Healthcare

Positive (Maintain)

Policy and System Changes Ahead

HIGHLIGHTS

- The US had cited a withdrawal from WHO, signaling a possible healthcare crisis from insufficient support for health programmes, although China is expected to replace as main funder.
- The DRG system had mixed results in its implementation, while the WBB system was cancelled. This arises the need for a thorough study among the public and private sectors to ensure increased efficiency and better cost management.
- Outsourcing to private sectors HSOP had reduced waiting time and ensure lesser disruptions to treatments, offset by increased losses due to reduced profitability from fixed payments.
- Pharmaceuticals expected to increase medicine security and reduce monopolization through OTP 2.0 but risks of competition and increased dependency on imports will persist.

SECTOR DEVELOPMENT: GLOBAL

US withdrawing from WHO: a crisis trigger? Newly elected President Trump had picked up from where he had left off in his first term and withdrew from the World Health Organization (WHO) and the Paris Agreement. The decision to sever ties with the WHO was widely criticized as a significant setback for global health efforts, weakening the organisation and isolating the US. The WHO has long played a key role in global health diplomacy, outbreak response, and scientific collaboration, with the US as a major funder and leader for over 75 years. The withdrawal could jeopardize critical health initiatives, especially in combating tuberculosis and HIV/AIDS, while also reducing funding for other global health programs, including sexual and reproductive health. Trump had listed his reasons for withdrawing from WHO, including: (i) mishandling of Covid-19 pandemic, (ii) failure to act independently from political influence of WHO member states, and (iii) unfair onerous payments. The US is currently WHO's largest financial backer, contributing about 18% of the overall funding, followed by China at 15%. In CY20, after Trump's announcement to stop the US's funding to WHO, China had pledged an additional USD30m to WHO.

OUR VIEW

China's opportunity to lead WHO. China has the potential to emerge as a leader, notably for the Global South, given that its contributions have grown significantly (+34% since CY20 to USD115m per year) and its substantial progress in universal health coverage (UHC) with the possibility to promote similar reforms. China's leadership could also strengthen international cooperation on health issues, particularly in the Asia-Pacific region. However, the downside risks are: (i) biased decision making, (ii) transparency issues in health crises, and (iii) geopolitical tensions with countries in strained relationship with China. Nevertheless, we are optimistic that the overall potential outcome will be beneficial to WHO, given China's experience in: (i) rapid development of healthcare infrastructure, (ii) prioritisation of NCDs and healthy aging, and (iii) enhancement in global health security through strong public health systems and improved health equity.

COMPANY *IN FOCUS*

KPJ Healthcare Bhd

Maintain BUY | Revised Target Price: RM2.75
Price @ 7 February 2025: RM2.40

- Strong 3QFY24 performance due to increased patient visits
- Vast network of services in Malaysia
- Strategic expansion to cater to local and foreign demand

SHARE PRICE CHART

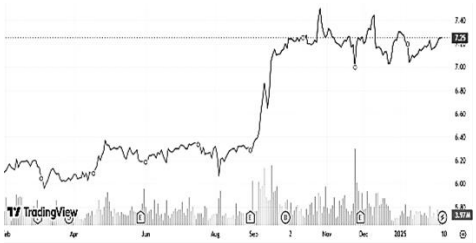


IHH Healthcare Bhd

Maintain NEUTRAL | Target Price: RM7.56
Price @ 7 February 2025: RM7.25

- Strong earnings growth
- Global presence with persistent expansions
- Well-established in medical tourism

SHARE PRICE CHART



HMPV: A new endemic worry. Human Metapneumovirus (HMPV) has recently gained attention as a growing public health concern, particularly in China, India and the UK, aligning with seasonal spikes in respiratory illnesses. HMPV spreads through respiratory droplets, contaminated surfaces, or close contact and typically causes flu-like symptoms. While mild in most cases, it can lead to severe respiratory conditions, particularly in infants, the elderly, and the immuno-compromised. Diagnosing HMPV is challenging due to its similarity to other respiratory infections, and Polymerase Chain Reaction (PCR) testing remains the most reliable method, though not widely accessible. Hospitalizations linked to HMPV are rising with some countries reporting that up to 15% of seasonal respiratory infections and at least 1% of deaths are due to the virus. This is attributable by: (i) increased mobility, (ii) reduced immunity post-pandemic, and (iii) improved diagnostic tools. However, inconsistent global testing and reporting hinder a full understanding of the virus's impact.

