SECTOR THEMATIC

Thursday 29th October 2026

POSITIVE (Maintain)

Healthcare

PharmaView Expert Series 2026 (Part 2)

Analysts

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HIGHLIGHTS

- NCDs represent the top drug expenditures in Malaysia, driven heavily by an aging demographic.
- High household OOP leads to severe financial risks for patients and increases potentiality of demand destruction for novel NCD drugs.
- MOH utilizes generic procurement while preserving capacity for patented innovator molecules.
- MaHTAS evaluates cost-effectiveness using ICER thresholds, while MEAs serve as formal risk-sharing mechanisms to provide early access to specialized therapies while containing public fiscal exposure.
- Achieving sustainable access requires innovative financing, value-based negotiations, strategic procurement, generics and biosimilars, and regional cooperation to secure nationwide medicine security.
- These frameworks benefit domestic players like Pharmaniaga and Duopharma in the long run.

INTRODUCTION

We attended Pharmaniaga's PharmaView Expert Series 2026, the first in line of Pharmaniaga Bhd's (Pharmaniaga) yearly initiative in conferring leaders within the healthcare ecosystem and pharmaceutical subsector to gain insights from within, to share knowledge and best practices, and to address additional catalysts for investments in the sector. In Part 2 of 2 of this report, we break down the key takeaways from the first presentation titled *"Navigating the High-Cost Medicines Era: Balancing Access, Value and Sustainability",* presented by MOH, and share our views on the frameworks in existence to support the cost of procuring medicines and ensure that the spillover to patients is not severe.

KEY TAKEAWAYS

Expenditure on NCD drugs trending upwards in line with demand. Malaysia faces high rates of non-communicable diseases (NCDs), reflecting the similar trend on a global scale, with drugs used in oncology, diabetes and cardiovascular diseases to rank as top therapeutic expenditures in the healthcare sector (see Chart 1). These expenditure trends are also fuelled by the aging demographic, which contributes to the higher incidence of complex conditions i.e. a mix of two or more NCDs in one sitting. Domestically, patient visits in the public sector had jumped from year to year, influencing the overall pharmaceutical spending by the Ministry of Health (MOH). This further creates a higher demand for expensive antineoplastic agents and biologics (see Chart 2).

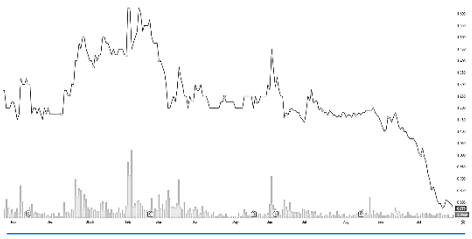
COMPANY *IN FOCUS*

Pharmaniaga Bhd

BUY | Target Price: RM1.44
Price @ 28 Oct 2026: RM0.78

- Predictable supply volumes
- Leverage on long-term concessions
- Ability to capture dominant share of off-patent generics and biosimilars
- Infrastructure moat of drug warehouses

SHARE PRICE CHART



Duopharma Biotech Bhd

Non-rated | Fair Value Price: RM1.36
Price @ 28 Oct 2026: RM1.12

- Secured predictable supply volume
- Key beneficiary of budget displacement between generics and high-value drugs
- Leverages on reduction of import reliance
- Resilient financial profile

