BB Healthcare Trust

Monthly News
March 2020

Marketing document

As at 03/31/2020	Value	1 Month (March)	YTD	Since Launch (ITD)
Share	124.00	-10.0%	-14.7%	23.0%
NAV	121.46	-10.8%	-15.6%	36.0%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 31.03.2020, NAV and share price returns are adjusted for dividends paid during the period (but not assuming reinvestment)

Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed.

Welcome to our March update. One's arc through history is often recalled through epoch-defining events; sometimes foreseen, sometimes not. For certain through, future generations will ask what these moments were like. Our parents saw many: watching the Apollo 11 landing, the Cuban Missile Crisis or the Equal Pay Act. We never imagined that our generation's might involve an insentient particle less than 0.000013 cm in size…

Summary

BB Healthcare Trust Ltd is a high conviction, unconstrained, long-only vehicle invested in global healthcare equities with a max of 35 stocks. The target annual dividend is 3.5% of NAV and the fund offers an annual redemption option. BB Healthcare is managed by the healthcare investment trust team at Bellevue Asset Management (UK) Ltd.

The ides of March

The second half of March was challenging for us all, as markets grappled with the fast-evolving situation and were almost broken as a price discovery mechanism in the middle of the month. Thankfully, we seem to have turned something of a corner sentiment-wise, but there will inevitably be bumps in the road ahead.

Measured in dollars, the MSCI World Index has declined 21.4% year-to-date, and fallen >34% from its peak on 19th February to its trough on 23rd March. In our 'ad hoc' update of 20th March, we outlined our belief that the risk-reward was looking to the positive. As we go to press, the World Index stood 15.6% above its trough at month end.

The MSCI World Healthcare Index' peaks and troughs occurred on the same dates. This Index has declined 12.0% year-to-date and fallen ~27% from peak to trough, outperforming the wider marketplace (as one would expect, given its classical 'defensive growth' characteristics). The Healthcare Index' stood 17.6% above its trough at month end.

As we highlighted in the recent 'ad hoc' release, these are challenging circumstances for our strategy; our focus on operationally geared plays through a concentrated portfolio of selective exposures leaves us more at the mercy of liquidity squeezes and volatility spikes, both of which are innate characteristics of market corrections (cf. Q4 2018).

Consequently, March has seen BBH materially underperform its benchmark. The Trust's Net Asset Value (adjusted for the dividend payout) has declined 10.8% to 121.46p, versus a 1.1% decline for the benchmark, when measured in sterling. Although this is disappointing, we see current conditions as exceptional: a number of our holdings are trading at valuations that simply do not reflect their fundamental value or prospects and we have taken advantage of these circumstances to add to the portfolio, as detailed later in the factsheet.

Given the recent update in the 'ad hoc' release we have dispensed with our usual commentary on the benchmark's sub-sector performance, but this will return next month. The performance table is opposite.

In that same 'ad hoc' release, we noted our belief that the risk/reward looked firmly to the upside from here and that we would be looking to increase our gross exposure. Propitious as the timing was, we did not expect the market to rebound so strongly from its lows. Moreover, we are not hugely buoyed by a rally led by cyclicals and consumer sentiment-driven stocks. As Mark Twain observed: whenever you find yourself on the side of the majority, it is time to pause and reflect. Is this more former feline fakery? Is the market cheap enough? This latter question is vexatious indeed…

The current adjusted P/E ratio of the S&P500 Index has fallen from a recent peak of ~24x to ~18x (i.e. -25%; it was 16x at the low), which implies thus far only a modest contribution from cuts to EPS forecasts, so there is clearly more earnings downside to come. The cyclically adjusted PE ("Schiller PE") has declined from 31.2x at the end of January to ~24x today, which is a bit more reassuring, but this metric stands well above long-term averages.

