Douglas, PSL Group	Georgina Butcher, Astellas Pharma Europe
2013	Stephen Godwin, The Planning Shop international	Bob Douglas, PSL
2012	Jacky Gossage, GSK	Angela Duffy, The Research Partnership
2011	Kurt Ebert, Roche	Bob Douglas, Synovate Healthcare
2010	Rob Haynes, Merck Inc	Roger Brice, Adelphi
2009	Bob Douglas, Synovate Healthcare	Janet Henson
2008	Steve Grundy, Marketing Sciences	Anne Loiselle, Abbott Laboratoriese
2007	Barbara Ifflaender, Altana Pharma	François Feig, Merck Serono
2006	Hans-ChristerKahre, AstraZeneca	Barbara Ifflaender, Altana Pharma.
2005	Colin Maitland	Hans-Christer Kahre, AstraZeneca
2004	Isidoro Rossi, Novartis	Dick Beasley
2003	Janet Henson and Bernadette Rogers	Dick Beasley
2002	Allan Bowditch, Martin Hamblin GfK	Rainer Breitfeld
2001	Panos Kontzalis, Novartis	Allan Bowditch, Martin Hamblin GfK

2019 Nominations were:

Carolyn Chamberlain, Adelphi Research (now at Purdie Pascoe)

Carolyn has always been an active member within EphMRA and has championed its importance both internally and externally at all of the companies she has been a part of.

Georgina Butcher – former Board member and Ethics Committee Chair

Georgina is a long standing EphMRA supporter and has been involved with the Association for many years now – always happy to share her experience and expertise.

Mattias Blomgren, Janssen

Mattias heads up the Market Research Centre of Excellence at Janssen. Mattias has ensured that market research continues to be embedded in the decision making process at Janssen, underpinning strategy development across commercial activities. In addition to his day job, Mattias sits on the EphMRA Ethics Committee and is an active contributor to the organisation.

Anton Richter, M3 Global

Anton is a very strong EphMRA supporter and always happy to help out with advice and expertise. A very experienced representative of the data collection member companies.

Piergiorgio Rossi, SGR International

Piergiorgio has contributed greatly to EphMRA. He was an original AM Board member and has been on the Code Steering group from 2009 and then has been on the Ethics Committee for many years now.

Amr Khalil, Ripple International

For many years now Amr has been an active member of the Programme Committee, maintaining this voluntary role whilst also running a boutique market research agency. Last year Amr further cement edhs commitment to the Association by becoming a Board member.

And so, the winners were announced by Karsten Trautmann, EphMRA President as:

Winner

Anton Richter,
M3 Global Research

Tom Pugh, M3 Global receiving the President's Award on behalf of the Winner, Anton Richter

Runner Up

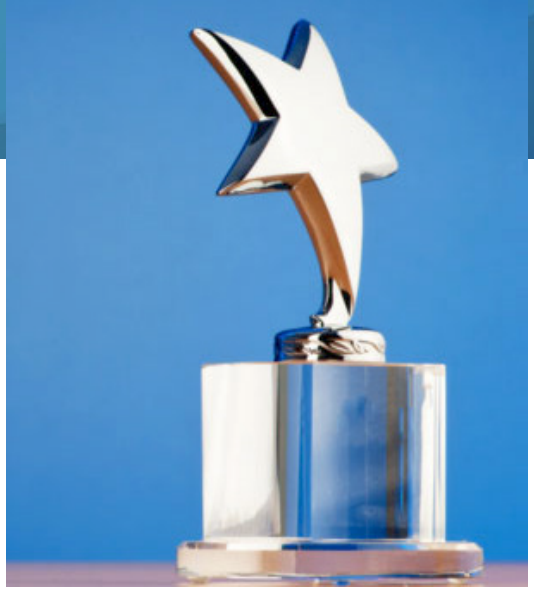
Mattias Blomgren,
Janssen

Joint 3rd Place

Georgina Butcher (ex Astellas) and Carolyn Chamberlain,
Purdie Pascoe

EphMRA Awards

EphMRA members are engaged in a huge range of healthcare market research initiatives, studies and projects and the Board wants to take this opportunity to learn more and to enable members to show case their expertise.



1. Business Impact through Innovation - sponsored by Adelphi

WINNER:
Interactive Disease pathways – How Janssen and Cello put the patient experience front and centre.

Stewart West, EMEA Market Research Manager-Immunology Janssen and Gavin Buck, Director, Cello Health Insight.

Stewart West and Lorna Kirman receiving the Awards (Gavin not present) from Stuart Cooper, Adelphi (sponsor) and Karsten Trautmann, President of EphMRA

EphMRA Awards

RUNNER UP:
Using facial analysis to uncover deeper reactions to pharmaceutical communication materials.

Richard Head, Director at Research Partnership and Sarah Fletcher, EMEA Business Insights Manager at Janssen.

2. Future Leaders: 'MR Excellence Case Study Award' - sponsored by AplusA

WINNER:
Using an integrative design to identify opportunities for appropriate, early usage of a pioneering hospital antibiotic

Daniel Rayner, Associate, Insight Dojo Ltd.

Daniel Rayner with Alexander Edte, AplusA and Karsten Trautmann, President of EphMRA

EphMRA Awards

RUNNER UP:
Outlining key learnings from a multi-market, dual phase segmentation study

Faye Holmes, Senior Research Manager, HRW

RUNNER-UP:
Innovative Patient Adherence Research

Clare Murphy, Senior Research Associate, Kjt Group
[not present at the conference]

Faye Holmes receiving her Award from Alexander Edte, AplusA (sponsor) along with Karsten Trautmann, President of EphMRA

Awards Steering Panel

Thank you to our Steering Panel/Judges:

- **Gavin Taylor Stokes** - Adelphi
- **Tim Dungey** - SERMO
- **Helena Cannon** - Strategic North
- **Peirgiorgio Rossi** - SGR International
- **Richard Habis** - psyma
- **Charles Chaine** - AplusA
- **James Cain** - SERMO
- **Marcel Slavenburg** - SKIM
- **Gillian Newbold** - Narrative Health

Award Submissions

EphMRA received a number of Award submissions – and we are pleased to feature some of these here.

EphMRA Future Leaders – MR Excellence Case Study Award 2019

Outlining key learnings from a multi-market, dual phase segmentation study

Faye Holmes, Senior Research Manager, HRW, f.holmes@hrwhealthcare.com

Background

During the initial market landscaping study, we identified that the **importance of primary care** in the management of agitation in Alzheimer's Disease (AAD) cannot be overlooked. Research was therefore required to understand if primary care HCPs are the first decision makers, as well as evaluating their role and importance in the management and treatment of agitation patients.

Focus of qualitative phase	Focus of quantitative phase
Understanding who is involved; how and why	Understanding and sizing who in the primary care population have the most potential and are worth pursuing
Mapping the integrated primary care pathway and scoping perceptions of a novel treatment	

Mixed methodologies across 13 markets *(UK, Spain, Germany, Italy, France, Austria, Netherlands, Belgium, Switzerland, Sweden, Denmark, Finland, Norway)*

1. *Qualitative phase*

Extended screening; *a flexible and iterative approach to ensure we are speaking to the right stakeholders in each market*

Individual depth interviews; *to provide a nuanced understanding of individual's involvement in AAD and what factors are important to them in new treatments*

Fusion groups; *an excellent forum to map primary care sites and understand influence and relationship between different primary care stakeholders in AAD management*

Sample; *n=190 GPs, nurses and primary care focused specialists treating AAD*

2. *Quantitative phase*

Online survey; *20-minute questionnaire to ultimately identify high value segments based on attitudes and behaviours to help allocate resources to the right stakeholders*

Sample; *n=989 GPs and primary care focused specialists treating AAD*

Project role

- Liaising with external suppliers to ensure **high quality work**
- Mentoring the executive team to **instil best practice**

"Working with Faye on such a complex, multi stage and multi market study highlighted her ability to juggle competing priorities, a widespread team and her **ability to empower team members to take ownership of areas that suited their strengths best**." ***Tessa Brayford, HRW Research Executive on the project***

- Working with senior directors to **flag any possible issues**
- Main contact for insights lead to keep **everyone informed throughout**

"This project was integral to developing our strategy for the new AAD asset. **The project ran smoothly with all internal stakeholders being involved at relevant moments. This was due to excellent communication throughout the project lifecycle**, efficient project management and clear delivery of the key insights." ***Elisabeth Roscher-Nielsen, Insights Manager, Otsuka***

- Ultimately ensuring objectives are met to ensure **maximum impact for clients**

Key learnings

A partner not provider

- Building up a strong relationship with clients to become a **trusted partner** whose expertise and therapy area experience is relied on
- Hosting **open and transparent conversations** to problem solve for example discussing recruitment issues in Nordic markets and brainstorming solutions following review of early screen out data

Multiple touchpoints throughout

- **Kick off workshop**: an internal survey for all key stakeholders was carried out at the kick off workshop to support hypothesis generation. All key stakeholders had the opportunity to feed in killer questions. Local market representatives given opportunity to share learnings from tactics pursued in their countries
- **Interim findings shared**: Central Location summaries, qualitative debrief, marked up questionnaire from soft launch data
- **Segmentation solutions meeting**: vital touchpoint to discuss which segments provide best solution

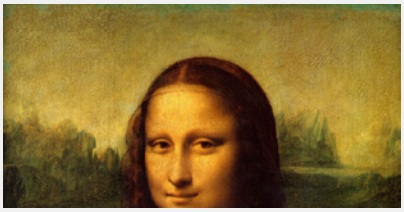
Deliverables that live on

- **Clean, crisp slides** which illustrate key insights in a simple manner
- **Segment fact sheets** to aid understanding of key characteristics associated with each group
- **Animated executive summary** of mapped patient pathway and segment overview to create a short, memorable and unique deliverable which inspires action and embeds the findings within the team
- **Infographic** to illustrate integrated primary care pathway – an easy future reference tool to remind of the stakeholders involved
- **Typing tool** which is intuitive and quick to use
- **Country specific reports** so that each market can identify nuances

BRAINS and cheek

Mona Lisa: Building an Iconic Brand

The Challenge



We knew this was a huge task - standard market research wasn't going to cut it!

A number of mergers and acquisitions had left customers confused regarding our client's branding in the Life Science category.

With a huge product and service offering, recently organised into distinct portfolio brands, and with different customer groups, it was important to create a clear narrative to unify the business and strengthen its market position.

Our client set themselves the highly aspirational goal of becoming "iconic" within the Life Science category in the next 3 years.

What we Did

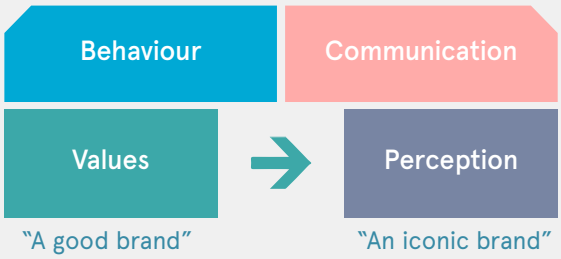
We looked to the consumer world for inspiration and to learn from iconic brands. We devised a number of creative exercises to go beyond what already exists in the Life Science space and encourage new ideas.

Stakeholder Interviews	WHY?	Ensure internal alignment with global strategy
Desk Research	WHY?	Identify patterns/ themes of iconic consumer brands to inspire our participants
Industry Expert interviews	WHY?	Learn from real world practice to inspire the workshop
Tailored Recruitment	WHY?	The customers (e.g. researchers, process engineers) tend to think in literal or rational terms. We vetted each via a telephone interview to find creative and inspiring individuals
Participant Homework	WHY?	To get participants into the right mindset and come to the workshop armed with ideas
Co-creation Workshops	WHY?	We needed a setting where participants could engage in blue-sky thinking and build on each others' ideas and experiences
Cultural Read	WHY?	"Iconic" is culturally & time-relevant. We looked at iconic codes and likely emerging narratives so our client did not find itself iconic in the past tense!

What we Found

We used videos, from the workshops & expert interviews, throughout the presentation to bring the customer's point of view to life. For each building block we identified iconic consumer brands that we could learn from in the Life Science setting.

- We identified four building blocks required to take a brand from being simply "good" to being "iconic"
- Each block represented a number of different iconic features that were inspired by the consumer setting
- Semiotics analysis identified 6 future territories of interest and relevance to the Life Science space
- Three potential strategic platforms were developed as a result
- Today, a number of initiatives have, and are still being rolled out (plus improved communication of existing offerings)



BRAINS and cheek

Interested in finding out more? Get in touch.

Sian Lewis, First Officer
sian@brainsandcheek.com

We exist to provide our beloved clients with a courageous and fun approach to market research and strategic consultancy, to help open-hearted individuals solve unconventional business challenges with a breath of fresh air!

Breaking Down Walls: Understanding the Needs of Sensitive Populations

Natalie Erickson
Consumer Insights Manager
Optum, UnitedHealth Group
natalie.erickson@optum.com

Stuart O'Connell
Sr. Research Manager
KJT Group, Inc.
stuartoc@kjtgroup.com

Introduction

Background

In order to increase engagement in its behavioral health case management services, Optum required voice of the consumer input from individuals and caregivers to those who have been hospitalized due to mental health conditions or substance use disorders.

Research Objectives

- Explore unmet needs related to behavioral health case management, understanding barriers to current support service use
- Determine preferred methods of communication and trusted information sources
- Understand attitudes towards current Case Management messaging strategy

Methodology and Techniques

Respondent Types

Mental Health Consumers	n=9
Substance Use Disorder Consumers	n=9
Caregivers	n=6
Total	**n=24**

Methodology

45-minute Telephone In-depth Interviews

Field Dates

January 31 – March 5, 2018

Screening Criteria

Mental Health Consumers	Diagnosed with Depression, Bipolar, or Schizophrenia; 18+ years old; two or more inpatient stays in past 3 years due to mental health
Substance Use Disorder Consumers	Diagnosed with a Substance Use Disorder (Chronic drug/ alcohol abuse); 18+ years old; two or more inpatient stays in past 3 years due to substance use disorder
Caregivers	Primary/ joint caregiver for 11-26 year old(s) with relevant mental health or substance use disorder; person(s) receiving care had one or more inpatient stay due to mental health and/or substance use disorder in past 3 years

White Glove Recruitment

- Extensive phone prescreening, ensuring recruits were both suitable for and comfortable with participating
- Transparency early on by disclosing all topics that would be discussed

Allow for the Rational and the Emotional

- Using projective techniques* discussions guides were designed to go beyond the rational to unearth the emotional; these two aspects of decision making are often misaligned, especially concerning sensitive topics

Establish a Positive Transactional Model

- Adopting an adult-to-adult transactional model** during discussions helped build trust and enabled open discussion about the most sensitive of topics

*Projective techniques used were word associations and role playing related to diagnosis and experiences.
**Transaction model taken from Eric Berne's Transactional Analysis: http://www.ericberne.com/transactional-analysis/

Key Findings

Tailored Services

Condition-specific outreach is needed – one size does not fit all

Offering additional condition-specific services and information would fill a significant unmet need

Type of Outreach

Not only method, but style of communication is important – consumers feel ostracized and want to feel like they are being heard and cared about

Consumers require personalized, empathetic outreach to build trust and convey understanding

"Do talk with them and find out the hurdle they're having, what their problem and why they called." – Tony, Depression

Roles who Reach Out

While consumers trust their doctor and/or counselor/ therapist most to communicate information, they are receptive to hearing about services from anyone experienced with their condition who takes time to listen

"That's why it's good to have substance abuse counselors do this, because substance abuse counselors, they have been there." – Stanley, Substance Use

Impact

Insights from the study have informed the development of a personalized engagement strategy for consumers:

- Clearly identifying who's offering the program and empathizing with consumers' recent experiences
- Providing multiple modes for communication and ensuring confidentiality
- Tailoring services to their unique condition and needs
- Providing detailed program information ensuring full transparency and clarity of what is being offered

Improving the uptake of HIV testing and treating among young, high-risk men in South Africa

Of all the people living with HIV in the world, almost 1 in 5 of them are in South Africa.

Whilst young women account for two thirds of new infections, men are over-represented in AIDS deaths. This indicates that men are not testing as much as women and are not initiating treatment as readily as women.

International development donor the Bill and Melinda Gates Foundation (BMGF) approached us to understand why this was happening, and develop interventions to address this urgent problem.

It is uncommon for a market research agency to work in the international development space. We designed an iterative research approach that would create impact not just among our grantors, but also our wider stakeholders; government officials, NGOs and implementers.

We established a consortium with social marketing NGO Population Services International and human-centred design agency Matchboxology. Our research approach was iterative; we started with exploratory ethnographic interviews and in-depth interviews with men. We then conducted a quantitative segmentation to identify the highest priority groups.

Above: young men play pool in a tavern in Kwa-Zulu Natal

Our research insights revealed a rarely-seen side of young South African men.

By basing the programme on ethnography, which didn't focus solely on health-seeking behaviour but sought to understand men holistically, we were able to understand the wider contexts of their lives.

In our experience, some members of the healthcare community had frustrations with these men, who are notoriously hard for healthcare providers to engage, but our research gave men a rare opportunity to be vulnerable.

We found that men are operating under harsh circumstances. Fear, not bravado or indifference, is the emotion which so often keeps them away from health clinics.

Our research highlighted the need to implement services which work better for men – such as by adopting a 'harm-reduction' approach rather than a moralising one.

Intervention design is ongoing, but our research findings are already creating impact. We were requested to present the project five times at the 2018 International AIDS Society conference. This study has been quoted by the US ambassador to PEPFAR, and the head of the HIV response in South Africa.

For a piece of market research to earn the approval of, and inclusion into, the (academic) global health community is a rarity, enabling us to share our learnings with a vast, prestigious and powerful audience (such as PEPFAR, major funders of HIV programmes in South Africa).

Through our research approach, we will ultimately be able to generate interventions which will 'move the needle' on the uptake of HIV testing and treating services among young high-risk men.

Authors: Ellie Tait, Sunny Sharma, James Bell (Ipsos)

Fieldwork was conducted in the provinces of Mpumalanga and KwaZulu-Natal from April 2018 to January 2019. 18 men took part in the ethnography, 58 in the in-depth interviews and 2019 in the quantitative segmentation survey.

Delivering true innovation via a holistic multi-stakeholder approach

Market Context

The ongoing introduction of biosimilars gives prescribers and policy makers greater treatment options. However, they also face increased regulatory pressure to choose cost-effective treatment.

Within this challenging and increasingly competitive landscape, pharma companies must deliver clear rationales supporting their brands.

The Business Need

To maintain growth of Janssen's innovative biologics, the need was identified for the development of a patient-centric strategy built on an understanding of the influence of brand, customer loyalty and value-added services.

In response, Janssen created a Biologic Innovation Taskforce, bringing together experts from their commercial, forecasting and policy teams.

A Partnership Founded on Innovation

Together, Janssen and Ipsos entered a two-year partnership that leveraged expertise from both organisations.

Innovation was at the core of the relationship, enabling Janssen to confidently build its future growth strategy across multiple markets, stakeholders and therapy areas, by better understanding their needs and the balance between innovation and cost effectiveness from a policy, prescriber and patient perspective.

Innovative Techniques

We used innovative techniques to build holistic insights spanning all phases of the research programme, starting with a combined kick-off session:

Unique to this project was the linking of robust syndicated Autoimmune Therapy Monitor data with 'in the moment' insights, providing a baseline for layering policy frameworks and commercial insights.

A pop up online community, recruited directly from the Therapy Monitor, included a mix of online 'real-time' moderated discussions and individual tasks.Regional and local policy initiatives were used as stimuli within focus groups and IDIs/ TDIs with policy maps integrated into the commercial outputs, providing a single, holistic assessment of the evolving market.

Conflict focus groups with physicians with varying viewpoints on biosimilars were asked to build, present and critique opposing prescribing scenarios.

Rapid fire quantitative Rapid Research, conducted over a 48 hour period using Ipsos' Rapid Panel of HCPs, enabled us to quickly address any unanswered questions and knowledge gaps from the Janssen Biosimilar Task Force.

Impact

Project successes include:

- The creation of the Biologic Innovation Taskforce, encompassing multiple stakeholders and cross-country collaboration across European teams – driven by Business Insights.
- A deep understanding of rational and emotional perspectives across a range of stakeholders, which drives strategic planning for Janssen brands.
- Understanding of the existing policy environment impacting the uptake of biologics as well as emerging policy trends.
- Cross-country BI and Government Affairs collaboration to build insight on macro and micro environments

Planning for the Future

Key outputs were regional and country level infographic one page summaries, encapsulating all phases of research, from a commercial, forecasting and policy perspective. These easy-to-digest, story-lined summaries are currently being built upon by Janssen EU market Affiliates, helpingto guide their 2019 brand strategy planning.

2019 JH Award Winner

Winners:
Georgina Cooper & Soumya Roy,
Basis Health

EphMRA is delighted to announce the winners of the 2019 Jack Hayhurst (JH) Award for Best Paper at Conference in June.

Georgina Cooper & Soumya Roy from Basis Health have won the award for their outstanding paper at the conference entitled The Future of Research Debriefs – Immersive, story-led outputs that inspire action, so we wish to congratulate them both on winning this highly prestigious award. As new members of EphMRA we are delighted that their paper was so well received by delegates at the conference. We look forward to more inspired papers over the next few years!

All eligible papers were judged by members of the Programme Committee, who attended all the sessions and used a strict set of criteria to evaluate each paper. These criteria covered the delivery of the presentation itself; the overall value provided by the paper to delegates and an overall score for the presentation. In addition, delegates were asked to rate papers they attended and these scores, along with the post conference evaluations and the judges evaluations were all amalgamated to reach the final decision. So, the judging process is very rigorous and robust!

It was a very closely fought contest for 2nd and 3rd place, but EphMRA is also very pleased to announce that the runners up are Simon Ball from Celgene and Pamela Walker from Incite Consulting for their paper entitled Implicit insight into prescribing in relapsed refractory Multiple Myeloma. Congratulations to Simon and Pamela on being voted in 2nd place for the JH Award.

The 3rd place was won by Sam Hope from Blueprint Partnership and Lea Kalweit from Bayer for their paper entitled Rising to the challenge. Congratulations Sam and Lea on this achievement.

There were 11 papers eligible for the JH Award in 2019 - that is, papers which were presented by speakers which had gone through a rigorous selection process by the Programme Committee in the Autumn 2018 and Spring 2019.

There will be more information about our winners in the December EphMRA News and EphMRA would like to again congratulate our winners on their achievement.

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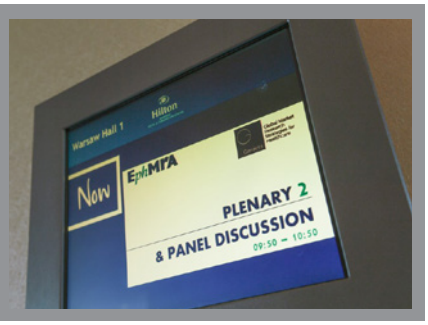
Thanks to the 2019 Conference Sponsors

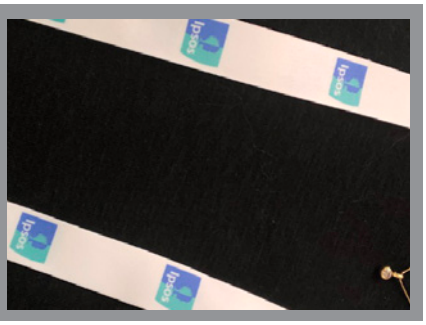
It's great to see so many companies supporting the conference – why not join them in 2020!

Delegate Bag - GLocalMind

Digital Signage - Genactis



Conference Lanyard - Ipsos Healthcare



Writing Pad - Ripple International

Water Bottle - M3 Global Research

Large Plenary Room Banner - Segmedica

Photographer - Research Partnership

Badges - IGV Marktforschung GmbH

WiFi Code - AplusA Research

Lecterns & Registration Desks - Survey Healthcare (SHC)

Tuesday 25 June

Workshop 1

Increase your Impact and Influence

Speaker:
Richard Newman,
Body Talk

Convenors:
An-hwa Lee, Research Partnership &
Cristiana Carata, Instar Research

In a dynamic and highly interactive workshop, Richard Newman of Body Talk discussed how to bring a message to life in the most engaging and effective way possible, through both body language and storytelling.

The workshop specifically looked at:

Style - what you can do physically and vocally to change the impact you are having on people around you when communicating information in any kind of interaction, whether you are speaking to one person or a group or standing up or sitting down.

Storytelling - how you can take any information and script it in a way that is memorable for you and more meaningful for your audience.

Style

Through body language and tone of voice, we can communicate a huge amount of information, irrespective of the words that are spoken.

The words you say at the beginning of a presentation may be the same as the words you say at the end of it but if you change your body language, it will change your voice which will change how people feel and react to everything that you say. In other words, it is possible to say all of the right words but deliver the wrong message because of your body language. Likewise, you can repeat the same exact words but deliver a very different message based on what you do physically and vocally. It is therefore critical that your vocal delivery serves the data and message.

It is a widely held misconception that you should be yourself when delivering a presentation. Do not be yourself! Personality can be important but there are certain fundamentals that every human being will react to.

In research that Body Talk conducted with University College London (a world-renowned centre for research on non-verbal influence and psychology) using over 2000 people aged from 18-65 from all over the world, participants watched a video and had to rate the person who was changing their non-verbal communication in terms of whether they would vote for them. The research found that it made no difference if there was a man or woman or an older or younger person in the video but, if there was a slight change in non-verbal behaviour, it made a massive difference as to how likely the respondents would be to vote for them. Small findings therefore make a massive difference in how people see you and this involves taking away any behaviours or habits you may have i.e. not being yourself.

It is possible to change your body language through taking a closer look at your posture, legs and arms.

Posture

This is where your physical presence comes from. It is the exact opposite of the way most people operate who tend to do the 'off-centre shuffle' when presenting. If gravity is working with you and not against you, you will have more physical gravitas when you speak. Other things you can to do improve your posture include:

- Standing the way you were physically born i.e. with your feet shoulder-width apart to obtain gravity.
- When sitting down, you can use your sternum to lift and realign your posture. Lifting it makes the message more important and gives emphasis. Lifting it or dropping it can therefore communicate a huge amount.

Legs

You do not want the focus to be on your legs when you are delivering a presentation. If you are sitting down in a meeting and feeling stressed, it is common to move your legs but this distracts people. Keep them still to draw focus to key words and messages.

When standing, look out for 'bobby' and 'pacey'. 'Pacey' is when somebody constantly and purposefully moves around. The speaker may think this is being dynamic but it reduces focus for the audience. Move for a reason, not because it makes you feel better. 'Bobby' is the person who constantly goes up and down on the spot. Remember to keep your feet still when you have something important to say.

Arms

With your arms, you should take what you are doing subconsciously and do it consciously. You need variety and congruency i.e. your body, voice and words need to be going in the same direction. Other points to remember are:

- Handshakes have the same impact as gestures.
- Put your palms down for a strong statement.
- Put your palms up for open statements or questions. When you are trying to get a discussion going, palms up is critical.
- Show people physically when it is time for them to speak up or be quiet.
- Avoid low energy gestures below the table.
- If you do no gestures, you are uninspiring.
- Some gestures mean different things in different parts of the world.

Other areas of body language to consider

- Your gestures change your voice.
- Before a call, think about how you want the other person to feel about your message i.e. what physicality do you need on the telephone.
- Avoid the denial position which denies you from being physically expressive.
- Also avoid the bluff position. If you physically lean towards people, they tend to back away and this will give you less engagement, not more.

Storytelling

A lot of people have a large amount of complicated content to communicate with limited time in which to prepare. It is important to remember that people care about what they need to hear. If you give people information in the order they need to hear it, you can compel them to listen. This is based on giving people the information they need in a way the brain is designed to receive it.

Breaking down your approach to your content will help you to structure and script it more effectively.

- The way that you hook people into your message is critical and involves about 20% of any communication. In order to get everybody engaged with your message, you need to tap into the instinct that every human has to avoid pain and gain pleasure. If you can show people listening to you how to avoid pain and gain pleasure, you can get them to listen to you.
- A problem is a challenge, concern or pain that your audience is concerned about. This is often based around money, time and values. In order to go from pain to pleasure, you are going from a problem to a promise, but it is not a guarantee. You are describing a better future before you go into detail. This will activate the part of the brain that looks out for highly charged emotional events. In other words, you are aiming to spark the brain before going into the details of the data.
- Larger amounts of information will be most effectively presented if they are delivered in a group of 3.
- Before finishing your presentation, recap.
- At the end of a presentation, most people are wondering what the presenter wants them to do with the information they have delivered. A prompt will prompt people into action promptly, but it needs to be something small and simple.

Key take-away messages

- Your body and your voice need to connect so you can communicate how you feel.
- Avoid the off-centre shuffle and anti-gravity.
- Stand with your feet shoulder-width apart and avoid wandering around for the sake of it.
- Stand still or sit still for key messages.
- Palms up is for open statements and questions and palms down is for key statements and strong messages.
- Avoid bluff and denial positions. Come back to the centred position for key messages.
- Think about pain versus pleasure to hook your audience in.
- Sell people a better future.
- Condense information into a group of 3 key points.
- Give your audience one simple next step they can take.

