Bellevue Healthcare Trust

AUGUST 2023

Factsheet

Marketing document

Investment focus

Bellevue Healthcare Trust intends to invest in a concentrated portfolio of listed or quoted equities in the global healthcare industry. The investable universe for the fund 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 are no restrictions on the constituents of the funds portfolio by index benchmark, geography, market capitalisation or healthcare industry sub-sector. Bellevue Healthcare Trust will not seek to replicate the bench-mark index in constructing its portfolio. The fund takes ESG factors into consideration while implementing the aforementioned investment objectives.

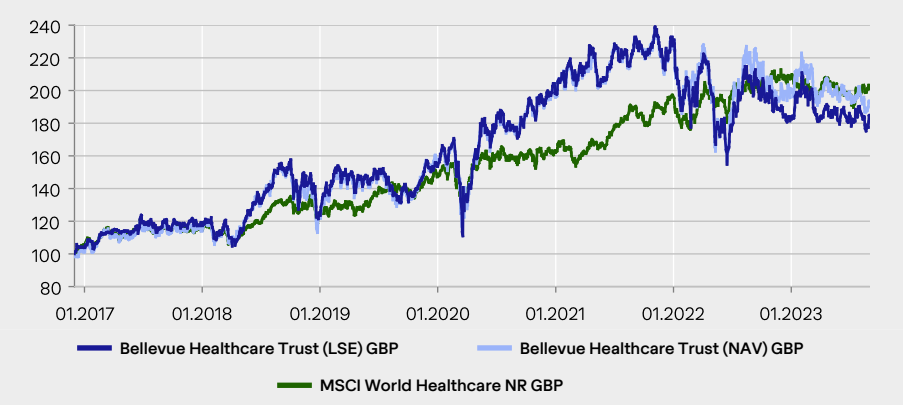
Fund facts

Share price	149.00
Net Asset Value (NAV)	155.34
Market capitalisation	GBP 817.62 mn
Investment manager	Bellevue Asset Management (UK) Ltd.
Administrator	Apex Listed Companies Services (UK) Ltd.
Launch date	01.12.2016
Fiscal year end	Nov 30
Benchmark (BM)	MSCI World Healthcare NR
ISIN code	GB00BZCNLL95
Bloomberg	BBH LN Equity
Number of ordinary shares	548,740,767
Management fee	0.95%
Performance fee	none
Min. investment	n.a.
Legal entity	UK Investment Trust (plc)
EU SFDR 2019/2088	Article 8

Key figures

Beta	1.35
Correlation	0.68
Volatility	27.9%
Tracking Error	20.96
Active Share	90.90
Sharpe Ratio	0.24
Information Ratio	-0.08
Jensen's Alpha	-4.77

Indexed performance since launch



Cumulative & annualised performance

Cumulative

	1M	YTD	1Y	3Y	5Y	10Y	ITD
Share	-2.9%	1.3%	-9.1%	5.1%	21.3%	n.a.	84.8%
NAV	-4.6%	-4.0%	-9.6%	9.4%	25.6%	n.a.	92.5%
BM	0.8%	-3.2%	1.1%	27.8%	51.9%	n.a.	100.9%

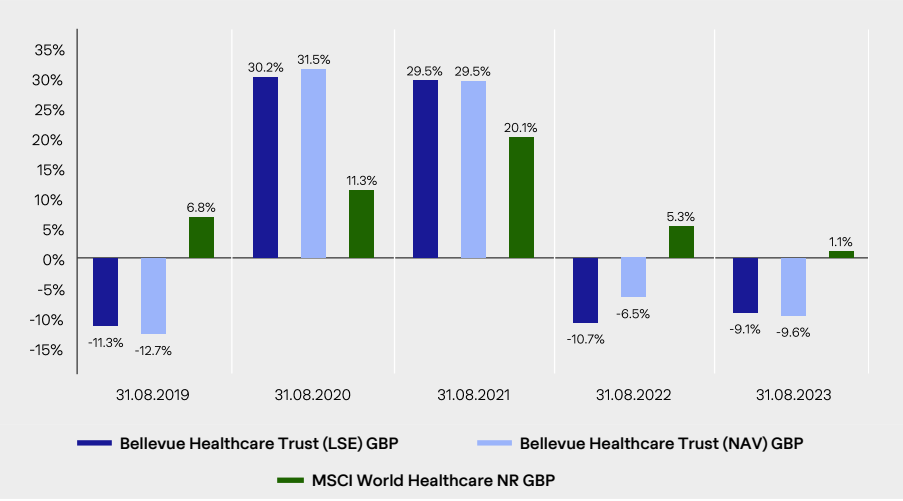
Annualised

1Y	3Y	5Y	10Y	ITD
-9.1%	1.7%	3.9%	n.a.	9.5%
-9.6%	3.0%	4.7%	n.a.	10.2%
1.1%	8.5%	8.7%	n.a.	10.9%

Annual performance

	2018	2019	2020	2021	2022	YTD
Share	4.9%	22.7%	29.1%	16.6%	-21.0%	1.3%
NAV	8.6%	25.9%	25.7%	15.2%	-11.1%	-4.0%
BM	8.8%	18.4%	10.3%	20.8%	5.8%	-3.2%

Rolling 12-month-performance



Source: Bellevue Asset Management, 31.08.2023; all figures in GBP %, total return / BVI-methodology

Past performance is not a reliable indicator of future results and can be misleading. Changes in the rate of exchange may have an adverse effect on prices and incomes. All performance figures reflect the reinvestment of dividends and do not take into account the commissions and costs incurred on the issue and redemption of shares, if any. The reference benchmark is used for performance comparison purposes only (dividend reinvested). No benchmark is directly identical to the fund, thus the performance of a benchmark is not a reliable indicator of future performance of the Bellevue Healthcare Trust to which it is compared. There can be no assurance that a return will be achieved or that a substantial loss of capital will not be incurred.