OUR VIEW

Apt timing to develop vaccines. There is currently no specific antiviral treatment or vaccine for HMPV, making symptom management the primary approach. The success of Respiratory Syncytial Virus (RSV) vaccines offers hope, though challenges remain in understanding immune responses and ensuring safety for vulnerable populations. We opine that prevention is the key to hamper the spread of HMPV, including (i) frequent handwashing, (ii) avoiding close contact with infected individuals, (iii) disinfecting surfaces, and (iv) wearing masks in crowded areas. While Malaysia's prevalence of this virus is marginal, we believe an Increased public awareness, improved surveillance, and additional collaboration among government, researchers and the pharmaceutical industry can enhance detection, treatment development and response efforts in the near term.

SECTOR DEVELOPMENT: MALAYSIA

DRG Payment System: A Biased System? The Diagnosis-Related Group (DRG) system is a method used to classify hospital cases into groups that are expected to have similar hospital resource use. Patients are grouped based on their primary and secondary diagnoses, comorbidities, age, sex, and medical procedures performed during their stay. Based on the patients, hospitals will receive a predetermined fixed amount for each case, encouraging efficiency and cost control. The payment will then be adjusted based on factors like hospital location and patient's discharge status. The main purpose of DRG is to: (i) standardize costs, (ii) reduce unnecessary charges, and (iii) provide transparency. However, the system – first introduced in the US - has faced challenges in other countries, including inadequate compensation for complex cases (such as critical illnesses, chronic diseases, and major trauma) and the potential avoidance of high-risk patients by specialists.

Potential lose-lose situation for private sector. Recently, the government has proposed implementing DRG to address rising healthcare costs, particularly in the private sector. The Ministry of Health (MOH) plans to implement a pilot DRG in Raka KKM, a yet-to-be-launched premium economy wing in government hospitals, by June CY25, while private hospital charges to benchmarked against Rakan KKM's reference prices. he Malaysian Medical Association (MMA) and the Association of Specialists in Private Medical Practice Malaysia (ASPMP) have highlighted key concerns regarding the DRG system:

(i) specialists refusing complex cases without sufficient compensation,
(ii) difficult standardisation due to diverse sector
(iii) inaccurate one-size-fits-all approach due to complications of a disease or illness,
(iv) unchanged 13th Fee Schedule – which regulates specialist charges – since CY13 does not reflect modern medical advancements, and
(v) private sector finding the system financially unviable, consequently shift complex cases from private to public hospitals, further straining the already overburdened government healthcare system.

DRG in MOHE hospitals promising. Despite the overall concerns on DRG, the Ministry of Higher Education (MOHE) had mandated DRG adoption in its teaching hospitals. Universiti Malaya Medical Centre (UMMC), which had adopted the system in the past 3 years, had seen an improved efficiency and quality of care, as well as improved financial sustainability through a better multi-year cost projection. DRG also prevents the avoidance of complex cases, from non-reimbursed if a patient is transferred prematurely. However, fraudulent claims have been a known issue, where hospitals exaggerate complications for higher reimbursement.

OUR VIEW

More studies needed for private sector. While DRG has a mixed results in its implementation, we believe the benefits could still be leveraged for certain institutions and clinics. IMU University had revealed that DRG does not require the electronic medical records (EMR) or advanced IT systems, making rural and remote health clinics as potential DRG takers with its easier access to conventional and traditional medical records. Additionally, EMR had reported errors from incomplete discharge summaries (65%) and untrained coders (30%) due to poor data entry by doctors, aptly due to the time constraints for administrative tasks. The real challenge for DRG would be for the private sector. Currently, Malaysia's private hospitals operate on a fee-for-service model, where healthcare providers are paid per service delivered. We believe that there is a strong need for thorough study and active engagement with healthcare providers, regulators, and industry representatives before DRG is rolled out nationwide in both public and private sectors. The DRG system should not be rushed and done in a short period of time to address the increasing health care costs in Malaysia.

