

Healthcare Built Space Part III: Medical Outpatient Buildings

October 12, 2026

WHAT IS A MEDICAL OUTPATIENT BUILDING?

Purpose-built clinical space where people see a doctor, get a scan, or have a procedure, and go home the same day.

HOW BIG IS IT The U.S. will spend \$6.0 trillion on healthcare in 2026, 18.7% of the economy, rising to \$9.0 trillion by 2034.	WHO RENTS IT More than 8 in 10 U.S. doctors work for a hospital or corporate owner, so rent comes from institutions.	WHO PAYS THE RENT 92% of Americans have health coverage, so rent is ultimately funded by insurers.
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DEMAND IS RISING AND MOVING OUTPATIENT		NOTHING IS BEING BUILT TO RECEIVE IT	
THE AGING WAVE 65M → 76M Americans aged 65 and over, today to 2035. The people who will be 75 in 2035 are 65 today.		THE PIPELINE IS SHRINKING -12.6% Completions over the past year. Forecast to fall another 26% in 2026, to a decade low.	
THEY USE FAR MORE CARE \$22,356 vs \$9,154 Healthcare spending per person per year, 65 and over against a working-age adult.		BARELY ANYTHING UNDER WAY 2% Space under construction as a share of everything standing, and that counts no allowance for older buildings falling out of clinical use.	
CARE HAS LEFT THE HOSPITAL 30% → 62% Outpatient share of hospital patient revenue, 1995 to 2025.		NEW SPACE COSTS TOO MUCH \$34.44 vs \$24.99 NNN Triple net rent per sq. ft. a new building must charge, against existing space. Few tenants will pay the difference.	
THE SHIFT ISN'T FINISHED 20% vs 7% Projected growth over the next ten years in outpatient visits and procedures, against hospital admissions.		TENANTS DO NOT LEAVE ~89% Annual tenant retention. Clinical buildouts are expensive and cannot be moved.	
THE COLLISION, IN THE DATA			
92.2% OCCUPANCY, CLIMBING SINCE 2021 WHILE TRADITIONAL OFFICE HAS FALLEN		Every Quarter RENT HAS RISEN SINCE 2017	
		+86% GROWTH IN SALES VOLUME, YEAR OVER YEAR	

These buildings cannot be replaced at the rent they charge today.

- Demand is set by people already born and already aging.
- Supply cannot respond for years, even if capital wanted it to.
- Most of the stock has never been institutionally owned.

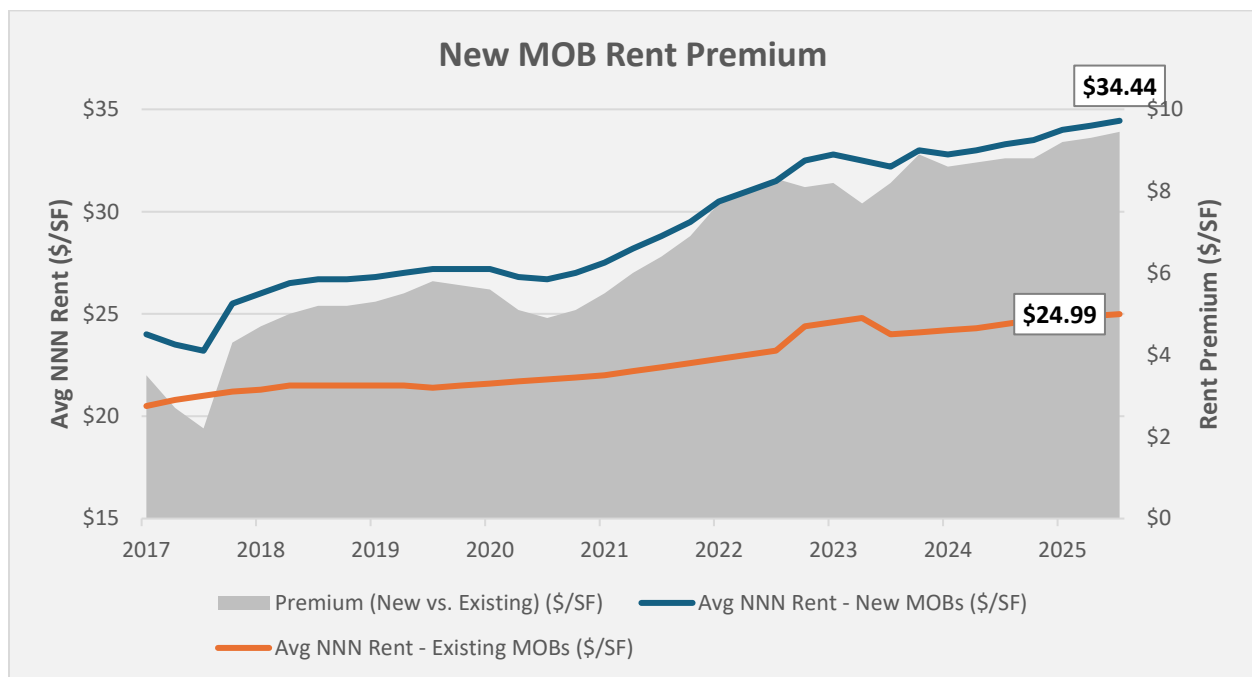
Sources: Revista 2Q26; U.S. Census Bureau; CMS Office of the Actuary; AHA Trendwatch Chartbook; Vizient; CBRE; Transwestern; Physicians Advocacy Institute; KFF.

Executive Summary

This paper is Part III of our series on healthcare built space. [Part I](#) introduced the U.S. healthcare system and the physical infrastructure that delivers care. [Part II](#) went deep on senior living, which we described as an operating business with some real estate around it. This paper turns to the other major category of healthcare real estate, the medical outpatient building ("MOB"), and it is the reverse: real estate with some operations inside it.

Medical outpatient buildings are where most American healthcare actually happens. Doctor visits, scans, blood draws, physical therapy, and a growing share of surgery all take place in them, and the patient usually goes home the same day.

The main takeaway of this paper is: demand for these buildings is set by forces already locked in, while the supply response has nearly stopped, and the gap between the two is visible today in occupancy, rents, and what investors are paying.



Source: Revista

The paper covers five areas:

- **What these buildings are.** Purpose-built clinical space. Switching costs are high. Relocating disrupts patient care and revenue, and the tenant's heavy investment in the buildout stays behind with the building. That's why medical tenants tend to stay put far longer than typical office tenants. Leases are long, and rent steps up every year.

- **Who rents the space.** Hospitals and corporate owners now employ 82% of U.S. doctors, so the rent is typically collected from large institutions. Retention now runs near 89% a year, the highest ever recorded.
- **The demand engine.** Americans aged 65 and over grow from 65 million today toward 76 million by 2035. They use far more care than younger people, \$22,356 a year against \$9,154 for a working-age adult. And care keeps leaving the hospital, with outpatient work now making up roughly half of hospital patient revenue.
- **Who pays the rent.** Insurers and the government do, routed through the doctors and hospitals that lease the space. That makes the rent steadier through a downturn than most commercial tenancy, and it leaves reimbursement risk with the tenant.
- **Why nothing gets built.** Completions are falling toward a decade low. Medical space is expensive to build, so a new building needs roughly 35% to 40% more rent than the market average to justify itself. Few tenants will pay that.

