PRIMARY HEALTH/PHO COMMUNICATIONS
CAMPAIGN RESEARCH

Research Report For

MINISTRY OF HEALTH

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1. Executive Summary

Introduction

- A national survey of 1018 household health decision makers was undertaken to benchmark public awareness and understanding of Primary Health Organisations (PHOs) and the Primary Health Care Strategy, to inform development of communication strategies.

- There are three types of PHOs, Access, Interim and Mixed. Access PHOs have higher NZDep status populations enrolled in their practices than Interim PHOs, and Mixed PHOs have practices that have both Interim and Access populations within the PHOs enrolled patients. Because Access PHOs have higher proportions of high needs populations than Interim PHOs, Government has prioritised Access PHOs and Access practices in Mixed PHOs to receive subsidies before Interim PHOs.

- Data collection was between 19 March and 2 May 2004. At the time the survey began there were estimated to be approximately 2.5 million patients covered by 59 PHOs - 33 Access, 13 Interim and 13 Mixed.

- There had been very little expenditure on PHO/Primary Health Care Strategy communications prior to the survey.

- The total sample of 1018 included supplementary Maori and Pacific people's samples, giving a final sample of 308 Maori, 298 Pacific Peoples and 478 of Other Ethnic groups.1

- Stratified random sampling was used and the data were collected using CATI (computer assisted telephone interviewing).

- The best estimate of the response rate was 73%.

Understanding of Primary Health Care and Awareness of PHOs

- Forty-four percent of respondents were aware of PHOs.

- Of those who were aware of PHOs, just over half knew or thought that their usual GP/family doctor belonged to a PHO. Most of the rest did not know whether they belonged or not.

- Despite most of the South Island not having access to PHOs at the time of the survey, South Island respondents were as likely as their North Island counterparts to be aware of PHOs and know or think their doctor belonged to one.

- Almost two thirds (63%) of the 44% who were aware of PHOs mentioned at least one advantage, the main ones being: “cheaper healthcare” (19%), “provide wider range of health services” (16%), “collective knowledge/ support colleagues” (14%), and “better access to a doctor” (11%).

- The majority (70%) of those aware of PHOs were unable to specify any disadvantages, the main ones being: “not see own doctor/ lose relationship” (9%), and “doctor less available” (7%).

1 People could be in more than one ethnic group
SUPPORT FOR COMPONENTS OF PRIMARY HEALTH CARE STRATEGY

• There was widespread support for three key components of the Primary Health Care Strategy that were specifically asked about, these being: a focus on keeping people well, use of a greater range of health professionals and community consultation.

Greater focus on well health

• Nearly all people surveyed (89%) showed at least some support (66% strongly support) for their family doctor’s practice providing services that focus on keeping people well.2

• Those more likely to strongly support this concept included: those in Access PHOs, particularly those on low incomes; Maori, particularly those on low incomes with children; and those living in rural areas.

Use of range of health professionals

• A high proportion of survey participants (87%) also stated they support the greater use of a range of health professionals to provide services where they have the skills to do so (54% strongly support).

• Those more likely to strongly support this concept included: those in Access PHOs on low incomes; Maori, particularly those on low incomes and those in Access PHOs; and Other ethnic groups3 on low incomes with children.

• Over a quarter (28%) of those who had consulted a GP in the last year also talked with a practice nurse during their last visit.

Community consultation

• The majority of people who were aware of PHOs would like them to involve the community more in the decisions regarding which services should be provided (70%).

• The most preferable means were through surveys (29% of those wanting more community involvement), family doctors (26%) and the board meeting with community groups (10%)

• Those more likely to want PHOs to involve the community more included: Pacific Peoples, Maori, those is Access PHOs, low income households, and Community Services Card holders.4

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2 Participants were told: “The changes involving PHOs are supposed to lead to a number of changes in the way general practices operate. One of the aims is to have more focus on keeping people well, not just dealing with people when they are sick. This might mean that your family doctor's practice would offer things like regular check-ups, classes for people with diabetes, and help with weight reduction. How much do you support or oppose your family doctor's practice providing these sorts of services to keep people well?”

3 “Other ethnic groups” is all those apart from Maori and Pacific Peoples. This and other terms are defined in a Glossary of Terms at the end of the report.
Continuity of care

- Although continuity of care and the need to enrol with just one PHO was not asked about directly in the survey, there was not a lot of mention of it when there was any opportunity, such as in describing PHOs. This may indicate either that people have no real concern about the need to join one practice/PHO, or that they are not aware of the importance of enrolment.

- The survey found that lack of continuity of care was the most common concern people had with PHOs. This is therefore a potential focus for communications.

- Of those who recalled PHO advertising, having to join up with one doctor was the most recalled content, although it was still only mentioned by 10% of these people.

- Of those participants who believed their usual GP/ family doctor belonged to a PHO, ten percent had visited a doctor who was not part of their usual practice in the past twelve months (excluding doctors in after-hours clinics and hospitals). There was little evidence of these other doctors trying to get the people to switch to their practice or PHO.

Reduced Fees

- Although reduced fees/cheaper health care was the most mentioned benefit of PHOs, it was still only mentioned by 19% of the 44% who were aware of PHOs. However, the 19% level rose to 46% among those in Access PHOs, where the reduced fees are most evident and have been most promoted.

- The mention of reduced fees as a benefit of PHOs was also higher among: Maori and Pacific respondents, plus those who had been to a GP within the last 3 months, or were holders of Community Service Cards.

- As shown in the table below, people were paying a lot less at Access PHOs, but some of this differential probably existed before the introduction of the Primary Health Care Strategy, given that Access PHOs have been introduced into the areas most in need.

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4 There is obviously overlap between these groups with Maori and Pacific Peoples being over-represented in Access PHOs and the low income group.
<table>
<thead>
<tr>
<th>TYPE OF PHO</th>
<th>MOST RECENT FEE</th>
<th>USUAL FEE</th>
</tr>
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<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Access</td>
<td>$16</td>
<td>$15</td>
</tr>
<tr>
<td>Interim</td>
<td>$33</td>
<td>$37</td>
</tr>
<tr>
<td>Mixed</td>
<td>$33</td>
<td>$30</td>
</tr>
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</table>

- Fees being paid by the Maori and Pacific respondents were below average (mean $23 for most recent visit by Maori and $20 for Pacific respondents), but this was in large part a product of their greater presence in Access PHOs.
- Those with Community Service Cards ($23) and High User Cards ($21) were other groups paying less.
- As shown in the graph below, reported fees progressively increased with increasing household income, indicating that reduced fees are in fact reaching the most financially in need.

![Mean fee for most recent visit to GP, by Household Income](image)

- Only five percent of those who had visited a GP in the last twelve months mentioned decreased fees as a change they were aware of at the practice, although this was again higher in Access PHOs (13%).
- Fifteen percent of the 78% who had visited a GP in the last twelve months reported paying less than usual on their most recent visit, while 14% reported paying more. When reasons for fee decreases were removed that could not be associated with the Primary Health Care Strategy (e.g. fee reduction because now on ACC) the 15% reporting fee decreases lowered to 8%, and the 14% reporting increases lowered to 11%.
• Among Access PHOs the 8% level for fee reductions rose to 18% and there were only 1% mentioning fee increases.

• Maori respondents were also more likely to mention fee reductions (14%) and less likely to mention increases (6%); likewise for Pacific respondents (15% reductions and 6% increases).

• The size of the reductions was greater than the increases. The mean fee reduction for the eight percent paying less was $17 and the median $20. The mean increase for the 11% paying more was $7 and the median $5.

• Reduced fees were the dominant change people would like to see in the way family health care services are delivered (24% reduced fees and 6% reduced fees for children), so there is a lot of potential to promote the reduced fees, particularly once they have also been introduced into Interim PHOs.

COMMUNICATIONS

Preferred and current means of communication

• More than half of all people interviewed (56%) felt their doctor or their practice was the best way for information about PHOs or changes to the delivery of family healthcare services to be communicated to them (see last column in table below). The three main vehicles for this were: information being sent in the mail from the practice (30%), directly from the GP/doctor (21%) and brochures/information displayed in doctors rooms (13%).

• While just under a quarter mentioned advertising, it should be noted that people are usually reluctant to acknowledge they are influenced by advertising, so the level of mentions does not necessarily reflect its effectiveness.

• The key group of those who are not currently aware of PHOs were more likely to prefer mailed communications from their GP or the GP's practice.

• The most prevalent current source of information on PHOs was from media items/news (58% mentions in total), with newspapers featuring strongly as part of that.

