Budget Sensitive

Office of the Minister of Health

Cabinet Expenditure Committee

Interim Inpatient Bed Capacity: Programme Business Case

Proposal

1 This paper seeks approval for the approach to market to secure a contract for the design and construction of at least three interim and relocatable inpatient units to relieve immediate and future bed capacity pressure. The Programme Business Case (PBC) for the interim inpatient units is attached at **Appendix A**.

Relation to government priorities

2 The proposed investment is aligned with the "Achieving the Health Targets – High Level Implementation Plan July 2024 – June 2027" announced on 12 September 2024.

Executive Summary

3 s 9(2)(g)(i) . This significantly impacts on health outcomes and Health New Zealand | Te Whatu Ora's (Health NZ) ability to meet the Government's Health Targets. It is preventing timely surgery, prolonging Emergency Department stays and creating system inefficiency through the administrative overheads of surgery cancellations. The extent of capacity pressure will also complicate planned hospital redevelopments as they lack the space to "decant" inpatient wards (temporarily relocate patients and staff) so that the wards can be redeveloped.

4 Health NZ has explored the purchase of at least three interim and relocatable inpatient units ("units") to respond to capacity challenges in the health system. The proposed units would be deployed across the hospital network by Health NZ in accordance with priority of need and staffing levels. Each unit is anticipated to have a capacity of either 28 or 32 beds to optimise cost efficiency, construction speed, and transportability, with an anticipated economic lifespan of up to 50 years.

5 The units will:

5.1 **Reduce Emergency Department (ED) stays** (as per the Health Target) through adding bed capacity for patients needing to be admitted to a hospital ward from the ED.

5.2 **Enable faster cancer treatment** (as per the Health Target) by freeing up regular hospital ward capacity for patients needing a hospital bed during their cancer treatment.

5.3 **Reduce wait times for elective treatment** (as per the Health target) through adding bed capacity and reducing or, where possible, eliminating cancellation of treatment due to critical shortages and patient flow issues.

5.4 **Provide the necessary temporary capacity to enable existing hospital wards to be decanted** as part of the planned hospital redevelopments.

6 Health NZ has engaged with similar market solutions through the delivery of a temporary inpatient unit at Wellington Regional Hospital, and early engagement on a unit for Hawke's Bay. The detailed design and construction of the proposed additional three temporary inpatient units will be the subject of a tender process.

7 Of the three anticipated units, it is envisaged that two units will be continuously providing additional capacity (incurring additional staffing costs for either **65.87 FTEs** [28 bed unit] or **70.12 FTEs** [32 bed unit]), and one unit will be continuously serving as a decant ward in support of a redevelopment (no additional staff cost). Health NZ will fund these additional staffing costs out of baseline.

Component	**3x 28 bed units $m, present value**	**3x 32 bed units $m, present value**
Capital costs of investment	s 9(2)(b)(ii)	
Ongoing operating costs of asset operation (p.a.) excluding depreciation		
Ongoing operating costs of service delivery (p.a.), excluding depreciation [Based on two units providing additional capacity & one unit decanting to support redevelopment]		
Total WOLC (2xcapacity; 1xdecant)		

Whole of Life costs appraised over 20 years, at a discount rate of 2%.

8 Health NZ is taking a programme approach to this investment so that further approval can be sought for another tranche/s of units in future if required. I am seeking to present the Implementation Business Case (IBC) to Cabinet for approval in February 2026, informed by tender responses and with contract award occurring shortly thereafter. The deployment of each individual unit, and any future relocation, will be subject to my approval.

Background (Strategic case)

9 The health system is suffering from insufficient inpatient beds. s 9(2)(g)(i) . The deficit is particularly acute in Auckland area hospitals and in Wellington, as well as some provincial centres.

10 This shortfall is principally owed to the ever-increasing demand driven by population growth. Within this demand, increasing numbers of older people is the largest driver. By 2043 the number of New Zealanders aged 80 years and over is forecast to double.

11 Bed pressure across the network is therefore concentrated in adult medical, surgical, and mental health beds with high occupancy rates. Adult medical and surgical beds currently run well above best practice of 85-90% occupancy.

