BB Healthcare Trust

Monthly News
July 2021

Marketing document

As at 07/31/2021	Value	1 Month (July)	YTD	Since Launch (ITD)
Share	193.40	-1.0%	12.2%	122.3%
NAV	192.98	-0.8%	13.5%	122.3%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 31.07.2021, NAV and share price returns are adjusted for dividends paid during the period, assuming reinvestment in relevant security. Full performance data is on page 7.

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 July update. Whilst the preceding month proved to be a positive one for equities in general and healthcare in particular, it was not so for us as a propitious start to Q2 reporting failed to translate into sustained positive share price performance for our holdings where we again lost ground in a turbulent week of factor-driven volatility. The Market can be a cruel mistress indeed, but positive fundamentals will only be ignored for so long...

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

The MSCI World Index continued its longstanding upward trend through July to once again make all-time highs (albeit with a transient mid-month dip). In sterling terms, the Index rose 1.0% (+1.7% in dollars). An extrapolation of the market's rising trend through 2019 and into early 2020 would get you to an implied value for the index today of around 3,100, as compared to its month-end close of 3,069: it is almost as if the pandemic never happened and certainly as if the market is pricing in that it will have no longer-term repercussions.

For those of us who are long in tooth, it all feels a bit like early 2010, when the market's rapid recovery in the face of the 2008/9 credit crisis took us by surprise (again driven by huge stimulus packages). The market's jubilance was not short-lived, the rapid recovery did not trigger another sell off until mid-2011 (when the MSCI World Index declined 20% from July to October), followed by a sideways shuffle through to Q3 2012 before a multi-year bull market trend was again re-established. It is for good reason that axiom's about irrationality and solvency are oft repeated.

Historical precedents aside and trying to be objective, we find this return to the long-term bull market trend quite a difficult concept to get one's head around given the disparate levels of success in containing the pandemic's associated morbidity and in rolling out vaccinations. Right now, it feels like more countries are moving backwards rather than forwards in terms of rolling back restrictions.

July saw a further extension of the Services/ Tech-led market dynamic, with Commercial & Professional Services (+6.0%), Technology Hardware (+5.5%) and Med-Tech & Services (+3.9%) leading the charge. Likewise, it was the more obvious cyclical and inflation/interest rate plays that lagged during the month, with Energy (-6.3%), Banks (-2.4%) and Transportation (-2.4%) the worst performing sectors.

It is perhaps worth noting that China's Tech behemoths are not included in the MSCI World as the Index focuses on primary listings and China 'A' shares are not considered easy to own for global institutional investors. As such, the recent sell-off in Chinese Tech in response to the latest bout of seemingly arbitrary and capricious government crackdowns has not impacted this Index.

As we noted last month, part of this ongoing dynamic may relate to mounting fear over the continued march of the delta variant. There is a growing feeling (wrong in our view) that the pandemic is no longer in abeyance and we could face a fourth wave of massive morbidity and mortality, hence investors may choose to return to those safe haven stocks that worked so well in 2020 and may also moderate their views on resurgent consumer discretionary activity driving inflation.

This concern is understandable to some extent; case numbers are undoubtedly on the rise globally. However, vaccinations continue apace (at least for those of us fortunate to live in wealthy countries) and the evidence that mass vaccination can break the link between infection and serious morbidity is clear, at least for the strains currently circulating.

Now that the carrot of vaccine protection is losing its lustre for younger groups or the vaccine wary, governments are looking to the stick of vaccine passports for travel and mass events etc. as a way to sustain the momentum in getting to herd immunity (cf. France). Libertarians (and generally speaking, we would count ourselves as advocates of this philosophy) may well be aghast at such tactics, but the cost/benefit and risk/benefit for the adult population is now very clearly in favour of vaccination.

Healthcare

Once again, the macro narrative outlined above would intuitively be a supportive one for healthcare and this was indeed the case. The MSCI World Healthcare Index rose 2.9% in sterling terms (+3.6% in dollars), outperforming the wider market. The subsector performance is highlighted in Figure 1 below:

BENCHMARK SUB-SECTOR PERFORMANCE AND WEIGHTINGS

Sub-Sector	Weighting	Perf. (USD)	Perf. (GBP)
Healthcare Technology	0.8%	15.0%	14.1%
Dental	0.9%	14.5%	13.7%
Facilities	1.2%	14.2%	13.4%
Tools	8.5%	9.0%	8.2%
Other HC	1.5%	7.5%	6.8%
Services	3.1%	6.4%	5.7%
Distributors	1.1%	5.9%	5.1%
Focused Therapeutics	8.6%	5.0%	4.4%
Med-Tech	15.5%	3.7%	3.2%
Conglomerate	11.8%	3.3%	2.5%
Diagnostics	2.6%	2.4%	1.8%
Diversified Therapeutics	33.0%	1.8%	1.1%
Managed Care	9.2%	0.8%	0.1%
Generics	0.5%	-0.1%	-0.8%
Healthcare IT	1.7%	-1.9%	-2.6%
Index perf.		**3.6%**	**2.9%**

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 30-06-21. Performance to 31-07-21.

