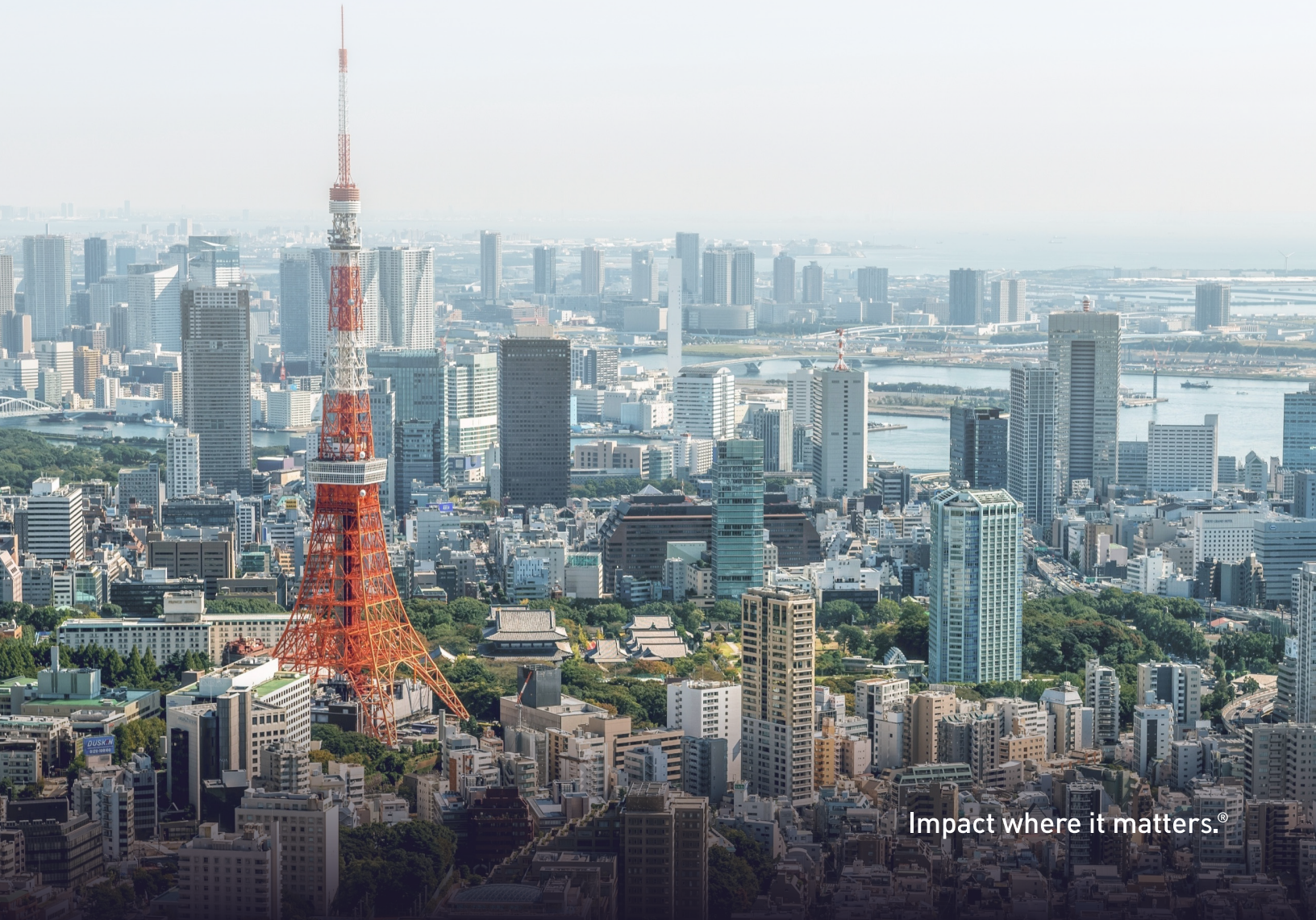
WHITE PAPER

Medical affairs: The trusted integrator of Japan's healthcare ecosystem

How medical affairs can lead Japan's next healthcare collaboration model

By Bora Erdemli and Yomogi Torikai



This white paper includes contributions from guest authors Masahisa Jinushi of Tanabe Pharma and Yohei Ohashi of UCB. It was published jointly by the Pharmaceutical Research and Manufacturers of America (PhRMA), the Japanese Association of Pharmaceutical Medicine (JAPhMed) and ZS.