• The survey findings suggest that the information people have received from their GP or general practice has been primarily in relation to the cheaper fees and having them sign up to the PHO, but with low mentions of any other benefits.
### Response to current advertising

- The level of unprompted recall of advertising for PHOs and other changes in the ways family health care is delivered was 5%. After prompting, it increased to 12%.

- These low levels of advertising recall are consistent with the low levels of advertising expenditure prior to the survey (this was a benchmark survey).

- The response to the advertising was more likely to be negative, particularly: *“didn’t understand it/ too brief/ want to know what it means in real terms”*.

- Recall of any specific messages was low.

### Interest in knowing more

- It is positive that over half those surveyed were wanting more information about PHOs and the Primary Health Care Strategy, as communications will be a lot more successful if people are willing recipients.

- The respondents generally wanted to understand what PHOs are and how they affect people.

### Service Utilisation

- Nearly all people interviewed (99%) stated they go to a family doctor/GP, Accident and Medical Centre, nurse or hospital A&E when they or a family member is unwell.

- Seventeen percent of people in the survey also used other health care providers, including 9% who used pharmacists.

- One in ten reported seeking assistance from complementary and alternative medicine providers.

- The majority (78%) had been to a doctor at some point in the past twelve months. A quarter had been in the previous four weeks and a total of half had been in the previous three months.
ACCESS TO PRIMARY HEALTH CARE

• Three percent of respondents put off at least one visit to the GP in the last twelve months mainly because of cost and another one percent partly because of cost. The three percent rose to 12% among Pacific respondents and was 10% among respondents with children aged both under five years and five to fifteen years.

• As this three percent were just as likely as others to have visited the doctor in the last 3 months, they may be people with a comparatively high need to use the doctor. These people were not over-represented in Access PHOs and they had low awareness of PHOs.

• Seven percent had put off a visit to a doctor in the previous twelve months for non-cost reasons. The reasons were not asked, however this group is over-represented in rural areas, so geographic access is likely to be an issue for some. The levels were also higher for those in Access PHOs and for Maori.

• The literature review undertaken as part of this programme of research concluded that there are significant barriers for certain groups to accessing primary care. In particular, Maori, Pacific peoples and those with low incomes appear to be especially affected. While the changes from the Primary Health Care Strategy may have begun to address some of these issues, access was not the main focus of this study and a more detailed study is needed to investigate this issue more fully.

MAORI

• The proposed changes met a very positive response from Maori; the greater focus on wellness, using a range of health care professionals and involving the community more.

• On the other hand, Maori had lower awareness of PHOs than many other groups, but those who were aware were much more aware of the advantage of reduced fees. This reflected the fact that Maori had high representation in Access PHOs and those in the Access PHOs were paying lower fees.

• Maori who were aware of PHOs were above average in their prompted awareness of the advertising and also among the most positive about it. While they were below average in specifying advertising as a preferred means of communication, their response to the advertising to date coupled with their above average desire for more information suggests they may be a reasonably receptive audience. However, as with any advertising, the appeal will depend on the extent to which there are communications designed specifically to reach Maori.

PACIFIC PEOPLES

• Pacific Peoples had very low awareness of PHOs (18%), which may in part be due to the difficulty many have because English is often not a first language amongst Pacific peoples.

• Pacific Peoples were above average in support of greater community involvement by PHOs and on the whole were keen for more information on PHOs.
• Obviously it would be important for this information to be appropriately targeted, especially
given the number of different Pacific nations that there are. Pacific peoples were lower in
mention of the standard channels for communication, and this may reflect the fact that
many of their health messages are better communicated through churches and other
community avenues, rather than mainstream channels.

OTHER ETHNIC GROUPS
• Respondents in Other Ethnic Groups did not have any distinguishing features.

CONCLUSIONS
• There is a lot of openness to further information and several key benefits that can be
communicated, so there is a lot of opportunity for the PHO/ Primary Health care Strategy
communications programme to make an impact.
• The features that will appeal most to people are:
  ■ Cheaper fees
  ■ Greater focus on wellness
  ■ Greater community involvement.
• Other communication strategies that need to be considered are:
  ■ How PHOs will deliver continuity of care and the benefits associated with this
  ■ The benefits of having access to a greater range of health professionals. However, as
    this is already the most mentioned advantage of PHOs, it would seem preferable to
    focus on other messages.
• A follow-up survey at a later date will be able to assess the impact of the communications.
2. **Introduction**

**Research Objectives**
This survey was the main part of a programme of research to develop an evidence-based platform for a medium to long-term communications campaign to increase public understanding of the implications of changes to the new primary health care environment.

- More specific objectives were to:
  - Benchmark public awareness and understanding of PHOs and the Primary Health Care Strategy
  - Inform development of communication strategies

- Important related areas for the research to explore were:
  - People's commitment to getting enrolled with a PHO, staying with one provider or "shopping around"
  - People's access to primary health care services (e.g. costs, prescriptions, x-rays, specialists)
  - People's expectations around confidentiality of their information held by Primary Health Care providers

**Other Components of the Research Programme**
This benchmark national survey of 1018 people was preceded by a small qualitative exploratory study and a review of relevant literature. Both were used as input into the development of the survey. The other component of the research programme is pre-testing of advertising concepts.

**PHOs and Primary Health Care Strategy**
The Primary Health Care Strategy was launched in February 2001. Primary Health Organisations (PHOs) are the main vehicle by which the Primary Health Care Strategy (PHCS) is being implemented. The objectives of the Primary Health Care Strategy, as specified in the Ministry website, are to achieve:

- "A greater emphasis on population health, health promotion and preventative care"
- Community involvement
- Involving a range of professionals and encouraging multidisciplinary approaches to decision-making
- Improving accessibility, affordability and appropriateness of services
- Improving co-ordination and continuity of care
• Providing and funding services according to the population's needs as opposed to fee for services when people are unwell"

INTRODUCTION OF PHOs
There are three types of PHOs, Access, Interim and Mixed. Access PHOs have higher NZDep status populations enrolled in their practices than Interim PHOs, and Mixed PHOs have practices that have both Interim and Access populations within the PHOs enrolled patients. Because Access PHOs have higher proportions of high needs populations than Interim PHOs, Government has prioritised Access PHOs and Access practices in Mixed PHOs to receive subsidies before Interim PHOs. Government expects the Primary Health Care Strategy to be fully implemented by 2008-2010, and by then all PHOs will offer lower and reduced fees to all age groups.

Since October 2003, Interim PHOs had been subsidised to offer cheaper fees to patients aged 6 to 17 years old. Reduced fees for all PHO enrollees in Interim PHOs aged 65 plus were being introduced from July 1, 2004, but this was after the survey period. Access PHO enrollees already had this benefit at the time of the survey.

The first two PHOs commenced on 1 July 2002. At the time the survey began in mid March 2004, there were estimated to be approximately 2.5 million patients covered by 59 PHOs - 33 Access, 13 Interim and 13 Mixed. There were just under 1 million enrollees in Access funded PHOs, the rest being a balance of Mixed or Interim Access PHOs. While all regions in the North Island had some PHOs and generally high coverage, there were almost none in the South Island at the time the survey began.

COMMUNICATIONS ACTIVITY
In the period preceding and during the interviewing (the interviewing ran from 19 March to 2 May), national advertising of the Primary Health Strategy and PHOs was very light. There had been a radio campaign in December 2003 and January 2004, which involved two weeks on 21 iwi radio stations and four Pacific Peoples stations followed by another two weeks on mainstream radio.

There was some limited television time during the survey period. This initial part of the campaign accounted for less than 10 percent of the airtime booked for the rest of the year. Its reach with the public was anticipated to be small. There were 61 spots, with 23 in primetime during the two week campaign from March 28 to April 10. Billboard advertising featured on 30 sites nationally for the calendar month of April. Radio advertising played on 21 iwi stations and 4 Pacific Island stations for three weeks during April. Four national cinema sites had 15 second advertisements.
3. Research Methods Overview

This chapter provides an overview of the research methods, with more detail being included in Appendix A.

National Survey

- A national CATI (computer assisted telephone interviewing) survey was undertaken between 19 March and 2 May, 2004. A stratified random sample of 457 interviews was supplemented by 561 interviews from Maori and Pacific Peoples samples, to give a total sample of 1018.

- The General sample was drawn from Telecom white pages and the Maori sample from electoral rolls (both Maori and General rolls). The Pacific sampling frame was Statistics New Zealand mesh blocks with 40% or more Pacific Peoples households.

- Quotas were set so that at least 40% were male within each of the three samples.

- Data were weighted by age and ethnicity, to more accurately reflect the New Zealand population. The weighting also took into account the number of eligible persons in the household, to adjust for the probability of selection.