The Q2 reporting season has delivered what the bulls hoped for; robust evidence of recovering elective procedure volumes in the US and a contemporaneous tailwind of higher than trend acuity (i.e. the average patient in hospital is sicker than normal and thus more profitable to treat). This is as you would expect during re-opening, with patients prioritised by need. It is also obvious that one can choose to continue to ignore more minor ailments or defer treatment if you are COVID wary, but the sicker patient cannot easily weight up such a decision.

In terms of positive earnings revisions, hospitals (Facilities) have been the big winners here, alongside procedural Med-Tech companies. However, the latter has not seen the same flow-through into share price performance, reflecting as we have noted previously, already elevated longer-term expectations and also valuations relative to history.

Continued robust R&D spending has helped the Tools sector, which has also seen some positive revisions and share price follow-through. As a corollary, Managed Care is reflexively perceived as a loser (someone has to pay for this treatment after all) in spite of positive Q2 reporting against lowballed expectations (as we have noted many times, the insurers seem to be doing all they can to suppress windfall profits arising from the pandemic and their over-provisioning can be used to smooth out rising costs in 2022 & 2023 if needed).

As regards healthcare more widely, the strength was broad-based, with Healthcare IT and Generics as the only negative performers during the period-in-review, but this belies some interesting things under the surface. Vaccine behemoth Moderna rose an incomprehensible 50% during the month and accounted for almost 12% of the Focused Therapeutics sub-sector weighting. As such, it accounted for more than 100% of that sub-sector's return during the month. Had it gone sideways, Focused Therapeutics would have declined 1.0% during the month. Indeed, this single stock accounted for around 15% of the healthcare sector's 3.6% return for the month!

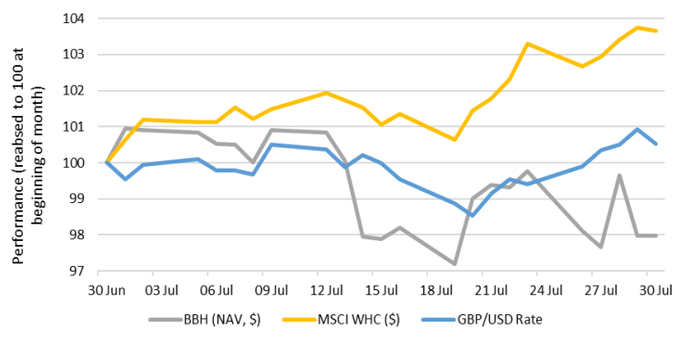
We do not usually talk about factor behaviours within the wider sector, but we make an exception this month (for reasons that will become depressingly apparent in the next section of the factsheet). If we break down the Index performance by market capitalisation, we saw Mega Caps ($50bn+ mkt. value) rise an aggregate 3.6%, Large Caps ($10-50bn mkt. value) rise 2.4% and Small/Mid-Cap (<$10bn mkt. value) rise only 0.3%.

The Trust

Frustratingly, the factor dynamics alluded to above were unfavourable to our portfolio, in spite of the generally positive sentiment toward healthcare and, with only one exception thus far, better-than-expected Q2 reporting updates for our holdings. During July, the Trust's net asset value declined 2.4% in sterling to 192.98p, underperforming the MSCI World Healthcare Index by 5.3%.

