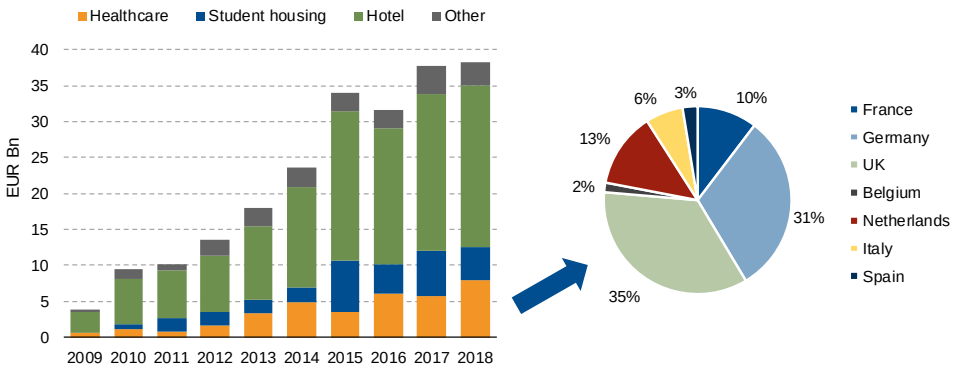
Healthcare: an attractive segment for alternative CRE investors

Alternative real estate investments have gained pace in the last decade as investors have sought out higher yields and taken steps to avoid procyclical investments in the mid-to-late phase of the economic cycle. This report looks into the healthcare real estate sector and particularly the care homes segment in Western Europe[1]. We will provide insights into the drivers of investor appetite, segment fundamentals, challenges in coming years and conclude with viewpoints from a credit rating agency standpoint.

Since the outset of the global financial crisis, alternative real estate investments in Europe have seen a constant increase, reaching EUR 38bn in 2018, up from EUR 5bn in 2009, representing a constant annualised growth of about 25% over that period (Figure 1). Trailing the hotel sector, healthcare investments were the second largest contributor to growth in investment volumes in 2018, reaching EUR 7.7bn, up 40% over the previous year. Healthcare fundamentals make the sector attractive for investors in the mid-to-late phase of the economic cycle. However, the segment's share of 2%-4% in current national commercial real estate (CRE) investments is modest.

Figure 1: Volume of alternative investments in Europe



Source: CBRE, Your Care Consult, Scope Ratings

A 10-year healthcare performance look-back

Since 2007, the Western European healthcare sector has performed better than traditional asset sectors with like-for-like 29% value appreciation[2] compared to around 20% for office and industrial and 10% for retail.

In the meantime, its volatility has been lower than peers, with 4.5% annual volatility compared to traditional asset classes, where volatility has oscillated between 6.8% (retail) and 9.1% (office). This reflects investor appetite for the asset class, the segment's lower sensitivity to economic cycles and its underlying characteristics.

[1] In this report, we primarily focus on the largest European markets: France, Germany, Italy, Spain and the United Kingdom.

[2] Measured on an unweighted country average capitalisation rate basis. i.e.: 1 - (1 – capitalisation rate$_{2007}$) / (1 – capitalisation rate$_{2018}$)

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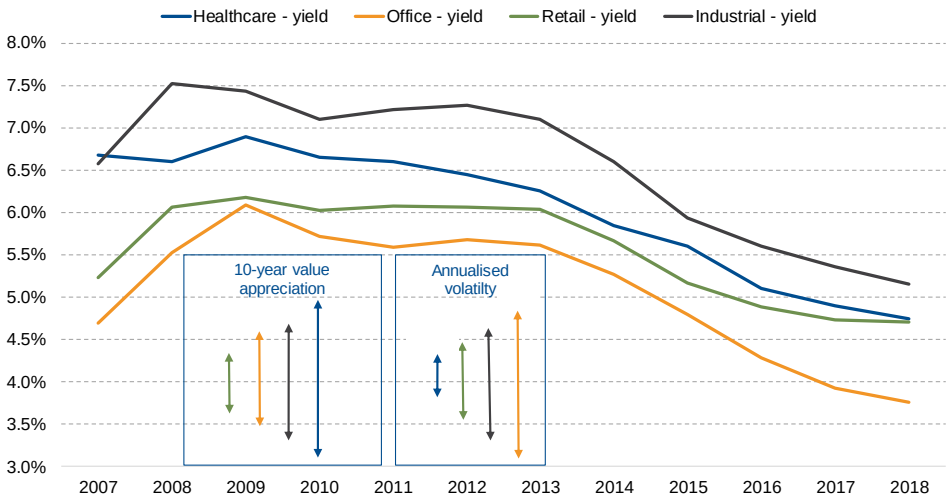
Figure 2: Western Europe CRE prime yields and annualised volatility[3]



