Clinique Reims-Bezannes Courlancy Santé

# HEALTHCARE REAL ESTATE: EUROPEAN DEMOGRAPHICS AT THE HEART OF TOMORROW'S CHALLENGES

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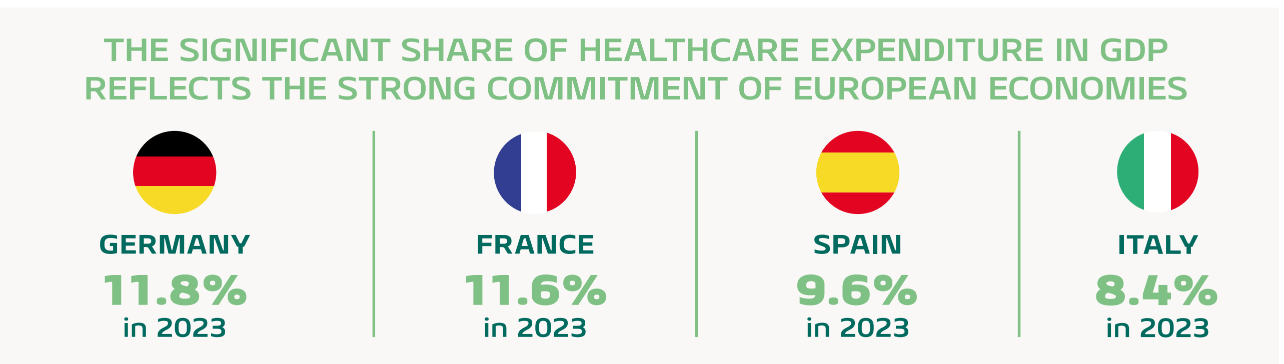
## 1. A SECTOR DRIVEN BY SOLID FUNDAMENTALS: SUPPLY WILL NEED TO BE DEVELOPED TO KEEP PACE WITH RAPIDLY GROWING DEMAND.

- **Rapid population ageing and demographic pressure are creating structural needs in European healthcare systems.** To meet these needs, massive investment is required, both to develop new capacity and to modernise part of the real estate stock that has become obsolete (nursing homes, hospitals, clinics, etc.). For example, we estimate that **the financing needs of nursing homes will require tens of billions of euros of investment** to accommodate the seniors of tomorrow.
- While government budgets are tight and need to be controlled, it should be remembered that **healthcare spending accounts for a significant share of European GDP, between 8% and 12%, backed by publicly funded social security systems, which are increasingly costly.** This highlights **the priority given to this sector by public authorities and the strength of its long-term economic fundamentals.** However, in the face of budgetary constraints, **governments will need to mobilise private capital** to finance the development of healthcare infrastructure.

## 2. HEALTHCARE REAL ESTATE, AN ATTRACTIVE ASSET CLASS FOR DIVERSIFICATION IN A PAN-EUROPEAN PORTFOLIO.

- Healthcare real estate offers an **attractive risk/return profile**. This performance is driven by **strong demand and leases that are significantly longer on average than for traditional commercial real estate**. Healthcare offers **good diversification within a real estate portfolio,** relying on **solid tenants** and uses that are **less sensitive to economic cycles,** resulting in **low volatility**. This asset class also meets various **ESG and SRI objectives: environmental** (climate resilience, reduction of emissions and consumption), social (well-being, access to healthcare, quality of life) and **governance** (construction site charter).
- Investing in this asset class requires **in-depth sector expertise in order to mitigate the risks inherent in this business sector,** which we have identified across several dimensions: **operations** (dependence on the operator, lease term, difficulty of changing operators, reputational risk, size of the operator, financial strength, quality of management); **regulatory** (strict and evolving standards, operating licences, price regulation, potential reforms); **vacancy** (product mismatch, local market saturation, changing needs); **technical and obsolescence** (specific features of the building, adaptation costs, functional life, energy-intensive assets, reduction of consumables and carbon footprint), as well as **liquidity** (market depth, location). The **key success criteria** to be considered before any investment is made are: **the strength of the operator; the quality of the lease; the location and the technical condition of the building.**






### HEALTHCARE REAL ESTATE: THE KEY DRIVERS

**Demographic trends**

**The size of the general population** promotes economies of scale, a better allocation of resources, and a more diversified healthcare offering.

**Aging population in Europe:** drives the demand for healthcare services and facilities.

**Technological advancements:** healthcare providers are increasingly adopting advanced medical technologies and telemedicine.

**Reimbursement mechanisms and insurance coverage:** impact the demand and design of healthcare facilities.

**Growing awareness of preventive care and wellness initiatives:** stimulates the demand for facilities promoting health and well-being.

**Healthcare operators**

**Government regulations:** shape the development and operation of healthcare real estate.

**Compliance challenges:** Healthcare operators must adhere to strict regulations. Non-compliance can result in penalties, legal action, or loss of accreditation.

**Consolidation of healthcare operators in the European market:** Several healthcare providers, such as hospitals, clinics, or medical services, are merging or forming partnerships to create larger entities.

**Investors**

**Investor interest:** in «alternative» asset classes such as healthcare real estate.

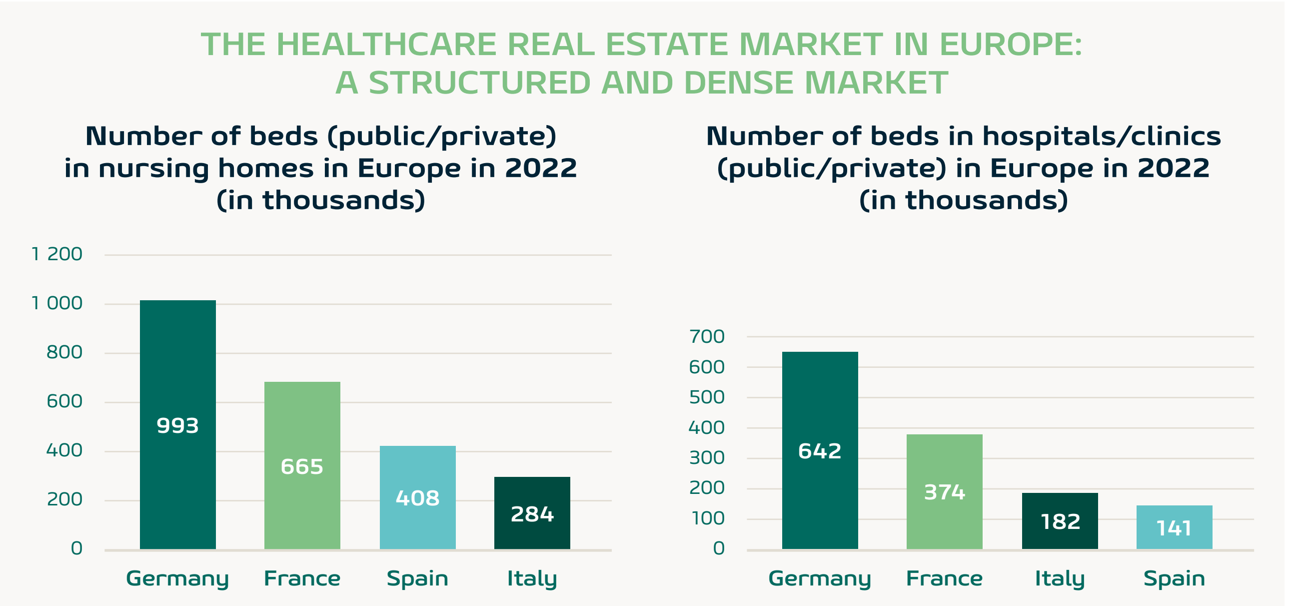
**Partnerships with operators to create long-term value:** Collaborating with healthcare operators to develop or manage real estate, leveraging their expertise in delivering quality healthcare services while generating long-term value for investors.

**Value linked to ESG strategy:** to comply with regulatory requirements

**Asset performance**

**Low volatility:** compared to other asset classes.

**Optimizing the risk/return balance.**



# THE EUROPEAN UNION WILL EXPERIENCE SIGNIFICANT DEMOGRAPHIC CHANGES IN THE COMING YEARS.

**Between 2010 and 2040, the population of the European Union will stabilise, rising from 440 million to 452 million inhabitants.** Current projections therefore indicate moderate overall growth (an average of +0.1% per year). Between 2010 and 2020, population growth was driven by births, longer life expectancy, and immigration. Between 2025 and 2040, the overall population will stabilise. It will be characterised by two trends: on the one hand, the working-age population will decline, while on the other, the number of senior citizens (aged 65 and over) will increase significantly.

**The coming years will be marked by significant disparities between countries.** Countries such as France are expected to maintain a more favourable demographic momentum than the European average. Conversely, Eastern European countries are expected to experience population declines due to emigration and low birth rates.

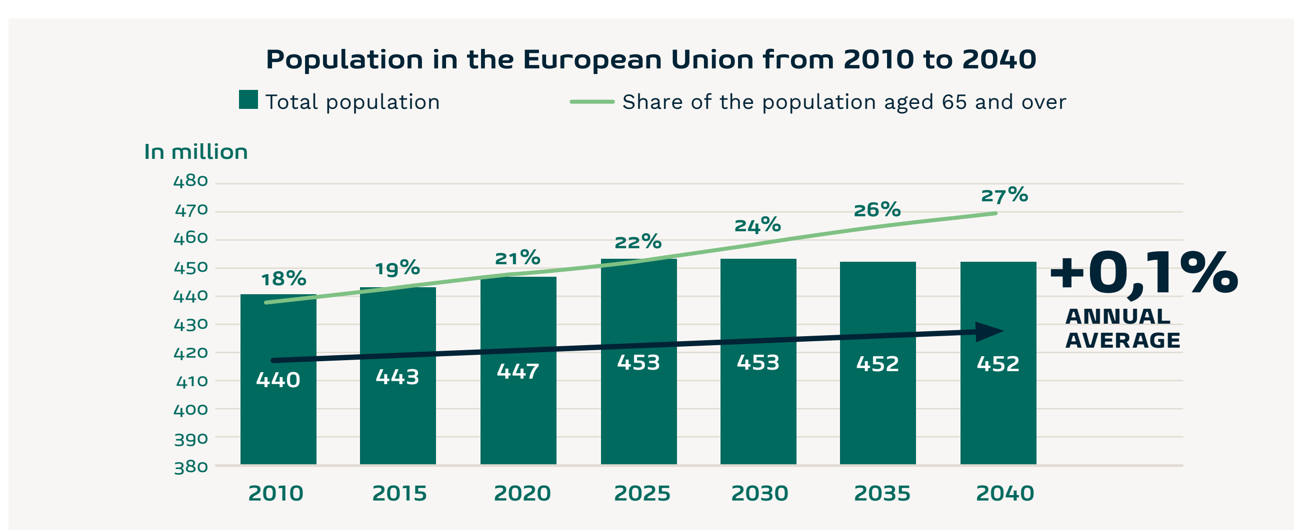
**Demographic ageing will become increasingly apparent.** The proportion of people aged 65 and over will rise sharply from around 17% of the population in the early 2010s to nearly 26-30% in 2040.