- Qualifying respondents were people in the household who make decisions about which family doctor or health care services they or others are going to use. If there was more than one qualifier there was a random selection, based on the person who had the last birthday.

- At least 15 calls (usually more if necessary) were made to try and obtain interviews and maximise the response rate. The best estimate of the weighted response rate was 61% for the general sample and 86% for the combined Maori and Pacific supplementary samples, giving an overall response rate of 73%.

Representativeness Of The Sample

The tables below compare the unweighted and weighted sample with available data from the 2001 Census, for the Total Sample, Maori, Pacific Peoples and Other Ethnic Groups.

There was no Census data based on the qualifying criteria for this survey, so assumptions had to be made as to whether it was likely to vary from the general population. The Census data presented below is based on those aged 20 years and over. The survey sample did allow people aged 16 and over, but the contact criteria was likely to restrict the numbers aged under 25 years. Also it was assumed that there would be more females than males who qualified. Household census data is not available by ethnicity, as there could be more than one ethnic group represented in the household.

All the samples reflect a similar pattern of being under-represented in the lowest income levels, although it must be remembered that the Census data was collected in 2001. The Total Sample and Other Ethnic Groups sample were over-represented with children aged 0 to 4 years, while the Maori sample was under-represented in this group.
In terms of region, there was an over-representation of those living in Wellington in the Total Sample, which was due to the region being over-represented in the Pacific sample which was based on regions with 40% or more Pacific residents. Because some of the Maori sample was also drawn from this sampling frame, Maori are also over-represented in Wellington. A further consequence of the Pacific Peoples sampling frame was under-representation of those living in secondary urban areas.

### TOTAL SAMPLE

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<td>(n=)</td>
<td>(n=)</td>
</tr>
<tr>
<td>Maori</td>
<td>30 (1,018)</td>
<td>11 (1,018)</td>
<td>11 (2,510,367)</td>
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<td>Pacific Peoples</td>
<td>29 (1,018)</td>
<td>5 (1,018)</td>
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<td>56 (1,018)</td>
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<td>0-4 Years</td>
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<td>9 (1,018)</td>
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<td>0-4 Years</td>
<td>38</td>
<td>80</td>
<td>44</td>
</tr>
<tr>
<td>5-14 Years</td>
<td>62</td>
<td>132</td>
<td>56</td>
</tr>
<tr>
<td>Personal Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Zero Income</td>
<td>3</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>$1 - $5,000</td>
<td>2</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>$5,001 - $10,000</td>
<td>4</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>$10,001 - $15,000</td>
<td>10</td>
<td>49</td>
<td>9</td>
</tr>
<tr>
<td>$15,001 - $20,000</td>
<td>10</td>
<td>49</td>
<td>9</td>
</tr>
<tr>
<td>$20,001 - $25,000</td>
<td>8</td>
<td>37</td>
<td>8</td>
</tr>
<tr>
<td>$25,001 - $30,000</td>
<td>6</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td>$30,001 - $40,000</td>
<td>13</td>
<td>63</td>
<td>13</td>
</tr>
<tr>
<td>$40,001 - $50,000</td>
<td>9</td>
<td>45</td>
<td>10</td>
</tr>
<tr>
<td>$50,001 - $70,000</td>
<td>10</td>
<td>49</td>
<td>11</td>
</tr>
<tr>
<td>$70,001 - $100,000</td>
<td>6</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>$100,001 or More</td>
<td>3</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Not stated</td>
<td>15</td>
<td>74</td>
<td>14</td>
</tr>
</tbody>
</table>
### Characteristics of the Sample

Based on the weighted data, 30% of Maori and 43% of Pacific respondents were in the low income group, compared with 28% of Other Ethnic Groups. Low income was defined as a household income of $40,000 or under, which approximated the median household income in the 2001 Census, which was $41,652.
Type of PHO

Respondents were asked whether they would be willing to supply the name and street of the medical practice or doctor that they usually attend. Of these all but 60 did supply details. These were then used by Ministry staff to identify whether the practice was part of an Access or Interim PHO. There were 225 identified as Access, 177 as Interim and 426 as Mixed. Unfortunately the remaining 129 were left grouped, so it was not possible to differentiate those who were not part of PHOs and those where there was insufficient detail to ascertain the correct status. Of the 426 Mixed, 205 (48%) were predominantly Access and 221 (52%) were predominantly Interim. Based on weighted data, 31% of those classified as Mixed PHOs were predominantly Access and 69% Interim.

The table below shows the weighted data for types of PHO by different groups of interest. It can be seen that high proportions of Maori and Pacific respondents were in Access PHOs and most of the rest were in Mixed PHOs.

<table>
<thead>
<tr>
<th>TYPE OF PHO</th>
<th>Total sample</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>11</td>
<td>29</td>
<td>15</td>
<td>9</td>
<td>34</td>
<td>35</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Interim</td>
<td>28</td>
<td>32</td>
<td>29</td>
<td>11</td>
<td>2</td>
<td>2</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>Mixed</td>
<td>40</td>
<td>36</td>
<td>41</td>
<td>40</td>
<td>47</td>
<td>39</td>
<td>40</td>
<td>39</td>
</tr>
<tr>
<td>None/unclassified</td>
<td>22</td>
<td>20</td>
<td>19</td>
<td>15</td>
<td>16</td>
<td>22</td>
<td>20</td>
<td>21</td>
</tr>
</tbody>
</table>

* Significantly higher  ◆ Significantly lower
COMPARISON WITH OTHER SURVEYS

Provisional data is available from the 2002/03 New Zealand Health Survey that allows comparison by whether people have used a GP in the previous twelve months, by the sub-groups listed below. However, it should be noted that was a random sample of adults aged 15 and over, while the current survey was based on health decision makers in the household. However, it can be seen that there is quite a high level of consistency between the two surveys.

<table>
<thead>
<tr>
<th>VISITED GP LAST twelve MONTHS</th>
<th>Phoenix Survey (weighted data)</th>
<th>2002/03 NZ Health Survey**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sample</td>
<td>78</td>
<td>80</td>
</tr>
<tr>
<td>Male</td>
<td>71</td>
<td>75</td>
</tr>
<tr>
<td>Female</td>
<td>83</td>
<td>85</td>
</tr>
<tr>
<td>Maori Male</td>
<td>70</td>
<td>66</td>
</tr>
<tr>
<td>Maori Female</td>
<td>79</td>
<td>82</td>
</tr>
<tr>
<td>Pacific Male</td>
<td>69</td>
<td>74</td>
</tr>
<tr>
<td>Pacific Female</td>
<td>77</td>
<td>82</td>
</tr>
<tr>
<td>European/Other Male*</td>
<td>72</td>
<td>77</td>
</tr>
<tr>
<td>European/Other Female*</td>
<td>82</td>
<td>87</td>
</tr>
</tbody>
</table>

*  The NZ Health survey had Asian as a separate category but the sub-sample size was to small to allow this on the Phoenix Survey. Asian is not included on this table (it also excluded from 'Other')

** NB The NZ Health Survey data is provisional, until such time as it has been officially released.

INTERPRETATION OF THE FINDINGS

Although the response rate was relatively high, there is still a need to acknowledge that the accuracy of the data are limited by sampling and non-sampling errors. In particular it may be that those who did not respond or were not included in the sampling frame were different from those who did respond.

This was a telephone survey and although New Zealand has high levels of phone ownership (96% at 2001 Census), the levels are lower for Maori (88%) and Pacific Peoples (87%). Telecom have also recently informed Phoenix Research that 18% of possible residential households choose not to list in the White Pages. It should also be noted that listed mobile phones were not included in the sampling frame used in this survey.
REPORTING
Percentage and mean differences for the survey data are only reported if they are statistically significant at the 95% level\(^5\). The significance tests for percentages compare the proportion in the group with those not in the group, but with the same qualifying criteria. If, for example, analyses based on those who are aware of PHOs report Maori as being more likely to give a particular answer, this means the proportion of Maori aware of PHOs who gave this answer is significantly different from non-Maori who are aware of PHOs. Data based on large samples can be significant even though it appears to be very similar to the Total Sample figures, because it can still differ significantly from the small number who are not in the group. The significance tests are based on the weighted data presented in the tables and the unweighted bases. This allows the analyses to benefit from the large numbers of Maori and Pacific Peoples sampled, even though they are weighted down in the Total Sample data.
A glossary of terms is included as Appendix C.

