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Inelastic Demand, Elastic Policy: Rethinking the Defensive Status of Healthcare Equities in Asian Capital Markets

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Abstract

Healthcare equities are conventionally classified as defensive on the grounds that inelastic demand produces stable cash flows and low systematic risk. This paper argues that the classification is conditional rather than intrinsic. In many Asian markets, the state is simultaneously the dominant payer, price-setter, and regulator of the healthcare sector, so that the price at which stable demand is monetized becomes a policy variable. Drawing on conceptual analysis and an integrative synthesis of literature on asset pricing, policy uncertainty, pharmaceutical pricing intervention, public finance, and behavioral finance, the paper distinguishes demand stability, a property of the sector, from cash-flow control, a property of the institutional setting. It proposes a typology of four exposure regimes defined by payer concentration and policy predictability, and it specifies a fiscal-transmission channel through which geopolitical energy shocks may reach healthcare valuations: in energy-importing economies that subsidize fuel, subsidy burdens narrow fiscal space, raise the likelihood of health-expenditure containment, and affect the revenues of state-paid firms. Because this channel operates through budget cycles, it may unfold after, and run counter to, the immediate defensive rotation into healthcare that accompanies such shocks. The energy shock associated with the 2026 war involving the United States, Israel, and Iran serves as an anchoring context rather than an object of empirical analysis. Five propositions are developed, concerning payer dependence, policy-uncertainty sensitivity, fiscal transmission, time-varying defensiveness, and classification-driven investor behavior; they are advanced as theoretical claims rather than empirical findings. The paper derives implications for portfolio construction, disclosure regulation, and the design of fiscal and pricing policy, and it outlines an agenda for empirical testing.

Keywords: *healthcare equities; defensive sectors; policy uncertainty; fiscal transmission; pharmaceutical price regulation; energy shocks; Asian capital markets*

1. Introduction

Healthcare equities occupy a settled position in investment practice and in the conventional taxonomy of equity sectors: they are classified as defensive. The rationale is intuitive. Demand for medicines, diagnostics, and hospital care is relatively insensitive to income and the business cycle, so the cash flows of healthcare firms are expected to be more stable than those of cyclical industries, and their exposure to systematic market risk correspondingly lower. This classification has practical consequences. It informs sector rotation, portfolio construction, and the widely held expectation that healthcare holdings will cushion portfolios during recessions and crises.

The defensive classification, however, rests on an assumption that is rarely made explicit: that stable demand translates into stable revenue. This assumption is most plausible where healthcare firms set prices in competitive markets or negotiate with fragmented private payers. It is considerably less secure where the state is simultaneously the dominant payer, the price-setter, and the regulator of the sector. That configuration is common across Asian economies. It operates through social health insurance schemes, administered reimbursement schedules, centralized procurement, and statutory price ceilings. Related research on ASEAN economies has also examined universal health

coverage as a form of economic infrastructure (Patron et al., 2026). Under these conditions, the revenue of a listed healthcare firm is a function not only of patient demand but also of fiscal and regulatory decisions. Demand stability, in other words, may be partly converted into policy dependence. The defensive label may then describe the sector's insulation from the business cycle while understating its exposure to the state.

The war that began in 2026 offers an instructive setting in which to examine this tension. Since the United States and Israel launched strikes on Iran on February 28, 2026, the Strait of Hormuz, which carried roughly a fifth of global oil and gas before the war, has been largely closed to shipping following Iranian attacks (Al Jazeera, 2026). Asian economies are disproportionately exposed: in 2024, 84 per cent of the crude oil passing through the strait was bound for Asian markets, with China, India, Japan, and South Korea together accounting for 69 per cent of these flows (The Week, 2026). The shock has also proved persistent rather than transitory. A ceasefire was reached on April 8, and the United States and Iran signed a memorandum of understanding on ending the war on June 18 (Xinhua, 2026). Yet as of October 2026 the conflict has resumed, and Tehran has signalled that it will continue military and diplomatic pressure while a United States naval blockade of Iran's southern ports remains in place (Al Jazeera, 2026).

The immediate market response to the war illustrates why the defensive classification warrants closer scrutiny. Market commentary from the early weeks of the conflict reported that pharmaceutical stocks in Tokyo and Hong Kong declined, a movement attributed to the likelihood of rising raw-material costs (TheStreet, 2026). Indian healthcare equities, by contrast, behaved more like the textbook defensive case: around the time of the announced ceasefire, healthcare stocks led the list of gainers in India's BSE 500 index (Business Today, 2026). Such reports are commentary rather than systematic evidence, and they are cited here only to illustrate heterogeneity. They nonetheless suggest that the sector's defensive properties are not uniform across markets. Sector-level evidence from the same shock points in a similar direction (R. G. Atento et al., 2026). They also show that much of the attention to the war's market effects has concentrated on a fast channel of input costs and risk-off rotation.

A slower channel has received less attention, and it is this channel that the present paper examines. Governments across Asia responded to the energy shock fiscally. They deployed a mix of price caps, rationing, and stockpile releases (Fortune, 2026), and many provided subsidies to absorb fuel-price increases, including diesel subsidies in Thailand, the use of state fuel reserves in Vietnam, and consumer rebates in Singapore (Council on Foreign Relations, 2026). Such responses require governments to allocate limited fiscal space among competing crisis instruments, a problem that Philippine policy analysis has examined directly in the context of oil-price volatility linked to geopolitical conflict (A. G. Atento et al., 2026). The fiscal consequences have been substantial. Indonesia's 2026 budget projected a deficit of 2.7 per cent of GDP on the assumption of oil at US\$70 per barrel, an assumption that soon appeared unrealistic, and budget cuts came to be regarded as inevitable (East Asia Forum, 2026). In India, authorities were reported to be prepared to let the fiscal deficit widen to as much as 4.8 per cent of GDP, against a target of 4.3 per cent set in February, as war-related energy subsidy costs mounted (Bloomberg News, 2026). An independent bottom-up estimate placed the additional deficit for 2026–27 at between 0.19 and 0.69 percentage points of GDP, depending on the duration of the war (Goel, 2026). Regionally, the Asian Development Bank warned that inflation in Asia could exceed 5 per cent in 2026, against an earlier projection of 2.1 per cent, depending on how long the war lasts (Majalla, 2026).

When fiscal space narrows in this way, health expenditure becomes a plausible candidate for containment, because it is large and administered through state insurers and procurement agencies. Containment need not take the form of explicit cuts. It may operate through reimbursement adjustments, delayed transfers, procurement price pressure, or slower expansion of coverage. Each of these bears directly on the revenues of firms whose principal customer is the state. Contemporaneous budgeting in the Philippines illustrates the kind of fiscal decision through which such pressure reaches the sector: the proposed 2027 subsidy for the national health insurer was reported at P74.4 billion, compared with P129.78 billion under the 2026 General Appropriations Act (Daily Tribune, 2026). The insurer's role extends beyond payment to hospital accreditation, and hospital-level evidence identifies staffing, budget, and equipment constraints as the most frequently reported challenge in implementing its accreditation standards (Garcia & Atento, 2026). The determinants of this proposal are multiple and contested, and the present paper does not attribute it to the war. The example is used only to show the institutional pathway connecting public finances to healthcare-sector cash flows.

These observations point to an unresolved intellectual problem. Three bodies of scholarship bear on it but have developed largely in isolation from one another. The asset-pricing literature explains sectoral defensiveness primarily through the demand characteristics of industries. The literature on policy uncertainty and regulatory risk establishes that government decisions can be priced in equity markets. The public-finance literature examines how fiscal stress shapes expenditure priorities, including health spending. What is missing is an integrated account of how a macroeconomic shock, transmitted through public finances, alters the risk profile of a sector whose defensive status is premised on demand stability. The problem is sharpened by a further possibility. Fiscal pressure tends to intensify during downturns and crises. If price and expenditure interventions become more likely when fiscal conditions

deteriorate, then the policy risk borne by state-paid healthcare firms is not cycle-neutral, and the defensive properties of the sector may weaken in precisely the conditions in which investors most rely on them.