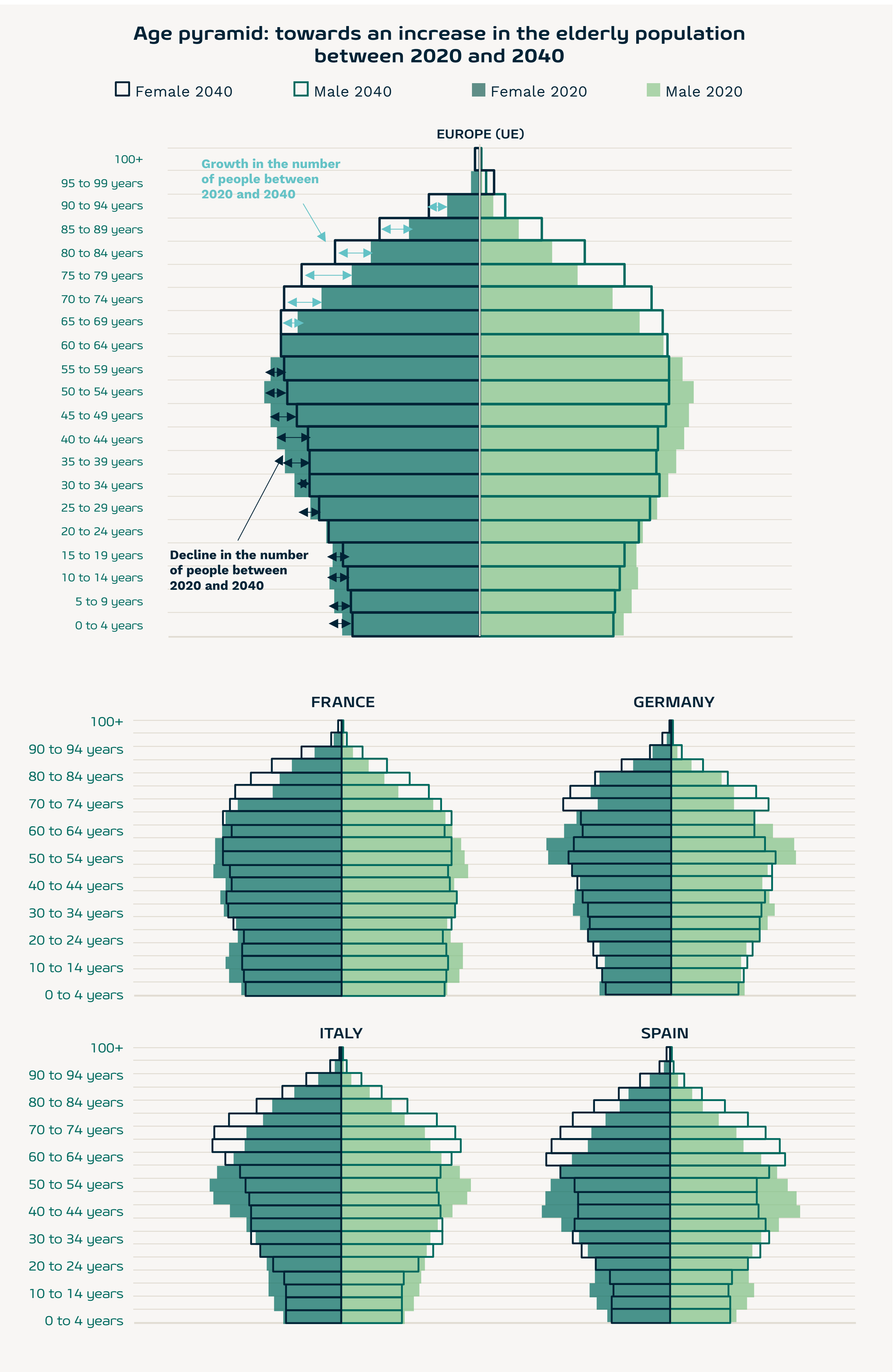
This trend is due to rising life expectancy and falling birth rates. This situation will therefore change the distribution between age groups, with baby boomers moving from young retirees to the elderly.

**The birth rate is expected to remain below the population replacement level.** The threshold for generational renewal is 2.1 children per woman. However, the current fertility rate is 1.5 children per woman, or even lower, leading to an ageing population and, ultimately, a negative natural growth rate.

**Immigration has been one of the drivers of population growth since the early 2000s, compensating for a sometimes-low natural growth rate.** By 2040, while immigration will remain necessary to maintain the working population, its impact could be limited by political and social factors.

**These demographic changes will have a significant impact on real estate, both on medical and social establishments and on hospitals and outpatient facilities, which will have to respond to new public health challenges.**



# THE CHALLENGES OF AGEING: TOWARDS A MAJOR DEMOGRAPHIC SHIFT IN EUROPE.

The indicator used to analyse **the ageing of a population** is the **dependency ratio.** This is the ratio between people aged over 65 and the working-age population (aged 15-64).

This means that in the European Union, **for every three people who were retired** or close to retirement in 2012, there were **ten people of working age. In 2040, this trend will accelerate, with five people retired or close to retirement for every ten people of working age.**

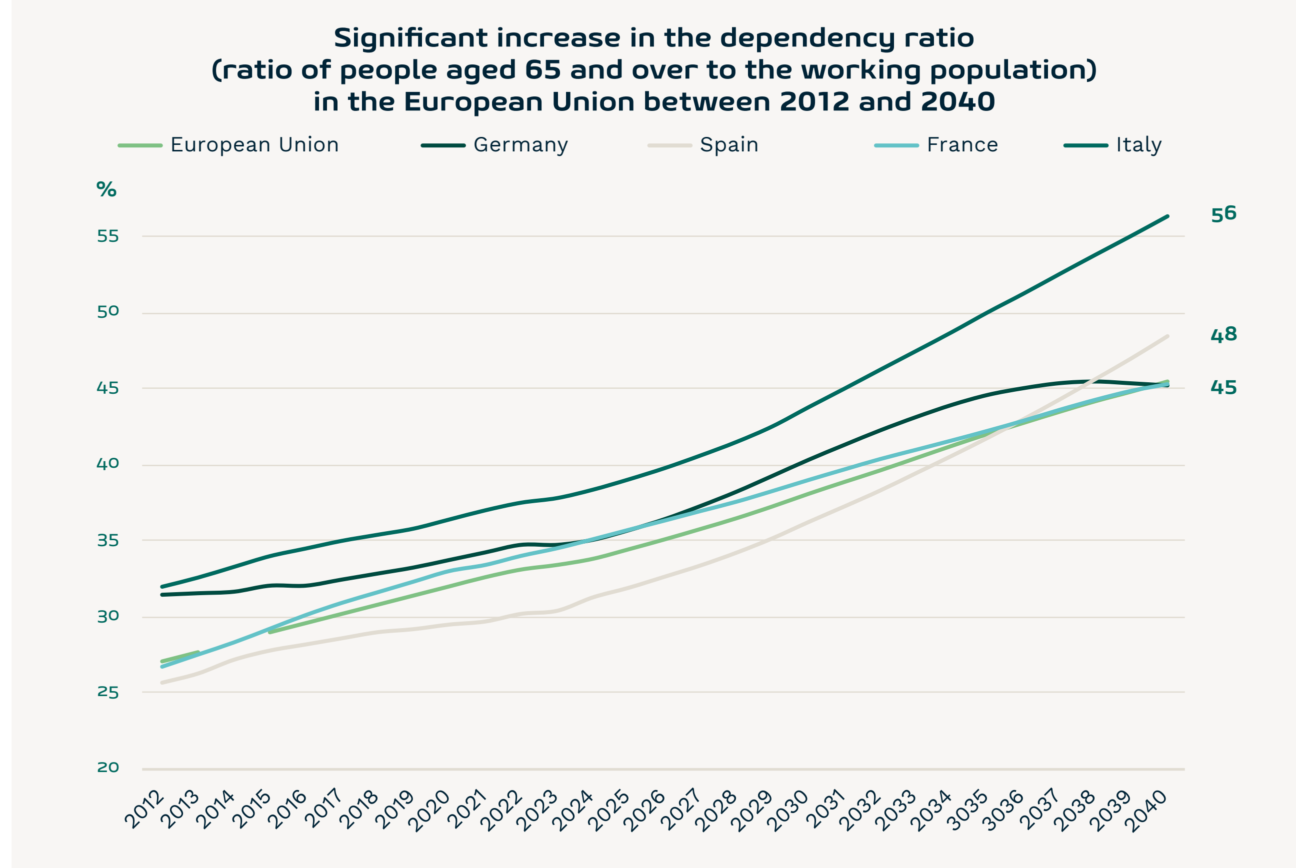
Analysis of the dependency ratio over the period 2012-2040 confirms this ageing trend, with the ratio set to rise above **45% in 2040,** compared with less than **27% in 2012.**

**In France,** the dependency ratio will rise from 26% in 2012 to 45% in 2040. This sharp increase is due to the ageing population and the retirement of the baby boomers, which will no longer be offset by birth rates and immigration.

**In Germany,** after experiencing rapid growth in the dependency ratio, which is expected to continue until 2030, the ratio will stabilise at around 45% in 2040. The country has undertaken reforms (particularly pension reforms) to anticipate this ageing, but still faces a birth deficit.

**Spain** has one of the highest dependency ratio growth rates. This can be explained by a combination of two factors: a rapid decline in the birth rate that began with the 2008 crisis and one of the highest life expectancies in Europe.

**In Italy,** the ratio will reach a very high level of 56% due to low fertility rates, high life expectancy and emigration of young workers.




# AGEING, LOSS OF INDEPENDENCE AND DEPENDENCY.

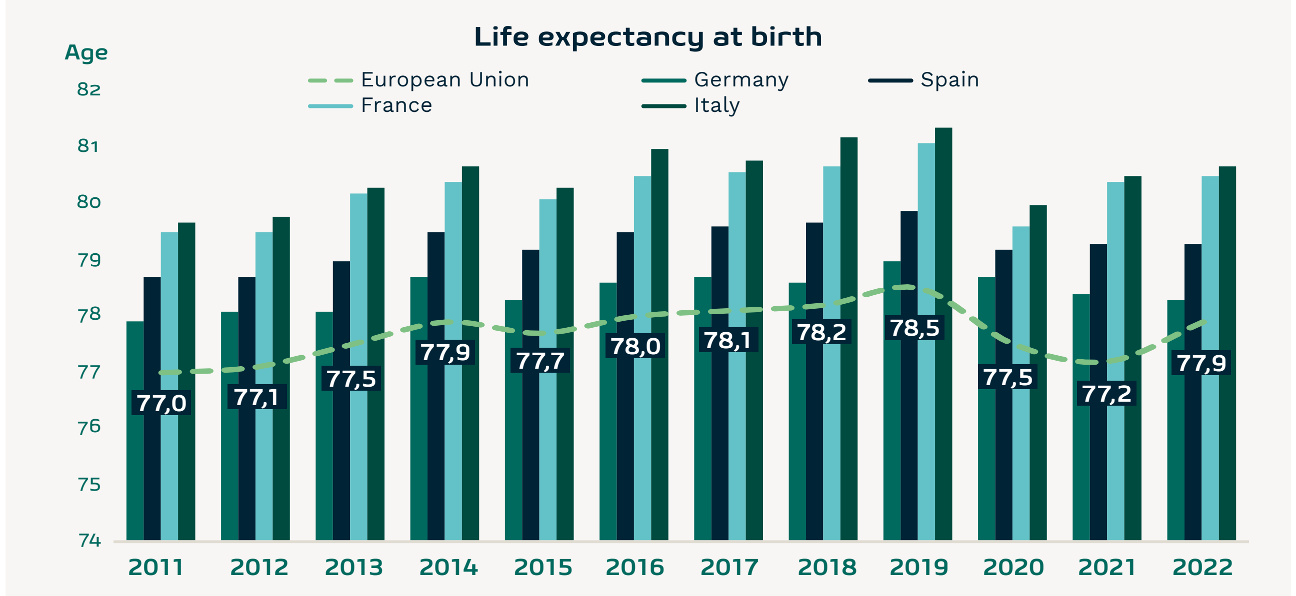
Longer life expectancy has been made possible by medical advances and improved living conditions, with life expectancy trending upwards, despite the impact of the COVID crisis. Life expectancy is expected to increase further by 2040.

