# BB Healthcare Trust

Monthly News
June 2021

Marketing document

| As at 06/30/2021 | Value | 1 Month (June) | YTD | Since Launch (ITD) |
|---|---|---|---|---|
| Share | 198.40 | 7.9% | 13.3% | 124.5% |
| NAV | 197.63 | 8.4% | 14.4% | 124.2% |

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 30.06.2021, NAV and share price returns are adjusted for dividends paid during the period (but not assuming re-investment). Full performance data is on page 5.

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 June update. The Western world continues its slow march toward normality, with growing evidence that high levels of vaccination can break the link between SARS-CoV-2 infections and severe COVID-19 resulting in hospitalisation and death.**

**Even more transmissible strains are not obviously derailing this journey, but there is still a long way to go before humanity at large can truly return to our old ways. 'Building back better' has become a common refrain of the political classes in recent months. Whilst this may seem a hollow soundbite, it has significant resonance for healthcare, as the industry's coalface creaks under the pressures of returning to normal post COVID.**


## 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.


## *Monthly review*

### The wider market

During June, the MSCI World Index appreciated 4.4% in sterling terms (it rose only 1.4% in dollars; with the dollar strengthening during the month, bolstering the local currency performance). As noted in the previous factsheet, the market is settling down into something of a more stable narrative, accepting that inflation is coming back and interest rates will rise over time.

With recovery now priced in, it will be interesting to see how the coming months unfold. If the recovery continues to gather momentum and to surprise to the upside, then equities will remain the asset class of choice, otherwise it could be a rather quiet summer.

There do appear to be some residual concerns over variant strains and the potential for another COVID wave to derail the recovery in late summer, but an objective view of the data increasingly supports the argument that current vaccines are good enough to suppress morbidity to the point where this disease no longer risks overrunning healthcare systems and, as such, we can all get back to worrying about something else if we apply a degree of common sense to our behaviour.

Like influenza, this virus will continue to circulate and mutate: there will be hospitalisations and deaths. We must accept endemic SARS-CoV-2 as the new reality of the human condition. New vaccines may well be needed in time, as might booster shots, but for now the focus must be on getting as many adults across the globe double-jabbed as quickly as possible, since this conveys the highest level of protection.

The technology complex roared back into favour during June, as the market gyrated away from playing interest rate rises and inflation and back toward fundamental growth. The top three performing sectors in dollar terms were Software & Services (+7.1%), Tech Hardware & Equipment (+6.8%) and Semiconductors (+6.2%). On the other side, last month's interest rate and inflation-sensitive winners were this month's losers by and large with Banks (-5.1%), Insurance (-5.0%) and Materials (-4.3%) propping up the bottom of the table.

During June, the dollar recovered versus sterling and the Euro (these two are flat over the month versus each other) on the back of more hawkish Federal Reserve commentary around the cadence of interest rate rises and timing for stepping back on quantitative easing in the face of mounting inflationary pressures. We noted the illogical recent weakness of the dollar in the face of such pressures in last month's factsheet and it is gratifying to see a more reasonable outlook emerge: dollar/sterling now lies modestly above where it stood at the end of April.

### Healthcare

A refocusing toward longer-term growth as the broader market narrative would intuitively be positive for the relative performance of healthcare, and so it proved to be. The MSCI World Healthcare Index appreciated 6.0% in sterling terms (+2.9% in dollars), outpacing the broader market by 1.6% over the month.

The subsector performance is highlighted in Figure 1 below and it is notable that performance was led by the 'growthier' sub-sectors that lagged during May: Healthcare Technology, Diagnostics, Tools, Focused Therapeutics (i.e. Biotech) and Healthcare IT.

Again mirroring the broader market macro, the laggards this month were the three best performing sub-sectors from May. In summary then, the sector's movement during April and May resembles the perambulations of an inebriated crustacean; despite the appearance of purposeful progress, we haven't really gone anywhere other than a bit sideways...