Medical affairs can become the trusted integrator Japan's healthcare ecosystem needs. Its authority comes from science, but its future value will come from connecting science, evidence, stakeholder insight, patient experience and enterprise decisions in a way no other function can.

Leaders from 25 companies came together at the Japan Medical Affairs Summit 2026 to discuss which collaborations create value, which add load and how to tell the two apart early enough to matter. They emphasized medical affairs' standing as an independent scientific authority and were careful about any action that could affect the function's reputation. At the same time, they argued that its future value lies less in what it knows than in its ability to connect stakeholders that rarely connect themselves.

They also discussed how organizations must address several enablers for medical affairs to become a stronger enterprise integrator. These enablers include greater alignment on compliance guardrails; clearer governance and decision rights; broader recognition of medical affairs' strategic value; more connected systems; more consistent translation of insights into action; and continued development of business fluency and enterprise acumen among leaders.

The leaders at the summit reached a shared conclusion: Collaboration does not improve by adding more meetings or touch points. It improves when the operating model, governance, data and insight flows, talent, culture and measurement are rebuilt to support it. The summit eventually determined five imperatives for medical affairs leaders in Japan:

1. Treat medical affairs as a distinctive creator of value
2. Make compliance a working system for responsible collaboration
3. Build an engine that carries evidence into decisions across the asset life cycle
4. Establish partnerships across the healthcare ecosystem
5. Replace activity metrics with impact metrics

"Medical affairs leaders are no longer debating whether collaboration matters. They are debating how to make collaboration safe, scalable, measurable and valuable."

Medical affairs is at an inflection point

Medical affairs built its reputation on a familiar set of contributions: Scientific exchange with clinicians, medical information, evidence generation and credible scientific counsel inside the company. Those contributions still hold, but the world around them moved faster than the operating model. Clinical choices now respond to real-world evidence (RWE), patient experience, local practice patterns, health economics, digital data, AI-derived insight and policy. Companies today need quicker, sharper decisions across R&D, medical, market access and commercial.

Japan feels this pressure more acutely than most markets. The country carries a well-documented drug loss problem: Of the medicines the U.S. Food and Drug Administration (FDA) and European Medicines Agency (EMA) approved between 2016 and 2020, roughly 70% remain unavailable to Japanese patients, and the gap widens for products from emerging biopharma.

In July 2024, the government answered with a five-year plan to close the lag, including by setting targets to begin development on dozens of stalled products. The causes of this lag are often regulation and declining pricing predictability over an asset's life. Frequent price revisions, evolving premium eligibility and uncertainty around postlaunch repricing make Japan harder to model as a launch market, especially for smaller companies deciding where to commit development resources. The response therefore calls for what medical affairs is built to supply: A clear account of Japan-specific unmet need, locally relevant evidence and an understanding of where patient care falls short.