We have noted already the extent of the market cap skew to performance during the month and the outsize drag from having no exposure to Moderna. In respect of our own sub-sector performances, the picture paints something of a contrast to what we saw at the sector-wide level:

Whilst Tools was our best performing grouping (+10.9%) and Healthcare IT one of our worst (-3.0%), it was our holdings in the Diagnostics (-8.8%) and Focused Therapeutics (-6.4%) categories that weighed on our results for the month. Our Med-Tech and Diversified Therapeutics portfolios also lagged their benchmark compatriots, but to a much lesser extent. The monthly evolution of the NAV is illustrated in Figure 2 below and it shows that the majority of the underperformance came in two brief 'spasms' of dislocation in the middle and end of the month:



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

At the risk of repeating ourselves once more (this time from May's missive), the fundamentals of the portfolio companies simply do not justify this level of divergence from the wider sector's performance and we therefore assume this to be a short-term aberration. We have thus taken advantage of these volatile conditions to add to the portfolio, both in terms of re-weighting existing holdings to maximise upside potential and further adding to the portfolio with one new company (in the Focused Therapeutics category), taking us to 33 active positions plus the Alder CVR (it is worth noting the latter represents only 5bp of the Trust's month-end gross exposure).

We continued to deploy capital throughout the month. In terms of inflows, activity meaningfully increased compared to June with 6.2m new shares issued via the tapping programme during the month. The leverage ratio has remained broadly flat compared to 1.6% at the end of June 2021. The evolution of our sub-sector weightings is illustrated in Figure 3 below:

EVOLUTION OF PORTFOLIO WEIGHTINGS

	Subsector end June 21	Subsector end July 21	Change
Diagnostics	5.9%	5.7%	Unchanged
Diversified Therapeutics	13.7%	12.5%	Decreased
Focused Therapeutics	27.4%	26.9%	Decreased
Healthcare IT	7.0%	7.4%	Increased
Healthcare Technology	3.1%	3.4%	Increased
Managed Care	12.3%	12.4%	Unchanged
Med-Tech	17.4%	18.8%	Increased
Services	9.5%	9.0%	Decreased
Tools	3.8%	3.9%	Unchanged
	100.0%	**100.0%**	

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 30-06-21. Performance to 31-07-21.

We have added to holdings across the portfolio, save for Diversified Therapeutics, Tools and Services where we have reduced exposure. As noted previously, much of our activity has been re-weighting.

The last three months have been very frustrating, but one cannot get caught up in looking at shorter-term performance beyond ensuring that any share price reaction to company specific newsflow is understood. Sometimes, the markets just don't do what you expect and defy rational analysis at the stock-specific level and, in these periods, underperformance can just 'happen'.

To our minds, the correct action is to take advantage of short-term volatility events to maximise risk/reward. Within this, the wider narrative does not argue yet for the deployment of significantly more leverage as this increases exposure to market macro risk, so the correct decision is to re-allocate within the same broad level of gross exposure and this is what we are doing.

Managers' Musings

State of the Nation

This month we turn away from the longer-term consequences of the pandemic to consider the immediate repercussions of the UK Government's decision to remove restrictions. Make no mistake, this is a bold experiment that will either go down in history as an enormous mistake or show the world how to live with the virus at an acceptable cost to wider society despite more transmissible variants emerging, as opposed to those counties whose return to normal has been predicated (unsuccessfully and unrealistically in our view) on a 'zero COVID' policy (e.g. Australia, New Zealand).

Even for someone unlucky enough not to reside on this Sceptred Isle, this is no academic exercise. As night follows day, the winter will come and with it the respiratory disease season. The best part of two years of social distancing has reduced exposure and natural immunity to RSV, Influenza and those bacterial infections that bedevil emphysema sufferers. The lack of influenza makes this season's strain selection trickier than usual and it is perfectly reasonable to assume the vaccine will be less effective than in a typical year. All of this to come and COVID will not go away.

For the dispassionate observer (which is the role that your managers must take in order to fulfil our obligation to our investors), the UK's attempt to escape the grip of this pervasive pathogen will inform us all as to where we need to be positioned in terms of the acuity curve and in terms of what are reasonable expectations for capacity utilisation over the coming 6-12 months.

First though, we need to understand where the baseline lies, so that we can monitor what happens next. This is not about case numbers, it's about hospitalisations and about people's behaviour. Few of us are willing participants in the healthcare system but, at the same time, lower acuity procedures can be delayed for protracted periods and the growing backlog of these will only be cleared if capacity is there to facilitate this. When might we be able to get back to 100% of historical capacity and then re-start the longstanding trend of increasing this capacity to meet ever-growing demand?

Letter from America

Before we consider matters at home, it is worth reflecting on the state of play in healthcare's most important market – America. The picture there varies from state to state, reflecting disparate vaccine take-up and adherence to social distancing measures and mask mandates. These will impact the RE as the delta variant sweeps through the country and it also gives us some sort of benchmark against which to compare the UK.