BENCHMARK SUB-SECTOR PERFORMANCE AND WEIGHTINGS

Sub-Sector	Weighting	Perf. (USD)	Perf. (GBP)
Biotech	9.1%	1.8%	4.8%
Conglomerate	11.2%	-4.1%	-1.3%
Dental	0.5%	-20.1%	-17.8%
Diagnostics	2.0%	-7.0%	-4.3%
Distributors	2.8%	-1.5%	1-4%
Facilities	1.1%	-26.2%	-24.1%
Generics	0.4%	-18.5%	-16.1%
Healthcare IT	1.0%	3.1%	6.1%
Healthcare Tech.	0.7%	-5.7%	-2.9%
Managed Care	8.5%	-2.7%	0.1%
Med-tech	15.4%	-8.6%	-5.9%
Other HC	1.4%	-12.6%	-10.1%
Pharma	34.3%	-1.0%	1.9%
Services	1.9%	-7.5%	-4.8%
Specialty Pharma	3.9%	-9.4%	-6.8%
Tools	5.9%	-3.5%	-0.7%
Index perf.		**-3.9%**	**-1.1%**

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 29-02-20. Performance to 31-03-20.

Are those meretricious metrics of use when comparing this crisis to, say, 2008? As of the end of March, the technology sub-sector accounted for almost 26% of the weighting of the S&P500. In August 2008, it was <17%. Simply put, the market has evolved profoundly since the previous crisis and thus the utility of comparisons regarding the forward pricing of potential recessionary scenarios is probably of little value.

One can at least take some comfort that the market has climbed the wall of worry by the lack of share price reaction to companies withdrawing their 2020 guidance and/or warning over the Q1 20 outlook. None of this should be a surprise and one can argue that anyone buying shares down here has a clear idea that they are buying uncertainty. The market is calmer, but far from serene: the VIX volatility index has declined from its peak of 82.7 in mid-March to a mere 58.9 at month end. Prior to March, volatility had not spiked above 40 since 2015 and the 5-year average value is less than 16. For this reason, we continue to act slowly and with caution.

We are where we are, but where are we?

As we go to press, SARS-COV-2 continues its minatory sweep across the globe, overwhelming national-level critical care infrastructure and forcing medical professionals into the unenviable position of deciding who gets appropriate supportive care and who does not. Worse, the medical evidence to assist this decision-making process (in terms of reliable prognostic indicators of disease course) are immature at best. Our thoughts go out to those at the frontline in such intolerable circumstances.

We would continue to emphasise the facts that the majority of people will not experience serious illness and many of those that do will recover, the

simple maths of a novel infection in a global population of billions means that many thousands of people will die earlier than otherwise would have been the case and, likewise, our sympathies are with those who are personally affected by this pandemic.

Although upsetting to read, individual case reports of an otherwise young and healthy person succumbing to this conditions are exceptions and thus newsworthy. One could make an analogy with deaths in aircraft accidents cause international headlines, but the vastly greater number of vehicular deaths do not. One can only get a true picture of risk from looking at the data in its entirety.

Furthermore, the societal efforts to mitigate this tragedy will have very profound economic consequences. We are in the early innings here in the UK, but all of us in the London office (which is of course closed) already know someone personally who has lost their job or their business. High street stalwarts are calling in the receivers at an accelerating cadence. Government assistance on a previously unimagined scale is coming, but it will be too late for some. This is a second-order tragedy for society as a whole and one that is likely to impact us all for many years to come.

In such circumstances, our tribulations seem of trifling relevance, but we have a job to do and we are very cognisant of our role as custodians of hard-working people's savings. For the investor, the challenge in recent weeks has been trying to reconcile how much of all of this is priced into markets. We cannot expect analysts and companies to provide timely or accurate estimate revisions, so there is a degree to which this is a nuanced 'gut feel' situation. The reckoning will unfold over the coming weeks.

What anyone with a financial model can do though is look at the valuation sensitivity to a 2-3 quarters of challenging trading conditions and compare that to the prevailing share prices. The definition of challenging will of course vary by sub-sector within healthcare; the closer one is to the end consumer and the more discretionary/elective the product's use then the harsher the impact is likely to be. Why only 2-3 quarters, you may ask? It bears repeating that the fundamental demand drivers for healthcare services stand apart from the wider economy.