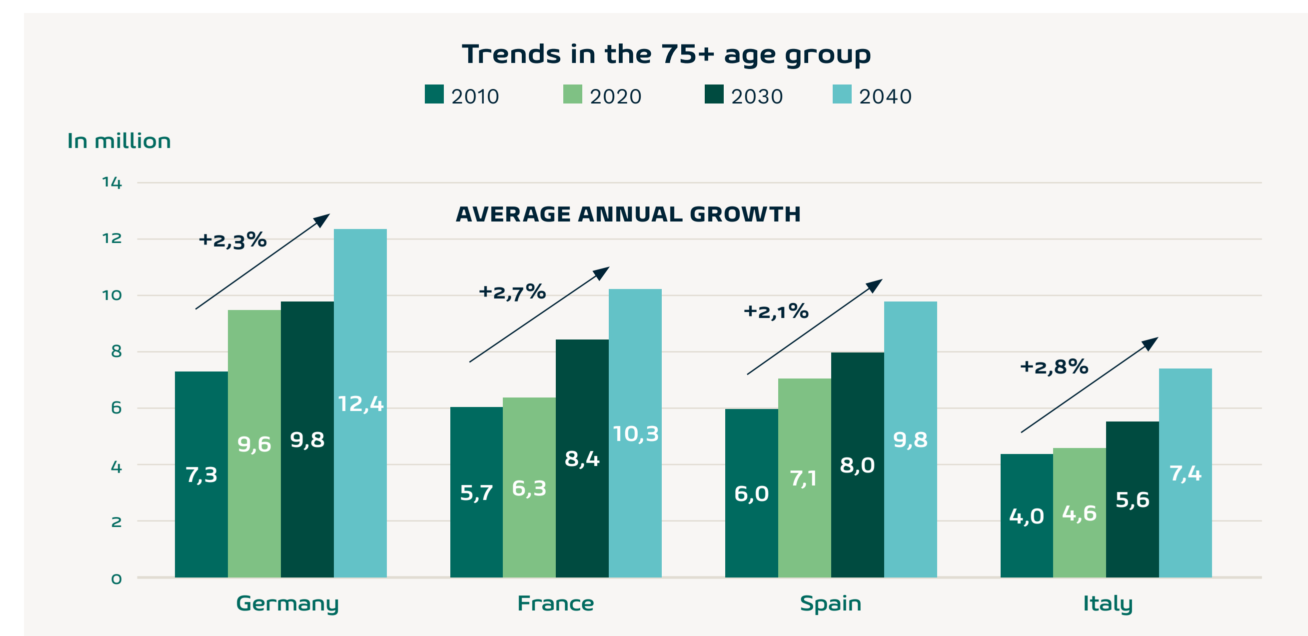
At the same time, **the ageing population will lead to an increase in the number of dependent elderly people requiring care.** The probability of dependency increases from the age of 75 and reaches a critical threshold at 85. Loss of independence must be accompanied by assistance or care, particularly for the population aged 75 and over, which will increase from 44 million in 2020 to more than 64 million in 2040 in the European Union. As a result, the proportion of people aged 75 and over will grow faster than the general population between now and 2040.

**Old age requires specific care and facilities:**

- **long-term care:** people aged 75 and over are most affected by dependency and chronic conditions.
- **specialised facilities and services** will be needed to meet this rapidly growing demand.

Germany will have the largest number of people aged 75 and over by 2040. In fact, there will be more than 12 million seniors in this age group. France ranks second with 10.3 million individuals. Spain and Italy are close behind the heavyweights of the euro zone with a rapidly growing population aged 75 and over, estimated at between 7 and 10 million people in these countries by 2040.



# HEALTHCARE SPENDING IN EUROPE: YEARS MARKED BY SIGNIFICANT GROWTH.

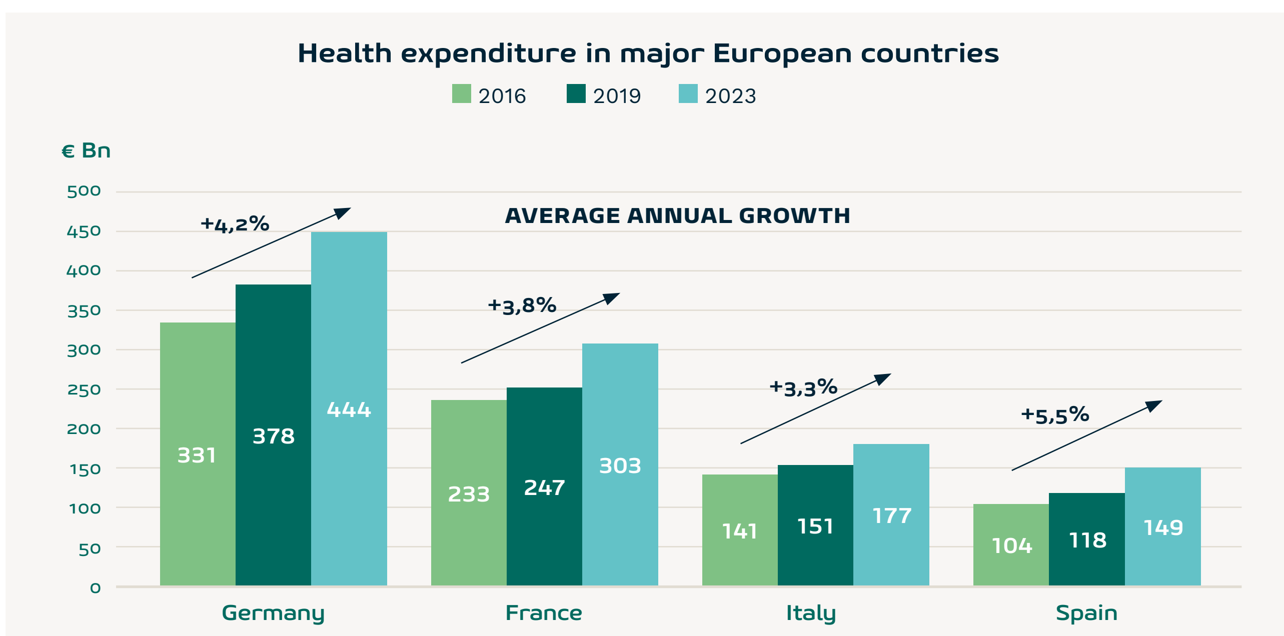
Over the period 2016-2023, healthcare spending in Europe was influenced by various factors such as the COVID-19 pandemic, the accelerating ageing of the population, and medical innovations.

Overall health expenditure includes current health expenditure and all curative and rehabilitative care. **All of these expenditures were on the rise during the period 2016-2023.**

Healthcare expenditure in the 27-member European Union was close to €1.7 trillion in 2023, up by an average of around 4% per year since 2016.

By country, **Germany has the largest budget** with more than €440 billion in spending in 2023, **followed by France** with more than €300 billion, Italy with €177 billion and Spain with €149 billion.

There are significant disparities between countries in terms of per capita health expenditure. While the highest per capita expenditure is found in Western Europe, the lowest is in Eastern Europe. There is a strong correlation between income and health expenditure. Thus, high-income European countries generally spend the most on health per capita.




# THE MAIN HEALTHCARE SYSTEMS: THEIR STRUCTURE, FINANCING METHODS, AND DISTRIBUTION OF EXPENDITURE.

## THE HEALTHCARE SYSTEM IN GERMANY

### The structure

**National (Federal)**

**Federal Ministry of Health (Bundesministerium für Gesundheit)**

Bundesministerium für Gesundheit

- The Federal Ministry of Health is responsible for developing policies at the federal level. Its tasks include drafting laws and administrative regulations within the healthcare system.

**Regional (Länder)**

- The federal states (Länder) have their own legislative powers, implement federal laws, and plan the financing of hospital care. They ensure technical and hierarchical supervision of the municipal public health service.
- The Länder are also responsible for overseeing regional social security funds, health professional organizations, and associations of contracted healthcare professionals.

**Health coverage system**

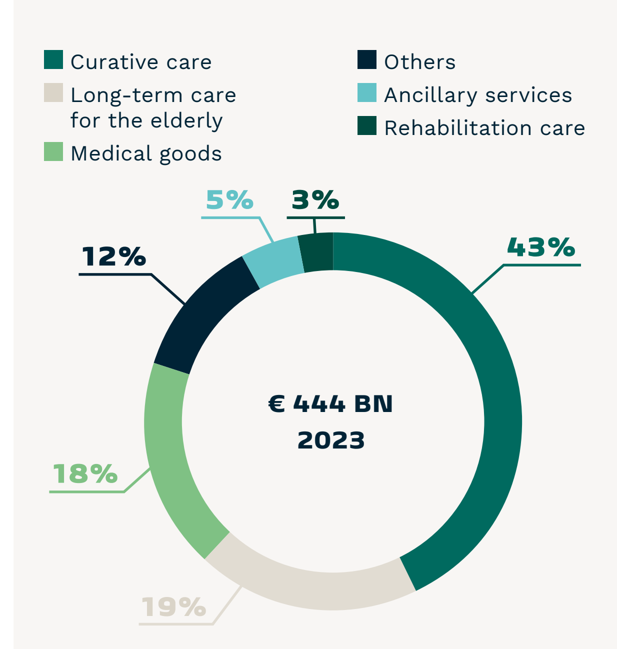
**Mandatory Health Insurance (GKV) and Private Health Insurance (PKV)**

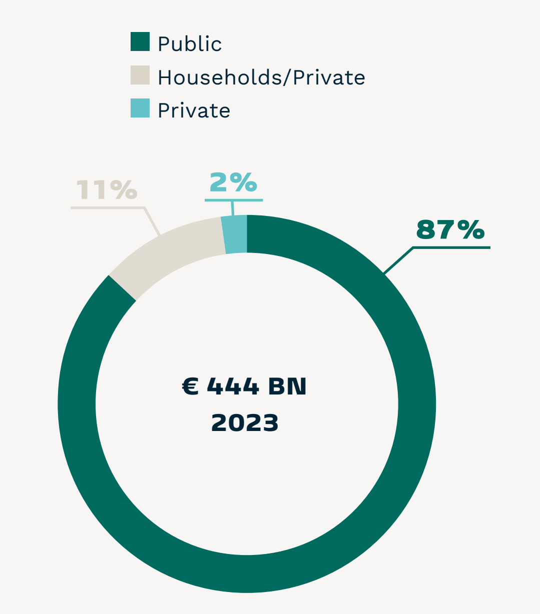
- The population must be affiliated with the legal health insurance system.
- Health Insurance covers several services (prevention, promotion, screening, treatment, and emergency care, etc.).
- The model relies on strong involvement from both public and private insurance funds.

