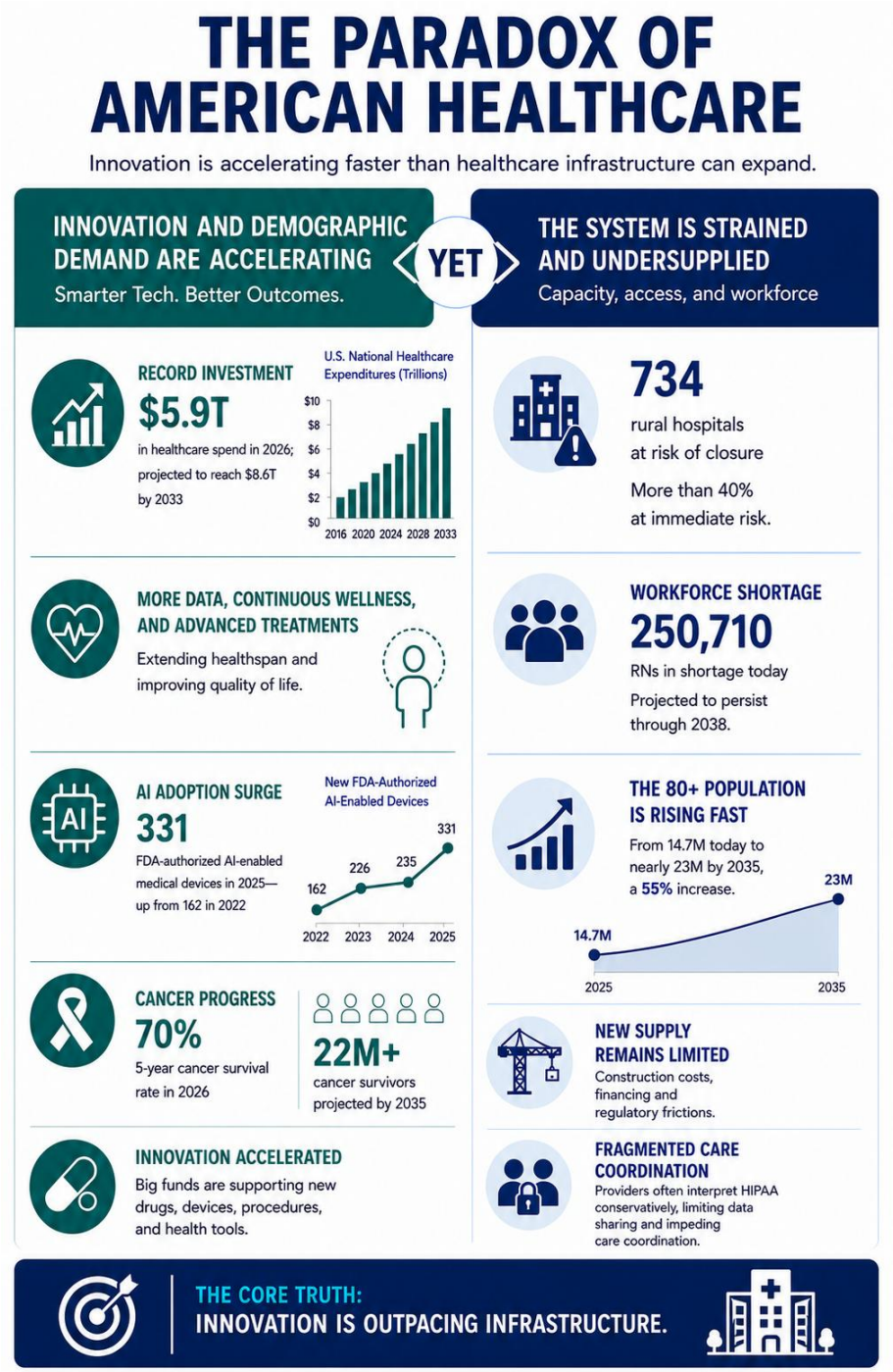
Healthcare Built Space: Infrastructure for an Inevitable Future

June 2, 2026

Executive Summary



This paper is the first in a Virtus white paper series on U.S. healthcare built space: a foundational overview of how the U.S. healthcare system works, where it is headed, and why the physical infrastructure that delivers care is structurally undersupplied relative to the demand now arriving. Parts II and III turn from this system-level view to deep dives on senior living and medical outpatient buildings (MOB), respectively. The central argument is straightforward. U.S. healthcare is in the most innovative period in its history, with national health expenditures on track to surpass $8.6 trillion by 2033, record public and private R&D investment, and accelerating adoption of AI, GLP-1 therapies, and value-based care. Yet the infrastructure required to deliver that care, including senior housing, MOB, and the workforce that staffs them, has fallen materially behind. Innovation is outpacing infrastructure. Five takeaways anchor the paper:

- **The system is fragmented but globally unmatched in scale and innovation.** It excels at specialty care, R&D, and capital depth, but struggles with cost, access, and care coordination.
- **Care is migrating out of hospitals.** Outpatient volumes are projected to grow 10.6% over the next five years, while inpatient volumes remain essentially flat, as hospital-at-home and telehealth expand, reshaping which categories of built space matter most.
- **The demographics are locked in.** The 65+ population grows from roughly 65 million today to about 76 million by 2035 and forms the broad base of MOB, specialty, and active-adult demand. Within it, the care-intensive 80+ cohort that drives needs-based senior living climbs from 15 million to nearly 23 million by 2035 and close to 29 million by 2045. Chronic disease prevalence in older adults roughly doubles by 2050 as the caregiver support ratio falls from 7 to under 3, pushing informal care into formal, facility-based settings.
- **The supply response has collapsed.** Senior housing construction sits at its lowest level since 2012, with nearly 60% of NIC-tracked markets having no active development, while new MOB rents run roughly 38% above in-place rents, a signal that new supply cannot be built economically at scale. Construction costs, labor scarcity, and tighter financing make the gap structural, not cyclical.
- **Specialist capital has a durable advantage.** Operator selection, state-by-state regulatory fluency, and proprietary deal flow are not commoditized inputs. The complexity that makes healthcare built space hard to underwrite is precisely what concentrates returns among those equipped to navigate it.

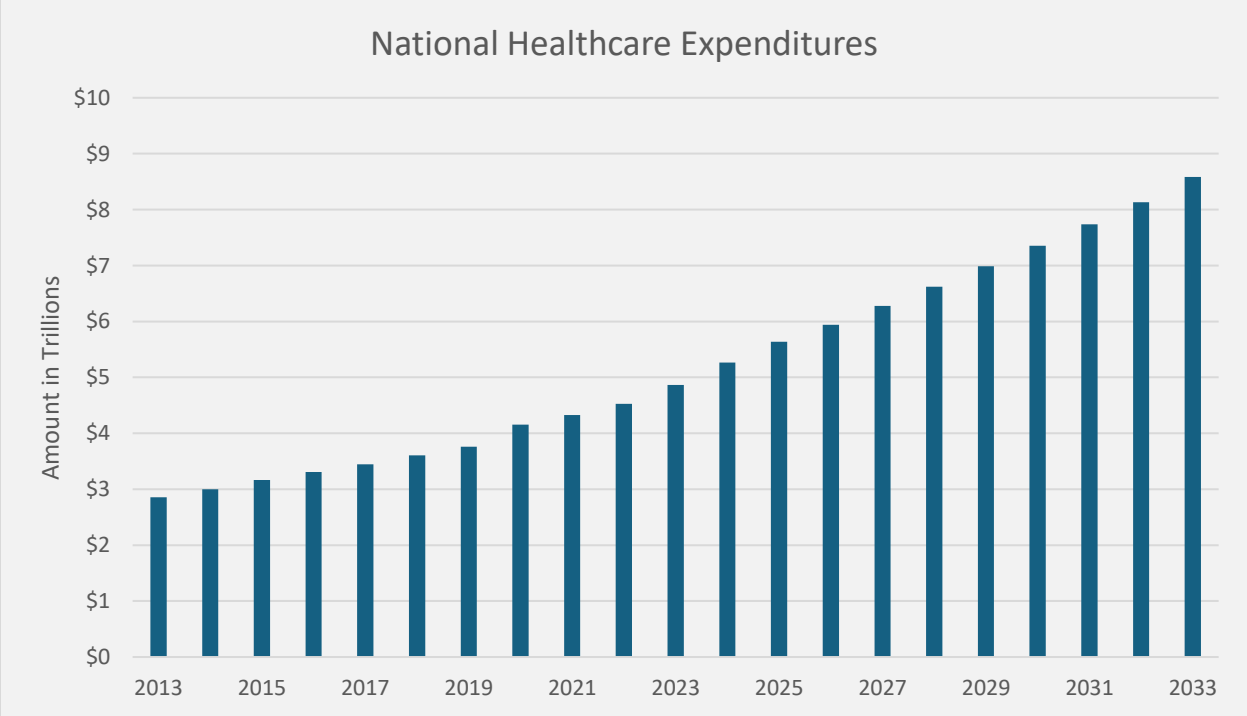
Healthcare built space sits at an unusual collision of demographic inevitability, technological acceleration, and structural underinvestment in physical capacity. None of the three is a cycle. Together, they represent a structural shift in U.S. healthcare infrastructure that will unfold over the next two decades.

Section 1: The U.S. Healthcare System: Structure, Strengths, and Trajectory

The U.S. healthcare system differs materially from both international healthcare systems and most other sectors and markets, operating through a uniquely complex and fragmented structure. **There is no single payer, no single regulator, no single price for the same service in the same city, and no single point of policy control. Coverage and care are delivered through a hybrid of private insurers, public programs, and a patchwork of provider organizations operating under different ownership, payment, and tax structures.** This section offers a descriptive overview of the system, identifies what it does well and poorly, and outlines the trends most likely to reshape it over the next decade. The intent is to give an investor enough context to interpret the demand and supply signals that follow in later sections.

How the System Works

The U.S. healthcare system is approaching a scale unmatched anywhere in the world**. National health expenditures are projected to reach approximately $5.94 trillion in 2026, up 5.3% from 2025, and the Centers for Medicare & Medicaid Services (CMS) forecasts spending will climb to roughly $8.6 trillion by 2033, or nearly $24,200 per American.** By then, healthcare is expected to consume more than one-fifth of the U.S. economy, rising from 18.6% of GDP in 2023 to 20.3% by 2033. It is delivered through three interlocking components: the payer landscape, the provider landscape, and the payment model.



Source: Centers for Medicare & Medicaid Services (CMS)

Coverage and payers. Most Americans receive coverage through one of several channels: employer-sponsored insurance, Medicare for older adults and certain disabled populations, Medicaid for lower-income households and eligible groups, individual insurance purchased directly or through Affordable Care Act (ACA) marketplaces, military-related coverage, or no insurance at all. **Approximately 92% of Americans had some form of health coverage in 2024** (KFF).

