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HOSPITALS REPORT

HEALTHCARE - UK & EUROPE - Q1 2026

RESEARCH



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KEY TAKEAWAYS

Demand for acute and specialist care across the UK and Europe continues to rise, driven by ageing populations, rising chronic disease prevalence and ongoing capacity constraints. The EU-27 65+ population is projected to rise by c. 30 per cent between 2025 and 2050, while the 80+ cohort will almost double.

For Healthcare investors, hospital real estate opportunities remain highly market and asset specific, shaped by regulatory context, ownership structures and the alignment between changing healthcare needs and investable real estate opportunities.

Delivery models are adapting across markets, with a shift towards outpatient, ambulatory and digitally enabled care, reducing reliance on inpatient hospital beds while expanding the investable healthcare 'cure' real estate universe.

Rehabilitation and step-down facilities are increasingly being utilised to relieve pressure on acute hospitals by enabling earlier discharge and improving patient flow, further reinforcing the need for hospital-adjacent real estate assets. Mental health hospitals also represent an attractive pan-European real estate segment, supported by growing demand and relatively high levels of private provision.

Capacity constraints and cost inflation within public healthcare systems are increasing reliance on private providers in certain segments and geographies, underpinning the investment case for private hospital and outpatient healthcare real estate.

The UK has seen particularly strong growth in private hospital activity over the last five years, due to elevated NHS outsourcing, and higher self-pay and private medical insurance volumes, as patients seek faster access to elective and diagnostic care.

Workforce shortages and costs have become a significant operational challenge across hospital systems, with nurse and doctor availability limiting capacity and rising labour costs exerting sustained pressure on hospital margins.

Technology adoption is accelerating, improving triage, care coordination and efficiency, but remains complementary to physical hospital infrastructure rather than a replacement.

Capital markets activity is likely to remain selective in the near term, reflecting elevated bond yields and financing conditions that remain tighter than pre-pandemic norms.

Investors are directing their focus to assets with strong covenants and exposure to outpatient, rehabilitation and mental health delivery. As rates ease and liquidity improves, transaction volumes should recover gradually, supported by ongoing migration to ambulatory care and expanding private elective capacity.



UK & EUROPEAN HOSPITALS



Report Author

THOMAS ATHERTON

STRATEGY & MARKET INTELLIGENCE MANAGER, SAVILLS OCM

Over the last two decades, curative care delivery across Europe has undergone a significant transformation. Advances in diagnostics, anaesthesia and minimally invasive procedures have enabled an increasing share of activity to shift from inpatient to day-case and outpatient settings

Now, clinical specialisation and an increased emphasis on community-based and preventive care are reshaping how and where care is being delivered. Diagnostic and chronic treatment pathways are increasingly concentrated in specialist centres, while high-throughput surgical hubs and ambulatory facilities assume a greater share of elective activity. As a result, inpatient hospital beds per capita have declined across most European countries, even as treatment volumes have increased.

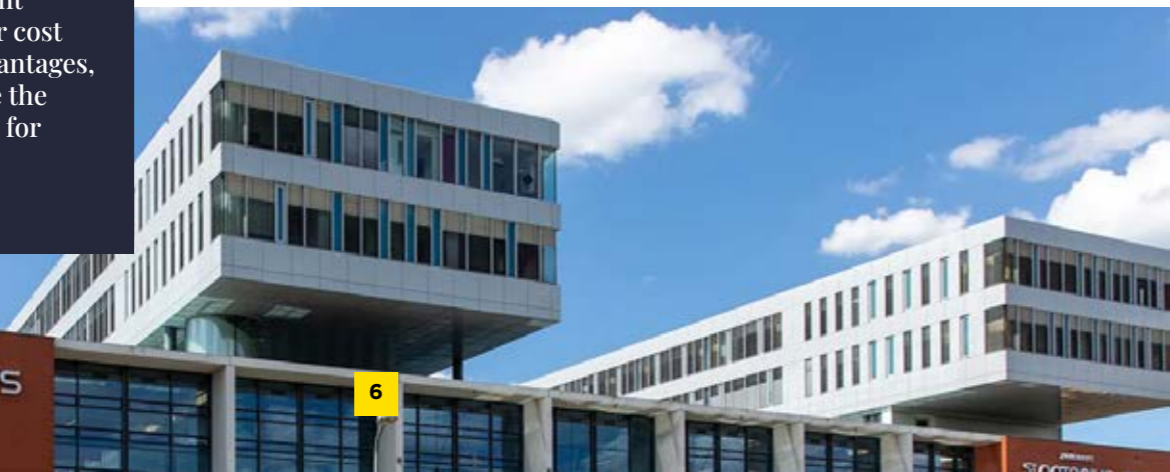
Despite this transition, hospital utilisation remains strong. Ageing populations, rising chronic disease prevalence and the expanding scope of treatable conditions continue to support growing hospital activity levels, while the COVID-19 pandemic exacerbated pre-existing capacity shortfalls and elective backlogs.

Although outpatient services offer clear cost and efficiency advantages, it does not remove the fundamental need for hospitals. Instead, it is reshaping their function, concentrating high-acuity and complex care within acute facilities while relocating lower-complexity and ancillary services to settings where they can be delivered more efficiently, including outpatient, specialist and step-down environments.

Historically, the predominance of public ownership in acute hospital provision has constrained the ability of private capital to access underlying real estate across many European markets, whereas outpatient, mental health, specialist and rehabilitation assets are more commonly compatible with third-party ownership.

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Although outpatient services offer clear cost and efficiency advantages, it does not remove the fundamental need for hospitals.



C. 10%
Decline in hospital beds per capita in the EU between 2012 and 2022, reflecting the ongoing shift to adjacent cure settings

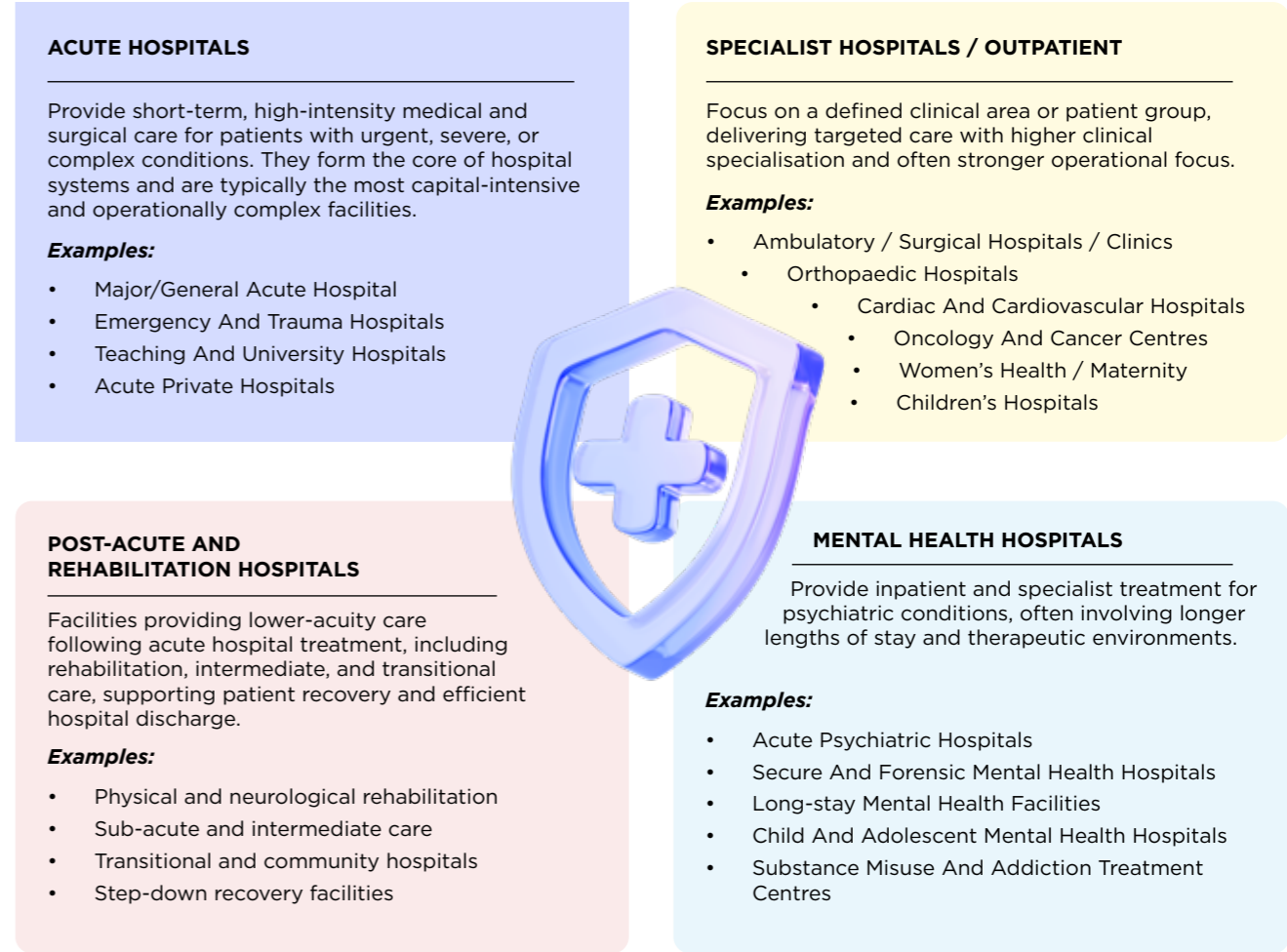
The investible market varies materially by geography due to differences in ownership models, regulation and reimbursement structures. This variation defines both the scale and the composition of hospital real estate investment activity across Europe.

Since mid-2023, higher bond yields, elevated financing costs and tighter debt markets have further reshaped investor behaviour, limiting

transactional activity and prompting a shift in investor strategies towards asset management, balance-sheet protection and selective capital deployment.

In this environment, investors are increasingly concentrating on assets that align with evolving care pathways, offer operational flexibility and demonstrate resilience under tighter capital conditions.

FIG 1. HOSPITAL TYPES



Healthcare systems, definitions, and structural classifications vary across European geographies.

HEALTHCARE FUNDING, OWNERSHIP AND PROVISION FRAMEWORKS

Funding And Service Provision Models Shape The Settings In Which Care Is Delivered

Across Europe, healthcare funding systems are primarily insurance based or government funded.

Germany, the Netherlands and Switzerland operate compulsory health insurance models, under which all residents are required to hold coverage, typically provided by regulated private insurers, to ensure universal access. These systems are characterised by competition between insurers, greater patient choice and contributions are linked to income or premiums.

The United Kingdom, France, Italy and Spain follow tax funded or government-led models, where healthcare is financed largely through payroll, income or general taxation and delivered predominantly through publicly managed systems. In these countries, the state plays a more direct role in both funding and provision, with services generally free or low cost at the point of use.

Insurance based systems rely on regulated market mechanisms to deliver universal coverage, while government funded models depend on centralised tax collection and public service delivery to achieve similar outcomes.