SHARE PRICE CHART

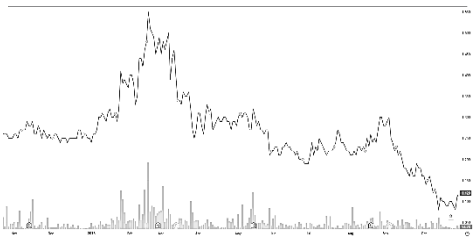
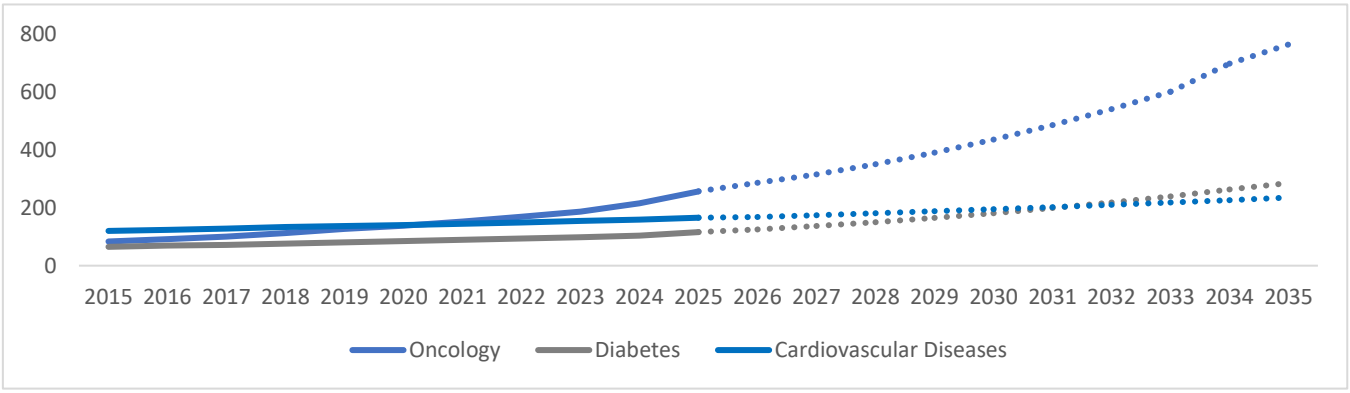
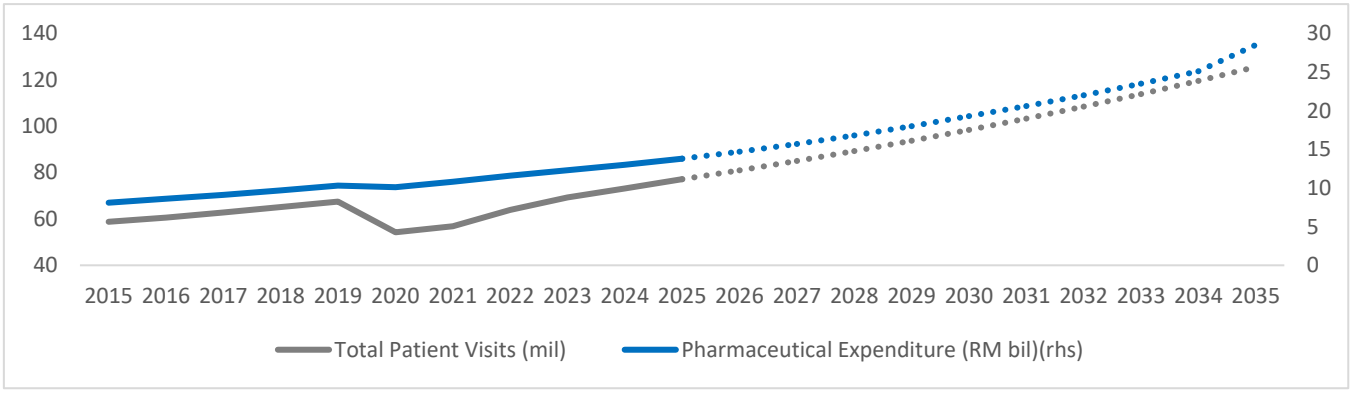


CHART 1: AVERAGE GLOBAL EXPENDITURE ON NCD DRUGS (USD BIL)



Sources: WHO, AHA, WHF, IARC, GLOBOCAN, IDF, IQVIA, MBSBR

CHART 2: MALAYSIA HEALTHCARE SECTOR: PATIENT VISITS (MIL) V PHARMACEUTICAL EXPENDITURE (RM BIL)



Source: MOH, MNHA, IHME, MBSBR

TABLE 1: MALAYSIA'S TOP 3 NCD PREVALENCE (2015-2035)

Key NCD Prevalence	Prevalence/Cases		Estimated Prevalence/Cases	Thesis
	2015	2025	2035	
Type 2 Diabetes	**Prevalence:** 17.5% of adults (~3.5m)	**Prevalence:** Up to 22.5% of adults (~5.2m)	**Prevalence:** 25%-27.5% of adults (>6.5m)	• Malaysia continues to rank the highest in ASEAN due to lifestyle (sedentary, high-sugar diet) with >50% of population identified as overweight • Only approximately 1 in 5 adults are clinically diagnosed (weak awareness, accessibility issues) • Gradually increasing proportion of young onset diabetes

