Bellevue Healthcare Trust

MARCH 2024

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 benchmark index in constructing its portfolio. The fund takes ESG factors into consideration while implementing the aforementioned investment objectives.

Fund facts

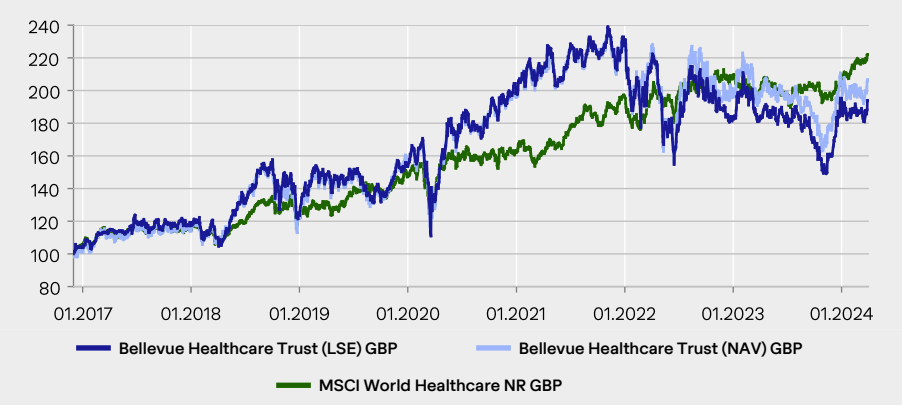
Share price	156.20
Net Asset Value (NAV)	166.58
Market capitalisation	GBP 722.09 mn
Investment manager	Bellevue Asset Management (UK) Ltd.
Administrator	Apex Listed Companies Services (UK) Ltd.
Launch date	01.12.2016
Fiscal year end	Nov 30
Benchmark (BM)	MSCI World Healthcare NR
ISIN code	GB00BZCNLL95
Bloomberg	BBH LN Equity
Number of ordinary shares	462,288,550
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	1.41
Correlation	0.65
Volatility	28.4%
Tracking Error	22.21
Active Share	90.64
Sharpe Ratio	0.08
Information Ratio	-0.30
Jensen's Alpha	-11.57

Source: Bellevue Asset Management, 31.03.2024;
Calculation based on the Net Asset Value (NAV) over the last 3 years to 31 March 2024.

Indexed performance since launch



Cumulative & annualised performance

Cumulative

	1M	YTD	1Y	3Y	5Y	10Y	ITD
Share	4.1%	-0.8%	5.4%	-9.6%	33.2%	n.a.	93.8%
NAV	4.5%	0.5%	4.1%	-2.7%	40.2%	n.a.	106.4%
BM	2.3%	8.7%	10.9%	37.2%	68.3%	n.a.	121.9%

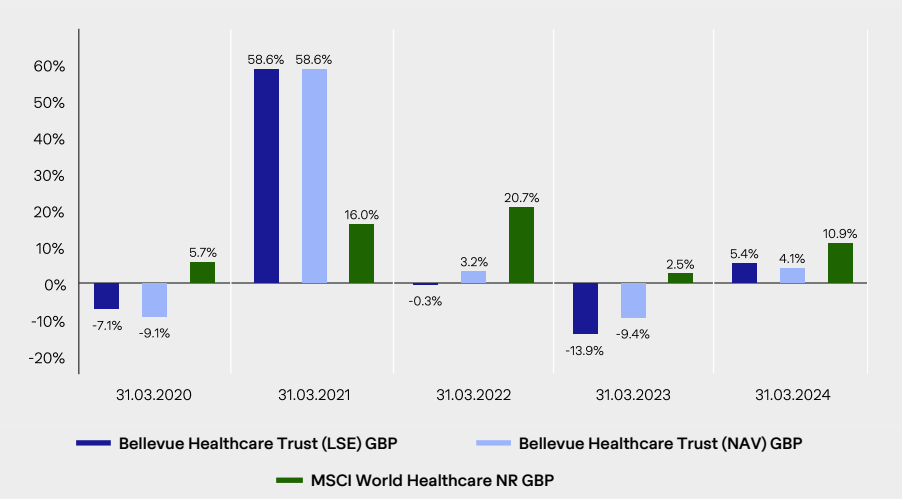
Annualised

1Y	3Y	5Y	10Y	ITD
5.4%	-3.3%	5.9%	n.a.	9.4%
4.1%	-0.9%	7.0%	n.a.	10.4%
10.9%	11.1%	11.0%	n.a.	11.5%

