WHITE PAPER

IGNITING PATIENT ACTIVATION IN EUROPE:

What pharma can do now

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Pricing pressure is on the rise. Portfolios are shifting toward complex treatment journeys and precision therapies. What should pharma do now? As detailed in the 2026 Future of Health Report, it's time to embrace patient centricity and recognize patients are a core stakeholder in go-to-market strategies.

But addressing the treatment barriers that prevent patients from moving forward in care journeys takes more than building awareness. We have to help patients seek care, navigate the system and advocate for the right treatments. That shift matters most in rare and specialty conditions, where the diagnostic journey is longest—but the logic applies to any asset whose patients are hard to find and harder to route.

Patients are central to solving the pressure of today's go-to-market model

Pharma's commercial model in Europe faces structural headwinds. As pricing pressure keeps intensifying, teams are expected to do more with less: leaner launch budgets, tighter access environments, higher performance expectations. At the same time, pipelines are moving toward smaller, more precisely defined patient populations. That compresses the commercial opportunity per asset and puts a premium on activating the right patients efficiently, rather than trying to reach everyone.

For instance, consider a rare neuromuscular condition. Its symptoms—muscle weakness, fatigue, fluctuating function—are so often misattributed that patients can consult seven to 10 specialists and wait years for a diagnosis. And newer treatments are gated further by specific antibody status. Historically, pharma's answer to this type of complexity has been to work the healthcare provider (HCP) channel harder—more specialist engagement, and more sophisticated models to predict which clinicians will see eligible patients and when to reach them.

But when eligible patients are managed mostly in primary care and only see a relevant specialist once or twice a year, even the sharpest predictive model can't fix this structural problem: Demand signal is too sparse, encounters are too unpredictable and the window to act is too narrow. And the sales force—the most expensive channel in a pharma company's toolkit—loses effectiveness against a population it was never designed to reach.

In the backdrop of this structural problem, we're seeing an increasing number of innovative therapies launch into primary care or primary care-adjacent settings, where engagement is fragmented, hard to scale and reliant on time-constrained physicians navigating ever more complex eligibility criteria.

All of this results in a widening gap between clinical potential and real-world impact. Increasingly, the decisive moments happen upstream, before patients enter formal care pathways, and often before pharma has had a chance to engage. Patients are becoming central actors not just in treatment decisions, but in initiating, navigating and sustaining the journey itself.

Why traditional patient engagement no longer moves enough patients to care

European patient engagement has always followed a different model than the U.S. Without large-scale branded DTC advertising, pharma companies in Europe have leaned on patient advocacy, disease awareness campaigns and support and adherence programs. These have raised awareness, but they typically sit upstream or downstream from the journey and are removed from the care pathway.

Not being allowed to advertise to consumers presents more challenges as journeys get increasingly complex. In many therapy areas, the core challenge is no longer helping patients understand a condition, but activating them: helping them take the next step by seeking care, finding the right provider or following through on treatment.

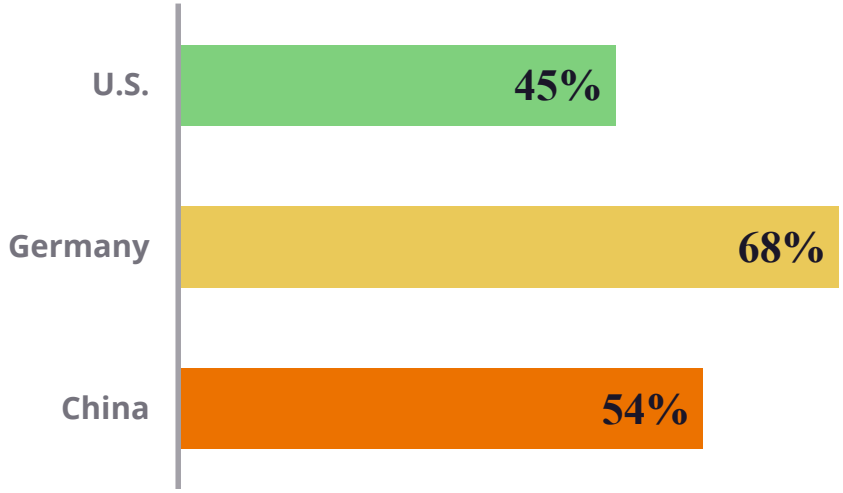
But across markets, navigating the system doesn't feel like accessing care—it feels like fighting for it. Symptoms are present, but the right appointment takes weeks. Referrals get lost. Self-advocacy gets harder.

