ephmra
excellence - community - standards

Welcome to the December 2022 News

Delivering the membership benefits to you

Ensuring you know what's on offer

Welcome to the EPHMRA December 2022 News

Contents

Member News

Agency Members can include one piece of News for free: 50 words max (increased from 30 words) plus photo/logo.

Member Articles

In addition we encourage companies to submit articles for publication – these can be on any topic you think the EPHMRA audience would find interesting. There is no charge for these articles but it's an offer only available to Agency Members of EPHMRA.

Each article can be one A4 page long (full page) and supplied ready formatted as follows:

No bleed	297mm x 210mm
With bleed	307mm x 220mm
Type Area	277mm x 190mm

Resolution/Artwork - If using photoshop or software dependent on resolution please ensure that it is set at the correct size and that the resolution is set to no less than 300dpi. Finished artwork needs to be supplied in CMYK with embedded fonts, or text should be converted to outlines/paths and supplied as an EPS. Print quality PDF files are also acceptable. PLEASE NOTE: We cannot be held responsible for any misprint, if fonts are not embedded/converted and the file is not in CMYK.

System - Apple Mac

Programmes - Quark Xpress, Adobe Illustrator, Freehand, Adobe Photoshop

File formats - Graphics should be supplied (CMYK) in the following formats EPS, TIF, JPEGS and Print Quality PDF files.

Copy Deadline

For the March 2023 News -
Copy deadline is 15 January 2023
Send to generalmanager@ephmra.org
www.ephmra.org

Get in touch

If you have any enquiries, suggestions or feedback just email us: Bernadette Rogers, General Manager
Email: generalmanager@ephmra.org

November Update from Karsten Trautmann, Merck KGaA, President of EPHMRA

Dear Friends and Colleagues

Good to be back in touch with you after what has been a very busy year and I hope you are all doing well! In the feedback from you, our members, there is a very strong push in Q4 to end the year on a very productive note!

As we are starting a new membership year, I would like to take the opportunity to share with you a short update on our activities in EPHMRA.

First of all we held two successful one day meetings in 2022 – one in London and one in Basel – and it was great to meet members again in-person to share best practices and exchange on latest trends. In 2023 we will return to our annual conference being in-person (June) as well as our 3 one day chapter meetings (London, Berlin and Basel).

The online webinars and topic-specific sessions will remain online offerings so that we can reach out to all sections of the membership.

On this note I would like to highlight our ethics and compliance service, which is a key member benefit, where we are developing an online training course called 'The Fundamentals of Data Protection and Healthcare Research' in the next months. We will keep you updated when the course will be finalised and can be accessed as part of your membership.

In addition the Ethics Committee along with the Compliance Network have been working on a project to develop Consent Form templates across UK, France, Germany, Italy and Spain highlighting what essential information needs to be included.

Finally as training is a key element of EPHMRA and in our interactions with you this has been highlighted to be a continued key element in the future - we created a new platform to continue developing our training offerings. The platform is more interactive and offers an enhanced training journey and learning experience.

I'd like to take the opportunity to thank everyone, who is involved in a Committee and Working Group, developing EPHMRA and contributing to the tremendous work behind the scenes:

- Board
- Classification
- Data & Systems
- Ethics
- Fieldwork Forum
- Forecasting
- LDC
- NFC
- Programme Committee

I hope that gives you an overview as to what is happening across the Association and trust that you and your families have managed to stay safe and well.

If you have any comments, suggestions or feedback please do not hesitate to share with me and get in touch at any time.

Karsten Trautmann

Karsten Trautmann
Merck Healthcare KGaA
EPHMRA President

Meet the EPHMRA Board

Who are your representatives on the board?

Karsten Trautmann
Merck KGaA
Board Industry Member
President

Thomas Hein
Thermo Fisher Scientific
Board Industry Member
Past President

Richard Head
Research Partnership
Board Agency Member

Xander Raijmakers
Eli Lilly Nederland BV
Board Industry Member

Stephen Potts
Purdie Pascoe
Board Agency Member

Marcel Slavenburg
SKIM
Board Agency Member

Carolyn Chamberlain
Blueprint Partnership
Board Agency Member

Amr Khalil
Ripple International
Board Agency Member

Ana Maria Aguirre Arteta
Novartis
Board Industry Member

Paul Warner
Vifor Pharma
Board Industry Member

Vijay Chand
AstraZeneca
Board Industry Member

Focus on our new Board Industry Members

Ana Maria Aguirre Arteta
Global Governance Director

Board Industry Member, Novartis

Global POP* Governance Director and Internal ISO Auditor in Novartis (Basel).

*Patient Oriented Program (POP) is a Novartis umbrella term covering Novartis programs to support patient care, market research or to gain insights from patients/Health Care Professionals. More than 20 years professional experience (17 years is in the pharmaceutical industry with companies including Novartis, Roche, Gruenenthal, Altana Pharma, Bayer AG), leading international teams (up to 60 people, located in EU, S. America, Africa and USA), in the departments of Research & Development (R&D)/ Pharmacovigilance, Quality and Pharma Development. I worked at global and local level cross functional with other departments (e.g. Medical Affairs, Marketing, Legal and Regulatory Affairs). I have knowledge in different
therapeutic areas including, oncology, respiratory, immunology, neuroscience and infectious diseases as well as in Drug Development and Project Management during my role in Roche.

Paul Warner
Head of Business Planning and Market Insights

Board Industry Member, Vifor Pharma

Paul has worked in the pharmaceutical industry his entire career and has no intent of changing course. Working on medicines that change people's lives is incredibly rewarding. He began his career at ZS Associates, supporting both biotech and large pharmaceutical companies on projects spanning sales and marketing. It's here that he developed a particular passion for market research. Since his consulting days, he has worked in local, regional, and global business units in various market insights leadership roles across Biogen, Shire (later Takeda), and now Vifor. He finds particular motivation in uncovering insights that drive tangible business decisions. Paul began his career in the US, and in 2015 made the leap to Switzerland, where he now lives with his wife, two young kids, and high energy Hungarian vizsla.

Vijay Chand
Director, Global Reporting

Board Industry Member, AstraZeneca

Vijay has 15 years of experience in the industry, working agency side and more recently on the Pharmaceutical side with AstraZeneca. In his current role, he leads Global Commercial performance reporting which provides a holistic view on performance across internal data assets, primary market research and secondary syndicated data for key AZ brands.

This role also covers Data systemization, strategy and global commercial data governance.

Prior to joining AstraZeneca, Vijay worked for Themis Analytics and IQVIA. Vijay is a current member of the EPHMRA Classification Committee and has recently assumed the chair position on the Data & Systems committee

Ethics Update

The 2022 Code of Conduct was launched in September 2022 – see here on the web site:

https://www.ephmra.org/code-conduct-aer

There you will also find the 2022 AER Guidelines and AER proformas.

Online Training

The online training is free for member companies.

The online training is now accessible with your www.ephmra.org web site log in

Training

On connecting in to the training platform each colleague has their own individual training dashboard where you can see the courses and tests available to you. All these are free of charge and you can save and download your certificates.

The training modules available to you are:

A. EPHMRA Ethics Online Training Modules and Competency Tests

1. EPHMRA Code of Conduct Training Course
2. EPHMRA AER Training Course
3. Code of Conduct Competency Test – complete test
4. Code of Conduct Competency Test – supplementary test EPHMRA members who are also BHBIA members will have the opportunity to take this supplementary test which covers EphMRA specific requirements and, in combination with the BHBIA Legal and Ethical Guidelines Competency Certificate, meets EPHMRA's full requirements.
5. AER Competency Test – complete test
6. AER Competency Test – supplementary test EPHMRA members who are also BHBIA members have the opportunity to take this supplementary test which covers EPHMRA specific requirements and, in combination with the BHBIA certificate, meets EPHMRA's full requirements.

B. Just starting your career in healthcare market research? Young Professionals? New to the industry?

We have the training for you! Let's take a look at what's included?

2 Online training courses

- Introduction to International Pharma MR
- Managing a Research Project

3. Webinars with industry experts

- Basic Skills: Project and Product Lifecycle
- Positioning and Messaging
- Projective Techniques

C. Further Ethics Online Training

2 more courses with certificates of completion

1. Preparing for Field
2. Code of Conduct for Medical Personnel Reviewing Market Research

Code Enquiry Service

Did you know you can ask EPHMRA a question about the Code of Conduct.

If you are preparing a project or preparing to go into Field then we are here to help.

As an Association we are happy to received Code enquiries from EPHMRA Member companies. These enquiries need to reference the section of the Code you have a question about and sorry we are unable to answer any questions of a commercial nature. Our ethics consultants assess and review each question received and we welcome these enquiries as they

help to improve our Code. There is no charge for this service as it is a Member benefit.

Please can you submit your enquiry via this online form. Please kindly note:

A written answer to your question will be provided by email. Telephone queries cannot be answered.

Most questions can be answered within 3 working days. However some may take a little longer as we may need to consult other sources to help with the answer.

EPHMRA may contact you by email or phone to request further information or clarification in order to answer your question.

The reply given by EPHMRA is not legal advice and if a legal opinion is required then you should seek this separately. EPHMRA cannot be held liable for any reply which is subsequently found to be incorrect - we give our reply based on our best endeavour and knowledge.

Find the Enquiry Form here: https://www.ephmra.org/form/code-of-conduct-enquiry-form

Question 1

At EPHMRA we are often asked about 'Naming the Client' and so below is the extract from the Code which we refer to:

2.11 To meet GDPR requirements, the end client or the commissioning client company must be named in three situations: a) If they are a data controller or joint data controller or b) If they are the source of personal data e.g. they supply a list of names to be used for sampling or c) If they receive personal data e.g. they receive non-anonymised audio/video files – live or delayed These three situations all operate independently.

2.12 The source of the personal data and recipients of personal data must also be named at the time that personal data is obtained.

2.13 If the end client is receiving personal data, they must be named before any transfer takes place

2.14 If naming the end client before the interview would undermine the integrity of the work, this may be done at the end of the interview BUT Market Research subjects must be made aware at recruitment that:

- the client will be named at the end of the interview;
- they can withdraw their consent at any point;
- the justification for this should be documented.

Question 2

A typical question which we are happy to answer might be:

We have a query about providing clients with data on "incompletes". Are there any industry standards for this? Background: When hosting a survey we tend to get some respondents who start the survey but who does not complete it. They decide to drop out for one reason or the other. These respondents also do not typically receive an incentive and clients are also not paying for this data. Do the clients still have the right to get the data from the "incomplete" respondents?

To answer this EPHMRA consulted the Fieldwork Forum and forwarded their answer to our member.

Upcoming Webinars

Survival Psychology - How to recognise it, manage it and not let it hijack you!