This paper addresses that problem through conceptual analysis and integrative literature synthesis. It first examines the theoretical basis and evidentiary support for the classification of healthcare equities as defensive assets. It then analyzes how policy uncertainty and regulatory risk enter equity valuation in sectors whose revenues depend on government pricing decisions. Building on these foundations, it conceptualizes how state-dominated health-financing structures in Asian economies convert demand stability into policy dependence at the level of firm cash flows, and it theorizes the fiscal-transmission channel through which energy shocks may reach healthcare valuations. From this synthesis, the paper develops a conceptual framework and a set of propositions specifying the conditions under which healthcare equities retain or lose their defensive properties, and it derives implications for investors, securities regulators, and the design of fiscal and pricing policy. The 2026 conflict serves as an anchoring context throughout; it is not an object of empirical analysis, and the paper's claims are advanced as conceptual propositions rather than tested findings.

The remainder of the paper is organized as follows. Section 2 reviews the related literature across five themes and identifies the gaps the paper addresses. Section 3 describes the conceptual methodology. Section 4 develops the analytical synthesis, the conceptual framework, and the propositions. Section 5 discusses theoretical and policy implications, and Section 6 concludes.

2. Review of Related Literature

2.1 Defensive-Sector Theory and the Equity-Market Profile of Healthcare

In its narrow form, the proposition that healthcare equities are defensive receives substantial empirical support. Studies across developed and emerging markets report that healthcare and pharmaceutical equities carry market betas below unity, generally attributed to the non-cyclical character of demand for essential medical goods and services (Mutinda & Langat, 2024; Ramakau et al., 2025). Among large-capitalization United States equities, established pharmaceutical constituents display lower betas and expected returns than cyclical technology and financial stocks (Mutinda & Langat, 2024). Comparable patterns appear in emerging markets: Indian pharmaceutical firms exhibit betas well below one against headline benchmarks (Khandelwal & Bagga, 2026; Parmar, 2026), and South African healthcare returns show low correlation with the aggregate index (Ramakau et al., 2025).

Evidence on downside behavior points in the same direction. Defensive stocks have been found to buffer portfolio losses during market downturns (Agarwal, 2024). Long-horizon evidence spanning two centuries indicates that defensive equity strategies provided effective protection across major crisis regimes (Baltussen et al., 2026). In European equities, healthcare assets exhibited negative drawdown betas during the COVID-19 crash (Feder-Sempach et al., 2026), and in the United States, portfolio strategies that adjust exposure to the healthcare sector were found to contain maximum drawdowns (Hamada et al., 2026).

The literature nonetheless qualifies this picture in three respects. First, low systematic risk is not equivalent to low total risk. Individual Indian pharmaceutical stocks display idiosyncratic volatility exceeding that of the broader index, and concentrated pharmaceutical portfolios have suffered drawdowns of more than 25 per cent despite low betas (Khandelwal & Bagga, 2026; Parmar, 2026). Defensiveness, in this sense, is a property of market exposure rather than of overall stability. Second, the sector is internally heterogeneous: during the pandemic, pharmaceutical and testing firms outperformed while medical service providers suffered steep drawdowns from volume disruption (Perroni et al., 2025; Zhao et al., 2025). Third, healthcare's macroeconomic sensitivity appears conditional on political and geopolitical regimes. Indonesian evidence indicates that the sector's responsiveness shifts across political administrations and under geopolitical shocks (Garnia et al., 2026; Sari et al., 2026). Evidence from the 2024–2026 oil-price surge likewise suggests that energy shocks are not neutral for defensive sectors: a global health-sector benchmark traded further below its expected growth trajectory than the broader market, a shortfall attributed to oil-sensitive input costs and household budget pressure (R. G. Atento et al., 2026).

The methodological profile of this literature warrants attention. Much of the sector-specific evidence relies on capital asset pricing estimates for small samples over short windows, and a large share of the crisis evidence is drawn from the COVID-19 period. Asian emerging-market asset-pricing evidence shares this temporal profile; an extended Philippine study of size premiums and volatility clustering, for example, spans the COVID-19 disruption, the post-pandemic recovery, and the 2022–2023 monetary tightening cycle (R. G. O. Atento, Atento, et al., 2026). The strongest long-horizon evidence concerns defensive investment styles in general rather than the healthcare sector specifically (Baltussen et al., 2026). This matters because the pandemic was a health shock, one that raised demand for some healthcare products while depressing activity elsewhere. Evidence drawn predominantly from such an episode may

not generalize to shocks of a different origin, such as an energy shock transmitted through public finances. More fundamentally, the literature establishes that healthcare equities are insulated from the demand cycle but is largely silent on the source of their cash-flow stability. It does not distinguish stability that derives from the volume of demand from stability that depends on the price at which that demand is monetized. That distinction is where the state enters the analysis.

2.2 Policy Uncertainty and Regulatory Risk in Asset Pricing

The literature on economic policy uncertainty converges on two findings. Elevated policy uncertainty depresses equity returns, with effects concentrated in economic contractions and in the lower quantiles of the return distribution (Karabiber, 2026; Sánchez-Gabarré & Castellanos García, 2026; Umore et al., 2025). It also raises market volatility: increases in national and global uncertainty indices are associated with sustained rises in long-run volatility components and implied variance (Feng, 2025; Güngör & Güngör, 2024; Isah et al., 2024; N. Wang et al., 2024).

The proposed mechanism is that investors demand compensation for the forecasting difficulty that policy instability creates, producing downward repricing when uncertainty rises (Qian & Poshakwale, 2025; D. Song & Zhao, 2025). Importantly for the present argument, policy uncertainty appears to constitute a distinct systematic risk component: standard asset-pricing models leave meaningful pricing errors unless a policy-related factor is included (Helmi & Aljaid, 2026). Specific policy dimensions, including tax, fiscal, and monetary policy, also generate idiosyncratic volatility beyond their effects on aggregate market risk (Lin et al., 2025; Shin et al., 2024; Xiao et al., 2024). Asian markets are well represented in this evidence, with studies of China (Qian & Poshakwale, 2025; N. Wang et al., 2024; Xiao et al., 2024; Zhu et al., 2025) and of the constituents of Japan's Nikkei 225 (Shin et al., 2024).

The exposure is not evenly distributed across industries (Msomi & Kunjal, 2024; Zhu et al., 2025). Industries whose revenues or operating parameters depend on government subsidies, pricing regulation, or policy mandates exhibit amplified price reactions to policy fluctuations (D. Song & Zhao, 2025; Zhu et al., 2025). Time-varying estimates for Chinese industry returns suggest that production linkages account for roughly two-fifths of the equity response to policy-uncertainty shocks (Zhu et al., 2025). Heavily regulated firms also face higher financing costs and elevated crash risk when policy environments deteriorate (Qian & Poshakwale, 2025; D. Song & Zhao, 2025).

The evidence is not uniform in direction, however. Climate policy uncertainty has been associated with positive responses among regulated utilities and renewable-energy equities, reflecting transition expectations, whereas broader economic policy uncertainty imposes valuation discounts on the same firms (Suyadal, 2025; X.-Q. Yang & Nie, 2024). This divergence suggests that what matters is not only the magnitude of policy uncertainty but its content: whether anticipated policy changes are expected to expand or compress the revenues of affected firms.

