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FROM HEALTHCARE REAL ESTATE TO THE WELL-BEING SOCIETY:

new challenges for Europe

SUMMARY

EDITORIAL

While healthcare real estate needs to be considered on a European scale to achieve a relevant investment strategy, the sector benefits from solid and encouraging fundamentals resulting from continued demographic pressure and the rapid ageing of the population. Investing in health infrastructure also means offering the possibility to all to enjoy better health and promote well-being, which are essential elements for improving the quality of life in our societies.

Henry-Aurélien Natter, Head of Research Primonial REIM

EXECUTIVE **SUMMARY**

Enabling people to live in good health, and promoting well-being at all ages, are essential conditions for improving the quality of life.

Prior to the pandemic, major progress had been made to improve the health of millions of people. Significant advances have increased life expectancy and reduced the impact of certain major causes of death.

But new efforts are now needed, to address health issues old and new and to ensure continuous improvements in the population's health and well-being.

Improvements in health and well-being will come in part through an expansion of real estate infrastructure:

retirement homes and assisted-living senior housing | nursing homes | hospitals/ clinics | psychiatric institutions/ well-being centres

This expansion of European healthcare infrastructure creates numerous challenges which have been clearly identified:

- institutions will have to invest massively to offer suitable solutions;
- as public supply is limited, governments will need to turn to private investors in healthcare real estate across Europe, to meet future demand for new buildings and for the renovation of some ageing, even obsolete, facilities.

These significant healthcare real estate infrastructure needs are driven over the long term by demographic factors:

- the general growth of the population, which will put pressure on healthcare systems;
- the rapid ageing of the population, which will result in people living longer in better health, but will also leave senior citizens facing the development of the conditions that come with advanced old age.

Healthcare real estate constitutes a responsible investment as it contributes to a model of society which has at its heart the good health and well-being of individuals, healthy living, or the fact of promoting well-being for all. Prevention is a financial as well as a medical necessity. Funding preventative measures (tackling obesity, screening for cancer, etc.) generates savings that will allow healthcare systems to remain viable.

The general shift towards upstream prevention rather than downstream medical intervention is a fundamental trend. The main global causes of avoidable disease are smoking, dietary imbalances and excess alcohol consumption. Some studies have also identified pollution as a factor in shortening life expectancy. There is a consensus that the costs of prevention are less than the costs of medical treatment if the groups affected are sufficiently large[1]. As a result it is likely that public policy will increasingly incorporate this approach, as it becomes more culturally acceptable. One example is the phased tobacco ban in New Zealand from 2023.

The continuing demographic pressure and rapid ageing of the population are creating needs that make investment in healthcare infrastructure an absolute necessity. There is a real need for the renovation of existing facilities and for additional beds in healthcare establishments and nursing homes in order to cope with future demand, and this need represents investment in the tens of billions of euros.

Understanding the drivers of the demographic and real estate trends affecting healthcare infrastructure is therefore essential for building a Europe-wide long-term investment policy.

MAIN HEALTHCARE INFRASTRUCTURE FOR REAL ESTATE INVESTORS **WHAT IS INVOLVED?**

Preventative systems, health, medico-social and R&D	Generic term	Real estate
Facilities active in preventative health		Gyms, well-being and recovery centres, hydrotherapy establishments, thalassotherapy establishments, well-being clinics, etc.
Municipal structures	Surgeries	Surgeries, care homes/health centres
Medico-social establishments	Retirement homes	Nursing homes
		Assisted-living senior housing
Hospital and outpatient establishments	Hospitals, clinics and treatment centres	Medical, surgery and obstetrics hospital establishments - Hospitals and clinics
		Recuperative care establishments
		Psychiatric establishments
Life Science		Laboratories*

[1] Cohen JT, Neumann PJ, Weinstein MC (February 2008). «Does preventive care save money? Health economics and the presidential candidates». *The New England Journal of Medicine*

FROM THE DEMOGRAPHIC CHALLENGE TO THE HEALTH CHALLENGE

GROWTH AND DEMOGRAPHIC CHANGES IN EUROPE WILL **INCREASE LONG-TERM DEMAND FOR HEALTHCARE REAL ESTATE**

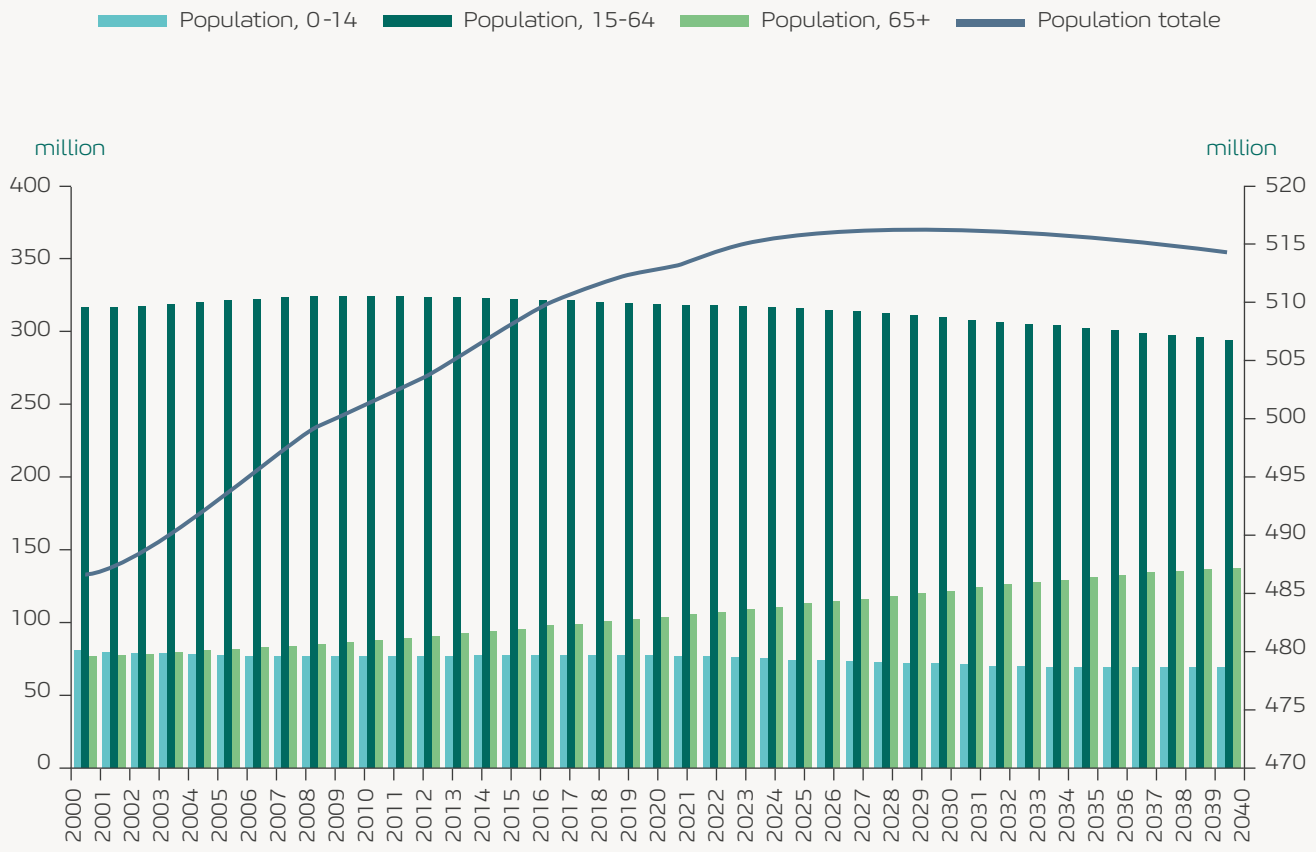
The population of the European Union and the United Kingdom will increase from 486 million in 2000 to more than 515 million in 2040. However, although the European Union's overall population is expected to increase, national populations will see different trends. Meanwhile, future demographic changes will have an impact on real estate, both for medico-social establishments and for hospital and outpatient facilities.

Over the next twenty years, the number of under 14s will remain stable, the number of those aged between 15 and 64 will shrink and the number of seniors (65 and over) will increase rapidly, climbing from 16% of the population at the beginnings of the 2000s to more than 27% by 2040.

This situation will therefore cause a shift in the distribution between generations, which will change radically as baby boomers move gradually from young retirees into old age.

The imbalance between supply and demand will persist, especially as demographic pressure will continue to be felt over the coming years. The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Turning towards the quality of life, this suggests that **medico-social establishments will have to respond mainly to demand from the under 65s whilst medico-social hospital establishments will mainly address the challenges of the senior population.**

Population of the European Union (plus the UK)
2000-2040



THE CHALLENGE OF AGEING

The ageing of Europe is an established fact. Nevertheless, as we have just seen, analysis by age group helps define the gradual changes that will take place and their overall consequences for society and thus healthcare infrastructure.

