A Klick Health POV

Fixing pharma's personalization problem

Moving beyond traditional audience personas towards real-time engagement.



Brian Fox
President,
Chief Growth Officer
Klick Health

Jamie Lutzky
EVP, Head of
Strategy
Klick Health

Jenna Mitby-Manning
Managing Director,
Omnichannel Enablement
Klick Health

For a decade, pharma has treated personalization as a content problem: pick a segment, build a persona, tailor the message, and then count the clicks. The thinking has been simple: more variants, more opportunities for relevance, more lift. Generative AI seemed to make that model irresistible by creating content variants nearly for free. But the best personalization systems in the world don't win by producing content. They win by listening and matching content.

Consider Netflix: they don't make a custom version of each movie. Amazon doesn't reformulate dish soap to fit a household. TikTok doesn't generate new videos for each viewer. What they do is observe: what you played, what you skipped, what you searched for, what you abandoned. Then they use that to identify the right thing to present to you at the right moment. They aren't making personalized content. They're matching existing content to wants or needs. The personalization is in the matching, not the manufacturing.

That's the real shift. Personalization used to be about defining audiences and pushing content at them. Now it's about observing what people do (and what they don't do) and responding to what's actually happening. It's about listening through data signals. Today's pharma systems mostly do the first. Tomorrow's will need to do the second: sense the moment, respond to it, learn from how it goes, and do it better next time.

This fundamentally changes how most pharma marketing happens. Listening does not mean collecting more dashboards. It means connecting four things pharma usually keeps separate: signals, patterns, interventions, and outcomes. Instead of running customers through a pre-built journey, the brand reacts to what's actually happening for them. That matters more than it used to because the brand isn't the only voice in the room anymore. Customers are also asking Google, asking AI assistants, talking to peers, and reading whatever lands in their feed. In that environment, trying to control the journey doesn't work. Responding to it does.



FROM PERSONAS TO PATHWAYS

This changes the basic unit of personalization. Most pharma brands today plan around personas: research-built archetypes meant to stand in for real customers. Content gets built to fit the persona. Campaigns get planned around delivering the right persona-message pairing at the right stage of the funnel.

A persona is a guess at why someone might do something. A signal is the record of what they actually did. Behavior changes constantly. A physician might need education on Tuesday and reimbursement help on Thursday (or might need both at different times in the same day when seeing different patients). Personas flatten that into one stable identity. Signals catch the shifts as they happen.

Personas can still guide strategy, but pathways must replace personas when it comes to personalization. Within a pathway, what matters is the pattern of what someone is doing right now.

Here's what this looks like. An HCP searches for diagnostic criteria, spends time on an indication-specific page, and downloads a patient-identification tool. Then, the HCP's journey stops. No single one of those moves means much, but put them together and you get a pattern: this physician is trying to identify the product's fit for a patient and has concluded the fit isn't there.



The HCP, however, is aware of the drug and may consider it again. Having an MSL contact the HCP may be the best next step to discuss fit criteria for future patients.

A different example. A long-time patient on therapy has a coverage change, misses a refill window, starts reading more side-effect content, and then goes quiet on the channels that normally see activity. The pattern says lapse risk is rising and a generic refill reminder is the wrong response. A proactive call (if the patient has opted in to hub services) would be much more effective.

When thinking about the pathway, what someone hasn't done can often be more revealing than what they have. The patient who hasn't refilled. The physician who hasn't prescribed for a second patient. The HCP who watched a MOA video and then went cold. Personas can't see any of that. Signals can. Search behavior and AI-assistant queries are increasingly the earliest visible signals in many pharma categories. People ask Google and ChatGPT long before they ask a brand. The funnel often starts there.

Not every category produces the same quality of signal. Some therapeutic areas generate dense, recurring behavioral data. Others are sparse and hard to observe. The same principles apply, but the interventions get broader, the confidence in any specific call drops, and the learning loops slow down.



THREE THINGS HAVE TO BE TRUE

For personalization to move commercial outcomes, three things have to hold at once. First, there must be a real friction worth resolving. Second, you need a signal that tells you the moment is happening. Third, you need a way to connect the signal to the right response and learn from what happens next.

That combination is rare in pharma. Most current programs overinvest in producing content and underinvest in the systems that notice moments, coordinate responses, and improve. Without those systems, more variants just produce more clutter.

None of this requires building a consumer-scale recommendation engine overnight. Most organizations can create real lift by getting more responsive in a handful of high-friction moments first: treatment initiation, reimbursement navigation, adherence risk, and triggered engagement. The opportunity is to start building the signal flow, the response infrastructure, and the feedback loops that make this kind of personalization possible at all.



WHERE THIS WORKS, AND WHERE IT DOESN'T

This approach works best where three conditions overlap: behavior is observable, the moment matters, and the brand can intervene in time. That makes it especially relevant in specialty markets, treatment initiation, reimbursement navigation, adherence, patient support, and HCP practice change.

Pharma's investment is often upside-down on this. Most personalization spending sits upstream, where signal is thin and most of what gets called insight is inferred from personas and engagement metrics. Downstream is different. Patient support, access, and adherence have richer behavioral signals and clearer points to intervene. They also get a fraction of the budget.

