BB Healthcare Trust

Monthly News
September 2020

Marketing document

As at 09/30/2020	Value	1 Month (September)	YTD	Since Launch (ITD)
Share	166.00	5.4%	20.4%	80.9%
NAV	165.66	5.4%	18.5%	83.8%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 30.09.2020, NAV and share price returns are adjusted for dividends paid during the period (but not assuming re-investment). Full performance data is on page 6.

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 September update. A witty and upbeat moniker for the end of summer elides us; the only words we can think to associate with the world around us and markets in general are pteropodidae and guano. We cannot reconcile continued market optimism with deteriorating fundamentals. The sell-side's obdurate disinterest in the divination of reasonable valuations for supposed growth as the market's leadership narrows is beyond maddening; it's all about 'stories' apparently. Ho hum, one must battle on.

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.

"I, that did never weep, now melt with woe that winter should cut off our spring-time so."

Wouldn't it be nice if there were something other than COVID, governmental incompetence and stock market irrationality to write about? The enjoyment we long derived from these updates is ebbing away under the relentless fusillade of forces we feel unable to repel.

Contradictorily, and taking a purely literary perspective, the fount of idiocy upon which to comment is boundless and thus the material to fill these pages spews forth. We will try to maintain a witty and irreverent tack, but it is proving increasingly hard to do so.

On the subject of being Witty, we cannot otherwise begin than by addressing the 'scientific' briefing we were all subjected to on 21st September. 'Extrapolation' and 'fact' are neither etymologically related, nor proximate in the dictionary, but the briefing seemed nonetheless to conflate these two words, unintentionally or otherwise. Let us recall that the first national lockdown of 23rd March was to "protect the NHS", as capacity in intensive care was likely to be exceeded were no action taken. Several points were made (we have paraphrased):

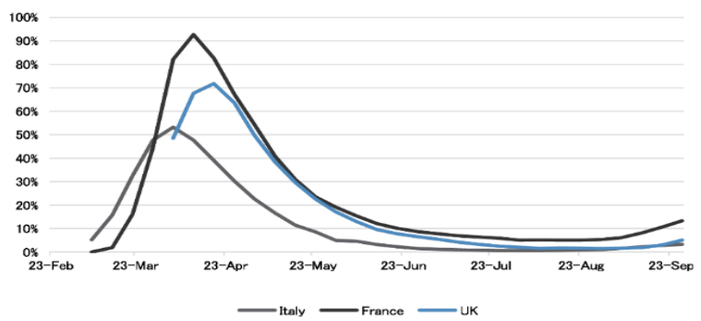
- 'The number of cases is doubling every seven days' (true) and that an increase in deaths is likely to follow (an entirely fair and logical qualitative conclusion).
- 'The positivity rate for tests has increased' (true, so the increase in cases is not solely a function of increased sampling, but this was not quantified. Positivity has increased only modestly to around 2%, which was where we were in June as we opened up again, and the increase is skewed to the young. The lowest point was 0.4% in late July).
- 'Hospitalisations are increasing' (true, but no comment on the rate, other than to say it is 'following', which could lead many to surmise the relationship is 1:1, when this is clearly not the case).
- 'Treatment is better and the mortality rate has been reduced' (unarguable really, but would have been helpful to quantify just how much lower it is: an age-controlled study of outcomes in New York State suggests that it has more than halved since the beginning of the pandemic, and there is no reason not to extrapolate across developed nations, given similar overall healthcare outcomes and capabilities).
- 'By mid-October, a simple extrapolation would imply 50,000 cases per day, leading to 200+ death/day by early November' (when we would be at 200,000 cases/day). Mathematically, this extrapolation is unarguable, but where does one stop with such a simplistic approach? The same logic suggests that, by Christmas, we would have millions of cases per day and sometime in early 2021, the entire population of the UK will have died of COVID. Clearly the last point is ridiculous, but surely that also makes the former highly questionable?
- That the amateurish projection was then reported in some quarters of the media as manifest destiny is inexcusable. Did the Government or media learn nothing from parroting Prof. Neil Ferguson's factitious predications the first time around? We cannot refute his UK "no lockdown" scenario as it did not happen, but he claimed Sweden would see 90,000 COVID-19 deaths without action and instead saw 4,000. His previous forecasts on Swine Flu, BSE and the Bovine TB epidemic bear scrutiny.

