BB Healthcare Trust

Monthly News
November 2019

As at 11/30/2019	Value	1 Month (November)	YTD	Since Launch (ITD)
Share	145.00	12.0%	25.0%	54.9%
NAV	143.11	11.5%	24.8%	55.8%

Sources: Bloomberg & Bellevue Asset Management AG, 30.11.2019, 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.

As our financial year draws to a close and the calendar year end totters into view through a maelstrom of cocktails and canapés, one can look back wistfully on 2019 and ponder the learnings of the last twelve months. In so doing, the picture is less benevolent for the healthcare specialist than the generalist, but there are many reasons to be optimistic for 2020…

Summary

BB Healthcare Trust 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).

(Don't) look back in Anger

It has been a great year for equity investors. As we go to press, markets are making all-time highs and the MSCI World Index is up 12.3% in dollars in the twelve months to November 2019. However, healthcare has lagged the market; the MSCI World Healthcare Index has risen only 8.0%, ending a three-year run of sectoral outperformance.

Were it not for the sector's strong recovery in November (more of that below), the relative picture would look grimmer. With its effulgent demand drivers, healthcare stands above the ongoing debate over the global macro-economic outlook, surely making this a surprising outcome. Why might it be so?

If the sagacious spectator attempts to distil healthcare's underperformance to a single theme, it would be US Politics and the debate around 'Medicare for All' ('M4A'). As Chart 1 below illustrates, the World and Healthcare Indices delivered comparable returns up to the beginning of March and then the wider market began to pull away. In early April, healthcare began to lag, driven by the sell-off in Managed Care companies enmeshed in the M4A debate.

We have discussed this topic many times during the year and our strong views on the subject have been the lynchpin of our asset allocation decisions during 2019 (i.e. high weighting to Managed Care). Coming as it does on the eve of the UK general election, you are probably all fed up with politics and would rather this factsheet discussed something (anything) else.

Nonetheless, November's developments (and the market's reaction to them) merits further discussion, particularly regarding the "setup" into 2020, which we think will be a positive year for the sector despite the election clamour reaching its acme. Beforehand, let us first review the Trust's performance.

A little ordinary human enthusiasm

Measured in sterling, the Trust's net asset value appreciated 11.5% over the month to 143.11p, beating the healthcare benchmark by 6.8%. Approximately 60% of the positive performance during November can be attributed to the stocks in the October top 10. It was a relatively benign month on the FX front, with sterling weakness around the general election contributing 0.65% to the positive evolution of the NAV over the month.

The index's sub-sector performance is summarised below. Managed Care, Biotech, Dental and Healthcare IT all performed well and these helped our performance during the month. Again, we would highlight that Healthcare Technology is a single stock category (Dexcom) and the company had very positive Q3 results.

BENCHMARK SUB-SECTOR PERFORMANCE AND WEIGHTINGS

Sub-Sector	Weighting	Perf. (USD)	Perf. (GBP)
Biotech	9.8%	8.7%	8.7%
Conglomerate	11.3%	2.8%	2.8%
Dental	0.5%	9.3%	9.3%
Diagnostics	2.0%	7.8%	7.9%
Distributors	3.0%	9.5%	9.6%
Facilities	1.2%	3.6%	3.7%
Generics	0.4%	12.1%	12.2%
Healthcare IT	1.0%	7.6%	7.7%
Healthcare Tech.	0.3%	47.4%	47.4%
Managed Care	8.5%	10.9%	11.0%
Med-tech	15.8%	2.9%	2.9%
Other HC	1.3%	-4.7%	-4.6%
Pharma	34.1%	2.4%	2.5%
Services	1.6%	1.0%	1.1%
Specialty Pharma	3.5%	6.9%	6.9%
Tools	5.8%	3.7%	3.8%

Source: Bloomberg/MSCI and Bellevue Asset Management. Weightings as of 31-10-19. Performance to 30-11-19.

Our performance amounts to a net gain over the financial year of 6.3%, versus 8.1% for the benchmark. We are clearly disappointed that we were unable to outperform the wider healthcare sector during the financial year, but nonetheless we remain optimistic on the outlook in both the short and medium term.

Notwithstanding the very positive result in November, the annual deficit stems from our significant underperformance in the volatile periods of December 2018 and the summer months of 2019, which we have simply not been able to turn around. The more positive recent performance does not reflect any change in strategy or material alterations to our holdings, but highlights the inappropriateness of the valuation declines during those periods. The market has taken a while to catch up, but it is gratifying to see some rationality returning and the background volatility of the sector has been helpfully benign in recent weeks.