We have various data sources available to us. Federal databases and quarterly reporting from healthcare providers (both the facility operators undertaking the procedures and the managed care providers footing the bill). In addition to this, we have a number of regular surveys of hospital managers, physicians and so on from Wall Street to give a qualitative read on the current situation. Each of these will have its strengths and weaknesses and one needs to try to stitch all of this together to make a blanket view of what is likely going on currently, and what this might mean for the outlook in both the short and medium term.

Our current conclusions on the state of play from these disparate data sources is broadly as follows:

- The US system is now operating at close to 100% of pre-pandemic (i.e. end 2019) capacity and there is growing confidence that a return to pre-pandemic capacity will be achieved in the second half of the year, assuming that the pandemic can continue to be kept under control (COVID cases account for 3-5% of current admissions).

- Whilst Wall Street seems fixated on the above metric, demographic factors deliver a positive case growth trend of around 3% per annum and thus normality as defined by the pre-pandemic baseline would be around 105% of pre-pandemic levels by mid-2021. As such, we are still 'missing' quite a few patients and procedures versus this trend line.

- Elective procedures are patchy to the extent that we have yet to see employment return to pre-pandemic levels and there is an explicit linkage between employment and healthcare utilisation through the provision of employer-funded health insurance.

- There is also some residual reluctance to go to hospital (either electively or via the ER) due to COVID wariness. This is more prevalent amongst the elderly than the younger age groups, despite vaccinations being higher amongst the older cohort. This is reflected in commercial channels (employer sponsored insurance) having returned to pre-pandemic utilisation levels, whereas Medicare (over 65s) remains below pre-pandemic levels.

- Where providers offer capacity via ambulatory surgical centres (ASCs; akin to a private day case hospital here in the UK), take-up is much stronger there than in the traditional hospital setting and we expect this part of the market to continue to expand as a proportion of total capacity. There is a (correct) perception that patients are safer from accidental COVID exposure in these facilities and they generally have lower operating costs so providers are happy for patients to opt for routine procedures in this setting.

- The hospital capex trend has normalised and seems very much centred on a post-COVID dynamic (i.e. equipment lifecycle management, capacity expansion and productivity enhancement).

- The reluctance for some older 'double jabbed' patients to undertake planned elective procedures seems to be a contributory factor to the higher than expected acuity of overall admissions hospital operators are reporting, since their care is often for lower margin care like orthopaedics and Medicare reimbursement rates tend to be lower than for commercially funded cases. Simply put, the 'missing' patients are the less unwell and less profitable. This is positive for Facilities' operating margins.

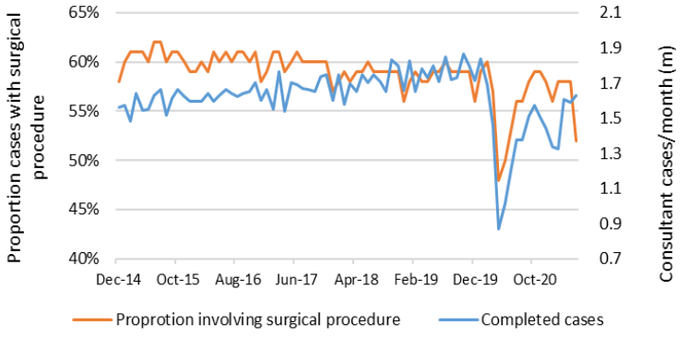
- In line with the comment above, emergency room visits have not returned to pre-pandemic levels and, where there are emergency admissions via the ER, they tend to be higher acuity (i.e. more serious and thus more profitable for the hospital treating the patient). This likely reflects the lower incidence of accidents as activities that might result in injury (sports, road traffic etc.) have yet to return to pre-pandemic levels. Whilst people may want to avoid hospitals due to COVID, there comes a point where you know you need care and such patients are more likely to be admitted following that ER visit.

- It is possible that some of the 'missing' patients and ER visits are occurring in so-called Urgent Care Centres (akin to Minor Injuries hospitals here in the UK). This is a relatively nascent industry segment in the US and data on utilisation is more difficult to come by. However, the number of UCs has almost doubled in the past eight years and is expected to continue to grow at a double digit rate for several years to come.

Inpatient hospital care

In contrast to the US, with its patchwork of private and public operators and different insurance schemes, the UK is a monolithic single provider system and our health service makes a significant amount of data available through the NHS Digital 'dashboards' platform [1]. This allows us to look at the system-wide activity levels from a single source.

