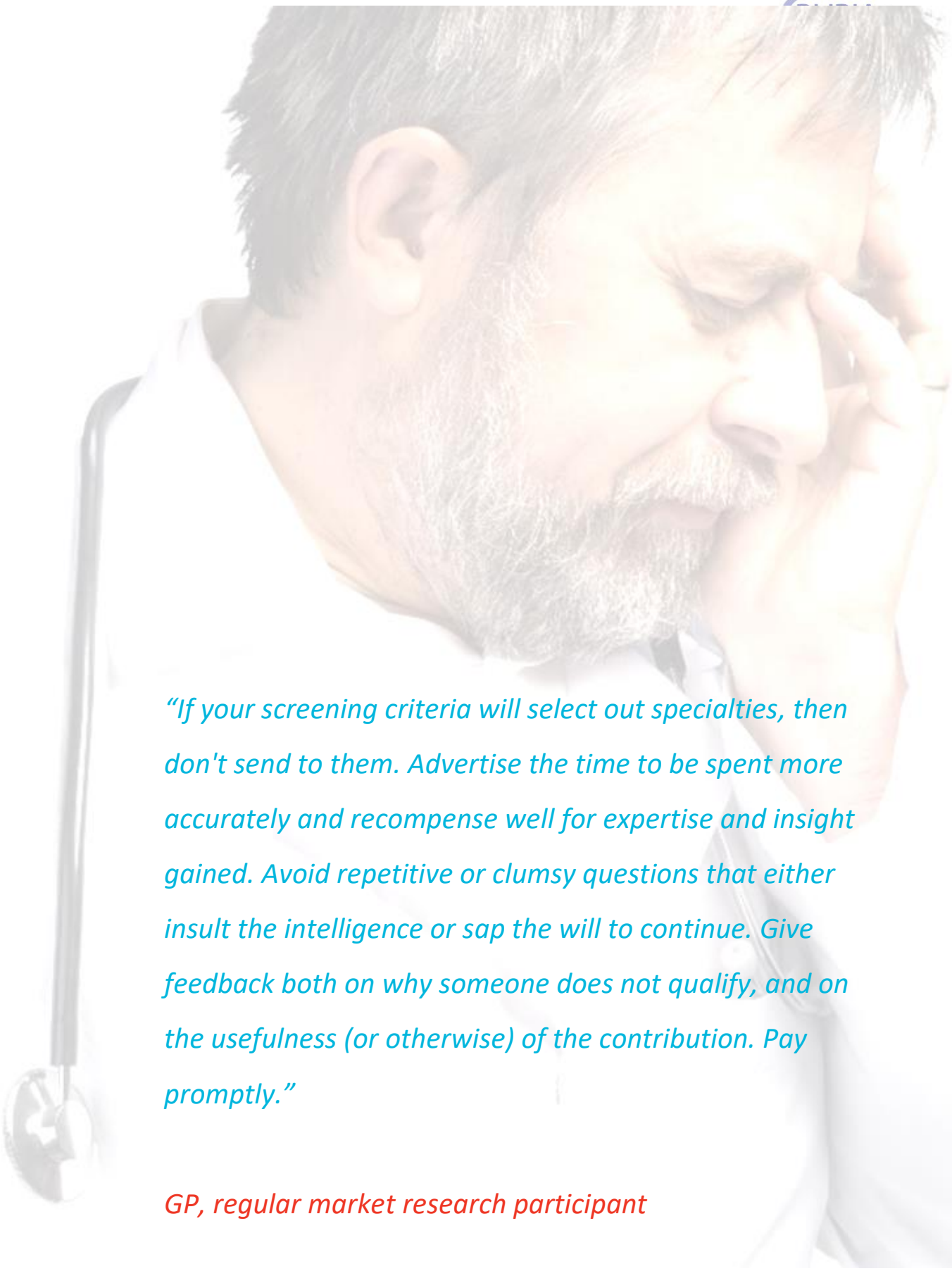
BHBIA

TIME FOR CHANGE TIME FOR

Reversing the decline in HCP participation

Initial Response Rate Task Force Report



"If your screening criteria will select out specialties, then don't send to them. Advertise the time to be spent more accurately and recompense well for expertise and insight gained. Avoid repetitive or clumsy questions that either insult the intelligence or sap the will to continue. Give feedback both on why someone does not qualify, and on the usefulness (or otherwise) of the contribution. Pay promptly."

GP, regular market research participant

CONTENTS

EXECUTIVE SUMMARY

Healthcare market research is becoming slower, costlier and less credible as a result of an ongoing decline in the response of health professionals (HCPs) to our invitations to take part.

This threatens the quality and sustainability of healthcare market research. If we can re-engage with HCPs now, by addressing their concerns and showing them the value of their contributions, they will participate more often and encourage others to follow suit. The BHBIA Response Rate Task Force has undertaken qualitative and quantitative research to establish what is holding HCPs back, and what we must do.

It's not about how much we pay them. What really matters is how we show that we value them, their time, and their expertise. **The frustration is with "screening".** HCPs say it's too long and stringent. Fixing it heads the top five changes we must make:

1.	*Improve screening*	Target more effectively, tighten the control of screening questions, be flexible with quotas, and collaborate before fieldwork, to stop wasting HCPs' time and improve data quality
2.	*Be more open and honest about timings*	To stop participants feeling they have been misled, or treated like a commodity
3.	*Improve research design and minimise repetition*	Not being bored or confused will help participants to engage more, and give better quality input
4.	*Pay promptly*	Being paid late or not at all is a real issue. Putting this right is fundamental to treating HCPs with professionalism and respect
5.	*Make participation more convenient and comfortable*	To enable more HCPs to participate, and demonstrate that we care about them

You can see the specific actions needed to achieve these, along with other recommended changes, in Key Findings and Recommendations and the summary chart on page 12.

Time for change

We have already acted via a collaboration with the Fieldwork Forum on a screening guidance document, and have plans to create and distribute supporting materials as far and wide as possible. Over the coming weeks we will seek endorsement of these recommendations from senior business intelligence professionals as well as prominent HCPs, and offer industry training to support their adoption. We plan to report again in 2020 to evaluate what progress has been made. Please act too by reading this report, sharing its messages, and making the essential changes now.

INTRODUCTION

Why a Response Rate Task Force?

In recent years, HCPs have become less willing to take part in market research. The evidence for this lies in the digital records of panel companies, the testimony of independent recruiters, and in ever-lengthening fieldwork periods. Supply-side practitioners agree that it is becoming increasingly difficult to obtain the size and quality of sample demanded by research buyers, and by good practice.

The issue slipped beneath our industry radar for some years. In the competitive world of recruitment and fieldwork it typically paid to try ever harder to achieve the sample size and specification being asked for, without query or complaint. However, once response rate issues broke the surface several years ago, via the market research press and submissions at conferences and forums, some in the industry felt a sense of relief that the problem was now out in the open, whilst others were taken aback at this previously little understood threat to market research quality.

In September 2015, the BHBIA announced the setting up of a dedicated Response Rate Task Force, to identify the specific problems, and recommend on how to address them. On its inception in October 2015, the Task Force comprised over 30 volunteer BHBIA members from all tiers of the industry. With this excellent support, we divided into three streams, each looking at a major theme in what we knew would be a multi-faceted problem:

1. The impact of our research design
2. The impact of remuneration
3. The impact of our communications

Our first meetings took place in November 2015, and following two meetings per stream we came together as one large group in the spring of 2016, with some clear hypotheses to test.

An evidence-based approach

From the outset, we agreed that an evidence-based approach would give the Task Force's recommendations the highest possible credence, and thereby the best chance of being widely adopted across the industry, at all levels from research buyers to independent recruiters.

We were determined not to be a talking shop for industry-led speculation about the causes and solutions, and so once we had scoped out the issues in the three streams, we embarked on a BHBIA funded programme of primary qualitative and quantitative research amongst HCPs to understand the problem from the only perspective that truly matters, that of participants themselves.

Our initial discussions decided that - in addition to regular participants - including the views of HCPs who either do not currently participate in market research, or whose participation had lapsed, would be crucial. We understood that whilst recruiting such people would be inherently challenging, we stood to learn some fundamental lessons about why some 'switch off' when market research opportunities are presented, and how to address that.

Ensuring good practice is good business

The Task Force has benefitted from input from all tiers of our industry: independent recruiters; fieldwork and panel companies; research agencies; and research buyers. This mix has helped us appreciate, as a group, that our recommendations must represent good business for all parties. There is no value in returning guidance to BHBIA members that significantly increases supply-side costs in what is a mature and highly competitive market for research sample. Equally, we appreciate that the research buying environment is under budget and resource pressure from procurement and pharmacovigilance departments, as well as being subject to other regulatory and commercial interests.

Our intention was to arrive at a readily implementable set of recommendations that not only met with BHBIA Board approval, but which a range of industry leaders would feel comfortable endorsing, thus maximising the weight the findings carry, and increasing the chances that they will convert into everyday practice.

New recruits?

One keynote we would like to sound in this report is that our collective success or failure in addressing the major issues identified will not only decide how the response rate problem is resolved in the short to medium term, but also potentially clear the way for the recruitment of new participants. Our contention as a Task Force is that the recruitment of fresh HCPs into all forms of market research will follow on naturally if we get these basics right. Further, that until we do so, there is little or no value in investing heavily in attracting new recruits.

ACKNOWLEDGEMENTS

First and foremost, thanks to the BHBIA Board for inaugurating and funding this Task Force, and to Leesa, Sam, and Aline for organising venues and meetings.

Next, to all contributing Task Force members - listed overleaf - who have volunteered their valuable time and ideas to the cause over the last 18 months and more.

Special thanks to Jane Galvin and Peter Slade for conducting and reporting the qualitative interviews, and to deFacto Research for recruiting them.

To Ram Patel for his thorough review of the quantitative survey design.

To James Macleod for representing the Task Force at BHBIA Board meetings.

To Jeanette Crowder, Katie Wallington, Marie Harrison, Emma Owen, and Ram Patel for detailed and constructive comments on the draft.

To Engine Rooms, for use of their viewing facilities.

And a special mention for fieldwork companies SHC Universal and SERMO, for generously recruiting and administering the quantitative fieldwork at cost-price, allowing the Task Force to achieve a much more robust HCP sample base for its budget than would otherwise have been possible.

TASK FORCE MEMBERS

Co-Chairs	John Aitchison	First Line Research
	Melanie Bayley	deFacto Research
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	Steve Johnstone	AbbVie
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KEY FINDINGS AND RECOMMENDATIONS

Foreword

We make five key recommendations in this report. Three of which relate to issues of trust and goodwill in relation to how we treat HCPs who choose to participate in market research.

Arguably the most basic tenet of market research is that its continued success is founded on the goodwill of participants. In this report, we reveal the ways in which goodwill amongst HCPs has been eroded, and offer specific and evidence-led guidance on how to repair it.

The first recommendation, to urgently revise our screening approaches, should be our clear priority.

This is undoubtedly the greatest frustration felt by potential participants and we have devoted most attention to it, outlining multiple detailed recommendations.

We do not mean to imply that our five key recommendations represent the whole story. However, they do clearly offer themselves as the most significant obstacles to participation and as a Task Force we believe they are the things that, together, we most urgently need to change.

