Budget Sensitive

Office of the Minister of Health

Cabinet Expenditure Committee

Ten-year Health Infrastructure Plan

Proposal

1 This paper seeks:

1.1 in-principle agreement to a 10-year strategic plan for built health infrastructure: the Health Infrastructure Plan ('the HIP');

1.2 release of a public summary of the HIP that outlines timelines and intended investments; and

1.3 agreement to report back on an equivalent strategic investment plan for digital health infrastructure, to be integrated with the proposed HIP.

Relation to government priorities

2 The HIP supports the Government Policy Statement on Health 2024-2027 in Priority 5: Infrastructure, and its objective of a 10-year national infrastructure and investment plan. The HIP also supports increased treatment capacity that contributes to the achievement of the Government's health targets.

3 The Plan is aligned with the Government's infrastructure priorities (see Cabinet minute ECO-24-MIN-0048), including developing a 30-year national infrastructure plan and improving health infrastructure.

Executive Summary

4 As set out in my Health Delivery Plan, this Government is relentlessly focused on delivering more health services for New Zealanders. Modern and fit-for-purpose infrastructure, and delivering against promised infrastructure projects, is a key part of this, and is needed both to achieve our health targets and to restore public confidence in the health system.

5 Outdated facilities are limiting changes to models of care and our ability to increase capacity of services and improve patient outcomes. Many buildings are not clinically fit-for-purpose, require substantial remedial work, or carry seismic, safety and compliance risks. There is a substantial infrastructure programme underway which will see critical improvements across our healthcare facilities; however, we need clear scoping and planning, and to think broadly about how best to deliver modern infrastructure for New Zealanders.

6 My key priorities are to stabilise Health NZ's governance and accountability arrangements, drive shorter stays in emergency departments, get on top of an elective surgery backlog, enable faster access to primary care, provide clarity on the health

infrastructure investment pipeline and adjust regulatory settings to unlock and protect capacity in the system to deliver more for New Zealanders.

7 Providing clarity on the health infrastructure investment pipeline and the intended level of investment in built infrastructure is important to give communities visibility of the investment they are getting into healthcare facilities across New Zealand and to signal partnership opportunities to market providers.

8 There is significant catching up to do in the delivery of health infrastructure. Therefore I am focused on four areas in particular to speed up HIP delivery:

8.1 Developing a long-term infrastructure pipeline which provides clarity to the public and to the construction industry around the level and type of investment needed in our health infrastructure including remediation of existing buildings and building of new capacity.

8.2 Requiring Health New Zealand to consider a range of funding and financing tools to deliver increased investment in health infrastructure including shifting to longer-term contracts with the private sector for the delivery of service.

8.3 Standardising hospital design and delivery to reduce capital delivery cost and to drive operational efficiencies.

8.4 Considering whether a separate health infrastructure entity within Health NZ should be established to manage and deliver Health NZ's infrastructure across New Zealand. This has the potential support better value for money for taxpayers and maintain health infrastructure to a higher standard.

9 These focus areas will be carried through in the implementation of the 10-year HIP. The HIP sets out a programme of targeted investment in built infrastructure (facilities and supporting infrastructure) with a focus on enabling clinical services across the country, shifting services closer to communities within lower cost facilities, and maintaining critical assets. The proposed pipeline would deliver 10 percent additional bed capacity by 2034/35, renew almost one third of current capacity, and see most major redevelopments commence within the 10-year period.

10 The HIP reflects a new approach to infrastructure, including improved planning, scaling and sequencing of investments, and enhancing control over the design and scope of builds to increase cost effectiveness and better manage risk. The pipeline proposes a forecast total capital investment averaging s 9(2)(b)(ii) encompassing all funding sources including Health NZ baseline, private investment, and new Crown funding.

11 To support transparent planning, I am seeking Cabinet's in-principle agreement to the HIP (**Appendix 1** as the public document and **Appendix 2** as the investment pipeline), subject to individual approval of proposed investments and their business cases. Pending agreement, I intend to announce an in-principle investment pipeline at the Global Investment Summit in March and publicly release **Appendix 1**.

12 A Digital Investment Plan (DIP) is also in development, s 9(2)(b)(ii)

Background

State of the health infrastructure portfolio

13 Health NZ inherited a large portfolio of built assets (approximately 1,200 buildings across 86 campuses with an average age of 47 years) from the former District Health Boards (DHBs). Uneven levels of investment and a fragmented system resulted in a portfolio that is poorly suited to meet the needs of New Zealanders. This has resulted in the following issues:

13.1 Remediation needs outbalance capacity uplifts in some locations: the size of the health estate weights investment towards remediation of assets, instead of investments to uplift capacity or shift models of care. This is particularly pronounced in areas which have seen low investment historically, including the Central and Midland regions. Remediation is unavoidable in some instances, and as such investments are inherently high priority to prevent potentially significant disruption of services.