Source: Colliers, Cushman & Wakefield, Scope Ratings

Drivers of investment attractiveness of the healthcare sector

Core investment with long-term value and steady cashflows…

The healthcare sector is attractive for real-estate investors looking for long-term core investments due to its steady inflation-linked cashflows with limited leasing costs, its positive long-term fundamentals and its potential residual value.

Healthcare real estate is usually rented to a single tenant (operator) under inflation-linked triple net leases with a long tenor (10 to 25 years). This provides predictable and stable cash-on-cash return with limited letting costs. Moreover, people's need for treatment and care arises irrespective of the overall state of the economy. This results in the sector's low correlation with the economic cycle, unlike traditional CRE segments. Last but not least, it may provide exit strategy opportunities to investors who would like to turn aged assets into residential properties.

Market structure overview

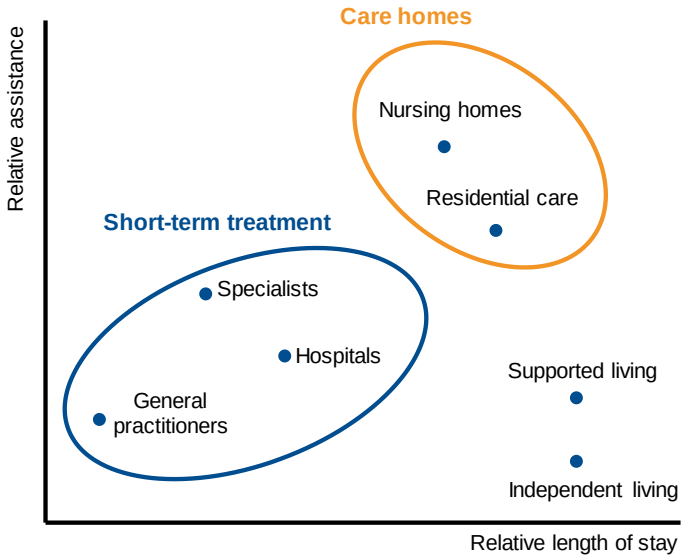
Type of healthcare real estate assets

One market, several subsectors….

Healthcare assets can be classified into two broad categories: i) properties that aim to improve the condition of patients by providing short-term treatment and ii) properties that provide long-term assistance to people in their daily lives without the intention of significant cure. Types of short-term facilities range from general practitioners' offices, which in most cases is the first step of entering healthcare; hospitals, which can provide acute care for more serious illnesses; to institutions that require a very high level of special expertise, such as plastic surgery. Other assets provide accommodation for people, usually the elderly, with different levels of assistance and length of stay (Figure 3).

[3] Expressed in standard deviations

Figure 3: Schematic overview of healthcare facilities



Source: Scope Ratings

…function of the relative assistance and the length of stay

Independent (senior) living can be viewed as one example of such assets from an investor-perspective, even though it does not strictly belong to the healthcare segment. These are housing communities that provide certain services and an adequate social environment for residents, but which do not offer material assistance to their daily lives. Supported living is also a community-based type of living for older or disabled people who do not need permanent serious care but who do require assistance with daily activities such as washing, shopping, cooking etc.

Care homes or long-term nursing and residential care facilities "comprise establishments primarily engaged in providing residential long-term care that combines nursing, supervisory or other types of care as required by the residents" (Eurostat, 2016). These establishments provide accommodation and healthcare services 24-hours a day for elderly residents with qualified care staff. Nursing homes are the most expensive, providing continuous medical care. This report focuses on the latter type of long-term care assets, since these are the most likely to provide investment opportunities. Short-term treatment facilities like hospitals are more often owned and operated publicly and do not allow for private participation.

Different market structures among countries

The market structure assessed by ownership type and profit orientation varies between countries. The share of publicly-owned care homes is the lowest in the UK and Germany, with less than 10% market share, whereas in countries where governments are traditionally more involved, like France, the share of publicly-owned institutions is above 40%.

The role of the private sector differs across jurisdictions. In some countries, a significant share of care homes operates solely on a non-profit basis, therefore providing limited opportunities for investors. In contrast, in the UK most private providers are for-profit in line with government policies incentivising an increased role for private capital in long-term care. Publicly and privately-owned care homes often differ both in profitability and the quality of care.

