THE NEW ZEALAND MEDICAL JOURNAL
Journal of the New Zealand Medical Association

Patients "falling through the cracks". The Canterbury Charity Hospital: initial progress report

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Abstract

Aim To present the early experience of establishing a community-funded and volunteer-staffed hospital in Christchurch, New Zealand. This was to provide free selected elective healthcare services to patients in the Canterbury region who were otherwise unable to access treatment in the public health system or afford private healthcare.

Methods Data were reviewed relating to the establishment, financing, staffing and running of the Canterbury Charity Hospital. Details were provided of patients referred by their general practitioners who were seen and treated during the first two and a half years of function.

Results Canterbury Charity Hospital Trust, established in 2004, completed the purchase of a residential villa in 2005 and converted it into the Canterbury Charity Hospital, which performed its first operations in 2007. By the end of December 2009, 115 volunteer health professionals and 79 non-medical volunteers had worked at the Hospital, provided a total of 966 outpatient clinic appointments, of which 609 were initial assessments, and performed 610 surgical procedures. Funding of $NZ4.3 million (end of last financial year) came from fundraising events, donations, grants and interest from investments. There has been no government funding.

Conclusions There is a substantial unmet need for elective healthcare in Canterbury, and this has, in part, been addressed by the recently established Canterbury Charity Hospital. The overwhelming community response we have experienced in Canterbury raises the question of whether the current public health system needs attention to be re-focused on unmet need. We contend that unless this occurs it might be necessary to establish charity-type hospitals elsewhere throughout the country.

The health reforms of the early 1990s introduced a "revolutionary policy of commercialisation" to the public health system of New Zealand.[1] These reforms, which divided the medical profession, had wide-ranging effects on public health services. Perhaps the most visible change was in the provision of elective hospital services.

Four years into the health reforms, "hospital waiting lists for many procedures had become longer, by as much as 50%".[2] Thereafter, patients with non-urgent conditions for whom treatment could not now be provided in the public hospital system within an arbitrary timeframe, were either refused outpatient assessment or dropped from elective waiting lists. The unmet need also became unseen.

A group of individuals in Canterbury, mostly but not exclusively health professionals, became concerned at the apparent inability of some patients to gain access to services previously available within the public health system. This growth of unmet societal need evolved despite an increase in the use of private health care[3] and notwithstanding the fact that some health practitioners were seeing patients in their private rooms free of charge. Failing to find a solution to these problems through official channels, the Canterbury group established the Canterbury Charity Hospital Trust (CCHT).

The aim of CCHT was to provide free specialist medical services, including day surgery, for patients from the Canterbury District Health Board (CDHB) region who were unable to access care through the public hospital system and who could not afford private care. The venture was based on charitable funding, a largely volunteer workforce and a utilitarian concept of treating as many patients as possible within available resources.

It was always accepted by the trustees of CCHT that the venture would not address all the unmet and apparently increasing need in Canterbury. It was, however, intended that the Canterbury Charity Hospital would not compete with either public or private healthcare providers but see only those patients who "fell through the cracks".

We present here the experience of CCHT in setting up the Canterbury Charity Hospital, and report on the staffing and patients involved in the first two and a half years of function. Some implications for healthcare in New Zealand are discussed.

Methods

CCHT initially considered a number of options for patients in the CDHB region who had limited access to elective health services. These included the use of operating theatre and outpatient clinic facilities in Christchurch public and private hospitals during "down-time". This option was found to be impractical for a number of reasons, but mainly due to the difficulty of matching volunteer staff time with service resource availability. It became obvious that a standalone facility was needed. Accordingly, a large, old, residential villa in the Christchurch suburb of Harewood was purchased by CCHT and converted into the Canterbury Charity Hospital.

All funding for the venture has come from the local community. A local newspaper has facilitated the collection of individual donations from the public. CCHT will not consider accepting any government funding in order to retain its independence and avoid the administrative/bureaucratic burden that such funding would inevitably incur.

The design of this facility was provided *pro bono* by a local architectural firm. Renovations were undertaken by a major contracting company and a number of subcontractors at much reduced costs. The architects and the contractor subsequently won regional and national awards for their work on the Canterbury Charity Hospital based on the opinions of their peers.