### Financing mechanisms

| Public | Private | Households |
|---|---|---|
| The Mandatory Health Insurance (GVK-Gesetzliche Krankenversicherung) covers 90% of the population and is financed by taxes and social contributions based on income. It is managed by public health insurance funds (Krankenkassen). The system operates on the principle of solidarity. | Private Health Insurance (PKV-Private Krankenversicherung) is available to employees with an income above a certain threshold, self-employed individuals, and civil servants. It offers benefits that are often more comprehensive and personalized. | A moderate contribution is required from patients (co-payments, individual room charges in hospitals, etc.). |

### Breakdown of expenditures



## THE FRENCH HEALTHCARE SYSTEM

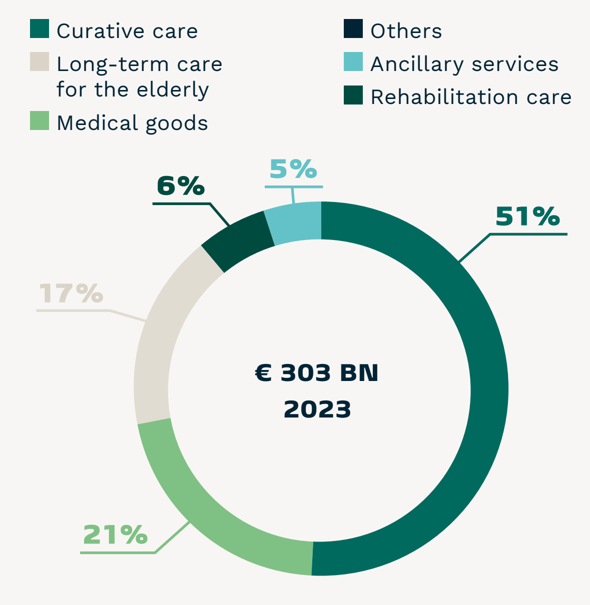
### The structure

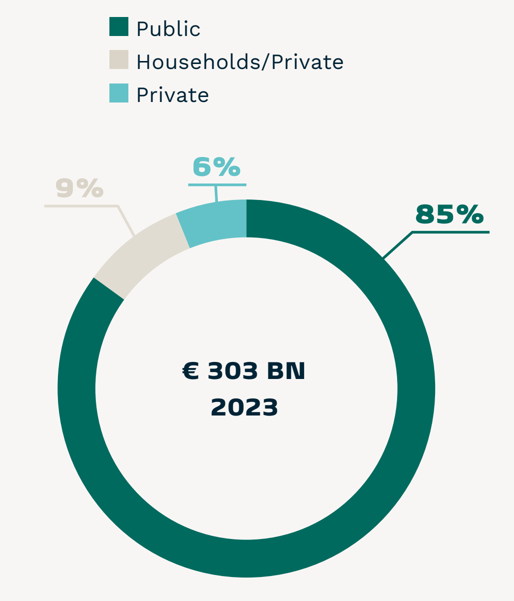
| National | Regional | Health coverage system |
|---|---|---|
| **The Ministry of Health** | **Regional Health Agency** | **Health Insurance and Supplementary Health Insurance** |
| | | L'Assurance Maladie – Agir ensemble, protéger chacun |
| • The Ministry of Health defines policies and oversees the management of healthcare resources and expenditures. | • Regional Health Agencies (ARS) oversee public health policy in regions and regulate the healthcare provision in the hospital and medico-social sectors. | • The insurance covers 5 branches (Health, work accidents and occupational diseases, family, old age, dependency).<br>• Supplementary insurance covers what is not included by health insurance. |

### Financing mechanisms

| Public | Private | Households |
|---|---|---|
| Compulsory health insurance schemes are funded through mandatory contributions (social security contributions, taxes, and levies). Health Insurance covers 100% of the population (employees, self-employed, retirees, students, etc.) and reimburses a large portion of medical expenses (consultations, hospitalization, medications, etc.). | Supplementary health insurance (mutuals and private insurance) covers all or part of the remaining costs after reimbursement by Health Insurance. They are mandatory for employees in the private sector (through their employer). | Households bear the costs not covered by Health Insurance or supplementary health insurance (medical franchises, excess fees, co-payment, flat-rate contribution, expenses not covered by the supplementary insurance). |

### Breakdown of expenditures




## THE HEALTHCARE SYSTEM IN ITALY

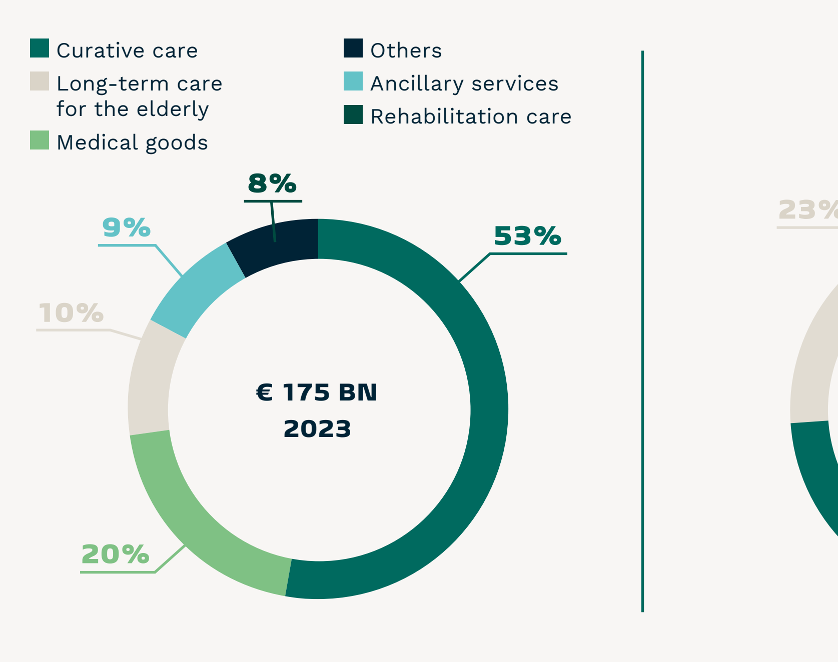
### The structure

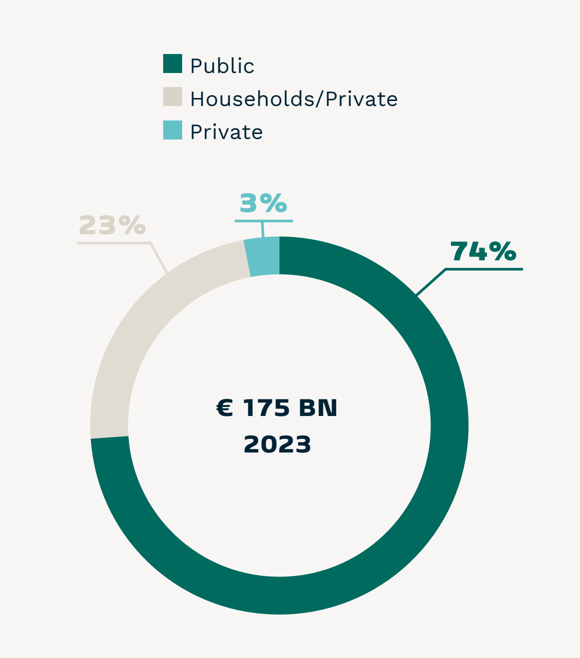
| National | Regional | Health coverage system |
|---|---|---|
| **Ministry of Health (Ministero della Salute)**<br> Ministero della Salute | • Regional governments are responsible for pursuing major national objectives. They manage the budgets and organization of care (hospitals, doctors, waiting times).<br>• Local health agencies (Aziende Sanitarie Locali – ASL) form the basic components of the Italian national health system.<br>• Regions can adopt various models, more or less integrated / separated, to provide care to the population. | **Servizio Sanitario Nazionale (SSN)** |
| • The government defines the general principles and funding.<br>• Minimum standards are set by the national government through the «Livelli Essenziali di Assistenza» (Essential Levels of Care), and each region can set a higher ceiling if it is able to finance it. | | • Basic care includes free services provided in health centers or public or contracted private hospitals (general medicine, pediatrics, maternity, hospitalization, medications).<br>• Other services (specialist consultations, dental care, etc.) are only partially covered. |

### Financing mechanisms

| Public | Private | Households |
|---|---|---|
| The SSN (Servizio Sanitario Nazionale) was established in 1978 based on the principles of universal coverage, solidarity, and dependency, similar to the UK's NHS system.<br><br>The SSN is financed by taxes (both national and regional) and managed by the regions. | Insurance and mutuals are not mandatory in Italy. They are taken out by those who wish to access private care more quickly or cover expenses not covered by the SSN (e.g., specialized and private hospital care, fee overruns, dental and optical care). | Italians can choose to pay directly for a private consultation to avoid waiting.<br><br>Co-payments apply in certain cases (specialists, medications, exams). |

### Breakdown of expenditures



## THE HEALTHCARE SYSTEM IN SPAIN

### The structure

#### National

**Ministry of Health (Ministerio de Sanidad)**

- The national Ministry of Health has limited responsibilities.
- It sets the broad outlines of health policy.
- It has authority over legislation related to pharmaceutical products and ensures the fair functioning of healthcare services throughout the country.

#### Regional

- Health responsibilities have been fully devolved to the regional level.
- The main responsibility covers the organization and delivery of healthcare services. Health expenditures are primarily decided and funded by regional administrations, but must adhere to the overall budget set at the national level.

#### Health coverage system

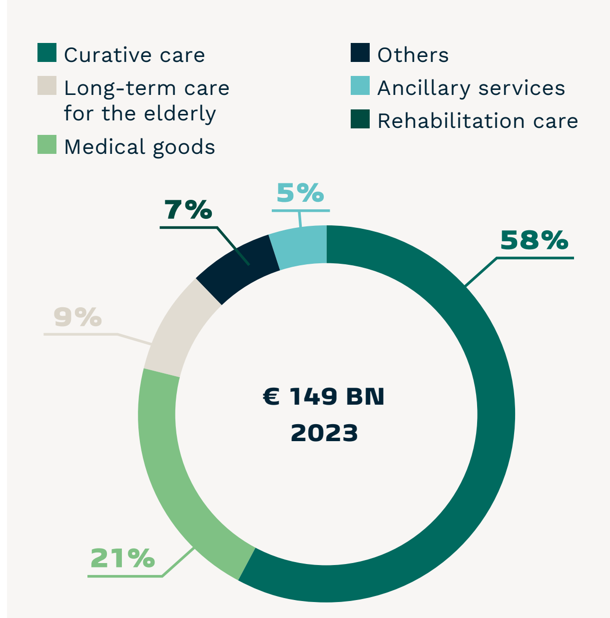
**Sistema Nacional de Salud (SNS)**

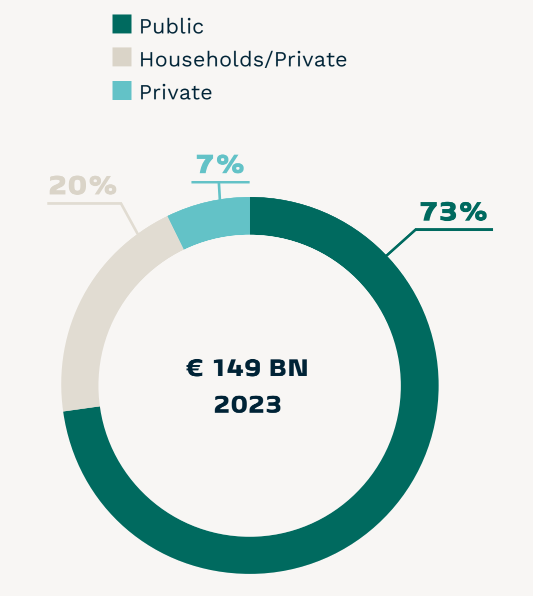
- The national healthcare system fully or partially covers basic services (prevention, diagnosis, treatment and rehabilitation, emergency and non-emergency medical transportation, medications and medical devices, dietary products).