Positive outcomes from HSOP. MOH had introduced the Hospital Services Outsourcing Programme (HSOP) in CY24 with a funding of RM144m, involving 91 private hospitals and 46 MOH hospitals, to cater for at least 30,000 outsourced patients. The programme aims at improving healthcare accessibility and quality by reducing patient congestion in public hospitals by outsourcing patients to private healthcare facilities. Under HSOP, patients are referred from public to private hospitals, while coordinating treatments between the two sectors. HSOP covers four key areas: (i) Radiology and imaging (CT scans, MRI, ultrasound), (ii) Nephrology (AVF surgery), (iii) Cardiothoracic surgery (adult and paediatric heart surgery), and (iv) Cardiology (diagnostic tests and interventions). Under the programme, AVF surgery wait times dropped by -75%, from 16 weeks to 4 weeks, MRI and ultrasound waiting times decreased by -20%, from 20 weeks to 16 weeks, and CT scan wait times were reduced by -14%, from 14 weeks to 12 weeks. HSOP is similar to the DRG system.

But private reported losses. The Association of Private Hospitals Malaysia (APHM) had recently revealed that private hospitals have incurred financial losses under HSOP. Despite this, private hospitals continue to participate as a corporate social responsibility (CSR) initiative to support the government. While HSOP is similar to the DRG-based model, its calculations are considered inaccurate, resulting in private receiving payments lower than the actual treatment costs, especially for complex cases. APHM had emphasised the need for a review to ensure HSOP's sustainability in the long run.

OUR VIEW

Undeniable benefits to HSOP. Despite the short timeline of HSOP implementation and the limited return for the private sector, we believe the benefits would eventually outweigh the drawbacks. Improved access to quality healthcare services and reduced waiting times ensures a better overall patient outcome. This will consequently increase the demand for inpatient services in both public and private sectors. Additionally, private healthcare providers can expand their reach and promote efficient use of resources, while public healthcare providers could focus on more complex cases and improve staff coordination. We anticipate that HSOP will continue to be operated, as its feasibility is yet to reach its full potential, especially when the system can be expanded beyond the main four disciplines.

Unpopular stance on WBB. The Waktu Bekerja Berlainan (WBB) or Staggered Working Hours system was proposed by MOH to reduce overwork, improve work-life balance, and enhance the welfare of medical officers. Key changes included capping on-call shifts at 18 hours (down from 24-33 hours) and reducing weekly work hours from 99 to 72. However, strong opposition from healthcare workers led to its cancellation during the pilot phase for failing to compensate doctors fairly for night shifts and weekday on-call duties. Three doctors' groups—MedTweetMY, Hartal Doktor Kontrak (HDK), and MMA—opposed WBB, citing several concerns:

(i) 18-hour weekday shifts (3pm-9am) are ineligible for on-call allowances, despite covering graveyard hours, making them exploitative and dangerous,
(ii) on-call allowance increases were only available to WBB participants, creating inequality,
(iii) severe manpower shortages made it impractical to implement a shift system,
(iv) medical and dental officers, as well as specialists, could not claim the Elaun Tugas Atas Panggilan (ETAP) allowance for 18-hour weekday shifts, as they were considered part of the standard 45-hour work week, and
(v) higher on-call allowances (RM275 for medical officers, RM315 for specialists) were only available for weekend or public holiday calls lasting 15 or more hours outside regular working hours.

Ultimately, WBB failed to address staff shortages or reduce workloads, leading to its rejection.

OUR VIEW

Better wage system must be sought amid staff shortage. There are several alternatives to the WBB system for healthcare workers that can help improve work-life balance and efficiency, namely:

(i) **Flextime.** This system allows healthcare workers to choose their start and end times within a set range of core hours. This flexibility can help balance workloads and ensure continuous patient care. Downside risks: coordination risk, miscommunication and supervision challenges.