Cardiovascular Disease (CVD) (combining hypertension, ischemic heart disease, heart failure)	**Prevalence:** 18% of adults	**Prevalence:** Up to 21.5% of adults	**Prevalence:** 23%-25% of adults	• Interconnected with diabetes and metabolic diseases (98% of CVD patient has at least one) • Remains as large in cases as diabetes prevalence • Average age of a heart attack patient is 59 years old (significantly younger than average and closer to aging range of 60+)
Cancer	**Cases:** average 28,000 cases per year	**Cases:** average 49,000 cases per year	**Cases:** average 69,000 cases per year	• Aging population and late-stage presentation a primary driver • New annual cancer diagnoses expected to surge, exposing a higher prevalence over time • Top cancers: Breast (~19%), Colocteral (~14%), Lung (~10%)

Source: NHMS, MOH, UM, MBSBR

CONTEXT: PHARMACEUTICAL EXPENDITURE

Financial realities demand comprehensive supporting strategy.

However, the key issue with the drug expenditure is the high cost passed down to patients. In Malaysia, the public sector accounts for 51% while the private sector accounts for 49% in total of pharmaceutical uptakes. While the public sector is largely supported by government subsidies, the private sector saw approximately 79% of private health financing are out-of-pocket (OOP) payments. This heightens the risk of a catastrophic demand destruction for novel NCD drugs, while NCD prevalence remains high. Hence, MOH has been aggressively shifting its strategies toward Value-Based Procurement (VBP), Health Technology Assessment (HTA) and Managed Entry Agreements (MEAs), which are expected to heavily impact local drug manufacturers, multinational pharma firms and drug distributors, with the Health White Paper (HWP) as the main policy guidance.

VBP: balancing procurement by volume and value.

To note, MOH spent approximately 78% on generics, and the remaining 22% on patented and novel drugs. The therapeutic expenditure hierarchy in Malaysia's public health sector is led by metabolic and diabetes care, which, compared to the global expenditure, represents the largest overall spend by volume and budget at ~18%–20% of total public drug expenditure. This is followed closely by cardiovascular and lipid management therapies driven by chronic hypertension and hypercholesterolemia maintenance at ~11%-15%. Despite serving a smaller patient volume, oncology and immunomodulators drive the fastest unit-cost inflation and absorb over 20% of novel drug funding.

HTA: supporting VBP through stricter ICER.

To sustainably manage these costs, MOH had strategically utilizes generic procurement, intentionally preserving budget capacity to fund the remaining cost required for essential patented innovator molecules. To manage the pharmaceutical spending by the government, Malaysia's Health Technology Assessment (MaHTAS) unit within the MOH uses specific quantitative benchmarks to determine if a drug delivers value for money, namely:

(i) **Cost-effectiveness thresholds:** Malaysia traditionally evaluates the Incremental Cost-Effectiveness Ratio (ICER) by the additional cost required per Quality-Adjusted Life Year (QALY) gained against national economic benchmarks:
- Cost-Effective (~ RM50k-55k per QALY)

(ii) **Budget Impact thresholds:** if a new drug falls below the ICER threshold (below RM50k per QALY), it may still be rejected or restricted if its budget impact exceeds the annual allocation capacity of the specific therapeutic discipline

This initiative is expected to build localised health-economy and budget-impact models early within the MOH drug procurement process, subsequently improvise VBP by ensuring a robust supply chain reliability and capacity.

MEAs: lightening manufacturers' cost burden.

Managed Entry Agreements (MEAs)—implemented in Malaysia primarily via Patient Access Schemes (PASc) and Medicines Access Schemes (MASc)—serve as formal risk-sharing mechanisms negotiated between MOH and pharmaceutical manufacturers. They enable public health facilities to provide early access to high-cost, specialized therapies (e.g. immunotherapies for oncology, biologics for autoimmune disorders) while containing fiscal exposure and mitigating clinical uncertainties. To operationalize PASc, four mandatory compliance components must be established: (i) restrictions in enrolment to clinical sub-groups to prevent off-label budget spillage, (ii) defined phase-based financial obligations to ensure continuity of care, (iii) annual audits to ensure manufacturers honour the rebate obligations and verify clinical compliance, and (iv) clear regulatory mechanisms retention to re-evaluate or decommission the scheme.