The result is a market that has been tightening for several years and continues to do so. Occupancy sits at 92.2% while traditional office occupancy has fallen sharply, rent has risen in every quarter since 2017, and investment capital has followed into the sector.

Section 1: What Is a Medical Outpatient Building?

Today in the U.S., most healthcare does not happen in a hospital. It happens at a location outside the hospital, and the patient goes home the same day. The buildings where all of that takes place are called medical outpatient buildings ("MOBs"), fka as medical office buildings. Outpatient simply means the patient is not admitted for an overnight stay.

These are usually the buildings across the street from the hospital, the clinic in a high-access suburban area, or the facility for specialized care. There is roughly 1.1 billion sq. ft. of MOB space across the 100 largest U.S. metro areas, and that total grows a little over 1% a year (Revista).

What Makes These Buildings Different From Regular Offices?

From outside, an MOB can sometimes look like an ordinary office building. Inside, it is a different animal. Exam rooms need plumbing at every sink. Imaging machines are heavy enough to require reinforced floors, and X-ray rooms need lead in the walls. Surgery and treatment rooms need piped-in medical gases, backup power, and air handling systems that meet clinical standards. Waiting rooms, nurse stations, and lab space have to be laid out to meet health regulations.

All of that costs the doctor's practice a great deal of money to install, and almost none of it can be taken along if they move. A practice that has spent so much on the setup has effectively planted itself. That single fact shapes everything about how these buildings perform as investments, and we come back to it repeatedly.

In addition, MOBs typically require higher parking ratios, heavier HVAC loads, larger floorplates, hallways and elevators, and ideally with covered drop-off and pickup. MOBs rarely work well in higher-density high-rise or even mid-rise buildings. That's why the majority of the investable product is purpose-built as MOB, rather than a conversion from traditional office or retail.

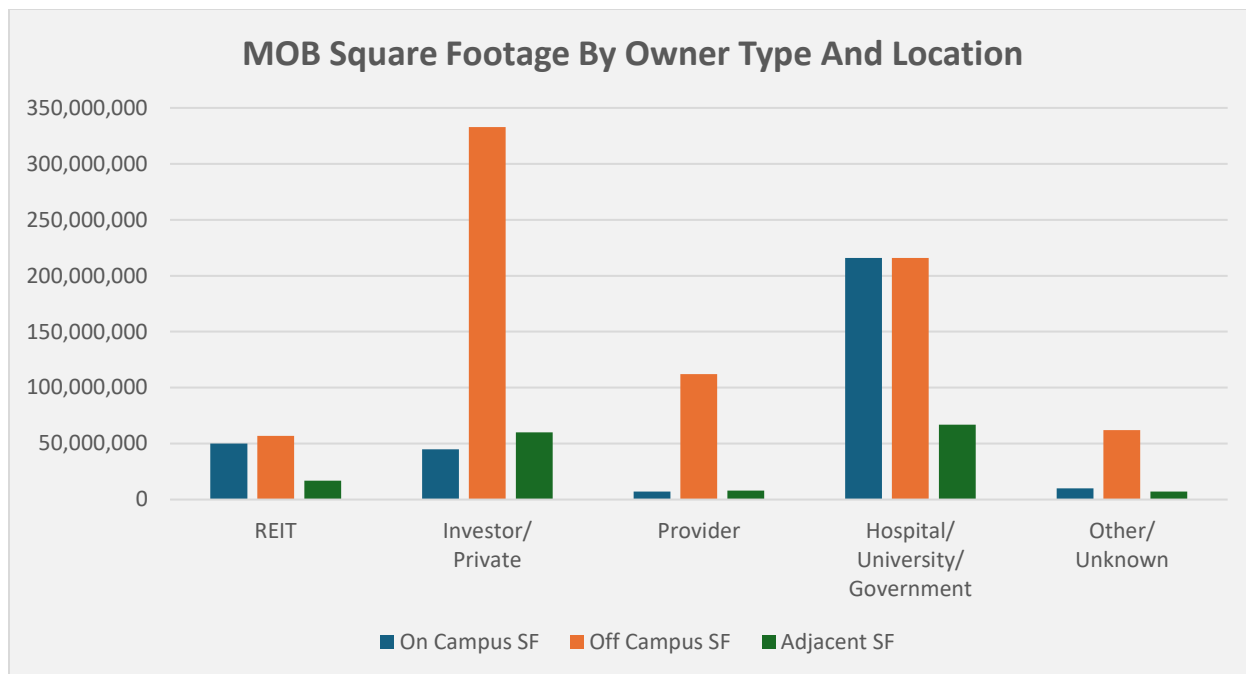
Three Kinds of Location

Where an MOB sits relative to the nearest hospital tells you most of what you need to know about it.

On the hospital campus ("on-campus"). These buildings sit on hospital land, often on land the hospital leases to a developer for a long term. They house the specialists who need to be steps away from an operating room or emergency room: surgeons, cardiologists, oncologists. Because the hospital controls the land, it usually controls who gets to lease space there. The providers here often get the highest reimbursement rates from Medicare, Medicaid, and insurers. The downside is the hospital has more influence over your building operations and especially who you can lease to, often retaining rights related to tenant approval.

Next to the hospital campus ("adjacent"). These sit immediately across the street or around the block. They see much of the same doctor and patient traffic, charge somewhat less rent, and are freer to lease to whomever they like. For certain providers, being off-campus but within 250 yards of the main hospital often allows the provider to receive on-campus reimbursement rates from Medicare, while the landlord retains more functionality and agency on leasing.

Away from the hospital, out in the community ("off-campus"). These are the clinics built where patients actually live: near neighborhoods, retail corridors, and highway exits. Convenience is the whole point, both for the patient and the providers. While reimbursement rates may not be as high as on-campus, the cost of healthcare delivery is far lower in these settings. This is where most new outpatient care is going, and it is the type most investors own in the modern era.



Source: Revista Q2 2026

Revista sorts every building into these same three buckets, and it also tracks who owns them. **Hospitals, universities, and government owners are the largest group, holding 39.0% of all the space. Private investors hold 34.2%, medical providers who own their own buildings 10.6%, and real estate investment trusts ("REITs") hold 9.6% (Revista).** No single type of owner controls the market.

The pattern across locations is worth noting. Health systems own heavily in both places, roughly half on their own campuses and half out in the community, so they are not simply landlords of their own front door. The large public REITs look much the same, because their strategy is to buy buildings affiliated with health systems, and those tend to sit on or beside a campus. Private developers and private equity funds are the ones concentrated in the community, where roughly three-quarters of their space sits.

