GSK plc

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Graham Parry Analyst

Good morning, everybody, and welcome to Session 2 of the second day of the Bank of America Global Healthcare Conference today. It's my pleasure to be able to introduce our first European company this orning, which is GSK. And from GSK, we've got Emma Walmsley, CEO. We also have a new CFO, Julie Brown, sitting in the front here, and Nick from IR as well. So perhaps, Emma, welcome.

It's a pleasure to have you here as always, an annual event. Perhaps it would be worthwhile, just a couple of opening remarks from you, just thoughts on where GSK is at the moment and where you're executing against your plan.

Emma Walmsley Executive

Yes. Well, first of all, thank you very much, everybody, for joining us this morning. Great to see you. And I would say the headline is we're feeling good. We are delivering on all of the commitments that we've laid out in the transformation journey for GSK, most foundationally a step change in operating performance.

Kicked off, following on from the separation of -- the successful separation of Haleon. That step change starting with a very strong year in 2022 and a very strong first half of 2023, driven by our innovation and a shift in our portfolio to innovative vaccines and specialty care. I think in the first half of the year, we're heading towards GBP 5 billion of sales from products that were launched just from 2017, and that's GBP 1 billion more than it was last year, and really pleased with the progress. Always more work to do, but on the pipeline and the support and the ambitions for the growth ahead. So absolutely delighted to be launching the world's first approved vaccine for RSV.

Hopefully, in coming weeks, we will be getting to the approval of momelotinib in myelofibrosis. We have lots of other areas of data around some of our core assets that we continue to build with indication expansion and new data, so new data on Nucala, data on Shingrix in China with 100% efficacy, ongoing new news emerging for Jemperli, too.

So really pleased at Q2 to be giving -- to be delivering double-digit growth and an upgraded outlook, but most importantly, because I try not to be short-term focused, just feeling strong not only about the outlook to '23 but the prospects for the strong and competitive outlook we've given through to '26, which is a big step change for us. And maybe most importantly, and I'm sure you will come for that, our prospects through the end of the decade and real ability to digest the patent profile that we have.

Graham Parry Analyst

And actually, just on the guide. So you've got a 2021 to 2026 guidance at the moment, we're sort of in the middle point of that. So when is an appropriate time to update? Obviously, Arexvy is now launched, and that's a big part of that and we'll come on to that because it's looking -- there's a lot of prescriptions going ahead at the moment. But when is the right time to think about addressing the guide and thinking about the guide towards the end of the decade?

What bits do you need to have clarity on to be able to think about doing that?

Emma Walmsley Executive

Well, first of all, the guidance we give is on an annual basis, and we've given guidance for the 5-year outlook. And as a reminder, it's a floor guidance. So it says more than 5 and more than 10, and then we update, and I am delighted to have Julie in the room with us, watching carefully what I say. So we will update you in February on an annual basis. We're still -- we're incredibly pleased with the momentum the first year of that last year, we're halfway through the second year of 5 years, and we feel really good about our prospects there.

So we'll update you annually on what we're looking at. And the outlook and the ambition for 2031, which we laid out in June '21, I would say, our confidence just gets stronger and stronger, and again, that was a floor outlook. From a sales point of view of doing more than 33. Obviously, the building blocks because that's what happens in our industry, you have some things that go much better than you expect and other things that don't work out. That's normal.

But net, we're in a stronger position now than we were in '21. We're giving several updates through this year. We tend to do it by therapy area. We have another one coming up on HIV. And I think as Julie laid out in the road map of Q2, in our Q4 results will kind of make sure that we bring visibility to those building blocks through a variety of meetings through this year and keep you informed of how we're doing against what we said we'd be doing in June '21.

Graham Parry Analyst

I think let's go to one of the bright spots, so Arexvy.

Emma Walmsley Executive

There are many bright spots.

Graham Parry Analyst

This is definitely the one in focus at the moment. I think that obviously good data launched, The initial prescription data looks extremely strong. If we sort of track it against Shingrix, it looks like it's doing significantly better in the first few weeks than even Shingrix. So -- but obviously, it's a different dynamic. It's a more seasonal vaccine, et cetera.

So perhaps just help us through your kind of initial thoughts on that, those initial few weeks and, I guess, the sustainability of the sort of strength and launch that you're seeing.

