Bellevue Healthcare Trust

MARCH 2022

Factsheet

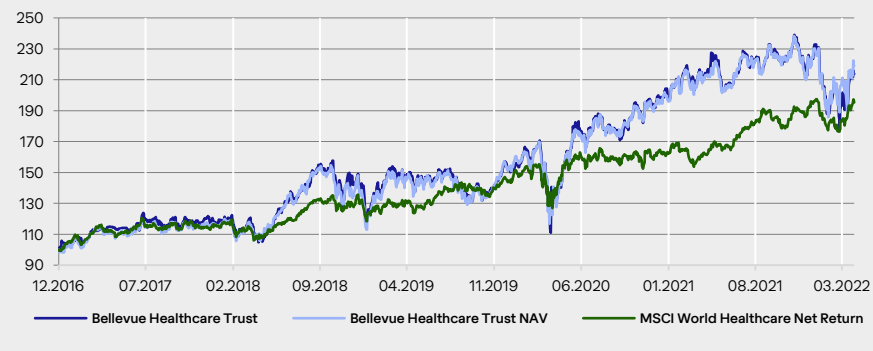
London Stock Exchange (LSE)

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, bio-technology, 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 is no restrictions on the constituents of the fund's portfolio by index benchmark, geography, market capitalisation or healthcare industry sub-sector. Bellevue 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.

Indexed performance since launch



Cummulated & annualized performance

Cummulated

	1 M	1 Y	2 Y	3 Y	4 Y	5 Y	ITD
Share	9.7%	-0.3%	58.1%	46.9%	94.5%	86.4%	113.7%
NAV	5.8%	3.2%	63.6%	48.7%	99.1%	98.3%	118.9%
BM	6.8%	20.7%	41.4%	48.1%	83.2%	75.1%	95.3%

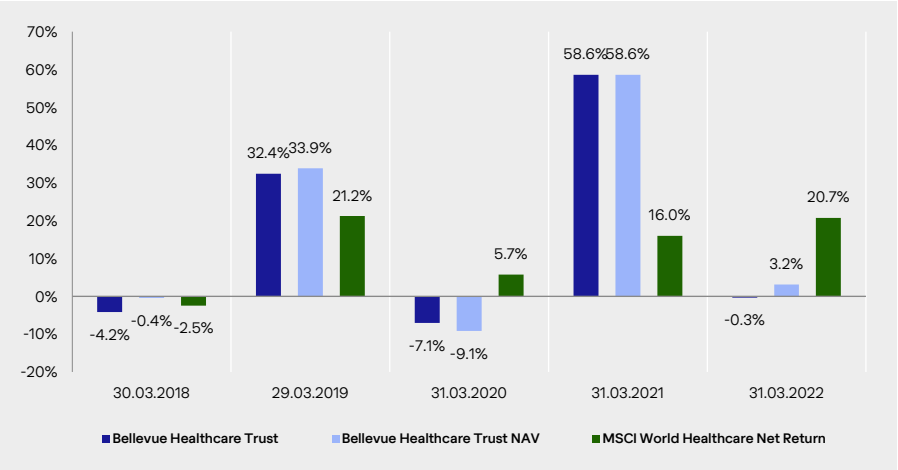
Annualized

1 Y	3 Y	5 Y	10 Y	ITD
-0.3%	13.6%	13.3%	n.a.	15.3%
3.2%	14.1%	14.7%	n.a.	15.8%
20.7%	14.0%	11.8%	n.a.	13.4%

Annual performance

	2017	2018	2019	2020	2021	YTD
Share	14.8%	4.9%	22.7%	29.1%	16.6%	-7.5%
NAV	12.7%	8.6%	25.9%	25.7%	15.2%	-3.0%
BM	9.4%	8.8%	18.4%	10.3%	20.8%	-0.4%

Rolling 12-month-performance



Fund facts

Share price	GBP 182.80
Net Asset Value (NAV)	GBP 186.93
Volume	GBP 1'083.7 mn
Cut off time	17:00 GMT
Investment manager	Bellevue Asset Management (UK) Ltd
Administrator	PraxisIFM Fund Services (UK) Limited
Launch date	01.12.2016
Fiscal year end	Nov 30
Benchmark	MSCI World Healthcare Net Return
ISIN code	GB00BZCNLL95
Bloomberg	BBH LN Equity
Number of ordinary shares	579'752'365
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	1.25
Correlation	0.8
Volatility	27.4%
Tracking Error	17.16
Active Share	95.42
Sharpe Ratio	0.75
Information Ratio	0.24
Jensen's Alpha	0.68

Source: Bellevue Asset Management, 31.03.2022;
Calculation over 3 years.