Methodologically, the field relies heavily on aggregate news-based uncertainty indices and mixed-frequency volatility models, and it typically treats sectors as aggregates. Healthcare rarely appears as a distinct object of analysis, and uncertainty specific to health financing, such as reimbursement, procurement, or pricing policy, is seldom measured separately from general economic policy uncertainty. The evidence is nonetheless consistent with the interpretation that stable underlying demand does not neutralize regulatory exposure: a sector can be insulated from the business cycle while remaining exposed to the state. What this literature does not yet provide is an account of when policy risk intensifies, and in particular whether it varies systematically with the fiscal condition of the government making the decisions.

2.3 The State as Payer and Price-Setter: Cash-Flow Exposure of Healthcare Firms in Asian Markets

Where the literature examines specific state interventions in pharmaceutical markets, its findings on firm finances are relatively consistent. The largest body of evidence concerns China's centralized volume-based procurement, which replaces decentralized commercial distribution with reverse-auction bulk tenders (Yan et al., 2025; S. Zhang et al., 2026). Event-study evidence indicates a significant decline in pharmaceutical firms' price-to-cost markups following the reform (Yan et al., 2025). Studies of listed pharmaceutical enterprises report reductions in net profit, because the guaranteed volumes awarded to winning bidders fail to offset the depth of tender discounts (Ke et al., 2024; X. Li, 2025). In-hospital expenditure on affected drugs falls markedly (Cheng et al., 2026; J.-L. Wang et al., 2024; Y. Yang et al., 2025), and market concentration rises as non-certified generic producers exit (Y. Yang et al., 2024). China's national drug price negotiation follows a similar logic: formulary inclusion secures institutional access in exchange for price reductions that compel operational restructuring (Xu et al., 2026). At the level of equity valuation, policy implementation has coincided with short-term declines in the market value of exposed firms (X. Li, 2025), effects that are moderated for firms signalling strong research capability (Qiu et al., 2025; Xu et al., 2026).

Evidence beyond China, though thinner, points in the same direction. South Korea's 2012 drug price reduction policy was followed by declines of between 7 and 60 per cent in sales of firms' self-manufactured products and by a

shift toward co-promoted foreign originals exempt from the cuts (Choi et al., 2025). In India, statutory price caps under the Drugs Prices Control Order were associated with declining sales volumes, as manufacturers curtailed promotional effort on margin-compressed therapies (Jaikumar et al., 2024). In the Philippines, the Universal Health Care Act provides the policy framework for coverage expansion, although implementation gaps in community-level service delivery persist (Morcilla & Quinto, 2026).

The literature also documents that firms adapt, which complicates any simple reading of policy as uniformly value-destroying. Manufacturers have raised prices on non-tendered products to recover margin (Qiu et al., 2025; T. Wang, 2026), shifted distribution from public hospitals toward less regulated retail pharmacy channels (Y. Yang et al., 2024), and redirected capital toward differentiated research pipelines (Ke et al., 2024; X. Li & Xu, 2024; Qiu et al., 2025). In the Philippine retail pharmacy sector, a case study of the dominant chain under universal healthcare reform similarly describes firm adaptation within a regulated industry and underscores the need to align affordability policies with private-sector viability (A. G. Atento & Atento, 2025). Severe price cuts, however, are recognized as a threat to the operational viability of some producers (Chang et al., 2024; Ke et al., 2024; J. Li et al., 2024). Combined with rising concentration, these findings suggest that state pricing interventions redistribute value within the sector, between scale leaders and marginal producers and between regulated and unregulated product lines, as much as they reduce it in aggregate.

The methodological character of this literature shapes what it can support. Most studies apply difference-in-differences, interrupted time-series, or event-study designs around discrete policy dates. Much of the work appears in health-policy rather than finance outlets, and the outcomes examined are more often innovation, expenditure, or market structure than equity valuation, so direct evidence on stock-price effects remains limited relative to evidence on operating performance. Taken together, the findings establish that where the state controls pricing and procurement, the price at which stable demand is monetized becomes a policy variable. These interventions, however, are treated in the literature as structural reforms with their own institutional logic. Whether their timing or intensity responds to the fiscal position of the government is not examined.

2.4 Energy Shocks, Fiscal Pressure, and the Reallocation of Public Health Expenditure

The fiscal-transmission argument requires two links, from oil-price shocks to fiscal stress and from fiscal stress to health-expenditure containment, and the literature supports them unevenly. Evidence on the first link is mixed. Across oil-importing OECD economies, inflationary oil shocks were found to improve fiscal balances in the medium term and to lower debt-to-GDP ratios, implying more fiscal space than conventional accounts assume (Banerjee, 2024). In Türkiye, higher crude prices raised indirect tax revenues and reduced government borrowing, with the fiscal outcome hinging on the tax response (Cetin et al., 2026). In Jordan, by contrast, oil-price shocks significantly widened the fiscal deficit for several quarters and accounted for around 9 per cent of its variance, consistent with subsidy and import-cost pressures (Al-Sawaie et al., 2025). Panel evidence for MENA importers finds no clear average effect on fiscal balances (Bazi et al., 2026), while studies of import-dependent economies more broadly find that oil shocks worsen trade and current-account positions, a plausible route to subsequent fiscal strain (Ali et al., 2025; Rai & Garg, 2026). Philippine time-series evidence further cautions against presuming the direction of oil-shock effects: year-over-year increases in oil prices were positively rather than negatively associated with new business formation (R. G. O. Atento, Quinto, et al., 2026).

One interpretation reconciles these findings: the fiscal sign of an oil shock depends on fiscal architecture. Where energy is taxed, revenues may rise with prices; where energy is subsidized, expenditure rises instead. This is an inference from the pattern of results rather than a finding any single study establishes. It is nonetheless consequential, given the prevalence of fuel subsidies and price caps among Asian economies during the 2026 shock described in the Introduction.

Evidence on the second link is considerably stronger. In Brazilian municipalities, fiscal austerity had an immediate negative effect on total health expenditure, with persistent medium-term deterioration in large municipalities (Maia et al., 2024). A parallel time-series study argues that the post-2014 weakening of health spending reflected a policy choice rather than an automatic consequence of recession (Castanheira et al., 2025). Within the European Union, member states under excessive-deficit surveillance significantly consolidated health spending, with sharper contraction in Southern Europe (Cerón, 2024). South Africa's 2023/24 cuts have been described as the largest post-apartheid reduction in public health spending (Bhorat et al., 2026); Ecuador reduced its public health budget, including allocations for pharmaceuticals and medical devices (Ortíz-Prado et al., 2026); and Senegal's domestic government health spending did not rise in real terms over more than a decade despite formal safeguards (Federspiel et al., 2026). Containment operates through reduced own-source spending, delayed transfers, and slower real growth in allocations (Maia et al., 2024; Ortíz-Prado et al., 2026). One caveat is that consolidation does not mechanically improve fiscal health and may worsen the primary balance in the short run (Buthelezi, 2025).

Two features of this evidence bear directly on the present argument. The characterization of health-spending containment as a policy choice (Castanheira et al., 2025) places it squarely within the category of discretionary government action that, as Section 2.2 established, can be priced as policy risk. The Ecuadorian case further shows that containment can fall specifically on pharmaceutical and device procurement, the budget lines that constitute revenue for listed suppliers (Ortiz-Prado et al., 2026). The limitations are equally clear. The retrieved evidence comes from Europe, Latin America, Africa, and the Middle East rather than Asia; its outcome variable is public expenditure, not firm revenues or equity valuations; and no retrieved study examines the full chain from energy shock to fiscal stress to health-spending containment to healthcare-firm valuation.

