BB Healthcare Trust

Monthly News
March 2021

Marketing document

As at 03/31/2021	Value	1 Month (March)	YTD	Since Launch (ITD)
Share	189.50	3.8%	8.2%	114.4%
NAV	187.14	3.2%	8.3%	112.3%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 31.03.2021, NAV and share price returns are adjusted for dividends paid during the period (but not assuming re-investment). Full performance data is on page 6.

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

Welcome to our March missive. As we take our first tentative steps out of lockdown, there is cause for optimism here in the UK. Nonetheless, the embers of the pandemic smoulder on across the waters, where restrictions are again in a tightening cycle and a fresh crisis could yet engulf us all.

Our recent (and presumably much hoped for) positivity on the longer-term outlook appears antecedent to a period of more febrile market sentiment and macro driven sub-sector correlations as growth gave ground to value and laggards turned into leaders.

It feels as if the market is struggling for a coherent narrative. In many ways, this is a more perplexing period to navigate than the market correction some twelve months ago. Healthcare fund management is nothing if not challenging!

Summary

BB Healthcare Trust Ltd is a high conviction, unconstrained, long-only vehicle invested in global healthcare equities with a max of 35 stocks. The target annual dividend is 3.5% of NAV and the fund offers an annual redemption option. BB Healthcare is managed by the healthcare investment trust team at Bellevue Asset Management (UK) Ltd.

Monthly review

The wider market

Dynamically, March has been somewhat a repeat of February; the MSCI World Index advanced 4.2% in sterling terms (+3.1% in dollars). This reversed much of the sell-off seen in late February, although the high's of the month did not quite reach the altitudinal peaks of the prior period. Once again, we saw a pattern of a rapid advance in the first half of the month, followed by a sell-off in the second, albeit a short-lived one.

The sub-sector performance was led mainly by non-healthcare defensives: Utilities (+7.7%), Capital Goods (not defensive, we admit, +6.6%), Household & Personal Care (+6.6%) Food, Beverage & Tobacco (+6.4% in dollars), Food & Staples retailing (+5.7%). At the other end of the spectrum, the longstanding market leaders of the pandemic period or the recent darlings of re-opening trade were the laggards: Software (-0.5% in dollars), Materials (+1.1%), Media & Entertainment (+1.2%) and Pharmaceuticals & Biotechnology (+1.2%). The dispersion between sectors was notably narrower this month.

In summary then, we continue to see a market rotation away from Tech and higher PE-rated leadership stocks toward cheaper assets. The continuation of this dynamic probably arose from a combination of broader valuation concerns, allied to the rising numbers of positive COVID tests in several advanced economies, reminding everyone that we are not out of the woods yet and "normality" in the sense we want it to mean is still some way off. We will return to the importance or otherwise of this point later.

Healthcare

One might have surmised that a more defensive mindset would be positive for the healthcare sector and this was broadly the case, with the MSCI World Healthcare Index rising some 3.2% in sterling terms over the month (+2.2% in dollars), although the sub-sector performance again reflected this wider market macro of value catch up (12 month laggard sectors doing very well), rotation away from anything that feels like "tech" and generally more defensive positioning.

The overall picture was not helped by the resuscitation of leftist firebrand Bernie Sanders from his apparent post-election slumber. He came out swinging, with his "Prescription Drug Price Relief Act" (like most Sanders bills, we have seen this one before, the last time being 2019) and then promptly used his position as Chair of the Senate Health, Education, Labour and Pensions Subcommittee to call a hearing on drug prices.

Sanders is also chair of the Budget Committee for the current Congress, which gives him powers to push certain bills through via the reconciliation process. He has never been so powerful or influential. As such, he is harder to ignore this time around than in 2019. All he needs is a vehicle onto which some drug pricing-related legislation could be appended.

Such an opportunity duly arrived via the much-trailed infrastructure bill that Biden revealed on March 31st. This will also cover some health and social care policy items, but we will have to wait for the details (as discussed further below).

All of the above served to dampen sentiment toward drug companies in general and the higher rated companies in particular, with a general "risk-off" attitude toward drug-related exposures. The healthcare sub-sector performance is summarised in Figure 1 below and is not really one that would obviously suit a longer-term-focused fundamental investor.

Leaving valuation to one side and considering growth, does one really want to be overweight Distributors and Facilities and underweight Diagnostics and Services? Even accepting some degree of valuation frothiness in the Dental, Healthcare IT and Healthcare Technology spaces, we would still think on a PEG basis that you wouldn't make such a bet on a multi-year view.