Source: Bellevue Asset Management, 31.08.2023;
Calculation based on the Net Asset Value (NAV) over the last 3 years to 31 August 2023.

Welcome to our August update. Summer is officially a washout. While we bask in the unexpected September sunshine, there is little macro cheer on offer. It's going to feel like a long road to Christmas.

Within healthcare, the debate continues to polarise in a somewhat irrational manner, creating a bifurcated value opportunity that is too compelling to ignore but, at the same, is probably going to take some time to be realised.

We remain anchored to a long-term, fundamentally driven approach and see no reason why a more pragmatic and valuation-sensitive dynamic will not reassert itself in the fullness of time.

Monthly review

The wider market

The much discussed (by us at least) gradual upward melt of the MSCI World Total Return Index, despite many an economic canary filling the mines with haunting song, finally stalled in August. It was more of a softening of sentiment than a sharp correction; the index declined 2.4% in dollars (-0.9% when measured in sterling).

However, lower levels were tested mid-month (-5.4%). Consequently, our previously evinced caution relating to broader equity sentiment has not abated by any means. We continue to feel that any support is very fragile and narrowly based.

More malevolent than mellifluous, the aforementioned sonnets of these finches have been roundly ignored until now. What changed? The short answer is 'nothing' in terms of the broader macro-economic scenario, which continues to show signs of weakening.

The oft-used phrase "no news is good news" clearly does not apply in China, where no news apparently means that the government is too embarrassed to publish an economic data series anymore. We know things are bad and getting worse, but we have little idea how bad they really are or how quickly they are worsening, which is unhelpful to say the least.

One billion global consumers exercising restraint is a lot to absorb. Whilst the average revenue exposure to China for an S&P500 company is only ~5%, it is much higher for the US tech names that have been driving the performance of broad market indices during 2023.

Moving onto more open economies, the US M2 money supply (i.e. as the cash in circulation plus deposits in current accounts and savings accounts) turned negative for the first time in more than 60 years.

Bank of America reported that credit card spending was now showing a bifurcation between renters and owners in the US. Most property owners have been shielded from interest rate increases by the tendency for buyers to use very long-term fixed rate mortgages there. In 2021, 70% of outstanding mortgages were 30-year fixed rate policies.

Renters, on the other hand, are experiencing typical year-on-year rent increases. When combined with broader cost-of-living increases, this is finally beginning to impact discretionary spending.

In summary then, we could describe the still-buoyant US economy and the consumer spending that drives it as still being held up by the 'haves'. Whilst savings balances are winding down, overall 'cash' levels remain elevated versus 2019, so a 'hard landing' scenario still appears far off at worst and at best unlikely.

Conditions in Europe seem much worse, especially in Germany (as an aside, the average revenue exposure to China for DAX companies is more like 15%) and worse still in the UK, but most of our readers are all too aware of these facts, so we need not dwell upon them further.

Regular readers will recall that we cautioned that the music might stop in last month's missive. Our lack of conviction on market direction was reflected in the absence of leverage within the Trust. However, we take no comfort from recent events and the market's agathokakological actions leave us ruing the day, but more of that anon.

The MSCI World sector performances are summarised in Figure 1. We would like to note that the data in Figures 1 & 2 now reflect monthly total return performance rather than solely share price performance. This was requested by some investors and so we have changed our models accordingly. In most months, it will make very little difference, but we are keen to make our data as useful to our investors as possible.

It is cheering not to see healthcare overall at the bottom , but we would draw the reader's attention to the difference between the Pharma names at the top and the Equipment & Services names in the last quartile. Bifurcation is a broader theme, it seems. One would be hard-pressed to discern a 'factor rotation theme' in this performance. We see some classic defensives at each end of the list, as indeed do we see some of the more pro-cyclical and consumer discretionary names. A tricky market indeed.

Sector	Monthly perf
Pharmaceuticals, Biotechnology	+2.1%
Energy	+1.9%
Consumer Discretionary Distributors	+1.1%
Consumer Durables & Apparel	+0.0%
Software & Services	-1.0%
Insurance	-1.1%
Commercial & Professional Services	-1.3%
Media & Entertainment	-1.5%
Telecommunication Services	-1.7%
Semiconductors & Semiconductor Equipment	-1.8%
Financial Services	-2.1%
Real Estate Management & Development	-2.5%
Consumer Staples Distribution	-2.6%
Household & Personal Products	-2.6%
Capital Goods	-2.7%
Technology Hardware & Equipment	-2.9%
Equity Real Estate Investment	-3.1%
Food, Beverage & Tobacco	-3.6%
Automobiles & Components	-4.3%
Materials	-4.4%
Consumer Services	-4.8%
Health Care Equipment & Services	-5.3%
Utilities	-5.4%
Transportation	-5.5%
Banks	-6.6%

Source: Bellevue Asset Management, 31.08.2023

One common factor is shared across the majority of these areas though, and that is the prevalence of thematic memes. As we have noted before, most of the year-to-date positive performance in the market has been driven by Mega-Cap Technology companies associated (correctly or otherwise) with being beneficiaries of AI/machine learning advancements.