Tuesday 25 June

Workshop 2

Measuring and Demonstrating ROI: Building the Business Impact of Insights

Speaker:
Andrew Cannon,
Executive Director, GRBN

Convenors:
Alexander Rummel, Aurum Research
& Marcel Slavenburg, SKIM

The value of insights as a strategic business partner and their role in measuring ROI was the focus of a workshop with Andrew Cannon, Executive Director of GRBN and CEO, Valo Foresight Services.

How insights have to be a strategic business partner within an organisation

There is frequently a mismatch between how insights teams see themselves and how marketers view them. Research carried out in the US in 2015 found that half of insights people felt that they were strategic consultants but only one quarter of marketing departments felt that this was correct. In other words, there is a mismatch between what insights teams think they deliver and what marketers think they deliver.

The research found that only 1 in 5 insights teams are within the top two boxes (a strategic business partner / a source of competitive advantage).

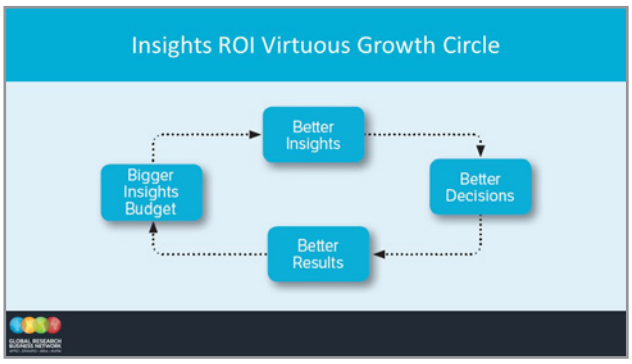
The measurement of ROI is critical to this perception.

Why and how to measure the ROI of insights?

ROI is not about cheaper and faster. Organisations which have this as part of their KPIs frequently get caught in a circle of diminishing returns and these should not be your defining metrics.

It has been found that the ROI of insights is way above anything else that a company can do in terms of adding value to a business. ROI is important because:

- It is about the real and measurable impact of insights.
- It enables strategic competitive advantage.
- There is frequently an aversion to making investments when the ROI is not forecasted, measured or known.



Measuring the ROI of insights can result in

- Growing the budget and your allocation of budget.
- Enabling you to control your budget more effectively.
- Helping the business to uncover the right information.
- Getting you a seat at the strategic top table.
- Increasing stakeholder satisfaction.
- Preventing the company from making bad decisions.
- The possibility of getting more resources.
- More respect, leading to potentially increased career possibilities.

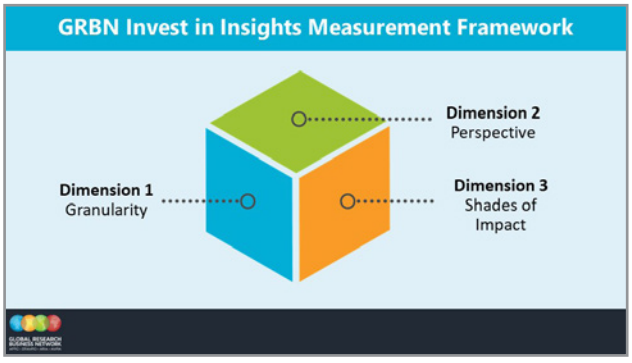
It is important to remember that better insights lead to better decisions lead to better results for the business lead to a bigger insights budget. In other words, there are benefits on a company, Insights department and an individual level. If organisations do not measure ROI, budget and growth can be reduced.

However, there are a number of barriers to measuring ROI which include:

- ROI is often not tangible.
- A time lag that can arise between the delivery of insights and the business result.
- An individual project might not necessarily have a direct impact.
- It can be difficult to isolate the impact of insights.
- Consumer insights can be distant from delivery-makers.
- The business objectives not being clearly defined.
- A lack of alignment on what is important to the organisation.
- A lack of time and staff.

How to measure the ROI of insights

The idea that you can measure perfectly from an ROI perspective is doomed. Instead, it is important to focus on things that you are able to measure.



Think of your approach to measuring ROI in terms of granularity, perspective and shades of ROI.

Granularity is about what you are measuring. Start at a project level and think about what the ROI for this particular project is. You should not share this outside of your department unless a project equals a business decision. You do not want your stakeholders to interfere with research methodology decisions. Setting quantifiable business objectives is very important and linking projects to strategic priorities and reporting on how Insights feeds into the key strategic priorities will help gain you a seat at the strategic table.

Perspective is to forecast ROI as well as actually measure ROI with financial ROI measurement being the goal. You will find that you sometimes have to accept that you can forecast ROI, especially a financial return, but not measure it. Not every project will get a high ROI, but it is important to follow all projects, and not cherry-pick, but of course highlight the big wins in your ROI reporting.

In terms of the shades of ROI, remember that you will not have to measure a quantified return for every piece of work.

You will always find:

- Measured financial metrics.
- Surrogate measures (metrics) that are of value to the business.
- Feedback from stakeholders
- Stories, which can be hugely valuable as they are often remembered before numbers. A story with firm financial metrics and great anecdotes can help to create a compelling account of the power of insights.

Tying all of these elements together will enable you to measure the business impact of Insights effectively.

ROI measurement variables

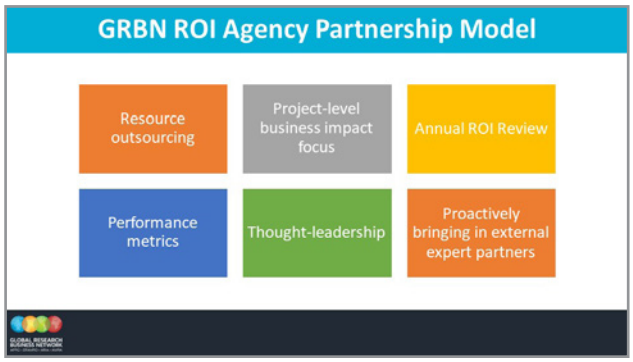
The two key ROI management variables involve looking at opportunities and managing risk. To demonstrate these, we measure:

- Financial metrics, where profit is the gold standard. Most insights functions do not have cost information but if you have this, you can create a profit matrix. If not, just use sales information. You can also measure cost avoidance.
- Surrogate measures which feed into the financial metrics. Preference is a good example of a surrogate measure as if you know the preference, you can usually model the sales.

You could also use other metrics including the net promotor score, a satisfaction score, positioning, market share and the share voice. Think about what your KPIs are and what your metrics for measurement are. Some of the measurements will come from primary research and some from the forecast team.

Agency ROI partnerships

Agencies have a direct incentive to shift the client's thoughts away from how they can do the work themselves to how they as agencies can add business value. When an agency is a strategic partner, they can add value.



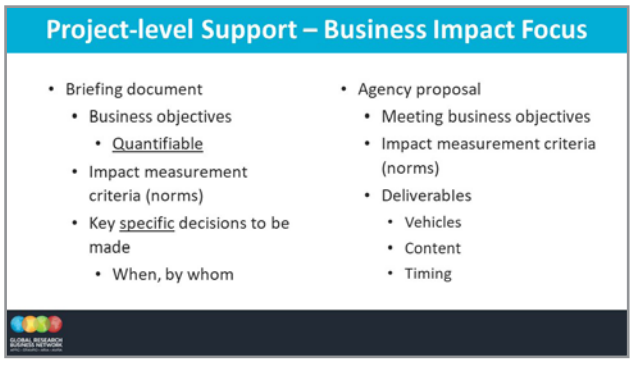
Creating a successful agency partnership model lies at the heart of delivering ROI.

Things to consider:

- Think about to what extent you should outsource to partners i.e. what is not high value.
- On a project level, there should be a business impact focus i.e. what are the quantifiable business objectives?
- You should have an annual ROI review at least once a year to evaluate what you have done from an ROI perspective.
- You should consider setting performance metrics for your agency based on ROI metrics.
- You want your agency to give you thought leadership, not just project management. This will help clients to understand what does and does not work.
- You want your agency to bring in external experts. This is hard if the focus is just on project profitability but is valuable for ROI.

If you can achieve these six things, you will have a much better agency-client relationship.

A successful agency-client partnership starts with the briefing document which should contain quantifiable business objectives and impact measurement criteria (surrogates).



It is also important to undertake an annual ROI review with the agency to understand the overall ROI delivered, how projects should be improved, the challenges involved and how a stronger business impact could be achieved.

Tips for success

- Dissemination of insights is critical. If you are not getting your insights disseminated, you are not going to succeed on your ROI to your fullest ability.
- If you cannot build models, work with a department or outside partner which can. This will help you measure the impact of insights and build them.
- Analytics are your friends. Try and work with them as they have data that can justify your value.
- Talk about the value of insights within your company.
- Start. If you don't start now, you won't start.

There are five possible next steps.

Key takeaway messages

- The ROI of insights is the most important thing a company can have in terms of adding value to the business.
- ROI enables strategic competitive advantage.
- Measuring ROI can bring a number of key business and personal benefits.
- It is important to focus on things you are able to measure and not aim for a perfect measurement scenario.
- Tying a number of elements together, including financial metrics, surrogates and stakeholder feedback, will enable you to measure your business impact more successfully and tell a compelling Insights ROI story.

Saving the world by staying at your desk

Article | Bors Hulesch
Captain, Brains and Cheek

First, let's tell the truth.

Are you old enough to remember the time when emails used to be printed off, and filed for posterity? It wasn't even that long ago – maybe 15 years? More recently, we've moved on to the virtue-signalling email footer that reads: "Only print this email if you really need to". When you add recycled paper and refillable printer cartridges, it suddenly feels as though everyone is doing their bit.

Cut to today though, and we have yet to experience any serious attempt at, or even a discussion of, decarbonising the business intelligence industry. Tokenistic feel-good gestures such as reusable cups aside, we are still guilty of gorging on jet fuel, car fuel, disposable plastics and wasteful resource management, without regard for the downstream consequences. If this were how we managed our financial resources, it would certainly be seen as a dereliction of duty. So why not have the same prudent approach when it comes to our one and only habitable planet?

Consider that everything has a calculable carbon footprint. Your flights, your hotel stays, your office party, your day working from home, your take-away lunch, the contents of your waste basket, and yes, even recycling has a carbon bill attached to it. Before we can take action, we need to acknowledge and accept that we are very much part of the problem.

To make progress, we first need to come clean about the fact that the measures so far do little more than appease and comfort. To assess the scale of the problem, our company has been monitoring our carbon emissions for the past 9 years. It appears that our average travelling exec is responsible for about 50 tons of work-related carbon emissions each year. Compare that to the 6.5 tons per year for the average UK resident, or less than 2 tons for the average Indian.

Then, let's take responsibility.

If you are a qualitative researcher like me, you're not going to like what comes next. And if you are a people person like me, you're not going to like it either. However, the uncomfortable truth is that the vast, VAST majority of our emissions as an industry comes from air travel. The main culprits are face-to-face meetings and qualitative fieldwork. Particular shout-outs go to long haul and business class flights.

Now, I've lost count of the number of times I've said the following words to our clients: "Yes, we will attend the fieldwork in person. It's the best way to ensure quality." And also these: "Yes, we'll fly over for the kick-off meeting, the debrief meeting, the workshop, the credentials meeting, the conference, etc. SURE. It's not a problem!"

These sentiments are nothing more than manifestations of the basic human instinct for personal interaction. Knowing the people you work with; seeing the interviews with your own eyes; briefing the moderators yourself; all of these are commendable and understandable intentions. Unfortunately, they go against the grain of another basic human instinct – that of our survival.

Something will have to change substantially. My view is that we can either initiate that change ourselves, or be forced by circumstance to change at a later date. History will judge these decades harshly as it is. Why not stay ahead of the curve, so that we can look future generations in the eye?

Before you get worried: I'm not suggesting for business intelligence to cease all commercial activity as an industry. However, business as usual will need to be transformed. While clients demand personal presence today, they may well be asking for sustainable projects in the near future. Therefore, we need to ask ourselves: can we deliver good research that is also beneficial, or at least neutral, for the environment?

Finally: let's implement solutions.

Many of our pharma clients are beginning to decouple profits from emissions (with varying success). As part of these initiatives, environmental credentials are starting to appear on procurement questionnaires, and clients are increasingly likely to look for climate neutral status from their partners or projects. You may wonder, how is it possible to achieve climate neutral status for a company, or for a project?

For the material bits, the time-tested maxim still holds true: reduce, reuse, recycle, upcycle. Don't print if you can look on a screen. Don't buy if you don't need to. Don't replace if it's still serviceable. Don't bring more packaging waste into the world. Dispose of waste responsibly. You already know all this.

For your travel however, you can only do two things: reduce or offset.

Reducing is tricky, and is likely to meet with resistance. When face-to-face is the best option, both colleagues and clients may feel that the immediate need to do a good job trumps the long-term environmental consequences. We are addicted to the efficiency and convenience of hopping on a plane, and relinquishing this benefit will require conscious effort from those of us who fly, and a change of mindset for those who request us to fly.

Carbon offsetting in comparison is cheap and easy. By buying an offset, we remove the same amount of warming effect from the global system that we've put into it by conducting our business. For our travelling exec above, we pay about £400 per year to offset all of their carbon emissions*.

However, this system only works as long as there are ethical offsets available and on the current trajectory, we will only be able to access quality offsets for the next decade or so. This is the timeframe in which we will need to wean ourselves off fossil fuels by coming up with ways to reduce our travel emissions to a bare minimum.

Try this.

As an exercise, I invite you to ponder: can you replace a flight with a train? Which of your trips could be swapped for video conferencing, teleconferencing or even plain emailing? Which partners or clients may be persuaded to give up some of the human connection, for the sake of human survival? Which bits of fieldwork would be 'good enough', if observed via video link?

I'm willing to wager that you could forgo 20% of your carbon emissions right now, without significant loss to productivity or quality. Try it, and let me know how you fare. I'd love to hear your story about stepping back from the climate precipice; as a person, as an organisation, and as an industry.

Remember, we don't need to save the planet from people. We need to save people from the planet. And we can do most of our bit by staying at our desks.

*For a socially and environmentally sustainable carbon offsetting scheme for your organisation, visit: www.myclimate.org
To join the climate movement, visit: https://rebellion.earth
Email me your story: bors@brainsandcheek.com

brainsandcheek.com

Can the Future of Healthcare Market Research be Virtual?

Market research has evolved dramatically over the decades, from quantitative data collection methods like Paper and Pencil Interviewing (PAPI) to Smartphone Assisted Personal Interviewing (SAPI) and Tablet Assisted Personal Interviewing (TAPI) techniques. To be noted here is the absence of research techniques dedicated to fulfil the unique and specific requirements of healthcare MR.

Recent developments have made VR and AR applications practical, cheaper as well as significantly more accessible. While current applications are mostly limited for entertainment purposes, they contribute towards making VR / AR mainstream.

The immersive experience provided by VR is already being implemented in a variety of healthcare scenarios that range from pain and stress management therapy to medical training and surgical preparations. VR services in the medical / healthcare segment are forecasted to generate US$285 million by 2022.

Treatment for schizophrenia or paranoia is another area where VR treatment shows promise. Deep implementation of VR in medical education can also be used to train students on a myriad of medical conditions and situations even before they graduate.

Can VR and AR-based research hold the candle to existing healthcare MR methods?

Implementation of VR and AR technology in the healthcare MR field could push research forward by leaps and bounds. Think real-time access to patient and doctor interactions to researchers or a first-person view of a new medical tool through novel usage of VR and AR.

This can be further complemented with the use of health monitoring wearables, which can enhance data collection methods when utilized along with supplementary assets such as physician notes, web searches, online healthcare purchases, social media, etc.

Engaging in alternative technologies to enhance healthcare MR

Machine learning (ML) based predictive analytics is another technology healthcare MR can benefit from – an area of MR that Borderless Access has already set foot in. We have already implemented predictive analytics and ML-based heat map data to derive richer insights for our customers and maximize their ROI.

In the area of healthcare research, we have extended the use of ML through HealthSight™, an advanced analytics-driven, DIY programmatic project management suite that uses ML to reduce research cost and time. Designed from scratch as an advanced, future-ready Windows application, HealthSight enables researchers to commission multiple research projects simulteneously as well as manage every minute aspect of these projects from a single touch-based platform.

Also in the offing are VR surveys to conduct product testing and concept testing among physicians and patients. The aim of these surveys would be to develop the next generation of MR techniques, aimed at the healthcare segment, which can obtain deeper insights, reduce errors, increase ROI and enable quick and clear decision making for our clients.

Conclusion

The next phase of change in MR is almost upon us. It is time to reorganize operations to take advantage – rather than be a victim – of the new dynamics that are driving healthcare. The winners will be organizations that are willing to evolve and adapt to the new environment and are ready embrace alternative techniques.

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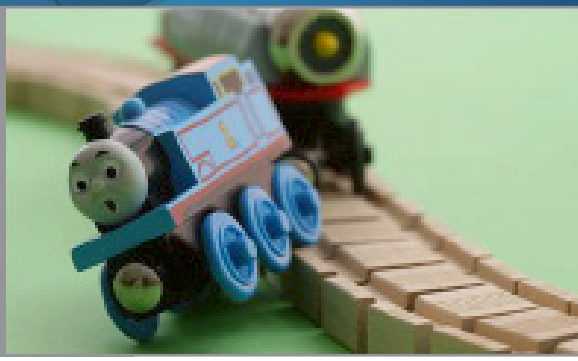
Business Intelligence must "step-up" to prevent a Pharma Industry Train Wreck!



Pharma is a growing, prospering industry, so where's the problem?

The global pharmaceuticals market generated $934.8 billion revenue in 2017 and some forecasters predict 5.8% annual growth for the sector through 2021(1). In the U.S. alone, national health expenditures on medications are forecast to reach $605 billion in 2026; the pharma audit and data analytics supplier IQVIA predicts global spending on drugs is set to grow at a 3-5% Compound Annual Growth Rate from 2018E-'22E. (2)

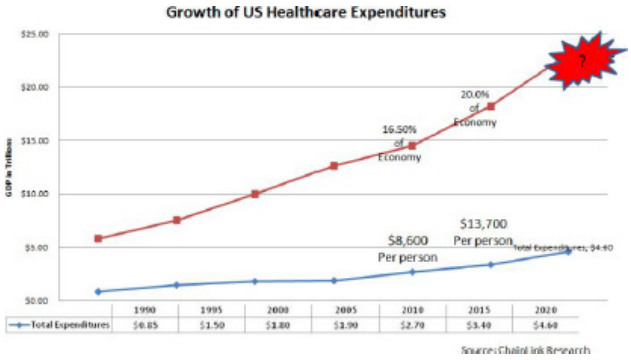
While the financial outlook for the pharmaceutical industry still seems to be positive, such an appearance may be deceptive. Many stock analysts point to the fact that that the industry has experienced an unprecedented amount of challenges and changes over the past several years, with Global market growth trending down with the current pace of growth well below the historical 5-year average. On-going cost containment measures from both public and private payers, combined with an increasingly competitive global corporate dynamic for investment and improved R&D return, have and will continue to weigh heavily on Pharma's operations.

Misgivings about pharma's future are reflected in the current price/earnings ratios of Big Cap pharma companies. Currently they are at a discount to both the Standard & Poor's average and to pharma's own 10-year average.

The reason is that a forward P/E multiple is correlated with long-term growth projections and a major storm cloud looms over pharma's prospects for revenue growth. Starting anytime within the next five years, pharma may embark upon a sustained period of flat growth because approximately 70% of the industry's operating margins derive from the United States and, in one form or another, the U.S. will likely adopt some form of price control that promises to precipitously curtail those margins.

Why are U.S. price controls inevitable?

The inevitability of U.S. control over drug prices is not difficult to discern. A recent study by Johns Hopkins (3) found that U.S. prescription brand drugs are the most expensive in world. On average, branded prescriptions before rebates cost 4.3 times more in the United States than in the UK, 3.8 times higher than in Japan and 3.4 times higher than in Canada. Even after rebates, people in the U.S. paid 3.6 times more than those in the UK, 3.2 times more than those in Japan and 4.1 times more than those in Canada. Moreover, the longer brands remain on the U.S. market, the more expensive they are in comparison to other countries. Aside from the U.S., governments of these countries have become involved in regulating pharma's prices, illustrating the cost containing effect of such association.



The existence of exorbitant drug costs causes major distortions in the entire U.S. economy and social structure. The Organisation for Economic Cooperation and Development (OECD) found that the middle class in the U.S. is shrinking primarily because of the outsized costs for health care, education and housing (4). The economic burdens associated with these three factors mean that, *"many middle-income households face a considerable risk of sliding down into the lower-income class,"* according to the OECD. And medications, although a smaller portion of the total health care bill than provider costs, constitute the fastest-growing part of the U.S.A.'s healthcare budget (5). As a line item, drug costs represent almost 20 percent of employers' health insurance benefit costs (6).

Certain quarters of the U.S. have been grumbling about drug prices for years and nothing has changed. What's different now?

The situation in the U.S. is ripe for enacting some form of price control on medications because in an increasingly polarised political environment, the growing disdain for the pharmaceutical industry and a shared commitment to making drugs more affordable, constitutes one of the few areas of agreement between the major parties.

As an example, the Big Cap analyst for investment bank Morgan Stanley, David Risinger, recently made the following point in a report to clients (7).

"Historical Republican support of Pharma-Bio is waning and, in some cases, flipping! Republicans' broad-based support of the industry appears to be diminishing, and some Republicans are issuing unexpected proposals. An example is that Senator Rick Scott (R-Fla.) proposed a bill which included having Americans pay no more for drugs than other industrialised nations including the UK, Canada, and Germany."

In the U.S. Congress, lawmakers have submitted more than 40 bills to control drug prices and President Donald Trump also floated his own inchoate plan to achieve the same goal. In 2018, 39 states passed 94 laws targeting pricing and costs. Both Democrats and Republicans, including the White House, have bills to peg American prices to those in Japan and Europe.

Some bills would let the Medicare program negotiate directly with drug companies and maintain a restrictive formulary to reduce prices. Various approaches to let Medicare use its purchasing power for lowering drug prices enjoy broad bipartisan support and is favored by 80 percent of Republicans and 90 percent of Democrats.

At the present time, however, efforts to enact federal price-control legislation remain highly improbable, largely because the U.S. Senate requires an absurd level of consensus to pass any measures in dispute. Despite that, if the Democrats elect a president in 2020, he can use executive authority (either "march-in rights" or compulsory licensing) to reduce prices on branded drugs.

Although price control action at the federal level appears problematic until at least 2021, the pharmaceutical industry and its lobbyists also appear concerned by efforts at the state level. In Florida, for example, the state with the highest percentage of elderly residents, the state House recently approved a move backed by the Republican governor to allow imports from Canada (8). Other states are considering regulating drug sales within their borders as public utilities, under a system where state commissions/agencies would set drug prices. At the same time, strongly Democratic states such as California, Massachusetts and Maryland are considering forming an "interstate compact" to control drug prices.

Initiatives at both the federal and state levels reflect the fact that U.S. politicians are responding to constituent demands in which eight out of 10 Americans say the cost of prescription drugs is "unreasonable." (9)

The pharmaceutical industry's public image in the U.S. goes beyond the perception that its products are increasingly unaffordable. Last year the Gallup poll asked Americans to rate their perception of more than a dozen sectors in the U.S. economy and pharma came in last (10).

The pharmaceutical industry has long enjoyed insulation from market competition due to government-granted patents that confer exclusivity. At the same time, the government has steadfastly refused to either maintain drug price affordability by mandate or by using its own considerable purchasing power. At a minimum the public expects that this insulation from a competitive market and a laissez-faire government approach, obliges pharma to exercise good citizenship and a strong concern for public well-being. The questionable actions of many pharma companies during the past twenty years have contributed to the perception that the industry is fundamentally driven to achieve exorbitant profits by "exploiting" society's most vulnerable segments – the aged, the sick and those of modest means.

So, is there a way for pharma to mitigate public vilification and onerous regulation?

Pharmaceutical companies and their lobby, the Pharmaceutical Research and Manufacturing Association, have so far sought to address the distrust of the pharma industry's public image and government regulatory efforts as principally matters for public relations and political influence. Through media advertisements and political contributions, the industry's reflexive response to the matter of unaffordable medication costs has centered on the explanation, that high prices are needed to fund the R&D that advances the standards of care.

Growing doubts about this justification for high drug costs have added to feelings of public distrust of the industry. While staunch loyalists to pharma's pricing claim that only one in ten new molecular entities started on clinical studies ever gain regulatory approval, the fact remains that pharma spends substantially more on marketing and sales than on R&D (11). Despite claims about the high absolute expenditures on research, over the past twenty-five years pharma has been the world's most profitable industry, whether assessed in terms of earnings/equity, earnings/sales or earnings/assets.

When one takes into account the fact that government tax credits reduce pharma's costs by almost 50% and that "all 210 of the new drugs approved by the FDA between 2010 and 2016 were funded by the National Institutes of Health," the industry's claim about the necessity of high prices appears especially weak.

The effort to justify high drug prices is just one example of how pharma relies upon questionable means of addressing public image and government efforts via its communications/public relations/advertising functions and government affairs operations. The growing public perspective on this is captured in a recent comment to the effect that, *"People know that the drug corporations are spending money to influence every aspect of drug development and pricing policy, and it makes them angry."* (12)

Adequately addressing pharma's public perception and consequent government actions will require the industry to substantially reconfigure the fundamental nature of its business model and the way it defines its role in society. At most times, pharma managements regard public opinion and government activity as relatively peripheral matters that it can safely delegate to the PR and government departments while those in the C-suite go about their principal tasks of developing and selling their patent-protected products. The time has come for management to reassess its approach to these core activities.

Pharma actually deploys a function that can play a key role in not only accurately assessing the developing situation, but also remains capable of providing insightful solutions. Unfortunately, the industry underutilizes this activity, tending to use it exclusively for tactical operations at the product and franchise level. We are referring here to Business Intelligence (BI).

How can BI help pharma to improve its public image and mitigate government intrusion?

Some companies use BI, under the rubric of Marketing Research, to discern customer needs and attitudes. At the same time, they rely on Competitive Intelligence to better understand the thinking, planning and resources of other companies.

We use the term Business Intelligence to refer to both of the above functions, but also to include the activities of collecting and assessing political intelligence and public opinion in a dispassionate manner that does not involve preset operating strategies or goals.

A BI possessing the capability of addressing public perception and government involvement should accept as its only presupposition, the need for pharmaceutical companies as profit-seeking enterprises in a capitalist system, to show some return on equity. Beyond that, the amount of return, the time periods for measuring growth, as well as the objectives, strategies and methods for achieving it must all be subject to empirical inquiry, rather than accepted as mandates from the C-suite responding to Wall Street. By making the pharmaceutical industry's bedrock fundamentals subject to constant, empirical assessment, BI can do an infinitely better job than the PR and government affairs functions at allaying the threats from public opinion and government intrusion because the latter departments accept pharma's dysfunctional premises as givens. To effectively use BI for the purposes of assessing and adapting to the imperatives of politics and public opinion, management must give it a seat at the senior decision-making table and ask it to provide evaluated options for action.

The approach presented here is not new to other industries' management sectors. Although it may be novel to pharma, the industry is typically a late adopter of innovative managerial thinking. Procter & Gamble, for example, introduced the product management system in 1929, but pharma did not adopt it until well into the 1950s.

The present notion has its roots in 1960, when Jerome McCarthy (13) of Harvard introduced the concept of "marketing mix," which Phillip Kotler, (14) a few years later, popularized as the 4 P's of marketing: product, price, place and promotion. By the 1980s, after advising the pharmaceutical company G.D. Searle, Kotler added two more P's to his typology: politics and public opinion.

If management must change the way it thinks of BI, managers within that function must also alter the way they define their jobs and appreciably widen their scope of professional acumen. They must increase their knowledge to address larger, strategically significant issues that are integral to establishing the long-term sustainability of individual pharma companies and the sector, and thereby, function as a "truth teller" to senior management.

Some of the issues that BI must regularly assess and put on the record for senior management to consider include the following.

- As demand for branded medications declines, how long can branded pharma companies continue regular price hikes that are three times greater than cost of living increases, thereby defying a fundamental tenet of a competitive market?
- Will the public and the government permit pharma to base its R&D upon the search and development of patented compounds and market exclusivity, even though research is capable of demonstrating that repurposed, generic compounds can advance standards of care?
- What is the cumulative effect upon public perception and government activity of pharma devoting ever increasing proportions of its R&D to rare conditions in order to charge higher prices, while selling fewer units and neglecting research in areas such as anti-infectives that affect vastly larger populations?
- When and how will the growing percentage of pharma revenues from emerging markets oblige pharma to forsake its price-based growth model in favor of one based on volume?
- What other social and political trends loom on the horizon that will adversely affect pharma?

In a world undergoing ever more rapid change and dislocations, an industry that fails to regularly monitor major trends and adjust accordingly, risks going the way of Polaroid, Laura Ashley, BlackBerry, The Record Industry, The Camera Industry etc..

Not only must corporate directors look to BI as a source of empirical assessment and truth telling, but professionals within this functional area must no longer limit themselves to remaining primarily a service to line management at the brand and franchise levels. A failure on the part of BI to accept and agitate for addressing the threat to pharma will produce, at a minimum, an unparalleled level of consolidation across the industry.

That may not be financially harmful to C-suite occupants, for whom a merger or acquisition will trigger the bonus provisions of their contracts, but for many BI professionals, a wave of industry consolidation will mean the end of their careers!