BENCHMARK SUB-SECTOR PERFORMANCE AND WEIGHTINGS

Sub-Sector	Weighting	Perf. (USD)	Perf. (GBP)
Distributors	1.2%	13.6%	14.8%
Managed Care	8.7%	12.9%	14.1%
Facilities	1.2%	6.4%	7.5%
Conglomerate	12.5%	3.6%	4.7%
Diversified Therapeutics	33.2%	2.1%	3.1%
Tools	7.9%	1.1%	2.2%
Med-Tech	16.0%	1.0%	2.2%
Generics	0.5%	-0.5%	0.5%
Other HC	1.3%	-0.5%	0.5%
Focused Therapeutics	8.5%	-1.2%	-0.2%
Services	2.7%	-1.6%	-0.6%
Dental	0.8%	-2.7%	-1.6%
Diagnostics	2.7%	-3.4%	-2.5%
Healthcare Technology	0.8%	-6.5%	-5.5%
Healthcare IT	1.8%	-9.1%	-8.2%
Index perf.		**2.1%**	**3.2%**

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 28-02-21. Performance to 31-03-21.

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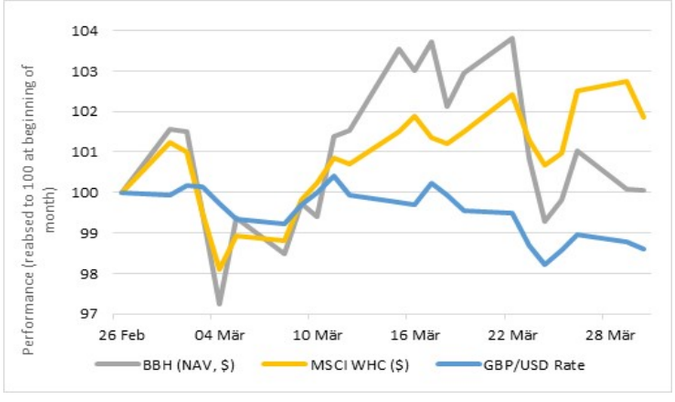
The Trust

The overall market dynamic (at both the market macro and the healthcare level) was frustrating and somewhat challenging for our strategy. As a consequence, we modestly underperformed versus the benchmark, albeit still with a decent absolute development for the month. Adjusting for the shares going ex-dividend on March 25th, the Trust's net asset value rose 3.1% in sterling to 187.04p, versus +3.2% for the comparator MSCI World Healthcare Index.

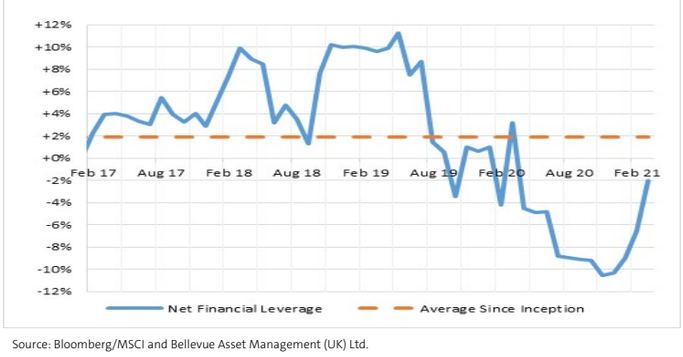
The evolution of the NAV in US dollars over the month is illustrated in Figure 2 below. Our relative and absolute performance in the middle of the month benefitted from Roche's announcement that it was acquiring Genmark Diagnostics on March 12th. We estimate this contributed around 100bp to our monthly absolute performance and, adjusting for this, we essentially mirrored the wider benchmark until the end of the third week, whereupon the aforementioned healthcare macro factors became a headwind. The weakening of sterling versus the dollar was a slight benefit over that period, such that our overall sterling performance for the month recovered most of this deficit:



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

Regular readers will be aware that we have been carrying a degree of cash rather than being levered since late 2019, reflecting our level of macro concerns over the sector and valuations. This caution increased significantly in H2 2020 (Figure 3), as the share prices continued to make significant progress in the face of what we strongly felt were erroneously optimistic assumptions regarding post-pandemic normalisation and attendant increase in healthcare procedure volumes.

As these assumptions have fallen more into line with our own thinking, we have become less concerned about the risk of material downgrades to sales and earnings forecasts weighing on the stocks we might own. As such, we have been broadening the portfolio exposures in terms of sub-sectors and deploying the cash into both new and existing portfolio holdings. This process materially accelerated during March and our net cash pile has further declined from 6.6% of gross assets at the end of February to 2.0% at the end of March, with around a third of this earmarked for the forthcoming dividend payment due to be made in late April.