Source: Bellevue Asset Management, 31.03.2022; 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.

Top 10 positions

Jazz Pharmaceuticals	7.2%
Option Care Health	5.8%
Sarepta Therapeutics	5.7%
Amedisys	5.4%
Caredx	5.4%
Insmed Incorporated	5.3%
Anthem	4.6%
Tandem Diabetes Care	4.1%
Axonics Modulation	4.0%
Outset Medical	3.9%
Total top 10 positions	51.6%

Sector breakdown

Focused Therapeutics	25.8%
Med-Tech	14.1%
Services	13.6%
Diagnostics	13.1%
Diversified Therapeutics	10.0%
Managed Care	8.2%
Healthcare IT	6.6%
Tools	4.5%
Health Tech	4.1%

Geographic breakdown

United States	95.4%
China	0.9%
Others	3.6%

Market cap breakdown

Mega-Cap	14.7%
Large-Cap	9.1%
Mid-Cap	55.2%
Small-Cap	21.0%

Source: Bellevue Asset Management, 28.02.2022;
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 subfund 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.

Welcome to our March missive. The market's mercurial meandering feels endless as geopolitical and macro-economic considerations continue to hog the limelight. Scant consideration is given to company level newsflow and sub-sector correlations are frustratingly prevalent and size factor continues to play an outsize role. There is little fun to be had in this market.

Nonetheless, we hold to our much discussed course. This cannot last forever and, at some point, more typical market dynamics should reassert themselves. As and when they do, we feel the portfolio is very well positioned to benefit and we remain of the view that the return potential of the current portfolio is the most compelling that we have had since launching the Trust in late 2016.

Monthly review

The wider market

Markets mirror society. It is sad in some ways then, to reflect that the stock market has priced in the Ukraine conflict and to a large extent moved on. A new reality of higher energy prices, higher inflation, disrupted supply chains and protracted conflict in Eastern Europe is now presumed. There is a fairly clear consensus that Russia is a pariah state and no longer a viable trading partner, even for oil, gas, wheat and fertiliser, where it occupied dizzyingly high global market shares.

It is also a reality that Ukraine won't be exporting much of what the world has previously relied upon; its high quality arable land and bountiful mineral and energy resources make it perhaps the most important country that no-one previously worried about.

In light of this, the MSCI World Index rose 4.5% in sterling (+2.5% in dollars), but one would expect investors to remain cautious as long as Russia shows no signs of bowing out of it's Ukrainian folly. The index is now 11% above its 2022 low (also in March) but still down ~4% year-to-date.

The monthly sector performance below bears out a picture of dispassionate but still cautious risk re-appraisal, with Energy and classic defensives faring best. In these crazy times, there is always an exception to prove a rule, and this month it is the autos sector coming in third place.

Of course, regular readers will guess what comes next. Ex. Tesla, the sector return would have been closer to -5%, right at the bottom of the list. This makes sense: cars are energy intensive to produce and use a lot of raw materials and electronics. They are also expensive purchases and one easily deferred if money is tight(ening). For these reasons, broad inflation and raw material supply issues are not their friend. Tesla apparently is different: the company increased prices twice during the month to offset rising input prices and the stock market seemed to love this (for now at least), marking the shares up 24%.

Aside from financials, the losers were branded goods and clothing companies. Again, one can defer or trade down as money gets tight. Generally then, we can say that March madness was not obviously on display and we are settling into some sort of 'new normal' (at least until the next crisis).

Energy	7.5%
Food & Staples Retailing	6.8%
Automobiles & Components	6.6%
Pharmaceuticals, Biotechnology	6.0%
Commercial & Professional Services	5.1%
Transportation	5.0%
Utilities	4.8%
Insurance	4.7%
Real Estate	4.6%
Technology Hardware & Equipment	4.3%
Semiconductors & Semiconductor	2.5%
Health Care Equipment & Serivces	2.2%
Diversified Financials	2.1%
Retailing	1.6%
Media & Entertainment	1.2%
Consumer Services	0.4%
Capital Goods	0.3%
Telecommunication Services	0.3%
Food, Beverage & Tabacco	-0.1%
Consumer Duables & Apparel	-2.9%
Banks	-3.1%
Household & Personal Products	-4.4%

Source: Bellevue Asset Management, 31.03.2022

Healthcare

Heightened geo-political tensions and rising rates generally make a supportive environment for healthcare outperformance, and so it was again during March. The MSCI World Healthcare Index rose 6.5% in sterling (+4.5% in dollars). As before, the broader picture was one of defensive positioning, with investors 'hiding' in Pharma stocks, Distributors and Managed Care. Continuing the previous theme, there is an outlier and for healthcare it was growth investors' darling Dexcom's 22% rise during March on the EU approval of its G7 sensor that drove the Healthcare Technology sub-sector into pole position.