12 The bed capacity profile across the network is also currently not well matched to the actual level of population health demand and health workforce in each location. Generally, the smaller the health facility, the lower the average occupancy rate over 12 months. By contrast, New Zealand's largest health facilities are operating at or above 90% occupancy[1].

13 Health NZ is working to implement system and operational shifts to improve the efficiency of service delivery, but bed capacity shortfalls and mismatched bed capacity profiles are key current and future problems driving the need for comprehensive or targeted redevelopments of a number of hospitals. This includes Dunedin, Nelson, Wellington, Tauranga, Hawke's Bay, Palmerston North, and Whangārei. This is further compounded by other factors, including the seismic non-compliance of key buildings, and generally degraded facilities that are preventing delivery of timely access to quality care.

14 The 10-year Health Investment Plan (HIP), developed by Health NZ, sets out a number of significant hospital redevelopments over the next 10-years that intend to respond to the capacity challenges New Zealand currently faces. These planned redevelopments are complex and will take considerable time to design and build, with many having not yet been designed, costed or approved. The earliest injection of a large number of additional inpatient beds is expected to come via the Nelson Hospital redevelopment (subject to Cabinet approval) when the new Inpatient Unit will go live in late 2031. Nelson Hospital has poor seismic resilience and the current state compromises Health NZ's ability to deliver care in a disaster. Health NZ is also progressing a range of smaller scale bed capacity increase projects, but these will not deliver the capacity step-change of larger redevelopments.

15 These challenges are having the following impacts:

15.1 Reduced patient flow and increase system blockages: Not being able to admit patients into fully occupied wards is exacerbating pressures elsewhere in the hospital. The most significant example is that the lack of inpatient ward beds forces patients to remain 'bed-blocked' in the Emergency Department (ED) until a ward bed becomes available, placing further pressure on ED resources.

15.2 Unsafe or unsuitable care: The inability to admit patients into wards is resulting in some patients being cared for in unsuitable and potentially unsafe areas. This is likely leading to poorer patient outcomes.

15.3 System inefficiency and cancellations: The increasing use of hospital overflow areas is compromising business as usual functions, such as elective surgeries. At times of high demand and critical capacity shortage, elective surgeries need to be cancelled – causing system inefficiency.

15.4 Remediation and redevelopment risks: The current capacity pressure is so pronounced that it will complicate the fixing of this problem via the planned hospital redevelopments. Hospital wards must be decanted (i.e. emptied of patients, staff and equipment) so that redevelopment works can commence – but for the most part these hospitals now lack the additional space to relocate these patients, staff and equipment temporarily. Their overall occupancy rate is simply too high.

Analysis (Economic Case)

16 Given the existing bed capacity pressure, the time required for additional beds to come online, and the fact that this pressure will itself complicate proposed hospital redevelopments, an interim solution is needed to ease the pressure and aide progress against the Health Targets.

17 Health NZ identified a Longlist and Shortlist for potential solutions. A modular, relocatable, and easily implementable solution was sought to allow Health NZ to be flexible in where capacity is added. This also meant identifying a solution that would supplement the proposed hospital redevelopments was critical.

18 Longlist and Shortlist options included exploring the base case – no intervention – against combinations of standardised or bespoke inpatient units built either onsite or offsite, with Health NZ either completing design or outsourcing. Options were assessed against the following Investment Objectives (IO) and Critical Success Factors (CSF) shown in Table 1.

Table 1: *Investment Objectives and Critical Success Factors*

IO 1: Improved health outcomes	**CSF 1:** Strategic fit & business needs
IO 2: Increased hospital efficiency	**CSF 2:** Potential value for money
IO 3: More cost-effective service delivery	**CSF 3:** Supplier capacity and capability
IO 4: Help to enable permanent improvements in infrastructure	**CSF 4:** Potential affordability
	CSF 5: Potential achievability

19 Shortlist evaluation (in **Table 2** below) produced the preferred option (**Option C: relocatable standardised units**). To seek innovative solutions from the market, Health NZ intends to set high level design principles only, leaving the market to advise on the final design. This preferred option scored higher than an alternative approach of Health NZ completing design and then tendering for construction. Setting high level design principles only will provide the lowest cost mechanism of delivering additional inpatient beds while promoting innovation from the market.