Owner Type	On-campus SF	Off-campus SF	Share on-campus
Health systems, universities, government	113.4M	106.3M	52%
REITs	47.5M	45.1M	51%
Private developers and operators	12.2M	43.0M	22%
Private equity funds and advisors	9.6M	20.9M	31%

Source: Virtus Analysis of Revista top owner data from Q2 2026 covering the 98 largest MOB owners in the top 100 metros

Who Rents the Space?

Twenty years ago, the typical tenant list in one of these buildings was a dozen small practices, each owned by the doctors working in it. That has changed almost completely. **As of the start of 2026, hospitals employed just under 60% of U.S. doctors, and corporate owners, a category that includes insurance companies and private equity firms, employed just over 22%. Together, 82% of doctors work for someone else, leaving only 18% still in a practice they own themselves** ([Physicians Advocacy Institute](#)).

For a building owner, this can be a meaningful upgrade in credit among other things. Rent used to be collected from small businesses. Now much of it is collected from large health systems and corporate groups with real financial strength behind them. That is important because of who is signing the leases. Health systems and large specialty groups together took more than 8 out of 10 medical leases in 2025 ([JLL](#)). Health systems are also taking up bigger spaces, often 40,000 to 60,000 sq. ft., enough to put several specialties under one roof.

One tenant type deserves its own mention: the ambulatory surgery center, or ASC. These are small surgical facilities where patients have real operations and go home the same day, everything from knee replacements to cataract surgery. There are more than 6,300 of them certified by Medicare nationwide ([Journal of Vascular Surgery](#)), and the government keeps expanding what can be done in them. For 2026 alone, Medicare added 289 procedures to the list it will pay for in a surgery center, plus another 271 that had been allowed only in a hospital until then ([CMS](#)). Outpatient knee replacements grew 293% between 2019 and 2023 ([athenahealth](#)). While far cheaper to build than on a hospital campus, a surgery center is the most expensive space to build inside an MOB. Its tenant is the least likely to ever leave, plus it creates an anchor in a multi-tenant building with attractive cross-referral patterns for the providers.

How Does the Rent Work?

Leases in these buildings run longer and behave more predictably than office leases. Three structures cover almost everything, and they differ only in who absorbs the cost of running the building.

The most common is the **triple-net lease**, where the tenant pays the property taxes, the insurance, and the operating costs on top of the base rent. The owner's income is insulated from rising expenses because those costs pass straight through to the tenant, which is especially beneficial in an inflationary environment. Next is the **modified gross lease**, where the owner covers operating costs up to a set level, usually whatever they run in the first year, and the tenant pays its share of anything above that, also an inflation hedge for the landlord. Least common is the **full-service gross lease**, where the tenant pays one number, and the owner absorbs the operating costs. Medical buildings lean heavily on the first two.

Leases typically run on average six years, albeit new leases are often ten years plus, and nearly all of them raise the rent automatically each year by a fixed percentage, currently averaging around 3%. The owner therefore knows years in advance that the rent goes up, whatever the wider market does. Newer leases are being written with steeper increases, with bumps above 3% or rent tied to inflation now coming back en vogue ([JLL](#)).

Then there is renewal. When a lease expires, these tenants overwhelmingly sign another one. Tenant retention across the sector has climbed to almost 89% a year, alongside occupancy of roughly 93%, the strongest in a decade ([Transwestern](#)). Two things explain that loyalty. The first is the buildout described above, which a practice will not walk away from to save a dollar of rent. The second is patients. A practice's patients know where it is, and a doctor who relocates risks losing some of them along with the referral relationships built up over years. Rent is also a small line in a medical practice's budget, running roughly 5% to 10% of revenue against about 60% for staff salaries (MMCG Invest).

What the Owner Is Actually Selling

Put together, the product is straightforward. The owner provides a building with expensive clinical infrastructure and rents it to medical providers who cannot easily leave and generally do not want to. There is no care to deliver, no clinical staff to manage, and no medical outcome the landlord is responsible for. Those belong to the tenant. Our Chief Investment Officer describes senior living as an operating business with some real estate around it. A medical outpatient building is the reverse: real estate with some operations inside it.

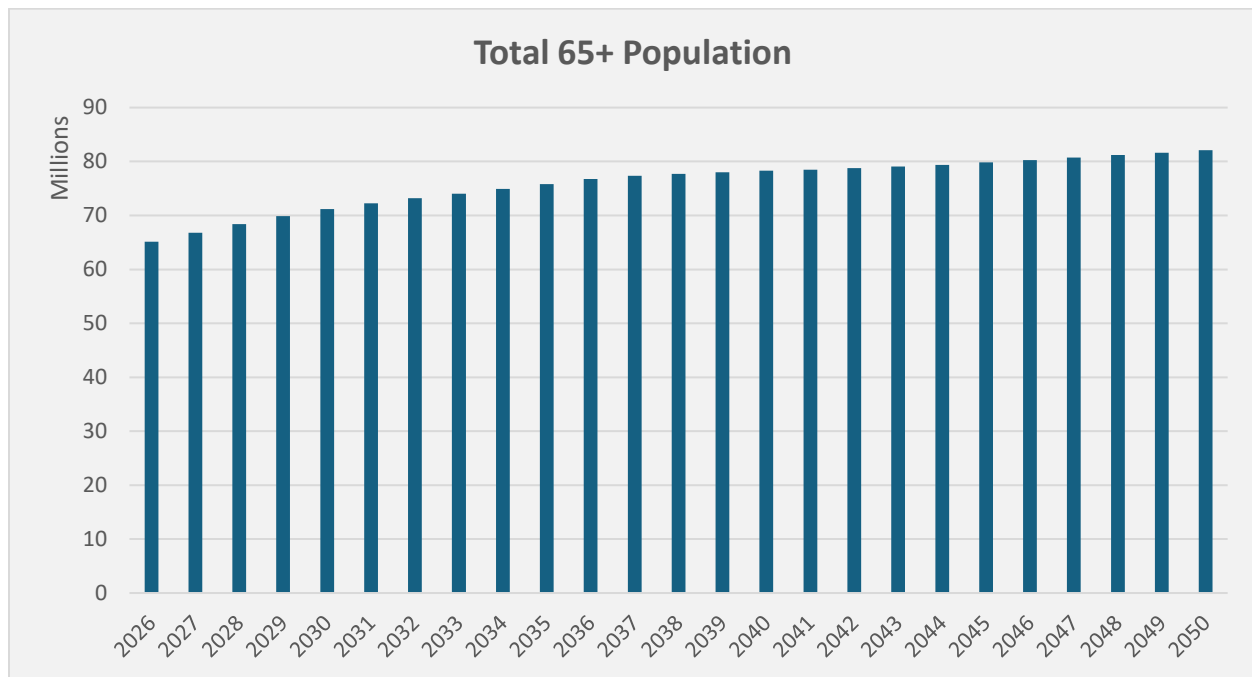
What the owner manages instead is the rent, and admittedly a number of idiosyncrasies when it comes to building operations and meeting the unique needs and personalities of healthcare providers. That means keeping the building full by renewing tenants before their leases expire and filling any space that opens up, maintaining the building so it stays competitive with newer options nearby, collecting the automatic rent increases written into each lease, and resetting rents to the current market when a lease comes up for renewal. On a hospital campus, it also means staying on good terms with the health system that owns the land and refers the patients. It is a landlord's job, and the skill in it is tenant relationships and timing rather than running an operation.