Coverage through compulsory health insurance or government schemes makes up the bulk of healthcare financing across the European Union. Taken together, they account for approximately 80.6% of total health spending in 2023. Household spending, through out-of-pocket and self-pay payments (including co-payments), remains a material component of health expenditure, accounting for around 15% of total EU health spending in 2023. Voluntary health insurance contributes a further c. 4.5% at the EU level, although the extent of its role varies significantly by country.

Funding systems influence the provision of hospital services, with both insurance funded and taxation funded systems contracting care from state, non-profit, and for-profit providers.

The balance between these provider types varies materially by country, reflecting differences in legislation, reimbursement design and government involvement in service planning. These dynamics also interact with wider system pressures, including rising healthcare needs, staffing shortages and persistent waiting lists.

Over the last two decades, acute care has shifted increasingly towards outpatient and day-case delivery, driven by advances in surgical techniques, diagnostics and anaesthesia. In parallel, mental health and rehabilitation have developed into increasingly institutionalised sub-sectors, with clearer operating models, specialised facilities and a growing base of investible assets spanning inpatient, step-down and community settings.

Across all hospital segments, these trends have driven greater specialisation and the concentration of complex activity into fewer, higher-acuity facilities, reflecting funding constraints, reimbursement incentives and the need to improve system efficiency by providing care in lower-cost settings, where clinically appropriate.

FIG 2. EU-27 HEALTHCARE FUNDING BY SOURCE, 2023

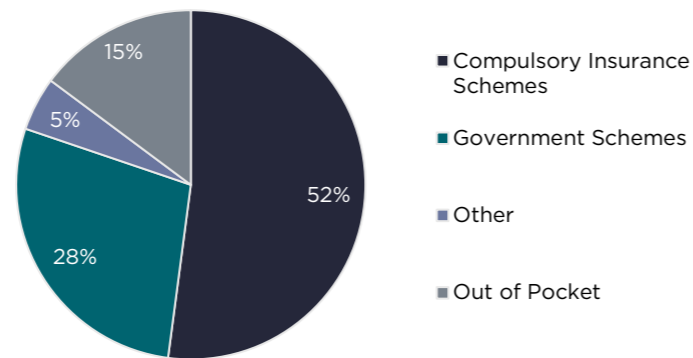
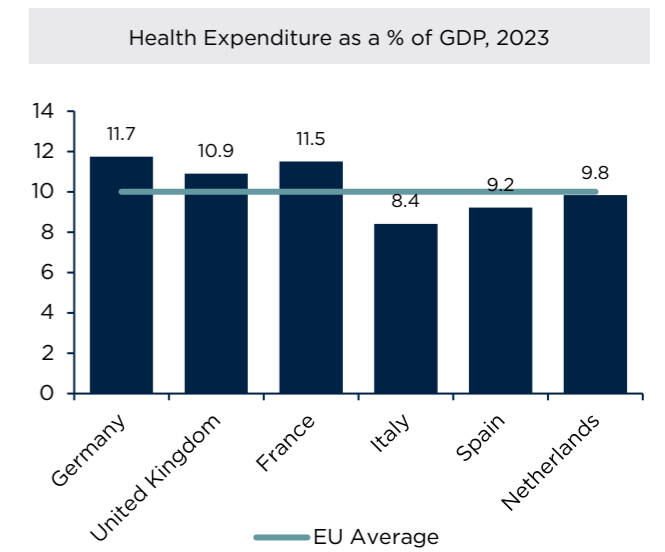
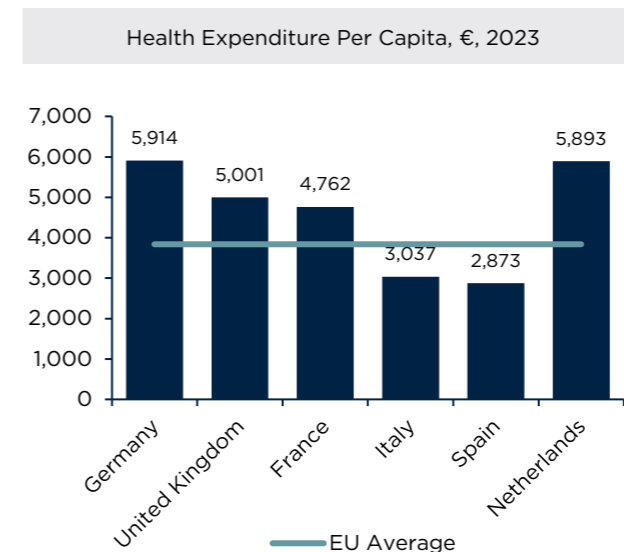
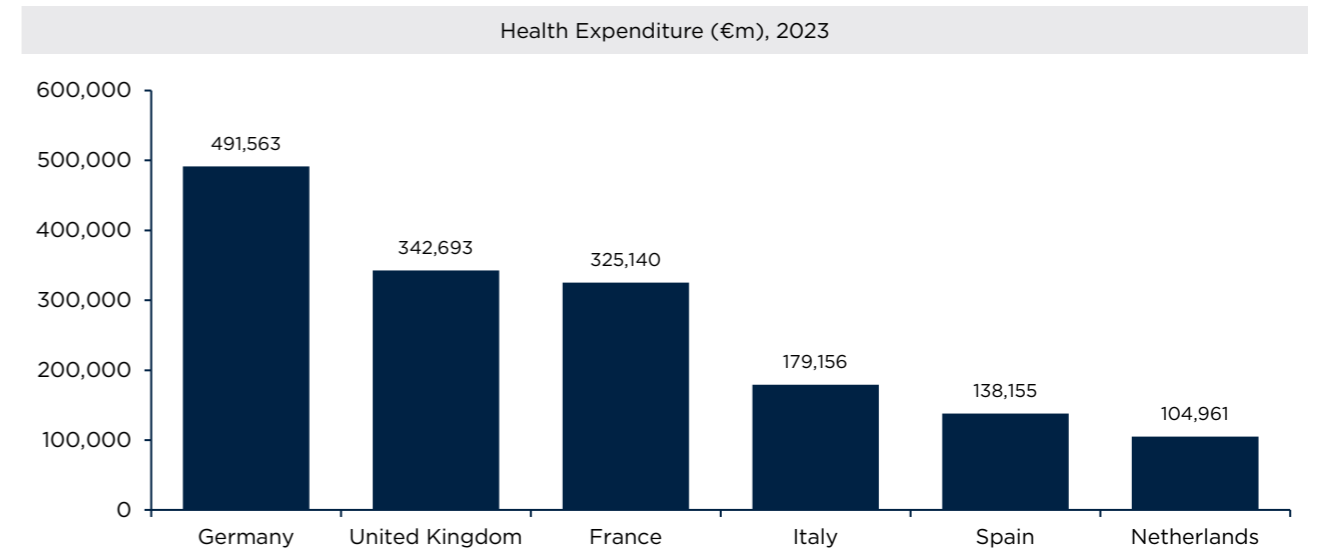
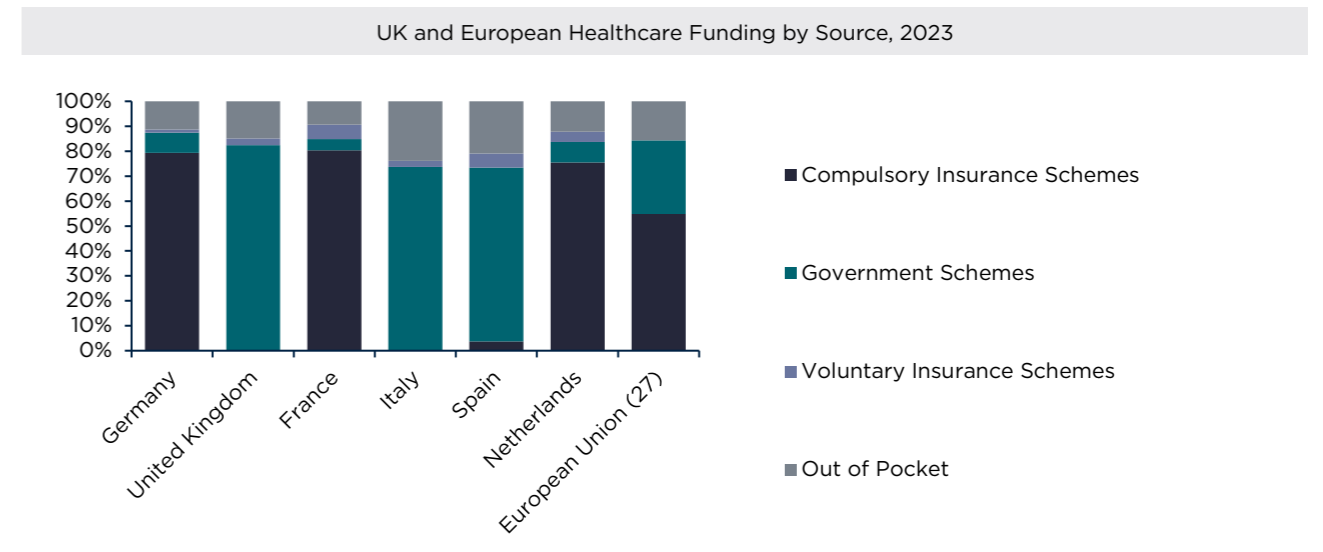


FIG 3. UK AND EUROPEAN HEALTHCARE SYSTEMS COMPARISON



Source: Eurostat, OECD, ONS

HOW OWNERSHIP SHAPES THE INVESTIBLE HOSPITAL LANDSCAPE

Across Europe, hospital provision is delivered through a combination of public, non-profit and private operators, with ownership, funding systems and regulation determining which assets are accessible to private capital

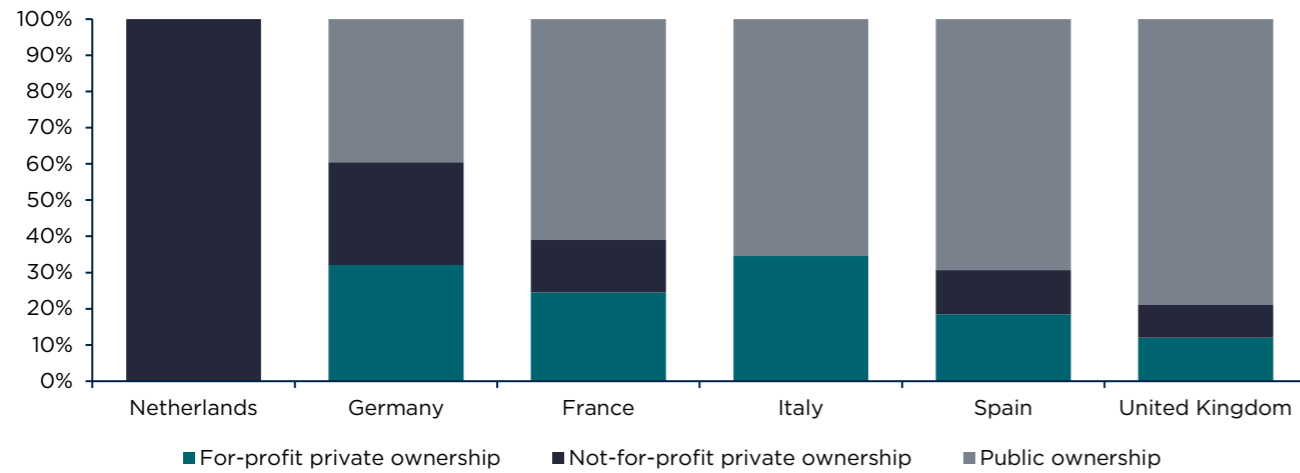
Acute hospitals in many countries are state owned, embedded within national or regional planning frameworks and rarely tradable, limiting direct real estate investment opportunities.