Emma Walmsley Executive

Well, first of all, we think this is a very important launch for patients and for GSK. It is early days, and I wouldn't be drawing those kinds of comparisons, but we feel very positive about it. Most of all because we have great efficacy and we think a differentiated profile. We have our adjuvant in the asset, and we are bringing an enterprise approach to the launch. This is a market that will be driven mainly by the retail market for all sorts of reasons that's in the interest of retailers and payers and everything that the world has learned in terms of adult vaccination over the last few years.

There is no question that 94% efficacy amongst those with comorbidities resonates well with health care professionals, simply because those are the ones that represent over 90% of the burden in hospitals. So that matters. We have a label with co-admin. We believe because RSV is a reasonably stable virus, that there is value in being a longer duration protection vaccine, and that second season data will come through. But we've always said that this is a -- should not -- you should not expect the overall ramp that you would have with Shingrix for several reasons, but not least we're not alone in this market and the awareness of RSV versus shingles from a consumer point of view as a bit lower.

But we're really pleased with the start and we'll look forward to updating you with more visibility at the next quarter results and beyond that. I mean this is a long run. Remember, this is an asset we think is GBP 3 billion of sales over time. And it's one of the important additional building blocks, demonstrating our leadership in vaccines technology and the real opportunities of profitable growth through adult vaccination, which we see both in -- at a time when the external environment, regulatory environment is what it is for our industry. There are very few places where it's better to be than in adult vaccination simply because preventing disease is just better for payers, government budgets, burdened health care systems and most of all patients.

The U.S. spends GBP 9 billion a year on vax treating people with vaccines preventable diseases. And you're just seeing these trends -- positive trends in terms of governments looking at the opportunity in the prevention agenda. If you think about, it's where science is moving on in most of our sectors. So lots of opportunities for RSV and the building blocks beyond that in mRNA and pneumococcal.

Graham Parry Analyst

So in terms of the ACIP recommendation for Arexvy, I think the original plan was scale for a full broad recommendation and it has a shared clinical decision-making recommendation. That doesn't seem to be holding it back at the moment. So is this because what we're seeing is there's a very clearly defined at-risk patient population you highlight in the comorbid population where you've got that very strong data? And so there's an initial pool of adults that are obviously going to be highly motivated or their clinicians are going to be highly motivated to get them on to the vaccine? And then does it get a bit harder after that?

And do you have any sort of sense of the -- how big that pool is?

Emma Walmsley Executive

Undoubtedly, the people who put themselves at the front of the queue are there with motivation, so there will definitely be those. We always see that in the vaccines. You can -- it's a consumer market and you can subsegment it. And so the kind of super enthusiasts, I will, when I remember the -- if I get fronted and advised right the way through to those that foundationally don't believe and fundamentally object. So of course, that's true.

All of that said, there are 77 million Americans who -- for whom this could be a relevant vaccine. Of course, we'd rather have had been in a position where it was recommended for everybody upfront. But health care professionals include pharmacists. So in a world where most of the market will be in retail and seriously intelligent people who are data led, you can argue that when you're double clicking on the details of the data, that's not unhelpful on a relative basis for us. So -- but there's no question it would be preferable to have a broader recommendation.

And we think over time, we'll get there. We've got more data coming through, whether it's the [5059] cohorts, we will hope to get 2 seasons in the label next year. As I said, we still think there's opportunities in the multi-season space here, and we have ongoing clinical programs on this as well. So let's keep an eye on that. And by the way, everybody will always focus on the U.S.

market, rightly because it's the biggest. But just from our experience in adult vaccination big assets, it's really important not to lose sight of the opportunity for both launches and growth ex U.S. And I think that's one of the differences -- you alluded to Shingrix earlier. That's one of the differences with Shingrix, where not least because we readied ourselves from a supply point of view, we'll see earlier international launches as well.

Graham Parry Analyst

Yes. Actually, I was going to ask that, about manufacturing. So a question I'm getting a lot at the moment just given the trajectory on the initial prescriptions, is there any manufacturing restraint here? I know in the past, you talked about being able to meet demand in the Shingrix capacity being helpful for Arexvy as well. But just perhaps an update on that just given perhaps a faster launch than most people were expecting.

Has that taken GSK by surprise? And are we still okay on manufacturing supply?

Emma Walmsley Executive

Yes. We've been reasonably consistent, I think, Graham, on our views on the ambition for this. It won't be as fast as Shingrix. It's going to be very big. It will have a different profile, both in geographic spread and growth rates, and we will make sure we do not have any supply problems because it's also a competitive situation.