Generally speaking, we are reluctant users of these services, based on need not want. As such, negative consumer sentiment has limited impact on demand. Whilst the idling of elective capacity (emptying beds to forestall the system being overrun with Coronavirus admissions) is a short-term headwind; patients will go onto waiting lists and the majority of those planned procedures will take place in the months that follow a normalisation of emergency admissions. Thus, a short-term headwind in 2020 becomes a tailwind into 2021. This will not be so for many other sectors of the economy, where lost demand is lost forever.

Our long-term core thesis (that the healthcare systems of the Western world are broken and cannot be fixed, they must be re-imagined and made fit for purpose in a world with an ageing population burdened with chronic morbidity) has been given a fillip by recent events.

For example, electronic triage (e.g. Teladoc), near-patient testing and lower acuity care points have been forcibly tested in a baptism of fire in recent weeks. We never imagined the ExCel centre or the car park at Chessington World of Adventures as future care delivery venues, but these are strange times indeed. We hope and expect that the wider deployment of such services and products will now be accelerated.

One of the barriers to transition has been political reluctance to increase spending. In principle, everyone is happy to see more money being invested, but willingness to pay more tax to fund it has been the sticking point. In the UK for example, polling by YouGov showed a significant swing in favour of this in 2018, but only to 54% and Labour lost the recent election on a services spending mandate (although perspicuously, they claim to have "won the argument" – cognitive dissonance is not dead). All joking aside, it will be fascinating to see where public opinion lies when the dust has settled. Any structurally higher spending commitments around the world can only be a positive for the sector

In summary then, whilst we do not yet know how and when all of this will come to an end, we do understand that its medical impact will be transient and, from a statistical point of view, limited. Let us consider what is left to worry about and how the end might begin.

The known unknowns

This situation evolves so quickly that any attempt to qualify one's thoughts on paper is likely to become redundant almost as soon as it is finished (although any recycled paper can contribute to the 1.3m tonnes we Brits use in that most personal of ways – 2.5 rolls per person per week apparently). Nonetheless, we can at least update readers as to how our thinking has evolved in recent weeks (we are taking the recently published 'ad hoc' letter as read).

With regard to the epidemic itself, it continues to evolve as one would expect for an emergent disease of moderate virulence to which there is little to no innate immunity. Any statistics must be viewed with caution (and doubly so when they come from China, where the currently reported low levels of asymptomatic cases and the sudden and dramatic stop in community spread warrant scrutiny; media stories on these topics are beginning to circulate and we leave readers to draw their own conclusions based on China's track record on openness with its people and the world at large).

Anyone analysing the outbreak and its trajectory will continue to struggle with the "denominator problem" until serological testing on large cohorts give us a true picture of prevalence within the community (almost certainly much higher than any data would suggest today) and the numbers of asymptomatic cases (derogatively referred to as "silent spreaders" by the media).

We are still of the general view this spreads like influenza, is a bit more dangerous than influenza but we cannot yet know how much more dangerous on a "case fatality ratio" basis due to the aforementioned missing data. Imagine if we did not vaccinate hundreds of millions of vulnerable people against influenza every year: estimates are that the programme reduces mortality by 50%; and yet it still kills around 500,000 per annum globally.

A final point to bear in mind is that there is a difference of dying of something and dying with it. With healthcare systems in many countries overwhelmed, it may never be clear what finally ended someone's life when they have multiple risk factors, especially the very elderly. Based on what we know about how the numbers are being gathered, if one dies in hospital with a heart attack after testing positive for Covid-19, that would be counted as a virally-related death in Italy, but may not be in the UK or Germany. It would be unlikely to be considered virally-related in China.

One government study in Italy suggested that only 12% of coronavirus deaths documented there could be directly attributed to the viral infection, because so many of the victims have complex pathologies with multiple pre-existing conditions.

Only through autopsies and data analysis (which health systems have scarce resources for when so overwhelmed as Italy is) will the true picture emerge and it will be many months indeed before we have the time and resources to look back over all this data and hone its accuracy. This would go a long way to explaining why Italy seems to be such an outlier in terms of fatalities per capita and again highlights the dangers of comparing between countries in a simplistic manner and we continue to be frustrated by some media stories in this regard.

Aside from the data accuracy, there are probably only two things that we worry about as "known unknowns": the impact of obesity in America and the "second wave" in Asia. Let us deal with these in turn.