13.2 Older buildings not fit for clinical purposes: for example, 70 per cent of mental health facilities surveyed in 2019 did not meet therapeutic or safety requirements, and several emergency departments in main hospital sites (including Wellington, Palmerston North, Hawke's Bay, and Middlemore) do not have sufficient points of care or suitable spaces to safely treat patients. Older buildings also present asset failure and ongoing service delivery risk.

13.3 Significant seismic risk: across the portfolio many buildings need remediation or replacement to meet statutory deadlines, reduce safety risks, and ensure provision of clinical service in the wake of a large earthquake. A total of 792 Health NZ-owned buildings have been seismically assessed, with 107 Importance Level (IL) 3-or 4-rated buildings (of greatest clinical importance) not yet assessed. A high-level review by Health NZ of the 107 remaining buildings indicates that most do not yet need to be assessed as they are newer, have low occupancy, or are low-risk builds such as single-stories. Between 20-30 require further assessment, which will take up to 18 months to complete.

13.4 Supporting infrastructure (such as power and water services) risk: only 11 of 34 assessed hospital sites have sufficient back up water to last longer than three days in the event of a civil defence emergency.

13.5 s 9(2)(g)(i)

14 A growing, ageing and more diverse population is increasing demand on the health system where there are already capacity constraints. Capacity gaps are particularly pronounced in adult inpatient beds, renal dialysis spaces, cancer treatment services, theatres, and emergency care. Meeting built infrastructure needs is central to managing future healthcare capacity across New Zealand.

15 There are currently 66 in-flight Ministerially approved health infrastructure projects, worth a cumulative $6.3 billion. A total of $5.9 billion of this is funded by Crown capital with $314 million funded by depreciation and $73 million from other sources. Most of the investment to date has been to maintain capacity by replacing buildings at the end of life. Investment has been insufficient to shift from sustaining systems to lifting capacity to match the growing demand. It will take sustained, long-term effort to shift this imbalance.

16 Part of this imbalance can be addressed through better asset management as outlined in Health NZ's National Asset Management Strategy (NAMS), which has been approved and will be published in March 2025. The NAMS sets out how Health NZ will better manage the health estate and associated health and safety risks through improved asset management practices to meet Government expectations.

17 Priority activities in the NAMS include the development of a national asset management policy, an asset "levels of service" framework, a condition assessment programme, an Asset Management Information System, and risk management and criticality frameworks. With increased asset management maturity, Health NZ will have improved evidence and insight to inform investments into National Remediation Programmes and future updates to the HIP.

18 The current maintenance and renewals budget for Health NZ is $141 million in 2024/25 (including maintenance FTE), sourced from Health NZ baseline funding and varies year-to-year. The budget excludes major asset renewals such as hospital refurbishments, which are often sought through direct Crown funding requests.

19 Maintenance is mainly reactive and is prioritised based on the criticality of the clinical service provision (e.g., ICU, theatres), urgency of the work order (e.g., Health and Safety) and compliance requirements. Due to Health NZ's current financial position, the outsourced maintenance budget has been reduced; however, it continues to retain insourced maintenance capability.

20 In comparison to other agencies with large asset portfolios and industry benchmarks, Health NZ spends less on infrastructure maintenance, which constrains its ability to maintain and upkeep health assets.

10-year infrastructure planning

21 In April 2022, Cabinet directed Health NZ to deliver an improved, nationally planned approach to health infrastructure, including a 10-year plan for capital investment [CAB-22-MIN-0132 refers]. The plan is to include prioritisation of investments to support the Government's decision-making in a fiscally constrained environment, informed by an assessment of market capacity to deliver.

22 The proposed HIP is underpinned by Health NZ's National Clinical Service and Campus Plan, which seeks to shift models of care and service delivery settings of the health system closer to home and communities. The HIP is also informed by the Government's Health Targets, and my own priorities as Minister of Health. Together, these outline the improvements in the delivery of care I expect to meet New Zealand's health needs and set the conditions for how investment in infrastructure is prioritised.

23 Work is underway to integrate Health NZ's planning across built, digital and health technologies into a single 10-year infrastructure roadmap, which will be a summation of priorities for investment. It will cover Health NZ's infrastructure capacity (how much can be built, procured and planned, where and when) and capability (what can be built and planned successfully) to support delivering timely access to quality care.

24 The same approach is being undertaken for digital infrastructure through the Digital Health Infrastructure Plan (DHIP) s 9(2)(b)(ii) [redacted]

25 Following confirmation of the HIP and progression of the DHIP, there will be a clearer understanding of the potential uplifts in capacity across the health system and any changes to settings of care or service delivery models that will enable care to be delivered closer to home and in a more timely manner.

26 Improved long-term infrastructure investment planning is a priority for this Government and a key reason why the Minister for Infrastructure has directed the Infrastructure Commission to develop a 30-year National Infrastructure Plan. The HIP will also be an input into this national plan and will enable the Government to consider health investment need alongside other sectors.