How medical affairs can lead in Japan

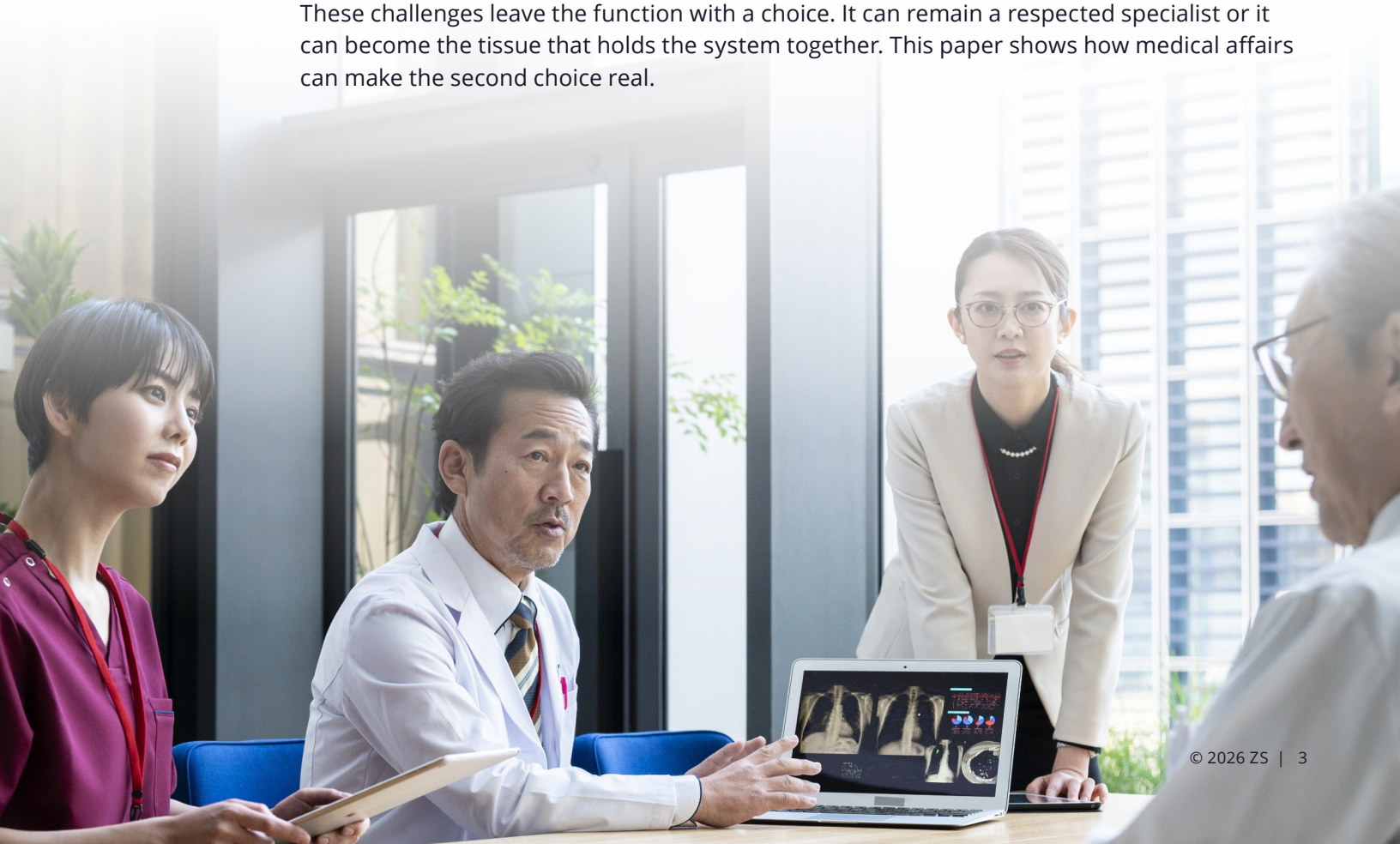
Meanwhile, the data environment is opening. Recent reform of the Next-Generation Medical Infrastructure Act in Japan allows pseudonymized medical data to be created and reused—which serves research and regulatory work far better than fully anonymized data—and a nationwide platform is being assembled to link records across institutions. While uptake is uneven and only a handful of certified intermediaries are operating, the trajectory is set, and the raw material for RWE is more reachable than it has ever been.

This direction extends a case ZS has made before: Medical affairs in Japan can be a leader in developing a model of care that's outcome-driven, patient-centered and increasingly AI-enabled. It can produce the RWE regulators payers and clinicians now expect, and judge itself by outcomes rather than activity.

At the summit, the leaders tested this idea against the challenges of the Japanese market, which include:

- Clinical practice that differs from global norms
- Compliance guardrails that can be interpreted differently across organizations
- A patient-advocacy landscape still taking shape
- Unresolved digital-health policy
- The standing pressure to prove value to both local and global leadership

These challenges leave the function with a choice. It can remain a respected specialist or it can become the tissue that holds the system together. This paper shows how medical affairs can make the second choice real.



The collaboration gap inside pharmaceutical organizations

Across industries, the richest opportunities sit at the intersection between functions, offices and organizations, where working together proves the most difficult. Gartner research finds that about four in five leaders report what it calls collaboration drag—often consisting of the slow accretion of too many meetings, too much peer review, unclear authority and endless buy-in.

When the collaboration drag is significant, companies are roughly 37% less likely to reach or beat their business objectives. This is partially because of how leaders are trained, as most learn to run their own teams long before they learn to work with peers who answer to different goals. And silos are not one problem but several: some are systemic, some protective of turf, each needing its own solution rather than a single cure.

Pharma is no exception, and medical affairs cannot lead collaboration across the healthcare ecosystem until it addresses collaboration challenges within its own organization. Our pre-summit survey explored where those challenges exist. Leaders identified differing interpretations of compliance guardrails and uncertainty about how to apply them as the biggest barrier to internal collaboration. The second most common barrier was a limited cross-functional understanding of medical affairs' role and value. Leaders also identified the greatest opportunities for collaboration in early asset planning and trial design, integrated data and insight management and peri-launch strategy. This was followed closely by stakeholder engagement and integrated evidence planning.