Non-profit acute hospital real estate accessibility is variable across geographies but in many cases not investable. In some systems they operate as independent charitable providers outside the state hospital estate, allowing their real estate to be owned and leased by third parties.

In others, they are closely integrated into public planning frameworks, deliver statutory public service obligations and are reimbursed at regulated tariff levels, which limits the ability to separate real estate ownership from operations.

By contrast, private for-profit providers are more likely to operate within structures that allow third-party ownership, sale and leaseback and long-term leasing, making their assets the most readily acquirable for investors.

FIG 4. HOSPITAL BEDS BY OWNERSHIP, 2023



Source: Eurostat, The Kings Fund & LaingBuisson (UK)

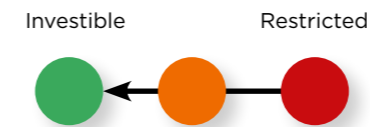


C. 61%
Private ownership of hospital beds in Germany vs 39% in France

However, the scale of private sector involvement in hospital delivery does not directly equate to the depth of the investable real estate market.

The differing levels of investable opportunities are due to a range of factors and are illustrated through the following country-specific examples:

FIG 5. HOSPITAL REAL ESTATE INVESTMENT OPPORTUNITY COMPARISON EXAMPLES BY SEGMENT AND COUNTRY



COUNTRY EXAMPLES



IN GERMANY, THERE IS A MIX OF ACUTE CARE PROVISION BETWEEN STATE HOSPITALS AND PRIVATE FOR-PROFIT AND NOT-FOR-PROFIT OPERATORS

However, private acute care hospital real estate, like public hospitals, is not typically able to be acquired. This reflects its integration into state hospital planning, the non-reimbursement of rent under the dual-financing model and regulatory requirements for operators to retain long-term control of their premises.

As a result, although private operators play a meaningful role in service delivery, the acute hospital estate remains largely inaccessible to real estate investors. Instead, the primary investable segments are found in rehabilitation clinics, specialist centres and outpatient facilities.

Notably, there has been rising demand from both occupiers and investors for [Medical Office Buildings](#) in Germany, reflecting the increasing importance of ambulatory care outside the acute hospital setting.



While private operators play a significant role in German hospital care, access to real estate for acute care hospitals remains structurally difficult.

As care models increasingly shift towards rehabilitation, outpatient and ambulatory facilities – which is the political will behind the current hospital reform – a growing proportion of hospital-related infrastructure, such as medical office buildings, is becoming investable for real estate capital where this was not previously the case. The demand for such properties will continue to rise in the future.”



Max Eiting, Head of Healthcare, Germany - Savills



IN THE UNITED KINGDOM, THE MAJORITY OF ACUTE CARE IS DELIVERED BY THE PUBLIC SECTOR THROUGH NHS HOSPITALS, WITH MORE LIMITED PRIVATE PROVISION COMPARED TO GERMANY

Like in Germany, public acute hospitals in the UK are not typically open to private ownership. Historically, the principal route for private capital into public hospital infrastructure was the Private Finance Initiative, which funded around 100 hospital projects

before being abolished in 2018 following concerns over rising financing costs, escalating unitary charges and poor value for money.

However, alongside the public system, a private hospital sector has developed over the last two decades, with several operators having sold their real estate into PropCo OpCo structures. This has created a well-established investment market for private acute care hospital assets.

In recent years, elevated NHS waiting lists and capacity constraints have resulted in a higher share of NHS-funded care being delivered in private hospitals, while extended waits have also supported expansion in privately funded activity.

These dynamics have strengthened utilisation and revenues across the independent sector, reinforcing sustained investor interest in UK acute care assets.



In the UK, private acute hospitals sit outside the public estate and are therefore investable, which continues to differentiate the market from many countries in continental Europe.

Increasing NHS outsourcing over recent years, alongside sustained growth in private pay, has underpinned utilisation, revenue and operational margins. Strong operational KPIs tied to increased structural demand and recent scalable opportunities have driven new investor appetite in the sector.”



Caryn Donahue, Head of Healthcare & Senior Housing, UK & Europe - Savills



FRANCE OPERATES A MIXED SYSTEM WHICH INCLUDES PUBLIC HOSPITALS, PRIVATE FOR-PROFIT PROVIDERS AND NOT-FOR-PROFIT OPERATORS

Legally, the not-for-profit sector is private and isn't part of the state public hospital domain. However, these operators perform public-service missions under regional health authority oversight, are reimbursed at the same regulated tariff levels as public hospitals through the T2A system and are embedded within national and regional hospital planning frameworks.

In practice, this combination of public-service obligations, regulated reimbursement and planning integration constrains the separation of real estate ownership from operations, meaning that not-for-profit hospital real estate is generally not accessible to investors.

This contrasts with the United Kingdom, where not-for-profit hospital operators sit outside the NHS hospital estate and are regulated and reimbursed in a similar manner to for-profit providers, placing them closer to the private hospital market from an investment perspective.

While UK not-for-profit hospital operators haven't generally monetised their own freehold estates, transactions such as Nuffield Health's acquisition of Aspen hospitals demonstrate that they are willing and able to operate hospitals under third-party lease structures where the real estate has already been separated from the operating business.

COUNTRY EXAMPLES

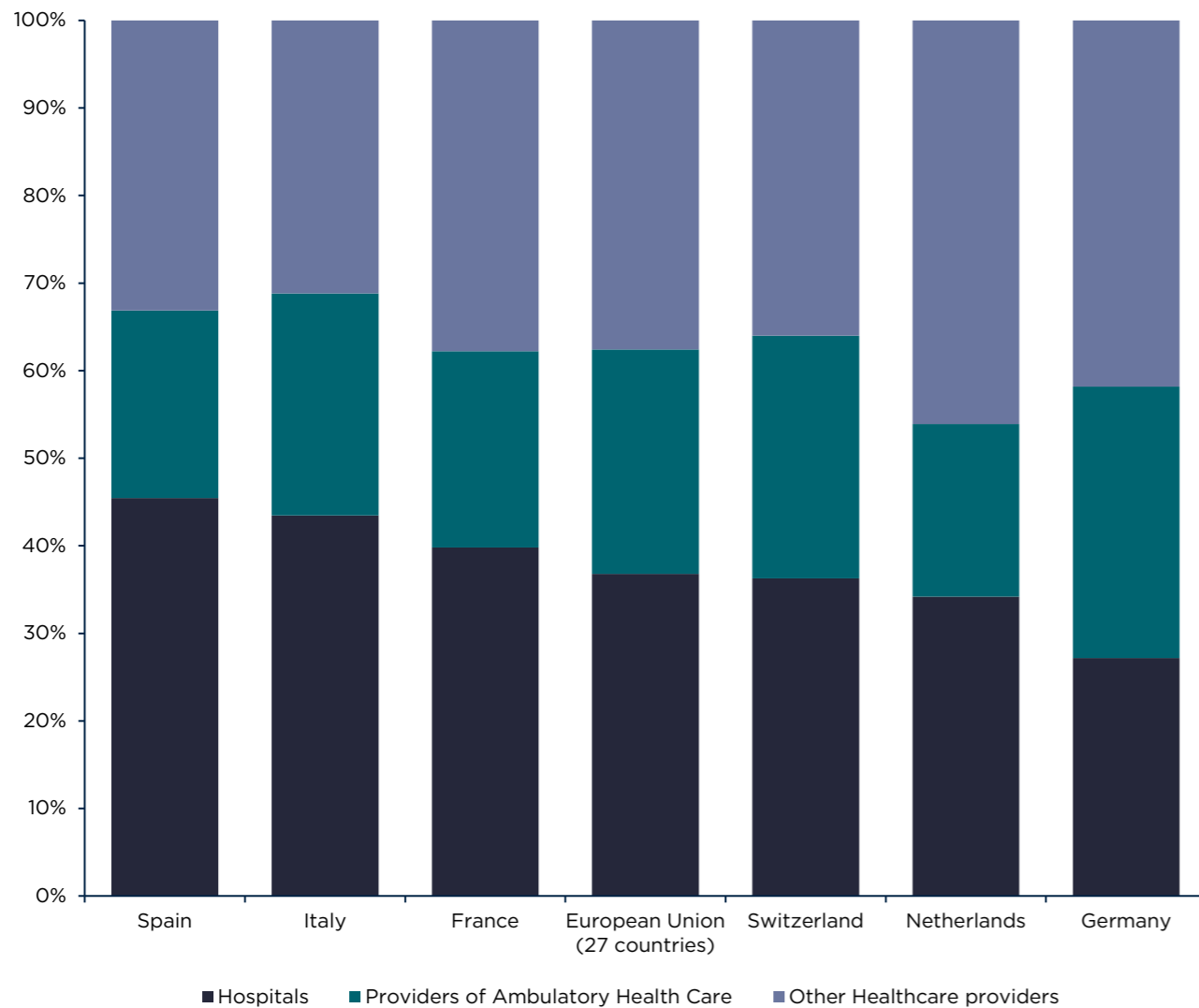


IN THE NETHERLANDS, HOSPITALS ARE REQUIRED TO OPERATE ON A NOT-FOR-PROFIT BASIS, ENTIRELY RULING OUT PRIVATE FOR-PROFIT OWNERSHIP OF ACUTE HOSPITAL REAL ESTATE

This has been counterbalanced by the rapid growth of outpatient and day-clinic provision, which can be operated by private providers. A greater share of procedures in specialties such as orthopaedics and ophthalmology is now delivered in these settings, expanding the investable universe.

Across Europe, severe financial and operational pressures on public health systems suggest that a larger share of hospital activity is likely to be delivered by privately operated facilities over time. These facilities are more likely to be accessible to private capital, particularly in mental health, elective, rehabilitation and outpatient care, highlighting an opportunity for healthcare real estate investors.

FIG 6. HEALTH EXPENDITURE BY SETTING, %, 2023



Source: Eurostat



CAPITAL MARKETS OVERVIEW

Annual investment volumes in hospital real estate are lower than in elderly care, reflecting both the limited number of hospital assets available to transact and the larger average ticket sizes, which reduce liquidity and narrow the pool of potential investors

Hospitals also require a greater level of clinical, operational and regulatory expertise than most other healthcare real estate sectors. Acute and specialist facilities are complex to operate, subject to intensive clinical oversight and dependent on specialist staff.

As a result, hospital investment activity tends to be episodic and concentrated in a relatively small number of large transactions rather than a steady flow of single-asset deals. In the UK, significant transaction activity in private acute hospitals occurred in 2019 and 2020.