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

The evolution of our sector weightings is illustrated in the table below (Figure 4). As part of the cash work down described above, we have actively deployed capital into holdings in every sub-sector we hold and also re-commenced some exposure to the Healthcare Technology space, having been absent from it since late 2019 (due mainly to valuation-related concerns). More broadly, there has been a continuation of the diversification trend discussed in recent months; less therapeutics, more Med-Tech, Services and Healthcare IT/Technology.

The material decline in our Diagnostics exposure reflects the exit of our position in Genmark; we are actively looking for new names to add in this area, but one must navigate some challenging valuations given COVID testing, allied to a dispersion of views as to how (and when) such testing revenues will begin to decline.

The notable increase in Managed Care weightings reflects substantial outperformance (per Figure 1) rather than outsized additions in this area. Part of the reduction in the Focused Therapeutics weighting reflects us exiting the residual position in GW Pharma, another M&A target. Following the exit of these two positions and our Healthcare Technology addition, the active investment portfolio decreased from 30 stocks to 29, excluding the Alder ADR. We issued 8.9m shares via the tapping programme.

EVOLUTION OF PORTFOLIO WEIGHTINGS

	Subsector end Feb 21	Subsector end Mar 21	Change
Diagnostics	7.7%	3.2%	Decreased
Diversified Therapeutics	16.7%	15.9%	Decreased
Focused Therapeutics	32.4%	28.2%	Decreased
Healthcare IT	5.2%	6.1%	Increased
Healthcare Technology	0.0%	0.4%	Increased
Managed Care	11.3%	14.1%	Increased
Med-Tech	15.9%	18.6%	Increased
Services	6.9%	9.1%	Increased
Tools	3.8%	4.4%	Increased
	100.0%	**100.0%**	

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 31-01-21. Performance to 28-02-21.

Managers' Musings

Idus Martiae

Even the most coldly rational of people (hopefully that includes us, but we leave that for you to decide) must be wondering what on earth is going on at a political level currently.

Doubtless we are all sadly used to the depredations of the political classes and their crapulous self-exculpations when things go awry, but the apparent declaration of war against the Oxford/Astra vaccine by most of our former EU partners (at both a national and supra-national level) is more than alarming: the only vaccinations that count are the ones in peoples' arms and, in the middle of a pandemic, any responsible politician should be doing all they can to maximise this outcome, rather than let doses go unused in freezers.

The development of these vaccines was accelerated and that has resulted in some data coming out in a rather haphazard fashion. With specific regard to the Oxford/Astra collaboration; let us not forget that Astra was not really in charge of the initial clinical trial design (phase 1 was underway before Astra signed its collaboration agreement with the Oxford group); this was led by the academics of the Oxford group and was borne more of proof of concept than registration trial quality. Moreover, Astra are doing all on not-for-profit basis, a decision we imagine they are beginning to regret.

This easy to transport and store vaccine will, alongside the similarly pliable J&J offering, probably form much of the COVAX commitment for less developed countries. It is all well and good to undermine such products when you have easy access to alternative options as many European countries will soon have, but poorer nations do not and they have just the same need to maximise vaccine outcomes amid now more sceptical populations. For all its carping about not getting enough vaccines from Astra, the EU met its own target to have 100 million doses delivered by the end of March 2021.

Any decision about the safety or efficacy of a vaccine must be balanced against the risks arising from the condition the vaccine is intended to prevent. Whilst SARS-CoV-2 in aggregate is not associated with significant mortality, its potential effect on the elderly and the vulnerable is worrisome and that is why most countries are prioritising these groups in their vaccine rollout.

Libenter homines id quod volunt credunt

So what, if any, is the scientific basis for all this kerfuffle? Let us deal first with side effects. The concern that seems specific to the Oxford/Astra jab is a rare clotting disorder known as cerebral venous sinus thrombosis (CVST) and a general increase in bleeding events concomitant with low platelet counts. CVST manifests through blood clots in the sinus channels that drain fluid from the brain. Clots in this region can result in elevated intracranial pressure, causing neurological symptoms and even death if not identified early.

In terms of natural prevalence, CVST arises at a frequency of 3-4 per million, is most common in the younger to middle aged adult (30-50) and is more common in women than men (sex ratio 3:1), in part due to the very small increased risk of the condition arising from the use of oral contraceptives. Various medical conditions can exacerbate the background risk, including chronic inflammatory diseases and cerebrovascular conditions.

The rates of this condition reported as a post vaccination side effect vary greatly by country and, in aggregate, show no clear age or sex-related pattern. The UK regularly updates its records on post-vaccination side effects and reported there had been 22 cases of CVST amongst 18.1 million recipients of the Oxford/Astra jab by 22nd March. This is equal to around 1.22 per million.