Annual performance

	2019	2020	2021	2022	2023	YTD
Share	22.7%	29.1%	16.6%	-21.0%	7.0%	-0.8%
NAV	25.9%	25.7%	15.2%	-11.1%	2.4%	0.5%
BM	18.4%	10.3%	20.8%	5.8%	-1.6%	8.7%

Rolling 12-month-performance



Source: Bellevue Asset Management, 31.03.2024; 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.

Welcome to our March update. We return from a busy few weeks on the road, having met with dozens of companies and doctors. The general tone of these meetings was positive and we executed on a number of new investments as a consequence.

Although there are still many macro-related issues driving febrile market sentiment (narrow market leadership, memes like AI, implied valuation, geopolitics, rate cut expectations), the healthcare machine continues to motor along nicely and there are plenty of innovations and policies to sustain hope in a system better able to meet the needs of an ageing population.

We may well be old lags at this point, and like you trying to live with a wholly dysfunctional NHS (a global outlier in all the wrong ways), but it is very hard not to be an optimist about the future of this essential industry.

Monthly review

The wider market

March was yet another positive month for equities, with the MSCI World Index again making new all-time highs during the month. The MSCI World Total Return Index rose 3.2% in dollars (+3.2% in sterling).

The sector return breakdown is summarised in Figure 1 below and we would make the following comments. It was a broader-based rally this time, as compared to February's AI-led upswing. Nonetheless, NVIDIA accounted for about 80% of the Semiconductor sector's 7.2% return.

The energy sector led the charge, as oil prices rose to levels not seen since October 2023 on continued tight supply and fears over "Middle-East" supply disruption. Banks have generally recovered on the potential watering down of proposed higher capital buffers and the receding risk of recession.

Sector	Monthly perf
Energy	+9.3%
Banks	+7.6%
Semiconductors & Semiconductor Equipment	+7.2%
Materials	+6.7%
Real Estate Management & Development	+6.7%
Utilities	+5.9%
Capital Goods	+5.5%
Media & Entertainment	+4.2%
Insurance	+4.1%
Financial Services	+3.6%
Food, Beverage & Tobacco	+3.0%
Health Care Equipment & Services	+2.7%
Pharmaceuticals, Biotechnology	+2.5%
Automobiles & Components	+2.5%
Household & Personal Products	+2.1%
Equity Real Estate Investment	+1.9%
Consumer Discretionary Distributors	+1.7%
Commercial & Professional Services	+1.5%
Telecommunication Services	+1.4%
Consumer Services	+1.1%
Consumer Staples Distribution	+0.3%
Consumer Durables & Apparel	+0.0%
Software & Services	-0.1%
Transportation	-0.4%
Technology Hardware & Equipment	-2.6%

Source: Bellevue Asset Management, 31.03.2024

In a reminder of both the dangers of narrow market leadership and that Technology stocks can actually go down as well as up, the negative performance of the Technology Hardware sector is due entirely to Apple (71% weighting within the sector). The stock fell 5% on concerns over the outlook for the iPhone in China and anti-trust litigation risk in both the EU and the US.

Healthcare

The MSCI World Healthcare Total Return Index rose 2.4% in dollars (+2.3% in sterling), again underperforming the wider market amidst bullish equity sentiment. This is not hugely surprising given the sector's classically defensive characteristics. A brighter economic outlook/lower risk of recession is not going to directly impact demand for healthcare services.

The sub-sector performance breakdown is summarised in Figure 2 below and we would make the following observations: Healthcare Technology powered ahead on the back of Dexcom rising 21% on excitement over its first over-the-counter device being approved and a less negative than expected patent case ruling regarding competitor Abbott Labs.

Hospitals and Services continue to benefit from signs of improving demand from patients and/or healthcare companies, in particular on the Services side around the apparent re-opening of the follow-on financing window. We have seen a number of smaller companies successfully raise funds in recent weeks and have also seen service providers like contract research providers (CROs) and contract/outsource manufacturers (CDMOs) reporting improved volumes of incoming RFPs.