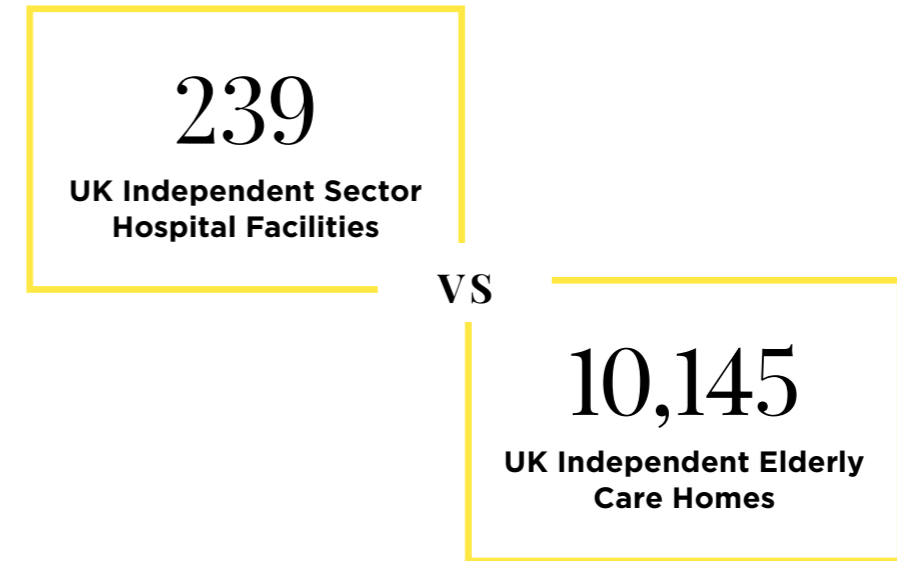
By 2020 and 2021, much of the investable standing stock had been transacted, leading to a subsequent slowdown in volumes. More recently, investment activity increased again, although the majority of 2024 and 2025 volumes were driven by the same portfolio of hospitals previously held by NorthWest Healthcare trading again, rather than the introduction of new assets to the market.

Despite these constraints, hospitals have remained one of the most active healthcare investment verticals over the past five years, ranking second only to elderly care. From an income perspective, hospital assets exhibit defensive characteristics.

Operators typically allocate a higher proportion of revenue to capital expenditure, meaning that rent represents a relatively smaller share of total operating costs. As a result, hospital assets, particularly in the acute segment, generally achieve higher rent cover ratios than care homes.

Reputational and operational risk is inherent across healthcare, but the regulatory environment for acute care is materially more stringent than in long-term care. Higher clinical governance standards and oversight have reduced the incidence of large-scale operator failures in hospitals relative to the care sector. This stronger regulatory framework contributes to lower counterparty risk for hospital landlords and expands the investor pool for cure assets.

Barriers to entry in hospital provision are significantly higher than in elderly care. High capital expenditure requirements, specialist staffing needs and lengthy regulatory approval processes restrict new supply. As a result, the risk of rapid market share erosion through new entry is relatively low, increasing the defensibility and longevity of owning existing hospital assets.



Notably, medium-stay inpatient facilities, including rehabilitation and mental health hospitals, offer a more accessible route for real estate investors. These assets tend to be smaller, less medically complex and more commonly operated by private providers. Germany and the wider DACH region have particularly strong rehabilitation markets, underpinned by demographic drivers and a state-backed reimbursement structure.

Hospital real estate is a specialist, scale-driven segment rather than a high-volume trading market. Liquidity is constrained relative to elderly care, but this is offset by high barriers to entry and resilient demand. Returns depend less on transaction cycles and more on asset quality, operator strength and positioning within evolving care pathways. As activity shifts towards outpatient, rehabilitation and specialist settings, the investable universe is expanding.

“Liquidity is constrained relative to elderly care, but this is offset by high barriers to entry and resilient demand.”



FIG 7. KEY TRANSACTIONS OVER THE LAST 24 MONTHS

Country	Transaction Name	Sub-sector (Acute, Rehab, Mental)	Deal Type	Date	Value, €m	Properties	Beds	Vendor	Investor
United Kingdom	EPF Spire Portfolio	Acute	Acquisition	In-Closing	c. 1,500	12	n/a	Malaysia's Employees Provident Fund ("EPF")	Blue Owl
Italy	Sale of Italian healthcare portfolio by Icade to BNP Paribas REIM	Acute & long-term care (mixed)	Sale of investment vehicle stake	Dec-25	173	23	n/a	Icade	BNP Paribas REIM
United Kingdom	Nuffield Health lease surrender to Barts Health (two hospital sites)	Acute	Lease surrender and transfer back to public owner	Nov-25	n/a	2	55*	Nuffield Health	n/a
United Kingdom	King Edward VII's Hospital	Acute	Acquisition	Oct-25	n/a	1	56	King Edwards VII's Hospital	Bupa
United Kingdom	New Victoria Hospital	Acute	Acquisition	Aug-25	n/a	1	33	The Victoria Foundation	Bupa
United Kingdom	HICL NHS Portfolio	n/a	Acquisition	Aug-25	c. 260	n/a	n/a	HICL Infrastructure	APG
United Kingdom	PHP public share-buy out of Assura (hospitals in portfolio)	Acute	Public Share-Buy Out	Aug-25	c. €860m (£1.79bn total buy-out value)	14	n/a	Assura	Primary Health Properties
France	Le Floride post-acute care & rehab clinic (Barcarès)	Rehab	Acquisition	Jun-25	n/a	1	180	Institutional investor (unspecified)	La Française REM
Germany	Medical Properties Trust & Praemia REIM German Hospital (MEDIAN GROUP) Portfolio Refinance	n/a	Refinancing	Jun-25	702	n/a	n/a	n/a	Song Capital
Portugal	Corticeira Amorim Factory - Corroios, Seixal	Acute	Development	May-25	60	1	42	Amorim	Luz Saúde
Italy	IASO Real Estate Fund	Rehab	Portfolio acquisition (hospital real estate fund)	May-25	n/a	11	1,200	Trilantic Europe	Colliers Global Investors
Spain	Boadilla del Monte new hospital building (Hospiten)	Acute	Acquisition of hospital building (via REIT structure)	May-25	200 (total investment in hospital)	1	160	n/a	Banca March
Spain	Mallorca Hospital Development	Acute	Development	Mar-25	65	1	89	n/a	Azora, Sanitas (Bupa) & Mapfre
Spain	Sanitas new hospital in Madrid (Méndez Álvaro)	Acute	Building Conversion	Dec-24	80	1	110	LaFinca Global Assets (building owner)	Sanitas (Bupa)
Spain	Hospital Marina	Acute	Development	Oct-24	77	1	120	n/a	Colonial, Sanitas (Bupa) & Mapfre
Portugal	Braga Hospital	Acute	Development	Sep-24	45	1	40	n/a	CUF
United Kingdom	NorthWest Healthcare Properties UK private hospital portfolio	Acute	Acquisition	Aug-24	c. 575	14	n/a	NorthWest Healthcare Properties REIT	Assura
Germany	Psychosomatic rehab clinic (Scheidegg)	Mental	Acquisition	Jul-24	n/a	1	55	n/a	Threestones Capital (Eurocare IV fund)
France	Emeis 8 clinic buy-back	Mental / Rehab	Buy-back	Jul-24	185	8	n/a	Private	Emeis
Spain	Two psychosocial rehabilitation centres (Madrid area)	Mental	Acquisition	Jun-24	n/a	2	89	n/a	Atland (SCPI Épargne Pierre Europe)
Portugal	Santarém Hospital	Acute	Development	May-24	58	1	42	n/a	Luz Saude
Italy	The Hermitage Capodimonte Hospital	Acute	Acquisition	May-24	n/a	1	250	n/a	ICS Maugeri
United Kingdom	LondonMetric public share-buy out of LXI REIT (12 private hospitals in portfolio)	n/a	Public Share-Buy Out	Mar-24	n/a	12	n/a	LXI REIT	LondonMetric
United Kingdom	Spire Tunbridge Wells	Acute	Acquisition	Mar-24	c. 12	1	28	Spire	Maidstone and Tunbridge Wells NHS Trust
Ireland	Beacon Hospital	Acute	Acquisition (including operating platform)	Feb-24	342	1	251	Denis O'Brien	Macquarie Asset Management
France	Clinique SMR Les Trois Soleils, Boissise-le-Roi (Île-de-France)	Rehab	Acquisition	Jan-24	n/a	1	282	n/a	Amundi Immobilier (SCPI Amundi Delta Capital Santé)
France	Clinique du Parc Lyon	Acute	Acquisition	Jan-24	n/a	n/a	n/a	Primonial REIM	AEW

*(reported for one site)

Note: Data compiled from various online sources and should be considered indicative only

TRANSACTIONAL ACTIVITY

The period between 2020 and 2025 saw continued institutional engagement with UK and European hospital real estate, despite heightened market volatility during the Covid pandemic

Activity was supported by long-term demographic demand and the exposure of structural capacity constraints within public health systems during COVID-19.

Since mid-2023 in particular, higher bond yields and tighter debt markets have reduced overall transaction velocity, with many owners and investors prioritising asset management, operational optimisation and balance-sheet stability over discretionary acquisition activity. As a result, deal flow has remained episodic and selective, rather than reflective of sustained market-wide rotation.

More recently, early signs of stabilisation have emerged, including greater liquidity and more borrower-friendly conditions in debt markets during

2025. However, long-term borrowing costs and bond yields remain elevated relative to pre-pandemic norms, creating ongoing competition for capital on a risk-adjusted basis.

As interest rates continue to ease across the UK and Europe, as they have through 2024 and 2025, financing conditions are improving and bid-ask spreads are narrowing. Transaction activity is therefore anticipated to recover further, with capital deployed selectively into healthcare real estate segments that are adaptable to changing care pathway, operationally critical and supported by the long-term healthcare needs of the population.



While transaction activity has been more limited since mid-2023, improving financing conditions and stabilising inflation are gradually restoring market momentum.

Capital remains disciplined, with investors focused on high-quality assets that offer secure income and clear strategic relevance.”