### BENCHMARK SUB-SECTOR PERFORMANCE AND WEIGHTINGS

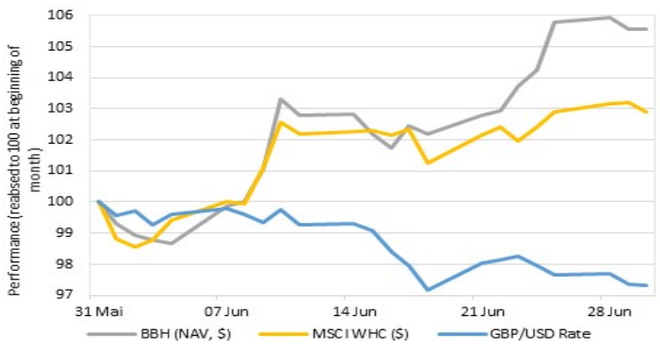
| Sub-Sector | Weighting | Perf. (USD) | Perf. (GBP) |
|---|---|---|---|
| Healthcare Technology | 0.8% | 11.0% | 14.2% |
| Diagnostics | 2.5% | 9.5% | 13.8% |
| Tools | 8.2% | 7.2% | 10.2% |
| Focused Therapeutics | 8.2% | 7.0% | 10.0% |
| Healthcare IT | 1.6% | 6.3% | 9.3% |
| Services | 3.1% | 4.8% | 7.9% |
| Diversified Therapeutics | 32.6% | 4.4% | 7.4% |
| Other HC | 1.5% | 3.9% | 6.7% |
| Dental | 0.9% | 3.1% | 6.0% |
| Med-Tech | 15.6% | 1.9% | 4.8% |
| Distributors | 1.1% | -0.2% | 2.6% |
| Conglomerate | 12.4% | -2.1% | 0.7% |
| Managed Care | 9.8% | -3.2% | -0.4% |
| Facilities | 1.3% | -4.0% | -1.3% |
| Generics | 0.5% | -5.2% | -2.5% |
| **Index perf.** | | **2.9%** | **6.0%** |

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 31-05-21. Performance to 30-06-21.

### The Trust

In many ways, the narrative described previously was an ideal one for the Trust, given what happened during May: in addition to a material FX headwind that made little sense in the wider macro narrative, there was also largely inexplicable negative de-coupling of our portfolio from the wider healthcare sector's performance.

Our May missive suggested this would likely reverse sooner rather than later, given the historical pattern of such de-coupling events (we have seen three similar occurrences during our tenure). During June, the Trust's net asset value rose 8.4% in sterling to 197.63p, outperforming the MSCI World Healthcare Index by 2.6%. We have not recovered all of the underperformance from May, but we have made a good dent. The monthly evolution of the NAV is illustrated in Figure 2:




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

Again, rather echoing the broader sector and market-wide narrative, it was holdings exposed to the highest growth end-markets that drove the outperformance, aided by the currency tailwind created by our relative over-exposure to dollar-denominated assets.

We continued to deploy capital throughout the month. It was a quieter period in terms of inflows, with only 3.6m new shares issued via the tapping programme. Gearing remains on a modest upward trend: the month-end leverage ratio stood at 1.6% of gross assets, compared to 0.7% at the end of May 2021. The evolution of our sub-sector weightings is illustrated in Figure 3 below:

EVOLUTION OF PORTFOLIO WEIGHTINGS

| | Subsector end May 21 | Subsector end June 21 | Change |
|---|---|---|---|
| Diagnostics | 5.5% | 5.9% | Increased |
| Diversified Therapeutics | 14.5% | 13.7% | Decreased |
| Focused Therapeutics | 26.1% | 27.4% | Increased |
| Healthcare IT | 6.5% | 7.0% | Increased |
| Healthcare Technology | 2.9% | 3.1% | Increased |
| Managed Care | 13.3% | 12.3% | Decreased |
| Med-Tech | 18.0% | 17.4% | Decreased |
| Services | 9.3% | 9.5% | Increased |
| Tools | 3.8% | 3.8% | Unchanged |
| | **100.0%** | **100.0%** | |

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 31-05-21. Performance to 30-06-21.