TABLE 2: SUMMARY OF PASC FRAMEWORK

Type of MEA	Description	Schemes
Financial-based	Focuses directly on price and volume adjustments without linking drug costs to patient-specific clinical outcomes	• **Dose-Cap (Expenditure):** Pharmaceutical supplier covers 100% of drug cost once patient exceeds a pre-negotiated threshold or cycle limit • **Free-Goods or Threshold Discounts (Volume-Based):** Structures like Buy One, Get One (BOGO) allow public hospitals to lower the average cost per dose without altering the official global list price of the drug • **Simple Rebates:** Confidential discounting wherein a percentage refund or net-price adjustment is returned directly to purchasing MOH facilities or central procurement fund
Performance-based	Addresses clinical uncertainty by tying healthcare expenditures directly to real-world patient outcomes	• **Outcome-Linked Rebates:** Manufacturer provides partial or full refund if a patient fails to achieve predefined clinical metrics • **Coverage with Evidence Development (CED):** MOH grants temporary listing on the MOH Medicines Formulary (MOHMF) for a fixed evaluation term while real-world evidence (RWE) is systematically collected to confirm effectiveness in local demographic before final long-term listing

Meanwhile, MASc formalizes how high-cost, specialized, and novel pharmaceuticals enter public healthcare facilities. This framework transitions patient access from ad-hoc, informal corporate donations or charity programs into a legally binding, highly regulated risk-sharing mechanism that protects public health budgets while guaranteeing patient safety and treatment continuity. To prevent financial exposure and safeguard patient welfare, every MASc submission must satisfy 4 Mandatory Scheme Guardrails before obtaining MOH approval:

(i) **Eligibility (Clinical Criteria):** Establishes strict, evidence-based inclusion and exclusion criteria (biomarker profiles, disease staging, treatment line) to define precisely which patient sub-groups qualify, preventing off-label usage or indication creep

(ii) **Duration (Treatment Timeline):** Sets explicit time limits or cycle caps on how long subsidized, co-funded, or free treatment support lasts per individual patient

(iii) **Remaining Costs (Deficit Allocation):** Stipulates financial obligations up front—clearly defining who pays for ongoing maintenance drug cycles, diagnostic companion testing, or co-pay elements once the initial scheme allocation is consumed

(iv) **Continuity (Exit and Transition Strategy):** Enforces mandatory transition plans so patients do not face abrupt, dangerous treatment disruptions if a scheme term expires, a trial ends, or a supplier exits the market

THE VALUE TRIAD IN HEALTHCARE

Adoption of the Triad would reform the pharmaceutical subsector.

The Value Triad in Health Care (Access, Value, and Sustainability) represents a shift in how modern health systems and HTA bodies evaluate and procure pharmaceuticals. It moves health authorities away from transactional, unit-cost minimization toward VBP, ensuring health systems can deliver equitable care today without compromising solvency tomorrow. At the center of the Triad lies the sweet spot of strategic healthcare procurement. We noted that achieving this balance requires two non-negotiable operational components: (i) a fair price, and (ii) a reliable supply. By shifting to VBP, MOH could prioritize a drug's total lifetime value—such as reducing hospitalizations and ensuring supply security—over initial cost alone. Consequently, regulatory approval via the National Pharmaceutical Regulatory Agency (NPRA) is no longer sufficient for commercial success, as high-cost novel therapies must demonstrate health-economic value and utilize MEAs or PASc to secure public formulary listing. Simultaneously, the ongoing global supply disruptions have tested supply chain resilience, prompting local manufacturing to prioritise national drug security, by maintaining strict buffer stocks while favouring domestic generic and biosimilar producers for public procurement.

TABLE 3: SUMMARY OF THE VALUE TRIAD IN HEALTHCARE

Pillar	Core Principle	Primary Operational Goal
Access	Delivering clinically effective, evidence-based treatments promptly	Eliminating health disparities, geographical barriers and waiting times for essential medicines
Value	Ensuring that health outcomes (gains in survival, quality of life, reduced hospitalizations) justify the financial outlay	Maximizing the ICER relative to national health spending thresholds.
Sustainability	Structuring financial and procurement commitments to ensure that the health system remains solvent for future generations	Managing aggregate budget impact to prevent overcrowding or crowd-out of other vital public health services

Ensuring accessibility and sustainability remains top priority for the subsector.