2.5 Sector Narratives, Classification Heuristics, and Investor Perception of Healthcare Risk

The behavioral literature indicates that investors treat healthcare as a refuge during uncertainty. Capital is directed toward healthcare, utilities, and consumer staples during periods of elevated volatility (Batoryk & Viblyi, 2025; Fithriyana et al., 2025; Goyal & Kansal, 2026), and during contractions investors overweight non-cyclical equities with inelastic end demand while reducing exposure to cyclical (Batoryk & Viblyi, 2025; Ramakau et al., 2025). Global risk-aversion shocks also alter cross-asset hedging demand, with healthcare and consumer staples requiring smaller hedging allocations than volatile cyclical sectors (Ngene et al., 2025). In post-pandemic India, retail investors featured prominently in healthcare-stock trading, with confidence in the sector shaped by market sentiment and expectations of recovery (Goyal & Kansal, 2026).

This refuge-seeking behavior does not guarantee protection. During the pandemic, attention concentrated on thematic concept stocks, introducing short-term pricing noise alongside fundamentally motivated reallocation (Zhao et al., 2025), and sub-sector outcomes diverged sharply between manufacturers and service providers (Perroni et al., 2025). Evidence on geopolitical stress indicates that the safe-haven properties of sectors are regime-dependent rather than fixed (Gheorghe & Panazan, 2025; X.-Y. Song et al., 2025).

A second strand concerns whether sector classification itself shapes price behavior. Firms sharing sectoral labels have been found to exhibit return comovement not fully explained by fundamentals, consistent with category-based trading and index-tracking allocation (Perera et al., 2026; Sinaga & Baskoro, 2026). Unsupervised clustering of Sri Lankan equities reveals co-movement patterns misaligned with formal industry classifications and driven instead by shared liquidity, momentum, and sentiment shocks (Perera et al., 2026). Sentiment factors distort cross-industry returns (Kumar & S., 2024; Laopodis, 2024), industry volatility concentration predicts aggregate returns through attention and discount-rate channels rather than cash flows (Y. Zhang et al., 2024), and volatility spillovers propagate along sectoral boundaries (Fithriyana et al., 2025; Lou et al., 2024).

This literature is thinner and methodologically more varied than that reviewed in the preceding themes. Much of it is recent, drawn from smaller emerging markets, and not designed to test label effects for healthcare specifically. Its relevance to the present problem is nonetheless direct. If investors rotate into healthcare on the strength of its classification rather than on an assessment of its policy exposure, then the sector's perceived defensiveness and its actual risk profile need not coincide. The literature reviewed here does not establish such a divergence, but it provides a plausible behavioral basis for it: a sector label resting on demand stability could continue to attract defensive capital even where the conditions sustaining that stability, the pricing and fiscal decisions of the state, are shifting.

2.6 Synthesis of Literature

Read together, the five bodies of literature yield an apparent contradiction. Two of them, the evidence on defensive-sector behavior and the evidence on investor rotation, describe healthcare equities as insulated. Two others, the evidence on policy uncertainty and the evidence on state pricing interventions, describe the same firms as exposed. The insulation findings are robust within their scope: healthcare equities exhibit below-market systematic risk and have provided downside protection during contractions (Baltussen et al., 2026; Feder-Sempach et al., 2026; Mutinda & Langat, 2024), and investors treat the sector as a refuge accordingly (Batoryk & Viblyi, 2025; Goyal & Kansal, 2026). The exposure findings are equally consistent: policy uncertainty is priced as a distinct systematic risk, with amplified effects in industries that depend on government pricing and mandates (Helmi & Aljaid, 2026; D. Song & Zhao, 2025; Zhu et al., 2025), and where the state controls procurement and prices, interventions compress margins, reduce profits, and depress valuations (Ke et al., 2024; X. Li, 2025; Yan et al., 2025). The contradiction dissolves once the two sets of findings are understood as describing different dimensions of risk. Healthcare equities are insulated from the demand cycle but exposed to the state, and the literature has documented each dimension without examining how they interact.

The points of disagreement are informative. The fiscal effect of oil shocks on importing economies differs in sign across settings (Al-Sawaie et al., 2025; Banerjee, 2024; Cetin et al., 2026), consistent with the interpretation that

fiscal architecture, taxation versus subsidization of energy, determines whether an energy shock tightens or relaxes the budget constraint. Policy uncertainty likewise affects regulated firms in opposite directions depending on the content of the anticipated policy (Suyadal, 2025; X.-Q. Yang & Nie, 2024), and state pricing interventions redistribute value within the sector as well as reducing it (Qiu et al., 2025; Y. Yang et al., 2024). In each case, outcomes depend on institutional configuration rather than on the shock alone. Finally, the strongest link in the fiscal chain, that consolidation compresses health spending, is characterized as a discretionary policy choice (Castanheira et al., 2025; Maia et al., 2024). This places health-spending containment within the category of government action that equity markets are known to price.

2.7 Gaps in the Literature

The first gap is conceptual. The defensive-sector literature does not distinguish cash-flow stability that derives from the volume of demand from stability that depends on the price at which demand is monetized, and it therefore cannot identify the conditions under which state pricing power erodes defensiveness. The second gap concerns the evidentiary base. Sector-specific crisis evidence is concentrated on the COVID-19 pandemic, a health shock that raised demand for some healthcare products, and whether defensive properties hold under shocks of different origin, particularly energy shocks transmitted through public finances, is largely unexamined. The third gap concerns measurement: policy-uncertainty research rarely isolates healthcare as a sector and does not distinguish health-financing policy uncertainty from general economic policy uncertainty. The fourth gap concerns timing. State pricing interventions are studied as discrete structural reforms; whether their timing or intensity responds to the fiscal position of governments has not been investigated, and equity-level evidence remains thin relative to evidence on operating performance and innovation.

The fifth gap is the most consequential for the present problem. No retrieved study examines the full chain from energy shock to fiscal stress to health-spending containment to healthcare-firm valuation, and the constituent links are documented almost entirely outside Asia, even though Asian economies combine heavy energy-import dependence, widespread fuel subsidization, and state dominance of health financing. Finally, the possibility that classification-driven investor behavior sustains a gap between perceived and actual defensiveness has not been tested for healthcare.

2.8 Contribution of the Present Paper

This paper makes four contributions. First, it reconceptualizes the defensive status of healthcare equities as conditional rather than intrinsic, separating two sources of cash-flow stability: insulation from the demand cycle, and exposure to the pricing and expenditure decisions of the state. Second, it integrates literatures that have developed separately, namely asset pricing, policy uncertainty, health-financing intervention, public finance, and behavioral finance, into a single account of how healthcare-sector risk is constituted in state-dominated markets. Third, it specifies a fiscal-transmission channel through which energy shocks may reach healthcare valuations, extending mechanisms documented outside Asia to the institutional setting of Asian economies. Fourth, it develops a conceptual framework and propositions designed to be testable with market and fiscal data, providing a basis for future empirical work and for implications relevant to investors, securities regulators, and the design of fiscal and pricing policy. These contributions are advanced as theoretical propositions grounded in synthesis, not as empirically established findings.

3. Methodology

3.1 Research Design

This paper is a conceptual study employing integrative literature synthesis and theoretical framework development. It does not collect or analyze primary or secondary data, and it reports no empirical results. Its analytical findings arise from the comparison, integration, and interpretation of published evidence across several bodies of scholarship that bear on a common problem: the conditions under which healthcare equities retain or lose their defensive properties in Asian capital markets. A conceptual design was selected for three reasons. The central problem requires connecting literatures that have developed largely in isolation, namely asset pricing, policy uncertainty, health-financing intervention, public finance, and behavioral finance. The mechanism of interest, the transmission of an energy shock through public finances to the valuations of state-paid healthcare firms, has not been specified with sufficient precision to support direct empirical testing. And conceptual work is the appropriate stage at which to formulate propositions that subsequent empirical research can examine. Comparable conceptual designs have been used in healthcare management research to integrate fragmented literatures into a processual framework with testable propositions (R. G. Atento et al., 2025).