The consequences are measurable: According to our 2026 Future of Health Report, 30% of U.S. patients say a diagnostic delay led to a worsening of their condition. Yet the system often fails to register that experience—while 62% of doctors believe their patients feel cared for, only 26% of patients actually do. This is a breakdown in trust that shapes whether and when patients engage at all.

The 2026 Future of Health Report underscores the pattern: A significant share of patients engage only when symptoms turn acute. And many delay care because specialist access is hard to secure, the process feels like a hassle or they don't trust the system. Cost and prior bad experiences reinforce avoidance.

FIGURE 1:

Patients who avoid seeking care until they're sick



Healthcare doesn't have an awareness problem, because patients usually know something is wrong. The barrier is activation. The industry must turn that awareness into a care pathway that feels accessible, credible and worth the effort.

Patient activation works in Europe—it just looks different

There's a persistent belief that patient activation simply doesn't work in Europe. Usually that view comes from looking at Europe through a U.S. lens. If you expect large-scale branded direct-to-consumer (DTC) or symptom-based media campaigns, Europe will feel less mature.

But that doesn't mean activation isn't happening. It just happens through different channels and ecosystems, ones that are often closer to care and more trusted by patients.

Look at Europe on its own terms and a set of scalable activation pathways comes into view:

- Pharmacies, which are increasingly a first point of clinical contact rather than a dispensing endpoint
- Digital navigation platforms, now the default starting point for finding and booking care
- Virtual care and telehealth, which expand access across primary and specialty settings

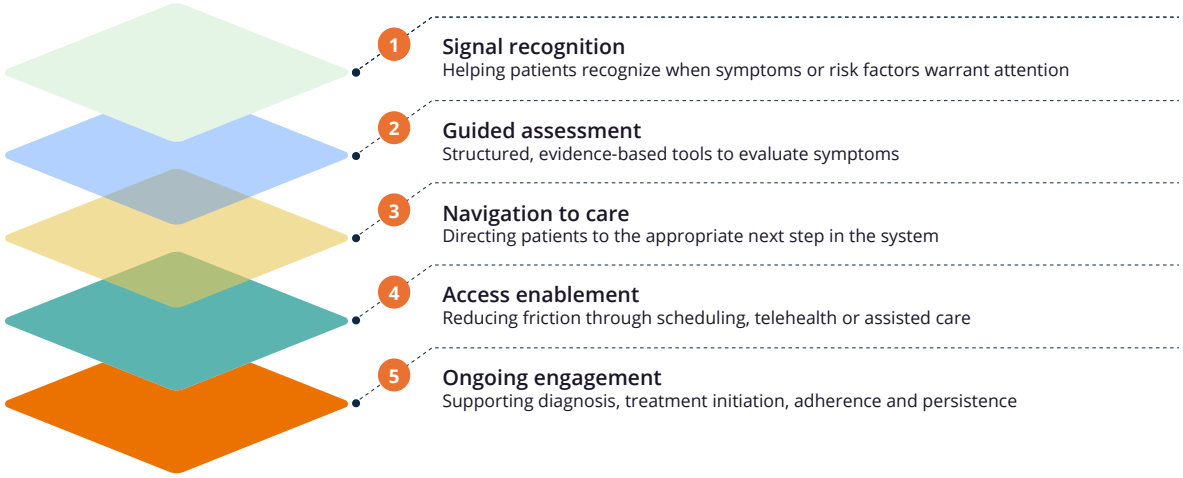
This trio of pathways isn't new. What's changed are the conditions around them. Digital infrastructure, patient acceptance of virtual care, rising expectations on speed and convenience, and sustained cost pressures have combined to push these channels to the center of the pathway.