The Five-Part Strategy for Sustainable Access establishes a continuous lifecycle model for pharmaceutical procurement and reimbursement management. It reframes market access from a static, one-time administrative event (regulatory filing and initial formulary listing) into an ongoing, dynamic process that adapts as clinical evidence evolves, market competition shifts, and patents expire (see Table 4). MOH's shift to a continuous lifecycle procurement framework fundamentally alters subsector dynamics, compelling multinational innovators to engage in early horizon scanning with MaHTAS 24 to 36 months pre-launch, while actively tracking local RWE to prevent price reductions or restrictions during post-listing reassessments.

Concurrently, Loss of Exclusivity (LOE) triggers competitive re-tendering that drives steep price erosion among off-patent molecules, liberating public budget capacity that the MOH reallocates toward novel therapies entering the pipeline. To power this continuous cycle of assessment and reassessment, healthcare concessionaires and distributors must integrate digital inventory tracking, hospital prescribing registries and real-time supply analytics to maintain national demand planning and supply security across the nation. To support these strategies, MOH proposed five structural levers to achieve the final objective of these frameworks and policies – nationwide medicine security. The levers include: (i) innovative financing, (ii) promoting value-based negotiations, (iii) enforcing strategic procurement, (iv) expanding generics and biosimilars, and (v) encouraging regional collaboration.

TABLE 4: FIVE-PART STRATEGY FOR SUSTAINABLE ACCESS

Lifecycle Stage	Core Objective	Primary Operational Actions
Anticipate	Horizon scanning and pipeline forecasting	• Identifying high-impact pipeline molecules 2–3 years ahead of launch • Modeling early disease prevalence and projected budgetary impact
Assess	Local HTA	• Evaluating clinical efficacy, safety and pharmacoeconomic value relative to current standard of care using local epidemiologic data
Negotiate	Value-based contracting and access schemes	• Establishing fair net prices, volume-based discounts, spending caps or structured PASc and MEAs
Measure	Post-listing RWE tracking	• Monitoring post-market clinical health outcomes, real-world patient utilization, actual budget absorption and supply chain continuity
Reassess	Formulary lifecycle review and re-tendering	• Conducting periodic reviews to adjust reimbursement tiers, renegotiate pricing or transition to generics and biosimilars upon LOE

SUPPORTING FRAMEWORK: MOH MEDICINES ACCESS ARRANGEMENTS

The MOH Medicines Access Arrangements framework represents a structured, multi-tiered gateway to govern how pharmaceuticals transition from regulatory approval by the NPRA to actual clinical utilization and reimbursement in public facilities. This model balances universal public health coverage with the fiscal constraints of a tax-funded healthcare system. Additionally, this framework is an essential gateway to pass MaHTAS health-economic evaluations and secure public reimbursement without overwhelming hospital budgets. Simultaneously, local generic and biosimilar manufacturers could secure massive, predictable supply volumes by anchoring demand in Tier 1 tenders for chronic disease management, directly liberating the fiscal space needed to fund Tier 3 innovative therapies. To support this ecosystem, logistics providers and distributors must manage sophisticated administrative eligibility tracking for access schemes while maintaining stringent cold-chain integrity and track-and-trace capabilities across public hospital networks for temperature-sensitive biologics.

Reshaping commercial strategies for a win-win ecosystem.

TABLE 5: SUMMARY OF THE MOH MEDICINES ACCESS ARRANGEMENTS

Access Tier	Scope	Operational Mechanics	Budget and Clinical Function

Tier 1	Standard Public Formulary (FUKKM)	• Primary, main-line public health drug list
		• Categorized by prescriber level:
		  ○ Category A/A*: Consultants, Subspecialists
		  ○ Category B: Medical Officers
		  ○ Category C: Paramedics
			• Accounts for the vast majority (over 80%) of public pharmaceutical spend
			• Focuses on standard-of-care essential medicines, off-patent generics and established blockbusters

Tier 2	Special Approval Medicine (UKK)	• Exception pathway for unlisted, restricted or orphan drugs • Requires named-patient applications submitted by hospital specialists to the Director General of Health or designated MOH committees	• Serves emergency, refractory, or rare-disease clinical cases where standard Tier 1 options have failed Capped spending, handled case-by-case
Tier 3	Medicines and Patient Access Schemes (MASc, PASc)	• Risk-sharing framework for high-cost, specialized therapies • Uses dose capping, BOGO or outcome-linked rebates	• Mitigates fiscal disruption while providing early access • Caps total financial exposure for public budgets while lowering patient cost barriers