Interestingly, there is significant overlap between our key recommendations, and those that emerged from similar research undertaken by the MRS Development Fund (2014), that found:

> *"Four major issues impact negatively on both quality of data collected and participants' attitude towards research. These are: Excessively lengthy questionnaires, or a lack of honesty/transparency about the potential length of the interview; Repetitive questioning; Insufficient opportunity for participants to have their say; Excessive classification section"*
> Findings of the MRS Development Fund (2014)

There are other important observations and guidance to be found in our report, along with several findings that some readers may find surprising (for example, remuneration levels do not feature in our key recommendations, nor in the above MRS research outcomes).

Several problems and their associated recommendations apply predominantly or sometimes exclusively to online surveys, and we thought it worth prefacing the report with the reasons for this. Firstly, online surveys account for approximately two-thirds[1] of all quantitative healthcare research presently conducted, and it is therefore the method that UK HCPs are most likely to encounter. Secondly, many of the obstacles to participation identified in our primary research were associated more with online surveying than with other methods[2]. Thirdly, online research continues to grow and diversify, especially now that mobile technology and social media use are firmly established, and we therefore expect our reporting in this area to be of both general interest and future relevance.

That said, we were careful to ensure, within the bounds of available budget and resource, that our primary research covered all methods and approaches commonly employed in healthcare market research. For more details on the primary qualitative and quantitative research undertaken please refer to the Appendix.

As well as the full report that follows, there is a summary chart of the key issues and opportunities on the following two pages.

John Aitchison, First Line Research
Task Force Co-Chair

Melanie Bayley, deFacto Research
Task Force Co-Chair

[1] According to industry data, and estimates from fieldwork managers at several large UK research agencies

[2] We acknowledge a methodology bias in our primary quantitative research, see Appendix

Summary of Recommendations

Top ways to encourage HCP participation:		
Improve screening	Better targeting	➢ Contact HCPs where specific role/speciality is known ahead of making a broader invitation
		➢ Seek to improve the breadth and depth of profiling information held
		➢ Always include 'Other, please specify' in the role/speciality question, allow HCPs entering something to continue, and review later
		➢ Engage more with local recruiters – they are usually good at finding qualifying HCPs
	Don't screen for seniority or recent participation	➢ If HCPs pass a screener in all other respects, don't penalise them for seniority or recent participation. Ask for this information later in the questionnaire / guide
	Stricter management of screening questions	➢ Ask no more than five screening questions after establishing relevant role/speciality
		➢ Always ask screening questions first, omitting those irrelevant to qualification
		➢ Always screen out as early as possible, don't keep HCPs hanging on
		➢ Tell respondents why they haven't qualified and enable their feedback
		➢ Use / adapt the BHBIA recruitment script, to improve professionalism
	Apply flexible quotas	➢ Use 'soft' and 'non-interlocking' quotas, allow flexibility
		➢ Monitor rates of non-qualification, and take early remedial action
	Collaborate with all parties before fieldwork	➢ Share draft screening questions with Fieldwork teams as soon as available
		➢ Have some flexibility on caseload and/or prescribing thresholds
Be open and honest about timings		➢ Err on the longer side or give a range when stating expected duration
		➢ Acknowledge, apologise or remove content if the advertised time overruns
Improve research design		➢ Always pilot and/or internally pre-test all materials
		➢ Identify problem questions (in online research) by analysing the meta-data

	➢ Encourage more open qualitative question techniques, and incorporate the latest thinking into questionnaire design
	➢ Research buyers – stay engaged through the fieldwork process to check these actions are carried out satisfactorily
Pay promptly	➢ State the payment terms clearly before starting the research, and on finishing it
	➢ Pay HCP remuneration within two weeks of completion
	➢ Have written procedures for handling late or non-payments, and make these available to HCPs
Make participating convenient and comfortable	➢ Arrange interviews for after 9pm, which many HCPs would find convenient
	➢ Send online survey invitations later in the day when HCPs tend to be less busy
	➢ Always provide refreshments at central location interviews
Make sure longer research tasks are fair and engaging	➢ With research that takes longer, check it pays accordingly and that engagement is maximised
Avoid death by terms and conditions	➢ Use the industry standards and proformas in the BHBIA's Legal & Ethical Guidelines
	➢ Replace reading these out in face-to-face/telephone research with a pre-participation consent form
Make it work with the latest technology	➢ Always pre-test online surveys, using browser and device emulation software
	➢ Remove questions that won't work on mobile devices
	➢ Capture, use, and share data about how participants complete online surveys
Sensible sample sizes	➢ Use a sample size calculator
	➢ Query requests for larger sample sizes
Give feedback	➢ Once qualified, tell HCPs more about why you're conducting the research
	➢ Seek to share non-sensitive and/or contextual findings with HCPs
	➢ Write regular articles about success stories for healthcare journals and the media

1. Urgently revise our screening approach

Whilst our qualitative research flagged screening [3] as a potential issue, it was in the quantitative phase that the true scale of the problem became apparent, emerging as easily the most significant obstacle to participation amongst UK HCPs.

"Failing to qualify for the main research task (i.e. following preliminary questions)" was, on aggregate, the clear number one obstacle to participation to emerge from our quantitative research work[4], and in our crowd-sourcing[5] section – which asked HCPs for suggestions on how we might reinvigorate levels of participation – six of the top ten ideas related to improving our screening approaches.

It is also worth noting that problematic screening is increasingly becoming a data quality issue for the industry, with mounting evidence to suggest that some participants choose to 'game' the system by anticipating the answers they think are most likely to qualify them, regardless of veracity. Examined from any perspective, our screening approaches are in urgent need of an overhaul.

During the compilation of this report we checked on what the BHBIA, EphMRA, and MRS Codes of Conduct (and supporting guidelines) had to say about screening, and found it to be sparse. This is perhaps surprising given that related areas are covered in detail (e.g. participants' rights and privacy, honoraria, question design etc.) and we recommend urgently plugging this apparent gap.

In total, we identify five themes related to screening approaches, based on our interpretation of the research evidence. Within each of these we detail several specific recommendations. Whilst a number of these relate most keenly to online quantitative research, where several of the major issues reside, other methods – most notably telephone interviews and to some extent pre-recruitment for qualitative interviews – are not exempt.

[3] The term 'screening' includes all types of pre-recruitment and qualifying questions

[4] From amongst n=32 items presented, using a quasi-random, pair-wise, forced-choice, 'knock-out' method. See Appendix for more information. The list of obstacles was sourced jointly from qualitative outcomes and Task Force discussion.

[5] Each participant in the quantitative research was asked to contribute one idea on how participation amongst HCPs could be improved, as well as rank ideas submitted by others. This crowd-sourcing methodology ensures each new idea has a 'fair' exposure (at least 5 HCP viewings), and that thereafter it is only re-shown if its rank is over a certain threshold value (calculated 'on the fly'). In this way, the most popular ideas rise to the top, and less popular ideas are rejected. See Appendix for more detail on the method and seed / core ideas.

Qualitative evidence

See references in Appendix:

- Negative experiences

Quantitative evidence

See references in Appendix:

- Q10 - Obstacles to participation
- Q11 - "The following are in my opinion NOT valid reasons for non-qualification..." / "The most irritating technical problem is…" / "The most irritating administrative problem is…" / "Market research could make me feel more valued by …"
- Crowdsourcing contributions

1a. Better targeting

There are several aspects to this. Firstly, and most significantly, many HCPs reported feeling highly frustrated when a recruiter or field company whom they believe must already hold information about their role / specialism sends them invitations to participate in studies for which they discover, after screening, that they do not qualify.

> *"[Do not waste] my time with inappropriate requests for which I will disqualify once I have answered the preliminary questions"*
>
> (#1 ranked crowdsourcing idea, seen 233 times - Psychiatrist, infrequent participant)

> *"You already have details of my specialty and type of practice but then ignore this information by sending irrelevant studies. I then spend several minutes undertaking a screening survey before I am told I am ineligible. This behaviour is unprofessional and NOT conducive to retaining [my] patronage of market research."*
>
> (#4 ranked crowdsourcing idea, seen 343 times – Surgeon, regular participant)

> *"Going through screening is such a pain, eventually to know that you are not eligible… As you already have details of potential participants, this should be used to do selective sending out of invitations"*
>
> (#7 ranked crowdsourcing idea, seen 226 times – GP, regular participant)

"Make sure that I am suitable before sending my email to take part"

(#9 ranked crowdsourced idea, seen 302 times – Hospital pharm., infrequent participant)

Secondly, some HCPs reported a frustrating inability to select their exact role / specialty from the options presented. Typically, this was because their specialty is differently or more specifically described, but nonetheless their understandable complaint is that they entered the survey believing it to be relevant based on the invitation and/or other introductions.

Thirdly, our qualitative research feedback, supported by comments from Task Force members, reports that from the HCP perspective being 'screened-out' can feel like a rejection, and can suggest either that their opinions lack value or that their practice is atypical or somehow lacks relevance. This potential emotional impact is often overlooked, and deserves more attention.

Fieldwork and panel companies are well represented on the Task Force, and their input has made clear that capturing and repeatedly referencing good quality information on specialty and role is logistically challenging: Not everyone provides it in full; it goes out of date; and descriptions can vary regionally and by centre type. Field companies are aware that for this latter reason some will screen-out because they do not find their specialty described precisely. Field companies will often dispatch to a broader and/or larger number of panellists to help prevent genuine respondents from being missed. The flip side of that action is, inevitably, that some HCPs will receive invitations for non-relevant studies. This issue mainly affects quantitative online research, but is also relevant to telephone based research.

Recruiters and qualitative colleagues on the Task Force point out that there has been a move away from using local recruiters in recent years. Local recruiters often have an in-depth and up-to-date knowledge of the relevant HCPs and can be effective in targeting individuals likely to meet the screening criteria, thereby reducing the attrition rate. This approach sometimes received criticism for its perceived reliance on a limited pool of reliable participants. However, now that panel companies utilising large opted-in databases and various other – less personal – modes of recruitment are an established part of the landscape, some note that this reliance on a small pool of regular responders still exists. That is, whilst panel companies may dispatch invitations widely, a large proportion of actual participation can be traced to a hard-core of opted-in HCP panellists.

We recommend:

- **Dispatching initially only to those for whom role / specialty information is held**. The intention here is to minimise the perceived 'scattergun' approach to recruitment that so infuriates respondents. The fact is that the completeness and recency of supply-side participant panels varies (for any number of commercial and/or practical reasons). Nevertheless, we recommend that panel companies dispatch only to those for whom relevant profiling information is held in the first instance – and delay dispatching to a broader base of sample until necessary, to minimise the number of HCPs who are incorrectly invited to an irrelevant research opportunity. In the longer term we expect the quality of participant profiling in the industry to improve, driven by client scrutiny and the implementation of an industry-wide customer satisfaction measure (see later).

- **That the role / specialty question includes an "Other, please specify" option (with those entering an alternative being allowed to continue)**. For some this may already be standard practice, but through the Task Force meetings we ascertained that it is not always implemented. We recommend allowing participants who do not find a match, to enter their specific role / specialty details. We further propose that they would then proceed through the remaining screener questions and – assuming they otherwise pass – be allocated to a subset for review, and possible retrospective inclusion. The HCP could be contacted to inform them of this action and any associated delay, and provided with return contact details should they wish to discuss or explain in more detail.

