MEDICAL CARE CENTRES

2019

Cushman & Wakefield
Healthcare Properties

CUSHMAN & WAKEFIELD

CONTENTS

FOREWORD

Ambulatory medical care is undergoing structural change:

- the large number of clinics closing in rural areas and, at the same time, a perceived lack of medical care
- a structural fund set up by the federal government to reduce overcapacity in inpatient medical care
- an ageing and thus more illness-prone society
- rising healthcare spending with no increase in efficiency
- continuous “ambulantisation” of medical care
- short to medium term demand for new buildings and further investments is necessary

In social, economic and political terms, the provision of medical healthcare is a major subject of contention in Germany these days.

“Outpatient before inpatient” is not only the approach pursued to increase efficiency in nursing care for the elderly, but is also increasingly the foundation of structural change in medical and therapeutic care in Germany. The amount of outpatient medical care continues to increase. Despite an enormous increase in health expenditure and the number of patients (both outpatients and inpatients), the average occupancy rate of hospital beds has fallen from just under 84.1% in 1991 to an average of 77.8%. Recently, the Federal Health Minister Jens Spahn declared that an “intelligent care network, from the district clinic close to the patient’s home to university medicine” is just as indispensable for holistic care as regional high-quality and needs-based medical care - both outpatient and inpatient. An annual federal budget of €500 million serves to foster projects in the federal states to improve structures in hospital care and thus also to close units contributing to inpatient overcapacity.

The growth market for outpatient medical care is gaining momentum. As a substitute and complement for inpatient medical care, medical care centres (MCC’s) are increasingly appearing, at least for a large number of clinical conditions. An MCC accommodates outpatient medical practices in various specialties as well as specialist medical retail and other related facilities with a medical or health-related focus. However, the sustainability of an outpatient care facility must be analysed both locally and regionally in detail with regard to the catchment area.

The potential for consolidation and professionalisation in the still highly-fragmented operator market and the growing interest of institutional and long-term (real estate) investors as well as outstanding socio-economic fundamental data make MCC’s one of the most interesting and sought-after asset classes at present, and not only in Germany. As MCC properties already constitute an established investment asset class in countries such as Australia, the United States or Great Britain, they are also expected to increase in importance in Germany.

We hope you find this report on medical care providers to be both informative and thought-provoking as we share some interesting insights from our examination of the German healthcare system and its implications for real estate.

01

GERMAN MEDICAL CARE

IN A EUROPEAN CONTEXT

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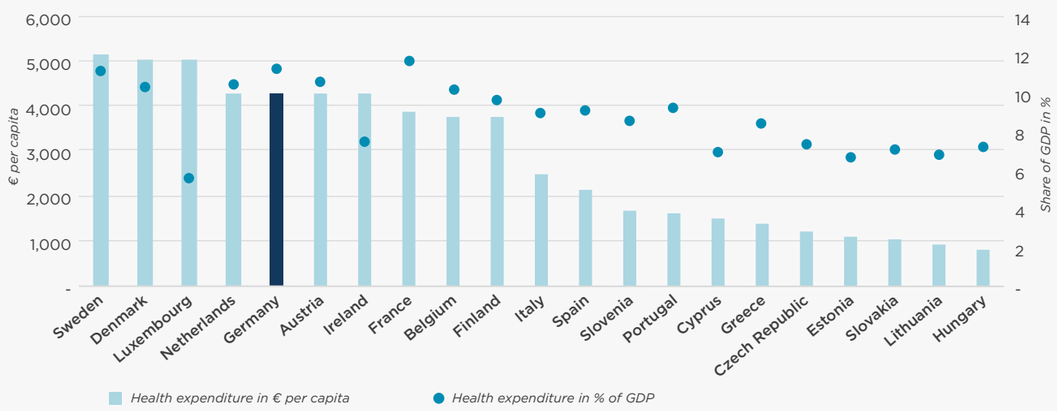
IN A EUROPEAN CONTEXT

With the introduction of a state health system in 1883, Germany took on a pioneering role worldwide and still today has one of the most comprehensive and innovative medical care systems.

Within Europe, Germany is the country with the second-highest per capita health expenditure in relation to gross domestic product after France. This is both due to the extensive range of services provided by the German health system and to the above-average GDP - which makes this expenditure possible. As a result, Germany has succeeded in establishing a first-class innovative healthcare system that guarantees not only excellent primary medical care but also preventative medicine, with a resulting increase in life expectancy. In recent years, for example, there has been a sharp decline in cardiovascular disease and the average life expectancy at birth was 80.7 years in 2015, slightly above the European average of 80.6 years.

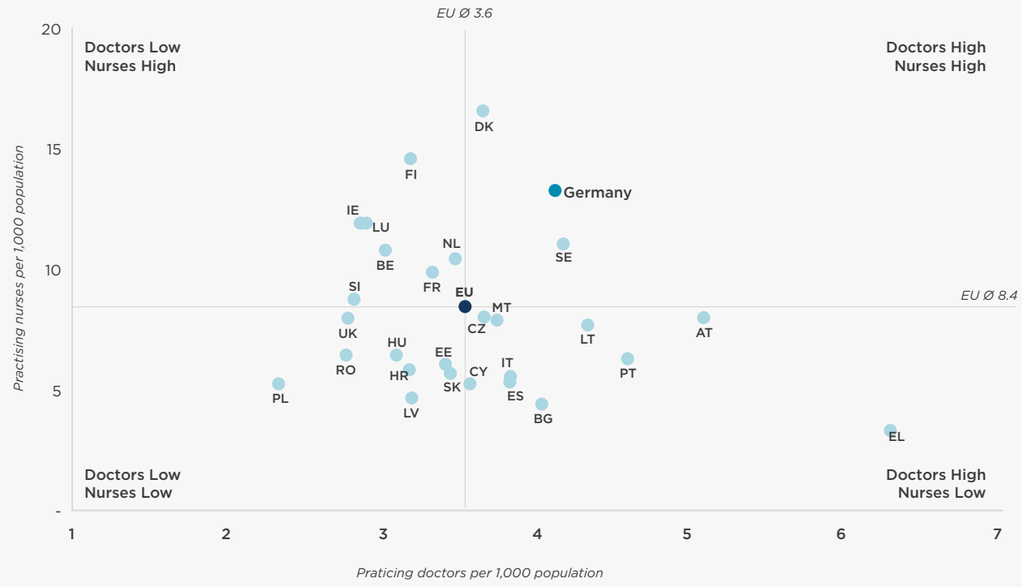
A great strength and, at the same time, a major cost factor of the German healthcare system is the large number of medical nursing staff and the extremely high hospital density in Germany. Within Europe, Germany is the leader in terms of practicing doctors and nursing staff per 1,000 inhabitants. In addition, with 813 beds per 100,000 inhabitants, Germany has a very high density of clinics and hospitals, 58% above the European average despite the number of beds having been reduced by 11% since 2000. Germany is also the leader in Europe in terms of the number of doctors and medical nursing staff as well as hospital density, however it does have the lowest ratio of doctors to beds.