Foreign-headquartered companies identified early asset planning and a unified external strategy as the greatest opportunities for collaboration. Meanwhile, Japan-headquartered companies prioritized insight management and peri-launch execution, seeing them as opportunities to better demonstrate the value of medical affairs across the organization and to senior leadership, while strengthening external stakeholder relationships. Despite these different priorities, both groups reached the same conclusion: Effective collaboration requires clear governance, defined roles and disciplined execution.

FIGURE 1:

The collaboration maturity journey

Maturity stage	"We're in silos"	"Let someone else handle it"	"Let's collaborate"	"Let's break down silos"
Strategy	Minimal cross-functional planning across field teams	Some planning and coordination is shared	Informed cross-functional planning across teams	Collaboration designed into structure and operations
Operations and reporting	No systematic reporting process	Ad hoc pulling and sharing of reports	Established processes with clear guidelines	Streamlined, accountable, outcome-linked outputs
Insight sharing	Information kept within teams	Some sharing on ad hoc request	Appropriate sharing that guides strategy	Shared standards and compliant synthesis

Compliance: From a source of doubt to an operating discipline

The discussions about compliance were some of the most revealing. Leaders discussed the need for clearer governance, as some teams apply guardrails differently or feel uncertain about where the line falls. Several leaders described firewalls applied unevenly, shaped more by a given leader's appetite for risk or by company history than by any written rule. They also noted that when a hard question surfaces, the burden tends to fall to medical affairs to answer it, even while business accountability stays unclear.

The pre-summit survey reinforced this point: Of the 20 participating companies, unclear or inconsistent interpretations of compliance expectations and firewalls were among the most frequently cited internal barriers to seamless collaboration between medical affairs and other functions. The same theme surfaced again when leaders were asked which collaboration roadblock they would remove tomorrow if they could, with two leaders explicitly naming an excessive compliance mindset. This result demonstrated that the main obstacle is often not the rule itself but the absence of shared, practical guidance for applying it consistently.

The conversation kept returning to the same framing: The firewall is not the question; the threshold is. Where exactly should the line sit and who gets to draw it? These two situations made the point that the real work is interpreting the rule, not learning it:

- **Prelaunch collaboration**: Promotion before approval is plainly off-limits, yet prelaunch is not a collaboration blackout. Insight from scientific exchange, unmet-need assessment and disease understanding belongs to asset strategy. Many companies already involve medical affairs early in evidence planning and in the unmet-need assessment, while also maintaining clear boundaries from promotional strategy and tactical execution—which is where targeting and speaker selection live.
- **Commercial participation in medical affairs advisory boards:** Some companies bar observers outright, some cap the number and some decide by seniority or stated purpose. Where commercial participation is permitted, leaders emphasize the importance of predefined observer roles, documented rationale, safeguards against promotional use and transparent criteria that are understood by all functions. The lack of shared understanding, clarity and playbook is a common pain point.

The implication for leaders is straightforward. Medical affairs needs governance with standard approval routes, escalation rules that name who decides and when, playbooks for the situations that recur and decision rights clear enough to define accountability, escalation pathways and the appropriate role of each function.

Rigid rules slow decisions without making them safer. Clearer and leaner rules can do the reverse.

From support function to strategic value creator

Summit attendees discussed the importance of ensuring medical affairs is viewed as an equal strategic partner to other functions within pharma. The leaders in attendance believe that medical affairs earns influence not by matching these other functions but by owning what only it can produce.

Leaders agreed that language matters. When medical affairs describes itself as a support function to commercial, development or brand teams, it can unintentionally diminish its strategic importance. Medical has its own mandate, decision-making authority and accountability. The shift leaders described is from scientific expert to enterprise integrator—a role that not only determines whether an initiative is scientifically sound but also understands how it informs decisions, advances patient outcomes and supports innovation across the healthcare ecosystem.

Two behaviors separate the organizations that have made the shift. The first is a willingness to say no. Leaders shared the example of MSLs who were pulled into field representative-driven requests because everyone enjoys and values an MSL visit. However, the value of the visit in the moment is not the point. The question is whether medical affairs resources are deployed with intent. Teams with an advanced mindset have learned that turning down low-value requests is not a failure to collaborate. Rather, it protects credibility and reserves scarce scientific attention for the work that creates impact.

