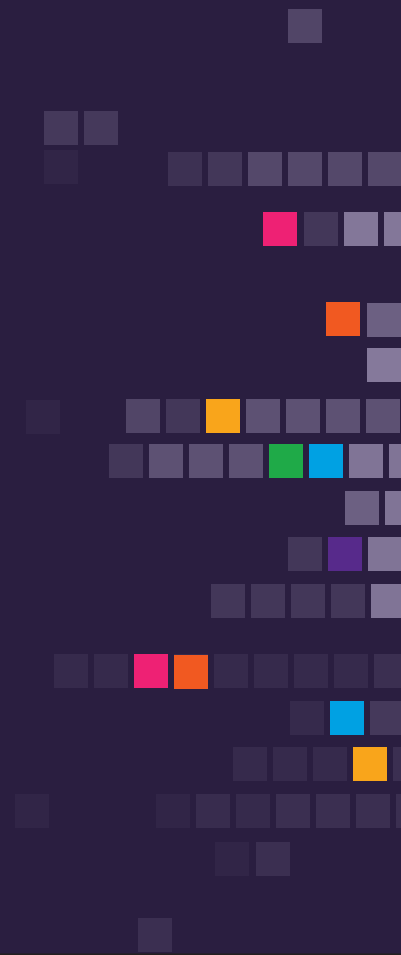




How successful medical meeting leaders reach their goals lessons from 13 experts

February 2014



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February 2014



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Terminology

The following abbreviations and terms are used in this paper:

CME	Continuing Medical Education
CRO	Clinical Research Organisation
EFPIA	European Federation of Pharmaceutical Industries and Associations
ESHLSG	Ethical Standards in Health and Life Sciences Group
HCO	Health Care Organisation
HCP	Health Care Professional
HCR	Healthcare Compliance Regulation
Industry	Commercial companies in the healthcare sector
Meeting	a CME educational activity encompassing congresses, conferences and workshops
Regulator	a trade association (either national or international) who sets HCRs
Sponsor company	a pharmaceutical or medical device company providing funds to a medical association
Healthcare sector	all stakeholders in the sector, encompassing industry, associations and regulators
Third-party observer	an industry expert not assigned to one of the other stakeholders with extensive experience of HCR
TSV	Total Shareholder Value

Snapshot

There are two kinds of medical association and there are two kinds of medical meeting: those who are likely to survive and prosper, and those who don't keep abreast of regulatory changes and legislation. The most successful medical associations and sponsor companies have a twin-track mind-set: they refine their current approach to quality and transparency while advancing new models for professional education and interactions with healthcare professionals (HCPs).

The old model is defunct

A series of powerful drivers, including changes in how interactions with HCPs are conducted, will continue to shape the relationship between medical associations and sponsor companies, making it critical for medical associations to remake their business model and upgrade their skills in order to survive.

Identifying best-practices for shaping strategies

An MCI benchmarking study that included a survey of recognised leaders at medical associations, sponsor companies, regulators and third-party entities found consensus about adaptive change present in the medical meetings industry, discordance over the effect on education quality and pessimism over the possibility to derive a harmonised European approach.

MCI has identified three critical paragons to help the medical meeting industry adapt to future realities, influence stakeholders and develop an innovative new ecosystem.

Background

Medical associations bring together speciality or sub-speciality physicians and, primarily through educational programmes, contribute to advancing the quality of medical care they provide. As such, medical associations are commonly regarded as representing expertise and authority. Perception of their activities and standards of scientific integrity define their long-term viability and reflect on the appreciation of the profession at large.

Most medical associations, if not all, receive extensive funding from sponsor companies and rely heavily on it. Industry involvement in medical education has been described as being “pervasive”ⁱ; the journey to which began in the early 1980s when policy makers, faced with funding cuts, suggested that industry sponsorship be a substitute for government supportⁱⁱ. Contributions from sponsor companies have historically subsidised the educational programmes of medical associations through the purchase of exhibition space and sponsorship items, and through paying for the travel and registration of individual doctors. An estimated \$3bn- \$5bn is spent each year on educational support by the pharmaceutical industryⁱⁱⁱ with the mean payment per physician (of those receiving large total payments) during the 2009-2010 period in the US being \$141,020^{iv}.

In recent years, the financial ties between HCPs and sponsor companies have faced intense scrutiny. Numerous studies have shown that doctors who expose themselves to company promotion tend to prescribe more, with higher costs and lower quality^{v,vi}. However, doctors have long repudiated this, with many denying any egregious behaviour and malleability to medical marketing. There is a general concern that industry influence (specifically promotion) compromises clinical decision making and healthcare delivery thus adversely affecting patient care. In the public domain, this is portrayed as a matter of conflict of interest. Industry argues that collaboration with HCPs is essential to scientific advancement and ultimately to improved patient care.

Medical education is a tough problem. As the practice of medicine depends on the availability of effective medicines and devices, doctors need industry to educate them about their products. Medical education, however, is not supposed to resemble an advertisement. Careful attention is therefore paid when the industry sponsors continuing medical education (CME) activities and funds medical associations who then curate the content of the education. Well-documented changes to healthcare compliance have ushered in a new era of transparency.

Reporting mechanisms currently being rolled-out would have been thought of as unnecessary and unworkable only a few years ago. Later this year (2014), all such physician payments by pharmaceutical companies are to be made public in the US; European disclosure is slated for 2016^{vii}.

The recent announcement by GlaxoSmithKline (GSK)^{viii} that it will stop paying doctors to promote its drugs is the result of a disentanglement process undertaken (or at least considered) by many life science companies. The management of doctor interactions is being forcibly reconceived and at a pace that many medical associations struggle to keep up with. Institutionally risk adverse, they are confronted with waning sponsorship revenue and a need to recognise new funding models. There is no immunity to change.

This paper features the results from a qualitative and quantitative survey of attitudes and opinions intended to provide a deeper and wider understanding of these issues. Recognising the differing perspectives proffered and applying this knowledge appropriately can mean the difference between taking a medical association to the next level and experiencing declining fortunes.

Methodology

Cohort

Recognised leaders and influential decision makers within the medical meeting industry were identified and classified in one of four groups: (a) *medical association*, (b) *industry/sponsor company*, (c) *regulator*, (d) *third-party expert*. The cohort was intentionally kept small and exclusive, with an even representation between all four groups preferred. A total of thirteen experts participated in the survey (60% acceptance rate), the prime reason for non-acceptance being 'other work commitments'. The cohort was composed of $a=3$, $b=4$, $c=2$, $d=3$. Participation was on invitation and was voluntary.

Data collection

In November and December 2013, the authors conducted a survey to collect information on the participants' views and experiences in the medical meeting sector. Except for five participant-specific questions (Section B in the survey), the same survey instrument was used across the survey population. The instrument (Section A in the survey) measured either positive or negative participant responses to ten questions using the Likert bipolar scaling method. The format of the seven-level Likert item was (1) *strongly disagree*, (2) *disagree*, (3) *mildly disagree*, (4) *neutral*, (5) *mildly agree*, (6)

agree, (7) *strongly agree*. A neutral mid-point was retained so as not to force participants to select a negative or positive position. In addition, an eighth position was offered, (0) *don't know*, for instances where participants may simply not have an opinion. Standard labels were used in order to minimise different notions of engagement from participant to participant; no problems were subsequently experienced by participants in placing their point-of-view on the scale. The authors also asked the cohort to explain the reasons for their given response. Section B was qualitative in nature only.

Analysis and interpretation

Proper statistical interpretation of the survey results was particularly pertinent given the relatively small cohort. The authors recognised the limitations of the survey data in that it did not generate precise numerical information, thus corresponding metrics were created in line with statistical norms. Analysis was undertaken at the standard corresponding margin of error (i.e. 95% confidence intervals). Variation analysis was performed using the *correlation variation* method.

Key findings from the survey are represented collectively in diverging stacked bar charts and, subsequently, in turn in pie charts. The interpretation of

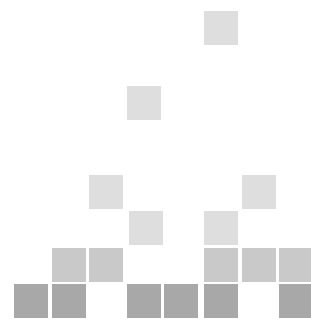
these charts is straightforward; darker colours on the chart represent higher levels of the indicator being plotted. In interpreting the charts, one should not be looking at the colour at a specific point but at the colour change trends.