### Financing mechanisms

| Public | Private | Households |
|---|---|---|
| The Spanish legal healthcare system is universal, almost entirely funded by taxes and contributions. The public sector provides most of the care through health centers (centros de salud) for primary care and public hospitals for specialized care. | Taking out private insurance is optional. These insurances help avoid public sector waiting lists and provide access to private establishments. | Patients must pay a moderate contribution for:<br>• Medications (a portion of the price based on income),<br>• Certain specialized medical procedures. |

### Breakdown of expenditures




# HEALTHCARE REAL ESTATE: A MULTIFACETED ECOSYSTEM.

Healthcare real estate is organised around four main types of infrastructure:

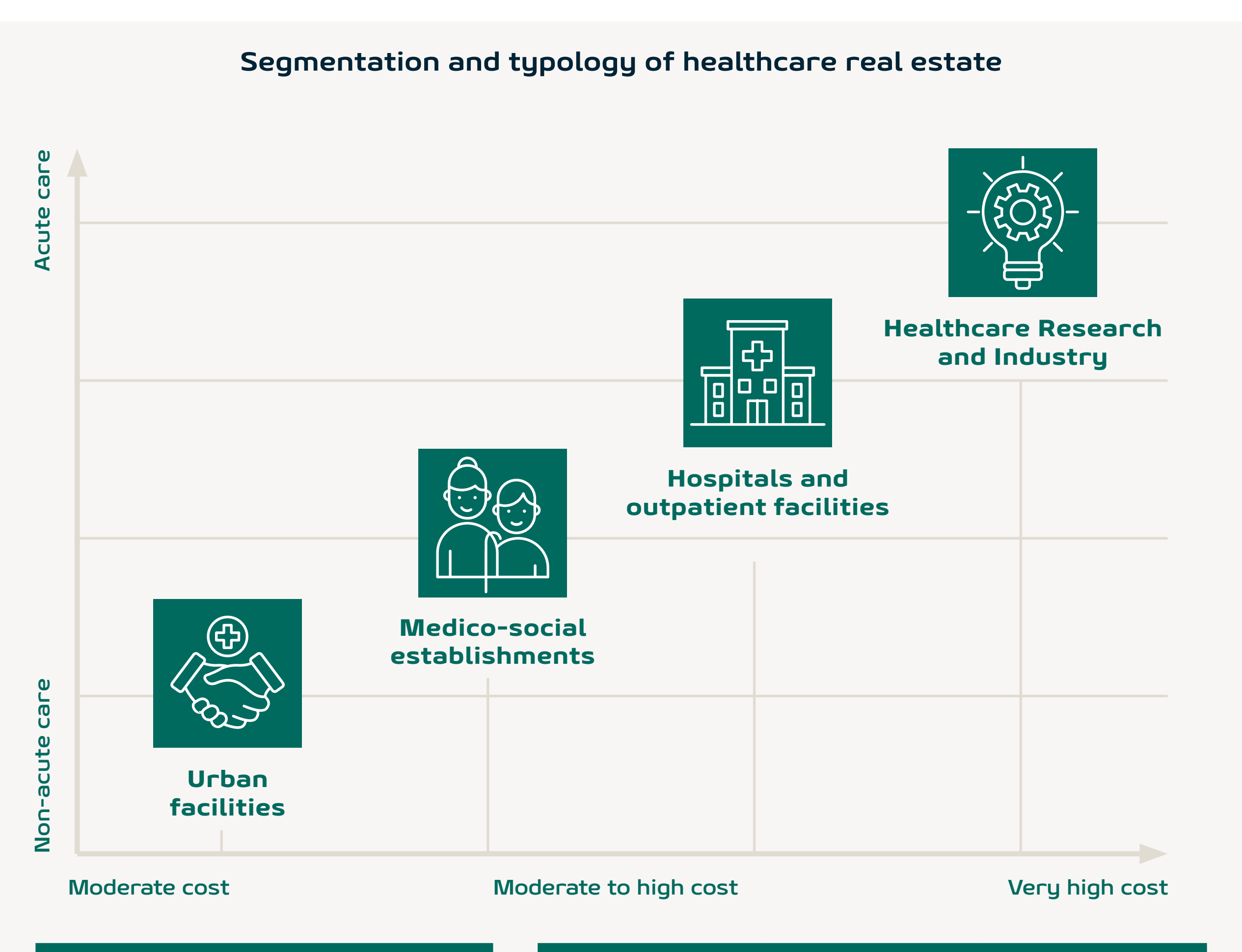
- **Urban facilities provide routine and preventive care outside hospitals,** including consultations, tests, radiology, dental care and pharmacies. They include **medical and paramedical practices, healthcare centres and laboratories.** Care is non-acute, and costs are moderate.
- **Medical and social care facilities** provide residential or outpatient care for people with disabilities, dependency issues or in precarious situations. They include **retirement homes, specialised facilities, and residential care centres.** Care ranges from non-acute to acute, with moderate to high costs.
- **Hospitals and outpatient facilities** provide care requiring hospitalisation, surgery or monitoring, **including hospitals, clinics, and rehabilitation centres.** Care can be acute or non-acute, with moderate to high costs.
- **Research and the healthcare industry** involve **university hospitals, pharmaceutical laboratories, and biotechnology,** with very high costs. The demographic transition will lead to a significant increase in chronic, neurodegenerative, and mental illnesses. This change will put increasing pressure on existing infrastructure.

At the same time, therapeutic advances, technological innovations (Artificial Intelligence, telemedicine, robotics) and prevention policies could bend certain incidence curves.

Apart from acute hospital care (surgery, obstetrics), three major categories of healthcare needs require specific real estate structuring:

- **rehabilitation and functional rehabilitation care** for patients with musculoskeletal, neurological, and cardiovascular conditions, or those undergoing post-cancer treatment. These facilities require specific equipment.
- **care for mental disorders,** including severe depression, bipolar disorder, psychosis, dementia, and neurodevelopmental disorders (including autism spectrum disorders). These conditions require real estate facilities with a strong human dimension, incorporating both secure spaces and therapeutic environments that promote reintegration and independence.
- **dependence linked to neurodegenerative diseases,** such as Alzheimer's or Parkinson's. The progressive development of these conditions requires adaptable, medicalised residential facilities with high standards of environmental quality, safety, and individualised support.

**Segmentation and typology of healthcare real estate**




| Healthcare Research and Industry |
| --- |
| Research centers and life science |
| • University hospitals and research centers.<br>• Pharmaceutical and biotech laboratories/life science. |

| Hospitals and outpatient facilities | | |
| --- | --- | --- |
| Hospitals, clinics, and rehabilitation centers | | |
| • Psychiatric facilities. | • Convalescent care facilities (post-surgery). | • Medical, surgical, and obstetric establishments (hospitals, clinics. |

| Urban facilities | |
| --- | --- |
| Prevention and well-being | Primary care |
| • Thermal and thalassotherapy centers.<br>• Rehabilitation and wellness centers. | • Medical and paramedical practices.<br>• Care centers.<br>• Radiology centers and medical laboratories. |

| Medico-social establishments | | |
| --- | --- | --- |
| Shelter centers | Institutes for people with disabilities | Retirement homes |
| • Shelters for people in precarious situations. | • Specialized facilities for children, adolescents, and adults with disabilities. | • Nursing homes.<br>• Retirement homes. |

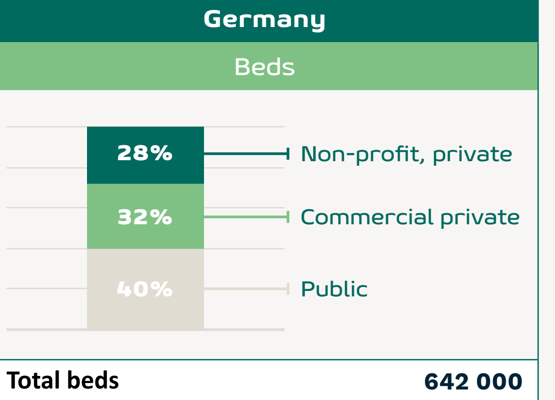
# THE HOSPITAL SECTOR FAVOURS SHORT STAYS, WHICH ARE CONSIDERED MORE PROFITABLE.

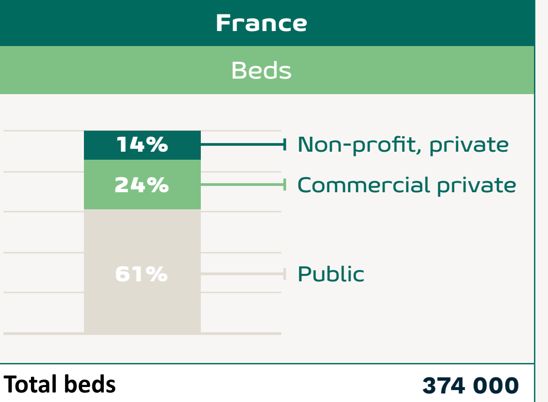
A large part of hospital care in Europe is controlled by the state, particularly long-term care, which accounts for between 40% and 70% of beds. **The main countries analysed in Europe** (Germany, France, Italy, and Spain) **have a total of 1.3 million beds. Private for-profit establishments account for between 30% and 60% of all beds.** These establishments provide *'MCO'* care, i.e. medical, surgical, and obstetric care, as well as *'SSR'* care (follow-up and rehabilitation care).

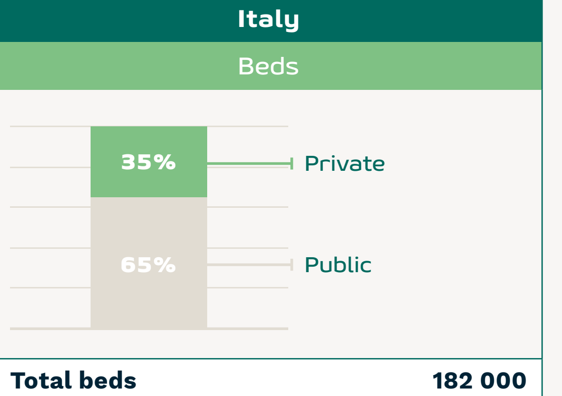
At European level, there has been a downward trend in the number of beds and hospitals over the last two decades. This trend is offset by an **increase in the average size of establishments** (mergers, consolidation) in a drive for efficiency. The public sector needs the private sector to develop because it cannot meet all the demand for medical care. On the other hand, budgetary pressure and the search for control over public spending also explain why the public sector needs the private sector to take over.

