研究ノート

The Hospice Movement in Aotearoa New Zealand:
A Case Study of the Community Mission of Mary Potter, Wellington

Zane Ritchie
Josai University

1.1. Introduction

The modern hospice movement represents one of the most significant philosophical shifts in healthcare over the last century (Clark, 2018; World Health Organization, 2020). It is a response to the often impersonal, cure-focused model of modern medicine, asserting instead that a person's value and needs do not diminish as they approach the end of their life. Hospice care is not about giving up, but about a radical reorientation towards life itself, ensuring that a patient's final days are spent with the greatest possible degree of dignity, comfort, and meaning (Clark, 2018; Kellehear, 2007; MacLeod & Van den Block, 2018). In New Zealand, this movement, is characterised by a partnership between government funding and community ownership and support. This paper will explore the beginnings of hospice care, its introduction and evolution within the New Zealand context, and examine funding and service delivery with a brief case study of Mary Potter Hospice, Wellington.

1.2. A Brief Historical Context

The word "hospice" derives from the Latin *'hospitium'*, meaning guesthouse. Its roots can be traced to medieval times when religious orders offered shelter and comfort to pilgrims, the sick, and the dying. (Connor, 2017). However, the birth of the modern hospice movement is universally credited to Dame Cicely Saunders. A former nurse, social worker, and later physician, Saunders revolutionised care for the dying. In 1967, she founded St. Christopher's Hospice in London, the first institution to combine expert pain and symptom management using what were at the time, novel methods like the regular administration of analgesics ("pain control") with holistic, compassionate care in a community setting (Cicely Saunders Institute, n.d.). St. Christopher's was not just a place of care; it was a living laboratory for clinical research and a training ground for a new generation of palliative care pioneers from around the world. It was here that Saunders came up with her guiding principle, "You matter because you are you, and you matter to the last moment of your life" (Cicely Saunders Institute, n.d.). This powerful message became the catalyst for a global movement that spread rapidly throughout the 1970s and 1980s.

1.3. Palliative Care vs Hospice Care

To better understand the hospice movement, it is important to distinguish between two key terms that are often used interchangeably. Palliative care is a broad, umbrella term for an approach that improves the quality of life of patients and their families facing problems associated with life-limiting illness. It focuses on the prevention and relief of suffering through early identification, assessment, and treatment of pain and other problems, whether physical, psychosocial, or spiritual (World Health Organization, 2020). Importantly, palliative care can begin at the diagnostic stage and be provided alongside traditional medical treatment.

On the other hand, hospice care is a specific type of palliative care for people in the final stages of a terminal illness. It typically begins when curative treatment is no longer pursued, and the focus shifts entirely to quality of life and comfort (MacLeod & Van den Block, 2018). The philosophy is holistic, addressing what the founder of the modern movement, Saunders, termed "total pain", a concept encompassing physical discomfort, mental distress, social isolation, and spiritual anguish (Clark, 2018).

Hospice care views dying as a natural process and neither hastens nor postpones death. It provides holistic support that addresses the physical, psychological, social, and spiritual needs of patients while extending care to their families through illness and bereavement. This model prioritises patient autonomy and choice, enabling individuals to maintain control over their care. Delivered through an interdisciplinary team of healthcare professionals and trained volunteers, hospice care embodies a compassionate, person-centred approach. (Tatum et al., 2020).

1.4. The Hospice Movement in Aotearoa New Zealand

The hospice movement began gaining ground in the late 1970s, driven from the grassroots level by individuals, community groups, and religious orders who saw a gap in the existing healthcare system. The first hospices were often established through immense volunteer effort and charitable fundraising. One of the very first was Te Omanga Hospice in Lower Hutt, which began providing care in 1979. Around the same time, the Mary Potter Hospice in Wellington was also established, founded by the Little Company of Mary, an order whose mission was already aligned with caring for the sick and dying. Other early pioneers included Mercy Hospice in Auckland. These organisations were born out of a collective recognition that New Zealanders deserved a better, more compassionate alternative to dying in a busy, acute hospital ward.

The hospice movement was formalised with the establishment of Hospice New Zealand in 1986. As the national body, it provided a unified voice for member hospices, developed

standards of care, facilitated training, and began seeking government support. This began the transition of hospice care from a collection of local initiatives to an integral part of the New Zealand health landscape.