Whilst inquiries are not the same thing as booked revenues or firm orders, it is a positive sign nonetheless and a leading indicator of improving revenue growth. Just under half of the performance of the Diversified Therapeutics sub-sector came from Novo Nordisk and Eli Lilly.

	Weighting	Perf (USD)	Perf (GBP)
Healthcare Technology	0.7%	17.3%	17.2%
Facilities	1.1%	8.1%	8.0%
Services	2.2%	7.0%	7.0%
Dental	0.5%	4.7%	4.7%
Diversified Therapeutics	40.1%	3.7%	3.7%
Med-Tech	14.2%	3.2%	3.1%
Diagnostics	1.2%	2.5%	2.4%
Healthcare IT	0.5%	2.3%	2.2%
Managed Care	10.3%	2.1%	2.0%
Distributors	2.0%	1.8%	1.8%
Focused Therapeutics	7.5%	1.9%	1.8%
Generics	0.6%	0.8%	1.1%
Tools	8.0%	0.7%	0.5%
Conglomerate	9.9%	-1.1%	-1.2%
Other HC	1.3%	-13.0%	-13.1%
Index perf		**2.4%**	**2.3%**

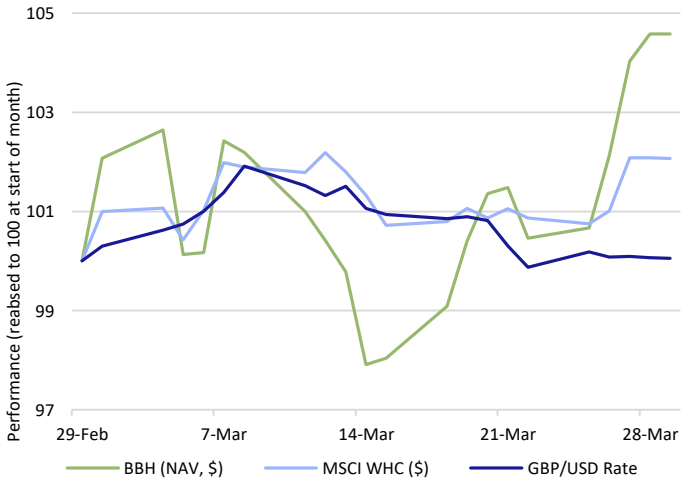
Source: Bloomberg/MSCI and Bellevue Asset Management, Weightings as of 29.02.2024, Performance to 31.03.2024

On the other side, the Tools space continues to languish on concerns over slower capital spending by academic institutions and also smaller private companies. On the former, it would seem that whilst the budget of the US government's National Institutes of Health (NIH), the primary provider of research grants in areas of biomedical and public health research, is set to increase again this year, logjams in Congress (ongoing continuing resolutions or 'CR's, rather than a definitive budget signed off by Congress and the President) mean that the organisation can only disperse money conditionally and thus at a lower level (90% of prior year funding).

In such scenarios, which are increasingly common, the first thing to be postponed are capital purchases. In an election year, customers are apparently wary that no final budget will be forthcoming.

The Trust

March saw a positive outcome in both relative and absolute terms. During the month, the Trust's Net Asset Value rose 4.6% in dollar terms (+4.5% in sterling) to 166.58p. The evolution of the NAV over the course of the month is illustrated in Figure 3 below:



Source: Bellevue Asset Management, 31.03.2024

The result was driven by a broad-base of sub-sector performance. Healthcare Technology and Diagnostics were by far the largest positive contributors during the month, with Focused Therapeutics and Healthcare IT the only modest detractors. The evolution of our sub-sector weightings is illustrated in Figure 4 opposite, and we would make the following comments:

As noted in our February missive, March is always a busy time for meetings with companies and key opinion leaders. It is also often a time of significant evolution for the portfolio, and this year was no different. We added five companies to the portfolio during the month (two of which we have held previously) and were thus actively adjusting weightings across all our sub-sector exposures.

