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WHITEPAPER

THE VALUE OF PATIENT PREFERENCE

How Nordic Pharma Affiliates Can Utilize Patient Preference

DLIMI 2020

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SUMMARY

Approval bodies such as the FDA, EMA and NICE will soon focus on patient preference evidence when approving new medical treatments. In response to this, it is inevitable that pharma HQs will begin to concentrate on generating such evidence. They will expect that the evidence is utilized by local affiliates for commercial benefit. This whitepaper explores the ways in which local affiliates and commercial capabilities can include patient preference and patient involvement in pre- and post-launch activities specifically in the Nordic context using Denmark as example. Our message is that affiliates with strategies aimed at developing capabilities for the utilization of patient preference will have a strong competitive advantage in the future.

To ensure the whitepaper proceeds with a workable understanding of patient preference in place, this whitepaper outlines key understandings of patient preference, referring to relevant stakeholders and related methods for capturing patient preference. Following this, the paper will explore how commercial organizations can utilize patient preference by supporting medical affairs, market access, sales/marketing activities and HCP/patient engagement in general. The paper concludes that affiliates will need to begin to develop clear strategies and operational capabilities for the effective utilization of patient preference and patient involvement if they wish to stay competitive.

Readers acquainted with developing patient preference evidence may skip the introductory part of the whitepaper. General Managers and other business leaders knowledgeable about patient preference would benefit on focusing on how to utilize patient preference, which is highlighted in the first and last part of the whitepaper whereas commercial specialists with expertise within patient preference may find the last part of the whitepaper of particular interest.

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THE RELEVANCE OF PATIENT PREFERENCE FOR PHARMA

'Patient centricity' treats the patient perspective as a guiding principle in the development and introduction of medicines. That principle is often stressed in the mission statements and branding of pharma companies, and while many companies have some form of patient engagement, large scale patient interaction is limited among most pharma companies. In general, patients have a limited and mostly passive role in the development of medicines, and treatments involving prescribed medicines, at least, are controlled by the caregivers and healthcare professionals (HCPs) who administer those medicines.

This has certainly been true in the Nordic countries, where priority bodies, healthcare authorities and HCPs are the de facto decision-makers for medical treatment and therefore pharma's key audience and stakeholders. But things are changing. The role and importance of patients' preferences is about to be transformed, and the pharma sector must prepare for this development. In the following, the definition of patient preference will be discussed. For now we will refer to patient preference as one type of patient experience that in a pharma context covers how a patient assesses the desirability/acceptability of a health intervention compared to others[1].

Regulatory bodies with global reach such as the FDA (US Food & Drug Administration), NICE (National Institute for Health and Care Excellence in England), and EMA (European Medicines Agency) have signaled the paradigm shift in drug development by calling for evidence about patient preference when approving medicines. Such evidence documents patients' self-reported preferences, choices and needs relative to a specific drug's outcomes and safety profile.

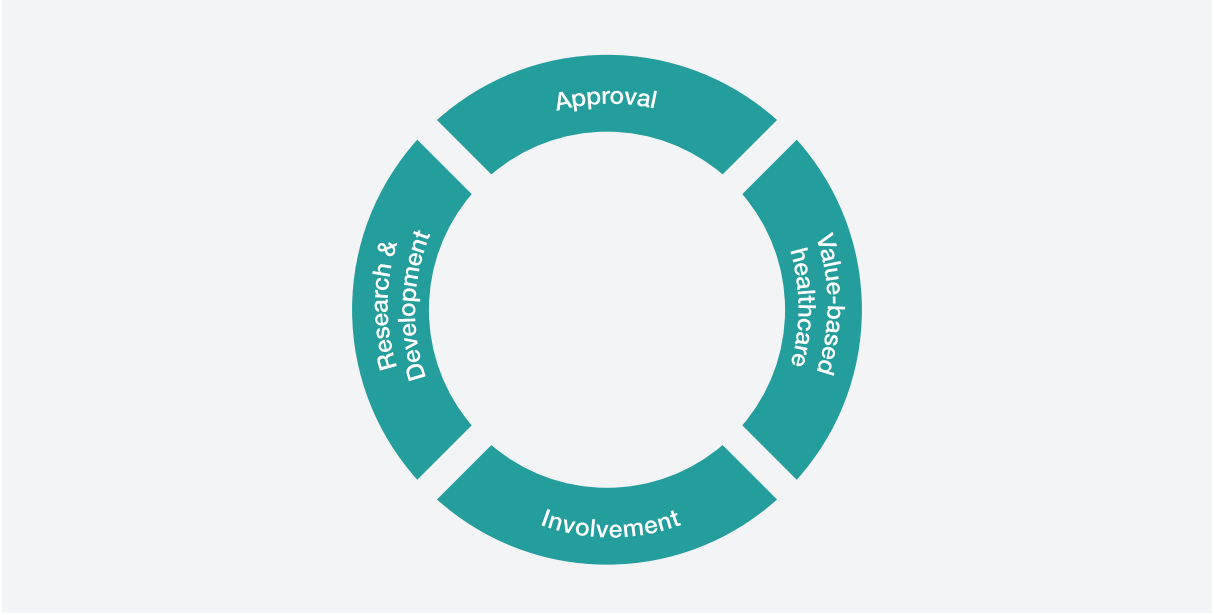
The FDA has already published several guidelines on how pharma can gather and manage evidence about patient preference in their development programs for regulatory approval[2-5]. In fact, by 2021 the FDA will expect pharma companies to include evidence about patient preferences in their evidence package when they apply for approvals[6]. NICE has also issued guidance on how pharma companies can include evidence about patient preference in the regulatory approval process[7,8], and EMA has outlined plans to include this kind of evidence in approvals for new medicine[9,10].