- **Consider increasing engagement with local recruiters, where appropriate to the objectives, and where recruiters commit to replenishing their HCP sample pool**. We of course do not want to be prescriptive as to the types of companies that should be chosen for recruitment and fieldwork, but we do think a recruitment marketplace in which local recruiters are fully utilised is beneficial to the response rate problem, because of their ability to find people who will qualify through screening without burning[6] through sample unnecessarily. Of course, the quid pro quo must be that local recruiters give commitments to expand their sample pool, on an ongoing basis.

[6] 'Burning' through sample is often used to describe the process of making many initial contacts, for relatively little return in terms of actual participation occasions.

1b. Don't screen-out for …

We asked HCPs what reasons for screening-out most irritated them. The most prominent mention was for role / specialty, as covered above. Thereafter, participants were most irritated when excluded because of their level of seniority. This can affect experienced HCPs who have practiced in their specialty for more than 30 years, as well as newly qualified HCPs who have been in post fewer than three years. The specific frustration is that these people may well qualify for the main research task (i.e. pass other screening questions) and thus be relevant to the research objectives in all other respects. As a Task Force, we feel that it is likely that significant numbers of relevant, willing, potential participants are being turned away unnecessarily for this reason.

A further source of HCP frustration (in some cases, bafflement) is being excluded for having recently completed other market research on the topic or therapy area. Unsurprisingly, those HCPs whose opinion we are most interested in are also those most likely to be in demand by research companies. We know that it is likely that many will have been recruited to similar studies within recent memory. Some may argue that exclusion on this basis is unnecessary and /or irrelevant, whilst other colleagues may be concerned about potential biasing and/or conditioning effects amongst frequent participants. In view of the response rate issues we face, the Task Force is of the view that a willing and knowledgeable participant is a good participant.

We recommend:

- **Not screening-out based on seniority.** We propose that if the research sponsor wishes to ask a question about number of years professional experience this should be made *inconsequential* to screening, and asked later in the questionnaire or interview. HCPs with greater experience (e.g. more than 30 years) or newly qualified into specialty (e.g. less than 3 years) should be allowed to proceed - assuming they pass other qualifying questions. In some settings, especially qualitative ones, it may be the case that more experienced HCPs are crucial to the objectives, in which case we agree that exceptions might be made.

- **Not screening-out based on recent participation.** Similarly, if the research wishes to ask a question about whether HCPs have completed research on the topic or therapy area within a recent time-frame this should be for information-only and not form part of the screening section. We recognise that some may have concerns about whether relaxing such criteria may lead to over / repeated engagement with HCPs. This is

possible, but our judgment as a Task Force is that we cannot now afford to be too purist about such a possibility – we are moving into territory where any relevant respondent is a good respondent!

1c. Stricter screener question management

Task Force members reported, both anecdotally and based on company data, that the number of qualifying questions being asked has increased over recent years, with some members reporting as many as 20 separate screening questions and/or screening sections that take as long as ten minutes to complete. Privately held data suggests that the average, per online research study, is eight distinct screening questions[7].

These Task Force research findings make clear that many HCP respondents are upset when – having completed a comprehensive raft of screening questions – they are excluded from full participation, usually without explanation, and almost always without remuneration.

There was a feeling amongst supply-side Task Force members that occasionally research buyers seek to bundle questions that are not strictly consequential to qualification together with genuine screening questions. It was also felt that an undesirable orthodoxy may be in danger of emerging, whereby researchers aim to ask all screening questions before screening-out the participant, rather than screening-out at the earliest opportunity.

With all this in mind, our specific recommendations point towards reducing and/or limiting the number of screening questions asked, as follows:

We recommend:

- **A maximum of FIVE screening questions (excluding role / specialty)**. That is, five screening questions after the role / speciality of the participant has been established as being relevant to the study. For example, once it has been determined that the HCP is an oncologist actively treating metastatic breast cancer patients, then a maximum of five further screening questions may be asked to confirm their specific relevance. We recognise that some may regard this as a challenging recommendation, and the Task Force therefore intends to engage in coming months with fieldwork suppliers, agencies, and client-side companies to pilot it. More to follow.

[7] Data sourced from a random selection of 15 separate online quantitative studies, sponsored by 10 different clients, over a three-month period between October 2016 and January 2017. Source: First Line Research.

- **Always asking screening questions first.** Task Force members could readily provide examples of questionnaires or recruitment scripts that mixed questions inconsequential to qualification, with genuine screening questions. We recommend always asking screener questions first - unless doing so would create a confusing or illogical break in the flow of the interview or survey. We further recommend placing classification / demographic questions inconsequential to qualification or quota control at the end of the questionnaire (or, at the very least, outside of the screening section).

- **Screening-out at the earliest opportunity**. In our view, it is unethical to engage a participant in answering further questions once their ineligibility has been determined with certainty[8]. Our research findings make clear that this causes deep frustration, and potentially undermines trust in our professionalism. Many HCPs sense that we are deliberately detaining them. Our recommendation is that participants be screened as early as possible and that fieldwork companies should be free to act assertively to query, and if necessary refuse to field, any research materials that do not do this.

- **Always issuing reasons for non-qualification (and allowing participant feedback)**. This affects online research more than face to face or telephone. Recruiters in these latter settings have an obvious interpersonal opportunity to discuss non-qualification with each HCP. By contrast, with online research it is logistically easy to redirect the participant to a page with a short message informing them of non-qualification or, worse, to no message at all. We strongly recommend that all recruiters and panel companies routinely issue polite, factual, reasons for non-qualification. Whilst we acknowledge that many fieldwork organisations will already do this, feedback from HCPs and Task Force members suggest that some do not, or that the quality of our communications could be significantly improved. The onus should be on research agencies and buyers to supply the relevant copy for these messages, when submitting the questionnaire. Furthermore, we recommend allowing all non-qualifying participants the opportunity to respond. Apart from the courtesy of allowing a right of reply, we would expect such action to have other desirable consequences: perhaps prompting changes to screening criteria and/or possibly even allowing the retrospective inclusion of incorrectly screened participants.

[8] Our earlier recommendation suggests that in the case of participants who MAY not qualify based on ambiguous or incomplete information (particularly role / specialty), they are allocated to a subset for later review. This recommendation excludes such participants.

- **Adopt the BHBIA recruitment script**. The BHBIA Legal and Ethical Guidelines were updated in September 2016 to include a new recruitment script[9]. As co-Chairs of the Task Force, Melanie and I have contributed to its review and hope that BHBIA members will adopt it. It relates, clearly, what we need to tell participants in advance of participation and can be adapted to a variety of research settings and methods. Whilst we do not encourage or expect that researchers will wish to apply the script 'verbatim', and that some companies will already have their own similar scripts in place, being consistent in what and how we communicate to participants will help pre-empt many of the recruitment related issues reported by HCPs. These findings reinforce the importance of finding a clear and concise way of getting across all the essential information, and the BHBIA recruitment script offers this.

[9] Available online at https://www.bhbia.org.uk/guidelines/legalandethicalguidelines.aspx

1d. Applying flexible quotas

Alongside screening, quotas are a significant cause of HCP non-qualification. From private company data, we estimate that reasons for non-qualification in UK based HCP online market research studies are currently split: 82% due to screening (including refusal of terms and conditions); and 18% due to quota controls[10].

Quota management can be straightforward or complex, depending on study requirements. For example, on rare occasions it is deemed necessary to have multiple quota limits that interlock with each other such that many different sample "cells" exist and must each meet their target. However, most quotas are non-interlocking, for example based on demographics – to simply ensure that the sample retains a reasonable balance across gender, age, region etc. Complex, interlocking, quotas are generally undesirable, since they naturally result in greater numbers of otherwise eligible participants being rejected simply because their sample cell happens already to be full, rather than because they failed the screening questions.

Quotas can also be 'hard' or 'soft', with the latter implying a more pragmatic approach in which some slack will be tolerated, something that hard quotas do not allow. In most cases there is little reason, from the perspective of sample quality, for imposing hard quotas – and they offer greater resistance to qualification and fieldwork progress than soft quotas.

Given the response rate issues we face, we recommend that quotas should be both 'non-interlocking' and 'soft'. That said, we have written in to our recommendations measures to help ensure that fieldwork companies do not have carte-blanche to relinquish recruitment criteria in favour of sample size or speed of delivery, without consultation.

We recommend:

- **Implementation and in-advance agreement of 'non-interlocking' and 'soft' quota controls**. Complex, interlocking, quotas should be avoided unless agreed as being essential by all parties involved. The number of quotas in place should be minimal and independent of each other (i.e. non-interlocking). Furthermore, each should be 'soft' such that some leeway is allowed as fieldwork progresses toward completion. Having quotas that approximate to an ideal should deliver sufficient sample quality whilst at the same time minimising the number of otherwise eligible participants who are excluded from the survey for reasons of quota management. However, we believe this will only work if all parties involved in the project agree in advance (in writing) what

[10] Data sourced from a random selection of 15 separate online quantitative studies, sponsored by 10 different clients, over a three-month period between October 2016 and January 2017. Source: First Line Research.

represents acceptable leeway in the soft quotas, to avoid situations where soft quotas over-run to the extent that they risk jeopardising the validity of the outcomes. There are clear mutual benefits, as implementing such an approach should also deliver the fastest feasible fieldwork times, as well as making the process of completing fieldwork less painful, and less wasteful.

- **Monitoring rates of non-qualification.** We encourage those managing fieldwork to monitor daily the number and split of non-qualifiers. Specifically, we recommend identifying the proportion of non-qualification occasions that are due to screen-outs versus those due to quota management. Researchers will then be able to make decisions aimed at minimising drop-out, and maximising sample achievement.

1e. Cross-tier collaboration pre-fieldwork

Those working in recruitment and fieldwork are eager to review and advise on screening criteria as early in the study process as possible. Typically, a proposal or quote uses a 'best guess' as to likely screening criteria, which is then firmed-up after commissioning. Task Force members in fieldwork management positions report that final screening questions are often only shared with them immediately prior to fieldwork, leaving little or no time to address any concerns. Collaboration between the research buyer, agency, and fieldwork supplier / recruiter is not something that a guideline or recommendation can ever ensure, given the many ways in which we work together and the varying demands of our projects. However, we believe there are several easy to implement actions that could be taken to improve quality and minimise stress prior to fieldwork start.

We recommend:

- **In-advance sharing of draft screening criteria with all parties**. Task Force members are acutely aware of the time pressures we all face when it comes to getting market research projects into field, and we certainly do not wish to add to that burden. Our recommendation to circulate screening questions as soon as they are drafted, to all parties involved in the project, should avoid any unnecessary drag on the process. If recruiters and panel companies have advance sight of screening questions – ideally at least five working days prior to estimated fieldwork start – it creates an opportunity for them to input their expertise. This could happen concurrently with other project tasks thereby avoiding last minute stress or fieldwork delay, whilst simultaneously allowing precious time for researchers on all sides to discuss and resolve any issues.