Cohort Demographics

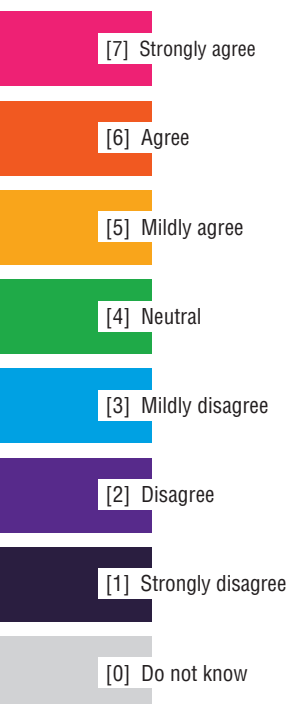
Name	Position	Institution or Company	Country
Michel Ballieu	CEO	ECCO (European CanCer Organisation)	Belgium
Isabel Bardinet	CEO	ESC (European Society of Cardiology)	France
Umit Dereli	Secretary General	ARTED (Association of Research Based Medical Technologies Manufacturers)	Turkey
Anna Frick	IHC Lead Congresses and Events	Novartis Pharma AG	Switzerland
Nigel Glover	Director of Global Congress & Events	Takeda Pharmaceuticals	United Kingdom
Martin Hess-Janorschke	Senior Global Event Manager	F. Hoffmann-La Roche Ltd	Switzerland
Susie Hide	Director	EANS (European Association of Neurosurgical Societies)	United Kingdom
Lisa Keilty	President	PMC2	United States
Christian Mutschlechner	Director	Vienna Convention Bureau	Austria
Linda Nielsen	COO	ESVS (European Society for Vascular Surgery)	Denmark
Angelique Russell	<i>formerly</i> Associate Director, Meetings Europe	<i>formerly</i> Bristol-Myers Squibb	France
Nancy Russotto	Compliance Panelist	Eucomed	Belgium
Roeland Van Aelst	Vice President of Compliance EMEA and Canada	Johnson & Johnson	Belgium

Disclaimer

Each of the cohort participated in the survey as individuals and not as representatives of their organisations. The views presented herein represent their own perspectives, not those of their organisations.



Survey results



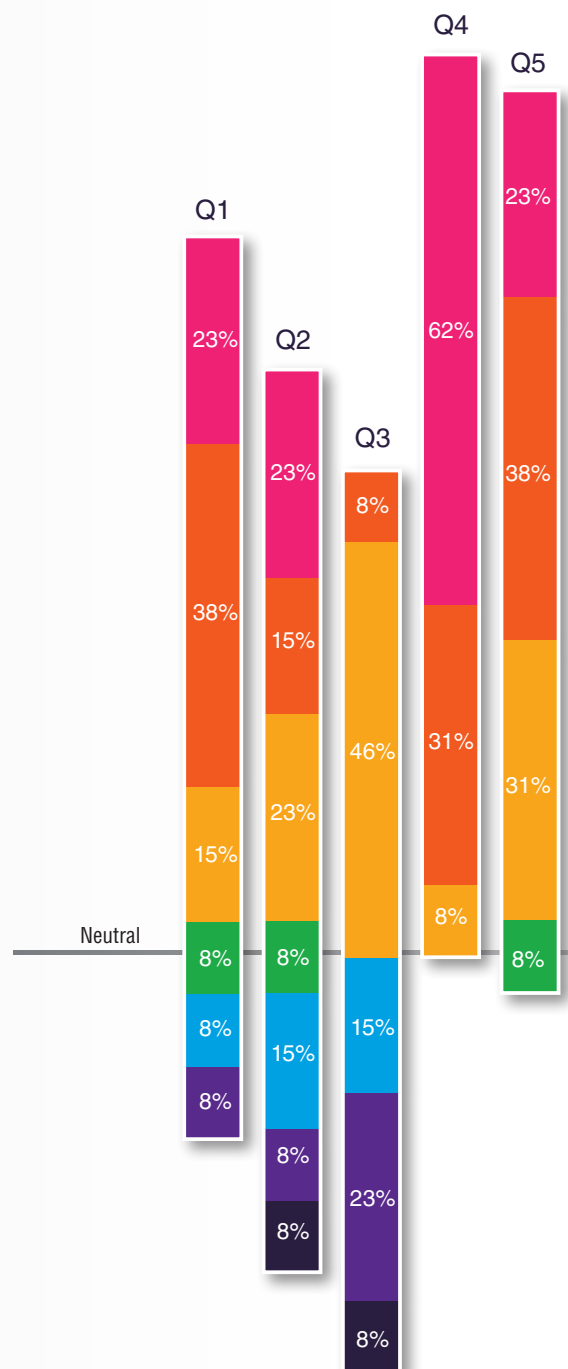
Q1 Will healthcare compliance regulations (HCR) and disclosure requirements have a positive impact on how the industry is perceived by the general public?

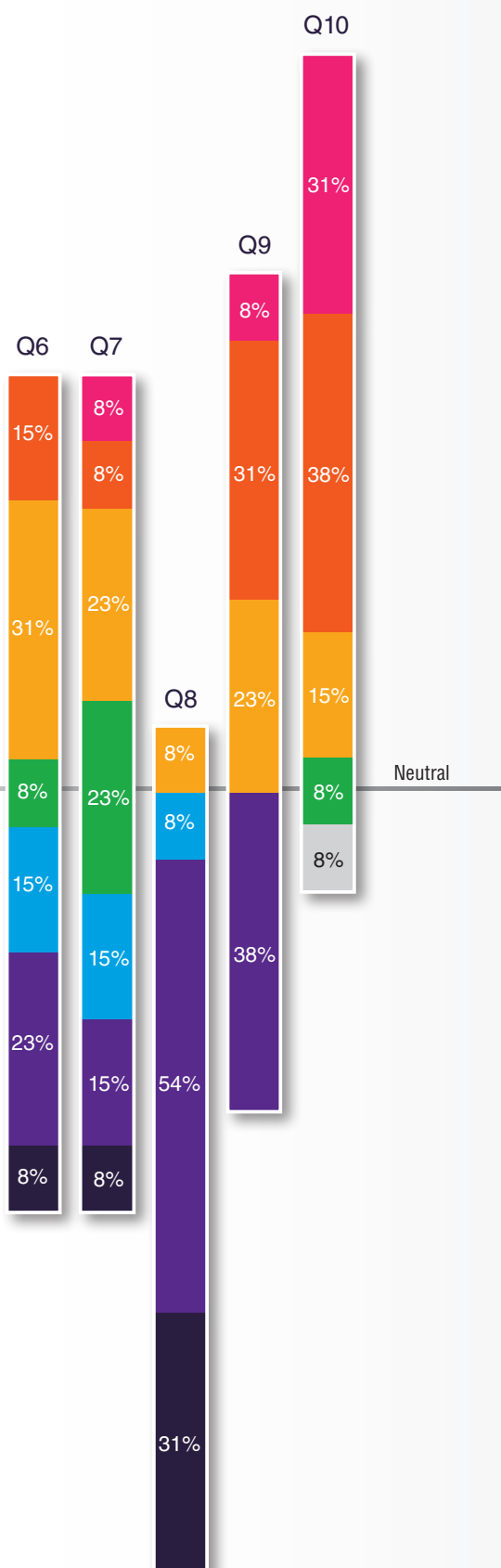
Q2 Should medical associations play a leading role in assisting sponsors meet their HCP spend reporting obligations?

Q3 Are HCRs directly responsible for improving the quality of medical education?

Q4 Should HCRs and disclosure requirements be harmonised across Europe so that one single code is in force?

Q5 Is the current business model for professional continuing medical events (CME) changing?





Q6 Do medical associations have a good understanding of the regulatory environment?

Q7 Are medical associations sympathetic toward sponsor companies and their HCP spend reporting obligations?

Q8 Will compliance regulations prevent industry from providing any kind of support to medical associations in the future?

Q9 Will compliance regulations and transparency reporting be applied to medical associations in the future?

Q10 Are there reasons for optimism when considering the future of medical associations and their meetings?

[7] Strongly agree

[6] Agree

[5] Mildly agree

[4] Neutral

[3] Mildly disagree

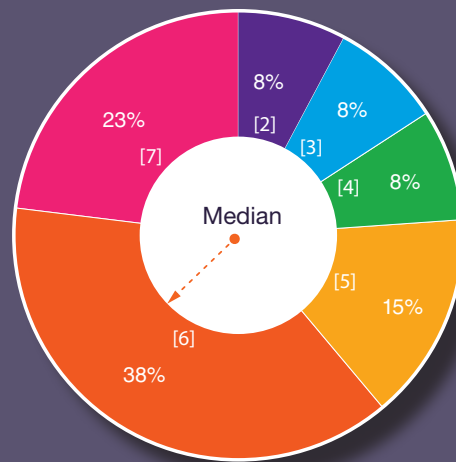
[2] Disagree

[1] Strongly disagree

[0] Do not know

Median: 5.65

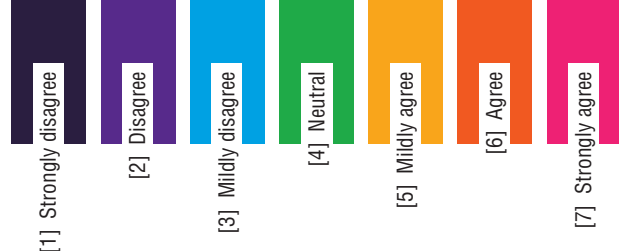
Correlation Variation: 0.263



QUESTION

1

Will healthcare compliance regulations (HCR) and disclosure requirements have a positive impact on how the industry is perceived by the general public?