Table 2: *Shortlist evaluation*

Shortlist Option	A Base case [No temporary inpatient wards constructed]	B Relocatable standardised units – Health NZ design, tender for build	C Relocatable standardised units – Health NZ set high level design principles only	D Bespoke size inpatient standardised unit for a general ward and treatment areas
Ranking against Investment Objectives & Critical Success Factors	4 (does not meet)	2 (partially meets)	1 (fully meets)	3 (partially meets)
Whole-of-life-cost ($000, WOLC) **2 units are used to provide additional capacity; 1 unit used as decant wards**	0	Expected to be higher than option C	s 9(2)(b)(ii)	Will be higher than Option C due to extra costs of being non-standard size

Shortlist Option	A Base case [No temporary inpatient wards constructed]	B Relocatable standardised units – Health NZ design, tender for build	C Relocatable standardised units – Health NZ set high level design principles only	D Bespoke size inpatient standardised unit for a general ward and treatment areas
Final outcome	**Discard**	**Discard**	**Preferred**	**Discard**

20 The proposed solution is the purchase of at least three standardised relocatable inpatient units, using modern construction techniques, potentially including modular construction. Each unit is anticipated to have a capacity of either 28 or 32 beds to optimise cost efficiency, construction speed, and transportability, and will have an anticipated economic lifespan similar to that of permanent units - of up to 50 years. In addition to transportability, this limited size will also ensure the units can be temporarily placed on a hospital campus (as opposed to off campus) to maximise patient and staff flows.

21 Purchasing at least three units strikes the optimal balance between the level of bed capacity deficit, the need to support more than one hospital simultaneously, and cost. Tender responses will indicate whether a fourth unit is also affordable. Of the three anticipated units, it is envisaged that two units will be providing additional capacity (incurring additional staffing costs for either **65.87 FTEs** [28 bed unit] or **70.12 FTEs** [32 bed unit]), and one unit will be serving as a decant ward in support of a redevelopment (no additional staff cost) at any one time. Health NZ will fund these additional staffing costs out of baseline.

22 The units will provide care for:

22.1 Adult patients over 18 years of age for inpatient care over 23 hours.

22.2 Patients who require beds arising from care provided by medical and or surgical specialities and subspecialities.

22.3 Short term care of less than 23 hours.

22.4 Assessment and treatment care of less than 23 hours.

23 The units will not be intended for intensive or high dependency care, cardiac care, maternity care, child healthcare, infectious diseases, rehabilitation care or mental health care. These services will continue to be delivered in permanent buildings.

24 Inviting market responses for two sizes of standardised units (28 and 32 bed) will potentially provide optionality to suit the specific capacity needs and the available land on each hospital campus. However, given the small overall number of units, the market may indicate it is more economic for all units to be the same size. If this eventuates, the recommendation is for 32 bed units due to the high level of need and the relatively lower cost per bed.

25 Due to the mid- to long-term profile of health infrastructure, there will continue to be a strong need for the units beyond the completion of the currently scheduled hospital redevelopments. For instance, over the anticipated life of the units, up to 50 years (i.e., out to 2077, 50 years from commissioning in 2027), it is almost certain that other

hospitals either awaiting redevelopment or not yet scheduled for redevelopment will experience a level of capacity pressure that requires temporary support.

26 Aside from the general capacity deficit, it is also possible over this lifespan that hospitals will encounter a need to surge in additional bed capacity for major unexpected events (e.g., a pandemic or natural disaster).

27 The current redevelopments are being planned on the basis of demand modelling out to 2043. Some level of capacity deficit is therefore expected to re-emerge in these hospitals beyond 2043, which these units will then be able to support.

Deploying the units

28 I will approve where these units will be deployed across the network based on Health NZ advice informed by:

28.1 **clinical leadership review** to confirm need for increased capacity to support models of care.

28.2 **regional clinical service planning** that will employ increased capacity as part of the change in the network of service delivery.

28.3 **projected capacity pressure in different locations**: updated projections would be employed to confirm site location.

28.4 **health and safety considerations** such as risk level to patients and staff in existing buildings and priority for health and safety remediation work that requires a decant ward.