On a calendar year-to-date basis, we have delivered a total return of 25.2%, versus 17.5% for the benchmark. November also marked our important third year anniversary: the fund has delivered a total return (in sterling) of 56.7%, versus 46.0% for the benchmark and is the best-performing UK healthcare Trust over this timeframe. One can always do better and is always learning,

but we are confident this initial three-year period demonstrates the viability and scalability of the strategy that we are prosecuting.

Now, without further ado, let us dispense with festive frivolities and return, with exasperating pertinacity, to another necessarily expansive consideration of healthcare politics...

A question of allegiances

Elections are tricky things. The world is arguably in a period of technological change in the relationship between labour and growth not seen since the industrial revolution. Opinions on the pros and cons of this "knowledge economy" are both complex and divisive and the intractability of the issues it raises around inequality has seemingly led to ever more polarised politics across advanced economies.

Perhaps as a consequence, post-modern (post truth?) elections have become pugilistic; one plays the person as much as the ball and the canny congressional hopeful must find common ground to take up arms. After all, elections are won by convincing the recalcitrant to change their vote from whoever prevailed last time.

Where is this common ground to be found? In the vituperative and yet reparative struggle to salve blue collar concerns over living standards and inequality with the realities of an economy now driven by global factors seemingly beyond any single government's control. If this seems like hard work though, one can instead find a subject everyone cares about and tell the voters you can make it better for them.

Healthcare is the perfect topic for such solititude. Virtually everyone appreciates that it is important, expensive and struggling under various demographic and demand pressures. Personal experience makes it highly relatable and its complexity allows politicians (far too much) leeway to bamboozle with various claims and counter-claims (cf. Corbyn and "the NHS will be up for sale").

The age of chivalry was dead

This brings us neatly to the Democratic primaries. A primary election is not the real thing – it is internecine conflict; a phony war to demonstrate ideological purity rather than an actual battle for the hearts and minds of the recalcitrant centrist. It is a truism that candidates moderate their position as the campaign progresses.

In late 2018, the primary contest was pitched as a two-horse race between a centrist (Joe Biden) and a "radical" ideologue (Bernie Sanders). Other runners and riders joined the fray, but there was some surprise when it was Elizabeth Warren rather than Kamala Harris, who emerged as the clear third candidate around May 2019.

Sanders is not the architect of Medicare for all (that was Congressman John Conyers in 2003) but he brought the issue to the Senate and gave it prominence during the Democratic primary campaign of 2015/16.

Biden instead favours "fix and expand Obamacare", arguing that a single payor system was unworkable/undeliverable through Congress. This echoes the position of his former boss – Obama seemingly did support the Conyers proposal back in 2003, but became more pragmatic as time went on, presumably recognising that he could pass an alternative option but not deliver a total replacement of the current system.

Elizabeth Warren became an elected official in 2013, so her historical views on the ideal role of government in healthcare provision is less clear. However, her early career was researching personal bankruptcy in the US, for which catastrophic medical bills are a major driver. She has supported M4A throughout her Primary campaign and is a co-sponsor of the Sanders bill.

Having covered the broader subject of M4A many times before, we will simply and note that the Sanders proposal is intentionally vague around some of the final details as to how it will work (which has a bearing on its cost) nor does it seek to explain how it would be paid for. These vagaries give rise to three three key issues when taking the proposal to the electorate:

- **Implementation:** how long should it take to move to a single payor system, and how will the government make the system work when the private insurance industry is so fundamental to the operation of the current system (and so popular)? In 2018, 34% of enrolees were on a privately run Medicare Advantage (MA) plan and this proportion rises every year because the MA offer is more attractive. Moreover, 160 million Americans have employer-sponsored health insurance coverage and many of them like what they have.

- **Payment rates:** the independent US healthcare system as currently construed could not survive if providers were only reimbursed at Medicare rates. The US Centres for Medicare Services (CMS) estimates that 80% of US hospitals lose money treating Medicare patients, but make it up on private insurance work that attracts much higher rates (for simplicity's sake, one can assume private rates are somewhere around 2x Medicare).

- **Funding:** it is widely acknowledged that this policy will increase government expenditure significantly and the books must be balanced through taxation, which is inherently unpopular if the cost falls back to the individual (i.e. the voter). What will this scheme mean for the "median" swing voter?