(ii) **Compressed Work Weeks.** This system enables employees to work the same number of hours over fewer days., providing an extra day off each week, which can help reduce burnout and improve overall well-being. Downside risk: health risks, reduced productivity and work-life imbalance.

(iii) **Job Sharing.** Job sharing involves two or more employees sharing the responsibilities of one full-time position. This can be particularly beneficial in healthcare settings where the demands of the job can be intense. This arrangement can provide greater flexibility, reduce fatigue, and allow for better work-life balance. Downside risks: coordination issues, inconsistent coverage and higher staff costs.

(iv) **Telecommuting.** This allows healthcare workers to perform certain tasks remotely – particularly for administrative tasks, consultations, and follow-ups. This helps reduce the need for commuting and providing more flexibility in their schedule, as well as reduce the spread of infections and improve overall efficiency. Downside risks: isolation, communication barriers and poor ergonomic setup.

Implementing these systems requires careful planning and communication to ensure that patient care remains uninterrupted and that all staff members are supported. We believe that these systems should be tested as well to ensure that the issues of overcrowded hospitals and staff burnout can be addressed and resolved for the long term.

Reducing monopoly on pharmaceuticals. MOH had recently proposed an updated Off-Take Policy (OTP) 2.0 to address medicine security, reduce drug prices, and strengthen the local pharmaceutical industry. MOH will offer 3-year contracts to local pharmaceutical companies to encourage production of critical off-patent drugs that currently have only one registered supplier (PRH). These contracts can be extended by 2 years if the company performs well and exports the product; otherwise, the policy ends. OTP 2.0 aims to reduce monopolistic pricing of medicines. MOH is conducting "sourcing missions" in countries like India, China, Brazil, and Turkey to secure generic drug supplies and increase competition. A double-supplier policy will mandate at least 2 suppliers for pharmaceuticals and medical devices to enhance medicine security and control costs. Additionally, the National Pharmaceutical Regulatory Agency (NPRA) has accelerated approval timelines for drug evaluations, namely:

(i) **Generic/hybrid drugs:** Reduced from 210 days to as few as 30 days under fast-track options.

(ii) **New chemical entities/biologics:** Cut from 245 days to as low as 30 days in some cases.

Meanwhile, the Medical Device Authority (MDA) has also shortened approval times:

(i) **Class A devices:** Reduced from 30 days to 14 days.

(ii) **Class B, C, D devices:** Shortened from 60 days to 20 days, with compliance evaluations reduced from up to 36 months to 1-18 months.

OUR VIEW

Finding the balance between security and independency. OTP 2.0 is expected to increase competition, lower costs, and strengthen Malaysia's pharmaceutical supply chain, subsequently ensuring better access to essential medicines. OTP 2.0 provides pharmaceutical companies with a guaranteed market for their products and reducing the financial risk associated with bringing new products and technology into the market. With a secure market and a more stable supply chain, investments in R&D will commence efficiently, further stimulating economic growth and sustainability of the pharmaceutical sector. However, downside risks include: (i) biased favouritism of a company/brand, (ii) financial burden on government and purchasing companies, and (iii) increased dependency on outsourced products. Nevertheless, the policy ensures a stable market and encourages innovation. In the long run, an effective implementation of OTP 2.0 is crucial to maximise the advantages in time-saving approvals and solid contracts, while mitigating inefficiencies or corruption within the sector.

MOVING FORWARD

Managing costs takes centerstage. Moving forward, we are anticipating that the healthcare players will continue to find ways to leverage on the proposed changes in the policies and systems introduced within the sector. One of the main issues that we expect the sector to continue addressing is the rising private sector costs. The key drivers to the rising costs are: (i) post-Covid medical supply instability, (ii) changes in MYR currency against USD, (iii) workforce shortages from training disruptions, preference for locals and brain drain, and (iv) costly robotic surgeries and medications due to higher demand. Generally, in the private sector, staff wages make up of 30-36% of operational costs, while insurance, depreciation, and amortization raise total costs to over 40%, leaving only about 10% net profit. Ultimately, patients will bear the rising costs. Nevertheless, with the continuous discussions and support among healthcare stakeholders, we anticipate that this matter will be resolved smoothly without burdening both service providers and patients in the long term.