If we take the mid-point of the prevalence data for the condition (3.5 per million), then one should reasonably expect to see around 63 cases per year amongst those 18 million vaccinated people, or around 16 cases in a three month period (which is roughly how long we have been distributing the vaccine. There are probably other adjustments we need to make, given the prioritisation of the elderly (lower CVST risk) and the vulnerable, some of whom would have conditions associated with increases CVST risk, but there is insufficient data to make such adjustments.

So, what we are talking about is an apparent increased risk of CVST of 0.35 per million or ~1 in 3 million. This is a very low risk event. On the other hand, one cannot really ignore the same UK dataset that shows only two CVST cases amongst the 10 million-odd recipients of the Pfizer/BioNTech shot (i.e. 0.2 per million). However, the risk of CVST amongst the elderly is low and the Pfizer jab's earlier approval means that the age range of recipients is much higher than for the Oxford shot, so these confounding factors make a comparison difficult.

At this time, our view is that we have yet to see robust data to justify the contention of a material CVST event risk using the Oxford/Astra vaccine; which was the same conclusion reached by the EMEA and WHO when these cases first came to light. The WHO reiterated its view on 6th April 2021, noting that, although further cases had been reported, the risk/reward remained positive. On 7th April, both the EMEA and UK MHRA held press conferences to update the public on their most recent findings. Unfortunately, their recommendations seemed rather different, which will further muddy these already turbid waters.

The EMEA concluded that there appeared to be a link between the vaccine and the elevated thrombotic risks, albeit that such risks remained rare and the overall risk/reward for the Oxford/Astra shot was very favourable. They further concluded there was insufficient evidence to determine any specific risk factors, especially as relates to the age or sex of the recipient. As such, they were making no recommendations and simply would update the product information with appropriate warnings regarding possible rare side effects and leave national agencies to make specific recommendations at the country level within the EU. Whilst making the latter point, the agency seemed to hope countries would come together and make a joint recommendation themselves, but this was not how things unfolded.

In contrast to the EMEA, the UK regulator (MHRA) concluded that the risk/benefit for younger patients was unfavourable and now those under 30 should be offered an alternative vaccine. It also highlighted a much higher risk of events in women versus men. To be frank, the risk of symptomatic COVID-19 for the under 30s could also be described as "rare" (the US CDC defines the hospitalisation risk for the under 30s to be about 10x lower than for the over 75s for instance and the risk of death is >300x lower. In fact, your risk of death is estimated to be about 1 in 500, similar to your lifetime risk of dying whilst crossing the road). This group, which represent around 10m of the UK's 54m adults were not even planned to be widely offered the vaccine until August (unless they had a serious medical condition).

As such, the risk/benefit threshold for these patients is understandably much lower, mainly because COVID-19 is so benign for them. This message has of course gotten lost in translation, with the media focus very much on the qualitative "clot risk". One could go so far as to argue that the UK decision is meaningless: they are basically saying "those of you currently not entitled to a vaccine are no longer entitled to the Astra/Oxford vaccine that you can't have anyway". By the time they are widely offering doses to the under 30s, other options are likely to be readily available. Morevoer, the evidence in this group must be based on very small numbers given how few young people have had the jab at this point, so that seems rather meaningless to us as well. Finally, anyone who is much older who is due to get a shot with this jab is now going to worry because that is human nature.

Whilst we are disappointed with how the UK has chosen to handle this issue, the EU as a collective entity does not come out of it well either. For whilst we could suggest the EU regulator has "followed the science" more clearly than the UK seems to have done, politicians are a breed apart. Many countries have already pre-empted any scientific findings whatsoever to restrict use of the Oxford/Astra jab to the elderly and Italy joined them on the 7th April as well. Such a restriction is no more rational than the UK's "no under 30s" since the evidence to make such a demographic cut off is so weak.

All of this rather begs the question why some governments are reacting in the way that they are. Granted, when we reach the point of a local vaccine over-supply issue, then one has the luxury of being able to specify the use (or non-use) of a specific vaccine in a specific age group, but this is certainly not the case in somewhere like France, where the ICU capacity is rapidly filling up (and not just with old people) and allegedly half the country's delivered Oxford/Astra jabs have gone unused.

Here in the UK, we are very reliant on the Oxford/Astra shot to complete our programme and confidence is now undermined. Before anyone gets too excited about alternatives, we would point out that there was a numerical imbalance of clotting events in the J&J vaccine trial that were skewed to younger patients as well. As ever though, we will wait until there is some tangible scientific data before trying to draw any conclusions about increased risks with any of the other vaccines.