Perhaps the real reason that the market did not rise further is not because there was a dose of realism creeping in, but rather an absence of additional AI froth. Goldman Sachs noted that AI was mentioned on the Q2 conference calls of 32% of the S&P500's constituent companies. It becomes clearer by the day that fundamentals are taking a back seat in this market: memes rule the roost in 2023.

Healthcare

The MSCI World Healthcare Total Return Index declined in absolute terms (-0.8% in dollars, +0.8% in sterling) but meaningfully

outperformed the rate of decline of the wider parent index (+240bp) for the first time since April.

The sub-sector performance breakdown is summarised in Figure 2. The positive return was very much driven by the mega-cap pharma names ("Diversified Therapeutics") and, within this, the two GLP-1 obesity-exposed companies, Novo Nordisk and Eli Lilly

Suffice to say, that the same meme has functioned contrariwise on the Healthcare Technology sub-sector (*"no more type 2 diabetics"*), Managed Care (*"someone has to pay for all these GLP-1 drugs"* and Medical Technology *("less obesity means less surgeries for the heart, the limbs and bariatrics"*).

Novo Nordisk is now Europe's biggest company, and we have seen the first $100bn sales forecast for the GLP-1 class of drugs (2022 sales across diabetes and obesity: $24bn). As we go to press, Novo and Lilly have added $205bn to their combined market value since the end of July.

Without the contribution of these two companies, we calculate that August's MSCI World Healthcare Index total return would have been 224bp lower at -3.0% and thus it would have again *underperformed* the MSCI World Index (which itself would have returned ~20bp less without the contribution of these two companies).

This obesity-mania is the meme-du-jour and warrants further discussion, but we will save that for the musings section.

	Weighting	Perf (USD)	Perf (GBP)
Generics	0.4%	8.0%	9.7%
Diversified Therapeutics	37.3%	3.9%	5.5%
Focused Therapeutics	8.1%	1.0%	2.6%
Other HC	1.3%	0.6%	2.4%
Tools	8.2%	0.7%	2.2%
Services	2.3%	-1.3%	0.2%
Distributors	1.7%	-1.5%	0.0%
Healthcare IT	0.5%	-1.7%	-0.2%
Facilities	1.0%	-3.5%	-1.7%
Dental	0.6%	-4.6%	-3.1%
Conglomerate	11.4%	-5.1%	-3.6%
Med-Tech	14.2%	-5.1%	-3.7%
Managed Care	10.5%	-5.5%	-4.0%
Diagnostics	1.5%	-9.6%	-8.2%
Healthcare Technology	1.0%	-22.2%	-21.0%
Index perf		**-0.8%**	**0.8%**

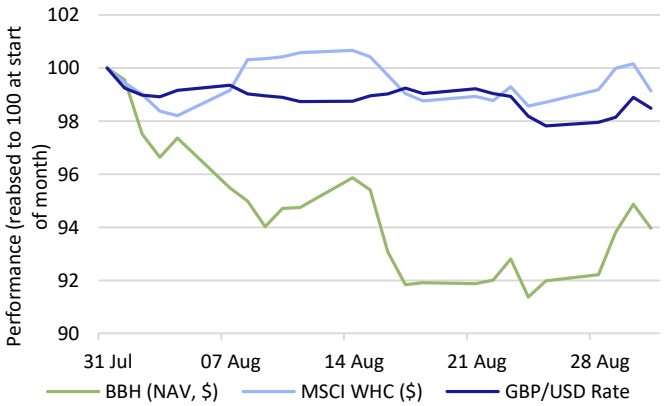
Source: Bloomberg/MSCI and Bellevue Asset Management, Weightings as of 31.07.2023, Performance to 31.08.2023

The Trust

Even leaving aside the fact that we did not, and still do not, own either Eli Lilly or Novo Nordisk (more on this anon), we were going to struggle to meet the index's performance amidst this general binary re-shuffle on anything linked to obesity. We are, after all, quite 'long' obesity exposure, and rightly so. It is the pre-eminent healthcare issue of our time.

We are happy to be corrected on this, but we cannot think of any "magic bullet" treatment of for a chronic medical condition and thus obesity isn't going to disappear overnight, nor its outsized impact on the wider healthcare system, but that presumption feels like the best way to characterise the behaviour of the healthcare sector during August.

During August, the Trust's Net Asset Value declined 4.6% to 155.34p over the month, underperforming the comparator MSCI World Healthcare Total Return Index by 535bp. Eight of our 29 holdings declined >15% during the month and two of these declined by >20%, despite what we continue to characterise as a generally positive reporting season regarding Q2 23 updates. The evolution of the NAV over the course of the month is illustrated in Figure 3 opposite.



Source: Bellevue Asset Management, 31.08.2023

Medical Technology and Healthcare IT were by far the worst performing sub-sectors within the portfolio, and obesity-related factors (based on questions asked on conference calls) were undoubtedly a contributing factor in both cases. Focused Therapeutics, Services and Diversified Therapeutics were the only positive contributors during the month and only Focused Therapeutics constituted a material positive performance, albeit one well offset by losses elsewhere.