Dental is a seemingly obvious loser as the consumer discretionary screw tightens. Will the resilience of consumer demand surprise us again, as it did during the pandemic? The difference this time is that valuations were much higher going into 2022. As such, there is much less margin for error and it feels right these companies have seen a material correction as the outlook has become less certain. We are curious to see how the numbers fall out during Q1 reporting. As much as we like Align Technology as a business, we are still a long way from being comfortable with re-investing.

	Weighting	Perf (USD)	Perf (GBP)
Healthcare Technology	0.8%	16.4%	18.7%
Distributors	1.3%	7.6%	9.7%
Focused Therapeutics	7.0%	7.0%	9.0%
Diversified Therapeutics	35.1%	6.2%	8.3%
Managed Care	10.5%	5.9%	7.9%
Tools	8.5%	4.9%	6.9%
Conglomerate	12.2%	4.5%	6.5%
Generics	0.4%	4.0%	6.0%
Services	2.8%	3.3%	5.3%
Facilities	1.2%	0.7%	2.6%
Med-Tech	14.7%	0.4%	2.3%
Diagnostics	2.1%	0.1%	2.1%
Other HC	1.6%	-3.0%	-1.2%
Healthcare IT	1.2%	-3.3%	-1.5%
Dental	0.8%	-9.9%	-8.2%
Index perf		**4.5%**	**6.5%**

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 28.02.2022. Performance to 31.03.2022.

One final word on the Pharmaceuticals sector (which lies within our Diversified Therapeutics categorisation); global large cap pharma is seeing generalist inflows and there is much conversation amongst sector specialists around the US pharma sub-index closing the relative "valuation gap" to the S&P500 (in terms of forward P/E multiples). Like an irritatingly catchy Christmas song, this repetitive feel good tune has come around in most market corrections over the past decade.

This inevitably leads to the usual hand-wringing question of how permanent any such re-rating will be. The magnitude of the relative re-rating seen in Feb-March 2022 is already greater than we saw in the same period of 2020 when COVID fear reached its zenith.

Is this the start of a Pharma renaissance? In the land of the blind, the one-eyed man is king and, inasmuch as this benighted sector has many problems (not least persistently poor R&D productivity), these are well known and well understood. They are also inured to geo-political vagaries. Pharma is the foil blanket for the weary investor at the scene of a disaster, but no more. It will be cast aside as soon as people feel better. Because, after all, nothing has really changed.

The Trust

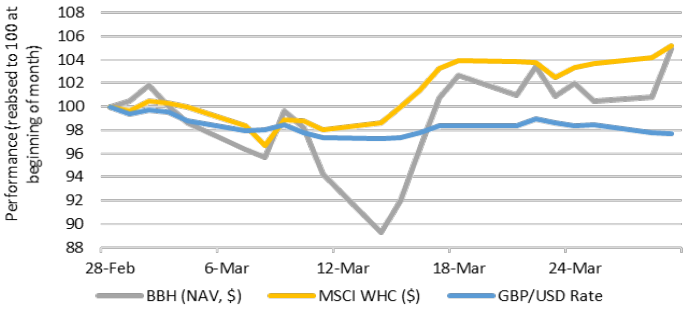
Adjusting for the impact of the shares and NAV going ex-dividend on March 17th, the Trust's net asset value rose 5.8% to 186.93p, and thus modestly underperformed the MSCI World Healthcare Index. In terms of total shareholder return, the picture was improved by the discount to NAV narrowing by ~300bp over the month.

Although the Trust's shares continue to trade at a persistent discount, this is also true for the peer group and for much of the wider investment trust sector and reflects the macro backdrop. Per the RNS issued on April 12th 2022, the board has re-affirmed its commitment to managing the discount at a reasonable level and is willing to utilise share repurchases in order to achieve this (subject to ongoing shareholder approval).