Section 2: The Demand Engine

Demand for these buildings is demand for doctor visits, scans, treatments, and same-day procedures. Three forces are pushing all of those up at once: there are more older Americans every year, each of them uses far more care than a younger person, and a growing share of that care is being delivered outside the hospital.

More Older Americans

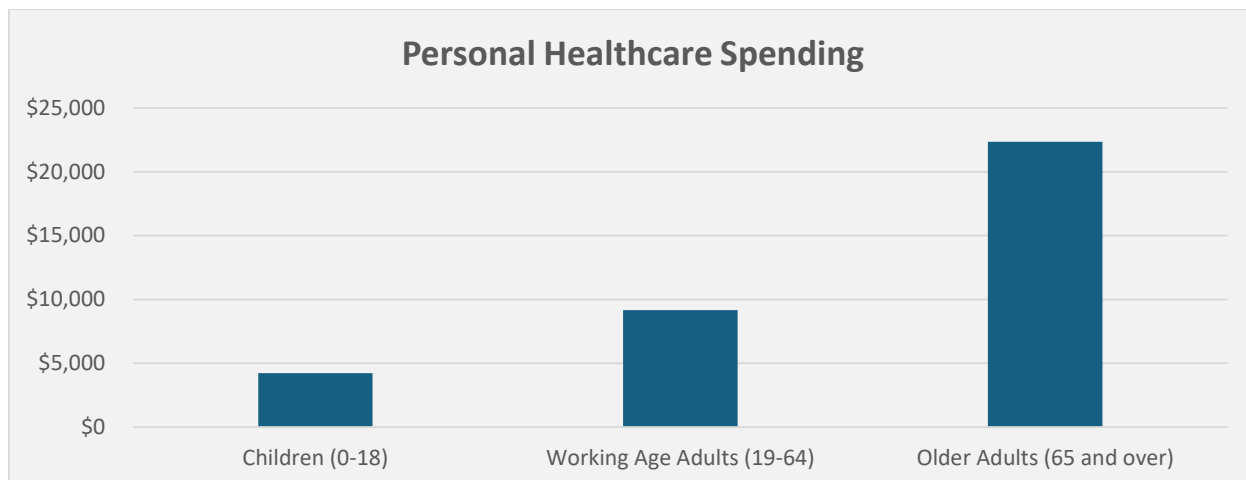
The baby boomers, born between 1946 and 1964, are now all past 60, and the oldest are past 80. The number of Americans aged 65 and over is on track to grow from roughly 65 million today to about 71 million by 2030 and 76 million by 2035 ([U.S. Census Bureau](#)). The 80 and over group grows faster still, from roughly 15 million today toward 23 million by 2035. Unlike most forecasts, these are not guesses.



Source: U.S. Census Bureau, 2023 National Population Projections

Older People Use Far More Care

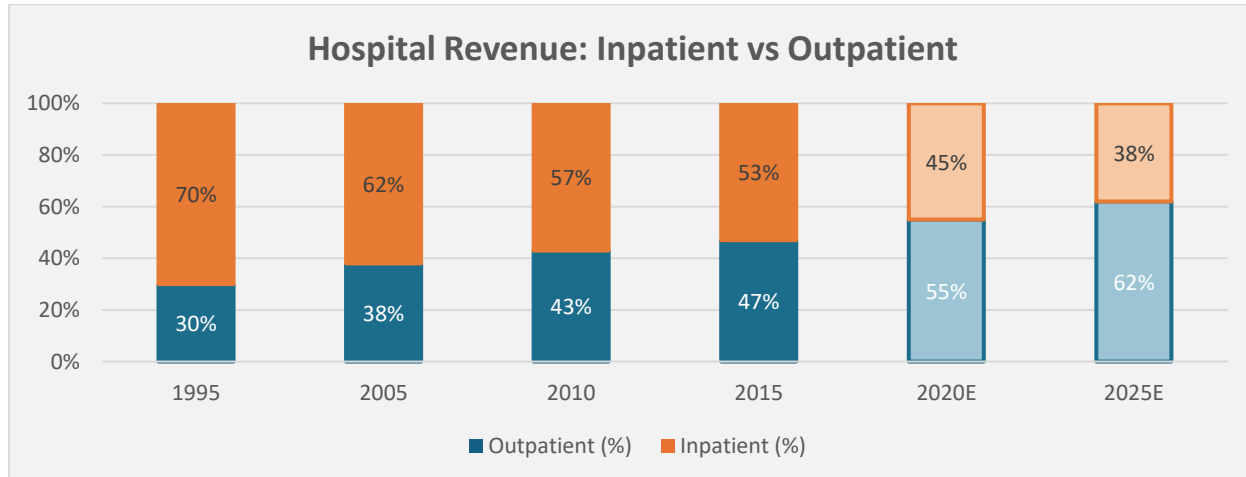
Age is the strongest predictor of how much healthcare a person uses. **In the most recent breakdown available, personal healthcare spending averaged \$22,356 a year for each American 65 and over, against \$9,154 for a working-age adult (19–64) and \$4,217 for a child (0–18) ([CMS](#)).** A 70-year-old sees more specialists, has more scans, takes more medications, and is far more likely to need a knee, hip, cataract, or heart procedure. Nearly all of that happens in outpatient settings. Every year, several million more Americans cross into the age bracket that uses two and a half times as much care as the one below it.



Source: CMS, National Health Expenditure Accounts, Age and Sex Tables, 2020

Care Is Leaving the Hospital

The third force is where care happens. **Care has been moving out of the hospital for thirty years, and the clearest way to see it is in hospital revenue.** Outpatient work made up 30% of hospital patient revenue in 1995. By 2018, it was 49%, nearly half, having climbed almost every year in between ([AHA Trendwatch Chartbook](#)). The trend has only continued: outpatient revenue grew 45% from 2022 to 2025, against 15% for inpatient ([JLL](#)).



Outpatient share of hospital patient revenue, 1995 to 2025. Solid bars 1995 to 2018 from AHA; shaded bars for 2020E and 2025E. Source: AHA Trendwatch Chartbook 2019, Table 4.2 (community hospitals) for 1995 to 2018. 2020E and 2025E are Virtus estimates extending the AHA series using JLL outpatient and inpatient revenue growth rates. Shading marks the estimated years.

That shift is set to continue. Over the next ten years, outpatient volumes are projected to grow 20% while inpatient discharges grow just 7% ([Vizient](#)). Of the ten fastest-growing categories of patient volume, eight are outpatient ([JLL](#)).

Two things drive the shift. Medicine has changed: procedures that once needed a hospital bed, from joint replacements to many heart procedures, are now done safely in a surgery center with the patient home by evening. And the payment rules have followed. Medicare is phasing out the list of procedures it will only pay for in a hospital, which removes the last formal barrier for hundreds of surgeries. Health systems are responding by building and leasing outpatient locations, which cost less to run than hospital space and sit closer to where patients live ([JLL](#)).