> *"Well-designed and conducted patient preference studies can provide valid scientific evidence regarding patients' risk tolerance and perspective on benefit."*
>
> *FDA 2016, p.9.[1]*

It is clear that the incorporation of patient preference evidence in regulatory approval will impact drug development and evidence generation. This means that the pharma affiliates which manage the local introduction of new medicines should expect to receive evidence dossiers from their headquarters (HQs) that includes evidence about patient preference. Each HQ will expect its local affiliates to use every means available for local approval and commercial activities, including evidence on patient preference. This raises the main question: How can local affiliates operating in the Nordic region capitalize on this new type of evidence in accordance with their HQ's expectations?

The answer to this question may not be too far away. The first thing to say is that public healthcare systems in the Nordic countries are already adapting to the model of value-based healthcare. In this model the quality of a treatment is determined by the clinically relevant outcome in balance with the patient's experience and priorities. In line with this, patient representatives and organizations are represented in priority institutions and Health Technology Assessment (HTA) bodies, as well as local advisory boards in hospitals. They give voice to patients' needs and priorities when medical treatments are assessed, approved and prioritized[11,12]. Likewise, HCPs in hospitals and clinics refer increasingly to patient preference when choosing treatments. They are already seeking to involve patients in his/her own treatment and recovery plans[13].

Fig. 1: Overview of the patient preference landscape



These developments present an opportunity for pharma affiliates in the Nordic region to improve patient access, value differentiation and patient value. However, this opportunity will only be seized if local affiliates know how to utilize patient preference evidence for commercial purposes. In particular, they will need to understand how this is done in the context of a value-based healthcare system.

Using Denmark as example, this whitepaper will help managers and commercial specialists in the Nordic pharma affiliates to prepare their commercial organization and access activities to ensure they make best use of patient preference evidence. It will support commercial leaders in pharma affiliates to:

- Use patient preference as evidence for stakeholder engagement, insight generation and patient involvement.
- Develop the necessary capabilities, across the commercial organization, for utilization of patient preference.
- Manage expectations at HQ level about the ways in which patient preference evidence can support local commercial activities and access in general.

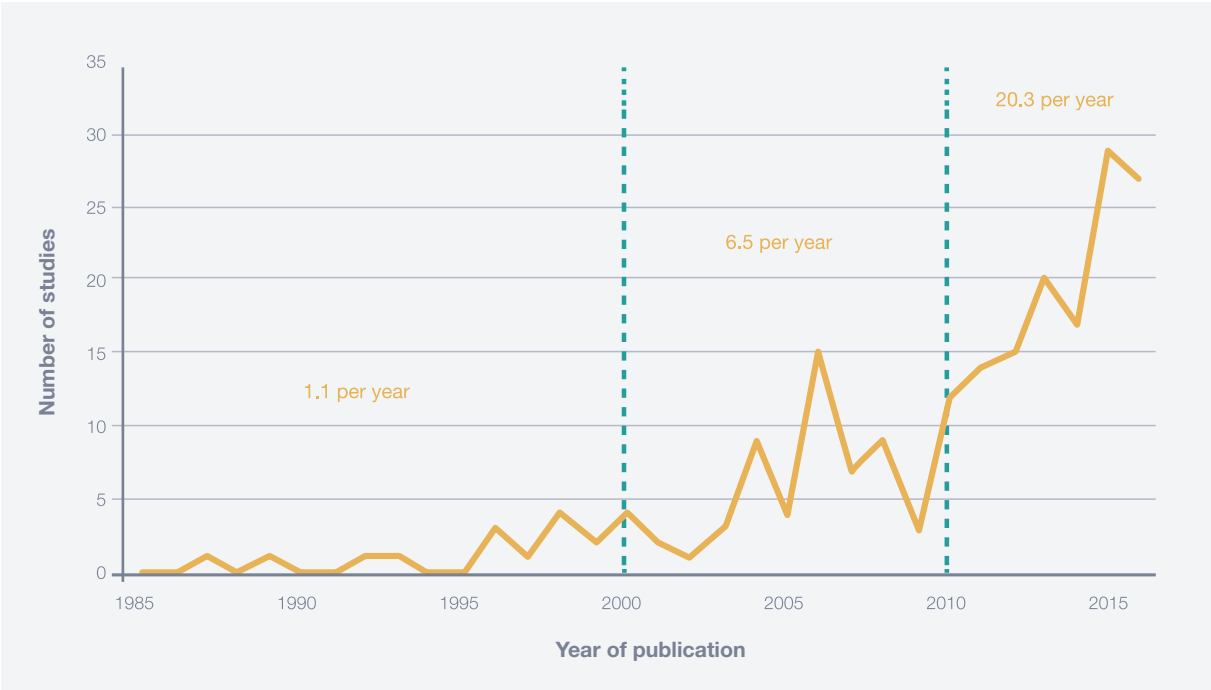
UNDERSTANDINGS OF PATIENT PREFERENCE

It is apparent from the way key stakeholders handle the term 'patient preference' that understandings of it vary[14,15]. This creates uncertainty about how, exactly, patient preference is to be included in drug approval processes, and how to employ patient preference in local engagement in a post-launch setting. Given this, perhaps the most important thing is to understand stakeholders' differing approaches to the notion of patient preference. With this understanding it is at least possible to appreciate the current status of patient preference definitions.