Priorities for health infrastructure delivery

27 Getting back to the basics of clear planning and scoping is critical to ensuring delivery of core projects on time and within budget, and to maintaining public confidence. However, further changes to how we deliver modern health infrastructure for New Zealanders are needed to ensure sustainability over the long term and value for money.

28 I am therefore focussed on three in particular to speed up HIP delivery:

28.1 Working with the private sector to deliver more health services. This will create more capacity in the health system faster, particularly for elective treatments and radiology health services, and result in better value for money and improved outcomes for patients. This will be delivered by shifting to longer-term contracts with the private sector and support private investment in health infrastructure and deliver greater value for money for these services for the Crown.

28.2 Working with Health NZ to identify ready to deliver projects to support early delivery where possible, and to identify projects where early investment now will enable longer term savings or efficiencies, ie purchasing land which may be required in the future, or seed funding for design of major projects so key decisions can be made earlier.

28.3 Engaging with the market to support development of a stronger construction market which can support delivery of the Health Infrastructure Plan. This will include early market engagement on major builds which are planned such as Nelson and Whangarei and major car parking projects which are required to help improve access for patients to hospital services.

Developing the HIP

29 The HIP is intended to:

29.1 provide a detailed investment plan that enables better management and sequencing of the built infrastructure portfolio. By setting out priorities for investments and indicating the scale of these investments, it will ensure that all investments are part of a nationally managed approach. It will also provide a means to track and manage performance across the portfolio.

29.2 outline a work programme to deliver investment-ready business cases for Ministers and prioritise the allocation of planning and design resources.

29.3 (through the published document), signal the proposed sequencing of investment in health infrastructure to the public, the clinical workforce, and market providers.

30 As with other long-term plans for capital intensive sectors, the HIP will be subject to periodic reviews to address changes in government priorities. These reviews will also consider inputs gained through the NAMS, and changes to respond to new technologies or advancements in healthcare design and delivery.

31 While the HIP represents a new approach for infrastructure investment for the health system, the benefits of a long-term plan have been demonstrated in other capital-intensive sectors, including transport and defence. The development of the HIP has required new approaches to prioritise and maximise efficiency from Health NZ.

32 The HIP will also support the long-term delivery of the health targets, largely by resolving significant remediation issues facing the health estate that could create further backlogs or capacity challenges. Additional capacity will only go-live to support the delivery of health targets from 2028 onwards.

Underpinned by a National Clinical Service and Campus Plan

33 The National Clinical Service and Campus Plan is a single national plan being developed by Health NZ to outline long-term shifts in the models of care and service delivery settings of the health system to bring care closer to home and communities. The first iteration of the National Clinical Service and Campus Plan was developed in 2023 and is currently being refreshed to ensure a full system approach, including working with partners is presented. It presents an analysis of existing settings and models of care against forecasted geographic and demographic changes over the next 20 years. It details changes required to meet shifting demand and build a more equitable and financially sustainable health system, which is reflected in the HIP. This includes:

33.1 planning hospitals as networks, both locally and nationwide, to establish priority for provision of clinical services to meet healthcare needs;

33.2 shifting some services from hospital sites into community and rural settings so more healthcare is provided closer to communities in lower cost facilities;

33.3 building a sustainable relationship between Health NZ and the private sector to support capacity, particularly for elective treatments and radiology; and

33.4 providing facilities that enable the concentration of complex, high-cost care on fewer sites to support economies of scale (such as the type of paediatric care delivered at Starship Hospital in Auckland) while increasing local delivery of specialist care that can be delivered in community and rural healthcare centres. The exact number of hospital and mental health beds that will be required to meet projected demand will be highly dependent on the model of care that is used. The proposed Health Infrastructure Plan is highly dependent on shifting services into the community and having more services delivered closer to the patient, rather than in hospital level care.

34 This is also why I have set expectations that Health NZ partners with the private sector to lift performance across all health targets. While we have a publicly funded healthcare system, it does not need to be publicly delivered. My clear view is that patients are more focused on receiving timely and quality care, than being concerned about who delivers it.

35 I expect Health NZ to put in place medium term (circa 3 years) agreements with private providers to allow for a fair market price to be found prior to moving towards longer term agreements (circa 10 years). Health NZ already contracts the private sector for around 10 percent of elective surgeries annually, but does so on an ad hoc basis. This means that Health NZ is paying premium rates for these surgeries, and not getting value for money. This practice must stop immediately, and longer-term contracts must be put in place to deliver value for money and better outcomes for patients.

Addressing critical asset risks

36 Supporting clinical service delivery requires prioritising investment to address the risk of failing infrastructure. Investment prioritisation included the following criteria:

36.1 compliance requirements for continued clinical service delivery;

36.2 managing seismic challenges, including statutory remediation timelines for Earthquake Prone Building Notices (EPBNs), risks to life during seismic events, and post-disaster functionality; and

36.3 remediation of asset degradation to address specific known risks of facilities being unable to support continued services.