Whilst we are ranting about blood clots, here is some more context. Firstly, the most dangerous activity for a woman under 30 in terms of clot risk is taking oral contraceptives. The "pill" at least doubles the risk of CVST or wider thrombotic events for this demographic. This seems to be a much greater increase in event risk than for the Oxford/Astra shot, but one that society

does not seem to make much of a fuss over. Secondly, symptomatic COVID-19, whilst rare in the young, is associated with materially higher risks of thrombotic events. Some studies have reported clotting-related issue in around a third of patients (remember when "COVID Toe" was added to the list of symptoms in mid-2020?). It would be more tragic than ironic to read in the coming months about a young person dying of a blood clot arising from COVID-19, having refused the vaccine on the grounds of risk of clots. Context is everything.

However, it is not just side effects that have been called into question with respect to the Oxford/Astra shot, it's efficacy has also been besmirched by some European politicians. Is there any merit to these comments? Again, one needs to be rather careful comparing the initial preliminary dataset from the Oxford project with the US-focused datasets from Moderna and Pfizer. Far more useful is a comparison of the Oxford/Astra US trial, albeit with the caveat that certain "trickier" variants are now more prevalent in the US than was the case when the Pfizer and Moderna primary endpoints were struck.

The Oxford jab saw 76% overall efficacy, 85% prevention of symptomatic COVID-19 and 100% efficacy against severe infections. This compares to 94% prevention of symptomatic COVID-19 for Pfizer's results reported in the NEJM in December 2020. Objectively then, one might say that the Oxford/Astra jab's efficacy at the margin might be lower than say, Pfizer or Moderna in absolute terms, but it still prevents the vast majority of symptomatic and all serious cases – you know, the ones that actually harm people. What's not to like? Even if you are an EU politician who is angry about Brexit for whatever reason and would rather not use something developed by the UK, you cannot ignore the compelling real-world data shown opposite. This vaccine is working in every way that matters. And it is here, now for you to give to your vulnerable citizens. How can anyone in good conscience not be supportive of its use?

Alea jacta est

Nonetheless, if anyone throws enough mud, some will stick. The perception of the Oxford/Astra jab relative to other options now seems to be in the gutter, in terms of both safety and efficacy and it is hurting EU member states more than anyone else (although vaccine centres are reporting that Astra refusers have now become a reality here in the UK as well). This situation was not helped by the US intervening in respect of Astra's press release regarding its US trial. The company could have handled this better, we agree, but subsequent accusations of wilful misrepresentation seem very wide of the mark to us.

Moreover, the sadly ongoing MMR saga shows us all too clearly that facts do not matter after a certain point; perception is everything. Once you have rumours out there, any government or corporate statement to the contrary is: 'just some deep state cover up', especially when the UK is almost standing alone in trying to defend the product (based on real-world data from its widespread use here in the UK – surely the best sort of medical safety evidence you can get).

The unhelpful and unscientific utterances from European politicians go beyond the vaccine itself, to accusations that the UK is impeding the flow of critical supply chain items, for which there is also zero evidence. Quite why anyone wants to weaponise this global tragedy for a bit of distracting 'whataboutery' is beyond us, but then again, so much about our social media age is baffling.

So, let us now 'speak our own truth' (this seems a very popular notion these days). Ms Von der Leyen: based on the public disclosures that have been made, it seems unarguable that the Commission's appointed representatives messed up the European vaccine procurement scheme – own your mistake instead of seeking to shift the blame elsewhere.

Beyond Europe, we have China insisting that visitors must have its home grown SARS-CoV-2 vaccines, for which peer reviewed efficacy data remains strangely elusive. At least Russia has published its data in a peer-reviewed journal. There again, China has ongoing form for not being transparent when it comes to this virus, as the WHO highlighted when publishing its recent report into the origins of the pandemic.

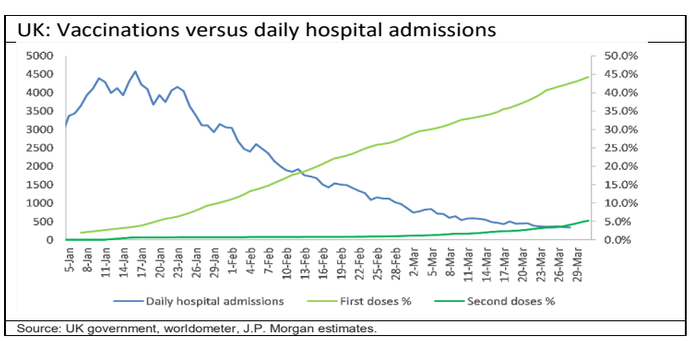
What a mess, and what a shame. One cannot but feel all of this could have been handled so much better. However, we feel no sense of ~~schadenfreude~~ epicaricacy* at the relative failure of the EU versus the now independent UK in regard to COVID cases and vaccinations; there is much truth in the now over-used platitude "no one is safe until we are all safe"; at least not in a world where one wants to be free to travel from one country to another. So all of you out there who have chosen politics as a career (yes, we all know it's a career, not a noble act of public service) – we would urge you to desist from the partisanship and polemics that are so much in evidence at the moment and focus on the greater good. The vulnerable need to be vaccinated as soon as possible.