Patient preference in regulatory and HTA bodies

The FDA was one of the first among regulatory bodies to argue for the value of patient preference. In 2016, it issued its first guidance on how to include patient preference in applications for regulatory approval, encouraging pharma to include patient preference information in order to facilitate FDA decision-making[1]. However, the numbers of patient preference studies began to rise before 2016.

Fig. 2. Number of patient preference studies published between 1985 and 2015



Source: https://doi.org/10.1016/j.drudis.2019.05.001

The review of 208 studies from which this graph is taken found that published studies on patient preference were becoming much more frequent before the FDA and other approval bodies called for them to be conducted (see Fig. 2)[16].

The FDA has compiled a list of guidance documents for applicants. These address, among other things, the methodical issues raised by the generation of patient preference evidence that is based on patient experience[2]. The FDA has also already evaluated several patient preference studies in their approval process for new medical treatments[17], and it is expected that more studies will be included in future approvals.

The FDA treats patient preference as a part of the broader notion of ‘patient experience’. The latter covers all data collected by any person tasked with providing information about patient experience of a disease or condition including patient preference (see Fig. 4).

Zooming in on patient preference, the FDA defines this as follows: "qualitative or quantitative assessments of the relative desirability or acceptability to patients of specified alternatives or choices among outcomes or other attributes that differ among alternative health interventions."[1] Patient preference data is seen as particularly useful in evaluating patients' perceived risk-benefit profiles when medical treatments are being provided.

In Europe, we have witnessed EMA initiatives designed to increase patient involvement in drug development and approval. The Patients' and Consumers' Working Party (PCWP) is a clear example of this. There are others signs that patient preference is on EMA's radar. Thus, in reflecting on its strategy for 2025, EMA highlights patient preference as an element in the provision of better evidence to underpin regulatory assessment and decision-making while maintaining objective risk-benefit balance for patients[10]. Presently, there is no formal guidance or requirement to systematically include patient preference studies in EMA decision-making[18]. However, the development of guidance is part of EMA's 2025 strategic plan[10].
In England, NICE has also begun to talk about patient preference.

> *"Improved evidence generation also offers a chance to capture patient preferences better during the evaluation process and make clinical development and regulation more cost-effective, potentially reducing the burden on healthcare systems."*
>
> *EMA 2018, p. 14*[10]

There is nothing new about NICE recommendations referring to patient experience, but recently the value of including patient preference studies in submissions for medicine approval has also been recognized[7]. For now, however, NICE is not including patient preference data in its evaluation of the cost of a medicine relative to the outcome of treatment. This is because patient preference evidence reflects a particular patient populations' acceptance of a specific medical treatment, whereas economic evaluation is based on QALY measures which are thought to enable comparative evaluation between treatments and patient populations[7]. Still, NICE does not rule out patient preference studies being taken into consideration alongside other types of evidence in the future, especially if a choice is to be made between very different treatment options[7].

CASE 1:
Using patient preference insight to strengthen engagement

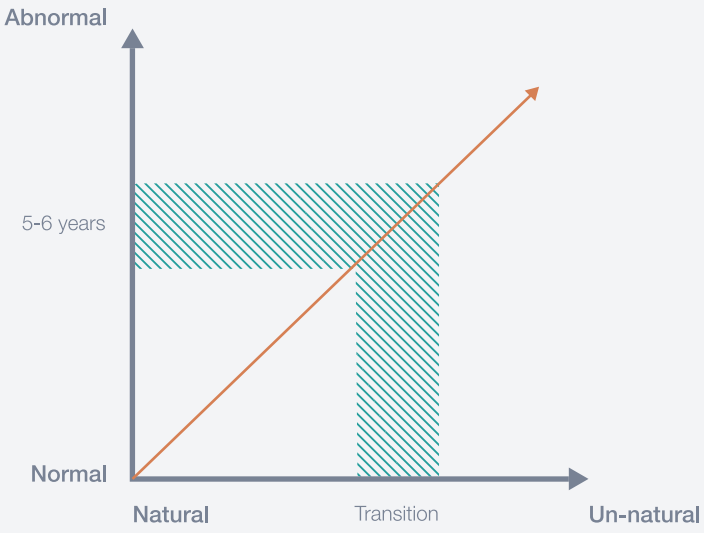
Background
A pharmaceutical company is seeing a decline in sales in one of their products. They are therefore keen to develop a better understanding of patient preferences around the product, as this will enable them to improve marketing directed at patients.