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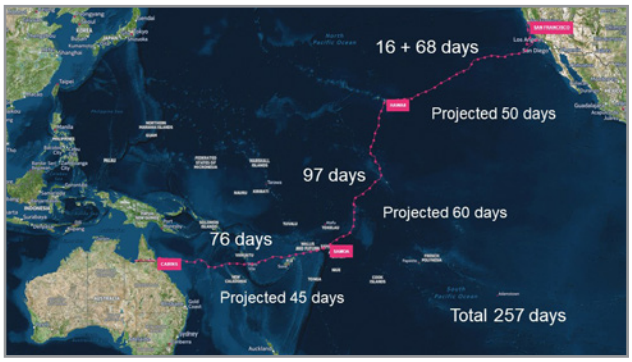
Wednesday 26 June

Keynote Plenary 1
Losing sight of shore

Speaker:
Natalia Cohen,
Motivation and Leadership Expert

Chair:
Carolyn Chamberlain,
Purdie Pascoe

Our keynote speaker this year was Natalia Cohen – one of a team of six women who set two world records when they rowed, unaided, across the Pacific Ocean. Natalia described her journey across the Pacific and highlighted what she had learned in the process about leadership and overcoming challenges. She had crossed the literal Pacific Ocean, she explained, but we all have our own Pacific to cross in the challenges that we face in our own lives. Her presentation sought to demonstrate to us that we too could be successful in achieving our goals.



Natalia began by painting a vivid picture of her experience, 1,000 miles from land, in the middle of the Pacific Ocean in an eight-metre rowing boat, feeling waves crash over her and watching a wall of water coming towards her. She described the isolation, the exhaustion, the sleep deprivation and the psychological hurdles of her undertaking, but despite these difficulties, she had loved every minute!

Natalia voiced the question that many of us were asking: "Why?!" Despite the apparent hardships, she explained, she had loved the opportunity that this adventure gave her to learn three key lessons: how to work together as a team; how to embrace change; and how to look for the positives in any situation. In our rapidly changing industry, these three lessons are as relevant to us as to the women rowing across the ocean.

Rewinding to the start of her incredible journey, Natalia described the six women in the team – all very different in personality, skills and experience, who collectively wanted to raise awareness and money for their chosen charities, Breast Cancer Care and Walking With the Wounded. One was a natural "planner" – the spreadsheet queen of the ocean! Another was goal-focused and full of determination – before she had set foot on the boat, she was already visualising the finish of the journey! Some were introverts; others extrovert. Some had rowed before, others had not. These women didn't know each other, but came together as a team, each with different skills to contribute, to achieve their shared goal. In the same way as a newly formed team in our professional lives, the women needed to quickly learn about each other, what brought out the best and worst in each other, and work out how best to work together. Natalia described the differences of each team member as their greatest successes – they were each able to bring something valuable to the team, each leading a specific element of the expedition, helping each other through their weaknesses and capitalising on their strengths.

> "The strength of the team is each individual member. The strength of each member is the team"

When Natalia considered the size of the challenge ahead – rowing from San Francisco (USA) to Cairns (Australia), she had found it overwhelming. The only way she could contemplate the undertaking was to break the challenge down into manageable, and achievable, chunks.

Natalia described how the preparation for the journey was as difficult as the journey itself. They needed to do everything from PR, marketing, address legal requirements, practical aspects as well as physical training preparation. To do this, they aligned themselves with experts in every field from ocean experts, sea survival experts, and sports psychologists.

Their preparation included running through every "what if" scenario, as well as working through all of their hopes and fears. They held very open and honest dialogue that went beyond mere skills to explore personalities, including identification of communication and leadership styles, and "hot buttons": those (sometimes minor) irritations that bring out the worst in us. Natalia explained how sharing the things that bring out the best and worst in ourselves can enhance mutual understanding and teamwork.

Despite their differences, the preparation united them behind a set of core values which they termed "SPIRIT": Strength, Perseverance, Integrity, Resilience, Inspiration and Trust, which underpinned everything they did.

However, despite this preparation, their projected journey time of 6 months was to take 9 months, with their resilience being tested at the very start of their journey. The weather proved to be a key variable that was completely beyond their control. Despite their careful planning, within the first 10 days of the journey, they had been blown off-course and waves flooded one of the boat compartments causing a fire which knocked out one of the essential charge controllers for their solar-powered batteries. Morale was low. They needed to make their first big decision: to continue or to turn back. They made a decision to continue. Ten minutes after taking that decision, the remaining charge controller blew. They had no choice but to return to land to make essential repairs. Morale was even lower than before.

An email from a family member provided words of comfort and inspiration, reminding them that when they set out again to restart the journey, they would now be "experienced ocean rowers", rather than complete novices. This message triggered a mental shift, helping them to reframe the situation. They made the most of their unplanned time ashore, adjusting the boat (and their sea-sickness medication) to help them cope with the weather conditions, before setting off for a second time. Natalia observed that sometimes it is not the situations that matter – it is how we pick ourselves up and carry on.

"Failure if only the opportunity to begin again, only this time, more wisely"

Realigning behind their core SPIRIT values and leaning on their understanding of each other's "hot buttons" and leadership styles was combined with a process of constant review and reflection of what was going well and less well, and helped them to take appropriate action as required.

Natalia described the concept of "healthy conflict", using the analogy of a pebble in a shoe: the pebble becomes more and more uncomfortable the longer we walk, but if we take the time to stop, take off the shoe and remove the pebble, we can then carry on. The team applied this principle to conflict, ensuring that they addressed conflict as soon as it arose rather than allowing resentment to build up. In the middle of the Pacific, Natalia reminded us, there is no escape! They all needed to learn to confront one another without causing, or taking, personal offense. These tools helped to align the team and get them working together before they even stepped on to the boat.

Natalia then described the boat itself. "Doris" was twenty-nine feet long and seven feet wide. At each end was a small cabin – barely the size of a single bed. Despite being equipped with solar-powered batteries, a desalination unit, state of the art satellite navigation and a satellite 'phone to contact the onshore support team, privacy and personal space were in short supply.

The women worked in pairs in 2-hour shifts. Natalia described how they protected the cohesion of the wider team, using handover techniques, rotating the pairs and weekly "social time" to bring all four rowers together at the same time and ensure team unity and connection.

Despite the inevitable highs and lows of the journey, Natalia described how the team, and each of us, always has a choice of how to respond to any situation. In some situations, our response is the only element over which we have any control. The team chose to enjoy the journey and to actively seek out the positives of every challenging situation. Each rowing pair would share a "daily highlight". This could be something interesting or entertaining, or something as simple as a beautiful sunrise.

Natalia described the crushing darkness of night-time rowing, and the techniques they used to distract or entertain each other in the darkness. There was time to get to know each other and look for positive relationships within the team. They had time to truly listen to each other, with empathy and compassion, so that everyone felt valued and understood. She described not only the connections with each other, but how they also connected with the environment and with their inner selves, increasing their understanding and awareness of their own internal dialogue.

Using all of these tools, Natalia explained, they were able to work together to achieve their goal – albeit in a timeframe 50% longer than planned. Natalia identifies four key insights that she believes helped the team cross the Pacific, but which are transferable to life on land, and to the lives of all delegates in the room:

- Trust and Respect: Natalia urged us all to believe in ourselves, to know our strengths and to trust in the people around us
- Find your SPIRIT: core values can provide a shared vision, but we also need to understand our own personal motivations and values. No decision is ever the wrong decision if aligned with your values, Natalia reminded us
- Take all challenges stroke by stroke: There will always be challenges, accepts Natalia, but we need to break them down into manageable pieces, and then have unstoppable mentality to make them happen
- Control the Controllable: We need to find the variables that we I control, even if only the choice to see the positives. Don't waste time and energy trying to control things that will never be within your control. Then make that conscious decision to celebrate successes, connect and enjoy the journey

Natalia ended with words of encouragement to us all. Our industry is undergoing big changes and there will be challenges ahead, but she reminded us, times of transition can offer moments of great opportunity as we navigate the every-changing waters of the healthcare industry. She wished us luck and courage to successfully cross any "Pacific" that we may find ourselves in.

Written by: Carolyn Chamberlain, Purdie Pascoe

Wednesday 26 June

Keynote Plenary 2

Transforming Pharma sales and Marketing with Artificial Intelligence: The New Pharma

Speaker:
Andrée Bates,
Eularis

Chair:
Tracy Machado,
Phoenix Healthcare

Andrée Bates presented a fascinating insight into the world of Artificial Intelligence, illustrated with impactful case studies of its use within our industry as well as highlighting tips and pitfalls for our own projects using AI.

Andrée opened with a videoclip which played to our imaginations – a humanoid's perspective of the world, including a very "human" accident with a waist mechanism actuator! This served to demonstrate how advanced and life-like humanoids now are, using Mission Impossible-like human masks and replicated speech patterns, to produce some unsettlingly lifelike copies of real people.

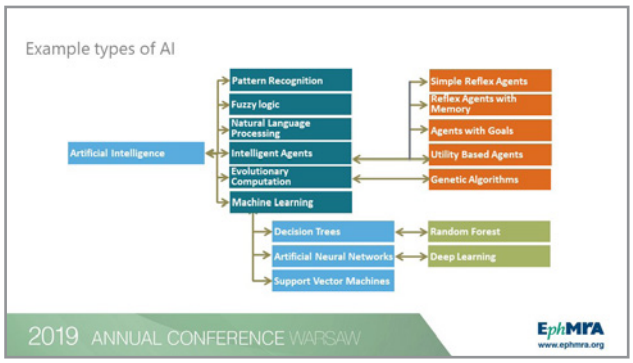
Andrée acknowledged the concerns that are sometimes expressed about robots taking over human jobs, but quoted Sabine Hauert (Co-founded of Robohub) who reassures us that "robots are not going to replace humans, they are going to make their jobs much more humane. Difficult, demeaning, demanding, dangerous, dull – these are the jobs robots will be taking".

For the market research industry, Andrée notes, we will want our humans to be thinking strategically and adding value to our insights, with the less desirable aspects of our jobs delegated to robots. She used the example of her own digital assistant, "Amy".

Amy is a programme that is "invited" to a meeting invitation, and which then goes through the tedious iterations of scheduling, checking availability of each participant, identifying a suitable timeslot and emailing Andrée with any problems. The program is so effective that Andrée has even had people say, "can you thank Amy for me for setting up the meeting".

The potential for connecting our virtual and tangible lives is already being explored with products such as Alexa, but Andrée also showed a humorous clip to demonstrate how far we can go in "connecting the dots": a bank raid was foiled as a result of one of the raiders who had used his mobile 'phone to visit the bank website for mortgage information and another who had clicked an email about student loan consolidation. The identity of both raiders was notified to bank staff on entering the building – and a potential raid was quickly transformed to a selling opportunity!

Having set the scene, Andrée then provided an overview of AI, describing it as the intersection between maths and computing, with data as its lifeblood. With algorithms such as "machine learning", Andree uses the parallel of learning a new skill such as tennis or piano – the more you practice and receive input, the more the neuronal pathways in the brain develop, making the skill easier to perform. In the same way, AI uses input data to "learn" and develop.



Andrée outlined the different types of AI and their various subtypes, before highlighting a key success factor for research using AI: the importance of understanding which type of AI is most suitable for which problem and your available data. For example, "deep learning", a subtype of artificial neural networks within machine learning, is very good for image processing and has been used to look at tumour growth and predicting which tumours will turn into a secondary tumour. Using a different type of AI might not give such good results.

She highlighted the changing environment of the pharma market research industry, with customers becoming more sophisticated and educated, competition coming from unexpected places such as Amazon, Google and Apple, and new approaches disrupting the landscape.

Amazon was tipped as a future competitor, due to its access to a range of integrated data sources. As well as browsing and purchasing behaviour from its own website, Amazon can use Alexa to record every conversation in the household (permitted for targeting advertising) and identify relevant health topics. Amazon Comprehend Medical is an automated medical transcription service which generates highly relevant data content. By purchasing or forming links with other companies such as JP Morgan and Berkshire Hathaway, Amazon has been expanding its business reach and acquiring various pieces of the puzzle and is well-placed to become part of the healthcare system. Within the limits of data protection requirements and appropriate consents, tech giants could become formidable competitors for pharma, Andrée hypothesises.

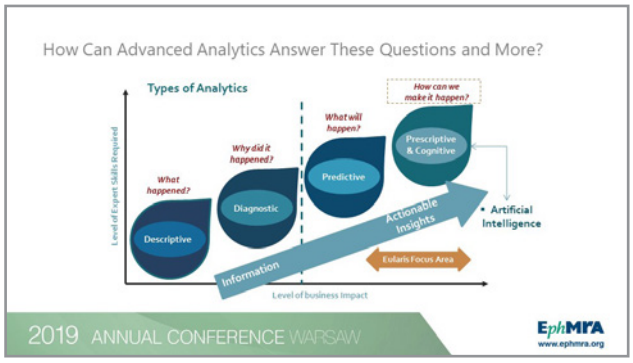
Andrée suggests we will see a market shift as pharma embraces new ways of working.

Data, she observes, is currently focused at the macro level (such as % of doctors saying X), but future data will be available at a micro and individual level. Segmentation will become more sophisticated, moving from segmenting doctors by type, prescribing habits or personality to segmenting at a detailed level informed by every they do inside work and inside the home. Analysis, Andrée hypothesises, will move from being largely linear and statistical to including much more complex non-linear relationships as well. Our brands will become more focused on outcome/value-driven treatments. For us, as market researchers, we will accelerate our move from a static and silo-ed function to being much more dynamic and engagement-led function.

Andrée used examples of specific questions and requests from clients to illustrate the changing landscape:

- Data: bridging the "gaps" in data to move from describing existing data to understanding underlying causes and predicting the missing data
- Segments: identifying new generations of stakeholders with new requirements and predicting which segments have the highest growth potential – including the most effective methods of engagement for each segment
- Brands: optimising focus and resources in a landscape where 2 out of 3 brands fail to meet revenue expectations
- Decisions: contract timelines using existing datasets to deliver almost "real time" analysis and guide decisions on segmentation, engagement and brand strategy

Our landscape, and our market research response, Andree described, has moved through stages from Descriptive (What happened?) and Diagnostic (Why did it happen?) to Predictive (What will happen?) and finally to Prescriptive and Cognitive (How can we make it happen?). It is this last stage, with greatest business impact, that Andrée believes AI can facilitate.



Although AI is not new, Andrée notes that the explosion in AI is due to the explosion in data: in 2017 alone, we generated as much data as in the previous history of mankind. AI's strength is being able to sort through data rapidly and systematically to identify and predict patterns and trends, with consequent value for application across the pharma product lifecycle.

Andrée's next tip for success was to make sure we always start with the strategic business questions and select the most appropriate dataset for a solution, rather than spending finite resources mining data without knowing what we're looking for. She cautioned us against data bias, using an example of the British Army trying to predict which woodland settings were most likely to harbour tanks. The approach resulted in the flawed conclusion that tanks are only found in sunny woodland – caused by an artefact of their woodland photos (the data source) being taken on sunny days. This demonstrated Andrée's next tip for success: ensuring the data is clean and unbiased – a process she calls "data wrangling".

But how can AI be applied in pharma?

Andrée shared some illustrative case studies to inform and inspire.

AI was used to drive presentation of patients with a rare genetic condition. The rarity of the condition meant it was not cost-effective to educate all doctors when >99% would never see a patient. An alternative approach was required. AI was able to use facial recognition technology, in a genetic condition in which the facial features were similar, to identify potential patients with photographs appearing on the internet. But how could they be alerted to the potential condition in an ethical and sensitive manner? This project raised privacy concerns, which required a more strategic, and sensitive, solution. A retargeting cookie was planted for each potential patient in the same way as advertising networks. This was followed by a Google Ad buy for those cookies which were used in conjunction with specific wording to identify internet searches relevant to the condition by those identified with children with the condition. The ad that came up caught the parents attention due to being a picture of a child with the condition, which then prompted the parent to click on the website outlining details of the condition, and then present the child to their doctor. Andrée noted the GDPR requirements that would need to be taken into consideration when conducting this type of project, citing companies such as Facewatch who database everyone with an online photograph, with permission to do so due to their safety / anti-terrorism / anti-drug application. A potential solution might be to include life-saving applications such as this example, in order to gain approval.

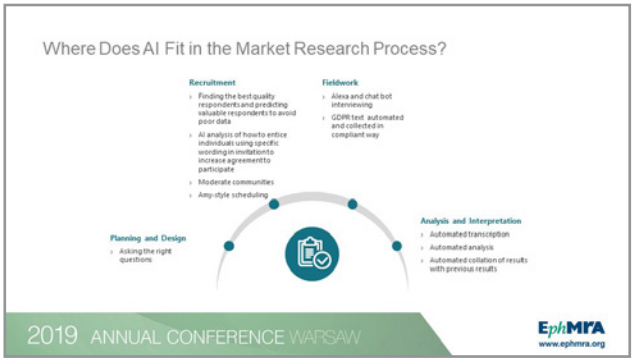
Another application of AI within pharma involved identification of patients suitable for a specific treatment. The client had a third line cancer product in an area where eligible patients were rare due to high mortality rates at second line treatment stage. A trial was conducted using Electronic Healthcare Records to identify the factors about the third line patients that differed from those who died at second line therapy. Data protection did not allow individual patient identification, but did allow physician identification, enabling the client to visit the physician and provide information about the treatment option for a patient who had not yet reached third line treatment stage.

AI can be used to identify optimal KOLs in a given therapy area, using public data in a similar way to the CIA mapping terrorists and drug cartels. The data sources included publications, conference abstracts, Sunshine Act data and patent applications which were mapped to identify a pool of potential KOLs. The client was able to use the data in different ways to address questions across the organisation from Sales & Marketing to Clinical and Discovery.

Andrée also discussed the application of AI for personalised selling, patient identification, patient adherence and digital transformation.

Andrée next talked about the AI techniques evolving within market research. Data collection, she observed, was moving from a historical focus on F2F, to gamified smartphone surveys and social media sources. AI can be layered into Big Data in real time to automate analysis and prediction of future behaviours.

AI, she stated, can be applied to the entire market research process from planning & design to analysis & interpretation.



She shared an example of AI being used for quality control of online communities. This approach analysed previous participation using natural language processing to look at quality of response and level of engagement. Andrée's tip for success here was never to underestimate the importance of the computational linguist in ensuring the quality of text classification. The analysis provided suggested actions to the online moderator to engage individual participants and keep the community high quality and healthy for use in future market research projects.

Another example described using AI to database a client's existing insight library of previous market research outputs, transforming it from a disconnected, underused resource to an easy-to-use chatbot-accessed integrated system that enabled new team members to quickly find the answers to questions such as "what is the key unmet need in this patient segment" or "what imagery will speak to this target segment" and preventing insight to be lost when the team members changed.

Andrée concluded with some thoughts on how the market research function is likely to change. She believes that more surveys will be conducted via chatbot in the future. Pure analysis jobs will reduce, being taken over by AI, but subject matter experts will still be required during the AI learning process. AI will enhance data quality and in future will be "smart" enough to explain findings.

Market researchers will be able to focus on the strategic part of the job, crafting business recommendations, focusing on the resulting actions and disseminating insights across the organisation.

The role of Compliance will remain crucial to AI application, stated Andrée, but future AI will adapt its processes to integrate consent actions and ensure compliance with each individual's rights over their own data.

She concluded with a quote from Devin Wenig (eBay CEO), warning us that "if you don't have an AI strategy, you are going to die in the world that's coming".

Following Andrée's presentation, there was a lively panel discussion about the implications of AI on the industry. The panel comprised Andrée Bates, Eularis; Thomas Hein, Thermo-Fisher Scientific; Sarah Phillips, IQVIA and John Grime, Strategic North. The session was facilitated by Tracy Machado, Phoenix Healthcare.

Written by: Tracy Machado, Phoenix Healthcare

Wednesday 26 June

Keynote Plenary 3

Driving launch success: less can be more in the right channel mix

Speaker:
Sarah Rickwood,
IQVIA

Chair:
Dennis Engelke,
Jazz Pharmaceuticals

Sarah's paper demonstrated how the correct mix of promotional channels can drive successful product launch with lower spend than we might have predicted. In some cases, she explains, "less" can deliver "more".

Sarah first provided some context, describing how the traditional commercial model in pharma is now under pressure and needs to change.

Looking at some broad economic metrics quickly confirms that industry return on R&D investment has been reducing for some years. Taking data from the top 25 innovative pharma companies, the profit per $1 of R&D spend has reduced by 20% over the past decade. At the same time, Sarah noted, looking at productivity (in terms of the number of new product approvals) suggests that the industry is in a very fertile period with many new products coming through, with exciting developments in new areas such as cell and gene therapy. However, R&D ROI cannot keep pace as R&D costs are growing faster than net sales and SG&A cannot rise to the same extent as R&D spend is rising. The pharma commercial model, Sarah concludes, needs to become more cost-effective.

Sarah notes other external pressures on the current commercial model, including a decline in contact time for traditional sales representatives (down 22% in the EU5 since 2012), and regulations in some countries that reduce the frequency and duration of time reps spend with physicians. Added to this, Sarah explains that specialty products account for a larger proportion of new product launches than in the past, with correspondingly smaller numbers of target physicians within each specific specialty- although time spent with physicians should not necessarily fall proportionately, as specialty products are typically more complex and for complex conditions.

Having spoken to a number of pharma company executives about the commercial landscape, Sarah reports that nobody in the industry believes that the 22% decline is going to be reversed. Pharma companies are facing a 3-way problem: the need to deliver an increased number of product launches in this era of high productivity, while consistently maximising commercial success; they need to do so without significant increase in SG&A budgets – and in some cases, with a decrease in SG&A; and they need to launch products into complex and increasingly competitive, often specialty, environments.

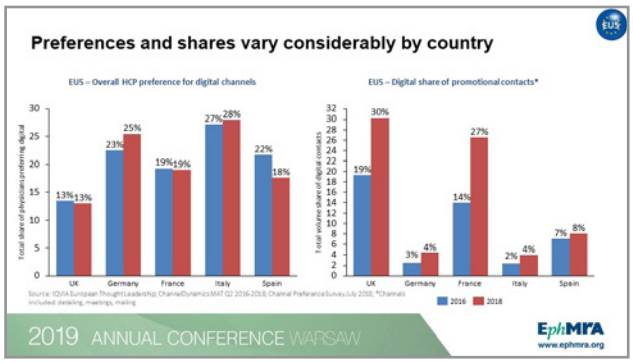
The challenge is clear: pharma companies need a "best in class" specialty commercial model. However, Sarah reminds us, challenge drives change.

Sarah described two key components required for a "best in class" model: the right tools, and the right team. The tools required are a full spectrum of multichannel approaches which offer genuine choices to ensure the right channel is available to the right physician at the right time. The right team, Sarah explains, should consist of all customer-facing roles from traditional reps, MSLs, patient support, payer liaison and business development.

Sarah showed data demonstrating the reduction in numbers of traditional reps in some countries between 2013 and 2018 (e.g. by 29% in Germany). Traditional promotional spend has declined by 5% over the same period – although Sarah notes that digital promotional spend grew by 11% (but still a small proportion of total promotional spend as digital channels are relatively cheap compared with the costs of a traditional sales force). Digital's share of volume of contacts is creeping up, standing at 11% in 2018.

Sarah highlighted the importance of physician preference. When HCPs are asked which channel they prefer, 33% said they prefer traditional sales reps, and 22% prefer digital channels (the remainder preferences are fragmented across meetings, events, seminars, publications, and "other"). Sarah noted that the preference for digital channels has remained stable over the past 3 years, but she anticipates an increase as Millennials become the dominant generation among physicians.

Highlighting the "gap" between HCP preference for digital channels and the percentage of promotional contacts that are digital, Sarah noted that there are considerable variations by country. For example, in the UK and France, digital's share of promotional contacts is much closer to the preferred channel type than in the other EU5 countries. In Germany and Italy, HCPs would like more digital contact than they are getting. In Japan, however, HCPs want less digital contact – preferring the traditional rep relationship. Sarah surmises that high volume, low quality emails may have commoditised the Japanese digital approach, and HCPs perceive a lower value as a result.



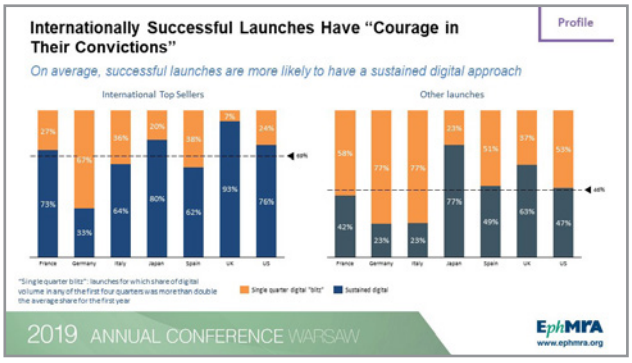
This mixed picture for multi-channel approaches often prompts a common question from pharma company executives: what is the ROI for digital compared with traditional sales reps? What is the commercial impact? Sarah notes that this rather binary question risks over-simplification of the benefits of a truly multi-channel approach.

Instead of calculating ROI, Sarah suggests that we look at the channel mix for the most successful product launches compared with the rest. Sarah defined the "International Top Sellers" (ITSs) as the products that were consistently in the top quartile of launches based on absolute sales in 2 or more countries for the year following launch.

Looking at the first 5 years of sales for innovative medicines, the EU5, USA and Japan collectively account for 86% of all sales. Promotionally speaking, these markets are therefore a priority to pharma companies. Sarah then examined the promotional mix for the ITSs in these seven key markets.

The average digital share of promotional activity volume was 64% higher for the ITSs than for the other products. Sarah was careful to point out that it is not possible to conclude that this is a causal relationship, but that it was important to understand the detail and complexity to leverage this finding appropriately.

A reasonable hypothesis might be that spending was higher overall for the ITSs, contributing to their commercial success. However, Sarah revealed that spend (in value) was 45% less per launch than the average for other products, across all seven countries. She admits this sounds counter-intuitive and therefore intriguing – how can we spend less but get more?



Looking at the nature of the ITSs, Sarah explained that they were all specialty products (rather than traditional primary care products), although there were also specialty products that were not as successful as the ITSs. Comparing the more, and less, successful specialty product launches, Sarah found that the more successful launches include more digital in the mix. This was consistent across all countries, even where digital uptake differs in each country. She also found that the digital investment was sustained over the first year of launch, rather than utilising an initial "blast" in the first quarter and then reverting to traditional rep contact.

Sarah summarised four key findings for successful product launches:

- All the ITSs were specialty products: the R&D focus currently is on specialty therapy areas which tend to be more complex and require a more sophisticated interaction
- Although specialty launches have lower promotional spend than primary care launches, within the specialty group the ITSs had higher promotional spend (but still less than in primary care)
- ITSs have a higher share of digital contacts in volume terms than other launches and more sustained digital activity over time
- HCPs don't always value digital channels as much as traditional channels. Sarah views this as a call to action to ensure our digital contacts are high quality rather than just high volume-low cost.

Bringing the findings together, Sarah predicts that the successful commercial model of the future will be truly orchestrated, with the customer-facing team being enhanced, not replaced, by digital interactions. Quality data will be needed to inform the model, integrating different datasets to provide a single view of customers. She notes the importance of AI and machine learning in commercial reporting to create an individualised customer approach. She predicts that a technology-enabled, multi-channel, orchestrated approach will transform the commercial model, and it will deliver individualised engagement at full scale.

Wednesday 26 June

Parallel Session 1

Interactive Disease pathways: How Janssen and Cello Health Insight put the patient experience front and centre

Speaker:
Stewart West, Janssen & Lorna Kirman,
Cello Health Insight

Chair:
Stuart Cooper,
Adelphi

This paper was the winner of the EphMRA 2019 MR Excellence Award – Business Impact Through Innovation and was sponsored by Adelphi

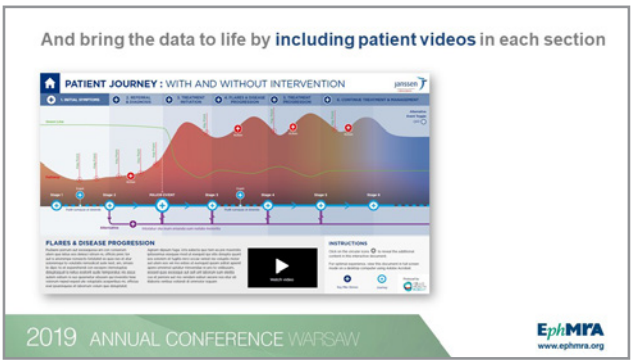
Janssen is a company that puts patients at the heart of their business. So, understanding the patient journey is a foundation of their strategic thinking for brands. This was at the forefront of their thinking when considering the ulcerative colitis market. Previously, with Crohn's disease, the treatment pathway was strongly transactional, with a great deal of HCP insight. Whilst this was useful, they felt that some important aspects of the patient experience were missing. With the upcoming indication for ulcerative colitis, Janssen set out to review pressure test the existing CD pathway and uncover the emotional impact of both UC and CD by engaging more meaningfully with patients, immersing themselves in context of patients' real lives.

They also realised that to be a truly patient centric organisation they had to be not just smart about how they engaged with patients, but to be creative in the way they implemented the results within the business. Bringing the research findings to life in a way which placed the voice of the patient at the centre of their business decisions was also a key requirement of the project.