The second behavior is arriving with an agenda. Cocreation doesn't end with a seat in the cross-functional leadership meeting. To act as an integrator, medical affairs must come knowing what it needs to say, what it needs to learn and which decision it wants to shape. Forums and seats are the setting, not the contribution.

Without a shared understanding of medical affairs' role and value, organizations won't involve the function early enough to shape decisions where it can create the most impact. In the pre-summit survey, a lack of cross-functional understanding of medical affairs' value proposition was the other most cited barrier to internal collaboration. Several leaders pointed out that medical affairs engagement in strategic discussions was delayed, or even absent, because of this gap. To resolve this situation, medical affairs must articulate and demonstrate its value in cross-functional environments.

"Medical affairs earns its relevance by doing what others cannot: Shaping scientific judgment, evidence strategy, disease understanding and the long-term value of the ecosystem."

Talent and the enterprise mindset

For medical affairs to be an equal strategic partner, its biggest challenge isn't scientific expertise but an enterprise mindset. Prior ZS research in Japan reached the same conclusion: Medical affairs' impact is limited less by its scientific capabilities than by its ability to translate science into strategic value. To do that, leaders need a strong understanding of the priorities and operating models of functions such as commercial, marketing, market access, R&D, government affairs and corporate affairs. This enables medical affairs to connect scientific insights to patient outcomes, asset strategy, healthcare system needs and business decisions while maintaining its scientific independence.

> **"The effectiveness of medical affairs will rest less on what it knows than on how it shows up."**

The gap between medical affairs and other functions has a generational shape in Japan. A cohort raised on strict firewalls tends to read separation as compliance, while a younger cohort assumes business literacy and forward engagement as a matter of course. The friction shows most at middle and senior levels, where the change is hardest. Leaders without an enterprise mindset cannot help their people cultivate one. Two features in Japan contribute to the gap:

- A firewall that keeps medical affairs at arm's length from business accountability
- A habit of deference to senior clinicians, which can turn scientific exchange into a one-way briefing rather than a conversation between peers

To fix this, leaders believe that well-designed training will be necessary but not sufficient. What works is gaining experience and understanding on the job. The group talked about intentional rotations and secondments into other functions such as marketing, market access or clinical development. Several leaders argued that medical affairs should be given opportunities to co-lead assets alongside commercial. Shared accountability for strategic decisions and outcomes helps medical affairs develop a deeper understanding of its role in asset planning and its impact on business success.

In this context, strong organizations are building capability frameworks that span scientific depth, business acumen, compliance judgment and communication. These frameworks are reinforced by senior leaders who set the tone and show clear interest in the quality of insight and dialogue, not scientific accuracy alone.

Evidence as the engine of better decisions

Evidence generation was one of the most discussed topics at the summit and an area where medical affairs is uniquely positioned to lead. Leaders described a shift from viewing evidence as a medical affairs-owned output delivered after launch to treating it as a strategic asset that informs decisions throughout the product life cycle. To play that role, medical affairs must be involved earlier than many organizations allow—often beginning in phase 2 and, sometimes, phase 1. Early involvement enables medical affairs to shape evidence strategies around the realities of the Japanese market, including local unmet needs, clinical practice patterns and the patient outcomes and quality-of-life measures that matter most.

> **"Medical is moving from evidence producer to evidence architect, deciding which questions matter, when they must be answered and how the answers will change decisions."**

In the pre-summit survey, early asset planning and clinical trial design emerged as one of the largest opportunities for stronger cross-functional collaboration—though it was cited far more often by leaders from multinational companies than by those from Japan-headquartered firms. The conclusion was clear: Medical affairs creates the most value when it shapes evidence needs and relevance in Japan early enough to influence study design rather than responding after key choices have already been made.

A timing problem also shaped the conversation at the summit. Leaders know that evidence is wanted at launch or at key life cycle decision points when evidence-planning needs become most visible, yet generating it takes years. Going faster is the wrong fix. The right one is to plan earlier and plan differently, matching the evidence to the stage of the life cycle.

- **Prelaunch:** disease understanding, unmet need, mechanism of action, patient burden and local clinical-practice gaps
- **Early postlaunch:** early clinical experience, safety, treatment patterns and the drivers of physician decisions
- **Later life cycle:** long-term outcomes, guideline positioning, reimbursement relevance, practice standardization and patient outcomes

Japan's increasingly open data environment brings this within closer reach, as there's now an opportunity to rely more on claims data, electronic records, registries and patient-reported outcomes. This will reduce duplication and strengthen the quality of evidence for regulators, payers and clinicians. While investigator-sponsored and company-sponsored research remain distinct, business stakeholders can help identify priority evidence needs, with medical affairs continuing to lead execution.