- **Being flexible on caseload and prescribing thresholds.** Potential participants can be lost as fieldwork chases ambitious qualifying targets related to caseloads or prescribing habits. We understand that such criteria need to be in place, but recommend that agency and supply side researchers allow flexibility. Specifically, that all parties review initial recruitment efforts and jointly assess how feasible the original requirements are in the face of actual fieldwork experience. This information can be an important finding in its own right, and striving without scrutiny for unrealistically high caseload thresholds is an obstacle to fieldwork progress, as well as a waste of good participants.

2. Set expectations honestly and openly

Our qualitative findings emphasised that HCP participation in market research is predicated on an expectation of good faith, and that lapsed or non-response was often attributed to that having broken in some way, and/or to an innate distrust of market research as an activity.

We found that those who make time for market research do so because they find the interviews or tasks interesting, or a good way to keep up to date with clinical developments, or because they are curious as to the issues currently on pharmaceutical company marketing agendas. Naturally, remuneration is important – we would be untenable without it – but Task Force moderators interpreted from the qualitative research that HCPs must firstly regard the market research opportunity as being worth their while, for non-monetary reasons. After that, if remuneration meets expectations, the opportunity to participate will typically be taken up.

Outcomes from the quantitative phase suggest that our recruitment communications may often state the expected duration of research in optimistic terms. This affects online surveys most of all, but recruitment in other research settings is not exempt. "Research that takes longer than advertised" emerges as HCPs second biggest obstacle to participation (on aggregate, out of 32) according to our HCP survey. Importantly, it is not the duration itself that is the point here (see later entries), but the perception that it took them longer than they were led to believe.

> *"Advertise the time to be spent more accurately."*
>
> (part of the #8 ranked crowdsourcing idea, seen 200 times – GP, regular participant)

There are many understandable, and unavoidable reasons why research activities might take longer than expected: Some people talk slowly; others are more ponderous when operating a keyboard and mouse; the road traffic is almost always awful; the viewing studio has double-booked; the network goes down… and so on! These sorts of problems are NOT the issue - the serious obstacle to continued HCP participation comes when people feel they have been deliberately misled or, worse, treated as if they were a commodity rather than a participant.

Qualitative evidence

See references in Appendix:

- Reasons for taking part 1 & 2
- "Is it worth my while?"
- Negative experiences

Quantitative evidence

See references in Appendix:

- Q10 - Obstacles to participation

We recommend:

- **Being conservative and/or stating a likely range when advertising expected participation duration**. In a competitive market for fieldwork, and with intense project time pressures, industry personnel on all sides are keen to make things happen on time and to specification. It can therefore be tempting to understate expected research durations with a view to attracting participants. As we reveal later, some HCPs are needled when their remuneration rate is effectively reduced because the research task takes significantly longer than expected. Their time is usually at a premium and many are upset when market research unexpectedly encroaches on their professional or leisure time. Most damagingly of all, they may simply feel that they are being misled. Making a conservative, rather than an optimistic, initial statement of research task duration would leave fewer participants with such grievances. An alternative solution is to state a likely duration range (e.g. 20 to 30 minutes) that will accommodate most participants actual experience.

- **Being proactive if a research activity takes longer than advertised.** When research takes a participant longer than expected, we recommend reacting to this immediately and/or automatically. For example, in qualitative settings, the moderator / interviewer may opt to drop questions perceived as being less important if time is obviously pressing. Comments from HCPs suggest that a simple acknowledgment would be appreciated, and may well prevent bad feeling arising. We do not necessarily link this to any increase in remuneration – our interpretation of the evidence is that this is about preserving goodwill.

3. ‘Call out’ poor design and repetitive questioning

In our quantitative research, on aggregate, HCPs placed “Repetitive and/or boring questioning” as the third most significant obstacle to participation (out of 32 possible obstacles). Then, when asked to tell us in their own words about, ‘the biggest problem with market research design’ the top two answers by category[11] were “Repetitive / boring questions” (23% of those asked mentioned this), and “Question wording - ambiguous / badly worded / unclear / too complex” (19% mentioned this). Taken together, 63% of all the entries related in some way to question design, or interviewer / moderation skill. In the crowdsourcing, where participants made their own suggestions for improvements and ranked those made by others, the evidence kept coming:

> *“Don't expect me to spend my time wading through poorly designed questions”*
> (#5 ranked crowdsourcing idea, seen 402 times – Surgeon, regular participant)

> *“Avoid repetitive or clumsy questions that either insult the intelligence or sap the will to continue.”*
> (part of the #8 ranked crowdsourcing idea, seen 200 times – GP, regular participant)

> *“Don't try tricky questions, or ask for a percentage of patients, as we will just guess - this does not produce good research”*
> (#10 ranked crowdsourcing idea, seen 134 times – Paediatrician, infrequent participant)

Qualitative research is less affected although not exempt from this criticism, with lack of flexibility (i.e. avoiding repetition / sameness / sticking to the script) the most common category in answer to the question, “The skills that interviewers / moderators lack is/are …”.

Some research tasks are perceived by HCPs as simply not that interesting, or as not giving the participant the right kind of opportunity to say what they want to say. In the quantitative work, “Research topics / subject matter tend not to be of interest” ranked 12 out of 32 as an

[11] Asked as an open (free-text) question, and then coded into like categories.

obstacle to participation and, “Not being able to fully or properly express my views” ranked 17 out of 32.

If the priority is to eliminate poor questions, our first step should be to offer participants a richer research experience. Whilst it can be argued that the content research buyers wish to test or understand is not always inherently riveting, there remains little excuse for adopting rigid approaches to questioning that fail to accommodate the participant’s viewpoint.

> *“The ones that underestimate the time, or with very complicated or repetitive questions are much less enjoyable, and if I recognise that as I start, I might stop”*
> (GP, regular responder, in the qualitative)

The roots of this problem run deep – it is a fact that anyone can write and field a market research question, for whatever purpose, without reference to any authority or required standard. Whilst this is not an issue we can or wish to address in this report, we set out three different recommendations aimed at reducing the negativity caused by poor questioning, based on adopting regular piloting, more ‘open’ questioning techniques, and the adoption of participant feedback-based industry standards.

Qualitative evidence

See references in Appendix:

- Negative experiences

Quantitative evidence

See references in Appendix:

- Q10 - Obstacles to participation
- Q11 - “The biggest problem with MR design is …” / “Market research could be a lot more enjoyable if …” / “The skills that interviews lack are …”
- Crowdsourcing contributions

We recommend:

- **Piloting / pre-testing all research materials**. As already mentioned, Task Force members fully appreciate that project deadlines are rarely relaxed, and that pre-testing of research materials is not always a priority when the pressure is on immediately before fieldwork. However, as a cross-tier group we strongly recommend piloting and pre-testing as by far the best way to identify and address problems with questionnaire or discussion guide design, wording, or flow. We understand that sometimes this involves additional budget as well as time and whilst it is obviously best to test amongst participants themselves, in situations where this is not possible we recommend early 'pre-approval process' testing amongst colleagues and making full use of "soft launch"[12] data, with a view to identifying any sticking points.

- **Analyse research meta-data to pinpoint problem questions**. This recommendation relates specifically to online surveys which, by their digital nature, produce (or can be made to produce) passively captured data on how participants complete. For example: How long it takes to answer each question; or the point at which a grid question becomes a problem in terms of causing dropouts and/or poor data quality. These and other data are excellent for pinpointing problems and suggesting solutions. The most common problems are already known, and we hope that research suppliers (panel companies, research agencies) will share these with research designers and buyers and that they, in turn, will accept the evidence and alter the design accordingly. Ideally this should happen at piloting stage, but adjustments can also be made in field, or simply logged retrospectively and learned from. Whilst many online research companies already undertake such analysis there is scope to expand the practice.

- **Encourage more open qualitative questioning techniques, and incorporate the latest thinking into questionnaire design**. Many qualitative practitioners already use techniques that help participants fully express their views. However, it emerges from discussion in Task Force meetings and our qualitative research that some still read from a script, or slavishly follow the guide. In all forms of research there are ample opportunities to learn from related disciplines such as copywriting, psychology, marketing, and behavioural science when it comes to improving the quality of our questions. Given that anyone is free to write and field a survey or conduct an interview it is more important than ever that industry professionals lead on all aspects of research design, and we look to the BHBIA to continue to provide a range of training

[12] "Soft launch" refers to the common practice of releasing a limited batch of sample at the outset of fieldwork, and then reviewing and the outputs, before committing to "full launch"

options in this area, and to private companies to ensure all staff are adequately trained.

- **Research buyers engaging with the fieldwork process**. To keep standards high and effectively 'police' the recommendations above we recommend that research buyers take an active interest in who is conducting their fieldwork, and how. Whilst it is important that 'the client' takes a passive role during interviewing itself, it is equally important that they remain engaged with the process, to ensure interviews are conducted as per the design intention, and to expected standards. Some Task Force members felt that research buyers sometimes effectively 'leave' the research process after the design stage and 'return' for the delivery of findings, putting fieldwork out of mind.

4. Ensure participants are remunerated promptly

It came as a shock to many on the Task Force that late payment of remuneration, as well as instances of claimed non-payment, featured so prominently in our research findings - both qualitative and quantitative. The primary culprit would seem to be online research.

"Remuneration that is not received promptly, or is late, or is not received at all" was placed as the eighth most prominent obstacle (out of 32) to research participation. We make no apology for promoting this above several other issues that may, arguably, have appeared above it[13]. It seemed to us such a worrying finding, and so fundamental a tenet of our professionalism that it must be highlighted, and rectified!

> *"You might have to badger them half a dozen, seven, eight times …*
> *to get paid for something that you did three months ago"*
> (Hospital specialist, regular participant, in the qualitative)

> *"Pay me if you promise to; at a reasonable rate, and straight away"*
> (part of the #5 ranked crowdsourcing comment, seen 402 times – Surgeon, regular participant)

> *"It is a big problem. I have received cheques written to the wrong doctor.*
> *I just shred them as I don't have time to sort it out"*
> (GP, regular participant, in the qualitative)

Our research shows that participant expectations in this regard are not unreasonable. We appreciate that quality checks sometimes mean that payment cannot be immediate (especially with online research), however a period of two weeks (see recommendations below) would seem to be ample time for any checks and balances to be conducted.

Many readers may have assumed that the three recommendations set out below were already established practice. If not exactly as stated, then in some similar form. Sadly, it seems that the HCP participant experience suggests otherwise, hence their inclusion here.

[13] Remuneration levels are given a separate mention - outside of our top five recommendations.

Qualitative evidence

See references in Appendix:

- Negative experiences

Quantitative evidence

See references in Appendix:

- Q10 - Obstacles to participation
- Q11 - "I expect remuneration to be received by ..."
- Crowdsourcing contributions

We recommend:

- **Being explicit as to payment terms**. Not rocket science, but it seems that when and how remuneration will be received is not always apparent to participants. Some may reply to say that it will be covered somewhere, perhaps in the small print, and that participants will have missed it – but the point raised by HCPs is that it is not always clear *to them*. We recommend being explicit and upfront with payment terms both prior to starting the research task and on completion, so that participants are left in no doubt as to expectations.