Payer	Population Covered	Share of Population	Key Characteristic
Employer-Sponsored	161M	48.6%	Tied to employment; largest source
Medicaid	67M	20.4%	Federal-state; income-based
Medicare	49M	14.8%	Federal; 65+ and disabled
ACA Marketplace/Individual	21M	6.6%	Subsidized individual purchase
Military or Federal Program	4M	1.3%	Specialty federal programs
Uninsured	27M	8.2%	Concentrated in lower-income and minority groups

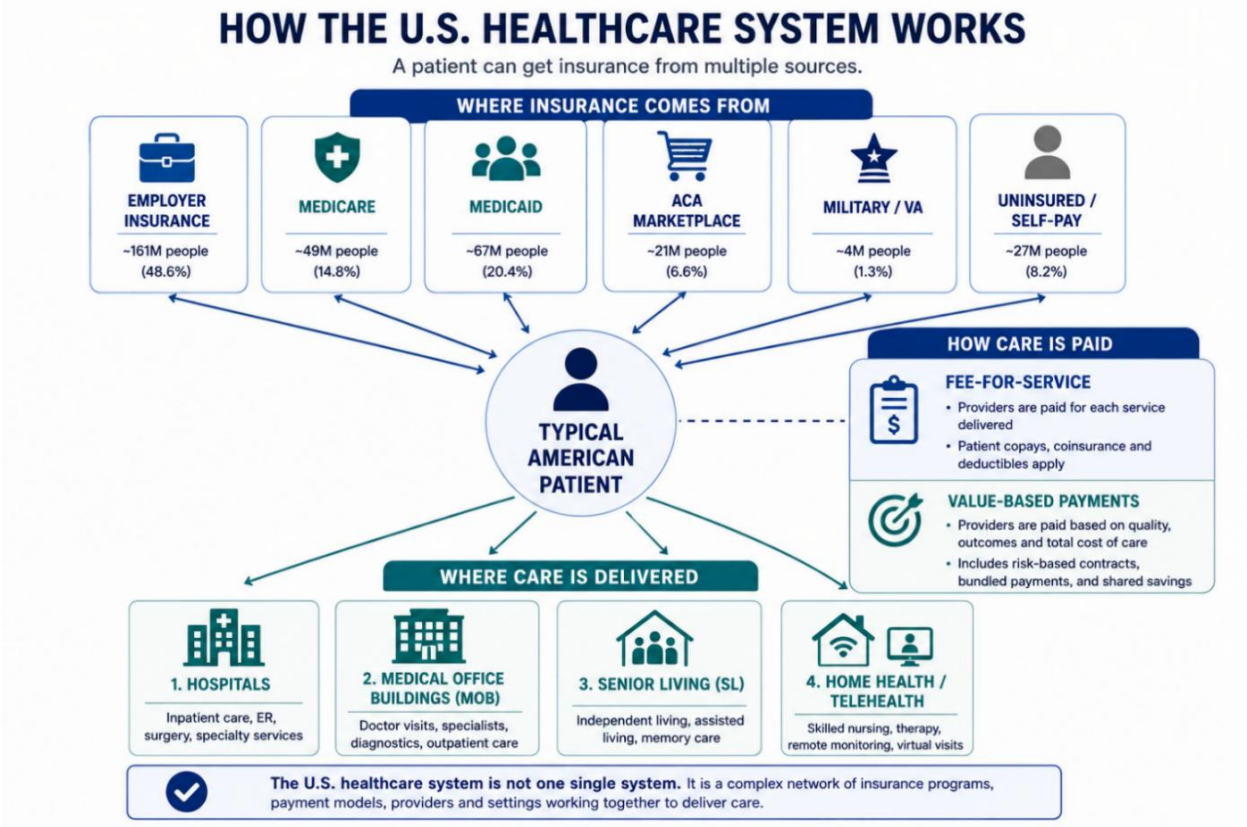
Source: KFF. Coverage figures reflect the primary source of coverage as estimated by KFF from the U.S. Census Bureau American Community Survey data, 2024. Individuals with multiple coverage sources (e.g., Medicare-Medicaid dual eligibles, military families with employer coverage) are counted under their primary source. Total enrollment in any individual program may be higher than the primary-coverage figure shown.

Employer-sponsored insurance covers approximately 161 million Americans, just under half the population, and is the single largest source of coverage and the most distinctive feature of the U.S. system globally. Medicaid, the joint federal-state program for lower-income populations, covers approximately 67 million people. Medicare, the federal program for adults aged 65 and over and certain disabled populations, covers approximately 49 million as a primary source, with total Medicare enrollment of approximately 67 million when including those who also receive Medicaid; more than half of all Medicare beneficiaries are now enrolled in Medicare Advantage, a privately administered alternative that has more than doubled in share over the past decade (KFF Medicare Advantage Tracker). ACA Marketplace and individual non-group coverage cover approximately 21 million people. Military and federal programs, including Veterans Affairs, Tricare, and the Indian Health Service, cover another 4 million as a primary source. The uninsured population stood at approximately 27 million in 2024 (KFF Health Coverage Data).

Unlike many developed countries, however, the U.S. does not operate a single national healthcare system. A typical American interacts with three or four over a working career, switching as they change jobs, age into Medicare, or move across state lines. Coverage volatility is a structural feature of the U.S. system.

Providers. About 60% of U.S. hospital beds are operated by nonprofit health systems, with the remainder split between for-profit operators and public hospitals (American Hospital Association). **The number of independent physician practices has been declining for two decades. As of the start of 2026, approximately 82% of U.S. physicians were employed by hospital systems, large group practices, or other corporate entities, including health insurers and private equity, with only 18% remaining in physician-owned practices** (Physicians Advocacy Institute). This consolidation is a quietly important fact for healthcare real estate: Medical Office Buildings (MOBs) increasingly lease to large multi-physician groups and health-system subsidiaries rather than to single-physician practices, which improves tenant credit but concentrates leasing exposure.

Payment models. Most U.S. healthcare is still paid through a **fee-for-service model, where providers are reimbursed for each visit, test, procedure, or service delivered. Patients typically share part of those costs through copays, deductibles, and coinsurance.** At the same time, insurers and government programs are gradually shifting portions of the system toward value-based payment models that reward providers for improving outcomes and managing total healthcare costs more efficiently. Medicare Advantage is the clearest example of that shift today, with private insurers taking on more responsibility for managing patient care and financial risk. The CMS Innovation Center has set a target for all Medicare beneficiaries and most Medicaid beneficiaries to be in accountable care relationships by 2030 (CMS Innovation Center).



The result is a healthcare system that is highly fragmented and often difficult to navigate. It is a marketplace of overlapping payers, providers, regulators, and intermediaries. A single hospital may be paid by Medicare, Medicaid, employer-sponsored insurers, Medicare Advantage plans, ACA marketplace plans, and uninsured or self-pay patients, each with different prices, documentation requirements, approval processes, networks, and reimbursement rules. That fragmentation creates complexity, but it also creates one of the world's largest healthcare markets, with deep capital formation, advanced academic medical centers, a globally important biopharmaceutical and medical technology industry, and a strong base of specialty care.

What the System Does Well

The U.S. system has structural advantages that are real and durable.

Innovation. The U.S. is often among the first markets where new drugs, devices, diagnostics, procedures, and digital health tools are developed, funded, commercialized, and scaled. The National Institutes of Health funds approximately $48 billion of biomedical research annually, the largest single source of biomedical research funding in the world, supporting nearly 50,000 competitive grants to more than 300,000 researchers at over 2,500 universities, medical schools, and research institutions across every state (NIH). Private investment runs in parallel: U.S.-headquartered biopharmaceutical companies invested approximately $104 billion in research and development in 2024, roughly half of all global pharmaceutical research spending (PhRMA). The U.S. is home to the largest concentration of biotech firms, medical device manufacturers, and digital health startups in the world, and ClinicalTrials.gov, the federally maintained registry, lists more than 530,000 studies, with more U.S.-located studies than any other single country (ClinicalTrials.gov). Novel drugs and devices typically reach U.S. patients first, often months or years ahead of approval in other major markets.

Specialty care concentration. The top U.S. specialty centers, including Mayo Clinic, Cleveland Clinic, MD Anderson, Memorial Sloan Kettering, and Johns Hopkins, attract patients and clinicians globally and produce outcomes for complex diseases that compare favorably with any peer system. Cancer survivorship outcomes continue to improve materially: the American Cancer Society's 2026 report found that **the five-year survival rate for all cancers reached 70% for the first time, up from roughly 50% in the mid-1970s,** while the number of U.S. cancer survivors is projected to exceed 22 million by 2035 (American Cancer Society). GLP-1 therapies show the same pattern in cardiometabolic disease. What began as a diabetes and obesity drug class is expanding into cardiovascular risk reduction: in 2024, the FDA approved semaglutide to reduce the risk of cardiovascular death, heart attack, and stroke in adults with cardiovascular disease and obesity or overweight, after a trial of more than 17,600 participants in which **major adverse cardiovascular events occurred in 6.5% of treated patients versus 8% of placebo patients**.

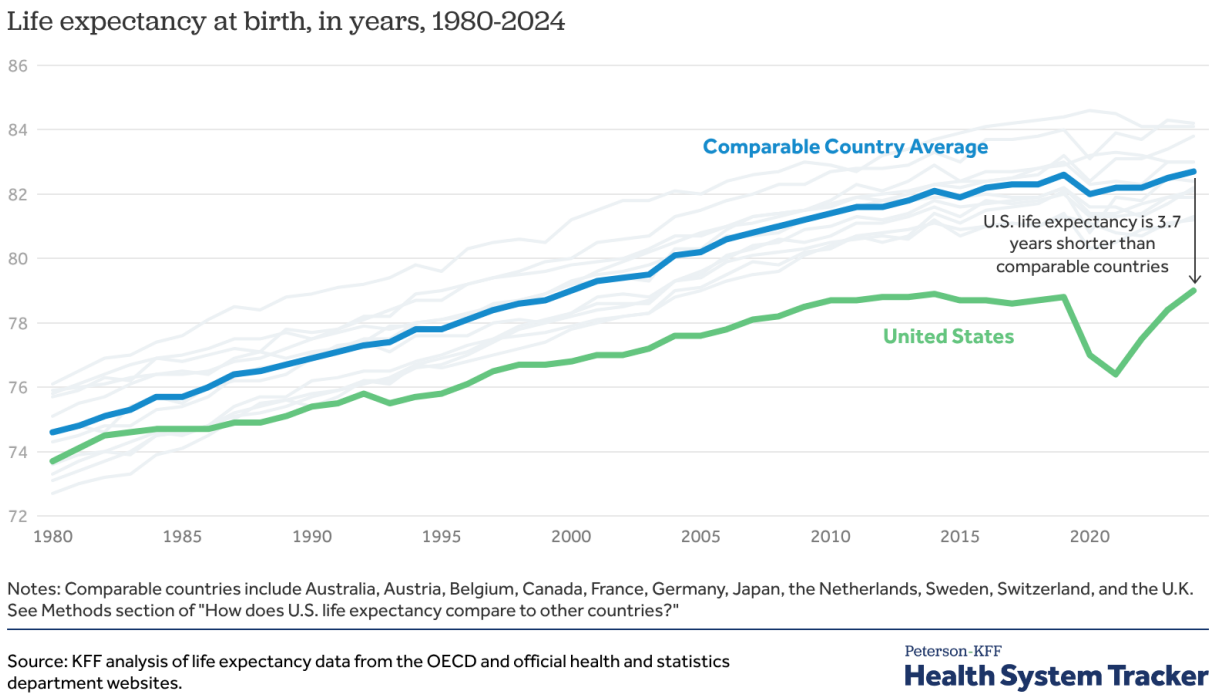
Capital depth and flexibility. The U.S. system absorbs trillions of healthcare spending annually, supports approximately $100 billion of private biopharmaceutical R&D, and channels significant institutional capital into health technology, medical devices, and provider infrastructure. New therapies, technologies, and care models get funded and deployed at a pace that few peer systems can match.

Choice and access for the well-insured. For Americans with employer or commercial Marketplace coverage, the system offers broad provider choice, short waits for elective procedures, and rapid access to advanced diagnostics and specialty consultations.

What It Does Poorly

The system's weaknesses are equally well documented and equally structural.