We were net sellers of Diagnostics, but this was offset by strong performance. We added materially to our Focused Therapeutics holdings, with one new position and a substantial increase in one of our existing holdings. We were material net sellers of Healthcare IT holdings and modestly added to Healthcare Technology. Most of the increased weighting there was performance driven.

We increased our weighting in Managed Care via the addition of another holding that we previously held but sold out of. Medical Technology saw one addition to the portfolio, offset by two positions being significantly reduced. We added two new companies to the Services sub-sector, one of which is another re-purchase of a historical holding.

That company is interesting in the sense that we sold out of it because a new management team sought to move the business in a different direction that we did not like (another Teladoc-like situation). As we expected, this was unsuccessful, justifying our decision to exit. That management team is gone and the business has returned to its original roots, effectively allowing us to re-prosecute the same investment case as the last time around. There are no sacred cows at BBH. We were net sellers of the Tools sector.

The average discount to NAV was unchanged during March at 6.3%; the company re-purchased 0.3m shares during the month. The leverage ratio improved from a -3.8% (i.e. net cash) position to -0.2% at the end of the month. We are mindful that we will have a dividend outflow during April and expect to end the coming month with modest gearing.

	Subsectors end Feb 23	Subsectors end Mar 24	Change
Diagnostics	13.6%	13.3%	Decreased
Focused Therapeutics	19.6%	22.8%	Increased
Healthcare IT	11.6%	8.3%	Decreased
Healthcare Technology	10.9%	13.0%	Increased
Managed Care	6.9%	8.1%	Increased
Med-Tech	15.9%	13.8%	Decreased
Services	13.0%	14.2%	Increased
Tools	8.7%	6.5%	Decreased
Diagnostics	13.6%	13.3%	Decreased
	100.0%	**100.0%**	

Source: Bellevue Asset Management, 31.03.2024

Managers' musings

Breaking it all down

In the most simplistic and reductive terms, the investment strategy pursued by the Trust has three elements. The first is to understand the evolution of the healthcare delivery paradigm; how it is changing and what the future delivery of products, technologies and services might look like from a medium- to long-term perspective.

The second element is to take a view on which of these changes seems the most attractive from an investment point of view, considering the addressable market for future products, technologies or services and also the defensibility of those future revenue streams (given our intention to hold investments for three to seven years, all other factors being equal).

The third element is company specific. Where there may be more than one way to invest in a particular theme, we need to decide which option represents the best strategy to benefit from the changes that we foresee. Sometimes, we may conclude that there is no attractive way to play a particular theme, in which case we move on to something else.

In many ways, the most intellectually interesting part of the continuum described previously is the first stage; speaking with key opinion leaders across the sphere of payment, regulation and care as to how things could or should improve in the future.

There is always a degree of uncertainty in these kinds of prognostications. As we have noted many times (most recently in regard to the current enthusiasm for all things related to Artificial Intelligence and Machine Learning), the "future" often arrives in a different form and in a different way than first imagined, at which point, you need to pivot and think about alternative outcomes to those previously envisaged.

To our minds at least, this flexibility of thought goes to the heart of the job that we are paid to do. It is part of the reason that we put the effort into these discursive factsheets – we want you to gain insight into both what we are thinking about and how we are thinking about it.

No plan survives first contact with the enemy

A good illustration of this latter point would be the Trust's historical holding in Teladoc. We first began to buy the shares in February 2018, when they traded around $38. We rapidly scaled this to be the second-largest position in the portfolio, arguing that telemedicine (or, more specifically, 'electronic triage' and 'case management', Teladoc's two principle services at the time), was the most compelling opportunity to cut costs in primary care that we had yet come across.

Recall that one in four primary care physician appointments are concluded to have been medically unnecessary after they have taken place, which is a bit of a problem. Tele-visits cost between 50% and 75% less than face-to-face appointments and are generally much shorter,

which increases physician productivity (employed doctors can be viewed as a fixed cost).

All of this went well enough until early 2020, when excitement over virtual appointment capabilities grew exponentially due to the restrictions imposed during the COVID-19 pandemic. The necessity to continue to see patients but minimise physical contact greatly accelerated the adoption of tele-medicine services across the globe, but it began to play out in a slightly different manner than we expected.