28.5 **space constraints**: the available space on a hospital campus for a unit to facilitate patient and staff flows.

28.6 **workforce capacity:** the current workforce (including consideration for any shortages) and workforce planning in a given hospital to allow a unit to be fully staffed from its go live date.

28.7 **the need for decant wards to support a redevelopment:** to support hospital build programme as they progress.

28.8 **the availability and innovation of commercial providers**: providers will need to be able to construct the units and innovate to be successful.

29 Decisions on where these units will be deployed will be made at a later date but there are already examples of where they would be beneficial. In some areas, urgent seismic refurbishment work is required but there is nowhere to decant patients currently. A temporary ward would allow refurbishment to take place with minimal patient disruption and see this work completed quicker than doing it room-by-room or needing to repurpose other non-clinical space. On the other hand, the temporary inpatient ward in Wellington and the ward being designed in Hawke's Bay are both examples of boosting capacity using this model. The proposal is a novel solution to numerous existing challenges.

Financial implications (Financial Case)

30 The Whole Of Life Cost (WOLC) is summarised below. It is based on the 66.6% staff costs (2 temporary units) / 33.3% no staff costs (1 temporary unit) scenario above. The high WOLC reflects the high operating cost of the units requiring additional staff, given inpatient units are required to operate and be staffed continuously day and night. Currently unknown costs include that of transporting the units to different locations around the country, and utilities connection costs (including water services and electricity). Health NZ will fund additional staffing costs out of baseline.

Table 3: *WOLC*

Component	**3x 28 bed units $m, present value**	**3x 32 bed units $m, present value**
Capital costs of investment	s 9(2)(b)(ii)	
Ongoing operating costs of asset operation (p.a.) excluding depreciation		
Ongoing operating costs of service delivery (p.a.), excluding depreciation [Based on two units providing additional capacity & one unit decanting to support redevelopment]		
Total WOLC (2xcapacity; 1xdecant)		

Whole of Life costs appraised over 20 years, at a discount rate of 2%.

31 It is proposed that the funding required for this investment be sourced as set out below.

Table 4: *Funding required for the 28-Bed Option (2 x capacity units plus 1 x decant unit)*

Source	Amount ($000) by year						
	FY1	**FY2**	**FY3**	**FY4**	**FY5**	**FY6-20**	**Total**
Capital funding required							
Depreciation	s 9(2)(b)(ii)						
HCE (capex)							
Total capital funding							
Operational funding required							
Health New Zealand	s 9(2)(b)(ii)						
HCE (opex)							
Total operating funding							

Table 5: *Funding required for the 32-Bed Option (2 x capacity units plus 1 x decant unit)*

Source	Amount ($000) by year						
	FY1	**FY2**	**FY3**	**FY4**	**FY5**	**FY6-20**	**Total**

Capital funding required	
Depreciation	s 9(2)(b)(ii)
HCE (capex)	
Total capital funding	
Operational funding required	
Health New Zealand	s 9(2)(b)(ii)
HCE (opex)	
Total operating funding	

Implementation (Commercial and Management Cases)

32 The market has already demonstrated the ability to provide singular interim inpatient units through the delivery of units at Wellington Regional Hospital, and early engagement on a unit for the Hawke's Bay. This proposal is seeking a market solution at greater efficiency through a standardised design and repeatable construction approach. As the units will be relocatable, local market capacity issues will not be a barrier.

33 Health NZ is taking a programme approach to this investment so that further approval can be sought for another tranche/s of units in future if they prove a fast and cost-effective means of easing capacity pressure. In addition, as the recommended solution is to be designed and fully costed by the market in tender responses a, Health NZ has determined that a Detailed Business Case (DBC) is not required (i.e. the investment can proceed straight to an IBC).

34 Should Cabinet approve this first tranche, a competitive two stage tender process will commence in July 2025. Health NZ has used and is using the same provider for the Wellington Regional Hospital units and the proposed Hawke's Bay units but will ensure other providers are given the opportunity to tender. Health NZ will own the designs produced so they can be used for any future units.