Cost without commensurate outcomes. The U.S. spends roughly $14,885 per person on healthcare, nearly triple the OECD average of $5,967 and well above the next highest spender (OECD Health at a Glance 2025). Despite that spending, U.S. life expectancy is 78.4 years, below the OECD average and below most major developed peers (Peterson-KFF Health System Tracker).



Source: Peterson-KFF

Administrative complexity. The **U.S. spends approximately 15-30% of healthcare expenditures on administration, the highest share among peer countries and roughly double the OECD average** (Health Affairs). The fragmentation of payers is the dominant driver.

Access inequality. The Center for Healthcare Quality and Payment Reform's latest analysis finds **that 734 rural U.S. hospitals are at risk of closure due to financial problems, with more than 40% of those hospitals at immediate risk of closure.** The U.S. Department of Health and Human Services classifies 101.7 million Americans as living in designated primary care shortage areas as of March 31, 2026. Furthermore, the uninsured population remains concentrated in lower-income and minority groups (KFF).

Workforce shortages. McKinsey's 2022 forecast of a shortfall of 200,000 to 450,000 registered nurses (RNs) for direct patient care by 2025 has proved accurate, with **the realized national deficit landing at about 250,710 RNs nationwide** according to the Health Resources and Services Administration (HRSA). HRSA projects the shortage will persist through 2038, with a 10% RN shortage in 2027, dropping to 8% by 2032 and 6% by 2037. While AI and other advanced technologies will make providers, including RNs, more efficient and care more available, the overwhelming demographic demand for increased healthcare from the aging population still requires more providers to deliver in-person care.

Fragmented care coordination. A persistent weakness of the U.S. system is that patient information often does not move smoothly across hospitals, physician groups, insurers, pharmacies, and specialists. **This problem is frequently blamed on the Health Insurance Portability and Accountability Act (HIPAA), even though HIPAA was originally designed to allow the secure sharing of information for treatment, payment, and healthcare operations.** In practice, providers often treat HIPAA as a reason not to share data rather than a framework for sharing it safely.

The result is a healthcare system in which patients frequently become the coordinators of their own care. A patient may visit a primary care physician, then a specialist, then an emergency room, only to repeat the same paperwork, medication history, imaging scans, or blood tests because the systems do not communicate seamlessly with one another. A hospital in one network may not have immediate access to records from a physician group in another. A specialist may not see updated medication changes from a recent hospital discharge.

That fragmentation contributes to duplicate testing, delayed diagnoses, medication errors, administrative costs, and patient frustration, even inside one of the most technologically advanced healthcare markets in the world.

The aggregate picture is a system that is world-class at the high end of complex care and at the technological frontier, and structurally inefficient and inequitable at the level of population health. That tension is the starting point for everything that follows in this paper.

Where the System Is Going

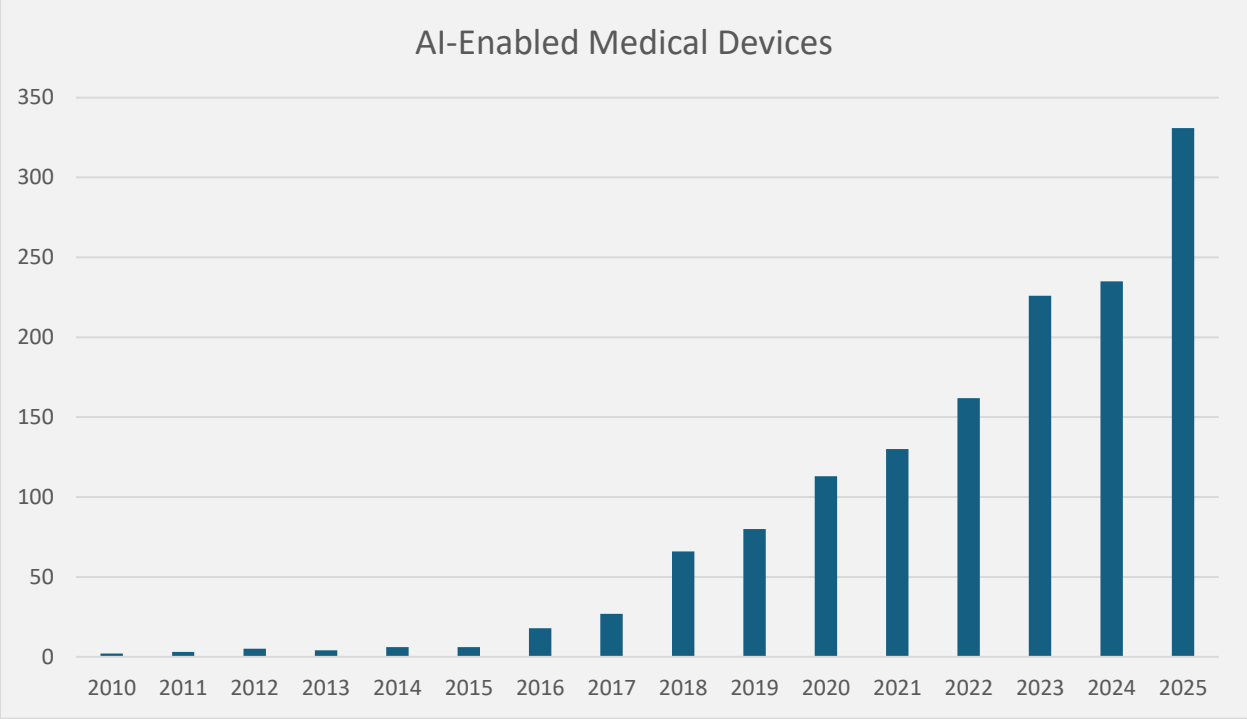
Four trends will shape U.S. healthcare delivery over the next decade and are directly relevant to demand for physical healthcare infrastructure.

The site-of-care shift. Care delivery has been migrating out of inpatient hospital settings for two decades and is now accelerating along two parallel paths. **The first is the move from inpatient to outpatient:** procedures that historically required hospital admission, including knee and hip replacements, certain cardiac procedures, and a growing list of outpatient surgeries, are shifting to ambulatory surgery centers and outpatient settings under pressure from payers and aided by surgical technique advances. McKinsey analysis shows that total joint replacement procedures performed in inpatient settings fell from 78% in 2018 to just 9% in 2023, and roughly half of the remaining hospital outpatient surgical cases are eligible to be performed in ASCs (McKinsey). **Outpatient volumes are projected to grow 10.6% over the next five years,** against essentially flat inpatient volumes (JLL). **The second is the move from facility to home:** the Acute Hospital Care at Home program, launched as a pandemic-era waiver and extended through 2030, now operates across 366 hospitals in 139 systems and 37 states (American Medical Association). Telehealth has settled into structural use at 5% to 7% of medical visits and well over half of behavioral health visits. Together, these shifts are the single most important macro driver of medical outpatient building demand and underpin much of the rent and occupancy strength quantified later in this paper. They also reframe what counts as healthcare infrastructure: alongside hospitals and MOBs, the system increasingly depends on ambulatory surgery centers, infusion suites, urgent care, and home-based delivery, categories that have not kept pace with where care need is going.

Vertical integration. The boundary between payers and providers has been dissolving. UnitedHealth Group's (one of the nation's largest commercial insurers) Optum subsidiary now employs or contracts with approximately 90,000 physicians, roughly 10% of U.S. doctors, and operates the largest medical group in the country (Medpage Today). CVS Health acquired Aetna, another large commercial insurer, in 2018 and Oak Street Health in 2023, building a vertically integrated payer-pharmacy-clinic platform. Amazon acquired One Medical in 2023. Walmart entered and exited primary care between 2019 and 2024, illustrating both the appetite and the difficulty. The strategic logic is consistent: payers want to capture risk-bearing physician relationships, and physicians increasingly need the capital and scale that integrated payer-provider platforms can provide. For healthcare real estate, vertical integration improves tenant credit at the property level but concentrates exposure to a smaller number of large counterparties.

AI integration. AI is moving from research-and-development novelty into clinical workflow at a meaningful scale. FDA authorizations of **AI-enabled medical devices rose from 162 in 2022 to 331 in 2025, more than doubling in just three years, showcasing the change in leadership and a push to remove barriers and bureaucracy.** AI is increasingly affecting diagnostics, imaging,

monitoring, workflow efficiency, and long-term care delivery. Early clinical evidence is no longer theoretical. In the MASAI mammography trial, **AI-supported screening reduced interval cancers from 1.76 to 1.55 per 1,000 women and increased the share of cancers detected at screening from 74% to 81%** (The Guardian). Beyond regulated medical devices, ambient AI (automated documentation, sensing-based monitoring, predictive workflow tools) is being designed into new hospital and outpatient construction from the ground up. Academic medical projects like the UT Austin Dell Medical School and MD Anderson Medical Complex Project are planning around AI-native infrastructure rather than retrofitting it.



Source: U.S. Food and Drug Administration

Unlike other white and grey-collar jobs that are being usurped by AI, most healthcare provider categories continue to experience greater demand for personnel than supply of qualified personnel. Using radiologists as an example, it has often been assumed that radiologists would be primarily replaced by AI, given its ever-advancing ability to read imaging, interpret it, and provide accurate input to providers. Contrary to what many thought, what has occurred is that radiologists continue to be in demand because, with the advent of AI, far more imaging is being ordered and produced for providers and patients. This means providers and patients benefit from higher quantity and quality of imaging, which ultimately can facilitate better care or addressing issues that may have gone ignored. This is a common trend when new, seemingly disruptive technology enters the marketplace. Rather than usurping the need for humans, it makes humans more efficient, and demand for the service increases with greater access.

Workforce evolution. The U.S. healthcare workforce is being reshaped by simultaneous labor scarcity, technology adoption, and care model change. Nurse practitioners and physician assistants are taking on a growing share of primary care visits as physician supply lags demand: **HRSA's latest workforce projections show NPs as the fastest-growing clinician category in the U.S.** health system, with primary care NP supply projected to exceed demand even as primary care physician supply continues to fall short (HRSA Workforce Projections). Travel nursing, which expanded sharply during the pandemic, has remained an elevated share of staffing in most acute and senior care settings, and hospitals are increasingly adopting AI-driven workflow tools and team-based care models, in which physicians work alongside larger teams of allied health professionals, to compensate for clinician shortages. Each of these shifts has direct implications for how clinical buildings are designed, staffed, and operated.

These four trends do not resolve the demand-supply imbalance that anchors this paper. If anything, they intensify it. Care is moving out of hospitals into outpatient settings that are themselves underbuilt. Payers and providers are consolidating around platforms that need MOB and ambulatory infrastructure to operate at scale. AI is raising throughput inside existing buildings but not replacing them. And the workforce reshaping is happening on top of, not as a solution to, the demographic surge described in the sections that follow.