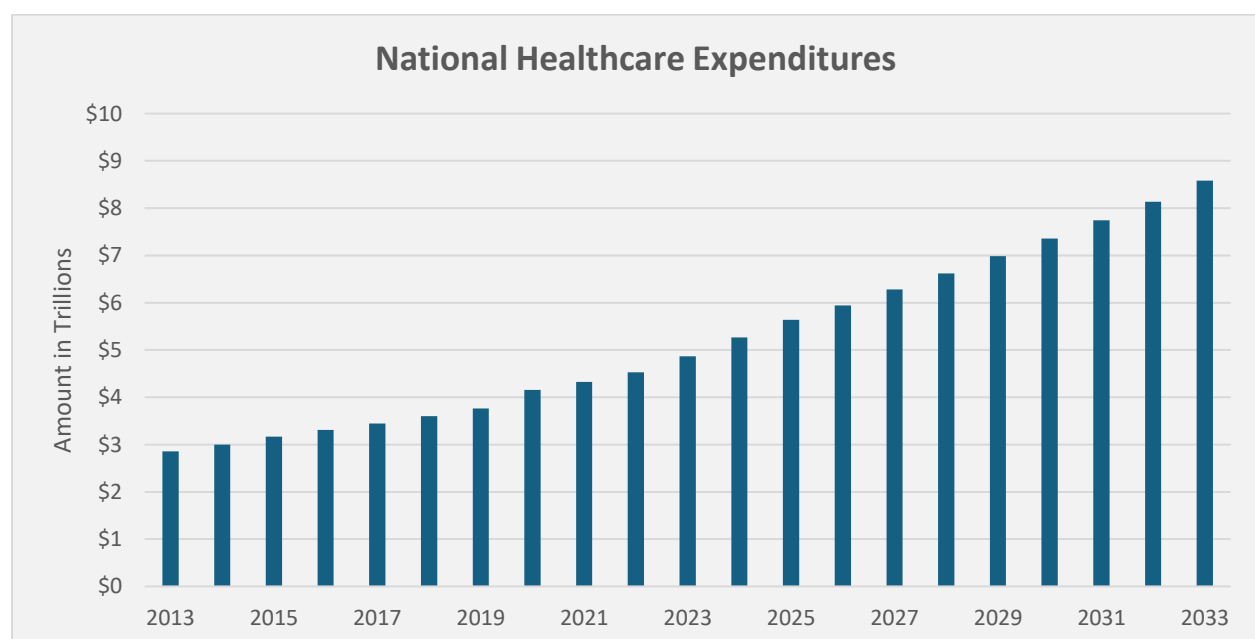
Telehealth Does Not Replace the Building

The obvious question is whether online telehealth visits cut into all this. They do for one type of appointment: the conversation. Mental health, follow-ups, and prescription checks have moved online in large numbers. Anything that needs hands, a needle, or a machine has not. Even in a forecast that assumes virtual visits reach 20% of all doctor visits by 2036, total visits still grow 19%, meaning the number of in-person visits keeps rising (Vizient).

The Bottom Line

More older Americans arrive each year, each of them uses far more care than a younger person, and a growing share of that care is delivered outside the hospital. None of the three reverses within the life of a real estate investment.

The spending numbers show the scale of it. National health spending is projected to reach nearly \$9.0 trillion by 2034, or 20.6% of the U.S. economy, up from \$5.3 trillion and 18.0% in 2024 ([CMS Office of the Actuary, in Health Affairs](#)). That is the pool the tenants in these buildings draw from, and it is growing faster than the economy around it.



Source: CMS Office of the Actuary, in Health Affairs

Section 3: Who Pays the Rent?

In most real estate, the tenant earns money from customers and pays the landlord out of it. Healthcare is slightly different. Patients rarely pay the doctor directly. An insurer does. So, the rent in a medical building is funded by insurers, Medicare and Medicaid, routed through the doctors and hospitals that lease the space.

Following the Dollar

Almost everyone in the U.S. is covered by someone. **Roughly 92% of Americans had health coverage in 2024, through one of a handful of channels.** We provide more details about this in [Part I](#) of this healthcare series.

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.

Medicare covers nearly everyone over 65, the group that uses the most outpatient care, and it paid \$1.1 trillion in 2024, about a fifth of all U.S. health spending ([CMS](#)). Employer insurance covers most working-age patients and pays considerably more for the same service, because Medicare sets its prices by regulation while employers and their insurers have to negotiate with providers. One study of \$77 billion in claims found employer plans paid hospitals an average of 254% of Medicare rates for identical services at the same facilities, with most of the variation explained by how much negotiating power the hospital had locally ([RAND](#)). Between them, the money behind a medical tenant comes from large, stable institutions that pay their bills.

The healthcare provider collects those payments and pays its own costs from them. Labor comes first and takes half or more. Supplies, equipment, and insurance follow. Rent sits well down the list. What an insurer pays therefore swings a practice's finances far more than rent ever will, which is why a healthy practice rarely lets rent become the reason it moves.

Where the Site Is Starting to Matter Less

Medicare has long paid more for a service performed in a hospital outpatient department than for the identical service in a doctor's office, often two to four times more ([Bipartisan Policy Center](#)). That gap is closing. Congress narrowed it for new off-campus hospital locations in 2015, and CMS has been extending equal pricing to older hospitals, service by service since: clinic visits, then drug administration, and imaging is proposed for 2027 ([CMS](#)).

The industry term is site-neutral payment. As the premium for delivering care inside a hospital shrinks, the incentive to keep care in the hospital shrinks with it, and care moves to the cheaper setting.

What This Means for the Landlord

The rent is funded by insurers and government programs instead of consumer spending, which makes it steadier through a downturn than most commercial tenancy. Reimbursement risk sits with the tenant, because the landlord collects the same rent whatever the insurer paid. And the policy drift favors the lower-cost setting, which is where the demand described in Section 2 was already heading.