\(^5\) The significance testing does not take into account any design effects.
4. Understanding Of Primary Health Care And Awareness Of PHOs

4.1 Awareness of Primary Health Organisations (PHOs)

Initially, one in every two respondents (50%) claimed they were aware of Primary Health Organisations (PHOs); however, after being read an explanation of PHOs the awareness level dropped to 44%, as 6% said they were mistaken in saying they had heard of PHOs.

This is a very similar figure to the 43% who declared they had heard of PHOs in a brief UMR Research Ltd telephone survey for the Ministry of Health in November 2003. (The survey interviewed 750 respondents over the age of 18.)

The table below shows the responses of some groups of interest. Low income are those with household incomes below $40,000. All the others are included in the Medium to High Income group. Other ethnic groups is all those who are neither Maori nor Pacific Peoples. People with Children are those with any children aged 0 to 15 years. For the purposes of this study, Older people are those aged 65 years and over.

Where a group is significantly higher this is denoted by a blue square and where it is significantly lower it is denoted by a red diamond. The numbers immediately under the column headings denote the bases. The figures as reported are based on the weighted base (W), but the unweighted base (UW) is also reported, to represent the actual number in the survey.6

The commentary following the table reports on the significant differences for both these groups and other demographics.

<table>
<thead>
<tr>
<th>HEARD OF PHOs</th>
<th>Total sample</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (1018)</td>
<td>UW (365)</td>
<td>UW (427)</td>
<td>UW (513)</td>
<td>UW (109)</td>
<td>UW (298)</td>
</tr>
<tr>
<td>Yes</td>
<td>44</td>
<td>43</td>
<td>46</td>
<td>46</td>
<td>41</td>
<td>49</td>
</tr>
<tr>
<td>No</td>
<td>48</td>
<td>46</td>
<td>45</td>
<td>50</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Mistakenly said aware of PHOs</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6 The unweighted base for Maori and Pacific is a lot larger than the weighted base, due to the oversampling of these two groups.
Those significantly more likely (than the general population) to be aware of Primary Health Organisations were:

- Low income households from Other ethnic groups (56%)
- Aged 45-54 years (55%)

Although Other ethnic groups is also shown on the table as being significantly higher, this group often has significant results even though their level varies little from the average. This is because they are such a large group. Their findings will only be commented on in the text if they are notably different from average.

Those significantly more likely to be unaware of Primary Health Organisations were:

- Aged 16-24 years (75%)
- Maori (64%), particularly low income Maori (67%)
- Pacific Peoples (79%), particularly those on low incomes (87%)
- Community Services Card holders (54%)

It should be noted that awareness of PHOs did not vary significantly between those who last visited their GP within the previous three months (45% awareness of PHOs) and those who had not (44%). There were also no significant differences by type of PHO; 40% among those in Access, 49% among those in Interim and 45% among Mixed (both Access and Interim practices within the one PHO). There was also no difference between the North Island (43%) and South Island respondents (46%), despite there being almost no PHOs operating in the South Island at the time of the survey.
4.2 Understanding of Primary Health Organisations (PHOs)

It should be noted that this and several of the other sections are based on the 44% who were aware of PHOs. Among those respondents the main understanding of PHOs related to: “combination/group of different practices” (17% of the 44% aware of PHOs), “an organisation of health care providers” (13%), “first port of call when ill/see GP first” (9%). Cheaper fees were mentioned by 8%. Only 5% mentioned anything about signing up with one doctor. A third (34%) reported not having any understanding of PHOs.

<table>
<thead>
<tr>
<th>WHAT UNDERSTAND A PHO TO BE</th>
<th>Sample AWARE of PHOs</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination/group of different practices</td>
<td>17%</td>
<td>15%</td>
<td>18%</td>
<td>4%</td>
<td>6%</td>
<td>13%</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>An organisation of health care providers</td>
<td>13%</td>
<td>12%</td>
<td>18%</td>
<td>13%</td>
<td>19%</td>
<td>14%</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>First port of call when ill/see GP first</td>
<td>9%</td>
<td>4%</td>
<td>12%</td>
<td>4%</td>
<td>5%</td>
<td>9%</td>
<td>3%</td>
<td>9%</td>
</tr>
<tr>
<td>Cheaper</td>
<td>8%</td>
<td>9%</td>
<td>5%</td>
<td>18%</td>
<td>22%</td>
<td>6%</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>Sign up with one doctor</td>
<td>5%</td>
<td>7%</td>
<td>3%</td>
<td>2%</td>
<td>9%</td>
<td>4%</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>34%</td>
<td>35%</td>
<td>31%</td>
<td>29%</td>
<td>35%</td>
<td>35%</td>
<td>35%</td>
<td>34%</td>
</tr>
</tbody>
</table>

■ Significantly higher  ◆ Significantly lower

Those significantly more likely (than the average respondent aware of PHOs) to mention combination/group of different practices were:

- Living in main urban areas (20%)

Those significantly more likely to understand a PHO to be an organisation of health care providers were:

- Medium-high income households (18%)
- People with children aged 5-15 years only living in household (21%)

Those more likely to mention cheaper were:

- Pacific Peoples (23%)
- Maori (18%), particularly those on low incomes (20%) and those with children (22%)
- Community Services Card holders (17%)
- Those in Access PHOs (15%)

Those more likely to mention signing up with one doctor were:

- Those in Access PHOs (11%)
- Older people with low incomes (11%)
• Those who had visited a GP in the last 3 months (7%)

Consistent with the lack of PHOs in the South Island, respondents from there who said they were aware of PHOs were more likely to report that they don’t know what a PHO is (46%).

It should be noted that for all the data that were based on the 44% of respondents who were aware of PHOs, there were too few respondents to compare low income people in Access PHOs with low income who were not in Access PHOs. Likewise, for examining Maori and Pacific in Access PHOs compared with those not in Access PHOs.
4.3 Practitioner Member of Primary Health Organisation

Around a third of the respondents (32%) who were aware of PHOs stated that their usual GP/family doctor does belong to a Primary Health Organisation, and a further 20% said they think their GP/family doctor is a member. Fewer than a fifth of respondents either said their GP/family doctor was not a member of a PHO (9%), or they did not think they belonged to a PHO (8%). The remaining 31% were unsure as to their doctor’s PHO status.

As a proportion of the total sample, these results equate to slightly less than a quarter (22%) who know or think that their usual GP/family doctor does belong to a PHO.

<table>
<thead>
<tr>
<th>USUAL GP/FAMILY DOCTOR BELONGS TO A PHO</th>
<th>Sample Aware of PHOs</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, do belong</td>
<td>32</td>
<td>38</td>
<td>31</td>
<td>52</td>
<td>51</td>
<td>30</td>
<td>35</td>
<td>34</td>
</tr>
<tr>
<td>Think belong</td>
<td>20</td>
<td>22</td>
<td>20</td>
<td>16</td>
<td>14</td>
<td>21</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>Think don't belong</td>
<td>8</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>No, don't belong</td>
<td>9</td>
<td>13</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>10</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Unsure/don't know</td>
<td>31</td>
<td>25</td>
<td>32</td>
<td>24</td>
<td>27</td>
<td>33</td>
<td>30</td>
<td>35</td>
</tr>
</tbody>
</table>

*Significantly higher  *Significantly lower

Those more likely to believe their usual GP/family doctor does belong to a PHO were:
- Those in Access PHOs (58% of those who are aware of PHOs)
- Maori (52%)
- Pacific Peoples (51%)
- High User Health Card holders (63%)
- Those who had been to a GP in the last 3 months (41% compared with 21% for those who had not)

Those more likely to think their usual GP/family doctor does belong to a PHO were:
- Those in Interim PHOs (29%)
- People with children aged 5-15 years only living in household (32%)
- Those living in rural areas (35%)
- Those who had last been to a GP more than a year ago (29%)

Those more likely to state they think their usual GP/family doctor does not belong to a PHO were:
- Respondents in the South Island (13%)
- Those with no children aged 0-15 years living in household (11%)
Those more likely to say they don’t know if their usual GP/family doctor belongs to a PHO were:

- Those who had not been to a GP in the last 3 months (40%), particularly those who had last been 3 to 6 months before (45%)
- Living in main urban areas (35%)

No particular demographic group was identified as being more likely to say their doctor does not belong to a PHO.
Despite most South Islanders not having access to PHOs, there were 24% of all South Island respondents who knew or thought their doctor belonged to a PHO which was a similar level to those in the North Island (22%).
4.4 **Perceived Advantages of Membership With PHO**

Almost two thirds (63%) of those aware of PHOs (i.e. out of the 44% aware) mentioned at least one advantage for patients whose GP/family doctor belongs to a Primary Health Organisation.