Simply put, every large provider and various new entrant software companies began to build their own services. There was even a company that went public that year, Amwell, whose traditional business was building 'white label' services of this type for healthcare companies. We began to worry that Teladoc's opportunity to gain market share and establish itself as the 'go-to' provider would be eroded because the pandemic accelerated market conversion to a speed that literally no-one could keep up with. All of a sudden, commoditisation looked to be inevitable in a short period of time. We began to scale back our holdings (having made a very nice IRR).

The situation changed again in August 2020, when Teladoc announced that it was spending $18.5bn buying another digital health company called Livongo. We never liked this business, so we sold our holding down to zero (the share price at this stage was >$200). We likened the deal to putting ice cubes in champagne: you don't add anything and you dilute what was good in the first place! Clearly, one would not do such a deal unless one worried about the core business prospects.

The rest is history. The shares went sideways for a bit, briefly exploded to a high of $294 in February 2021 and then began an almost unbroken decline to this day. Over the course of 2022, Teladoc booked impairment charges on its Livongo acquisition totalling $13.4bn. At the end of this process, the shares stood at $26. We had to wait a little longer for the denouement, but this came in February 2024 when the CEO reset expectations for FY24, guided for low-to-mid single digit revenue growth over the coming three years and announced a cost cutting programme. On the results call, the CEO said:

> *"It's important to remember that most U.S. healthcare consumers have access to virtual urgent care today, so it's largely a replacement market at this point. We've consistently taken share in this market, and we expect to continue to do so, but it's fairly well penetrated"*

In other words, it's over. You have become a utility. It is no longer about growth, it's about margins now. The shares are currently trading at $15, but this still feels like a generous forward multiple for what is a low revenue growth business. The company expects profits will continue to rise faster than revenues over the coming few years, but that margin improvement will struggle too once the low hanging fruit has been picked from the cost base.

Talking of fruit, the conference call would have been a fruitful session for buzzword bingo, AI of course got a mention, but everyone is doing that, so whilst it will drive cost out and prices down; it will probably not boost margin (a win for the consumer, not the Teladoc shareholder).

Perhaps the company can buy out some of its struggling peers to further consolidate the sector (think mobile telecoms as an analogy). Maybe it could start with Amwell. Those shares stand at $83c today, down 98% from the early 2021 high. Unlike Teladoc, it is still nowhere near profitable and may well run out of cash before it gets to breakeven. Doximity is a slightly different model for online primary care and has fared much better. It is profitable, still growing double digits and has no debt. The shares have nonetheless halved since 2022, but the multiple still looks dizzying to us.

Rinse, repeat, recycle

Our decision to sell out of Teladoc was much discussed with investors at the time. It was, not unreasonably, viewed as a 'big call', given that it was previously our second biggest holding and telemedicine was something that we had been very vocal about at the time. Moreover, it was a very successful investment for the Trust and was also not obviously "going wrong" at the time of sale. Finally, many analysts loved the Livongo deal, and of course the shares continued to rise after our exit, making us appear to have got it "wrong", at least for a time.

We recall comparable discussions around our exit of Illumina for very similar reasons in 2021 (it bought back the GRAIL stake, which set off Livongo-like alarm bells for us). In what should be a surprise to literally no-one, the core business is not doing well and group revenues are still forecast to be lower in 2024 than they were in 2021. The shares have 'only' lost 74% of their value since, but there is a valuable residual annuity within Illumina that will be hard for peers to compete away (this is less clear for Teladoc, in our view).

The same types of discussion do not seem to be far from BBH investor's minds today, albeit in a mirror-like form. The oft-asked question of the moment is not "why did you sell out of X" but rather "why don't you own Novo Nordisk/Eli Lilly (or both)". We are well aware that GLP-1 drug plays account for >12% of the portfolio at both our closest Trust peers and Lilly is the largest position in each case. These companies have been, and continue to be the largest contributors to the wider healthcare index's performance. With this being the case, our decision not to own these shares has unarguably hurt us on a relative performance basis.

It did not impact our relative and absolute performance for calendar 2023, when we still outperformed the benchmark (and our peers), but it hurt us a lot in the middle of that year and is hurting again in 2024, hence the discussion comes back to the fore.