So I am not -- of the things I worry about, but it's not that.

Graham Parry Analyst

Yes. And then just in terms of contracting with pharmacy chains, obviously, you're in a technically in a battle with Pfizer there. But actually, is this just everybody is taking both because it's just a big open market at the moment. There's no sort of individual contracting or anything like that.

Emma Walmsley Executive

Well, of course, we have contracts with our pharmacy change, but I don't think we should overdo that fact. I like competition. Competition is good for the -- the big question is how big can this market be and at what pace. And having serious quality invested competitors is better for the size of the market. It's definitely better for patients.

It's better if you have a better profile. And it's not unhelpful internally.

Graham Parry Analyst

And then just in terms of the revaccination rate, you touched on it before. You said you hope to get 2 seasons on the label. So do we have to wait now for 2 season dates come through or 3 seasons dates will be to come through next year. And then if we see a benefit of a revaccination after 2 years, is that -- you then file -- and what's the time frame for getting that on the label then? Can you do that in time for that season?

Emma Walmsley Executive

Well, I think we will probably look to file 2 season data, which we've seen this year so we get that in the label for the next year. That would be the plan.

Graham Parry Analyst

Okay. And then any thoughts...

Emma Walmsley Executive

Obviously, then we have first season data coming later.

Graham Parry Analyst

And then any thoughts on longer-term competitive dynamics. So I know you talked about this is a GBP 3 billion opportunity and you've got you and Pfizer there, but Moderna's got an mRNA vaccine. Sanofi is now actually going into Phase IIb with a triple RSV, hMPV PIV. It looks like it's sort of all -- the capacity of dynamic market might be picking up. So to what extent is

there a first mover advantage from just being the first established product, do you think?

Emma Walmsley Executive

I think it's -- as it ever was in this sector, there's first-in-class and best-in-class and you try and do both. I mean, the key for us is continuing to do our work on the clinical program. And by being first, you're always going to be a bit further ahead on the multi-season question, which is one of the areas of differentiation. Of course, that also impacts the cohorts and the geographic launches will impact the cohorts. And if you've been vaccinated this year, you won't be worried about it when someone else launches next year.

So...

Graham Parry Analyst

Okay. Any others on Arexvy in the room before I move on to Shingrix? So -- okay, so let's talk about Shingrix. So Shingrix, obviously, at the other end of the curve is much more fully penetrated now. And it stalled a bit in Q2.

Perhaps you can just talk through the dynamics of what was happening there in the U.S., I think it was down 10% year-on-year. So you sort of hit full penetration with some accounts. But what's the outlook for Shingrix in the sort of broader market? Do you think you can still continue to grow this in the U.S.?

Emma Walmsley Executive

Coming through in the U.S. alone, and we're less than 3% penetrated ex U.S. and Germany, I think. So we're a long way from this vaccine having reached everyone who could benefit from it. When you simply think that 1 of the 3 of us can suffer from shingles and it's horrible, and this has phenomenal efficacy over a sustained period.

I mean, I think we're at least 10 years, and we're going to get a readout on 12 coming through. We just had data come through in China of 100% efficacy, which is not unhelpful in the market that's got 100 million over 50s who we think are relevant for the private market. Obviously, people can get very excited about the democratic in China. But that's a market that's not far off being the size of the U.S. market.

So I just -- I think we need to be careful about the assertion of fully penetrated. Now that said, it gets a hell of a lot harder, back to your earlier comments on the sort of cohorts of the super enthusiast boluses versus the -- it gets harder and it gets a bit more expensive to penetrate in the U.S. Actually, our TRxs in the U.S. I think were plus 8% last quarter regardless of where the reporting was. But there is no question that, that growth will eventually peak.

Just to remind you, at a total level, Shingrix had another record quarter, and we expect this to be another record year. And we expect it to be an asset that will be at least GBP 4 billion. And 90%, I think, of the growth last quarter was ex U.S., but there is still room, as I said, for penetration. It would just be a slightly differently shaped curve. And we're really thoughtful about other ways that we can expand and fuel the growth, in which I can get to if you want to, but room for more for sure.

But the really important thing is vaccines, this -- even when it does reach a peak and we have room to go at a total level for that for sure, that doesn't then fall off a cliff. We believe this is an asset that will be a multibillion asset through the end of the decade. And the key point is what's coming next in our profitable vaccines cohort. And that's when you add RSV, you add an mRNA, and these are all multibillion opportunities which we still have to have further data readouts. But you add mRNA.