HEALTH EXPENDITURE IN EUROPE (2016)



Source: Eurostat, Cushman & Wakefield, 2019

COMPARISON OF NUMBER OF DOCTORS TO MEDICAL NURSING STAFF



Source: Eurostat, Cushman & Wakefield, 2017

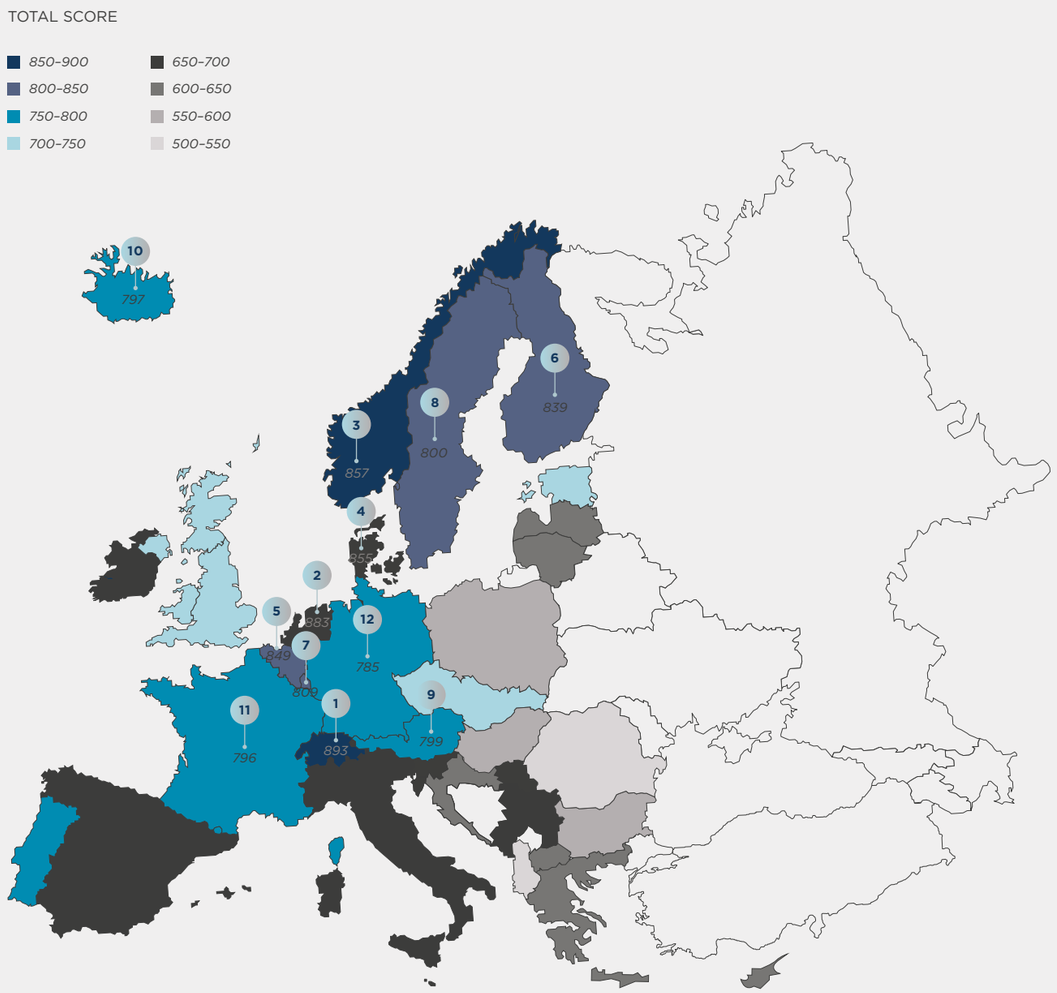
EUROPEAN HEALTH CONSUMER INDEX 2018

One of the most renowned published indicators comparing countries' health systems, the Euro Health Consumer Index (EHCI*) of Health Consumer Powerhouse, does not place Germany at the top of Europe's rankings despite it having the strongest quantitative medical care ratings.

COUNTRY	RANK	TOTAL SCORE	PATIENT RIGHTS AND INFORMATION	ACCESSIBILITY (WAITING TIMES FOR TREATMENT)	OUTCOMES SCORE	RANGE AND REACH OF SERVICES	PREVENTION	PHARMA-CEUTICALS
Switzerland	1	893	113	225	278	99	95	83
Netherlands	2	883	125	175	256	125	113	89
Norway	3	857	125	138	278	120	119	78
Denmark	4	855	121	175	267	120	95	78
Belgium	5	849	104	213	244	115	101	72
Finland	6	839	113	150	278	120	101	78
Luxembourg	7	809	100	188	244	109	95	72
Sweden	8	800	117	113	267	125	101	78
Austria	9	799	108	175	244	104	89	78
Iceland	10	797	121	188	222	104	107	56
Frankreich	11	796	104	188	233	104	83	83
Germany	**12**	**785**	**104**	**163**	**244**	**83**	**101**	**89**

Source: Björnberg, Phang, Cushman & Wakefield, 2018

** The EHCI considers six different criteria against which the health system is assessed. The following criteria are weighted by the different high maximum points patient rights & information (max. 125), waiting time for treatments (225), outcomes (300), range and reach of service (125), prevention (125) and pharmaceuticals (100).*



Germany comes only twelfth in the ranking. When it comes to the provision, assumption of costs and currency of medicine, though, Germany is in equal first place with the Netherlands. Switzerland ranks number one in Europe on the Health Consumer Index. It has earned itself an excellent reputation in the healthcare sector, particularly due to its availability and waiting time for treatment. In terms of the accessibility of service and preventative medicine, few other countries come close to the Scandinavian countries (Denmark, Finland, Norway, Sweden). In terms of patient rights and information transparency, Germany ranks second-last in the top-ten, ahead of Luxembourg. The Netherlands and Norway share first place in this regard.

02

GENERAL MARKET ENVIRONMENT

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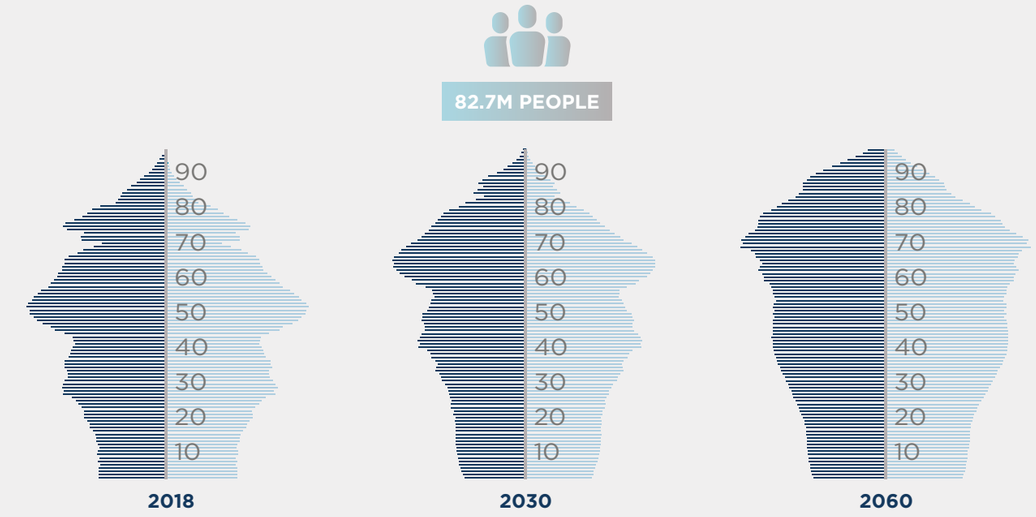
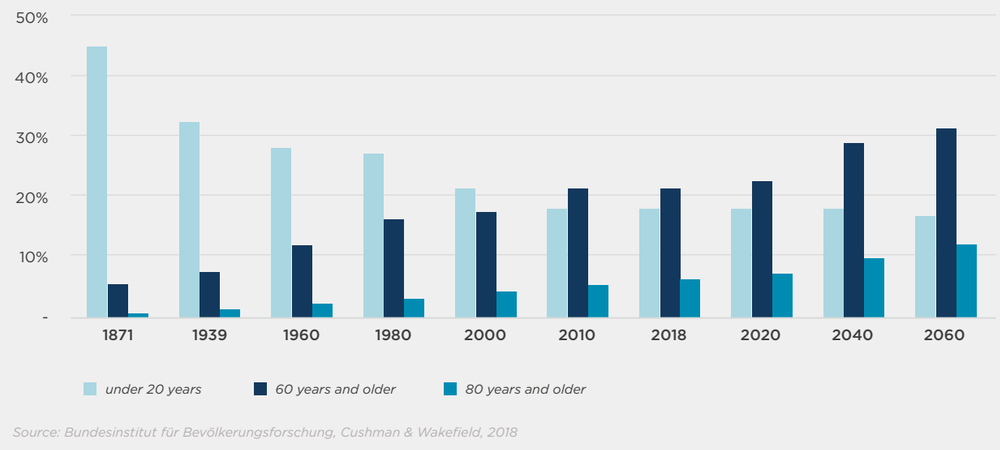


Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2018

Germany has been undergoing demographic and medical-therapeutic provision changes for many years. The aging population requires ever more care and medical treatment accompanied by immense advances in inpatient and outpatient medical care. Outpatient care in this context is defined as treatment by a doctor in a practice (including employed doctors) or in the outpatient department of a hospital. In contrast, inpatient treatment is defined as treatment for which the patient is admitted to a clinic for at least one night.

The life expectancy of the German population has increased significantly. According to the 2015/2017 mortality table of the Federal Statistical Office, life expectancy at birth is 83.2 years for girls and 78.4 years for boys. By 2060, the federal authority predicts that this will continue to rise to 88.8 years and 84.8 years respectively. In addition, the growing size of the 60-plus generation as a proportion of the total population represents a major challenge for the German healthcare system. Today, every fourth German citizen is Generation 60-plus. This corresponds to about 20 million people. Nursing care for the elderly and medical care are becoming ever more important due to the increasing incidence of multimorbidity - suffering from several chronic illnesses with a lasting effect on the state of health and requiring continuous treatment – in old age, and are facing inevitable structural change.

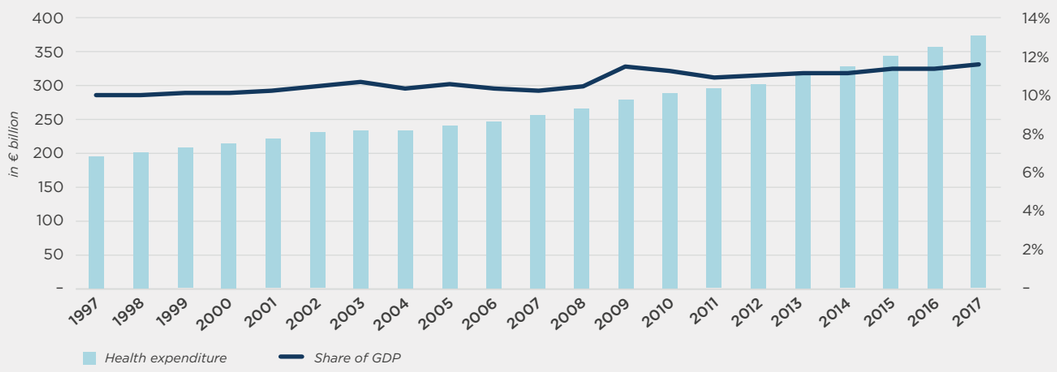
AGE GROUP PROPORTIONS 1871 TO 2060



Source: Bundesinstitut für Bevölkerungsforschung, Cushman & Wakefield, 2018

In 2017, German health expenditure exceeded the threshold of €1 billion per day for the first time. That year, more than €375 billion was spent on healthcare, corresponding to 11.5% of GDP. In 2017, employees and employers financed almost half of all healthcare expenditure via social security contributions. The future divergence between the number of contributors and per capita expenditure will result in an adjustment of the cost-unit landscape becoming necessary and a maximisation of the efficiency of medical care. The current pay-as-you-go system of statutory health insurance funds faces the problem of a considerable increase in the costs for future contributors to finance health services. This problem is magnified when taking into account that every citizen in Germany is obligated to take out health insurance. In the statutory (non-private) sector, insured individuals currently pay 14.6% of their gross income into a health fund, whereby this contribution is shared equally with their employer. The health fund distributes these funds, including state subsidies, in accordance with specific criteria to the statutory health insurance funds, which are then responsible for paying for patients' treatment. In the private health insurance sector, in contrast, contributions are not calculated on the basis of gross income, but in accordance with the scope of benefits and state of health of the contributor. Unlike statutory health insurance, privately insured persons have to pay for treatment in advance, but are subsequently reimbursed for these costs. However with private health insurance funds, statutory health insurance funds are not required to form reserves, which will make it more difficult to reconcile the divergence between contributors and expenditure per capita in the coming years.

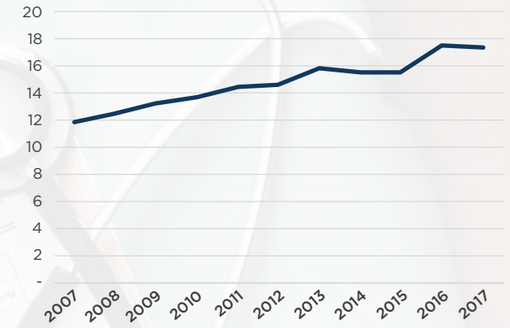
HEALTH EXPENDITURE AND SHARE OF GDP



Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2019

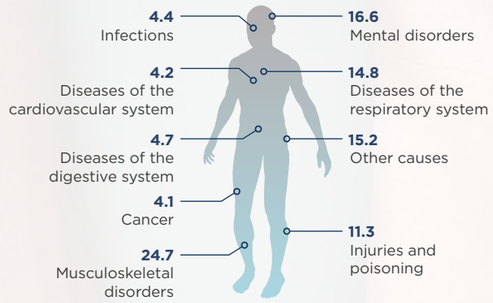
However, not only the increasing ageing of the population, but also the increase in multimorbidity and the average number of sick days are driving up the costs of the German healthcare system. In the last 10 years, the average number of sick days per statutorily insured member of employees' health insurance funds (including recipients of unemployment benefits, excluding pensioners) has risen by 30.8% from 11.9 to 17.2 days per year. The majority of cases of illness do not last longer than one working week, though, and 80% of employees are back at work after two weeks at the latest according to the umbrella association of health insurance funds.

AVERAGE NUMBER OF SICK DAYS



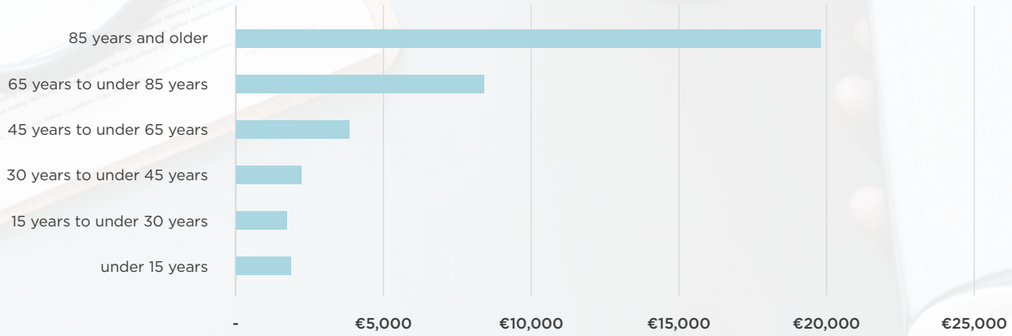
Source: BKK Dachverband, Cushman & Wakefield, 2019

PERCENTAGE OF SICK DAYS ACCOUNTED FOR BY ...