It remains the case that the vast majority of people will barely notice they have COVID and suffer no long-term effects from having it. This is not to dismiss fatalities or so-called Long-CoVID (prevalence data for the latter is very hard to find), but it is a more robust statistical observation than some of those made at the briefing: the infection fatality rate (IFR) for SARS-CoV-2 has been estimated at 0.004% for the 0-34 age group, rising to 0.06% for the 35-44 age cohort. For the 45-54 age group, is 0.2%. On the other hand, it is 22.3% for the over 85s.

Across all age groups, the IFR for influenza (post vaccination) is around 0.05%. The SARS-CoV-2 IFR will of course reflect measures taken to reduce transmission and so one can reasonably argue that if no precautions were taken, it would be higher. However, the data temporally spans the pandemic and the mortality rate has fallen, so it may well also be lower.

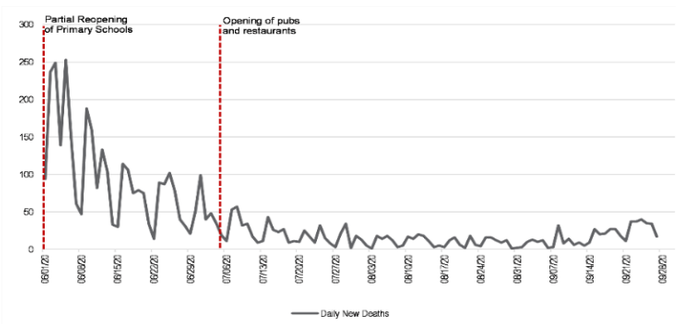
Regardless, the point still stands – this disease kills the elderly and the vulnerable and leaves the majority untroubled. This reality can be seen in the data on hospital admissions and deaths and this should surely inform policy:

Figure 1 shows the percentage of ICU beds occupied by COVID-19 patients. It is currently ~5% for UK, versus 70% at peak in April.



Source: JP Morgan, WHO, Worldometer 30-09-20.

Figure 2 shows the death rate in the UK since re-opening began in earnest in June.



Source: JP Morgan, WHO, Worldometer 30-09-20.

Regarding Long-COVID, it is worth noting that large studies of patients with community-acquired pneumonia (CAP) show that a significant proportion (>50%) report fatigue up to three months post recovery, along with cough and dyspnoea (at lower rates). Some report ongoing severe chest pain and these effects are not confined to the elderly. So, whilst the pervasive symptoms of those whose initial infection would be defined as mild are intriguing, it is not unreasonable to expect those who have suffered more overt respiratory symptoms from an infection to see ongoing complications for several months.

Why might it be the case that the 'second wave' appears less deadly than the first? Has the virus mutated? More on that anon. As noted previously, treatment has improved. Is that enough on its own to explain the differences? Probably not. What, then? At the risk of sounding like a broken record, we think the most logical explanation is our recurring factsheet guest star 'the denominator problem', but these past two months, it has been joined by its vapid cousin, 'the numerator problem'.

Any mortality estimate, and an IFR is always an estimate based on a prevalence assumption and depends on sampling. We know three things are very likely:

1) At the beginning of the pandemic, testing was both limited and inaccurate. As a consequence, sampling focused on the overtly symptomatic, who were by definition high risk for mortality? Dying with something and dying of something are not the same thing and we have already seen a tightening of the criteria that define a COVID-associated death (and arguably more tightening is needed to exclude accidental deaths post diagnosis etc.)

2) Population studies (both antigen and antibody) have long shown that the virus is more prevalent than symptoms would suggest, with up to 50% of adults being asymptomatic (probably higher in children). As a consequence, the denominator is wrong and the disease is far less lethal in the non-elderly than the early data suggested.