The product is used in the treatment of younger children. It is administered mainly by GPs in the primary sector. Uptake is therefore driven by the parents, who function as a 'patient by proxy'. This means that their preferences become a key focal point of the study.

Explorative study
Following extensive dialog with the customer with the aim of fully understanding their needs and knowledge gaps, DLIMI designed a qualitative interview study. The key element in the study design was several in-depth interviews with parents with children in touch with the disease and treatment in question. The interviews focused on understanding the patient journey including the needs, dreams, barriers and pain points influencing attitudes connected with the treatment. Following this, further interviews were conducted specifically focusing on the reasons for opt-in/ opt-out of medical treatment among parents.

Insights
A key finding was that parents were hesitant to agree to the medical treatment for their children because they saw the disease as a "natural" and socially "normal" condition in the early years of their children's life. This perception was echoed by the GPs responsible for initiating the treatment, and thus children were often introduced to the medical treatment in question (if at all) at a later stage in their life when their parents, and they themselves, were more likely to see the condition as "unnatural".

Fig. 3: Parent perspective on development of condition



Natural development for a child

Using the insights gained through the interviews with parents, DLIMI was able to provide the customer with new insights into the preferences of potential patients. The insights covered unmet needs related to the treatment and indeed the entire patient journey. DLIMI formulated recommendations for marketing engagement that would enable the pharmaceutical company to better meet the patients' preferences and pain points and introduce the theme of medical treatment earlier in the patient journey.

Result

By engaging the patients (here, parental proxies) directly through qualitative explorative interviews DLIMI elicited patient preferences that the HCPs and other knowledge sources had been unaware of. Close engagement with the patients and their preferences enabled the pharmaceutical company to improve its understanding of what really mattered to the patients and thus strengthen its marketing engagement.

Danish recommendations and reimbursement committees

In Denmark, patient preference has been an integral part of the so-called MTVs (Medical Technology Assessments) for years. However, these are seldom used for medicine evaluation[19], although the authorities and evaluation bodies responsible for the assessment, approval and reimbursement of medicines in Denmark do have patient representatives whose role it is to give voice to patient needs and perspectives.

Patients and patient representatives also attend meetings of the special committee of the Danish Medicines Council (Medicinrådet), which recommends medical treatments in the secondary sector. Their role is to add the patient perspective to the evaluation process[11]. And patient preferences are sometimes explicitly included in the Council's treatment guidelines (e.g. in connection with multiple sclerosis[20] and multiple myeloma[21]). However, the Council is yet to state explicitly how patient preference evidence should be used in applications for recommendations specifically and in their work in general.

The blueprint for the newly formed Treatments Council (Behandlingsrådet), which will be responsible for recommending all non-medical treatments in the secondary sector, also explicitly states that the Council must take patient preference into account in their work[22]. But again, guidance is lacking as to how this should be done.

Turning, finally, to the primary sector, the Danish Reimbursement Committee (Medicintilskudsnævnet) has a patient representative to ensure that the patient perspective is reflected in reimbursement decisions[12]. However, so far no formal guidelines have been presented on systematic use of patient preference evidence.

Patient preference in value-based healthcare

With this summary of the situation in the regulatory arena in mind, let us now ask how patient preference is handled in the healthcare systems of the Nordic region using Denmark as example.

In the Danish healthcare system the concept of value-based healthcare is moving care away from a productivity paradigm in which optimal use of resources is central, towards a value-based healthcare system in which the outcomes of treatment are the main focus[13]. As a result, patient preference has become an important factor in the development and delivery of treatment. Patient feedback and other forms of patient involvement in clinical care are receiving increasing attention.

> *The patient should, in his/her meeting with the healthcare system, be asked: "What is important to you?" and be included in his/her own treatment (…). The treatment takes the individual patient's need, wants and capacity as the point of departure (…)."*
>
> *Region Hovedstaden 2019, authors' translation, p. 3* [13]

To meet both clinical needs and the needs of the healthcare system, patient preferences are being included in the form of 'patient reported outcome (measures)' (PRO, or PRO(M)) as one element in the delivery of value-based healthcare[23]. It is important to note that PRO(M) records the patients' own reports of their health status. They offer a snapshot of treatment outcomes as assessed by the patient. They do not reveal how the patient values the outcome of one therapy as compared with another: that is what patient preference studies are designed to do[24].

Another way in which patient preference enters value-based healthcare is through 'patient involvement'. Here, HCPs seek to understand and reflect the preferences of the patients under their care by involving them in their own treatment and recovery. The aim is to align treatment plans as far as possible with the patient's own preferences, so that treatment decisions respect the patient's perspective on his or her own care[13].

> *[…] we collect and disseminate knowledge about patients' experiences, because patients and other users of the healthcare sector have unique knowledge of their own course of treatment, experiences and needs, which can be crucial for ensuring good and coherent information, communication and continuity in the treatment."*
>
> *KOPA, Authors' translation[25]*

Hospitals, clinics and patient advocacy organizations have developed an array of tools, programs and methods designed to ensure that HCPs and patients are able to accommodate patient involvement. Especially digital tools, such as apps, have been utilized to support patient involvement, and it is likely that digital and eHealth solutions will develop further as healthcare systems become more digitalized, and as patients themselves become 'digital natives'.