The set-up for operators also differs. In several countries the market is free i.e. operators can easily enter the market without direct government approval, like in the UK, Germany or Spain. In countries such as France or Italy, only licensed companies are allowed to

operate in the market. Operators play an important role in securing a constant income stream by choosing attractive locations to open new homes and maintaining consistently high occupancy rates while keeping costs at a reasonable level and still ensuring a good quality of care for clients. Experienced operators with a proven history are more likely to run profitable care homes, while the performance of new entrants can be more uncertain.

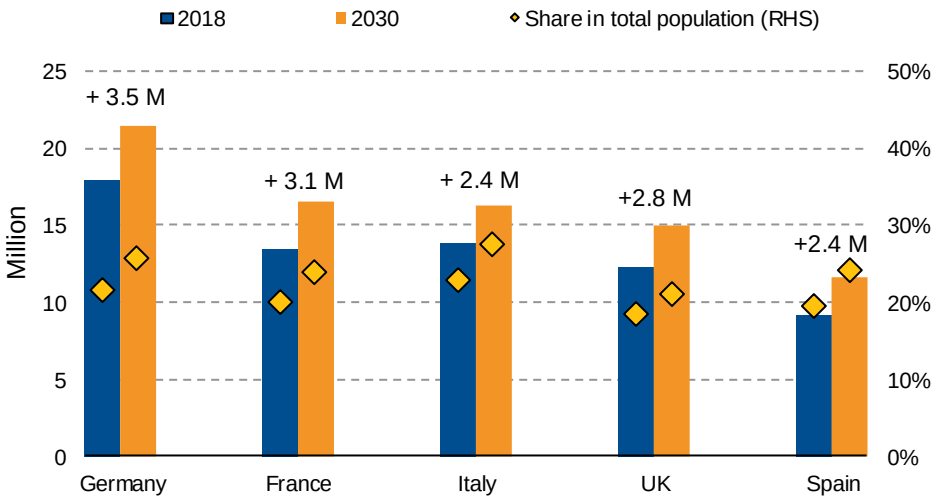
Sound fundamentals: demographic change, increasing demand, public and private financing

Demographic change

Aging population supports future demand growth

Europe's population is ageing, strongly supporting demand for healthcare, both medical and residential. This trend will continue. People are living longer, while the number of children being born is decreasing. It is expected that the current population of the European Union aged 65+ will grow from the current 101 million by more than 20% to 124 million by 2030. Also, the share of elderly people in the total population will increase: it is expected that in Europe the current 20% share will increase to almost 24% in the coming decade. The increase is expected to be the highest in Germany, where the current 18.5 million 65+ population is projected to grow by 3.5 million people (Figure 4). This suggests that further capacity will be needed, in terms of both physical assets and human staff.

Figure 4: 65-and-above population in 2018 and 2030



Source: Eurostat, Scope Ratings

Imbalance between growing demand and limited supply

… generating an imbalance between demand and supply

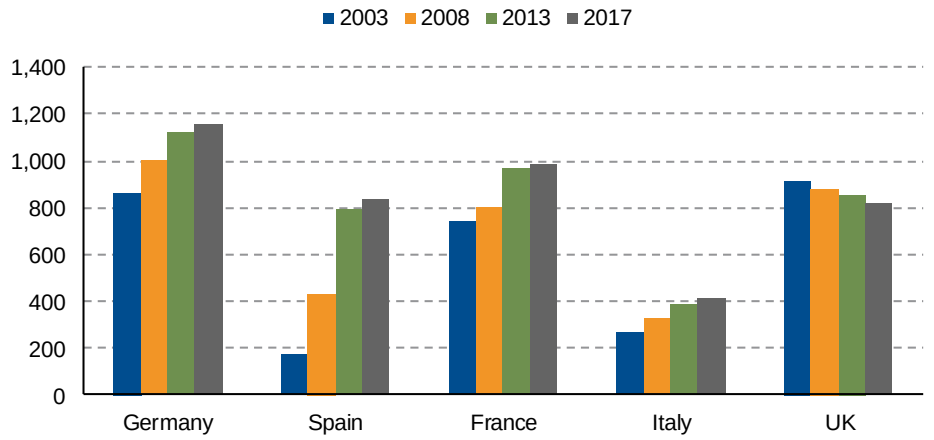
The sector is generally characterised by a demand-supply imbalance reflected in un-met need[4] and high average occupancy rates.