Xavier Cheval, Head of Healthcare - Praemia REIM France



SUPPLY

Transition to Outpatient Delivery and Estate Reconfiguration

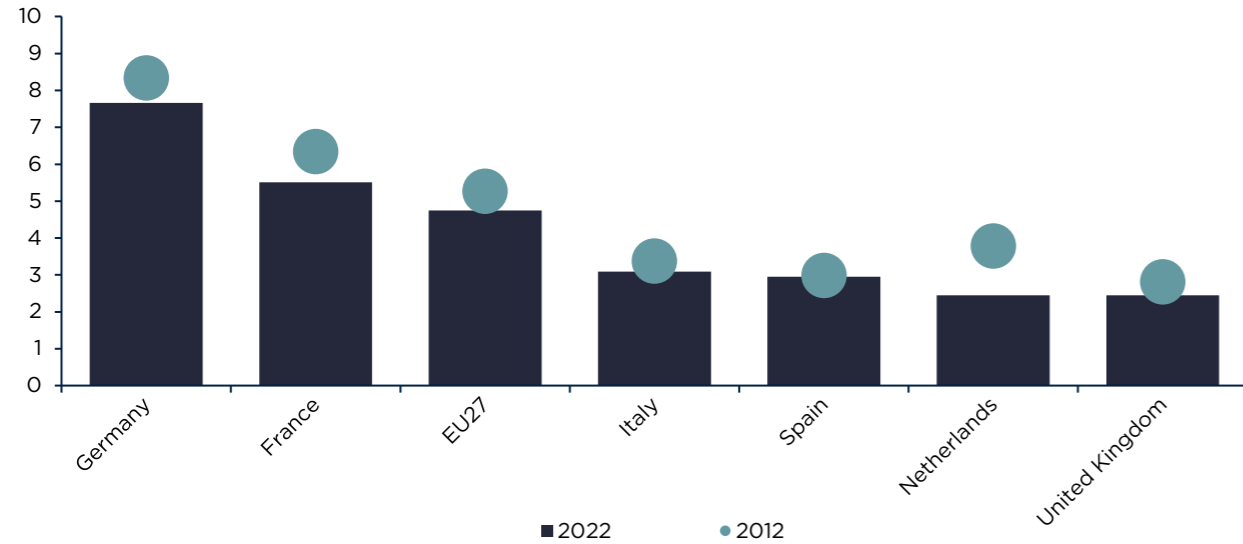
Over the last two decades hospital supply across Europe has been reshaped by the shift of activity into outpatient and ambulatory settings.

Advances in minimally invasive surgery, improved anaesthesia and same-day discharge models have enabled a greater share of procedures to be delivered outside traditional inpatient environments. Reimbursement structures and policy frameworks are reinforcing this shift, promoting treatment

in lower-cost, higher-throughput settings where clinically appropriate.

This transition is reflected in the decline in hospital beds per capita, which fell by approximately 10 percent across the EU between 2012 and 2022. Centralisation of complex and specialist services has reinforced the trend, with mergers and closures of smaller general hospitals across several markets.

FIG 8. HOSPITAL BEDS PER 1,000 POPULATION, 2012 AND 2022



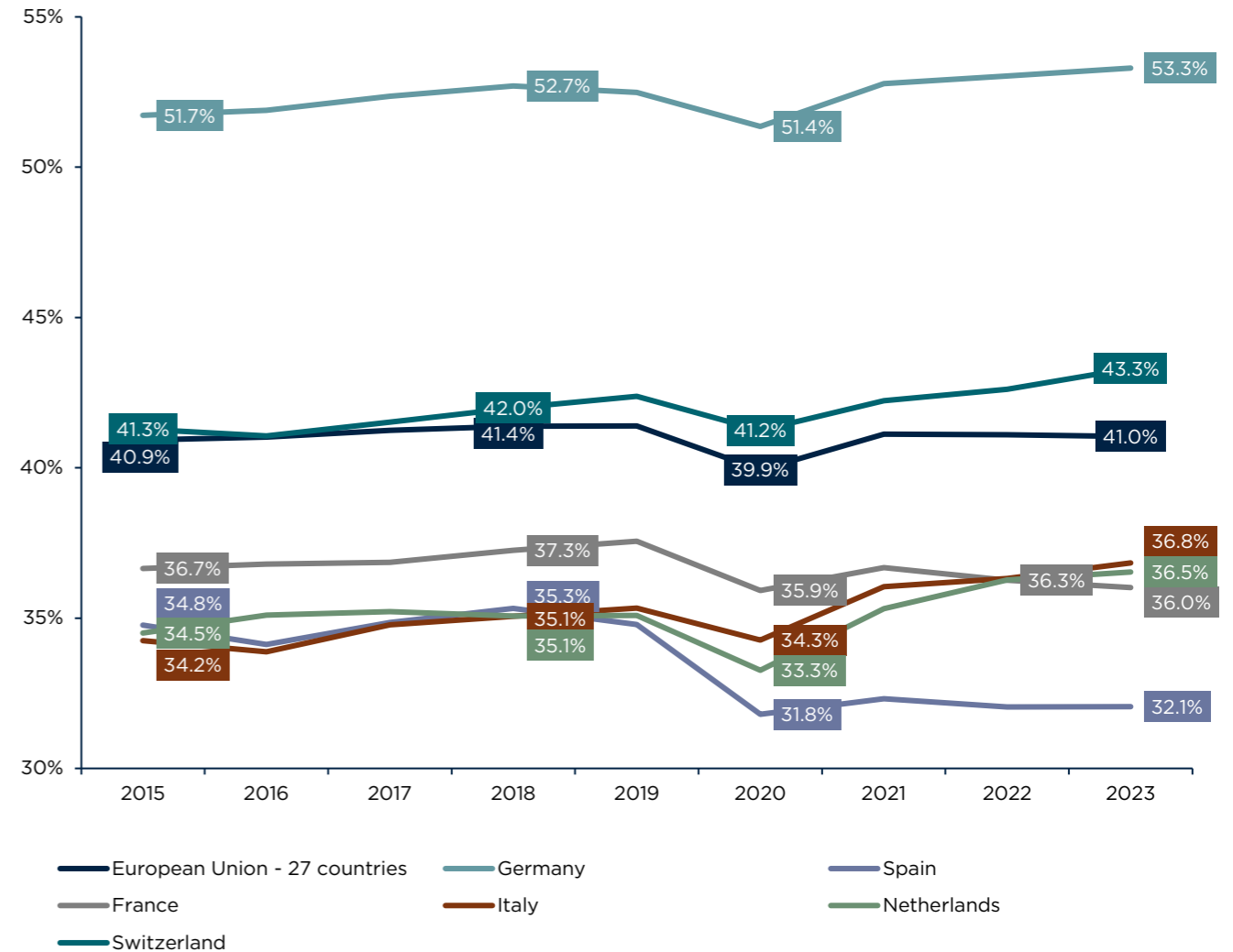
Source: OECD Health Statistics 2024; Eurostat
Note: The EU average is unweighted

Germany's Krankenhausreform, adopted in November 2024 and effective from January 2025, exemplifies this structural shift. The reform aims to reduce overcapacity, concentrate high-acuity services into designated centres and redistribute some services into outpatient or specialist settings. Estimates suggest hospital numbers could decline by 20-25 percent over time through downgrades or closures of smaller acute facilities.

In markets where overcapacity is not the issue and demand exceeds available supply, elevated build costs and higher borrowing rates have materially curtailed new hospital development, limiting the pace at which additional capacity can be added.

Importantly, a declining bed base does not equate to lower activity levels. Surgical volumes have continued to increase, while improvements in productivity and the migration of suitable procedures to day-case and outpatient settings have reduced the requirement for inpatient beds. Hospitals are increasingly focused on complex and tertiary care, supported by a distributed network of surgical hubs, diagnostics and specialist facilities. For real estate investors, this represents a redistribution of supply across formats rather than a contraction, broadening the range of investable outpatient and specialist assets.

FIG 9. AMBULATORY CARE AS % OF TOTAL AMBULATORY AND HOSPITAL EXPENDITURE, 2015 - 2023



Source: Eurostat

Workforce Constraints and Technology-Enabled Productivity

Healthcare workforce availability has become an increasingly significant restriction on hospital capacity across Europe. Ageing clinical workforces, persistent recruitment shortages and sustained labour cost inflation are limiting throughput, meaning effective supply is increasingly determined by staffing availability rather than physical bed stock. In most systems, shortages are reported across doctors, nurses and allied health professionals.

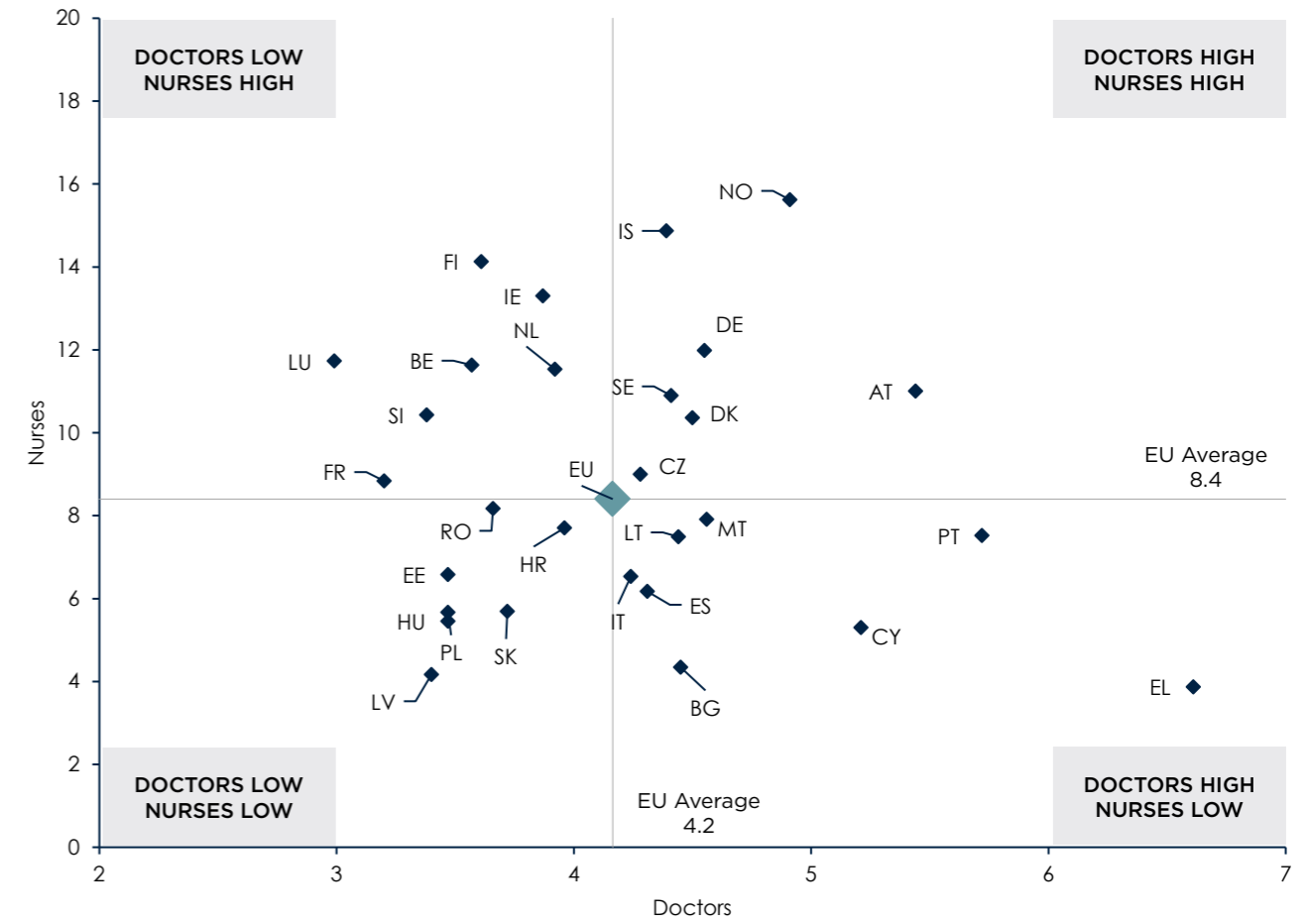
Technology is being deployed to alleviate these pressures and enable reduced staffing models. Telemedicine and remote consultations, while below pandemic peaks, remain above pre-2020 levels and are now embedded within triage, follow-up and chronic disease management pathways. Digital referral systems, electronic scheduling, remote monitoring and data-led workflow tools are enhancing efficiency and reallocating clinical time towards higher-acuity and procedural activity.