Building Hospitals Better: a new approach to planning, standardised design and delivery of builds

37 The HIP enables Health NZ to move towards delivering a new approach to building hospitals based on lessons learned from the redevelopments of Dunedin and Christchurch Hospital. "*Building Hospitals Better"* underpins the pipeline of the HIP and focuses on staged builds, standardised designs, and cost-effective partnerships. This approach to hospital development includes:

37.1 improved early planning through clinical network and site master plans to outline the distribution of services and supporting infrastructure;

37.2 national modelling of population demand to ensure a consistent approach to managing clinical capacity requirements of builds;

37.3 greater control over design through set functional requirements, standardised design, and nationally managed design consortiums for major hospital builds;

37.4 collaboration with the market to better match builds to market capacity and active responsibility and ownership of the supply chain; and

37.5 exploring alternative funding and procurement approaches such as long-term leases and PPPs.

38 *Building Hospitals Better* is expected to achieve more rapid and efficient procurement and increased innovation through better sharing of risk and reward to improve cost certainty and risk management.

Sequencing of investments

39 One of the most significant uses of the *Building Hospitals Better* approach in the HIP is in the sequencing of investments. Rather than seek upfront commitment to a full hospital redevelopment (which was incentivised in the previously fragmented system), a staged build enables phased delivery of investments across sites. This helps to address risks and issues based on criticality, reduces immediate fiscal commitment, and enables progression of hospital development on multiple sites simultaneously.

40 Staging of builds also enables Health NZ to allow adequate pre-construction periods for robust design work and provide appropriate signals to the market. Market capacity can be tested in advance of investment decisions and assessed against expectations, limiting risk of labour or material shortages leading to project delays.

41 Potential projects were assessed for clinical need and asset risk and were then sequenced in the HIP with consideration given to their relative priority, the lead time to achieve investment readiness, and dependencies. As such, some high priority projects are sequenced later in the ten-year period, allowing for detailed planning or necessary site developments to occur first (for example, upgrades to water or electrical systems).

42 Health NZ has recognised that the health sector needs to improve its planning to provide better cost estimation and manage optimism biases. This has resulted in a plan that delivers well progressed priority investments early on, with increasing investment in staged redevelopments and system change over the medium to long term, as the proposals are further developed through more detailed planning.

Health built infrastructure proposed 10-year investment track

43 Health NZ has assessed the suite of potential infrastructure investments against asset risk and projected health needs over the next 20 years. The proposed pipeline is a targeted uplift in access and capacity in areas of pronounced pressure and provides some system changes intended to reduce pressure on hospital sites.

44 I recommend that Cabinet agree, in principle, to the HIP (**Appendix 1** as the public document and **Appendix 2** as the investment pipeline for the next 10-years).

45 The actual annual total capital cost of the pipeline will vary year-to-year depending on endorsement of high-quality business cases following Gateway review for high-risk projects. However, capital investment of an average s 9(2)(b)(ii) is estimated to be required.

Improving the health estate with targeted new builds

46 The proposed pipeline would deliver 10 percent additional bed capacity by 2034/35, renew almost one third of current capacity, and see most major redevelopments commence within the 10-year period. The proposed pipeline would see targeted construction of new sites and a number of substantial redevelopments. This includes:

46.1 A new general hospital site for South Auckland. Middlemore hospital faces the greatest bed deficit and services an area with significant forecast population growth. A new hospital site will be required to service the growing population, s 9(2)(b)(ii) . This will be followed by design and planning of the new hospital, with construction commencing within the 10-year period.

46.2 Other new builds focusing on expanding community and rural health services to relieve pressure on major sites. This includes new sites in North Waikato, Papamoa, Central Otago, and rural North Island locations.

46.3 Investment to deliver substantial redevelopment and expansion of multiple general hospitals, including Palmerston North, Hawke's Bay, and Gisborne, along with continued investment in Nelson and Whangārei. Specialist hospitals in Wellington and Waikato will see significant investment.

Selection of the proposed pipeline

47 Alternative scenarios were explored. These are detailed in **Appendix 3**, alongside a summarised scenario analysis undertaken to determine the most suitable investment pipeline. The alternatives are not sufficiently balanced between realistic delivery, projected health needs over the next 20 years, and current fiscal constraints.

48 A pipeline with a higher level of investment would likely be unachievable due to construction market capacity, Health NZ's capacity, and current fiscal constraints. The scale of construction would also disrupt hospital service delivery. A pipeline with a lower level of investment would not address growth pressure or enable a regional hospital redevelopment programme and would see increasing risk of asset failure and service disruption through and beyond the 10-year period of the HIP.

49 While the preferred approach is balanced, some delivery risks remain relating to the ability of Health NZ and the market to increase rate of delivery. However, the approach to staged builds and sequencing provides assist in mitigating this risk. These risks will be subject to regular monitoring over the 10-year period.

50 Achieving the outcomes presented here will require Health NZ to demonstrate how they plan to improve their project delivery performance. Subject to Cabinet's approval

of a proposed investment pipeline, I expect Health NZ to provide me with an implementation plan, including detailed milestones for upcoming investments, and the planned allocation of resources and budgets to achieve these.