The main advantages perceived by respondents were “cheaper healthcare” (19%), “provide wider range of health services” (16%), “collective knowledge/support colleagues” (14%), and “better access to a doctor” (11%). These are discussed in more detail under the later sections on access to primary health care and other topics.

Those more likely (than the average respondent aware of PHOs) to mention at least one advantage were:

- Those in Interim PHOs (77%)
- Medium-high income households (70%)
- High User Health Card holders (79%)

Those more likely to be unaware of any advantages were:

- People with children aged both under 5 years and 5 to 15 years living in household (52%)

South Island respondents did not show any less awareness of advantages (60%).

<table>
<thead>
<tr>
<th>AWARE OF ADVANTAGES/ DISADVANTAGES OF PRACTICE BELONGING TO PHO</th>
<th>Sample Aware of PHOs</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (358) W (446) %</td>
<td>UW (126) W</td>
<td>(149) %</td>
<td>UW (168) W</td>
<td>(222) %</td>
<td>UW (55) W</td>
<td>(9) %</td>
<td>UW (154) W</td>
</tr>
<tr>
<td>Aware of advantages</td>
<td>63</td>
<td>59</td>
<td>70</td>
<td>71</td>
<td>61</td>
<td>63</td>
<td>66</td>
<td>60</td>
</tr>
<tr>
<td>Aware of disadvantages</td>
<td>29</td>
<td>28</td>
<td>30</td>
<td>29</td>
<td>39</td>
<td>28</td>
<td>33</td>
<td>26</td>
</tr>
</tbody>
</table>

▲ Significantly higher  ● Significantly lower
4.5 **Perceived Disadvantages of Membership with PHO**

The majority of respondents aware of PHOs were unable to specify any disadvantages for patients whose GP/family doctor belongs to a PHO (70%). The key disadvantages mentioned were: “not see own doctor/ lose relationship” (9%), and “doctor less available” (7%). These are discussed in more detail in the access section later.

Those more likely to mention at least one disadvantage were:

- High User Health Card holders (48%)

There were no outstanding characteristics of those more likely to mention no disadvantages.
4.6 Changes to Services GP Provides or Way They Provide Them in Last Twelve Months

One in every five people who took part in the survey (20%) stated they had noticed a change in the service provided by their GP over the past twelve months, or the way in which that service was provided. When those who had not visited a GP in the last twelve months are excluded, the figure rises to 22%.

<table>
<thead>
<tr>
<th>CHANGES TO SERVICES GP PROVIDES</th>
<th>Total sample</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>UW (1018)</td>
<td>UW (365)</td>
<td>UW (427)</td>
<td>UW (513)</td>
<td>UW (308)</td>
<td>UW (298)</td>
<td>UW (477)</td>
<td>UW (406)</td>
<td>UW (151)</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>20</td>
<td>17</td>
<td>23</td>
<td>21</td>
<td>17</td>
<td>19</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>No</td>
<td>69</td>
<td>74</td>
<td>64</td>
<td>71</td>
<td>74</td>
<td>69</td>
<td>68</td>
<td>76</td>
</tr>
<tr>
<td>Don’t know</td>
<td>12</td>
<td>10</td>
<td>13</td>
<td>8</td>
<td>9</td>
<td>13</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

[Significantly higher] [Significantly lower]

Those significantly more likely to have noticed a change in the service provided by their GP / family doctor over the past twelve months were:

- Those who had visited within the last 3 months (25%)
- Medium-high income households (23%)
- People with children aged 0-15 years living in household (24%)
- High User Health Card holders (40%)
- Those aware of PHOs (22%)
- Females (25%)
- Aged 35-44 years (27%)

However, people on low incomes, Maori and Pacific respondents were more likely to have not noticed a change in the last 12 months. There were no differences by type of PHO. Details on the types of changes are included in the later section on access.
5. **Support for Components of Primary Health Care Strategy**

5.1 **Greater Focus on Well Health**

**Mentions of Well Health Focus**
A greater focus on well health was mentioned by two percent of people when asked what changes they would like to see in the way family health care services are delivered.

Two percent of those who were aware of PHOs mentioned the prevention of illness before it happens as an advantage of PHOs. It was not mentioned as a disadvantage of PHOs. Only one person mentioned the wellness focus when recalling communications messages and two percent mentioned receiving more education material when visiting their GP.

**Support for Concept**
Nearly all people surveyed (89%) showed at least some support (66% strongly support, 19% support, 5% support a little) for their family doctor's practice providing services that focus on keeping people well. A small percent of respondents were opposed to these types of services being offered (3%), and a similar number did not respond because they felt this already happened in their practice (3%).

Those more likely to strongly support their family doctor's practice providing services that focus on keeping people well were:

- Those in Access PHOs (76%), particularly those on low incomes (88%)
- Maori (75%), particularly those on low incomes with children (88%)
- People with children aged both under 5 years and 5 to 15 years living in household (76%)
- Living in rural areas (78%)
- Aged 35-44 years (73%)

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7 Respondents were told: The changes involving PHOs are supposed to lead to a number of changes in the way general practices operate. One of the aims is to have more focus on keeping people well, not just dealing with people when they are sick. This might mean that your family doctor's practice would offer things like regular check-ups, classes for people with diabetes, and help with weight reduction. How much do you support or oppose your family doctor's practice providing these sorts of services to keep people well?
Those more likely to oppose this focus were:

- Aged 16-24 years (10%)
- People with children aged 5-15 years only living in household (7%)

Those more likely to state that their family doctor/ GP already provides services that focus on keeping people well were:

- High User Health Card holders (15%)
- Community Services Card holders (5%)
- Aged 65 years and over (8%)
5.2 Use of Greater Range of Health Professionals

As A Change Sought
In terms of changes to family health care delivery, just one percent mentioned wanting to see health professionals working together under one banner or as a one stop shop.

Awareness As Advantage Of PHOs
Responses relating to the concept of a greater range of health professionals dominated the reported advantages of PHOs, the relevant ones being:

- Provide wider range of health services (16% of the 44% who were aware of PHOs)
- Collective knowledge of health professionals/ professional support from colleagues/ better health care because they work as a team (14%)
- Better access to a doctor/ can see another doctor if usual one not available (11%)
- Can access other health professionals more easily/ referrals become easier (6%)
- One stop shop: tests, pharmacy etc (4%)
- Access to practice nurse/ alternative to doctor (3%)

There were 44% of those who were aware of PHOs who gave at least one of these responses or some other minor mentions that also related to the use of a greater range of health professionals.

Those more likely to mention provide wider range of health services as an advantage for patients whose GP/ family doctor belongs to a PHO were:

- Medium-high income households (21% of those in this group who were aware of PHOs)
- People with children aged 5 to 15 years only living in household (24%)
- Aged 45-54 years (25%)

Mention of collective knowledge/ support colleagues was lower among those who were aware of PHOs and had visited a GP in the last 3 months (10%) and increased progressively to 25% for those who had not visited in the last twelve months.

Those more likely to mention better access to a doctor were:

- Living in rural areas (22% of those in this group who were aware of PHOs)
- High User Health Card holders (26%)
- Medium-high income households (14%)
- Aged 55-64 years (20%)
- Those in Mixed PHOs (15%)

There was no mention of the availability of a greater range of health professionals in the recall of the PHO communications.
**Concern With This Resulting From PHOs**

As noted in the continuity of care section, nine percent were concerned that they would not get to see their own doctor.

Two percent were concerned that there would be restrictions on who they could be referred to; that they would be expected to use the PHOs specialists. Less than one percent reported a concern about seeing a nurse rather than a doctor.

**Support For Concept**

A high proportion of respondents (87%) stated they support the greater use of a range of health professionals to provide services where they have the skills to do so\(^8\) (54% strongly support, 28% support, 6% support a little). A small number were opposed to this strategy (7%), and for a few respondents this was already happening in their practice (2%).

Those more likely to strongly support the greater use of a range of health professionals to provide services were:

- Those in Access PHOs on low incomes (70%)
- Maori (65%), particularly those on low incomes (75%) and those in Access PHOs (75%)
- Other ethnic groups on low incomes with children (75%)
- People with children aged 0 to 15 years living in household (59%)

Those more likely to oppose the concept were:

- People with children aged under 5 years only living in household (15%)
- Living in main urban areas (8%)

**Changes Aware Of Being Implemented At General Practice**

Twelve percent of the 20% who were aware of changes in their general practice mentioned that they now see a nurse more often. This level did not vary by the time since their last visit to the GP. There were indications of a higher level for older people, but because of the small numbers answering, it was difficult to obtain significant differences.