Artificial intelligence represents the next stage of this evolution, improving diagnostic reporting, optimising scheduling and bed management, and automating administrative processes, thereby increasing effective output per clinician and per facility.

Technology enhances productivity rather than replacing physical infrastructure. Virtual care is effective in triage and lower-complexity pathways, but surgical procedures, advanced diagnostics and complex inpatient services remain inherently estate-dependent. Scans and surgeries must still be delivered in physical settings. For hospital real estate, this underlines the defensibility of the asset class, with core clinical activity anchored to specialist facilities even as care pathways become more digitally enabled.

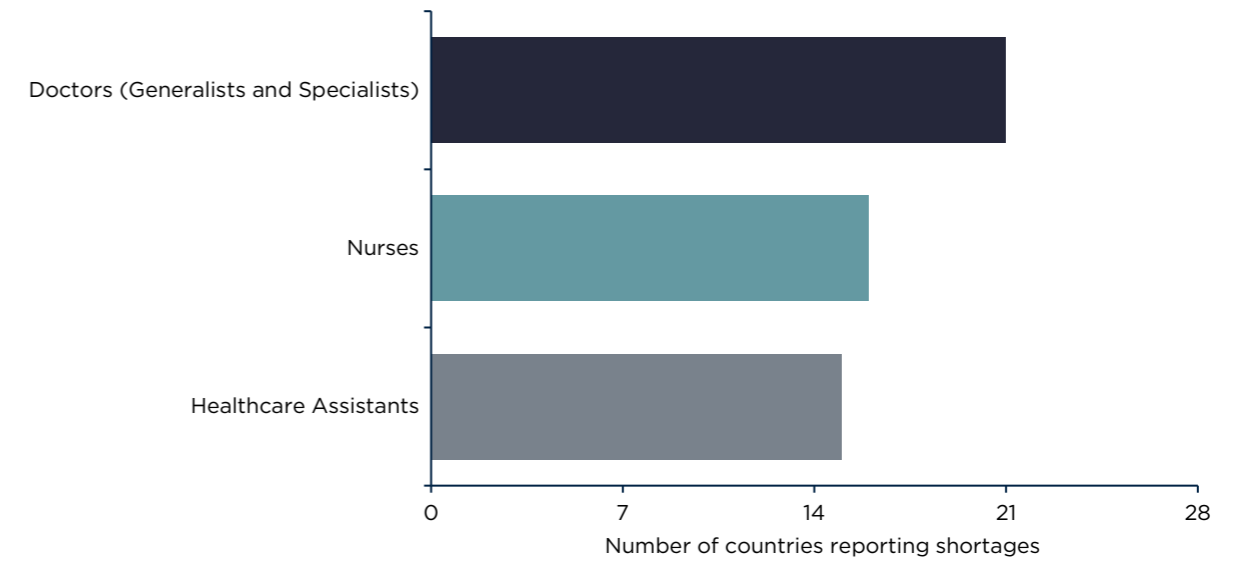


FIG 10. PRACTICING DOCTORS AND NURSES PER 1,000 POPULATION, 2022 (OR NEAREST YEAR)



Source: OECD
 Note: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). Data by countries varies in inclusion criteria so is only indicative.

FIG 11. EU COUNTRIES REPORTING SHORTAGES OF HEALTH WORKERS IN 2022 AND 2023



Source: European Labour Authority
 Note: Data refers to the second half of 2022 and/or the first half of 2023, based on 28 reporting countries (EU27 and Norway).

DEMAND

Healthcare Demand and Its Implications for Healthcare Real Estate

SERVICE REQUIREMENTS FOR HOSPITAL AND BROADER HEALTHCARE SERVICES ACROSS EUROPE ARE SHAPED BY LONG-TERM DEMOGRAPHIC CHANGE

As the population ages, both the complexity and volume of care increase, driving the need for acute and specialist services.

This core demographic trend is reinforced by a range of secondary demand drivers, including the introduction of innovative therapies and treatment pathways, advances in medical technology that expand the scope of treatable conditions and increasing health awareness among populations.

In mature markets, increasing care needs are increasingly being met through a shift in care delivery rather than a simple expansion of inpatient capacity. In less mature healthcare markets, service utilisation is supported by expanding access to basic healthcare services, rising national incomes, and a higher proportion of household and public expenditure being allocated to healthcare.

Ongoing trends towards digitisation, outpatient treatment, and more preventive models of care, combined with policy recognition that long term residential care is often more cost effective than

prolonged hospitalisation for older patients, suggest that greater healthcare demand will not necessarily equate to proportional growth in inpatient hospital capacity.

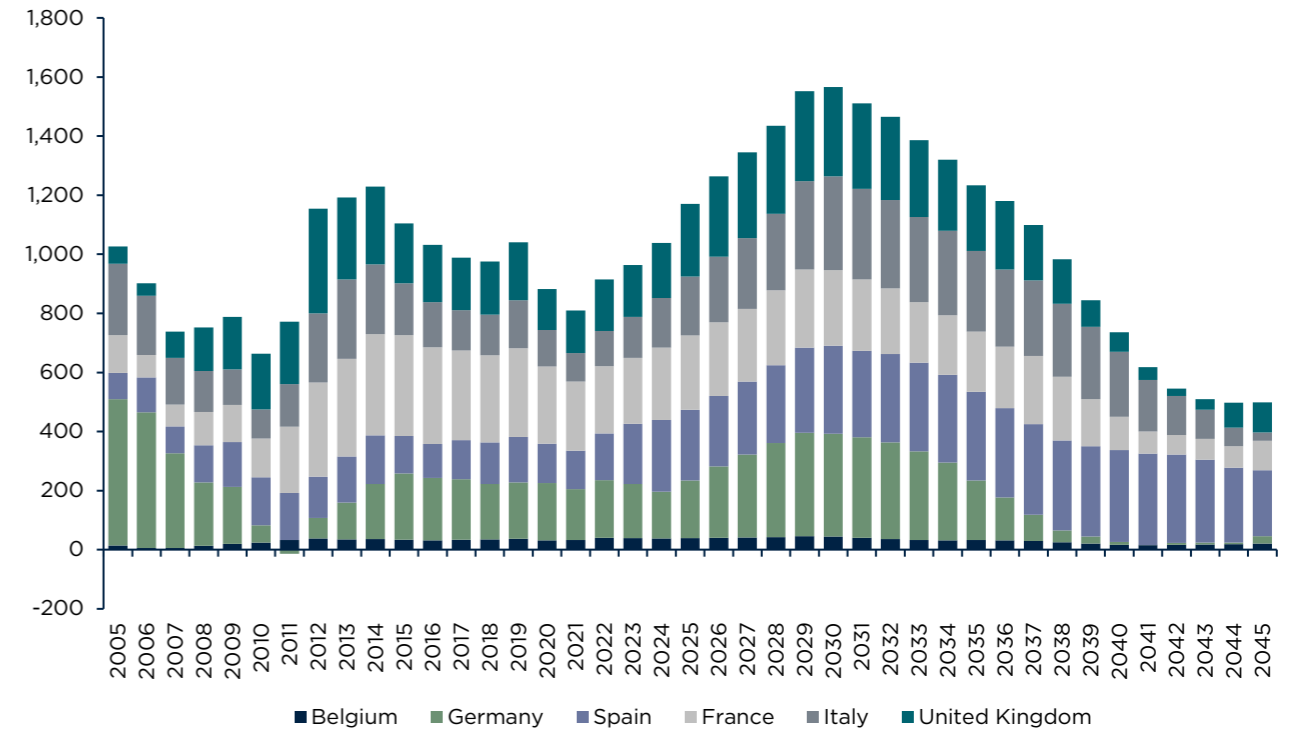
The implications of Europe's ageing population for future acute hospital demand are therefore more nuanced than in sectors such as elderly care. While an older population inevitably increases acute activity levels, it remains uncertain exactly how much of this will translate into hospital bed requirements.

Some of this additional activity is likely to be absorbed through changes in care settings and delivery models, with continued emphasis on efficiency, specialisation, and alternatives to traditional inpatient care.

For real estate investors, this shift underscores the importance of identifying where future clinical needs are most likely to be absorbed. The opportunity increasingly lies in aligning capital with efficient and adaptable operators that can respond to changing care pathways, and in investing in real estate that is designed to support flexibility, throughput and reconfiguration as care provision models evolve.

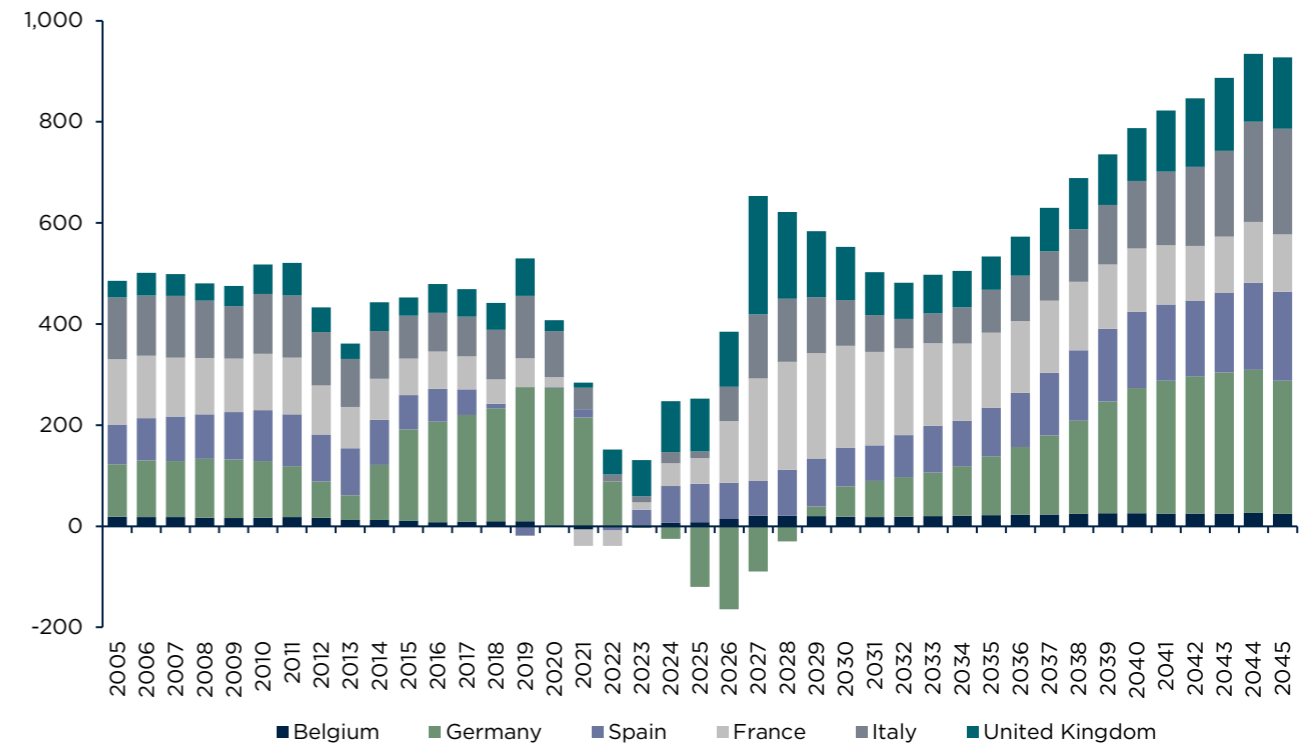


FIG 12. YEAR-ON-YEAR CHANGE IN NUMBER OF 65+ YEAR OLDS 000S, HISTORICAL AND FORECAST, 2005 TO 2045



Source: Oxford Economics

FIG 13. YEAR-ON-YEAR CHANGE IN NUMBER OF 85+ YEAR OLDS 000S, HISTORICAL AND FORECAST, 2005 TO 2045



Source: Oxford Economics

WAITING LISTS DEMONSTRATE DEMAND IS OUTPACING SUPPLY

Long waiting times for elective hospital procedures were already a feature of many European healthcare systems prior to the pandemic and have since become more acute. The suspension of non-urgent activity during COVID led to a significant accumulation of deferred treatments, resulting in persistently elevated waiting lists across the UK and Europe.