SURVEY RESULTS

Perceptions about the relationship between industry and HCPs are not entirely favourable and have been regarded as harmful if approached the wrong way. Lewis' rather negative analogy of "dancing with the porcupine" to describe academia-industry relations often typifies sentiment expressed in a wider context^{ix,x}. In a recent study, 25% of outpatients questioned revealed that they would be less likely to take a prescribed medication if their physician had recently accepted a gift in return for listening to a pharmaceutical representative's presentation about that drug^{xi}. This is important as it reflects patient trust in healthcare.

Even among patient groups, the overall reputation of the pharmaceutical industry declined in 2012. Only 34% of the 600 patient groups surveyed in 2012 stated that multinational pharmaceutical companies had an excellent or good reputation. The equivalent figure from the 500 patient groups responding to the 2011 survey was 42%^{xii}.

The cohort agreed that it is critical to change that perception since many good initiatives and projects are occluded by the general perception issue. The industry is challenged because good news stories are less interesting for the lead press - even those that report significant improvements to patient care. Instead, public scepticism has been fuelled by unfavourable media coverage, with contemporary television programmes and Hollywood films depicting the apparent pernicious behaviour of pharmaceutical reps and duplicitous doctors. Funding of medical associations, patient groups and allied charities "allows the company to attain the moral high ground and so limit their vulnerability to challenges regarding their [...] questionable practices"^{xiii}.

"The industry are the ones who have a problem with the public and the press."

They [public and press] all think these big medical companies are just in it for the money, rather than for health" (Nielsen). The pharmaceutical industry has shown itself incapable of effective communication and has struggled to get its message out in a way that the media can carry without distortion and people can immediately understand. "Pharma companies are very fragmented when it comes to responding to those [adverse press comments]" (Glover).

Recent compliance regulation and transparency initiatives offer a potential mechanism to reframe perceptions and to neutralise some of the negative thinking. *"I think there is a difference between having a positive impact and taking away some of the negative image" (Van Aelst). For Dereli it is imperative because "the industry has a social impact on the community".*

Whilst such guidelines are not new (the American College of Physicians issued its first set of guidelines on marketing and research collaboration with industry in 1990), opinions over the extent to which the general public knows that there are regulations governing those aspects of the industry are divided. Hide: *"The introduction and promotion of clear legislation governing such events sends a clear message to the general public".* This is opposed by other perspectives: Glover: *"I don't think they are presented with any degree of strength or focus in the press"* and Bardinet: *"There is no patient-centric vision".*

There is a real risk that disclosure initiatives will be ineffectual, or even counter-productive, should the sector not develop the tools to effectively sift the data and provide definition and clarity behind the numbers. Hess: *"We appreciate the wide interest in the disclosure of HCP payments but*

There is a real risk that disclosure initiatives will be ineffectual, or even counter-productive

will everyone really understand the details and put the amounts into perspective? One needs to see." A study of state disclosure laws in Vermont and Minnesota, USA, revealed that the laws do not provide easy access to payment information for the public and are of limited quality once accessed^{xiv}.

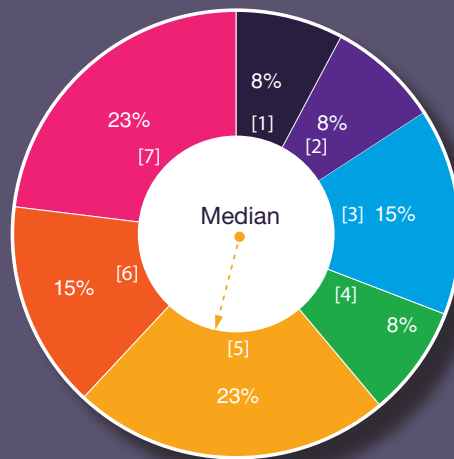
Failure to accurately report financial relationships between medical associations and sponsor companies in a uniform manner inhibits the ability of the patient and the general public to assess the credibility and risk of bias in prescribing. Russell: *"There is always a lag in the actual versus the perception. Compliance has done a lot to remove the junkets but there is still a bit of a perception that there [...] is still a bias in prescribing behaviours."*

Much will depend thus on the context in which disclosure information is presented and the industry needs to unite and form a suitable mouthpiece. *"Showing the investments that the industry makes in research and in education of healthcare professionals to serve patients better [...] will have a positive impact" (Van Aelst). As long as the industry cannot deliver the correct message in a united way, it will be unable to implement the changes that are needed and to alter public perception. "It would take a really strong effort to change that perception [...] this will take a long, long, long time to get it right" (Frick). Failure to proactively turn disclosure data in to a positive message will be a real missed opportunity.*

Median: 4.69



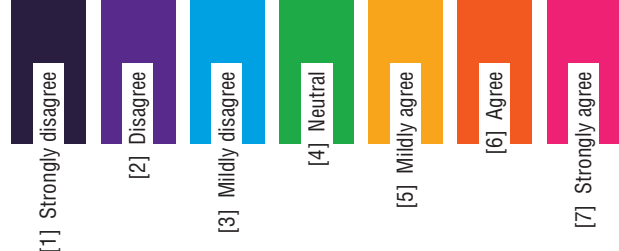
Correlation Variation: 0.274



QUESTION

2

Should medical associations play a leading role in assisting sponsors meet their HCP spend reporting obligations?



SURVEY RESULTS

There is disquiet over how the spend data is collected and published, and how it is put into context

Most medical associations do not collect individual doctors' prescriber numbers or other such unique identifiers; yet disclosure of these numbers by pharmaceutical and medical device companies is required in an increasing number of territories. One viewpoint is that medical associations can support sponsor companies by collecting these numbers at the moment of registration and subsequently provide these to exhibitors and sponsors attending the meeting to assist them meet reporting obligations. Healthcare companies attending medical association meetings have started requesting the numbers; though very few, if any, medical associations do currently collect them.

According to Frick, medical associations should be active here since *"it's not helping the sponsor companies but it is actually helping the HCP at the end of the day [...] the more transparent and the clearer the picture is, the more trustworthy the HCP is in front of patients"*. Keilty described this as being the medical associations' *"responsibility"*. There were additional calls for medical associations to *"improve their financial reporting"* (Hess) in order to *"break down the details to the lowest component and make it as easy as possible for the corporate to report"* (Russell).

Where there was recognition that *"medical associations cannot expect*

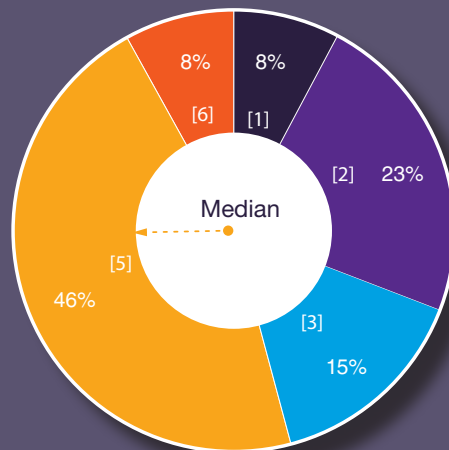
continuing support from sponsor companies unless they are prepared to work with them in a collaborative fashion" (Hide), the matter of disclosure remains tricky. *"Inevitably there are going to be tensions between the different groups and people don't like change. I think there's also the phenomenon that the reporting is in areas that are sensitive to some individuals receiving the support. So, there's been quite a push back"* (Russotto).

Ballieu believes that *"the problem is not transparency; the problem is what people who don't have the big picture will do with that information"*. The European Federation of Pharmaceutical Industries and Association (EFPIA) is calling for disclosure on association websites of the income received from pharmaceutical companies. Ballieu is against this due to the likelihood that the sums will be taken out of context and thus appear to be *"shocking"* with seemingly scant regard given how those incomes are used to finance initiatives that benefit healthcare professionals and the patient. A 2013 survey by the Ethical Standards In Health And Life Sciences Group (ESHLG) revealed almost 80% support among HCPs and their representative organisations that payments to doctors by commercial organisations should be disclosed on a single, publicly searchable database.^{xv}

The obligation to accurately collect and report spend data resides with the sponsor company; medical associations can merely facilitate that process. Nonetheless, to have a really transparent system, medical associations do play an important role in involving and representing physicians in how the information is collected and published and also how it is put into context. Such an approach would lead to *"better collaboration and probably more meaningful data to show"* (Van Aelst).

Median: 4.54

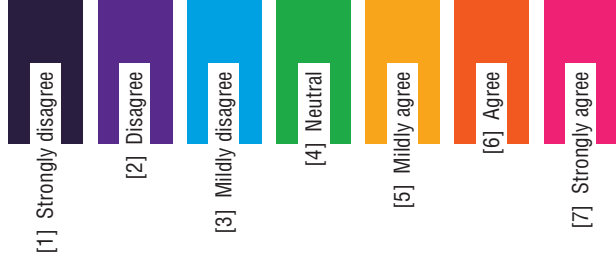
Correlation Variation: 0.276



QUESTION

3

Are HCRs directly responsible for improving the quality of medical education?