**Contact With Other Staff In General Practice**

Almost three in every ten (28%) of the 78% who had consulted with a doctor in the past year also talked with a practice nurse during their last visit. Additionally, a small number of people (3%) said they talked with someone else in the practice (other than a doctor, nurse or receptionist).

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\(^8\) Respondents were told: Another aim is to encourage greater use of a range of health professionals, not just your doctor, to provide services for you, where they have the skills to do so. For example, a nurse might see you for a regular health check or help with weight reduction. How much do you support or oppose the greater use of a range of health professionals?
Those more likely to have also seen a practice nurse during their last visit were:

- Maori in Access PHOs (53% of those in this group who had consulted a doctor in the last 12 months)
- Those in an Interim PHO (36%)
- Those who visited the GP within the last 3 months (31%)
- Aged 65 years and over (37%)
- Low income households (34%)
- Living in secondary minor urban areas (38%)
- High User Health Card holders (46%)
- Community Services Card holders (37%)

**Charges Associated With Use Of Other Staff**

Amongst those 23% of respondents who consulted with a practice nurse, or some other person in the practice (other than a doctor or receptionist), only a small proportion (13%) were charged for this consultation. Those significantly more likely to have been charged for this consultation with the practice nurse/other person were:

- Males (19% of this group who consulted with someone other than the doctor or receptionist)
- Aged 45-54 years (24%)
- Low income households (18%)
- People with no children aged 0-15 years living in household (17%)
- High User Health Card holders (25%)

People in Access PHOs were unlikely to be charged (2%), while in Interim PHOs the level was 14%.
5.3 Community Involvement

Comments Relating To Community Involvement
Almost no one (less than 1%) mentioned listening more to public needs or involving the community more as a change they would like to see in the way family health care services are delivered. Greater community involvement was mentioned by 4% as an advantage or PHOs and was not mentioned as a disadvantage. No one mentioned greater community involvement when describing their understanding of a PHO, or changes in their general practice. Just one person mentioned this issue when recalling communications messages.

Support For Concept Of Community Involvement
When asked directly about this issue, the majority (70%) of the 44% who aware of PHOs would like them to involve the community more in the decisions regarding which services should be provided. A small proportion (15%) stated they did not want more community involvement in PHO services decision-making, and a further 15% were unsure. Those more likely to want PHOs to involve the community more were:

- Those is Access PHOs (83% of this group who were aware of PHOs)
- Pacific Peoples (91%)
- Maori (85%)
- Low income households (82%)
- Community Services Card holders (79%)

The rates for the other groups were 65% for medium to high income households, 69% for Other ethnic groups, 72% for people with children and 62% for older people.

Preferred Forms Of Input Into PHOs
Amongst those people who would like to see PHOs involving the community more in decisions regarding the services provided (30% of the Total Sample), there was a wide range of communication methods specified. The most preferable means was through surveys (29% of those who would like to see more community involvement), however it must be remembered that they were taking part in a survey so this may have influenced their responses. Other options mentioned were: “family doctor” (26%), “board meeting with community groups” (10%), “write to PHO” (9%), “through community groups” (8%), or “telephone/ call centre/ hotline/ 0800” (7%).

<table>
<thead>
<tr>
<th>WAYS ABLE TO TELL PHOS ABOUT SERVICES WANTED</th>
<th>Sample wanting more community involvement</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Medium to High income</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (272)</td>
<td>UW (106)</td>
<td>UW (123)</td>
<td>UW (88)</td>
<td>UW (157)</td>
<td>UW (122)</td>
<td>UW (38)</td>
</tr>
</tbody>
</table>
There were no demographic differences in mentions of family doctors, but those more likely to prefer surveys were:

- Females (36% of females who would like to see more community involvement)
- Medium-high income households (38%)
- People with children aged 0-15 years living in household (41%)

Those more likely to prefer the board meeting with community groups were:

- Males (17%)
- Maori (20%)
- Community Services Card holders (15%)

Pacific Peoples were more likely to prefer use community groups (20%) and telephone/call centre/hotline/0800 number (24%).
5.4 Continuity of Care

Continuity of care as a change sought
Continuity of care received almost no mention as a change sought in the way family health care services are delivered. There were just one percent who mentioned wanting more stability of GPs in the practices and this was linked to providing incentives to retain rural GPs. These findings might be indicative of general satisfaction with what is currently provided.

Awareness of need to enrol with one PHO
When the 44% who were aware of PHOs were asked what they understood them to be, only five percent mentioned about signing up with one doctor. This level rose to 11% among those in Access PHOs and it was at a similar level for older people on low incomes. It was seven percent among those who had visited a GP in the previous 3 months.

Awareness of continuity of care as advantage of PHOs
There was very little mention of continuity of care as an advantage of PHOs. Two percent (of those aware of PHOs) mentioned continuity of care and two percent also mentioned that under PHOs their GP will get to know you better. This figure rose to six percent among those aged 65 years and over who had heard of PHOs. The other related comment was one percent who mentioned closer monitoring; having more people looking after you. In total there were four percent who made at least one of these comments relating to continuity of care.

Concern with loss of continuity of care resulting from PHOs
In contrast, continuity of care was the most mentioned concern regarding PHOs. Nine percent (of the 44% aware of PHOs) had concerns that they would not be able to see their own doctor and would lose that relationship. This level rose to 18% among those living in secondary minor urban areas. It did not differ significantly by type of PHO. There were only one percent who mentioned being concerned about having to stay with one GP.

Changes relating to continuity of care being implemented at general practice
No one specifically mentioned improvements in continuity of service as a change they had noted at their general practice. However comments relating to GPs extending their range of services could be seen as related to continuity of service. Three percent of the 20% who were aware of changes mentioned GPs now dealing with some medical complaints such as diabetes, rather than sending them to a specialist. There were also three percent who mentioned their GPs now doing minor surgery, which rose to 9% among those on low incomes.
A reduction in continuity of service was mentioned by one percent, who reported being allocated a doctor and not getting to see the same doctor. This figure did rise to 9% among Maori.

**Awareness of Continuity of Care from Communications**

Of those who recalled PHO advertising, the most mentioned specific comment (10%) was that you should select one GP and stay with them. This category included mentions of getting better service if you stay with one GP, but it was a much wider category than just that. There were also 4% who mentioned that you would continue to get the same level of care as previously.

**Use of More than One General Practice**

Of those 22% of respondents who believed or thought their usual GP/family doctor belonged to a PHO, 10% had visited a doctor who was not part of their usual practice in the past twelve months (excluding doctors in after-hours clinics and hospitals). Within this group of people who believed or thought their GP/family doctor belonged to a PHO, those significantly more likely to have visited a doctor who was not part of their usual practice over the past twelve months were:

- In Access PHOs (22%)
- Maori (22%)
- People with children aged 0-15 years living in household (15%)
- Aged 35-44 years (27%)

The levels for the other groups were 12% for low income, 10% for medium to high income, 7% for Pacific Peoples, 10% for Other ethnic groups and 9% for older people.

**Encouraged to Join Other Practice or PHO**

Only a small proportion of those visiting another doctor (7%) believed that the doctor tried to persuade them to switch to his/her practice/PHO.
6. COMMUNICATIONS

6.1 Best Ways to Communicate Information

More than half of all people interviewed (56%) felt their doctor or their practice was the best way for information about PHOs or changes to the delivery of family healthcare services to be communicated to them. The three main vehicles for this were: information being sent in the mail from the practice (30%), directly from the GP/doctor (21%) and brochures/information displayed in doctors rooms (13%). Other mentions grouped into the 56% were: receptionists (3%), nurses (2%), other staff (1%).

The media was also considered a good means of communicating, with four in every ten people (40%) specifying they would like to be informed through media items (other than advertising), while just under a quarter (23%) said advertising was one of the best methods. It should be noted that people are usually reluctant to acknowledge they are influenced by advertising, so the level of mentions does not necessarily reflect its effectiveness.

Mail-outs/ brochures/ fridge magnets (15%) would also be an effective way of relaying information about PHOs to some people.