Eli Lilly and Novo Nordisk jointly accounted for just over 11% of the MSCI World Healthcare Total Return Index at the turn of the year and their share prices are up 34% and 24% respectively so far this year. With the index having risen 7.5% year-to-date in dollar terms, one can attribute more than 40% of the year-to-date index performance to these two names. Surely people ask, "You must regret your positioning?".

With investing, you are wrong until you are right and you are right until you are wrong. The funny thing of course about being right by selling out of something, or not owning it in the first place, is that everyone forgets what you did (or rather, did not do). History seldom recalls the avoided risk.

A simple case, clearly stated

When one is investing, all you can do is make the best decisions that you can with the information that you have at the time. We are not being inflexible on the obesity market and we have spent a lot of time researching it. What is it that we do and do not like about the Novo/Lilly obesity investment case? We will lay out our view again, in the hope of putting this issue, and our views on it to bed once and for all.

Let us first acknowledge the theoretical addressable market ("TAM") for effective weight loss therapies (note the intentional use of the word 'theoretical' and the phrase 'effective weight loss therapies' rather than GLP-1 drugs): it is not unfair or unreasonable to say that the majority of people in western markets are fat. Too fat.

According to the UK government, nearly a quarter of 11 year olds in the UK are obese. That is really scary, because it sets you on a path toward Type 2 diabetes and fatty liver disease. Weight has always been much easier to gain than to lose (cf. previous factsheets on obesity drugs).

Turning to the adults: 26% of UK adults are obese (BMI 30+) and a further 21% are overweight (BMI 25-30). We are barely in the same league as

our US cousins though. There, 42% of adults are obese and 9% (or almost a quarter of the obese) are severely obese (BMI 40+; we used to call this morbidly obese, but like most 'bad' things it has unhelpfully been given a less scary name, to the obvious benefit of no one in particular). According the US CDC, 38% of American adults have pre-diabetes and 80% of them have no idea about this diagnosis. We had to double check that factoid. "Timebomb" springs to mind.

Serious as it is, diabetes is not the only consideration. Around 220 human diseases have been linked to obesity (i.e. being obese makes them much worse) and obesity is arguably the causative agent in a small subset of serious ones, especially cardiovascular/cerebrovascular disease and cancer.

Putting some numbers to the obesity crisis, there are some 50m potential patients in Europe and a further 70m in the US. That is a huge potential marketplace. We will probably approach 10m patients on GLP-1 therapy by the end of 2024. One can easily see how a simplistic analysis could forecast enormous category sales for safe and effective weight loss drugs and this seems to be where the market's mindset is.

We actually heard one CEO in this space claim that 150m Americans could be on anti-obesity therapy by the end of the decade. On the other hand, it might be sobering to consider that statins for high cholesterol, which are generic and thus cost very little, and have very robust evidence around the benefits of their usage, are still only being used by around 36m Americans today.

The size of this theoretical market from a patient identity/prevalence standpoint is not something that is worth debating, it is objectively very large. A good proportion of these patients (the most obese and those with the highest overall levels of risk for obesity-linked diseases) will not struggle to gain reimbursement for treatment, at least for a time.

There is also a very robust argument for bringing GLP-1 forward in the treatment continuum for Type 2 diabetes as an early intervention, due to the cardiovascular benefits of the therapies. As good as all this may sound for the two companies in question, there are some sensitivities to consider.

Firstly, the cost/benefit of these therapies becomes much less positive as you move into lower risk, less obese patients. Who will pay for their (currently very expensive) therapy? Secondly, around a third of patients have tolerability issues; these are much higher in the real world than they are in clinical trials. Thirdly, there is the question of optimal therapy duration.

Some commentators (i.e. the pharma industry) would argue that therapy needs to be life-long. As Prince sagaciously noted, 'forever is a mighty long time'. What does GLP-1 maintenance therapy look like for a non-diabetic patient? Payors will only fund this if the overall benefits are positive. The challenge here is confounded by the knowledge that weight rebound on cessation of therapy (any therapy or diet, to be fair) is very significant.

According to a recent report from the benefits consultancy Milliman, adherence to GLP-1 therapy for obesity beyond one year is <32%. How much of this is due to human nature, how much due to tolerability/side effects and how much is due to coverage restrictions/cost issues is unclear but the two-year health outcomes for the 70%-odd who come off therapy are probably not going to be hugely positive versus baseline and the benefit to the payor is going to be negative if the weight is regained despite spending all that money on the drugs.