To better understand the challenges that Europe will face, it is essential to identify the changes that correspond to major social issues such as:

introducing **preventive health and well-being policies** for the whole population;

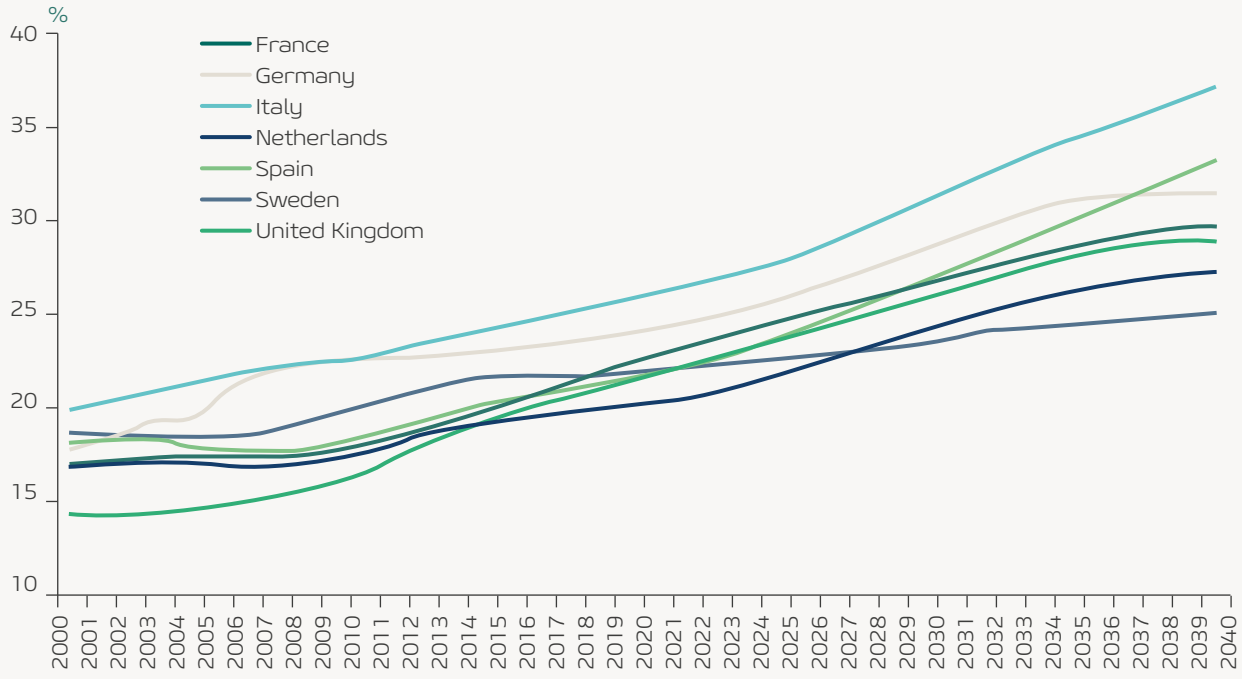
managing the very strong growth in the over-65 population over the coming years;

preparing for the demographic shock of the next two decades.

These demographic challenges need to be taken into account from today to ensure that our responses can absorb future demographic changes.

Over and above the volume of healthcare real estate that needs to be built or renovated, it will also be necessary for the various European authorities to determine the services and staffing resources that will be needed to tackle the coming peak in old age, which is set to last until 2050.

Share of over-65s in the total population of major European countries 2000 to 2040



AGEING **AND DEPENDENCY**

The number of people aged over 65 in the EU (plus the United Kingdom) will rise from 105 million in 2020 to 142 million in 2040. The change in the dependency ratio highlights the transition towards an older demographic structure (+15bp across the EU excluding the UK), but the trends differ according to country.

The ageing of the population will therefore result in an increase in the number of dependent senior citizens requiring care.

Assistance or medical care will be needed with the loss of autonomy, especially for the number of over-75s, which will rise from 44 million in 2020 to more than 66 million in 2040 in the European Union (excluding the United Kingdom). The likelihood of dependency reaches a critical threshold at the age of 85.

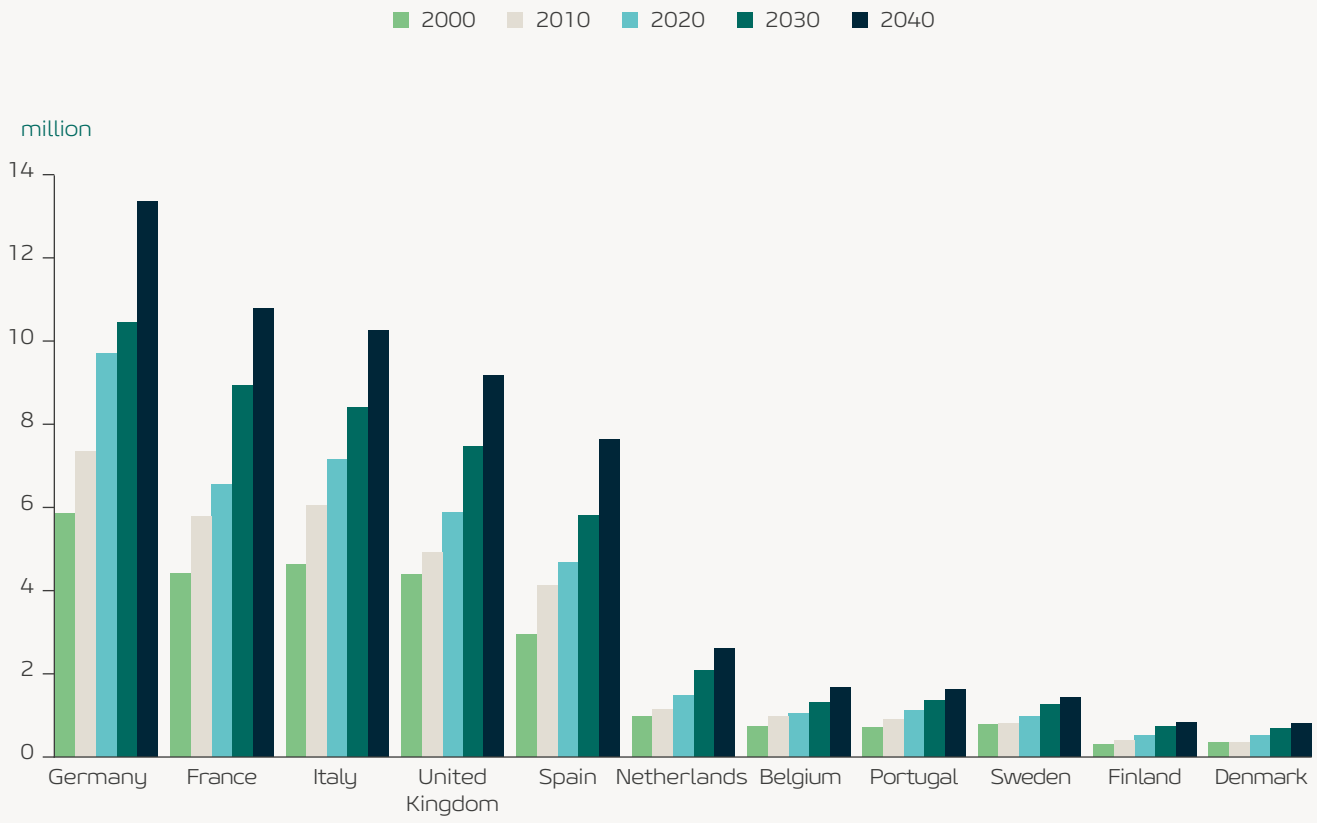
Germany will have the largest population aged over 75 by 2030, at 13 million,

France with 10.5 million,

Spain, Italy and the Netherlands follow close behind the euro zone's heavyweights, with strong growth in their population of over 75-year-olds, which will stand at between 3 and 10 million individuals in these countries by 2040,

The United Kingdom, this group will grow to 8.5 million people.

Europe: demographic trends amongst the over-75s, for whom the dependency risk is greatest



WELL-BEING, **HEALTHCARE'S NEW FRONTIER**

The notion of well-being is a central topic, but remains a difficult concept to understand. However, in recent years, the gradual emergence of new work has improved understanding of the topic. Thus for the WHO, health and well-being are not synonymous, but physical, mental and social health are important in feeling well. **The World Health Organisation believes that health is not merely the absence of disease or infirmity, but rather a state of complete physical, mental and social well-being.** However, in recent decades, the WHO has not sought to measure or describe well-being but has focused on mortality, illness and incapacity. The organisation will therefore gradually introduce tools on a global, and particularly European, level, to describe and understand the well-being of population, as well as measuring the progress made in its improvement.