<table>
<thead>
<tr>
<th>Best Ways to be Told about PHOs or Other Changes in Family Healthcare</th>
<th>Total Sample</th>
<th>Low Income</th>
<th>Medium to High Income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other Ethnic Groups</th>
<th>People with Children</th>
<th>Older People</th>
</tr>
</thead>
<tbody>
<tr>
<td>From advertising</td>
<td>23</td>
<td>25</td>
<td>24</td>
<td>17</td>
<td>8</td>
<td>25</td>
<td>26</td>
<td>15</td>
</tr>
<tr>
<td>GP/doctor in person</td>
<td>56</td>
<td>54</td>
<td>56</td>
<td>58</td>
<td>50</td>
<td>55</td>
<td>57</td>
<td>53</td>
</tr>
<tr>
<td>Directly from GP</td>
<td>21</td>
<td>21</td>
<td>20</td>
<td>24</td>
<td>22</td>
<td>21</td>
<td>19</td>
<td>30</td>
</tr>
<tr>
<td>Brochures etc in doctors' rooms</td>
<td>13</td>
<td>15</td>
<td>12</td>
<td>17</td>
<td>14</td>
<td>12</td>
<td>13</td>
<td>11</td>
</tr>
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<td>Mail-outs from doctors</td>
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<td>19</td>
</tr>
<tr>
<td>Other newspaper items</td>
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<td>20</td>
<td>13</td>
<td>6</td>
<td>21</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>TV items (not ads)</td>
<td>23</td>
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<td>26</td>
<td>20</td>
<td>11</td>
<td>24</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>Radio items (not ads)</td>
<td>9</td>
<td>12</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Mail outs- brochures/fridge magnets</td>
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<td>18</td>
<td>22</td>
<td>11</td>
<td>15</td>
<td>20</td>
<td>10</td>
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<tr>
<td>From MOH</td>
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<td>3</td>
<td>10</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Don't know</td>
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<td>5</td>
<td>6</td>
<td>9</td>
<td>24</td>
<td>5</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

*Significantly higher*  *Significantly lower*
Those more likely to specify their GP/their practice as the best way of communicating changes regarding the delivery of family healthcare services/ PHOs were:

- Other ethnic groups in Access PHOs (73%)
- Those not aware of PHOs (60%)
- Aged 25-34 years (62%)

Within this grouping of information from GPs/their practice, the key group who were not aware of PHOs were above average in preferring information to be mailed from the doctors (35%). Others who were more likely to mention mail outs were those on medium to high incomes (33%), and those from Other ethnic groups with children (37%). Older people were less keen on the mailed out information (10%) and would rather talk to the GP directly (30%). Other groups who were less keen on mail outs were those on low incomes (25%) and Pacific Peoples (21%). Maori were more likely to mention brochures and material displayed in the doctor's rooms (17%) and talking with the nurse (6%) or receptionist (5%).

Those more likely to specify media items (other than advertising) were:

- Low income people aged 65 years and over (50%)
- Those aware of PHOs (48%)
- Aged 45-54 years (49%)
- South Island respondents (47%)

Those more likely to specify advertising were:

- Other ethnic groups with children (30%), especially those with low incomes (41%)
- Those aware of PHOs (28%)
- Aged 45-54 years (28%)

Those less likely to mention advertising were:

- Low income Pacific Peoples (6%)
- Aged 55 years and over (15%)
- Those not aware of PHOs (19%)

Those more likely to specify mail-outs/ brochures/ fridge magnets were:

- Maori (22%)
- Medium-high income households (18%)
- People with children (20%), particularly those from Other ethnic groups on low incomes (20%)
- Those aware of PHOs (18%)
These results above show a link between accessing information via the media (paid and unpaid) and greater awareness of PHOs. It also indicates that those who have no awareness of PHOs would be most receptive to being reached via mailed material from GPs.

There were also seven percent who were not sure of the best way for them to be communicated with, this level being much higher among Pacific respondents (23%), particularly those on low incomes (28%). It was also higher for Maori on low incomes (14%).

**Communicating With Those Not Aware of PHOs**

Obviously those who are not currently aware of PHOs are an important group to try and communicate with. As reported above, they are above average in specifying information sent in the mail from their GP/practice as a preferred means of communication.

As noted previously, in terms of demographics, Maori and Pacific were strongly over-represented in this group, particularly Maori and Pacific on low incomes. Other groups more likely to be unaware of PHOs were those with Community Services Cards and those aged 16-24 years.

On most other questions that this group responded to in the survey they showed few distinguishing characteristics. They were a little above average in not wanting any changes in how their family health services are delivered or being unsure, perhaps reinforcing that they have a low interest in health matters. However, they were average for when they last visited a doctor, although they were a little above average for having put off a visit to the doctor in the previous 12 months (14% compared with 12% for the Total sample), including because of cost (7% versus 5%). They were less likely to use most alternatives to doctors, although they were not very much below average. They were average for using family and friends. This group who were unaware of PHOs were also average in their support for the changes such as a greater focus on wellness and involvement of a greater range of health professionals. They were also average in fees paid.

**Current Methods by Which Receive Communications**

The 44% of respondents who were aware of PHOs, had heard about them and other changes to the way family healthcare is delivered through a variety of communication methods. In particular, the main sources were other newspapers (i.e. not community newspapers) (30% of those aware of PHOs), GP/their practice (27%), TV items/news (19%), community newspapers (17%), TV ads (10%), and radio items/news (7%).

In total, 11% mentioned advertising, and 58% other media items/news (excluding advertising).

The first table below compares the ways in which people had heard about PHOs with the preferred methods of being communicated with. To enable direct comparison, the second and fourth columns of data present the shares of mentions\(^9\). It shows that GPs and their practices are a more preferred option than respondents felt were currently being utilised. The pattern was similar for advertising. The current

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\(^9\) All the mentions have been added and re-percentaged to total 100%. However, because of rounding the columns do not add to exactly 100%.
communications appear to have relied more on community and other newspapers than is consistent with participant preferences. The TV and radio items had similar levels for current and preferred.

<table>
<thead>
<tr>
<th>MEANS OF COMMUNICATION</th>
<th>Ways Heard About PHO Changes</th>
<th></th>
<th>Preferred Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Mentions</td>
<td>Share of Mentions</td>
<td>Total Mentions</td>
</tr>
<tr>
<td>GP/their practice</td>
<td>27</td>
<td>24</td>
<td>56</td>
</tr>
<tr>
<td>Advertising</td>
<td>11</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>Community newspapers</td>
<td>17</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Other newspapers</td>
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</tr>
<tr>
<td>TV items</td>
<td>19</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Radio items</td>
<td>7</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>
### WAYS HEARD ABOUT PHOs AND CHANGES IN FAMILY HEALTHCARE

<table>
<thead>
<tr>
<th>Ways Heard</th>
<th>Total Sample</th>
<th>Low Income</th>
<th>Medium to High Income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other Ethnic Groups</th>
<th>People with children</th>
<th>Older People</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP/their practice</td>
<td>27</td>
<td>29</td>
<td>30</td>
<td></td>
<td>28</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directly from GP</td>
<td>13</td>
<td>16</td>
<td>7</td>
<td>14</td>
<td>18</td>
<td>12</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Receptionist at doctors practice</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>8</td>
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<td></td>
</tr>
<tr>
<td>Brochures etc in doctors' rooms</td>
<td>10</td>
<td>13</td>
<td>11</td>
<td>14</td>
<td>15</td>
<td>10</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>TV ads</td>
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<td>9</td>
<td>3</td>
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<tr>
<td>Community newspapers</td>
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<td>22</td>
<td>16</td>
<td>6</td>
<td>18</td>
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<td>Other newspapers</td>
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<td>17</td>
<td>9</td>
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<td>29</td>
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<tr>
<td>TV items/news</td>
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<td>12</td>
<td>24</td>
<td>13</td>
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<td>19</td>
<td>20</td>
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<td>Radio items/news</td>
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<td>6</td>
<td>5</td>
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<td>7</td>
<td>8</td>
<td>14</td>
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<td>From friends/ acquaintances</td>
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<td>12</td>
<td>10</td>
<td>6</td>
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<tr>
<td>From working in the health sector</td>
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<td>8</td>
<td>9</td>
<td>1</td>
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<td>9</td>
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<tr>
<td>All mentions of advertising</td>
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<td>11</td>
<td>13</td>
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<tr>
<td>All mentions of other media</td>
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<td>34</td>
<td>21</td>
<td>61</td>
<td>56</td>
<td>66</td>
</tr>
</tbody>
</table>

*Significantly higher  ◆ Significantly lower*

Those more likely to have heard about PHOs and other changes to the way family healthcare is delivered through their GP/their practice were:

- Pacific Peoples (40% of Pacific Peoples aware of PHOs) and they were particularly high for getting information from the receptionist (14%)
- Females (32%)

There was no significant difference for mention of GP/their practice by type of PHO (Access 28%, Interim 20%).