We add pneumococcal, which was the great -- which will be more towards the end of the decade but a massive market, and that's what we think -- in pneumococcal, where we think we have a truly differentiated asset. That's a bit further out. So I couldn't be more excited about our prospects and our portfolio. Our technology differentiation and the return on all of that, that's going to come in our adult vaccination portfolio, which is exactly why strategically, we wanted to shift more here because it's good for everyone, and it's real deep know-how for GSK, more here, and in certain tiers in Specialty Medicines as well. Because it's a very profitable business as well as a sustainable.

Graham Parry Analyst

Yes. So at that point about the ex U.S. and China being as big as the U.S. I think if you look...

Emma Walmsley Executive

Not quite...

Graham Parry Analyst

Or potentially -- hypothetically. So if you look at the opportunity there and sort of your confidence in penetrating, I think if you look at consensus numbers at the moment, I think consensus has U.S. peaking in 2026 when you start to see a slowdown because you're more fully penetrated at that point and not -- and it doesn't have the rest of all catching up and driving growth on that point. So do you think there's an opportunity here to actually keep growing Shingrix beyond 2026 through ex U.S. markets?

Or is this more about stabilizing it or sort of seeing it just declined at a slower rate as U.S. slows down and rest of world continues to grow?

Emma Walmsley Executive

Well, I'm not going to sort of do an annual marker of the forecast. I suppose the key point that I'm saying is it will remain a multibillion asset. We have plenty of room for growth ex U.S. U.S. isn't done.

And at an overall level, it will be -- it is -- it will continue to contribute meaningfully to our overall P&L and profitable delivery.

Graham Parry Analyst

And ex U.S., a lot of the growth has been Germany, where you've obviously had a great performance there. So what are the next markets that we should be thinking about that are coming on stream? Because presumably, each time we get a new market on that gives a spurt of growth with the vaccine.

Emma Walmsley Executive

Yes. Well, I think there's more room in Europe more broadly. There is -- and it's interesting as we start to explore -- I don't know if I have told you, but when I was visiting with Italy quite recently, 1/4, maybe even 1/3 of their business is actually with oncology patients because you're talking about vulnerable patients, which is where you come to look at the possibilities of boosters and these kinds of questions as well because you just want to know what the immunocompromised to be being hit it. So that's just an interesting space to go. But so more in Europe.

Japan, we've just had an expansion of access to the over 18s in Japan and obviously a large and aging population. China, I've talked about. And what's also interesting is we're launching countries like Brazil. I mean, huge vaccine friendly populations. And there's further geographic expansion, but this notion of being able to continue to drive Shingrix with cohort expansion, the fact that we have all the co-admin data that we do, because one of the big pushes we've done successfully with Shingrix is to de-seasonalize, I know that's not English, but basically not only do it in the fall when you're competing for arm space and retailers love that.

We're looking at what data could come through, especially for that cohort of immunocompromised for a booster. Remember, we're starting vaccination people at 50. They're going to live a long time. So we want to make sure we have that opportunity. And there is some very interesting data, which we're exploring further on the impact, but it is a few sources now, the impact that Shingrix vaccination can have as far as dementia is concerned as well, which is obviously a massive agenda.

And this is a safe and proven vaccine, so we need to see where that could take us through.

Graham Parry Analyst

And sticking with vaccines, is there any other questions on Shingrix in the room before I move to just flu? So obviously, flu volumes are down this year and it seems to be a total market effect. Just perhaps talk through the dynamic there? Is this just sort of a post-pandemic vaccine fatigue issue? Or do we think volumes will start to go back up again?

Or is this a flat market from here or a declining market from here?

Emma Walmsley Executive

Well, for our particular flu asset, this is definitely going to be an asset that's in decline and we're very relaxed about that. We -- it's not a future-facing technology. It's not a profitable business for us. We forecast a decline in it. We'll manage that intelligently.

There is stuff going on in the broader market. But that's not really the point here. We don't consider ourselves to be a competitor in flu in a sort of meaningful way. What we're really excited about, and we really are very excited about, is the possibility to build a business in flu through an mRNA platform. And this is where -- this is one of the disease areas where efficacy currently stands at 50% if you're lucky.