3) Today, testing is both overly sensitive (cf. August factsheet), picking up viral RNA long after the virus is non-viable, and much more prevalent, capturing a numerator that is too high and a denominator that includes more asymptomatic patients. Simply put, if you sample more of those who are unlikely to get overtly ill, and your confirmed positive cases includes people who have already recovered without knowing they had it in the first place (so your prevalence assumption is elevated), the IFR will fall rapidly. Has anything actually changed at the macro-population level? No.

What can we conclude from the suppositions postulated above? The logical one would be that this is a disease whose morbidity and mortality is overwhelmingly confined to the elderly. Is the solution to mortality amongst the elderly to turn matriculation into incarceration, or to once again make the majority of leisure operations financially non-viable in a service-led economy?

Let us not forget too that half of all deaths in the UK have been in the institutional setting of care homes and these now effectively operate like prisons (which is also morally wrong), so that level of mortality is unlikely to be repeated in this second wave of COVID cases.

There needs to be a balance struck between economic survival, broad mental health and wellbeing and protecting the vulnerable. Granted, this is not an easy tightrope to traverse, but the objective observer can surely conclude we have not optimised the outcome on any of those metrics with the new measures imposed here in the UK.

Worse, we have been told these enhanced measures could remain in place for six months. No Halloween or Bonfire Night for the children, Christmas is ruined and New Year will be a damp squib. On top of that, we have economic malaise that will be compounded by Brexit and no real chance of escaping any of this with a holiday (assuming you are in the minority that will be able to afford one in the face of all this). To paraphrase the bard: it is going to feel like a very long winter indeed and we are already discontented before it has begun, destined to hate the idle pleasures of these days; in deadly hate the one against the other.

"The fool doth think he is wise, but the wise man knows himself to be a fool."

Political capital is finite, as is forbearance. It is simply not feasible to keep passing laws and pushing those least able to cope (mentally or financially) into near isolation through rolling restrictions, especially when they are not achieving the unrealistic goals set by those self-same politicians. We are not going to beat COVID. This is not a war in any sense; certainly not one that we can win and such language is unhelpful.

Surely, these restrictions must be honestly described as a strategy to regain control when the situation is perceived to exceed governmental tolerances (or when the testing system is utterly broken). There is already a debate raging on social media and talk radio asking why further restrictions are worthwhile, when even in countries where extreme measures were taken (e.g. Spain, Italy), the virus has swept back with a vengeance. This is only going to become more and more polarised as such measures break down and the Government encourages snooping and blaming the young as "covidiots". Is this really the kind of society we want to live in?

On the subject of testing, can anyone in Whitehall really be surprised that the mass return of 11.7 million people to schools and higher education, concurrent with the typical start of annual winter respiratory disease season would lead to a bolus of testing requests? Was it not obvious as well that the anxious parents of children whose schools require those with symptoms to either self-isolate for two weeks or get a negative test before returning would pressure the system yet further?

Donald Trump may well be considered an idiotic lunatic by many readers, but the US Federal Government has pounced upon the availability of rapid disposable tests like BinaxNOW (cf. August factsheet), hoovering up millions of them first for the staff in retirement homes (where the epidemiological data unequivocally shows mortality risk to be highest) and now giving 150 million tests to public (i.e. state run) junior and senior schools so they can rapidly deal with suspected cases amongst staff and pupils. This order is equivalent to three tests for every public school pupil in America, and this is just the first batch. The quality of this test in the real world remains to be seen of course, but these sorts of efforts are laudable and could do wonders for public confidence.

Meanwhile, in the UK, our 'leader' offers yet more fey flummery in the form of "Operation Moonshot", a leaked idea that seems simultaneously far away and unattainably costly. The proposals suggest using various unspecified technologies to undertake mass antibody and antigen testing (up to 10 million per day!), with a view to giving people some sort of potentially short-lived "digital passport" stating they are very unlikely to be a transmitter.