Possible call for a new regulatory body. As of writing, 70% of private hospital charges (e.g., wheelchairs, heart monitors, kidney dishes) are unregulated, while only 30% (specialist and drug charges) are monitored. This raise concerns over profiteering, which eventually will lead to calls for a new regulatory body to oversee hospital charges and health insurance. It is expected that health insurance – currently regulated by Bank Negara Malaysia (BNM) – will be moved to this new body to ensure consumer interests are prioritized over industry profits. We expect that this new agency is poised to address on both healthcare costs and aging-related expenses. To note, aged care in Malaysia is currently not covered by any comprehensive scheme under the government's jurisdiction.

MAINTAIN POSITIVE

All in all, we maintain our optimism in the sector, despite the anticipated changes and updates to existing policies and programmes for the private sector. The US's withdrawal from WHO is expected to place China as the next major funder to the organization, opening opportunities for our regional and local healthcare players to leverage on pharmaceuticals and medical device trades, advanced research and development, and Chinese medical tourists. The prevalence of HPMV, while still below 1% in Malaysia, signals the need for more development of vaccines in preparation of any future endemics. Malaysia's call for a reduced dependency on vaccine imports whilst developing and manufacturing local vaccines is timely, and HPMV could be the right catalyst to further improve our pharmaceutical sector.

The government is expected to continue seeking a sustainable system for both patients and providers, by improving three key drivers: sustainable medical workforce, affordable and comprehensive payment system for patients, and long-term positive cost management. While we remain vigilant on DRG and HSOP's implementation on a larger scale, we are confident that the balance between public and private sectors can be reached given the right timeline, framework and coverage. Pharmaceuticals is expected to remain sanguine under OTP 2.0 programme, although higher competition may impact its financial performance in the mid-term, in tandem with the need to reduce prices and dependency on one supplier, particularly for niche drugs.

Private hospitals are expected to remain resilient on the back of surging inpatient visits and in-house treatments from both domestic patients and medical tourists. The increase demand for inpatient treatments is anticipated to persist in the near term, fuelled by the continuous affordability of healthcare services and the safety of the country for foreigners and locals alike.

Our **TOP PICK** is **KPJ Healthcare (Maintain BUY, revised TP:RM2.75).**

We maintain a **BUY** call for KPJ with a **revised target price of RM2.75**. The new target price is derived from pegging a new PER of 31x to EPS25 of 8.7 sen. The increase in PER from 29x is taking into consideration of the robust medical tourism and expansion plans for KPJ coming into CY25, coupled with the expectation of a stable financial performance moving forward. However, the PER is still a discount from the sector's 3-Y average PER of 35x, due to potential short-term risks on regulation and policy changes from MOH.

We like KPJ for its strong financial performance. The group had shown a consistent revenue growth, with a significant surge in net income. Additionally, KPJ boasted the largest network of private hospitals in Malaysia (over 29 hospitals), with the opportunity to expand its bed capacity and services (approx. 5,000 beds by CY28). The latter also minimise the impact of fluctuation in forex as compared to its peers. The group is also capitalizing on the growing health tourism market, and the implementation of a new Hospital Information System (nHIS). We believe KPJ has a sustainable presence within the healthcare sector, given its strong foundation as a healthcare service provider and its lesser susceptibility to economic downturns.