*Note: we thought it best to replace a German word with an English one in case Ms Von de Leyen chooses to impose an export ban on language as well as vaccines – and why not? This is surely no less ridiculous or inappropriate.

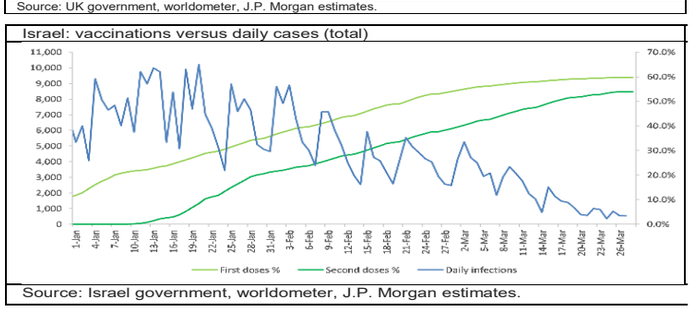
Ut est rerum omnium magister usus

Back to some science/facts. Amidst the polemics and prevarications, the data coming out of the UK, the US and Israel regarding the impact of vaccinations is all rather positive. For those of you looking for an uplifting musing on this topic, we would encourage you to listen to our recent Citywire podcast (see BBH website); we marked the anniversary of the first UK lockdown with a discussion on the future of vaccination and it is difficult not to feel reassured by the expert opinions on offer.

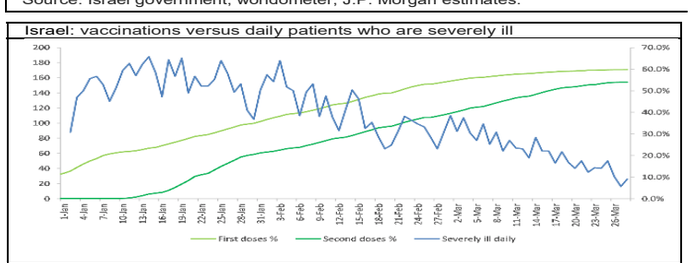
Figures 5-7 illustrate the impact of widespread vaccination on hospitalisations and severe cases. The US is in a somewhat different situation, in that it has chosen to end restrictions in a rapid fashion, whereas the UK and Israel are reintroducing freedoms at a measured cadence.



Source: UK government, worldometer, J.P. Morgan estimates.



Source: Israel government, worldometer, J.P. Morgan estimates.



Source: Israel government, worldometer, J.P. Morgan estimates.

We are still not there yet as regards robust data on the impact of vaccination on transmission of the virus. In reality, this is difficult to measure fully until there are no more restrictions and of course this creates a 'chicken and egg' situation and thus supports a cautious approach to unlocking here in the UK, and elsewhere for that matter.

As we go through this process, we sincerely hope that the Government sticks to its mantra of 'protecting the NHS and saving lives' and stops carping on about R numbers and cases. As we have said before, the only things that matter are morbidity (i.e. hospitalisations and deaths) and variant prevalence. If we remain in a situation where the vaccines continue to be 100% effective at preventing hospitalisations and deaths, then cases are irrelevant. Equally, if the variants in circulation remain susceptible to the vaccines that we have available, then all is well.

We are not ignoring the risk of 'long COVID'; this is a tragic reality for a minority of those who catch the virus but the risks of this condition remain low. A recent paper in Nature put the risk at 2% of those with self-reported symptomatic disease and of course we have no data as yet how long past 12 weeks such symptoms remain. There is a strong correlation between the severity of symptoms early in the disease and this later condition, which would argue that the asymptomatic or mild cases are at very low risk of developing into a longer-term syndrome. Since vaccination protects against severe disease, it surely follows that the incidence of 'long COVID' will fall in lockstep with severe case reports.

The UK's apparent caution in regard to 'transmission despite vaccination' is even more justified when one looks to the United States, where cases are now beginning to rise rapidly, portending a fourth wave. Given the high level of vaccination, time will tell if this proves to be a 'silent wave', with limited serious morbidity and attendant pressure on hospital systems (so far, it is looking good in this regard). Whilst it is uncomfortable to see this playing out as a real world experiment, the answers will be very useful to the rest of the world.