- **Prompt payment – within two weeks of completion.** Our findings make clear that participants do not necessarily expect to be paid immediately. One quarter of participants (25%) who raised this as an issue expected to be in receipt of remuneration within one week of completion. For a third (34%), two weeks was acceptable, and a further quarter (25%) suggested that payment within one month is fine. Whilst one week may not give some types of study quite enough leeway for field / quality control checks, two weeks should be ample, especially if quality control checks were conducted periodically throughout fieldwork. Our findings suggest that, if the above were applied, the issue would all but disappear since a majority of those who regard it as a major problem would be satisfied with that time scale. In face-to-face qualitative research settings participants would typically expect to receive remuneration immediately, but our recommendation for other settings is that remuneration should be settled within two weeks.

- **Written procedures (SOPs) for dealing with claimed non-payment or late payments.** Many research companies that administer remuneration will already have in place standard operating procedures (SOPs) or other written procedures governing the payment of participant remuneration. We recommend that all such companies or individuals include within those a subset of procedures that make clear what will happen in the case of claimed late or non-received participant payment. We further recommend that these procedures are available, on request, to all parties in the research chain, in the interests of transparency.

5. Make participation convenient and comfortable

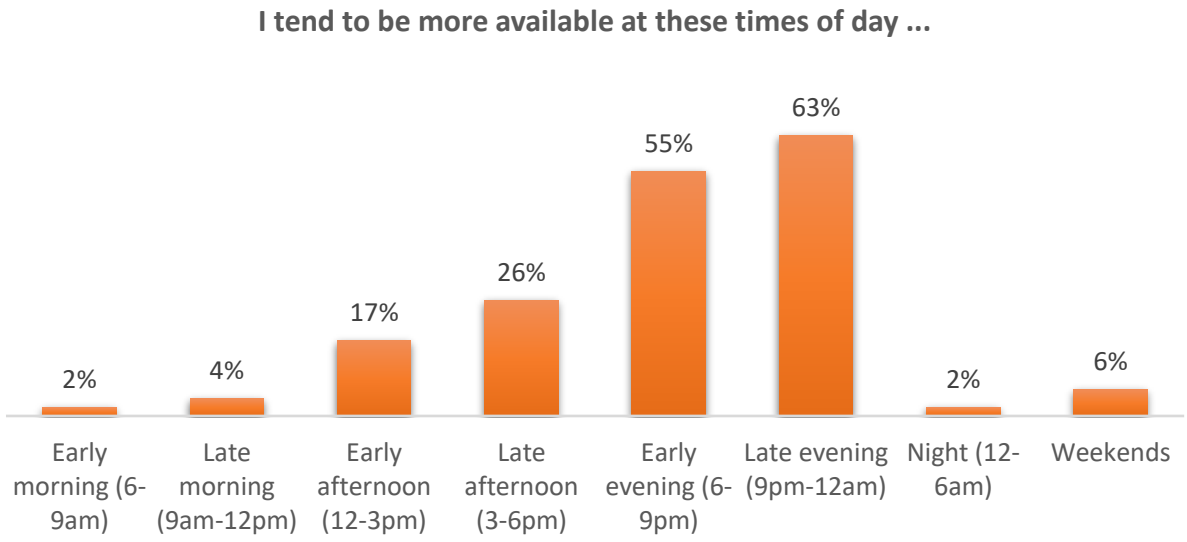
The last of our headline recommendations is to make it easier for HCPs to participate – especially when it comes to face to face or group work. Our qualitative research had hinted that this issue might emerge as a major one. Interviews found that increasing pressure at work coupled with a perceived inconvenience was putting people off. The former is beyond our control, but the latter we can address. It was shown to comprise three elements:

1. Restrictions on taking part at work, or discomfort about engaging during work hours
2. Time and cost involved in travelling to venues
3. Not enough notice / short lead times

In terms of obstacles to participation, "I just lack the time" (4 out of 32), "Opportunities to participate tend to be for inconvenient times" (11 out of 32), and "Opportunities to participate tend to be at inconvenient locations" (13 out of 32) all figured prominently in the quantitative.

> *"I don't think it's about the money really, because the money hasn't changed. It's about the fact people don't have the time"*
>
> (GP, non-participant, in the qualitative)

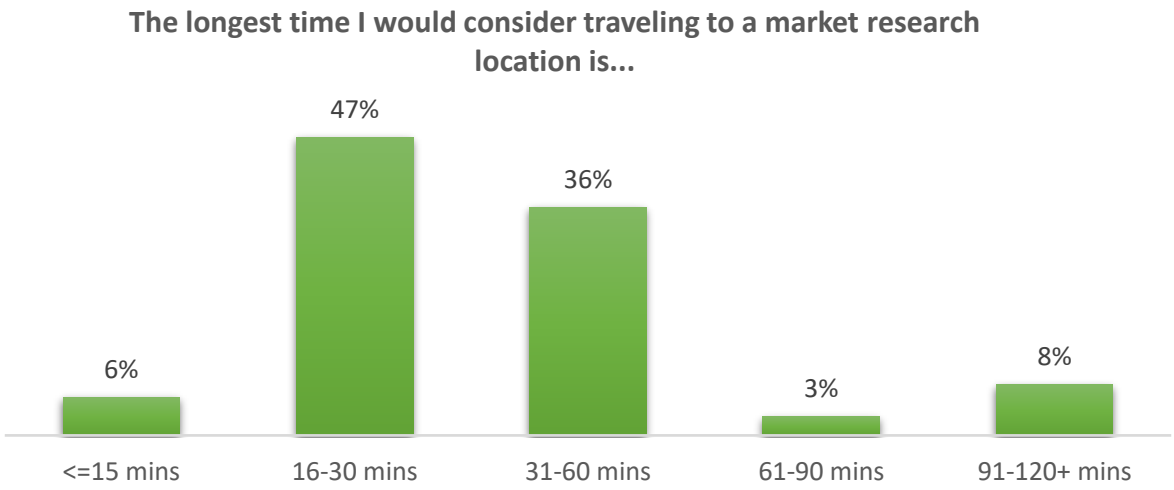
These issues could be addressed, at least in part, by issuing invitations to participate at more convenient times, so far as HCPs are concerned. Our research shed light on this:



Base: n=47 HCPs who selected "Opportunities to participate tend to be for inconvenient times" as a major obstacle to participation at Q11. % HCPs selecting each response. Multiple selections allowed, answers will sum to >100%

Whilst we know that evening is already the most common time of day to conduct research, note that over half the HCPs who are most concerned about the issue state that they tend to be more available in the **late** evening. If we could draw a similar chart to show when most research was *planned* we would notice a skew towards earlier in the day – typically late afternoon, going on to peak during early evening. This evidence suggests that afternoons are generally less convenient for HCPs, and almost nobody wants to take part in the morning.

Thinking specifically about central location based focus groups and one to one interviews, HCPs who stated that the inconvenience of traveling to such a location was amongst their top reasons for non-participation were asked for how long they would consider traveling (i.e. in terms of duration, rather than distance).



Base: n=56 HCPs who selected "Opportunities to participate tend to be for inconvenient locations" in their top four obstacles to participation at Q11. % HCPs selecting each response. Single choice, answers expressed as miles -or other- are excluded

It is interesting that just less than half (47%) are prepared to spend more than half an hour traveling, and just over half (53%) would only consider traveling up to half an hour. However interpreted, these do not seem unreasonable expectations. Of course, if more central location research were to happen later in the day then traffic conditions would be more favourable!

Whilst not having the time is a difficult argument to counter, the evidence from our research suggests that we could work on regulating the volume of invitations issued. On average, those surveyed thought they had received about ten invitations to take part (in research tasks of any kind) in the last three months. This was higher amongst GPs and hospital specialists and lower amongst pharmacists and nurses. Those invitations led to about three estimated participation occasions over the period, although amongst GPs it was as high as five.

Closer analysis of this data revealed that the higher the number of invitations received the lower the *rate* of participation. That is, those receiving higher numbers of invitations reject a higher proportion of them than do HCPs who are invited less often. We also find that most HCPs who claim to feel inundated by invitations, or claim not to have the time for market research, would welcome relatively small numbers of invitations per month (up to five), which suggests that moderating the number of invitations we send will improve our response rate.

It is interesting that other suggestions made in relation to making time for market research and/or its flexibility loop back to our number one recommendation – revising screening. For example, one third (32%) of those answering the question, "I would make time for market research if…" entered answers relating to better targeting and/or feeling that they would have a chance of qualifying. Similarly, the top answer to "The most irritating administrative problem is …" was about being invited to surveys for which they don't qualify.

Qualitative evidence

See references in Appendix:

- Barriers to Involvement

Quantitative evidence

See references in Appendix:

- Q6 - MR participations
- Q10 - Obstacles to participation
- Q11 - "I would make time for market research if…" / "The most irritating administrative problem is …" / "The longest time I would consider travelling to a market research location is …" / "I tend to be more available at these times of day …"

We recommend:

- **Arranging interviews and groups for the late evening (after 9pm), as well as the early evening (6pm to 9pm)**. The evidence suggests that this would be welcomed by many HCPs. Given the response rate climate, this is a change we could make relatively easily, and that would likely offer immediate dividends. We recognise that some companies and practitioners already cater for or encourage late evening and weekend interviews.

- **Send online survey invitations later in the day, to avoid the busiest times.** Testimony from Task Force members and data from online fieldwork companies suggests that better response rates to online surveys are achieved in the afternoon, once clinics have closed and/or physicians have done their morning rounds. This may also be the best time to contact HCPs for recruitment purposes.

- **Providing refreshments at central location interviews**. Although many will already routinely provide drinks and snacks for participants it appears, based on qualitative feedback, that not everyone does so. This can leave HCPs feeling under-valued before they begin, which may affect the quality of their subsequent feedback. It is a courtesy that can easily be arranged, costs relatively little, and helps make participants feel welcome and comfortable.

FURTHER FINDINGS AND RECOMMENDATIONS

Those five key recommendations are, in our assessment, the most important and potentially most impactful changes that we can make to address the problem of falling HCP response rates. But they are by no means the end of the story, nor do they comprise all the recommendations we wish to make.

There are other interesting and potentially significant observations that emerge from our research that should not go unnoticed. In some cases, they are the product of the research evidence. In others, they are interpretations from our discussions, and/or based on the testimony of Task Force members.

We also present a shortlist of things that we should not worry so much about. In part, these stem from areas of potential concern that arose in the qualitative work or in discussion but that were not substantiated quantitatively, and in part they simply reassure us on a few things that the evidence suggests we don't necessarily need to change!

However, we thought it worth first acknowledging what some readers may worry is an omission or an oversight – the topic of remuneration levels.

Research that takes too long

Overly long research tasks are a problem, especially lengthy online surveys, but they are not as much of a problem as research that turns out to be, or at least is perceived as being, longer than advertised. In other words, a 30-minute survey is not a problem so long as it takes 30-minutes, but a 20-minute survey that ends up taking 30-minutes, certainly is (see our second key recommendation, 'Set expectations honestly and openly'). Nonetheless, "Research that takes too long" was ranked sixth (out of 32) as an obstacle to participation in our quantitative research amongst HCPs, although it was not much mentioned in the qualitative.