Due to the increasing age of the population, the percentage of sick days due to musculoskeletal disorders has increased immensely, accounting for just under 25% of sick days in 2017. In addition, mental disorders (16.6%) and diseases of the respiratory system (14.8%) are increasingly prevalent causes of employee absence, together accounting for 31% of the total cost of illness in Germany. Symptoms of multimorbidity are becoming increasingly common in old age. It is also apparent that not only do the incidence of absences is increased, but also the average recovery time becomes more prolonged as people get older. For example, the average time-loss for employees over 55 is twice as much as the 35-39 age group. The continued demographic shift is likely to further increase the number of long-term absences from work caused by lillness. Employers must therefore deal with increased costs due to employee absences.

SICKNESS COSTS BY AGE 2018



Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2019

03
THE GERMAN HEALTHCARE SYSTEM

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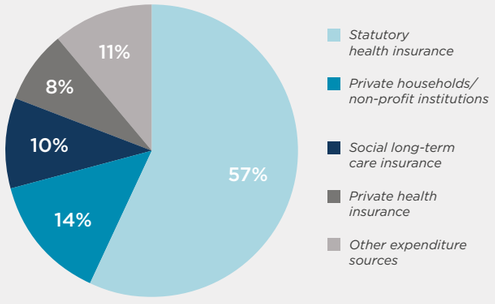
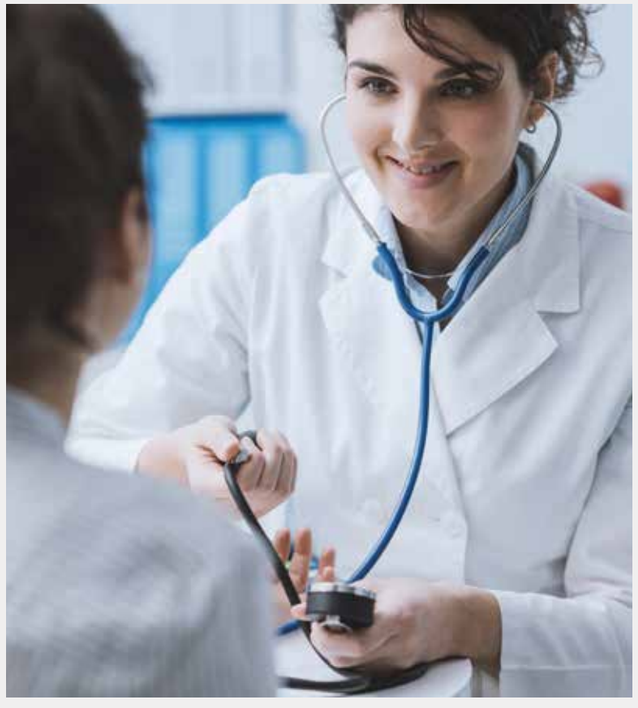
Under the laws of SGB V, every citizen in Germany is obliged to statutorily insure themselves unless their gross income exceeds a specific limit. If this limit is exceeded or if an individual is self-employed, they can take out private health insurance. The health system is paid by the contributions to the previously mentioned health fund. There are currently 109 statutory health insurers and 45 private health insurers in Germany. Around 90% of the population is insured by the 109 statutory health insurance funds, and the remaining 10% is privately insured. For statutory health insurers, financing is provided by the statutory health fund, which receives all contributions from citizens as well as state subsidies from tax revenues. If the costs of a health insurer are not fully covered by this fund, they are permitted to collect additional contributions. In 2017, €214 billion was expended from the statutory health insurance funds and €31.6 billion from the private health insurance funds, accounting for 57% and 8% respectively of total health expenditure. A historical examination of the development of health spending shows that the cost distribution has always been at a similar level.

HEALTHCARE EXPENDITURE 2017 BY EXPENDITURE SOURCE IN %

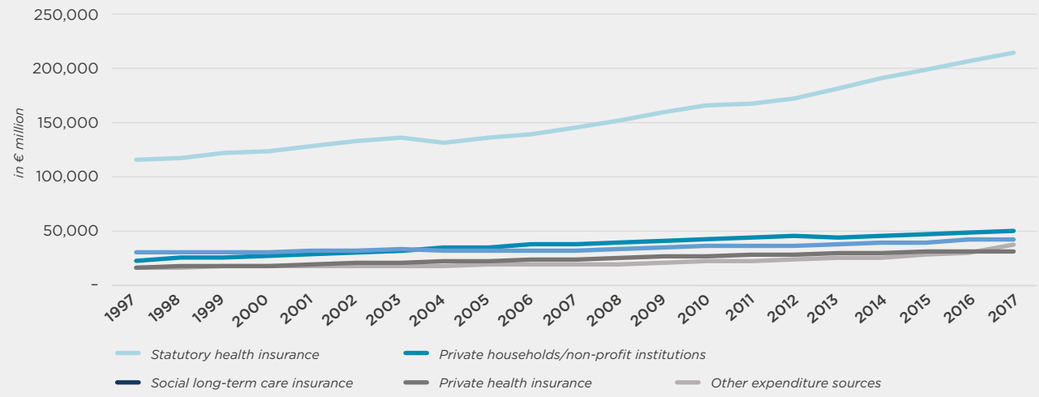


Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2019

Expenditure by social long-term care insurance has increased the most in the last 10 years, followed by expenditure by statutory health insurance funds. The general increase in health expenditure is expected to continue in the future, with the statutory health insurance funds and social long-term care insurers accounting for a large proportion of the rise.



DEVELOPMENT OF HEALTHCARE EXPENDITURE BY COST UNIT



Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2019

The statutory health insurance funds are responsible for paying doctors and hospitals for the treatment of patients. In the case of hospitals, this comprises the so-called running costs and in the case of doctors this is the treatment. For those with private health insurance, the insured person is billed directly and the costs are reimbursed by the insurer. In addition, hospitals receive funds to finance investments (e.g. new buildings, maintenance and repair of existing properties and the acquisition of new equipment) from the federal states, who are in turn financed by taxpayers. Due to the separation of operating and investment costs, the term dual financing is also used when talking about hospitals.

However, the ageing of society and increasing multimorbidity do not automatically mean that clinics are particularly profitable. According to the German Hospital Society (DKG), around one-third of hospitals incurred losses in 2017 and there is no improvement in sight as these losses are often attributable to rising costs in the healthcare system. The rising costs per capita with increasing age are attributed both to demographic change and to technical progress. The cost of illness per capita for people over 85 years of age is 10 times higher than that of people under 15 years of age. Although technological advances in medicine are increasing the effectiveness of treatments, the cost of purchasing modern medical equipment is quite high. The advantage of these devices is often that examinations and procedures, which previously required inpatient treatment can now be treated on an outpatient basis.

A large number of German hospitals are running at a loss! And according to a study published by the Bertelsmann Foundation in 2019, more than half of all German hospitals should be closed to ensure better patient care. At present, many hospitals lack adequate equipment and experienced medical staff to treat life-threatening emergencies such as severe strokes and heart attacks as well as to prevent deaths. By closing loss-making hospitals, merging hospitals in rural areas and expanding medical care centres, medical staff and expensive equipment can be bundled to provide better treatment. To ensure medical care in rural areas, 120 hospitals will receive financial support of €400,000 each from the health insurance funds in 2020. MCC's can certainly be an efficient component of a nationally functioning care network, but without doubt not exclusively and only in combination with inpatient medical care.