24 January 2023 / 2pm UK time

Speaker: Tony Brooks,
Leadership Psychologist,
Coach, Author

Convenor: An-hwa Lee,
Sr. Director,
Basis Health

The session will cover the following:

Where Survival Psychology originates from Why it can be so dominant and hijack us as a leader or business person 5 key ways in which survival thinking can impact us:

1. Imposter Syndrome – which will make us lose confidence and not make the most of great opportunities!
2. Defensive Mindset – where we take things too personally and don't grow from mistakes and challenges
3. Negative thinking and self-talk – which can keep us in a doubtful and negative spiral
4. The damage done by Ego – both to ourselves and other people around us
5. Tribal Behaviour – the dangers of silo, us & them and breakaway tribal behaviour in organisations

We will look at all 5 areas but also cover the fact that these are all symptomatic of the root cause - Survival Psychology and the challenge of 'not feeling good enough' in many areas of our lives.

The session will cover real life examples and challenges, with application within the specific industry. You will go away with tools to use in all 5 areas to significantly reduce the impact.

The Impact of COVID-19 on EU Cancer Services: Evolution or Revolution?

26 January 2023 / 14:15 - 15:00 UK time

Speaker: Claire Jackson,
Research Director,
7i Group

Convenor: David Twinberrow
Group Managing Director,
Genactis

Overview: COVID-19 created unprecedented challenges for healthcare systems, specifically cancer services. Cancer centres rapidly had to adjust care pathways, reallocate resources, shift cancer services out of the hospital to community settings, communicate with patients remotely rather than face-to-face and often adjust treatment pathways to reflect the new risks facing both healthcare professionals (HCPs) and patients. HCPs had to adapt quickly to new innovations, sometimes challenging their perspectives around what was beneficial to patient care.

A couple of years on, are these innovations still in place? How beneficial do healthcare professionals feel these are to patient care? Has COVID-19 driven an evolution or revolution in both thinking and practice? What challenges are health services still facing? Are biopharma and diagnostic companies aligned to the 'new normal'?

7i Group conducted a self-funded piece of primary research with European oncologists to answer some of these questions. This webinar will share these findings and explore the potential implications these have for biopharma and diagnostic companies. If COVID-19 has been a catalyst for change, shouldn't pharma follow and how should they adapt to changes in mindsets and service adaptations?

EPHMRA Online event - 20 October 2022

Market Research in Brazil and Argentina

Speakers: Bianca Zappiello, Qualitative Quotes Manager, FINE and Diego Casaravilla, CEO, FINE

In EPHMRA's latest webinar, Bianca Zappiello and Diego Casaravilla of FINE presented an overview of the healthcare systems in Brazil and Argentina, together with hints and tips on how to carry out successful market research in both countries.

The Brazilian healthcare system

Brazil is the largest country in both South America and Latin America, with a population of over 212m people. Its capital is Sao Paolo and the official language is Portuguese.

The Brazilian healthcare system has two sectors: the public sector and the private/supplementary sector.

- The public healthcare system is called SUS and is the largest government grant healthcare system in the world in terms of users and land area covered. It is free of charge for users, including for non-citizens. It focuses on medium and high complexity care as well as urgent care, emergency services, hospital care and pharmacies. A 2020 study found that almost 70% of the Brazilian population relies only on SUS, although there are issues with it including inefficient management, hospital overcrowding, a lack of well-trained professionals and long waiting lists.
- Private healthcare and private medical insurance are important because SUS does not support the number of people who need to use it. The supplementary system is therefore very necessary and is one of the largest private healthcare systems in the world. People who use it do not lose their right to use SUS. Around 70% of private healthcare plans are covered by companies that offer up to 100% of the payment costs to employees. There is also the option to have co-participation in which patients pay a percentage. Private plans can be used by any individual who does not want to rely on SUS, although only a small percentage of Brazilians pay out of their own pocket for appointments, treatment and medication.

Most doctors in Brazil are located in the main cities and parts of the country, such as in the south and southeast, have much less access to healthcare systems.

The Argentinian healthcare system

Argentina is the second largest country in the region after Brazil. It has a population of almost 50m people which is extremely concentrated around the capital Buenos Aires where one-third of the population lives. The official language is Spanish.

There are three different sectors in the Argentinian healthcare system: the public sector, social security and the private sector.

- The public sector covers people without any kind of insurance. It is funded by taxes at a national and local level and includes national hospitals, provincial hospitals and hospitals at local/county level.
- The main sector is social security. Unique to Argentina, the social security healthcare system is managed by trade unions that are funded by workers. A portion of their salaries goes directly to the unions and different unions organise specific healthcare activities.
- The private sector is smaller. It represents about 10% of the population, compared to social security which represents about 50%-60% and the public sector which represents 30-40% of the population.

Public healthcare facilities are universally accessible by everybody in the country, including non-citizens. This means that people from other countries come to Argentina to access healthcare and complex treatments. There is a set of basic mandatory services that social security and private healthcare must provide which includes maternity care, prevention of female cancers, hospitalisation and HIV. However, the latest treatments and practices are not always covered and can only be accessed via specific private healthcare plans or out of pocket by the patient.

Telemedicine in Brazil and Argentina

FINE has done a number of tracking studies to understand how relevant telemedicine has become in both countries.

Typical teleconferencing tools have been used but the usage of specific telemedicine apps has been extremely limited. The majority of consultations have been covered via platforms.

Post-pandemic, there has been a strong return to face-to-face interaction at all levels, including with pharma reps and medical training. However, there has been the potential development of telemedicine for specialties, with psychiatry being the most obvious option for telemedicine during the pandemic. Although there has been more development in this area than with other specialties, it is becoming a marginal practice compared to in-person care.

During the pandemic, most rep visits were virtual and there was a strong sense of the need to come back to face-to-face interaction. Half of the doctors were asking for a hybrid option but the other half just wanted face-to-face. Post-pandemic data has confirmed this and face-to-face is now the primary channel in both countries.

Hints and tips for doing Market Research in Brazil and Argentina

Sampling tips

- With oncology studies, oncologists are always the main treaters for almost all types of cancers except the ones that are haematological. These are treated by haematologists. Other specialists, such as pulmonologists, are usually only involved in the diagnosis stage and they then refer on to oncologists.
- Nurses do not prescribe treatments. They are only involved in treatment, execution and assistance, following what is indicated by the specialist.
- The specialists that are involved in Botox and filler injections in both countries are dentists, dermatologists, plastic surgeons and those in biomedical. Aestheticians do not exist in Brazil and Argentina.
- Physicians are not involved in pricing and decision-making. The profiles to target are purchasers and hospital administrators.
- It is extremely rare for patients to pay out of their pockets for high-cost medications. Patients that use the private healthcare system to get their prescriptions and get treated still go to the public healthcare system to get these medications. In-hospital medication, such as chemotherapy, is covered by private healthcare insurance.
- With regional quotas, there is different access to healthcare in each region of the two countries and it is therefore important to have a representative sample. The main centres are in the cities i.e. Sao Paolo and Porto Alegre in Brazil and Buenos Aires in Argentina. Most doctors are located in these cities and therefore you will get the best data in these locations.

Client moderation

It is feasible for the client to moderate in the local language in Brazil and Argentina but the following points should be considered:

- Be flexible around local manners i.e. informality and lack of punctuality. This does not indicate a lack of respect.
- Adopt the agenda to the participants' time zones and specific needs. e.g. physicians are usually more available at night and early in the morning. You will need flexibility from the moderator to accommodate these times and also to understand that it is common to have no-shows and last-minute cancellations. Flexibility will be needed with rescheduling.

English moderation

English moderation is feasible but only for qual projects as it is not really possible to reach targets through online surveys. Only small numbers of HCPs will conduct interviews in English and it is challenging to reach these potential participants as they need to speak fluent enough English to feel comfortable to take part. A small population in both countries speaks English and if English is required, there are usually a lot of refusals and any qual data obtained can be prejudiced. There are many terms that are mentioned in interviews which participants may not be familiar with. While English moderation is feasible for some specific profiles and with smaller samples, it is recommended that the local language is used whenever possible unless a qual output is required.

Best methodologies

FINE collected data during the pandemic on physicians' perceptions of market research, with the samples in both countries including GPs and a range of specialists.

- When asked if they liked participating in market research surveys, 75% of physicians in Brazil said that they are very happy to participate, with just 1% saying that they do not like to participate. It was a little higher in Argentina (79%). These results are valid across Latin America.
- The participants were asked how they prefer to be approached via different methodologies (this was more quant-focused but the results also apply to qual). In Brazil, there was a strong bias towards online (70%) with 28% saying that it is good. 22% said that face-to-face is invasive or not for them and 33% would only be happy doing face-

to-face in exceptional cases. The reluctancy was even higher with telephone interviews. The respondents were positive towards apps, although the challenge is to get them to download the app. If the app is available, they are very willing to do it, with 80% finding it good or the best method as it is more convenient for them. The results among participants were very similar in Argentina.

- When asked about the maximum time they are willing to spend answering market research surveys, two-thirds stated that they are open to spending 45 minutes or more completing a survey. 38% would be open to a longer duration (in Brazil) as long as the incentive is appropriate. Therefore, it is possible to do a long interview and patient profiles if incentives are involved.

In summary:

- Doctors in Brazil and Argentina like participating in market research surveys.
- They strongly prefer digital formats rather than face-to-face or telephone interviews. WhatsApp is increasingly being used to reach doctors.
- Brazilian doctors are even more enthusiastic than Argentinian doctors in terms of digital approaches.
- They are comfortable with interviews of up to 45 minutes and possibly longer.
- Qual interviews can be 60-90 minutes as long as the incentive is appropriate.

Access to patients

FINE has noted a significant increase in the number of patient projects, especially in Brazil and those that involve rare diseases.

- With complex diseases, debilitating conditions or conditions involving children, caregivers are very important and should be considered for the whole sample or part of it.
- For rare diseases (currently the most in-demand area), recruitment is very effective using support groups in both countries although visiting hospitals to reach patients has also been successful. In both countries for ethical reasons, physicians usually do not share any patient information - however, this is different in Mexico.

FINE has not found it feasible to recruit through patient advocacy groups. They have a strict internal policy not to participate in market research and not to provide any information on their patients. If the client contacts patient advocacy groups directly, it is possible that they may receive authorisation from them to recruit patients.

Access to payers

Access to payers is very challenging and a higher budget and different approach may be needed to reach them. Traditional field staff cannot be used and experts are required who were formerly employed in the pharma industry and who have a network of contacts. Payers are only accessible through a qual IDI approach and online is not recommended.