Perhaps, with the increasing use of mobile technology and social media, and ever-increasing work/life time-pressure, surveys will – naturally – become shorter, or get split whilst in field and re-assembled in analysis and reporting. Yet, in healthcare market research, we continue to recruit two-hour focus groups, and field 45-minute online surveys without flinching. Given the evidence we have seen, our interpretation is that participants are happy to participate over these longer durations so long as they are engaged, properly remunerated, and treated with respect. Research tasks that are perceived as boring or unproductive are likely to be rejected or abandoned as being too long, regardless of whether they run to time.

Quantitative evidence

See references in Appendix:

- Q10 - Obstacles to participation
- Crowdsourcing contributions

We recommend:

- **If longer research tasks are necessary, ensure they are engaging and properly remunerated**. We do not recommend against longer surveys per se because we know they are often considered necessary in healthcare, to cover the ground and investigate more detailed clinical opinion. It is when such tasks seem to drag that the problem arises. The answer, we feel, lies in the quality of the task itself – which is ultimately a professional challenge to research designers and moderators.

Terms and conditions

It may surprise some readers to learn that our market research "terms and conditions", including participants' rights and adverse event reporting obligations ranked as high as seventh out of 32 potential obstacles to taking part, according to our quantitative work. This makes them a greater perceived obstacle to participation amongst HCPs than poorly designed questions, or research on topics that lack interest!

Our qualitative work amongst HCPs led us to believe that the problem is about how the terms and conditions – which must either be listened to or read prior to participation – are perceived as an extra irritant on top of the key frustrations: non-qualification and poor targeting, research that takes longer than advertised, repetitive and/or boring questioning, and dwindling 'spare' time.

One obvious problem when thinking about how to address this is the need to meet our obligations under MRS, ABPI, BHBIA and data protection guidelines. That is, we must share this information with participants to gain their explicit, opted-in, consent. We now know that forthcoming data protection legislation (GDPR) will increase the burden in this respect, and we will therefore have even more information to share with participants in future.

Although we cannot say definitively from the evidence captured, we strongly suspect it is more of a problem in face to face and telephone research settings, where the information must be read out. In self-completion settings, the participant can at least choose to skim-read (or ignore), the information and select the relevant 'opt-in' choice as presented.

Qualitative evidence

See references in Appendix:

- Barriers to Involvement

Quantitative evidence

See references in Appendix:

- Q10 - Obstacles to participation

We recommend:

- **Adopting industry standards and proformas as set out in the BHBIA Legal & Ethical Guidelines**. Ultimately there is little we can do to make this problem go away since we must share the information with participants and gain their informed consent. However, we can apply this in a consistent and professional manner and to that end we refer readers to the BHBIA's Legal and Ethical guidelines, that are kept up to date as to the latest requirements, and also include useful pro-formas to help with implementation.

- **In face-to-face (and possibly telephone) settings, respondents could be provided with a consent form to complete immediately prior to participation**. Doing so would give participants the choice as to whether to read the terms and conditions in detail, or not, as they saw fit. Qualitative feedback and contributions from Task Force members confirm that in many cases, HCPs are already familiar with the content and are in principle already decided in favour of accepting.

Keeping up with technology

At least two-thirds of quantitative research amongst HCPs is now conducted online[14], which makes keeping up with technology relevant to any discussion of response rates. Whilst we can't control or legislate for the overall fitness of the internet, we can make sure that our online surveys and mobile based research tasks work reliably on all popular browser and device combinations. That is, HCP respondents should be able to complete just as easily on their smartphone as on their desktop computer.

The table below shows the type of device HCPs in our quantitative research used to participate at the outset of the survey, and how that compares with the breakdown amongst those who went on to complete.

	All HCPs who attempted the survey (n=617)	All HCPs who completed the survey (n=423)
Desktop / laptop	65.2%	66.4%
Smartphone / iPhone	20.6%	18.4%
Tablet / iPad	14.3%	15.1%

The first thing to note is that over one third of HCPs (34.9%) who attempted the survey did so using a mobile device. Privately held data from panel companies and online research companies confirms that this is a true reflection of the current picture, and that levels of mobile device use have at least doubled in the last twelve months (i.e. since summer 2016). Secondly, that smartphones are more commonly used than tablets.

In today's social media and 'App' rich environment, user experience must meet expectations otherwise people will move on. Panel company representatives on the Task Force confirmed that any difficulty completing online surveys increasingly leads to participants dropping out. We also know from survey meta-data that drop-out rates are appreciably higher amongst those using smartphones and tablets than amongst those using laptop or desktop computers with monitor/s. The table shows that in our survey the drop-off rate amongst participants using mobile devices was minimal – but we know that this is not always the case.

Beyond the obvious implications for completion rates, poor application of technology creates an image problem for market research. More so if we decide, as some companies are now choosing to do, to screen out potential participants at the outset of a survey based on which browser / device combination they are using. This is typically done to ensure that survey

[14] By which we mean online surveys, mobile / app based research, or research via other digital channels

questions will render as intended (which can sometimes only happen with larger screen resolutions) and which means rejecting those using most types of smartphone and some types of tablet at the outset of the survey. Such actions cause response rates to fall further, annoy participants, and tempt us to delay addressing the fundamental technical issues. Asking participants in this situation to complete later, using a different device, will do nothing to improve their patience with our profession.

Another corollary of survey usability is data quality. If HCPs are having to struggle through a survey we can expect the authenticity of their responses to be poorer. If such a problem could have been avoided by technology that worked as intended, then it is arguably unfair if – as an industry – we go on to reject that participant from the final sample and/or from payment, because of poor quality responses.

In terms of the extent of the technology problem, we found in the quantitative research that, "Technical problems that prevent or interrupt research completion" emerged tenth out of 32 potential obstacles to participation. Such problems had been predicted by the qualitative research, where a category of feedback emerged in relation to negative online research experiences. When asked in the quantitative research about "the most irritating technical problem" we find that answers in the category of "survey doesn't load / screen-freeze / programme crashes" are top, mentioned by almost one quarter (23%) of participants who told us such technical problems were a major obstacle to participation (n=77).

Qualitative evidence

See references in Appendix:

- Negative experiences - online surveys

Quantitative evidence

See references in Appendix:

- Quantitative survey meta-data
- Q10 - Obstacles to participation
- Q11 - "The most irritating technical problem is …"

We recommend:

- **Using browser and device emulation software to pre-test online surveys**. There are several commercially available online software options designed to accurately mimic combinations of device type, operating system, and browser version[15]. Using such services to routinely pre-test online surveys is a reliable way of pinpointing issues ahead of fieldwork. We recommend that such a practice becomes an expected quality standard in the industry.

- **Phase out question types that can only be rendered on larger screens.** Screening-out participants, because of the device being used, immediately after they have clicked on the invitation to an online survey should be avoided for the reasons described. Whilst it is desirable to capture and analyse this data, it is not helpful to act on it in this specific case. Rather, we recommend that survey designers who have a question that does not render well on smaller screens should either drop it, or create a version of it that does work on the most popular mobile device / browser combinations. If a question cannot be rendered on smaller screens but is judged essential, we recommend informing the participant and asking them if they would mind persevering – stating the reason. Whilst not ideal, this is better than screening them out. We acknowledge that education is needed as to the question types that work best for different types of device and platform, and we offer this as a suggested topic for future BHBIA training.

- **Capture, maintain, share, and act upon online survey meta-data records**. A huge variety of data on precisely how participants complete online surveys can be captured and used to understand technical problems, as well as identify opportunities for improving the participant experience. The more of this information that can be shared amongst online survey designers, and in training settings, the better.

[15] For example, Browserstack and CrossBrowserTesting

Sensible sample sizes

Although the evidence for this recommendation lies outside the scope of our primary research findings, multiple other sources[16] tell us that a disproportionately large swathe of healthcare professional retirements is expected over coming years, especially amongst GPs. Leaving aside an analysis of this, the implication for healthcare market research is that our potential sample pool will almost certainly reduce further as a result.

We note that research buyers and agencies continue to request relatively large round numbers for their quantitative HCP samples. For example, n=200 GPs or n=50 hospital specialists. On most occasions, we suspect these are the product of historical precedent or instinct, rather than a scientific approach. Using statistical sample size calculators often reveals that we could use smaller sample sizes without significant loss of confidence in the results. The BHBIA Legal & Ethical guidelines already point in this direction, suggesting to members that, "*You must limit [sample size] to only what's necessary for the MR objectives*".

For example, if a research buyer wishes to research GPs in the UK, we know that the practicing population size is circa 44,000. If we predict that about 60% will qualify, this gives an effective relevant population size estimate of 26,400. For a relatively high degree of statistical confidence[17] the recommended sample size would be n=96. If a lower level of statistical confidence is acceptable[18] then n=68 would suffice. Both levels are considered acceptable for market research. Our common experience is that many clients 'automatically' request a sample size of n=100 or n=200 for such a project, when the latter offers only marginally better confidence, costs more, adds to project time, and burns through valuable sample source.

We recommend:

- **Using a sample size calculator to estimate the optimal sample size for a given HCP population**. Such calculators are available freely, online.

- **Querying a large n= sample size request**. Such a query will often save research buyers time and money, with no loss of quality, and help preserve sample resources for the longer term. Client testimony suggests that it is not unheard of for agencies to try and increase the cost of a project by recommending sample sizes that are higher than statistically relevant – further reason to be vigilant in this regard.

[16] Including ***i*** newspaper, GP online, and BBC articles
[17] 95% confidence level, +/-10 percentage point margin of error
[18] 90% confidence level, +/-10 percentage point margin of error

Giving feedback

In the qualitative research, regular HCP participants told us that sometimes the research experience can feel incomplete, because they do not later learn whether their views made a difference, or even in what ways their data or opinions were used. As reported earlier, it is not just about the remuneration, the research must hold relevance or have intrinsic interest:

> *"It's just nice to know whether you're making a difference or not, otherwise it almost just becomes that you're doing it for the incentive and that's it"*
>
> (Nurse, regular participant, in the qualitative)

In the quantitative research this potential obstacle, stated as, "Not receiving feedback and/or not knowing how my opinion has counted" ranked exactly midway down the list, at 16 out of 32. That still makes it more of a problem than "Not being able to fully or properly express my views" (17/32), "Poor communication from market research companies and/or recruiters" (20/32), "Not enough variety in the type of remuneration offered" (22/32), or "Poor interviewers / moderators" (24/32).

When those who regarded this as a major obstacle to participation (n=47) were asked to complete the sentence, "After participating, I would like to know ….", by far the most common reply (n=47, as a category) was "Feedback on the research outcome / impact on business and/or product development".

The primary reason for not giving feedback to participants on the research outcomes is of course confidentiality. Naturally, clients do not wish their privately commissioned research findings to enter the public domain. Another reason is that it would take additional administrative and analysis time to organise such feedback, even if the principle and then the content of it could be pre-agreed between the research company and the sponsor. As we have previously stated, we do not wish to add unnecessarily to the time and resource burden.