As noted above, there is a paucity of prognostic factors for severity with this condition aside from age and pre-existing serious medical issues, especially those that compromise cardiovascular efficiency. These are obvious risks: the elderly have less lung capacity (it declines with age, around 1% per year from age 35) and weaker immune systems. Any cardiovascular problem is

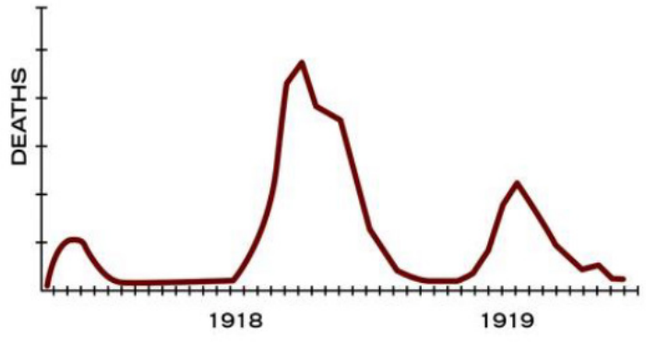
going to complicate the oxygen deficiency that inevitably arises in pneumonia (when the lungs partially fill with fluid).

There is one medical problem that tragically seems not to be widely accepted by society as a serious morbidity despite the risks that it brings: obesity. Clinicians routinely cite obesity's elevated risks for diabetes, CVD and cancer. However, it also raises challenges for pneumonia. The bigger you are, the harder your heart and lungs have to work as it is. If pneumonia takes hold, the battle is tougher. Obesity is associated with chronic inflammation-like responses, which suppress the immune system, so infection may take hold more easily. It is also more difficult to intubate obese patients and mobility issues may make self-isolation more risky in and of itself.

The prevalence of obesity in East Asia is low and it is lower in Europe than in the US. It thus remains a risk that the middle-aged obese in the US could be more needing of acute care assistance as this condition wends its way through the population. Although America is actually well placed versus Europe in acute care beds per capita, this may complicate the outbreak there. We continue to monitor the data and are pleased to see this risk being discussed openly in the US media; it gives us some confidence that it is baked into US stock market sentiment.

Let us turn to the second wave. As we have noted in previous factsheets, the governmental restrictions that have placed a substantial portion of the world's population on lockdown are unprecedented. They have demonstrably slowed the spread of the virus, flattening the peak. However, that is not the same thing as reducing the area under a curve. Prolongation does not, of and in itself, save lives. There are only two outcomes that can lead to the end of an epidemic such as this in a given population: 1) sufficient numbers gain immunity through exposure so that it lacks vectors and peters out 2) everyone gets vaccinated, which is essentially a synthetic version of option 1.

So, how do we get out of the situation that we are in, bearing in mind that a rapid return to normal levels of social contact is likely to prompt a second wave of infections and we still do not have a vaccine? Many will have seen charts like the one below from the Spanish influenza pandemic of 1918 and fear a recrudescence could be worse than before:



Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd.

We are not so sure this is a good proxy for two reasons: 1) the viral strain mutated and the second iteration was more deadly, which is unusual and 2) the escalating global conflict that was World War One led to insanitary conditions and huge global movements of people that made quarantine impossible. Many of the deaths in this outbreak were of secondary complications (just like people can get bacterial lung infections following viral pneumonia) and antibiotics were not yet available.

The beginning of the end?

Having imposed quarantines, what happens if a second wave comes in earnest? Will those restrictions be re-imposed? Will society tolerate this? Can the economy re-start if people fear a second shut-down? These are key questions for which definitive answers are currently lacking.

Our own PM loves a wartime metaphor and channelling a bit of Churchill. We think he should look to China in one sense and find his inner Sun Tzu: there is no instance of a nation benefitting from prolonged warfare and: he will win who knows when to fight and when not to fight. There has to be a plan to return to normal and the populous need to know that some sort of an end is in sight.

So how does society make an educated guess at how and when to commence this great abnegation? We think the answer will lie in serological testing, which will shortly begin in earnest around the globe. We have no reason to think the vast majority of those who have been exposed (and recovered if symptomatic) can be re-infected.