In Brazil, payers include:

- The Ministry of Health
- Medical auditors
- KOLs

In Argentina, payers include:

Trade union insurers

Private insurance companies

Tips to overcome cultural barriers

It is very important to understand cultural barriers in both countries. These include:

- Being flexible. It is common to have no-shows and delays, even with interviews confirmed on the same day. Doctors tend not to be very punctual.
- Relying on regional experts will help with the specifics of each market including healthcare systems, medical purchasing, reimbursement, feasibility and best methodologies for the target.
- Informal conversations and/or digital interaction are most likely to keep participants engaged.
- Focus groups are not recommended with KOLs or payers but they can be conducted with patients and physicians. Focus groups with physicians are best carried out face-to-face as it is more challenging online.

EPHMRA Online event - 13 September 2022

Expert Panel - Focus on Conjoint

Alexander Rummel of Aurum Research hosted EPHMRA's Expert Panel which aimed to exchange experiences of conjoint in terms of handling, design and analysis, based around three specific topics:

- Building virtual patients with conjoint.
- Conjoint designs for small sample sizes.
- Conjoint used in pricing research.

All of the panel experts gave an overview before opening up their topic for discussion. The panellists were:

- Richard Goosey, Head of Analytics, Research Partnership
- Remco Don, Director, SKIM Europe
- Dawn Palace, Senior Vice President and Joe Jones, Quantitative Scientist, Adelphi Group

Richard Goosey - Building Virtual Patients with Conjoint

Richard began by stating that in many ways, using virtual patients mirrors the way that doctors are trained in their final years at medical school where they are presented with a variety of patients and asked how they would treat them. Building virtual patients may mean that we can look at AI systems to predict how patients might be treated and what the outcomes might be.

A particularly interesting example of AI systems in use is at Boston A&E. 250,000 patient records have been taken from the last 30 years and when a patient comes into A&E, the system can forecast with 96% confidence whether they will die in the next 30 days. If large databases can be generated, we can begin to understand much more about treatment decisions and outcomes.

The use of conjoint enables patient characteristics to be mapped to treatment decisions. In a typical study, 1000 to 10,000 treatment decisions would be created in a focused analysis database, with each decision mapped to a patient characteristic.

When using conjoint to describe a virtual patient, the doctor is provided with a list of different treatment options and asked how they would treat the patient i.e. they reproduce what they do every day in their surgeries. The context is as realistic as possible, with the virtual patients constructed using attributes and levels as with every conjoint. The attributes describe the patient and have to be very carefully selected, for example, gender, current treatment or lifestyle. Each attribute has to have the capability to drive the treatment decision that is being made and as the levels change, the treatment decision can be affected.

A typical conjoint may involve 50 respondents in a study in 5 countries, with each doctor being given between 10 and 20 virtual patients. In this scenario, if each doctor gave 20 answers, a database of 5000 treatment decisions would be created. Medical input is essential to determine the necessary attributes which will be the decision-drivers in the choice of treatment. There can be an element of qual work to find out if anything has been missed, but determining the attributes and levels is critical, as this information is used to re-weight the conjoint data when the final dataset is available.

The questionnaire flow involves:

- A screener.
- Questions on adoption and usage of different products.
- The collection of the incidence of the attributes and levels within the individual respondent's case load for each attribute used for the virtual patient.
- A TPP if a new product is being evaluated.
- Virtual patient scenarios, with the new product added to the list of treatment choices along with other treatment choices that are currently available.
- Behavioural and demographic data which is collected to finish the exercise.

This type of data can be used in a number of different ways.

- As there is a selection variable i.e. the treatment choice that is made, Chaid can be used to analyse the uptake of a particular treatment. The uptake is driven by the characteristics of the virtual patients.
- The data can be used for evaluating TPPs i.e. the elements in the TPP that are resonating with the doctor and driving the selection of the product according to the patient scenario that is presented.
- It can be used for patient segmentation to state which types of patients are more likely to receive a particular type of product.

It can also be used in demand assessments. Between 10 and 20 scenarios are generally used for each interview and the data is weighted at individual respondent level to make sure that it is fully representative of patients at a market level. All of the attributes and levels in a percentage of patients in the doctor's current case load are taken and strong interactions between attributes - which might be combined - are taken into account. They are then taken out of the design. Care is taken with the number of attributes and levels versus the number of scenarios. This works well if there are elements of the patient that are considered to be important in driving the prescribing decision, for example, environmental and lifestyle factors. If you can position to a certain patient group and you understand the size of the group, you can start to see how the uptake level is going to increase in the group.

Remco Don - Conjoint designs for small sample sizes

Remco moved on to look conjoint designs for small sample sizes and began by considering what the desired sample size should be. A number of factors influence this, including:

- The number of attributes and levels that you want to take into account.
- How physicians have different preferences for certain attributes and levels. This has a big impact on what the optimal sample size should be.
- How you want to analyse the data i.e. are you interested in a specific sub-brand?

All of these elements can determine what the sample size should be. There are three ways that are generally used to determine the sample size:

- Experience. If you have conducted a lot of studies, you will know that you get reliable results with a certain sample size.
- There are some formulas that are used but they do not give the full answer when it comes to sub-brands or sub-samples that you may want to look at.
- More sophisticated methods around testing your designs i.e. looking at standard errors of your coefficients and looking at efficiency scores. These are methods that are available in some software packages.

All of these three methods have their advantages and disadvantages, with some being more theoretical while some are more practical.

Problems can arise with small sample sizes if preferences are very scattered. Having a low sample size means that capturing many different views into one combined view is very difficult and this can lead to results not being significant. It is therefore important to think about the consequences of a small sample size.

There are steps that can be taken to prevent this scenario arising:

- Try to reduce the number of variables.
- Try to limit the number of attributes and variables to the minimum and to the most necessary ones. The more attributes and variables you have, the larger sample you will need. Consider merging attributes and levels.
- Think about whether the levels are relevant. Is there a way that you can relax the screening criteria?
- You can of course increase the number of tasks and concepts to get additional data but be mindful that adding more tasks and more concepts does not always yield better results. If you are still trying to get different preferences, throwing many tasks at it will not give you the answer you are looking for. Tasks do not equal respondents.
- Think about running an aggregate analysis where you group everybody and look at an aggregate result. It is the most robust way to deal with these sample sizes. The more samples you get, the more you can think about advanced methodologies.
- There are also in-between methods such as latent class where you create groups of people who have similar preferences. You could collapse all the levels and think in terms of linearity.

Joe Jones and Dawn Palace - Pricing and conjoint

Joe and Dawn concluded the webinar with a look at pricing and conjoint, where the meaning of price is dependent on who is answering the question and which market you are in.

It is important to make room for pricing when managing grid size which in turn means managing sample size. One of the challenges with future pricing is that pharma companies focus on model agents with premium pricing.

With alternative specific pricing, you need to test different price points for different future products. In this situation, ask if you can pull MOA or brand out of the grid and use it as an external effect so that you don't have to have alternative specific pricing. You can have a broad range of prices across all future products and use the MOA or the product as an external effect later.

When you cannot pull out the manufacturer or brand from the grid, the alternative specific effects can be simplified by using a linear coefficient. You can also make an assumption. Instead of having a unique price code and an alternative specific effect across every manufacturer, you can make an assumption of relative price sensitivity across all of the competitors.

It is important to think creatively about where you need strong measurement and what matters in the grid. There is no correct answer for every pricing challenge but there are a number of strategies you can consider.

With premium pricing, you may have future products which are existing products where the pricing is based on large contracting. If the premium price is big, it can swamp everything else and if decisions are made only on price, you don't get good measurement on advocacy and safety. Two tasks can help with this:

- Remove the price so you can get really good measurement across all the other aspects of the grid.
- Bring pricing in so that you can see the effect of it.

One Day Meeting Report
Basel, 27 September 2022

Around 65 members gathered in Basel for the one day meeting – the first get together in Basel since 2019.

We had a great set of speakers and papers and here include the write -ups.

A BIG Thank you to our Convenors:

- Angela Duffy, Senior Director, Research Partnership
- Fenna Gloggner, Director, Global Customer Insights, Idorsia Pharmaceuticals
- Hannah Osborn, Founding Partner, Pure Healthcare Strategy

Paper 1: Activating Undiagnosed Patients to Seek Care Through a Mix of Research Methods and Behavioural Science Principles: Adelphi's NUDGE Methodology

Speakers: Michelle Krumenacker and Nick Southgate, Adelphi Research

The one-day meeting in Basel began with a presentation from Michelle Krumenacker and Nick Southgate of Adelphi Research on the use of NUDGE methodology to encourage patients to seek care sooner.

What is NUDGE?

Adelphi's client wanted to get more people who have symptoms relating to a heart condition to present to a doctor and seek treatment. Although it is clearly in their interest to access care, this also means that they needed to do something which they probably wouldn't. NUDGE methodology was therefore used to understand this more effectively with the aim of changing attitudes.

NUDGE is named after the book of the same name by Richard Thaler and Cass Sunstein, published in 2007. It was the first book to popularise behavioural economics and centres on the difference between what people should do and what they actually do.

Adelphi's client wanted people to come forward and get diagnosed as if patients get treated earlier, they suffer less and there is less burden on healthcare systems. A traditional approach would be to say that if you have x symptoms, you may have a heart problem and you should see a doctor. While everybody would say that they knew what to do, they often don't do it but applying NUDGE methodology helps people do something that they were struggling to get done themselves. NUDGE recognises the real-world friction where people acknowledge there is a problem but also acknowledge that they are not getting around to fixing it i.e. it focuses on trying to change behaviour and people's ability to approach a problem using mindsets.

Different people have different approaches as to how they might solve a healthcare problem. While some people are reticent and don't go to a doctor until it is too late, others like going and visit doctors regularly. Using NUDGE, Adelphi looked at the dominant strategies to group them, moving from the traditional association with motivation i.e. somebody's desire to do something to look instead at people's capacity to do something. In other words, it is not a question of how much a person wants to do something but how able they are to do it and see where the problem fits in their lives so they can act on it.

The mindset approach is different to segmentation in a number of key ways:

- Segmentations are about where people are now. A mindset is about how you might get them to where they need to be.
- Segmentation is about what people already do. A mindset is about how you change this.
- A segmentation tells you where to find people. A mindset will tell you how to take best advantage of where they are.
- Segmentation tells you people's existing habits. A mindset tells you how to piggyback on these habits.
- Segmentation tells you what people think. A mindset tells you how to change what people think.
- Segmentation tells you what people currently think. A mindset moves towards a desired state.
- Segmentations are more strategic. Mindsets are more tactical and are about working out interventions, messages and the fine detail to make things happen.

The NUDGE approach

The NUDGE approach has three phases:

- The first phase is Understand. Adelphi looked at some prior research through a behavioural science lens and used it to develop tentative mindsets for these patients. This was followed by a workshop to look at the mindsets and brainstorm activation ideas i.e. ways these patients could be encouraged to seek care.
- The next step in the process is Activate. The tentative mindsets were taken into qual research and used to test the activation ideas and better define them. It was important to remember that while the patients could be classified in terms of mindsets, this is more of a propensity towards something rather than a fixed state of affairs. Qual interviews were also used to pressure test some of the different activation ideas.
- The third phase is Target. The detailed mindsets and activation ideas were used to probe the respondents on their consumption habits and this led to improved messages and targeting suggestions for the client.