It's vital for pharma to work within these ecosystems rather than alongside them. But to do that deliberately rather than opportunistically, you need a way to see the whole journey—and where each channel does and doesn't reach.

The European patient activation stack

Channel choice matters in patient activation, but the real differentiator is how each channel is woven into an end-to-end patient journey. Rather than stopping at awareness, it's vital to create end-to-end pathways that move patients toward action. Our European patient activation stack (see Figure 2) features five stages every patient must pass through, from first signal to sustained engagement. We call it a stack because each layer only works if the one beneath holds.

FIGURE 2:
The European patient activation stack



In the European patient activation stack, activation moves from being a communication challenge to a healthcare-system design challenge—one that integrates engagement, clinical pathways and care delivery. To leverage the stack, therapy area leaders must determine at which stage patients drop off and which channels can carry them forward.

3 channels reshaping patient activation in Europe

Three European channels illustrate the shift especially well. While they are indeed the most developed channels today, it's important to note they are examples of a broader pattern—not an exhaustive menu. This same logic we discuss should extend to any channel that sits close to where patients actually enter care.

Pharmacies: A front door into the system

In some markets, pharmacies have become a genuine first point of contact. In France and Italy, thousands of pharmacies are equipped with assisted telemedicine capabilities—through providers such as Tessan, Medadom, MedEA and HTN—that connect patients to

physicians far faster than a traditional referral. What used to take months in conventional channels can now happen in a couple of days.

Pharmacies are also adding point-of-care testing, condition-specific screening and structured referral services—examples include cardiovascular risk testing and pharmacist-administered spirometry for case-finding. While these examples were once the domain of primary care, today pharmacies are pairing education with a clear path to action to reduce friction at decisive moments. Gaps in disease-specific knowledge and referral pathways still make it difficult to identify and route patients effectively, creating an opportunity for pharma to support better education, navigation and access.

Digital navigation platforms: Finding the right care

Digital navigation and scheduling platforms have become embedded in modern healthcare. What began as booking tools are now primary decision environments. They consolidate provider discovery, intake, scheduling and follow-up into one experience. For instance, Doctolib is a primary entry point in France and Germany, extending into outpatient records, peer tele-expertise and referral enablement. MioDottore plays a similar role in Italy, as does Doctoralia in Spain. Together they serve tens of millions of patients monthly, and their penetration is highest where public system wait times push patients toward private and mixed pathways.

That same pressure gives these platforms a more clinically significant role: When embedded at the point of referral, a well-adopted platform protects scarce specialist capacity while ensuring no patient who meets the clinical threshold is lost to misrouting.

These platforms don’t help patients recognize when symptoms warrant attention, however. And they provide no structured, guideline-based triage, because patients self-select with limited clinical guidance. This is where pharma can strengthen what platforms can’t or won’t build alone: structured triage, more precise provider matching and embedded education.

Virtual care: Access and convenience

Virtual care and online-first models are expanding rapidly. Providers such as Kry, Livi and Zava deliver faster, more convenient access while staying aligned with local regulation. While virtual care adoption is concentrated in chronic disease and metabolic health, telehealth now accounts for a persistent and rising share of outpatient interactions—and the official picture is more uneven than headline enthusiasm suggests.

Across mostly European OECD countries, about 13% of health consultations are now remote, with Norway leading the pack at roughly 21%. Teleconsultations exceed a quarter of consultations in Sweden, Denmark and Portugal and over a third in Estonia, according to the OECD’s Health at a Glance 2025 report.

Reimbursement plays a big role in whether people and countries embrace virtual care.

- Germany's removal of its video-consult cap in late 2023 triggered a roughly 40% surge within six months
- Spain reimburses telehealth consults at 85% of in-person fees
- The U.K. is planning for 30% of healthcare visits to be conducted via telehealth by 2028.

ZS analysis even suggests pharmacy and platform-enabled virtual access is running well ahead of these rates in the most digitally mature markets. But barriers persist: older or less digitally confident patients question whether virtual care suits their condition. Other patients disengage after a single encounter. And providers often lack disease-specific depth.