SUPPORTING FRAMEWORK: EVIDENCE FOR A VALUE DECISION

This outlines the multidimensional evaluation model used by MOH, primarily through MaHTAS and the Pharmaceutical Services Programme, to evaluate novel, high-cost pharmaceuticals. This framework applies a 5-pillar HTA model (see Table 6) to balance patient needs with public budget sustainability. We expected that this multidimensional HTA framework elevates reimbursement barriers for multinational innovators, requiring localized pharmacoeconomic dossiers and flexible MEAs to demonstrate cost-effectiveness and manage budget impact for public formulary inclusion. Concurrently, MOH's explicit accounting of opportunity costs favours local generic and biosimilar manufacturers, whose cost-effective chronic disease therapies generate the essential systemic savings needed to fund high-cost, specialized novel treatments for oncology and rare diseases.

Health economic evaluations, risk-sharing mechanisms to aid in future cost sustainability.

TABLE 6: SUMMARY OF THE 5-PILLAR HTA MODEL

Pillar	Evaluation Focus	Examples of the Clinical and Economic Evaluation
Clinical Benefit	Incremental value vs. standard care	• Drug offers meaningful improvements in overall survival (OS), progression-free survival (PFS), symptom relief or Quality of Life (QoL) compared to existing treatments on FUKKM
Patient Needs	Severity and unmet clinical need	• Severity of the condition • Other existing therapeutic alternatives • Specific biomarker sub-groups that can be targeted to maximize response rates

Evidence Confidence	Methodological rigor and long-term data	• Strength of the pivotal clinical trials • Endpoints clinically surrogate or true hard endpoints • Uncertainty around long-term real-world effectiveness
Budget Impact	Multi-year affordability and opportunity cost	• Total projected financial impact over a 3-5 year horizon • Other healthcare services, treatments or patient cohorts which might be underfunded or displaced as a result of listing the therapy
Managing Uncertainty	Risk-sharing and feasibility of MEAs	• Adaptability of MEA and PASc if clinical or financial uncertainty remains high to mitigate payer's risk

OUR VIEWS

Enhanced regulations and systems ensure a sustained resilience for local pharmaceuticals.

The transition toward VBPs and MEAs creates significant structural advantages for domestic manufacturers, concessionaires and patients across Malaysia's public healthcare ecosystem. Local generic and biosimilar producers gain high-volume demand security by anchoring Tier 1 (FUKKM) tenders, which generates essential budget savings that the Ministry of Health (MOH) reallocates to fund Tier 3 novel therapies. Concurrently, frameworks like PASc and MASc allow patients to obtain early access to high-cost biologics and specialized oncologics without overwhelming public funds. Furthermore, a strong emphasis on domestic manufacturing and data-driven logistics strengthens national drug security, optimizes inventory forecasting and fortifies supply chain resilience against global disruptions. Ultimately, these initiatives are meant to secure and sustain the access and value of drugs in a race against the future trends of a shifting demographic and growing NCD prevalence among the population.

Downside risk on financial impact and reimbursement barriers.

Despite these access pathways, we also anticipated commercial hurdles, severe price sensitivity and increased risk transfer onto pharmaceutical suppliers. Obtaining regulatory authorization from the NPRA no longer guarantees public reimbursement, as multinational innovators face strict dual gatekeeping through ICER thresholds and rigid multi-year Budget Impact Analysis (BIA) limits. Under performance-linked MEAs, clinical and financial risks shift heavily to suppliers, requiring mandatory rebates or refunds if novel drugs fail to hit real-world endpoint targets. Additionally, high OOP spending in the private sector continues to leave patients vulnerable to financial exhaustion, driving migration to the public system and creating a continuous risk of demand disruption for premium self-pay therapies.

Stakeholder support for both healthcare sectors in parallel.