Key learnings

Three key learnings emerged from the use of NUDGE methodology:

- Mindsets help us understand the stories that patients tell themselves that keep them stuck and prevent them from taking action and being motivated to seek care. In this study, the patients were grouped into three mindsets:
- "I have not taken good care of myself". These are patients who felt that they had brought their symptoms upon themselves, for example, through past poor health habits or that their symptoms were related to the ageing process. They felt that it was therefore not worth raising them with their physician.
- "I feel unseen or unheard". These patients were afraid to talk to their physicians about any concerns they were having. They may have raised concerns in the past but felt they were ignored because their doctors were not good listeners or because they lacked the language to clearly articulate their symptoms.
- People who felt that they were on top of their health and therefore understood that the symptoms were concerning. They had raised concerns with their doctor but could not come to any satisfactory resolution.
- Mindsets are fluid and patients move between them based on a variety of interactions. This could be with their doctor or with a new piece of information. It could also be because of a change in their symptoms.
- By understanding patients' mindsets, we can better understand them to see what activates them to seek care. In the "I did this to myself" mindset, the

best way to activate patients is to give them the confidence to trust what their body is telling them i.e. it is an 'equipment' problem, not just wear and tear on the body.

The original objective of the study was to develop messages and tactics to help patients seek care. The messages that were developed through the NUDGE approach, which took into account patients' mindsets, outperformed the client's prior campaign which had been based solely on information. On a scale of A-H, the top two messages (A and B) were the most relevant and linked the information presented in the messages to patients' mindsets. Message F was rated the highest on urgency but it was not rated very highly in terms of relevance, as urgency is not the same as giving people guidance.

The client moved forward with message B because although it was tied with message A in terms of relevance, it was more well-rounded and included more urgency.

Key takeaways

- Mindsets help us understand the stories patients tell themselves that keep them stuck.
- Mindsets are fluid. They evolve and show how patients change in their attitudes towards their own care.
- Mindsets open up a wider array of marketing interventions and tactics that can often be based on proven methods of behavioural change. In the study, the messages improved upon the prior campaign and the client came away with different ideas as to where to target their campaign through the quant profiling.
- The use of behavioural science enabled the client to better understand the consumer, formulate compelling activation statements and ultimately test and confirm in which direction to go. Developing mindsets enabled them to uncover insights they had previously missed.

Paper 2: The old, the new, the trendy: a different way of looking at needs in rare diseases

Speakers: Emilie Genero, Day One Strategy and Imogen Corbett, Janssen

In their presentation, Emilie Genero of Day One Strategy and Imogen Corbett of Janssen explained how using tried and tested methodologies smartly has led to new ideas and inspiration on how to better understand patient needs in rare diseases.

Focusing on what matters - the patient

In rare diseases, patients often feel that they do not have a voice within their community or within their care. Although we can never really pretend to be in patients' shoes and understand their journey, Janssen and Day One wanted to provide a solution for patients driven by patients, based on triangulating methodologies to give them the time and space to tell their stories however they wanted to. The key elements of the brief were therefore to:

- Better understand the lived experience of rare disease patients.
- Focus on the emotional stages of the patient journey.
- Explore the treatment burden and fully understand the treatment experience i.e. the pain points and unmet needs.
- Ideate different types of solutions with patients that they feel could improve their overall experience.
- Consult with the patients via a series of treatment solutions that were in pre-clinical development to assess patients' acceptance and openness to these options.
- Take action via listening to the insights to embed it into the clinical development team at Janssen so that the patient voice is taken forwards from the pre-clinical step within product development to develop products that are meaningful for patients.

The solution

Data sets were triangulated from different methodologies - the old, the new and the trendy - to get a deeper understanding of the patients' unmet needs.

- The trendy approach involved an online community held across five days. This gave patients the opportunity to participate in the comfort of their own homes and at their own pace, with thoughts, feelings and small actions captured via a series of engaging tasks. The Day One team was visible on the platform to encourage peer interaction and be there to answer any questions that arose without hindering any conversations. In rare diseases, patients often don't get the opportunity to talk to other patients and the safe space in the community encouraged communication via emojis and comments on other patients' posts.
- The old approach comprised one-on-one interviews which followed on from the online community in which a rapport had been developed with the patients. This made the interviews feel more genuine and allowed patients to dig deeper into topics expressed online which merited extra time. It provided an opportunity for patients to have a two-way conversation in which they could ask questions and react to topics. The interviews were an integral part of the methodology and provided a space to understand patients' needs better, resulting in rich content.
- The new approach followed the online community and the one-on-one interviews, using voice analytics to provide an extra layer of understanding. By this stage of the project, while some of the patients' emotions were clear and identifiable, the team felt that a deeper understanding would be missed without voice analytics. Unfiltered clips from the online community were run through the tool and these uncovered hidden emotions that would not have been found otherwise. They also enabled both the individual and the global picture to be analysed, with specific emotions zoomed in on to capture what was triggering them. This allowed Janssen to see and hear first-hand the emotions that would otherwise have been missed.

Key takeaways

- The different elements of the mixed methodology approach all proved successful in the study both individually and in combination. The online community gave patients the time and space to tell their stories in the way they wanted to without pressure. The one to ones gave depth and enabled the team to home in on specific areas for consultation. The voice analytics provided additional understanding through uncovering themes that were linked with hopes and anxieties that were very pertinent to the treatment experience. The analytics was a larger part of the final deliverable than anticipated.
- Blended methodologies are the norm. Carry on exploring what works together and different methodologies that could complement each other.
- The use of technology has never been easier. Look out for new and innovative ways of doing research but find something that works and try and make it as perfect as you can.
- Working in rare diseases involves methodological limitations. Blended methodologies need to offer more than the sum of their parts for them to be meaningful and maximise small samples.

Paper 3: Making it personal ... can we develop more compelling messages by combining insights from personality measures and voice emotion?

Speakers: Katja Reinhardt, Merck and Mike Pepp, Blueprint Partnership

A case study involving the use of personality measures and voice emotion to assess the emotional value of a fertility brand was the subject of the presentation in Basel from Katja Reinhardt of Merck and Mike Pepp of Blueprint Partnership.

The approach

Although the brand is not the biggest in Merck's fertility portfolio, brands prescribed in this space are widely interchangeable and there is little brand loyalty, with price being a major factor. As IDIs would not be sufficient alone, a multi-dimensional approach was needed to look at different angles, including personality measures to see if these could augment the findings.

Three questions formed the basis of the approach:

- Could looking at personality dimensions increase an understanding of physicians and their responses?
- Could voice emotion analysis be used to find the emotions that were accompanying some of the answers?
- Could these two elements be linked together i.e. could it be seen whether people with different personality traits respond in an emotionally different way to the brands and messages being tested?

30 interviews were conducted in three markets using two tools:

- Phebi.ai which is a voice analysis tool.
- Mini-IPIP which is a 2-question personality inventory.

A Big 5 personality traits approach was applied across both tools involving:

- Openness - a measure of how motivated people are by novelty and wanting something new, latest and different.
- Conscientiousness - a measure of how much they really want to get into the details.
- Extroversion - a measure of where people get their energy source i.e. is it internal or from engaging with other people?
- Agreeableness - the extent to a person wants to please others and avoid conflict.
- Neuroticism - the level of emotional stability. Some people have rapid mood swings, while others are much more stable.

All of these personality traits exist on a spectrum and were applied to each physician in the sample.

Phebi.ai

In order to learn about the emotions the physicians had during their conversations on the brand, phebi.ai was applied retrospectively. Changes in tone, pitch and rhythm were listened to in terms of the five key emotions of anxious, happy, sad, calm and strong. This was to see if there were things going on that the physicians were not willing to say about their preferences or brand choices, or things that they did not know themselves i.e. things they weren't aware of.

From the qual research using projective and enabling techniques, the brand seemed to have some emotional value for the people who preferred it, in spite of what was said upfront. Blueprint Partnership wanted to see if these differences could be explored and explained in more detail.

Mini-IPIP

25 of the 30 physicians interviewed completed the mini-IPIP, with the following groups emerging:

- Almost all of the fertility specialists are high on agreeableness and the ones that weren't were in the high neutral zone.
- The levels of conscientiousness were also high, reflecting that fertility is an area where everything has to be tailored to the patient.

When looking at the brand preferers as opposed to the others, there was a tendency for people who are most focused on the value of the brand to be slightly less agreeable and conscientious. They are more likely to be on the high end of the openness spectrum. Blueprint Partnership had thought that the specialists who are open-minded would be more open to multiplicity of brands as opposed to focusing on a single well-established product and wanted to explore this further.

Brand preferences

Looking at their placement in terms of the Big 5 personality types, the physicians who were less open and were more focused on a small selection of well-trusted products tended to be more happy and less anxious when talking about a brand and the alternatives, particularly when talking about a generic. These are people who want certainty and a brand is providing this for them.

The physicians who are generic users and have this emotional profile stated that if they had the choice, they would use the brand.

Physicians who were slightly lower on conscientiousness were also calmer when discussing brands. Brands have value for physicians and are in some way complementing the fact that they are not feeling that driven. The same physicians have both sad and strong emotions when they are discussing generics. There is some level of discomfort i.e. the generics do not meet their emotional needs in the same way as the brand.

Responses to messages

Although 11 messages were tested in total, the qual had identified that about five of these were the key ones that seemed to make a difference in terms of differential responses. The analysis was therefore directed at these five questions which including a focus on:

- Brand reassurance and experience i.e. the classic message in terms of numbers of patients treated and the safety and convenience of the product.
- Efficacy comparison claiming similar efficacy.
- Efficacy comparison claiming better efficacy i.e. the implication of a single word change from similar to better.

The brand experience message had power and emotional resonance with people who are brand users. Overall, they were happier and calmer in their response to that message than other doctors. This was particularly emphasised among the group of brand preferers who are less conscientious. The comfort in the brand was turbo-charged and it was apparent that they had a different response compared to the rest of the audience. The people who preferred a competing brand had a strong and less anxious response to the message. They were not engaging with it and it was not making them think that anything they were doing was wrong - they were simply rejecting it.

The efficacy comparison messages about similarity or superiority produced interesting results. The most marked difference was among people who were preferring the brand who were not strongly conscientious. They had a more powerful and positive emotional response when superiority was claimed. It was giving them confidence and a sense that what they were doing was beyond reproach i.e. they were doing the best they could do for their patients. This was true in a less marked way for those who preferred the brand. The ones with a lower level of conscientiousness were stronger.