Fig. 4: Overview of patient insights

With these developments, it is understandable that the notion of patient preference resonates with patients and patient organizations, and there is no doubt that patients will increasingly expect their preferences to be reflected in medical care to some extent.[26,27]

HOW CAN PATIENT PREFERENCE DATA BE COLLECTED? A SHORT OVERVIEW OF METHODS

Patient preference data can be collected using several different qualitative and quantitative methods. In general, qualitative methods are used to explore and understand the patient's own experience of the issues raised by the disease and treatment. Thus, these methods present an opportunity to understand patients from their perspective – to gain an insider's understanding of what matters to patients, and why.

Quantifiable data, by contrast, are gathered using quantitative methods for eliciting preferences. They are used to describe, compare and relate patient preferences[13]. Here, predefined questions and response-scales presented to patients in, for example, surveys deliver quantifiable assessments.

In a 2019 review, no fewer than 32 unique preference methods were identified[16]. Of these, a third were exploratory and two thirds were quantitative elicitation methods. In this hotchpotch of methods, a handful stand out as particularly popular:

- Qualitative exploration methods can be divided into individual and group methods. Semi-structured interviews and focus groups are the most used methods. Both are used within the social sciences and are well understood. These methods are often used in early stage research with the aim of understanding patients' unmet needs, and to identify the relevant endpoints and patient outcomes to be included in later stage randomized control trials (RCTs).

- Quantitative elicitation methods for the generation of evidence about patient preference can be divided into discrete choice methods, ranking methods, indifference methods and rating methods[16]. Among these, discrete choice experiments are the most usual. In them patients are asked to choose between different treatment/medicines profiles, allowing patient populations' acceptance of, and preference for, specific treatments to be measured and compared. Such studies measure preferences in a standardized, quantitative manner, and this delivers evidence about patient preference related to the specific treatment options that regulatory and HTA bodies can use for approval[28,29].

In the regulatory process, where patient preference is seen as a form of evidence, the quantitative methods (especially discrete choice) tend to be used. They allow a spectrum of patient preferences to be quantified, thereby ensuring that different outcomes are properly weighed on the same scale and can be compared[14].

However, there is an emerging consensus that patient preference has potential value beyond the regulatory context and throughout the medical product lifecycle (MPLC). This opens up the possibility of using qualitative methods (especially pre-market) to explore relevant outcomes as seen by the patient and quantitative methods to measure acceptance of, and preference for, treatments, as well as mixed methods combining qualitative and quantitative approaches.

Fig. 5: Patient preference methods

Patient preferences, and the methods for documenting these, take a somewhat different form in value-based healthcare. Here, the methods are applied in order to involve the patient's perspective in the actual treatment. This may involve dialog tools that have been designed to make patient preferences an integral element of the choice and administration of treatment. In some ways, these methods for involving patients are like qualitative methods, since the patients' own perspectives and understanding of their treatment, and their resulting preferences, are explored and built into treatments[14,30,31]. In addition, PRO(M) are employed to quantify treatment outcomes as reported by the patient[24,32].

Thus, although the FDA is the leading body in mapping, describing and issuing guidance on patient preference methods, consensus (or shared guidance) on how to work with patient preference and conduct patient preference studies is generally still lacking. This is especially true in Europe, where patient preference information is not systematically submitted or included in decision-making. However, in the US the inclusion of such data is an emerging trend[15], so there is little doubt that local affiliates will soon need to address

the following questions: How can we utilize patient preference evidence in our pre- and post-marketing activities? Which stakeholders will call for such evidence? How can this kind of evidence offer competitive advantage? What kinds of local capabilities do we need to develop to gain this advantage? These questions are taken up in the next section.

HOW CAN AFFILIATES UTILIZE PATIENT PREFERENCE?

From our own experience with clients in the Nordic region, DLIMI knows that there are already health sector employees with patient engagement roles. Ad hoc initiatives aimed at identifying and meeting patient needs also exist. This has a number of implications for, among other things, medical affairs, market access, marketing and sales. However, patient preference is still not utilized in a systematic way in affiliates' pre- and post-marketing activities. Instead, patient engagement activities are often scattered, and although this is a sign that there is a patient-centric mindset in the local affiliates, clear utilization of patient preference evidence and patient involvement is yet to be seen in commercial operations. The good news is that the local capabilities responsible for pre- and post-launch fall into two categories: those who are already prepared to utilize patient preference evidence in their work and those who can develop such readiness with reasonable effort.

At present, the relevant stakeholders are at various stages in their acceptance of such evidence. As pointed out earlier in this whitepaper, the authorities responsible for approval and reimbursement in Denmark do not have the necessary guidance on the handling of patient preference evidence in their decision-making (see p. 11). Despite this, the new paradigm of value-based healthcare is shifting the focus of the system and HCPs toward patient preference and patient involvement in general.

The first steps toward utilizing patient preference

As HQs invest in the generation of patient preference evidence their expectation that the evidence will be utilized locally will grow. Currently, Nordic affiliates do not seem to be involved in HQs' strategies for implementing patient preference evidence in local markets. However, this may change, as has happened with Real World Evidence (RWE) generation – i.e. RWE strategies supporting HQ global aims with which local affiliates must comply. RWE strategies are often based on, among other things, the principle of promoting documented outcomes from RCTs, and of filling any evidence gaps not covered by the RCTs.