Ambitious indeed. This room is packed with pernicious pachyderms: they cannot even get the current system to work properly at c600k unique tests per week and the much vaunted 'test and trace' App cannot log around a third of tests and seems not to work on a substantial proportion of older smartphones. Be in no doubt – these things will get fixed quickly despite the poor history of NHS IT projects over decades and the farcical procurement decisions during the pandemic. Does anyone know if the ministerial car these days is a yellow Reliant Robin van? Mange tout, mange tout.

Let us indulge in a flight of fantasy. If we leave all the above aside and overlook the proposal's expense and the lack of infrastructure to deliver it, there is still the problem of the inevitable false positive rate. Even if the selected test has a specificity and sensitivity of 99%, false positives would still occur and these would amount to thousands of people per day when testing at such a high rate. In turn, they and their families would likely need to self-isolate and related tracking and tracing could magnify these impacts further. It could rapidly descend into the sort of arbitrary curtailment of civil liberties that we have already...

As such, there is an argument that testing should really be reserved for people where the index of suspicion that they are infected is high – a very difficult issue when so many spreaders are asymptomatic. Testing has a place, to be sure, but mass surveillance testing is a quite an expensive leap to take when it is epidemiologically unproven as a strategy. Couldn't that money be better spent on supporting the vulnerable and those unable to work because their employment sector has been shut down?

It might cause one to wonder which side of the Atlantic's bombastic leaders is the greater fool?

Britain can at least claim unequivocal leadership in the political U-turn; world-beating indeed.

"Our remedies oft in ourselves do lie"

Our overriding message is the same one now for many months. We (society) must learn to live with the virus one way or the other. Hopefully, we will mitigate further the risks of overt symptomatic disease through vaccinations and develop additional treatments that positively impact mortality amongst the vulnerable groups.

SARS-CoV-2 will not go away, just like influenza or the other coronaviruses that circulate every winter, so there needs to be a much more realistic discussion around risk factors (both economic and social) and the possible futility of total containment.

If the containment 'battle', if one can call it such, seems lost, what next? We should move swiftly to protecting the most vulnerable over winter, which seems a far more achievable aim, both logistically and financially. Someone has to pay for all this at the end of the day, and that someone will be you and your kin for generations to come. We do not support locking the vulnerable up by the way, but rather offering as much assistance as they want to receive in order to reduce the need to mix with wider society (shopping, health care visits, etc.).

On the vaccines front, it is reassuring that the FDA has found some sort of a backbone and clarified further its expectations on the clinical data required to approve a vaccine, much to the dismay of the Cheeto-in-chief, who seems to think he can overrule the regulator. After the first 'Presidential' debate, is anyone surprised at such hubris? As detailed last month, this issue is simply too important to compromise on and we must hope that the line will hold in the face of unprecedented political interference.

We continue to worry that the vaccine trial outcomes will disappoint the media, in the sense that a vaccine will probably not contain spread fully or offer total protection, but rather reduce the risk of overt disease in the most vulnerable, as the flu vaccine does today. We should know in the coming few months just how effective the first swathe of vaccines will be and then the hard work of educating the public that an imperfect vaccine is still good enough to allow a return to some sort of normal and should be taken up (if it is evidenced to be safe).

There has been quite a bit of media focus recently on mutations of the virus. That SARS-CoV-2 would mutate into many sub-strains was inevitable (all viruses do) and it was also inevitable that certain mutations would dominate over time. These sub-strain families are known as clades and there are already more than 6,000 documented variants of SARS-CoV-2 and 10 times this number of mutation combinations, which have been classified into six clades. Since the virus' genome is >29,000 bases in length, it is likely that thousands more variants will appear over time.

The media have picked up on the so called "D614G" mutation, where the original "D" amino acid at position 614 on the fabled 'spike' protein has become "G". This particular clade is now found in the majority of samples, whereas it was largely absent in the initial pandemic wave. What does this mean? Probably nothing, but nature is a 'winner take all' competition and the D to G change must confer some benefit to the virus in terms of transmissibility, otherwise it would not have so comprehensively out-competed its predecessor.