The doctors who were using the generic had sad and strong reactions to the superiority message. These were the doctors who reported in the qual that they would rather be using the brand if they could but they were institutionally constrained and had to use the generic. These results showed that the emotional responses from the doctors were related to their preference for the brand and not for what they were currently able to do in terms of their prescribing behaviour. These are physicians who have to use the

generic but would rather use the brand when they are able to do this.

Value for Merck

Merck was able to see that the additional techniques added clear value with a very consistent picture. The personality test confirmed what was seen in the other feedback and provided a lot of reassurance. In particular:

- Stakeholders could better engage with quant-type results which felt tangible and easily relatable.
- The feedback about the personality traits of the fertility specialists added value on top of the other research and the results around motivation will help with future messaging and targeting.

Overall, the research was very well-received by Merck stakeholders and the team intends to use more mixed methodologies in future.

Key takeaways

- The idea of personality is a useful way of structuring information for brand teams because pretty much everybody has some understanding of what personality dimensions are. It is quite easy to explain and show why it is relevant.
- The use of personality and voice emotion together can work well to tell a simple story that makes sense and is not too much focused on the personality psychology element i.e. this is a group of people, this is what they need and this is how they respond to the messages.

Paper 4: Elevating your concept testing with AI powered insights and analytics

Speakers: Emilie Braund, Research Partnership and Alison Buchanan, Alison Buchanan Associates

In their presentation, Emilie Braund of Research Partnership and Alison Buchanan looked at optimising ad concept testing using a new approach anchored in behavioural science.

Updating concept testing

Concept testing has not evolved that much, even though most market research is now being carried out online and it is some time since it has been common practice to sit in a room with HCPs and a set of ads.

The standard metrics include:

- Stopping power i.e. the respondent flicks through a journal or scrolls through a website and the concept gets them to stop and read it.
- How the elements work together i.e. what is the message that is being conveyed and does it align with the communication objectives.
- The action that will be taken as a result of seeing the ad i.e. will the respondent seek out more information, think about the specific patients to use the product with and rethink their practice as a result.

While the overall goal of ad testing is to increase the use of the product, the desired action is often different from campaign to campaign and the communication objectives are nowadays much more anchored into the emotional aspects. Alongside this, our understanding of System 1 thinking and how people consume brand communication has increased hugely, although concept testing is still very anchored in System 2 approaches.

The RATER approach

Research Partnership and Janssen adopted a more robust approach to communication testing by developing a framework called the RATER approach which can be used in many different forms including message testing and detailed evaluation. Each pillar in the approach is anchored in behavioural science which enables concepts to be evaluated across a range of parameters. When concepts perform well across these parameters, they are indicative of the ability to change behaviours in physicians or customers. The framework is flexible and can also be adapted for communication objectives in different campaigns. The pillars are:

- Rapid - the concept needs to hold immediate appeal.

- Available - the doctor can recall the concept they have seen a few days later and the messages communicated.
- Attention - the concept grabs the eye and directs the eye to the right place straightaway.
- Emotion - the concept creates appropriate emotional associations.
- Rational - the elements work together to communicate a compelling clinical reason to take action.

A range of research techniques was layered onto the framework to capture insights and deliver more implicit System 1 responses to the concepts, as well as give a clear indication of a true response that the concepts are likely to deliver to get the emotional aspects and the System 1 thinking. The techniques were:

- Rapid - timed associations and emotional AI (facial analysis).
- Available - fuller memorability interviews.
- Attention - eye tracking and attention AI using Dragonfly software.
- Emotion - adapting some of the ratings scales to make them more novel and relevant to the communication objectives.
- Rational - detailed evaluation linked to the desired campaign objectives.

Rapid

The objective with the Rapid pillar of the approach was to capture the fast and conscious immediate reaction to stimuli. The respondents were shown a series of concepts for 5 seconds at a time. There was an attempt to trick them with a distracting question before they were then asked what they remembered of what they had been shown. Although assessing the stopping power was a critical part of the research, a short amount of time was spent on this.

There is always an element of retrospection and consideration when respondents are asked about what they have seen i.e. there is not an immediate impression. To address this, the team explored techniques such as time association and facial analysis. The latter is very relevant in concept testing as it replicates the glimpse test in which respondents are exposed to each concept for 5 seconds at a time. However, instead of doing this on a board, it is done on a screen. As the respondents look at the concept, their facial movements - the eyes, the mouth, the eyebrows - are tracked and a well-established AI tool maps these movements to a set of nine emotions to represent how the concept is performing. Using this method enables a true and instantaneous reaction to the stimuli at first glance without the element of retrospection and consideration i.e. it gets us much closer to System 1 thinking.

Attention

This is a measure of how well a concept grabs the eye and the team used eye tracking for the Attention pillar. Respondents' eyes are followed as they look through a concept to identify which elements they look at first and for how long. Eye tracking technology has improved from when respondents had to wear intrusive headsets but it is still not the easiest to use in practice as an emotion bar is used on top of the laptop screen to capture eye movements. It is still not very practical and is complicated logistically.

The alternative is to use AI and Research Partnership/ Janssen partnered with Dragonfly which is a tool that enables the assessment of the aspects that capture the eye without the need for the respondents at all. The Dragonfly algorithm is the result of neuroscience research and focuses on understanding the nature of how our brains interpret and process visual information as it enters the visual cortex. The algorithm takes an input (the image, visual or concept) and splits it into five neural pathways. These are:

- Light versus darkness.
- Texture.
- Contrast versus edges.
- Shape/colour/perspective.
- Patterns/orientation.

Dragonfly applies a set of highly sensitive weightings and sequencing steps to produce an accurate prediction of what the viewers will notice in the first microseconds of truth.

Several different functions of the Dragonfly tool were used when analysing the concepts:

- Attention maps enable an understanding of where the attention of an audience is most likely and least likely to be directed during the first glance.
- Heat maps use heat to visualise the distribution of attention. The red areas are the areas to which attention is most likely to be drawn. The blue areas are areas which are less attention-grabbing.
- Share of attention is the proportion of attention a specific element has opposed to other elements.
- Gaze path is the most probable path that the eye will take to look for the content, using scientifically validated gaze sequences.

All of these functions lower the risk of releasing content that is dull or contains too many distracting elements. The hotspots identify what correlates with the intended visual hierarchy.

In an example which showed an ad that featured a scar representing a question mark, the AI tool quickly and easily identified what worked well and what could be improved to make it even more powerful.

- Using the heat map, the headline and branding captured the attention very well but the picture of the scar itself was less likely to grab attention.
- Using automated hotspots identified the proportion of readers who were likely to see each of the different areas at first glance. 85% saw the branding at first glance together with the body text. The scar was not noticed at all at first glance. This demonstrated a big discrepancy between the scar and the other areas of interest in the ad.
- The gaze path i.e. the likely route through the concept found that the overall route covered all the main elements and key areas with the exception of the scar.

This example shows how the Dragonfly tool can confirm which components of the ad concept are contributing to its success. In this case, simple edits such as increasing the colour contrast between the skin and the scar are likely to ensure that the concept is processed well and the message is conveyed as it was intended to be and have a much stronger impact.

Emotion

It is important to understand the emotional resonance of a concept as this element is becoming more significant in communication objectives i.e. understanding the emotional journey of a patient. The idea is to assess the emotional pull of a concept and dig deeper compared to competitors i.e. to cut through the noise while conveying the right emotion for the concept.

In order to best capture the emotional response, it is worth considering associations on an emoji scale. The word selection can be via a wheel of emotion or it can be adapted to include emotions and words that the campaign is designed to evoke. These can be combined to focus on the campaign communication objectives.

Rational

It is important to assess the appeal of a concept in terms of System 1 thinking, although System 2 thinking is still very important. A more detailed review of the concept engages System 2 thinking i.e. how the visual, the text and the headline all work together to deliver the brand objectives. System 2 processes tend to be enhanced when decision-making physicians are held accountable by others such as patients or peers.

A detailed review typically mirrors an individual stopping flicking through a journal to study the material. It usually involves discussions supported by ratings against a certain number of standard metrics such as credibility, clarity, differentiation and motivation to prescribe. It is important to add the objectives of the product in the ratings and scales to ensure that the campaign is achieving what it is supposed to achieve, with suitable metrics to measure the concept against the communication objectives.

Availability

The availability heuristic describes the tendency to use information that comes to mind quickly and easily when making decisions about the future. We cannot retain all the information that is given to us and we filter out a lot of irrelevant information, only retaining what is really important. In concept testing, it is important that people remember the ad for the right reasons.

To address this, memorability interviews were conducted. These are short interviews that follow up 5-7 days after the main research. The respondents are asked for spontaneous recall of the concept and key information that they took away. This helps to identify what are the concepts that are most available to a physician a few days later, which ones are not recalled and what is the message that is being recalled. The context has a significant impact on behaviour. This exercise helps to assess how memorable materials are when 'life gets in the way'. Respondents are free from constraints to provide the right answers and the interviews are much shorter so there is not so much pressure.

Case study

Stelara, a novel biologic therapy that is used in different indications in auto-immune disease, had had a very successful ad campaign for ulcerative colitis and Crohn's disease but needed to be refreshed to take the brand to the next stage in its lifecycle. It needed to build on communication that was very rational to something that was much more emotional.

60-minute virtual in-depth interviews were conducted with gastroenterologists in six markets testing five new concepts. In addition to traditional techniques, facial analysis, 5-minute follow-up interviews and memorability interviews were incorporated, with the five concepts run through the Dragonfly AI software. All of the different components contributed to the overall findings.

- Facial analysis gave an immediate emotional reaction to each concept and showed which performed best in generating the desired emotional reaction at first glance without the element of retrospection and consideration.
- The memorability follow-up interviews were used to assess which concepts were remembered and what messages were remembered from these concepts.
- With the Attention pillar, the Dragonfly AI software helped to identify where the eye would be drawn to, the likely gaze path and any areas of confusion which would distract and detract from the desired communication objective.
- In terms of the Emotional pillar, new ratings were linked to the desired behavioural response, the communication objectives and the next steps that the team wanted to achieve. Emoji scales and framed questions were used to assess how well each concept fitted with the communication and campaign objectives.

Integrated together, the tools provided a much deeper insight into which concepts performed best and how they could be improved. The responses were presented in new ways with a much strong emotional component that met Janssen's campaign objectives.

Key takeaways

- RATER provided a framework for ad concept testing that has a solid and theoretical approach based on neuroscience. It incorporated many different elements into the research and gave huge insights compared to a very traditional approach. If the AI tools had not been used, issues would not have been identified with the marketing team's favoured campaign.
- Janssen used the results from the research to say which concept they wanted to go with in EMEA. This has been developed further and made more Europe-specific and market-specific. The team believes that it will draw on the emotional resonance of HCPs while building on the equity of the original campaign.