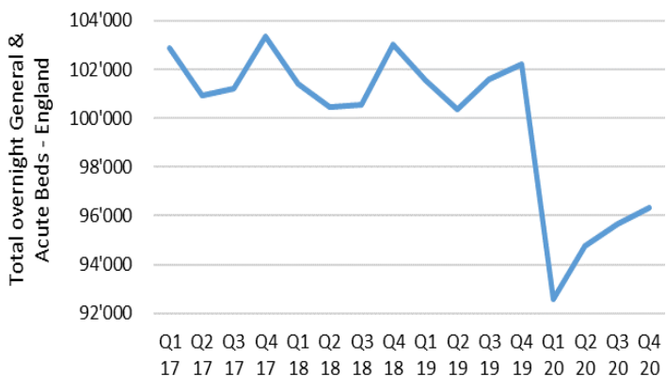
Let us begin with in-patient hospital care. The available data goes back to 2007 and shows a gradual positive year-on-year volume trend, as one would expect for a country with both a growing and an ageing population. Chart 1 below illustrates an unsurprising pattern; this gradual positive trend was upended by the pandemic in March 2020 and, as yet, procedure volumes have yet to recover to pre-pandemic levels, never mind re-establish the link with the underlying historical trend (and there is no reason to believe this trend should have changed at all).



Source: NHS Digital website, Bellevue Asset Management UK

1) https://digital.nhs.uk/dashboards.

Until the case completion rates returns to trend, the UK will continue to grow its backlog of low acuity procedures (aka 'waiting lists'). The reason for the current situation is two-fold. Firstly, care capacity has been diverted to dealing with COVID-19. Secondly, and arguably more importantly, the total number of beds in use has been reduced to allow for greater spatial distancing within hospitals and thus reduce the risk of nosocomial COVID-19 cases (Chart 2 illustrates this abrupt reduction in overnight bed capacity). Until this capacity is re-introduced (either directly or via the co-option of the c8,000 beds of private hospital capacity here in the UK), we have no hope of getting on top of the backlog.



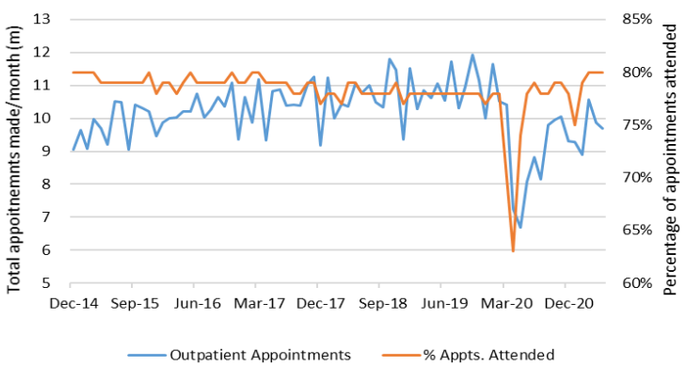
Source: NHS Digital website, Bellevue Asset Management UK

The other interesting element of this dataset is the proportion of admissions that result in a procedure has declined. We are not sure if this is an artefact of the pandemic or belies a more conservative management of patients as a real-world consequence of the pandemic itself; anecdotally, we have been told of more conservative strategies being used to manage some patients, thus delaying elective procedures to keep capacity available for COVID surges.

In conclusion then, the situation in the UK is far worse than the situation in the US vis-à-vis both available capacity and also its utilisation and, as such, we are likely to see a continued worsening in health outcomes quality as waiting lists grow.

Outpatient hospital activity

We see a similar pattern in outpatient hospital activity; volumes are below pre-pandemic levels and well below trend (Chart 3). If there is one positive in all of this, it is that people are more likely now to actually turn up to their appointments, perhaps because they struggled to get the appointment in the first place.