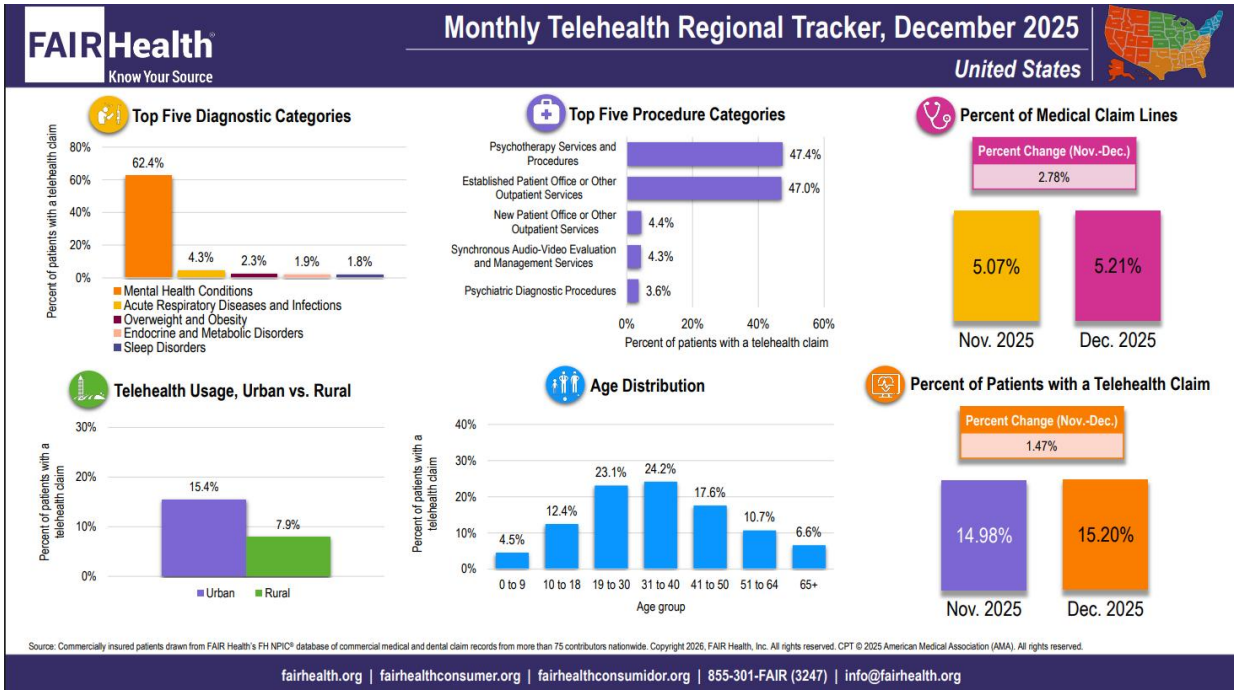
This is the paradox: capital continues to flow toward drugs, devices, and digital health, while the buildings, beds, and staff required to deliver that care have been chronically under-built and under-resourced. That gap matters because innovation only improves outcomes when the system can absorb it. A new drug, diagnostic tool, or care model still depends on physical access points, trained workers, and specialized facilities. **The opportunity in healthcare begins here: not with the idea that healthcare lacks innovation, but with the reality that its infrastructure is struggling to keep pace with innovation and increased care demand.**

Section 2: What Does Healthcare Look Like in 5-10 Years?

Any thesis about healthcare infrastructure must account for the technologies that could plausibly reduce demand for it. Wearables, AI diagnostics, hospital-at-home programs, and virtual care have all generated credible claims that the next decade of healthcare delivery will look meaningfully different from the last. We look at three plausible scenarios for how healthcare delivery evolves through 2035.

- **Tech-Optimistic.** Wearables, AI-assisted diagnostics, virtual care, and hospital-at-home programs are gradually reducing the need for some in-person healthcare visits. Technology is already becoming part of everyday healthcare. Smartwatches can now track heart rate irregularities, blood oxygen levels, and other health metrics in real time. Continuous glucose monitors, once used mainly by diabetics, are expanding into broader wellness and metabolic tracking. Remote patient monitoring has also grown rapidly as

doctors increasingly track chronic conditions without requiring patients to come into the office as often. At the same time, telehealth and online pharmacy platforms have made it easier for patients to refill prescriptions, speak with providers, and receive treatment for simpler medical issues without visiting a clinic in person. Yet even with all of this, the bull case has a structural ceiling. Roughly 63% of telehealth claims in late 2025 were for mental health conditions, where no physical examination is needed (FAIR Health). Outside of behavioral health, virtual care has not broadly substituted for in-person visits. Epic Research found that primary care telehealth held relatively steady at around 6 to 7% of appointments since 2023, down roughly 30% from its 2022 peak (Epic Research). Wearables generate data that informs clinical decisions but rarely replaces them, and remote patient monitoring augments care rather than displaces visits. AI imaging and ambient documentation change throughput inside a clinical building. They do not yet replace the building. Even the most ambitious tech-forward academic medical projects currently in design, including those built around ambient intelligence, robotics, and automation, are planned as new physical campuses rather than as substitutes for them. This reinforces that even bullish technology adoption assumes meaningful new built space.



Source: FAIR Health

- **Status Quo.** Technology adoption proceeds at the current pace. Telehealth holds at a low share of total visits. Hospital-at-home programs are expanding gradually but still account for a small share of total inpatient care. Physical care demand grows roughly in line with

demographic forces. Under this scenario, the rapid growth of the 80+ population is likely to place significant strain on an already capacity-constrained healthcare system. The cohort is projected to grow approximately 16.6% by 2028, nearly 28% by 2030, and more than 55% through 2035, increasing from roughly 15 million Americans today to nearly 23 million (NIC MAP). A demographic expansion of that scale, combined with existing shortages in healthcare labor, senior living, and care infrastructure, would further widen the gap between healthcare demand and available capacity.

- **Infrastructure-Stressed.** Technology adoption underperforms. Labor shortages worsen. Construction cost inflation and financing conditions continue to suppress new supply. The demographic surge fully lands on an already-thin physical footprint. Wait times extend. Rural access deteriorates. Capacity rationing emerges in markets with the worst supply-demand mismatch.

Scenario	**Key Assumption**	**Implication for Physical Healthcare Infrastructure**
Tech-Optimistic	Wearables, AI, virtual care, and hospital-at-home meaningfully substitute for in-person utilization.	Absent the coming surge in the 80+ population, technological advancements could have materially reduced physical healthcare demand over time. However, given the pace of demographic growth and the healthcare utilization patterns observed to date, we believe even a highly technology-enabled healthcare system will still require meaningful expansion in healthcare infrastructure capacity.
Status Quo	Telehealth holds at a low share of visits, and hospital-at-home remains niche.	Demand for physical infrastructure tracks the demographic curve, which causes the supply pipeline to lag further behind.
Infrastructure-Stressed	Adoption underperforms, while labor and construction constraints persist.	Acute capacity shortages, longer wait times, and rationing in undersupplied markets.

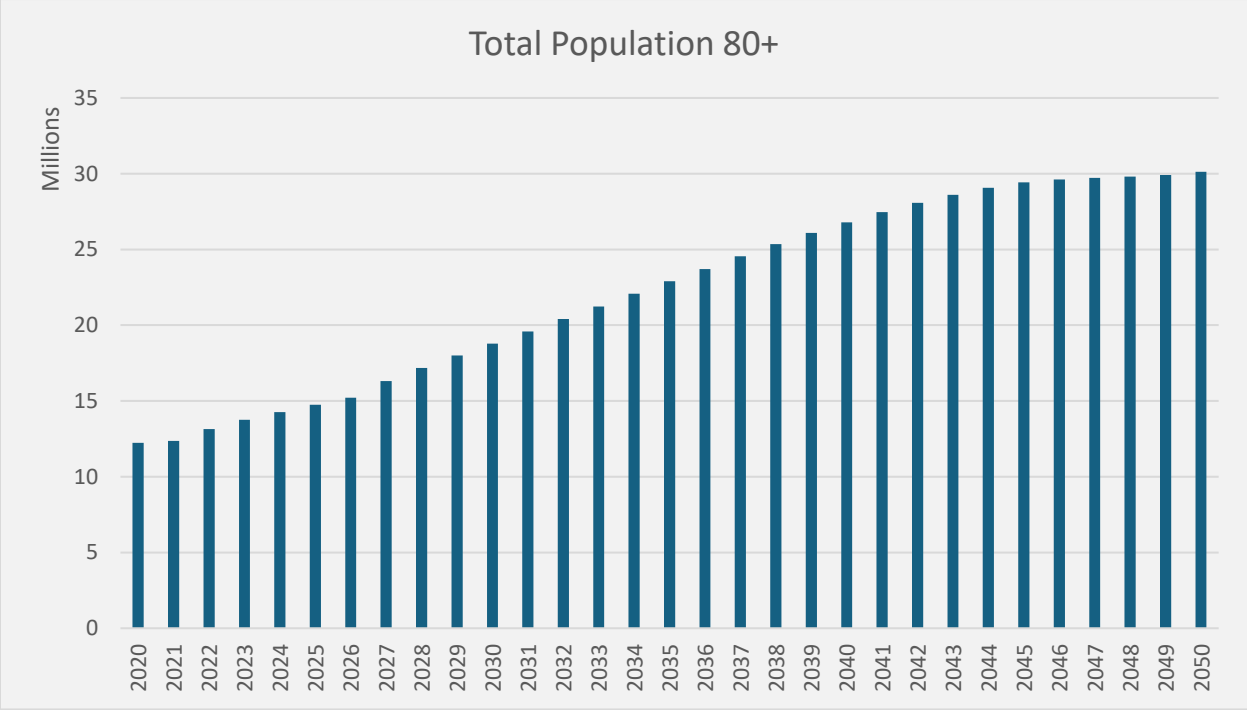
The main takeaway is that each scenario implies a different growth rate for physical healthcare demand. None implies a contraction. **The 80+ cohort is too large, too high-utilization, and too locked-in to be offset by any feasible rate of technology substitution within a 7-to-10-year private real estate investment horizon.** Even in the Tech-Optimistic case, the physical

infrastructure gap that opened during COVID and widened through the post-2022 construction slowdown cannot be closed by software or AI. The next section examines why the demographic driver underneath all three scenarios is non-negotiable.

Section 3: The Demographics Are Non-Negotiable

Most macro forecasts come with material uncertainty. Demographics are different. The people who will turn 80 in 2035 are already in their late 70s today, and the people who will be 80 in 2045 are already in their late 60s. Unlike growth assumptions or policy projections, the demographic curve for the next two decades is essentially locked in, absent a major unforeseen shock or Black Swan event.

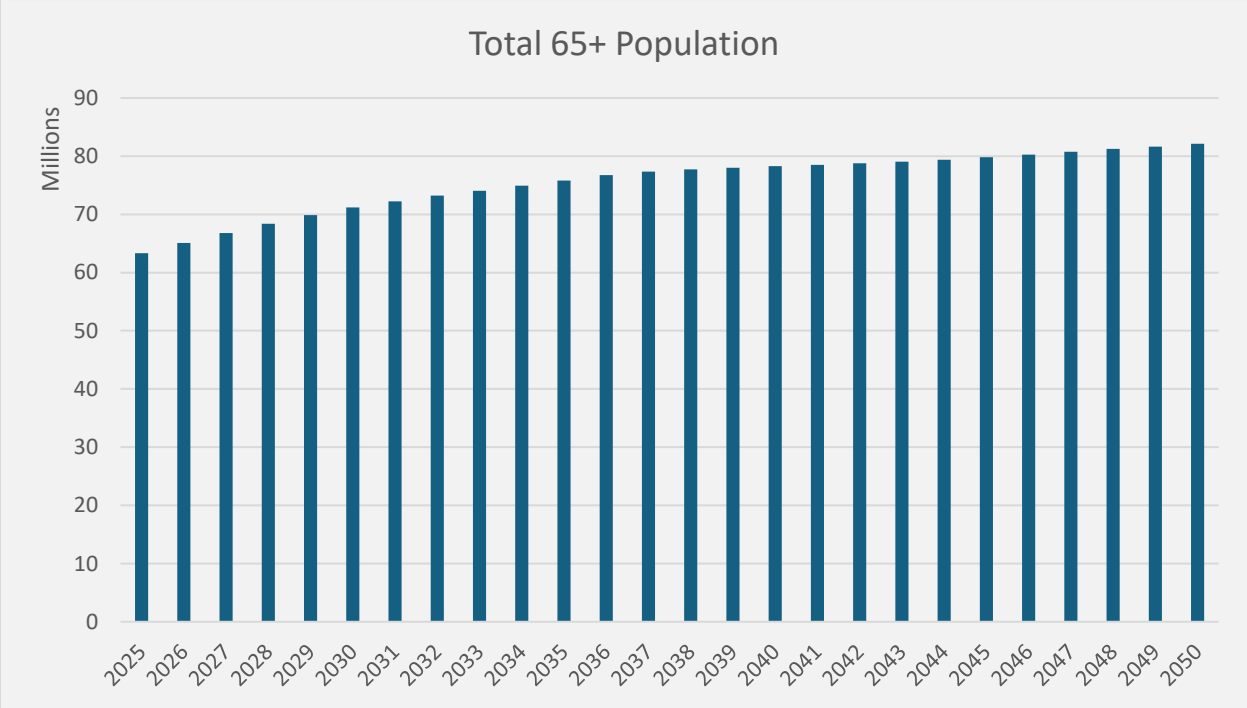
The 80+ population is projected to grow at a 5% CAGR from 2025 to 2030, against roughly 0.4% for the overall U.S. population (U.S. Census). **In absolute terms, the cohort is on track to grow from approximately 14.7 million in 2025 to nearly 23 million by 2035 and close to 29 million by 2045.**