1.5. The Evolving Model of Care

The model of hospice care in New Zealand has undergone a significant evolution. The early public perception, and often the reality, was of a hospice as an inpatient unit where people went to die. While these specialist units remain a vital component for managing complex symptoms and providing respite for families, they are no longer the primary focus of care.

Today, most of the care in New Zealand is provided in the homes of patients. Specialist community palliative care nurses are the backbone of this service, visiting patients at home to manage symptoms, provide support and education to family/whānau[1] carers, and coordinate care with GPs and other services (Ministry of Health, 2017). This shift recognises that most people prefer to remain in their own familiar environment for as long as possible.

The recognition that care does not end with the death of the patient has led to the development of bereavement support services for families and whānau, often for up to a year or more. And to ensure hospice and palliative care services are effective and equitable for Māori, the "Mauri Mate" framework provides an essential blueprint for ensuring hospice services in Aotearoa are both clinically and culturally competent. This involves recognising the whānau as the primary unit of care, requiring flexible communication and care plans that accommodate diverse family structures and dynamics. The framework emphasises the critical importance of integrating cultural protocols, such as ensuring spaces for whānau to gather, facilitating karakia (prayers and chants), and respecting practices around the tūpāpaku (deceased), thereby creating a physically and spiritually welcoming environment that affirms Māori identity and values at the end of life (Te Ohu Rata o Aotearoa, 2019).

1.6. Funding the Mission

The provision of hospice care in New Zealand is characterised by a unique and often precarious funding model. It is a partnership between the state and the community, but one where the community carries a significant financial burden. Te Whatu Ora Health New Zealand provides a government subsidy that covers, on average, only 50% of the total operational costs of a hospice (Nicol-Williams, 2025). The exact percentage varies by region and is a subject of continuous advocacy. The remaining funding for each hospice is met

1 "Extended family, family group, a familiar term of address to a number of people - the primary economic unit of traditional Maori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members." (Maori dictonary, online).

through community fundraising efforts such as public donations, the operation of hospice charity shops (op-shops), fundraising appeals and events and corporate sponsorship and grants from trusts. This operating model places hospices in a constant state of financial vulnerability. Fundraising efforts can be impacted by economic downturns, and the pressure to raise money diverts significant energy and resources that could otherwise be directed entirely towards patient care.

1.7. Hospices by the Numbers

The hospice sector's contribution to the health system is substantial, with the most recent data indicating that 32 member organisations collectively support over 20,000 patients and their families/whānau each year (Hospice New Zealand, 2023). Approximately 80% of this care is delivered in the community, directly in people's own homes, a model powered by the goodwill of over 10,000 trained volunteers whose contributions range from direct patient companionship and family support to operational roles in hospice shops and administration. This shows that hospice care is not a niche service, but an important pillar of the healthcare system for a significant proportion of New Zealanders toward the end of life.

The hospice movement has grown from its grassroots, charitable beginnings into a sophisticated and essential health service. With a philosophy that promotes dignity, compassion, and holistic well-being, it has successfully shifted the paradigm of end-of-life care from one of mere medical management to one of human support. Its evolution from an inpatient-focused model to a community-embedded one reflects its deep responsiveness to patient needs. However, its funding model, a partnership between the state and the community, ensures that its continued success remains a testament to the generosity of the New Zealand public. To better understand this model in action, the specific mission and work of the Mary Potter Hospice in Wellington is discussed below.

Section 2: Case Study: Mary Potter Hospice – A Wellington Mission

2.1. A Legacy of Compassionate Care

The story of Mary Potter Hospice is linked to its namesake, Mary Potter (1847–1913). In 1877, Mary Potter founded the Little Company of Mary in England, a religious order devoted to caring for the sick and dying, particularly those in critical and terminal conditions. (Mary Potter Hospice, n.d.) This mission, to offer solace and presence at life's most vulnerable moments, laid the spiritual and practical groundwork for the hospice that would bear her name over a century later.

In 1979, the same year Te Omanga Hospice was established in Lower Hutt, the Sisters of the Little Company of Mary responded to a need in the Wellington community by founding Mary

Potter Hospice, initially operating from a converted convent in Island Bay (Mary Potter Hospice, n.d.). The vision was to bring the modern hospice philosophy of Dame Cicely Saunders to the Wellington region, by offering an alternative to the sterile, impersonal environment of a hospital ward for the dying. The founding was driven by a combination of religious vocation and a clear-sighted understanding of a gap in community healthcare in the region.