How can pharma help fix this? The industry can play a multidimensional role by offering disease-specific education, guideline-based triage and structured referrals at the patient level. At the provider level, pharma should focus on sharing current evidence, guidelines and medical education. Virtual care platforms also represent a largely untapped opportunity for real-world evidence on patient journeys and outcomes.

Mapped against the stack, the picture (see Figure 3) is clarifying. No single channel carries a patient through all five stages. And when a channel does touch a stage, it often does so without the clinical depth a complex or rare condition demands.

FIGURE 3:

Where each channel reaches across the activation stack

Activation stage	Pharmacies	Navigation platforms	Virtual care
Signal recognition	**Partial** Footfall, ad-hoc screening	**Gap** -	**Gap** -
Guided assessment	**Partial** Testing, no disease depth	**Partial** Self-select, no triage	**Partial** Self-select, no triage
Navigation to care	**Partial** Tele-consult in some markets	**Partial** Discovery, patient self-routes	**Gap** -
Access enablement	**Covers it** Assisted care (in mature markets)	**Covers it** Booking, tele-consult link	**Covers it** Online-first consult
Ongoing engagement	**Gap** -	**Partial** Follow-up messaging	**Partial** Continuity often weak

Two patterns emerge that are worth paying attention to. First, the upstream stages are the emptiest: signal recognition is barely covered by any channel and guided assessment is, at best, partial everywhere. No channel offers disease-specific, evidence-based assessment on its own.

Second, it's clear pharma's value goes beyond filling gaps in the patient journey. It can strengthen parts of the journey that already exist but aren't designed for complex conditions. For example, a generic symptom checker becomes a validated, guideline-based assessment tool. Or a simple appointment-booking process can become a structured referral pathway. The opportunity for pharma is twofold: Fill what's missing and improve what's already there.

Case study 1: Accelerating action in rare nephrology

In rare renal conditions, diagnosis is often delayed and fragmented. Patients show early symptoms or abnormal labs that don't clearly point to a renal cause. These patients usually present in primary care—or not at all—before a specialist is involved, and this typically happens upstream of traditional pharma engagement.

ZS built a direct-to-patient (DTP) model that maps cleanly on the stack to meet these patients earlier. In this model, signal recognition comes from targeted outreach on social media with tailored messaging that helps at-risk patients connect vague symptoms to a possible renal cause. After engaging with the outreach, the process looks like this:

- First, patients complete an evidence-based self-assessment developed with leading nephrologists. It's not a generic checker, but a clinically grounded instrument, offering exactly the kind of rigor a channel can't supply alone.
- Next, based on their responses, the team engages patients to develop a structured summary of symptoms, history and risk indicators. Patients are also given clear guidance on whether specialist care is warranted.
- After that, patients who could benefit from meeting with a specialist are able to book directly with nephrology centers of excellence—access is built in. Other patients are routed to primary-care follow-up through Doctolib, and at-home urine testing is integrated via DocMorris.
- From there, the organization can prioritize ongoing engagement. In this renal example, 500 patients opted in to receive ongoing communications during the targeted outreach phase.

The early results show clinical enrichment, not just reach. In the first month, 5,000 patients completed the comprehensive self-assessment, 500 selected a care pathway and 50 were referred to partner nephrology centers of excellence. Those 50 patients are screened, clinically enriched patients who moved from awareness to seeking a specialist in just a single month—and in a disease area where that journey usually takes years. KOL feedback has been strong on this DTP model, particularly given how novel the approach is for conditions like rare nephrology.

Case study 2: Building a structured identification pathway in respiratory care

A leading pharma company partnered with a telemedicine provider in Italy to embed a structured, disease-specific identification pathway into community pharmacies for a chronic respiratory condition. The clinical problem was familiar: Many poorly controlled patients visit a pharmacy long before they reach a specialist, but without a structured assessment, that visit generates no clinical action and no referral.

The DTP model rewrote that encounter along the stack. The pharmacy visit itself becomes signal recognition. Guided assessment follows onsite, consisting of a brief validated symptom questionnaire plus diagnostic testing—a validated instrument where there had been none. Navigation comes next, with a specialist reviewing results remotely within 48 hours before issuing a report and advising on next steps. This turns a regular visit into a routed one.