The increase in Diagnostics was driven mainly by active allocation, as we continued to build a position in the new holding in this sub-sector that we initiated last month. Diversified Therapeutics has fallen due to relative performance and Focused Therapeutics has risen largely for the same reason.

Healthcare IT has risen through a combination of performance and allocation; we have added another Healthcare IT company to the portfolio (taking it to 32 active equity positions excluding the Alder CVR) and we will continue to scale up this holding over the coming weeks. The other changes to sector weightings have been largely driven by relative performance, although we have been taking some profits in Tools.

## *Managers' Musings*

### We the people

This month we again reflect on the longer-term consequences of the pandemic. Last month, we discussed the dependency ratio in its most widely understood form. However, healthcare offers another, more nuanced, take on dependency. Caring for people's health has always been an endeavour driven predominantly by human capital. Doubtless readers understand well the demographically-driven demand side of the healthcare equation. Simply put, more care will inevitably require more carers.

Whilst it is a coterie of pioneering researchers and daring surgeons who get all the attention, healthcare is a business like any other, with an army of barely noticed and poorly paid "key workers" who enable the enterprise to exist: good luck getting to the operating table without a hospital porter.

The problems now facing the healthcare and social care industries (we will come back to why they are so inextricably linked) are not unique. The roles at the base of the pyramid are semi-skilled and often pay minimum wage. There are shifts that include evenings and weekends. Let us be frank: nobody wants to work in this manner if they can find something more compatible with having a family and a social life.

Healthcare has other problems too. Unlike working in an internet retailer's "fulfilment centre" (oh, the irony!) or for a supermarket or call centre, one can look forward to almost certain contact with pathogens and all manner of biological effluvium. Then there is the psychological toll of being exposed to human suffering and death.

Both your managers have worked for a time during our idealistic undergraduate days within the beloved (and benighted) NHS. The mere fact we both ended up in Corporate Finance with its legendarily punishing hours, in preference to continuing down a healthcare-oriented career path surely speaks to the reality of the industry, even before we get into the labyrinthine bureaucracy and Kafkaesque processes that intervene in the desired goal of actually trying to help people.

As one moves up the organisation chart, the work becomes more skilled and there will be an increasing level of educational commitment required to hold such a post. Both here and in the US, further education is expensive and time-consuming. Here in the UK, the level of subsidy offered by the government for courses such as nursing was cut in 2010 following the financial crisis. This was a disaster and, following a collapse in applications to such courses, some of the assistance has been restored. It is nowhere near where it was though and recruitment numbers remain well below what is needed.

That having been said, those choosing to enter nursing, medicine or a related field such as physiotherapy or clinical lab work do so knowing that the pay isn't great and the rewards of preferment are more honorific than pecuniary. For example, we recently spoke to a senior nurse who had just taken on the responsibility of managing an additional team for what amounted to a further six pounds a week in her pocket. The promotion would also leave scarcely any time for patient interactions.

When asked why she would take such a role, the response was telling: "someone had to step up and do it". Simply put, the system is running on a combination of the altruistic goodwill of many, and the lack of better options for minimum/low wage employment for some. This is very far from "employer of choice" status. Even the most selfless human does not have an infinite well of goodwill on which they can draw when faced with real-world issues related to the cost of living and their shift patterns.

## Medical Loss Ratio

What is the point of the previous peregrinations? Self-evidently, the staff retention and turnover rate of such an industry is going to be poor and this, in and of itself, is a problem. Let's begin again at the bottom of the wage pyramid. In social care here in the UK and also in the US, the staff turnover rate is around 30% per annum and this proportion has been steadily rising for decades. What do we mean by 'turnover rate'? One in three people who take up a position leave it again within one year.

These are generally minimum wage jobs and staff providers have commented to us that local retention rates drop when new, larger-scale employment opportunities arise (e.g. new supermarket, warehouse etc.), especially if the work is less emotionally draining.