However, in our role as stewards of your capital, we are mindful of the inevitable tension between helping investors realise their holdings as close to NAV as possible and using capital to take advantage of compelling valuations in the wider healthcare sector to grow that NAV over time through expanding the portfolio of investments. It is not the Trust's job to be an endless supplier of liquidity to the market – that is what market makers are for.

As a reminder, the Trust has an ungated annual redemption option that takes place in November each year. This offers investors an opportunity to redeem their share at or near NAV and we continue to believe this commitment is the strongest discount control mechanism that a UK investment trust can use.

Diversified Therapeutics and Services were the leading drivers of the Trust's positive performance, followed by Healthcare IT and Managed Care. Tools and Diagnostics were the main detractors. Volatility remains frustratingly elevated and it continues to feel like the market is treading water. We feel like Vladimir and Estragon... The evolution of the NAV is illustrated in Figure 3 (which is adjusted for the dividend):



Source: Bellevue Asset Management (UK) Ltd.

The active portfolio has declined from 32 stocks at the end of February to 30 at the end of March. In addition, the payment was received from the crystallisation of the Alder CVR and so the total positions has also declined from 33 to 30. The reduction in the portfolio reflects a decision to concentrate our holdings in the Focused Therapeutics and Diagnostics categories into the best ideas, taking advantage of dislocated relative valuations to fund the expansion of some positions at the expense of others.

In terms of capital deployment, we added to 15 positions and trimmed five (in addition to exiting two). The absolute quantum of borrowings (in dollars) is unchanged and we saw no inflows during the month since we cannot issue new shares when the Trust is trading at a discount to NAV. The leverage ratio declined from 8.1% at the end of February to 7.4% at the end of March. If market conditions continue as they are currently, we would expect the leverage ratio to increase again in the coming months. The evolution of the portfolio is summarised in Figure 4:

	Subsectors end Feb 22	Subsectors end Mar 22	Change
Diagnostics	11.8%	13.1%	Increased
Diversified Therapeutics	11.3%	10.0%	Decreased
Focused Therapeutics	28.6%	25.9%	Decreased
Healthcare IT	5.9%	6.7%	Increased
Healthcare Technology	3.8%	4.1%	Increased
Managed Care	7.9%	8.3%	Increased
Med-Tech	14.1%	14.2%	Increased
Services	12.4%	13.3%	Increased
Tools	4.3%	4.5%	Increased
	100.0%	**100.0%**	

We would make a couple of comments. We have added across the board in Diagnostics as valuations remain compellingly low. With regard to Diversified Therapeutics, we have been trimming gradually our positions in Jazz and Bristol-Myers as valuations have risen. The primary driver of the reduced weighting in Focused Therapeutics is the selling down of our Vertex position as the shares are now trading closer to our fair value. The increased weightings of Managed Care is solely due to relative performance, whereas we have actively added to positions in the other groups.

As can be seen from the look of the factsheet, the re-branding of the company to "Bellevue Healthcare Trust" is complete. The Trust website is now **www.bellevuehealthcaretrust.com** and you will see some new corporate colours and layout. However, all of the content remains as before. We have also launched a Bellevue Asset Management UK page on **LinkedIn** and, over time, this will become another channel for additional content from your Managers.

The Trust's AGM will take place at midday on 22 April 2022, at the offices of the Company's solicitors, Stephenson Harwood (1 Finsbury Circus, EC2M 7SH). This will be our first 'in person' event for some years now that COVID restrictions have been lifted. The managers will not be giving a presentation, but will be available for a Q&A session. For those who cannot, or do not wish to attend, we can be contacted at any time for questions via the email address at the end of the factsheet (note – this has changed as part of the rebranding).

Manager's Musings

Twitter ye not

Sadly, we live in a reductive age, where people seem to want 240 character explanations to complex problems and for others to proffer beguiling binary solutions. Oh that life were so simple! Discourse becomes fissiparous and there is a tendency to focus on the minutiae rather than taking a top down view which encapsulates the inevitable trade-offs and compromises that workable solutions to real problems entail.

If history tells us anything, it is surely that the skilled diplomatist is one who recognises that you cannot always get what you want or even what is morally just, but you can find a solution acceptable to a plurality which, in the end, is what moves things forward. This reality of how progress is actually achieved is evident not just in geopolitical assessments but also in broader questions, such as the one that occupies much of our time – what does the future of healthcare look like?