In order to provide a holistic view of the journey a multi-mode methodology was used to engage with both patients and doctors.

This included some pre interview tasks such as getting the doctors to complete patient record forms, so that the interviews could be grounded in real patient details.

Patients were asked to complete a 'digital pathway tool'. A screenshot of the tool is shown below. This interactive tool helped the patients map out their disease journey, to capture key moments, their emotional state and to provide additional comments for detailed feedback. As well as providing a rich source of data about how patients actually experienced the disease, and giving the patients control of the tool to complete in their own time, this method allowed patients to re-energise their memories of their journey and to go back through their notes outside of the main interview, maximising the time we had with them. By having these journeys in advance of the interview, we were also able to tailor the interview. For example, knowing in advance a journey was particularly complex and preparing what to hone in on vs. a shorter journey and asking about what had made it so; this allowed us to get to that deep lay of insight within interviews.



An important part of the methodology was the inclusion of mobile ethnography with patients. Patients were asked to record their experiences and how they were feeling on their mobile phones. They were given the flexibility of recording this in their own environment and in their own time. The use of the patient's own phone to record their own experiences also meant that no observer was required and therefore kept any intrusion to a minimum. As a result, patients were able to articulate and record how they were feeling over a period of time, allowing them to often capture the moment when they were experiencing symptoms and when emotions were to the fore. This process was both engaging for patients and insightful in terms of how they actually experienced the disease and the impact it was having on their lives.

The agency gained immediate access to these video stories as soon as they were uploaded. They were also collated into a purpose-built dashboard. This is where the videos have been translated and transcribed with subtitles while the audio is still in the original language. This transcription of the videos enables the user to enter a search term and have all relevant videos come up. Allowing Janssen to bring a patient video into an internal meeting with relevant content for the agenda with ease and bringing to life the reality of the condition.

Given the large amount of data collected, the real work of identifying the insights and tailoring the communication of the findings to the various stakeholders began. There were many stakeholders, from market researchers, to marketeers, to the medical education and communications team to other specialist groups such as those looking at broader patient issues.

As well as being visually engaging and easy to use, the disease pathway was designed as a highly interactive tool. Whilst PowerPoint slides were available for reference, the interactive disease pathway became the main tool to present the findings.

It was set out as a diagram of the chronology of the patient journey, including a line showing the patient's emotional intensity over time. It was kept deliberately simple as an easy to understand overview, but the user had the ability to click on the 'major events' icons to view more detail at each stage of the journey if needed.

At each stage the user can also click through to see a summary of opportunities for Janssen to make a difference to the patients' lives. There was also a toggle button to visualise the impact on the emotional toll of the disease if the various opportunities to improve patients' lives were actioned.

In addition, key videos were included on the dashboard to bring the patient experience to life*. The videos were kept in local country language, with English subtitles, in order to retain the reality and emotional intensity of the actual patients. The retention of local language in the videos has allowed greater value to be extracted by the local marketing companies. So much so that no local Company felt the need to repeat their own local study.

The key to the dashboard was its interactivity. It was a tremendous success in getting the voice of the patients into the commercial, strategic and medical meetings of Janssen. It has also been used to immerse new starters to the business in the issues patients face with ulcerative colitis. An anonymised version of the dashboard, with the videos removed, has also been used by the sales team at medical conferences to engage with healthcare professionals to help align the doctors and Janssen on key issues concerning the patient experience of ulcerative colitis.

Janssen has succeeded in creating a foundational data source for ulcerative colitis which is flexible, engaging and easy to use, and has helped put patients' experience front and centre in the business and in the minds of its customers.

*GDPR compliant

Written by Bob Douglas, Consultant for Adelphi Group

Wednesday 26 June

Parallel Session 2

Using an integrative design to identify opportunities for appropriate, early usage of a pioneering hospital antibiotic

Speaker:
Daniel Rayner,
Insight Dojo Ltd

Chair:
Charles Chaine,
AplusA Research

This paper was the winner of the EphMRA 2019 Future Leaders MR Excellence Case Study Award and was sponsored by AplusA Research.

Daniel brought to EphMRA 2019 a concrete, innovative and multi-faceted case study, designed to address launch challenges faced by a new antibiotic in a complex clinical reality. With a highly bespoke approach and complete client engagement, Daniel and his colleagues were able to generate positive strategic and business outcomes that were then used to drive important decisions.

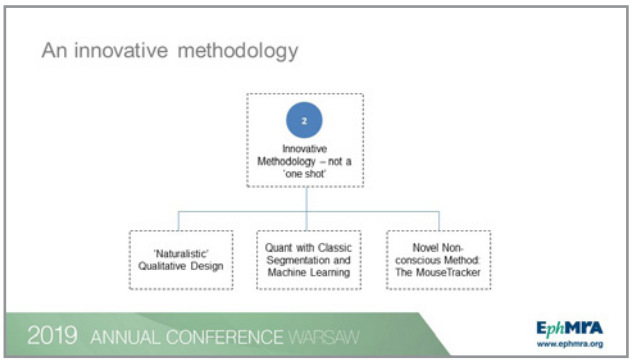
When it comes to new antibiotics developed for the treatment of highly resistant hospital-acquired infections, the current default tendency is to save them as the last resort due to concerns over the development of antibiotic resistance. However, this is not always the best strategy and there are opportunities at earlier stages of the treatment journey where targeted use of these types of antibiotics can help preventing the development of resistance. The current research was designed to identify opportunities for earlier usage of a new antibiotic, Product X.

Daniel opened the case study by setting out a complex landscape in which resistance to antibiotics is considered a high-profile area, as demonstrated by the level of priority assigned by the UK Health Secretary for the NHS. As a result, there is a significant amount of environmental pressure on physicians to lean towards reserving antibiotics to avoid the risk of being seen as promoting antibiotic resistance. This has led to the default behaviour of saving new antibiotics as the last resort.

In addition, antibiotic treatment decisions tend to take place within a composite and systemic environment with numerous influencers, for example, hospital set-up, protocols, and advice from colleagues. Therefore, physicians may not always be in full control of their own decisions with new antibiotics. Finally, physicians often have to make antibiotic treatment decisions with little information and under considerable time pressure, especially in the presence of suffering patients with high risks.

This landscape posed two main challenges for Product X. First, despite the intricacy of the scenario, there is a default tendency to delay new antibiotics to the end; second, the complexity of physician decision-making process makes it difficult to identify and characterise any opportunity or need for early usage.

Facing these challenges, Daniel and his team designed a multi-faceted and iterative approach with a "naturalistic" qualitative phase, a quantitative combo of classic segmentation and machine learning, and finally a novel non-conscious research method called the "MouseTracker".

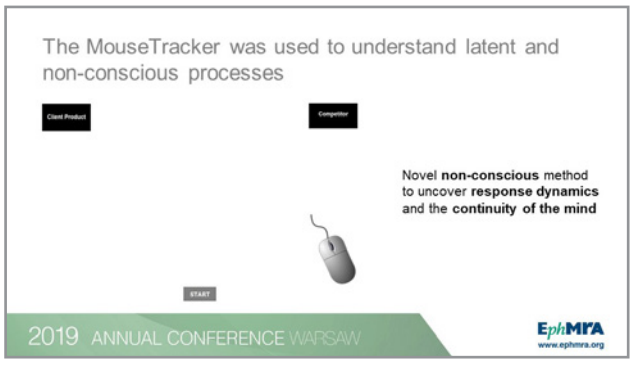


Daniel went on to explain that the initial qualitative component had been created to mimic the natural decision-making environment of physician: as a pre-task, physicians were invited to keep a diary journal of real-life cases of antibiotic-resistant patients, which were then used in subsequent interviews to ground the discussion to reality.

When it came to hypothetical scenarios, instead of presenting a static case, patient profiles were designed to be "dynamic", with patient progression being split into different days during the treatment journey and presented sequentially for physicians to react to and comment on. This enabled a better understanding of how decision-making and treatment pattern evolved over time in the real world. Finally, some interviews were carried out with "joint specialties" (e.g. an infectious disease specialist and a microbiologist) with the aim to gain insight into how different specialties work together in the clinical reality and how their interactions take place depending on treatment decisions made.

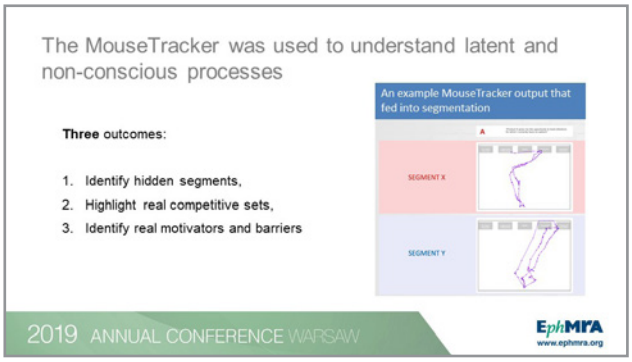
Moving onto the quantitative component, Daniel highlighted the benefit of adding machine learning (e.g. "Random Forest" algorithm) to segmentation (i.e. mixed mode cluster analysis), which not only allowed the identification of target physician segments for early usage of Product X, but also made predictions of whether a particular physician would fall into one of these opportunity segments.

In order to account for the impact of de-centralised decision making and the behavioural tendency to reserving antibiotics, a third element, the MouseTracker was introduced to uncover latent response dynamics and map out the continuity of decision-making process. The MouseTracker has been primarily used in the academic setting as a tool to investigate implicit processes but is more recently introduced to commercial research. It is a simple technique to set up during qualitative interviews: participants are placed in front of a computer with the required software installed and asked to have their hand on the mouse. A task then flashes up on screen. Usually this is an agreement task in which a statement is presented at the centre of the screen (e.g. about Product X) and participants indicate to what extent they agree with the statement by clicking on a scale. Alternatively, participants are asked to complete a drug choice task by selecting Product X or a competitor brand presented on screen while listening to an audio description of a patient profile.



The MouseTracker does not only record the option selected (e.g. agreement rating or product), but also the response time taken to make the selection and the trajectory of the mouse cursor movement. The response time and trajectory are considered indictive of latent processing and implicit thoughts involved in making decisions. Psychological theories behind this method argue that decision-making cannot be simplified to the eventual choice made, and it is only when the full evolution of response dynamics and the continuity of the minds are taken into consideration that we can begin to fully understand how decisions are made.

In the example given, although both Segment X and Y made the same choice, their mouse trajectories revealed distinct characteristics: before veering towards the option eventually selected, Segment X initially set out in a different direction, suggesting latent doubt or consideration associated with the initial choice.

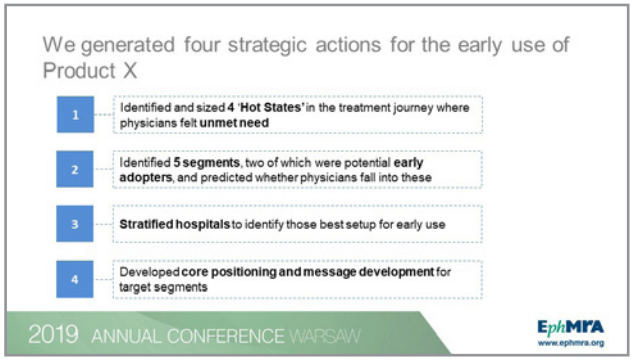


Results from the MouseTracker task were used in three different ways. First of all, it allowed segmentation to be based on latent attitudes and beliefs as well as active responses. In the same example given, physicians formed two unique segments despite having selected the same choice: evidently in their mouse trajectories, Segment X displayed doubt or disagreement before making their selection while Segment Y made their choice with confidence and decisiveness. Secondly, the drug choice task uncovered real competitive sets, especially products that were latently considered before choices were made. Finally, it shed more light on underlying motivations and barriers that influenced behaviours and decisions.

When it came to complex business problems, Daniel pointed out that the methodology itself only offered half of the solution. Working in a cross-functional and seamless way with the client team completed the picture and was vital for the success of this research. High-level engagement with the client helped to ensure all expert knowledge and experience on the subject were fully integrated into the research while keeping the broader business aims firmly in sight along the way. Daniel reflected fondly of his personal experience of presenting to and being involved in a problem-solving session with the CEO of the client company. It was motivating for him to witness a C-suite executive being committed to creating impact with insight from the research. The client's medical team also played an important role not

only during design and interpretation, but also in ensuring Daniel and his team were well equipped with all necessary medical and scientific knowledge by investing time into training sessions and discussions.

The original business objective was to identify opportunities for early use of Product X in the appropriate setting, Daniel reminded the audience before moving onto the main strategic outcomes generated to support this aim. This research identified and quantified four "Hot States" in the treatment journey where physicians experienced unmet need; uncovered five customer segments, with predictions on whether physicians would fall into the two segments representing potential early adopters; stratified hospitals to pinpoint those best set up for early use; and developed core positioning and messages for target segments. This case study was presented as a success story with qualitative and quantitative methodologies working together with synergy and digging deep into environmental and latent influencers for decision making.



Daniel concluded the presentation with five critical success factors for solving complex business problems: it is always important to lead with problem solving rather than diving straight into insight. At the very beginning of this research, a full-day workshop with an extended client team covering diverse roles and profiles generated considerable value when knowledge, hypotheses, and objectives were explored and discussed to form a solid platform at the onset of this research. Secondly, the success would be challenging to replicate without the seamless engagement with a cross-functional client team, especially the medical team in this case. Thirdly, "thoughtful innovation" is required to understand when classic techniques still offer good solutions and when cutting-edge techniques are needed to create incremental value. Fourthly, do not expect to get things right the first time; always take an iterative approach and look for opportunities where the design can be adjusted and improved throughout the project process. Finally, taking both a bottom-up and top-down approach is not paradoxical, as the former helps us to capture the full details and richness in a complex area while the latter directs all that richness towards the final business aim.

Written by: Xierong Liu, Ipsos Healthcare

Wednesday 26 June

Parallel Session 3

Using facial analysis to uncover deeper reactions to pharmaceutical communications material

Speaker:
Richard Head, Research Partnership (and Sarah Fletcher, Janssen – co-authored but did not present in Warsaw)

Chair:
Stuart Cooper, Adelphi

Applying technology in healthcare market research is a booming business, and it's easy to understand why. The potential benefits are numerous, from cost and time savings, to providing new insights which standard methods don't. The need behind this paper was Janssen's desire to understand doctors' emotional response to a detail aid for a drug used for multiple myeloma. This paper discusses the use of facial coding software in providing an innovative way of accessing the emotional response to communication material. Recent work in behavioural science has demonstrated the important role of emotions in decision making.

Facial coding itself is not a new idea, it was developed by the psychologist, Paul Ekman in the 1960s. It has long been recognised that the majority of human communication is non-verbal, and our facial expressions are an important part of this. Our facial expressions are a signal of our emotions. By relying just on the analysis of verbal responses to questions Janssen was concerned that there was an over reliance on the rational responses to communications material, and we really need to understand both how people think and feel.

It is only in recent years that the technology has become accessible in everyday life to read respondents' facial expressions in response to stimulus material, and by using algorithms, code their emotional responses. The mainstay of the market research studies conducted to data, using this approach, have been within consumer research, where it has been used to measure purchase intent. Results have shown that it gets more accurate results than simply relying on a verbal response. It is only recently that the facial coding technology has been applied within healthcare.

The way it works is that an individual's face is scanned, and the software creates so called 'memory markers', so that when we subsequently have an emotional response to a stimulus the software can detect deviations from these markers. The markers include the eyes, eyebrows the edges of the mouth and the nose. The algorithm analyses these deviations and maps them to 7 emotions, as well as levels of attention, distraction, drowsiness and positive and negative reactions. To give a few examples of how the software interprets the facial expressions, if a lip corner is depressed this would suggest concern and if the eyebrows were raised this would imply either surprise or recognition.

In this study a video of the drug detail was shown to doctors using a computer in a central location. The computer recorded the doctors' responses using a webcam to monitor the facial expressions. The video detail was followed by a face to face interview where doctors were asked a series of questions about the detail material.

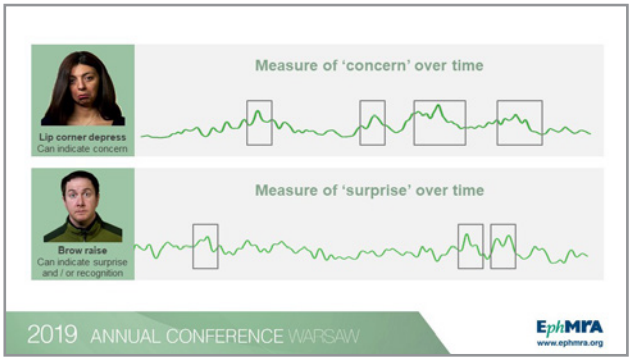
There were several technical issues and other considerations in making the study a success. Firstly, the study was conducted in a number of different countries. As the video detail was translated into different languages, and various languages differed in the time taken to speak them, the timings of the page turns had to be synchronised. This was important to ensure that the facial code outputs could be directly compared on a like for like basis across languages. Secondly, the moderators had to be trained to use the software and set up the interview rooms to ensure the respondents were at the optimal distance from the camera, that they were told to look into the webcam, and not to have direct light behind them in order to avoid a shadow effect. These were all learning curve considerations and should become second nature the more the methodology is used.

Despite these learning issues in setting the research up, overall the inclusion of the facial coding exercise did provide useful additional insights into doctors' reactions to the detail aid and how to improve its effectiveness.

We had expected the level of the doctors' engagement to drop off over the duration of the detail, bearing in mind that on average the video lasted 9 minutes. However, the level of engagement remained high throughout, which suggested that the interest in the brand story was strong.

However, we did see spikes in engagement linked to a number of the pages, which told us that some pages were of more interest than others. We also looked at the combination of some of the facial codes, as they made sense when considered together. For example, there were a number of points where the brow furrowed, which indicated that the doctor was concentrating on a topic, followed by a raised eyebrow which suggests an 'Ah ha!' moment, at the point when the doctor understood the message. This allowed us to focus on these topics specifically to understand whether or not they were too complex, or ambiguous, controversial or of major importance. Cross reference with the written responses helped us to fully understand the doctors' reactions and what, if anything, we need to change to make the story more fluent.

As this study was qualitative in nature, we were not trying to analyse the cultural differences across the different countries. We analysed the individuals separately and looked at how their scores changed over the duration of the detail. There has been work done looking at the cultural differences, but this topic is beyond the scope of this paper.



Overall the inclusion of facial coding in the detail test provided additional perspectives and insights to those which are normally generated. It allowed us to refine the detail material in a way which would not have been possible without it and the feedback we received from the product management team was very positive.

The experimental nature of the methodology for us within healthcare meant that there were a number of practical issues which we had to resolve along the way. The video capture of the doctors' faces thus did raise a number of consent, data sharing and storage issues. It was also clear that the doctors themselves benefited from an explanation and understanding of the methods used prior to the interviews, in order to ensure their wholehearted participation. We shouldn't forget that it was not just novel for us but also for the doctors too.

In conclusion, facial coding does provide the type of additional insights we were looking for at the outset of the project. It's an evolving technology with potential for combination with other technological solutions too, such as eye tracking, speech analysis and virtual reality. Together these innovative approaches will redefine the way we assess communications material in the future.

Written by Bob Douglas, Consultant for Adelphi Group

Wednesday 26 June

Parallel Session 4

Healthcare systems in selected Central and Eastern European Markets - How to increase your market access impact in emerging markets

Speaker:
Lucasz Drzazga,
SODA

Chair:
Erik Holzinger,
groupH

Lukasz Drzazga provided a comprehensive overview of the market access landscape in specific Central & Eastern European markets, highlighting the implications for successful market access research in these growing markets.

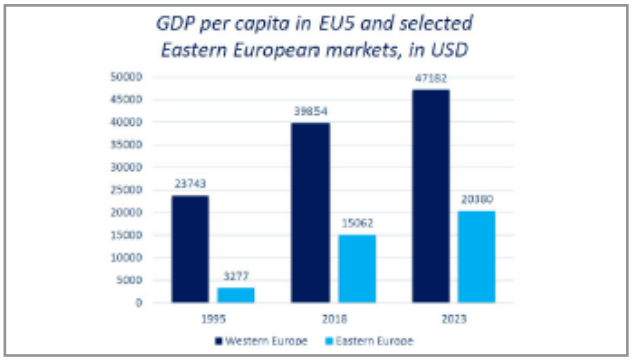
Macroeconomics – Two Europes Coming Together

Using the six largest CEE pharma markets (Poland, Romania, Hungary, Czech Republic, Slovakia and Bulgaria) along with Russia as examples, he first provided important economic metrics compared with the EU5 countries to set CEE markets into commercial context.

Despite historical and political differences leading to very different macroeconomic situations until the early 1990s, the pace of development in the CEE countries is now showing dynamic growth and a dramatic narrowing of the previous economic disparities.

Using data from the IMF, Lukasz showed that GDP per capita in 1995 for the EU5 countries was seven times higher than for the selected CEE countries; however, by 2023 this disparity is expected to have reduced to around double, reflecting the economic growth in these markets.

Looking at healthcare spend overall, again the EU5 out-spends the selected CEE countries.



When looking at pharmaceutical spend specifically, the presented figures showed that spend in the 7 selected CEE countries combined corresponds roughly to the spend in France. A particularly illustrative statistic highlighted that people in the Czech Republic spend less on pharmaceuticals than the people of Berlin spend in the night clubs. Some of this disparity, our speaker noted, was due to the relatively small population sizes in the selected CEE countries.

Although the macroeconomic statistics may paint a cautious picture, Lukasz noted that this economic disparity also highlights the growth potential of the CEE markets and the importance of these markets for our industry.

Market Access Landscape

Lukasz then outlined the decision-making process and relevant stakeholders in each of the selected countries, noting that in all countries the process is highly centralised, but highlighting similarities and differences that are important for market access in each case.

Russia (not in CEE but included in the analysis due to its size and importance), he explained, differed from the other 6 markets in that it was characterised by a binary reimbursement approach – products are either approved (100% reimbursed), or not approved (0% reimbursed). An approved product (included on the VED list) would be provided free of charge for particular segments of the population, with the cost to the healthcare system determined by the state following a decision by the Ministry of Health working closely with the Federal Service for Surveillance in Healthcare. Products not included on the VED list might still be available at a cost to the patient, with prices set by the manufacturer.

Russia was also unusual for the CEE region in that there was some regional decision-making: depending on the wealth of a particular region, the Regional Health Departments may decide to add further products to the national VED product list

In Poland, the Ministry of Health was highlighted as the only relevant decision-making body in terms of market access and pricing & reimbursement. Applications are assessed by the Health Technology Assessment Agency, working with the Transparency Council to provide a positive or negative recommendation to the MoH. A separate Economic Committee then conducts negotiations with the pharma company regarding price and risk-sharing agreements, with the MoH reserving the right to run its own final negotiations with the pharmaceutical company if desired. In Poland, our Lukasz explained, National Health Insurance employees were not included in payer research as they had little decision-making responsibilities and operated primarily as an executive body.

Similarly, in Romania, the Ministry of Health is the only relevant decision-making body. The National Agency for Medicines and Medical Devices may request opinions from other specialised committees within the MoH (eg National Health Insurance or KOLs) before making a reimbursement decision.

Lukasz noted that a key challenge in conducting payer research in Romania in recent years was the disruption caused by a corruption scandal, resulting in changes of personnel and a reluctance of those in post to take part in research.

Hungary followed a similar highly-centralised pattern, with the Ministry of Human Resources acting as the key decision-making body with the National Health Insurance body being responsible for market access and pricing & reimbursement decisions.

The Czech Republic and Slovakia again centred on centralised responsibility within the Ministry of Health, with the State Institute of Drug Control the department responsible for drug entry and evaluation, and also responsible for the level of reimbursement and maximum prices.

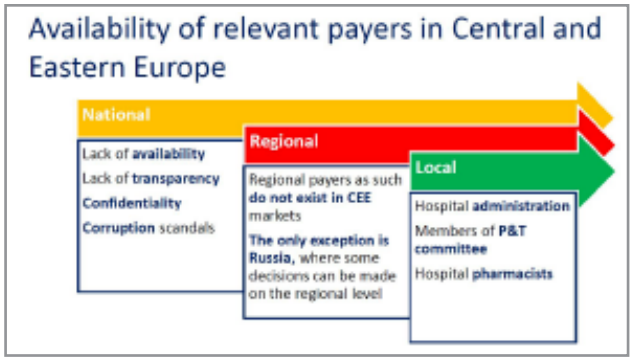
By contrast to the other markets, in the Czech Republic and Slovakia there are multiple Health Insurance Funds, with the largest of the Funds in each country being state owned and the remaining being private funds (altogether seven in the Czech Republic and three in Slovakia).

Finally, Bulgaria followed the centralised pattern with the Ministry of Health responsible for market access and Pricing & Reimbursement decisions, via the Bulgarian Drug Agency and National Council on Pricing & Reimbursement in cooperation with National Health Insurance bodies which therefore have some influence.

Lukasz noted that their experience in this region suggests that Bulgaria is the country most focused on minimising cost of treatment. Consequently, there is tough negotiation with pharma companies and a tendency to favour the cheapest products rather than those which are most innovative or appropriate.

Eligible respondent types for payer research

Having outlined the market access landscape in each country, Lukasz commented upon the availability of relevant national, regional or local payers to participate in market access research.



Despite the largely centralised process, respondents from the national decision-making bodies were largely unavailable for market research due to confidentiality regulations, disruption due to corruption or lack of transparency.

Regional payers do not exist in CEE in the same was as in Western European markets, with Russia being the only country where some decisions can be made at regional level.

Local payers therefore form the main target group for payer research, with hospital administration, Pricing & Reimbursement committee members and hospital pharmacists providing willing and relevant input to payer research.

Lukasz noted that alternative respondent types were also valuable in providing relevant information, such as ex-employees of the national agencies (difficult to find), Health Technology Assessment experts (slightly less difficult to find) Key Opinion Leaders and physician and patient associations.

Other relevant nuances and practical considerations

Our speaker concluded by providing further insight into the nuances of market access research in this region, noting that from a regulatory point of view the Central Authorisation procedure for pharmaceuticals in the EU has enabled a Marketing Authorisation Holder to submit a single application to the EMA covering all EU countries, therefore simplifying the approval process. Similar centralisation is also in evidence for market access – such as the Fair Pricing Initiative present in 9 CEE markets to jointly negotiate pharma prices.

Practical considerations in associated physician research in CEE countries included the need to be aware of differences in the type of treating physicians, with examples including the broader role of PCPs in Russia, and the management of hepatitis by Infectious Disease specialists rather than Hepatologists in some markets.

Lukasz urged us to carefully consider sample sizes in the smaller CEE markets, with samples of n=100 Rheumatologists being unfeasible in a country where n = 10-20 may be possible with a relatively open screening requirement.

He noted that remote data collection methods such as telephone or online surveys remain inefficient approaches in many CEE markets where face-to-face interviews are preferred and lead to greater research success.

Written by: Erik Holzinger, groupH

Ethics and GDPR Update

Speaker:
Camilla Ravazzolo,
Head of Policy and Standards, EFAMRO

Camilla Ravazzolo of EFAMRO gave delegates an update on developments over the past year since the implementation of GDPR in May 2018 and areas of particular significance now and in the future to pharmaceutical market research.

Breaches and fines

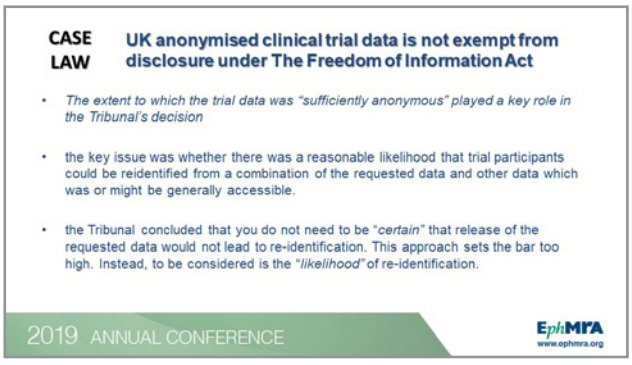
Although the number of breaches is high according to figures from the EU Commission, the number of queries and complaints to data protection authorities is perhaps lower than expected. Fines given by the national data protection authorities still have to be challenged in the courts.

The major areas of complaint are the unauthorised processing of personal data, the prevention of the processing of personal data and the rights of data subjects. They are referred to as complaints apart from in the UK where they are referred to as concerns.

Developments of interest in Hungary and the UK

In Hungary, the National Authority for Data Protection has gone into specific detail about what is expected from data handlers. Whatever procedures you may have when working in Hungary should be checked against these guidelines.

In the UK, a tribunal judge has ruled for the first time in a case on GDPR involving an individual who wanted access to information after a clinical trial. The university in question had refused access because they could not be certain that the other subjects would agree. In such cases, it is not about being certain that there is identification but is about likelihood.