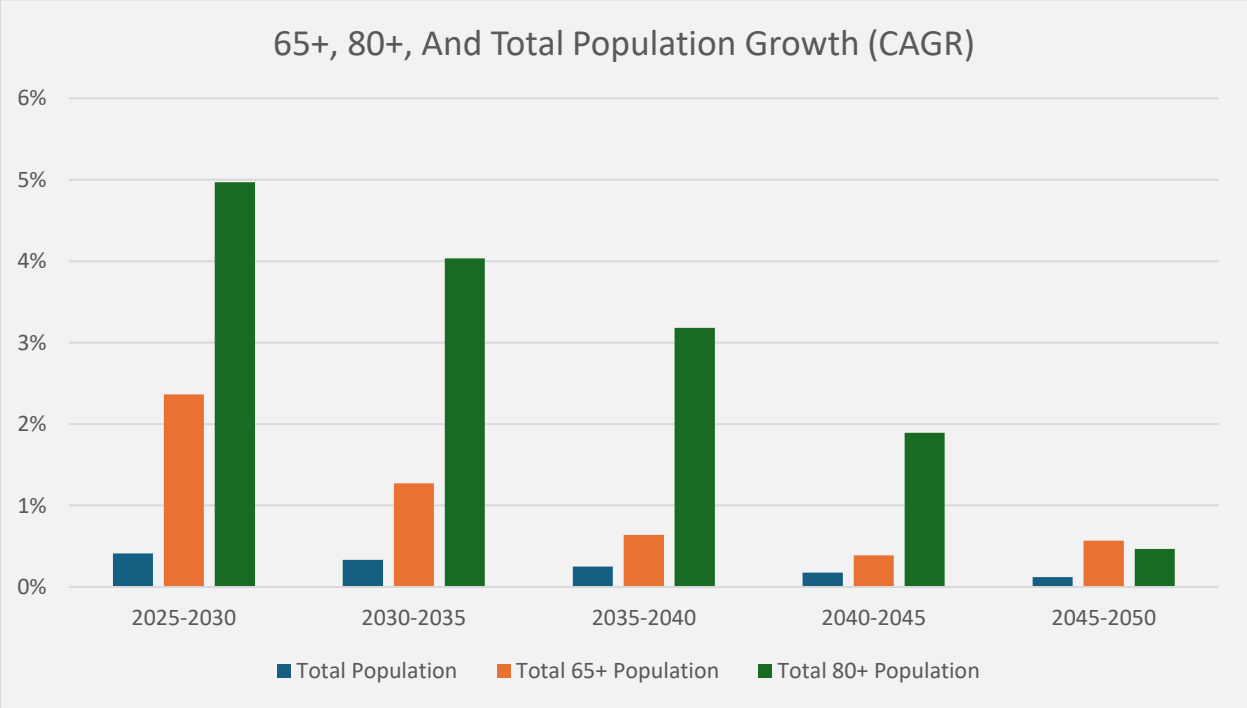
Source: U.S. Census

Beyond the most acute cohort, the broader 65+ population is the larger demand base and is already expanding rapidly. It is on track to grow from roughly 63 million in 2025 to about 71 million by 2030 and 76 million by 2035, reaching approximately 82 million by 2050, which is more than four times the size of the 80+ population, and adding close to 8 million older Americans this decade alone. The 65+ cohort expands at roughly a 2.4% CAGR from 2025 to 2030, well ahead of

the 0.4% growth rate of the overall U.S. population. Where the 80+ curve drives needs-based senior living, the 65+ expansion is the primary demand engine for medical outpatient buildings, specialty care, and 55+/Active Adult product.

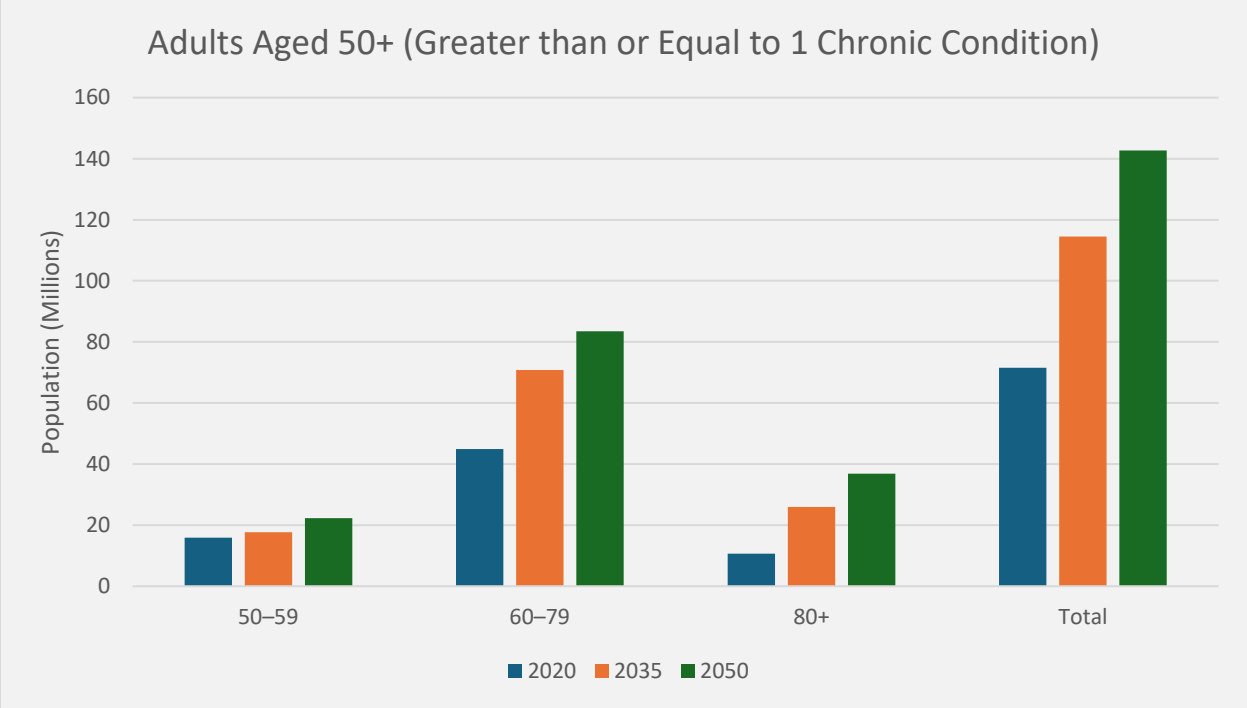


Source: U.S. Census



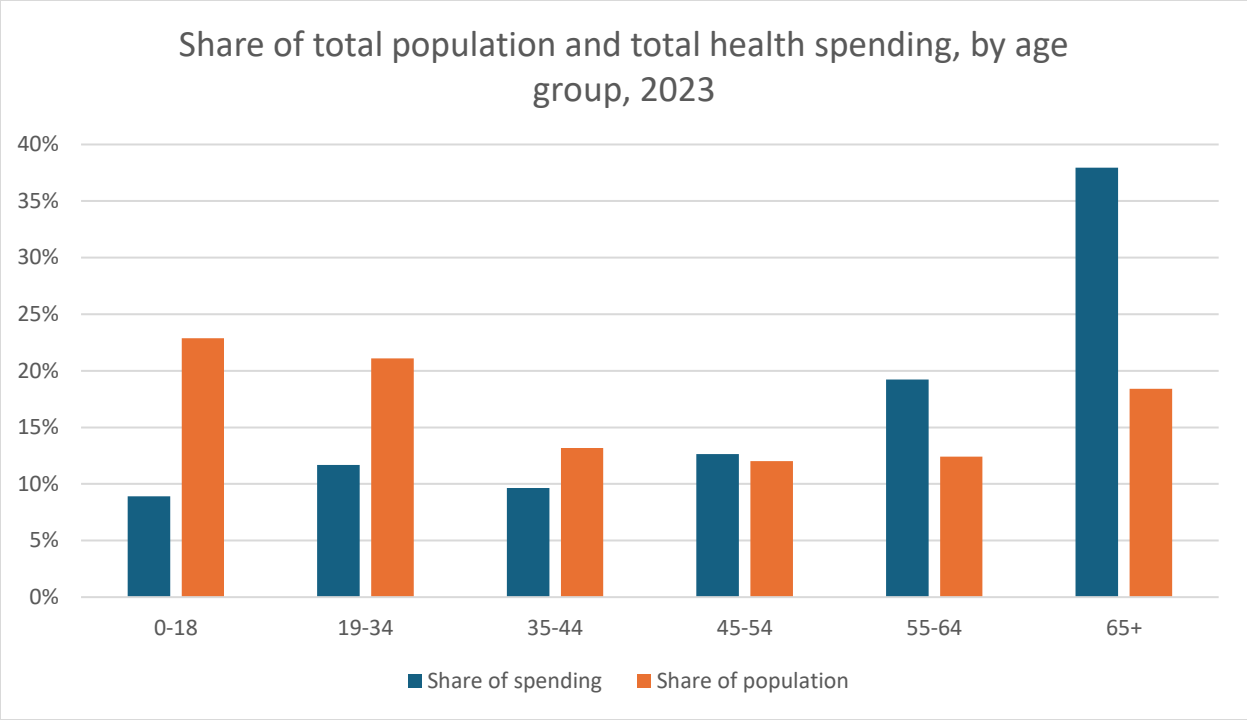
Source: U.S. Census

The demographic pressure compounds when combined with chronic-disease acuity. A peer-reviewed projection in Frontiers in Public Health (Ansah and Chiu, 2023) estimates that the **U.S. population aged 50 and over with at least one chronic condition will rise from 71.5 million in 2020 to 142.6 million by 2050, a 99.5% increase that essentially doubles the chronic-disease population in 30 years.** Within that, the **80+ chronic-disease cohort more than triples, from approximately 10 million in 2020 to roughly 37 million by 2050.** Chronic disease is one of the main reasons healthcare demands rise as the population ages. Older adults are not just a larger population group; they also use significantly more healthcare services per person.