An initial approach to well-being shows that it is achieved when individuals' fundamental objective needs are met and these individuals can benefit from their abilities. A different approach to well-being is centred on individuals' subjective perceptions. Subjective well-being relates in particular to the lived experiences of individuals in their own lives.

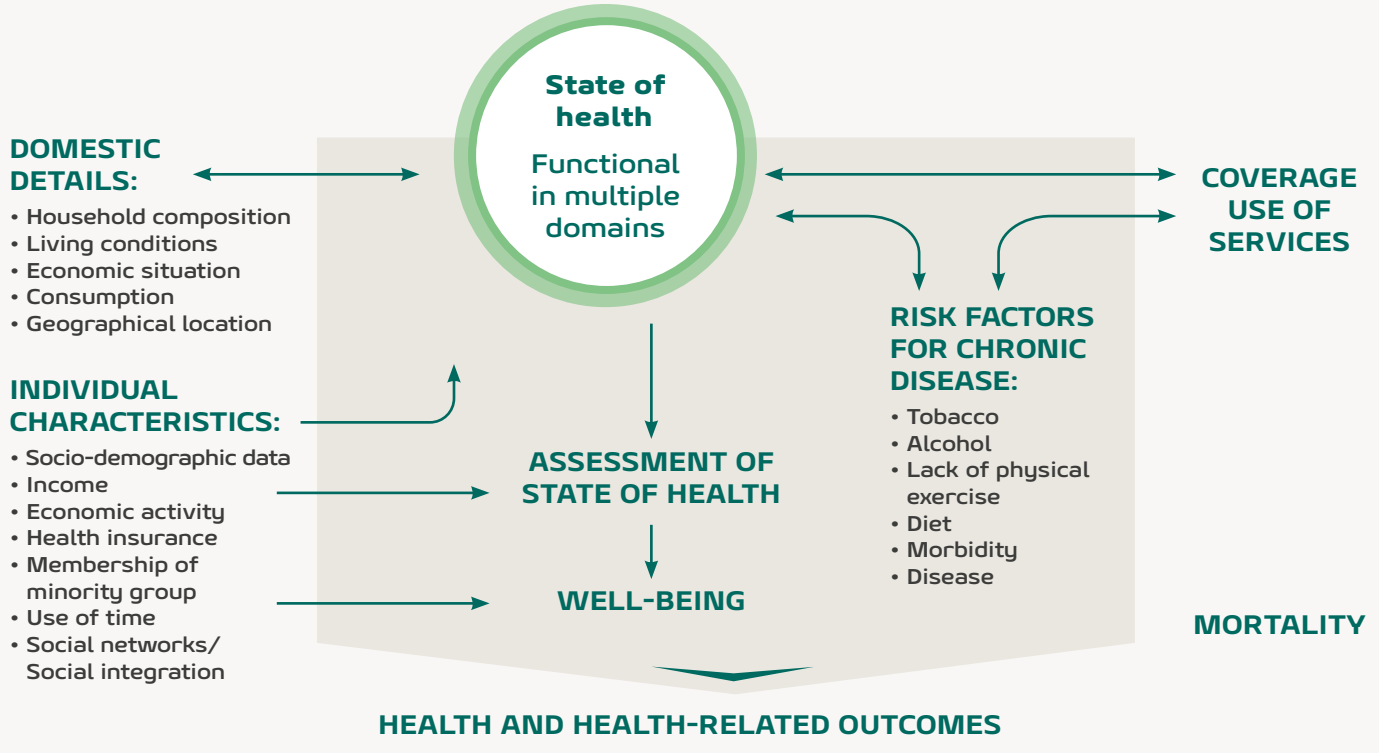
Key elements of objective well-being include individuals' living conditions and their ability to reach their potential, which must be equally distributed between all people, without discrimination of any sort.

Equal opportunities to enjoy good health are part of objective well-being. There are therefore links between health and well-being. Both physical and mental health affect well-being. Research shows that health is one of the factors that has the greatest influence on overall well-being. This said, the relation between physical function and well-being is not as intense. This situation thus requires the measurement of subjective well-being (such as the perception of pain).

Meanwhile, research has also shown that the relationship between health and well-being works in both directions in that health affects well-being in general, whilst well-being is an indicator of good or poor health in future. The two concepts therefore interact. It has been shown that other determinants, such as the political, economic and social context, can also have an impact. Researchers have further demonstrated the central role that health systems play in the various determinants linking well-being and health.

If well-being is considered as a combination of subjective assessments and emotional experiences then it can be measured. We find that the degree of well-being experienced is a notion close to that of happiness as they have similar determinants: the relation to health, chronic disease and incapacity, age, income, levels of education, social networks and the environment in general.

THE VARIOUS FACTORS **AFFECTING WELL-BEING**



LINKS BETWEEN **HEALTH AND WELL-BEING**

Health influences well-being

PHYSICAL HEALTH, LINKED TO WELL-BEING

This is particularly true of self-reported health

People suffering from chronic diseases may recover a degree of well-being over time, but not completely

HEALTH, IMPORTANT FACTORS FOR OVERALL WELL-BEING

MENTAL HEALTH, STRONGLY LINKED TO WELL-BEING

More strongly linked than physical health

Well-being affects health and life expectancy

SIGNIFICANT EFFECT OF WELL-BEING ON HEALTH

- Can add the equivalent of 7 to 10 additional years of life
- Comparable to 'traditional' factors such as eating fruit and vegetables
- Causal effect between well-being and health calculated mathematically

RANGE OF MECHANISMS

- Increased longevity (particularly in relation to suicide)
- Pain reduction and better pain tolerance
- Genetic health
- Shortening of genetic ageing
- Immune function
- Cardiovascular health

FROM THE HEALTH CHALLENGE TO THE REAL ESTATE CHALLENGE

HEALTHCARE SPENDING IN EUROPE **IS ON THE RISE**

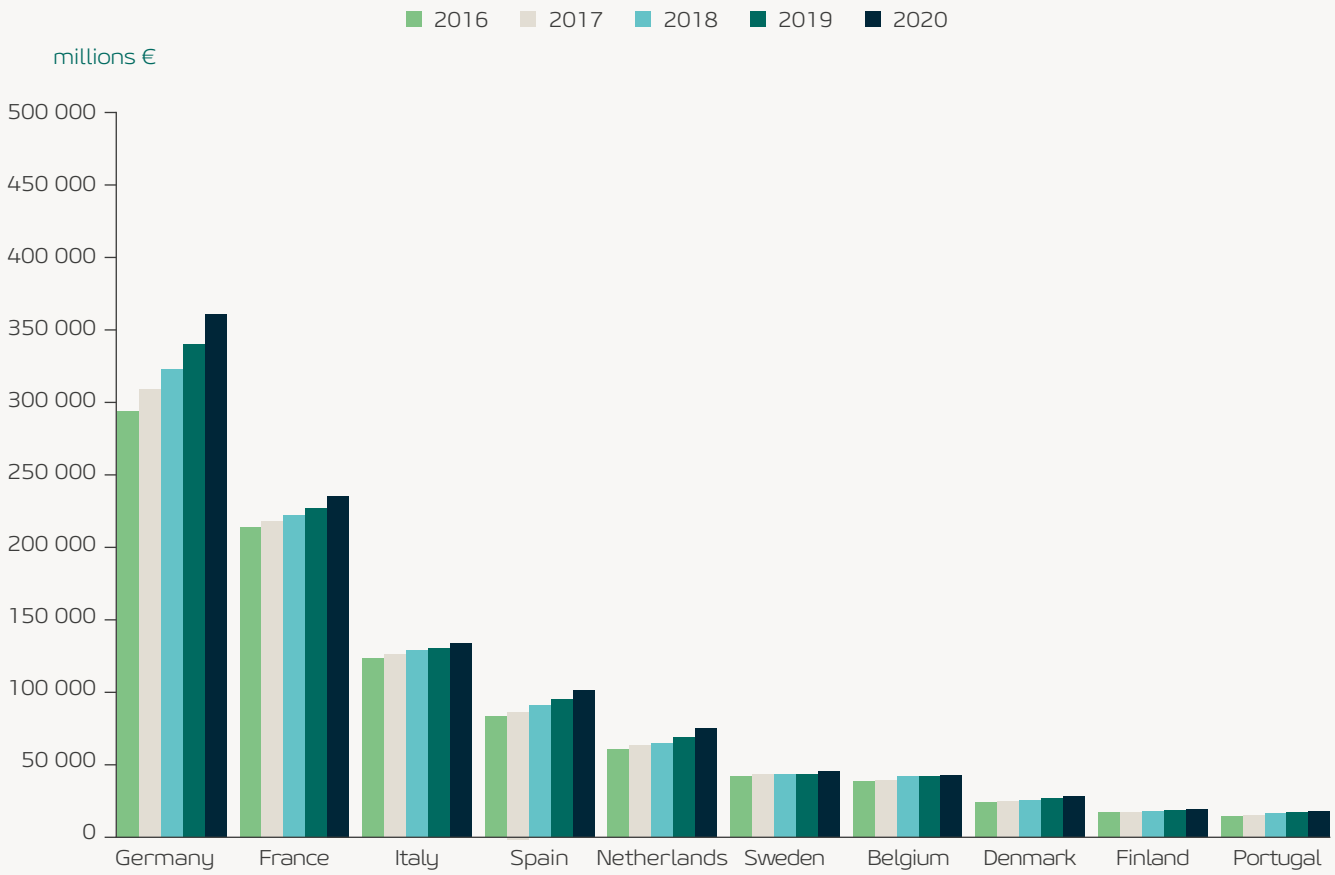
The different age groups have different healthcare and well-being needs and hence financing requirements that are specific to their situations. There are also differences between European financing systems.