Source: NHS Digital website, Bellevue Asset Management UK

A&E Visits

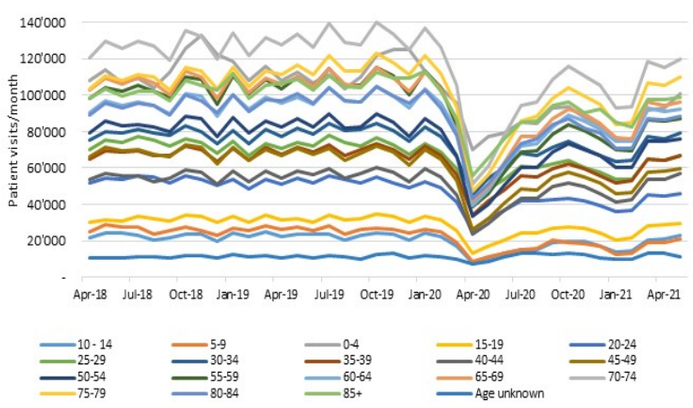
Whatever side of the political spectrum you find a home, and whether you like a broadsheet, tabloid or local paper, you don't have to look very far to find an "NHS in crisis" story about over-run A&E departments. We are not going to argue with the broad premise. As we noted last month, staffing levels are far from optimal, stress-related absences are a material issue and, as much as we hate the phrase, the "pingdemic" is currently a real problem in all areas of the UK's employment sphere.

Continuing the theme of last month, there are two potential drivers of capacity being overwhelmed in the NHS. The first is that too many people are coming in the front door. The second is that the capacity is not as high as it was or as it should be. As ever, the truth will be a complex interplay of the two, but we can interrogate the data to try to understand which is the more likely driver at a national level.

Chart 4 below illustrates the monthly volume of A&E attendances by patient age group and it echoes the theme of the previous sections. We can see the dip in activity in March 2020 as the lockdown jolted everyone into COVID awareness and the hard-hitting message to "protect the NHS" was rammed home through blanket advertising. Leaving aside the very elderly, who often enter the system at end of life, much of the A&E activity in younger groups is accident-driven. Road-traffic accidents, sports injuries, intoxication-related injuries or violence.

The restrictions that we have all lived with these past fifteen months would logically lead to reduced demand on the accident side of the ledger and, since we are not yet back to normal cf.2019, one would not expect activity levels to be as high as they were at that time. Broadly speaking, the data supports this elementary conclusion. Why then are some A&E departments struggling if, in aggregate, the NHS is are not seeing massively higher levels of footfall?

Local COVID pressures may play a role but Occam's razor brings us back to last month's theme of staffing levels. It is probably true that exhausted staff working in conditions of high absenteeism are not surprisingly struggling to work at the same levels of productivity as they did historically and are thus lower to process people through the system. If this is really the root cause of the issue, then things are going to get a lot worse before they get better, for all of the reasons articulated in last month's missive.



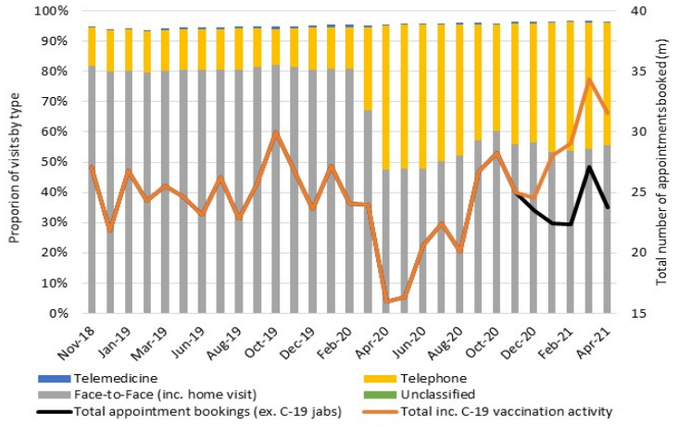
Source: NHS Digital website, Bellevue Asset Management UK

And what of the suggestion that an absence of GP access or delayed diagnosis of serious conditions is leading to A&E being overwhelmed by minor cases? We cannot really find any data to allow us to draw a robust conclusion on this point.

GP appointments

As noted previously, the media narrative is broadly that A&E is overwhelmed, in part because people cannot get in to see their GP so instead they are turning up at the hospital with the most minor of complaints, leading to hours of staff time being wasted triaging these cases. The other side of this debate of course is the prejudicial counterpoint widely made on talk radio and some sections of the media as to "what on earth GPs are doing, since you cannot get an appointment".

The data has a number of caveats; not least the methodology for stripping out COVID vaccination appointments from the data is a little crude by the NHS' own admission. Also, not every practice has the IT systems that allow full granularity in reporting appointment data, so there is a small proportion of activity that is unclassified. However, the data is nonetheless revealing (Chart 5 below)



Firstly, let's tackle the pejorative premise that GPs are 'swinging the lead' or otherwise workshy in these COVID times. Leaving aside the inevitable collapse in activity in March 2020 as the first lockdown kicked in and systems needed to adjust to a new reality, it is not really obvious that there are fewer appointments being offered today than before, especially when one accounts for the 27m appointments used up administering COVID-19 vaccinations since December 2020 to April 2021. Indeed, from February to April, these tasks took up 23% of total appointments.