REFERENCES

CHART 1: Diseases and Illnesses Prevalence (2015-2024)

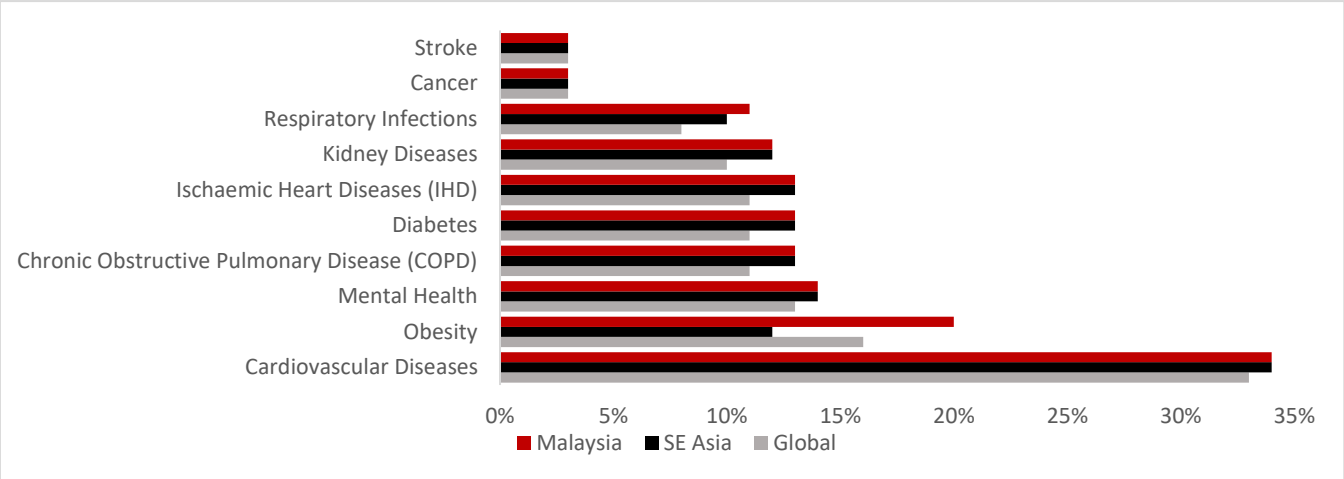


CHART 2: Global Healthcare CAPEX (USD tr)

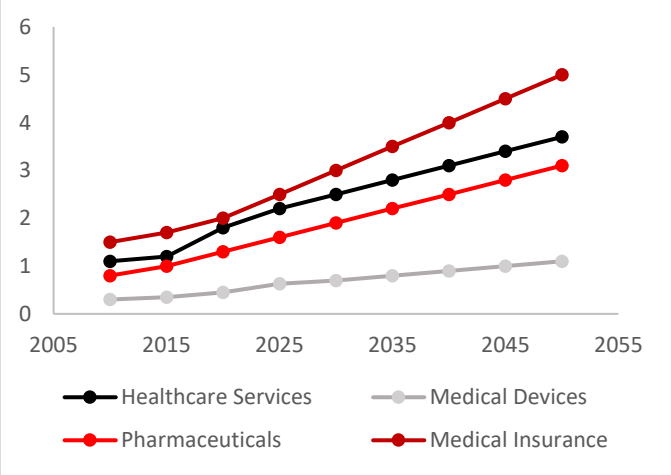


CHART 3: Aging Population (%)

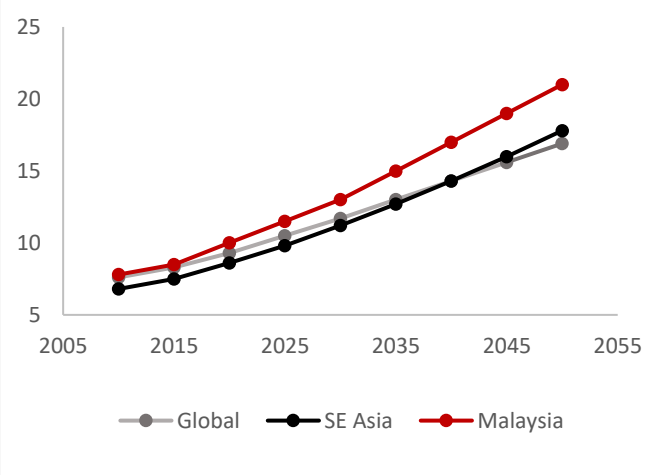


CHART 4: Malaysia's Disease Prevalence (mil of pop)