The number of beds available in care homes has increased in most countries in the last decade, but differences remain. The number of beds in Germany has increased by a meaningful 40% since 2000, while in the same period the number has remained roughly the same in the UK, resulting in a decreasing ratio of available beds per 100,000 inhabitants. The per capita number of beds compared to the population is also highest in Germany with 1,150 beds per 100,000 people, whereas the lowest number is in Italy with a mere 400, despite the constant increase in recent years (Figure 5).[5]

[4] 15% to 30% of unmet needs for healthcare is due to waiting lists, according to Eurostat.
[5] The number of beds in formal care itself is not a fair measure of the capacities in the sector, since in many countries informal care and home care play a significant role.

Care homes usually have high occupancy rates – around 90% – with some exemptions like France and Italy, where occupation rates are closer to 100%. This is due to the licencing structure and high barriers to entry.

Figure 5: Available beds in care homes per 100,000 inhabitants



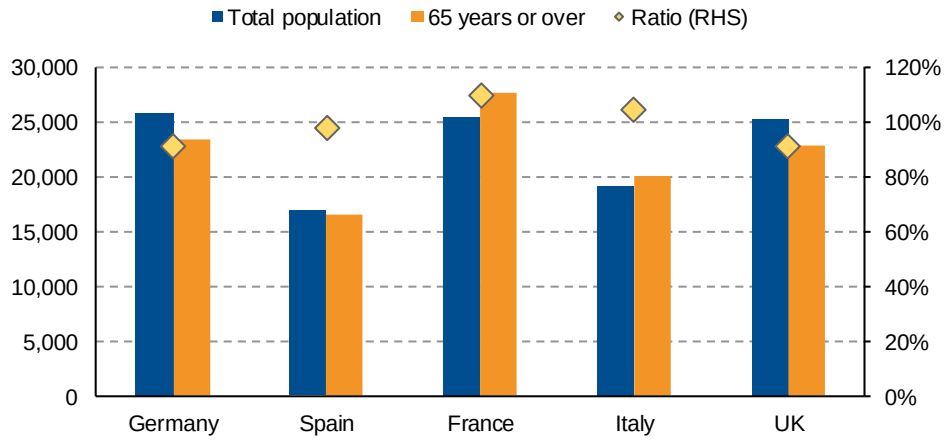
Source: Eurostat, Scope Ratings

Private financing

Income level of the elderly is not significantly lower

The funding for care derives from different sources, both private and public. Private financial sources include private health insurance and out-of-pocket payments. The income level of older people is not significantly lower than the total population. In 2018, the mean net income of the total population of the EU was around an annual EUR 19,900. For people over 65, it was EUR 19,100. In some countries, like France and Italy, the income of elderly people is roughly 5%-10% higher than the total population (Figure 6). These figures suggest that in these countries, affordability does not in general create a constraint for elderly people. Significant differences can exist, however, both between countries (e.g. in the UK the income of the elderly is only 90% of the total population's) and within countries with people with different social circumstances.

Figure 6: Average net income of the total population and the elderly



Source: Eurostat, Scope Ratings

Long-term challenges to be addressed: finding staff, sustainability of financing, government policy

Workforce

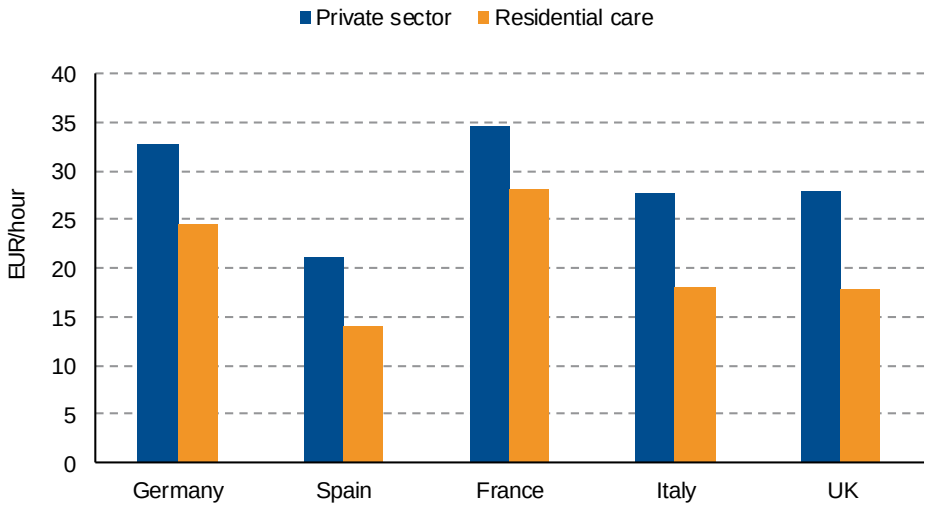
Recruiting, paying and retaining staff are the biggest challenges