It would not be unfair to describe Sanders as an inflexible ideologue. He does not deny the multitudinous complications and costs of implementing M4A (presumably why the Bill dodges many details), merely noting that healthcare is a fundamental human right and the US must join other developed countries in providing it to everyone.

Sanders is thus immune to criticisms around implementation; Sanders supporters know what they are voting for. For this reason, we think he is highly unlikely to secure the Democratic nomination, since the party bigwigs know he will be unwilling to moderate contentious policies to win over the all-important centrist swing voters.

Warren is in a different position; on paper, she has the potential to be more flexible and appeal to centrist voters and thus more likely to run the distance to the Democratic Convention. Until recently, she had not opined on the outstanding issues around M4A, preferring instead to hide behind Bernie. Eventually, he could drop out or fall away in the polls, forcing Warren (as the Bill's co-sponsor) to lead on the issue and explain the controversies highlighted previously.

We expected this eventual clarity to be some time away, but positive for wider sentiment when it did arrive, thinking the logical step would be a classical political "row back" where one talks down expectations and waters down policy to something more likely to win Congressional support and progress to actual legislation. We have gotten to where we expected, but via a different route...

DeJa Vu

On 1 November, Warren published her M4A funding proposal, the catchily entitled "ending the stranglehold of healthcare costs on American families". This was followed two weeks later by the "...plan for reducing healthcare costs in America and transitioning to Medicare For All", which covers implementation. The timing was probably to neuter criticism regarding a lack of detail ahead of the fifth Democratic Primary debate on 20th November. What can we learn from these documents and Warren's prognostications at that debate?

First the funding proposal: when one looks past the inevitable soundbites, it is a 28-page wonkfest that claims M4A will only cost $52 trillion over 10 years, roughly the same as the current system is forecast to cost. This is achieved through a combination of savings and new revenue raising options that allegedly will not impact the vast majority of individuals (only the very wealthy and corporations).

As with any manifesto, there is considerable latitude to "cherry pick" advantageous forecasts and, like the Sanders Bill, it does not provide definitive answers to all of the critical design questions that will ultimately impact the cost/benefit equation for America.

Furthermore, there are a number of principled positions Warren takes that we simply cannot agree with, such as not blocking patients from seeing the physician of their choice or being denied treatment. No rational healthcare system is a free-for-all and the US is already notably worse than other countries for over-treatment. This is not the route to tame healthcare cost growth.

Warren makes a lot of saving money via a single payer system. All of the points that she makes are undoubtedly correct, but we take issue with the magnitude of the savings achieved through her proposed initiatives:

- **G&A:** Warren suggests that an ecosystem of multiple insurance payors is overly burdensome, raising administrative cost. Even the NHS spends around 8% on administration, so the idea that the overall system can reduce expenditures to 2.3% versus the 12% insurers spend (bearing in mind almost 40% of Medicare is administered privately so really that 2.3% is more like 3.8%) feels optimistic.

- **Lowering hospital costs (1):** she also claims that it is not utilisation that drives cost inflation but inherently high costs. We think it is both and that high costs are in part due to the litigious culture of the US (which, as a former lawyer, Warren apparently does not seek to change). The costs in the private sector also occur in part because the hospitals treat Medicare patients at a loss; these expenses must be recouped somewhere. Warren acknowledges this and proposes 10% higher Medicare payment rates than today, but we think this too low to make the hospital system viable.

- **Lowering hospital costs (2):** Warren also suggests that hospital capacity is too concentrated and that anti-trust legislation should be used to break up networks to improve competition, which will then drive down prices. Whilst the variation across States for comparable treatment can be quite staggering, this is a business where it is very hard to make money:

According to Fitch, the median operating margin for the 220 non-profit hospitals in the US was 2.1% in 2018, compared to 1.9% in 2017. If this is a monopolistic stitch-up, then it's a pretty poor one (this fact, alongside the drive to move business to lower acuity settings, hopefully makes clear why we have no US hospital operators in the portfolio). Many operators argue that multi-facility networks are increasingly necessary to keep procurement costs down; we struggle to see how breaking companies up into smaller, less efficient units will deliver the desired results.

Warren is not alone in focusing on hospital costs. It is a logical focus when roughly two thirds of costs go to the interaction of the patient and the physician. The Trump administration has twice proposed mandatory reporting of treatment costs and for hospitals to disclose their discounting arrangements with both suppliers and insurance payors. There is the hope such transparency will encourage more competition.

We worry the opposite may be true: firstly, small hospitals will see all too clearly the merits of enhanced negotiating power and, secondly, those who are "too cheap" relative to their proximate peers will try to raise prices, knowing this is a very localised marketplace. In our view, the easiest way to lower hospital costs is to prevent patients going to them in the first place.