04
OUTPATIENT MEDICAL CARE

OUTPATIENT MEDICAL CARE

Generally, a formal distinction is made between outpatient and inpatient medical care. In this report, outpatient care within medical care centres (MCC's) is described in more detail. At the end of 2018, the German Medical Association counted 157,300 doctors providing outpatient treatment. Of these, 117,500 are practice partners and 39,800 are salaried doctors. In addition, there are 250,000 medical specialist employees who provide around 553 million treatments and also contribute to the over 80% of patients who receive an appointment within one month. Not only the demographic shift but also the politically-willed move from inpatient to outpatient treatment is feeding growth in the outpatient sector with corresponding additional personnel requirements in the coming years. In the wake of rising health expenditure, it is in the interests of both health insurance contributors and the state that outpatient care should be preferred to inpatient care. On average, inpatient treatment costs €4,239 per year per patient, almost ten times as much as the €475 per year per patient for outpatient treatment.

KEY PERFORMANCE INDICATORS OF THE AMBULATORY CARE IN GERMANY

102,000
MEDICAL OFFICES
throughout Germany

1 BILLION
CONSULTATIONS
per year

553 MILLION
treatments per year

83%
of patients in Germany get an appointment with a specialist within **1 MONTH**

The outpatient care in a medical practice costs
€475
PER YEAR
per patient

Inpatient hospital care on the other hand costs
€4,239
PER YEAR
per patient

165,000
general practitioners, specialists and psychotherapists

70%
of outpatient emergency patients are treated by general practitioners

250,000
Medical Assistants

12
YEARS
of training are usually completed by doctors and psychotherapists

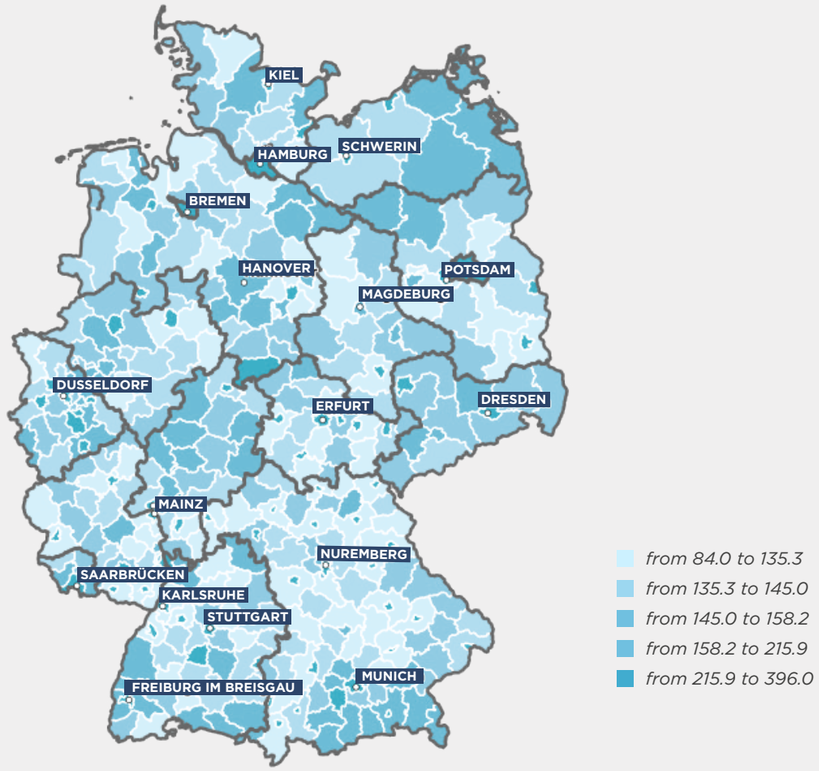
35.7
HOURS
of training per year are usually completed by doctors and psychotherapists

93%
of patients consider their doctor to be competent and have a good to very good relationship with their doctor

.Source: KBV, GKV-Spitzenverband, Destatis, Cushman & Wakefield, 2017

DOCTORS DENSITY (DOCTORS PER 100,000 PEOPLE)

ALL DOCTORS/PSYCHOTHERAPISTS, DISTRICTS 2018



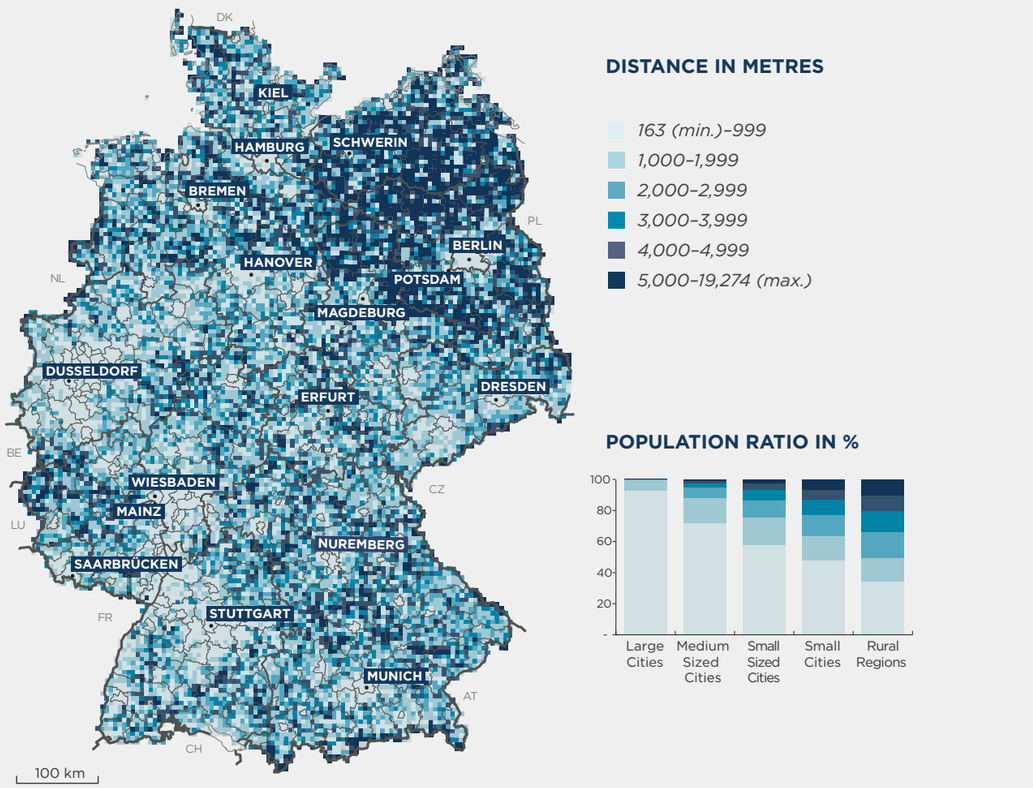
Source: Statistische Informationen aus dem Bundesarztregister, KBV, Cushman & Wakefield, 2018

Despite the fact that the number of medical practitioners increased by 1.5% last year, there are still clear regional differences in the supply of doctors in Germany. Rural regions in particular are struggling with a lower density and long travel times. Particularly problematic is the care provided by general practitioners, who are often the first point of contact in the case of acute illness. And a long journey to the nearest family doctor is associated with major discomfort for the acutely ill patient. In addition, family doctors have the highest average age compared to other practicing doctors - more than a third of all family doctors are over 60. Influenced by this demographic change, there will be further shortfalls in medical care in rural regions in the coming years as ever fewer young doctors are willing to practice there.