Despite the resumption of elective activity, waiting lists in many countries remain materially above pre-pandemic levels. This persistence reflects structural capacity constraints across theatres,

diagnostics and inpatient beds, indicating that system supply has not expanded sufficiently to meet underlying demand.

In publicly funded systems, sustained waiting time pressures are increasingly shaping policy responses and, by extension, real estate demand. When public hospitals face persistent capacity shortfalls, governments have tended to respond either through capital investment programmes or by outsourcing activity to independent sector providers.

FIG 14. CATARACT SURGERY

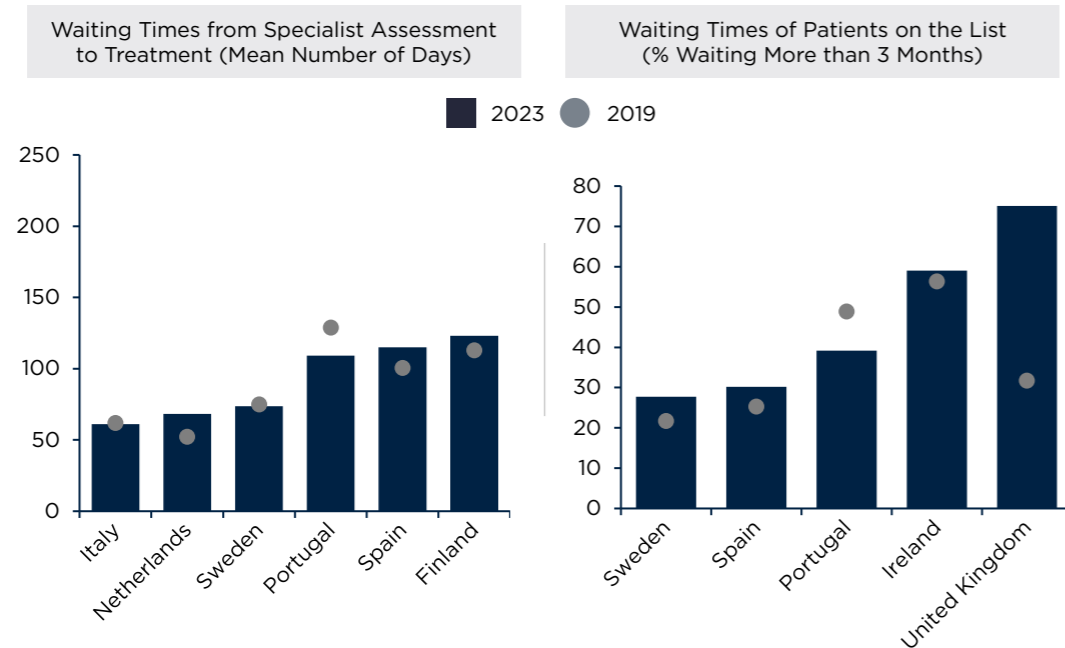
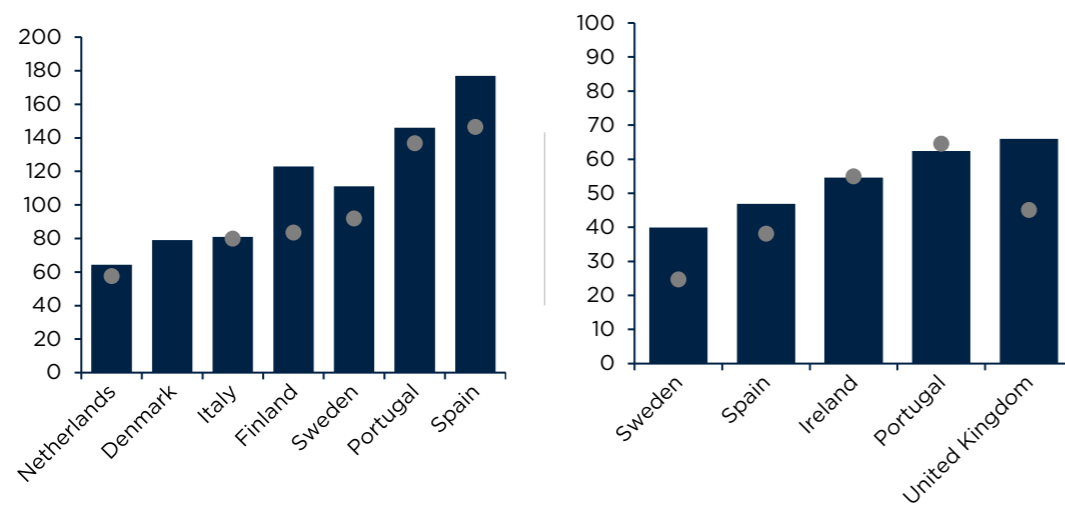


FIG 15. HIP REPLACEMENT



Source: OECD
Note: The latest year for Italy, Finland and the United Kingdom is 2022 (not 2023).

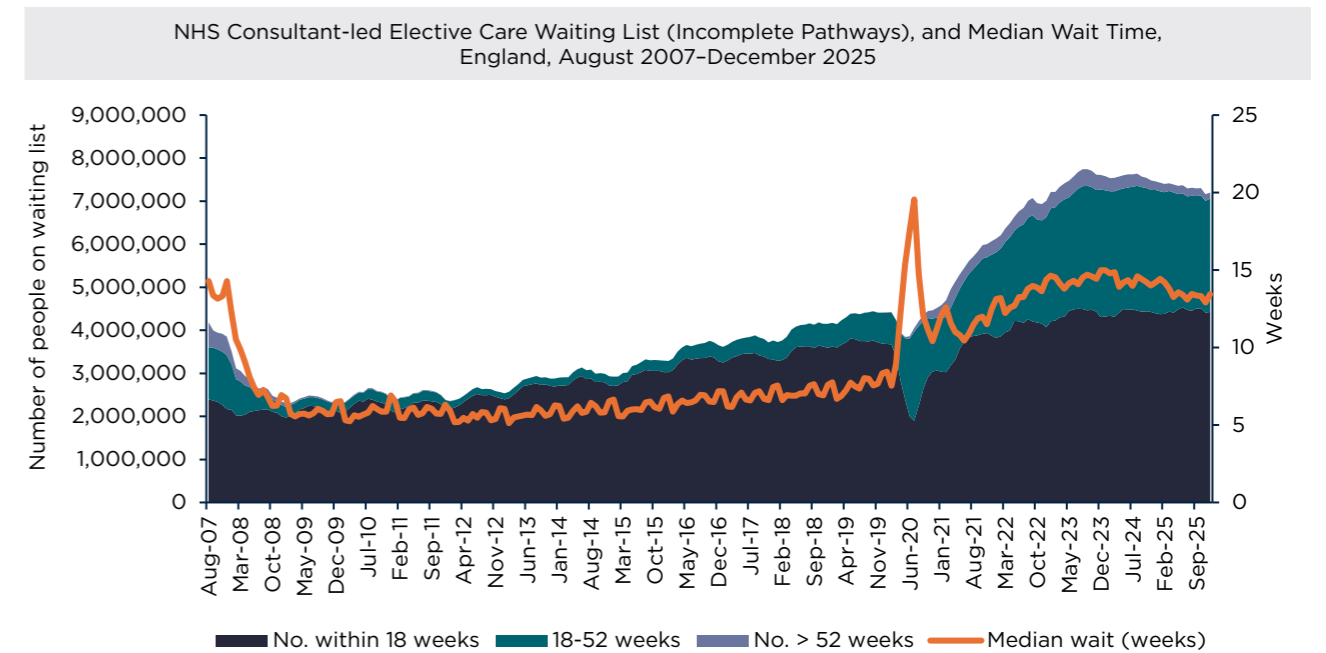
In the United Kingdom, for example, the elective waiting list reached a record level of c. 7.4 million treatments in August 2023, prompting the NHS to expand the use of private hospitals to deliver publicly funded procedures.

Elevated waiting lists can increase private sector activity in two ways. Firstly, it supports higher utilisation and revenue visibility for private hospitals through government contracting, while also stimulating private pay demand from patients seeking faster access to care. This was seen in the UK with growing political support for the use of the private sector alongside a rise in private medical

insurance and self-pay funded procedures.

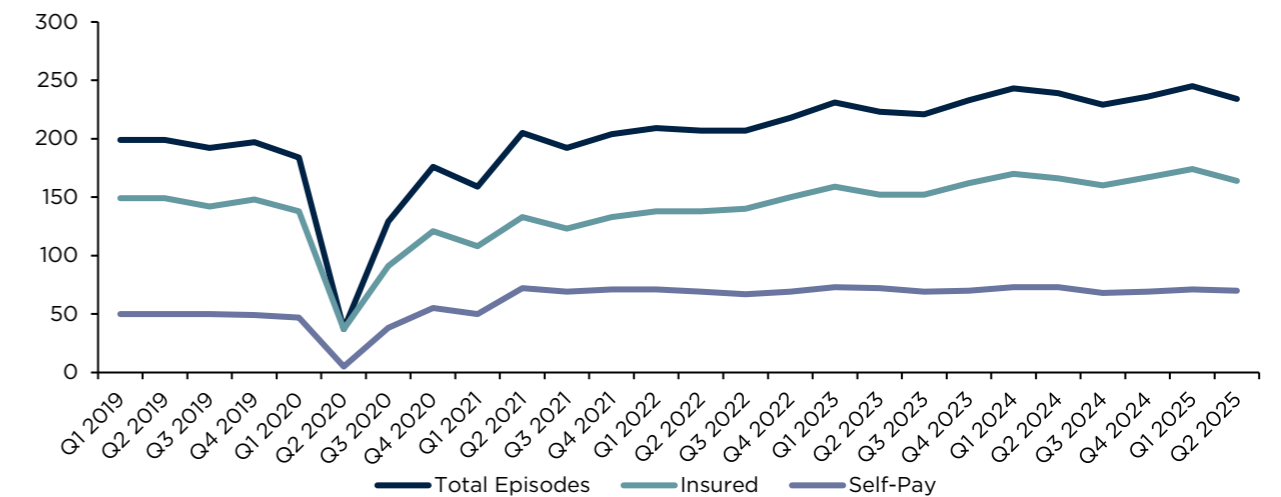
In parallel, persistent waiting-list pressures concentrated in specific specialties continue to support the case for targeted new development, particularly outpatient-led and high-throughput facilities in areas such as orthopaedics and ophthalmology, where capacity pressures are most pronounced. The expansion of specialist providers, such as Optegra in ophthalmology, demonstrates how unmet public-sector patient volumes are translating into scalable private-sector delivery models.