When people from outside the world of finance or healthcare ask us about the fund's investment strategy, they often appear to want us to ultimately describe some sort of magic bullet: a product, service or technology that is readily understandable and, at the same time, capable of fixing "the problem" (whilst also making us some money).

We can assuredly confirm that, upon finding such a bullet, we will be telling no-one else about it. However, we don't expect this to ever happen, because life is never so simple and straightforward. Fixing healthcare is not some grand gesture easily articulated and rapidly deployed. If it was, then the political classes across the OECD might actually try to implement the changes. To our minds, the future will not arrive with a bang, but through a million mellifluous whimpers.

Why do we think this? The solution will be multi-faceted because the problems arise from the interplay of many sub-optimal conditions. Trying to articulate this is harder of course and inevitably gives rise to the concern that the future will never arrive because no-one can see it. One can easily descend into some sort of absurdist Samuel Beckett existentialism. However, we know that Godot is coming, because we have seen him already.

How can we be so confident? In order to illustrate the solutions, we could start by trying to summarise the problems. We will of course focus on the US because it is both the largest and most important marketplace, representing ~$4trn of the global total healthcare spend of ~$10trn, but also because it is where the necessary changes are taking place first for various reasons that would occupy a factsheet on their own.

Readers can later decide for themselves the extent to which these models and solutions might be applicable to our own benighted NHS, given its unionised workforce, leviathan structure and sanctified totemic status amongst the electorate. Personal interest aside, it matters little for the Trust, since the UK only accounts for ~2% of global spending on healthcare.

"Dimensionalising the problem"

When trying to sound intelligent whilst discussing a complex issue, the first resort of the clueless is to 'engage with stakeholders' using impressive-sounding but ultimately vacuous terms. We thought we would give it a go too, hence the section title, but maybe not. Phrases like this one might seem very at home on the websites of leading consulting firms, but they feel at odds with our more practical approach.

Trying to be sensible then: we can think of four principle reasons why the US healthcare system delivers below OECD peer group outcomes despite materially higher relative expenditure:

1. The absence of a widespread **primary care** (i.e. family doctor) model to allow a holistic relationship-based care package to be put in place, including **preventative care**. In the US, only about 75% of the population are registered with a family doctor (it is high for the elderly but less than two thirds for the under 30s), whereas the ONS data for the UK suggests it is very close to 100%[1].

2. **Uneven access to healthcare** in the first place, particularly for lower socio-economic groups who are more likely to face health risks owing to their environment (workplace and domestic). Self-evidently, you won't initiate primary care involvement if you cannot afford the cost and a pre-COVID survey found that 32% of American families had elected not to seek care in the prior year owing to cost[2] (as an aside, one might wonder what percentage of families here in the UK have given up trying to get care because it is so hard to get a GP appointment, but that's a topic for another day).

3. The prevalence of a **fee-for-service** model where there is no disincentive not to treat someone as expansively (read: expensively) as possible.

4. **High medical malpractice liability risk:** this compounds the previous point. Diagnosis is imperfect and diagnostic errors can lead to serious harm, especially if emerging critical care events (such as a heart attack, stroke or sepsis) or an early sign of cancer are (dis)missed. These three categories (CV, infection or cancer) of misdiagnosis account for three quarters of adverse events from misdiagnosis and half of all US medical malpractice claims. The payouts can be very large if people die or suffer irreparable harm, creating a climate of fear that causes American doctors to apply a very low index of suspicion before ruling things out and over-treat due to fear of being sued[3].

Trying to fix all of the above would likely require a combination of two things; 1) comprehensive healthcare reform to address the first three things and 2) so-called 'tort reform' to cap malpractice payouts at a level that might impact behaviour and thus reduce over-treatment.

Turkeys don't like Christmas

Let us first consider the tortured history of tort reform. Readers will doubtless be aware that most members of Congress have legal backgrounds and owe their place in politics to an earlier career helping people to navigate the complexities of the legal system. As such, they tend not to be so keen on making it less complex and less remunerative. Even in the early 2000s, 70% of malpractice lawsuits did not result in an award to the plaintiff, but still resulted in six figure legal costs for the defendant. One cannot imagine the situation has improved much since.

George W Bush (the second one) generally gets a bad rap. Critics tend to focus on the illegal wars and the hundreds of thousands of people that died in them, the rendition of individuals from sovereign states, the legalisation of torture, the unlimited detention without trial and the blocking of access to birth control in developing nations. He also set a precedent for legally contesting the outcome of the Presidential election and genuinely seemed to like Tony Blair.