Paper 5: A summary of how a custom sales intelligence platform based on AI and Data Science is helping an Indian pharma company optimise local (postcode level) engagement across consumers and HCPs

Speakers: Ayush Atul Mishra and Manan Sethi, GRG Health

Ayush Atul Mishra and Manan Sethi of GRG Health presented a case study on the work they have carried out for a US/Indian generic manufacturer involving a custom sales intelligence platform based on AI and data science to tailor engagement as part of sales efforts using CRM data and other inputs.

Background

The client had three key objectives:

- They wanted to map out all of the prescribers in India so that their sales force could optimise coverage.
- They wanted to identify KOLs, local opinion leaders and influencers in the market.
- They wanted to marry the new data with their existing data which comprised:
- Internal CRM sales data
- External data bought in from various subscriptions from consulting and market research agencies.
- External data from siloed custom research projects in the US and India.

The biggest problem for GRG Health was that there was too much data. The client had a mandate to carry out more research and gather more data but there was no unified intelligence that was serving a common purpose. Every time they did research, the outcome was put into siloes i.e. the data sets were not talking to each other. GRG therefore not only had to map the HCPs across the country but had to put them on a common platform so that they could keep on building sustainable intelligence for the client.

The solution

GRG looked at postcodes as the common denominators and decided to put postcodes with all data created, finding postcodes for all the existing data so that the data sets could be synched.

With India having 19,000 postcodes, GRG used 100 postcodes as a pilot to see if they could be scaled up to create a unified sales intelligence and market research platform. This involved a three-step methodology:

- The prototype needed to be a sustainable model in which the client could keep on generating data in the future. Population data was added alongside the 100 postcodes on a map. This included demographic, sociographic and psychographic data, as well as household incomes and literacy data. Doctors, pharmacists and hospitals were also included on the map, with Google places used for this because the data is high-end and validated.
- Once both of these datasets were included on the map, some additional learning models were built in to create route optimisation so that if the sales team wanted to address one or two postcodes, they could create their own route and build their own objectives. A framework was also built in so that more models could be added in the future to address specific problems for these 100 postcodes.
- GRG started working with the client's data to figure out how much of the data had postcodes attached or if there was a way that postcodes could be added to the client's data. This was synched to the prototype and primary intelligence data was included to create a campaign for 80 HCPs involving quarterly trackers with a 40 % overlap.

The first phase of the project has been completed with four waves to take place in a year using a hybrid methodology. Recipients are asked for their insights on brand perception as well as client perception for brand prescription behaviour, brand recall awareness and brand performance. All of these insights are meta-tagged to the postcodes so the prescription trends of different postcodes can be seen and all future primary market research projects will be commissioned in such a way that identifies the postcodes of the respondents and includes them on the same platform.

Key outcomes

- For the first time, the client has been able to see population data and doctors' data together.
- A linear programming model gives a sentiment analysis i.e. whether the review of the doctor is positive or negative on Google or other platforms. For every postcode there is a potency map of doctors and potential doctors across therapy areas can be seen.
- Postcodes have been identified as clusters depending on the insights and the platform enables better segmentation of geographies to address specific objectives for the client.
- The client has been able to identify new KOLs based on potential as the doctors are scored in terms of attributes including their experience, awards they have received and their fees. It is also possible to calculate scores for postcodes i.e. some postcodes might have a good demographic mix.
- The client has been able to identify local niches and understand where to push its portfolio based on the postcode data.

Paper 6: Experience Management powered by the Voice of the Customer

Speaker: Reinhard Moschitz, Novartis

The final presentation at EPHMRA's Basel meeting was given by Reinhard Moschitz who gave an overview of the platform that Novartis has been using in conjunction with its CRM to look at in-the-moment customer experience.

The Voice of the Customer

The Voice of the Customer is a systematic approach for asking stakeholders (HCPs, payers and patients) for feedback so you can analyse it, take action and make improvements. It is not market research per se but adds an additional important source.

Novartis has 1m customers worldwide and all of them are asked to respond to the Voice of the Customer. It is in real-time and it is carried out either once a year or after particular interactions. The customers voluntarily give their consent for communication not to be anonymised and this is the big difference compared to other methods as with this data, it is possible to follow up on specific customer feedback i.e. it is not just a listening exercise. This requires self-awareness and a growth mindset to improve across the company.

How it works

Short surveys are sent out to customers which they can choose to answer or not via an app on their pad, phone or browser. The Novartis reps get an alert via email or the app when a survey comes in. An average rep has around 70 customers and around 7 surveys are sent to each customer a year so with a 10% response rate, they receive 50 surveys per year which are followed up personally. The rep will set up a meeting to dive into the feedback because the surveys are very short and only give indications of where problems might be.

As part of the survey, customers are asked how likely they are to recommend working with Novartis before answering questions on areas such as frequency of communication. The sales rep will take the responses through to the cross-functional brand team because they cannot solve this type of issue alone. They will then decide how best to follow up to offer even better value and greater personalisation at an individual level.

A second survey is a post-interaction brand survey which takes place after an interaction (remote or in-person) has happened. Questions are asked about the interaction, the brand and what the stakeholder would like to discuss next. The leading matrix is satisfaction of engagement and how likely the customer is to recommend the brand. There are three drivers on the brand and over time, the rep can understand the customer's perception of the brand

based on these drivers. This can be helpful so that reps can understand what to talk about in their next interaction e.g. efficacy.

The data from the surveys can be aggregated and it can be taken to global, regional or country teams to influence tactics or messaging. As the surveys take place in real-time, it can also be seen how the data evolves every week or month for a country, region or globally.

The Voice of the Customer is live in 33 countries including the US, China, Japan and Germany and it has reached around 6000-8000 reps so far. The survey has not been sent to every Novartis customer yet but it has been sent to over 20,000. More than 30,000 people have given individual feedback and most of them have been followed up individually with the minimum of a phone call. The response rate so far is 13%. At the beginning, customers have tended to give higher ratings because they are in a honeymoon period but the rating decreases over time as the customer becomes more open in their feedback.

Key takeaways

- There has been a very positive reaction to the Voice of the Customer. Customers appreciate being asked for feedback and appreciate even more that people come back to them and lean into the uncomfortable questions to learn more.
- Customers are not judged on their scores as Novartis only wants to see action and improvement.
- The platform has led to many more personalised interactions. The response rate is 20 times higher than with any other email that has been sent to Novartis customers.
- Customers prefer to be asked something than to be told constantly how great the company and its brands are. It has helped Novartis to have a constant pulse check.
- If companies prove that they are not just asking but analysing, engaging and taking action, stakeholders are more likely to respond over time. Although the technical element is easy, the change management component can be challenging for some internal stakeholders.

EPHMRA colleagues 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.

It's time to start organising your submission for the EPHMRA Awards - these are outlined below and open to all (including members and non members).
Winners will be announced in April 2023.
The winning papers will receive a certificate and memento award.

1. Future leaders and Future Rising Stars – An exciting, not to be missed opportunity!

Sponsored by blueprint partnership

Calling all Line Managers – a fabulous opportunity for a member of YOUR team to elevate their profile across our industry and to shine!
Please do have a look to see who in your Team could make a submission for this prestigious 2023 Industry Award! Who can you nominate from your agency or client company?
As a Professional, if you or a member of your team has been working in Healthcare Market Research for 5 years or less we are looking for your submission which focuses on one, two to three PMR insight projects you have played a major contributing role in. In your submission please outline the projects, their objectives, how it helped your clients and end stakeholders and what you've learnt in terms of your own professional development from being involved in these projects. We want you to share your experiences! We want to hear about them! Raise your profile and your company's profile across the Healthcare circuit.

2. Innovative Approach

Sponsored by AA PLUS

Your submission should demonstrate an aspect of a project that was done differently – there was something innovative included or the approach was more cutting edge. We'd like to hear about studies where you have tried new approaches – it may have been successful/partly successful – so tell us what worked/what didn't work and what you have learnt from this.

3. Making a Business Impact

Sponsored by Adelphi

This award is for a market research project that has made an impact on the business. It will showcase how, through the project design, implementation and insights generated you have made a difference. Please do highlight in your submission where the company's business has modified and improved its strategy and/or how the project made an impact and helped the client company move its business forward. This Award would ideally suit a joint submission – agency/industry.

Submission deadline 28 February 2023

How to submit:

Award submissions should be in the form of a total of 7 Powerpoint slides along with a zoom recording file in which you walk through the slides and give your 5 minute pitch. This recording should be no longer than 5 minutes.

Your submission should be organised around the following headings:

INTRODUCTION	BACKGROUND	METHODOLOGY	TECHNIQUES	CONCLUSIONS
Submission title, the name of those making the submission and their company names, job titles and contact email addresses.			Highlighting any new or different approaches taken	

After the submission deadline we will assess the submissions and some will be invited to walk the Judging Panel through your submission and to answer questions.

All Awards will be judged according to these criteria:

Making a business impact:

- Clarity of presentation and message conveyed
- Level of added value the approach provided given the business challenge
- Degree of measurable business impact

Innovative approach

- Clarity of presentation and message conveyed
- Level of innovation demonstrated
- Level of added value the innovative approach provided compared to more traditional approaches

Future leaders

- Clarity of presentation and message conveyed
- Demonstration of future leadership skills (skills beyond just being a good researcher)
- Ability to answer judge's questions well

Who will judge the Award submissions?

Members form the Judging Panel so they are assessed independently and by colleagues with a range of experience.

Winners

Each Award winner will be required to:

- make a presentation to the EPHMRA membership in May 2023.
- this will be via zoom and last for 20 minutes with 10 minutes for Q&A
- the session will be recorded and along with the slide deck presented be made available to the membership in the members area of the web site.

If you are chosen to be an Award winner we will contact you in advance of the MR Excellence Award Winners announcement to re-confirm the above.

Any questions? Please do get in touch and send your submission to **generalmanager@ephmra.org** by 28th February 2023.

Vox.Bio is excited to announce Stephen Godwin has joined the team as part of their Expert Network. Stephen will work closely with Vox.Bio, sharing his expertise from a long career in the pharmaceutical industry and providing guidance on storytelling, strategic workshops and KOL / stakeholder interview techniques.

Ripple International announces a new member: Virginia Lepri.

'Virginia has nearly 30 years' experience in international healthcare research blending strategic and tactical in affiliate and head office environments. She has an innate ability to swiftly translate business goals into pragmatic actionable insights. An avid crime stories reader, Virginia is curious, resourceful, and passionate.'

Research Partnership recently launched its new brand identity as part of Inizio Advisory. The company that acquired Research Partnership, Ashfield, along with UDG Healthcare and Huntsworth, have combined to form Inizio, a strategic partner for health and life sciences with a full suite of services including Advisory.