Reporting and future updates

51 I have directed Health NZ to provide regular detailed reports to myself and the Minister for Infrastructure on progress on agreed projects, including those in planning stages, as well as the overall HIP. Health NZ will also include the HIP projects within Treasury's Quarterly Investment Report (QIR) that is presented to Cabinet. I will report back to Cabinet annually on the delivery of the HIP and updates to the sequencing of investments. Health NZ will undertake a full review and update of the HIP every three years which will be presented to Cabinet.

52 I will also report back to Cabinet on opportunities to expedite delivery and utilise alternative sources of capital. These opportunities include:

52.1 a proposal to deliver low risk, high volume/scale remedial works to the estate through nationally coordinated programmes of work; and

52.2 alternative delivery or financing models for infrastructure investments, including PPPs, long-term leases, mixed ownership, and partnerships with private practice, NGOs, and Iwi.

53 Health NZ will also be asked to report to Ministers, the Ministry of Health and Treasury prior to each Budget process. This reporting will outline available depreciation capital levels (including proposed allocation towards national programmes and specific projects over $1 million), proposed funding approaches to any other upcoming HIP decisions, and any changes to capital estimates alongside opportunities to manage these through scope changes, trade-offs, or deferrals of investments. I also expect Health NZ to provide me regular updates on the progress of investments, how they are tracking to budget, and potential pipeline implications.

Financial implications

54 This paper seeks an indication from Cabinet on what level of financial investment is preferred: however, funding decisions to give effect to HIP investments are to be sought from Ministers through future Budget processes.

55 The proposed pipeline will require Crown capital investment over the next 10-years well above the previous 10-year average of approximately $700 million. The annual average capital investment in the pipeline is s 9(2)(b)(ii) from all funding and financing sources. This does not include potential investments from the DIP, of which an indicative pipeline and cost will be presented to Cabinet at a later date.

56 A significant uplift in Crown capital contribution over 10-years will be required. Health NZ's current depreciation allocation is not sufficient to cover the scale of investment needed in the HIP, noting that the proposed pipeline goes beyond minor remediation issues. Additional operating cost uplifts are also likely to be required in later years to fund changes or uplifts in service delivery as capacity goes online.

57 A number of infrastructure investments have been invited for a submission for capital funding in Budget 2025 in accordance with the priorities of the HIP. The total funding request in Budget 2025 is for about $850 million in capital over the forecast period.

Depreciation funding

58 Based on Health NZ's financial modelling, Health NZ's annual depreciation funding towards infrastructure investments could range from approximately $300-500 million. This is dependent on the rate at which assets are capitalised, and Health NZ's cash position. Health NZ's total depreciation budget in 2024/25 was $887 million. Depreciation investment into health infrastructure is $366 million in 2024/25, including $60 million towards major monitored health investments, 41 per cent of the allocation. The other portfolio that receives the largest share of depreciation funding is for replacement of clinical equipment - $319 million or 36 per cent of the allocation.

59 Depreciation funding is predominantly used for smaller scale investments, often focussed on asset remediation and maintaining services. Such small-scale projects are not included in **Appendix 2** and are typically assessed by Health NZ on an annual basis. Health NZ undertakes prioritisation of baseline capital each year and provides information on this prioritisation to the Treasury during each Budget process. The majority of HIP investments will require additional Crown funding as the current depreciation allocation is not sufficient.

60 Exact levels of investment will be determined through the annual budget process. Specific capital budgets for projects outside of the Budget 2025 process are based on early estimates and will be reviewed as detailed planning occurs. Ministers will be provided options to manage changes to estimates through the Budget process.

Alternative financing

61 The 10-year investment pipeline provides an opportunity to engage with private equity on a range of alternative financing and procurement options that may accelerate and enhance the delivery of health infrastructure. Private financing allows Health NZ to leverage expertise from outside the public sector to think differently about how to approach the complex challenges facing the infrastructure estate.

62 As per the *Building Hospitals Better* approach, the HIP sets out investments of varying scale that present opportunities to consider private financing and/or delivery of:

62.1 major hospital redevelopments, including through the use of PPP models;

62.2 rural and community hubs, including through mixed ownership and financing arrangements with community providers and Iwi;

62.3 private equity support for health clinical facilities, including leaseback; and

62.4 additional hospital site carparking is intended to be funded fully through the use of alternative financing arrangements for the build, own, operate and/or concession arrangements for the facilities, where it makes sense financially to do so. This will reduce the pressure on the capital budgets used for the

hospital redevelopment and remediation projects. A list of potential carparking investments is included in **Appendix 2**.

63 The undertaking of PPPs for major hospital redevelopments is likely to be an important part of helping address the health infrastructure deficit. Delivering hospitals as a PPP is more likely to be successful where the project is of sufficient scale or complexity that it would benefit from increased contractual incentives to manage risk and performance, and that innovative approaches to design, construction and service delivery may be employed. There also must be sufficient market appetite.