However, if we set aside these things for a moment (bear with us), he tried to do some good stuff around healthcare access and affordability. He implemented "Medicare part D", which helps to fund drug costs for retired seniors. He tried to instigate a widespread healthcare reform package where tax free savings accounts would be allied to catastrophic coverage insurance (i.e. a cap on out of pocket costs) to protect people from huge medical bills. The proposal would have coerced States into dealing with their uninsured populations by linking Federal funds to this outcome. The package did not make it through Congress, but was no less progressive or ambitious than the eventually successful "Obamacare" that followed a few years later.

Finally, he created PEPFAR, which continues to this day and has undoubtedly done more to slow the spread of, and mortality from, HIV in developing countries than any other programme. Indeed, until COVID-19 it was the world's largest public health initiative and is estimated to have saved millions of lives, making it one of the most successful preventative healthcare programmes in human history. As we noted at the beginning, few things are simple binaries of "this thing or person is wholly good or bad".

Whilst he was Governor of Texas, Bush successfully passed laws (seven in total) to limit damages payouts against businesses, doctors, health insurers and hospitals. In the years that followed, the number of such cases fell materially, as it was judged in many instances that the financial risk of pursuing a claim were not worthwhile. Some meritorious cases might well have fallen away due to these changes, but few would argue that the State had the right balance between plaintiff and defendant rights prior to his efforts.

Around the same time, Congressional Republicans made similar reforms a centrepiece of their ambitions for their agenda under President Clinton but he vetoed the relevant bills (Clinton graduated Yale law and was a professor of law before going into politics). Bush also tried to pass similar Federal laws as those that he successfully implemented in Texas, but to no avail. Various attempts to address the issue resurface every few years (2017 being the last one we are aware of).

The United States has a uniquely litigious culture and this undoubtedly impacts healthcare. No real progress has been made on this issue and we doubt that it will until another politician comes forward with tort reform as a centrepiece of their Presidential campaign. If we cannot rely on changes to the law to mollify the tendencies to over-treat, perhaps the broader fee for service model can serve as the basis for a more rational approach to care provision and access.

Value based care - perhaps there is a magic bullet?

As noted previously, Bush's attempt to pass a comprehensive healthcare reform bill was unsuccessful, but President Obama did manage to pass the Affordable Care Act ('Obamacare') in 2010, and this came into effect in from 2013 to 2014. The primary focus of commentary on the Bill has been around its success in reducing the number of uninsured Americans and the various Congressional attempts (60 and counting) since its passing for Republicans to defenestrate it, especially under President Trump.

The success of Obamacare cannot be questioned: there are fewer uninsured Americans today (roughly half as many) and, in the States that elected to expand Medicaid provision under the Act, morbidity and mortality amongst eligible populations has declined. The insurance pools have not worked as well as was hoped, so the cost of care is higher than was projected at the time of the Bill's passage, but it is a qualified success.

From our more 'wonky' perspective, one of the principle points of interest for us in our past lives was the Act's role in supporting so-called alternative payment models and value-based care through the creation of Accountable Care Organisations (ACOs) through the Medicare Shared Savings Program. This represented an evolution of the 1970s HMO model and the two differ in the sense that an HMO provides a fixed type of care package for a fixed price, whereas an ACO is less prescriptive in terms of the care on offer.

In simple terms, the Value Based Care (VBC) or "population health" model promotes holistic care. Instead of relying solely on episodic payments for each individual unit of service or care episode (commonly known as fee-for-service, FFS), VBC focuses on the quality and total cost of care. A primary care physician is responsible for disease management/health maintenance.

Two different models exist, known as one and two sided risk sharing. In both cases, the fee for service element continues but providers who deliver high quality care while reducing costs are able to share in the financial savings. In a two-sided model, the outcomes payments are higher but on the other hand, providers who deliver lower outcomes and or higher costs must fund the difference.

Around 70% of healthcare spending goes toward the treatment of chronic diseases and we know that costly and debilitating exacerbations related to conditions such as high blood pressure, high cholesterol, high blood sugar etc. represent 'modifiable risk factors'. Simply put, if we can make people change their behaviour (medically or otherwise), we can reduce the risk of these acute events.