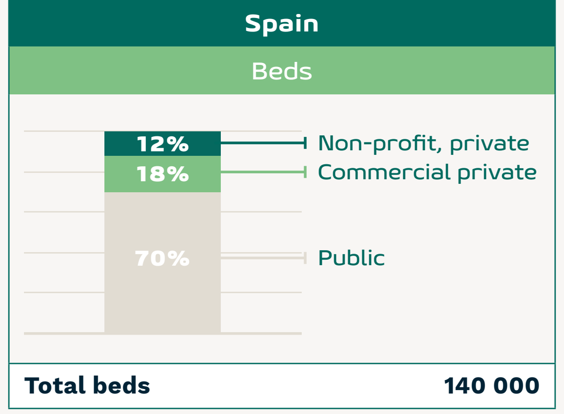
**Overall, the hospital sector is facing changes in its practices, leading to a reduction in the number of beds in favour of short-stay outpatient surgery and a 'rationalisation' of its coverage.**

**The hospital sector and clinics**



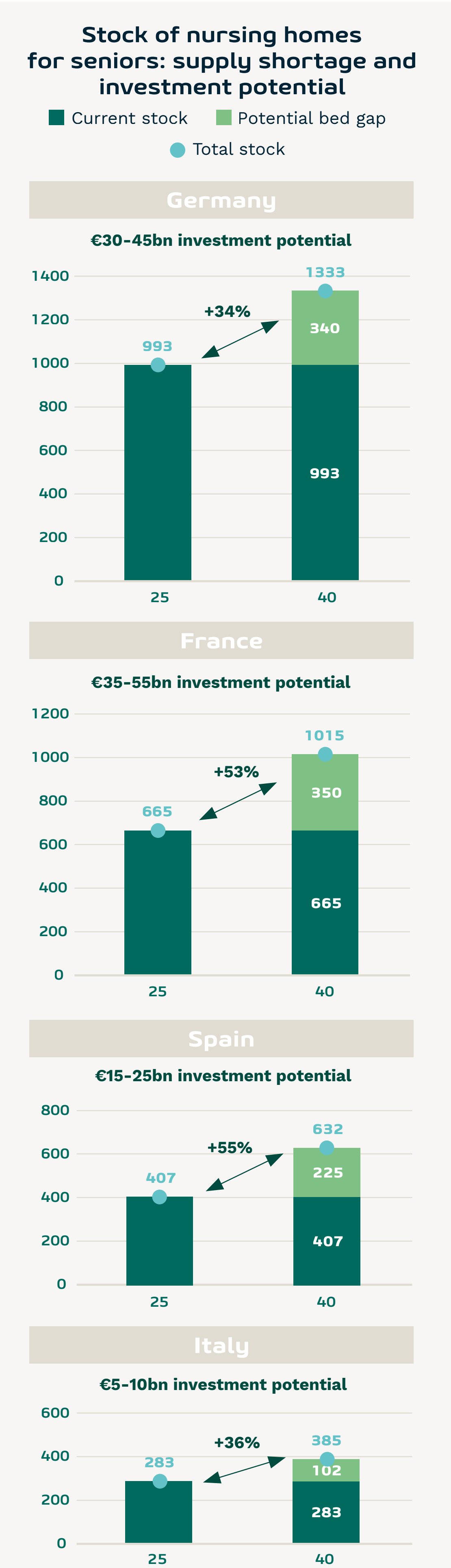



# EUROPEAN SOCIETY MUST INVEST IN AND ADAPT THE PROVISION OF NURSING HOMES FOR SENIORS IN LINE WITH THE DEMOGRAPHIC CHALLENGES OF AGEING.

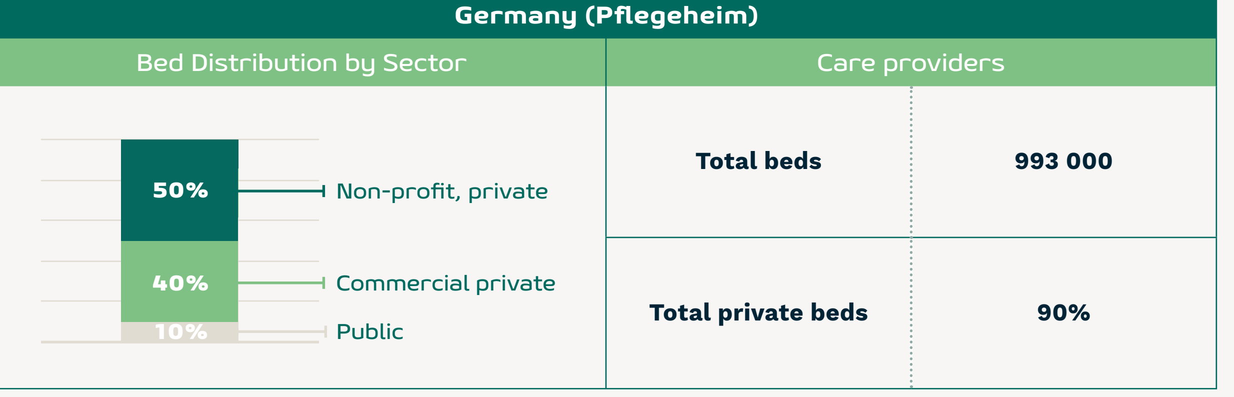
In terms of nursing homes, there is a strong predominance of **public** operators, which account for between **50% and 70%** of existing beds on average, depending on the markets analysed. The European Union currently has around **4 million beds in nursing homes for seniors.** However, the increase in the number of people aged over 75 has already had a clear impact on the supply deficit.

If we want to maintain the same level of coverage by 2040, we estimate that the number of beds in the European Union will need to be increased to **more than 4.6 million by 2040** in order to meet the needs of the coming years. This means **creating approximately 1.6 million new beds** to absorb demand, while construction remains sluggish since the COVID-19 crisis. The creation of the potentially missing beds represents a **potential investment,** all other things being equal, of **between €130 billion and €200 billion by 2040.** As budgetary constraints are tight for European countries, **the private sector** has been called upon to play an important role in the development of the sector. This role will intensify in the coming years.

**The European stock of nursing homes for the elderly is also facing a problem of obsolescence. Between 200,000 and 400,000 beds are in need of renovation.**




## Residential care homes for seniors: beds




**France (EHPAD)**

| Bed Distribution by Sector | | Care providers | |
|---|---|---|---|
| 25% | Non-profit, private | Total beds | 665 000 |
| 28% | Commercial private | | |
| 47% | Public | Total private beds | 53% |

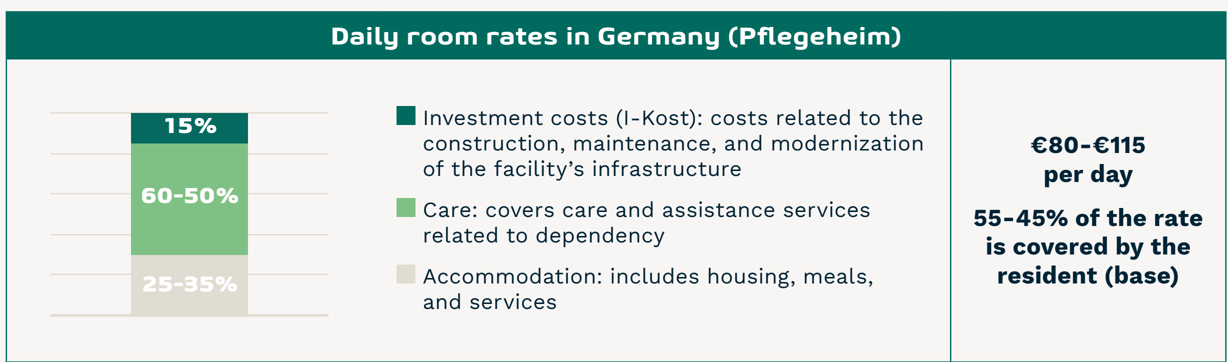
**Spain (Residencia de mayores)**

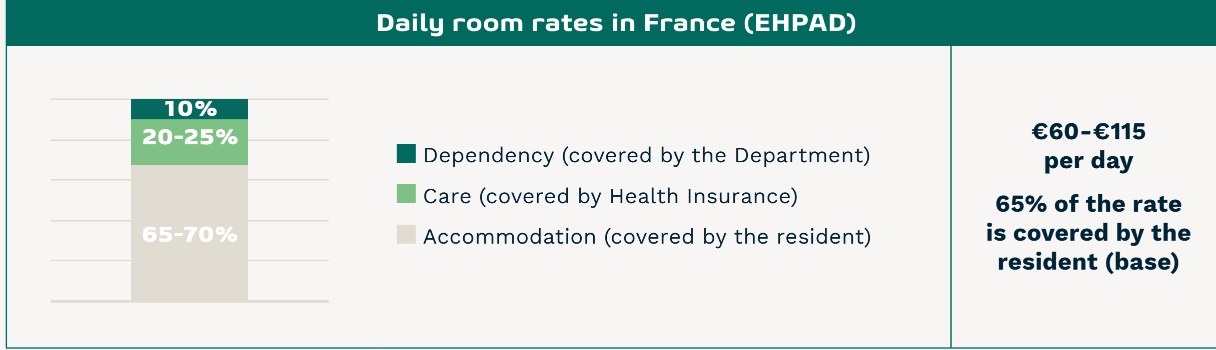
| Bed Distribution by Sector | | Care providers | |
|---|---|---|---|
| 40% | Non-profit, private | Total beds | 408 000 |
| 30% | Commercial private | | |
| 30% | Public | Total private beds | 70% |

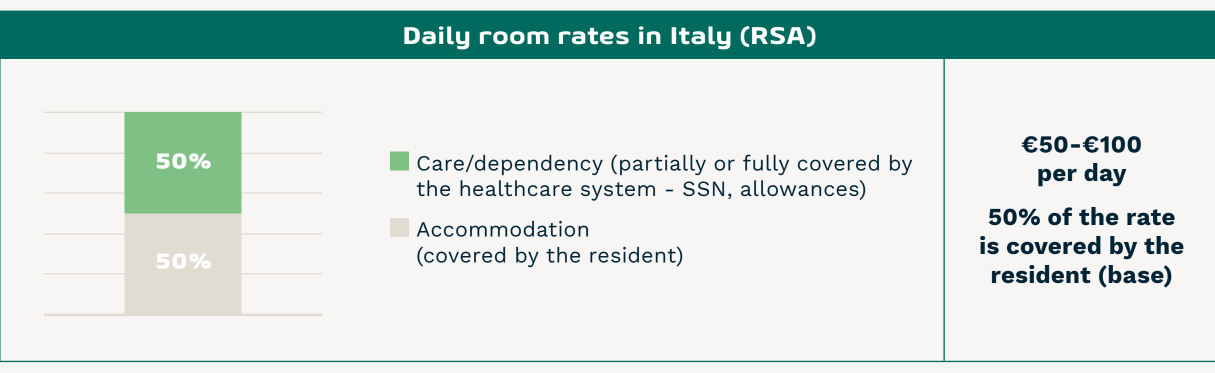
**Italy (RSA)**

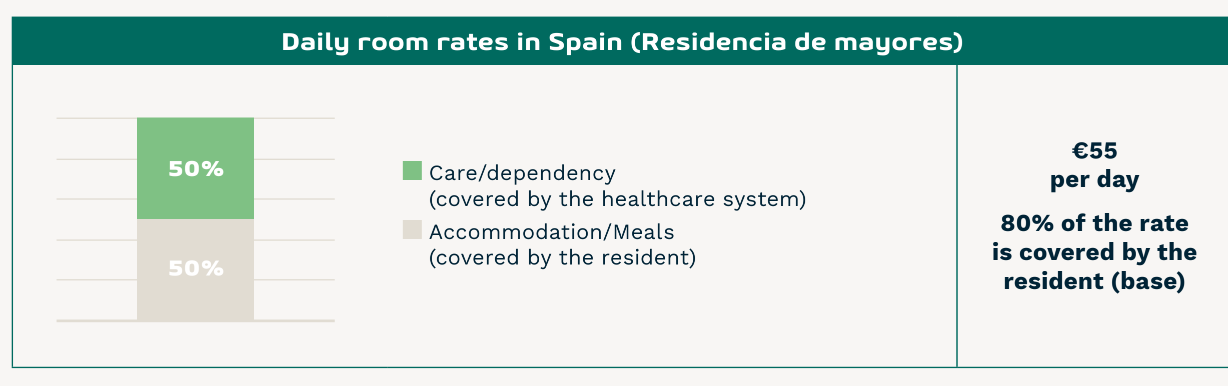
| Bed Distribution by Sector | | Care providers | |
|---|---|---|---|
| 35% | Non-profit, private | Total beds | 283 000 |
| 20% | Commercial private | | |
| 45% | Public | Total private beds | 55% |