3.2 Literature Orientation and Retrieval Strategy

Literature was retrieved through structured searches of a large-scale academic search index covering peer-reviewed literature. The search logic was organized around five themes derived from the research problem, each operationalized through two closed-form guide questions framed so that they could be answered substantially as yes or no on the basis of published evidence, such as whether economic policy uncertainty affects stock returns or volatility, or whether fiscal consolidation reduces government health expenditure. The ten questions were designed to be broad enough to retrieve multiple studies and specific enough to exclude tangential work. The closed-form structure required the retrieval process to locate evidence bearing on a defined relationship rather than material merely associated with a topic, and it allowed contradictory or qualifying findings to surface alongside confirming ones. The questions were formulated without presuming their answers, and retrieved evidence was read for disagreement as well as convergence.

3.3 Source Selection and Inclusion Logic

Sources were retained according to four principles. The first was direct relevance to the relationship specified by a guide question. The second was scholarly provenance, which required a complete and identifiable bibliographic record. The third was a priority on financial and economic outcomes, such as returns, volatility, margins, profits, valuations, and fiscal balances; studies published in health-policy outlets were retained where they reported firm-level financial or market-structure outcomes, while studies whose primary outcomes concerned care quality, access, or clinical results were excluded as outside the paper's scope. The fourth principle permitted evidence from outside Asia where it documented mechanisms of general relevance, particularly for the fiscal links examined in the fourth theme, with its geographic origin reported explicitly where it bears on interpretation. Claims were incorporated only where they could be attributed to an identifiable published source. Where a reported finding could not be reconciled with the stated focus of the source to which it was attributed, the claim was excluded rather than reassigned.

3.4 Thematic Organization

The five themes were sequenced to build the argument cumulatively. The first establishes the foundational premise under examination, the defensive classification of healthcare equities. The second supplies the explanatory mechanism, the pricing of policy uncertainty and regulatory risk. The third provides the institutional context, the role of the state as payer and price-setter in Asian healthcare markets. The fourth addresses the central tension, the links between energy shocks, fiscal pressure, and health-expenditure containment. The fifth introduces the integrative behavioral dimension, the role of sector classification and investor perception. The sequence thus moves from foundational concept to mechanism, context, consequence, and integrative implication.

3.5 Theoretical Lenses and Analytical Procedure

The primary lens is financial economics, specifically the theory of sector risk, systematic exposure, and the pricing of cash-flow uncertainty. Supporting lenses are drawn from the political economy of regulatory risk, which informs how government action becomes a priced factor; from public finance, which informs how fiscal pressure shapes expenditure decisions; and from behavioral finance, which informs how classification heuristics shape investor allocation. Health-financing structure enters the analysis as institutional context only, because it determines the degree to which firm revenues depend on state decisions.

The analysis proceeded in four stages. Evidence within each theme was first synthesized to identify convergent findings, disagreements, methodological tendencies, and contextual variation. Findings were then compared across themes using a common set of criteria: the source of cash-flow stability, distinguishing demand volume from realized price; the institutional configuration, including payer concentration, regulatory predictability, and fiscal architecture; the origin of the shock under examination; sub-sector differences; and the level at which outcomes were measured, distinguishing operating performance from equity valuation. Apparent contradictions across the literatures were next resolved through conceptual decomposition; in particular, the coexistence of evidence describing healthcare equities as insulated and as exposed was reinterpreted as reflecting distinct dimensions of risk. Finally, propositions were derived through disciplined inference from the integrated synthesis, together with the boundary conditions under which they are expected to hold. Each proposition is identified as a theoretical claim requiring empirical examination, not as a finding.

3.6 Role of the Contemporary Context

The 2026 war and its energy and fiscal consequences serve as an anchoring context for the analysis rather than as an object of empirical study. Contextual material was drawn from news reporting, policy commentary, policy research, and budget reporting, and it is used to illustrate the institutional pathways the framework describes and to establish the practical relevance of the problem. This material does not serve as evidence for the propositions. Market episodes reported in commentary are cited to illustrate heterogeneity, not to establish regularities. Because the conflict and its consequences are ongoing, contextual facts are reported as of October 2026.

3.7 Limitations

Several limitations follow from the design. Retrieval relied on a single academic search index, so relevant studies not captured by that index, including work in non-indexed regional outlets and in languages other than English, may have been omitted. The review is integrative rather than systematic: it does not follow a formal protocol for identification, screening, and appraisal, and it makes no claim of exhaustiveness or reproducibility in the sense of a systematic review. Initial screening of evidence drew on index-generated summaries of retrieved studies, which may compress or generalize original findings; attributions were cross-checked against each source's stated scope, but residual imprecision cannot be excluded. The retrieved literature is weighted toward recent publications and varies in methodological rigor and outlet quality. The evidence is also geographically uneven: evidence on state pricing interventions is concentrated in China, and evidence on the fiscal links in the fourth theme was drawn almost entirely from outside Asia, so the extension of those mechanisms to Asian economies is an inference rather than an observation. Finally, as a conceptual study, the paper cannot establish the magnitude, timing, or prevalence of the relationships it proposes, which remain matters for empirical investigation.

4. Conceptual Analysis and Discussion

4.1 Decomposing Defensiveness: Demand Stability versus Cash-Flow Control

The synthesis in Section 2.6 identified an apparent contradiction: healthcare equities are described as insulated in one body of literature and as exposed in another. Resolving it requires decomposing the cash flows on which the defensive classification rests. At the simplest level, the revenue of a healthcare firm in period t can be expressed as the product of volume and realized price:

$$CF_t = Q_t \times P_t$$

Using a first-order approximation around mean values, the covariance of cash flows with aggregate market conditions M separates into two components:

$$\text{Cov}(CF, M) \approx \bar{P} \cdot \text{Cov}(Q, M) + \bar{Q} \cdot \text{Cov}(P, M)$$

This expression is a heuristic device for organizing the argument, not an estimated model. Its value lies in what it makes explicit. The conventional defensive argument concerns the first term: because demand for medicines and care is relatively inelastic, the covariance of volume with market conditions is small, and this is the property the evidence in Section 2.1 confirms (Mutinda & Langat, 2024; Ramakau et al., 2025). The argument implicitly assumes that the second term is also negligible, so that realized prices do not covary with market conditions. That assumption is reasonable where prices are set competitively or negotiated with fragmented private payers. Where the state is the dominant payer and price-setter, however, realized price becomes a policy variable, and its covariance with market conditions depends on whether the policy decisions governing it are themselves related to the economic cycle. The defensive classification therefore describes the first component of risk while leaving the second unexamined.

This decomposition yields the paper's central distinction between **demand stability** and **cash-flow control**. Demand stability is a property of the sector. Cash-flow control is a property of the institutional setting: it concerns who determines the price at which stable demand is monetized. A healthcare firm can possess the first while lacking the second, and the defensiveness of its equity is then conditional on the behavior of whoever holds that control.

4.2 The Policy-Dependence Mechanism

Where cash-flow control rests with the state, three features determine the degree of policy dependence. The first is payer concentration, the share of firm revenue determined by state pricing, reimbursement, or procurement decisions. The second is the instrument through which control is exercised, such as statutory price ceilings, centralized tenders, formulary negotiation, reimbursement schedules, or the timing of payments and transfers. These instruments

differ in how directly they transmit to margins: centralized procurement compresses markups and profits even when volume is guaranteed (Ke et al., 2024; Yan et al., 2025), statutory price cuts can reduce sales of affected product lines sharply (Choi et al., 2025), and price caps can depress volumes as firms withdraw promotional effort (Jaikumar et al., 2024). The third is predictability, whether interventions follow known rules and schedules or arrive as discretionary shifts. Predictability is in turn shaped by broader governance conditions; benchmarking of the Philippines against ASEAN-6 peers, for example, finds persistently fragile governance indicators alongside volatility-sensitive external exposure (R. G. Atento, 2025a).