Looking to the future

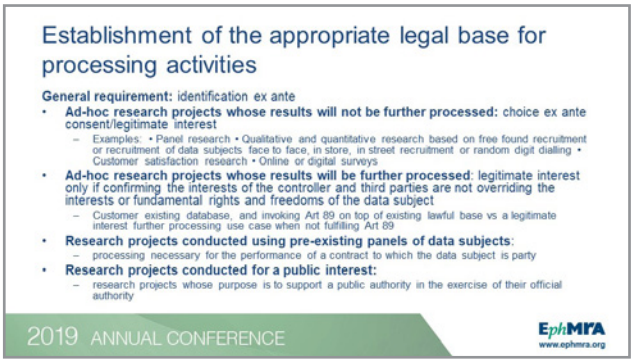
All national authorities are focusing on a series of topics e.g. how to distinguish a processor from a controller.

The European Data Protection Board is also looking at a wide range of topics and these guidelines will be released in the next 12 months. The UK is looking at other issues including anonymisation and pseudonymisation.

Codes of Conduct

The EFAMRO/ESOMAR GDPR Code of Conduct is an ongoing process that is going to take time. The EFAMRO Code of Conduct is involving national associations and once published, the Code will be available to all kinds of subscribers. The Code expresses the same standards and principles of other Codes of Conduct and is relying on the experiences of national associations.

The debate about data controllers and data processors continues and the Code will offer practical guidance on this as a matter of principle, rather than as an instruction. There is no absolute separation between the controller and the processor and there is also the possibility that there could be joint controllers. The decision-making tree outlines the steps that need to be considered when deciding who is a controller and who is a processor.



There has to be an appropriate legal basis for processing, and you have to decide before starting your project what is your legal ground to act. There is no real case law yet - but do not look for a way out of applying the GDPR.

A Code of Conduct for Health Research is also in development but as there are at least 80 parties involved, it is taking a long time. It will look at research in a very strict sense and will probably give practical guidance and examples, together with the legal basis for processing.

Key take-away messages arising from the discussion

- If it is a coordination of decisions, it is a joint controller situation.
- Every country has an interpretation and an implementation of the GDPR. Some countries have not defined research and have not taken Article 89 but some have and have taken a very strict approach. If you have a national code which is stricter, you abide by that code.
- There is no absolute controller-processor division. This distinction doesn't come from any data protection authorities.
- If you are able to record and justify, it is up to the national authority to say if you are GDPR compliant.
- The controller must be named and there is no option not to. If you try not to name the controller, you are trying to find your way out of the GDPR. However, there are ways to approach this differently in some countries.
- Naming the client and controller can bias the research. You can carry out the research and reveal the client at the end, although this is not possible in Germany.

Wednesday 26 June

Parallel Session 5

Forecasting and Data Analytics round table discussion

Facilitators:
Erik Holzinger, groupH &
Pascal Olier, Pierre Fabre Médicament

Pascal Olier and Erik Holzinger facilitated an insightful discussion on the topic of Forecasting and Data Analytics. There was a large group of attendees consisting of some very experienced individuals from both the pharma company and agency side, with regard to forecasting, as well as those who were hoping to increase their knowledge of this important business function.

The discussion focussed on four key areas, supported by a separate Handout to the audience with supporting data and analysis.

Key Take-Aways:

1 **US Long Term Outlook on Rx Spending** is a cooling of Rx net price growth to low single digits or even negative across the board whereby list price growth will continue to outpace GDP growth. Roundtable participants from the US in particular agreed that politically there is consensus between parties that drug prices have to decrease for consumers. Forecasters are advised to focus on net prices and to allow for future US net price decrease scenarios

2 **US Gross – Net Price Discounting** to PBMs and other stakeholders creates complexity that makes the interpretation of audit or manufacturer reported revenue increasingly difficult. While manufacturer report these discounts on aggregate, they are unknown at product level. While this affects pricing, manufacturer initiated patient programmes can introduce another distortion to reported revenue through audit data because they are distributed outside of audited channels. This can lead to revenue underreporting of up to 50%. Forecasters should anticipate even higher gross to net discounts in future driven by marketing battles becoming fiercer and focusing on market access and contracting

3 **The EphMRA META Analysis Project** on Forecasting Accuracy / Patient Share Adjustments was discussed. The value of potential outcomes was confirmed provided that after gathering suitable historic projects the analysis can remain manageable and meaningful. Roundtable participants suggested to various ways of simplifying the analysis and structuring the projects such as e.g. focus on patient share rather than revenue and the need to look at forecasts by type or archetype e.g. patient-based or market-based.

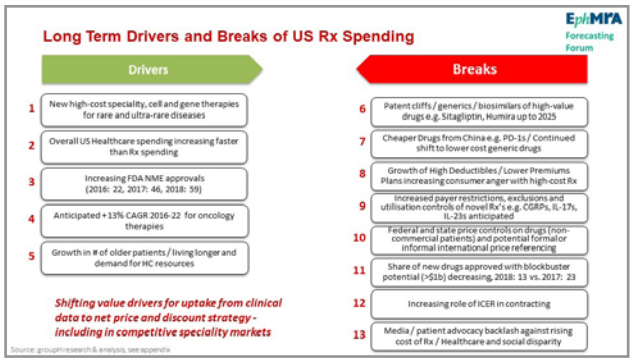
4 **The Forecasting Clinic** covered the topic of Predicting Time to Peak Share in Long Term Forecasting. Responses from the audience included the right use of analogues matching as many of the product, indication and market characteristics as possible and the use of expert judgement 'gut feel'.

1. US Long Term Outlook on Rx Spending

Erik kicked off the discussion by addressing the question - "why the focus on the US?" The reasons for this are mainly commercial. US retail sales in the mid-90s were about the same as EU retail sales. If you look at US retail sales today, they have grown to three times that of the EU retail market. At the same time expenditure for health has grown to about 17% of GDP. The Rx drug sales share of that health expenditure in the EU and other markets has decreased slightly but in the US it has been growing since 2013 to 12.6% but shows a slight decline again in 2016 to 12.3% (latest OECD data point). So essentially the US has been spending relatively much more on health overall and in the wake of this more on Rx drugs too compared to the EU during the last 20 years. It is interesting as it explains why the US is more than vital for EU Pharma companies.

60-80% and sometimes up to 90% of global sales go to the US, so few drug launches would be viable if just for the EU and the rest of the world. List prices of many Rx drugs in the US continue to increase at double digit year by year. There is considerably uncertainty if the market as such is sustainable and what future Pharma market growth rates might be based on conflicting drivers and a volatile political administration.

How is this uncertainty and volatility reflected in your long-term forecasting?



Erik invited others to give their view on how they represent the uncertainty of this major market in their forecasts. Is there any right way or best practice for this do you think?

It's not really a best practice but one thing I think for the US in particular, which is difficult, is to factor into long term forecasts the role of the patient and co-pay. How do patients with multiple co-morbidities decide which drugs they are not going to pay for? That lack of adherence will have an impact on your long-term forecast. I don't have an answer but it's a pretty critical and growing issue in the US (Large Agency, UK)

Erik: So, you mean adherence from an ability to pay point of view?

Yes, so if I'm a US patient and I have type 2 diabetes, hypertension, etc and I have five virtually asymptomatic diseases but I can't afford all five as prices are increasing, which are the three I am going to pay for and take home and which are the two I am not going to care about? I think that's a really difficult issue in the US. (Large Agency, UK)

Erik: There is a link to a video on one of the slides published in New York times which describes the case of patients with type 1 and type 2 diabetes who were forced to buy their insulin in Mexico and they cross the border and get it there for around a tenth of the price of the US, and when you look through the media there is a general disgruntledness among patients as they are facing either a co-pay, a fixed percentage on list prices increasing over recent years, or they are having a higher deductible that they have to first pay in cash as part of the agreement with their employer/ insurer until insurance kicks in. There is a trend for higher deductibles as this means lower premiums for most people. The question is exactly how does this translate into any forecast? Does anyone have any way to integrate that, as at the moment it is just a qualitative statement that is not easy to quantify as such?

Erik: This is just one of the factors that could have an impact on a long-term forecast. When at indication level you are projecting sales of any product, how much do you rely on 3rd party sources to project long-term growth in the market? Do you do this yourself or rely on someone else?

I try to have an idea myself and share my opinion with someone else and get someone else's opinion without telling them mine first, when there is no time to get an opinion from elsewhere outside the company. This is for a rough estimation and when you don't have time to go elsewhere. (Industry, Large Pharma, France)

Erik then addressed a question to the US representatives in the room. For a long-term forecast, from your opinion reading the news every day, what are the major uncertainties one should look at?

The political situation is very volatile but one thing both democrats and republicans agree on is the price of drugs. They want to push prices down and Trump is very vocal about it, in terms of reducing it. In terms of drivers, which contributes to the cost of healthcare, the US is a very legal country and doctors are very risk averse. No one wants to be sued for not checking out a condition or giving a patient a treatment or something like that. It really contributes to the cost as well. (Large Agency, US)

One important point to consider is the increasing number of patient support programmes. Either from within pharma or some state institution. We had a discussion in our committee yesterday to increase data in specialty markets. I did an investigation for Sanofi which showed there are three specialised websites to list to patients which patient support programmes they can access. These are on very high cost products most of the times. (Large Pharma, France)

Do we know whether the number of people using these programmes is increasing? (Large Pharma, France)

It should be investigated as a point to tackle, as there are several things that are quite unclear. Many of the programmes are run directly by pharma companies. It gives a difference between IQVIA sales and pharma reported sales. There are additional systems on top, like discount coupons so you need to go to listed pharmacies to get your product. They have an official price but that is not the final price. It is a much more complex system than before. It would be good to understand when a company has this sort of programme whether they are included in company reported sales. (Large Pharma, France))

Those programmes are increasing, and a driver is the cost transparency required in advertising, so immediately you have to disclose the pricing, you want to say you have a programme to reduce that. Another factor is the co-pay aggregators who ensure those programmes are being utilised. Not sure how we keep those programmes going and make sure the patient doesn't have to pay to that degree, but those are two factors. (Large Pharma, Italy)

Erik: As we speak, there is a presidential directive under discussion to force these price disclosures at a product level, which currently are not mandatory at a product level.

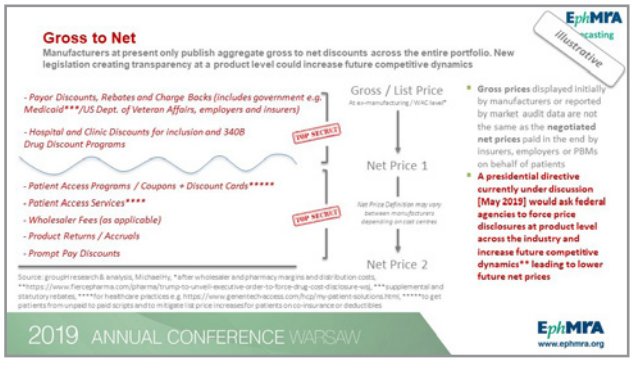
Most people are jumping on that bandwagon already, so you'll see it in the DTC commercials already for the major drugs, trying to stay ahead of schedule (Large Pharma, Italy)

From my first quick investigation it's difficult to know which price it is being sold at. To get the price you need to apply to be part of the programme which we cannot do. It also may not be the same price for every patient who can benefit from the programme. (Large Pharma, France)

... and as a result, while impact is class and indication specific, we anticipate an overall continuing trend of pressure on net price growth over the next 5 years. This may lead to year-on-year net price decreases in competitive speciality markets. The industry will experience increasing patient acquisition cost (higher rebates / discounts / performance-based agreements) and also more patient access programs (industry covering co-pays)

2. US Pricing Gross – Net

Erik then moved on to the issue of determining net prices. When looking at IQVIA ex-manufacturer prices and comparing to manufacturer reported sales you find there is a difference. For any commercial calculation you want to know how much money remains in the company and how much you have to pay in terms of discounts and rebates, so we have put together a slightly more detailed chart which explains the different deductions that could be made to arrive at a net price.



The main part is any discount or rebate that you must give to a PBM. This could also be called the 'patient acquisition cost'. The 'tricky' thing is: These discounts are by nature highly confidential, there is no way to just look them up somewhere.

Erik pointed to examples in the deck of companies who publish these discounts across their portfolio as part of their Transparency Report and showed that the average discounts for a primary care portfolio could be up to 50% or even sometimes more. For some other products it is actually zero, if it is sufficiently differentiated or has no competition. So you have this very, very large range of possible discounts which are confidential. How much company internally is paid for patient access programmes and services is also confidential, hence the difficulty at product level making the right deductions. It depends on the competitiveness of market – how many products are in the same class and how differentiated are they against the rest? Another important point is that the different health plans might not accept your product even with a discount, and they may exclude it if they can find another similar product where they can negotiate better commercial conditions. Over the past 5 years the number of new products excluded from health plans each year has increased by a factor of four since 2014 and that essentially means that to look at your real net price you are not just looking at a gross to net discount but you are potentially not covering the whole of the US. So, your market is not the total population but only the part where health plans would list your products. How can gross to net discounts be determined and future coverage estimated?

Erik asked the group whether this was an important question as part of their commercial planning?

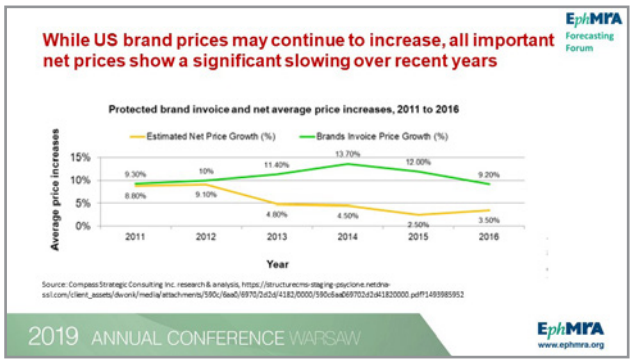
I'm not used to making forecasts in the US. I usually ask my market access department to tell me what to do. However, sometimes you need to do it rapidly without asking. Do you have any rules around the discounts that can be applied? Does anyone in the room have that kind of rule? It's a big issue. If you look only at IQVIA data you are overestimating what you can do in most cases (Large Pharma, France)

Mainly we are underestimating as all patient programmes are delivered directly, so outside of what you can have on IQVIA sales with regular delivery channels. For example, the question I had to answer last week, in volume, was double on the annual report of the company compared with IQVIA. The major fact I could see is there is a patient access programme for this product and coupons. (Large Pharma, France)

Are there programmes for all products? I have contrary experience, as IQVIA is ex-mnf, and then you have discounts you cannot know. The final sales can be less. (Large Pharma, France)

You need to investigate market by market you just type in Google the name of the product with the words 'patient access programme' and you can see. (Large Pharma, France)

Erik pointed to a case study in the handout on the launch of cGRP products for migraine. Amgen, Teva and Lilly have all launched products with a similar clinical profile, so there is now a fierce battle as to who is going to be listed by the payers. It is not so much about the clinical profile anymore as it's driven by the company discounting and market access strategy. A company may have the most brilliant physician launch plan but, in this case at least, it is very much driven by payer negotiations. Lilly seems to have an edge due to their experience within this franchise and primary care. It shows how forecasting can't be easily separated from market access anymore, it is not just about getting a 'price' from your MA colleagues.



So, to summarise, Erik explained that although the US sales seem to be three times those of the EU on paper, gross to net discounts apply. If you deduct the rebates, the price increases we have seen over the last 5 years (up to 10 percent on average) are closer to 1-2% net on average.

3. Rx Patient Share – EphMRA Meta-Analysis Project Draft

Erik then moved the discussion on to a project the EphMRA Forecasting Forum has been planning. This came up as an idea during a previous forecasting forum conference call. He observed that the power of EphMRA was in being able to assemble many different manufacturers in Europe to be able to look at past projects and tackle some of the questions that any individual could not answer. The proposal is to do a meta-analysis of forecasting projects that are at least ten years old and that must meet a couple of other criteria to be included. The hope is that it might provide some insight on physician stated preference share discounting as well as other methodological insights.

Anyone involved in forecasting for several years knows that this is one of the evergreen questions and it is almost impossible to come up with a precise answer. Different agencies have different approaches, some say this discount is 20% 30% or 50% etc and whether it is driven by unmet need, physician stated 'probability to prescribe' or something else. The only thing that everyone agrees on is that you must adjust them as the shares that you get are over-stated. One of the ideas was to pool 20 - 50 or so different projects for different products or companies that are way in the past, so that there is no issue with confidentiality, and see what happened in real life to those products.

The idea is to keep this among the members and also engage academia if possible as a resource to analyse the data. It should cost zero money if the industry contributes, discussions with potential academia / Marketing Analytics department are ongoing. I also think there could be a role for industry or agencies, the former because the project sponsor (if available) could add context to any slides and the latter because they understand best the strengths and weaknesses of different primary research methodologies.

Erik explained that this is still in the planning phase to ensure we are asking the right questions, as in this kind of structured meta-analysis it will be very important to differentiate where the potential differences comes from with regard predicted sales vs real sales. Is it physician over-estimation? product underperformance in real-world setting? competitor launches? Payer restrictions or other market access hurdles?

Erik: Given this proposed study, what are your ideas? Which other questions could be asked in your view?

I think it should be very complex to do, as you said sometimes you know the uptake can depend on different things, e.g. you have a clinical trial programme which doesn't work so these estimations can go down, a new competitor enters the market, new regulations. Mixing all these things in a meta-analysis without considering specificities would be complex (Biotech, France)

When I first heard about this project I thought "well fantastic", I need the results, but this is ambitious as after a few years it is difficult to find what are the initial hypotheses and what changed in the meantime, but I think we can try. If 10-15 companies do the exercise and look at the products that were launched, it doesn't cost anything. Personally, I will try to participate in this project, as we are always looking at the next stage and don't look back. We don't have time to look back, so worth doing to see what work we did to prepare and what does it look like now (Large Pharma, France)

Another thought would be to look at archetypes of situations, look at each archetype and try not to mix everything as will be something complex. (Biotech, France)

One problem I have with physician recall is even if a product is launched and they are prescribing it, what the physician says is the patient share can be very different from real world data, so we need to adjust what is the actual patient share and their perception of patient share at the moment (Large Pharma, UK)

It's quite tricky to do this type of research as this is apples and pears. I have seen so many different forecasts so need to differentiate between patient-based forecasts and sales-based forecasts, so group these and then to look at what will be better. Interestingly I saw a meta-analysis of forecasting models and the predicted outcome of how accurate it was. The only question was how many variables were in the model. The more variables = the more uncertainty and the wider the range. We have talked a lot about variables, and the more you put in, the more errors you have. The error can go in all directions, and where the errors went to, they were usually skewed in one direction. On many models you have multiplication, so if you multiply one error with another it is even worse. So, the important question is, what do you want to do with this analysis? (Agency, Germany)

Erik: I think one approach is to say we would probably need to look at the case studies and sort by product type, market or by level of differentiation or something more generic, and another way could be by the approach used. Prevalence based/patient based/ differential analysis model/apply formula from patient share or ignore all that, and as many consultants do, apply their own share as they know that you need to aggregate all the learnings from all possible market drivers. So, keeping that separate and hopefully after this long exercise looking at what approach may give better results than others might already give an interesting outcome. But, given the complexities of such a task, one should not set too high expectations from the beginning.

I did a different meta-analysis of how KPIs measured correlate with sales. The client had different KPIs for all studies and looked at which KPIs worked best or which really worked in predicting the outcome. I had to play a lot with sales data – which didn't really work. The best results were with analysis using units. That could be a question - what would be the best base for assimilation or forecasting in a particular area? In some indications it may not be possible. When it comes to packs, units worked best to correlate with the financial outcome, rather than the other way around. (Agency, Germany)

There could also be differences from one country to another. In Southern Europe they are usually more optimistic. At the same time, when you launch, they adopt a product quicker than Northern Europe but drop it quicker once a new competitor arrives (Large Pharma, France)

Erik: There are hopefully learnings along the way even if you just aggregate all these case studies and our hypotheses are confirmed. I don't think any of us have done this systematically.

We did that. We collected with my previous company the interest in the product, probability to prescribe and share of prescriptions. We asked for number of patients they would prescribe to but you can recalculate that. You saw for the UK that the middle of the scale is not mathematical, so regarding interest for the UK was 7, Germany 7.2, Mexico 8.5, Italy 8.5 so the middle of the scale is different from country to country. If looking long range for each country, you can make a benchmark and say whether they are above or below. (Agency, Germany)

4. Forecasting Clinic – Ask your peers at the Round table!

Erik invited individuals to put forward any questions they may have to see what advice the group could give them.

How do you predict time to peak share for long term forecasting? Sometimes 5 years, sometimes 15 years (Biotech, France)

I try to find analogues for a similar situation. Is it a new product or a me-too? Is it a new mechanism of action, which can delay uptake as doctors are not so confident with it? (Large Pharma, France)

I would suggest if it is a very niche product and an unmet need you will find your peak sooner. If any new entrants, so if very crowded, then it will be very different than if you are the only product in the market. No one answer – depends on various factors. (Large Pharma, UK)

Qualitatively – it's a gut feeling. Expert judgment. (Agency, Germany)

Erik: I would always think that finding good analogues is possible but there are some indications where it is difficult, but this is rare. How much effort do you want to put in for this? Depends on the purpose of the forecast and how important uptake curve shape and duration is. Does it matter if you are out by a year or two for a strategic, long term forecast? If close to launch, and sales targets will depend on it, then you get into a discussion ...

For sales forecasting you need to think beyond it and demand planning as well, as that is going to be an issue if you don't predict your sales market share correctly. (Large Pharma, UK)

Has anybody used predictive markets to forecast in pharma? You invite people to bet on possible outcomes of the future. Similar to IOWA election markets where they predict US presidential elections accurately. You use the wisdom of the crowds. You recruit people and pose the question in the form of what's going to happen in the future, for example in two years' time what percent of the market will a drug have? The answers will be 5%, 10%, 15%, etc, give people a number of points and you invite people to bet on what they think the best possible outcome will be. You can watch the discussion about it in an on-line environment, and watch the answers go up/ down as the discussion progresses. Could be patients, doctors or a combination of both. Anybody who has an interest in the outcome. I proposed it to a client who was interested in it, but they couldn't see how their KPIs would come out of it. They were more interested in their KPIs than their forecast (Agency, UK)

(laughing) ...the silence tells me my answer (Agency, UK)

Erik announced that we will have another face-to-face forum in Ingelheim, hosted by Boehringer Ingelheim, on 11th October. It will be free for EphMRA members, so just organise your own travel. Prof Paul Goodwin from University of Bath will be presenting. He is the author of Decision Analysis for Management Judgement, Forewarned - A Sceptics Guide to Prediction. We will put some other interesting topics together as well. We will also put topics together for the rest of the year for our one-hour conference calls every two months, based on your feedback.

Erik closed the session by thanking everyone for their attendance and participation.

Wednesday 26 June

Parallel Session 6

Quitting smoking is harder than we knew: Deep insights from a Consumer Consulting Board

Speaker:
Marianne Fletcher, Pfizer
& Magali Geens, InSites Consulting

Chair:
Amr Khalil,
Ripple International

Marianne and Magali presented a fascinating case study based on a Consumer Consulting Board to demonstrate how consumer research communities can deliver mutual value to both pharma company and patients.

Marianne and Magali opened their presentation with a short audience survey, highlighting the number of delegates who had not only tried to give up smoking, but who had tried to quit on more than two or three occasions. This brief exercise demonstrated the premise of their case study, namely that quitting smoking can be very hard and clearly harder than Pfizer had initially perceived.

Marianne introduced the Case Study, which was based on a consumer research community. She noted that although this was not a new approach, it had in this case been a game-changer in providing Pfizer with a new understanding of a well-researched patient group and resulted in community research being reimagined within Pfizer as a mainstream qualitative approach, overcoming previous barriers to use such as cost perceptions, time considerations and concerns regarding potential Adverse Event reporting.

Pfizer concluded that consumer research communities could be included in the research mix alongside depth interviews and ethnography to bring patients to the heart of business decisions and future-proof Business Intelligence insight whilst delivering mutual value.

Magali described how the research community was set up via Pfizer's innovation testbed in Australia and New Zealand. 90 community members were recruited, consisting of smokers and ex-smokers, and were invited to join a secure social media community platform coined the "Consumer Consulting Board", launched as the "Quit for Good" community.

With participant consent, Pfizer stakeholders were able to follow conversations on the platform as they happened, guided by an expert moderator.

The platform enabled Pfizer colleagues to "tune in" to the patient community any time, from anywhere, facilitating immersion into patients' lives as they struggled with the daily challenges of quitting smoking.

The community not only bridged the geographical gap between participants, but also brought together people of diverse backgrounds, life stages and smoking habits.

Magali reported high levels of engagement amongst these challenging-to-recruit consumers, with over 2,700 unique on-topic contributions within 2 weeks, including personal stories told via posts, videos and photo-journals. Within this large number of interactions, there were only 12 AEs reported.

Marianne then highlighted some key insights gleaned for the first time from the 336 community hours during the research.

1 Previous research had revealed that quitters found changing ingrained habits very difficult, such as avoiding smoking breaks with friends. The online community clarified that the biggest fear is quitting itself, as smokers cannot picture their lives without cigarettes. For smokers, quitting is NOT a rational process.

2 Pfizer knew that the support network was pivotal to quitting success, but the online community revealed that smokers feel judged by their partners and healthcare professionals – the very people whose support is required to help them quit. The research revealed that to quit smoking, Pfizer needed to help smokers to shift the culture of blame and responsibility to asking for help and support

3 Pfizer knew that smokers needed support in order to quit, but the online community highlighted the need for long-term support to embed the required lifestyle modifications in the same way as an alcoholic requires long term support in order to stop drinking for good.

Magali described the real-life testimonials that were generated by the online community emphasising the benefit participants derived from the involvement with the online community and underlining the need for unconditional and lasting support to successfully quit smoking.

This was further illustrated with a very emotional and deeply moving movie clip used in the Australian campaign following the success of the "Quit for Good" community.

Marianne announced that the Direct To Consumer campaign based on the community insights had won the prestigious "Prime" award for "Best Integrated Marketing Campaign". Within Pfizer, the impact of the campaign had been far-reaching, not least in terms of field force engagement when they were able to see the insights for themselves as well as sharing them with customers and healthcare professional bodies. It is an example of a customer support piece that demonstrates how Pfizer understands its patients and prioritises their needs when shaping future support: Pfizer has used the learnings in developing their smoking cessation programmes and supporting those trying to quit beyond simply providing medication, in order to increase their chances of success.

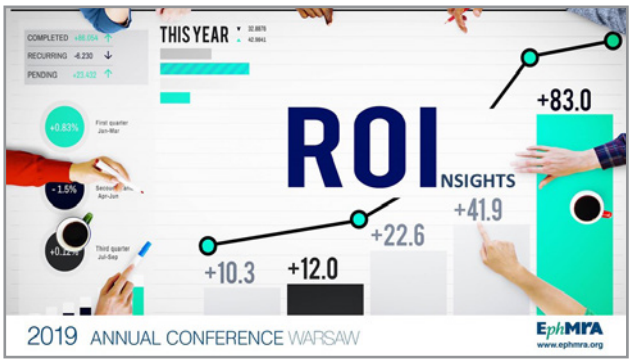
The findings are also being used to support healthcare professionals with medical education, helping them to communicate in a less judgemental way with their patients who smoke and offering more effective support.

Magali reviewed the learnings regarding the research design itself, noting that the research industry's focus on problem solving can sometimes hamper truly inspirational research, but that the Australian Innovation Lab setting had allowed the research community to maximise its full strengths, exploring challenges and answering questions that had not been predefined and delivering insights that went beyond the obvious.

Marianne highlighted the softer benefits of being able to listen and empathise which in turn created a safe, supportive community for participants to share and respond with emotional output, resulting in a willingness to be involved in future collaboration where participants felt heard, valued and supported.

The Pfizer team immediately understood that this platform provided what is currently the only way for patients to share their experiences and support each other, whilst simultaneously providing Pfizer with a unique opportunity to observe, interact and co-create with their ultimate stakeholders. This realisation has led Pfizer to reimagine the future shape of relationship-building with patients, and to invest in building sustainable relations with patients that not only provide deep understanding of their lived experiences, but which also deliver mutual value.

Before concluding, our speakers addressed the potential barrier of cost. Marianne highlighted the common challenge of securing the necessary resources required to build and use effective patient communities. Magali confirmed the challenges of "selling" community research to clients when procurement sheets do not include them as a specific option, often leading to unfavourable cost comparisons with traditional qualitative methodologies. In response, Marianne acknowledged the higher cost per participant of community research but concluded that the additional investment is worthwhile in terms of return in the form of genuine insights. Pfizer, she reported, were so convinced of the value of this methodology that the regional brand team has committed to further patient communities and recommended it to the global organisation where it is now being explored for other brands, diseases and geographies.



Our speakers concluded by highlighting the benefits of this approach not only in a mature-stage product (as per this case study), but particularly at earlier life-stages where it can be used in place of social media listening to capitalise on the benefits of the inherent social need to connect with peers but in a setting that caters for a research purpose. Marianne urged us to embrace the power of research communities to connect with consumers, listen intensively to gain a deeper understanding of their needs, but also to move the methodology from ad hoc research to a more structured engagement in which our industry can truly co-create solutions together with the patients – the people that we serve – in a truly patient-centred approach.

Written by Amr Khalil, Ripple International

Wednesday 26 June

Parallel Session 7

The SMART way to tap into patient emotions – can novel methodologies help understand patient emotions better and faster?