Coming back to the point raised earlier, there is no evidence as yet these mutations have contributed to innately lower morbidity. Whilst the absence of evidence is not evidence of an effect being absent, one must be led by data supporting causation, not apparent correlation. It is axiomatic that data will always lag an ever-changing situation on the ground, but wider sampling and better treatment seem far more likely to explain apparently lower morbidity and mortality.

As regards the vaccines in development, they are being tested right now, so their efficacy will be determined against the current strains (and Moderna released limited but positive data on anti-D614G clade antibody formation as we went to press). As such, it does not really matter that it is not the same as the ones circulating six months ago.

Could we see a mutational drift that leads to immunologically distinct variants as we have with influenza for example? Over time this is possible but that may not matter if we have a situation where vaccines must be given annually, as the vaccine can potentially be 'tuned' as necessary to the evolution of the pathogen as happens with influenza each year. As we have noted previously, there are many things about the vaccines that we worry about, but we do not think the virus is mutating fast enough at the moment for that to be a significant issue.

With those cathartic conniptions out of the way, we can now turn to the Trust...

Performance review

The wider market

For the first time since April, the healthcare sector managed to meaningfully outperform a volatile and generally 'risk off' stock market dynamic during September. In sterling terms, the MSCI World Healthcare Index rose 2.1% (it declined 1.5% when measured in dollars), compared to a decline of 0.1% for the MSCI World Index (which declined 3.7% in dollars), as tech stocks beat something of a retreat. We estimate that the ~4% decline in software companies and ~7% decline in Tech hardware contributed a third of the MSCI World's negative overall dollar performance during the month, although the energy sector was the real laggard as OPEC argues and another oil glut looms.

More broadly, the four horseman of rising pandemic data, make-or-break on the post-Brexit EU-UK trade deal, the US election and a very uncertain Q3 reporting season will conspire to elevate volatility during October and November and it would be difficult to bet against the market's overall direction remaining negative.

Healthcare will be caught up in the election rhetoric and some earnings risk around reporting season, but our prediction is that overall it will fare better than the wider market as political risk is already overly discounted and earnings risk is less sensitive to COVID restrictions than the market as a whole.

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Sterling declined 3.4% against the dollar during the month, and why wouldn't it? Britain and its service-oriented economy has continued to suffer through the emergence of wave 2 and we do not have the benefit of being the world's reserve currency.

Whilst this has been a tailwind for our performance during September, we are more cautious looking forward. The EU-UK trade deal feels like a coin-toss, but the risk for sterling is to the upside. Equally, the US dollar could weaken on a messy contested election scenario; the last thing America needs at the zenith of winter is an even less functional government.

Healthcare

The MSCI World Healthcare Index's sub-sector performance is illustrated in the table on next page. It has been something of a surprising month to our minds, with consumer-centric Dental and Animal Health (the latter lies outside the BBH mandate) leading the charge, even as the accelerating second-wave of the pandemic brought ever more restrictions and consumer reticence across the globe.

Healthcare IT at first glance feels anomalous, making progress as its tech brethren retreated. However, HCIT and Tools are to some extent contract service providers and there is little contract revenue risk at the moment to companies providing services to healthcare as an industry, being as the demand picture is so defensive.

Hospitals were an obvious laggard as the pandemic takes hold of the narrative once more, but surely that makes Dental and Animal Health (both highly consumer discretionary) harder to reconcile? A strange tape indeed.