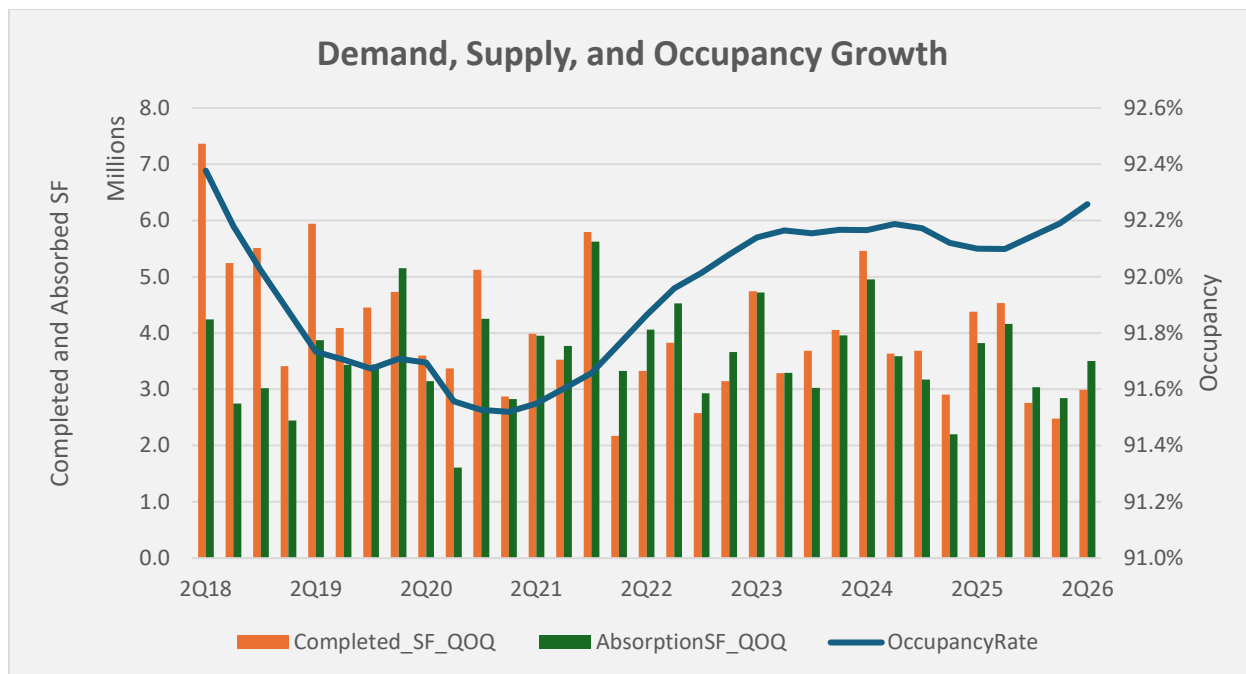
Section 4: Why New Supply Rarely Pencils

Demand of this kind usually pulls new supply behind it. In this sector and healthcare in general, it has not. Construction has been falling for years and is heading to a decade low. The reason is fairly straightforward: a new building costs far more to deliver than an existing one costs to buy, so the rent it needs to charge is far above what the market pays.

The Pipeline Is Shrinking

Across the 100 largest metros, 12.8 million sq. ft. of medical space was completed over the past year, down 12.6% from the year before, and the space under construction is holding flat at 25.8 million sq. ft., **a little over 2% of everything standing** (Revista, Q2 2026). CBRE expects completions to fall another 26% in 2026, to the lowest level in more than a decade ([CBRE](#)).

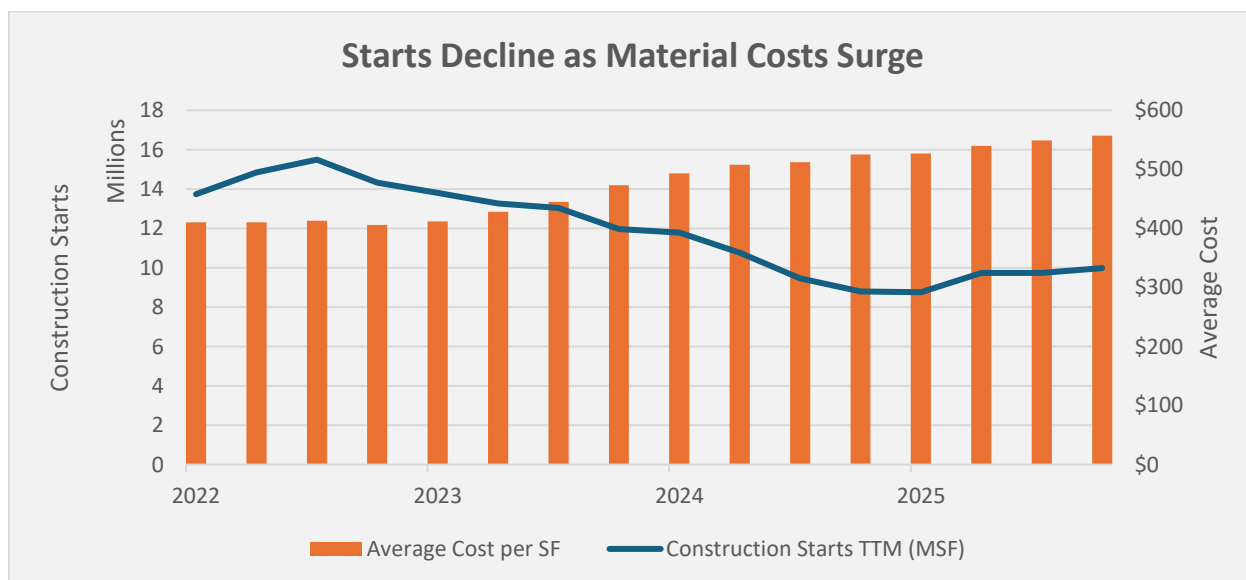
Meanwhile, tenants absorbed 13.5 million sq. ft. over the same year, up 6% (Revista, Q2 2026). More space was taken than was delivered, which is the simplest possible description of a tightening market, and it has been true for several years running. None of these stats take into consideration space coming offline due to functional obsolescence.