The evolution of the sub-sector weightings is summarised in Figure 4 below and we would make the following comments:

	Subsectors end July 23	Subsectors end Aug 23	Change
Dental	0.4%	0.0%	Exited
Diagnostics	10.2%	11.8%	Increased
Diversified Therapeutics	0.7%	0.6%	Decreased
Focused Therapeutics	21.5%	23.2%	Increased
Healthcare IT	10.5%	10.2%	Decreased
Healthcare Technology	4.5%	3.9%	Decreased
Managed Care	8.8%	9.0%	Increased
Med-Tech	20.9%	19.2%	Decreased
Services	14.1%	12.2%	Decreased
Tools	8.6%	10.1%	Increased
	100.0%	**100.0%**	

Source: Bellevue Asset Management, 31.08.2023

The investment portfolio declined to 29 companies in August after we exited our position in the Dental company Straumann. Over the month, the leverage ratio increased from a 3.2% cash position at the end of July to 1.0% geared at the end of August. This increase in gearing reflected a broad deployment of capital into depressed valuations as the month unfolded, and we would expect this to continue to unfold through September.

Our exit from Dental aside, Services and Diversified Therapeutics were the only sub-sectors where we did not add to overall holdings on a net basis. The relative reduction in exposure to Healthcare IT, Healthcare Technology and Med-Tech were driven by poor relative performance and Services saw a net reduction in exposure.

The average discount to NAV improved modestly during July, falling from 6.2% in July to 5.5% in August, and was generally better than the healthcare investment trust peer group average. No shares were repurchased during the month.

Managers' musings

"Apocryphal tales of egregious exuberance and pettifogging pessimism"

As previously alluded to in the 'wider market' section of this monthly missive, investors are living in the age of the meme. It is not just AI as a theme and Tech stocks in particular that are wagging the dog though. We have our own corpulent meme in the shape of obesity drugs. Its impact on investor returns is worthy of more than a few words in its own right.

Unless you have spent the last 30 years living as a castaway on a desert island with nary a volleyball for company, one cannot be unaware that obesity is a significant independent risk factor for increased morbidity and mortality across a spectrum of serious medical conditions: cardiovascular disease, diabetes, most common forms of cancer, osteoarthritis, liver disease, kidney disease, sleep apnoea, and depression.

Consequentially, the increasing prevalence of obesity is one of the primary drivers of increased all-cause mortality risk in the general population and arguably the main driver of the curve separation between lifespan and years of life lived in good health (as discussed in our April factsheet).

Simply put, westerners are, in general, too fat and the rest of the world is sadly catching up rapidly, with attendant consequences for health, lifespan and the economy. The US Centers for Disease Control (CDC) estimates that the annual direct medical costs associated with obesity in the United States alone are $173 billion per year. The indirect costs will be multiples of this.

It is thus understandable that investors are excited about the potential for an effective anti-obesity agent; with one in three people in Western markets overweight or obese, a significant vanity component and the undeniable health benefits of people being slimmer, what's not to like about this *idea*?

This is also a cycle that has played out several times before: fen-phen in the early 1990s, orlistat in the 2000s and rimonobant (2008). In all cases, side effects were highly problematic and efficacy much more limited than GLP-1s. For us old lags who remember, the hype at the time was palpable and the sales forecasts were always multi-billion dollar (and wrong).

Even so, the cadence of Wegovy's US launch since 2021 caught everyone by surprise – Novo Nordisk literally cannot make enough of the stuff to keep up with demand. For now, Wegovy remains the only approved GLP-1 formulation for weight loss; Lilly's Mounjaro is expected to be approved for obesity treatment within the next few months, but already has supply constraints (probably due to off-label usage in obesity).

Since launch in mid-2021, Bloomberg's consensus expectations for Wegovy sales in 2024 have tripled to $8 billion (range $6-10bn). Consensus expectations for Monjaro sales in 2024 currently stand at $7bn (range $6-11bn) and have doubled since mid-2021. Given the background outlined above, this commercial outlook seems perfectly plausible in and of itself.

Could obesity become a $100bn or even $200bn market in the next decade? Possibly. Some sell-side analysts think it will be bigger than $100bn before 2030, which we do struggle with, but there again, what investor wants to chat to the analyst with the second or third biggest forecasts? The action is in being the super-bull or the uber-bear. Everyone else becomes a bit player. This is how the sell-side "game" has worked for many a year.

However, this will not remain a two horse race and the challenge is how the market dynamics will ultimately play out. To our minds, there are three important questions. The answers to these 'known unknowns' will dictate the ultimate value of this marketplace, the allocation of market share within it and thus the attractiveness of any individual player and, in the fullness of time, the impact on other adjacent areas of healthcare (that is to say treatments for obesity-related conditions). Let us consider these points further.

Before we do, it is worth reminding readers that the primary mechanistic effect of GLP-1 is to suppress appetite. The GLP-1 hormone is produced naturally in the body by the stomach as it stetches; it is the body's signal to the brain to tell you that you are full. This is why GLP-1 facilitates weight loss: because you eat less. Hunger is also a hormone-driven sensation and GLP-1 works in opposition to this hormone pathway. If you don't feel as hungry, you don't eat as much.