Source: Frontiers in Public Health (Ansah and Chiu, 2023)

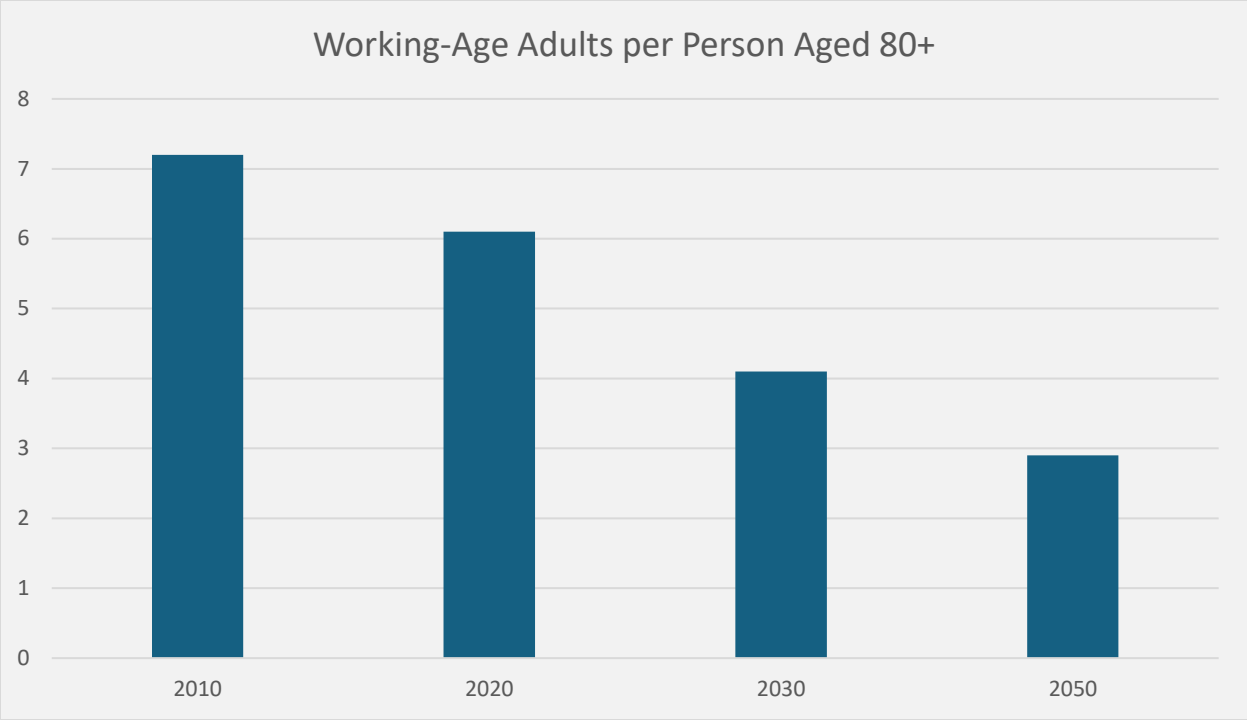
That higher utilization translates directly into spending. Health spending climbs steeply with age even as each older cohort's share of the population shrinks: in 2023, adults 65 and over accounted for roughly 38% of all U.S. health spending while making up only about 18% of the population, and the 55-and-over population consumed 57% of spending despite being just 30% of the population (Peterson-KFF). The per-capita gap is equally pronounced. Personal health care spending averages roughly $22,400 per person for adults 65 and over and nearly $36,000 for those 85 and over, about 8.5 times the $4,200 spent per child, and well above the $9,000 spent on the average working-age adult (aged 19-64) (CMS). As the 65+ and 80+ cohorts expand, this disproportionate per-person consumption compounds the demographic growth described above, widening the gap between care demand and the capacity available to meet it.



Source: Peterson-KFF

The third pillar is the sharp slowdown of informal caregiving capacity. The AARP Public Policy Institute's caregiver support ratio, defined as **the number of adults aged 45 to 64 available to support each person aged 80+, is projected to fall from about 7 in 2010 to 4 by 2030, and then to less than 3 by 2050.** This is what forces care that historically happened informally, at home, into formal, paid, often facility-based settings. As the ratio declines, demand for senior living, home health caregivers, and skilled nursing rises faster than demographic growth alone would imply.

These projections are sounding alarms across the institutional research community. The Association of American Medical Colleges projects a shortage of up to 86,000 physicians by 2036, citing population growth and aging as the primary reasons. Separately, HRSA's National Center for Health Workforce Analysis projects an acute shortage of health professionals across the board by 2038. The AAMC's physician projections, HRSA's workforce analyses, McKinsey's nursing forecasts, and the AARP caregiver ratio all converge on the same underlying point: **the population requiring care is growing faster than the infrastructure and workforce needed to serve it.**



Source: AARP Public Policy Institute

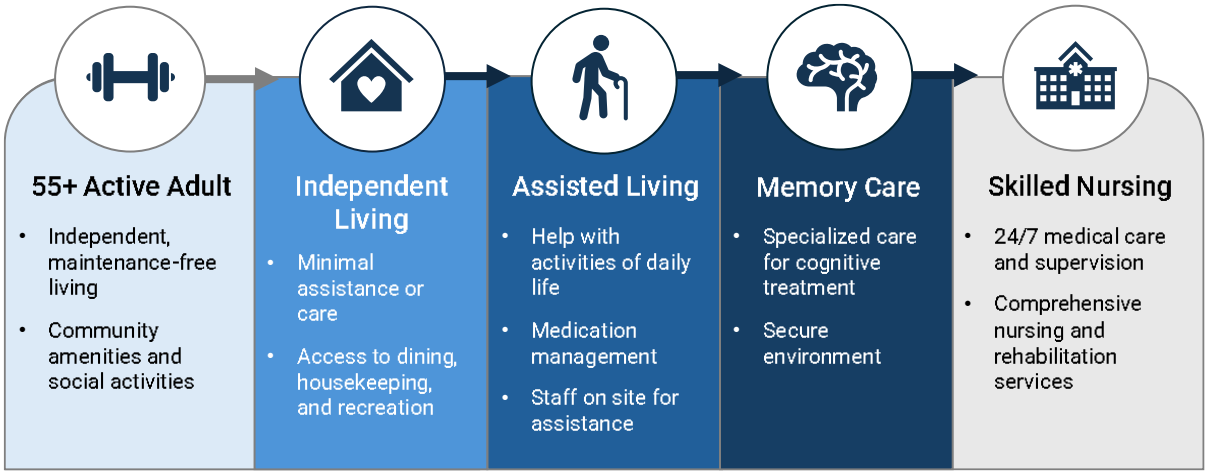
The remainder of this paper turns to the physical infrastructure side of that equation, where the supply response has been weakest, and the investment opportunity is most concentrated.

Section 4: A Taxonomy of Healthcare Built Space

Healthcare built space spans a wide range of property types, including acute care hospitals, ambulatory surgery centers, inpatient rehabilitation facilities, skilled nursing, behavioral health, life sciences, and the two categories that anchor this paper: senior living and medical outpatient buildings. **Each category has its own demand drivers, lease structures, regulatory exposure, and operating complexity. The paper focuses on senior living and MOB because they sit at the intersection of three conditions: institutional-scale market size, demographic-driven demand with no plausible substitute, and a supply pipeline that has fallen materially behind demand.** The other healthcare property types are either too small, too dependent on government reimbursement, or too operationally specialized to absorb the volume of institutional capital that senior living and MOB currently can.

Senior Living. Senior living is best understood as a continuum of housing-plus-services products differentiated by the acuity of resident need. From least to most acute, the spectrum runs from **55+ Active Adult** (independent, maintenance-free communities centered on amenities and social programming), to **Independent Living** (minimal assistance, with dining, housekeeping, and recreation), **Assisted Living** (help with activities of daily life, medication management, and on-site staffing), **Memory Care** (specialized care for cognitive impairment in a secure setting), and **Skilled**

Nursing (24/7 medical care with comprehensive nursing and rehabilitation). The first four categories are predominantly private-pay; skilled nursing is largely Medicaid- and Medicare-funded, which is why most institutional senior living strategies focus on the private-pay end of the continuum.

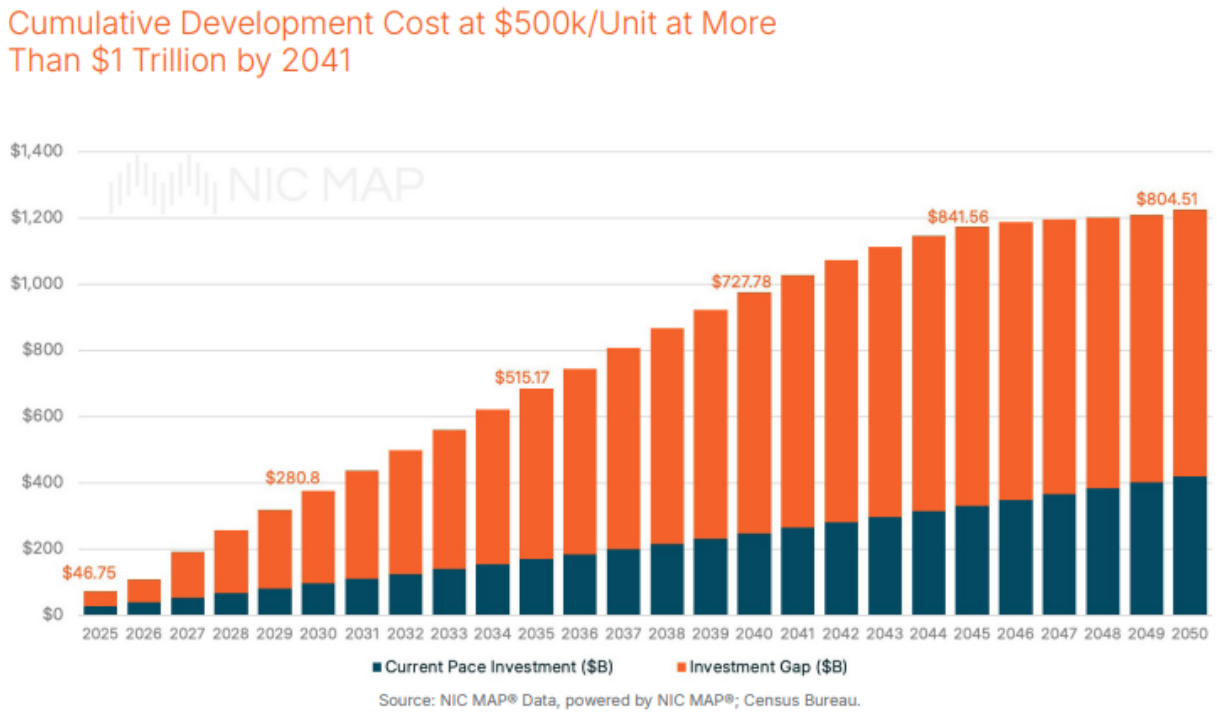


Source: Virtus

Demand is driven directly by the 80+ growth curve detailed in Section 3 for the latter four categories. **Occupancy in NIC MAP's Primary Markets reached 89.5% in the first quarter of 2026, the 19th consecutive quarter of gains and the highest level since the data series began in 2006.** The market is estimated at roughly $1 trillion in total investment value today and is projected to require more than $1 trillion in required investment by 2041, with an estimated $800 billion supply gap at the current pace of development (NIC MAP). The risks are operationally specific. **Operator selection alongside proper oversight of the operator and local staff are the most consequential factors in most any senior living investment, because the same physical asset can produce materially different margins depending on operator quality and especially onsite staff.** Our CIO has summarized it: "Senior living is an operating business with some real estate around it, while everything else we invest in is real estate with some operations inside of it." Some of our senior living communities require nearly ten times the staff of one of our larger middle-income housing properties. Think of a full-service hospitality model, and then add labor staffing, caregivers supporting some of the most fragile members of society. Of course, the big difference between hospitality and senior living is that the latter has evergreen demand while the former is highly cyclical.