We will also be waiting a few more months before we see the first data from variant vaccines. On a positive note though, recently published data does suggest that polyclonal antibodies produced in response to exposure to the B.1.3.5.1 "South Africa" variant offer decent coverage against the currently prevalent strains as well. The reverse is not true (we have seen the majority of current vaccines report much lower levels of protection against B.1.3.5.1). This is the strain that Moderna has selected for its next vaccine offering, so it may turn out that the shot is a good replacement for the first generation product and also that a mixture of the two mRNA vaccine sequences might not be needed, which would help greatly from a production perspective.

Whilst we are on the subject of the B.1.3.5.1 "South Africa" variant, Pfizer published some additional data at the end of March regarding the durability of its vaccine's effect in a placebo matched cohort of 46,000 people. Over a sixth month period post second dose, the vaccine reduced the potential for infection by 91.3% and was 100% or 95.3% effective at preventing severe disease, depending on one using the CDC or FDA definition of such disease respectively. Moreover, within this cohort, there were 800 patients in South Africa and the data from there showed both higher than previously expected antibody titers against the B.1.3.5.1 variant and a higher than previously expected degree of protection. The patient numbers are small, so this data needs to be interpreted with caution. However, this is very good news all around.

Given the absence of robust data on transmission and the prevalence of a number of 'variants of concern' that could result in reduced vaccine efficacy (and thus increased risk of severe cases), we continue to be amazed by the ongoing push toward vaccine passports and holiday travel. Let's leave aside the chilling civil liberties implications of this idea (democracy always dies in small increments; just ask someone from Venezuela or Hong Kong), or that it would be yet another penalising of the young and currently unvaccinated versus the older generations. We enjoy an overpriced warm beer as much as the next middle-aged person, but going to the pub is not a hill on which we want our children's civil liberties to die on.

There is no scientific evidence that vaccinated people could not spread variants from one country to another by coming into contact on a beach in some third country. You may not thank us for saying it, but we continue to think that the best thing that can happen here on 17 May is nothing – no unlocking of foreign travel before we know if variant booster shots can work. We have come this far and endured a lot of restrictions already – what difference would a few extra months of domestic-only travel make?

Let us not get too bogged down in the polemics; this has been another positive month on the science side in terms of seeing real-world data showing the vaccines are reducing sickness and death, showing impressive and durable efficacy and doing so with a very positive overall side effect profile. We just need to keep the focus on getting as many vulnerable people as possible vaccinated.

Veni, vidi, vici?

At the risk of mixing up one's metaphors of antiquity, that Biden's a bit of a Trojan horse isn't he? He campaigns as a rather boring moderate; a safe pair of hands and even a little bumbling. But lo, he does a "Columbo" on us and it turns out that he's a cheeky little schemer with an ambitious agenda and a knowledge of the workings of Congress that suggests he may actually get things done, even in the face of Republican opposition.

When it comes to healthcare sentiment, this has thrown the cat amongst the pigeons; the consensus view was that he would be something of a lame duck and thus would pick his fights carefully, with precious little time to expand the agenda. The aforementioned infrastructure bill is a case in point. Corporate tax rises would be a short-term headwind for PE ratios, but infrastructure is well understood to boost long-term GDP growth.

However, the big reveal on March 30th turned out to contain a cliffhanger. The second part of the proposal, which covers "social infrastructure" and is all the more controversial on the Republican side for essentially expanding the welfare state versus creating shovel ready projects that bring new jobs and we will not know the details until mid-April. We now face a short-term election-like overhang with respect to drug pricing legislation.

On the plus side, we got a proposal for $400bn of Medicaid funding, which may help some of the Managed Care stocks at the margin (since they have little capex and no R&D to create tax credits, they will be amongst the hardest hit by an increase in the Federal corporate tax rate).

Can Biden pull off the ambitious-sounding social and health reforms that have been alluded to? The bill in aggregate relies on tax increases for corporations (i.e. reversing Trump's 2017 tax cut) and closes some tax loopholes for funding. This will not go down well on the right of the aisle. In many ways then, this is probably the piece of legislation whose passage (or otherwise) will come to define Biden's legacy as the 47th President. It is going to be an interesting few months, but when hasn't it been interesting?

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

As ever, we will endeavour to respond in a timely fashion. We thank you for your support of BB Healthcare Trust.