Thus, once a serological test has confirmed that you are eliciting a strong immune response to presentation of the infection (and also confirmed this not due to actually being infected at that moment in time), you should be free to go about your business, presenting no risk to yourself or to others. One might thus imagine a situation where individuals are issued with "serological passports" confirming they are very low risk. This idea is reportedly being considered in Germany.

Whether or not there will be enough such people to allow businesses to re-open etc. is another question, not to mention the social apartheid of those who would have such a passport versus those who do not. Would this inadvertently create a rush to get infected, raising the spectre of a further overwhelming wave of hospitalisations? The politics of this approach look complex.

This means we are probably back to testing very widely and waiting for those signals of 'herd immunity' to have been reached. Again though, this is not straightforward. The threshold for herd immunity is related to the R0 value ("reproductive ratio") we have discussed before (this is an index of virulence; i.e. how easily a virus spreads through the community).

Simply put, the more virulent the pathogen (higher R0), the higher the proportion of the population with immunity needs to be for everyone to be protected. This is why the government frets about things like the MMR vaccine when the take-up drops below 90%; it really does need to be that high to be protective.

The R0 of SARS-COV-2 is not definitive, but looks to be in the range of 1-2, like influenza, which means the herd threshold is probably well north of 50%. Because of this, we will probably continue the comport of social distancing, travel restrictions and isolation for the most vulnerable for some months to come.

There will be a time though, when the data merits a change of tack. For now, it is a brave person indeed who questions the wisdom of these measures continuing indefinitely when they are seemingly so popular despite the economic and social depredations and when the virus poses a limited risk to the majority. As Neitzche said: "madness is rare in individuals, but in groups, states, and societies, it's the norm".

Developments within the Trust

As we signalled in our 'ad hoc' release, our plan was to add some new companies to the portfolio and to increase our gross exposure. Compared to the end of February, the portfolio has increased from 29 stocks plus the Alder CVR to 31 stocks plus the Alder CVR. We have added two Med-Tech stocks; one of which has been held previously.

Gearing has increased from -2.4% excluding the dividend (i.e. we were holding more cash than necessary to cover the pending dividend) to +3.7% (net of the dividend payment due in April). We issued 3.29m new shares through the tap programme during March and there will be a further 434,023 issued in April in respect of elections for the Scrip dividend option

for the second dividend payment in respect of FY2019, which saw an increased take-up this time around.

Our AGM was held and all resolutions were passed via proxy votes tendered. We are saddened that we could not have the opportunity to meet with some of our investors and update them on the Trust, but these are difficult times and we must all do our bit to mitigate the stress on the health service. We would remind you that you can submit questions to:

shareholder_questions@bbhealthcaretrust.co.uk.

We wish you and your families good health and thank you all for your continued support for BBH.

Paul Major and Brett Darke

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Standardised discrete performance (%)

12-month total return	1 year Mar 19 - Mar 20	3 year Mar 17 - Mar 20	Since Inception
NAV return (inc. dividends)	-8.8%	21.3%	36.3%
Share price	-10.2%	8.1%	23.0%
Share price (inc. dividends)	-6.7%	19.0%	35.4%
MSCI WHC Total Return Index	5.7%	25.0%	39.4%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 31.03.2020

NAV return and share price returns are adjusted for dividends paid during period where started (but not assuming reinvestment)

Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed

SUB SECTOR BREAKDOWN

Specialty Pharma	20.5%
Diagnostics	15.9%
Managed Care	14.7%
Biotech	13.8%
Med-tech	11.0%
Pharma	6.5%
Healthcare IT	5.5%
Dental	4.5%
Services	3.7%
Tools	3.2%
Facilities	0.7%

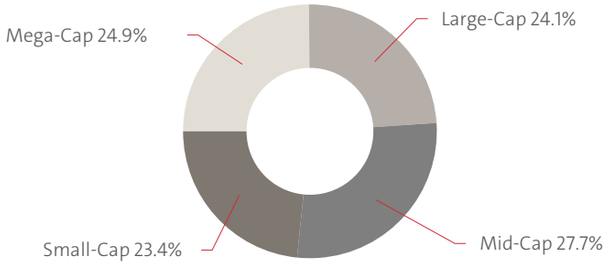
Source: Bellevue Asset Management, 31.03.2020