"Question 1: the market opportunity"

There are four 'known knowns'. We know these GLP-1 targeting drugs work effectively for weight loss, we know GLP-1 agonists have secondary health benefits, and we know lots of them are in development. We also know that rebound weight gain on cessation is a significant issue, as is tolerability.

As we headed into August, the market was expecting the publication of headline data from Novo Nordisk's SELECT study regarding the cardiovascular (CVD) benefits of Wegovy, its obesity version of the GLP-1 agonist semaglutide. If you were not living on that same desert island, it would be incredible not to expect the results of this study to be positive given the aforementioned comments on the wealth of evidence of obesity as a CVD risk in its own right.

Furthermore, we already have additional data from CV outcomes studies of GLP-1 drugs in diabetes patients showing CVD benefits independent of weight loss, owing to positive mechanistic impacts on blood pressure, vascular endothelium, atherosclerosis progression, general inflammation and myocardial ischaemia. It is perfectly fair to say this class of anti-obesity agents stands apart from any that has gone before in terms of wider positive health impact. Does that make them the last word though?

This CVD benefit, alongside the synergistic effects with other anti-diabetic agents and the low risk of potentiating hypoglycaemic explains why GLP-1 is already $20bn drug class outside of obesity treatment.

With all of this having been known, the move in the share prices of Novo and Lilly during August (and the consequential impact on the benchmark) was somewhat surprising in our view, but perhaps it was driven by the emergence of the previously mentioned $100 and $200 billion forecasts . It will be years before Lilly has similar data for Mounjaro but investors read across, seeing SELECT as a class effect, making it all the stranger to us that its success was not already assumed.

What could prevent these heady figures being attained? There are three main drawbacks to GLP-1 as an obesity treatment. The first is tolerability, the second (and related point) is persistence of effect and rebound weight gain, and the third relates to side effects.

This class of agents has been around since 2005, when Lilly launched the twice daily GLP-1 injection exenatide. Significant strides on tolerability have been made with daily, then weekly shots and gradual dose titration that has greatly improved immediate tolerability, reducing nausea and vomiting (the primary side effects driving initial discontinuations).

Even so, it is noteworthy with today's weekly shots that discontinuation rates are still significant at even the low initial doses. Some patients it seems are very sensitive to GLP-1 and, broadly speaking, clinical trials show 1 in 5 to one in 10 patients will stop therapy within the first year and up to a quarter will have stopped within two years.

Real-world data is, unsurprisingly, less compelling. A retrospective cohort study of 590 patients published in 2022 in the British Medical Journal (BMJ) among type-2 diabetic patients using GLP-1, based on data from the Clinical Practice Research Datalink, which covers 13 million patients in the UK.

This study found only a minority of patients (33% at 12 months and 44% at two years) achieved ≥5% weight loss, lower than that observed in clinical trials. 35% of the cohort had discontinued therapy within 12 months and 41% within two years (higher than in comparable trials). Admittedly, some of these patients were on the daily rather than the weekly formulations, but this was not a significant factor in the rate of discontinuation.

Why are real-world results worse? Trials include ongoing support that has been shown to encourage people to stay on therapy and maintain "lifestyle interventions" that would facilitate weight loss on their own; this is why the placebo arms of these studies also show weight loss. When this is no longer available, therapy's persistence and efficacy are inevitably compromised.

What happens if and when you do discontinue? Novo's STEP-1 trial follow up showed that one year after withdrawal from therapy and active support, participants regained two-thirds of their prior weight loss, with similar negative changes in cardiometabolic parameters. Anecdotal reports and our personal discussions with obesity specialists prescribing these drugs for weight loss suggest worse outcomes are often experienced.

Loss of appetite means protein intake is also impacted, and lean muscle mass is lost (albeit at a much lower rate than fat mass). Patients can end up fatter than before as they find a greater impact on activities of daily living with regained fat mass but lower muscle strength, increasing the risk of inactivity. In order to remain effective, these need to be chronic use medications.

This latter question raises further uncertainties in and of itself. Most of the studies of these agents have been relatively short-term (a few years) but patients will have to take them for decades. We now have patient registry data going back 20 or so years and so it will be possible to begin to assess the risks around chronic long-term therapy in the coming years, but we simply do not know if there are emergent risks around pancreatic health, for example.

In summary then, we can say that the GLP-1 class of agents are the safest and most effective anti-obesity agents that we have seen so far. They are not perfect though, proving less effective for some, intolerable to many and requiring lifelong adherence to maintain their benefits.

What we can say for sure *at this point* is that many patients will try them and, given all the press interest and current supply constraints, there is likely to be many months of pent-up demand out there in the market. However, in order for their commercial and health outcomes potential to be realised, patients need to stay on them long-term and the extent to which they are willing to do this (financially and tolerability-wise) remains highly uncertain in our view.

"Question 2: The competitive environment"

A number of sell-side firms have databases of clinical projects and there are now >100 molecules in development for obesity, many of which target the incretin hormone system (of which GLP-1 is a part). Some of these potentially promise significantly faster or greater weight loss, possibly improved tolerability through multi-modal action and more convenient oral dosing. There is no certainty that any of these will work (cf. Pfizer's promising-looking oral GLP-1 agonist lotiglipron, which was discontinued in June), but the race is on.

Oral dosing would clearly be a huge advantage and it is much easier to scale production of a small molecule than a synthetic peptide to meet demand. Tolerability would also be an advantage and we think a multi-model approach targeting more than one hormone pathway could offer significant benefits on the tolerability front.