The highest medical practitioner densities are in the major cities and their conurbations, while the lowest are found in structurally weak rural regions. Freiburg im Breisgau, with 395.3 doctors per 100,000 inhabitants, has the highest physician density in Germany and Corburg in Bavaria the lowest with 84.3 doctors per 100,000 inhabitants. The city state of Bremen with 296.2 physicians per 100,000 inhabitants has the highest physician density in comparison with the federal states; Brandenburg with 185.8 physicians per 100,000 inhabitants is at the bottom of the league.

DISTANCE TO THE NEAREST GENERAL PRACTITIONER

IN METRES, 2018



Source: Bundesinstitut für Bau-, Stadt- und Raumforschung, Cushman & Wakefield, 2017

With the aim of reducing expensive hospital treatment, the German Social Code legislation states that „outpatient before inpatient“ applies in Germany. Patients are only entitled to full inpatient treatment if the treatment goal cannot be achieved through outpatient care. However, this presupposes that the quality of outpatient care matches that of full inpatient care and is attainable for every insured person. Although Germany has good hospital infrastructure throughout the country, there is a lack of outpatient care centres - especially in rural regions. Experts have identified around 40 illnesses that do not require inpatient treatment with appropriate outpatient care.

Influenced by the high costs of the inpatient sector and demographic change, Germany‘s medical care landscape will inevitably undergo a structural change in the coming years. In order to increase the efficiency of outpatient care, medical care centres will be the central building block of medical structural change and will become a major widespread component of the medical infrastructure. According to experts, the increase in outpatient care will lead to the closure of loss-making hospitals without a specific care mandate and the bundling of equipment and personnel in medical care centres.

05

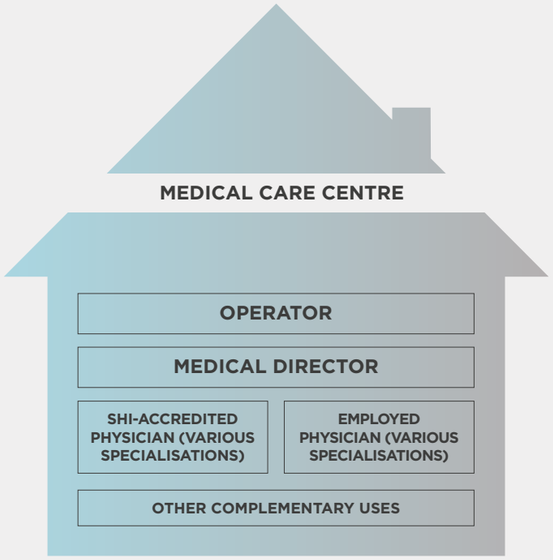
DOCTORS' PRACTICES AND MEDICAL CARE CENTRES

DOCTORS' PRACTICES AND MEDICAL CARE CENTRES

In Germany, a distinction is drawn between SHI-accredited physicians and employed physicians. SHI-accredited physicians require approval and organisation by the Association of Statutory Health Insurance Physicians. There are 17 such associations in Germany, one per federal state with the exception of North Rhine-Westphalia which has two. SHI-accredited physicians organise themselves in accordance with the SGB V legislation and thus in accordance with the planning of the health insurance association, which is based on municipal planning of requirements. The entry in the physicians' register, which is by the association, is just as much a prerequisite as the existence of a vacant doctor's position in a practice. According to the German Medical Association (Ärzte-ZV), the SHI-accredited doctor's registered office is the place of approval (practice address) and is also the place of business. Only licensed SHI-accredited physicians may employ other physicians in their facilities, provided that this corresponds to the planning requirements of the respective health insurance association. In addition to operating a medical care centre, SHI-accredited physicians also have the option of operating a sole practice or a joint practice.

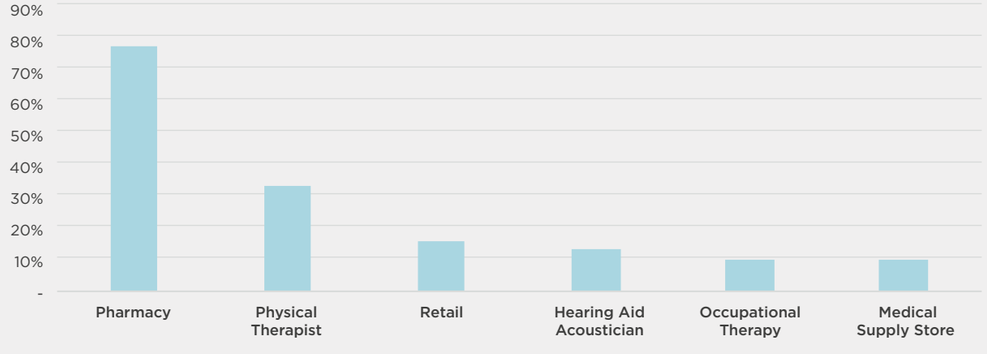
MCC's have been an essential part of outpatient SHI-accredited medical care in Germany since the regulations of Gesetz zur Modernisierung der gesetzlichen Krankenversicherung (GMG - Act to Modernise Statutory Health Insurance) came into force on January 1, 2004. Subsequent reforms within the framework of the SHI Care Structure Act 2012 and 2015 have further strengthened outpatient medical care and the synergies between medical and psychotherapeutic disciplines. An MCC makes it possible to provide medical care for various clinical symptom pictures from a single source and at a single location. It is a physician-led facility in which independently contracted physicians and, potentially, employed physicians work. The legal forms that MCC's can take are a partnership, a registered cooperative, a limited liability company (GmbH) and a public legal form.

Medical care in an MCC is provided by the SHI-accredited physicians or the employed physicians of the company operating it. In principle, an MCC is an operator property. In contrast to the classic, not clearly defined medical centre, a MCC is usually a property that is leased to a general tenant. An example of the structuring of an MCC is seen in the following illustration.



The management in an MCC is carried out by a medical director, who is also medically active themselves. Many MCC's have an interdisciplinary approach, which enables them to cover a wide range of disciplines for mutual synergies. Commercial benefits are achieved via the joint use of rooms, equipment and personnel. Further synergy opportunities that are increasingly common are other complementary uses, mainly comprising of pharmacies, physiotherapists and retail spaces. Experience has shown that MCC's require an area of 2,000 to 15,000 sq m, accommodating an average of 6-7 doctors plus the additional specialist retailers.