Total health spending includes current health spending and the cost of curative care and rehabilitation. All of this spending has been rising over the last five years. Health spending in the 27-member EU was around €1,500 billion in 2020, an increase of around 5% on 2019.

Germany had the biggest budget, at over €430 billion in 2020, followed by France with €280 billion, Italy with €160 billion, Spain with €120 billion and the Netherlands with €89 billion.

There are significant disparities between countries in health spending per head. The most generous benefits per inhabitant can be found in Western Europe, and the least generous in Eastern Europe. There is a high correlation between income and healthcare spending: high-income European countries are usually the ones that spend the most on healthcare.

Healthcare spending per country 2016-2020



NEW CHALLENGES, NEW CARE, **NEW REAL ESTATE SOLUTIONS**

Longer life expectancies and the importance attached to well-being for all individuals across a society must be supported by public and private actors as **the number of physically and psychologically dependent people and the impact of neurodegenerative diseases and forms of dementia will automatically increase. At the same time, it seems reasonable to expect that better prevention and medical advances will create possibilities for treatment of certain diseases that cannot currently be treated or are poorly treated at present.**

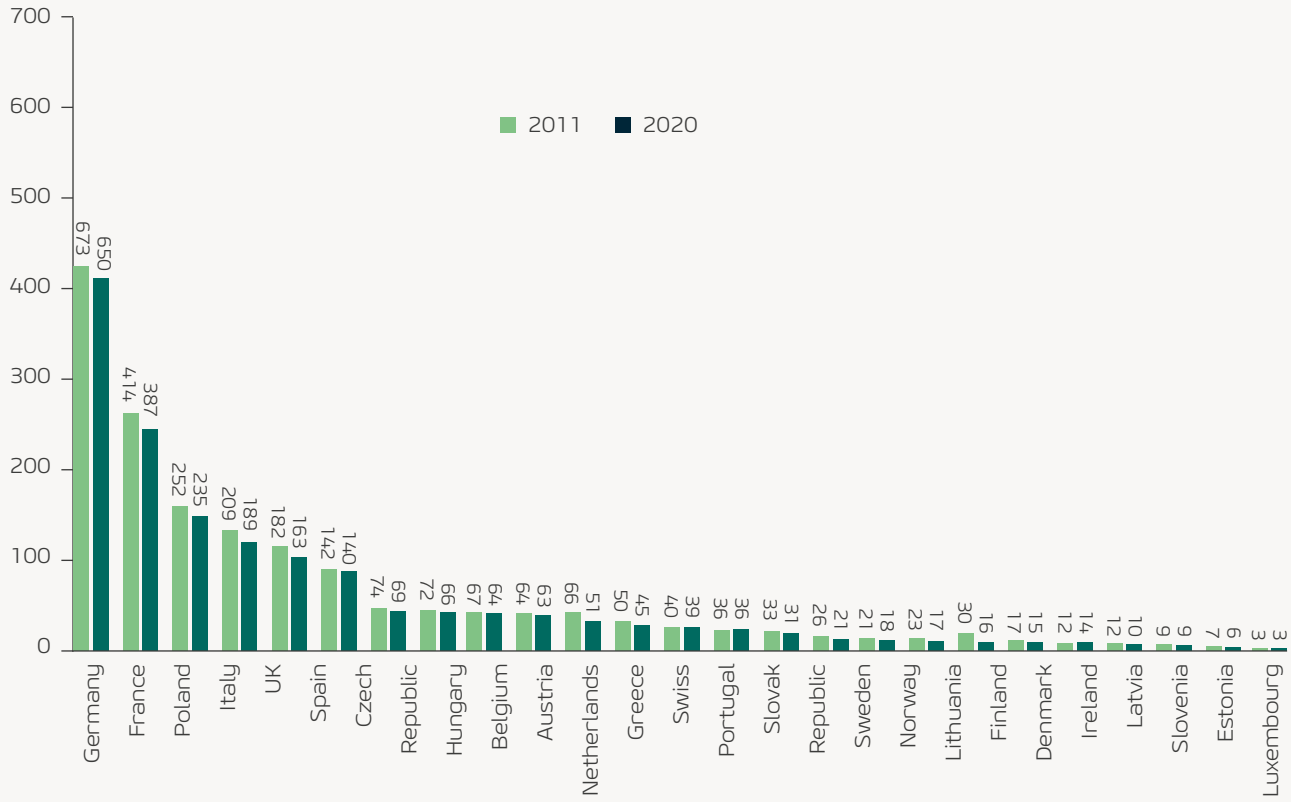
The provision of care for new patients in dedicated infrastructure is vital for individuals to get the treatment and support that they need. If we exclude medical, surgery and obstetric needs which are treated in hospitals and/or clinics, **we have identified three main families of care that require a specific response in medico-social establishments, hospitals and outpatient facilities:**

recuperative care needs (disorders in locomotion, the nervous system, cardiovascular issues, haematology and oncology);

psychological dependency, covering mental health issues – depression; bipolar disorder; schizophrenia and other psychoses – dementia, and developmental disorders, such as autism;

dependency linked to neurological disease. Alzheimer's disease is the most common form, accounting for 60% to 70% of cases.

Number of beds in (public/private) hospitals/clinics in Europe (in thousands)



THE HOSPITAL SECTOR IS STILL SEEING A SHIFT IN PRACTICE THAT FAVOURS SHORT STAYS OVER LONG STAYS

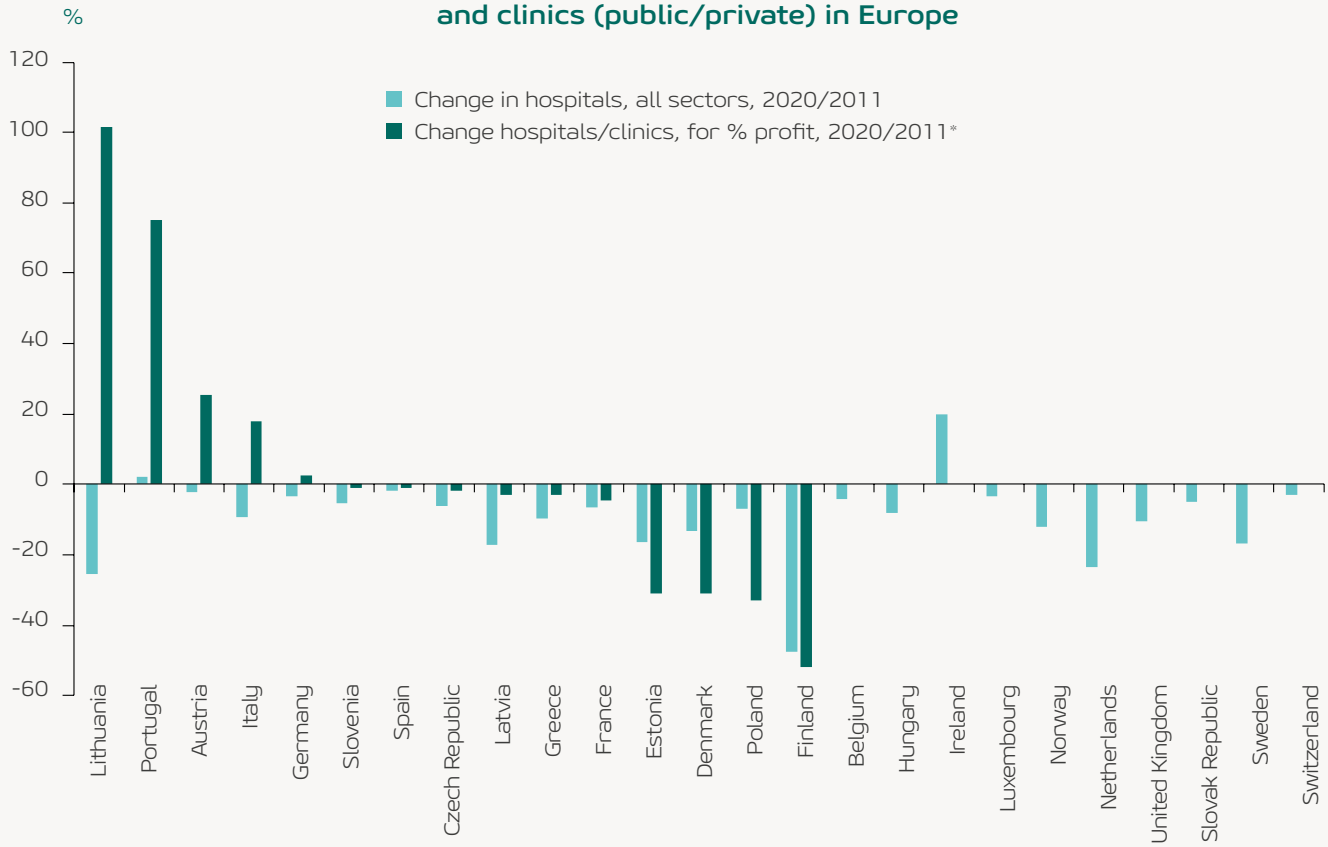
The regulations imposed by the public authorities play a major role in the care and financing available in European countries. The aim of the various regulatory bodies is to protect the public in terms of both treatments and healthcare infrastructure (construction, operation, etc.). The barriers to entry in the healthcare sector are therefore high, and there are also different standards in each country.