QualWorld is expanding with new project managers, translators and moderators in France, Japan, China, USA and Denmark, including our new Compliance & Quality Assurance Executive, Birama Ndiaye. He will ensure that we continue to comply with local regulations and quality standards in the 40+ countries where we provide fieldwork services.

It's been an exciting year so far at Blueprint Partnership! We've welcomed 16 new team members, presented at 4 industry conferences, shared our self-funded study on current adoption and opinion of neoadjuvant chemo-IO for respectable NSCLC, and we're recently back from a team building trip to Marbella!

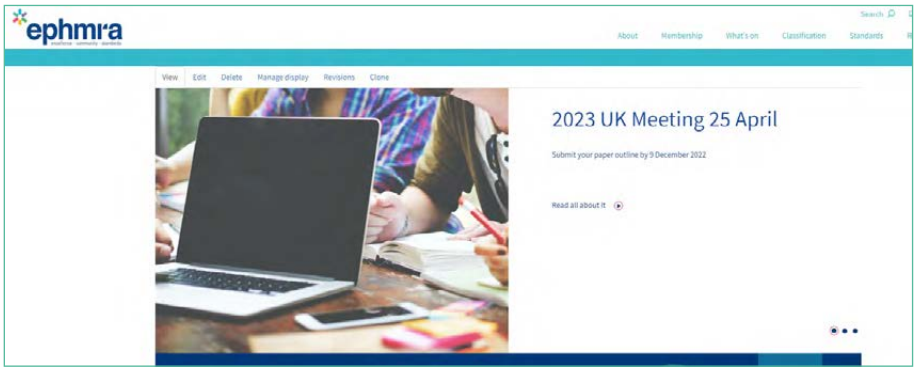
Basis, a global strategy and insight consultancy has named Paul Eccles as Managing Partner of the company's health division, Basis Health in New York. With over 15 years of experience, Eccles brings exceptional industry knowledge and strong leadership skills as the company continues its growth and commercialization.

Association News

All the News about what is happening across the Association is posted in our closed LinkedIn group:

(24) EPHMRA - encouraging excellence in providing insights combined with business knowledge. | Groups | LinkedIn

As well as here on the web site home page www.ephmra.org



ephmra

Adelphi Research | Inspire Action Drive Change

Head-to-head: Agile vs. Traditional

A comparison of methodologies

OUR CHALLENGE

Agile methods are on the rise, but are they any better?

According to the 2022 GRIT Insights Practice report, **78%** of research suppliers and **76%** of research buyers are using agile approaches.

But are they really better than traditional approaches, or innovation for innovation's sake?

GSK and Adelphi Research set up a unique head–to–head experiment

- Brand message testing research
- Two arms: Agile and traditional
- Same objectives, same messages, same respondent types in each arm

Traditional arm: Tele–depth interviews

75 min tele–depth interviews (TDIs)	N=50 in US (PCPs and specialists)
Message prioritization	Detailed message review
Performance on KPIs	Optimal story creation

Agile arm: Online bulletin board

75 min participation over 3 weeks	N=24 in US (PCPs and specialists)

- Ability to handle high volume of messages
- Series of phased tasks:

Week 1: Message review, prioritisation, performance on KPIs
Week 2: GSK refinement of brand story
Week 3: Message recall, reactions to refined story

KEY LEARNINGS

Do you want to provide unique higher quality insights to your project, let's show you how...

Success measured against metrics relevant to agency and client

AGENCY	SHARED	CLIENT
Recruitment	Quality of insights	Ability to view research
Respondent experience	Speed	Cost
		Quick insights

Recruitment

TRADITIONAL	AGILE
Good response rates	Good response rates
Ease of recruiting to a range of time slots	Challenge is getting the full sample to participate in the same timeframe

Respondent experience

TRADITIONAL		AGILE
A familiar methodology	=	Flexibility on how and when to participate
HCP is fully focused		Perception of greater burden with multiple engagements
Ability to ask questions to aid understanding		

Client Participation

TRADITIONAL	AGILE
Live viewing, request probes in the moment, tweak stimuli during fieldwork	No live viewing
Greater time commitment	Phased approach enables refinement of stimuli plus areas of focus

Speed of insights

TRADITIONAL	AGILE
Full findings available only after analysis and reporting are complete	Responses and topline data can be immediately available once each phase is completed

Quality of insights

Same overall pattern in terms of message performance, but...

TRADITIONAL	AGILE
Greater depth of responses, but no option to retest revised messages with same respondents	Less depth of responses, but opportunity to retest revised messages with same respondents
Lower insight confidence given typical smaller sample size	Increased insight confidence given potential for larger sample size
Higher ratings across the board	Lower ratings across the board

Our hypotheses on why ratings were lower in the agile arm

- Respondents put in less effort when they are not being watched
- Respondents may be more 'honest' when unaccompanied
- Lack of opportunity for clarification of messages

A behavioral economics lens on the differences

1. Greater cognitive effort required for a self–administered task – more energy diverted into navigating the interview
2. Having someone guide you through the discussion takes on the cognitive labour and responsibility for making it work
3. The sense of rapport, plus the feeling of being valued as an expert increases engagement

Cost

TRADITIONAL	AGILE
More expensive, primarily driven by moderation costs	Less expensive, primarily due to reduced moderation cost

IN SUMMARY
No outright winner, but each approach has its advantages

IMPLICATIONS FOR MARKET RESEARCH

One size does not fit all – approach must be tailored to needs and constraints

TRADITIONAL
- Complex recruits
- Depth of insight is the priority
- Complex topics
- Low volume of stimuli

AGILE
- Simple recruits
- Speed of insight is the priority
- Iteration required
- Large volume of stimuli
- Restricted budgets

HYBRID
- Agile pre–task followed by depth conversation or vice versa
- Note, cost implications must be considered
- Low volume of stimuli

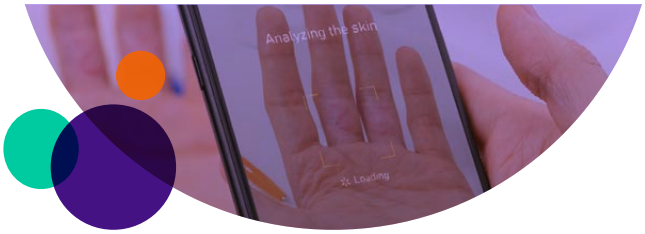
KEY TAKEAWAYS
- Agile and traditional approaches offer differing benefits and drawbacks
- Methodology selection must consider research and client needs, with approach selected on a case-by-case basis
- Client processes can also hinder methodology, e.g., turnaround time for approval of stimuli changes; market-specific requirements such as medical approval

Jarod Ricci, Strategic Insight Director, GSK | **Margaret Henry, PhD,** Director, Adelphi Research, Margaret.Henry@AdelphiGroup.com

Research Partnership
Inizio Advisory

HOW BEHAVIOURAL ECONOMICS CAN HELP YOU BUILD BETTER BRAND COMMUNICATIONS

Roy Rogers Director



For pharma marketers, accelerating brand performance means maximising return on investment, whatever the marketing spend. It's not enough to deliver clever campaigns – they need to be optimised to trigger the right emotions, and the right actions, to the right audience. Combining behavioural economics, technology, and artificial intelligence can make a world of difference...

In today's pharma industry, there's increasingly less time available for HCPs to interact with sales teams, absorb marketing materials, or learn about new products. And when marketers have just moments to make an impact, it's crucial they present those target HCPs with material that resonates and positively influences their future prescribing. To do that requires a deep understanding of how audiences consume marketing materials and messages – something that's improved significantly in recent years. But while there's now an appreciation of the subconscious behavioural biases that influence how we respond to marketing, our industry's still developing and testing most communications campaigns using more traditional insight gathering. Behavioural economics is your chance to go deeper.

The power of unspoken reactions

In his book, Thinking, Fast and Slow, Nobel Prize-winner Daniel Kahneman introduced the concept of system one and system two thinking – a way to understand how humans react, process information, and make decisions. System one thinking is all about instant gut reactions – the mental shortcuts, biases, and heuristics hard-wired into the human brain to help us survive. It happens so fast that it reflects how you instinctively feel about something, and the emotions it triggers. Meanwhile, system two is about more logical, considered, slow decision-making. Instead of reflecting what you feel, it reflects what you think. It's what traditional marketing insights – based on qualitative interviews, surveys and focus groups – have tended to draw on. You ask people a question, they consider the answer and tell you what they think.

Identifying the emotions that drive action

The problem is, the traditional, direct question and answer format of primary market research doesn't give you people's instinctive, emotional, system one reaction – and that's what they're far more likely to act on. But there's good news. Tech is giving us a whole raft of new ways to tap into target audiences' system one thinking – to better understand their gut reactions to brands and campaigns, and the actions they're likely to take. For marketers, these tools are a hugely valuable opportunity to create more impactful campaigns through deeper pre-launch testing and development. Building them into your creative process isn't about throwing out everything you've done before; it's about making it even better. In-depth, qualitative interviews and surveys are still powerful, but by adding new tools and techniques into the mix you can get an even clearer picture of how HCPs perceive your creative content – and make brand and prescribing decisions. Armed with that extra level of insight, you can refine your messaging, resonate better with prescribers, and make sure your product reaches more patients. Let's take a closer look.

Eye tracking... with added AI

The concept of tracking people's eye movements to see what draws their attention isn't new, but developments in AI have made it more accurate and – crucially – more accessible. In traditional eye-tracking research, respondents would sit in front of a screen, either on site or at home, and a webcam would monitor where their eyes were drawn as they were shown new material. The problem with that approach is a practical one. It demands a sizeable number of respondents, all sitting in front of the right technology, and capable of using it properly. Building in AI software that measures attention takes that complication away, enabling you to assess work faster and streamline your projects, using tech to replace real-life respondents for this aspect of the insights. It's a biological algorithm developed by Dragonfly AI, and is based on years of academic research into how the brain responds to visual content across five neural pathways. By applying the algorithm to pre-launch campaigns, you can replicate the way the human brain, regardless of country or region, will ingest and prioritise your content. The tech identifies where people will look first, what they'll focus on and what they'll overlook, enabling you to develop and strengthen your campaign.

Implicit response testing

What eye tracking can't tell you, even with the addition of AI, is what people feel about what they're seeing – and that's important. We know that, in addition to the rational reasons for believing a particular treatment is the right choice, prescribers need to emotionally feel it's the right decision if they're going to commit to doing it. That's where implicit response testing, or IRT, comes in. While the tech behind it isn't new, it's a tool that's starting to attract marketers' attention for the powerful customer insights it brings. The idea is to access your audience's instinctive, unspoken, system one reactions to whatever you're showing them, whether it's new branding, campaign work, or wider marketing content. While traditional research interviews tend to give us people's explicit, considered responses, IRT taps into their more implicit emotional responses by making them react at speed, and in the face of distractions. One application of the approach works by showing a piece of branding or comms, then displaying a series of adjectives on the respondent's screen. For each adjective – 'strong' or 'trustworthy' for example – they're asked to instantly hit a yes or no button to indicate whether the content they saw triggers that feeling. The tech doesn't just track the responses they give, it measures how many milliseconds they take to respond. Faster responses indicate more conviction, so you might see that while 80% of people said they felt your campaign conveyed trust for the brand, far fewer answered quickly enough to indicate they felt it with conviction – showing clear potential to improve before you launch.