State licensing regimes vary materially by jurisdiction, particularly in Assisted Living and Memory Care, with staffing ratios, wage floors, and certificate-of-need requirements differing at every state line, and in some cases with municipal or county overlays. The most basic operating questions, like how many caregivers a building must employ for a given resident census, are answered differently in California, Texas, Florida, and New York. New developments can carry a

lease-up risk of 24 to 30 months to stabilization, during which carrying costs accumulate against limited cash flow until breakeven occupancy is achieved, typically 73% - 78%, considering high fixed operating costs. **Labor is the largest line item in any senior living P&L, running on average around 55% of total operating expenses. While wage inflation rates finally came down in 2025 and 2026 (observed first-hand in our own portfolio), after double-digit growth YOY during the Pandemic, wage inflation remains sticky: assisted living wages rose 7.4% in 2024, 6.6% year-over-year in Q1 2025 per BLS data, and operators surveyed in mid-2025 were already modeling 5% to 10% base wage increases for 2026 in anticipation of further immigration-driven labor tightening** (Senior Housing News).

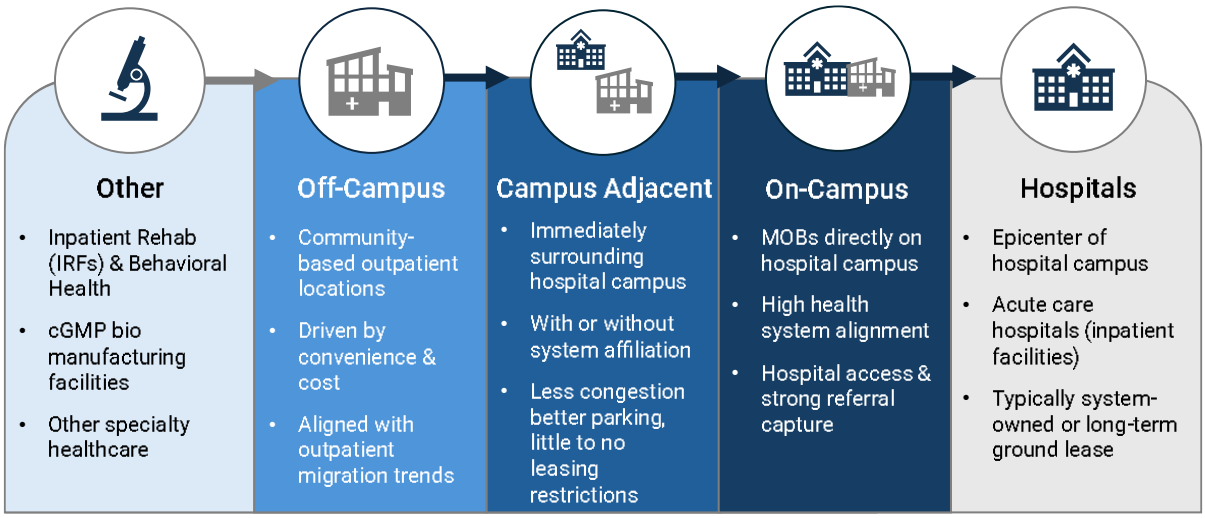


Investment Gap in New Inventory to Maintain 90% Occupancy. Source: NIC MAP

Medical Outpatient Buildings. MOB is best understood as a continuum defined by proximity and affiliation with health systems. From least to most integrated, the spectrum runs from **Other** healthcare assets (inpatient rehab, behavioral health, biomanufacturing, specialty healthcare), to **Off-Campus MOB** (community-based outpatient locations driven by convenience and cost, aligned with outpatient migration trends), **Campus Adjacent** (immediately surrounding a hospital campus, with or without system affiliation), **On-Campus** (directly on a hospital campus, with high system alignment and strong referral capture), and **Acute Care Hospitals** (the inpatient epicenter, typically system-owned or on long-term ground lease).

MOB tenancy is overwhelmingly clinical, with predominantly triple-net leases, 7- to 10-year tenors, frequently backed by personal or corporate guarantees, and built around expensive,

specialized buildouts (imaging suites, surgical rooms, specialized air- and fluid-handling systems) that make tenants exceptionally sticky. **National MOB occupancy reached 92.7% in Q4 2025 (JLL), while average rent growth remained healthy at 3.3% year-over-year, and outpatient volumes are projected to grow 10.6% over the next five years (JLL).** This demand is underpinned by the 65+ population, the primary consumers of outpatient, specialty, and diagnostic care, expanding from roughly 65 million today to about 76 million by 2035, a far larger base than the 80+ cohort that drives senior living. New construction rents are running roughly 38% above in-place rents, **with average existing MOB rents in the mid-$20s per square foot, while new developments are leasing at around $35 per square foot,** which creates a structural mark-to-market opportunity at lease rollover (Revista).



Source: Virtus

However, MOB comes with its own set of challenges. Hospital economics are inherently fragile. **Even a well-performing hospital typically operates on only 5% to 7% operating margins, leaving little room for reimbursement pressure, labor inflation, bad debt, payer mix shifts, or utilization volatility.** That margin profile helps explain why so many hospitals are part of nonprofit, public, academic, or faith-based health systems rather than purely private operating platforms.

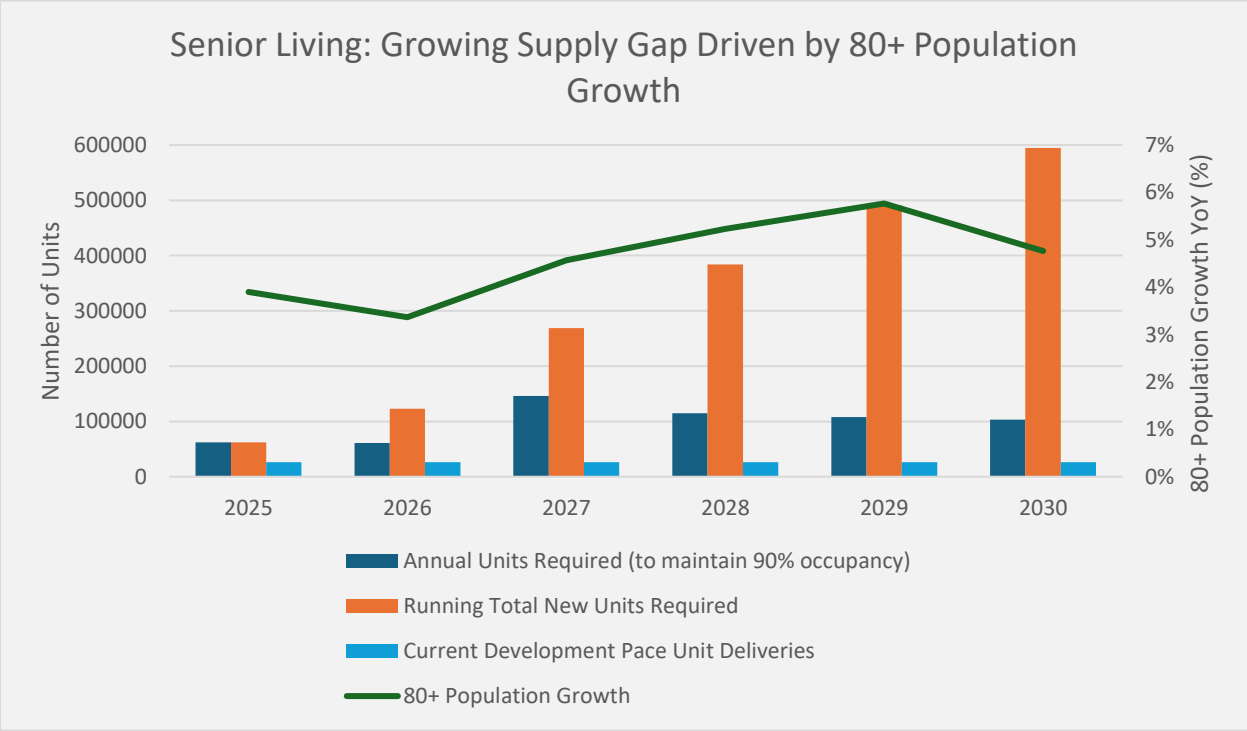
For private operators, the challenge is even sharper. Hospitals face durable patient demand, but they also operate in a business with high fixed costs, complex collections, heavy regulation, and many inputs outside their control. When hospitals and affiliated physician groups come under margin pressure, the effects do not stop at the hospital walls. They flow into the broader healthcare built space ecosystem through slower expansion decisions, tighter lease negotiations, greater scrutiny of outpatient footprints, and increased focus on tenant credit quality.

Both categories share the same underlying tension: clear demographic demand, constrained supply, and material operational complexity. Section 5 quantifies the supply side of that equation, where the gap is widest and most structural.

Section 5: The Infrastructure Gap Is Structural

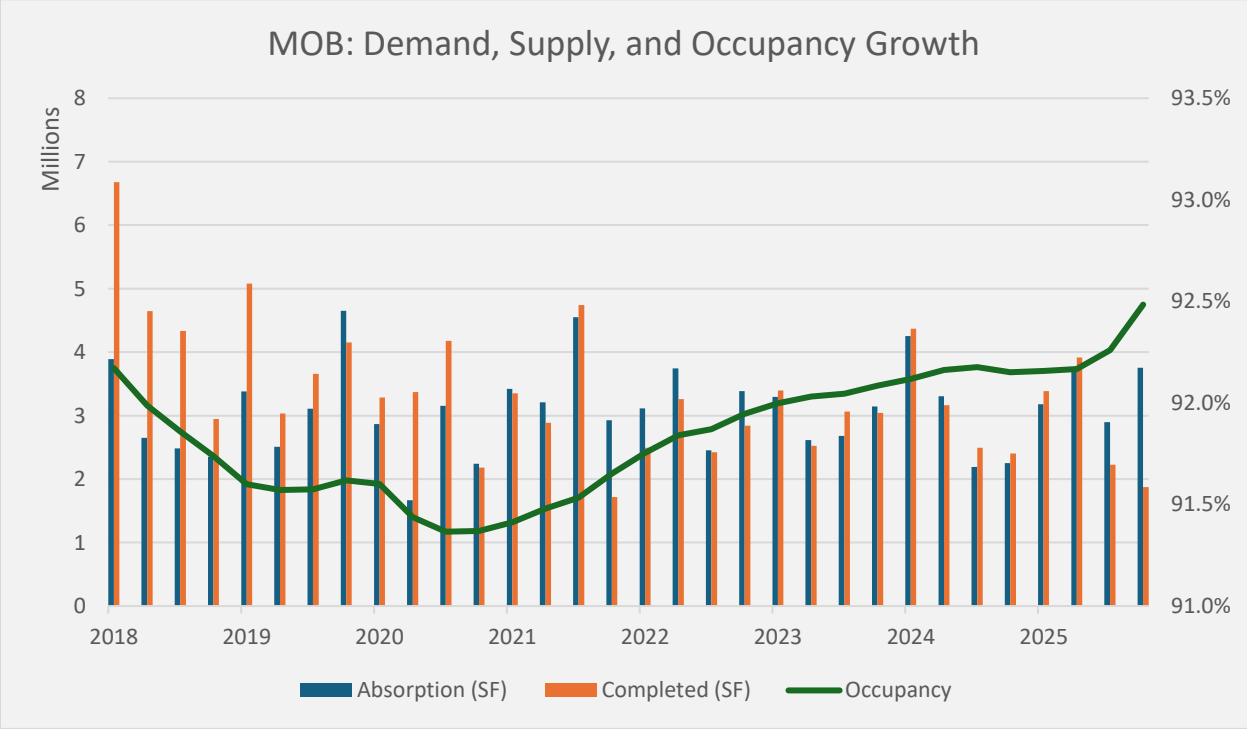
The supply side of healthcare built space has collapsed at precisely the moment demand began accelerating. **Construction starts in both senior living and medical outpatient buildings are running at multi-decade lows, even as 80+ population growth enters its steepest phase.** This collapse is structural rather than cyclical. The forces driving it (construction cost inflation, labor scarcity, and tighter financing) do not resolve in a single rate-cutting cycle, and the lead times required to bring new supply online mean the gap widens before it narrows.