35 I will present an IBC to Cabinet in February 2026, informed by tender responses and with contract award occurring shortly thereafter. Design and construction of the units is expected to occur from April to October 2026, with the units then expected to be deployed to and come online in their respective locations from February 2027. The deployment of each individual unit, and any future relocation, will be subject to my approval.

36 Health NZ has identified a number of potential risks, which are further detailed in the PBC (**Appendix A**). Key identified risks are:

36.1 **The risk of an inpatient unit become semi-permanent or permanent at a hospital:** this will be mitigated by aligning the use of units to Health NZ's 10-

year IIP, so that units are only provided when needed and fit within wider investment plans and site plans for individual hospitals.

36.2 **The risk of units being used for other unintended purposes such as intensive care, high dependency care, or dementia:** this will be mitigated by setting clear limits and expectations about the units' functions and limitations.

36.3 **Inability to provide any increased staffing:** Health NZ will factor in the required staffing increases in workforce planning, and this will be a key consideration in the recommended locations for the proposed units.

36.4 **Minimal response to tender:** Health NZ is confident that the response to tender will be sufficient, noting experience with the Wellington and Hawke's Bay temporary inpatient units. Health NZ will also see strengthened market relationships off the back of the publishing of the IIP which will provide market confidence in Health NZ.

Investment assurance

37 The proposed investment is assessed as medium risk so does not require a Gateway review.

Cost-of-living Implications

38 There are no cost-of-living implications arising from the proposals in this paper.

Legislative Implications

39 There are no legislative implications arising from the proposals in this paper.

Population Implications

40 The proposal will improve health outcomes for all populations through increased hospital capacity and supporting achievement of the Health Targets.

Human Rights

41 There are no human rights implications arising from the proposals in this paper.

Use of external Resources

42 Health NZ has a core programme team and will procure external experts with the required technical expertise to deliver the programme, for example a Quantity Surveyor. No external resources were used in the development of the Programme Business Case or Cabinet paper.

Consultation

43 The Treasury, the Ministry of Health and the Infrastructure Commission have been consulted on this paper.

Communications

44 The proposal has been submitted into the Budget 2025 process; communication of the project will be completed through that process.

Proactive Release

45 As the proposal has been submitted into the Budget 2025 process, I would anticipate delaying Proactive Release until its completion.

Next steps

46 Subject to approval of funding through Budget 2025, I will present an IBC to Cabinet in February 2026, seeking approval to award the contract and commence delivery.

47 Design and construction of the units is expected to occur from February to August 2026, with the units to be deployed and come online in their respective locations from December 2026.

Recommendations

The Minister of Health recommends that the Committee:

1 **Approve in principle** the Interim Inpatient Bed Capacity Programme Business Case – Tranche 1 (**Appendix A**), subject to Budget 2025 funding decisions;

2 **Authorise** Health NZ to issue a Request for Proposal for the Tranche 1 investment of at least three temporary inpatient units;

3 **Note** that three 32-bed units will have a total Whole of Life Cost of s 9(2)(b)(ii)

4 **Note** that the Whole of Life Cost may reduce if tender responses confirm it is desirable to procure a mix of 28-bed and 32-bed units;

5 **Agree** that a Detailed Business Case is not required, and that Health NZ will submit an Implementation Business Case for approval in December 2025;

6 **Invite** the Minister of Health to present the Implementation Business case to Cabinet for approval in February 2026;

7 **Note** that the Implementation Business Case will present the confirmation of costings, the initial site deployment for the units**,** and how the units will support regional clinical service delivery;

8 **Note** that all operational costs for this investment will be met from Health NZ baselines;

9 **Note** the importance of expediting the delivery of temporary inpatient wards, including for Nelson Hospital to enable earthquake strengthening works;

10 **Delegate** the Minister of Finance and Minister of Health to have the ability to drawdown capital funding early to ensure the addition of a potential Nelson temporary inpatient ward(s) is delivered no later than the end of 2025;

11 **Agree,** subject to Budget 2025 funding decisions, any capital funding draw down will be subject to Cabinet approval of the Implementation Business Case; and

12 **Note** that Health NZ is taking a programme approach so that Cabinet approval can be sought for a further tranche/s of units if required in future.

Authorised for Lodgement.

Hon Simeon Brown

Minister of Health