Local RWE initiatives must submit to these principles to be approved by the HQ. General managers and affiliate directors should expect similar developments in the utilization of patient preferences unless they get ahead of this development by building and showcasing their own organizational capabilities for, and commercial success with, capitalizing on patient preference.

> *We have several development programs which are producing patient preference evidence for regulatory purposes. We also expect this type of evidence to be of interest to local affiliates, e.g. in context of exploring opportunities for local approval."*
>
> *Patient Preference Director, HQ*

Currently, patient engagement is a cross-organizational task. Affiliates disperse this responsibility across several roles, and preparing operational utilization of patient preference evidence in pre- and post-marketing activities requires the various responsibilities and roles to be aligned.

At some affiliates, public affairs, or external affairs, plays an explicit role in patient engagement at stakeholder level. Elsewhere this role is found in market access and/or regulatory affairs. Finally, some affiliates appoint a designated 'patient engagement officer' who is responsible for dialog, interaction, stakeholder management and public affairs issues relating to patients and patient organizations. In some cases, these officers also drive efforts to ensure that patient involvement tools are available to HCPs and patients.

The important thing to see is that while most affiliates already have experience in patient advocacy, key resources with this experience will need to be transformed into 'patient preference champions' who are responsible for orchestrating patient preference across launch and brand teams. Either that or they will need to be dismantled so that 'patient preference evidence' and 'patient involvement' are integrated into all capabilities in pre- and post-market activities, leaving the orchestration in the hands of, for example, business unit managers and/or launch and brand leads.

In parallel with this, commercial specialists involved in pre- and post-market activities will need to develop their capabilities within patient preference. They will also have to find common ground on which to support each other in this area if commercial success is to be assured.

In the following sections we will dive into how different parts of affiliates' organization can utilize patient preference.

CASE 2:
Introduction of a treatment based on patient experiences

Background
A pharmaceutical company producing oncological therapies was planning the launch of an adjuvant indication to a drug that had already been used as primary therapy for metastatic disease. The adjuvant use involved the offer of medical aftercare to patients once they have been classified as “cancer free” with the aim of reducing the risk of the disease recurring. The company needed insights about how best to introduce this adjuvant treatment offer to the “cancer free” patients because the exact knowledge of disease stages and risk of relapse could not be assumed on the part of these patients. At the same time there was uncertainty about what level of relapse risk it would take for patients to accept an adjuvant treatment offer. Consequently, the company decided to explore the patients’ perspective on these themes to address the “white spaces” of knowledge.

Study design
Due to the open business questions and the relatively small patient population, the study was designed as qualitative market research based on in-depth interviews. Respondents were typically recruited for 90-minute interviews, but given the potentially emotional and sensitive nature of the patient journey, the interviews had no fixed end time.

Insights
Dialog with patients revealed a significant unmet need relative to the medical aftercare offer and ways to actively control one’s own destiny. Of their own accord, patients were looking for possible ways to prevent, or reduce the risk of, relapse. The medical aftercare offer proved suitable to fill that need, but the patients had no awareness of the adjuvant treatment route prior to being interviewed. Furthermore, the patient dialog revealed that they were informed about their stage of disease and even though they did not have exact knowledge about their risk of relapse, they were eager to prevent it. I.e. they proved to be quite open to this therapeutic offer.

Result
The insights were used by the company’s brand team in a qualified dialog with the clinicians and key opinion leaders in oncology. Obviously, the treatment was launched according to indication but the company´s guidance on how to involve the patients in the treatment decision was adjusted to address the patients’ actual needs. The HCPs also came to appreciate that for the patients it was more important to hear about the reduced risk of cancer recurrence than prolonged overall survival.

Medical affairs

It is clear that since regulatory authorities such as the FDA are advocating for patient preference data to be included in the design of drug research, as well as in RCTs, medical affairs will soon be faced with the opportunity of presenting such data to local approval bodies. But in what situations should medical affairs push to present preference evidence? And how can such evidence be successfully submitted when the authorities do not include patient preference evidence in their formal approval processes?

> *"Patient preference evidence allows medical affairs to initiate a dialog about medical treatments and real-world experience with KOLs. Connecting traditional evidence with patient experience will thus extend medical affair's touchpoints throughout the patient journey as well as to put the patients' experience front and center in the discussions with KOLs."*
>
> *PhD Gita Kampen, Head of Life Science Insights Centre, Chief Advisor DLIMI*

In its recommendations, NICE stresses that patient preference evidence becomes relevant when two different treatments which are equally safe, and have the same outcomes and evidential support, are being evaluated[7]. The idea is that patient preference evidence can be added to approval decisions to tilt the scales if other factors are equal. Nordic approval bodies are likely to adopt a similar view when they develop their own guidance on the evaluation of patient preference evidence. However, given that patient representatives are already involved in the approval bodies, they have to be asked just how much interest those bodies will show in patient preference evidence.