Access runs end-to-end without the patient leaving the pharmacy, and eligible patients arrive at in-person specialist consultations with a structured clinical summary already prepared. Continuity—a form of ongoing engagement—travels with that summary.

The initiative has produced an important output: Real-world evidence on identification and referral-conversion rates. While the collaboration is still in progress, in its first year it's expected to support 10,000 patients with access to specialist-led screenings and identify another 1,000-1,500 uncontrolled patients who can benefit from advanced therapies.

This is what a pharmacy-as-pathway looks like in practice: A trusted, accessible touch point turned into structured identification and referral infrastructure.

What these two case studies have in common

In these case studies, both organizations embedded education, navigation and access directly into existing care ecosystems—meeting patients where they already are rather than treating awareness as a standalone intervention. This offers patients clearer guidance on when to act and makes it easier to access the right care and navigate a complex system.

Shifting patients from being passive recipients to active participants is better for the healthcare system too. Activated patients initiate conversations with providers, persist with treatment and flag deterioration before it turns acute. Investing in patient-centric, technology-enabled models lets pharma close care gaps at scale and move patients to the right care sooner while keeping them engaged through treatment.

A roadmap for patient activation in Europe: 6 actions to design pathways

In Europe, patient activation works when it's unbranded, assisted, locally trusted and built into existing pathways. Replicating the U.S.-style model shouldn't be the goal. Organizations instead need to work within existing ecosystems so patients move more efficiently through diagnosis and treatment.

FIGURE 4:

Where the business case is strongest to pursue patient activation

	Traditional HCP engagement effective	Traditional HCP engagement failing
High unmet ID/access need	**Refine the existing model** Sharpen HCP targeting and predictive models	**Priority for patient activation** Where the business case is strongest
Low unmet ID/access need	**Maintain** Conventional engagement is sufficient	**Monitor** Watch for shifts in the journey

As pricing pressure rises and systems evolve, patient activation will only become more important. The companies that build it early will identify patients sooner, improve initiation and persistence, and demonstrate value where access and outcomes scrutiny only intensifies. These six actions can provide a practical patient activation foundation, regardless of therapy area, market or life cycle stage.

- Build the business case from a precise journey map. Map the full journey—symptom to initiation and persistence—granularly enough to see where patients drop off and where friction accumulates. Then assess the therapy area against two factors: the severity of unmet identification and access needs, and whether traditional HCP engagement is sufficient. The strongest case for a DTP patient activation model is where need is high and conventional engagement is falling short.
- Assess the activation ecosystem in priority markets. Pharmacy telehealth readiness, platform penetration and virtual-care adoption vary widely across Europe. A clear read on which channels are mature, trusted and accessible in each market should determine where investment generates the most patient impact.
- Rewire the commercial and medical model around pathways. A representative who's equipped to demonstrate a structured triage tool at a medical practice is able to have a different conversation than one presenting only product data. This shift requires medical affairs to operate upstream by contributing to identification frameworks, guideline-based triage tools and ecosystem partnerships. And it helps ensure activation rests on genuine clinical credibility.

- Build with the right partners. Activation can't be built in isolation. The strongest programs pair pharma's disease expertise with the reach and infrastructure of DTP platforms, telehealth providers, pharmacy networks and advocacy organizations—creating solutions neither side could deliver alone.
- Scale through sequenced deployment. Launch one market or region at a time, with enough depth to generate real evidence before you expand. Consolidate what travels—partnership terms, contracting, outcome frameworks—regionally or globally, so local teams execute against shared infrastructure rather than rebuild it.
- Treat data and evidence as a strategic lever. The digital infrastructure underpinning these channels can generate real-world evidence about journeys, pathway performance and outcomes in a way that traditional settings rarely allow. This is a valuable asset for demonstrating outcomes and strengthening clinical leadership beyond internal performance tracking.

Given how care is structured and delivered in Europe, the continent offers unique opportunities for pharma organizations to lead a DTP shift. The companies that learn to operate within these ecosystems will redefine how commercial performance is created in increasingly constrained healthcare systems.

About the authors

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About ZS

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