Episode one

TRANSCRIPT

NEW ZEALAND
INFRASTRUCTURE
COMMISSION
Te Waihanga

Infrastructure for a better future

Health Infrastructure Review

Blake Lepper
GM - Infrastructure Delivery, Te Waihanga

Derya Siva
Senior Advisor, Infrastructure Delivery, Te Waihanga

Robert Rust
former CE of Health Infrastructure in NSW

Please note: the transcript has been edited to make reading as easy as possible.

Introduction: Welcome to the Te Waihanga 'Infrastructure for a Better Future' podcast. A series where we talk to experts both from here and overseas about the infrastructure challenges we are facing. The episodes focus on the key areas of Rautaki Hanganga o Aotearoa, New Zealand's infrastructure strategy. Find out more about the strategy at www.**strategy.tewaihanga**.govt.nz.

Blake Lepper: Years of underinvestment in hospitals and other public health facilities mean that many are no longer fit for purpose. In many regions of New Zealand, the state of our infrastructure is directly contributing to inequities in health outcomes. The health reforms currently underway offer an unprecedented opportunity to deliver a step change in how we plan and deliver health infrastructure. It gives us a chance to think about investment at the national level, getting better outcomes from our infrastructure spend. Recommendations from a recent health infrastructure report by Robert Rust show just how to do this.

Most of Robert's 40-year career has been on major projects across the private and public sectors. His public sector work has been at the chief executive and chief operating officer level, including developing and delivering a portfolio of projects for New South Wales Health. Robert recently visited New Zealand and Te Waihanga asked him to unpack some of his key findings with us. Derya Siva, Senior Advisor, asked the questions.

Derya: Welcome Robert. Really great to have you here - looking forward to your insights. I'd just like to ask you a few questions. Why was health infrastructure New South Wales created?

Robert: Well, health traditionally delivered its capital works through the health agency and when you have a significant, as is the case in New South Wales and I'm sure in many other jurisdictions, a significant recurrent budget, often the infrastructure is seen as somewhat second string. Obviously, when major projects come along, that's not the case, but in more routine delivery. And sit within the organisation, sometimes well down the hierarchy, and perhaps don't get the level of independence and authority that's necessary to carry out capital works.

So, generally, it's not having the sort of direct access that you need to decision makers, to Treasury, to broader Government, on major

projects to make them to enable them to be delivered successfully. So, over time, in particular New South Wales, but many jurisdictions, are looking at specialised capital works agencies. Setting them up and using them for delivery of major projects. And some of those are, as you've said, independent, where the projects don't sit within the broader agency.

The other issue with New South Wales Health is the Director General spent a significant amount of her time dealing with capital works issues - which really is not her reason for being. She was there to deliver health services. An independent agency enabled her to effectively distance herself somewhat from the capital works whilst retaining responsibility for it. The health infrastructure unit had to then respond to the queries and criticisms of the market. And that freed up her time to do, as I say, to focus on what was more important to her.

Derya: You've had a lot of experience working at health infrastructure in New South Wales. I'd like to understand what makes standalone infrastructure units successful?

Robert: Well, in a sense, they're not entirely standalone, and it's a fair question. Most of the infrastructure units that are successful sit within the agencies. Now, New South Wales has tried standalone agencies where they are genuinely separate from the agency that they're servicing - and that didn't meet with a lot of success. Generally, they sit within the agency, but they do enjoy a significant amount of independence, generally answering through to a Director General. A feature of many of those agencies as an external advisory board, whose job it is to, I guess, ensure that the agency is delivering what it's required to. But equally it enables ministers, directors general, executives to satisfy themselves that what that standalone agency is doing – that it's been done properly and successfully and gives them an avenue to understand the performance.

The agencies really need to be able to respond to the demands of a construction environment. Which are dramatically different to the demands that exist within an agency delivering services with a recurrent budget on an annual basis and construction projects to extend over a number of years. They involve significant expenditure, they require a level of contingency because no project can be designed absolutely. So, using that contingency sensibly and effectively is a measure that's often used to look at success. And then there's just a simple matter of construction projects being difficult, both in terms of time and in terms of cost. And being able to monitor that and understand when projects won't be delivered, contrary to a Minister's statements, and how that's communicated back to Government and in turn to stakeholders in a way that enables them to understand the issues that have been confronted. Many of which are out of the control of all parties, and we only have to look at COVID to understand how you can get issues that that that are impossible to deal with and just need to be accommodated within the broader program.