2.2. Service Area and Facilities

Mary Potter Hospice serves a large and diverse area, encompassing much of Wellington region. This large catchment area necessitates a decentralised model of care, making its community-based teams essential. The most visible face of its services is the Inpatient Unit located in Newtown, Wellington. This purpose-built, 12-bed facility, situated close to Wellington Hospital, is designed to feel unlike a hospital, deliberately domestic and peaceful, with private rooms that open onto gardens, allowing patients to have privacy and a connection with nature. The unit provides 24/7 specialist medical and nursing care for patients with the most complex symptom management needs, or for those who require respite care to give their family and whānau a break (Mary Potter Hospice, n.d.-a).

However, much of Mary Potter's operation is outside of these walls, with the Community Palliative Care Service being its largest component. Teams of specialist nurses, doctors, and affiliated health professionals travel across the entire region to provide care in patients' own homes. This allows individuals to remain in their familiar surroundings, maintaining their autonomy and dignity for as long as possible. The administrative and operational hub for this extensive community network based in Newtown, which also houses other support services (Mary Potter Hospice, n.d.-b).

2.3. Access and Services

Access to Mary Potter Hospice services follows a clear referral pathway in which patients are typically referred by their General Practitioner (GP), a hospital specialist, or another healthcare professional. Once referred, patients undergo an assessment to determine the complexity of their palliative care needs. This process is carried out by specialist members of the hospice team, who work collaboratively to understand the physical, psychological, social, and spiritual needs of both the patient and their family. Following this assessment, an individualised plan of care is developed in consultation with the patient and family, ensuring it reflects their wishes and adapts as needs change. Care may involve support from doctors, nurses, physiotherapists, occupational therapists, social workers, counsellors, and spiritual carers (Mary Potter Hospice, n.d.-c).

The hospice offers a comprehensive range of free specialist palliative care services designed

to support patients and families through illness, death, and bereavement. Its multidisciplinary team provides medical and nursing care, social work, counselling, spiritual care, occupational therapy, and physiotherapy. The hospice also offers dedicated Māori and Pacific liaison support, as well as creative and therapeutic options such as art and music therapy, a biography service, and a companion service. The hospice further complements these services with a Day Programme that provides social connection and holistic support for patients and their families (Mary Potter Hospice, n.d.-d; Mary Potter Hospice, n.d.-e).

2.5. The Staff and Volunteers

The hospice's work is delivered by a multidisciplinary team, but its operational model depends heavily on volunteers, with over 600 of them contributing in various ways, assisting on the inpatient unit by providing companionship and making tea; working in the hospice's 11 charity shops across the region; helping with gardening and administration; and driving to support patient transport (Mary Potter Hospice, 2025). This vital contribution is the lifeblood of the organisation and demonstrates the value of the community ownership model.

2.6. Funding and Community Partnerships

Like all hospices in New Zealand, Mary Potter operates with a significant funding gap. According to its most recent Annual Review (Mary Potter Hospice, 2025), government funding covers a large portion, but a substantial shortfall must be met each year through community fundraising. This is achieved through a strong partnership with the Wellington community and a network of charity shops that provide a consistent source of income. The hospice also runs annual campaigns such as its annual appeal and Christmas raffle, which supports pallative care services in the Wellington region.

Section 3: Conclusion

3.1 Summary

The hospice movement in Aotearoa New Zealand represents a profound and compassionate evolution in societal values, shifting the paradigm of end-of-life care from a purely clinical, curative endeavour to a holistic model that affirms life and dignity until the very last moment. As this paper has outlined, this movement is built upon a delicate but powerful partnership between state support and community ownership, as evidenced by its funding model, its reliance on volunteers, and its embedment within local communities. The case study of Mary Potter Hospice serves as a microcosm of this national model and highlights the core hospice philosophy, from its origins in the mission to its modern, interdisciplinary approach to "total pain." It has successfully evolved from its initial inpatient focus to become a service primarily delivered in the community, directly responsive to patient and whānau preference.

3.2. Future Challenges

In spite of its successes, the hospice sector, including Mary Potter, faces significant challenges. An aging population will inevitably increase demand for palliative care services, placing even greater strain on existing resources. The ongoing challenge of sustainable funding also remains a pressing issue; the reliance on community fundraising in an uncertain economic climate present risk and creates inequities if some communities are less able to fund raise than others. Key opportunities and challenges include achieving greater equity by continuing to improve access and outcomes for Māori and Pasifika communities. In the area of human resource development it is important to ensure a sustainable, well-trained specialist palliative care workforce. And finally there is the economic argument, with the cost-effectiveness of hospice care reducing expensive and often unwanted acute hospital admissions, which strengthens the argument for increased and more secure government funding, presenting hospice care not just as a compassionate choice, but as a fiscally responsible one for the entire health system.