With rising demand for care, due to a growing and ageing population, **the European healthcare system faces obsolescence of public and non-profit facilities (hospitals and nursing homes)** and must address the financial constraints under which it operates.

A large proportion of the healthcare available in Europe is under state control, particularly in the long-term (hospital) care sector, where between 60% and 90% of the beds available are state-controlled. The main European countries analysed, including the UK, have 2.4 million beds. Meanwhile, profit-making private establishments account for a total of 500,000 beds in the main European countries analysed. These facilities provide medical, surgical and obstetric services, and recuperative care. Private care operators have a strong presence in countries such as Germany, France, Austria and Italy.

Taken as a whole, the hospital sector is facing a change in practice that will result in a significant reduction in the number of beds in favour of short-stay surgical treatments and a 'rationalisation' of its coverage.

Change in the number of beds in hospitals and clinics (public/private) in Europe



* Where data is available

EUROPEAN SOCIETY MUST INVEST IN AND ADAPT THE SUPPLY OF NURSING HOMES IN RESPONSE TO THE DEMOGRAPHIC CHALLENGES OF AN AGEING POPULATION

Public and non-profit players are also prominent in the nursing home sector, being responsible for between 60% and 90% of current beds, depending on the market. Europe has slightly over 4 million nursing home beds. **However, the increase in the number of people aged over 80 is already having a noticeable impact on the availability rate, which has fallen over the last 10 years.** Sector professionals estimate that this European supply (including the UK) should grow to more than 4.5 million by 2030 to meet demand in the coming years, resulting in the creation of around 500,000 new beds – although construction was slowed during the Covid crisis, with only 20,000 new beds provided in 2020 relative to 2019. The provision of beds to cover the potential shortfall represents several billion euros of investment, but European countries are under significant fiscal pressure; the private sector is already playing a major role that will develop over the next few years. Between 2011 and 2020, 315,000 new beds were created to meet growing demand. **European nursing homes are also facing the problem of obsolescence, as between 300,000 and 400,000 beds have been identified as requiring renovation in the short term, in France and Germany alone.**

HIGHLIGHTING THE ISSUE OF DOMICILIARY CARE

The principle promoted by the authorities and the desire of European citizens is to grow old at home, supported in particular by domiciliary care. However, in the event of a loss of independence, domiciliary care may cease to be an option.

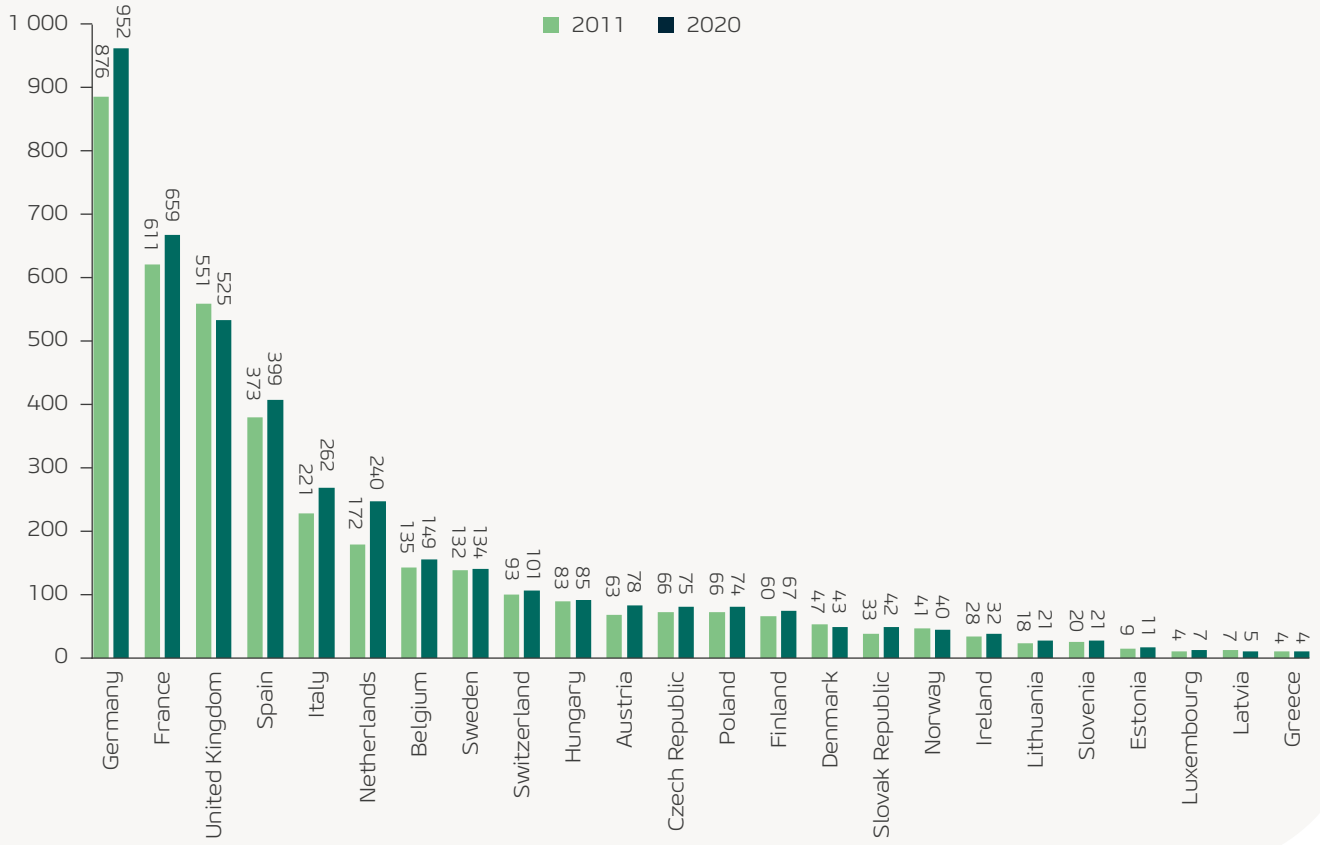
It follows that "at home" may represent different realities at different stages of an individual's life. As a result, traditional housing for seniors is already changing, with an explosion in the supply of assisted-living facilities, an option sought out by the over 65s as it meets their new needs.

Moreover, everything possible will need to be done to delay admission to nursing homes for as long as possible, not least for practical reasons: the authorities will be unable to manage the rapid growth in the over 85s, a critical age for the loss of independence, since the number of nursing home places will not be able to grow arithmetically. It is therefore down to the authorities to find the right balance: developing providential savings, improving care and building new nursing homes to meet the challenges of an ageing population.

In France[2], where the decade from 2020 to 2030 will see the number of people aged 75 to 85 virtually doubling, official projections identify an increase in numbers of severely dependent people from 700,000 to 900,000 between 2030 and 2050. Half of these will go into nursing homes, assuming an expansion of residential medical care and domiciliary care.