Human nature being what it is, we all want a quick fix; the easy option. However, gaining significant excess weight is not the work of a moment. It is estimated that you need to consume at least 7,000 excess calories to gain 1kg of additional body fat. The more active you are, the higher this number goes. It is thus illogical to imagine that there is ever going to be a quick fix to reverse this process, not to mention the issues around fat metabolism discussed in the September 2023 Musings.

Helping people change the habits that led to excess weight gain is critical to ensuring their weight loss becomes durable and they do not end up back where they started, or even in a worse position. This is not something that GLP-1 drugs do alone; ask any endocrinologist. That is why people tend to fair better on expensive programmes like WeightWatchers that provide support rather than just trying to do it all on their own. Primary care physicians (i.e. "GPs") do not provide this type of support (assuming you can even get to see one). Perhaps what we need are other drugs to help people keep the weight off at a much lower cost.

These points having been made, GLP-1 nonetheless represents the first broadly safe (if not very well tolerated) option for material weight loss. Assuming you can manage to tolerate the therapy (and pay for it), the majority of people could expect to lose a teens percentage of body weight in a year. This level of pharmacological efficacy has never really been possible before and so many of the questions posed previously have not really been debated by/with primary care doctors, as they have never come up before!

The next question then is whether the GLP-1-based approach can be improved upon. When one begins to consider these questions, the conclusion that comes to our minds is a very simple one – GLP-1 monotherapy is not the answer, nor is the use of a combination that enables faster weight loss than monotherapy alone. Perhaps this is why Novo and Lilly both have multiple additional compounds in development for the treatment of obesity. It is very easy to conclude that there is considerable room for improvement here.

Optimising weight loss

If we ignore the self-pay aesthetics crowd in New York and Beverly Hills for a moment, and focus on the genuinely obese, the goal of therapy is not to look better, but to be healthier. Obesity is a health risk, after all. Sadly, measuring long-term health outcomes in clinical trials ceases to be practicable due to size and expense considerations. We will need to look toward patient registries. What do those longer-term outcomes look like? We do not yet know, but we can say for sure that this is not just about cardio-metabolic parameters.

The core of this problem comes down to how GLP-1 drugs work. In the simplest sense, they cause food aversion. You want to eat less, so you do eat less. The body is in constant turnover and, without a ready supply of macronutrients, it will begin to waste away. What this means in practical terms is that, whilst you will preferentially lose fat mass, you will also lose lean mass (muscle, bone, organs).

It has long been known that the ideal ratio of fat mass to lean mass loss when shedding body weight is at least 75% to 25%. A subgroup analysis from Novo's STEP-1 study for Wegovy suggested a ratio of 10.4 to 6.9, or 60% to 40%.Whilst you can make the claim that body composition is improving when taking the drug (because you are losing more fat than lean mass), it is far from idealised.

Moreover, the more weight you lose, the more the ratio will pivot away from fat mass toward lean mass (as there is less fat to lose). The same turns out to be true with the speed of weight loss; the faster you lose weight, the greater the risk that you are losing lean mass alongside fat mass. Starvation is a highly effective and rapid weight loss technique, but there is a reason why it is not one advocated by medical professionals.

This problem is confounded by the fact that age ruins body composition as it is. Post menopausal women in particular can struggle to maintain healthy bone and muscle mass without regular exercise. The problem is less pronounced in middle-aged men, but we catch up in our later years.

Although obesity is increasingly an issue for the young, it has been most commonly diagnosed in the middle aged and GLP-1 monotherapy may thus not be the best route to successful weight loss in some patient

groups. To be clear, there is no robust evidence at this stage that long-term GLP-1 usage conveys any serious issues, but there again we have not got very much long-term data on its use in non-diabetic subjects.

What we do know is that GLP-1 is but one of many hormones involved in the control of appetite and thus one of many potential druggable targets for pharmaceutical interventions.