Patient preference evidence does present an opportunity to give voice to the patient's own acceptance of his or her medical treatment, and therefore it will appeal to patient representatives. Medical affairs must, however, consider the ways in which preference evidence can be presented when the authorities have no formal guidelines or processes for including it in their evaluations (yet).

One way to encourage the authorities to use patient preference evidence in their evaluations is by presenting the evidence to the relevant clinical KOLs (key opinion leaders) and patient organizations before formal evaluation takes place. Here, medical affairs should ally with market access and public affairs to confirm that the relevant stakeholders are targeted and ensure that the patient preference evidence is translated to the local context of the KOLs and patient organizations. It is vital to understand that the public healthcare ecosystem's principal stakeholders are imbedded in a value-based healthcare system, and thus patient preference evidence should be contextualized accordingly. Introducing the necessary information in an audience-sensitive manner will enable KOLs and patient representatives to become acquainted with this type of evidence. After this they will be able to formulate opinions about how to use the evidence in their decision-making and position themselves as members of evaluation committees.

Another route to ensuring there is a better understanding of patient preference among clinical stakeholders is to focus on whether, and in what way, they include PRO(M) in everyday clinical practice and decision-making. The point here is to explain how local PRO(M) are built, measured and fed into clinical decision-making, and to satisfy stakeholders that patient preference evidence complements and enhances local PRO(M) results.

Finally, medical affairs should consider how they can support local patient preference studies of patient segments within the therapeutic area in which they operate and collaborate when the clinical KOLs are calling for this type of evidence. Such studies can form part of phase 3 trials conducted at local centers. Alternatively, they could be phase studies IV in, for example, outpatient clinics.

The patient preference evidence that medical affairs will present will probably be developed as part of phase 2 and/or 3 RCT head-to-head studies. It is likely to present measurements of patient evaluations, choices and preferences relating to one medical treatment versus another, competing treatment. This means medical affairs will be well acquainted with study programs where patient preference data is generated (i.e. the relevant RCTs). However, the qualitative methods through which endpoints are developed and the quantitative methods through which patient preferences are measured, will be alien to them. The right methodological knowledge is critical to leverage these opportunities. This goes for both the qualitative methods through which endpoints are developed and the quantitative methods through which patient preferences are measured, as well as PRO(M) and how PRO(M) relates to patient preferences in general. Improving medical affairs' understanding of these methods is therefore best prioritized if the aim is to assist affiliates preparing to utilize patient preferences.

Market access

As a key capability of local affiliates in all pre- and post-launch activities, market access will have a central role in presenting patient preference evidence to payers, to KOLs, and for HTA decisions. As mentioned above, market access will need to ally closely with medical affairs, supporting them in presenting the evidence to the relevant authorities, and motivating KOLs and patient organizations to formulate opinions about, and guidance on, the use of patient preference in their evaluations and decision-making.

> *"Patient representatives sit at the table where the priority decisions are being made. And their voice is getting stronger thoughout the healthcare system – influencing priority decisions evermore. It is only a matter of time before patient preference evidence will be part of the formal decision-making processes. If nothing else then to be able to handle patients' growing influence on priority decisions."*
>
> *Niels Christian Hirsch, Lead Market Access, Chief Advisor, DLIMI*

One important job for market access is to translate outcome evidence from RCTs into patient value and economic impact assessments, so that HTA bodies and payers can arrive at decisions about the usage of a specific medicine. Market access might be tempted to use patient preference evidence from RCTs as evidence of a particular patient populations' preference for a treatment, and thus as evidence of that treatment's patient value. The preferred tool for this is normally the generic measure for life quality known as the QALY (quality-adjusted life-year)[33]. However, HTA bodies have been swift to point out that QALYs cannot be replaced by patient preference evidence because the latter is "only" evidence derived from a specific patient population about a specific treatment whereas the former offer a generic measure enabling comparison across treatments.

It remains true that patient preference evidence can be used to highlight case-specific treatments which, from the patients' perspective, have (un)acceptable side-effects, (ir)relevant clinical outcomes and/or other (un)acceptable implications. The highlighting of these patient experiences, and calculation of the added costs associated with, say, an experienced side-effect, will still be welcomed by payers and other decision-makers.

Most market access specialists – especially those proficient within HEOR (Health Economic Outcome Research), economics and/or the social sciences – will be acquainted with the study designs, survey questionnaires and quantitative methods used to measure patient preference. However, information about the way the authorities, KOLs, payers and other stakeholders use patient preference evidence, and about how to get this evidence into the decision-making, is bound to be of value to market access. These capabilities are normally found in policy-making and public affairs. Like medical affairs, market access must also be familiar with the way PRO(M) is used in the disease area in which they operate. They also need to develop an understanding of the ways in which patient preference evidence aligns with PRO(M).

Sales & marketing

For sales and marketing patient preference evidence offers a clear opportunity for differentiation, and to communicate added value and give voice to the patient perspective. However, as sales and marketing is moving away from transactional sales to knowledge-driven dialog and partnership[34], it will need to be well versed in methods and research designs for producing patient evidence as well as in the ways in which such data fits with the individual HCP's everyday clinical practice. Here, sales and marketing must ally with medical affairs and market access to acquire an adequate understanding of methods, results and the value of patient preference evidence. They also need to call for patient preference insights from market research so that they can see how patient preference is relevant to HCPs.