The desirability of faster or greater weight loss is more questionable in our view. Is the rate of weight loss the most desirable property, given a patient is going to need to stay on these drugs for life? Surely tolerability is the more relevant attribute, since side effects are a significant reason for discontinuation.

We also think that a gentler effect would help to preserve lean muscle mass, whereas a further reduction in protein intake due to greater appetite suppression would not be desirable. That said, a more potent drug might allow lower effective dosing and in this way increase the proportion of patients who can stay on therapy long-term or who achieve clinically meaningful weight loss (i.e. >5% of body mass).

Lilly and Novo are also developing next generation products: Novo has the dual acting weekly injection CagriSema and Lilly has both an oral GLP-1 agonist orforglipron and a combination product retatrutide. Should the market really presume this largely remains a duopoly between these two behemoths? If we look at early clinical data, one could argue that Altimmune, Alkermes, Amgen and Zealand all have injectable drugs in development with potential Wegovy-like efficacy.

Even if someone does not crack the holy grails of oral dosing, better tolerability or wider effectiveness, there is an interesting financial question around the impact of competition. If you are the third or fourth player to market, and you are not offering something additional in terms of efficacy (do we even need something better than the 20% weight loss seen with these drugs?), tolerability or convenience, what is your commercial lever? Even if you are brining something incremental, with efficacy already at these levels, what is the real economic value of those additional benefits?

We think there is a significant risk this could become all about price. These drugs currently cost around $1,000 per month. That is a lot for what is in effect a chronic use primary prevention product that does not permanently resolve a risk factor. If you are a late entrant, it surely makes sense to compete on price.

There is also the question of generic competition eating around the edges. Ozempic, the slightly lower dose formulation of Novo's semaglutide used in Type 2 diabetes treatment, could see generic competition in the US by 2031. The initial doses over months 1-3 are the same for each drug, but the highest dose for Wegovy is slightly higher than for Ozempic. If one is available generically, why not use that? Ozempic will also see an IRA-mandated price cut in 2027.

"Question 3: The impact on adjacent areas"

As noted previously; obesity increases the risk of a myriad of serious long-term health complications and directly causes damage to the cardiovascular and musculoskeletal systems. The damage that obesity does is cumulative. If you have joint damage due to excess weight and then you lose weight, the wear and tear will slow but not reverse.

Atherosclerosis (clogging of the arteries) is not reversible either (which is important for the long-term risk of vascular dementia or stroke), nor is kidney damage. However, there will be less strain on the heart if you lose weight, so the risk of a heart attack even with established ischaemic disease may be reduced. Liver damage is potentially reversible, if it has not progressed to the fibrotic stage.

Obesity is associated with chronic inflammation and, in turn, cancer because adipose tissue is an important endocrine organ that secretes several hormones and chemokines that can impact tumour behaviour and the tumour microenvironment. Losing weight can rapidly improve these parameters and *may* reduce the risk of developing cancer if weight loss is sustained, based on results from some observational studies.

However, other studies (e.g. breast cancer incidence in the Women's Health Initiative study of post-menopausal women) do not suggest that weight loss in later life conveys material risk reduction benefits, perhaps because the 'damage' has been done.

If we are living in a world where more and more people are losing weight and improving their health through anti-obesity drugs, we would expect a modest decline over the long-term in the incidence and then the prevalence of certain conditions, but we think this will take many, many years to become apparent.

In this respect, we think Q2 23 was a "jump the shark" moment. We were astonished to hear people argue that rates for bariatric surgery, interventional cardiological procedures and even insulin pumps and glucose monitors were at *near-term* risk from the (already presumed) success of these drugs. We even saw a suggestion that the growth rate of the dialysis market should be reduced because there will be less kidney disease moving forward.

If you step back for a moment, this literally makes no sense: the number of obese patients is currently growing much faster than the number of patients on these drugs, so *maybe* there will be an inflection in the longer-term growth rate of these things, but is that something we need to think about today?

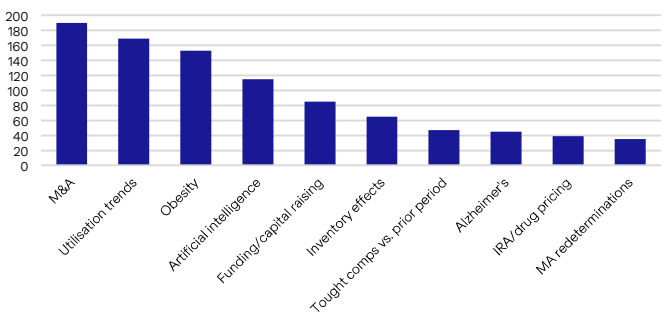
The madness was not confined to healthcare either, we also saw arguments to reduce exposure to alcohol stocks and restaurants because consumers will be less interested in these things if on these therapies. We are not all going to want to take them and, as noted previously, they are not a panacea for all the ills of the human condition.

Insulin pumps are used mainly by type 1 diabetic patients (around 90% of users are type 1), where insulin secretion has been completely lost due to an auto-immune reaction. If you do not receive exogenous insulin, you will die. This is an incontestable fact. How fat you are and whether or not you take a GLP-1 is neither here or there: using GLP-1 or losing excess weight may impact how much insulin you need, but not the importance of delivering it when needed – a job best done by a pump with an algorithm taking data from a continuous glucose monitor.