Predictability matters because of how policy risk is priced. The evidence reviewed in Section 2.2 indicates that policy uncertainty constitutes a distinct systematic factor and that its effects are amplified in industries dependent on government pricing and mandates (Helmi & Aljaid, 2026; D. Song & Zhao, 2025; Zhu et al., 2025). A predictable administered price compresses the level of cash flows but adds little uncertainty; a discretionary one adds both.

Policy dependence also operates on the distribution of outcomes within the sector, not only on its average. Pricing interventions concentrate market share among scale producers, penalize marginal firms, and induce strategic reallocation toward unregulated channels and higher-margin products (Qiu et al., 2025; T. Wang, 2026; Y. Yang et al., 2024), while firms signalling strong research capability experience more moderate valuation effects (Qiu et al., 2025; Xu et al., 2026). The implication is that policy dependence raises within-sector dispersion, which is consistent with the evidence that healthcare equities carry substantial idiosyncratic volatility despite low betas (Parmar, 2026). Descriptive evidence from the Philippine equity market likewise documents wide sectoral valuation dispersion and cross-sectional heterogeneity that index-level performance masks (Reyes et al., 2026). An investor holding the sector as a defensive aggregate may therefore bear policy risk that is partly diversified at the index level but concentrated in particular holdings.

4.3 The Fiscal-Transmission Channel: From Energy Shock to Healthcare Repricing

Policy dependence becomes cyclically consequential if the decisions governing realized prices vary with fiscal conditions. The literature reviewed in Section 2.4 supports the constituent links of such a channel but not the channel as a whole, which is therefore specified here as a conceptual sequence. An energy-price shock first imposes a fiscal burden whose sign depends on fiscal architecture: where energy is taxed, revenues may rise with prices (Cetin et al., 2026), whereas where energy is subsidized, expenditure rises instead (Al-Sawaie et al., 2025). In subsidy-based regimes, the shock narrows fiscal space, a pressure compounded by deteriorating external balances in import-dependent economies (Ali et al., 2025; Rai & Garg, 2026). Narrowing fiscal space in turn raises the probability of expenditure containment, of which health spending is a recurrent target, and that containment is characterized as a discretionary policy choice rather than an automatic consequence of downturn (Castanheira et al., 2025; Cerón, 2024; Maia et al., 2024). Containment then reaches healthcare firms through the instruments identified in Section 4.2, including reimbursement adjustment, procurement price pressure, delayed transfers, or reduced allocations for medicines and devices (Maia et al., 2024; Ortíz-Prado et al., 2026). Finally, to the extent that markets price policy risk, valuations adjust to the change in expected cash flows and to the increase in uncertainty surrounding them.

The analytically important feature of this channel is its timing relative to the fast channel of an energy shock. The fast channel, comprising input-cost pressure and risk-off rotation, operates within days or weeks. The slow channel operates through budget cycles, supplementary appropriations, and payer decisions, and therefore unfolds over quarters. The two channels may consequently produce opposite signals at different times. In the initial phase, healthcare equities may behave defensively as capital rotates toward the sector; as fiscal pressure accumulates and is transmitted through payer decisions, the same equities may face repricing that the initial rotation did not anticipate. Under this interpretation, the heterogeneous early responses reported during the 2026 shock describe only the first channel and are uninformative about the second. This is a conceptual implication, not an observation; whether such a sequence occurs is an empirical question.

4.4 A Typology of Healthcare Equity Exposure Regimes

The preceding analysis implies that the defensive properties of healthcare equities vary systematically with institutional configuration. Two dimensions, payer concentration and the predictability of pricing and expenditure policy, are sufficient to distinguish the four exposure regimes summarized in Table 1.

Table 1. *Healthcare equity exposure regimes*

	High policy predictability	Low policy predictability
Low payer concentration	Market-defensive. Cash flows track demand; the conventional defensive classification is most applicable.	Fragmented-volatile. Exposure runs through household budgets and erratic regulation rather than state payment; shocks transmit via household finance more than fiscal channels.
High payer concentration	Administered-stable. Policy compresses the level of cash flows but adds limited uncertainty; defensiveness is preserved at lower expected growth.	Policy-exposed. Cash flows depend on discretionary state decisions; defensiveness is most conditional and the fiscal-transmission channel is strongest.

Note. Fiscal architecture (subsidized versus taxed energy) moderates the strength of the fiscal-transmission channel within the high-concentration regimes. Regimes describe institutional configurations, not countries. Source: Authors' conceptual synthesis.

Fiscal architecture acts as a moderator across the high-concentration regimes. Where energy is subsidized, an energy shock is more likely to activate the fiscal channel; where it is taxed, the same shock may relax the budget constraint (Banerjee, 2024; Cetin et al., 2026). The typology classifies institutional configurations, not countries. National healthcare markets are likely to contain segments in different regimes, since centrally procured generics, negotiated innovative therapies, private hospital services, and export-oriented manufacturing may each occupy a different cell within the same jurisdiction. The assignment of specific markets or segments to regimes is an empirical task the typology is designed to structure, not to pre-empt.

4.5 Propositions

The integrated synthesis supports five propositions. Each is a theoretical claim requiring empirical examination.

Proposition 1. The defensive properties of healthcare equities are weaker in markets and segments where a larger share of firm revenue is determined by state pricing, reimbursement, or procurement decisions.

Proposition 2. In state-dominated healthcare markets, the return sensitivity of healthcare equities to policy uncertainty, and particularly to uncertainty concerning health-financing policy, exceeds that of healthcare firms in privately priced segments.

Proposition 3. In energy-importing economies that subsidize energy, deterioration in fiscal balances following an energy-price shock is associated with subsequent tightening of health-sector pricing, reimbursement, or expenditure, with a lag relative to the initial market response.

Proposition 4. The defensive performance of state-paid healthcare equities during energy shocks is time-varying, such that relative resilience in the initial phase may give way to relative underperformance as fiscal pressure is transmitted through payer decisions.

Proposition 5. Investor rotation into healthcare during periods of uncertainty responds more strongly to sector classification than to firm-level policy exposure, so that the relative valuations of policy-exposed healthcare firms may not fully reflect their exposure to fiscal conditions.