Our view is that the long-term outlook for this market will be one where the focus shifts to weight maintenance, body composition and the cost effectiveness of therapies and you need only look at some of the smaller biotechnology companies developing new drugs to see this shift being underway (i.e. disclosure of lean mass to fat mass ratios and ease of volume production in headline data releases).

This is also an area where non-peptide (i.e. small molecule) drugs could have a huge advantage, since they are much easier to make at scale; both Novo and Lilly are struggling to meet demand for their products and investing huge amounts into capex to increase volumes.

Combination approaches probably allow for gentler impacts, resulting in less nausea and thus better tolerability. We feel strongly that the goal of next generation therapies should not be to lose more weight in the first 12 months, but to be able to keep weight off with good preservation of lean tissue.

And this is where the field opens up. There are many companies working on such products and we cannot see why, if they are successful in proving the concept, other 'big pharma' players will not want to get in on the action via M&A or in-licensing. For this reason, we see a multi-player, fragmented market. And this is the reason why we do not own Novo Nordisk and Eli Lilly at their current valuations.

Both companies will continue to build an 'evidence moat' around their drugs, linking their use to improved outcomes in the commonest of those 220 obesity-linked diseases but let us not forget that it is the loss of the weight, not the mechanism of the weight loss per se that is driving the results here.

The positive outcomes are almost a foregone conclusion to our minds. Let us also not forget that short-term symptom improvement is not the same as long-term outcomes, which of course rely on the weight staying off and that, in and of itself, will rely on maintenance therapy which at this stage is an assumption not a reality outside of clinical trials.

Do we have some skin in the obesity game, that is to say – do we have exposure to potential second/third generation incretin obesity products? The answer is yes. We never said we didn't think obesity was a real market, all we have said is that we question the attribution of sales and market share to a duopoly of established players and questioned whether or not GLP-1 therapy as a mechanism was the "solution" to the obesity puzzle in a demonstrably obesogenic environment.

Some of you may also wonder if we have any exposure to the NASH/MASH fatty liver disease market. The answer to this is no. If obesity therapies are effective, then NASH/MASH risk will be greatly reduced, leaving only the F3/F4 patients with established fibrosis as a stand-alone market.

Sadly, we have yet to see any compelling efficacy in this group, but we have looked at several projects across many different companies. One day, someone will unlock the biology of fibrosis (in lungs as well as livers), but so far the reversal of fibrotic deposition remains elusive to our minds.

Sometime, in the next few years, we will find out the answer to the question of how these two markets (obesity and NASH/MASH treatment) will unfold. The approach we have taken is the same one that has served us well in the past. We will not invest if we cannot make the numbers work. We will also happily change tack if the situation develops differently to our current expectations and we are quite happy to explain, in detail via these factsheets, why we hold the opinions that we do.

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

Top 10 positions

Tandem Diabetes Care	7.3%
Exact Sciences	6.4%
Option Care Health	6.4%
Charles River Laboratories	6.3%
Insmed	5.8%
Dexcom	5.7%
Axsome Therapeutics	5.5%
Bio-Rad Laboratories	5.5%
Accolade	4.4%
CareDx	4.2%
Total top 10 positions	57.6%
Total positions	31

Sector breakdown

Focused Therapeutics	22.7%
Services	14.2%
Med-Tech	13.8%
Diagnostics	13.4%
Health Tech	13.0%
Healthcare IT	8.3%
Managed Care	8.1%
Tools	6.5%

Geographic breakdown

United States	97.8%
China	2.2%

Market cap breakdown

Mega-Cap	15.2%
Large-Cap	19.0%
Mid-Cap	42.1%
Small-Cap	23.7%

Source: Bellevue Asset Management, 31.03.2024;
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 actively 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):	24.9 (Low)	Coverage:	97%
MSCI ESG Rating (AAA - CCC):	A	Coverage:	97%

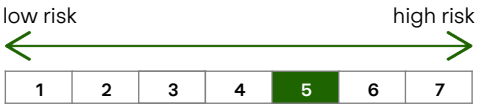
Based on portfolio data as per 31.03.2024; – ESG data base on MSCI ESG Research and are for information purposes only; compliance with global norms according to the principles of UN Global Compact (UNGC), UN Guiding Principles for Business and Human Rights (HR) and standards of International Labor Organisation (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.

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 circum-stances 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.

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