The technology of mRNA is the best thing that's adapted to these kinds of antigenic drift

every year because of the window that's shorter to adapt them. We've been working hard on a platform with CureVac. Obviously, we weren't first out. We won't be first out with flu probably but that's fine. The question is, do -- can we get to a differentiated asset, either in flu or potentially in a flu/COVID combo.

So that's the way we see that. And so we think the possibilities in the flu market are very meaningful, and this is where that technology is best placed to compete.

Graham Parry Analyst

Okay. Good. I might move to HIV.

Emma Walmsley Executive

Hurray.

Graham Parry Analyst

So I guess the -- perhaps just talk through the dynamics of the proportion of the business now that's in sort of your more novel presentations, whether it's long-acting or even 2-drug, and then perhaps talk about just the longer-term franchise protection strategy in terms of bringing through new long-acting agents as you go through lots of exclusivities on the [indiscernible]?

Emma Walmsley Executive

Yes. So I mean, the first thing to say is there will be a very useful, I think, update on these questions on the profile of the business and what's coming on 28th of September from Deborah and Kim, so the CEO of RV business and the Head of R&D. And obviously, you're touching on the question -- maybe the question that people want to understand for GSK. And our goal is to continue to pioneer and lead in innovation in HIV, as we have done consistently with dolutegravir and [indiscernible] and 2 drug regimens and, very importantly, with long-acting. The bet that we are taking, and so far, we are proven again to be correct on in terms of momentum, is that the market will shift to more long-acting.

We have a very material head start here, but everybody who's competing in HIV believes that long-acting is the solution both in -- or at least is where they are putting all of the R&D money, let's say, put it like that. There will still be a market for daily pills, but we think long-acting will be 1/3 of our business, and our momentum here is very good. We updated our outlook on HIV. We're feeling very strong about the performance there. We think 1/3 of the business will be in long-acting by '26.

We think that will go up pretty meaningfully by the end of '27. So it's not like something happens in '26. When it peaks, we think there's a lot of runway for it to grow further. And then really importantly, we have 3 distinct target medicine profiles to go into longer long-acting, at least 3 months in both treatment and prevention and also eventually bring the world's first self-admin to this as well. And this is really meeting the demands from patient expectations, and Deborah and Kim will update on the visibility of those programs and the road map for when you'll see what on that in a couple of weeks.

But the other aspect that, of course, is the sort of other side of the coin here is to give -- I think there's some misunderstanding is exactly what the shape of the glide path is around the patents, and so we'll bring a bit more visibility and specificity around that for people, both in terms of geography and different protections.

Graham Parry Analyst

Okay. Yes, I was going to ask on that. So on dolutegravir, I think the compound is expiring by April '28 in the U.S. and in 2029 in Europe. But it looks like you settled with at least on Juluca and Dovato with some generics.

You've also got some combination patterns that are now are listed as well. So what's the level of confidence of being able to protect at least that segment of the dolutegravir market sort of to 2030, which gives you a little bit more of a window to get the ultra-long-acting through?

Emma Walmsley Executive

Yes. Well, you've sort of outlined it, really, We've been able to settle on the ANDAs to date. That doesn't mean we won't have more coming through, but there is an upside here. Even without it, we feel confident, but it's an additional benefit that can come through.

Graham Parry Analyst

And I think in the past, you said about 30% of the market can go to injectable long-acting, that actually seems quite low. Is that just based on current market conditions? And could that go higher once you actually have the full target profile products?

Emma Walmsley Executive

Yes. I mean, I think -- and again, there's a question to ask the team in detail. But -- and I know the other main HIV player has a more optimistic view than that. And we're ahead. So it's always difficult when you are talking about a paradigm-shifting behavior to predict where the world will be in 7 years' time.

What we can say is the feedback we get from patients and from HCPs, our confidence in the innovation that's coming through and, frankly, our results so far make us feel that the key to this is, can -- your core question is, can we continue to lead in innovation? Will we digest the dolutegravir patents not only from a sales point of view but also from a profit point of view. And we believe that we can. And in large part, the innovation that's going to come through from HIV is going to be absolutely a key part of that. And we will have visibility in 2024 on exactly what Phase III is we're going to be moving into to deliver that in time, to your point, and with high confidence of probability of success.

Because we know what we're doing here, and we've done it consistently to date, so despite those who would question it.

Graham Parry Analyst

And it's probably too early to ask the question, but do you think you will have a self admin and an ultra long-acting that's physician-administered? Is that the ultimate how you see the market? Or...