SURVEY RESULTS

The continuous delivery of high-quality educational content is critical

At the recent 2013 London Healthcare Meetings Forum, 86% of attendees considered new compliance regulations as driving the delivery of more scientifically valuable meetings^{xvi}. Hide agrees: “the need to provide objective, evidence-based scientific data, driven by compliance, is likely to enhance scientific quality”. Bardinnet, contrastingly, feels that any correlation is “irrelevant”.

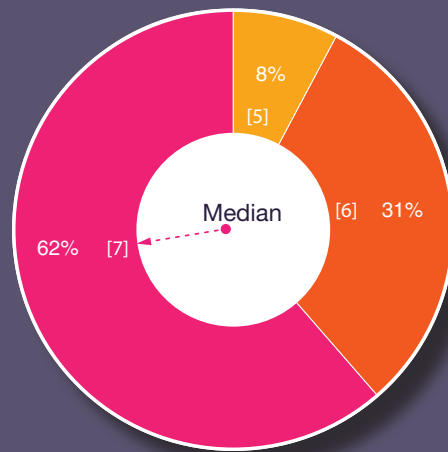
From a corporate perspective, compliance regulations have caused the firewalling of medical education and marketing, with education now being delivered by medical teams with considerably less promotional undertones. “The likelihood that there would be an improper bias decreases with the implementation of a good compliance and control programmes” (Van Aelst).

Ballieu, however, sees this firewalling simply as a “pretext for them [sponsor companies] to address the problem of their reputation and, of course, to [adjust] the level of financial involvement”.

Naturally, much depends on the starting point and, as Russotto points out, “the overall quality is improved in the disappearance of conferences that perhaps weren’t really contributing to medical education”. The aim of HCRs is not to improve the quality of medical education, but it is a by-product of the main purpose. As Mutschlechner summed it up: “Any association who does not deliver high-quality education is dead [...] quality has to be the focus”.

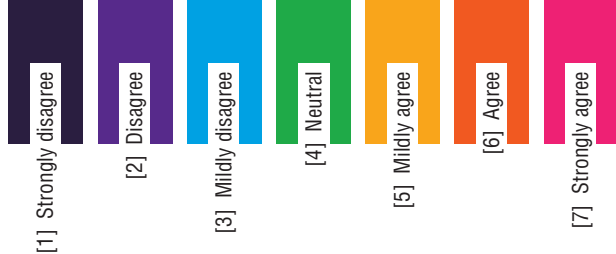
Median: 6.62

Correlation Variation: 0.252



QUESTION

4 Should HCRs and disclosure requirements be harmonised across Europe so that one single code is in force?



SURVEY RESULTS

Consolidating the numerous codes would take a considerable systems and cultural shift.

Compliance is only really effective if it is simple and strict, easily understandable and enforceable. Where there are different systems with different criteria there is a real risk that transparency gets blurred. *“It needs to be implemented across Europe to the same standard, otherwise there’s some hypocrisy where one country is weaker and another country is stronger”* (Dereli).

There was unanimous agreement among the cohort that there needs to be one single code in force with equal calls for harmonised interpretation and standardised due diligence. *“There is absolutely no reason why there should be a difference in the way we are transparent from country to country”* (Van Aelst). Nielsen advocates a European standard. This would govern cross-border and international meetings with national codes being used solely for local and national meetings.

Nonetheless, no single code exists. Part of the explanation for which is found in the very tenets of compliance itself: it a voluntary concept underpinned by the industry itself in order to avoid more formal legislation. As long as healthcare is not an EU competency, national codes and the discrepancies between them will remain. A second part of the explanation stems from a definite attitude that the pharmaceutical industry and medical device

industry are different and incompatible. Consolidating the numerous codes would take a considerable systems and cultural shift. *“One only has to consider the world of European CME accreditation to realise what the challenges will be”* (Glover).

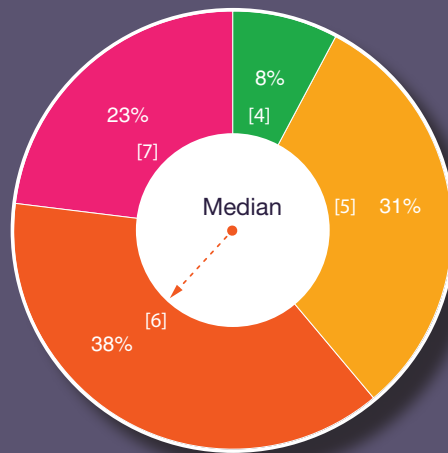
In Europe, dialogue between legislators, regulators, medical associations, industry and patients is required to seek solutions for standardised and harmonised approaches to CME and compliance. There is a certain collaborative dignity that can be realised in deriving a code set drawn-up in consultation with all stakeholders so that is not *“one-sided”* (Bardinet). Though it is not clear who should drive this: *“EFPIA and Eucomed haven’t proven to be strong enough so maybe they need either to be told that they are, or, maybe it requires other involvement.”* (Russell).

“I think it needs a revolution. A revolution where top CEOs of medical associations who understand the whole story go on a retreat with the CEOs of pharma and healthcare companies to find a European solution which is acceptable throughout Europe as a European standard” (Mutschlechner).

Notwithstanding the initiator issue, the cohort agree that harmonisation is unlikely to happen in the short-to-medium term. *“They have other fish to fry”* (Keilty).

Median: 5.65

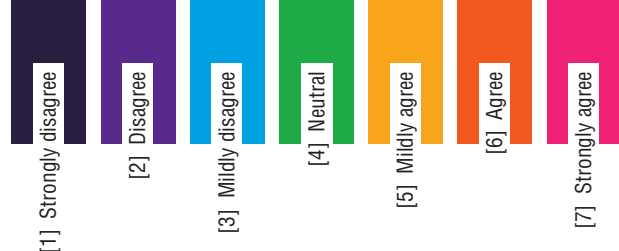
Correlation Variation: 0.263



QUESTION

5

Is the current business model for professional continuing medical events (CME) changing?



SURVEY RESULTS

Governments are in a fix. For a generation they have pushed medical education funding on to pharmaceutical and medical device companies. The recent reporting requirements imposed on the industry have had a tangible resource and economic impact. Due in part to this and in part to the need to preserve medical education integrity, sponsorship is on the decline with budget-capped governments being expected to pick up some of the bill for CME activity attendance.

Medical associations are also in a fix. For a long time, they have been structured around deriving proceeds from an annual congress. Now, they are being challenged to rethink that model and to do so quickly. *“They have to think about the benefits their medical association provides to society and about areas where they can collaborate with investors in a win-win situation”* (Frick). Bardinnet is in agreement, pointing out that the European Society of Cardiology (ESC) established a business model task force in 2009 which, over an 18-month period, determined new revenue streams, activities and sponsorship structures.

Direct delegate sponsorship is considered by some in the cohort to be a moribund concept: *“[if the current trend] continues, I expect that in three or four years, five years, that no individual delegate will be sponsored by industry to attend”* (Mutschlechner). Dereli considers the brunt of the delegate registrations will thereafter be borne by the attendee: *“I think they will find another way. Either they will use their own finances or find a company who will bypass [the regulations] to gain a competitive advantage because they want to have good relations with the doctor”*.

For Ballieu, it is a question of value-for-money: *“We pay more attention now than ever we did in the past to the cost of congress destinations”*.

In a recent survey of European CanCer Organisation (ECCO) congress participants, 60% of respondents cited ‘scientific content’ as being the primary reason for attending and 40% cited ‘networking’. Scientific content is indubitably the key draw card and research findings from a survey on medical meeting attendance undertaken by the Vienna Convention Bureau revealed that 80% of respondents would continue to attend even if they’re not sponsored but only if educational quality was optimal.

Mutschlechner believes that available sponsorship funds for medical associations will be maintained or even increased, though not in the traditional sense. *“These funds and even more funds will be directed completely into education and research tools. They need to have a clear education project and a good product”*. Nielsen reports that European Society for Vascular Surgery (ESVS) routinely seeks and uses indirect sponsorship (such as unrestricted grants) to cover speaker costs. *“Whilst it may not be strictly defined, there is a conceptual link between the company giving your society funds and a certain understanding that part of those funds will be used to invite a given person”*. The selection of speakers is made by the society: *“[selection] is all down to merit. We are completely scientific in that sense”*.

Hide agrees that the model is changing and anticipates *“a movement to an increasing number of specifically focused events, rather than general overview meetings”*. Russell agrees with this notion: *“even corporate standalones are too big. I think there will be more peer-to-peer meetings. They would be very niche, very specific, very topical and, from a corporate perspective, led by the medical teams”*.