It may well be true that the March 2020 to September 2020 period where people did not make appointments, perhaps taking the "stay home and protect the NHS" mantra a little too literally amidst so many headlines that the system was overwhelmed (when in reality it was hospitals that were struggling) has subsequently led to delayed diagnoses that are now, or will soon, bring pressure to A&E departments and hospital admissions (cf. all the various data points regarding reduced referral rates to oncologists, for example. It is inconceivable that the background incidence of cancer has changed for the better over such a short period of time).

How has this additional appointment capacity been facilitated? By shifting a significant proportion of non-vaccine appointment capacity into the virtual setting via Telephone or Telemedicine (which is any form of audio-visual interaction done online, be it on a mobile app or via the patient's PC). The transition to a greater proportion of telephone appointments has, unsurprisingly, resulted in fewer appointments being missed. The majority of us have been spending far more time at home, making it less likely you will miss the call when it comes. Missed appointments have fallen by around a third over the past year (to around 3-4%).

Longer-term investors in the Trust will be tediously familiar with our longstanding views on the importance of shifting to electronic/remote triage in the primary care setting as one of the most important efficiency gains that the healthcare complex could make (and not just here in the UK).

Those same investors may well recall that, as a consequence of this view, industry leader Teladoc was a top five position for the Trust as recently as December 2019 and yet today we hold none. We outlined our reasoning for not wanting to own this company anymore in the April 2021 Factsheet, describing Teladoc as "indisputably the Rolls Royce of telemedicine tech".

Chart 5 illustrates this point all too well. Compared to March 2019, face-to-face appointments have declined from >80% of capacity to >55%. However, of that 25% swing, telemedicine accounts for only around 2%, with the trusty telephone taking up the bulk of the work.

The truth is that you don't need any fancy technology most of the time, because much of the business of being a primary care doctor is very simple and routine: a phone call will suffice. This comment is not intended to demean the importance of GP's work, but rather to note it is overwhelmingly driven by the ongoing management of already diagnosed chronic conditions in older patients. This probably explains why telemedicine has not taken up as much of the workload as one might intuitively expect given that Zoom et. al. have literally taken over everyone else's working lives.

Even when you do need a visual connection, there are countless secure and very inexpensive apps that can facilitate this (Skype, Zoom, MS Teams, Facetime etc. etc.), although here in the UK, NHS GPs are not allowed to use these apps and can only use those approved by NHS Digital (there are several that meet this standard, but they are unlikely to be familiar to the public equity investor).

In conclusion then, the front door of the NHS is operating as it should have been all along. The door is no longer wedged open; first you must ring the bell to determine if entry is justified. Getting an appointment is indeed tougher than it was, in part because it was too easy beforehand but also because a huge amount of time is being used up on the vaccination drive. At some point, this activity will abate and there should be a lot more appointments (both electronic and face-to-face) available for the wider public. We will be watching for this and there will certainly be questions to be asked if it does not play out this way.

The sick man of Europe?

The veneration of our National Health Service to the cult-like worship otherwise reserved for a religious institution is one of the stranger aspects of the British psyche and it is a brave person indeed who dares to criticise it on social media. Nonetheless, it behoves us all to cast a critical eye over the services that we pay for and to speak truth to power (i.e. central government), wherever that takes us. It does not matter how dedicated the staff are; if there is more work than people or systems to do the work, then the work will not all get done.

Our national healthcare system has many, many problems and the service that it provides is not what we all want it to be. It is not good enough to note how fair it is, when in fact what we are saying is that it is equally unfair to everyone (and even that isn't true because many companies offer private healthcare that allows the fortunate to bypass the waiting lists and even see private GPs).

Things need to change. That criticism having been made, the operational response to the pandemic at the GP level objectively looks to have been good and hospitals have adapted as best they can to the crisis foisted upon them with little or no warning (and scarcely any PPE).

However, our system was straining to cope with volume-based demand even before the pandemic and the necessary response has inevitably accelerated the growth of the elective procedure backlog. Whatever you might want to believe, the only logical conclusion here is that things are going to get much worse irrespective of how severe the next wave of COVID is (or is not), although the tools to begin to make things better are being deployed.