Nevertheless, some companies – both within and beyond our sector – are experimenting with how providing selective feedback can work to help retain participants over the longer term. For example, showing participants retrospectively how their answers at particular questions (e.g. caseload) compare with those of others who took part in the research[19]. Where such actions can be proven to have had a positive impact on longer term retention rates there is a clear win/win opportunity – to give something back to participants, at the same time as preserving the sample pool.

[19] This approach is admittedly better suited to quantitative research than qualitative research

Qualitative evidence

See references in Appendix:

- Negative experiences

Quantitative evidence

See references in Appendix:

- Q10 - Obstacles to participation

We recommend:

- **Once a participant has qualified tell them something substantive about why the research is being conducted.** Historically, market researchers have thought it best to conceal, or at best briefly outline, the topic/s under research, so as not to prejudice participant answers. Add to that fears that declaring the focus of the research early on may tempt some to 'game' the system, and give answers to qualifying questions that they think will include them, regardless of their veracity. In other cases, the purpose of the research may be deemed too commercially sensitive to declare. Our recommendation is to include several sentences about the topic under research and its wider purpose, once a participant has qualified. In qualitative or telephone settings, the interviewer / moderator could explain this to the participant at the outset of recruitment and in quantitative online or other self-completion settings, this could be included on the introductory / landing page of the main questionnaire / survey itself, post qualification. In this way, HCPs get to learn more about the purpose without jeopardy to the screening process. We expect, based on our research, that this injection of meaning will improve the enjoyability of the exercise, and enhance goodwill. We further suggest that priming them with information about the purpose of the research may help them focus better, thus improving the overall quality of feedback.

- **Collaboration between research buyers and suppliers to seek opportunities to retrospectively share selective content with participants**. Non-sensitive and/or contextual findings from research may often be appropriate to share with HCPs, in a way that compares their answers with those of others. This kind of feedback appeals to people's natural curiosity, and demonstrates industry goodwill and proactivity, both of which are likely to play a role in keeping respondents positive about participation.

- **Regular articles in healthcare journals and other media channels about market research 'success stories'**. We recommend that pharmaceutical companies, research agencies, and industry bodies like the BHBIA write and submit articles for inclusion in the healthcare media (e.g. the BMJ, The Lancet etc.), for HCPs themselves to consume, showing how market research outcomes have had a positive impact. Whilst patient focused research might be the obvious candidate, positive findings relating to disease management, or HCP attitudes, beliefs, and behaviours are all – we speculate – likely to find an audience amongst the ranks of HCPs themselves. This would help spread the word about market research (see also "Recruiting lapsed and new participants"), show our work in a positive light, and go some way to demonstrating both how market research findings are used in practice, and how they can make a difference.

IMPORTANT NOTES

Remuneration

Some readers may find it surprising that whilst the topic of promptness and receipt of payment makes it into our top five recommendations, remuneration level does not. As noted in the report foreword, it also did not figure in the MRS's main findings when they completed similar research on the topic of response rates (2014). This is not to say that remuneration levels are not important, nor that they weren't mentioned at all, but in assessing the impact of remuneration levels on response rate we have been mindful of three things:

1. It is natural that most people, HCPs included, would like to be paid more for taking part in something.

2. In a similar way to the doctor who tells us that the number one thing a manufacturer could do to encourage their use of a product would be to lower the price, we should treat it as read, and enquire further for more actionable feedback.

3. We received no outright complaints about current levels of remuneration. Rather, we received numerous comments asking for 'fair' levels of remuneration, which often tied in with other comments about how research tasks often took longer than advertised, or anticipated. Given the nature of the research, this was an opportunity for HCPs to vocalise their concern on levels.

In the qualitative interviews, remuneration was rarely mentioned when participants were asked why they *didn't* take part in market research, yet it was mentioned a lot when asked about why they *did* take part. This was the first evidence suggesting that current remuneration levels are about right, and that not many are so put off by perceived low levels that it becomes an obstacle to participation.

Only two of the top ten crowd-sourcing contributions suggested increasing remuneration. A glance further down that list – to the less popular ideas – sees remuneration issues appearing with greater frequency, but never stated angrily or as a complaint. The much bigger issue is the claim that sometimes remuneration is not received on time, or not at all (see key recommendation #4), rather than not being remunerated sufficiently.

When participants were asked to decide the relative importance of 32 different potential obstacles to participation, "Insufficient remuneration for the time involved" came only fifth. We went on to ask participants who claimed this as a major reason for avoiding market research (n=111) what they thought an hour of their time spent in a market research activity was worth, in monetary terms. The first thing to note is that answers varied by role, with surgeons and pharmacists the most dissatisfied with current levels of remuneration, followed by GPs, hospital specialists, then secondary care nurses[20]. Average monetary expectations for each specialty are shown below (note the small base sizes for pharmacists and secondary care nurses).

"An hour of my time participating in market research is worth …"

	Mean (£)	Median (£)
Surgeons (n=18)	256	200
Hospital specialists (n=44)	127	100
GPs (n=31)	108	100
Pharmacists (n=14)	57	50
Secondary care nurses (n=4)	59	43

Base: n=111 HCPs who selected "Insufficient remuneration for the time involved" in their top four obstacles to participation at Q10 and answered Q11. (Numeric entry (£))

Whilst the expectations of dissatisfied surgeons would be difficult and perhaps even undesirable to meet, those offered by other specialties are by no means astronomical, which again suggested to us that current levels are about right.

When relevant participants (n=122) were asked how they chose between competing market research invitations, three answers were closely tied at the top (multiple selections allowed):

1. Based on the remuneration offered, 64%
2. Based on the time involved, 61%
3. Based on the topic being researched, 61%

Similarly, thinking about HCPs who claimed not to currently have time for market research (n=138), inadequate remuneration was their top answer (36%), but closely followed by lack of relevance / lack of interest (32%).

[20] 36% of pharmacists, 35% of surgeons, 29% of GPs, 23% of hospital specialists, and 12% of secondary care nurses surveyed ranked "insufficient remuneration …" in their top four obstacles to participation.

From industry experience, the testimony and call records of recruiters rarely include HCP refusal to participate that is based on insufficient remuneration. For example, a recent list based recruitment effort successfully contacted n=85 senior UK oncologists, of whom n=36 refused to take part. Helpfully, the recruiter's 'refusal' category was subdivided[21], allowing us to say that n=17 (47%) of refusals were attributed to lack of interest, n=15 (42%) to lack of time, and n=4 (11%) to hospital policy. None of the refusals were attributed to insufficient remuneration.

As an aside, the **form** of remuneration is not a big issue for most participants. It did not come through strongly in any of the research work, and we do not see any imperative to review the forms offered. In addition, we recognise that many pharmaceutical companies have strict internal requirements as to how HCPs are remunerated, which limits the scope for change.

These findings on remuneration suggest to us that it is more about attracting an HCP's attention with the right material, at the right time, and 'as advertised', as it is about the money. That said, we are certainly not recommending that remuneration levels be changed or lowered. HCPs would certainly notice if levels started to fall and the effect on response rates could be catastrophic! Rather, we are suggesting that current levels of remuneration are probably about right, and we feel that there is very little mileage in addressing the theme further given that other factors seem to cause greater irritation, and not forgetting that pharmaceutical industry interpretations of what represents *fair market value* (FMV) also constrain what can be offered.

Gender differences

It is worth drawing readers' attention to the fact that in several areas of the quantitative research we noted statistically significant differences by gender.

Male HCPs were more likely to:

- have taken part in market research than female HCPs *(3.5 occasions for males versus 2.4 for females, on average, in the last three months)*
- regard insufficient remuneration, or remuneration that was late or not received as obstacles to participation
- regard poor interviewers / moderators as an obstacle to participation
- regard seeing too few patients / having insufficient prescriptions as an invalid reason for non-qualification

[21] The six refusal categories were: do not do participate in market research; too busy / no time; not interested; cannot participate due to hospital policy; unwilling to participate due to incentive; do not treat / not relevant

Female HCPs were more likely to:

- select “On the basis of the time/work involved” and less likely to select “on the basis of the remuneration being offered” when asked how they chose between competing market research invitations
- regard poorly designed or poorly thought out questions as an obstacle to participation
- regard being screened out to due to specialty / role as an invalid reason for non-qualification

WHAT NOT TO WORRY ABOUT!

We arrived at the list of 32 potential obstacles to participation, fielded in the quantitative, following an analysis of qualitative feedback, and extensive Task Force collaboration. That thoroughness gives us confidence that our final list was as complete as it could reasonably be[22], and contained a broad cross-section of experience. Given this, we thought it worthwhile to briefly reflect on some of the potential obstacles that *don't* agitate HCP participants so much! With a lot to focus on at the top of the list, our recommendation is that the following are de-prioritised, since their impact would seem to be less than other factors.

- **Poor interviewers / focus group moderators; ranked 24th out of 32**. In general, qualitative research practice comes off better than quantitative in this report, and it seems that the interviewing and moderating part of our professional offering is not a major obstacle to participation. That said, a reminder that earlier we reported how some HCPs observed a lack of flexibility from some interviewers – typically in the form of unnecessary repetition, and slavishly sticking to the script.

- **Feeling taken for granted by market research companies; ranked 25th out of 32.** Our advance discussions as a Task Force wondered whether as an industry our approach to HCP participants was too complacent. In the event, this fear proved to be largely unfounded. However, this report has highlighted more specific ways in which HCPs do feel let down, and this observation should not detract from those.

- **The possibility of follow-up related to adverse event reporting; ranked 29th out of 32**. This was a relief, since we had feared that the burden of adverse event reporting might be increasingly perceived as an extra burden and/or a nuisance, and therefore a reason not to take part.

- **Concern about the impact of official directives (e.g. "Sunshine Act") on participation; ranked 26th out of 32** and **Employer restrictions on market research participation; ranked 31st out of 32.** Official obstacles to, or restrictions on, participation are of little weight relative to other concerns.

There were, of course, 'in principle' objections to participation amongst some HCPs, and whilst there may be some things we can do to address such concerns, our research showed that these were in the main solidly intransigent views, often based on a personal objection to taking part in any commercial activity.

[22] See Appendix for the complete list of obstacles shown to participants

RECRUITING LAPSED AND NEW PARTICIPANTS

Whilst recruitment for the quantitative research did go to lengths to include a good proportion of HCPs who had not participated in market research recently (14% had not participated in any market research at all in the last three months), the balance was inevitably towards those who did, whether less frequently (38% had participated only once or twice in the last three months), or more regularly (38% had participated once or twice in the last three months)

The following themes encapsulate the strongest lines of feedback to emerge from our research, qualitative and quantitative, amongst lapsed or non-participants. As mentioned in the introduction, we feel that these recommendations are for the future and that implementing preceding recommendations – especially those around screening – must be the priority.

Communicate the value

Many non-participants, as well as regular participants, told us that they don't see the point of doing market research if they can't see an outcome from it. A prevailing belief amongst non-participants is that market research is a purely commercial exercise, conducted to improve the marketing effectiveness of the pharmaceutical industry, and thereby its profits.

Whilst in some cases this belief may be philosophical and/or ingrained, we know that HCPs in the quantitative research who had NOT taken part in research in the last three months were significantly more likely to select "Not receiving feedback and/or not knowing how my opinion has counted" as a reason for non-participation. The impression from the qualitative research was that these HCPs might be won over if:

- **At the macro level**: they knew more about how participating in market research can positively impact patient care, or product development, or clinical developments.
- **At a micro level**: they thought there was something to learn from the experience – that participating would help improve their current practice, or clinical understanding.