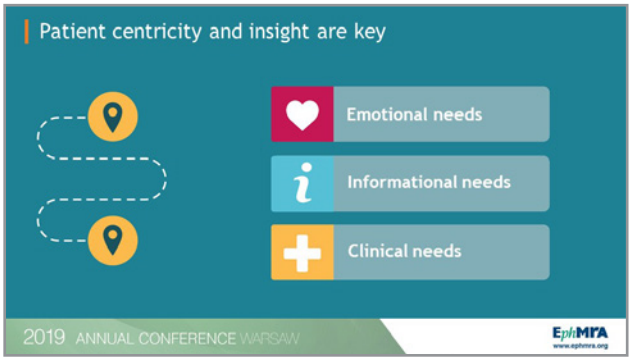
Speaker:
Thierry Barten, Pfizer
& Janneke van den Bent, SKIM

Chair:
Sarah Phillips,
IQVIA

Janneke and Thierry presented a case study exploring whether chatbots can help us to better understand patient emotions.

Janneke set the scene, noting that the world around us has changed significantly in the past 5 years and will continue to change over the next 5 years, with new technologies impacting behaviour and decisions, which in turn impact the environment for pharma business decisions.

As more and more patients are taking control of their own health and becoming more involved in their own patient journey, particularly via the use of online information sources, Pfizer wanted to explore how to better support patients and physicians in this changing world.



Thierry noted that patient centricity is the key umbrella under which pharma and healthcare is transforming. Previously, the HCP was seen as the all-knowing expert, with patients merely listening and following instructions. We have observed the transition in access to information, with patients now able to discuss their condition and their treatment options with their HCP and take the lead in choosing their own treatment path, with greater disease "ownership" from patients.

He hypothesised that HCPs will increasingly take on a consulting role with shared decision-making, and, as a result, the better HCPs understand patients' needs, the better they can perform this new role.

To keep healthcare affordable, Thierry noted, it needs to be value-based – not only in terms of clinical value but in terms of outcomes that are important to the patient: the patient, he believes, will evaluate more and more carefully and critically, the care they have been given.
He underlined the importance of pharma companies and HCPs ensuring that they understand their patients, in terms of both perceptions and reality.

For Pfizer, the goal of understanding treatment needs and expectations was very important. By understanding both new and switch patients they could trigger discussions or awareness amongst HCPs about these patient expectations, and therefore prescribe the most relevant treatment options.

In the rapidly-changing pharma world, Pfizer needed to understand the patients' understanding of their treatment, as well as their emotional, informational and clinical needs.

Using the specific example of atrial fibrillation, Thierry explained that AF occurs in over 25% of people aged fifty or over. It is quite easily managed with daily medication to prevent stroke, but patient adherence is vitally important to positive clinical outcomes.

Pfizer's previous research had mapped out the emotional journey before and after a diagnosis with AF. The team knew from the previous qualitative research that this period around diagnosis was emotionally overwhelming, with the emotional overload making it difficult for patients to absorb and retain details of what had happened and how they now needed to manage their condition. The research showed that patients' feelings of fear and anxiety remained long after diagnosis.

Pfizer wanted to understand more about this period of patients' lives so that the company could help HCPs understand and support patients during this critical time, thus closing the gap between patients' needs and physicians' actions. Pfizer realised that their previous research did not enable them to fully understand the patient perspective, and so SKIM was commissioned to conduct further patient research.

Janneke elaborated on the need for closer insight into the diagnosis journey, from the moment of diagnosis to the next appointment, to understand the highs and lows of the patient experience and to identify difficulties and unmet needs during this time.

Their first thought was to conduct a diary study that would capture "in the moment" experiences, based on the premise that the closer you get to the actual moment in question, the clearer and more accurate the observations will be. The diary approach, in tandem with a traditional in-depth interview, had been used successfully many times before as a good way to get close to patients and understand the details of their experience. However, experience had shown that patients sometimes struggle to provide the required level of detail and record it on a blank piece of paper.

The SKIM team wondered if a chatbot approach might be a helpful addition to the research. They hypothesised that using a chatbot in market research would be convenient for the patient, allowing the research to be more easily present in patients' lives at a difficult time. They also hypothesised that patients might enjoy talking to the chatbot and be more willing to interact with the conversational flow than in a traditional diary approach.

The team therefore designed a study to understand the experience of AF diagnosis, but also to understand the potential for added value when using a chatbot. The study was designed with two research arms: a traditional diary task plus telephone depth interview, vs a chatbot interaction over the course of two weeks.

Janneke described the process of designing a chatbot, explaining that previous knowledge was required to design the "dreampath" that most respondents would be expected to take, along with options for variation within the respondent group, critically evaluating each step to understand where and how it might vary. She also noted that building the perfect bot can be a challenge and described some examples of the bot struggling to understand language or a double response to a question, leading to some interesting miscommunications!

The results of the study proved interesting, both in terms of insights learned and in terms of the evaluation of the traditional vs chatbot methodology. The team found that the chatbot arm produced more detail than the traditional paper diary approach. Respondents were willing to participate, and the simple chatbot prompts encouraged them to provide more detail and longer responses than the one-sided diary entry. However, the chatbot did not outperform the traditional qualitative interview, which as expected proved highly insightful.

The team concluded that a hybrid solution of chatbot plus qualitative interview would deliver the best of both methods, with the chatbot diary providing excellent input for the qualitative interview, resulting in deeper conversations and providing moderators with the inputs to help uncover core patient needs.

Thierry outlined how the approach had helped Pfizer. The previous research, he reminded us, had provided insight on clinical and emotional needs, but with the limitations that the period around diagnosis itself was clouded with emotion, obscuring identification of patient information needs, but that conducting research too long after diagnosis made it difficult to assess acute needs.

The new approach identified emotional needs during diagnosis, enabling Pfizer to help HCPs to be aware of the issues and in turn help to support the patient. Pfizer believes that chatbots can be a powerful methodological tool to engage patients over a longer period of time, allowing us to stay close to the patient during emotional highs and lows without the intrusion of a moderator.

Thierry believes that this approach has industry-wide applicability from research to education service models and also triage models in disease management.

Janneke highlighted the value of the chatbot approach in diary studies, but also longitudinal research and other "in the moment" research such as patient-HCP interactions or HCP decision-making.

Janneke concluded with some advice for adoption of the chatbot approach. She reminded us that it takes time and background knowledge to set up the chatbot, and that an iterative process is required to iron out any glitches in the program pathway.

New technology, she said, can be daunting, but she urged us not to be daunted but to view chatbots as a good way to develop our digital journey, leveraging the opportunities provided by digital approaches and benefiting from the surprising levels of interaction between respondent and bot.

Written by: Sarah Phillips, IQVIA

Wednesday 26 June

Parallel Session 9

Driving Insights to Improve the Patient Experience: From the patient, for the patient

Speaker:
Mohamed Akrout, F. Hoffman-La Roche
& Roberto Cortese, Elma Research

Chair:
Tracy Machado,
Phoenix Healthcare

Mohamed Akrout and Roberto Cortese presented a case study showcasing how patient experience research can be used to drive change and improve the lives of other patients, by ensuring a complete understanding of the patient perspective and revealing the key barriers to change and how they can be overcome.

Our speakers first set the context for the case study with an audience participation exercise to bring to mind situations where change has led to fear, doubt or uncertainty in our own lives. This case study, they explained, was set in a therapy area for a rare, life-threatening, life-long condition. In this context, patients were often understandably reluctant to risk the reassurance of a long-term, well-established therapy that had so far served them well, in order to change to a new treatment option with considerable promise but also considerable perceived risk. The research undertaken allowed Roche and Elma to observe at close quarters while the patients bravely made the decision to uproot from their familiar treatment routine and step into the therapeutic unknown.

Roche was launching a novel, highly innovative, treatment in several markets, and wanted the launch strategy to be patient-centric by design. They wanted a market research programme that could capture a complete picture of the switch experience in real time, from their first conversation with their physician about switching through to being established on the new therapy. The objective was not only to optimise the launch strategy but to benefit the wider population of patients beyond those involved with the market research in order to improve the patient experience.

Our speakers highlighted three key challenges:

- Target patient population: This rare condition meant there was a very small patient population – only a handful of patients in each country. This geographically-dispersed target group had to be recruited within the very short time window of switching between the old and new treatment, within a flexible timeframe to accommodate different approval dates in each country
- Building trust: due to the serious nature of the condition, there was no margin for error in terms of treatment. It was crucial to build patients' trust and overcome doubts and fears for both patients are caregivers

- Complex dynamics: Roche needed to build relationships with stakeholders in a new therapy area, building a strong company reputation from the start. They needed to ensure buy-in from local affiliates, who were asked to invest time and energy into an unfamiliar type of market research. Elma had to overcome the challenge of recruiting rare patients, by building relationships with physicians and sometimes psychologists to help identify the appropriate patients

The strategic importance of the project encouraged the project team to consider new and innovative ways to explore the whole picture with eyes wide open. Using a videoclip of a group of people passing a ball to each other, our speakers demonstrated how easy it can be to focus our search on a specific event, to the extent that we might overlook other important, but unexpected, events right in front of us. To overcome the challenges of this project, the project team wanted to look at the situation from different angles and with different tools to embrace change and venture into unexplored territory.

The project approach included three principles:

- Augmented reality: a way to see change through patients' eyes that allowed the team to zoom into personal journeys in depth to identify universal and powerful insights that could be extended to the wider patient population
- Multiple lenses: they wanted an approach that would bring together different perspectives to uncover new insights, without the risk of losing any important elements
- Personalised approach: they wanted to design a flexible and personalised approach that would bring all elements together whilst allowing interaction between all stakeholders throughout the constantly-changing timeframes, to ensure swift responses to the emerging demands of the study design and implementation. Not only did the Roche and Elma project teams work together as one, but there was extensive collaboration with the extended Roche team to include Market Access, Medical and Commercial colleagues

The methodological solution was a prospective approach in three stages:

1 Ethnographic interviews
2 Online community
3 Traditional interviews

Ethnographic interviews:

Ethnographic interviews with patients and caregivers captured the patients' individual stories and emotional states before the treatment switch. This stage was key to understanding the backdrop to treatment change, allowing the team to observe the unspoken experiences that contribute to the hopes, expectations and fears that accompany such a change.

Online community:

An online community with the same respondents, plus others, was held over 3 months with no drop outs. This enabled a deep understanding of the concerns and experiences of patients to be revealed by listening closely as they came together as a group and shared their experiences and interactions in real time from treatment initiation, through first experience with the new therapy, to changes in daily life resulting from the new therapy.

The digital platform was fully customised, involving patients in weekly activities for 3 months, including uploading videos, music clips and use of other communication and engagement techniques. Patients are caregivers could access the community at any time and participate in private or collective discussions guided by the same specialist moderator who had established a personal relationship with participants in the ethnographic interviews.

Traditional interviews:

Traditional interviews with other players in the ecosystem, such as nurses, physicians and members of patient associations, were conducted to understand the broad context of influencers around the patient, and their contribution as key reference points for the patients.

Mohamed and Roberto then provided an insight into how the research findings had been used.

Our speakers emphasised how the findings had been integrated into the core strategy for the product launch, with the patient at its heart. Different teams from Market Access, Commercial, Medical, local and global all used the outputs to inform their activities, from how best to communicate the future "new normal" to patients, to supporting HCPs in answering questions and support patients throughout the switch journey.

The delivery of the project was also unique, our speakers explained. They provided regular updates to keep the different teams engaged throughout the process, via newsletter and video updates. Our speakers shared examples of the powerful patient videos describing the impact of the new therapy. Rather than a traditional debrief, the team held a planning workshop involving each country in a hands-on strategic exercise to work through local challenges and incorporate the findings into practical solutions.

In terms of key learnings, Mohamed and Roberto described how the project had demonstrated how our industry can move from "good" to "great". Rather than simply making the right treatment available, they urged our industry to truly put the patient at the centre of our product strategies, using a deep understanding of the patient experience to maximise the impact we deliver, contributing to the optimisation of healthcare delivery across primary, secondary and home care with a truly holistic approach.

Research, they urged, can be much more than just a tool. With careful design, it can be a platform not only to analyse but to predict patient needs and how our industry can deliver. Research, they assert, should be reframed as an engine of change.

Written by: Tracy Machado, Phoenix Healthcare

Wednesday 26 June

Parallel Session 10

Telling the Whole Story. Using data science to quantify brand health from unstructured responses

Speaker:
Neil Martin,
Ipsos Healthcare

Chair:
Mike Pepp,
Blueprint Partnership

Neil Martin shared some Ipsos research and development into using AI for analysis of unstructured responses within quantitative data. The findings revealed that natural language processing can provide valuable insights into brand health, but that care is required to select the appropriate research methodology for the study context.

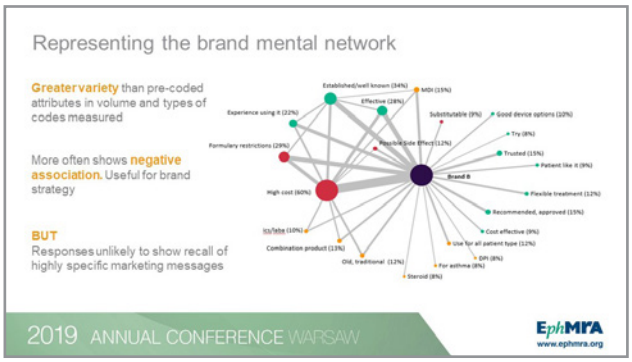
Neil presented an extension of the work shared in February 2018 at the EphMRA London Meeting. The premise for the paper is that brands act as a heuristic (mental short-cut) to a network of associations, feelings, images and experiences - which can be readily brought to mind when the brand is considered. Neil explained that human beings are efficient with the way they process information, and that not only can the brand trigger recollection of these complex interactions, but that exposure to one of the connections can similarly trigger recollection of the brand itself. For example, within healthcare prescribing, a physician who associates a particular brand with a co-morbidity is more likely to recall and therefore prescribe that brand if faced with a patient with the corresponding co-morbidity.

In research terms, when we ask respondents to give an opinion of a brand (e.g. rating it on a given metric), it is the salient memories that inform that numerical response.

Using this principle, Neil explained, we can use brand connections to understand key influences on decision-making.

Neil described research conducted at Ipsos to explore this principle, comparing and contrasting spontaneous and prompted brand associations (closed-ended questions using a predetermined list) within a particular therapy area vs. unstructured spontaneous verbatims (collected as typed online responses).

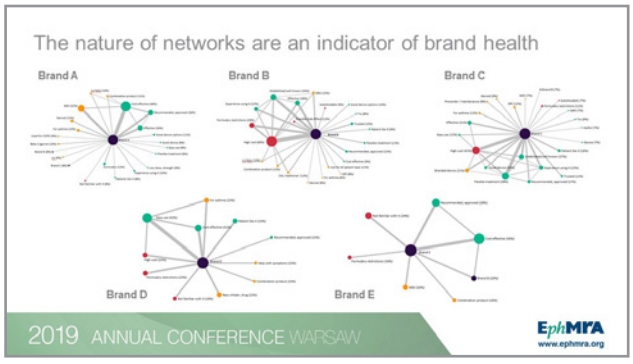
The unstructured verbatim responses were analysed using natural language processing algorithms. Neil showed verbatim examples from the study where the algorithm had classified responses such as "easier for the patient", "easy to use", "easy device" etc and coded them together into a theme the project team could examine to ensure it was meaningful, and then name. In this example, the theme was labelled 'ease of use'. Subsequently, each theme was mapped to show how (and how strongly) it is connected to the brand itself and to other emerging brand themes. The relationship between the brand and the themes can be shown visually as a brand mental network.



Neil indicated that compared with prompted data, spontaneous unstructured responses provide a greater variety of codes in greater volume. He noted that this might be useful when exploring differentiation between brands in a largely undifferentiated market. Furthermore, the spontaneous responses also showed a higher level of negative associations – possibly an artefact from the way in which pre-coded lists are constructed – which Neil suggested would be valuable in identifying, quantifying and understanding potential barriers to prescribing a brand.

Neil summarised the benefits of this application of data science, highlighting the ability to apply it to a large number of respondents' data points and the objectivity that computerised algorithms bring to the analysis of unstructured text. One downside of the approach, he highlighted, was its likely difficulty in measuring recall of highly specific marketing messages where inconsistent wording may cloud the ability to determine accuracy of recall.

Neil described how brand network mapping can provide insight on brand health. Using an example from the same study, he highlighted three brands with dense networks. These, he explained, were the brand leaders, with two other less dense and less interconnected brand maps representing new market entrants with less well-developed brand associations.

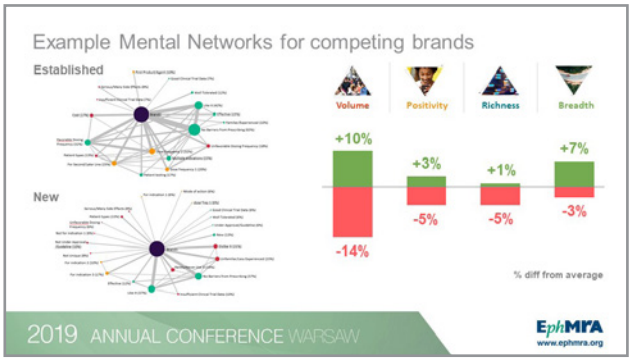


Neil developed this idea, showing how the automated detection of themes can support the development of simple indicators of brand health.

Neil described how the original research had been extended to 10 healthcare tracker studies, and also applied to voice-recorded unstructured responses. From this analysis, Ipsos identified four metrics which can summarise how rich, dense and connected are the identified themes for each brand:

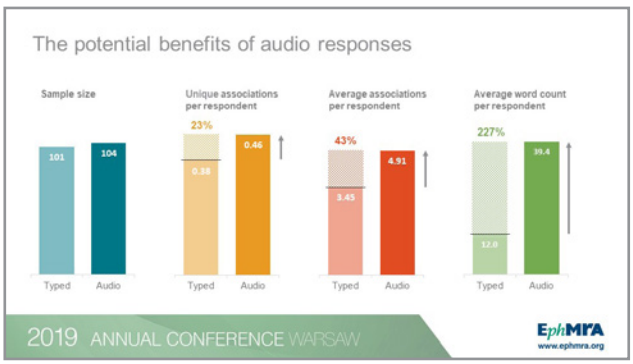
- Two respondent-level metrics:
  - Volume: how many different coded themed responses are generated per respondent for a brand
  - Positivity: the number of associations which are positive vs negative. In meta-analysis, Neil mentioned that, of all the metrics, this measure often correlates most highly with traditional attitudinal and behavioural measures of brand performance
- Two aggregated metrics (based on the whole sample):
  - Richness: the density of the codes across the network, showing the relative volume of unique associations for the brand and a measure of the opportunity for the brand to be brought top of mind by connections acting as triggers
  - Breadth: the spread in volume of information there was for each brand, showing whether a small number of respondents knew a lot about the brand, vs consistently high associations across the sample

Neil showed how the generated KPIs showed differentiation between brands, which support the understanding of the health of brands. He demonstrated how a new and established brand could differ in terms of these KPIs, allowing brand needs to be understood and depicted.



This useful diagnostic information about the brand, Neil explains, would not be available from pre-coded data alone.

Finally, Neil described the extension of the approach to analysis of voice data. A split sample was used to compare online typing vs recorded speech. This showed that audio responses increased the complexity and richness of information, allowing a greater number of associations and unique associations per respondent



However, Neil used a second study to highlight the importance of context in determining the suitability of a typed vs audio approach to data collection. In this study with retail opticians / oculists survey completion times were longer for audio vs typed responses and the mean number of words per respondent was only slightly higher for audio responses, while the mean number of codes per respondent showed no benefit. Closer scrutiny revealed the reason for the issue: this second study involved eyecare professionals who were completing the survey in-between attending to customers in their clinic or shop. In this setting, the typed response was an easier format which enabled them to pause and resume the survey as required, whereas the recorded voice response was far less convenient.

Neil concluded by encouraging us to think beyond pre-coded attributes and ratings in tracking surveys, acknowledging that they are important, but that automated analysis of unstructured data can provide additional valuable insight about brand health.

He urged us to explore opportunities to work with voice data to capitalise on the huge potential for richer content and improved survey engagement, but to be cautious of using innovation for innovation's sake, looking carefully at the context and remembering that "new" does not always mean "better".

Written by: Mike Pepp, Blueprint Partnership

Wednesday 26 June

Parallel Session 11

Augmenting Healthcare with AI: more intelligence, less artificial

Speaker:
Sharon Paik, Cognitive Consulting
& Candace Anderson, Radius Health

Chair:
Dennis Engelke,
Jazz Pharmaceuticals

Sharon and Candace's paper described how AI can be applied to improve healthcare management, with two case studies demonstrating how the theory can be put into practice.

They opened the paper with a videoclip explaining how high-powered computing using machine learning can improve health outcomes to save patient lives – and thereby saving healthcare costs. Computers can now identify anomalies within data, identifying unique insights and making suggestions or solving problems at rates comparable with human accuracy. Within healthcare, this facilitates targeted healthcare management.

The video noted that a wide range of rich datasets are important for developing intelligent algorithms for effective outcomes, from the patient genome to social media data. AI has already made a mark in healthcare via applications as diverse as disease identification and diagnosis, personalised treatment, smart electronic health records, behavioural modifications, drug discovery, clinical trial research and epidemic outbreak prediction.

A healthcare revolution is underway, states the video narrator. "Welcome to the new normal"!

Sharon provided a brief introduction to machine learning, a subset within AI, explaining that it is an algorithm focused on finding data patterns to make predictions. She noted that when people think of AI they tend to think of robots, but machine learning is essentially data-driven automation.

In healthcare, she explained, we use machine learning to improve accuracy, reduce medication errors, personalise precision medicine and optimise hospital processes, amongst other applications.

Taking improved predictions as an example, Sharon explained how AI uses a method called deep learning to take learned data and connections from machine learning to create an artificial, brain-like, neural network. This complex network maps out millions of connections to enable behavioural predictions.

Sharon outlined the progress that has been made in deep learning, from the descriptive state ("what happened?"), diagnostic ("why did it happen?") through to predictive ("what will happen?") and finally prescriptive ("how to make it happen") as the application moved from hindsight through insight to foresight.

Implementation of AI in healthcare is not without its challenges, however. Sharon noted that development costs can be high due to the need for high volumes of quality data. Datasets are often of different types and structures, leading to challenges in integration. In today's world of data privacy and security sensitivity, compliance with international regulations can also be challenging, such as addressing the different layers of regulation when collecting European data from the USA.

Sharon then shared a case study demonstrating the application of AI in improving outcomes in stroke – a condition that in 2017 alone affected more than 500 million people and cost more than $689 billion in medical expenses. The objective of the study was to look at factors affecting stroke prognosis and see if the team could identify those patients most at risk of stroke to see if they could reduce disease mortality. The analysis showed that machine learning was 20% better at assessing risk than the gold standard LACE Risk Score.

Machine learning was used at three points in the stroke patient journey:

Point 1: Early detection

Sharon explained that in 85% of cases, stroke is caused by a thrombus resulting in cerebral infarction. Early stroke symptoms are variable and not well known, resulting in few patients receiving timely treatment. Machine learning was implemented as a detection tool to recognise specific human activity and stroke symptoms in specific patterns that provided early warning signs of stroke. Use of laboratory test values and imaging from MRI and CT via patient records identified risk patients, and a stroke warning could be generated and sent to the treating physician.

Point 2: Treatment

Machine learning was used to predict and analyse performance of stroke treatment to identify which medications would give the best patient outcomes.

Sharon explained the critical step of emergency treatment with IV thrombolysis (tissue plasminogen activators or "clot-busters") and their impact on prognosis and survival rates. Machine learning was used to predict whether patients receiving tPA treatment would develop symptomatic intracranial haemorrhage. This was done using historic data on patients and the performance of these drugs, with a model using 56 different variables and 3 decision layers to predict outcomes.

Point 3: Monitoring and follow-up

Machine learning was also applied to improving prediction performance – specifically, predicting future stroke events. Physiological data was compiled from over 100 patients during the 48 hours following stroke. Supervised learning was used to predict readmissions or future stroke with high accuracy regarding severity, level of cognitive impairment and course of recovery.

Candace then shared a second case study showcasing continuous tracking in osteoporosis.

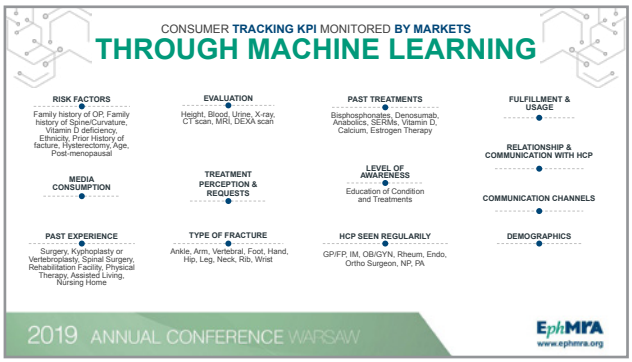
Osteoporosis, she explained, represented a large unmet need, affecting over 200 million people worldwide including around 30% of all postmenopausal women in the USA and Europe.

A major risk factor for osteoporosis is an initial fragility fracture, which increases the risk of a future fracture by 86%. It is therefore very important to identify patients who are at increasing risk of osteoporosis to aid early detection, diagnosis and preventative treatment.

Demographic and clinical factors from a consumer ATU study were used to look at KPIs – traditionally used to look at past performance but adapted here to anticipate future performance to produce continuous data.

This was done by looking at fragility fractures, osteopenia and osteoporosis, collecting patient data over 2 years for target patients with undiagnosed and diagnosed hip, vertebral and wrist fragility fractures.

Deep learning neural networks were developed to look at risk factors such as age of onset of menopause, family history or Vitamin D deficiency, as well as past experience of surgery, interactions with HCPs and demographics.



The outcomes allowed the team to identify the risk factors predictive of patients who were becoming "high risk", to trigger a patient intervention to prevent osteoporosis fractures.

Sharon concluded with key takeaways, highlighting that AI is accessible and available to use now. As a powerful computing tool, applications for AI in healthcare are endless, with some outputs being awe-inspiring, while others are simply about efficiently scaling data analysis with optimal velocity. Sharon urged us not to be daunted by AI, but to consider it just another way to look at data.

She left us with 5 key facts to remember about AI:

- AI isn't new – it began in the 1950s with the advent of new general-purpose computers
- AI is an application, not an end in itself – it is computer software and hardware that allows machines to perform tasks that mimic human intelligence and perception using machine learning, deep learning, natural language processing and computer vision
- AI needs emotional intelligence – crucially, AI is high IQ but low EQ. Therefore, the pairing of human and machine achieves the best results
- AI is not as smart as you fear – outputs are only as good as the data you input. Ai can process massive amounts of data and draw conclusions about it, but this complements human decision-making, not replaces it
- AI can be used by everyone – AI is not just for large companies like Google, Apple or Microsoft – AI is being used every day via open source AI development tools that are available to everyone

She urged us all to get involved!

Thursday 27 June

Plenary 4

The Promising Future of Business Intelligence within the Pharmaceutical Industry

Speaker:
Ana Perez,
Abbvie

Chair:
Letizia Leprini,
Bayer Pharmaceuticals

Ana presented the results of her recent survey completed by 95 EphMRA members, describing expectations of how our industry will change in the future.

Ana first reminded us of the current industry landscape, characterised by continuous change and evolution. She noted the increasing costs of medicines, citing the UK's National Health Service which has seen an average increase of 5% per year since 2010 – substantially higher than for the total NHS budget due to the increase in new therapeutics at high cost. More broadly, she explained, our industry is experiencing greater budget constraints alongside increasing costs, with GDPR changing the way we work and market access proving an increasing challenge.

Within Business Intelligence itself, we are all too familiar with reducing budgets, smaller teams, and less time to analyse more data. We need innovation to produce impactful insights required to drive key business decisions, Ana states.

The changing industry landscape leads to uncertainty, and Ana describes her "inevitable thoughts", such as Will I still have a job? Will I enjoy my job? How can I cope with the increased workload? How can I continue my professional development and move forward? Although we may all recognise the characteristics of our changing industry, do we have a common view of we envisage the future of Business Intelligence?

Ana conducted a survey amongst EphMRA members to find out.

Ana designed a survey asking, "What is the future for Business Intelligence?" and invited all EphMRA members to respond. The response rate was positive, with n=95 respondents overall, n=38 of whom were from industry and n=57 from agency companies. Ana shared an overview of demographics, showing that the sample included a mix of agency size and pharma size, with the majority of respondents in global roles, but around a fifth from each of regional and local positions.

Ana confirmed that most responses were very consistent between agency and industry respondents

The key BI challenges identified in the survey were dominated, perhaps unsurprisingly, by budget/resource constraints (38% of respondents) but demonstrating the impact to the business was also a key challenge identified by 31% of respondents. Challenges of breaking out of silos and working as a team also figured largely.

The key question of "How will the BI role change?" elicited a full range of answers, with the majority (55% of respondents) believing that there would be only a slight change. The remaining respondents were divided between believing our role would completely change (24%), no change (20%) or were not sure (19%).