- **Lowering drug costs:** Warren's plan assumes that the Democratic Drug pricing plan (which Republicans have declined to support) will be enacted. If not, compulsory licensing will be used to lower drug prices. International law makes this is a very difficult road to travel.

All of the above will supposedly hold healthcare cost inflation in line with GDP growth; a feat no developed country is currently managing, irrespective of its system design. If that is the starting point for fiscal balancing of funding, then it will be very challenging indeed. We do believe that healthcare cost inflation can be reined in (indeed it is the raison d'être of our strategy), but this is a multi-decade process predicated on far-reaching changes to medical practice that are not covered in M4A.

Moving onto the implementation proposal; Warren's plan is composed of two stages:

Firstly, an expansion of existing Medicare to those that want it and are aged 50-65. This seems sensible enough and probably uncontroversial. It will also be expanded to under 18s at certain low income levels and we would agree these relatively modest extensions can be achieved through legislative fiat.

What follows though is more complex and Warren acknowledges it will require specific legislation passed by Congress with the attendant risk of dilution or even being voted down. In the first instance, the new M4A will be offered on the Obamacare platform and to Medicaid beneficiaries as an alternative to current arrangements, i.e. an elective opt-in. This makes her proposal sound confusingly similar to those of M4A critics Biden and Buttigieg in the early years.

Thereafter ("no later than my third year in office"), when Warren expects most people to have voluntarily shifted to her options, she will look to enact legislation to force the remainder over. The implementation bill also specifically points to "supplemental private insurance… a private market could still exist", although it is vague as to what this could offer.

The key point from the implementation bill is its tacit acknowledgement of the need to get people to buy into this gradually. Of course, if Warren launches her alternatives and the marketplace remains oriented around private plans, there will be little appetite to move further legislation along.

There are cruel steel traps lying about everywhere

In some respects, Warren need not have rushed. The fifth Democratic primary proved to be a wide-ranging affair, with much less time devoted to this topic than many expected and the barbs thrown by the candidates were well-worn and not directed specifically to Warren's detailed proposals.

Nonetheless, her poll numbers do appear to have fallen slightly since early November (although it is impossible to attribute this to any specific issue and it may well be other candidates are simply now getting some airtime as the field of realistic candidates is winnowed).

However, this is unlikely to remain the case. Warren has opened herself up to detailed scrutiny on this topic and it is likely that her proposals will be found wanting. We think it will be difficult to sustain positive momentum if one is continually having to address fundamental criticisms of the policy. This will especially be the case if Warren secures the nomination and must face the simplistic, reductionist attacks of Trump; one can easily imagine how this will be pulled apart.

You've got to fight him

The other major political development during November was Mike Bloomberg entering the race for the Democratic nomination. He has deep pockets and a successful track record as a political moderate during his stint as Mayor of New York, and for succeeding in political races on the back of a late entry. He is pro Obamacare and a limited expansion of Medicare (for

those currently struggling to afford insurance – isn't that what Medicaid is for?), so will be another voice on the centrist side of this debate.

Bloomberg's public pronouncements suggest he is also likely to focus on the financing of the M4A proposal: "Medicare for All would destroy our hospital system"and "Doctors wouldn't be able to make enough money". He could well highlight many of the things that we have mentioned above. We think he will prove a much tougher opponent on these issues than Biden.

The injustice of it is almost perfect

The whole debate about healthcare provision in the US can seem very alien to those of us in countries where universal healthcare was a key part of the post-war settlement. However, one must try to remain dispassionate and objective. It does not really matter what one's political sympathies are, nor is there much of an argument that the US system is ruinously expensive versus any other developed nation. The M4A discussion is purely a question of realpolitik.

What will happen in the coming administration is a question of what is practicable from a legislative perspective and what can be safely executed without disrupting the existing system to the point of collapse. This is the obvious reason for a phased implementation and the comments of providers (by this we mean physicians, hospitals and clinics) and the Congressional Budget Office will be critical to gaining the necessary support to move things along. That said, we think the disruption caused by the implementation of M4A would impact most sub-sectors of healthcare.

Let us not forget, this idea has been kicking around Congress since 2003 and thus far has gotten nowhere. Even passing Obamacare was a hard-fought battle. Let us assume for a moment that Warren is sitting in the White House next Christmas, she will face mid-terms in 2022 that could tip the balance of power before the aforementioned three-year period is up. This will not be an easy sell to Congress.