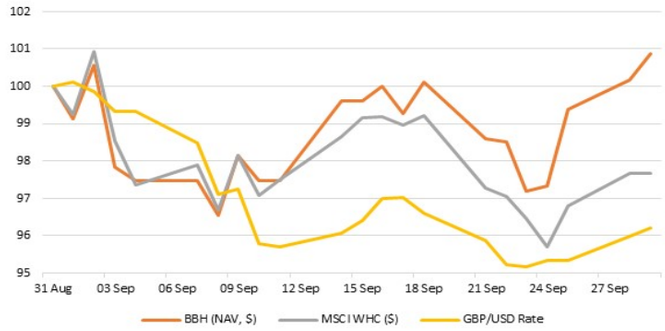
BENCHMARK SUB-SECTOR PERFORMANCE AND WEIGHTINGS

Sub-Sector	Weighting	Perf. (USD)	Perf. (GBP)
Dental	0.5%	7.8%	11.7%
Animal Health	1.4%	2.3%	6.0%
Tools	7.4%	2.1%	5.8%
Healthcare IT	1.6%	1.3%	5.0%
Diagnostics	2.1%	0.6%	4.2%
Healthcare Technology	0.8%	-0.1%	3.5%
Managed Care	8.6%	-1.7%	1.9%
Med-Tech	15.2%	-1.7%	1.9%
Diversified Therapeutics	35.5%	-1.9%	1.6%
Focused Therapeutics	9.2%	-2.2%	1.3%
Services	2.6%	-2.2%	1.4%
Conglomerate	12.5%	-2.7%	0.9%
Distributors	1.2%	-3.3%	0.2%
Facilities	1.0%	-5.6%	-2.2%
Generics	0.4%	-5.7%	-2.4%
Index perf.		**-1.5%**	**2.1%**

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 31-08-20. Performance to 30-09-20.

The Trust

The Trust's Net Asset Value rose 5.4% during the month, outperforming the sector benchmark by ~330bp to yield a month-end NAV of 165.66p. Our defensive approach and dollar-focused portfolio benefitted us during a generally negative environment and we have been quite active on the risk management side, taking profits from positive monthly returns and recycling them into lagging performers. The recovery in sentiment toward diagnostics in the latter part of the month (the reciprocal of more realistic timing on vaccines?) was a notable contributor to performance.



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

Our conservative positioning is again largely unchanged. The portfolio declined further from 28 stocks to 27; we exited one of our smaller Focused Therapeutics positions on a disappointing regulatory update. September saw another one of our inception top 15 holdings hit the canvas; we sold the remainder of our stake in Illumina (having been scaling it back significantly over recent months) on the detailed rumours of its acquisition of former subsidiary GRAIL.

We love the idea of liquid biopsy to detect cancer early and think that pan-cancer screening will change the world, but for our children and not for us. The science here is complex and needs expansive (and thus expensive) validation. If, at some point, you can buy a £1-200 pan cancer test from Boots, then we will all be at it and this will be one of the largest sectors of healthcare by value.

But when is that? 2030? 2040? We think it is somewhere in that timeframe. Will Illumina do well from this? Indubitably – it is the 'picks and shovels in a goldrush' analogy, but it is not the only game in town on the supply side. Do we need to be in this now? No. Does Illumina need to fund it? We think Gates and Bezos are in a reasonable position to pony up the cash, so probably no again.

What we really like are operationally geared plays on the themes that we have identified and can validate as being part of the inevitable healthcare change story. We think it is still too early to pick a winner in liquid biopsy from the early private runners (such as Thrive, GRAIL, Invata, etc.) or listed participants (e.g. Guardant Health). Diluting that operational gearing for something that is both far from commercial payback and highly uncertain is not for us and when it happens at an odd time (like TDOC-LVGO), it raises questions for us as well about the health of the core business – no-one puts ice cubes in champagne.

This does not mean we won't own Illumina again, it means the price point that interests us is now much lower, as is the case for Teladoc post Livongo. We have added another new diagnostics position to replace Illumina and we are happy with our long-term exposure to the liquid biopsy opportunity through our current holdings.

The evolution of our sector weightings is illustrated below. Performance aside, the increased weightings of Diagnostics and Managed Care reflect active allocations in favour of these sectors, although relative performance has also been a positive factor for Diagnostics.

EVOLUTION OF PORTFOLIO WEIGHTINGS

	Subsector end Aug	Subsector end Sept	Change
Diagnostics	11.2%	11.8%	Increased
Diversified Therapeutics	17.3%	15.9%	Decreased
Focused Therapeutics	32.9%	33.3%	Increased
Healthcare IT	3.6%	2.8%	Decreased
Managed Care	15.7%	16.0%	Increased
Med-Tech	7.9%	9.1%	Increased
Services	7.1%	6.8%	Decreased
Tools	4.3%	4.4%	Increased
	100.0%	**100.0%**	

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 31-08-20. Performance to 30-09-20.