3.3. Final Reflection

Hospices like Mary Potter are vital community institutions that stand as a testament to the idea that how we care for our most vulnerable and how we honour life at its close is a measure of society's compassion and maturity. The continued success of the hospice movement in Aotearoa New Zealand depends on sustained commitment from both the government and the public, ensuring that this important form of care remains in place for all New Zealanders, now and into the future.

References

Cicely Saunders Institute. (n.d.). Dame Cicely Saunders: A palliative care pioneer. King's College London. Retrieved December 8, 2025, from https://www.kcl.ac.uk/cicelysaunders/about-us/cicely-saunders

Clark, D. (2018). Cicely Saunders: A life and legacy. Oxford University Press.

Connor, S. R. (2017). Hospice and palliative care: The essential guide. Routledge.

Hospice New Zealand. (n.d.). What is hospice? Retrieved October 7, 2025, from https://www.hospice.org.nz/what-is-hospice/

Hospice New Zealand. (2023). Hospice NZ – BIM 2023 briefing document. https://assets.nationbuilder.com/hospicenz/pages/55/attachments/original/1714701612/Hospice_NZ_-_BIM_2023.pdf?1714701612=

Hospice New Zealand. (2024). Annual review 2023-2024. https://assets.nationbuilder.com/hospicenz/pages/58/attachments/original/1732056461/Annual_Report_23-24.pdf

Kellehear, A. (2007). A social history of dying. Cambridge University Press.

MacLeod, R. D., & Van den Block, L. (Eds.). (2018). Textbook of palliative care (2nd ed.). Springer.

https://link.springer.com/referencework/10.1007/978-3-319-31738-0

Mary Potter Hospice. (n.d.-a). Community palliative care. Retrieved September 20, 2025, from https://marypotter.org.nz/for-patients-families-carers/our-care/

Mary Potter Hospice. (n.d.-b). Frequently asked questions. Retrieved September 20, 2025, from https://marypotter.org.nz/about-us/frequently-asked-questions/

Mary Potter Hospice. (n.d.-c). Kaupapa Māori. Retrieved September 20, 2025, from https://marypotter.org.nz/our-services/kaupapa-maori/

Mary Potter Hospice. (n.d.-d). Our care – Inpatient unit. Retrieved September 20, 2025, from https://marypotter.org.nz/for-patients-families-carers/our-care/inpatient-unit/

Mary Potter Hospice. (n.d.-e). Support for Māori whānau Retrieved September 20, 2025, from https://marypotter.org.nz/for-patients-families-carers/our-support/support-for-whanau-maori/

Mary Potter Hospice. (2025). Impact report 2024-2025. https://marypotter.org.nz/wp-content/uploads/2025/10/MaryPotterHospice_ImpactReport_YE2025-1.pdf

Ministry of Health. (2017). Palliative care action plan. Health New Zealand | Te Whatu Ora. https://www.tewhatuora.govt.nz/assets/Publications/Palliative/palliative-care-action-plan_0.pdf

Nicol-Williams, K. (2025, May 12). Hospice NZ sounds alarm about cost cutting, reduced services at hospices. 1News. https://www.1news.co.nz/2025/05/12/hospice-nz-sounds-alarm-about-cost-cutting-reduced-services-at-hospices

Saunders, C. (2001). The evolution of palliative care. Journal of the Royal Society of Medicine, 94 (9), 430-432. https://doi.org/10.1177/014107680109400914

Tatum, P. E., Mills, M. E., & Perry, E. C. (2020). Hospice and palliative care: An overview. Elsevier. https://pubmed.ncbi.nlm.nih.gov/32312403

Te Ohu Rata o Aotearoa. (2019). Mauri Mate: A Māori Palliative Care Framework for Hospices. Hospice New Zealand. https://assets.nationbuilder.com/hospicenz/pages/38/attachments/original/1715088367/Mauri-Mate-full-framework-for-hospices-2020.pdf

World Health Organization. (2020, August 5). Palliative care. https://www.who.int/news-room/fact-sheets/detail/palliative-care