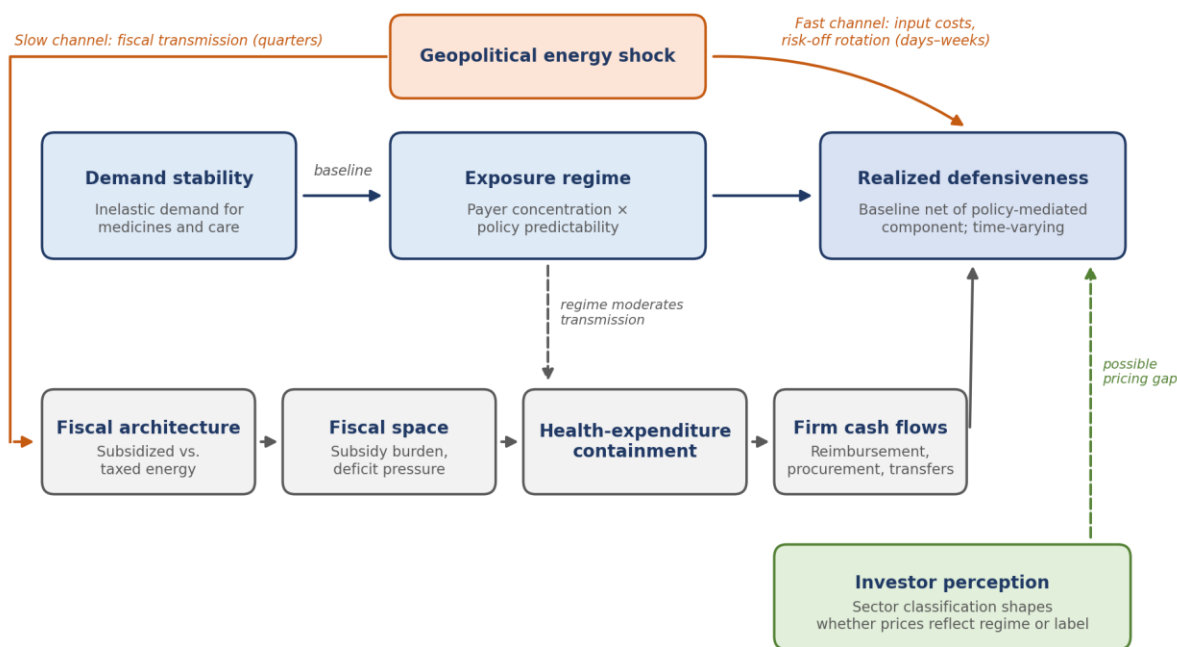
Propositions 1 and 2 follow from the decomposition in Section 4.1 and the pricing evidence in Sections 2.2 and 2.3. Propositions 3 and 4 formalize the fiscal-transmission channel. The expectation of regime-dependent rather than fixed relationships is consistent with macroeconomic evidence that the inflation–growth relationship in China and the Philippines changes across inflation regimes (Chen & Atento, 2026). Proposition 5 draws on the behavioral evidence that classification and sentiment shape allocation and comovement beyond fundamentals (Batoryk & Viblyi, 2025; Perera et al., 2026; Y. Zhang et al., 2024).

4.6 The Conditional-Defensive Framework

The analysis integrates into a single framework, depicted in Figure 1. Demand stability establishes baseline defensiveness, the sector property that the conventional classification describes. The exposure regime, defined by payer concentration and policy predictability, determines how much of that baseline survives the transfer of cash-flow control to the state. External shocks enter through two channels with different timing: the fast channel of input costs

and capital rotation is immediate, while the slow channel of fiscal transmission is moderated by fiscal architecture and unfolds through budget cycles. Investor perception, shaped by sector classification, determines whether market prices reflect the exposure regime or the baseline label alone. The framework's output is realized defensiveness, understood as the baseline property net of the policy-mediated component and variable over time rather than fixed.

Figure 1. *The conditional-defensive framework*



Note. Solid arrows denote proposed relationships; dashed arrows denote moderating or perceptual influences. The fast channel operates over days to weeks; the slow channel operates over quarters through budget cycles and payer decisions. Source: Authors' conceptual synthesis.

The framework's central claim follows. Healthcare's defensive status is neither a myth nor a constant. It is a conditional property whose strength depends on who controls realized prices, how predictably that control is exercised, and the fiscal pressure under which it is exercised.

4.7 Boundary Conditions

The framework's scope is limited in several respects. It applies to firms whose revenues depend materially on domestic state payers; firms deriving revenue substantially from export markets are exposed to the payment and pricing systems of other jurisdictions, and the domestic fiscal channel applies to them weakly, if at all. Firms with patented or differentiated products may hold negotiating leverage that moderates policy exposure, consistent with the evidence that research capability attenuates valuation effects (Qiu et al., 2025; Xu et al., 2026). The fiscal channel presupposes a subsidy-based fiscal architecture; in energy-exporting economies, or where energy is heavily taxed, an energy shock may relax rather than tighten fiscal constraints. The channel may also reverse under shocks of health origin, since in a pandemic public health expenditure tends to rise rather than fall, which is consistent with the defensive performance observed during COVID-19 (Feder-Sempach et al., 2026; Perroni et al., 2025). Legal earmarking or political protection of health budgets may slow containment, although the evidence that real health spending can stagnate despite formal safeguards suggests that such protection is imperfect (Federspiel et al., 2026). Finally, the framework concerns the pricing of healthcare-sector risk in capital markets; it makes no claims about the consequences of containment for health outcomes, which lie outside its scope.

5. Discussion and Implications

5.1 Theoretical Implications for Sector-Risk Classification

The principal theoretical implication concerns the basis on which sectors are classified as defensive. Conventional classification rests on the demand properties of industries. The analysis in Section 4 suggests that this captures only one of two dimensions governing cash-flow stability; the second, cash-flow control, is a property of the institutional setting rather than of the industry. If this is correct, defensiveness is better understood as an institutional property than as an industry property, and the same sector may be robustly defensive in one market and conditionally defensive in another, depending on who determines realized prices and how predictably they do so. A similar logic extends beyond healthcare: the valuation of regulated electric utilities, for instance, has been interpreted in light of the regulated and capital-intensive environment in which they operate (Espina & Atento, 2026).

Two further implications follow. Risk characteristics estimated in one institutional regime may not transfer to another, so that sector betas from privately priced markets are an unreliable guide to the behavior of healthcare equities in state-dominated ones. Cross-country evidence points in a similar direction, documenting substantial dispersion and asymmetry in market valuations relative to their historical benchmarks (R. G. Atento & Atento, 2025a). Risk characteristics estimated during one type of shock may likewise not transfer to another: because the crisis evidence on healthcare defensiveness is concentrated on a health shock that raised demand for some healthcare products, it may systematically overstate the sector's resilience to shocks of fiscal or energy origin. More broadly, the framework connects asset pricing to public finance in a way the existing literature has not. If the policy component of healthcare cash flows covaries with fiscal conditions, and fiscal conditions covary with the cycle, then the sector's defensiveness is partly endogenous to the fiscal cycle. That is a claim about the structure of risk, not merely about its level.

5.2 Implications for Investors and Portfolio Construction

For investors, the analysis implies that healthcare should not be treated as a homogeneous defensive allocation in Asian markets. Asian capital markets are themselves heterogeneous, with ASEAN markets moving in structurally divergent rather than converging directions over the past decade and a half (Chen et al., 2026). Two firms with identical demand profiles may carry very different risks. Where the propositions hold, the relevant distinctions run within the sector: the share of revenue paid by domestic state payers, exposure to centralized procurement or statutory pricing, reliance on export markets, and the degree of product differentiation. Because pricing interventions raise within-sector dispersion, security selection may matter more than sector allocation for investors seeking defensive exposure. This is consistent with Philippine evidence that firm-level fundamentals, particularly cash-flow-based valuation, help discriminate among listed stocks by relative price performance (R. G. Atento & Atento, 2025b).

The fiscal-transmission channel also has implications for investment horizon. If the slow channel operates through budget cycles, the hedging value of state-paid healthcare equities during a prolonged energy shock may decay over time even when it appears robust in the initial phase. Under this interpretation, fiscal indicators such as subsidy outlays, deficit revisions, and proposed allocations to state health payers function as potential leading indicators for the cash flows of policy-exposed healthcare firms. Investors relying on sector labels alone would be positioned to observe the fast channel but not the slow one.

5.3 Implications for Securities Regulators and Disclosure

The analysis bears on disclosure in two respects. The policy exposure of healthcare firms is material to valuation but is not consistently visible to investors. Disclosure of the share of revenue derived from government payers, and of exposure to procurement and reimbursement decisions, would allow markets to distinguish exposure regimes rather than pricing the sector as an aggregate. Enhanced disclosure standards have also been recommended for the Philippine equity market more generally, where valuations appear to reflect investor sentiment as much as fundamentals (R. G. Atento, 2025b). In addition, investment products marketed on the basis of defensive sector characteristics, such as sector funds and index products, may convey a stability that is conditional on institutional factors the label does not describe.