Emma Walmsley Executive

Let's see. I mean, both ultra long-acting and self-admin will definitely have opportunities in the market. You have to see how their relative profiles show up, see what share they have.

Graham Parry Analyst

And I know you've sort of talked a little bit...

Emma Walmsley Executive

And we're going to be first with both.

Graham Parry Analyst

I think you talked a little bit about the formulation challenges being overcome in terms of getting cabotegravir into self-administrative injectable. So the next decision choice presumably is do you go with the existing presentation of Cabenuva, which has got rilpivirine, you have to work with J&J on that? Or do you go for a fully owned GSK presentation with some of your own novel mechanisms? And how far down the decision path on that are you at the moment?

Emma Walmsley Executive

Well, again, I'll let the team answer in detail. But obviously, you're raising exactly what we have to weigh out, which is starting with the competitiveness of the asset, the continued life cycle innovation of these things. I mean, let's face it, we've started with long acting. What we're talking about is continually improving it but doing it in a way that serves an economic profile that makes sense for us as well as brings the best thing we possibly can for patients and how we do that over time. So we're very, very thoughtful on all of those questions.

Graham Parry Analyst

And then obviously, the key decision is what goes into Phase III, which we'll hear in 2024. So on September 28, what's the -- I guess, what's your investors to walk away from? What do you want to sort of help people to understand from that event?

Emma Walmsley Executive

Yes. I mean, clarity and confidence and practically consistency because there are different levels of understanding on the profile of our outlook near term and the success of long-acting full stop. By near term, I'm talking '26, not next quarter. The reality of the glide path, I don't know if I can say floor and its upside, on the patent itself because fundamentally, people -- there's just a slight marker that we've given visibility out to '26. So suddenly something happens then, which is categorically not the case.

And in fact, what happens is we continue to accelerate the delivery of long-acting, which obviously reduces structurally the exposure. And then most importantly, giving you a road map by product of some of the questions you were asking in detail now but which I don't know if my team if I gave you all the answers 2 weeks before they present it.

Graham Parry Analyst

We'll wait until the 28.

Emma Walmsley Executive

I'm sure even you will learn something.

Graham Parry Analyst

Okay. good. I'm looking forward to it. So I might -- actually there's any other questions on the HIV in the room before we move on to -- I'm just going to ask about the Zantac litigation. So obviously you settled the [Gertz] case in California.

There's another California trial coming up. Perhaps just maybe high level because don't want to talk about direct legal strategies, but high level, how do you think about settlement versus litigation? And is it where the litigation happen, California, for example, versus Delaware, influence your willingness to settle?

Emma Walmsley Executive

Well, I think you answered your own question. This is not the place for me to be discussing nor would I or legal strategy. What I will say is we have a brilliant internal and external team working on this. We are pleased with our progress so far. We will continue to act in shareholders' interest.

We are guided obviously by the reality of the science and the 14 independent studies. We'll continue to defend our position vigorously. And really, we'll keep everybody updated responsibly. We have the right people working on this. And everybody else is very, very focused on delivering on what we're here, for patients and shareholders and the momentum of the company.

Graham Parry Analyst

Okay. And do you have any differences between the different -- because there's litigation happening in different pockets in the U.S. at the moment, you've got lot cases in Delaware, also in California. Is there sort of a combined legal strategy across all of it? Or are you dealing with it sort of picking them off case-by-case, region by region?

Emma Walmsley Executive

Yes, I'll repeat my first answer on that question. So I'm not going to talk about legal here.

Graham Parry Analyst

So we'll wait to see what happens either ahead of or at the trial. I might shift gears on to IRA, so just overall exposures. Obviously, we've had the first 10 drugs. But if you look at your overall Medicare exposure, perhaps has helped people to understand what your actual exposure to the program is. And then it looks, if you sort of -- there's a number of studies out there suggest Trelegy might go on the list next time for the 2027 negotiation.

So is that something which you consider a risk? And how would that impact the business?

Emma Walmsley Executive

Well, first of all, I mean, the most important thing to say is with everything we know and can see, all of the IRA impact is fully factored into our outlook for '26 and beyond. I mean, again, we don't have total crystal balls of what will happen ahead. But it's very much factored in. The 2 -- I'll come back to Trelegy, but the 2 parts of the business that are most impacted are actually HIV in '25. But that's factored into the outlook and that's the catastrophic coverage piece.