What matters most is ensuring that evidence informs decision-making. Counting publications, congress presentations and studies measures effort, not impact. The leaders said it's important to determine whether evidence contributed to a scientific guideline discussion, an access conversation, a launch decision, a clinician's understanding or an outcome that benefits a patient.

Data and AI: From raw material to an insight-to-action system

Leaders called data the engine, or the currency, of medical affairs. The function holds or manages an unusually rich store of scientific information and external insight, drawn from publications, congresses, field interactions, dialogue with clinicians, patient engagement and real-world sources. However, in most companies this data is still handled by hand, parked in slide decks, email threads, local files, mismatched CRMs and people's memories. Four challenges keep this system from working:

1. Systems that don't connect
2. Poor interoperability across functions and borders
3. Reliance on generic technologies rather than tools built for medical affairs
4. A broken loop between finding an insight and doing something with it

Leaders said an important compliance challenge remains: Individual-level information about a clinician generally cannot travel far beyond medical affairs. They also know that aggregated, deidentified and synthesized trends usually can travel, and these are exactly what a cross-functional strategy needs. AI can close that distance, reading large volumes of information to produce compliant summaries of trends, sentiment and strategic implications. This is the real promise of AI for medical affairs. It's not a catch-all solution, but a way to turn the scattered knowledge into a shared view.

In the pre-summit survey, the technology and data category was the second most frequently selected investment priority for elevating collaborative capabilities within medical affairs. As leaders were asked which roadblock they would remove tomorrow if they could, many explicitly pointed to disconnected systems and system barriers to integrating internal data and insights. These opinions suggest that collaboration may remain constrained until companies connect their data, systems and insight flows well enough to support shared decisions.

As technologies emerge, governance cannot be neglected. Leaders talked about the need for defined standards for what counts as quality insight, shared taxonomies, expectations for validation and agreed uses. These standards will help medical affairs' judgment. The discipline to hold onto is the move from "so what" to "now what," since an insight earns its keep only when someone interprets it, ties it to strategy and acts.

From stakeholder engagement to ecosystem partnership

Leaders agreed that external engagement must move beyond measuring activity and focus instead on building purposeful partnerships. The pre-summit survey reinforced this view. Participants saw greater opportunity in collaborating with patient advocacy groups and the broader healthcare ecosystem than in traditional interactions with clinicians and external experts. However, they also identified persistent challenges, including the lack of a clear value proposition for partners and difficulty demonstrating the impact of these collaborations. The discussion focused on five areas where medical can strengthen its role in the ecosystem.

1. Patient advocacy and the policy ecosystem

Patient advocacy is one of medical affairs' largest—and most demanding—untapped opportunities in Japan. It remains fragmented and underbuilt compared to more mature markets, and ownership is unclear within companies. Sometimes medical affairs owns patient advocacy, sometimes corporate or government affairs owns it and sometimes no function does. This ambiguity creates a deeper gap in which patients have fewer reliable ways to be heard. As a result, valuable insights from patients often don't reach formal evidence or guideline debates.

Medical is well positioned to serve as a neutral connector between patients, healthcare providers and industry. It can translate patient experiences into evidence, unmet needs, patient-reported outcomes and quality-of-life measures while ensuring engagement remains within appropriate ethical boundaries. In Japan, however, direct interaction between companies and patients is often limited by cultural and structural factors. As a result, academic societies play an important role in bringing together clinical, patient and industry perspectives in a compliant and trusted setting. Leaders highlighted four components of a promising engagement model:

- Advisory boards that bring together physicians, co-medical staff and patients or caregivers
- Society-led forums in which the patient voice is expected and weighed beside clinical results
- Structured digital tools that let patients register symptoms and burden at times when they may find it difficult to speak up
- Joint work among companies, patient groups and academia to contribute patient needs evidence to broader scientific guideline discussions

It was clear from our discussion that advocacy's main obstacle is internal. Advocacy doesn't offer a quick ROI, so sustaining it takes patience and a clear understanding of what it can and eventually will change.