That doesn't make upstream personalization pointless. Search-informed content, adaptive sequencing, and responsive HCP engagement still earn their place. But the farther upstream you go, the harder it is to know what someone actually intends, and the harder it is to prove that responsiveness changed anything.

The other limit: when reach is the goal, responsiveness stops being the point. Broad awareness and brand-salience work still depend on scale, not specificity.



THE REAL ROLE OF AI

AI matters because it makes responsiveness operationally possible. It can detect patterns across fragmented signals, infer what those patterns likely mean, recommend the right intervention, and learn from the outcome quickly enough to change the next decision.

A chronic disease example makes this concrete. A long-time patient has an insurance change. Without AI, the brand sends a coverage notification. The patient misses a refill window, another reminder goes out. The patient starts reading side-effect content, more side-effect material gets served. Each response is technically triggered by a signal, but the brand is reading each signal in isolation, missing the pattern entirely, and repeatedly giving the wrong answer to the right question. This is Next Best Action as most pharma brands actually practice it today.

AI changes this in three ways that rule-based systems struggle to match. First, it finds signal combinations no human analyst would have thought to test and evaluates them fast enough to act on. Second, it interprets what those patterns mean for this brand, this therapy, this patient. Third, it identifies the right response, which often is not a content variant at all. In this case, the right answer is hub services reaching out about the insurance change, with a warm transfer to nurse support. The patient's actual problem gets solved. No new content required.

Beyond that single moment, AI adds two things: memory and speed. Every response feeds back into what the system knows. Every closed loop makes the next call faster and more accurate. Pharma could theoretically have reached these answers before, with enough analysts, enough time, and enough coordination, but that was never a realistic operating model. AI makes the translation between signal and response fast enough to matter.



MAKING THIS POSSIBLE

Building this requires a different kind of technical plumbing than most organizations have today. Most pharma personalization stacks are stitched together from separate tools: one system for digital assets (a DAM), one for publishing content (a CMS), one for tracking customer interactions (a CRM), one for managing data (a CDP), and one for reporting on results (a BI tool). That arrangement works for linear, planned campaigns. It does not work for personalization that has to read signals, decide what to do, and respond in the moment. The same general building blocks are involved, but the way they have to be wired together is radically different.



- **Data and intelligence**
  This is the foundation, and it has to be owned, not rented. Pharma brands need a stable customer identity graph, a way to recognize that a single physician searching, downloading, and engaging across channels is the same person, and that the same patient's hub interactions, refill behavior, and side-effect searches all belong to one record. Without that spine, signals fragment and patterns dissolve before anyone can read them. Once it is in place, AI does the highest-leverage work in this layer: predicting which patients are at lapse risk, scoring which HCPs are most likely to adopt, segmenting in real time as new signals arrive, etc. Work that used to happen quarterly can happen continuously.

- **Content**
  Here, the working model needs to flip. The old flow runs in one direction: strategy to brief, to development, to MLR Review, to distribution, to measurement. The new flow runs the other way. The audience signal generates the brief, then AI produces content to match. MLR review moves upstream into development instead of sitting at the end as a gate. Content stops being a plan executed against a calendar and starts being a response to what someone is actually doing.

- **Activation**
  Today, each channel acts on its own logic: the email platform sends emails, the rep tool triggers field alerts, the patient hub makes calls, and paid media often runs in its own walled garden. In a responsive system, the activation layer sits above the channels. It decides what the right intervention is (whether that is an email, a rep alert, a hub call, a different cadence, or a paid-media impression) and routes it to the channel that can deliver it. The hard part is not the routing logic. It is getting the signal to the channel fast enough to matter before the moment passes. Brand-owned channels can handle this today. Paid media is harder because of latency and walled-garden constraints, but it is possible with the right partners.



- **Measurement**
  This is where most brands stall because MMM and script-lift analytics exist, but the results rarely flow back into the system in time to change the next decision. In the current model, measurement is a reporting function: it tells you what happened after the fact. In a responsive system, measurement is a continuous feedback signal. Whether the patient refilled, whether the physician prescribed, or whether the HCP engaged after the MSL call, every outcome flows back into audience scoring and response logic in near-real time. That feedback loop is what makes the system learn. Without it, even a well-built AI stack executes responses but never gets smarter about which ones work.

Building this is not trivial. It is also not all-or-nothing. The practical starting point is getting customer identity right, standing up the feedback loop between measurement and intelligence, and running the content and activation layers against real behavioral signals in at least one high-friction moment. From there, the system expands. The brands that start now will have a compounding advantage.



THE NEW OPERATING MODEL

Pharma spent the last decade trying to personalize content. The next decade is about getting responsive: noticing when specificity matters, catching the moment early enough to act, and learning continuously from what actually changes behavior.

For pharma commercial leaders, the practical implications are clear. Stop adding content variants. Start building the systems that notice signals and respond to them. Move investment from upstream content to downstream signal and intervention. Tie incentives to the outcomes that matter: script lift, persistence, diagnostic adoption. Stop reporting on engagement metrics as if they were the same thing. The brands that do this will build a capability the rest will struggle to copy. The ones that don't will keep building content engines that get better and better at producing the wrong thing faster.



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We welcome your questions
and feedback. Please contact:

Michael Chambers
SVP, Opportunity Creation
mchambers@klick.com