While more and more people will be in need of care, costs will increase further. Staff costs represent the largest cost component. In the UK, for instance, costs are equal to almost 60% of total revenues. In the meantime, demand for nurses and residential care employees is rising. The number of nurses has increased in all major countries. The largest growth was in France, where the current 723,000 nurses represents a 13% increase in the last five years.

It is already hard to find skilled staff, and this is likely to become an even more scarce resource. Care is a very labour-intensive sector, having solid potential for job creation. However, the work itself is in most cases very challenging, mentally and physically, with demanding working conditions but relatively low financial compensation.

According to the last available data, average per-employee total labour costs[6] in residential care (which includes not only employee compensation but social security contributions, training costs etc.) are reported to be 30% lower on average in the major countries than in the private sector as a whole. The worst situation emerges in the UK, where labour costs are 36% lower in residential care (Figure 7). Given these conditions, migrants play a significant role. This is most apparent in the UK, where last year 15% of nurses were trained outside of the country.

Figure 7: Total labour cost (2016)



Note: Private sector includes industry, construction and services (except public administration, defence, compulsory social security).

Source: Eurostat, Scope Ratings

[6] Which includes not only the employees' compensation, but among other items social security contributions, training costs etc.

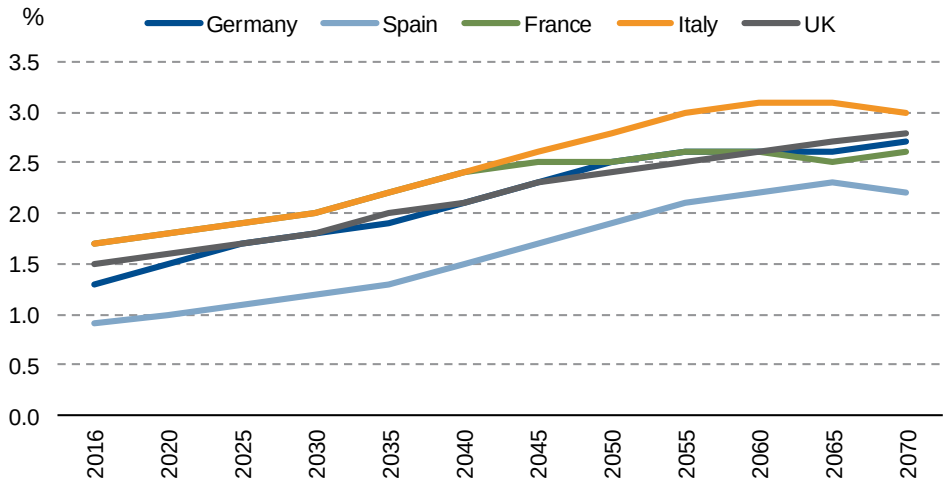
Sustainability of public financing

Increasing healthcare expenditure raises sustainability questions

Public funds include general government expenditures in the framework of national healthcare insurance and local government contributions. Public funds for financing long-term care have been increasing in the past and represent a significant component of government expenditures. It is projected to increase further. In recent years, EU-level[7] long-term care expenditure accounted for 1.6% of GDP in addition to 6.6% for other healthcare expenses (e.g. hospitals, medication).

According to European Commission projections, these expenditures will increase to 3.1% and 7.5% respectively by 2070 (Figure 8). On one hand, this shows that policymakers are aware of the increasing financing needs as a result of the ageing population, but on the other hand raises the question of sustainability of public financing and the need for more extensive involvement of private sources.

Figure 8: Projected expenditures on long-term care as % of GDP



Source: European Commission, Scope Ratings

Governments' fiscal space central to their abilities to fund future healthcare costs

Rising healthcare costs constitute a key concern for governments in advanced economies and pose long-term risks to the sustainability of public finances. It is important to take into account the amount of fiscal space available to governments in order to ensure that rising healthcare expenditure can be funded without endangering market access or the sustainability of public finances.