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Our cash balance remains largely unchanged at 9.1% (versus 9.0% at the end of August). We issued a further 3.6m shares via the tapping programme.

As noted previously, we expect the next few months to be quite volatile, both in terms of macro-economic considerations and equities as an asset class and this could play into the translational component of our sterling NAV versus a predominantly US dollar gross exposure. We have therefore elected to switch the majority of our cash balance into sterling for the time being, to provide a partial hedge against any further exchange rate volatility.

We always appreciate the opportunity to interact with our investors directly and you can submit questions regarding the Trust at any time via: shareholder_questions@bbhealthcaretrust.co.uk

As ever, we will endeavour to respond in a timely fashion and, in the meantime we wish you and your families well in coping with this challenging environment.

Paul Major and Brett Darke

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Standardised discrete performance (%)

12-month total return	1 year Sep 19 - Sep 20	2 years Sep 18 - Sep 20	3 years Sep 17 - Sep 20	since inception
NAV return (inc. dividends)	35.5%	18.5%	58.6%	83.8%
Share price	31.2%	11.4%	44.3%	66.0%
Share price (inc. dividends)	35.1%	17.7%	55.7%	80.9%
MSCI WHC Total Net Return Index	15.0%	19.8%	40.5%	60.7%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 30.09.2020

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

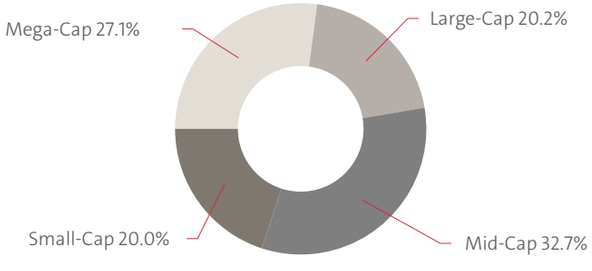
Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed

TOP 10 HOLIDINGS

Bristol Myers Squibb	7.6%
Anthem	7.3%
Esperion	6.7%
GW Pharmaceuticals	5.7%
Hill-Rom Holdings	5.2%
Charles River	5.1%
Humana	5.0%
Jazz Pharmaceuticals	4.9%
Alnylam Pharmaceuticals	4.8%
Caredx	4.6%
Total	**56.9%**

Source: Bellevue Asset Management, 30.09.2020

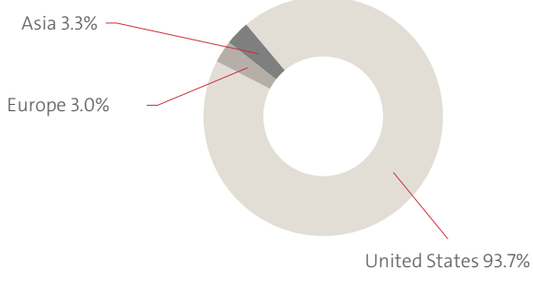
MARKET CAP BREAKDOWN



Source: Bellevue Asset Management, 30.09.2020

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

GEOGRAPHICAL BREAKDOWN (OPERATIONAL HQ)



Source: Bellevue Asset Management, 30.09.2020

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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

DISCLAIMER

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 Investment Trust
Launch	December 2, 2016
Market capitalization	GBP 790.5 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	476 194 689
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

CONTACT

Simon King
Phone +44 (0) 20 3871 2863
Mobile: +44 (0) 7507 777 569
Email: ski@bellevue.ch

Mark Ghahramani
Phone +44 (0) 20 3326 2981
Mobile: +44 (0) 7554 887 682
Email: mgh@bellevue.ch

Bellevue Asset Management (UK) Ltd.
24th Floor, The Shard
32 London Bridge Street
London, SE1 9SG
www.bbhealthcaretrust.com