Source: Revista Q2 2026

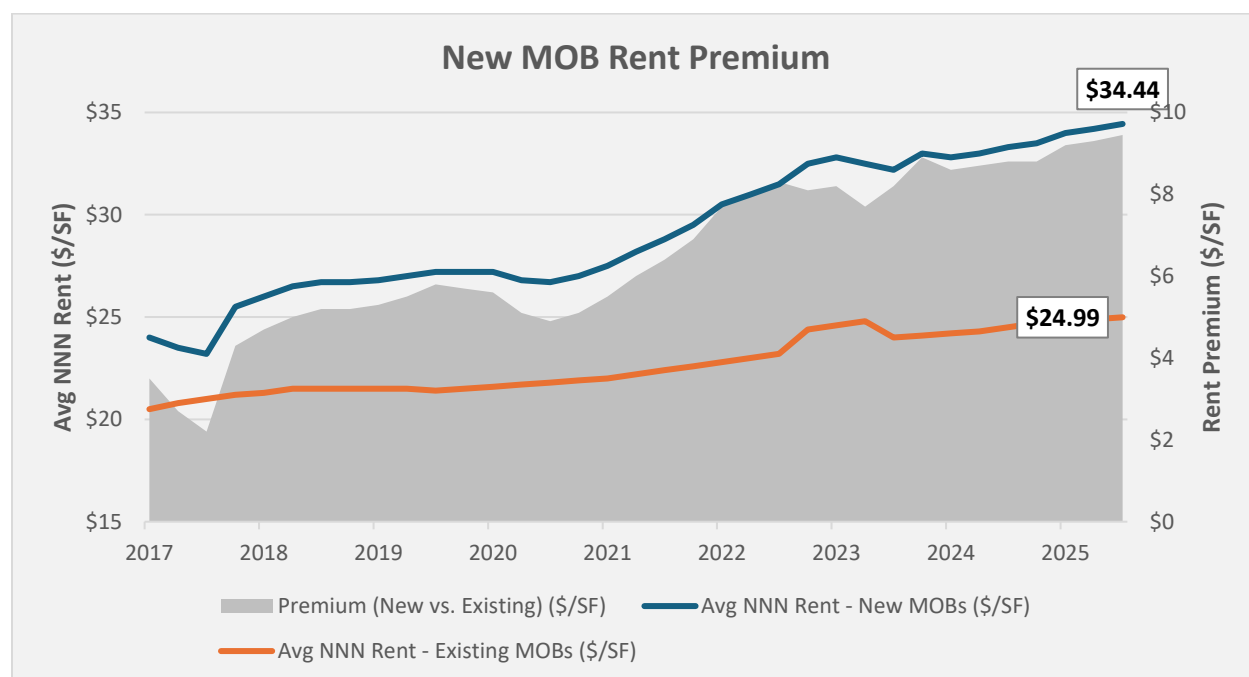
Why the Math Does Not Work

Building medical space is really expensive. The all-in cost of fitting out medical outpatient space now averages \$412 per sq. ft. nationally, and hard costs alone run \$226 ([JLL](#)). Those figures cover the interior only, before land, structure, and financing. Tariffs on steel, aluminum, and copper have added to material costs, and the pool of contractors qualified to build to clinical standards is small and getting more expensive ([Matthews](#)).



Source: Revista

A developer has to charge rent high enough to justify that cost. New buildings lease at around \$34.44 per sq. ft., against \$24.99 for existing space, a premium that has nearly tripled since 2017 (Revista). Independent estimates put the same gap at roughly \$33 against \$25 ([MedSpace USA](#)). Either way, a new building needs roughly 35% to 40% more rent than the market average to pencil.



Source: Revista

Very few tenants will pay that. Most providers are choosing lower-cost settings, which is the entire direction of travel described in Section 3. So, the developer either does not build or builds only when a health system has pre-committed to most of the space. That is why most new buildings are pre-leased before they open ([JLL](#)). Not to mention, construction lenders now generally require pre-leasing to breakeven occupancy before they will commit to fund. That is extremely difficult to pull off, especially in a multi-tenant building.

Buying Typically Beats Building

The other half of the arithmetic is what existing buildings sell for. **Across the top 100 metros, medical buildings traded at an average of \$389 per sq. ft. over the past year** (Revista, Q2 2026). Against an all-in development cost that runs several hundred dollars a foot higher once land and structure are added, the choice facing capital is straightforward: buying an existing, leased, income-producing building costs less than building one that may or may not be fully occupied at completion.

That is why 942 buildings changed hands for \$14.2 billion over the past year while the construction pipeline shrank (Revista, Q2 2026). Capital is active in this sector, and it is spending that capital on buildings that already exist. Buying transfers ownership and adds no new space to the market.

What Gets Built Instead?

Two things still get delivered. The first is the pre-leased, health-system-driven project, typically a large multispecialty clinic or a surgery center with a committed occupier. The second is conversion: taking an older office or retail building and rebuilding the inside to clinical standards. Conversions are hard because plumbing, floor loads, ceiling heights, and power are difficult to retrofit, and they take time. Neither route produces space at the pace demand is growing.

The Consequence

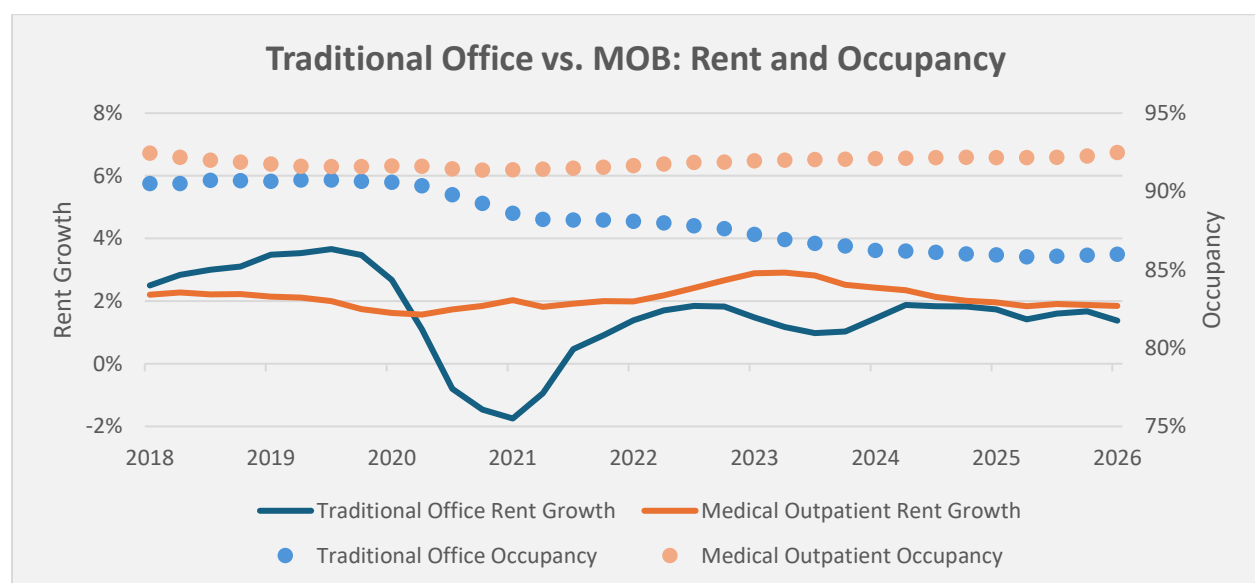
Supply cannot respond quickly here even if capital wanted it to. A medical building takes years to entitle, design, and construct, so the space delivered in 2029 is being decided now, and very little is being decided. Meanwhile, the 65-and-over population keeps growing every year.

Section 5: The Market Is Tightening

This is a sector where it is easy to see that demand is rising and supply is failing to keep up. That shows up in the numbers: in occupancy, in rents, and in what investors are paying for buildings.

Occupancy and Rents

Occupancy across the 100 largest metros stands at 92.2% and has been climbing since 2021 (Revista, Q2 2026). For context, traditional office occupancy has fallen through the same period and now sits in the low 80s.