One could again surmise (and Keir Starmer would argue) that a massive injection of cash could address this problem and to some extent it would

help. However, patient safety comes first and if the NHS is to increase its volume of work, it must first increase the volume of staff available to do the work. Even technological solutions take time to bed in, whilst people get trained on new systems and workflows etc. As discussed last month, this will not be a quick fix. Where more money might usefully be deployed quickly is in paying the private sector to help clear the backlog.

And this ironically is where the differences in the US and the UK systems become apparent. The former is mired in horrendous inequities of access and care quality that would shame other developed nations. That said, the profit motive on the provider side has encouraged additional investment in capacity and productivity to meet the demand that is now returning and, as such, the backlog of cases that we see in the UK is not arising there to the same extent. What can we learn from this?

The message seems to be a simple one: if you invest more, you have more. The NHS needs cash, but it needs to be spent on raising capacity and productivity. This is happening, but slowly. Since we are already in a massive COVID-driven deficit hole, what difference would another few tens of billions make?

Investment guidelines

The development of these datasets over the coming months (both here and in the US) will be instructive. For now, our wariness regarding any move down the acuity curve in terms of the Trust's holding persists since we are still rather far away from returning to the historical volume trend that we intuitively know is still there and that underpins out-year forecasts for many device/procedure related companies. Even before we talk about 'wave four' and 'Delta+', we are not yet out of the woods.

Stepping away from the UK and focusing on the US market (where the majority of the portfolio revenue exposures lie), the participants seem well attuned to the reality on the ground and to the risks in the outlook. As such, our confidence that the US healthcare system will be able to navigate its way through the continuing crisis whilst maintaining high levels of available capacity continues to grow, even if we think the focus remains at the higher acuity end of that curve.

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 July 20 - July 21	2 years July 19 - July 21	3 years July 18 - July 21	4 years July 17 - July 21	since inception
NAV return (inc. dividends)	26.8%	51.8%	56.7%	87.2%	122.3%
Share price	27.9%	53.1%	60.6%	94.9%	122.3%
MSCI World Healthcare Index (GBP)	16.1%	30.4%	45.5%	63.5%	86.2%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 31.07.2021

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

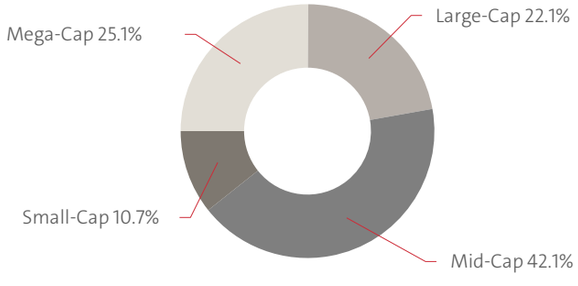
Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed

TOP 10 HOLIDINGS

Bristol Myers Squibb	6.3%
Hill-Rom Holdings	6.2%
Vertex Pharmaceuticals	6.0%
Jazz Pharmaceuticals	5.7%
Insmed	5.2%
Anthem	4.9%
Alnylam Pharmaceuticals	4.6%
Humana	4.1%
Bio-Rad Laboratories	3.9%
Option Care Health	3.5%
Total	**50.3%**

Source: Bellevue Asset Management, 31.07.2021

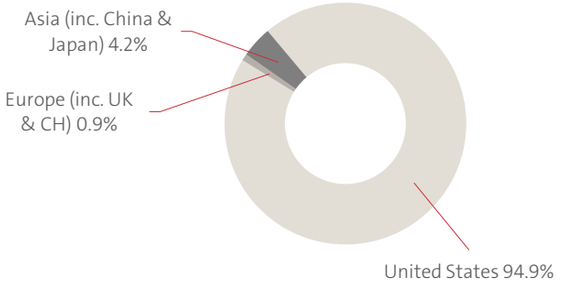
MARKET CAP BREAKDOWN



Source: Bellevue Asset Management, 31.07.2021

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

GEOGRAPHICAL BREAKDOWN (OPERATIONAL HQ)



Source: Bellevue Asset Management, 31.07.2021

Sustainability Profile – ESG

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

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

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

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INVESTMENT FOCUS

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

DISCLAIMER

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.

BB 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 Company's 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. ©

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 1052.1 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	544 027 153
Number of holdings	Max. 35 ideas
Gearing policy	Max. 20% of NAV
Dividend policy	Target annual dividend set at 3.5% of preceding year end NAV, to be paid in two equal instalments
Fee structure	0.95% flat fee on market cap (no performance fee)
Discount management	Annual redemption option at/close to NAV
EU SFDR 2019/2088	Article 8

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