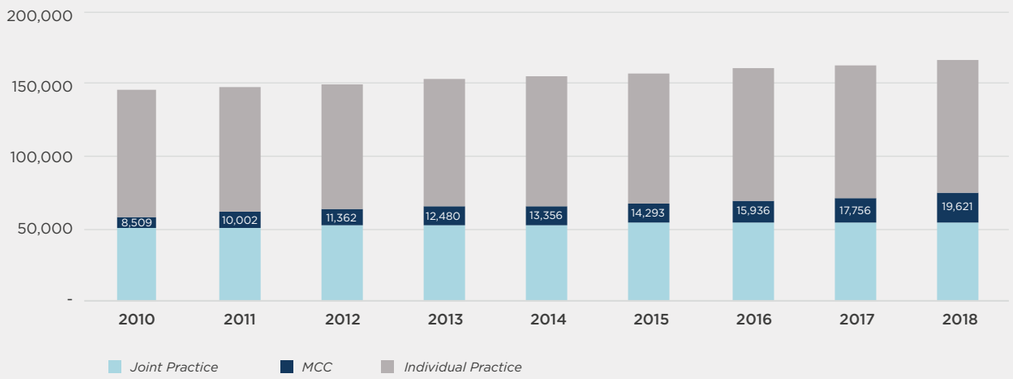
COMPLEMENTARY USES IN MCC'S



Source: PWC, Cushman & Wakefield, 2019

DEVELOPMENT NUMBER OF PHYSICIANS

IN JOINT PRACTICE, MCC, INDIVIDUAL PRACTICE

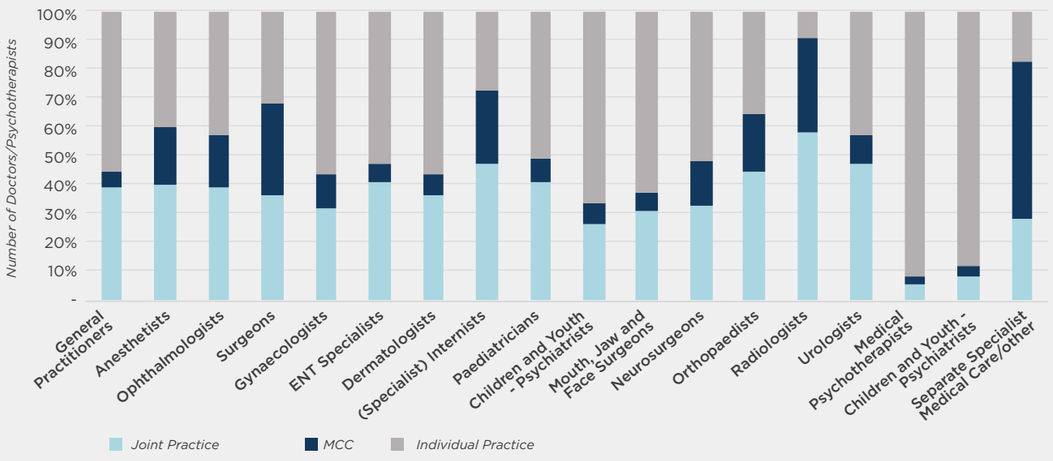


Source: KBV, Cushman & Wakefield, 2019

In recent years, the outpatient sector has seen a steady increase in the number of doctors in it. In particular, ever more doctors are deciding to join a medical care centre. Over eight years, the number of doctors in medical care centres more than doubled from 8,500 to almost 20,000. By contrast, the number of doctors in SHI accredited partnerships or individual practices rose by only 6%. This shows the attractiveness of medical care centres for doctors, especially for young doctors who appreciate the employee status in such centres.

SHARE PHYSICIANS/PSYCHOTHERAPISTS IN %

ALL TYPES OF PRACTICE, ALL DOCTORS/PSYCHOTHERAPISTS, 2018

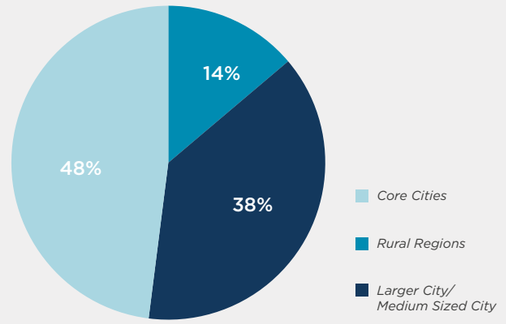


Source: KBV, Cushman & Wakefield, 2019

The distribution of practice types within the doctors' groups shows a clear trend regarding which doctors find medical care centres particularly attractive. In absolute figures, the number of general practitioners is well ahead, followed by physicians, surgeons, gynaecologists, orthopaedists and radiologists.

The geographical locations of medical care centres in Germany are disproportionately distributed between rural communities and core cities. About half of all MCC's are located in core cities, and only 14% in rural regions. MCC's are designed to significantly improve care in such areas and improve accessibility for residents. It is specifically the regional focus of many MCC's that shows how much potential lies outside the supposedly most attractive cities.

LOCATION OF MCC'S IN GERMANY



Source: KBV, Cushman & Wakefield, 2019

In a comparison of the 16 federal states, not only do the differences between rural municipalities and core cities become apparent, but also the differences between federal states. The two city states of Berlin and Hamburg have the highest MCC density per inhabitant in Germany. With 6.86 MCC per 100,000 inhabitants, Berlin leads, followed by Hamburg with 5.74. Thuringia also has a comparatively high density of MCC's at 5.44. In contrast to these three federal states, Baden-Württemberg has by far the fewest MCC's per 100,000 inhabitants at only 1.80 overall.

A further trend in the development of MCC's is the enormous increase in the number of employed physicians, primarily at MCC's operated by hospitals. This increase is, in part, due to the parallel increase in MCC's, but also their increasing attractiveness for young doctors. They do not have to bear the personal risk of being an SHI-accredited practice physician when starting out, and can increasingly pursue the desire for flexible working hours and a better work-life balance.

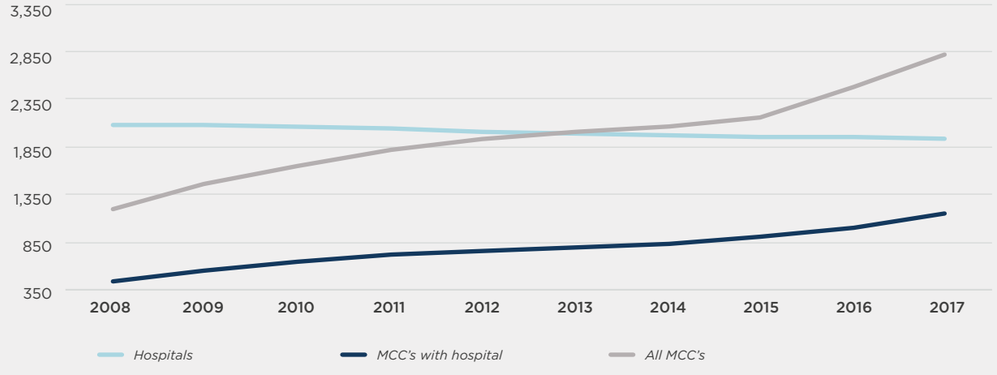
06
OPERATOR ENVIRONMENT

OPERATOR ENVIRONMENT

The shift in focus from inpatient to outpatient treatment and the introduction of medical care centres in 2004 brought a large number of operators into the market. The operator universe for medical care centres is currently characterised by a considerable degree of fragmentation, but with a growing tendency towards consolidation. Due to the fact that only hospitals, SHI-accredited doctors and municipalities are legally able to set up MCC's, hospitals are now often the institutional and professional operators.

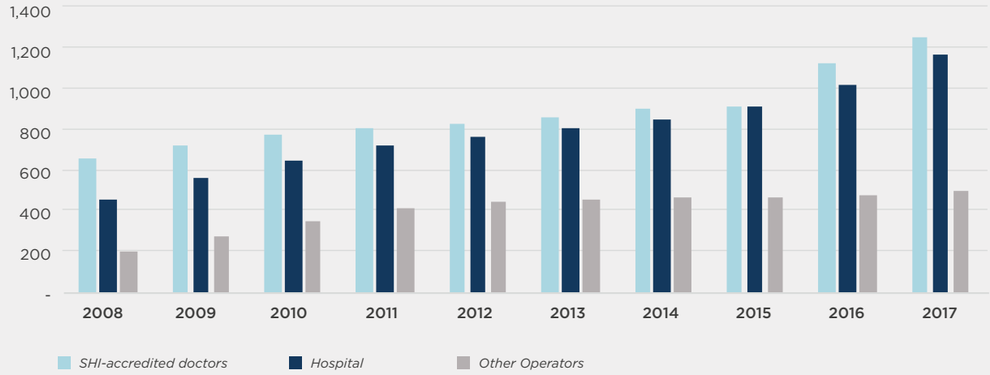
Since the introduction of medical care centres in 2004, the care landscape has expanded steadily. Above all, the growing demand for outpatient care is reflected in the 60% increase in the number of centres since 2008. The market is currently dominated by SHI-accredited physician and hospital operated MCC's, particularly due to hospitals, in the role of operating companies, promoting close cooperation between MCC's and hospitals. Further synergy effects result from the fact that MCC's are often in close proximity to hospitals.