FIG 16. INCOMPLETE REFERRAL TO TREATMENT (RTT) PATHWAYS (WAITING LISTS), ENGLAND



Source: NHS England

FIG 17. UK PRIVATE ADMISSIONS BY QUARTER, 000'S



Source: PHIN

HOSPITAL OPERATORS

Hospital provision across Europe spans public systems, charitable institutions and private operators, with differing ownership and funding models

Investable hospital real estate, however, is concentrated within the private segment, including listed groups, private equity-backed platforms, family-owned businesses, charities, and church or foundation-backed providers.

The most prominent European private hospital platform is Fresenius, through its Helios division. Fresenius Helios is Europe's largest private hospital operator, with Helios Germany operating more than 80 acute hospitals alongside a rapidly expanding outpatient network of medical care centres, and Helios Spain (operating under the Quirónsalud platform) running approximately 57 hospitals and around 130 outpatient centres.

Helios stated in its latest accounts that it is prioritising outpatient expansion and closer integration between hospitals and medical care centres. In Germany, reform of the hospital system is accelerating the concentration of complex care into designated centres while encouraging lower acuity services to migrate into outpatient and community settings. Large private operators such as Helios are positioning accordingly, but the transition introduces uncertainty around service allocation and reimbursement over the medium term.

France presents a different challenge. Private hospital operators are deeply embedded and demand remains stable, but operators are highly exposed to government-set reimbursement tariffs. Ramsay Santé, alongside other large platforms, has continued to deliver operational growth, including through expansion into primary care and outpatient services. However, tariff indexation has consistently

lagged underlying wage and cost inflation, reflecting wider pressure on public finances and the need to contain increasing health expenditure within a tight fiscal environment. Ongoing budgetary tension within the social security system, coupled with heightened political sensitivity around healthcare funding, has increased uncertainty around the pace and extent of tariff catch-up, placing sustained pressure on margins. From an investor perspective, covenant strength is therefore closely linked to operators' ability to drive efficiency, optimise case mix and diversify revenue streams.

In the UK, the private acute hospital market consists of a mix of listed operators, private equity backed platforms, charitable providers, and international entrants, with capacity concentrated among a small number of established domestic groups (and Australian Ramsay Health Care) alongside the increasing presence of premium international platforms from the US such as HCA Healthcare UK and the Cleveland Clinic.

The past five years have been positive for the UK private healthcare market, supported by increased NHS outsourcing and higher private medical insurance (PMI) and self-pay volumes as NHS waiting lists have lengthened. Self-pay and PMI has settled at a structurally higher point in the UK than prior to the pandemic, even as affordability pressures have intensified and competition between providers has increased. However, operators face mounting cost pressures, particularly labour inflation, while insurer concentration in the private market reduces pricing power.



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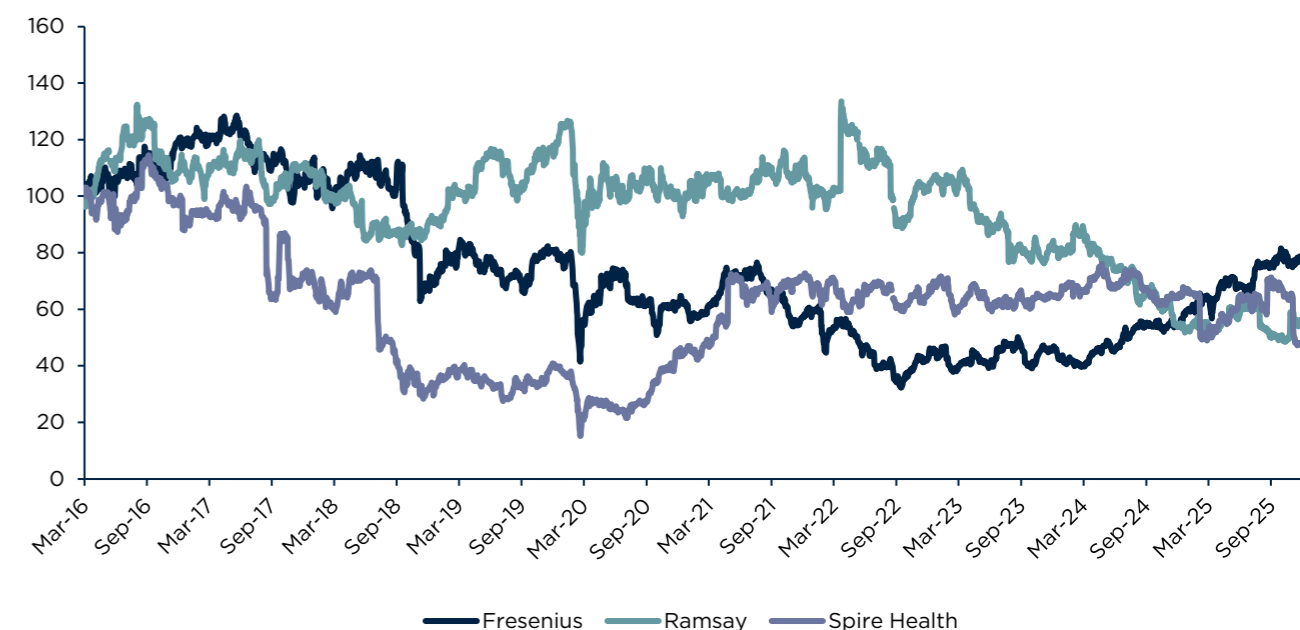


The example of Spire Healthcare illustrates current UK market dynamics. It's share price declined through 2023–25 amid margin pressure from labour cost inflation and uncertainty around NHS commissioning volumes, despite supportive demand. Against this backdrop, some investors view Spire as undervalued on an asset basis, with an owned estate valued at c.£1.4 billion versus a market capitalisation of c.£600–900 million, prompting a strategic review and reported private

equity interest from Bridgepoint and Triton in early 2026, which then contributed to an approximate 20 percent share price uplift in the days following the announcement.

Across markets, disciplined cost control and active management of service mix are critical. The principal risk is margin compression rather than reduced activity levels, reinforcing the value of adaptable, high-quality assets aligned to higher-acuity and integrated outpatient models.

FIG 18. HOSPITAL OPERATOR SHARE PRICES, INDEXED TO MARCH 2016 = 100



Source: Factset
 Note: Fresenius is a diversified healthcare group, with its share price reflecting multiple non-hospital businesses alongside hospital operations, while Ramsay Health Care is listed in Australia and derives earnings from a geographically diversified hospital platform.



Healthcare investors are now asking operators different questions than in the past. They focus on which new services operators are willing to introduce, how those services may be affected by technology and AI, and whether operational efficiency can be improved, including how the building itself can support that. These considerations are now firmly embedded in investment decision-making.

More agile operators, particularly those with higher-quality and more versatile assets, are able to accommodate new service lines. This helps to de-risk their businesses, diversify within a highly regulated environment, and restore profitability."



Xavier Cheval, Head of Healthcare - Praemia REIM France

OUTLOOK

Underlying demand for hospital care across Europe will remain strong, driven by a range of factors including ageing populations, rising disease prevalence and persistent capacity constraints within public healthcare systems, supporting sustained utilisation and long-term income durability across private hospitals and adjacent assets.

Margin pressure is likely to persist over the near term as labour cost inflation, staffing shortages and payer concentration weigh on profitability, increasing the importance of operational efficiency gains and service-mix optimisation.

Public and private operators are expected to continue rebalancing activity towards higher-acuity and complex care within hospitals, alongside expansion of outpatient, day-case and ambulatory services. Rehabilitation and mental health facilities are likely to play an increasingly important role within integrated care pathways, further broadening the real estate investment opportunity.

Workforce availability is set to remain a key determinant of growth, strengthening the case for investors to partner with operators that are actively deploying AI and other digital technologies to optimise clinical workflows, automate administrative processes and enhance asset utilisation. This will reinforce the premium placed on flexible, future-ready real estate aligned with technology-enabled care delivery models.

Transaction activity in hospital real estate has recovered gradually, supported by improved liquidity in debt markets during 2025 as financial conditions have stabilised. With interest rates easing, investors will likely re-engage, albeit selectively, focusing on high-quality, flexible hospital assets that are operationally critical and embedded within broader outpatient and regional care networks.

Capital deployment has also improved and this momentum is forecast to carry into 2026. Investment is likely to prioritise refurbishment, expansion and reconfiguration of existing estates, alongside targeted allocation to outpatient, mental health, rehabilitation and specialist assets where service requirements and funding frameworks are most supportive.





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UK & EMEA



Caryn Donahue
Head of Healthcare &
Senior Housing
+44 (0) 7800 916 955
caryn.donahue@savills.com



Craig Woollam
Head of Healthcare
+44 (0) 7870 555 754
cwoollam@savills.com



Marcus Roberts
Head of European OCM
+44 (0) 7807 999 187
mroberts@savills.com



Joel Gazeres
Director - Transactions
+44 (0) 7771 974 412
joel.gazeres@savills.com



Rick Savage
Head of Healthcare
Valuations
+44 (0) 7855 772 048
rick.savage@savills.com



Alan Bennett
Director - Valuation
+44 (0) 7779 901 976
alan.bennett@savills.com



Aileen Wu
Director - Valuation
+44 (0) 7815 467 489
aileen.wu@savills.com



Katarina Szinekova
Director - Valuation
+44 (0) 7974 877 625
katarina.szinekova@savills.com



Thomas Atherton
Strategy & Market
Intelligence
+44 (0) 7812 407 724
tom.atherton@savills.com

GERMANY



Max Eiting
Director, Head of
Healthcare
+49 174 4913958
meiting@savills.de



Thomas Berger
Director - Valuation
+49 1515 8005315
tberger@savills.de

SPAIN



Nuria Bejar
National Director,
Healthcare
+34 677 47 05 20
nuria.bejar@savills.es



Andrew Stevens
Director - Valuation
+34 626 18 88 17
andrew.stevens@savills.es

SAVILLS CAPITAL ADVISORS



Joe Guilfoyle
Co-Head of Savills
Capital Advisors -
Corporate Finance
+44 (0) 7790 909 175
joe.guilfoyle@savills.com



Andrew McMurdo
Co-Head of Savills
Capital Advisors - Debt
Advisory
+44 (0) 7787 503 243
andrew.mcmurdo@savills.com