As such, we feel that M4A anxiety has reached its denouement. The most credible supportive voice has done all she can to make the proposal sound robust and sell it to the middling voter, but we see very little that will broaden its appeal beyond a narrow (i.e. already Democrat supporting) base. The issues remain unsatisfactorily addressed and this leaves an open goal for her growing band of opponents (Biden, Buttigieg and now Bloomberg).

This leaves us with a setup where, in contrast to most election years, investor anxiety with respect to healthcare could ease rather than worsen as the election draws closer. This leaves us feeling optimistic about the coming year in terms of healthcare's relative performance.

Developments within the Trust

As of end November, the portfolio comprised 30 equity investments plus the Alder CVR (detailed in last month's update). We have added two new positions: we have re-bought one of our historical specialty pharma holdings and added our first company in the Tools space.

The Alder transaction left us in a net cash position at the end of last month and we deployed this into the new positions above, leaving us with a month-end leverage ratio of 0.9%. We have also slightly reduced our managed care exposure (from 16.9% at the end of October to 14.4% at end November) on the back of the sub-sector's strong run during the month, but hopefully the preceding paragraphs make clear our reasoning as to why there is still significant value on the table. We did not issue any shares through the tapping programme during November but were again able to place the shares returned via the redemption programme.

This is our last missive of 2019 and we wish you all a merry Christmas and a prosperous start to the New Year. If you cannot bear such a hiatus, 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.

Paul Major and Brett Darke

B|B Healthcare Trust

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Standardised discrete performance (%)		
12-month total return	**Nov 18 - Nov 19**	**Dec 16 - Nov 19***
NAV return (inc. dividends)	6.4%	55.8%
Share price	3.9%	45.0%
Share price (inc. dividends)	7.1%	54.9%
MSCI WHC Total Return Index	8.1%	46.0%

Sources: Bloomberg & Bellevue Asset Management AG, 30.11.2019

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

*Trust incepted on 2 December 2016. Therefore 12 months of perfromance data does not exist for the calendar year.

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

Diagnostics	17.0%
Specialty Pharma	16.9%
Managed Care	14.4%
Biotech	10.7%
Med-Tech	10.2%
Healthcare IT	8.9%
Dental	7.0%
Pharma	6.4%
Services	2.9%
Facilities	2.7%
Tools	2.0%
Health Tech	1.0%

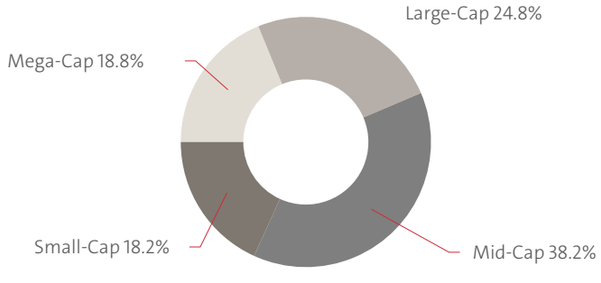
Source: Bellevue Asset Management, 30.11.2019

TOP 10 HOLIDINGS

Illumina	7.3%
Align Technology	7.0%
Anthem	6.9%
Bristol Myers Squibb	6.4%
Teladoc	6.3%
Humana	5.5%
Esperion	4.7%
Insmed	4.5%
Intuitive Surgical	3.5%
Jazz Pharmaceuticals	3.5%
Total	**55.5%**

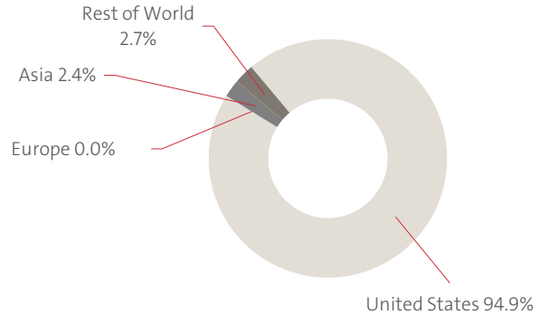
Source: Bellevue Asset Management, 30.11.2019

MARKET CAP BREAKDOWN



Source: Bellevue Asset Management, 30.11.2019

GEOGRAPHICAL BREAKDOWN (OPERATIONAL HQ)



Source: Bellevue Asset Management, 30.11.2019

"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 Asset Management AG ("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 629.2 million
ISIN	GB00BZCNLL95
Investment Manager	Bellevue Asset Management AG; 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	433 957 062
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

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