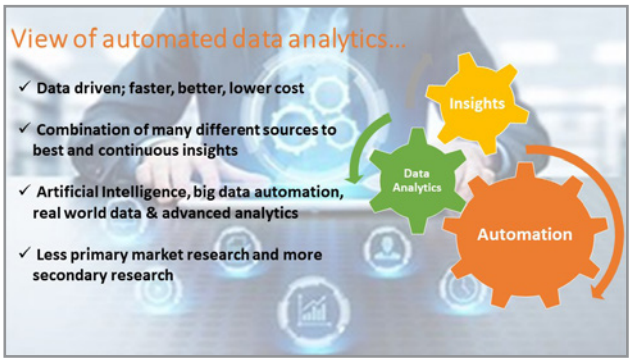
Predictions of how and what would change within the industry demonstrated a slightly different focus between agency and industry members, with agency members highlighting increased use of secondary data (including Big Data) at the expense of quantitative Primary Market Research, although qualitative PMR was still expected to account for a significant proportion of agency business. They also anticipated a move to more inhouse work compared with outsourced consultative work, despite the expected reduction in team size.

Industry respondents focused on greater integration with other departments and better alignment with Global teams, with perhaps a reduction in local projects. They were expecting to see a greater digital focus, with increased automation and use of predictive analytics. They did, however, echo their agency colleagues in predicting smaller teams and a consequently higher focus on insight generation.

Ana picked out integration as a key issue, with respondents anticipating greater integration within the pharma business to encompass market research, forecasting & analysis, competitive intelligence, digital solutions and planning & strategy.

Similarly, she summarised the potential role of automated advanced analytics, where respondents had predicted an increase in data-driven insights including Big Data automation and advanced analytics within AI.

Respondents were asked which new technologies were expected to impact the future of BI. Ana reported that AI was mentioned by over a third of respondents, with Big Data close behind. The integration of health and social media or personal data was mentioned by over a fifth of respondents.



Agency respondents were asked how technologies would impact on their businesses. A broad range of responses corroborated findings from other questions, such as the increase in qualitative / decrease in quantitative research and the greater use of analytics to understand new datasets and support traditional market research. The technology was also expected to drive faster results and quicker generation of insights. Notably, the skill set mix required to adapt to agency requirements was expected to change, with a need to step further towards commercial decision-making in a more strategic boardroom-style role.

Summarising the findings, Ana described the potential disconnect between the expected integration of different departments or specialties versus the new technologies which might suggest greater specialisation. She concluded that our industry will need people who understand both sides and can pull things together to work more efficiently and provide more impactful insights. Our skill set as BI professionals, she suggests, will change accordingly.

Ana drew four main conclusions from the study:

- BI teams will definitely change, with greater integration of BI with other departments within the business being key to ensure holistic insights and partnership with senior management
- The introduction of new technologies will change BI and the partner relationship with agencies
- The agencies will have an opportunity to develop a competitive advantage on understanding the new technologies and their application ahead of the industry. This will allow them to offer diverse services and more consultative work to the industry utilising advanced predictive and prescriptive analytics. This work has already started on some of the big players within the market research agencies.
- The introduction of new technologies will open opportunities for BI and agencies to understand customer and patients' behaviours as have never been done before with the possibility to predict future behaviour. Although the interpretation will require an up skilling from both agency and industry to understand data outcomes and smartly incorporate the emotional side of the analysis to it. One of the top 10 pharmaceuticals has already partnered with Google to utilise the most advanced technologies to better understand patients' behaviours and achieve best outcomes for patients and drug manufacturers.
- The availability of new technologies and the knowledge needed to integrate them into our businesses will provide an opportunity to develop our skill sets, but Ana reminds us that, despite the increasing application of technology, humans will always be needed to produce strategic insights.

She ended with a quote from Steve Droke, emphasising that knowledge is power only when it is applied, and human soft skills are required to develop true insight.

> "Knowledge is power, and enthusiasm pulls the switch".

Following Ana's presentation, there was a lively panel and audience discussion to discuss the future of the industry. The panel comprised Richard Hinde, Norgine; Karsten Trautmann, EphMRA President & Merck KGaA; Nicola Friend, Astra Zeneca and Ana Perez, Abbvie. The discussion was facilitated by Letizia Leprini, Bayer Pharmaceuticals.

Thursday 27 June

Plenary 5

Powering seldom-heard patients to tackle inequalities: Lessons from people living with cancer

Facilitators:
Dr Marie-Claude Gervais - Versiti
& Shae Eccleston, Patient

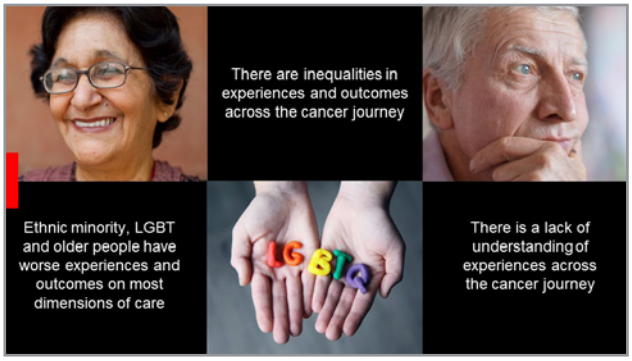
Chair:
Xierong Liu,
Ipsos Healthcare

Marie-Claude and Shae presented an insightful, sensational and highly personal case study exploring how seldom-heard patients with cancer can experience health inequality, and how listening carefully to these patients can help to improve healthcare services for all.

Marie-Claude set out a sobering description of how patients with cancer from seldom-heard groups can experience health inequality along their cancer journey. Acknowledging the advantages of patient empowerment and patient-centric care that had been discussed over the course of the conference, Marie-Claude explained that these advantages are not available to all patients.

She explained that healthcare services in society in general tend to be based around the needs and aspirations of the majority population, but that seldom-heard patients, whose needs may be quite specific, benefit at a slower rate from advances in treatment and services.

Ethnic minority, LGBT and older (65+) cancer patients on average have worse experiences and outcomes across most dimensions of the cancer journey, Marie-Claude explained. She outlined some of the key characteristics of these seldom-heard groups, including poorer health status with more co-morbidities, lower awareness and knowledge of cancer and its risk factors, more limited access to appropriate health services and discrimination in the healthcare system itself, all of which leads to lower satisfaction with healthcare and poorer patient outcomes.



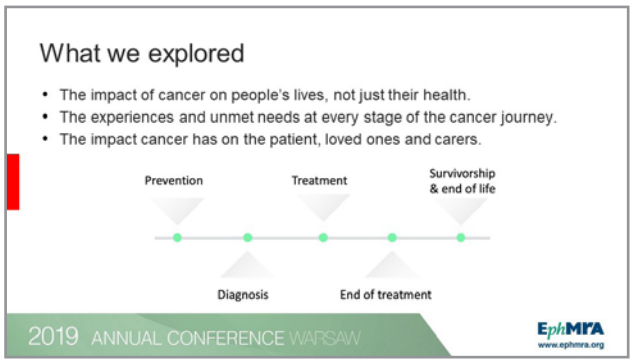
These patient types tend to be under-represented in clinical trials, social and market research, resulting in their needs and experiences being less well understood and catered for than those of "mainstream" people living with cancer.

In the case study presented, Versiti was commissioned by a large cancer charity to explore why such health inequality exists. The study design was subjected to a robust independent evaluation which reviewed the quality of recruitment and engagement, the approach and processes of the study itself, the quality of the evidence and insight and the benefits to participants as a result of the research process – as well as value for money.

The study was designed to engage participants in an online research community over a 2-month period, and involved 21 LGBT, 19 ethnic minority, and 50 older people living with cancer, as well as 24 professionals working in healthcare, including academics, diversity specialists and cancer specialists.

The in-depth and interactive qualitative approach involved 70 different research activities taking place in an online community, facilitated by 4 researchers whose role was to moderate, facilitate and analyse the contributions of all participants.

The study explored the impact of cancer on the health and day-to-day lives of patients and people around them, at every stage of the cancer journey from prevention through diagnosis, treatment, end of treatment to survivorship or end of life.



Marie-Claude described examples of activities included in the study, such as composing a diary entry for their day of diagnosis, the impact of cancer on multiple dimensions from spirituality to finance, projective techniques involving the Blob Tree to describe how they were feeling at different points in the journey, and rehearsing a conversation they would like to have with their HCP if there was no time limit.

The study confirmed that inequalities were often a result of deprivation from over-stretched healthcare services (with consequent reduction in time spent with HCPs, delays in access to specialised services and referrals which in turn led to suboptimal treatment), poverty and individual financial challenges (such as reliance on public transport reducing appointment attendance and being unable to afford respite, support or "little luxuries").

Cultural factors also played a role for some patient groups, notably black, Asian and other minority ethnic populations, with stigma and misconceptions around cancer influencing awareness, knowledge, uptake of routine screening and willingness to seek support. Other factors that impacted the patient experience included the greater reliance on spirituality, deference to doctors (especially amongst older people who were less likely to challenge their physician or seek a second opinion) or mistrust of the medical profession (such as LGBT groups).

Other health-related factors were also seen to impact on the cancer experience, including poorer health status, increased co-morbidities and increased mental health issues all being more prevalent in these populations. Marie-Claude described how the study had also found that healthcare professionals may lack the training and awareness to adapt their treatment approach or service design to the specific needs of the seldom-heard groups, and that in some cases there were "assumptions" being made which amounted to a degree of discrimination.

Marie-Claude then introduced us to Shae Eccleston: a young, black woman with a rare cancer, whose willingness to take part in the original study had helped to shape the insight derived from the study, and whose willingness to speak to our EphMRA conference delegates helped us all to form a greater understanding of seldom-heard groups.

Shae introduced herself, explaining that despite her already complex medical history, prior to her cancer diagnosis, she had been a professional with her own business, as well as a "typical" person just like any of the delegates in the room. Once diagnosed, she repeatedly experienced situations where she felt like the exception to the rule or felt as if she was facing barriers due to her age, ethnicity or personal circumstances. She was conditioned, she explained, to believe that she was the problem.

Shae described her initial reluctance to take part in the research, explaining that her previous experiences of helping with such activities had led to despondency when no tangible change was in evidence consequently.

Shae's initial responses in the research were short, and her contribution minimal, as she assumed that, as "the exception to the rule", this would meet the needs of the study but that the outcomes would not be relevant to her directly.

However, the empathy, skill and compassion of the research team enabled them to pick up on her reluctance, and the facilitator would offer reassurance, ask what she thought about her answer or how it made her feel. The lack of time pressure and genuine personal interest shown by the facilitators helped to build trust and she was placed in a safe space and was truly able to share what it was like to be Shae – the one they wanted to hear from. For the first time, Shae felt listened to and heard.

The characteristics of this study made participation convenient – she could participate from home, in her own time, via the internet, over several weeks and could complete each task at her leisure. This approach removed the potential barriers as a result of financial issues and other health problems including depression, which might have prevented her participation.

With personal examples, Shae described how the existing services were often unsuitable for her. As part of religious observance, she avoids pork and shellfish, meaning that every pack of medication she was offered had to be examined closely to determine if she could accept it. She needed to explain why it was not suitable, which was often met with resistance from healthcare professionals.

Her experience of the healthcare system repeatedly failing her with respect to her other co-morbidities impacted her trust in the system, where she had been seen as a "hypochondriac". Confidence and anxiety issues compounded the barriers of age and race and further impacted her experience.

Once diagnosed, she was unable to work, and during the consequent difficulties she found that there was inadequate support available to her.

Shae described her personal learnings as a result of participation in the study. She discovered that seldom-heard people may not be aware that they are seldom-heard, as their priority is surviving the current experience, rather than reflecting on diversity or how a different approach might be more appropriate for her.

As a result of participation in the study, Shae experienced a transformation which extended beyond the study to her interactions with her own doctors (with whom she felt more confident and able to challenge) and led her to become actively involved in patient advocacy and contributing her experience to help with service design, as well as personal achievements such as running her own business and writing books.

Marie-Claude then drew the treads of the case study together, asking us as an industry "what shall we do differently?". As food for thought, before opening the floor to questions, Marie-Claude's suggestions included a focus on health inequalities, "diversity-proofing" all healthcare services through training for HCPs to raise awareness of different patterns and needs, redesigning services as appropriate, and ultimately mitigating negative impacts of potential inequalities in our current healthcare systems. For the pharma industry in particular, she urged us to think about how we invite people for clinical trials, tailoring our communications to ensure everyone receives the same opportunities, and supporting more community-based programmes for seldom-heard groups. Finally, we should all spend a moment to reflect upon the way in which we conduct clinical, social and market research and the potential impact it has on people's lives.

Written by: Xierong Liu, Ipsos Healthcare

Thursday 27 June

Plenary 6

Not Fade Away: How immersive technology and ethnography allows consumer empathy to survive organisational change

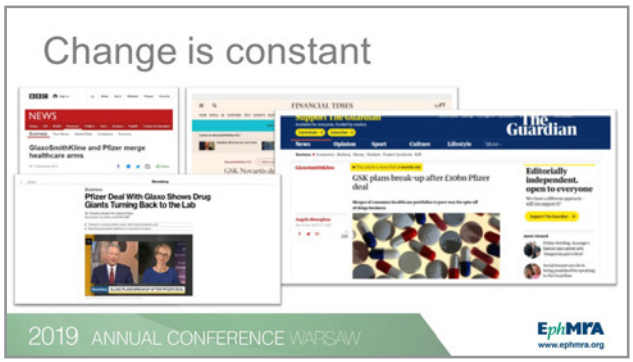
Speaker:
Nick Leon, Naked Eye Research
& Mark Manning, GSK

Chair:
Carolyn Chamberlain,
Purdie Pascoe

Nick Leon and Mark Manning delivered an engaging and memorable paper demonstrating how immersive technology and ethnography can help research insights to survive beyond the current project team and provide a toolkit for onboarding new team members. They presented a version of this paper at ESOMAR but this presentation built on their paper – offering greater insights for the audience to gain value from.

Mark, who is no stranger to the uncertainties of organisational change, set the context by highlighting the changes within his own organisation, GSK, especially in the Consumer Health area with the joint venture Pfizer and GSK. Within this changing landscape, few employees are confident that they will be in the same job in six months' time. Despite this personal uncertainly, the mission of the business remains the same: to innovate, service people's needs and ensure that the organisation keeps learning and progressing. Our priority as insight generators, they explain, is therefore to ensure that our research is going to live beyond the current organisational structure and remain relevant, memorable and actionable in the future.

Most research outputs, Mark notes, rely on datasets and PowerPoint decks – both of which are very useful and very necessary. However, he observes, data is not generally discussed and remembered once the researcher leaves the room and even less so when the current team has moved on. We need to bring to life the stories and human experience behind the data in ways that are interesting and memorable so that the insight lives and breathes inside the business and can be revisited in the future, no matter what the organisational structure.



Building capacity to learn and engage with research from the outset of the design phase can help us create impact and help future users to understand and act upon our insights.

Mark introduced an example from GSK where the use of immersive technology and Google Cardboard glasses enabled the whole team to listen to insights, follow journey maps and quickly understand the consumer perspective and the implications for the business. As well as the more traditional discussions and workshops to discuss the data, the research outputs were designed so that anyone walking into the business could pick up a pack (containing the slide deck, films, and immersive headsets) and quickly become immersed and engaged with the business context. This approach served to get people excited and to hold better conversations with colleagues, building on the learning to help the business move forwards ever-more quickly.

Nick then talked about the specifics of the project and its challenges. The project objectives were to understand the market landscape for symptomatic 'flu remedies to identify commercial opportunities to guide R&D'. With a focus on emerging markets, GSK colleagues based in offices in structured environments such as Switzerland or Singapore needed to be able to understand the specific challenges of the local market setting.

Using immersive technology (including drones) and ethnography, the project team was able to gather new perspectives of peoples' lives in emerging cities such as Lagos and Jakarta where the rapidly expanding middle classes are creating a new target market about which the company knew relatively little. The business needed to understand the realities of managing 'flu and fever at home "on the go", including the touchpoints and role of healthcare professionals, family members and the local community including lifestyles and cultural traditions which might be as varies as using smartphone apps to communicate with the family doctor or visiting herbalists to make traditional remedies.

The ethnographical approach revealed very early on in the study that people in Lagos (Nigeria) work long, hard hours, with their entrepreneurial culture limiting their willingness to take a day off with fever – they needed fast results from a 'flu' medication.

Immersion in the local environment revealed that the city itself had a significant impact on health, with the fast pace, long hours, unimaginable traffic, environmental toxins such as pollution heat and dust, and limited availability of non-contaminated food all contributing to the daily grind, and taking a toll on the immune system and energy levels. Close observation of people's homes revealed that the drainage ditches harbour malaria in the rainy season, and with some people suffering from malaria 4-5 times per year, the client's medication was sometimes taken to relive malaria fever symptoms. This was new insight for the client.

Nick needed the team to understand this "mega context" and understand exactly what fast city life looked like in Lagos. He created the first insight: "Speed", where drone footage of the city helped to give a sense of reality to the context of how people live, dramatizing the feedback and helping to piece together a comprehensive picture of the local reality. Speed to recovery matters massively in Lagos, he explained, and the immersive approach helped to demonstrate this insight in a way that other data couldn't achieve.

Nick created a short film showing the work "behind the scenes". The film was used internally as a communications piece to create awareness of the project and engage colleagues before they attended the planned workshop, enabling people to get excited about what they were going to see and preparing them for participation in an active presentation.

Nick described how 360 immersion facilitates memory by using sensory immersion to allow colleagues to step into the shoes, hearts and minds of the people they serve. Through this technology, they were able to go on home tours, visit doctors' surgeries and local pharmacies, as well as step into people's kitchens and watch while a mother made traditional herbal remedies. Films gave colleagues a view of people going about their daily chores and highlighting key business insights such as the proximity of pharmacies stocking global brands next to street hawkers selling counterfeited and traditional medicines.

The result, Nick explained, was more engagement and better understanding of the world, with research that everybody wanted to talk about.

In a different project for GSK, the team had used a new narrative to tell people's stories. Nick described a technical "embodiment" in Lupus: an approach that enabled the project team to stand in the patient's shoes and look at their world, adding emotional significance to things that can be abstract to explain, and building empathy which makes the memory even stronger.

They were able to show the patient perspective on living with pain; memory loss experienced with Lupus; and even the impact of a flare where the patient was restricted to a view only of the ceiling for a period of two weeks. This was storytelling in a very different way.

As well as the impact of immersive approaches to engagement and memory of the current team, Nick described additional benefits of being able to repurpose and apply the insights to other situations. The Lupus work was showcased at the New Scientist Exhibition in London, allowing a whole new audience to access the film and to widen the discussion of the insight, giving it a life of its own to live on beyond the confines of the original project.

Our speakers concluded by emphasising that where all research needs to be engaging and actionable, it also needs to be memorable. They urged us to design for that experience, creating talking points and amplifying the big issues, allowing the research to survive and seeking opportunities to repurpose the insight for future use in training, at symposia or leadership events.

They left us with the challenge of how to design our research in order to keep better conversations going once we have left the room. Our research should "re-return, not fade away", no matter what the shape of the future organisation.

Written by: Carolyn Chamberlain, Purdie Pascoe

Thursday 27 June

Parallel Session 12

The Future of Research Debriefs - Immersive, story-led outputs that inspire action

Speaker:
Soumya Roy & Georgina Cooper,
Basis Health

Chair:
Letizia Leprini,
Bayer Pharmaceuticals

Soumya Roy and Georgina Cooper presented an inspiring paper on the future of research debriefs, describing with the aid of case studies and real client feedback, how immersive, story-led outputs can inspire action.

In this section of the conference dedicated to future trends, our presenters described a trend that they expect to gain more and more importance in the future: a move away from PowerPoint-centred research debriefs and towards immersive, action-led debrief "experiences".

Our presenters first reviewed the importance of storytelling in the market research industry. The presenters discussed how Insights agencies need to become experts at distilling insights from multiple information sources, and to go beyond making sense of the data and start to tell compelling stories which engage the audience emotionally and inspire action.

Using real stories, creatively told, their paper provided three examples of where storytelling and immersive debrief experiences has inspired action and led to a tangible business impact.

The first case study described how "boring" tracker data was presented on an iPhone using an interactive game to ensure the results were firmly embedded within the organisation.

The second case study described a solution to a different kind of storytelling challenge, the need to ensure that the outputs from a patient quantitative segmentation study were brought to life and led to action within an organisation.

Outputs from quantitative studies such as this are often not fully embedded within the business, as a result Basis designed a "research theatre" video portrayal of the segments which was an experience that fully immersed the client in the findings and brought the patient segments to life.

Our speakers' final case study demonstrated how the use of virtual reality video can immerse clients in the patient journey and enable them to both feel and understand moments of truth. Due to the practicalities of providing a VR experience to all delegates, our speakers had produced a video simulation in which a patient had undergone an MRI scanning procedure. They urged us to consider the extent to which we were able to "feel" the patient experience via outputs communicated in this way, and therefore more likely to act, in comparison to a standard PowerPoint presentation.

Our speakers summarised a set of actionable hints and tips for immersive, story-led outputs.

- These three case studies provide real examples of how we can make sense of data and tell the story in a way that allows full client immersion and inspires them to take action
- Impactful storytelling needs to be included as a step in the research process, with corresponding resources (both time and skill)
- Continually challenge that status quo – are PowerPoint debriefs always the best way to communicate our messages or can we do things differently to ensure we achieve our clients' objectives?
- We need to ensure immersive and active audience participation to stimulate discussion and drive change
- Avoid technology for technology's sake – there may be non-technological solutions that deliver impact (such as the immersive theatre experience)
- One size does not fit all. Keep client objectives in mind and tailor solutions to achieve them, rather than running a standard approach to all projects

Soumya and Georgina concluded by noting that today's trend if for insights agencies to become experts at sense-making and storytelling to immerse customers in engaging narrative that ignites an emotional, not just rational, reaction, ensuring that our insights "stick" in clients' minds and inspires action.

Thursday 27 June

Parallel Session 14

Agile Research: Buzzword or Game-Changer?

Speaker:
Tim Dungey, M3 Global Research
& Paula Coyle, Research Partnership

Chair:
Amr Khalil,
Ripple International

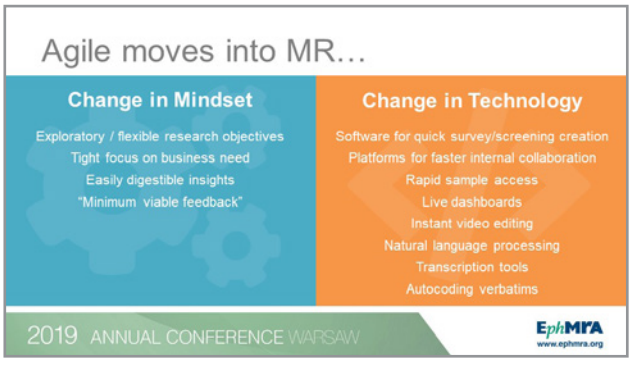
Tim and Paula presented a fascinating overview of Agile Research, explaining what it is and describing a case study that compared Agile with traditional research to help them answer the question "Is Agile a buzzword or a game-changer?".

Tim first explained the background to Agile research, from its inception at a conference of software developers in 2001 to the present day. Despite its almost two-decade existence, there is still little consensus about the definitions of Agile. It was designed, he explained, as a solution to the challenge of the new disruptive digital technology in the online era, within which software developers were finding their place. This group of competitor developers came together to launch the Agile Manifesto – a collective pledge for a new way of working to embrace a new era.

Tim outlined Agile's four key principles:

- Instead of talking about processes and tools, talk about individuals and interactions
- Instead of comprehensive documentation, the outputs would be working software
- Instead of negotiating contracts with clients, they would collaborate with customers
- Instead of having a set plan, they would respond to changes happening around them

Agile quickly spread to other sectors, including market research, within which some developments in technology helped to facilitate the Agile cause (such as DIY survey programming, online panels for quick survey sample access, live dashboards and tools to make sense of large datasets such as natural language processing and auto coding verbatims. More than a change in tools, Agile required a change in mindset from a position of fixed research objectives to being able to adapt research objectives as you go along, and trading excess data for bite-sized insights "on the go".



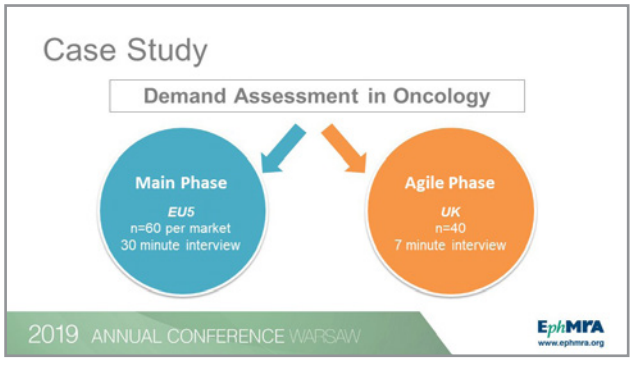
Tim described the concept of "minimal viable feedback" – born from the "minimal viable product", but applied to research to mean starting with a basic business insight and then allowing the reactions to those insights to guide the direction of future research.

Tim noted that the perception of Agile is that it is simply very quick. However, he emphasises the key characteristic of Agile as being "nimble" – changing direction as you go along, taking learning from each insight and then deciding how to proceed.

In healthcare, Tim and Paula report an increasing level of interest and discussion about Agile, both within research agencies and amongst pharma clients. Paula reports regularly receiving requests from clients to demonstrate her Agile approaches and applications. So how can it be used within healthcare?

Tim outlined the use of Agile in gauging consumer understanding of new products and services as they are being developed; exploratory conversations with customers to help build proposals, testing brand names or promotional messages and refining each draft with input from the real world; and real-time feedback on issues requiring quick reactions, such as competitor launches.

Paula then shared a case study that combined a traditional and Agile market research approach. An Agile online survey (5-7 minutes) was conducted in parallel with a full piece of traditional product profile testing (30 minutes) to explore demand for a new product and a likely new competitor. The main study was conducted across the EU5, whereas the Agile study utilised a smaller sample size in the UK only.



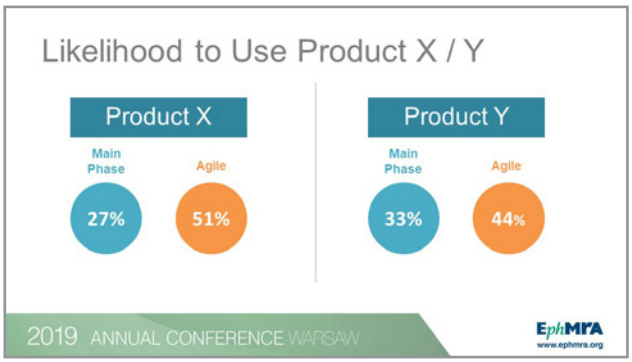
Paula described the findings and how the methodologies compared.

Addressing the common perception that Agile research is simply faster, Paula confirmed that it was in fact quicker to achieve the target sample, with set up and fieldwork being 7-8 days compared with 20 days for the full survey.

However, other comparisons were equally relevant and interesting.

Looking at "likelihood of use", results were similar for each product in each sample arm, but did show marked differences between the agile arm and the traditional arm. The agile arm saw over-inflated figures, which Paula hypothesized, as being due to less detailed questioning requiring less detailed consideration by physicians.

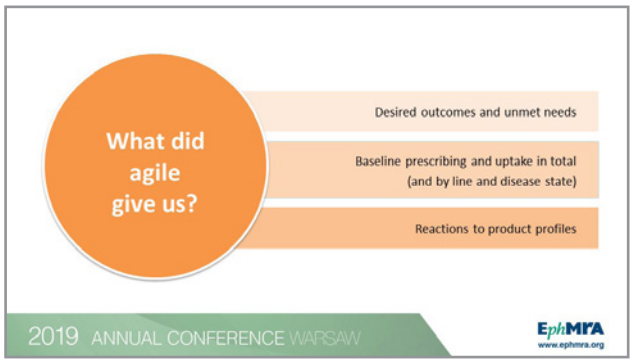
Market share, however, was almost identical for both products between the two sample arms. Paula noted that market share is a likely parameter for "minimal viable feedback" – the figure that would be required as quickly as possible in order to feed into a product forecast.



Drivers of prescribing also showed little difference between the two methodologies, which gave additional confidence in the methodology.

Paula reviewed the benefits of the full research arm, which included the additional time to include background questions which provided valuable context for interpretation of the results, as well as desired outcomes and unmet needs which allowed correlation with key driver information. Prescribing and market share could be broken down by line of therapy and disease state, and the impact of alternatives such as endpoints, launch order and competitors could also be explored, along with a deep dive into the TPP.

The Agile arm, with its reduced survey duration, was not designed to provide as much detail. So, what DID the Agile arm deliver? As well as the quicker results, Agile delivered reactions to the product profile – open-ended as well as numerical responses – which were shown to correspond to the findings from the main arm. Good insight was obtained on potential market share and drivers for prescribing.

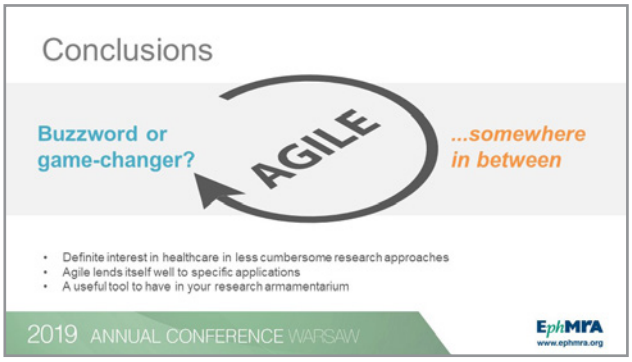


Reflecting on the comparison of Agile and traditional approaches, Paula noted the benefits, which included not only faster results but more frequent insights due to the iterative nature of the approach, but the requirement for close discussion and communication with the client which led to greater partnership.