Derya: So, what do you see is the biggest challenge for the new head of health infrastructure?

Robert: Well, Derya, unquestionably getting the confidence and trust of Government. The new health infrastructure unit has a number of projects ahead of it - it's working in a very difficult environment. And the government being confident that it can lead its projects with a unit and expect that they'll be delivered successfully is critical to it getting the freedoms that it needs to continue to do - to build major projects.

Derya: What does that look like?

Robert: Look, it's delivering projects successfully, but more importantly, that people remain fully informed when issues arise. As I said before, we're in a difficult environment. Not only is the construction market struggling to deliver due to the impacts of COVID, but equally you have a massive program of projects to be delivered and you're standing up a brand new organisation within the broader health system, which itself is undergoing significant change. And all of that, I guess, will make it difficult for an organisation to operate successfully, with that amount of change occurring and being able to do so will be critical to its success.

Derya: How do you ensure that capital renewals and maintenance get as much attention as new builds?

Robert: Government policy, I think is changing in this area and New Zealand has policies which require agencies to properly manage assets, to make sure that they sweat them - that they get the full value out of their lifecycle. To do that, obviously, preventative maintenance is a critical part of that, as is appropriate upgrades as and when required to keep them capable of delivering services in a meeting contemporary sort of standards. Most jurisdictions, I think,

suffer from underinvestment in this area traditionally, and again, you're seeing a number of governments moved to requiring agencies to properly manage assets through the lifecycle. That simply means that if money is provided to maintain an asset, it must be used to maintain it. And preventative maintenance, unfortunately, is an area where it's not necessarily clear that maintenance needs to occur because you're doing it in advance of potential failure. So, fix when fail is obviously not a particularly well, efficient way to deal with it. Because of the impacts of the failure and other facts, you're running the asset into the ground. It's a matter of making sure that number one, the appropriate money is made available for proper maintenance and upgrades when it's appropriate. And number two, that it is spent on an annual basis and not diverted to what are seemingly critical issues to do with service delivery, but ultimately at the detriment of the asset base that was being maintained.

Derya: So, what I'm hearing is that planning maintenance is really important?

Robert: Absolutely and New Zealand is well on the way. There are studies that have been done that have identified the maintenance deficit that exists. Now it's a matter of reducing that deficit so that facilities are being brought up to standard. Now with rapidly changing models of care, it is clearly quite difficult, in some instances, to have to adapt facilities to new models of care. That's just something that has to be managed, but they need to be kept in good condition.

Derya: Why is longer term planning important?

Robert: Longer term planning is important simply because in the short term, you don't want to do something that precludes you doing things in a medium to longer term, or alternatively is something that is not required in the medium to long term. So classically, on a major hospital site, some kind of master planning is always a very sensible approach, because you need to contemplate what happens at the end of the life of the facility you've just built. And having allowed provision for future buildings enables you to do a rather seamless transition into a new facility, rather than having to go and locate a new site and rebuild a building and then all the issues associated with that transfer to the new site.

So, master planning is critical. But then more particularly making sure that what has been built can be used for its useful life and it's not something that is required in the very short term that will no longer be required in the medium term and hence need to be removed – that's clearly not an efficient use of government funds.

Derya: Has the nature of construction contracting changed?

Robert: Yes, I mean, for the reasons I outlined previously, it's now difficult for contractors to provide fixed price to government. Notwithstanding their desire to do so and to properly compensate them for the risks associated with issues such as supply chain shortages, escalation of costs and lack of experienced contractors, would be prohibitive and not provide value for money. So, governments are needing to move more towards risk sharing and taking away some of the more significant impacts that could occur - if they occur - taking the risk away from contractors to do that.

That's forced us into collaborative style of contracts, as opposed to the traditional lump sum, where government sits down with contractors and tries to determine which areas of the contract it's prepared to take a risk on and which areas the government can sensibly assist in taking risk on the prices that may arise in executing those works. So, the general move is to collaborative contracting - and that brings back into play alliancing, incentivise target cost, managing contractor style contracts, which varies, but in a robust market contractors tend to move to a lump sum and when government asks for a lump sum, contractors tend to respond. In a market where government's becoming a price taker it needs to respond to the risk appetite of major contractors and that's where it's sitting at the moment.

Narrator: Thanks for listening to infrastructure for a better future. To find out more about the infrastructure challenges we are facing this strategy visit www.**strategy.tewaihanga**.govt.nz.