TOP 10 HOLIDINGS

Anthem	7.4%
Illumina	6.5%
Bristol Myers Squibb	6.5%
Esperion	5.5%
Intuitive Surgical	4.7%
Align Technology	4.5%
Hill-Rom Holdings	4.3%
CareDx	4.0%
Humana	3.9%
Alnylam	3.8%
Total	**51.1%**

Source: Bellevue Asset Management, 31.03.2020

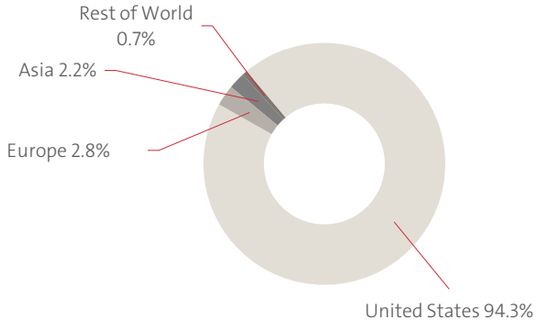
MARKET CAP BREAKDOWN



Source: Bellevue Asset Management, 31.03.2020

"Mega Cap >$50bn, Large Cap >$10bn, Mid-Cap $2-10bn, Small-Cap <$2bn."

GEOGRAPHICAL BREAKDOWN (OPERATIONAL HQ)



Source: Bellevue Asset Management, 31.03.2020

"two companies representing ~5% of the portfolio have a non-US legal domicile (primarily for tax reasons) but operate out of the United States and their primary stock market listing (in terms of volume traded) is in the United States".

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INVESTMENT FOCUS

- The BB Healthcare Trust invests in a concentrated portfolio of listed equities in the global healthcare industry (maximum of 35 holdings)
- Managed by Bellevue group ("Bellevue"), who manage BB Biotech AG (ticker: BION SW), Europe's leading biotech investment trust
- The overall objective for the BB Healthcare Trust is to provide shareholders with capital growth and income over the long term
- The investable universe for BB Healthcare is the global healthcare industry including companies within industries such as pharmaceuticals, biotechnology, medical devices and equipment, healthcare insurers and facility operators, information technology (where the product or service supports, supplies or services the delivery of healthcare), drug retail, consumer healthcare and distribution
- There will be no restrictions on the constituents of BB Healthcare's portfolio by index benchmark, geography, market capitalisation or healthcare industry sub-sector. BB Healthcare will not seek to replicate the benchmark index in constructing its portfolio

FIVE GOOD REASONS

- Healthcare has a strong, fundamental demographic-driven growth outlook
- The Fund has a global and unconstrained investment remit
- It is a concentrated high conviction portfolio
- The Trust offers a combination of high quality healthcare exposure and targets a dividend payout equal to 3.5% of the prior financial year-end NAV
- BB Healthcare has an experienced management team and strong board of directors

MANAGEMENT TEAM

Paul Major

Brett Darke

GENERAL INFORMATION

Issuer	BB Healthcare Trust (LSE main Market (Premium Segment, Offical List) UK Incorporated Investement Trust
Launch	December 2, 2016
Market capitalization	GBP 542.2 million
ISIN	GB00BZCNLL95
Investment Manager	Bellevue Asset Management (UK) Ltd.; external AIFM
Investment objective	Generate both capital growth and income by investing in a portfolio of global healthcare stocks
Benchmark	MSCI World Healthcare Index (in GBP) - BB Healthcare Trust will not follow any benchmark
Investment policy	Bottom up, multi-cap, best ideas approach (unconstrained w.r.t benchmark)
Number of ordinary shares	440 776 085
Number of holdings	Max. 35 ideas
Gearing policy	Max. 20% of NAV
Dividend policy	Target annual dividend set at 3.5% of preceding year end NAV, to be paid in two equal instalments
Fee structure	0.95% flat fee on market cap (no performance fee)
Discount management	Annual redemption option at/close to NAV

DISCLAIMER

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