Paul Major and Brett Darke

B|B Healthcare Trust

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Standardised discrete performance (%)

12-month total return	1 year Mar 20 - Mar 21	2 years Mar 19 - Mar 21	3 years Mar 18 - Mar 21	4 years Mar 18 - Mar 21	since inception
NAV return (inc. dividends)	58.6%	44.1%	93.0%	92.3%	112.3%
Share price	58.6%	47.4%	95.2%	87.1%	114.4%
MSCI WHC Total Net Return Index	16.6%	23.9%	51.0%	48.0%	65.5%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 31.03.2021

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

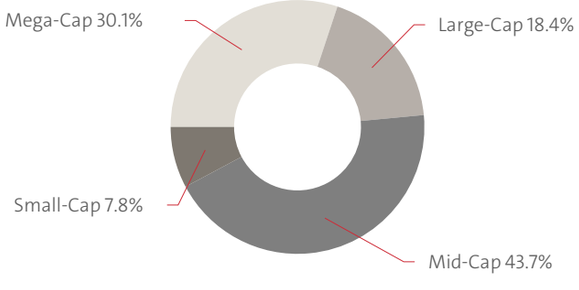
Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed

TOP 10 HOLIDINGS

Bristol Myers Squibb	7.1%
Insmed	6.5%
Vertex Pharmaceuticals	6.4%
Jazz Pharmaceuticals	6.3%
Anthem	5.7%
Hill-Rom Holdings	5.6%
Alnylam Pharmaceuticals	4.7%
Humana	4.6%
Bio-Rad Laboratories	4.4%
Charles River	4.2%
Total	**55.5%**

Source: Bellevue Asset Management, 31.03.2021

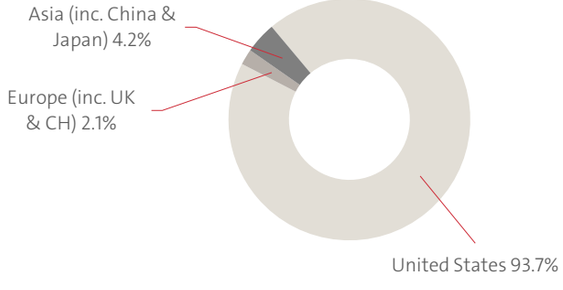
MARKET CAP BREAKDOWN



Source: Bellevue Asset Management, 31.03.2021

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

GEOGRAPHICAL BREAKDOWN (OPERATIONAL HQ)



Source: Bellevue Asset Management, 31.03.2021

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INVESTMENT FOCUS

- The BB Healthcare Trust invests in a concentrated portfolio of listed equities in the global healthcare industry (maximum of 35 holdings)
- Managed by Bellevue group ("Bellevue"), who manage BB Biotech AG (ticker: BION SW), Europe's leading biotech investment trust
- The overall objective for the BB Healthcare Trust is to provide shareholders with capital growth and income over the long term
- The investable universe for BB Healthcare is the global healthcare industry including companies within industries such as pharmaceuticals, biotechnology, medical devices and equipment, healthcare insurers and facility operators, information technology (where the product or service supports, supplies or services the delivery of healthcare), drug retail, consumer healthcare and distribution
- There will be no restrictions on the constituents of BB Healthcare's portfolio by index benchmark, geography, market capitalisation or healthcare industry sub-sector. BB Healthcare will not seek to replicate the benchmark index in constructing its portfolio

DISCLAIMER

FIVE GOOD REASONS

- Healthcare has a strong, fundamental demographic-driven growth outlook
- The Fund has a global and unconstrained investment remit
- It is a concentrated high conviction portfolio
- The Trust offers a combination of high quality healthcare exposure and targets a dividend payout equal to 3.5% of the prior financial year-end NAV
- BB Healthcare has an experienced management team and strong board of directors

MANAGEMENT TEAM

Paul Major

Brett Darke

GENERAL INFORMATION

Issuer	BB Healthcare Trust (LSE main Market (Premium Segment, Offical List) UK Incorporated Investment Trust
Launch	December 2, 2016
Market capitalization	GBP 970.0 million
ISIN	GB00BZCNLL95
Investment Manager	Bellevue Asset Management (UK) Ltd.; external AIFM
Investment objective	Generate both capital growth and income by investing in a portfolio of global healthcare stocks
Benchmark	MSCI World Healthcare Index (in GBP) - BB Healthcare Trust will not follow any benchmark
Investment policy	Bottom up, multi-cap, best ideas approach (unconstrained w.r.t benchmark)
Number of ordinary shares	515 970 455
Number of holdings	Max. 35 ideas
Gearing policy	Max. 20% of NAV
Dividend policy	Target annual dividend set at 3.5% of preceding year end NAV, to be paid in two equal instalments
Fee structure	0.95% flat fee on market cap (no performance fee)
Discount management	Annual redemption option at/close to NAV

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