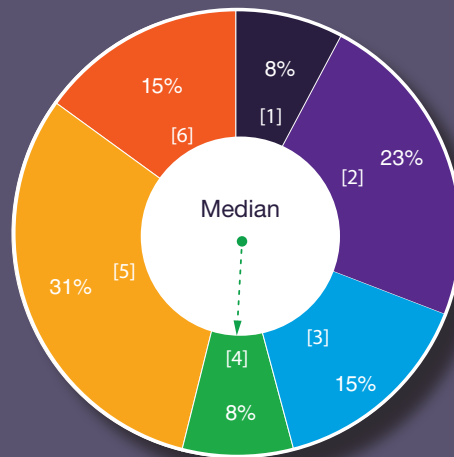
Medical associations need to adapt to the needs of the individual physician; for some it may be too late already

Nielsen highlights the core need to have a single recognised European CME system: *“I see it absolutely as the European Union of Medical Specialists (UEMS) who has to provide this”*. The issue is that European CME requirements fundamentally lack alignment and consistency, with little or no cross-border recognition of CME attainment. Hess foresees how this will change: *“I am convinced that Europe will move to a more American model”*. The current CME system considers attendance at accredited education activities but does not assess the successful application of educational learning in delivering better patient care. Could that be about to change in Europe with HCP performance being directly correlated to patient outcomes? Frick certainly thinks so: *“that’s what you’ll be measured on and that’s where [medical] education plays a crucial role”*.

The pace of change is likely to be incremental though and will seemingly take longer than expected, particularly as Van Aelst points out *“we are just at the beginning”*. Medical associations need to adapt to the needs of the individual physician; for some it may be too late already. Those who survive and are successful in the future will conjoin the continual deliverance of scientific content, recognised for its high educational standard, with innovative and effective platforms for developing powerful communal networks of healthcare professionals.

Median: 3.57

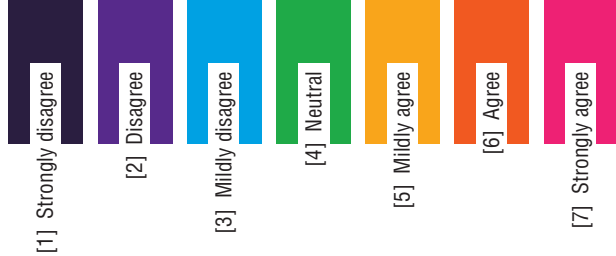
Correlation Variation: 0.280



QUESTION

6

Do medical associations have a good understanding of the regulatory environment?



SURVEY RESULTS

Efforts need to be made to communicate the rationale behind compliance and to get all medical associations to an acceptable level of understanding

Regulatory environment complexity is exacerbated by national differences and regular clausal amendments. *"Many of the stakeholders involved are interpreting the codes and regulations differently. This makes it difficult to find common ground sometimes"* (Hess). Consequently, maintaining up-to-date knowledge can be demanding, though as Nielsen observes: *"The information is out there. There is no excuse not to know."* This contrasts sharply with Bardinnet's assessment that medical associations *"have very little knowledge and even less desire to know."*

Bigger associations by their nature tend to have a larger complement of professional staff, are better aware and better prepared, with some even employing dedicated compliance officers. Small- and medium-sized associations typically don't have that. They have time and resource limitations which negatively impact on awareness. *"Medium-sized associations, such as our own, have some basic understanding, gleaned from attendance at related industry events and newsletters, etc., but such knowledge is often fragmented and inconsistent"* (Hide). Frick opines that association or company size is not the central element to preparedness but rather the therapy area specialism with some far more ready than others. *"It is actually the combination of the various stakeholders and*

their level of access. How much are they forced to be really compliant?"

Glover feels that overall *"they are getting better [...] yet medical societies still insist on trying to run congresses in Italy and in places where there are real challenges"*. The regulatory debate on this matter is, today, complicated by a paucity of understanding of educational needs and how they are paid for. Ballieu referred to the unpreparedness and inflexibility experienced recently with a national regulator when faced with a regulation barring congress medical advertising to non-prescribers. *"We tried to convince the ministry and had hoped they would be flexible, though at the end of the day they demonstrated not to be. We tried to defend the concept of the HCP – it is not because you're not a prescriber that you don't understand what a drug is and that you cannot grasp the difference between a commercial message and a scientific meeting [...] the researchers, the inventors of the drug, [were not able to] see the final product [because] they're not prescribers"*.

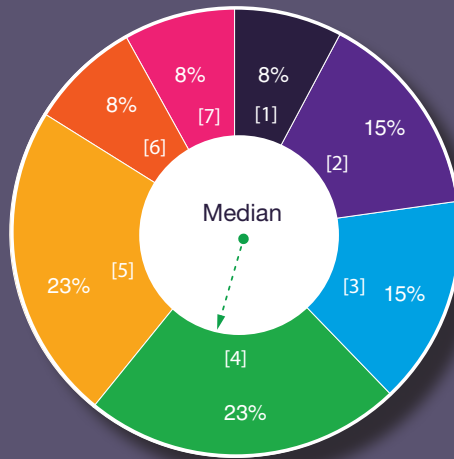
The establishment of an association for associations is notably absent and would have been helpful here. One of its core competencies should be to position compliance on the agenda of all medical associations and provide guidance on its interpretation – a much-needed role not performed by EFPIA or Eucomed. Efforts need to

be made to communicate the rationale behind compliance and to get all medical associations to an acceptable level of understanding. More fruitful dialogue will then follow between sponsor companies and medical associations, and not just with those privileged with proactive leadership and executive committee drive.

Median: 3.69



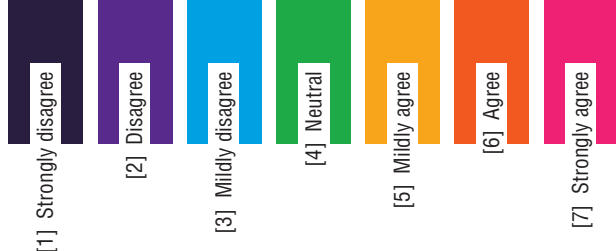
Correlation Variation: 0.280



QUESTION

7

Are medical associations sympathetic toward sponsor companies and their HCP spend reporting obligations?



SURVEY RESULTS

Associations increasingly focus on accommodating industry compliance and transparency demands

Creativity in accommodating the industry is a recurring theme amongst the cohort. Hide affirms that “*medical associations have no choice but to be sympathetic to sponsor companies if they wish to retain their support*”.

Medical association/sponsor company conversations have been reconceived and conformational changes have intertwined with a certain affinity maturation to define the new relationship. Ten years ago, organisational discussions centred on venue space and hotel conditions; today, those discussions relate to venue appropriateness, social networking activity and the extent to which sponsor companies will be able to provide support.

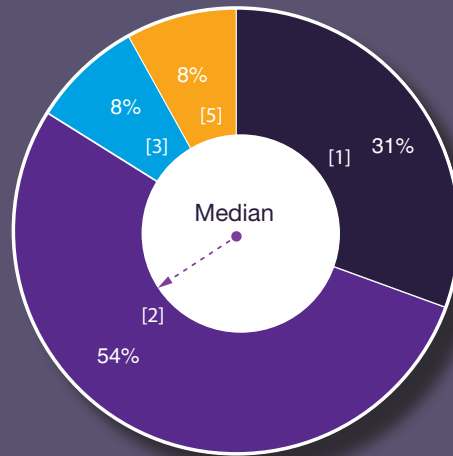
Nonetheless, there is wariness. “[*medical associations*] remain convinced that these are ploys for savings and shareholder satisfaction [and are] detrimental to innovation and care” (Hide). Equally, there is a general keenness to avoid an “*Orwellian world of prohibitions and restrictions*”^{xvii} that has been initiated and defined by the industry.

As Mutschlechner recognised, medical associations may legitimately ask about transparency and HCP reporting obligations: “*if I need to do it what could be the output for me?*” and that’s difficult to answer”.

All participants agreed that an awareness of compliance and transparency considerations, with good governance procedures in place, are critical. Dereli recommends that “*medical associations should have very strict, well defined, clear and specific policies and procedures that govern how sponsor companies interact with HCPs at association events*”. Through this, one inferred gain is that medical associations can help raise the compliance knowledge level of small, less aware companies to a minimal level that all companies could be expected to meet.

Median: 1.73

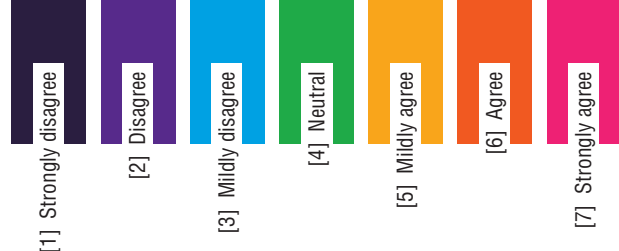
Correlation Variation: 0.159



QUESTION

8

Will compliance regulations prevent industry from providing any kind of support to medical associations in the future?