64 Implementation of the HIP will require Health NZ to work with National Infrastructure Funding and Financing Limited (NIFFCo) to identify opportunities for private sector investment across the full HIP pipeline as well as develop the internal capability for these procurement and delivery arrangements. Initiatives of high potential for alternative financing and delivery arrangements will be highlighted within the implementation plan for further discussion by Ministers before the end of 2025.

Operating cost implications

65 Health NZ has developed indicative impacts to incremental operating costs that will derive from the investments planned within HIP. The assumptions used to model operating costs include:

65.1 An average depreciation applied from the financial year following the completion of investments;

65.2 Workforce costs applied to uplifts in clinical capacity;

65.3 Clinical supplies applied to uplifts in clinical capacity;

65.4 Non-clinical costs, including utilities and building services applied against assumed increased gross floor areas of building;

65.5 Non-capital data and digital costs based on a percentage of the overall capital costs of the facilities; and

65.6 Assumptions around efficiencies are not included, as these would need to be incorporated into respective business cases.

66 Escalation has been applied to the above assumptions and operating costs forecast over a 20-year period. Prior to FY29/30, operating increases come predominantly from projects that are already in delivery. The long duration of infrastructure projects means that most of the operating cost impacts of projects on the HIP fall outside of the ten-year period. Overall, the modelling suggests that by 2032/33 the current portfolio of in-flight projects will add an additional $1.030 billion per annum to Health NZ's operating baseline, and the HIP investments will add a further $1.404 billion by 2032/33 and a projected average increase of $0.305 billion per annum out to 2044/45. For context, the total Vote Health non-departmental revenue increased over the period from 2014-2025 by approximately $6 billion.

67 Operating cost implications of the proposed investments will be further refined as projects are progressed, and funding sources will be identified closer to completion. The capital charge impact of any Crown capital investment has not been factored into the HIP modelling. The current capital charge cost is 5% on any Crown capital investment.

Other Implications

68 This paper has no cost of living, direct population, legislative, regulatory, human rights, or climate implications.

Use of external Resources

69 The taskforce established by the Public Service Commission to provide independent advice on the performance and future direction of the health system has assisted with the development of this paper.

Consultation

70 The Ministry of Health, The Treasury and the Infrastructure Commission were consulted in the preparation of this paper. The Department of the Prime Minister and Cabinet were informed.

Treasury Comment

71 The Treasury supports the delivery of a Health Infrastructure Plan and the intent to execute this as part of an integrated national investment plan that delivers investment matched to service need and future models of care.

72 We understand that Health NZ will be developing an implementation plan to present to Minister Brown by June this year. The Treasury recommends that this plan addresses the following residual concerns relating to the deliverability, integration, and affordability of the IIP. These concerns are not insurmountable, but they will require a concerted effort in the context of a significant programme of change.

73 First is the ability of Health NZ to deliver this scale of investment uplift while inflight infrastructure projects are experiencing delays and reporting underspends. We understand Health NZ experienced a 54% underspend against the 2023-24 Capital Plan (2024-25 reporting is not yet available) and based on the December 2024 Quarterly Investment Reporting, 56.5% of Health investments are tracking to agreed delivery timeframes. s 9(2)(b)(ii) . It is important that system and project specific issues with inflight investments are addressed, to put Health NZ in the best position to deliver the planned scale of increased investment.

74 The integration of a data and digital investment plan, and a refreshed clinical services and campus plan, is important in ensuring that investments are prioritised and developed based on a cohesive plan for health care delivery across New Zealand. Assumptions around the built solutions for individual investment must continue to be challenged throughout the development of business cases. This should enable Health NZ to realise the benefits of changes in models of care and service delivery.

75 Consideration must also be given to the fiscal constraints at play. At this stage not all the costs associated with the IIP can be know, however, we particularly note that further investment will be required on the Data and Digital Investment Plan, which is likely to primarily increase operating costs. With significant increases in investment expected across capital intensive agencies, the IIP will need to remain flexible to respond to the outcomes of the annual Budget process, where prioritisation will be necessary to meet the constraints of capital and operating allowances.

Communications

76 The summary of the HIP (**Appendix 1**) is intended for a public audience. The benefits of publishing the HIP include:

76.1 transparency of the timing of delivery, including staged investments;

76.2 greater efficiency of planning and delivery resources; and

76.3 the ability for the market to plan for potential investment opportunities.

77 I am seeking Cabinet agreement to publish the public summary of the HIP (**Appendix 1**), noting investments are presented thematically and exclude individual cost profiles.

Proactive Release

78 I propose the proactive release of this paper as soon as is practicable, with appropriate redactions to protect the confidentiality of advice tendered to Ministers ahead of future fiscal decisions on the content of this paper.