**Residential care homes for seniors: breakdown of price per day per resident**




# THE EUROPEAN HEALTHCARE REAL ESTATE INVESTMENT MARKET.

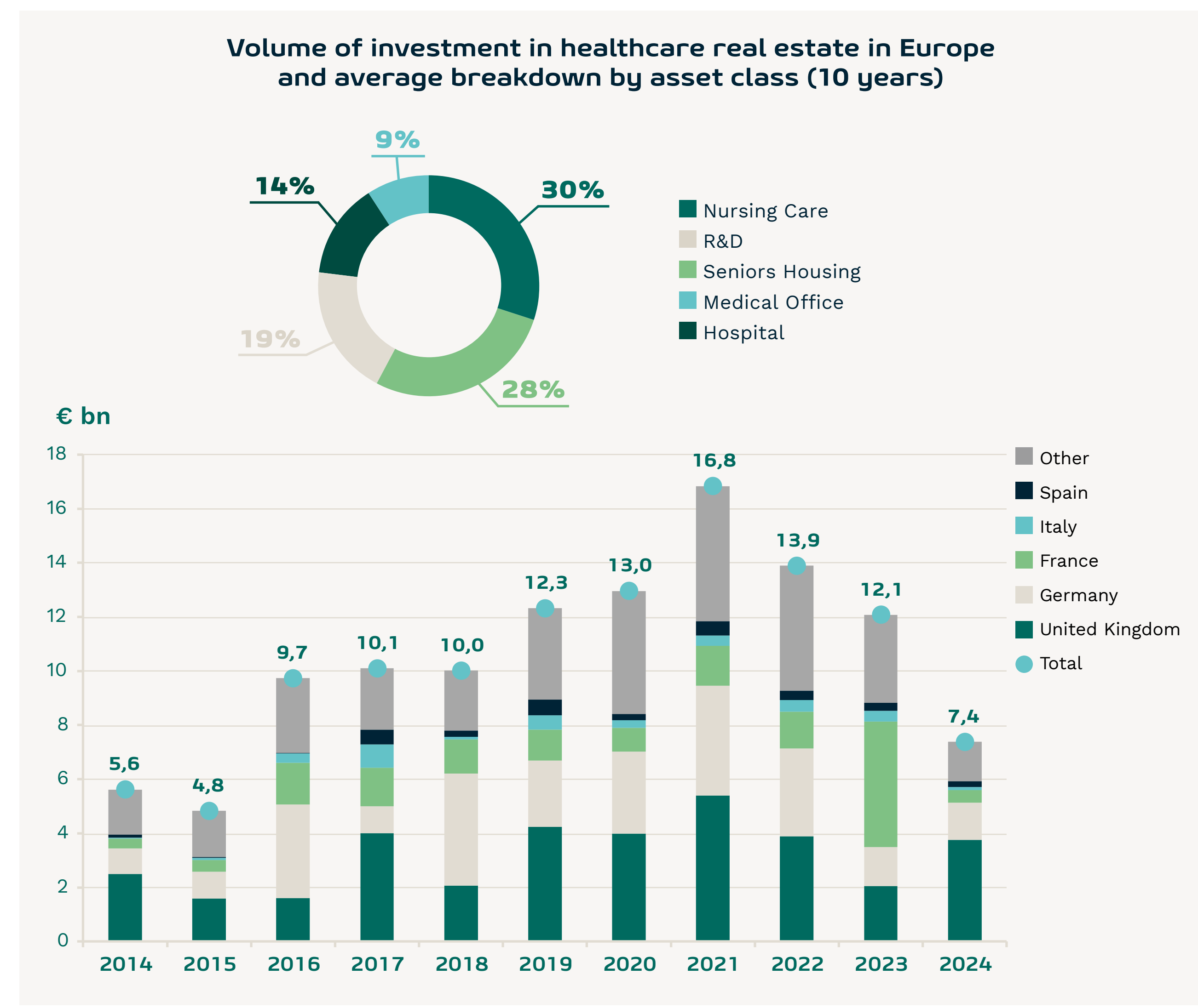
The amounts invested in **healthcare real estate in Europe has tripled** in volume in the space of 20 years, demonstrating investors' growing interest in this type of property. **Healthcare is one of the so-called 'alternative' asset classes** in Europe. It currently accounts for **less than 5% of annual real estate investment volumes.**

**Between 2014 and 2024, total capital invested amounted to more than €115 billion.** The market was characterised by a sharp increase in capital flows to all healthcare asset classes, namely: retirement and nursing homes; hospitals and clinics; healthcare centres; laboratories and R&D facilities.

Over the last decade, an average of more than €10 billion has been invested each year. **Between 2019 and 2023, between €12 billion and €17 billion will be invested annually.** Like all real estate asset classes, healthcare faced investor caution in 2024 due to the ECB's policy of lowering interest rates and expectations of a slowdown in valuations.

**The main European healthcare markets were the United Kingdom, Germany and France.** Between €1 billion and €3 billion is invested on average each year in each of these markets.

**By asset class, senior assisted living facilities, nursing homes, and hospitals/clinics dominate with nearly 70% of capital flows** over the 2014-2024 period. The remaining quarter is fairly evenly split between R&D (laboratories, life sciences) and medical practices.



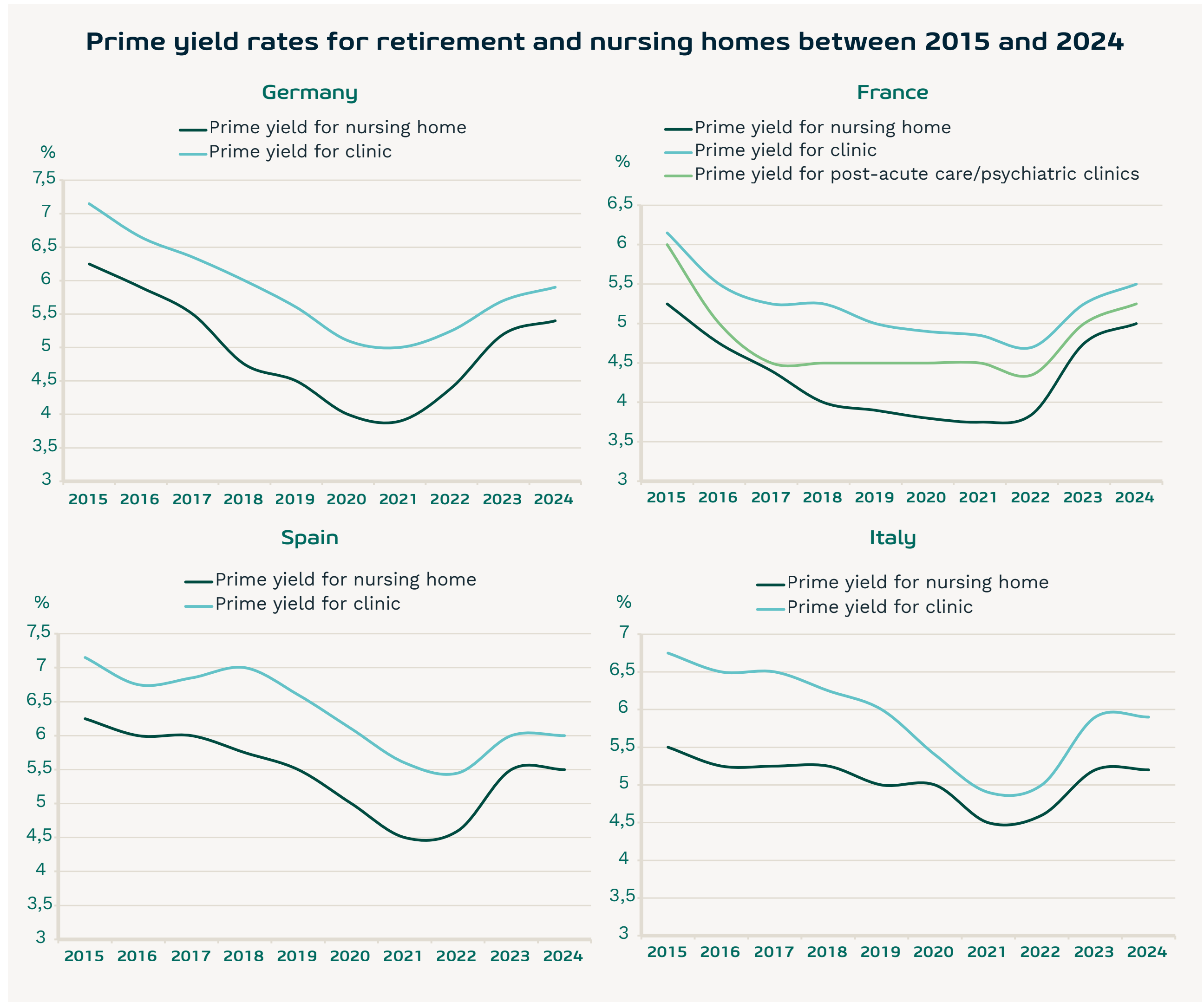
# HEALTHCARE REAL ESTATE YIELD RATES.

Yield rates have been steadily declining over the past decade, up to 2021, and have held up very well during the health crisis.

During the inflationary period between 2022 and 2024, healthcare real estate proved resilient, with prime rates that corrected by 10 to 150 basis points compared to prime office real estate, which saw corrections of between 150 and 250 basis points. Between the end of 2023 and the end of 2024, the vast majority of markets remained stable. Some markets, such as France, experienced some late decompression.

France, Germany, Italy, and Spain have **prime yields of between 4.5% and 6.0% for nursing homes.**

**The prime yield for clinics was between 5.0% and 6.0%** in France, Germany, the Netherlands, Italy, and the United Kingdom. Clinics offer a higher risk premium than nursing homes due to a less liquid and more fragmented market. Finally, the technical infrastructure gives these buildings limited reversibility compared to nursing homes. By way of comparison, the estimated premium rate for life science infrastructure in Europe is around 5%. This asset class also experienced a 100-basis-point increase from its lowest rate in 2021/2022.