CCHT is run by four trustees and operates under a Charitable Trust deed. It is supported by a number of committees including a Clinical Board, which oversees the quality and safety of all clinical services. This Board has representation from both primary and secondary care medical practitioners, nurses and lay people. There is also a committee that organises major fundraising events. Legal and accountancy services are provided *pro bono* by local firms.

Canterbury Charity Hospital is staffed by a large number of non-clinical volunteers some of whom provide a regular, recurring commitment, whilst others provide their expertise less regularly according to personal circumstances. They assist with, for example, administration, cleaning, gardening and transport. The current volunteer clinical staff list consists of physicians, surgeons, anaesthetists, nurses and operating theatre technicians, all *pro bono* (see Results). There is also a skeleton staff of two full-time paid equivalents to cover clinical, management and technical functions and a part-time consultant for marketing, public relations and fundraising.

All patients must be referred by their general practitioners (GPs), who are the gatekeepers to the service. Four criteria must be met for acceptance of a patient for treatment:

- The patient must be unable to access a service they require through the public hospital system;
- He/she must be unable to pay for private care, have no medical insurance, and not be entitled to Accident Compensation Corporation funded treatment;
- A signed confirmation of eligibility to treatment at Canterbury Charity Hospital is required from the GP and the patient; and
- The GP must also confirm that the patient's medical condition is affecting their quality of life and/or ability to work.

Canterbury Charity Hospital provides a free day surgical service and medical outpatient consultations for some clinical conditions. The list of clinical services has changed with time depending on the types of referral, and volunteer staff and resource availability. GPs and the public can obtain an updated list of available services on the CCHT website (www.charityhospital.org.nz).

Since there are no overnight stay facilities in the Canterbury Charity Hospital, limited respite care after day surgery has recently been made available *pro bono* through other providers. Where special investigations are required, GPs are requested to organise these but when this has proved impossible they are organised by Canterbury Charity Hospital staff. A limited number of radiological and necessary special investigations are provided *pro bono* by other organisations.

After all medical and surgical procedures, patients have access to a free telephone number for advice about immediate problems. All patients are followed up by telephone call and most are offered follow-up clinic appointments.

Results

The concept of a free, volunteer-staffed, day surgical service for those in the CDHB region who could not otherwise obtain access to care was trialled first by performing operations in the mobile surgical bus, which provides a national surgical service.[4] The first operating list in the new Canterbury Charity Hospital was performed on the 31 August 2007, 2 months after extensive renovations were completed.

The fully equipped Canterbury Charity Hospital was officially opened by the Anglican Bishop of Christchurch, the President of the Royal Australasian College of Surgeons and the Deputy Head of the New Zealand Nurses Organisation in October 2007 (Figures 1 and 2).

Figure 1. The Canterbury Charity Hospital as viewed from Harewood Road

Figure 2. The Canterbury Charity Hospital Operating Theatre

A regular day surgical service was not implemented until the following year. The timeline of major events is shown in Table 1.

Table 1. Timeline of major events for Canterbury Charity Hospital (CCH)

July 2004	CCH Trust established
April 2005	First day surgery procedures performed on mobile surgical bus
May 2005	First major fundraising event (Christchurch Town Hall concert)
August 2005	Purchase of old villa at 349 Harewood Road, Christchurch
August 2006	Contract signed with main contractor to renovate old villa
June 2007	Renovations of old villa into CCH complete
August 2007	First operations at CCH—General Surgery service started
October 2007	Official Opening of CCH
August 2008	Gynaecology and Cardiology services started
Sept 2008	First cataract operations performed
Nov 2008	Podiatry service started
Dec 2008	Dermatology service started
Feb 2009	Plastic and Hand Surgery services started
March 2009	Neurology service started
June 2009	Vascular Surgery service started
July 2009	Orthopaedic Surgery service started

All data are summarised as at 31 December 2009.Table 2 shows the increase in the number of patients seen and treated annually at the Canterbury Charity Hospital since

its opening in 2007, and prior to that in the mobile surgical bus or in specialists' private rooms. There were a total of 609 initial outpatient appointments and 357 follow-up appointments, and 610 surgical procedures were performed.

Table 2. Numbers of outpatient appointments and surgical procedures at Canterbury Charity Hospital

Calendar year	2005-2006	2007	2008	2009
Initial appointments	11	24	199	375
Follow-up appointments	0	11	125	221
Total number of treatments	11	11	220	368

Of the 609 initial appointments, data were collated for 597. The total number of patients seen at these 597 initial outpatient appointments was 575 (56% male; 44% female) with a mean age of 51.6 years, (SD=19.1, range 2 to 92 years). Of this group, 466 patients (56% male; 44% female; 73.3% <65 years) received treatment with 25 further patients awaiting treatment. Some (65, 13.9%) received two or more treatments.