Such high turnover rates are undesirable for the recipients of care; does one really want a revolving door of strangers coming in and out to help with intimate ablutions? What must it be like for someone with dementia, where routine is so important to have to cope with such change?

This turnover also has cost implications. There is a lot of paperwork to manage social care services, which are generally charged out by the hour, with a recipient of care being assessed and entitled to a certain number of hours of paid care and anything further being self-funded. There is training and supervision as well, with the training obviously costing employers more than they would like due to the high staff turnover.

Broadly speaking, one can assume that costs and a high single digit profit margin mean that the 'charge out' rate for providing such care is about 2x the minimum wage. In the UK, local authorities pay out a teens hourly rate (it varies by location) to independent operators. With the minimum wage now of c£8.40, the United Kingdom Homecare Association claims that it is impossible to sustain a business that receives less than £18.40 per hour. The important point to note here is that the profit margin is thin. No-one is getting rich providing social care under the current model.

If we move up the wage scale into the private nursing sector (i.e. more skilled social care), the turnover rate halves to around 15% per annum. If we move into hospital nursing roles, the rates in the US have been in the 17-19% range for many years now and 90% of this is "voluntary" (which means the employee initiates it, not the employer).

To be fair, this data does not capture people who move from one hospital to another to secure higher wages via a promotion, so one cannot necessarily liken it to the figures for social care where it's far less likely people will move for pay or promotion in the social care sector because the opportunities to do so are much more limited).

Again though, there will be attendant costs for re-training as different hospitals have different systems and processes and some of these people will be leaving the profession. The data shows that the majority of nursing departures occur within 1-2 years of joining the profession. Hard work and idealism gets you into nursing college, but so often the reality falls short of the aspiration and there are much easier ways for hard-working people to make a decent living.

Data for doctors is a little better. The level of commitment to the profession from an idealistic perspective must be high, given the very long education and training cycle. However, it is notable that an increasing number of junior doctors in the UK choose to take the option of a career break between foundation year two and three. Some leave to go abroad (there has always been a global circulation of medics, especially between the UK and Canada and Australia), but will they return?

These departures make planning for the NHS very difficult and explains why the number of (heavily subsidised) medical school places available in the UK has doubled in the past few years. Some wags refer to this growing brain drain as "Drexit". It is tempting to think of this as a British problem, but it turns out to be a universal one across the Western world. You will easily find Drexit-related articles from US-based institutions for instance.

Data on who does return is patchy and difficult to analyse; people may disappear for one year or for many and may return at a much higher training level. What is clear though is that the funnel of new medics completing training here in the UK is much narrower than those starting it and this problem is getting worse.

## Taking stock

The entirely obvious result of the observations summarised previously is that we face two mutually incompatible realities. There is a global (and growing) shortage of healthcare workers from the bottom of the industry to the top, even as everyone recognises that demand for healthcare services will continue to rise inexorably. This is a 'not so hidden' crisis. How bad is it? Let us first consider the pre-pandemic situation.

A 2017 report from Mercer tried to estimate the likely deficit in US healthcare workforce numbers, based on Government projections that the healthcare industry would end up employing an additional 2.3 million Americans by 2025, half of them directly in patient-related care. Figure 4 below summarises the deficit forecast by occupation and we have added in skill levels. The primary issue will relate to the adequate staffing of social care.

| Job Type | New job created by 2025 | Growth vs. 2017 | Expected workforce gap |
|---|---|---|---|
| Home Health (basic) | 423,200 | 32% | 446,300 |
| Nursing assistant (semi-skilled) | 407,396 | 16% | 95,000 |
| Lab Technologist (degree) | 49,400 | 13% | 58,700 |
| Lab Technicians (degree) | 60,717 | 18% | 40,000 |
| Nurse practitioner (skilled) | 51,445 | 30% | 29,400 |
| Physicians (degree) | 102,970 | 16% | 11,000 |

Closer to home (but again focusing on the pre-pandemic period), the NHS reported 106,000 vacancies as of September 2019, 77,000 of which were full-time. 44,000 were nurses and 9,000 were doctors. To put this into context, the NHS employs around 1.3 million people (1.1m of whom are full-time). The ongoing vacancy rate in the US is around 5%, which is not much lower than the c.7% implied by these NHS figure. Whilst these deficits have existed for decades, they are continually expanding and although our trans-Atlantic healthcare systems are very different structurally, we are struggling with very similar issues.