> **“Medical affairs can carry the patient voice from anecdote to evidence, and from evidence to change in the system.”**

2. HCP and KOL collaboration beyond visits

Counting visits was a common topic at the summit. We reiterated that the aim of field engagement isn’t to gather information or provide education for its own sake. Instead, it’s to create scientific exchange good enough to deepen understanding, expose evidence gaps, sharpen the next question and support a better clinical decision.

Leaders also noted that different physicians demand different things. Some want timely information, some want a deeper conversation and some are ready for genuine cocreation or a long partnership. Engagement should match what they want instead of treating every contact as the same.

Over time, medical affairs helps develop the next generation of scientific leaders and sustain academic communities, especially when disease leadership is still forming.

3. Evidence generation with external partners

External evidence work should open with a problem, not a study. Leaders were firm that the right first question is what problem the work will solve, not who wants to run a study. Partnerships with academia, societies, registries and investigators pay off when they focus on a real evidence gap and on what matters to patients.

It’s then the role of medical affairs to frame the question, test the rigor, apply a patient-value filter, plan the route to publication or dissemination, and make sure the work can contribute to scientific guideline discussions, clinical practice understanding or a shared evidence base.

One execution problem became clear. Partners often experience one company through many doors: medical affairs, R&D, development and sales. The solution to this siloed environment is a deliberate one-company experience, with clear roles, a single point of contact, faster governance and responsible stewardship of long commitments.

4. Digital health, AI and wearable partnerships

The conversations around digital health, AI and wearable partnerships were fascinating. The problem in this area is not a shortage of tools, but the absence of a system that turns a stream of patient data into actionable insights for a clinician. And priorities differ by disease. In chronic conditions, continuous monitoring can support disease management, adherence and duration of therapy; when diagnosis comes late, digital tools can push detection and risk assessment earlier. Leaders agreed that clinical meaning should be the litmus test, because more measurement doesn't equal more impact. After all, while a biomarker that hasn't been established can still generate data, that doesn't mean it's meaningful for clinical practice change.

Medical affairs plays a unique role in evaluating new data and technologies. It can determine which signals are clinically meaningful, which endpoints are robust enough to inform decisions and whether analytical models produce results that are scientifically valid and reliable. Medical affairs can also help define appropriate use cases for new technologies, distinguishing between applications in clinical research and patient support, each of which has different requirements for governance, consent and data use. In doing so, medical affairs helps ensure that data is used responsibly and in line with established standards.

Leaders were just as clear that the limits are structural, not technical, and that scaling needs the whole ecosystem to move. Japanese medical teams need clearer government guidance, faster and more predictable data access, better data structure and interoperability. If access stays slow and uncertain, investment will go elsewhere and Japan's drug loss problem will worsen. The willingness to invest is there. Progress depends on shared urgency across government, academia and industry, and on framing the use of data around how it benefits patients and the public rather than the industry.

"Digital health will not scale through pilots alone. It needs clinically meaningful endpoints, medical governance, regulatory clarity, interoperable data and a value story centered on patients."

5. Cross-company and industry collaboration platforms

Consortia are among the most underused avenues for collaboration, and one of the most often abandoned. Companies repeat one another's work on disease education, congress activity and RWE generation—even though a shared approach would be cheaper and more credible. Earlier industry collaboration attempts tended to collapse because of antitrust worries, competitive sensitivity, unclear governance, weak senior sponsorship or misaligned objectives. Leaders at the summit pointed out the problem clearly: Everyone agrees the industry should collaborate, but almost no one manages it.

Here are the two things a productive partnership requires:

1. **A genuinely precompetitive problem:** The strongest partnerships focus on challenges that no single company can solve alone, such as disease awareness in rare or overlooked conditions, education that no brand owns, shared RWE generation activities, common impact frameworks, evidence interpretation that sits next to guidelines, and neutral forums that an association or third party convenes. Leaders saw medical affairs as the most credible function to lead this work because it brings scientific integrity, neutral framing and a common language.
2. **Strong governance:** Effective collaborations require clear governance structures that promote transparency and compliance. Company-only meetings invite compliance risk, and leaders at the summit favored models hosted by industry associations or other neutral organizations, with broad participation, documented decision-making processes and safeguards against exclusionary or anti-competitive behavior. One interesting idea that stood out in our discussions: A cross-company consortium that uses shared metrics or pooled real-world data to measure disease-level impact, recognizing that no single company can fully attribute changes in outcomes within a competitive market.

"Consortia shouldn't be discussion forums. They should be problem-solving mechanisms with clear governance, neutral convening and measurable external value."