COMPARISON DEVELOPMENT HOSPITALS, MCC'S WITH HOSPITALS, MCC'S



Source: KBV, Cushman & Wakefield, 2019

OPERATOR AND THEIR SHARE IN MCC'S



Source: KBV, Cushman & Wakefield, 2019

However, the German Scheduled Services and Supply Act (TSVG), which came into force on May 14, 2019, partially restricts hospitals as operators. For example, only 5% of dental MCC's in over-supplied planning areas and 20% in under-supplied planning areas may be in the hands of a hospital operator.

In the future it is likely that even more clinics will be subject to takeovers by investors and operators, in order to enable further expansion of the MCC network. In recent months, there has been particular movement in the dentistry segment, with takeovers and the building of interregional dentist chains. These relatively new practice chains such as Zaheins, Zahnstation, DentConnect and KonfiDents are establishing themselves relatively quickly in the market via the acquisition and opening of MCC's. In contrast, in rural areas, strengthening of provision is expected by more operator-led MCC's

However, it is not only the dental MCC sector which is growing; large hospital operators such as Helios, Asklepios and Ameos also hold a large number of MCC's in their portfolio. Based on the synergy between MCC's and clinics, it is possible for such supra-regionally-active companies to develop comprehensive- network coverage.

HOSPITAL AND MCC OPERATORS

	OPERATOR	NUMBER OF HOSPITALS	NUMBER OF MCC'S	REVENUE IN € MILLION	PATIENTS	EMPLOYEES
1	Helios[1]	86	125	5,970	5,231,445	66,000
2	Asklepios[1, 2]	70	44	3,400	2,300,000	47,000
3	Sana[1]	53	25	2,703	2,157,000	34,000
4	Rhön Klinikum[1, 2]	5	10	1,233	850,147	17,000
5	Schön Klinik[1]	26	11	837	300,000	10,000
6	Ameos[2]	41	14*	890	n.a.	13,200
7	SRH Kliniken[1]	16	26	727	1,053,560	9,017
8	Mediclin[1]	36	10	645	122,954	10,000
9	Paracelsus[1, 2]	24	9	409	100,000	5,500

Source: Cushman & Wakefield, 2019

**Policlinic*

[1] *Data from the annual report 2018*

[2] *Data from the homepage as of: 1. October 2019*

The strong interest from institutional financial investors cannot be ignored. The high level of transaction activity in recent years is reflected above all in the consolidation of existing MCC structures and the establishment of new ones. Private equity firms are particularly interested in dental and radiological medical care centres. The buy-and-build strategy implemented by investors, with the emergence of chains, is often seen as well. Nordic Capital acquired the companies Ober Scharrer Group (ophthalmic medicine), SFE Beteiligungsgesellschaft (owner of Zahnstation) and DPH Dental Partner Holding, all in 2018. With around 65 ophthalmic properties, the Ober Scharrer Group is one of the leading operators of medical care centres. With the acquisition of the dental practice chain Zahneins, which has more than 20 locations in Germany, Summit Partner has established itself in the field of dental MCC's. In addition, the Carlyle Group consolidated its footprint in the German market with the partial acquisition of Ameos, a leading hospital and MCC operator in Germany.

The operator market is becoming increasingly dynamic. According to the German Medical Association and the National Association of Statutory Health Insurance Physicians, there were around 130 takeovers in the medical care centre segment between 2013 and 2018, of which 15% were carried out by foreign investors.

07

INVESTMENT IN MEDICAL CARE CENTRES

INVESTMENT IN MEDICAL CARE CENTRES

On the real estate investment side, the market for MCC‘s is also at a very early stage. On one hand, the asset class is less established within the healthcare real estate segment than, for example, nursing homes. On the other hand there are some socio-demographic and economic similarities. Medical care centres, structured as classic operator properties with a general lease agreement, are currently developing into core investment products in the German healthcare real estate market. In countries such as the USA, Great Britain and Australia, these special-purpose properties are already established as a highly sought-after asset class.

It is expected that MCC’s will also assert themselves in the German market in the medium-to-long term. As previously explained in this report, one of the few remaining growth markets is benefiting from the deregulation of the German healthcare market and the accompanying privatisation, the trend away from inpatient and towards outpatient care and professionalisation of the market, driven in part by takeovers of operators, and from increasing consolidation of the still-fragmented market. Due to the extreme lack of product, especially in the existing real estate segment, the lack of a clear definition and differentiation of the MCC asset class from traditional medical centres, (where often only one practice is located in a residential and commercial building), and the fact that professionalisation of the operator market and the associated increase in demand for MCC‘s is just beginning, there are few meaningful figures regarding annual investment volume. The range of prime yields varies significantly, depending on the location of the properties and the creditworthiness of the operators, as well as the structure of the general rental agreements, at 3.5% (top 7), 4.0%–4.5% (medium-sized towns) and up to 5.0% (rural regions).

In addition to a sustainable situation with regard to socio-economic circumstances, the main value drivers for MCC‘s are a competitive environment that matches regional needs. A highly-creditworthy, renowned operator with a positive image and a well-thought-out conceptual mix of medical specialist areas and other uses that create synergies (e.g. opticians, pharmacies, etc.) is just as relevant as modern areas that meet doctors‘ and patients‘ requirements. Due to the long terms (10 years plus), the leases are, of course, of major importance. Market-compliant indexation, maintenance and repair provisions as well as regular disclosure of operating figures are essential prerequisites for institutional investors.

08
OUTLOOK

OUTLOOK

The structural change in inpatient and outpatient medical care has only just begun. The major demographic shift, which will lead to steadily rising health expenditure, presents medical care with a major challenge.

While the lack of economic viability of inpatient care in the regions endangers the nationwide functioning of a needs-based care network, the demand for healthcare in the regions will increase. MCC‘s are increasingly appearing as substitutes and complements to inpatient care as a response to supply bottlenecks. Due to the limitations on the conditions that can be treated on an outpatient basis in MCC‘s, only a well thought-out balance between outpatient and inpatient medical care ensures a demand-oriented medical care network.

Rising demand will inevitably increase the importance of MCC‘s throughout Germany. The professionalisation and consolidation of the operator market, caused by increasing interest from market-leading operators and institutional investors, will lead to the successful widespread establishment and strengthening of outpatient medical care. The construction of new facilities and investment in the existing MCC supply network are absolutely necessary in order to meet this increased and rising demand.

MCC‘s will increasingly assert themselves as an institutional asset class and will become more attractive for institutional (real estate) investors. Compared with established asset classes, such as office real estate, the sustainability of MCC investment depends on a large number of additional parameters, such as, in particular, a comprehensive catchment area analysis, an operator with a good credit rating, an owner-friendly medium-to-long-term general lease and a positive operating result.

Due to the lack of market transparency, regional differences and the high significance of various regional socio-economic and demographic parameters, the variations in lease provisions and the key importance of the operator, investments in medical care centres are extremely consultation-intensive. Numerous value-driving or value-decreasing factors can hide behind apparently lucrative investments. Specific know-how in this segment is indispensable in order to make sustainably profitable investments. However, the current state of the market and the predicted development of outpatient medical care, as well as the pioneering role of other strong economic countries, make the successful establishment of the asset class very probable. Throughout the German market there are prospects for growth!

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