Recommendations

The Minister of Health recommends that the Committee:

1 **note** that the Health Infrastructure Plan is a key component of Health NZ's 10-year infrastructure roadmap, which is currently under development and will cover built and digital infrastructure and health technologies;

2 **note** that agreement in principle to the Health Infrastructure Plan is not an agreement to fund the proposed investments;

3 **agree** in principle to the Health Infrastructure Plan (**Appendix 1** as the public document and **Appendix 2** as the investment pipeline), with the commitment of all funds being subject to relevant business case approval and internal and external Budget decisions;

4 **agree** the Minister of Health can make further editorial changes to the Health Infrastructure Plan (**Appendix 1**) prior to publishing;

5 **agree** to publish the public version of the Health Infrastructure Plan (**Appendix 1**);

6 **note** Health NZ will provide an implementation plan to the Minister of Health by 1 July 2025, including detailed milestones and delivery resources for investments out to Budget 2027;

7 s 9(2)(b)(ii) [redacted]

8 **invite** the Minister of Health to report to the Cabinet Expenditure Committee by December 2025 with the first of three annual progress updates on the planned delivery of the Infrastructure Investment Plan.

Authorised for lodgement

Hon Simeon Brown

Minister of Health

Appendices

Appendix 1: Public Health Infrastructure Plan (attached)

Appendix 2: List of proposed projects in the HIP

Appendix 3: Investment scenario option analysis

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Projects outside of the investment portfolio for immediate progression to alternative financing

Name of project	Region	Campus	Facility type	Escalated capital estimate ($000)
1100 space multi-storey carparking building	Central	Wellington Hospital	Carpark	9(2)(i)
1200 space multi-storey carparking building	Northern	Manukau Health Park	Carpark	
New multi-storey carparking building Hospital (spaces tbc)	Northern	Middlemore Hospital	Carpark	
Hospital Redevelopment Car Parking (spaces tbc)	Te Waipounamu	Nelson Hospital	Carpark	
350 space car park to accommodate increase in demand	Northern	Whangarei Hospital	Carpark	
Second multi-storey carpark	Northern	North Shore Hospital	Carpark	
Car park to accommodate increase in demand (spaces tbc)	Te Manawa Taki	Tauranga Hospital	Carpark	
700 space car park to accommodate increase in demand	Central	Hawkes Bay Hospital	Carpark	
700 space car park to accommodate increase in demand	Central	Palmerston North	Carpark	
Mason Clinic	Northern	Mason Clinic	Carpark	
Carpark to support new hospital site	Te Waipounamu	New Dunedin Hospital	Carpark	

Appendix 3: Investment scenario option analysis

Health NZ has undertaken a detailed assessment of the four scenarios (and the baseline scenario) against a set of criteria. The below table shows a high-level summary of this analysis, based on a simplified matrix. The scoring is not intended to be cumulative (as each criterion could be weighted depending on priority) but provides a reasonable outline of the potential impact of these scenarios.

Scenario title and description	Affordability		Deliverability			Clinical value		Remediation of asset stock
Sub-category	Capital	Operating	Market Capacity	Health NZ delivery capacity	Workforce to operate	Operate a more efficient health system	Alignment to Health Targets	
Criteria use to assess	*Average capital investment per year required (new and baseline)*	*Ratio of high-level models on operating uplift required by 2038/39*	*Average number of new major builds agreed ($300+ million)*	*Number of new projects on average committed (baseline and new)*	*New Capacity that comes online (% more than available in 2024)*	*Drawing on the agreed assessments of clinical service impact*	*Total Points of Care uplift for health targets by 2029/30**	*Assessed risk of asset failure provided on scenarios*
Scenario 1: Maximum investment to address infrastructure deficit	Score = 1 s 9(2)(b)(ii), s 9(2)(g)(i)	1 *Ratio: 1.98*	1 *31*	1 *21.2*	1 *15.9% more capacity*	5 *Uplift across the major hospital campuses, including both specialist and generalist hospitals, and a shift in services closer to communities.*	5 *POC uplift: 1,375*	5 *Asset risk: low*
Scenario 2: Targeted Uplift in Access and Capacity (preferred)	**3** s 9(2)(b)(ii), s 9(2)(g)(i)	**2** ***Ratio: 1.49***	**2** ***20***	**3** ***11.0***	**3** ***10.4% more capacity***	**4** ***Large-scale improvement in quality and capacity for generalist hospitals only.***	**3** ***POC uplift: 1,001***	**4** ***Asset risk: medium***

Scenario 3: Repositioning for Future Change	3 s 9(2)(b)(ii), s 9(2)(g)(i)	3 Ratio: 1.25	3 *14*	4 *9.7*	3 *9.0% more capacity*	3 *An increase in capacity and enhancement of facilities with major hospital redevelopments addressing some of the pressure on the health system.*	3 *POC uplift: 1,004*	3 *Asset risk: high risk of failure*
Scenario 4: Sustaining Current Settings	4 s 9(2)(b)(ii), s 9(2)(g)(i)	4 Ratio: 1	4 8	4 *8.4*	4 *6.1% more capacity*	2 *The provision and some shift of some services to rural and community hubs to shift some of the burden from the main hospitals.*	2 *POC uplift: 910*	2 *Asset risk: still extreme risks*
Baseline Scenario	5 s 9(2)(b)(ii), s 9(2)(g)(i)	5 N/A	4 *10*	4 *5.1*	4 *No more capacity than today (remediation only)*	1 *The pressures that are emerging across the health system estate will intensify.*	1 *POC uplift: 0*	1 *Asset risk: growing risk*

Scoring: This scoring for each category is ranked from 1 to 5. For affordability and deliverability: 1 - highest risk; 5 - lowest risk. For Clinical value and remediation of assets: 1 – lowest level of benefit; 5 – highest level of benefit.