The group who received treatment were significantly younger than those who did not (50.6 years compared to 55.9 years, Independent t-test p=0.010) but the percentage of males did not differ between the groups; 52% for those not treated compared to 56% for those who were (Chi-square test, p=0.395). For the rest, either no treatments were required or they were deemed unsuitable because: the treatments they needed were outside the scope of what Canterbury Charity Hospital could provide; they had extensive medical comorbidities; or, their temperaments or social circumstances were inappropriate for day surgery.

Where co-morbidities were a relative contraindication to treatment, patients were usually seen at an anaesthetic and/or appropriate medical assessment clinic before a final decision was made about management.

In an analysis of the last 300 patients seen at Canterbury Charity Hospital, 20% stated that they were currently employed, 41% indicated that they were unemployed, and 39% did not specify their employment status.

Table 3 provides a breakdown of medical and surgical procedures by specialty provided at Canterbury Charity Hospital. The most frequently performed procedures were for the treatment of groin and umbilical hernias, haemorrhoids, pilonidal sinuses, cataracts, and tubal ligations for sterilization. There were three surgical complications: a local infection following repair of an umbilical hernia, which responded to antibiotic treatment; a haematoma in an inguinal hernia repair which required evacuation; and, insertion of a lens of incorrect refraction, requiring replacement surgery. Overnight respite care after surgery was required because of social circumstances for three patients.

Table 3. Breakdown by specialty of medical and surgical procedures performed at Canterbury Charity Hospital

Calendar Year	2005–2006	2007	2008	2009
Medical	0	0	8	22
Dermatology	0	0	3	4
General Surgery	7	11	198	221
Ophthalmology	4	0	4	42
Gynaecology	0	0	5	36
Orthopaedic/Hand	0	0	0	22
Podiatric	0	0	0	13
Plastic	0	0	2	8

The clinical and support staff complement involved in providing service through Canterbury Charity Hospital is shown in Table 4. Whereas the vast majority of staff are resident in Canterbury, valuable service has also been provided by medical personnel from Invercargill, Nelson, and Hawke's Bay. Many staff beyond those indicated in Table 4, both medical and non-medical persons, have offered their time and may be called upon as services provided by the Canterbury Charity Hospital continue to expand.

Table 4. Staff Composition at Canterbury Charity Hospital

Staff type		Numbers ever worked since 2005	Numbers working in 2009
Volunteers	Anaesthetists	19	13
	Nurses	60	33
	Physicians	8	7
	Surgeons	18	18
	Technicians	8	6
	Non-Medical	73	33
Employees	Part Time	2	2
	Full Time	1	1

CCHT and the CDHB signed a Memorandum of Understanding in April 2008. This facilitated cooperation between the two organisations in a number of areas such as staff availability, training opportunities and use of resources in emergency situations. CCHT shares some costly or irregularly used resources, such as ophthalmological equipment, with other healthcare organisations.

It has been a basic tenet of CCHT that the standards of care for all services will meet and/or exceed those expected of the New Zealand public health system. Medical and surgical procedures are performed and supervised by medical, surgical and nursing specialists, working within their vocational scopes as listed with the Medical Council of New Zealand. CCHT has two independent credentialing officers, and all medical and nursing staff are subjected to a strict credentialing process, the outcomes of which are monitored by the Clinical Board.

The trustees are, of course, concerned with the long-term financial viability and sustainability of the venture. Accordingly, they intend to maintain strict expenditure disciplines and ensure that the limited available resources are expended on clinical services. CCHT is working to create a reserve fund that will provide an income to protect the long-term viability of the Canterbury Charity Hospital.

The total funds raised from 2005 until the end of the last financial year were $NZ4.3 million and came from: CCHT organized fundraising events (3.5%); donations from individuals, businesses and community groups (60%); grants from charitable trusts (33%); and interest from investments (3.5%). The initial costs of purchasing, renovating and equipping the Canterbury Charity Hospital were $NZ2.3 million. Since 2006, a further $NZ400,000 has been spent on equipment.