Measuring what matters

One thread that ran through every discussion: Activity-based measurement does not work. Leaders said counting visits, insights, publications, events, advisory boards and interactions shouldn't be treated as stand-ins for impact.

Insight collection, they worried, can slide into a mechanical routine in which a field colleague asks a question, notes the answer and files it. That is capture, not insight. The difference is worth stating precisely. Insight isn't something heard. It's something interpreted, placed in context, tied to strategy and able to inform a decision.

A second distinction separates what a clinician felt from what the organization gained. A physician may find a discussion useful, yet the company still needs to know what changed—whether understanding improved, a misconception fell away, an evidence gap appeared or a disease strategy grew sharper.

The same test holds in external-facing activities as well. Advocacy isn't measured by meetings; digital work isn't measured by launch; consortia aren't measured by their founding; and partnerships aren't measured by a single publication.

In place of counting, we propose six dimensions of impact (see Figure 2).

FIGURE 2:

From activity metrics to impact metrics

Impact dimension	What we count today (activity)	What we should measure (impact)
Decision	Meetings attended, seats at the table	Internal or external decisions that changed because of medical affairs input
Evidence	Number of studies and publications	Evidence gaps closed, and how the evidence was used
Stakeholder	Visit and interaction counts	Improved understanding, trust or readiness to act
Patient	Number of advocacy meetings	Better-captured burden, improved pathways, outcomes that matter to patients
System	Activities delivered	Contribution to scientific guidelines, care pathways, health system discussions, standards or coordination
Capability	Training sessions executed	An organization that is faster, clearer, more aligned and more confident in collaboration

The framework also answers a problem the survey raised: demonstrating the value of partnerships. Where no single company can claim the result, aligned metrics and pooled data across companies can make shared impact visible in a way no single company could show alone.

The leadership agenda for medical affairs in Japan

These five imperatives can form an agenda for leaders in Japan.

FIGURE 3:

The medical affairs leadership agenda for Japan

Imperative	Practical actions
1. Treat medical as a distinctive value creator	• Drop the language of support • Name the outcomes and decisions medical affairs owns • Come to cross-functional forums with a point of view • Protect credibility by declining low-value requests • Grow the next generation of leaders with rotations and brand co-leadership • Build capability frameworks covering business sense, compliance judgment and communication
2. Make compliance a working system	• Publish scenario playbooks and decision-right matrices • Agree on escalation rules in advance • Separate strategic insight-sharing from tactical execution • Clarify decision rights, accountability and escalation pathways • Pilot clearly governed collaboration models within existing guardrails
3. Build an evidence-to-decision engine	• Bring medical affairs into asset strategy from phase 2 • Write life cycle evidence roadmaps with Japan-relevant and patient-relevant endpoints • Integrate evidence planning • Judge evidence by its effect on decisions
4. Establish partnerships across the healthcare ecosystem	• Partner with patient advocacy groups • Collaborate with HCP/KOLs beyond visits • Explore partnership opportunities in evidence generation • Connect digital health, AI and wearable partners • Start consortia activities with industry peers
5. Replace activity metrics with impact metrics	• Adopt the six dimensions of impact • Redefine insight as interpreted and actionable • Measure shared impact across companies where attribution is impossible alone

Sequence matters. Compliance, governance and capability come first because they unlock everything else. The evidence engine and the new metrics are where medical affairs leadership becomes visible to the wider company. The external work, patient voice, ecosystem partnership and consortia all compound as the internal base grows stronger.

Medical affairs as the trusted integrator

Japan's healthcare system is fragmenting across stakeholders and data sources. But it's also opening through policy reforms and a rising appetite for evidence that is real-world and rooted in what patients experience. The best function to draw the pieces together is the trusted one already sitting where they meet. Medical affairs has the scientific credibility, the long view of disease and the respected standing to be that integrator.

Medical affairs must now develop everything else: the operating model, the governance, the data and technology foundation, the metrics and—above all—the capabilities and behaviors that turn credibility into influence. The summit's discussions showed that Japan's medical affairs leaders know this. They have moved beyond asking whether collaboration matters and are now working out how to make it disciplined, measurable and genuinely valuable. In doing so, they're choosing to lead Japan's next model of healthcare collaboration as its trusted integrator.

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The views expressed in these discussions were shared in a personal capacity and do not represent the official positions of their respective companies. All comments and viewpoints in this paper have been fully synthesized and aggregated; no individual statement or company-specific view is attributed or identifiable, and the paper reflects collective themes and insights only.

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