SURVEY RESULTS

In a notable paper, Rothman, McDonald, Berkowitz *et al* presented a proposal for controlling conflict of interest between medical associations and industry that advocated a goal of \$0 contributions from industry *inter alia*^{xxviii}. The American Medical Student Association's "PharmFree" strategy advocates the severing of many of the financial ties, whilst other US doctors are already pledging to cut all their ties to drug companies by signing up to the 'No Free Lunch' pledge^{xxix}. Other calls for a comprehensive ban on all industry funding of CME have also been made so that it be independent of industry influence^{xx, xxi}.

It should be remembered that industry funding is a complement to governmental support. Some estimates suggest that, in the US, sponsorship remains reasonably small compared with National Institute of Health (NIH) funding.^{xxii} Other estimates suggest approximately half of medical education is funded by industry; though having a precise figure is spectacularly difficult. Sponsor companies have competed to spend money on HCPs in mature, affluent markets. In less developed countries, resources are meagre and inconsistent, with little funding available from governments to support continuing medical education. Without industry support, there is a shortfall in adequate and available budget that endangers the value of medical education. "The risk with the self-paying model is that the needy, in terms of education and funding, don't receive it" (Rusotto). Glover agrees: "without the funding from medical education, I'm sure that physicians generally would not be as talented or as capable as they are".

A second 2013 study by ESHLSG evaluated the role of pharmaceutical sponsored medical education

Industry and medical associations need to form collaborative partnerships that will innovate and improve healthcare

and showed three-quarters of HCPs believe that industry should continue to provide medical education for HCPs with European and international meetings overwhelmingly considered to be extremely valuable (64% and 62% respectively) compared to local and national meetings (20% and 40% respectively)^{xxiii}.

The evidence suggests that the industry and the medical profession will need to work closer together to innovate and improve healthcare in general. The support offered to medical associations needs to be conducted in an ethical and balanced way that truly benefits the patient. Frick advocates a collaborative partnership through which the sponsor company and medical association "work jointly together to identify the activities that we both think will have an impact on the patient [...] it might be that companies will collaborate to get to this point".

The cohort all felt that various dimensions of support and cooperation are still possible. There is, however, an ongoing change in focus in the way that industry support is applied. Instead of sponsoring HCPs directly, it is expected that sponsor companies will channel these funds to medical associations in the form of grants and educational awards intended for them to invite HCPs. Nielsen reports that this is already happening with her meeting

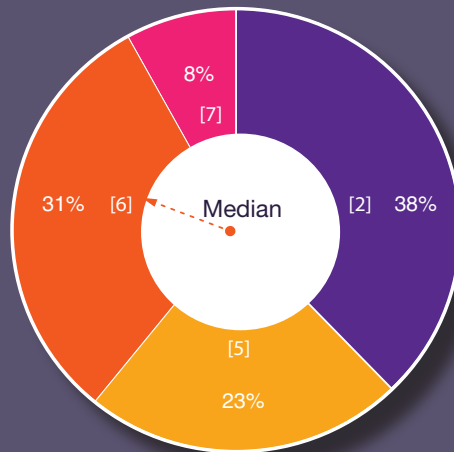
and stresses the need for creativity in matching up sponsor intent with that which is possible. Hess agrees: "new ways of support will be found".

Ballieu reports that demand for sponsor hospitality suites has risen significantly. "They used to be a drab and very neutral type of meeting room. Now they are beautifully decorated [...] with a lot of money spent in the setting". The emphasis within the EFPIA guidelines on perception and on that which is visible to the public is perhaps the prime causal effect here. Hospitality suites by their nature offer a private environment.

It is widely felt that compliance regulations will not prevent industry from providing support in the future and that sponsorship funds will remain available and will cease only if they are seen not to be a good investment. The content and strategic policies of the recipient medical association need to be strong enough and articulated in such a way as to allow the sponsor company to effectively track its return on objectives (ROO).

Median: 4.69

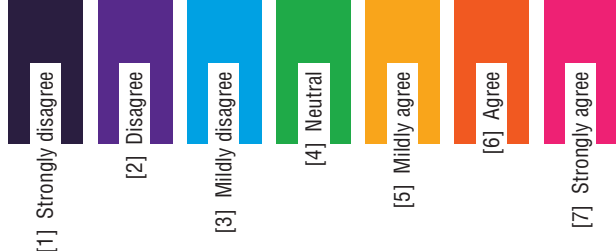
Correlation Variation: 0.274



QUESTION

9

Will compliance regulations and transparency reporting be applied to medical associations in the future?



SURVEY RESULTS

As scrutiny and transparency increase, so must medical associations' preparedness

A common view among the experts interviewed in this study was that medical associations will be compelled to operate under greater scrutiny and transparency in the future. Both Hide and Nielsen felt their associations would need to prepare for an increasingly audit-ready environment and need to abide by industry-driven codices. Bardinnet feels that medical associations *"already do"*. Keilty concurs: *"I think they have to walk the same walk as everybody else"*.

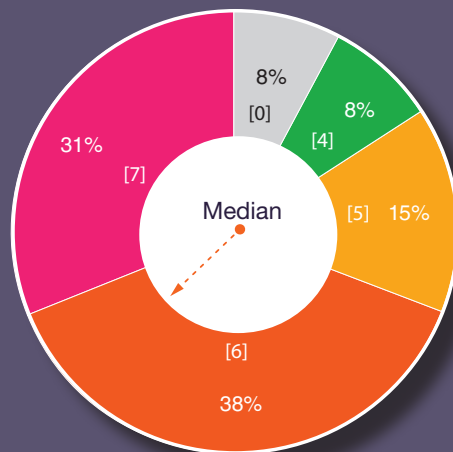
The degree to which this *"walk"* will extend, however, is unclear and to be determined. Many associations currently operate like businesses, particularly when under professional leadership. Annual reports offering a degree of financial transparency are available, though the sharing of which is voluntary and down to the policies of the given association. Likewise, there is no common approach to the level of data granularity that is to be presented, an issue particularly pertinent to indirect sponsorship which runs the risk of becoming *"a nightmare of data because essentially every attendee of a medical conference is indirectly sponsored"* (Mutschlechner). Where there is no law in statute and whilst the regulators lack the authority to impose it, there is little immediate stimulus for financial disclosure by medical associations. Bardinnet issued calls for a code

for medical associations to be drafted and referred to the ongoing work by the Biomed Alliance in this space.

Correlation is currently low between the sponsorships disclosed by drug companies and those by medical associations, patient groups and related charities. A 2012 Italian study evidenced that only 29% of patient/consumer groups publicly declare receipt of pharmaceutical funding and sponsorship^{xxiv}. Ballieu highlighted the case of a patient advocacy group which disclosed financial data on its website. A journalist subsequently read that the primary revenue source was the group's congress and duly (mis)reported that the group had sold itself to the pharmaceutical industry. As a result, Ballieu reports *"that there is a real and legitimate fear of being transparent because of how the data could be misrepresented"*. Frick counters this belief with the assertion: *"I am not convinced. Actually, I think we are a bit too afraid. To be transparent can never be a bad thing in my view"*.

Median: 5.88

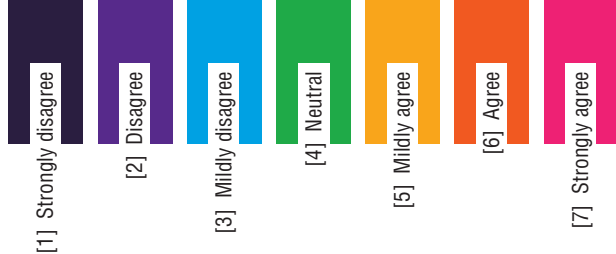
Correlation Variation: 0.277



QUESTION

10

Are there reasons for optimism when considering the future of medical associations and their meetings?



SURVEY RESULTS

Medical meetings of the future require new revenue models and more powerful, highly-personalised learning experiences

Relationships between medical associations, HCPs and industry are fundamental to achieving major healthcare policy objectives around the world. They are central to the translation of research findings into practical applications that improve patient care and public health. Educational meetings are the core modus for accomplishing this and, consequently, all participants felt that “medical conferences will remain a key platform of education, data dissemination and networking” (Hess).

Hide points out that “the fact that compliance legislation is forcing us to be more inventive in selection of topics and formats will ultimately strengthen the position of medical meetings rather than undermine them”.

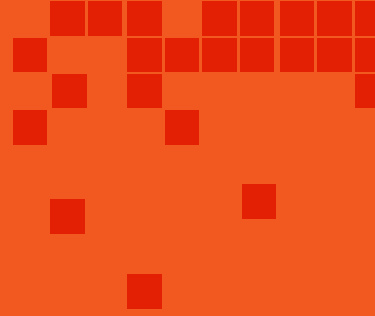
An emerging trend among larger medical association meetings is for a lowering in the ratio of scientific posters being accepted for presentation at medical congresses. The raising of the acceptance bar heightens the quality level thereby safeguarding the meeting’s credibility and integrity. Small and medium-sized meetings will be obliged to follow the trends set by the larger meetings with those meetings which currently need to do everything possible to attract attendance struggling to survive in the long term. Bardinet feels that “traditional sponsorship will decrease significantly and the coming two years will be very tough”.