# THE PERFORMANCE OF HEALTHCARE REAL ESTATE IN EUROPE: BETWEEN STABILITY AND RECURRING RETURNS

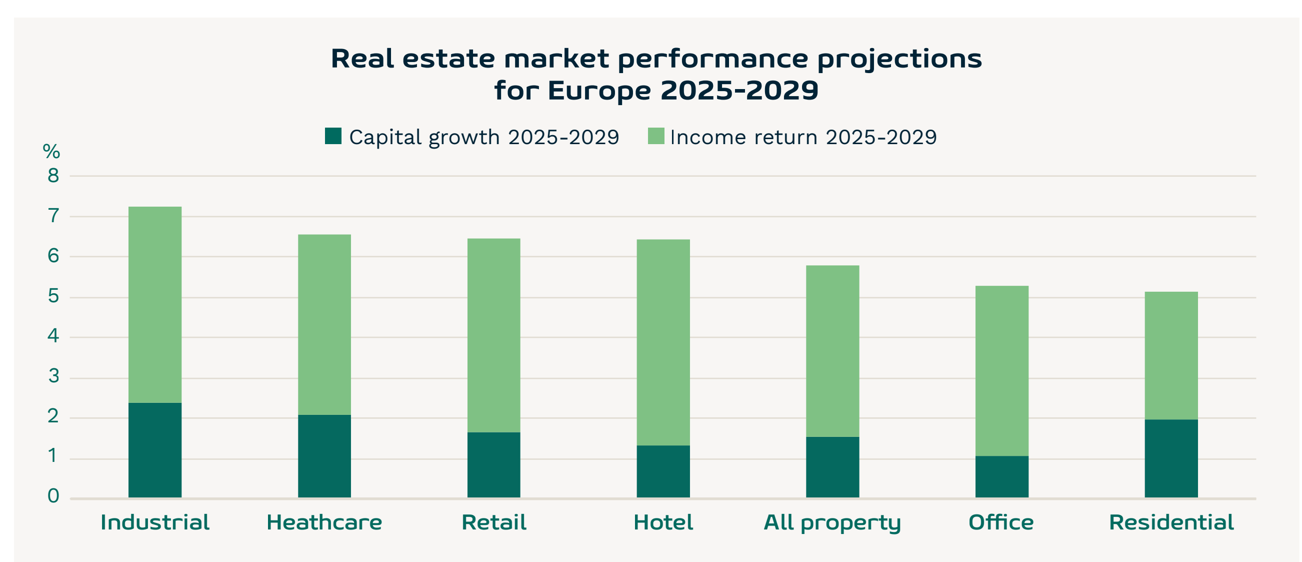
The total return of healthcare real estate in Europe is based on the MSCI index. It shows that **healthcare real estate has an average annual total return of around 7% between 2013 and 2024** (compared to an average of 5.6% for all asset classes).

There is a disparity in performance between asset classes, which means that sensitivity to crises is not the same. We have seen a decline in the overall performance of real estate during the Covid crisis, with healthcare real estate holding up better than other real estate asset classes. Similarly, during the inflationary period that led to the ECB raising its key interest rates, healthcare real estate posted an overall positive return (healthcare +4.0% vs. offices -1.0% in 2024).

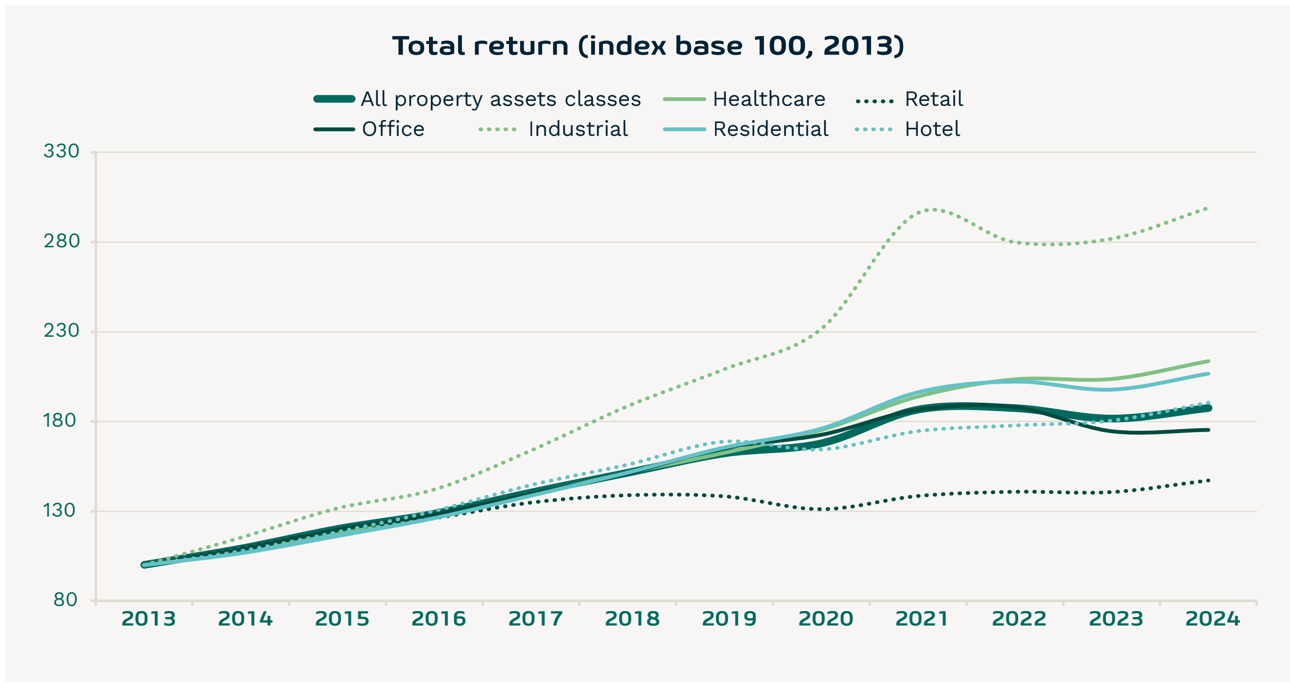
The breakdown of the total return for healthcare varies. **Capital growth tended to fluctuate between -5% and 5.5% depending on the cycle** (impacted during the period analysed by interest rate dynamics). Over a long holding period (2012-2024), **healthcare real estate confirmed its ability to deliver high performance** behind logistics real estate. **Income return remained within a range of 4% to 6.5% on average during the period analysed, thus forming a stable component of the overall return.** Healthcare real estate benefits from significantly longer fixed lease terms (12-20 years on average) than traditional commercial real estate.

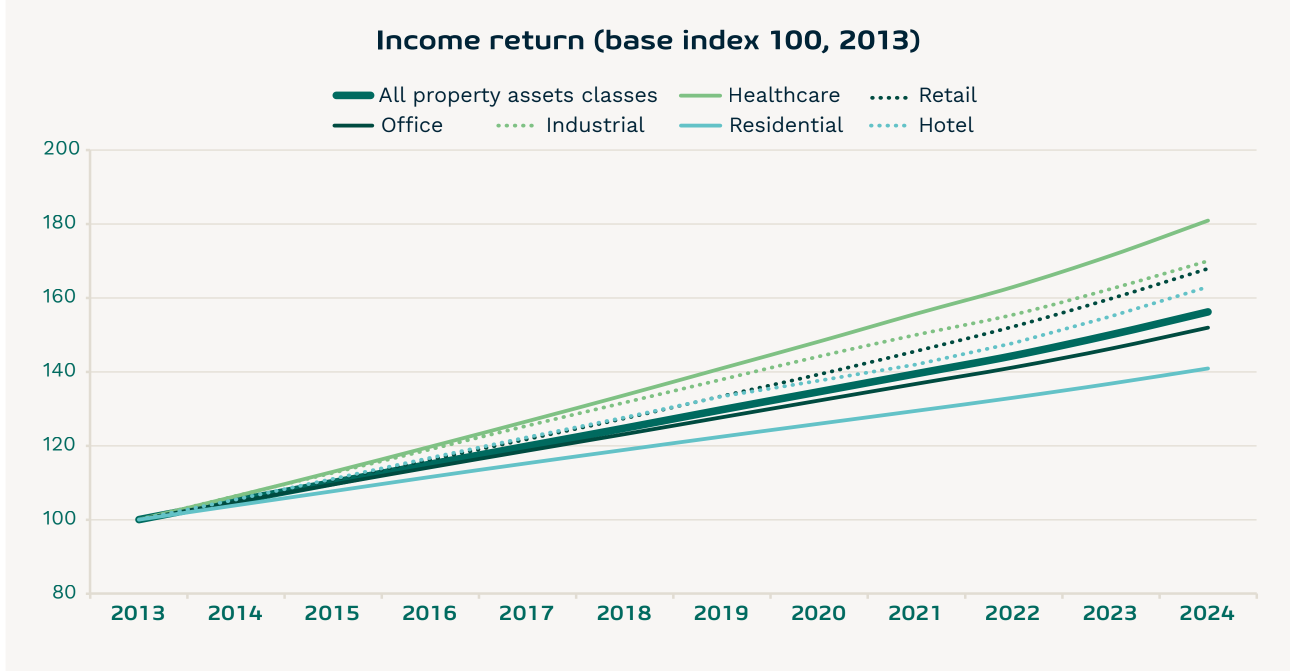
In the coming years, we believe that the total return on healthcare assets in Europe should be capable of delivering a robust level of performance. **This growth will be driven mainly by rising rents rather than a compression of yields,** as bond yields are not expected to return to their pre-pandemic levels for the time being. **Total returns will therefore be driven mainly by rental income.** Within the euro zone, **we favour France and Germany due to the depth and liquidity of these markets. We favour Spain and Italy for their potential and the development of these markets.**

**In terms of risk/return, healthcare is an attractive diversification asset to include in a portfolio.** This asset class offers optimal diversification to offset volatility risk and protect against excessive negative impacts on the portfolio from economic cycles.



# HEALTHCARE REAL ESTATE PERFORMANCE IN EUROPE.




### About Praemia REIM

**Praemia REIM** brings together **450 employees** in **France, Germany, Luxembourg, Italy, Spain,** the **United Kingdom** and **Singapore.** The company leverages its values of conviction and commitment as well as its European-scale expertise to design and manage real estate funds for its national and international clients, whether individuals or institutions.

Today **Praemia REIM** holds more than **36 billion euros** in assets under management.
Its conviction allocation is composed of:

- **50%** healthcare/education,
- **30%** offices;
- **8%** residential;
- **6%** retail;
- **5%** hospitality;
- **1%** logistics.

Its pan-European platform manages **97 funds** and comprises more than **96,000 investor customers,** including **58% institutional** and **42% individual.** Its real estate portfolio includes more than **1,600 buildings** spread across the main asset categories and located in **11 European countries.**

**www.praemiareim.com**

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**Sources used throughout the document:** Praemia REIM Research and Strategy, BNP PRE, BFS, C&W, CBRE, CBS, CSB, CSO, CZSO, Destatis, DZS, Eurostat, IMF, INE, INSEE, INE, INSSE, ISTAT, JLL, Knight Frank, KSH, MSCI, New Economics Foundation, NSI, OECD, ONS, WHO, Oxford Economics, Savills, SCB, SSB, Statbel, Stat Poland (GUS), Statistik Austria, Statistics, Statistics Finland, Statistics Lithuania, Statec, YCC.

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