Criteria descriptions:

- **Capital**: Affordability of average amount of capital expenditure per year
- **Operating**: Affordability of the relative level of operating uplift required to operate the facilities
- **Market capacity**: Number of large-scale projects and assessment of market to deliver on these

- **Health NZ delivery capacity**: Average number of projects to be initiated measured against demands on delivery and governance systems (e.g., project management or other delivery capacity)
- **Workforce to operate**: Increase in bed numbers across hospital sites (as an indicator of potential additional workforce needs, noting that some beds require more workforce, and some beds require less
- **Operate a more efficient health system**: The assessed benefit in terms of ability to provide timely and quality care (an agreed assessment of clinical service impact)
- **Alignment to Health Targets**: Relative delivery of additional capacity directly supporting Health Targets
- **Remediation of asset stock**: Assessment of residual risk level at this level of investment

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Four investment scenarios were developed for consideration

Four different scenarios have been developed that outline the enhancement of service delivery and level of asset risk that is addressed at different levels of total investment. The scenarios all reflect the identified priorities identified in the assessment of population and health need and asset risk.

Scenario One: Maximum investment to address infrastructure deficit

Demonstrates delivery against all known capital requirements. The total proposed investments over the period will deliver upon completion a 15.9% increase in capacity and renew facilities of nearly half of current capacity (45.5%).

Key benefits: The level of investment allows for uplift across the major hospital campuses, including both specialist and generalist hospitals, and a shift in services closer to communities.

Key risks: Risks associated with asset failure are addressed early and the risks around insufficient capacity and lack of access are materially addressed within the ten-year period. However, the level of investment required exceeds construction market capacity.

Average cost: The average total capital cost per annum for this scenario is s 9(2)(b)(ii) s 9(2)(g)(i)

Scenario Two: Targeted Uplift in Access and Capacity (Preferred)

Outlines a level of investment that provides improved access and uplift in capacity but there remains an ongoing gap with the growth in demand. The total proposed investments over the period will deliver upon completion a 10.4% increase in capacity and renew nearly one third of current capacity (29.2%).

Key benefits: large-scale improvement in quality and capacity for generalist hospitals only, as well as shift of services into communities to address acute demand on hospital services.

Key risks: Pressures remain on specialist and generalist hospitals in the short term until reduced in the medium and long term.

Average cost: The average total capital cost per annum for this scenario is s 9(2)(b)(ii) s 9(2)(g)(i)

s 9(2)(b)(ii), s 9(2)(f)(iv)

Key: Rural Hub | Urban ambulatory Hub | Specialist Unit | Generalist Hospital | Specialist Hospital | Mental Health | Remediation Programmes

Note: figures exclude cost estimation risk

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Scenario Three: Repositioning for Future Change

Positions health system for improvements over the longer term. Challenges remain in medium term around service provision in some areas. The total proposed investments over the period will deliver upon completion a 9.0% increase in capacity and renew just over a quarter of current capacity (26.4%).

Key benefits: An increase in capacity and enhancement of facilities with major hospital redevelopments addressing some of the pressure on the health system and positions the system for an uplift in the years beyond the timeframe of the plan.

Key risks: With some major redevelopments only commencing initial stage in this period there will be sustained pressure on the health system in the short and medium term alongside the ongoing risks around the retention of some aged building stock and supporting infrastructure.

Average cost: The average total capital cost per annum for this scenario is s 9(2)(b)(ii) s 9(2)(g)(i)

Scenario Four: Sustaining Current Settings

Prevents further degradation in services while retaining current levels of risk and challenges around service provision. The total proposed investments over the period will deliver upon completion a 6.1% increase in capacity and renew under a fifth of current capacity (16.2%).

Key benefits: A focus on the critical risks and the most urgent requirements sees the provision and some shift of some services to rural and community hubs to shift some of the burden from the main hospitals.

Key risks: The level of risk around asset and service failure will increase as investment deficit grows. Some generalist hospitals will see sustained pressures on their services. High reliance on successful shifts to off-site care options to address capacity issues.

Average cost: The average total capital cost per annum for this scenario is s 9(2)(b)(ii) s 9(2)(g)(i)

s 9(2)(b)(ii), s 9(2)(f)(iv)

Key: Rural Hub | Urban ambulatory Hub | Specialist Unit | Generalist Hospital | Specialist Hospital | Mental Health | Remediation Programmes

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