Source: CoStar and Revista

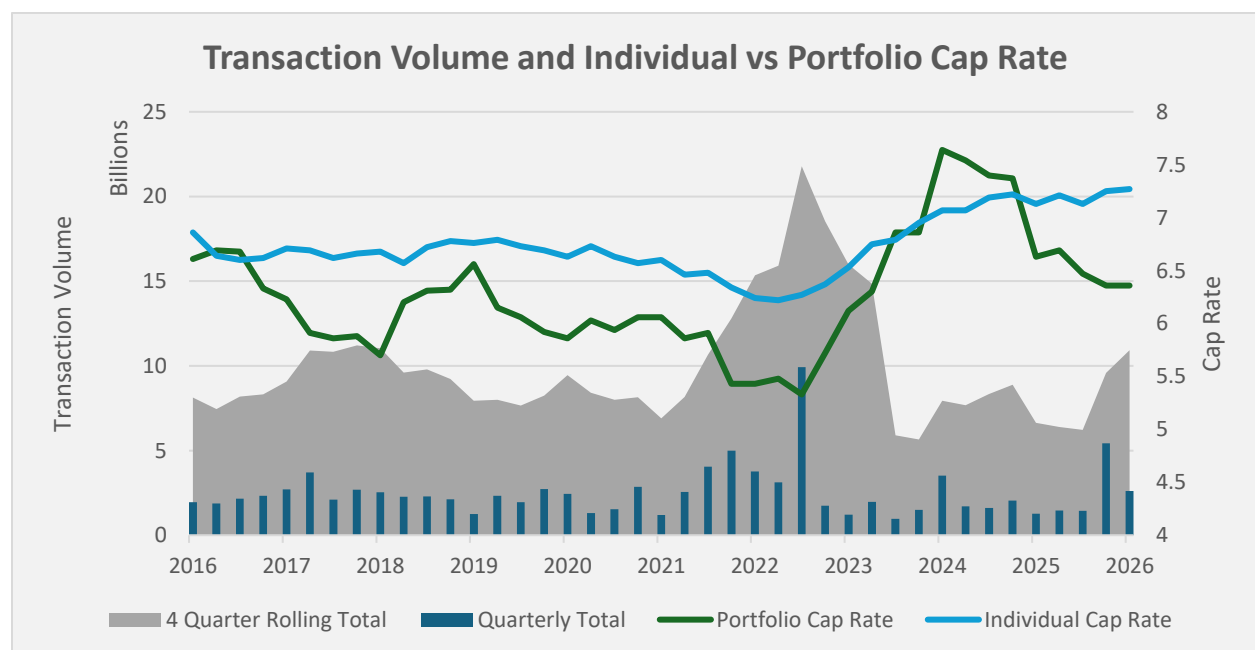
Average rent is \$26.18 per sq. ft., up 2.9% over the past year, and rent has risen in every single quarter since 2017 (Revista, Q2 2026). The increases are modest in any one year, which is characteristic of a sector where leases run long and step up contractually. No year in the past decade saw medical space rents fall.

Capital Has Noticed

The investment market has repriced accordingly. **Over the twelve months to June 2026, 942 medical buildings sold across the top 100 metros for \$14.2 billion.** Compared with the prior twelve months, the number of buildings sold rose 38%, dollar volume rose 86%, and square footage traded rose 72% (Revista, Q2 2026).

Two transactions define the shift. In October 2025, Welltower sold its entire outpatient portfolio, 296 buildings and 18 million sq. ft. across 34 states, to Remedy Medical Properties and Kayne Anderson for \$7.2 billion, creating the largest owner of outpatient medical buildings in the country at 52.4 million sq. ft. ([Remedy and Kayne Anderson](#)). In July 2026, Brookfield took a 49% stake in an 86-building portfolio alongside Healthpeak, valuing it at \$2.1 billion, at a 5.9% cash yield and roughly \$380 per sq. ft. The portfolio was 95% leased with six years of average lease term remaining ([Healthpeak](#)).

What both deals have in common is the kind of buyer. Global alternative asset managers with no meaningful prior position in this sector are now buying into it at scale, which is what happens when a property type moves from specialist to mainstream.



Source: Revista

Cap Rates

Cap rates, the yield a buyer accepts on a building's income, tell the same story. They rose sharply through 2023 as interest rates climbed, peaking near 7.5% in early 2024, and have been compressing since, back toward 6.5% by mid-2026 (Revista, Q2 2026). The Brookfield deal at 5.9% shows what the best-quality portfolios now clear at. Buyers are accepting lower yields, which means they are paying more for the same dollar of rent. This is tougher to justify as the 10-year Treasury rises above 5% and MOB leases have fixed bumps, albeit typically with OPEX passed along to the tenant.

Where the Value Sits

The rent gap from Section 4 is what makes this more than a story about rising prices. An owner holding a building leased at \$25 per sq. ft. in a market where new space costs \$34 to deliver holds an asset that cannot be replicated at that rent. Each time a lease expires, the rent can move toward what the market now bears, and each year the cost of building an alternative goes up. That is the whole case for existing, well-located medical buildings.

Who Captures It?

Ownership in this sector is unusually fragmented. As Section 1 showed, health systems, universities, and government hold 39% of the space, private investors 34%, and REITs under 10% (Revista, Q2 2026). No one controls the market, and most of the stock has never been institutionally owned.

That fragmentation is why the buildings rarely come to market in an orderly way. A health system deciding whether to sell its outpatient buildings is making a strategic decision about its own balance sheet, and it tends to talk first to people it already knows. The same is true of the physician groups and local developers who own much of the rest. Access depends on relationships built over years with health system executives, physician groups, and regional developers, which is difficult for a newcomer to assemble quickly. Virtus has been acquiring in this sector for two decades and has completed 86 outpatient medical acquisitions over that period.

Conclusion

The point of this paper is a simple one. **Medical outpatient buildings are where most American healthcare now happens, and the demand for them is set by things that are already decided.** The number of Americans aged 65 and over, and 80 and over, grows every year. Older patients use two and a half times the healthcare of a working-age adult, and almost all of that type of care is delivered outside a hospital. Care has been leaving the inpatient setting for thirty years and continues to, helped along by medicine that makes same-day procedures possible and by payment rules that now favor the lower-cost location.

Against that, the supply response has been close to absent. Completions are falling toward a decade low, and a new building costs so much to deliver that it needs 35% to 40% more rent than the market average to justify itself. Very few tenants will pay that, so very little gets built, and capital that wants exposure to the sector buys existing buildings instead, which adds no space. The result is visible in the numbers: occupancy at 92.2%, rents that have risen every quarter since 2017, and cap rates compressing as more institutional investors have noticed.

For the owner of a well-located building, the economics are unusually legible. **The tenants are institutions funded by insurers and government programs. They sign long leases with contractual increases, they have spent heavily on space they cannot easily move, and roughly nine in ten of them renew.** The buildings they occupy cannot be replaced at anything close to the rent they currently pay.

This is a particular moment in U.S. healthcare, and capturing it takes more than noticing the demographics. The buildings are owned by health systems, physician groups, and regional developers, and they change hands through relationships built over years. Underwriting one requires judgment about the health system next door, the specialties in the rent roll, the reimbursement exposure of each tenant, and whether the buildout inside the space is worth what it cost. Those questions take sector experience to answer. The demographics will do their work regardless of who owns the buildings. Which owners capture the benefit depends on knowing which buildings to buy, and from whom, and how to deal with all the idiosyncrasies and nuances of building operations, and especially leasing to healthcare providers.

[Part I](#) of this series introduced the U.S. healthcare system and the physical infrastructure that delivers care. [Part II](#) examined senior living, an operating business with real estate around it. This paper covered the other side of that coin: real estate with operations inside it, serving the same aging population through a different kind of building and a different kind of business. Together they describe where care is going and the space required to deliver it.

Authors:

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