Undoubtedly, many prospective bariatric patients (i.e. those eligible for stomach stapling or gastric band surgeries) will try GLP-1 drugs before resorting to surgery. Here in the UK, you need to demonstrate your commitment to losing weight before you are allowed to have surgery and anaesthesia in the morbidly obese is risky, so some patients are contra-indicated due to body mass.

We do expect a transitory reduction in bariatric procedures but, over time, the rate will increase back to trend as people roll off GLP-1 or become eligible for a drug-free life after losing enough weight, perhaps having used GLP-1 drugs to facilitate the required pre-operation weight loss.

Figure 5 below shows the most common themes mentioned on conference calls (keyword mentioned within S&P500 healthcare universe). Utilisation has been the key topic for a year now and M&A is always up there. But obesity at #3?



Source: Goldman Sachs

We would argue strongly that the healthcare world is not going to change overnight because of these drugs, but one could be forgiven for thinking that it will by the commentary surrounding us currently.

"We have no appetite for this"

Let us summarise our overall position. We do not disagree with the broad idea that tacking obesity is a compelling and potentially very substantial market opportunity within pharmaceuticals. We would also agree that the once-weekly injectable GLP-1 agonists developed by Novo Nordisk and Eli Lilly are the best products developed *thus far* to address this opportunity, but they are no panacea.

However, there is no certainty that the dynamic between these companies will remain as it is; others may yet supersede them and pricing may yet come under significant pressure. For these reasons, we do not think that owning Novo Nordisk or Eli Lilly makes sense at 33x and 47x 2024 earnings respectively, versus an average of 15x 2024 earnings for the Bloomberg US pharmaceutical index.

Objectively, you can say that we are wrong; not being exposed to these two companies (one of which we have historically owned) has undoubtedly hurt our short-term relative performance. The year-to-date dollar total return of the MSCI World Healthcare Index stood at +1.3% as of the end of August 2023.

We have created a version of this index that excludes the GLP-1 obesity darlings Novo Nordisk and Eli Lilly and then pro-rates the other index constituents accordingly. This "ex-GLP" index has delivered a comparable year-to-date total return of -2.1%, lagging the real index by 335bp.

Simply put, the healthcare fund manager's year has largely turned on whether or not they have been over or underweight these two stocks. We have spoken with some buy side analysts where they have articulated significant internal pressure to maintain a positive view on these companies even as their valuations have doubled. We are very fortunate that Bellevue does not work in such a way and we are free to hold any opinions that we can objectively justify; there is no "firm-wide" view placed on us from above.

In the same vein, we have also been hurt by our exposure to areas such a bariatric surgery (even though is immeasurably immaterial in our portfolio), type 1 diabetes management and interventional cardiology. We have been adding to exposures in these areas and we will continue to do so because nothing has really changed at this point and we challenge anyone to prove otherwise.

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@bellevuehealthcaretrust.com

As ever, we will endeavour to respond in a timely fashion and we thank you for your continued support during these volatile months.

Paul Major and Brett Darke

Bellevue Healthcare Trust

Top 10 positions

Axonics	7.4%
Option Care Health	7.1%
Exact Sciences	6.3%
Insmed	6.2%
Evolent Health	5.6%
Pacific Biosciences	5.2%
Bio-Rad Laboratories	4.8%
Axsome	4.6%
Accolade	4.6%
UnitedHealth Group	4.2%
Total top 10 positions	56.0%
Total positions	29

Sector breakdown

Focused Therapeutics	23.2%
Med-Tech	19.2%
Services	12.2%
Diagnostics	11.8%
Healthcare IT	10.2%
Tools	10.1%
Managed Care	9.0%
Health Tech	3.9%
Diversified Therapeutics	0.6%

Geographic breakdown

United States	97.1%
China	2.9%

Market cap breakdown

Mega-Cap	13.2%
Large-Cap	18.6%
Mid-Cap	46.0%
Small-Cap	22.1%

Source: Bellevue Asset Management, 31.08.2023;
Due to rounding, figures may not add up to 100.0%. Figures are shown as a percentage of gross assets.
For illustrative purposes only. Holdings and allocations are subject to change. Any reference to a specific company or security does not constitute a recommendation to buy, sell, hold or directly invest in the company or securities. Where the fund is denominated in a currency other than an investor's base currency, changes in the rate of exchange may have an adverse effect on price and income.
Market Cap Breakdown defined as: Mega Cap >$50bn, Large Cap >$10bn, Mid-Cap $2-10bn, Small-Cap $2bn. Geographical breakdown is on the basis of operational HQ location.

Benefits

- 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 fund offers a combination of high quality healthcare exposure and a targeted 3.5% dividend yield.
- Bellevue Healthcare Trust has a strong board of directors and relies on the experienced management team of Bellevue Asset Management (UK) Ltd

Inherent risks

- The fund invests in equities. Equities are subject to strong price fluctuations and so are also exposed to the risk of price losses.
- Healthcare equities can be subject to sudden substantial price movements owning to market, sector or company factors.
- The fund invests in foreign currencies, which means a corresponding degree of currency risk against the reference currency.
- The price investors pay or receive, like other listed shares, is determined by supply and demand and may be at a discount or premium to the underlying net asset value of the Company.
- The fund may take a leverage, which may lead to even higher price movements compared to the underlying market.