Given how wasteful healthcare is and in particular how the US system ends up spending a lot more than other OECD countries for generally poorer outcomes, this seemed like a fantastic business opportunity to us and we expected VBC schemes to attract lots of lives and for the number of ACOs to mushroom in the years after the passage of the Act.

However, this view proved to be premature. Medicare ACOs still only covered ~10.5m lives in 2021, out of a total of ~64m in the wider Medicare programme. This is despite the majority of ACOs hitting their care quality markers and still generating savings amounting to almost $2bn per annum from those 10.5m lives when compared to traditional Medicare. Why hasn't it been more popular?

Sumptuary saprophytes

One cannot under-estimate the extent of the change in system-wide behaviour that the ACO model represents. Whilst HMO models are the most common type of insurance in the US and consumers are used to being told what is and is not covered and where they can or cannot go for care, the physician has always had the fee for service model. If they come, you can bill them. You just need to be the right side of the fee cut-off line to ensure that the insurance companies will reimburse your time.

As such, the ACO model represented a new challenge. You would realise bonuses or maybe receive a bill based on a nebulous concept of patient satisfaction and health outcomes. Physicians know better than most of us that people rarely follow medical advice. Moreover, the model dictates that you identify those with material risks and then optimise their care. Is this as easy in reality as it sounds on paper?

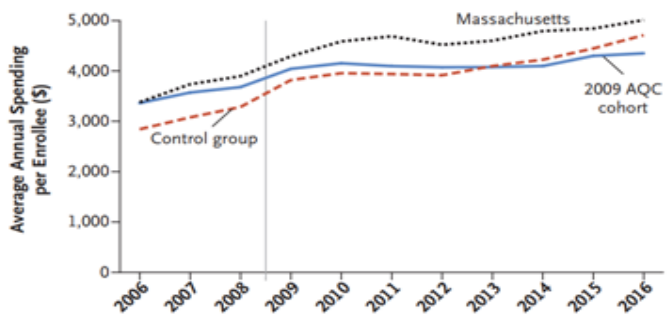
Pareto's law applies in healthcare as it does to everything else and failing to get that smaller proportion of higher-risk patients where they need to be could compromise your overall effort. In addition, the intensity of care means that you cannot look after as many patients (as you need to see them more often). Shrinking your book of business is an anathema to anyone trying to earn a living (although the data shows that overall primary care earnings are not lower and can be much higher).

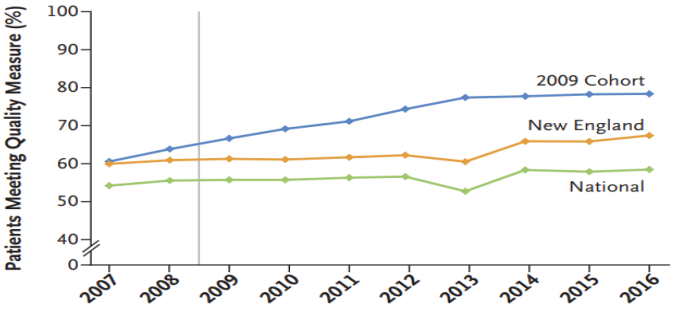
Finally, we must not forget that most physicians are not all about the green. They have pledged an oath to do no harm and went into medicine to help people. There has been concern that ACO systems and their bundled care approach (with hospitals and other providers working with family doctors to provide a vertically-integrated care paradigm) could worsen clinical outcomes. Aside from the financial risks emerging from this, if you really are concerned about poor outcomes, you are not going to sign up. As a result of these reasonable concerns, physicians have proven to be more reluctant to join organisations and thus for existing ACOs to recruit more doctors and grow their business than we initially hoped.

The scores are in

The challenge posed by the arguments above is the difficulty in refuting them. As noted previously, the burden of care stems mainly from chronic disease and the additional exacerbations resulting from sub-standard disease management could take years to become apparent. However, the data is coming through and now the pandemic is largely behind us, we expect the transition to accelerate.

There are innumerable papers that one can look at to see the impact of these sorts of programmes, but an 11-year study reported in the New England Journal is particularly interesting[4]. It covers a two sided VBC programme introduced by the State of Massachusetts in 2009 known as "AQC". We include two charts from this paper; one showing annualised spending versus a control group (which is from multiple states and not adjusted for any incentive payments) and an average for Massachusetts (more useful in our view) and the other showing a measure of the outcomes quality:





Whilst this cohort looked to be on a more positive trajectory in terms of spending and health quality (i.e. they were a bit healthier on average), the gap on spending widened and persisted over time whilst outcomes also further improved. In light of these sorts of findings and ever more learnings on how to manage patients better in these schemes, the savings are growing and the incentives to deploy this approach become more compelling over time. VBC and population health have finally come of age.