Senior Living. The single most striking data point may be this: **as of Q3 2025, nearly 60% of the 140 markets tracked by NIC MAP currently have no new development projects underway, a dramatic shift from three years ago, when only one-third of markets had no active construction.** Units under construction in Primary Markets remained at their lowest level since 2012 as of Q1 2026, with year-over-year inventory growth dropping to a record low of 0.4%. NIC MAP estimates the **U.S. needs roughly 549,000 additional senior living units by 2028 and 806,000 by 2030, with the current delivery pace tracking at roughly one-third of that requirement and a cumulative $300 billion investment shortfall. To maintain even 90% occupancy by 2030, the industry would need to develop at nearly twice its historical maximum pace.**

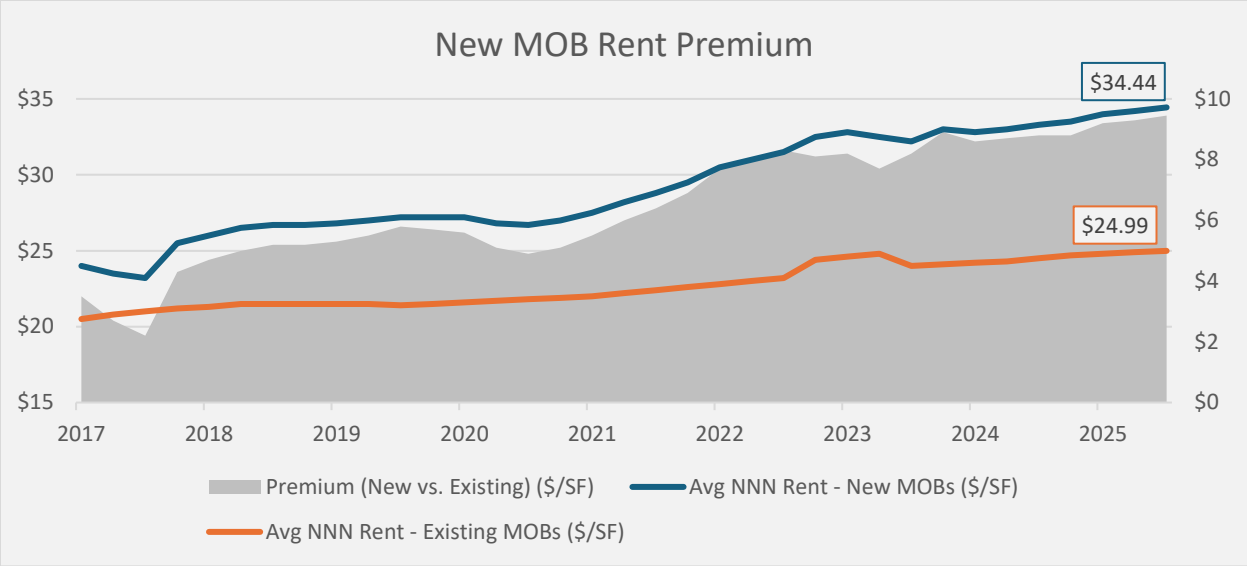


Source: NIC MAP

Medical Outpatient. The MOB supply story is structurally similar. **Q4 2025 construction starts ran at 1.2% of inventory (Revista), near a cyclical low, and developer-led starts are half of what they were in 2019.** This does not even account for the loss from functionally obsolete medical infrastructure that is coming offline. Absorption has consistently exceeded completions over the past three years, pushing national MOB occupancy to a record high of 92.7% in Q4 2025 (JLL). The binding constraint is replacement cost, not absent demand. **Average NNN rent for new MOB construction reached $34.44 per square foot in 2025, against $24.99 for existing inventory, a $9.45 per square foot premium that has nearly tripled since 2017 (Revista).** New rents are running at roughly 38% above in-place rents, and even those levels do not always clear the development hurdle once land, financing, and contingency are layered in. Part of the rent premium also reflects rising buildout specifications. New outpatient construction increasingly incorporates sensing infrastructure, automated logistics, and clinical-grade data systems that existing inventory cannot economically retrofit.

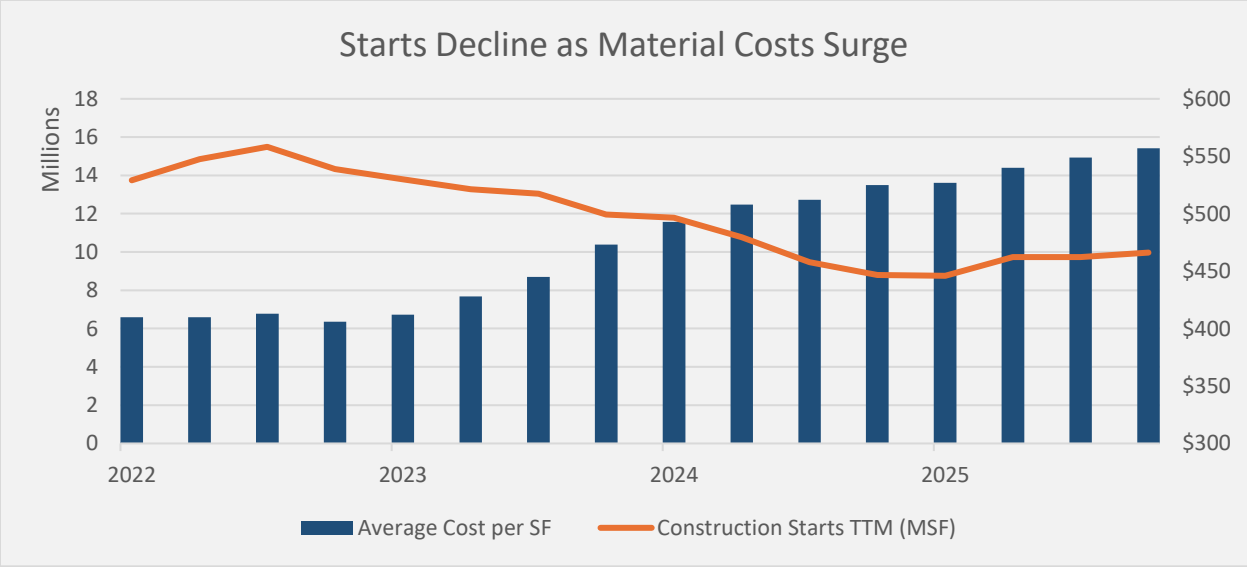


Source: Revista



Source: Revista

Why is this structural? Three forces are converging. First, construction cost inflation: average MOB cost per square foot has risen materially since 2022, even as construction starts have declined, an inverse relationship that confirms costs are the binding constraint rather than appetite. Second, labor scarcity: skilled-trades shortages and senior living operating labor remain in long-term deficit, eroding both development pro formas and stabilized operating margins. Third, financing: higher base rates, stricter construction lending standards, and a narrowed spread between development yields and stabilized cap rates have made new projects difficult to underwrite. None of these are transient pressures that ease with the next Fed cut. Each carries multi-year persistence.



Source: Revista

Lead times compound the problem**. NIC MAP reports that the average senior living construction cycle has stretched to 29 months in 2025, up from 21 months in 2017. MOB projects run similarly long.** Even if capital decided today to flow aggressively into new development, meaningful inventory cannot reach the market before 2028 or 2029, which is precisely the window in which 80+ population growth enters its steepest annual increment. The gap is not only real; it is widening on a trajectory the supply side cannot bend back without years of sustained, well-priced development that is not currently in motion.

Section 6: Why Specialist Capital Wins

The complexity that makes healthcare built space hard to invest in is precisely what makes it rewarding for those equipped to navigate it. Demographic-driven demand and a structurally-supply-starved market are not a secret. **Capital has been aware of the senior living and MOB thesis for the better part of the decade. Yet the asset class remains dominated by a relatively small set of specialists, and concentration has, if anything, tightened over the past several quarters. The reason is that domain expertise, operator networks, and proprietary sourcing are not commoditized inputs that generalist capital can hire its way to.**

Generalist capital faces real and persistent barriers. **It cannot easily underwrite operator quality, where the spread between top-quartile and bottom-quartile performance can erase the demographic tailwind on a specific asset.** It lacks state-by-state regulatory fluency in assisted living and memory care, where staffing ratios, wage floors, and certificate-of-need requirements differ at every state line. It has no incumbent operator relationships in a market where the best deals rarely reach a marketed process. And it rarely sees off-market deal flow in a fragmented ownership landscape dominated by regional families, operating partners, and small platforms. Specialist capital, by contrast, holds all four: the labor and reimbursement knowledge to underwrite an operating business plus real estate, the operator relationships that source deals before they are marketed, the regulatory fluency to model state-specific cost structures, and the proprietary pipeline that comes from being a known counterparty.

Conclusion

Healthcare built space sits at an unusual collision of forces that is structural rather than cyclical. The U.S. healthcare system is in the middle of its most innovative decade on record. GLP-1 drugs are reshaping the treatment of chronic disease. AI-enabled medical devices crossed 1,400 cumulative FDA authorizations in 2025. Hospital-at-home programs have scaled from a pandemic pilot to 366 participating hospitals. Telehealth, while smaller than its 2022 peak, is structurally embedded. National health expenditures are on track to pass $8.6 trillion by 2033. The system is innovating faster than at any point in modern memory.

And yet the physical infrastructure that delivers all this innovation is meaningfully under-built and chronically under-resourced. Senior living units under construction are at their lowest level since 2012. Nearly 60% of NIC-tracked markets have zero senior living development underway. New MOB rents are running 38% above in-place rents, a spread that signals new supply cannot be built at scale economically. The senior living investment shortfall is on track to exceed $300 billion by 2030, with the cumulative gap projected to exceed $1 trillion by 2050. The shortage of nurses, physicians, and support staff is becoming increasingly severe at a time when the caregiver ratio continues to decline.

All of this is happening as the U.S. enters the steepest expansion of its older population on record. **The 65+ population grows from roughly 65 million Americans today to about 76 million by 2035 and 80 million by 2045, while within it, the 80+ cohort, the most care-intensive segment, enters the steepest growth curve in U.S. history, climbing from roughly 15 million today to nearly 23 million by 2035 and close to 29 million by 2045.** The cohorts that will need the most care are the largest in absolute terms the country has ever produced, arriving exactly as supply, labor, and informal caregiving capacity recede.

This is a narrative we plan to continue building on through future additions to our white paper series. Parts II and III turn from the overall thesis to the specific dynamics within each market. **Part II: Senior Living Deep Dive** examines how the collision of a near-zero supply pipeline and the steepest 80+ demographic curve in U.S. history is reshaping the senior living market itself: pricing, rate growth, occupancy, and the resident affordability question that emerges as monthly rates compound against the largely fixed retirement incomes that pay them. Operator selection, market scoring, and underwriting sit inside that broader market lens. **Part III: Medical Outpatient** examines the rent gap, the rollover opportunity, and the cost barriers preventing new supply from competing with existing inventory.

Authors:

- Terrell Gates- Founder and CEO of Virtus Real Estate Capital
- Dr. Nitish Kumar- Research Specialist at Virtus Real Estate Capital