[2] Haut-Commissariat au Plan Report, "Quand les baby-boomers auront 85 ans" (When baby-boomers hit 85), January 2023

Number of nursing home beds
2011 to 2020 (thousands)



Change in the number of nursing home beds
2011 to 2020

HEALTHCARE REAL ESTATE FROM THE INVESTOR'S POINT OF VIEW

THE EUROPEAN HEALTHCARE
REAL ESTATE INVESTMENT MARKET

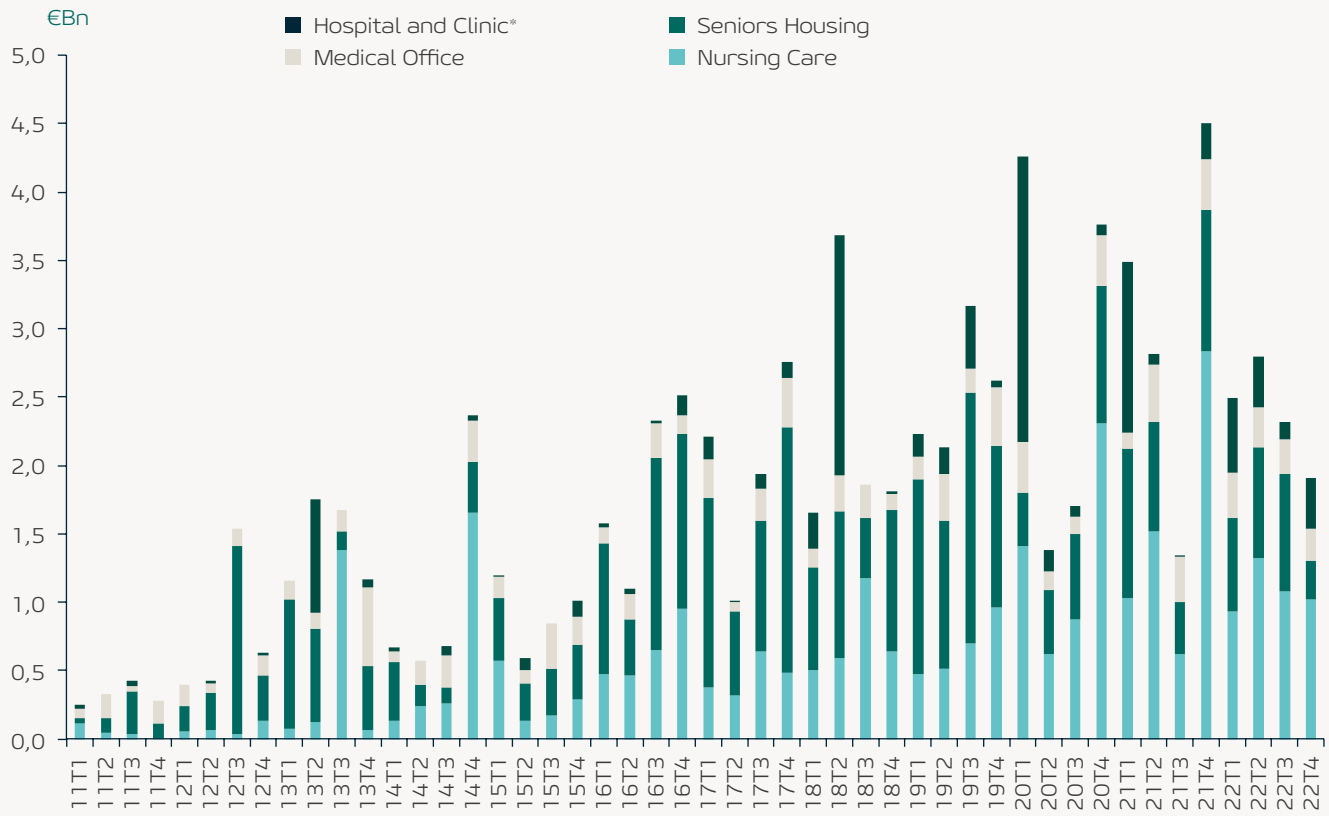
The European healthcare market saw private investment of nearly €100 billion between 2011 and 2022. The market has seen a steep increase in investment capital flows towards all categories of healthcare assets, namely retirement homes, nursing homes, clinics and care facilities, due to sector operators' high demand in line with their development.

Over the last decade an average of €7 billion a year has been invested. Up until 2015, the average annual investment was €5 billion. There was then a turning point with between €7 billion and €12 billion invested every year between 2016 and 2022.

The principal European healthcare markets have been the UK, Germany, France, Sweden and the Netherlands.

By asset class, investment was dominated by assisted-living facilities and nursing homes, which accounted for three-quarters of investment between 2011 and 2022. The remaining quarter has been made up of hospitals/ clinics and health clinics in roughly equal measure.

Volume of investment in healthcare real estate in Europe



* Data is indicative due to non-exhaustive monitoring

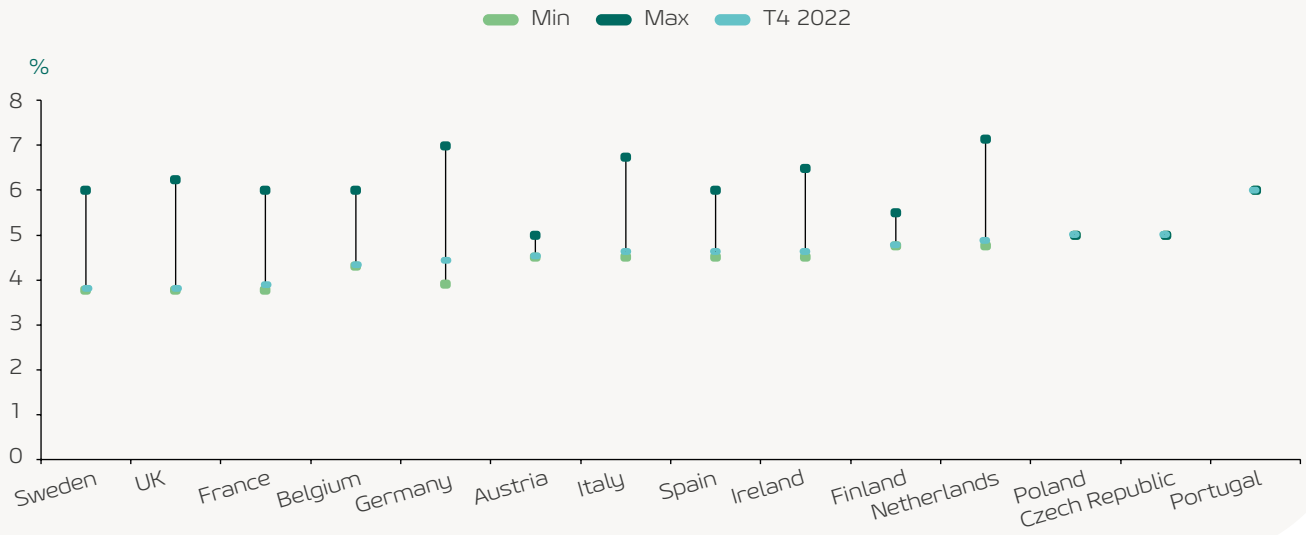
YIELDS ON **HEALTHCARE INFRASTRUCTURE**

Yields, which have been under pressure for a number of years, were continually squeezed during the last decade, but have held up very well during the public health crisis and more recently the cost of living crisis.

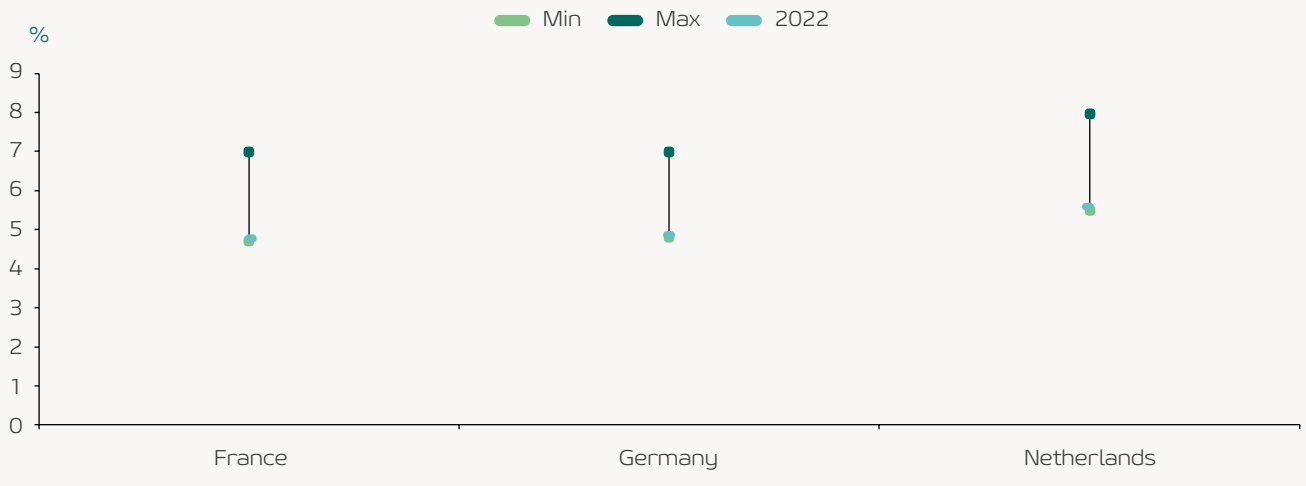
The prime yield for retirement and nursing homes has stayed below the 4.5% threshold in Sweden, the UK, France, Germany and Belgium. The lowest yields in this group of countries can be explained by the fact that they are considered safer and more mature than other countries. They therefore offer investors a lower risk profile.