Many organisations and individuals donated their time, expertise and resources *pro bono* or at highly discounted rates, in order to keep the setup costs to a minimum. All major equipment was purchased from non-government grants and most of the furniture and fittings were donated. Since the Canterbury Charity Hospital became operational in July 2007, the annual operating budget has been $NZ350,000 and, each year, a progressively increasing percentage of income has been spent on patient care. From 1 April 2009 to 31 December 2009, 75% of the budget directly related to patient treatment expenses.

Whilst the primary objective of this endeavour remains the mitigation of unmet clinical need, a secondary objective has evolved—the teaching of medical and nursing staff and students. Partial or complete loss of elective surgery from the public hospitals has left a void in the training of medical[5] and nursing personnel in these procedures. This is now being addressed, at least in part, by staff and patients in the Canterbury Charity Hospital.

Junior doctors have assisted with outpatient clinics and procedures; surgical trainees have learnt procedures that are now rarely performed in the public hospital system. Third year undergraduate nurses have observed the patient clinical pathway from initial assessment to final discharge. Postgraduate nurses have gained clinical experience in their current specialty area or in other specialty areas. A large number have gained clinical experience in the perioperative setting. CCHT supported a number of volunteer postgraduate nurses, who were either retired or not employed as nurses, to regain or maintain their registration status. Such teaching and mentoring, as with the clinical services themselves, is provided *pro bono.*

Discussion

As noted by Gauld, the new system introduced by the New Zealand health reforms of 1993 “performed poorly, in keeping with problems of market failure endemic in health care”.[6] The need for the Canterbury Charity Hospital arose out of this, and the data shown here suggests the need is ongoing. For example, it is unusual now for patients with haemorrhoids, inguinal hernias, and similar problems, without associated complications, to receive elective treatment in the Christchurch public hospitals, whereas patients with these afflictions were routinely operated on in the public system in 1970s and 1980s.

Of particular note, 73.3% of patients treated in the Canterbury Charity Hospital were under 65 years of age (mean age 50.6 years) and 41% were unemployed (see Results). These data suggest that there are many patients within the "working age" population in Canterbury who are unable to gain access to the public hospital system and are considered by their GP to have their quality of life and/or ability to work compromised by their medical or surgical disorder. This fact, along with the obvious point that treating such disorders early, before they become severe or complications ensue, raises the issue of whether the health reform-based restrictions of care in the public health system are cost-effective.[7,8]

Moreover, our patient eligibility criteria selectively determine the clinical and economic characteristics of the patients referred by Canterbury GPs. This population may, therefore, represent only a proportion of the existing unmet need. The fact that the Canterbury Charity Hospital saves money for the Government provides the potential for moral hazard (i.e. the incentive to save money overcomes the desire to address the healthcare needs of the whole population). It is hoped that charity hospitals do not become the default back-up, and that attention is re-focused on the provision of an effective universal public healthcare system.

The experience of CCHT is that there is excellent, sustained and sufficient goodwill within Canterbury to establish and run a charity hospital. In this regard CCHT may prove to be a template for the establishment of similar hospitals in centres elsewhere in the country. Indeed, the Auckland Regional Charity Hospital is already functioning,[9] and a somewhat similar venture has been mooted in Dunedin. Regarding practicalities, it should be noted that substantial time, funding and effort were required to establish a purpose-built hospital.

We suggest that the experience of CCHT should be the catalyst for a debate on the future of New Zealand's healthcare systems. In particular, should we now accept that the current public healthcare system is as efficient and cost-effective as is possible—in which case the need for charity-like hospitals will become necessary in cities and towns throughout the country? Alternatively, is it possible to improve the structure and functioning of the public healthcare systems, such as by reducing the burgeoning bureaucracy and the associated escalating costs.[10,11]

As far as the future of the Canterbury Charity Hospital is concerned, the trustees of CCHT intend to extend the current services according to the evolving unmet needs of the Canterbury community. In the immediate future this may include dental treatment.

Conclusion

Establishing the Canterbury Charity Hospital has proved to be a highly satisfactory endeavour as gauged by the large and increasing number of patients treated, the continuing expansion of clinical services, the high level of continued community financial support, and the substantial number and sustained commitment of the volunteer workforce. It illustrates some of the current deficiencies in the public health system that need to be addressed. If not, charity-type hospitals might be needed elsewhere throughout the country to mitigate some of these deficiencies.

Competing interests: None known.

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