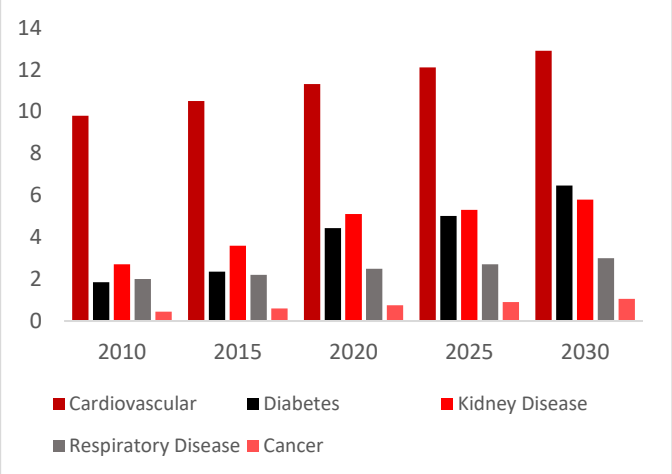
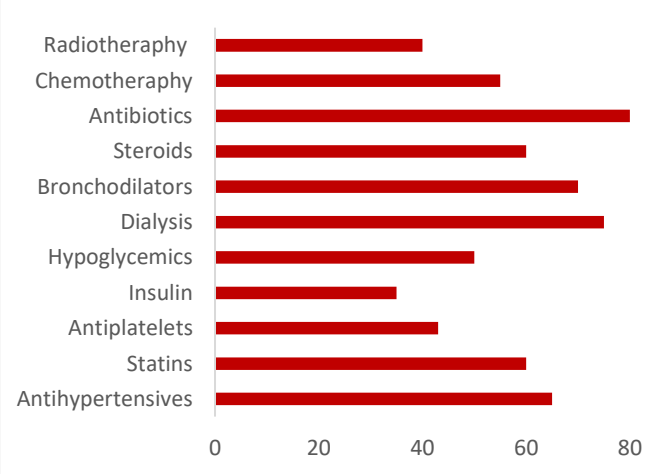


CHART 5: Malaysia's Medical Treatments (% of patients)



Sources: WHO, World Bank, Pharmacy GOV, Diabetes Atlas, Macrobond, Bloomberg, MIDFR

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MIDF AMANAH INVESTMENT BANK: GUIDE TO RECOMMENDATIONS

STOCK RECOMMENDATIONS

BUY	Total return is expected to be >10% over the next 12 months.
TRADING BUY	The stock price is expected to rise by >10% within 3 months after a Trading Buy rating has been assigned due to positive news flow.
NEUTRAL	Total return is expected to be between -10% and +10% over the next 12 months.
SELL	Total return is expected to be <-10% over the next 12 months.
TRADING SELL	The stock price is expected to fall by >10% within 3 months after a Trading Sell rating has been assigned due to negative news flow.

SECTOR RECOMMENDATIONS

POSITIVE	The sector is expected to outperform the overall market over the next 12 months.
NEUTRAL	The sector is to perform in line with the overall market over the next 12 months.
NEGATIVE	The sector is expected to underperform the overall market over the next 12 months.

ESG RECOMMENDATIONS* - source Bursa Malaysia and FTSE Russell

☆☆☆☆	Top 25% by ESG Ratings amongst PLCs in FBM EMAS that have been assessed by FTSE Russell
☆☆☆	Top 26-50% by ESG Ratings amongst PLCs in FBM EMAS that have been assessed by FTSE Russell
☆☆	Top 51%- 75% by ESG Ratings amongst PLCs in FBM EMAS that have been assessed by FTSE Russell
☆	Bottom 25% by ESG Ratings amongst PLCs in FBM EMAS that have been assessed by FTSE Russell

* ESG Ratings of PLCs in FBM EMAS that have been assessed by FTSE Russell in accordance with FTSE Russell ESG Ratings Methodology