One answer to these calls would be for individual pharma companies (in partnership with their research suppliers) and/or the BHBIA to find outlets through which positive market research outcomes could flow into the HCP media. For example, where market research had led to a deeper understanding of different types of patient and/or their care experience (i.e. via segmentation analysis), summaries of the outcomes and learnings could be turned into stories – perhaps after a delay, to respect and preserve any commercial sensitivities.

And we should not lose sight of the fact that many regular participants find participating in market research intrinsically enjoyable, or a handy way to keep up to date with both industry and clinical developments.

> *"One thing that's good is that perhaps you're finding gaps in your knowledge that you didn't think you had."*
>
> (Specialist, in the qualitative)

> *"It changes the scenery from the intensity of general practice"*
>
> (GP, in the qualitative)

Could the positive sentiments of such participants be harnessed, such that they become active advocates for healthcare market research amongst their colleagues?

Counteract unfounded privacy concerns

Other non-participants expressed a concern that market research might involve their personal data being placed on a database that will be passed-on, and that may in turn lead to multiple unwanted emails and/or unrelated junk email. Given our industry standards in this area, the BHBIA and its individual member companies could easily counter concerns and reassure regarding adherence to data protection guidelines, privacy issues, spamming, and related issues such as 'sugging' (selling under the guise of market research).

> *"I don't want my email or my phone number to be placed on a particular database, and then passed on to third parties"*
>
> (GP, NON-participant, in the qualitative)

> *"Many colleagues are not really aware of market research companies or they think it's spam"*
>
> (Specialist, regular participant, in the qualitative)

> *"My main problem with it is if it's coming from a pharmaceutical industry, my worry is that they're doing it as a form of advertising"*
>
> (GP, NON-participant, qualitative)

Whilst our terms and conditions already cover this ground thoroughly, we currently have no mechanism in place to reach potential participants and/or HCPs at large to communicate in advance that all BHBIA member companies abide by terms which commit them to relevant, legally enforceable, standards in these respects.

FOR FUTURE CONSIDERATION

The following ideas were proposed by Task Force members or suggested themselves based on the findings, but – on review – were felt to be either too ambitious for present consideration and/or would need to be subject to a wider consultative process, with a view to gauging members' views and assessing demand. We present them here for interest only.

Offering prize draw entry if extended or late screening is required

We recognise that sometimes it may be necessary to ask more than half a dozen screening questions, for example when seeking a highly specific target group. HCP participants in our research told of not being paid or acknowledged for having completed what they perceived as substantial numbers of questions, and Task Force members confirmed that this is common practice – i.e. non-qualifiers are typically not remunerated or otherwise rewarded, regardless of screener duration. We put forward the idea of administering a prize draw approach in such circumstances, so that all non-qualifiers who have spent an average of five minutes or more in screening tasks[23] are given a chance to win a prize (e.g. vouchers)[24].

A healthcare research ombudsman

One idea that emerged early on in Task Force discussions, and which we continued to count as relevant after primary research had completed, was the case for a healthcare market research Ombudsman. Our idea is for the creation of a role or body that:

1. Acts as an independent arbiter in disputes between HCPs and research companies over alleged payment or malpractice, issuing recommendations as to their resolution.

2. Is charged with representing the interest of HCPs who take part in market research.

3. Shares a record of grievances received from HCPs with the BHBIA and relevant working groups, for the monitoring and understanding of problems.

[23] i.e. as an average time taken, across all non-qualifiers and all aspects of screening - including any initial terms and conditions confirmations and/or other introductory preamble.

[24] Task Force discussions indicated that such an approach had worked well in consumer research

Our research feedback suggests that HCPs would appreciate access to an independent arbiter in the event of disputes that cannot be resolved by the usual contact between themselves and the research company, especially financial disputes. The presence of an Ombudsman may also help show that the industry is serious about protecting the rights of, and carrying out other obligations towards, HCPs who participate in market research. Such an office would enable us to keep track of the most serious issues over time. Arguably it is also a mechanism that, had it existed previously, may have seen the response rate crisis coming.

A healthcare market research "PR" campaign, amongst HCPs

To help tackle the myriad response rate issues and attract new HCPs into market research and we tentatively propose that the BHBIA consider sponsoring a communications campaign, amongst HCPs, aimed at raising the profile and perception of healthcare market research. As previously mentioned, there seems little value in doing this before we have collectively addressed the existing response rate and image problems, but the feedback from amongst non- and lapsed participants suggests that many would be open to persuasion, and that relatively few object strongly 'in principle'.

> *"Colleagues of mine ask me this again and again, how did I get into that? I can't remember how I got into it and it self-perpetuates itself. I think there are a large group of people who would be keen to do it, but don't really know how to access it"*
> (GP, regular responder, in the qualitative)

An industry-standard 'HCP satisfaction' measure.

Many research agencies and fieldwork companies now include their own feedback or customer satisfaction question at the end of interviews or surveys. As a Task Force, we agree that this is good practice, but would ideally like to see the industry – ideally under the auspices of the BHBIA – design, agree, and implement a standard and compulsory "customer satisfaction" style measure to gauge the quality of research experience. We foresee the following benefits:

- Consistency: being able to judge every research experience by the same token
- Resource: a large, informative, data bank accessible to BHBIA members
- Troubleshooting: eliminating approaches that deliver a poor experience

The competitive environment that we expect would be created by the transparent, attributed, and publicised reporting of such a measure should have the effect of pulling standards up, as companies strive for superior scores. The fairness of the system would not be open to question if – for each project scored – the name of all parties involved in the project were attributed (i.e. sponsor and/or agency and/or field company).

We appreciate that significant obstacles would confront such an initiative, not least gaining universal buy-in in the face of commercial and privacy concerns, and multiple logistical challenges. Nevertheless, the Task Force would like to persevere with our thinking about how to design such an initiative, or some version of it, in the interests of encouraging excellence in participant-led research design.

APPENDIX

Links to research documentation

Qualitative research

Conducted by Jane Galvin & Peter Slade, recruited by deFacto Research

Summary of findings:
https://goo.gl/QYhkAF

Discussion guides:

Regular responders:	*Non/lapsed responders:*
https://goo.gl/BuB5Fw	https://goo.gl/DXaQU1

Quantitative research

Conducted by First Line Research and recruited by SHC Universal and SERMO

Explanation of knock-out method: obstacles to participation

HCP participants in the quantitative research were asked, via the knock-out methodology described below, to select what they felt was the most significant obstacle to participation from a list of n=32. This was done in randomised pairs, and over a series of rounds[25]. On each occasion, the "most significant obstacle" in each pair stayed in the knock-out competition, to go up against another first round 'winner', randomly selected, in the next round. This process continued over four rounds until an overall 'winner' (i.e. a most significant obstacle) emerged.

Using this methodology, it is likely that, for an individual participant, two things regarded as major obstacles happen to meet each other in an early round, with the participant forced to choose only one of them. Whilst this is unavoidable for an individual, the effect is mitigated in aggregate, because over four hundred participants each obstacle will have just as much chance as any other of making it through the rounds. The obstacles themselves were the outcome of qualitative findings and Task Force discussion.

[25] Participants were unaware of the passing of each round, they simply selected as appropriate on each occasion asked. They were aware that they would be asked the same question, but with different items to choose between, on multiple occasions. See quantitative questionnaire for more details.

Administrative problems and/or late-running research
Colleagues may disapprove of my participation
Failing to qualify for the main research task (i.e. following preliminary questions)
I am concerned about the impact of official directives (e.g. “Sunshine Act”) on participation
I can catch up with scientific and industry developments in other ways.
I disagree with market research in principle
I don’t get the opportunities to participate
I feel taken for granted by market research companies
I get too many invitations to participate and/or I feel inundated
I just lack the time
I prefer to spend the time doing other things
I tend not to engage with commercial and/or Pharma related activities
I’m unsure what market research is and/or what it is used for
Insufficient remuneration for the time involved
Lengthy and/or off-putting terms and conditions
My employer places restrictions on market research participation
Not being able to fully or properly express my views
Not enough variety in the type of remuneration offered
Not receiving feedback and/or not knowing how my opinion has counted
Opportunities to participate tend to be at inconvenient locations
Opportunities to participate tend to be for inconvenient times
Participating in market research isn’t intrinsically enjoyable
Poor communication from market research companies and/or recruiters
Poor interviewers / focus group moderators
Poorly designed or poorly thought-through research questions
Remuneration that is not received promptly, or is late, or is not received at all
Repetitive and/or boring questioning
Research that takes longer than advertised
Research that takes too long
Research topics / subject matter tend not to be of interest
Technical problems that prevent or interrupt research completion
The possibility of follow-up related to adverse event reporting

Explanation of crowd-sourcing method

A "crowd-sourced" approach to potential solutions allowed us to test any ideas we already had as to how to improve response rates, as well as capture and test those contributed by HCPs themselves. In a nutshell: we started with a basket of ideas (n=16, see below). The extent to which each is presented for ranking changes dynamically according to how previous HCP participants have ranked, and how popular new ideas prove. Each HCP participant ranks their top three from the list presented to them, and then adds one idea of their own. There are rules to ensure that:

- New ideas get a minimum exposure (at least n=5 presentations)
- Highest ranked ideas form a dynamic top 10, and are shown alongside new ideas
- Poorly ranked ideas drop out of the top 10 or out of contention altogether (i.e. if rank score is too poor after minimum exposure)

Everything is dynamic – mathematical rules seek to ensure that every idea gets a fair chance and that good ideas rise to the top by popular opinion. The pre-provided ideas were as follows. They were formulated from Task Force discussions, and a reading of the qualitative findings.

A communications campaign, explaining what market research is and how it is used
Create an ongoing advisory panel of health professionals, to advise the market research industry on these issues
A market research ombudsman, to whom you could take complaints about bad practice or payment problems
Improve the value of remuneration offered
HCPs engaged to undertake market research covertly, and publicly publish / blog about their experience
Improve the range of remuneration offered
Release selected market research findings to the public domain
Impose financial penalties on research companies for late or non-payment of remuneration
A Participant <-> Researcher Charter which sets mutually agreeable research standards
Make it easier to qualify for surveys / reduce the volume of "screening" criteria
More open research techniques, enabling participants to more fully express their views
Shorter surveys and interviews
Feedback to the participant on how their responses compare with those of their peers
A process to "name and shame" market research companies guilty of poor practice
Change the name from "market research" to something else
Introduce compulsory professional qualifications for market researchers (i.e. as with other professions)

Data tables (opens web page):
https://goo.gl/DwGYb7

Crowdsourcing outcomes (opens web page):
https://goo.gl/Eg1fuu

Questionnaire:
https://goo.gl/7XoBmV

Further references

MRS Code of Conduct, 2014
BHBIA Legal and Ethical Guidelines, September 2016
MRS Questionnaire Design Guidelines, 2014
Confirmit White Paper, “An Innovate Approach to Fighting Survey Fatigue”
M3 Industry Compliance document

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