## Can we have our beds back?

The reason that we keep including social care in this discussion is because of 'bed blocking' or 'delayed transfers of care' as it is known inside the NHS and 'delayed discharge' (which sounds like an unfortunate medical complaint) in America. One of the challenges of an increasingly elderly population from a medical side is that many of your customers will take a long time to heal and will likely require additional help during their convalescence.

This usually means discharge into a low acuity facility (often a nursing home) or back into the community with appropriate home healthcare support having been put in place (known as a 'complex discharge' in the NHS), rather than on one's own responsibility to follow care advice, known as a 'minimal discharge' (not that people ever follow medical guidance when it is given, but that can be the subject of another missive).

If appropriate supportive care for complex discharge case cannot be arranged to the satisfaction of the supervising hospital consultant, then they cannot discharge the patient and the bed becomes blocked. For the healthcare industry then, failing to solve the social care problem is like blocking the exhaust pipe of a car. At a certain point of time, the back pressure will cause the engine to shut down. Age UK estimates that bed blocking takes up 2,700 beds every day here in the UK, or around 2% of available NHS bed space.

## Salubrious-sounding solutions

Having laid out the problem, the solution seems obvious - healthcare workers need to be paid more in order to attract and retain staff, especially at the bottom of the scale and formal training for skilled rolls needs to be better subsidised to make this a more accessible career path.

This wage point may well be true, but let us consider the potential implications of a solely wage-based solution. Firstly, it will cost a lot of money to address these concerns. The NHS wage bill is somewhere around £50 billion per year and the tax take in the UK as a whole was ~£700 billion in 2019, ~£300 billion of which was income tax and National Insurance.

All other factors being equal then, a 10% increase in the NHS wage bill is equivalent to more than a 1% increase in the income tax take or several pence on the basic rate of tax. Let's not forget that such a move would do nothing to immediately close the deficit at the higher skilled end, as this will require time for people to be educated and trained to the relevant level.

The second problem is a relative one for the lower paid. Amazon et al. have deep pockets. If we head into a 'war for talent' at the lower end of the wage scale, then the healthcare system will lose because, pound for pound, the job that does not expose you to the most unpleasant aspects of the human condition is going to win out.

Yes, the altruistic minority will stick it out, but there are limits to the number of people who are of this mindset. Therefore the employment environment also needs to change: it needs to be easier and more rewarding to be a healthcare worker. How do we move forward to make this a reality, rather than some far-fetched utopian-sounding fantasy?

## I am become death, destroyer of Worlds?

All of the preceding circumlocution describes a pre-pandemic perplexity of long standing. The question of how the pandemic has impacted recruitment and retention remains a much-discussed topic, with all manner of soundbites that favour a positive or negative conclusion.

We are all aware of the many who came out of retirement to help the NHS and the legions of volunteers who have helped on the vaccine rollout. On the other hand, one cannot really avoid articles and radio phone ins about how NHS staff are struggling to cope with the stress that the pandemic has wrought upon their profession. Figure 5 below shows NHS data for absenteeism by staff role on an annual basis and then for Q4 2020 and the most recent data (February 2021).