In France and Germany, clinic yields have also been squeezed, falling from nearly 7% in 2012 to less than 5% in 2022. Health clinics offer a greater risk premium than nursing homes as this is a shallower and narrower market. In addition, the technical infrastructure required means that these buildings are less adaptable to other uses than nursing homes.

Prime yields for retirement homes and nursing homes between 2013 and 2022



Prime yields for health clinics between 2013 and 2022



PERFORMANCE OF HEALTHCARE ASSETS IN EUROPE

The overall performance (or total return) of healthcare real estate in Europe, based on MSCI indices, consists of income return and capital growth. This indicator shows that healthcare real estate had a average annual total return of 8.4% between 2012 and 2021, or 100 bp above the average for all asset classes.

In addition, we can observe that over this period healthcare real estate asset values in different European countries did not vary in the same way as real estate asset values as a whole.

For instance, although we saw a reduction in overall performance during the Covid crisis, healthcare real estate held up better than the real estate class as a whole. This demonstrates the considerable resilience of the healthcare asset class.

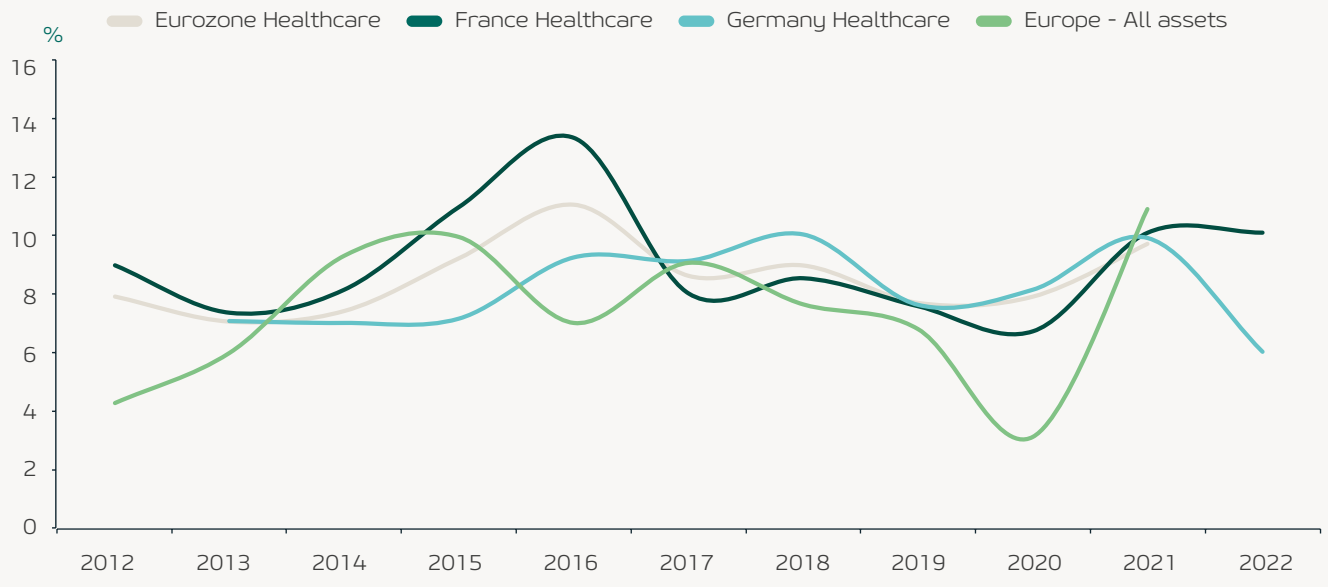
When it comes to the analysis of total returns for healthcare assets, characteristics vary. **Capital growth tend to fluctuate between 0% and 6% as a function of the cycle, whilst income return have remained within a range from 4% to 6% on average over the review period, thus creating a stable element of total returns.**

Over the next few years, we believe that total returns on healthcare real estate assets in Europe should deliver a satisfactory level of performance. **Total returns will be driven by income return and to a lesser extent by capital growth. By eurozone country, we think that the markets in France, Germany, Spain, Italy, and the Netherlands are the deepest and most liquid and will have the ability to deliver high levels of performance.**

Looking at the risk-return profile, it is worth noting that healthcare is an attractive inclusion in a portfolio, in order to achieve optimum diversification in terms of both volatility and the reduction of the portfolio's exposure to economic cycles.

The SMARRT© model (Smart Modelization by Analyzing Risk-Return Trajectory) developed by Primonial REIM's Research & Strategy team aims to optimise allocations in response to changes in macroeconomic circumstances. Results show that in current conditions, **the optimum allocation within a diversified real estate portfolio is to include between 10% and 30% of healthcare real estate to maximise performance and diversify risk.**

Total returns on healthcare real estate in France, Germany and the eurozone compared to overall real estate returns in Europe



HEALTHCARE REAL ESTATE AND **EXTRA-FINANCIAL PERFORMANCE**

As the years pass, extreme climate events grow more frequent. These events doubtless presage the climate reality of the future.

The future of the climate depends in part on the choices made on reducing current emissions of greenhouse gases. The use of carbon-based fuels (oil, coal and gas) contributes directly to increases in global temperatures and thus to increasing the likelihood and frequency of extreme events.

Thus significant changes now need to be made to ensure drastic reductions in greenhouse gas emissions.

Overall, the real estate sector, including healthcare real estate, represents between a one-quarter and one-third of Europe's emissions, and thus has a key role to play.

Over and above cutting emissions, it is also necessary to anticipate future changes in the climate (heatwaves, drought, rain and snowfall, forest fires, floods, coastal flooding).

At the same time, actions will also be necessary to improve the well-being of individuals (increase in single rooms, audit, creation of spaces, etc.).

There are therefore advantages in going beyond solely 'environmental' investments to include social aspects.

HEALTHCARE REAL ESTATE, **AN ASSET CLASS MEETING ESG CRITERIA**

	Impacts	Objectives	Actions
Healthcare	• Environmental • Social	• Actions to reduce climate change (reduction in energy consumption and reducing the carbon footprint of assets) • Good health and well-being	• Work to reduce energy consumption and contribute to reducing carbon footprint of assets • Audit of climate risks • Development of single rooms • Well-being audit carried out by third-party organisations (particularly for nursing homes) • Investment helping to improve the well-being of patients (shared spaces, exercise facilities, external spaces, etc.)

THE CONCENTRATION OF HEALTHCARE OPERATORS CONTINUES, **WITH THE GOAL OF INCREASING CRITICAL MASS AND INTERNATIONALISATION**

The future of healthcare real estate depends strongly on the financial viability of operators/tenants, particularly as we are expecting the contribution of income return to become a predominant share of total returns. The current consolidation of operators is having a positive effect on the quality of tenants.

The healthcare sector is highly regulated in Europe, for establishments such as hospitals, clinics and nursing homes. An administrative authorisation issued by the supervisory authority is usually required to operate this type of institution.

In France, for example, any project to create, convert or extend a healthcare or medico-social establishment requires such authorisation. The number of new authorisations is also limited by the French public authorities.

In Germany, the sector is indirectly supervised by the public authorities through standards and compliance with these standards.

The complex laws and strict standards to be adhered to are limiting the number of newcomers on the market. Meanwhile, the healthcare sector is seeing continued pan-European consolidation. Markets such as France and Germany are considered to be quite far along in the consolidation process, whereas the Spanish and Italian markets are viewed as still offering a potential reservoir of new acquisitions.