As should be clear by now, sales and marketing will have to expand its market insight scope so that it includes the role patient preference plays for HCPs and patients. This will make it possible to consider patient preference evidence when positioning products and marketing messages. Sales and marketing

teams will also need to understand the methodology of patient preference evidence generation so that they can communicate messages derived from patient preference information.

Finally, those handling sales and marketing will encounter patient preferences in eHealth solutions. Digital services for chronic patients are slowly – but surely – being launched for patients and HCPs with the aim of adding patient value and differentiation by delivering digital solutions that support patient involvement[35]. Diabetes[36], ADHD[37], skin diseases[38], COPD[39] and arthritis[40] are just some of the disease areas in which these services are being introduced. Sales and marketing will need to be in a position to include these solutions in their communication and interaction with HCPs as one means for HCPs to involve patients in their own treatment.

Market research

Market research already takes a keen interest in patient insights, so it is in a strong position to understand the relevance of patient preferences and the methods used to explore them. As an in-house service provider for all commercial teams, market research will ideally be the "go to" capability for sales, marketing, and even market access and medical affairs, when it comes to patient insight generation. However, it will not necessarily be ready to handle patient preference evidence when the need arises. Exploring local patient insights and patient needs can be useful when patient preference evidence is being introduced. More specifically, market research into patients' needs can highlight the fit between local patients' needs and patient preference evidence from HQ. This may help to strengthen the implementation of patient preference evidence. It may also indicate which aspects of this evidence should be in the forefront of sales and marketing activities.

> *"It is worth remembering that core commercial questions concerning launch preparation, market and treatment dynamics, and HCP preferences are already being answered by market research capabilities. This includes insights about patient perspective and experiences as well."*
>
> *Mette Tang Lohse, Head of Sales, Chief Advisor, DLIMI*

In addition, market research is a useful ally when ways to strengthen patient involvement or develop tools for patient engagement are being explored. The development of tools for patient engagement requires an extensive understanding of, among other things, patients' unmet needs, treatment options and interaction with HCPs, as well as the techniques through which HCPs already involve patients in their own treatment.

Building such insights also falls within the scope of market research. However, the actual development of new solutions and tools for patient involvement via methods such as co-creation, agile development and other design methods is not part of market research's traditional repertoire, and it must therefore be developed, or procured, by external service providers.

Digital patient engagement

Lastly, it is necessary to highlight digital patient engagement, since patient involvement in the current healthcare system is increasingly enabled via digital solutions such as apps, and affiliates' marketing and sales activities are also in the process of being digitalized.

Medical affairs, can as already mentioned, explore the possibility of conducting patient preference studies with local KOLs and clinics. Similarly, sales and marketing can, if internal guidelines permits it, look into opportunities to develop apps in collaboration with clinical KOLs and HCPs with the aim of involving patients in their own treatment. The benefit of this – apart from creating patient value – is that, potentially at least, strong relations with stakeholders such as patient organizations, KOLS, patients and HCPs will be built through their participation in the development of the digital services. For example, patient preference evidence can be presented to stakeholders who are being invited to participate in the building of digital solutions if it shows that patients have unmet needs that the digital tools can meet. Naturally, in some cases digital solutions will not be suitable. Improved patient information, changes to patients' treatment journeys, or other adjustments in clinical practice to align treatment with patients' preferences, may well improve patient experience of treatment. The point is to focus on local initiatives and build patient involvement solutions from the bottom up.

This whitepaper has outlined the key concepts and capabilities, the critical stakeholders, and the commercial opportunities involved in the utilization of patient preference. The next step is to build and execute local strategies for using patient preference evidence and creating patient involvement. It goes without saying that affiliates at the forefront of this development are more likely to enjoy continued commercial success than their competitor companies.

CONCLUSIONS

Patient preference evidence is here to stay. There is a growing focus on it among regulatory and approval bodies both in the US and Europe. However, a clear definition of this kind of evidence, and guidance on how to define, generate and utilize information about patient preference, is currently underdeveloped. In this whitepaper, it has been argued, in the context of the Nordic value-based healthcare system, that if local affiliates are to meet HQ expectations around the future use of patient preference evidence in pre- and post-launch activities, they must do several things:

- Take a lead in managing HQ expectations about the way patient preference evidence can be used to support local commercial activities and access in general.
- Explore and develop methods and strategies facilitating the use of patient preference as evidence in stakeholder engagement, insight generation and patient involvement.
- Work to develop capabilities, across the entire commercial organization, for the utilization of patient preference.

The growing importance of patient preference has ushered in a new world that we are still coming to terms with. However, it is clear that patient preference evidence offers huge opportunities, and that local affiliates who are early adopters of the above goals will have a strong competitive edge in the future.

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ABOUT DLIMI

DLI Market Intelligence (DLIMI) is a leading provider of business intelligence and Real-World insight to pharmaceutical and health-related companies operating in the Nordic region. We offer pharmaceutical sales statistics on a variety of platforms as well as market research, market access support, real world studies, and consultancy services covering Denmark, Sweden, Norway and Finland.

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All cases are approved by clients.

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