And on our oral drugs, obviously. And then our general meds business which you'll remember, we've given an outlook of being broadly stable in. And that will see some impact on the A&P next year. But it's fully factored into being broadly stable. We've done a really -- I mean, the team have done a really good job to keep that business growing.

It is a wonderful business, extremely cash generative and has long-term prospects not only of scale reach but of good profits and returns. And we're very confident we can digest that through. Don't forget, for Trelegy, which you referred to -- well, I think it would be unlikely to hit '26 simply because -- and I remember this well because it was in my first year as CEO that we got this great drug approved and then invested strongly in its life cycle innovation and new indications. And that was in, I think, the last quarter or the fall of 2017 because I remember being very focused on it. And I think to get into the next round, you have to have been in 2016.

So it's not [indiscernible]. But anyway, even beyond that, this is a field that is -- inhaled respiratory is heavily discounted in the U.S. anyway. So we -- obviously, we watch this by asset in a lot of detail. I am always thoughtful about the environment in the biggest market in the world, as everybody is.

But we obviously have less exposure than those with huge, huge assets. We have a lot of blockbusters. We have plenty of several billion profile assets, but we're not going to be in the front line of the sort of multi, multi-heavy spending exposure. I think it does inform a bit the way we continue to look at capital allocation discipline in oncology. And it's going to be interesting to see how the weight loss drugs are paid for and what knock-on effect that has.

But in terms of our profile, even if it's harder to model, Graham, it's good to have the spread that we have in this kind of context. And GSK has a long-term reputation for responsible pricing and engaging constructively. And I would finish with, don't forget the real positive in vaccines. In the end, this is all about efficient allocation of government money in theory. So there's nothing more efficient and effective than preventing disease before it starts.

Absolutely nothing. So -- and we see that with regulators around the world, and we like to engage constructively on this kind of thing.

Graham Parry Analyst

One last -- I'm going to squeeze one last question in, just on M&A. The -- I guess one of the ideas around Haleon spend deleveraging, reducing dividend as it just gives you a bit more balance sheet flex to help sort of bolster mid-stage pipeline. So just an update really on your thoughts on priority between adding 2 different franchises in HIV, infectious disease,

vaccines, respiratory, Where do you see the best opportunities? And is oncology something which GSK is still pursuing? Or is that sort of noncore these days?

Emma Walmsley Executive

Well, I think we've been extremely clear and consistent in our priorities for BD because it's -- it might be M&A. Sometimes it's different kinds of business development and partnering as well. But what was weird was GSK not doing it. We now do about -- I think, about 50% of our portfolio is like the partner or bought in, which is much closer to normal. And it is a priority.

And Julie laid out very clearly our capital allocation priorities to be investing in growth, both organically and inorganically as well as returns to shareholders, all underpinned by a strong balance sheet. And that's really the work we've been focused on. In terms of priorities within that, we invest in prevention where we are great champions and treatment. I mean, you have to look at the Affinivax acquisition as the kind of thing that we continue to do. And in treatment, it's consistently across those 4 key TAs.

3 where we have large businesses and a long-term track record. In infectious diseases, really ongoing thoughtfulness about assets and partners there, built up a nice portfolio of antibiotics. And we continue to think about partners in our hepatitis area as well. If you look at HIV, they've been partnering in terms of technologies. Like Halozyme, Respiratory, we just closed the BELLUS deal on camlipixant, and we haven't touched on the real opportunities for growth we see in our respiratory specialty franchise, profitable growth whether it be in [indiscernible] with new indications in Nucala, whether it be with depemokimab, but also adding this asset of camlipixant from the BELLUS deal, which we think could be truly differentiated.

And all of these will have data in '24 and '25. And at some point later this year, we'll try and bring an update on a bit more specificity on those. And in oncology, this is part of the high risk but potentially high-reward space that adds to a balanced profile. But it's a small business for us. We are extremely thoughtful about the discipline of capital allocation, especially in an evolving environment.

We're really looking forward to seeing momelotinib come through. And I think it will be very interesting to see how we execute against that in terms of demonstrating the smartness of the decision and the quality, which we keep making great leaps forward on of GSK's execution in the field.

Graham Parry Analyst

Fantastic. We're actually slightly over time. That's my fault. Great to have you here, Emma. Thanks very much today, and have a good day.

Thanks, everyone, to the audience as well. Thank you.

Emma Walmsley Executive

Good to see you.