These concerns are sharpened by the evidence of substantial retail participation in healthcare equities (Goyal & Kansal, 2026). Philippine survey research on individual investment decisions has examined risk tolerance, capital-market knowledge, and government trust as predictors, with government trust rated comparatively low among respondents (Lantin-Magana et al., 2026). If, as Proposition 5 suggests, rotation into the sector responds to classification more than to underlying exposure, the gap between perceived and actual defensiveness is likely to be borne disproportionately by investors least equipped to assess policy risk. Whether this warrants regulatory

intervention depends on empirical evidence the present paper cannot supply, but it is an issue that investor-protection frameworks are positioned to examine.

5.4 Implications for Fiscal and Pricing-Policy Design

The analysis also has implications for policymakers, though these concern the financial consequences of policy design rather than health outcomes. The first concerns predictability. The evidence that policy uncertainty raises financing costs and crash risk for regulated firms (Qian & Poshakwale, 2025; D. Song & Zhao, 2025) implies that discretionary, fiscally driven containment carries a cost beyond its direct effect on firm revenues: it may raise the cost of capital for the sector and thereby affect investment in productive capacity. Rules-based approaches, such as scheduled price revisions, transparent pricing formulas, and published procurement calendars, could achieve comparable cost containment with less policy uncertainty, moving segments from the policy-exposed regime toward the administered-stable regime.

The second concerns fiscal architecture. Reliance on energy subsidies creates a pathway through which energy shocks are transmitted into the finances of the health sector, a pathway that arises not from any feature of healthcare markets but from the way the budget absorbs energy prices. Fiscal buffers, contingency provisions for energy shocks, or protected funding arrangements for state health payers would weaken this linkage, though each involves trade-offs that lie beyond this paper's scope. The broader point is that policymakers face a trade-off rarely made explicit: short-run fiscal savings from discretionary health-sector containment may be partly offset by higher risk premia and financing costs across the sector.

5.5 Theoretical Boundaries and Limitations

The framework and propositions are conceptual and untested. They specify relationships and conditions; they do not establish magnitudes, timing, or prevalence. The evidentiary foundation is uneven: evidence on state pricing interventions is concentrated in China, and evidence on the fiscal links of the transmission channel comes almost entirely from outside Asia, so its extension to Asian economies is an inference that requires direct examination. The decomposition in Section 4.1 is a first-order heuristic. It concerns revenue rather than profit, it omits the cost side of firm cash flows, which the fast channel of an energy shock affects directly, and it ignores interactions between volume and price, such as the volume guarantees attached to procurement tenders. The two-dimensional typology necessarily simplifies institutional variation that is, in practice, continuous and segment-specific. Finally, the 2026 conflict is ongoing, and its contextual role in this paper is illustrative; nothing in the analysis depends on, or establishes, any particular account of how its fiscal or market consequences will unfold.

6. Conclusions and Recommendations

6.1 Conclusions

This paper asked under what conditions the defensive characterization of healthcare equities holds in Asian capital markets, and how the state's role as payer, price-setter, and regulator, together with the fiscal pressure generated by geopolitical energy shocks, shapes the risk profile that investors price. The answer the analysis supports is that healthcare's defensive status is conditional rather than intrinsic. The literature establishes that healthcare equities are insulated from the demand cycle, with low systematic risk and well-documented downside resilience. It equally establishes that firms whose revenues depend on government pricing and procurement are exposed to policy decisions that markets price as a distinct source of risk. These findings are not contradictory; they describe two different dimensions of risk.

The paper's central conceptual move is to separate demand stability, a property of the sector, from cash-flow control, a property of the institutional setting. Where the state determines the price at which stable demand is monetized, the sector's defensiveness depends on how that control is exercised. Three further insights follow from this distinction. Policy exposure varies systematically with payer concentration and policy predictability, which together define distinct exposure regimes in which the conventional defensive classification applies with very different force. In energy-importing economies that subsidize energy, a geopolitical energy shock may reach healthcare valuations through a slow fiscal-transmission channel, running from subsidy burdens to narrowing fiscal space to health-expenditure containment to firm cash flows, that unfolds after, and may run counter to, the immediate defensive rotation into the sector. And if investors allocate to healthcare on the strength of its classification rather than its policy exposure, perceived and actual defensiveness may diverge, most of all in the conditions where investors rely on the

sector most. These conclusions are advanced as theoretical propositions grounded in literature synthesis; they have not been empirically confirmed.

6.2 Limitations

The paper's conclusions are bounded by its design and evidence base. The review is integrative rather than systematic and draws on a single academic search index. The evidence on state pricing interventions is concentrated in China, and the evidence on the fiscal links of the transmission channel comes almost entirely from outside Asia, so its application to Asian economies is inferential. The analytical decomposition is a first-order heuristic that addresses revenue rather than profit, and the typology simplifies institutional variation that is segment-specific in practice. The 2026 conflict that anchors the analysis remains ongoing, and its role is illustrative rather than evidentiary.

6.3 Directions for Future Research

The propositions are designed to be testable, and several lines of empirical work follow from them. Propositions 1 and 2 could be examined by estimating whether the share of firm revenue paid by government payers moderates the market betas and downside performance of healthcare equities across Asian markets. The development of a text-based index of health-financing policy uncertainty for major Asian markets would allow this form of uncertainty to be distinguished from general economic policy uncertainty and its pricing to be estimated directly. Propositions 3 and 4 could be examined by combining panel data on healthcare equity returns with fiscal indicators, such as subsidy outlays, deficit revisions, and proposed allocations to state health payers, across the 2026 energy shock, with particular attention to the lag between initial market responses and subsequent payer decisions. Comparisons of export-oriented and domestically paid firms, and of differentiated and centrally procured product segments, would test the framework's boundary conditions. Studies of fund flows and retail trading could establish whether rotation into healthcare responds to sector classification independently of firm-level exposure, as Proposition 5 suggests. Finally, the empirical assignment of Asian markets and market segments to the proposed exposure regimes would provide a foundation for each of these lines of inquiry.

6.4 Recommendations

The following recommendations are offered in proportion to the conceptual nature of the evidence. Investors in Asian healthcare equities should look through the sector label to the institutional sources of each firm's cash flows, including the share of revenue paid by domestic state payers, exposure to centralized procurement and statutory pricing, and reliance on export markets. During prolonged energy shocks, they should monitor fiscal developments as potential leading indicators for policy-exposed holdings rather than treating initial defensive performance as durable.

Securities regulators should consider whether disclosure of revenue derived from government payers, and of exposure to procurement and reimbursement decisions, would improve the pricing of healthcare-sector risk. They should also consider whether investment products marketed on defensive sector characteristics adequately convey the conditional nature of that defensiveness, particularly given substantial retail participation in the sector.

Fiscal and pricing authorities should recognize that the predictability of health-sector pricing and expenditure policy has capital-market consequences. Rules-based mechanisms such as scheduled price revisions, transparent formulas, and published procurement calendars can contain costs while limiting the policy uncertainty that raises financing costs for the sector. Where fiscal architecture links energy prices to the budget through subsidies, contingency provisions or protected funding arrangements for state health payers would weaken the transmission of energy shocks into health-sector finances, though each involves trade-offs that warrant evaluation in specific national contexts.

For researchers, the principal recommendation is to treat the defensive classification of healthcare not as a settled premise but as a conditional hypothesis whose validity depends on the institutional and fiscal setting in which it is tested.

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