The challenges of the Agile approach included the balance of minimal screening vs identification of the appropriate sample, and the need to think carefully about each question and how to structure them, in order to optimise each question in a time-limited survey. As noted above, the Agile approach can deliver only limited depth of insight as a result.

Paula suggests that Agile approaches can be applied to a broad range of business issues within healthcare, capitalising on the nimble insight delivery in areas such as background preparation for pitches, early BD / asset assessments, initial forecasting as part of a bigger piece of research, or obtaining reactions pre- and post- new campaigns.

Agile, however, is not without challenges in healthcare. Paula provided a sanguine caution about the challenges of approval times, noting that a saving of 3-4 days in recruitment time would not offset a 12-week approval period. However, she feels that approval times can be mitigated with forward planning, such as establishing a bank of standard, pre-approved questions which could be fed into the Agile process over iterations, or a pre-approved survey structure which could then be used across multiple brands or therapy areas.



Tim concluded by returning to the original question: Is Agile a buzzword or game-changer?

In the view of our speakers, it lies somewhere in-between. There is a definite interest in Agile approaches in healthcare as clients seek a less cumbersome research approach using a digital solution, where Agile can clearly perform more nimbly than traditional approaches. However, Tim does not believe that Agile research will cause the same level of disruption within healthcare as it has brought to other sectors, such as software development.

In specific applications, he believes, Agile is a very powerful tool, enabling some clients to conduct research where previously it was not possible. He believes that it is a valuable addition to the armamentarium of research approached and urges us all to embrace it and get prepared – if a need for Agile research arises, we will need to be ready to move very quickly!

Written by: Amr Khalil, Ripple International

Thursday 27 June

Parallel Session 15

Beyond Behavioural Economics: A fully integrated view of behavioural drivers

Speaker:
Peter Simpson,
Segmedica

Chair:
Viv Farr,
Narrative Health

Peter's paper described how a one-dimensional view of brain science and decision-making may not provide us with the whole picture. By going beyond Behavioural Science, and integrating psychology, neuroscience, sociology, anthropology and linguistic analysis to our business problems, we can uncover deeper insight and identify effective communication routes tailored to our customers.

Peter's paper was based upon three central propositions:

- We cannot fully analyse market research responses unless we know something of the psyche of the respondent:

  Peter believes that psycho-profiling every respondent often gives a very different view of the results

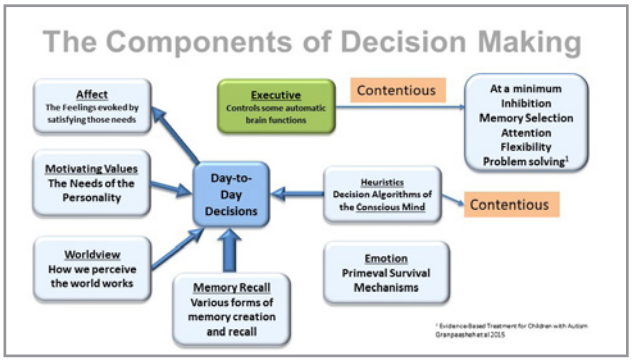
- People react according to who they are, not according to what they treat or what condition they have:

  Peter's approach is underpinned by the proposition that people's reactions are based on personality, and therefore an individual will react the same way to type two diabetes as to terminal cancer, although clearly the context will be very different and needs to be understood

- We have to address all aspects of decision making:

  Peter reminds us that Behavioural Economics is a very useful approach, but just one piece of the decision-making picture. He took some time to review his own view on the components of decision making, but acknowledged that there was still room for differences of opinion on the brain and how it works, reminding us that "there is a general rule that for any 2 experts, you'll get 3 opinions"!

He shared a diagram of the key components of decision making, starting with Motivating Values, which, he explained, are the unconscious needs of the personality. The Affective system is an output of day-to-day decisions, where the unconscious brain translates our decisions into effect; feeling good or bad according to how our actions support our needs.



Peter distinguishes between "attitudes" and "Worldview", explaining that Worldview is not widely discussed in research, but is a powerful driver of behaviour. He describes it as an unconscious view of the world around us, which is difficult to change, requiring great investment and patience.

Heuristics, he explained, are potentially contentious. There are 123 experimentally verified heuristics and cognitive biases contributing to decision algorithms of the conscious mind, including the set we call Behavioural Economics.

Peter explains that they are good for measuring individual decision choices (such as choosing between Product A and Product B), but that for complex, multi-faceted views, attitudes, beliefs and behaviours in healthcare, we need to consider a much broader range of influences.

Another potentially contentious component of decision making is the evolving idea of an executive semi-conscious motor which controls some automatic brain functions. Executive control has been postulated within memory selection and level of attention, which are important in decision making.

Memory Recall is a component of decision making that may prove a "wildcard", Peter explains, as the unconscious brain sets the recall hierarchy according to its survival value. For example, Peter describes how we can remember falling off a bicycle aged 5 but may forget to pack something as we leave our hotel room. Memory recall is highly idiosyncratic, based on beliefs and biases which make it difficult to predict behaviours.

Peter makes a point of separating "emotion" from the decision-making process, explaining that despite widespread preference of analysing rational and emotional drivers, the approach has been so oversimplified that the outputs have proven unhelpful.

Looking in more detail at emotions, Peter described the axes of valence (the positive or negative outcome of any situation) and arousal (the extent to which the brain is focused on the given context) which work together to result in positive or negative feelings about a situation which can be post-contextualised in examples such as "I hate you because you ran into my car". Peter cautions against trying to identify emotions generated from qualitative research based on this post-contextualisation, as more precision is required before we can use emotion to predict behaviours.

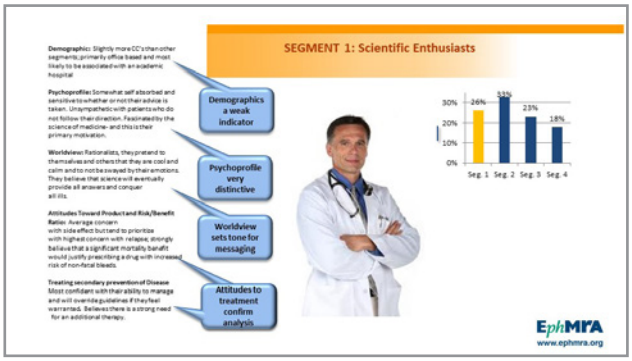
Peter described how humans take their assumptions, including Worldview, and process it through logic to inform our attitudes, beliefs and decisions. He warns us to be aware that when someone else has a different view which we may believe to be fantastical, it may not be because they are illogical nor over-emotional, but because they simply have different assumptions to us. Our motivating values and heuristics further complicate the picture. However, one of the greatest mistakes made in undertaking attitudinal segmentation, Peter explains, is to consider attitudes and beliefs to be inputs to the decision-making process, when they are actually outputs from the blend of assumptions and logic. Behaviour and experience feedback and modify our assumptions in a process we call "learning", but until our attitudes change, they are an excellent predictor of behaviour.

Peter then presented three case studies to demonstrate the benefits of an integrated view of behavioural drivers.

The first case study described a physician segmentation to position a drug in the US market.

Qualitative research was used to build rational and non-rational needs, followed by a quantitative segmentation which incorporated the needs into a choice model which formed the basis of the outputs.

Using one of the defined segments ("Scientific Enthusiasts") as an example, Peter described how demographics were a weak indicator of segment, but that the psychographics were very distinctive. The segment's Worldview was used to set the tone for messaging, and Attitudes helped to further inform the creative guidance.

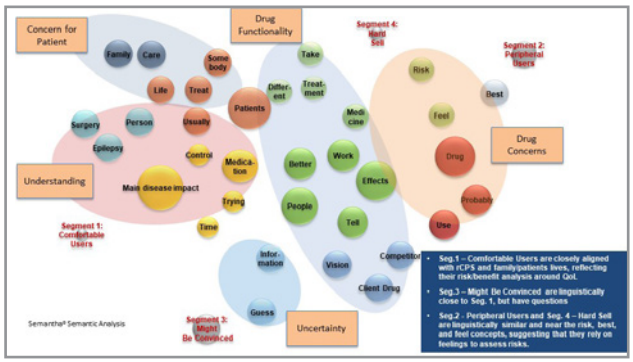


Based on the personality-based segmentation, clear and specific creative guidance was provided, enabling the client to message based on the physician's preference for factual/technical product details, a strong self-image and evaluative approach based on cohort data and statistical evidence rather than individual patient examples.

The second case study described the use of semantics and linguistic analysis via an advanced text analysis tool. The client had identified three customer segments: strong users (who used their product all the time), occasional users and strong non-users. Their strategy was to identify the occasional users and convert them to the strong user category – but it wasn't working.

The client's product was used to treat a rare condition, so the respondent sample size was limited to n=20 physicians. Peter described the task-based qualitative approach which encouraged free language, rather than shaping responses by using specific questions. An open task such as "talk to me about this disease" generated free language which was processed using a sophisticated linguistic analysis tool combining machine calculation and linguistic co-creation in a relational database.

Peter shared an example of the outputs: a perceptual map based on computer aided semantic analysis which used spot size and colour to distinguish different themes according to their intensity and frequency. Overlaying the physician segments, it was clear that Segment 1 (Strong users) had a very different profile to Segment 2 (Occasional users), and that the largest segment was the third group of "Strong Non-users", who had insufficient information about the product.



This approach enabled Peter to advise his client to focus on the "uninformed" segment, some of whom would be converted to "Strong users", rather than wasting resources trying to encourage greater use of the drug amongst the "occasional users", who, it turned out, were risk-averse and were unlikely to increase use of the drug beyond exceptional circumstances.

Use of semantic analysis in combination of psycho-profiling had enabled the client to fully understand what was going on and to reduce marketing spend whilst achieving a greater return.

Peter's final case study described a globally validated, long-standing instrument used in personality segmentation. He described 6 personality types, divided into two groups: hedonic types (prioritising themselves and their need for stimulation and risk taking) and altruistic/conservation types (prioritising other people and things, from other people to the environment).

These two groups were invited to take part in curated but unmoderated groups to explore healthy eating, with a task to design a new healthy food product or service. Not only were the suggested products from the two groups very different, but their styles of interaction and working processes were also markedly different.

Applying this approach to pharma, Peter noted the insight that could be gained into treatment regimens and compliance, amongst other issues.

Peter concluded by summarising the opportunities for the application of brain science in our industry.

Using standard personality models for segmentation can help us go deeper into human processes whilst working with smaller sample sizes to reflect the current industry focus on oncology and rare diseases. Combining personality segmentation with contextual research for each disease state or drug allows us to reduce costs and reduce the risk of a standard segmentation (whose outputs can sometimes be unexpected). Peter notes that clients have an opportunity to gain a pan-enterprise understanding of markets, as personality-based segmentations are not required for every disease area.

He concluded by urging us not to take a single element of brain science as a complete solution, but to select the appropriate tool for the job, combining brain science with a qualitative understanding of respondents' lives to improve insight and actionability.

Finally, he urged us to avoid using the word "emotion" other than in its strict scientific context!

Written by: Viv Farr, Narrative Health

Thursday 27 June

Parallel Session 16

Rising to the Challenge

Speaker:
Sam Hope, Blueprint Partnership
& Lea Kalweit, Bayer AG

Chair:
Viv Farr,
Narrative Health

Sam and Lea presented an interesting case study that explored physicians' subconscious decision-making processes and demonstrated how a simple methodology can uncover more accurate insights into physician behaviours.

Sam first set the scene with a review of how the human mind, with its subconscious prioritisations, applies unintentional biases which influence our perceptions and behaviours. Humans, she reminds us, are complex souls and don't always articulate our own behaviour very well. As moderators, our challenge is to recognise an answer that doesn't ring true, and to use techniques at our disposal to dig deeper to try to uncover the true picture behind physician responses. Probing and projective techniques, she says, go some way towards uncovering the truth, but why not involve physicians themselves in the analysis of their own behaviours? Is there a way to design research to solicit a more accurate account of what physicians actually do, rather than what they believe they do?

Lea and Sam worked together to develop an experiment to see if a new approach could overcome the impact of the physicians' unintentional biases. They decided to explore ways to challenge respondents more and took the opportunity to test their theory and its outputs.

Lea outlined the context for this particular challenge.

Bayer needed to understand the role of Cardiologist in managing a specific cardiovascular co-morbidity that was usually managed by other specialties. Patients were treated by the Cardiologist for their longstanding cardiovascular disease, but these patients often have metabolic disease and other co-morbidities, and the role of the Cardiologist in managing one of these other conditions was unclear.

Previous market research revealed that Cardiologists have both the opportunity and tools to diagnose and manage the condition, but the extent of their active role was vague and the previous research outputs were conflicting. When asked directly, Cardiologists claimed that they DID screen, diagnose, actively treat and monitor patients with this co-morbidity; yet other information sources suggested otherwise. The team needed to know what was really going on.

Sam picked up the story, describing how they discussed the potential reasons for the disconnect. Were Cardiologists unintentionally de-prioritising the co-morbidity because it fell somewhat outside of their core expertise, but were not consciously recognising this when asked directly? What other factors might be at play? They needed an approach that would reveal the truth.

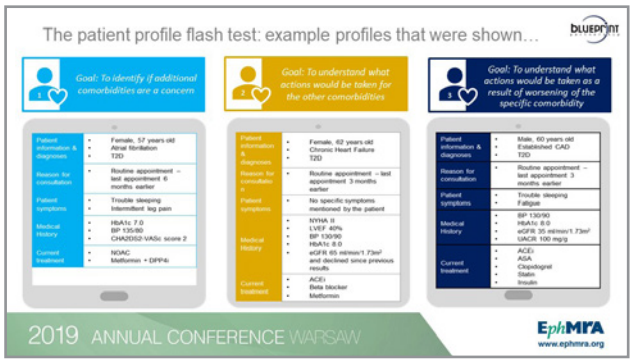
The trial approach was simple in its design. Physicians were recruited based on their role in cardiovascular disease, but without a focus on any one co-morbidity.

During the interview, they were presented with some typical, complex, co-morbid patient profiles, all of which contained indicators for the core disease along with other co-morbidities and included a point of concern regarding the specific co-morbidity of interest. Physicians were shown the profiles for 15 seconds, and then asked what they would do for that patient. With little time to absorb the details of the profile, they were asked what action they would take for the patient, what were their main concerns, and how comfortable they were in managing this particular patient.

This line of questioning was deliberately very "open" and avoided giving any direction on what they should be focusing on. (Sam noted that in traditional research, often the moderator focuses the respondent quite quickly onto the particular areas of interest in order to fully explore the clients' priority issues).

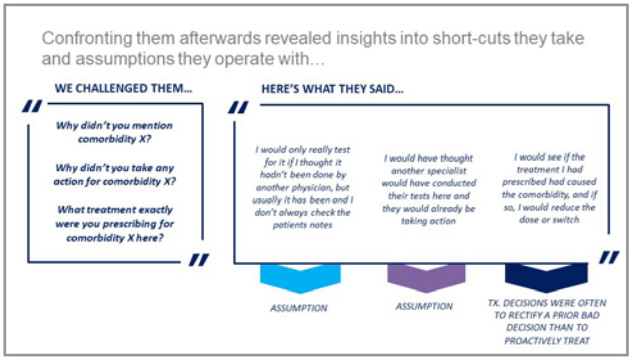
The research revealed that the "clues" regarding the co-morbidity were rarely, if ever, picked up by the respondents. Physicians' responses focused on the cardiovascular disease, its cause and its progression.

Sam noted that this approach was giving us their "knee jerk" reactions, characterised by their natural priorities and concerns, rather than their idealistic version of their role in practice. This told the team that the co-morbidity of interest was a low priority.



The flash test was followed by a classical qualitative exploration of their responses, including some very direct questioning to explore the disconnect between the idealised behaviour and the "knee jerk" response, which revealed some insights into the short-cuts and assumptions they were taking.

When challenged on why they had not mentioned Co-morbidity X, respondents were invited to assess their own responses and behaviours. Many explained that they would only test for this condition if they thought it had not already been explored by another specialist. There was an assumption that another physician would have already tested for it. A revealing insight was that they might only look at this particular co-morbidity if they suspected that their chosen treatment for the cardiovascular condition might have caused or exacerbated it – in which case they would reduce dose or switch treatment.



Sam commented that this level of candid honesty was unusual in a market research setting and surmised that the approach had encouraged them to question themselves. When asked "what would you do to manage this patient's co-morbidity?", physicians were likely to provide a stylised, idealised answer which overclaimed the extent of their involvement in treating the co-morbidity. By eliciting their "knee jerk" response and then challenging them directly, far greater nuance and insight had been revealed.

Sam reflected upon other learnings from the approach.

She noted that gentle confrontation, in a safe environment, had facilitated their self-analysis and challenged their true vs reported behaviours. Physicians were keen to explain why they had deprioritised the co-morbidity.

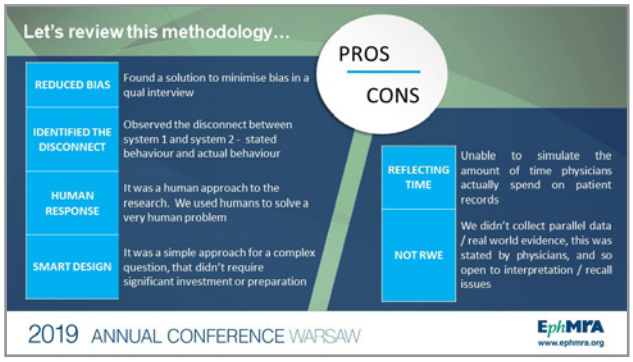
The approach had unearthed a fear: physicians wanted to give a heartfelt answer as to why they were undertreating. They expressed concern that their core prescribing sometimes has a negative impact on the co-morbidity and that this is a key underlying fear during prescribing.

The approach identified a gap. Physicians were able to identify and articulate a clear unmet need that the team had not previously discovered: they wanted to be able to proactively treat the heart without negatively impacting the co-morbidity. Sam noted that this would not have been identified with a different methodology.

But what was the value for Bayer?

Lea described how the methodology had filled a key knowledge gap and elucidated the disconnect between perceived vs actual physician behaviour. Bayer was able to identify different drivers and barriers that offered opportunities for the brand team to activate them in a different way, addressing the co-morbidity to ensure that it was proactively treated, rather than considered an afterthought. Bayer could help physicians to overcome their false assumptions that other specialties were managing the co-morbidity and offer support to reduce the fear of the potential negative impact of core prescribing on the co-morbidity, to facilitate more proactive and confident prescribing.

Sam summarised the methodology and highlighted some strengths and weaknesses.



This approach had reduced bias in interviews. By ensuring the interview flow did not focus respondents on the specific co-morbidity, they were able to spontaneously focus on their natural priorities, giving a more accurate and lifelike reflection of their true behaviours.

The approach provided a human solution to a human problem, and as a simple approach to a complex question, did not require significant investment or preparation.

Sam also noted the limitations of the methodology, noting that the 15 second exposure time did not reflect the amount of time physicians usually spend on patient evaluation. Real World Evidence was not used to corroborate the findings – the approach relies of stated outcomes by physicians, and so are subject to the vagaries of interpretation and recall.

Sam and Lea then finished the session with a lively discussion with others sharing how they had used novel approaches to explore the differences between perceived and actual behaviours.

Written by: Viv Farr, Narrative Health

Thursday 27 June

Plenary 7

High frequency change: Our evolving toolset, from rocks, to robots

Speaker:
Tom Cheesewright,
Applied Futurist

Chair:
Sarah Phillips,
IQVIA

Tom gave an engaging and thought-provoking paper about the future of our world, highlighting the tools that will have the most impact on our personal and professional lives.

Most of Tom's clients, he explained, are concerned not with the distant future, with its dreams of science fiction becoming reality, but are focused on the next 5-10 years and the impact that disruptive trends and technologies may have on their businesses. Their objective is to spot the issues that could "take them out at the knees" in the near future, and to identify the opportunities that these changes will bring to the business.

Tom reviewed some of the themes evident in the presentations we'd heard over the course of the conference, such as uncertainty, frequency of change, the challenges of extracting insight from an increasing volume of data, lack of time and human resource and the increasing demands of ever-shrinking timeframes. These challenges, he said, are familiar challenges evident in other industries too, and Tom believes that all these vectors of change are driven by a universal human characteristic: the use of tools. The use of tools was first detected in proto-humans over 3.5 million years ago, explained Tom, where the remains of proto-humans such as "Lucy" in north-eastern Ethiopia were found alongside animal bones bearing marks, chips and scars from the first tools, make from sharpened rocks, used to kill and prepare food. As a species of toolmakers, says Tom, today's tools of AI, VR, drones and the like, are used in the same way to augment our capabilities and improves our lives, making things easier. Technology, says Tom, if life's lubricant, lowering the barriers to entry and enabling each person to do more with less.

He notes that, as well as benefits, this presents some challenges. If things are easier, information moves faster, products move faster and change happens faster - or more specifically, change happens at higher frequency. He notes that this is another common theme across the industries that he sees: the perception that change happens faster now than in the past – although compared with the industrial revolution, the advent of the washing machine, or the shift from horse & cart to car, Tom believes that the current period of change is no more dramatic, but the flow of information facilitated by modern technology has increased, bringing us constant news about high-frequency waves of small changes constantly buffeting us and sometimes disrupting our lives and our businesses.

Apple makes $2.3 million per employee per year. (Only one pharma company, Gilead, currently makes more than Apple). Tom explains that Apple, and companies like it, achieve such impressive figures by empowering each employee via the use of technology to do more with less.

Comparing today's companies with equivalent companies a decade ago, they employ a fraction of the people, but every person has the tools to perform at their maximum capability.

Use of technology doesn't necessarily mean that human jobs are going to be taken over by machines, although Tom believes that work that doesn't add value will be automated, such as the manipulation of massive spreadsheets or data mining. He suggests that the time freed up by such automation will be better spent on more valuable human tasks that machines cannot (yet) undertake.

Tom reviewed some examples of the falling cost of technology, describing a camera the size of a little fingernail which cost 5 cents to manufacture. When the cost is so small and the potential value so great, why not put them everywhere? Less than five years ago, he noted, people were not ready to have cameras pointing at them everywhere they went. Privacy was a real concern. Now, however, he believes that we have already become accustomed to being filmed, with almost every cyclist with a camera on their helmet and many cars with dashcams, alongside kids filming everything with their drones and every other person uploading selfies.

The combination of omnipresent technology and our acceptance of it will produce enormous amounts of data about our behaviour, environment and health. Tom highlighted the increased use of mixed reality as a future trend, predicting that in 10 years' time, most people will spend 10 hours a day in mixed reality, seamlessly blending the digital and physical worlds. Tom views Google Glass as a successful experiment, rather than a failed product, with the next generation of display technology overcoming the limitations of the initial concept and perfectly tracking the physical world.

As researchers, this will help us to jump into the shoes of any individual and help us to understand their unique perspective. Biometric technologies will help us to interpret heart & respiratory rate and galvanic skin response in a number of ways using the next generation of apps such as MyFitnessPal. Tom noted that a team at MIT can already identify mood within one of 5 categories with 80% accuracy just by measuring heart and respiration rate, with application across mental health.

The privacy concerns that accompany this personal data have not disappeared, he believes, but our attitudes towards privacy has changed. Tom predicts a shift from the use of such personal data by giant corporations to a scenario where our personal data remains within our own personal perimeter, where we will choose how, where, and for what purpose our personal data will be shared.

He described the change in focus within AI from a giant factory-scale processing engine for enormous volumes of shared data to a "personal AI assistant" – a co-processor for our own mind which undertakes the tasks we don't want to do, managing, moderating and curating our personal data and releasing to third parties on a policy basis only when there is a shared value – such as shopping for car insurance or buying toilet paper or tins of tomatoes – we will provide the parameters and specification and our personal AI will do the brokering.

Tom advocates dedicating time to foresight to avoid being swept away by the high-frequency waves of change. His own proprietary methodology teaches this process in ½ day, focusing on what is causing pain today (slowing people down, stopping teams being productive, undermining the potential success of the business) and inviting agents from outside our own businesses or sectors (agencies, technology suppliers) to join a discussion and provide a different perspective to our own. Combined with desk research about current trends in adjacent industries, this process can help us to isolate the intersection between the major trends and our business pressures to identify the "next big thing" that might disrupt our businesses and trip us up.

Tom summarised four key takeaways:

- **Technology lowers friction, amplifying our power:**

Tom describes technology as a lubricant, but emphasises the importance not of the technology itself but how it is used to amplify the capabilities of the people in our organisations. Technologies should be adopted on the basis of the value it adds to the organisation

- **Expect sensory augmentation, enhancing the rich data available:**

Tom believes there will be massive sensory augmentation over the next few years with personal information being recorded and shared. This huge wave of data coming our way may overwhelm us unless we can build the tools and processes to use it effectively

- **Mixed reality creates an entirely new environment for marketing, communication and research:**

Tom describes the scariest and biggest transformation to all of our lives as the complete blending of the physical and digital world – important not only in the information it brings us but in how we engage with people, including our respondents. The shift from traditional communication (face to face, telephone, online) to mixed reality research environments may create a whole new class of professional

- **We will offload tasks at home and at work to semi-autonomous AI:**

Tom believes the future will include brokering not just between humans but AI to AI. This will require a new set of tools and disciplines to work out how to extract the data you need from somebody else's personal data perimeter

These future changes have already been identified and are things that we can now start to design for and specify now, to ensure that our toolset continues to evolve from rocks to robots.

Written by: Sarah Phillips, IQVIA

Member News

Ifop has launched its Veterinary Initiative to address the specific needs of this industry. It is led by William MacGillivray and Valérie Crousse, veterinary herself and marketer. Contact : William.MacGillivray@ifop.com

Hall & Partners Health hires Beth Stagg, former Managing Director of Evoke and Head of Strategy at TBWA\WorldHealth London. Beth joins as Managing Partner of the European Health Division.

Research Partnership is delighted to announce the promotion of Andrew Stokes to Senior Director, in recognition of his significant contribution to the company since he joined over 19 years ago.

G&G Associated introduces Crossing Over which combines focus group with specialists (proprietary panel of 10.000 subscriptions), Web Analysis & data collection of PRFs. Learn more on www.ggassociated.it

IFAK with new holistic approach in patient centricity research. Unique cooperation with its associated CRO Winicker Norimed delivers one stop shop for patient market access + patient journey data.

Adept Field Solutions is delighted to announce the launch of Language Pharmacy – a translation agency specialising in healthcare market research translations, transcriptions and interpreting. Contact Marina Pekris: info@languagepharmacy.com www.languagepharmacy.com

Call for Speakers 2020

EphMRA

Flanders Meeting & Convention Center Antwerp
23–25 June 2020

We will soon be looking for papers for the conference next year in Antwerp and the closing date for these is 18 September 2019 and we welcome all contributions from EphMRA members and non members.

You can find the full document with all the requirements for submitting a paper and ideas of topics on the EphMRA website:
www.ephmra.org

and also the conference website:
www.ephmraconference.org

If you have any questions about submitting a paper, please contact Caroline Snowdon, Events Manager at:
events@ephmra.org

or Bernadette Rogers, General Manager at
generalmanager@ephmra.org

We look forward to hearing from you!

Join us in Antwerp for our 2020 Conference

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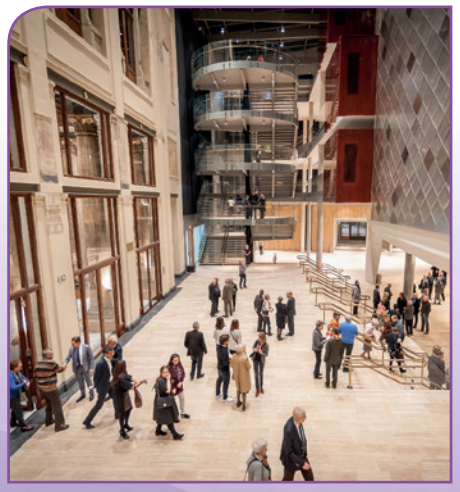

23–25 June 2020

Put the dates in your diary!

EphMRA is delighted to announce that our conference in 2020 will be held in the beautiful and historic port city of Antwerp, Belgium. Located near to the capital city, Brussels, Antwerp can be reached easily by rail from mainland Europe. Alternatively, fly to Brussels and take the train (2 an hour) from the airport to Antwerp city centre – a stone's throw from the Flanders Meeting and Convention Center where the conference will take place. A taxi from Brussels airport will take around 20-30 minutes.

EphMRA delegates will be in the heart of this thriving community for what we hope will be another inspiring and thought provoking conference in 2020.

The Flanders Meeting and Convention Cente is a beautiful venue which incorporates a state of the art concert hall – hosting some of the top classical musicians in the world. The Convention Centre offers delegates light and modern conference facilities and very close by are a wide range of hotels to meet all budgets and requirements.

We are already planning the event and are looking for outstanding speakers to put forward their ideas for papers again over the summer, for what we hope will be another outstanding conference next year.

Put the dates in your diary and we look forward to seeing you in Antwerp!