“We will continue as an association; how our meeting will be is a different

matter [...] I have no doubt we’ll still have a meeting in ten years’ time. It is just a question of how big it is; I don’t think there’s room for growth at the moment” (Nielsen).

Ballieu: “I would be scared for the small organisations. I think the small congresses will have to be drastically changed into workshops and things like that but they will not be revenue generating. I am optimistic for the bigger congresses”.

In spite of concerns for borderline meetings, the cohort’s consonance over a positive future for the medical meetings industry was universal. There will be new revenue models and greater use of technology to personalise the learning experience. Congress morphology will perceptively evolve with progressive demands for new ways of interacting which will collectively define the meeting paradigm for the next generation. Mutschlechner foresees a time when meetings will be qualified by their impact factor. A lot will depend, however, on how this is published and on initiatives to make it possible for the public to appreciate the data.



The voice of the stakeholder

We try to
consider
industry as
partners and not
money machines

The medical association

The proclivity is for dialogue and an inclusive attitude; larger medical associations want a seat at the compliance table to help shape regulations that are “*practical whilst remaining effective*” (Ballieu). Antithetically, smaller-sized associations feel simply swept along by the compliance tide. “*We would not inhibit change and we would go with the flow*” (Nielsen); “*we are too small for resistance to compliance regulations to be a sensible or viable option*” reveals Hide.

Through compliance restrictions, there has been an increase in the proportion of active participants in association meetings. The drive to build on this through the cultivation of positive experiences and feedback loops is termed by Ballieu as the “*enthusiasm generator*”. Crowd-pleasing and the personalisation of experiences are pivotal facets that all meetings should render as central precepts of the delivered output.

Today, there is no clear nor pressing compliance demand being made of medical associations and calls for complete bans on industry funding of CME activity are keenly rebutted: “*this, in a world of economic recession and failing health systems is unrealistic and will not happen*” (Bardinet). “*[It would be] unspeakably unfair with regard to our own events which are indubitably compliant today*” (Hide). Instead,

collaborative innovation with sponsors is occurring that predicates corporate objectives without compromising the sponsors’ statuses with the regulators. “*We try to consider industry as partners and not money machines [...] the money is on their side and the need for money is on ours*” advocates Ballieu.

The current archetypal association model is cast around deriving surplus congress proceeds to fund loss-making, member-centric activities that are central to the association’s mission. Scientific journals, membership programmes and outreach programmes all present a financial liability. Without industry support many medical associations will cease to exist and other sources of financing plus a reconfiguration of the association business model are urgently required. Bardinet referenced the need to proactively plan, pointing out that ESC has been deliberately evolving its business model since 2010 and still has a further two years to go before reaching its set position. Funding is a prime concern to all and close attention is being paid to alternative sources. One possible source, the EU, is deemed to be excessively bureaucratic and the funding scope within the EU Horizon 2020 Programme in particular to be too narrow to be of immediate applicability to an association’s general activities. To contend for these funds demands a

sidestepping away from the typical core mission and diverts critical resources that may be better deployed elsewhere. One further possible source lies in the diversification and the cultivation of new sponsor types. Recruiting clinical research organisations (CROs) is a first step in this process.

Medical associations imbue a sentiment of credibility that uniquely positions them at the inference of commercial interests and knowledge ownership. This authority needs to be harnessed, with medical associations undertaking a role in the further dissemination of knowledge gained at a CME activity by the participant in the parent clinic or hospital department. “*Training is our main goal*” asserts Nielsen. There are considerable benefits to be gained here if undertaken correctly, particularly when one considers “*industry is not legitimate in assessing the value and depth of [...] education*” (Bardinet).

The sponsor company

Sponsor companies are obligated to conduct funding assessments in an efficient, structured and systematic way. Medical associations must show themselves to be trustworthy and a good fit for partnering

There is an assumption that audited appraisals of potential medical association recipients will sequentially increase over the medium term. There is an equal realisation that the process must remain realistic and bearable for associations. Internal corporate due diligence processes will classify those associations perceived to be trustworthy and a good fit for partnering. Besides, corporate managers are already accustomed to conducting benchmarking exercises that determine the appropriate level (fair market value) of support offered. The conditions and appropriations are patently different between those afforded to associations and those to individual HCPs. In the latter case, outlays are internalised centrally as much as possible: *“we prefer, as an example, to book an airline ticket ourselves rather than giving the money to the individual for them to book the airline ticket”* states Van Aelst.

Through the provision of financial support, industry seeks a forum in which it can assiduously take part in physician dialogue. *“That’s our expectation of how value is demonstrated and measured”* (Glover). Talk of commercial undertones in medical communication is today unfashionable. Current doctrine prescribes that the *sine qua non* for authentic and unobjectionable financial support is that it be philanthropic, yet the manner by which this can satisfy corporate total shareholder value (TSV) commitments remains undetermined. Hess: *“our industry needs to market their products and be profitable. There is nothing wrong with this”*.

Sponsor companies are learning to be more precise and exact in their congress participation and communication activities. Previously, physician discussions held in a unilateral and commercial manner were the norm. Now the hope is that with a redefined

scientific engagement, HCP interaction will provoke new conversations that *“trigger new trials, new needs and new products”* (Frick).

Calls for a ban on industry-funded CME activities were rejected due to the *“wealth of knowledge and data”* it its possession (Frick). Knowledge, here, has its roots in the innovative science being undertaken by industry and in the need to disseminate go-to-market information to HCPs as quickly and as efficiently as possible. Van Aelst indicated the lack of a real alternative: *“the alternatives for the forms that we deal with today do not necessarily give the indication that they would be better”* while Hess raised the ethicality of education sponsorship: *“do we need to be ashamed of providing support, or, is it our obligation?”* There were widespread calls for enhanced collaboration with medical associations and for their contributions to help identify the right funding path. Instinctively, options for indirect sponsorship mechanisms offered via third-parties are typically met with a guarded response out of a concern over less transparency and an increased requirement for vigilance. Likewise, the notion of unrestricted educational grants carries its own delimitations; primarily in that they be used solely for educational purposes.

For a risk-adverse industry, there was genuine appreciation of the concepts being generated by medical associations and their willingness to test them. The encircling use of technology and new didactic approaches in enabling congresses to be genuinely paperless, interactive and personalised has begun and requires greater collaboration between the association and industry for it to be commonly deployed.

The regulator

Regulators in many places across Europe see direct sponsorship as being suspect; therefore the knee-jerk reaction has been to ban it. Russotto is unconvinced of the totality of this approach and believes there is a balance to be had: *“I think that direct sponsorship in Europe is still a very useful means of supporting healthcare professionals to attend conferences”*. One ready example is the support that direct sponsorship allows for doctors from less-affluent countries to attend conferences for continuing education. A lack of direct sponsorship *“would lead inevitably to different standards of healthcare across Europe”* (Russotto).

Financial need rarely enters into the discussion on who is going to be sponsored. Most companies sponsor physicians with a certain stature who are then expected to disseminate the education gained to other HCPs. Building in financial criteria could be something to consider for the future. Russotto suggests *“one could have a rule saying that a single HCP cannot be sponsored by the same company for more than a certain amount over two consecutive years”*. Concepts such as this are useful when adopted alongside transparency in safeguarding the use of direct sponsorship for education and not for buying influence.

Current legislation governs direct sponsorship and there is a belief that *“indirect sponsorship requires a set of rules just as direct does”* (Russotto). The use of indirect funding models is acceptable but less-preferable to regulators. There are clear recommendations that they be employed solely with associations of good standing whose reputation and credibility are well considered in their context. Techniques to identify such associations are expected to stop short of full auditing according to the regulators, *“I don’t think it will go as far as*

that as long as there is comprehensive due diligence” (Dereli). Some medical associations may need to adapt and position themselves accordingly. *“A medical association, I think, would be very smart in structuring itself in a way that it can receive and manage funds; some will for sure be better than others at doing it”* (Russotto).

The regulators acknowledge that they are member organisations and that, thus, their scope of influence is defined largely by the breadth of their membership. Although their guidelines and codes of practice may be commonly accepted, there are no formal constraints to prevent non-members from diverging away and conducting their activities in a more free-spirited way. Instead, there is a reliance on a multiplier effect through which non-member companies are less well-regarded and through which their professional environment is subjugated by those companies who are members.

The regulators believe that transgressions by non-members primarily happen inadvertently and due to a lack of awareness or familiarity to the rules. This is particularly true in the medical

device industry as it is predominantly composed of small and medium -type businesses. Compliance infringements are handled through consultation with the violator; a process that informs of the negative impact of their behaviour and of the transcending of industry rules. Often this has proven to be satisfactory for realignment, in cases where it has not, the matter is then referred to the relevant national governmental body.