This pan-European consolidation strategy is allowing the largest operators to achieve economies of scale. The main European operators include Korian and Ramsay Santé from France, Asklepios from Germany, Gruppo San Donato from Italy and Quirónsalud from Spain. It is to these operators' advantage to attain critical mass internationally as this will make them more financially stable and ensure greater operational efficiency. These are key criteria in risk assessments by investors.

MAIN OPERATORS IN EUROPE

Operator	Asklepios	Orpea	Korian	Sana Kliniken	Ramsay Santé	DomusVi	Gruppo San Donato*	Quirónsalud	Fresenius Helios
Core business	Hospitals/ clinics	Nursing homes	Nursing homes	Hospitals/ clinics	Hospitals/ clinics	Nursing homes	Hospitals/ clinics	Hospitals/ clinics	Hospitals/ clinics
Revenue (€m) in 2020*	5 117	4 299	4 534	3 300	4 300	1 370	>1 600	3 800	10 900
Number of beds*	31 000	90 000	90 556	>11 00**	443***	436***	5 500	8 267	29 955

* Or the last year available/**Medical care beds/***Number of establishments

OUR EVALUATION GRID FOR HEALTHCARE REAL ESTATE INVESTMENT IN EUROPE

We analysed various criteria (demographics, sociological factors, real estate, healthcare spending, bed availability ratios, etc.) to identify the most attractive healthcare infrastructure markets.

We have thus attributed scores to each of the markets analysed. The model identifies three main categories of market. France, Germany, the Netherlands and Belgium, for example, are the countries with the most reliable risk/return profile. These are Tier 1 markets.

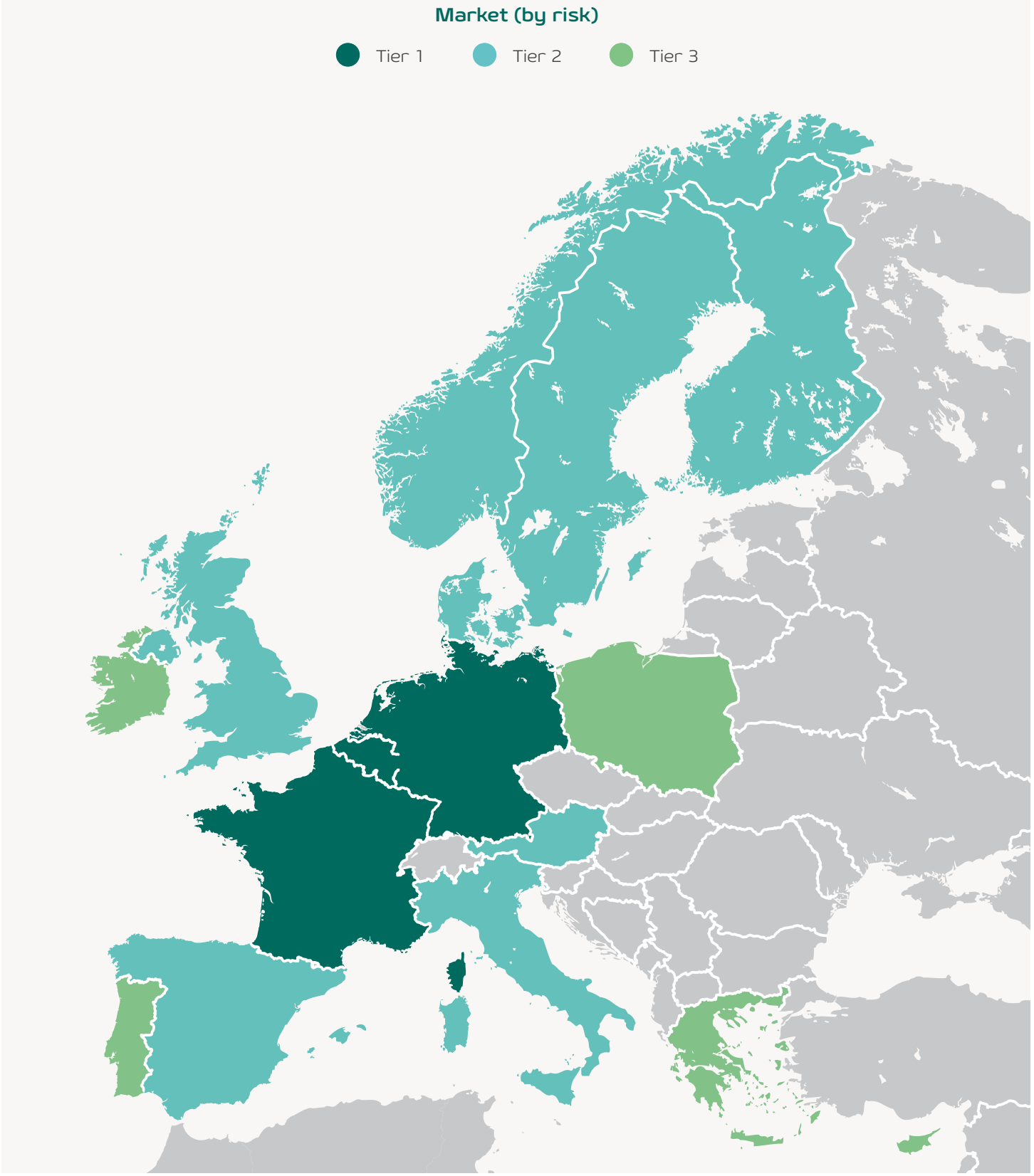
Spain, northern Italy, Finland, Denmark, Norway, Sweden and Austria are Tier 2 markets, with good risk/return profiles but not the same depth as the Tier 1 markets. Lastly, Portugal, Ireland, Greece and Poland, for example, are markets where opportunities will arise as the markets themselves develop. These are Tier 3 markets.

For healthcare infrastructure, we also recommend:

- Choosing international operators in countries where there is good healthcare coverage, or otherwise in regions where the senior population has high purchasing power;
- Checking the quality of buildings and that they are located in city centres or close to large conurbations to be sure of securing a return on capital when the assets are sold;
- Limiting exposure to poorly situated or badly designed buildings in zones where there are high climate risks (sudden flooding from rivers or the sea, droughts and heatwaves if the property isn't designed for them, etc.).

Lastly, we believe that investing in healthcare infrastructure on a European scale is the best option, to both achieve a good distribution of risk across various markets, and guarantee a distribution of risk based on demographic trends, while making an investment that serves a purpose and is socially engaged.

HEALTHCARE REAL ESTATE CONVICTIONS AND INVESTMENT STRATEGIES IN EUROPE BY PRIMONIAL REIM



Sources used in the document: Primonial REIM Research and Strategy Department,CBRE, Savills, BNPP RE, JLL, Knight Frank, MSCI , Oxford Economics, Eurostat, OCDE, FMI, Stabel, NSI, CZSO, DST, Destatis, Stat, CSO, Statistics, INE, INSEE, DZS, ISTAT, CSB, Statistics Lithuania, Statec, KSH, CBS, Statistik Autria, Stat Poland, INE, INSSE, Statistics Filand, SCB, SSB, BFS, ONS, OCDE, Eurostat, OMS, New Economics Foundation, WHO.

ABOUT PRIMONIAL REIM

WHO WE ARE

Primonial REIM has a workforce of 400 employees in **France**, **Germany**, **Luxembourg**, **Italy**, the **UK** and **Singapore**. Its values of conviction and commitment as well as its expertise on a European scale are used to design and manage real estate funds for its national and international clients, whether they are individuals or institutions.

Primonial REIM currently has €34.8 billion of assets under management. Its conviction-based allocation breaks down into:

44%
offices

33%
healthcare/education

11%
residential

6%
retail

5%
hotels

1%
logistics

Its pan-European platform manages **61 funds** and has more than 100 000 investor clients, **54% of which are individual investors** and **46% institutional**. Its real estate portfolio consists of more than **1 535 properties** (offices, health/education, retail, residential, hotels) located in **10 European countries.**

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The Research & Strategy Department's role is to formalize Primonial REIM's real estate investment strategies, based on continuous monitoring of the French and European markets. Although collective real estate accounts for a growing share of institutional portfolios and household savings, it is at the crossroads of financial (hierarchy of rates), economic (tenants' business models), demographic (the metropolisation phenomenon) and societal (changes in usage) factors. This is why a cross-cutting analysis is needed, which is also long term and therefore in keeping with the horizon of most real estate investors. Real Estate Convictions Germany offers Primonial REIM's quarterly view of the most important asset classes: offices, retail, residential, healthcare, hotel and logistics.

www.primonialreim.com

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VALUE FROM VALUES

Primonial REIM, a simplified joint-stock company with capital of 10,000 euros, registered with the Business and Company Register, Paris, under number 884 030 842, with its head office at 6-8 rue du Général Foy, 75008 Paris, and with the tax identification number FR18 884 030 842.

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