Scope recently analysed[8] the fiscal space of 35 countries around the world taking into account the impact of future increases in healthcare spending on governments' fiscal space. Our analysis found that Germany has 'significant' fiscal space, while France, Spain and the UK all had 'some' fiscal space, indicating a degree of budgetary room to support economies in contingent scenarios.

The ability of these countries to sustainably finance upcoming healthcare costs is less of a concern than it is, for instance, for Italy, which faces high long-term care costs as a share of GDP over the 2020-70 period with 'limited' fiscal space, according to Scope's research (Figure 9).

[7] European Union excluding the UK
[8] Lennkh, A. and T. Vasse. (2019) Fiscal space in a low interest rate context: growing for most, not present for all (Scope Ratings).

Figure 9: Scope's fiscal space assessment* – 'significant', 'some' or 'limited'

Region	Scope's fiscal space assessment								
	Limited			Some			Significant		
Euro area	IT			BE	CY	FR	AT	EE	FI
				GR	MT	PT	DE	IE	LV
				SI	ES		LT	LU	NL
							SK		
Non-euro area				HR	HU	PL	BG	CZ	DK
				RO	UK		SE		
EFTA							NO	CH	
Other	CN	JP*	TR		RU				
	US*								

*Scope's assessment does not take into account the disproportionate benefits for certain countries of having a global reserve currency.

Aged and partially obsolete care home markets and regulatory requirements

Quality of buildings and regulations

Another challenge is the quality of the properties. A significant proportion of buildings are aged, e.g. in France half of the care homes were built more than 25 years ago, and in the UK 85% of care homes are 40 years old[9]. Obsolete buildings will result in capital expenditure needs, which can reduce profitability or even capacity to operate due to regulation. Maintaining the quality of buildings is a must; several countries have rules on this.

Another risk factor concerns quality expectations, not only for the buildings but for the quality of service. In the UK for example, the Care Quality Commission[10] is constantly monitoring and assessing the quality of services provided, with the ultimate aim of confirming that institutions are safe, effective, caring, responsive and well led.

Scope's credit rating approach to healthcare CRE

Scope assesses the credit risk of commercial real estate debt – including the healthcare segment – based on cash flows generated by the assets being financed. The credit risk is twofold: i) term default risk, which relates to the borrower's failure to service interest and principal obligations during the term of the loan; and ii) refinancing default risk, which relates to the borrower's failure to refinance its debt at maturity.

Scope runs various scenarios that test base-case cash flows using different stress levels on our main assumptions: capitalisation rates, rental value haircuts and vacancy rates.

These stressed inputs will impact projected cash flows, collateral value and consequently a loan's term-default probability and recovery rate.

Capitalisation rates are based on historic market observations and are location, asset-type and quality-specific. AAA assumptions reflect through-the-cycle capitalisation rates increased by a volatility premium. This volatility premium is typically a multiplier of historic annual volatility. The lower volatility of healthcare assets compared to traditional asset classes will result in lower AAA capitalisation rates.

[9] Source: Knight Frank.
[10] Independent regulator of health and social care.

When assessing the net cash flows available to service the debt, Scope looks at contractual rental income and estimated rental income. The credit quality of tenants/operators will be considered in order to assess their likelihood to default on contractual rental payments as well as the soundness of their business plans. Credit to business plans will be commensurate with Scope's perception of the quality of those business plans.

To assess the credit quality of an operator, Scope looks at – among other things – their profitability. The source of financing of patients will drive future income stability and also exposure to government policy change, according to whether fees are paid by private out-of-pocket funds or local government subsidies.

For vacancies, Scope will typically not assume a structural vacancy, since healthcare properties are usually let to only one operator. However, we will assess temporary vacancies reflecting a re-letting period following an operator default or after the maturity of a lease. Temporary vacancies will be determined by local market insights, macroeconomic trends and by specific asset characteristics (e.g. whether it is fit for purpose or requires tenant improvements, etc.).

At a property level, irrecoverable costs will also be assumed depending on the type of lease agreement in place (i. e. simple, double net or triple net lease).

With regard to other refinancing risks, Scope assumes a CRE loan to be in refinancing default if the portfolio exit debt yield is below the all-in refinancing rate. A minimum debt amortisation rate will be one of the components of the all-in refinancing rate. It reflects the estimated remaining economic life of the CRE assets. For healthcare real estate assets, Scope would typically assume a 40-year economic life representing an annual debt amortisation rate of 2.5% (i.e. 1/40).

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