You can find a detailed presentation of the risks faced by this fund in the "Risk factors" section of the sales prospectus.

Management Team

Paul Major
Co-Portfolio Manager

Brett Darke
Co-Portfolio Manager

Sustainability Profile – ESG

EU SFDR 2019/2088 product category: Article 8

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

Key Figures:

CO_2-intensity (t CO_2/mn USD sales):	23.5 (Low)	Coverage:	97%
MSCI ESG Rating (AAA - CCC):	BBB	Coverage:	97%

Based on portfolio data as per 31.08.2023; – 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; norms-based exclusions based on annual revenue thresholds; ESG Integration: Sustainability risks are considered while performing stock research and portfolio construction; Stewardship: Engagement in an active and constructive dialogue with company representatives on ESG aspects as well as exercising voting rights at general meetings of shareholders.MSCI ESG Rating ranges from "leaders" (AAA-AA), "average" (A, BBB, BB) to "laggards" (B, CCC). The CO_2-intensity expresses MSCI ESG Research's estimate of GHG emissions measured in tons of CO_2 per USD 1 million sales; for further information c.f. www.bellevue.ch/sustainability-at-portfolio-level.

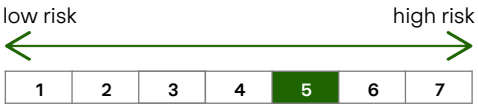
Bellevue Healthcare Trust

Objective

The fund's investment objective is to achieve capital growth of at least 10% p.a., net of fees, over a rolling three-year period. Capital is at risk and there is no guarantee that the positive return will be achieved over that specific, or any, time period.

Risk Return Profile acc. to SRI

This product should form part of an investor's overall portfolio. It will be managed with a view to the holding period being not less than three years given the volatility and investment returns that are not correlated to the wider healthcare sector and so may not be suitable for investors unwilling to tolerate higher levels of volatility or uncorrelated returns.



We have classified this product as risk class 5 on a scale of 1 to 7, where 5 corresponds to a medium-high risk class. The risk of potential losses from future performance is classified as medium-high. In the event of very adverse market conditions, it is likely that the ability to execute your redemption request will be impaired. The calculation of the risk and earnings profile is based on simulated/historical data, which cannot be used as a reliable indication of the future risk profile. The classification of the fund may change in future and does not constitute a guarantee. Even a fund classed in category 1 does not constitute a completely risk-free investment. There can be no guarantee that a return will be achieved or that a substantial loss of capital will not be incurred. The overall risk exposure may have a strong impact on any return achieved by the fund or subfund. For further information please refer to the fund prospectus or PRIIP-KID.

Liquidity risk
The fund may invest some of its assets in financial instruments that may in certain circumstances reach a relatively low level of liquidity, which can have an impact on the fund's liquidity.

Risk arising from the use of derivatives
The fund may conclude derivatives transactions. This increases opportunities, but also involves an increased risk of loss.

Currency risks
The fund may invest in assets denominated in a foreign currency. Changes in the rate of exchange may have an adverse effect on prices and incomes.

Operational risks and custody risks
The fund is subject to risks due to operational or human errors, which can arise at the investment company, the custodian bank, a custodian or other third parties.

Target market

The fund is available for retail and professional investors in the UK who understand and accept its Risk Return Profile.

Important information

This document is only made available to professional clients and eligible counterparties as defined by the Financial Conduct Authority. The rules made under the Financial Services and Markets Act 2000 for the protection of retail clients may not apply and they are advised to speak with their independent financial advisers. The Financial Services Compensation Scheme is unlikely to be available.

Bellevue Healthcare Trust PLC (the "Company") is a UK investment trust premium listed on the London Stock Exchange and is a member of the Association of Investment Companies. As this Company may implement a gearing policy investors should be aware that the share price movement may be more volatile than movements in the price of the underlying investments. **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. An investor may not get back the original amount invested.** Changes in the rates of exchange between currencies may cause the value of investment to fluctuate. Fluctuation may be particularly marked in the case of a higher volatility fund and the value of an investment may fall suddenly and substantially over time. This document is for information purposes only and does not constitute an offer or invitation to purchase shares in the Company and has not been prepared in connection with any such offer or invitation. Investment trust share prices may not fully reflect underlying net asset values. There may be a difference between the prices at which you may purchase ("the offer price") or sell ("the bid price") a share on the stock market which is known as the "bid-offer" or "dealing" spread. This is set by the market markers and varies from share to share. This net asset value per share is calculated in accordance with the guidelines of the Association of Investment Companies. The net asset value is stated inclusive of income received. Any opinions on individual stocks are those of the Portfolio Manager and no reliance should be given on such views. This communication has been prepared by Bellevue Asset Management (UK) Ltd., which is authorised and regulated by the Financial Conduct Authority in the United Kingdom. Any research in this document has been procured and may not have been acted upon by Bellevue Asset Management (UK) Ltd. for its own purposes. The results are being made available to you only incidentally. The views expressed herein do not constitute investment or any other advice and are subject to change. They do not necessarily reflect the view of Bellevue Asset Management (UK) Ltd. and no assurances are made as to their accuracy.

The most important terms are explained in the glossary at www.bellevue.ch/en/glossary.

Bellevue Asset Management (UK) Ltd. 24th Floor | 32 London Bridge | London SE1 9SG
www.bellevuehealthcaretrust.com | www.bellevue-am.uk