There is a longstanding pattern of increasing absenteeism and this does seem to have worsened for clinical staff since the pandemic. The most commonly reported reason for absenteeism in 2020 was mental health related (stress etc.), accounting for more than 20% of the incidents. Some of the increase may be due to caution – if you felt ill during the pandemic or had close contact with someone testing positive for COVID, this may lead to prolonged absence due to mandatory self-isolation. We do not have data breaking this out of the numbers, making it difficult to form robust conclusions on the current situation.

| | 2016-17 | 2017-18 | 2018-19 | 2019-20 | Q4 20 | Feb-21 |
|---|---|---|---|---|---|---|
| All staff groups | 4.16% | 4.19% | 4.21% | 4.48% | 4.84% | 4.65% |
| Professionally qualified clinical staff | 3.54% | 3.55% | 3.55% | 3.75% | 4.17% | 4.05% |
| HCHS doctors | 1.25% | 1.29% | 1.29% | 1.49% | 1.70% | 1.45% |
| Nurses & health visitors | 4.44% | 4.47% | 4.48% | 4.73% | 5.39% | 5.37% |
| Midwives | 4.75% | 4.93% | 4.80% | 5.11% | 5.46% | 5.02% |
| Ambulance staff | 5.49% | 5.31% | 5.31% | 5.38% | 6.12% | 6.34% |
| Scientific, therapeutic & technical staff | 2.98% | 2.97% | 3.02% | 3.24% | 3.41% | 3.18% |
| Support to clinical staff | 5.57% | 5.63% | 5.67% | 6.04% | 6.65% | 6.33% |
| NHS infrastructure support | 3.73% | 3.74% | 3.79% | 4.04% | 3.75% | 3.55% |

In summary then, there is certainly a long-standing trend of staff finding the work increasingly difficult to cope with. Doubtless many would leave the profession if they could, and this latter point is the critical one – whilst the pandemic may well have prompted an increased proportion of clinical staff to reassess their commitment to working in healthcare, its terrible impact on the wider economy and on further education has made escape routes via alternative employment or re-training very difficult to access.

Our view is this: the next few months will be very telling. We are seeing job vacancies in the broader marketplace rising and employer after employer citing issues with recruiting and retaining staff. Wage inflation seems the inevitable consequence of this tight labour market and such a situation undoubtedly plays into the hands of the more nimble private sector employers than large organisations with unionised collective bargaining or the public sector. We could well be on the cusp of a new, accelerating crisis in healthcare and social care staffing.

## Practical solutions

How do we address the current labour force issues, other than by throwing huge amounts of money at the problem that society can ill afford? First and foremost, working conditions can be improved. We do not refer to the exposure to risk, nor to the difficulty of confronting death and suffering. These are unavoidable realities for frontline caregivers.

However, the administrative side of the business can change dramatically. There are many, many studies that show how much money is wasted in healthcare and how much time is spent by frontline staff on administration. Better IT systems would be a great place to start, as would hiring more non-clinical staff to take the administrative burden away from the frontline. These changes alone would help to stem the coming personnel crisis as we would need fewer clinical staff to meet demand if we used them more efficiently.

We have seen countless examples of businesses across healthcare and social care that are using technology to save money and then use that money to recruit more skilled or previously retired people back into social care and home health assistance. One provider we recently met with claims to be paying its staff 30% above the minimum wage, so this shows what is possible if paperless systems are scaled up.

We spend quite a lot of time immersed in the weeds of this subject and believe fervently that the salvation of healthcare lies in these hidden 'middle office' types of solutions. The BB Healthcare portfolio is full of companies that are delivering connected care tools to enable better management of services and also exposed to operators who have built huge data verticals from the patient to the provider to analyse and improve the cost and quality of care through relentless incremental improvement (think six sigma, but for healthcare).

What investors may be less aware of is that we have four companies in the portfolio who are using innovative IT solutions and management to improve care delivery efficiency and site of care, or helping patients find the provider in their area that can serve them better. These four companies represent nearly 10% of the portfolio and we expect that proportion to rise further in the coming months.

Doubtless the news will continue to focus on those pioneering researchers and daring surgeons whilst lamenting the broader suffering of healthcare workers in general. In the background though, changes are coming and they offer genuine hope in what might otherwise seem a depressing long-term picture.

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. We thank you for your support of BB Healthcare Trust.