Since Malaysia operates a dichotomous health system – wherein funding is split almost evenly between public funds (50.7%) and private financing (49.3%) – we believe that the pharmaceutical players must execute parallel commercial models to capture the market value across both sectors. To note, the public sector, which consists of MOH tenders, is more volume-based through value-driven bids, while the private sector is more margin-driven with brand-differentiated positioning. For the public sector, companies are expected to demonstrate cost-effectiveness through HTAs, spending caps and supply low-cost, off-patent generics and biosimilars Conversely, for the private sector, companies must implement flexible payment terms, co-pay assistance and PASc to keep novel therapies accessible. For shareholders, the strategic plan is as follows:

Stakeholder Group	Primary Strategic Focus	Primary Strategic Challenge	Recommended Operational Realignment	Strategic Market Opportunity
Multinational innovators	• Secure early market access via PASc and MASc proposals • Protect reimbursement across the full drug lifecycle	• High OOP costs limit initial self-pay adoption for premium novel therapies in the private sector • ICER alone does not guarantee listing due to high total budget impact	• Pivot commercial strategy from product-feature marketing to real-world health economics (HEOR) • Proactively propose risk-sharing and PASc models during HTA reviews • Demonstrate incremental clinical superiority and manage budget impact • Define objective clinical endpoints • Establish clear assessment windows	• Bridge affordability gaps and support early public formulary inclusion through PASc • Accelerated listing on the MOH Medicines Formulary (FUKKM) and broader patient uptake via structured public access schemes
Local generic manufacturers	• Target core, high-volume Tier 1 (FUKKM) tenders for chronic conditions • Capture volume during market reassessment points	• High revenue reliance on winning competitive public MOH tenders	• Upgrade bioequivalence and biomanufacturing standards • Ensure robust API sourcing • Target high-volume chronic disease categories (metabolic, CVD) • Support public healthcare budget sustainability and national security	• Expand manufacturing capacity for high-volume chronic disease medications (metabolic, cardiovascular) to capture rising public sector volumes • Secure long-term, high-volume multi-year public procurement tenders under strategic preference policies
Community pharmacies and retail	• Administer eligibility tracking and scheme compliance	• Patients actively shop for lower-cost generic alternatives due to OOP constraints	• Deploy digital demand-forecasting, real-time inventory tracking and temperature-controlled cold-chain capabilities across rural and urban facilities • Monitor patient response parameters • Track drug utilization • Enforce financial rebate triggers upon treatment failure	• Expand generic substitution options, transparent price display, and patient-centric chronic disease management support programs • Establish durable, long-term strategic partnerships with public health authorities to guarantee national medicine security

Sustainable access is a shared responsibility.

The overall subject of medicine security warrants a multi-stakeholder collaboration to ensure long-term healthcare access and financial sustainability. In an era dominated by high-cost precision biopharmaceuticals, advanced immunotherapies and growing chronic disease burdens, no single entity can bear the financial and operational weight of healthcare access in isolation. The ecosystem converges on a unified operational objective – partnerships should deliver appropriate care that patients can access, benefit from and continue. This eliminates disconnected silos where a drug is registered by regulators but remains unaffordable to patients, or where patients initiate therapy only to drop out due to personal financial exhaustion.

Maintain POSITIVE on the pharmaceutical sector.

Malaysia's healthcare system is successfully transitioning toward a sophisticated, value-driven procurement and reimbursement model designed to balance individual patient access with long-term public fiscal solvency. By combining the frameworks discussed with the robust local generic and biosimilar substitution, MOH is actively addressing the escalating cost pressures of NCDs and how we, as part of the collective stakeholder to the sector, could contribute to reduce the burden of medicine insecurity. All in all, the event left us with a maintained optimism on the domestic pharmaceutical landscape. Our **TOP PICKS** are **Pharmaniaga (BUY, TP:RM1.44)** and **Duopharma Biotech (NR, FV: RM1.36).**

Pharmaniaga benefits from these frameworks by its ability to anchor long-term MOH procurement tenders for chronic disease medications, securing predictable supply volumes and profitability. The group also operates as a primary logistics concessionaire and major supplier, giving it a strong foothold in the area. Pharmaniaga is also positioned to be prioritised for the manufacturing of generics and biosimilars. As public procurement policy aggressively prioritizes off-patent chemical generics and complex biosimilars to generate systemic budget savings, local manufacturing champions capture a dominant share of prescription volume. Likewise, Duopharma is a leading domestic generic drug manufacturer, and as such, has the capability to secures massive, predictable and recurring supply volumes through long-term public tenders. The implementation of HTA and BIA models to control the high costs of novel oncology and biologic drugs indirectly relies on low-cost generics and biosimilars to create fiscal space. Both companies are poised to leverage with Malaysia's call to reduce import dependency of finished pharmaceutical products. This ultimately insulates these players from external global logistics shocks.

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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