Facial coding and voice anlaytics

While it tends to be used most in consumer advertising, facial coding is another useful way to identify the emotional responses generated by your communications. Based on years of academic research into the known meanings of instinctive facial expressions, it captures images of respondents as they look at your work, overlaying their faces with a grid and running a coded analysis of what various areas of the face tell us about positive, negative, and engaged responses. By aligning those responses to a range of emotions, researchers can give you a picture of what respondents were feeling. In a similar way, voice analytics software works to identify people's emotional responses to what they're being shown. They're asked to talk about what they see, but as well as collecting their considered, system two thoughts, voice analytics can decode the emotions behind particular expressions and voice patterns, helping you access their unspoken feelings too.

Availability analysis

Understanding how your campaigns and communications make HCPs feel in the moment is hugely powerful, but we can also use behavioural economics to go further, identifying which elements of your messaging or creative work stay with them days or weeks later. To do that, we use a technique called availability analysis. While it's lower-tech than some of the tools above, it's a highly effective way to understand which elements of your creative are working hardest – what sticks in people's minds and which messages really, truly land. It's built around the premise of the availability heuristic – a well-known behavioural bias – which describes our tendency to use information that comes to mind quickly and easily when we're making decisions. Improbable but pertinent things can cloud our recall, for example a strong association with a serious adverse event, even if incredibly rare, can stick in a prescriber's mind. It comes down to the fact that, as humans, we just can't retain all the information that's given to us. For that reason, it's essential that marketers understand which elements of their messaging are likely to be retained long-term, and how that will influence prescribing decisions. For example, if you spoke to a doctor for an hour, using various pieces of visual comms, and then called them back an hour later to see what they remembered, chances are they'd be able to recall the majority of what you'd said. But if you called them a week later, the amount they'd be able to remember would be much, much smaller, with recall dropping off dramatically after a few days. Availability analysis helps you identify which pieces of information remain 'available' in the HCP's mind, so you can understand the stickiest parts of your messaging and check whether your key messages are as memorable as they should be

Turning insights into strategic recommendations

Each of the above approaches is an opportunity to understand, and influence, your target audience more effectively. But once you've got these insights, it's crucial to apply them strategically – identifying gaps, adapting content and format, and improving your branding and campaigns so you get a better return on investment from your marketing spend.

Health Literacy: Healthcare Market Researchers' Responsibility and Opportunity

By Intellus Worldwide's Clear Health Communication Taskforce

Low health literacy is related to medication errors, device misuse, lower compliance, and poor health, but is traditionally not considered in market research studies. The purpose of this article is to raise awareness of how health literacy could be used as a lever to improve public health, while challenging market researchers to consider health literacy as both a responsibility and an opportunity in their research designs.

I. Negative impact of low health literacy on compliance

Patients' well-being suffers with poor understanding of their health and available treatments. Device and medication misuse can cause problems for patients' health. In the US, billions of prescriptions are written every year. More than half are taken incorrectly or not at all.[1] In a survey of 1,000 patients, nearly 75% admitted to not always taking their medication as directed.[2] Another study of over 75,000 commercially insured patients found that 30% failed to fill a new prescription.[3] There are many explanations as to what leads to medication errors, device misuse, and lower compliance. With an aging population, there has been an increase in the number of medications – with different dosing schedules – given to individual patients to treat a variety of chronic medical conditions. This can lead to confusion over treatment schedules. There can also be contraindications among various medications resulting in unintended side effects or other problems affecting adherence to a prescribed plan. In 2009, Kaiser Permanente conducted an exhaustive literature review on the topic of non-compliance and found **seven patient-related barriers to compliance:** forgetfulness, financial challenge, lack of knowledge, lack of social support, culture/beliefs, lack of health literacy, and denial/ambivalence.[4] Although high cost of medications is often referenced as a major reason for poor adherence, compliance rates improve only marginally when the cost barrier is removed. Health literacy may be a key lever to improving patients' health.

The Role of Health Literacy

The key to understanding and improving compliance is the role of health literacy, which has been defined as "the degree to which individuals have the capacity to obtain, process, understand, [and act upon] basic health information and services needed to make appropriate health decisions."[5] Multiple studies suggest a link between low health literacy and low comprehension. Research shows only 12% of the population is health literate.[6] People with low health literacy may not understand their health issues (e.g., diabetes, high blood pressure, high cholesterol). This lack of understanding can result in devaluing its treatment, which can negatively impact their health in the long term. While certain populations are at greater risk for experiencing limitations on their health literacy (e.g., individuals who speak English as a second language), the state is by no means static. Rather, health literacy is dynamic, changing for individuals based on the context of any given situation. Even people with advanced education and reading skills can face health literacy challenges. Consider the stresses imposed by health emergencies. At such times, even the most health literate individual may experience difficulties understanding or processing health information. Simpler and easier-to-understand patient materials, therefore, benefits everyone.

II. Low Health Literacy Challenge for Market Research

There are four main challenges that low health literacy presents to market research:

Recruitment. Patients with low health literacy are traditionally screened out of samples because researchers want respondents who can understand the information provided in the study and can effectively communicate their feedback. This common practice leads to the exclusion of an important segment of the population. When the study has implications for communications to patients, such as patient education materials or instructions on using a device, this approach is not only deficient in research design, but it also doesn't allow for the learnings that will help create materials that can be better and more easily understood. It is difficult to recruit people with low health literacy and the tools are still being developed.

Participation. Patients who are lower in health literacy tend to be more reluctant to participate and voice their opinions. This lack of participation arises from lower confidence or embarrassment in their abilities, such as having difficulties speaking, reading, and/or understanding – whether it is a challenge with the English language or medical terminology. Researchers must change the way they collect their data in order to make this work. For

[1] Cutler DM, Everett W. "Thinking outside the pillbox – medication adherence as a priority for health care reform." New England Journal of Medicine. (2010). 362:1553-1555.
[2] Osterberg L, Blaschke T. "Adherence to medication." New England Journal of Medicine. (2005) 353:487-489.
[3] "Enhancing prescription medication adherence: a national action plan." National Council on Patient Information and Education. August 2007.
[4] Oyekan E, Nimalasuriya A, Martin J, et al. "The B-SMART appropriate medication-use process: a guide for clinicians to help patients – part 1: barriers, solutions, and motivation." Permanente J. (2009) 13:62-69.
[5] US Dept Health & Human Services. Healthy People 2010. Washington, DC: US Govt Printing Office. 2000.
[6] US Dept. Health & Human Services, Office of Disease Prevention & Health Promotion.

example, during in-person research, moderators should provide extended warm-up time at the beginning of the interview to build trust. They should also understand that bland or non-committal participation (e.g., "yes I agree", "no I do not like that") are a signal of potential problems, and thus be prepared to shift activities as needed to get more involved participation and better data.

Analysis. Once included into the research, data for low health literacy patients should be analyzed separately from those with adequate literacy to ensure the needs of this at-risk group are not missed. With the proper data collection techniques, researchers should have uncovered the true reactions of the low health literacy group to be included in consideration, rather than being lost in background noise.

Stimuli. The stimuli used in research – which is often closely linked to the actual communication to the patients – should be formatted to follow best practices for health literacy.[8]

III. Results Market Research Study

In an effort to better understand health literacy, the Clear Health Communications Taskforce conducted two market research studies, one with healthcare practitioners (not discussed here[7]) and another with patients. As noted above, special efforts were taken to include low health literacy patients who are not usually included in traditional market research studies.

Patient Study

For the patient study, the objectives were to: (1) Assess individuals' health literacy; (2) Assess comfort with filling out medical forms; and (3) Determine how an individual's health literacy impacts their ability to read a medication label

Sample. Research was conducted with 805 patients, half of whom had high blood pressure (hypertension) and half among the general population. Special recruitment was in place to ensure adequate numbers of patients with low income and low education. Respondents completed a 10-minute online survey.

Method. Although the Newest Vital Sign (NVS) has only been validated for in-person research, we adapted the tool for online use. A component of this research was used to understand how the NVS may be administered online. The measure used was a series of 6 questions about an ice cream nutrition label. Respondents were grouped into adequate vs. limited health literacy based on their score. Half of each group was randomly given the traditional label and half was randomly given the optimized label.

Stimuli. For the purposes of this study, the traditional pharmaceutical label was modified into the optimized label by following some of the health literacy best practices described in the list above. This was a proof of concept study, to allow us to document the effect a minimum change would have. If this were an actual market research study for a product to be launched, we would recommend engaging a health literacy consultant and conducting research with people who have low health literacy.

Key Findings. Contrary to expectations, the improved label did not have a big effect among those with low health literacy, with only slightly improved comprehension of the product label.[8] This highlights the importance of additional work such as including low health literacy respondents in research and hiring a health literacy consultant to achieving a better result for this group. Most surprising to us, the biggest positive effect on comprehension was seen among those who had adequate health literacy. The comprehension level was raised by over 30%, to a level indicating that almost everyone with adequate health literacy understood the basics about the drug. This illustrates a side benefit of including those with low health literacy in our research - that by doing so we will improve comprehension for all. This patient study shows the need to: (1) Include low health literacy patients in the sample design; (2) Separately analyze performance of low health literacy patients; and (3) Carefully craft patient communications using best practices and expert consultation. Health literacy can be a key lever in improving patients' health. With some simple techniques[8], comprehension can increase, which could lead to improved compliance, as well as reduced medication errors and device misuse.

V. Intellus Worldwide's Clear Health Communications

Intellus Worldwide's Clear Health Communications Taskforce provides today's leaders in healthcare marketing research with the tools and understanding required to address the needs of all patients. By providing education, resources, and training, the team works to drive change within our industry and at regulatory agencies. This initiative is a collaboration of members across the healthcare industry including manufacturers, payers, and agency organizations. We welcome you to connect with us: https://www.intellus.org/Member-Resources/Clear-Health-Communications-Taskforce-an-Intellus-Health-Literacy-Initiative

[7] Patient counseling materials: The effect of patient health literacy on the comprehension of printed prescription drug information Research in Social and Administrative Pharmacy · Sep 3, 2018. https://www.sciencedirect.com/science/article/abs/pii/S1551741117308331?via%3Dihub

[8] Low Health Literacy and its impact on market research. Quirk's Media Oct. 2017. http://bluetoad.com/display_article.php?id=2895943&view=441559