What does the future hold for compliance? *“I think rendering these systems obsolete is probably a sign of success and I think it is generational. We’re talking about deeply ingrained cultures and behaviours that are difficult to change. I think new generations are much more aware of this and will be much less likely to fall into patterns that they themselves feel uncomfortable with”* (Russotto).

Rendering
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The third party observer

There is still a higher expectation from the HCP to that which can be provided by either the industry or the medical association

Mutschlechner feels that the pendulum of compliance restriction has swung too far and needs to regress to a more practical position. He refers to the taboo over listing 5-star hotels on congress websites as “ridiculous” since it denies information access to individual HCPs who may wish to stay there.

The role of the convention and visitor bureau (CVB) has also changed under healthcare compliance. The previous practice of promoting and selling the destination has been changed to one of ensuring the city has the appropriate infrastructure to conform to compliance and of being an informed “discussion partner for the association” (Mutschlechner).

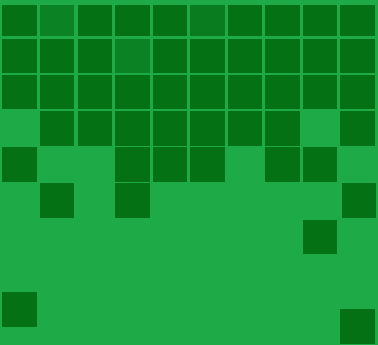
Keilty has observed some companies endeavouring to use their non-membership of trade regulating bodies as a competitive advantage. Commonly, this takes the form of offering luxury hotel accommodation to HCPs. Russell observes that the regulatory bodies of EFPIA and Eucomed have limited powers to sanction aberrant companies beyond fines and negative publicity. This limitation arises since “they’re quite vague and are all built upon local requirements” (Russell). The hope is that the transparency requirements will bring all companies into line in the patients’ best interest.

The shifting emphasis from marketing and sales to research and development at sponsor company level demands a new form of interaction and product from medical not-for-profits. “The challenge for medical associations - and some do it already- is simply to forget traditional corporation models and to define new products and to build up

a different relationship with companies” (Mutschlechner). Whilst some third-party experts in our cohort believe that compliance is an excuse for many things, there is widespread agreement that creativity and a different approach will reap rewards since industry “prefers to invest its money in such a way than pay profit taxes” (Mutschlechner).

Alongside financial aspects, the greatest impact that compliance will bring to medical associations is felt to be on the level of reporting required and the way in which this information is disclosed. The application of which concerns providing greater detail, such as the pricing of individual components bundled in the congress registration fee, and learning how to publicise that information correctly. It is not only medical associations who need to adapt. Russell pointed out the need for readjustment by many HCPs over matters related to the fair market value (FMV) of their services. It is suggested that there is currently a “disconnect since there is still a higher expectation from the HCP to that which can be provided by either the industry or the medical association” (Russell).

The future offers “golden years” to Mutschlechner. He feels that organisational proficiency, ease of access and a cultural receptiveness are all attributes that make Europe a more appealing option than North America; “they get the same education and it’s easier for them to attend”.



■ Three reframing must-haves for ■ the medical meeting industry



THREE REFRAMING MUST-HAVES FOR THE MEDICAL MEETING INDUSTRY

MCI has identified three critical paragons to help the medical meeting industry adapt to future realities, influence stakeholders and develop an innovative new ecosystem.

Medical associations need renewal

Macro trends are creating new pressures for the medical association, including more volatile congress attendance, less certainty about sponsor revenue, significantly more intense cost pressure, and a greater than ever need to deliver the highest possible levels of education and interactivity. Associations are under increasing pressure, and that pressure is not about to abate. Relying on traditional approaches is no longer enough, and they must find ways to do more with less. They need to be creative as well as being seen to be careful.

Educational meeting providers who cannot demonstrate that their content offering and networking possibilities genuinely add value to the doctor and patient will suffer. Those who succeed, by contrast, will build a sustainable competitive advantage through more effective collaborations and partnerships, with and beyond industry, that develop new value-adding innovations.

Many leaders in associations and within the industry do not have the data metrics to allow them to systematically align business priorities with educational strategies. This data void means that decisions over which educational projects should be discontinued or those which should receive a disproportionately high level of funding are made on the basis of instinct with inevitable trade-offs for the value of the educational portfolio and return on objectives.

MCI advises medical associations to think strategically about trade-offs and make explicit decisions over their mission and remit on the basis of the size of future opportunities. Successful medical associations will be those who adroitly underinvest in certain endeavours in order to direct resources to more promising initiatives.

Industry needs a prolocutor

Antecedental legacy still haunts the industry. Compliance and transparency initiatives bring behavioural data in to the public realm and deliberately shift the balance of negative consequences to reward more appropriate actions. It is essential not just to track compliance with the audit effort but to actively encourage and reward it. Whilst the rules may be basic, interpretation of them is very broad and underestimating the impact of this greyness would be a big mistake. Industry needs to show that their own regulatory code is sufficiently stringent and detailed enough to prevent the appearance or reality of undue industry influence and bias. The regulator can be helpful because they can endorse a system that has been developed by industry and promote conformity to it among small companies who tend to feel that it is being imposed upon them.

The good news is that compliance can blunt the edge of industry criticism by significantly improving ethics and transparency which incidentally improves the calibre and effectiveness of medical education. However, industry focuses mainly on the technical features of compliance and data reporting, rather than building a message around the advantages that the regulations offer in outcomes and efficiency through a singular focus shift on educational quality and patient benefit. The general evidence does not suggest that medical associations will be obligated to full disclosure; the emphasis is placed more on the individual HCP.

Successful transformation is not just about making technical changes to guidelines and sponsorship processes; it is about changing public perception. The process has already commenced in certain territories. In 2010, the Association of the British Pharmaceutical Industry (ABPI) and

the UK Department of Health published a toolkit entitled *Moving beyond sponsorship – joint working between the NHS and the pharmaceutical industry*. It advocated a range of new strategies to improve patient care outcomes and improve company reputations.

MCI has identified a clear need for an industry prolocutor to re-orientate public perception to one of trust and to reframe the communications landscape to one of value. Both healthcare compliance regulations and transparency reporting are important and critical aspects to ensuring the transparent, unbiased and ethically-acceptable sponsorship of medical education. The best communications will focus on insights and added value to the patient community, not just the data.

Stakeholders need to collaborate

The healthcare sector is dysfunctional and highly-malleable. Distinct engagement and probity between responsible leaders from industry, associations, regulators and patients is required to shape a single European compliance and CME framework that will remodel the educational landscape and form a strong underpinning for improved knowledge access and patient care. Leading European medical associations, particularly, need to empower themselves and collectively become a more prominent and powerful voice in Europe. The principle is razor-sharp and there is widespread support. Uncertainties and concerns over who should lead such collaborative ventures is, unfortunately, an increasingly familiar story. Whoever will be given the mandate will have considerable influence on the how the medical meeting industry functions moving forward.

Moreover, each stakeholder has the potential and responsibility to develop the capabilities for providing evidence of the health-economic benefits of continuing medical education. Because the process is iterative in nature, one key change in the future will be the careful analysis by patients of the extent to which their doctor is undergoing continuing medical education.

In our experience, stakeholders need to involve themselves and focus on a handful of key levers that drive success. Ascribing highest priority to HCP efficacy, they need to identify strategies and external-facing processes that direct legislators to harmonise CME and compliance codes.

Given the scope and scale of the three paragons, healthcare industry executives could be excused for not knowing where to start. However, both responsible stakeholders and healthcare leaders must make it their highest priority to shape a new framework that will transform the medical meetings industry and focus attention on innovations and progressive developments that improve healthcare value and patient care.

MCI sees immense opportunities for those segments of the medical meetings industry that choose to lead the development of this new framework. They will be easy to spot, for they will be the ones who succeed in competently demonstrating patient value and in doing so, securing financial capital and competitive advantage.

As MCI's benchmarking study demonstrates, medical associations and sponsor companies face a number of challenges; success does not come easy. Adopting the twin-track mindset (refining their current approach to quality and transparency while advancing new models for professional education and HCP interaction) may not be effortless but it can be accomplished. It requires for stakeholders to become proactive and to generate organisational buy-in through pinpointing the areas and actions that are likely to have the most impact. It demands time, patience and effort at all levels. The opportunity is there and those medical associations and sponsor companies who fail to make these changes will face a future of reduced financial ability and diminished influence.

MCI's healthcare experts have a range of solutions and tools to help leaders seize this opportunity, and future papers in the MCI Thought Leadership Series will further explore the three paragons and show the reader that stakeholders needn't risk being put on the defensive.

If you would like to learn more about the ideas explored in this research paper, please contact one of the authors.



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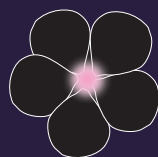
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