**Paul Major and Brett Darke**

# B|B Healthcare Trust

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June 2021

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## Standardised discrete performance (%)

| 12-month total return | 1 year June 20 - June 21 | 2 years June 19 - June 21 | 3 years June 18 - June 21 | 4 years June 18 - June 21 | since inception |
|---|---|---|---|---|---|
| NAV return (inc. dividends) | 26.1% | 53.8% | 68.7% | 87.1% | 124.5% |
| Share price | 24.0% | 52.3% | 73.1% | 96.1% | 124.2% |
| MSCI WHC Total Net Return Index | 10.9% | 30.2% | 50.7% | 56.7% | 80.8% |

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 30.06.2021

All returns are adjusted for dividends paid during the period, assuming reinvestment in relevant security.

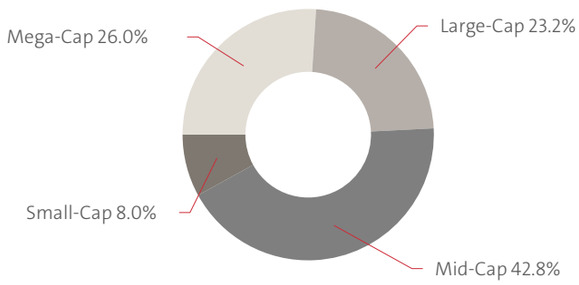
Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed

## TOP 10 HOLIDINGS

| | |
|---|---|
| Bristol Myers Squibb | 6.3% |
| Insmed | 6.0% |
| Jazz Pharmaceuticals | 6.0% |
| Vertex Pharmaceuticals | 6.0% |
| Hill-Rom Holdings | 5.1% |
| Anthem | 4.9% |
| Charles River | 4.4% |
| Alnylam Pharmaceuticals | 4.4% |
| Humana | 4.1% |
| Accolade | 3.8% |
| **Total** | **51.0%** |

Source: Bellevue Asset Management, 30.06.2021

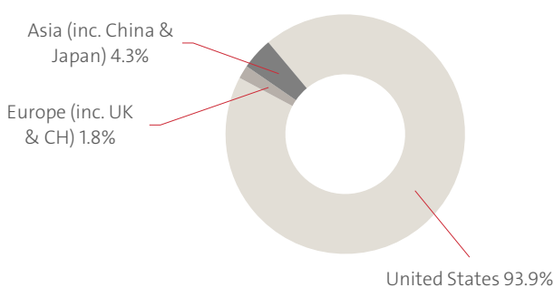
## MARKET CAP BREAKDOWN




Source: Bellevue Asset Management, 30.06.2021

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

## GEOGRAPHICAL BREAKDOWN (OPERATIONAL HQ)




Source: Bellevue Asset Management, 30.06.2021

## *Sustainability Profile – ESG*

| | | | | |
|---|---|---|---|---|
| **Norms-based exclusions:** | X | Compliance UNGC, HR, ILO | X | Controversial weapons |
| **ESG Risk Analysis:** | X | ESG Integration | | |
| **Stewardship:** | X | Engagement | X | Proxy Voting |

**CO2 intensity (t CO2/mn USD sales):** 23.5 t (low) MSCI ESG coverage: 100%

Based on portfolio data as per 30.06.2021 (quarterly updates) – ESG data base on MSCI ESG Research and are for information purposes only; compliance with global norms according to the principles of UN Global Compact (UNGC), UN Guiding Principles for Business and Human Rights (HR) and standards of International Labor Organisation (ILO); no involvement in controversial weapons; ESG Integration: Sustainabiltiy risks are considered while performing stock research and portfolio construction; The CO2 intensity expresses MSCI ESG Research's estimate of GHG emissions measured in tons of CO2 per USD 1 million sales; for further information c.f. www.bellevue.ch/en/corporate-information/sustainability

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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
- The Fund takes ESG factors into consideration while implementing the aforementioned investment objectives

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## 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 1071.4 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 | 537 849 403 |
| 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 |
| EU SFDR 2019/2088 | Article 8 |

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