Capturing a data vertical on the patients is a key element of measuring and improving quality and we are seeing these captive lives being used to support the ongoing site of care shift, with more VBC patients being sent to cheaper-to-run ambulatory care centers (ACCs) for any non-emergency specialist treatment. This is supporting a build-out of additional ACC capacity which creates a virtuous circle of lower cost care capacity for everyone.

Because the physicians themselves are so incentivised to do what is best for their patients in the longer-term, we also think the VBC transition will accelerate the ultimate site of care shift – one where care is given in the home (and again this is a trend that has accelerated as a consequence of the pandemic).

Competitive consequences

We expect the acceleration of value based care within Medicare and beyond to have meaningful competitive consequences for the healthcare landscape in US healthcare. Physician time is finite and the key to all of this is identifying who to spend the most time with and what to do with that time – Pareto's peremptory. One must also recognise that the savings accumulate over time and so this time represents an investment. It probably has a negative NPV initially but will payback over multiple years. If this sounds like the work of an algorithm, then that's because it is. Those with the best data on how to do the most in the least amount of time will get the best outcomes.

As a physician, you don't want to be partnered with the wrong providers. As such, it does rather feel that United Health is incredibly well positioned to take additional share over time. We don't generally like conglomerate business models, but when it comes to building a healthcare data vertical, there is no other way. Our other major bet in this area has been Evolent Health, which is a software provider that provides the administrative and clinical analysis software to enable smaller entities to run VBC programmes.

As noted previously, we also expect the site of care shift away from the traditional hospital setting and toward care at home to accelerate post COVID and in lock step with growing penetration of population health initiatives. This is reflected in our portfolio with Option Care Health (home infusion services), Amedisys (broad-based medicalised care in the home setting) and Outset Medical (transition to home haemodialysis for ESRD patients) all featuring in the top 10 holdings.

Many of you will have heard us talk about the trifecta of perfection for a product, technology or service that we would want in a prospective investment: it will improve patient outcomes, it will lower the cost of care and it will enable caregivers to make better decisions on behalf of their patients (in truth it is often this third aspect that drives the first two). The data presented above suggests that population health approaches, through the application of financial incentives, do indeed tick all of these boxes. The future of healthcare, in the US at least, is already here.

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 weeks.

Paul Major and Brett Darke

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

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.

The risk indicator assumes you keep the product for 5 years. The actual risk can vary significantly if you cash in at an early stage and you may get back less.

The summary risk indicator is a guide to the level of risk of this product compared to other products. It shows how likely it is that the product will lose money because of movements in the markets or because the fund is not able to pay you.

This fund is classified as 6 out of 7, which is a medium-high risk class. This rates the potential losses from future performance at a medium-high level, and poor market conditions will likely impact the capacity to pay you.

The portfolio is likely to have exposure to stocks with their primary listing in the US, with significant exposure to the US dollar. The value of such assets may be affected favourably or unfavourably by fluctuations in currency rates.

This fund does not include any protection from future market performance so you could lose some or all of your investment.

If the fund is not able to pay you what is owed, you could lose your entire investment.

Target market

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

Chances

- 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 3.5% dividend yield.
- Bellevue Healthcare Trust has an experienced management team and strong board of directors.

Inherent risks

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

Management Team

Paul Major
Portfolio Manager
since inception of the fund

Brett Darke
Portfolio Manager
since inception of the fund

Awards

Sustainability Profile – ESG

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

CO2 intensity (t CO2/mn USD sales):	26.5 t (low)	MSCI ESG coverage: 100%
MSCI ESG Rating (AAA - CCC):	A	MSCI ESG coverage: 100%

Based on portfolio data as per 31.03.2022 (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; norms-based exclusions based on annual revenue thresholds; ESG Integration: Sustainability risks are considered while performing stock research and portfolio construction; Best-in-class: systematic exclusion of "ESG laggards"; MSCI ESG Rating ranges from "leaders" (AAA-AA), "average" (A, BBB, BB) to "laggards" (B, CCC). Note: in certain cases the ESG rating methodology may lead to a systematic discrimination of companies or industries, the manager may have good reasons to invest in supposed "laggards". 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/sustainability-at-portfolio-level

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.

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