Those more likely to have heard through TV items/news were:

- Medium-high income households (24%)
- Aged 45-54 years (31%)

Those more likely to have heard through radio items/news were:

- Aged 65 years and over (14%)
- People with children aged 5-15 years only living in household (12%)

Those more likely to have heard through community newspapers were:

- In Access PHOs (35%)
- Medium-high income households (22%)
• Living in rural areas (32%)
• High User Health Card holders (34%)

Those more likely to mention other newspapers (i.e. not community newspapers) were:
• In Interim PHOs (39%)

Those more likely to have heard through TV ads were:
• High User Health Card holders (21%)
• Aged 25-34 years (18%)
• Those in Mixed PHOs (14%) and not those in Interim PHOs (4%)

**Differences by Form of Communications Received**

Those who had received information from GPs or their practices were more likely to:
• Know they belong to a PHO (54% versus 32% for all those who were aware of PHOs)
• Mention signing up with one doctor when describing PHOs (16% vs 8%)
• List cheaper healthcare as an advantage of PHOs (29% vs 19%), despite being less aware of any advantages of belonging to a PHO (47% mentioning no advantages vs 37%)

These findings suggest that the information people have received from their GP or general practice has been primarily in relation to the cheaper fees and having them sign up to the PHO, but with low mentions of any other benefits.

Those who had received information from advertising were a small group (n=44 unweighted) and were more likely to:
• Be unsure whether their GP belonged to a PHO (52% vs 31%)
• Mention better access to a doctor/ can see another doctor if the usual one is not available (23% vs 10%)
• Mention cheaper for children as an advantage of PHOs (7% vs 2%)
• Want to find out more about PHOs (75% vs 55%), particularly a "lot more" (51% vs 32%)

This last finding is of interest, particularly because it is a marked difference and it points to advertising as an important vehicle to communicate more information. This is addressed in more detail in the final section of this chapter.

Those who reported receiving information from other media, such as items on TV and in the newspaper, were more likely to:
• Be aware of at least one advantage of PHOs (68% vs 63%)
• Mention as benefits of PHOs, a greater range of health professionals (48% vs 44%), and providing a wider range of health services (20% vs 16%)
• Mention the disadvantage of not seeing your own doctor (13% vs 9%) and generally be more aware of disadvantages (34% vs 29%)
### 6.2 Response to Current Communications

**Advertising Recall**

As noted above, there was 11% unprompted awareness of advertising for PHOs and other changes in the ways family health care is delivered\(^\text{10}\). After prompting, the advertising recall increased to 27%\(^\text{11}\). Translated to the Total Sample, the unprompted recall was 5% and the prompted recall 12%.

<table>
<thead>
<tr>
<th>RECALL ADVERTISING</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Aware of PHOs</td>
<td>UW (358) W (446)</td>
<td>UW (168) W (222)</td>
<td>UW (105) W (34)</td>
<td>UW (55) W (9)</td>
<td>UW (219) W (397)</td>
<td>UW (154) W (167)</td>
<td>UW (60) W (85)</td>
</tr>
<tr>
<td>Unprompted</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Prompted</td>
<td>27</td>
<td>30</td>
<td>29</td>
<td>42</td>
<td>38</td>
<td>27</td>
<td>30</td>
</tr>
</tbody>
</table>

Unprompted recall was higher among:
- High User Health Card holders (21% of those in this group who were aware of PHOs)
- Those aged 25-34 years (18%)
- Those in Mixed PHOs (17%) and not Interim (4%)

Prompted recall of advertising was higher among:
- Those in Access PHOs (41%)
- Maori (42%)
- High User Health Card holders (49%)
- Females (33%)

\(^{10}\) Based on the 44% who were aware of PHOs.

\(^{11}\) Prompted recall is the sum of those mentioning having seen or heard advertising when asked how they have heard about PHOs (unprompted recall) plus those who recall seeing or hearing advertising when asked directly whether they have seen or heard any.
IMPRESSIONS OF PHO ADVERTISING

Among the 12% of respondents who recalled seeing or hearing advertising about PHOs or other changes to the delivery of family healthcare services, the reactions to the advertising were somewhat mixed. Twenty percent of the impressions could possibly be classified as positive, although there is some question as to whether one of the main categories is in fact addressing the advertising or rather the nature of the changes. There were 10% who mentioned this category of “good/positive move/logical/helpful” and if they are excluded from the grouping of positive comments about the advertising itself, the level of positive comments decreases from 20% to 12%\(^\text{12}\). These two levels of positive ratings are shown as types I and II in the table below.

In contrast, 38% have been classified as negative. The most commonly expressed negative comment was “didn’t understand it/too brief/want to know what it means in real terms” (19%).

<table>
<thead>
<tr>
<th>FEELINGS/IMPRESSIONS ABOUT ADS FOR PHOS</th>
<th>Sample who recalled ads</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (111)</td>
<td>UW (39)</td>
<td>UW (53)</td>
<td>UW (40)</td>
<td>UW (23)</td>
</tr>
<tr>
<td></td>
<td>W (122)</td>
<td>W (45)</td>
<td>W (64)</td>
<td>W (14)</td>
<td>W (3)</td>
</tr>
<tr>
<td>Didn’t understand/too brief</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Didn’t take much notice</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Good/positive/logical</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Positive impressions (I)</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Positive impressions (II)</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Negative impressions</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

NB: The Pacific Peoples and Older People bases are very small so these data should be interpreted with caution.

\[\text{\# Significantly higher} \quad \text{\# Significantly lower}\]

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn’t understand/too brief</td>
<td>19</td>
<td>11</td>
<td>30</td>
<td>9</td>
</tr>
<tr>
<td>Didn’t take much notice</td>
<td>11</td>
<td>12</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Good/positive/logical</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Positive impressions (I)</td>
<td>20</td>
<td>25</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Positive impressions (II)</td>
<td>12</td>
<td>13</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>Negative impressions</td>
<td>38</td>
<td>41</td>
<td>44</td>
<td>19</td>
</tr>
</tbody>
</table>

Those above average for positive responses were:

- Maori (50% and 29% for the two levels of positive classification, based on those Maori who recalled advertising)
- Those in Access PHOs (58% and 26%)\(^\text{13}\)

People with no children aged 0 to 15 years living in household were the only group to be over-represented in the negative responses (46%).

\[\text{\# Significantly higher} \quad \text{\# Significantly lower}\]

\(^\text{12}\) Some people could have been in both the category removed and those remaining, which is why the removal of the category with 10% mentions only reduces the proportion with positive mentions by 8%.

\(^\text{13}\) The unweighted base is only 33 people, so the findings should be interpreted with some caution.
MESSAGE TAKE-OUT FROM ADVERTISING
When asked what they felt the advertising was trying to tell people, the dominant response was that it was an “awareness campaign about changes” (37% of the 12% who were aware of the advertising). The most mentioned specific messages recalled were “select one GP and stay” (10%), and “lower cost of seeing a doctor” (9%), but these were at quite low levels.

The lack of strong message recall was reflected in 15% stating they were unsure what it was trying to tell people, or that it was “not very clear/bewildering” (5%).

<table>
<thead>
<tr>
<th>MESSAGE TAKE OUT</th>
<th>Sample who recalled ads</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (111)</td>
<td>UW (39)</td>
<td>UW (53)</td>
<td>UW (40)</td>
<td>UW (22)</td>
<td>UW (55)</td>
<td>UW (50)</td>
<td>UW (12)</td>
</tr>
<tr>
<td>Awareness campaign about changes</td>
<td>W (122)  %</td>
<td>W (45) %</td>
<td>W (64) %</td>
<td>W (14) %</td>
<td>W (3) %</td>
<td>W (106) %</td>
<td>W (51) %</td>
<td>W (14) %</td>
</tr>
<tr>
<td>Select one GP and stay</td>
<td>37 32 44 33 47 37 28 19</td>
<td>10 4 11 11 5 10 16 -</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower cost of seeing doctor</td>
<td>9 8 10 14 2 8 16 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Go to doctor/don't put it off</td>
<td>7 10 7 3 - 8 - 29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change for the better</td>
<td>7 13 3 16 2 5 6 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

↑ Significantly higher  ↓ Significantly lower
6.3 **Interest In Knowing More**

Over half (55%) of those aware of PHOs would like more information about them and the changes to the way family healthcare is delivered\(^{14}\).

<table>
<thead>
<tr>
<th>INTEREST IN KNOWING MORE</th>
<th>Sample aware of PHOs</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lot more</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>37</td>
<td>30</td>
<td>45</td>
<td>57</td>
<td>31</td>
<td>44</td>
<td>25</td>
</tr>
<tr>
<td>Little more</td>
<td>22</td>
<td>30</td>
<td>18</td>
<td>21</td>
<td>27</td>
<td>23</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Don't want to find out</td>
<td>45</td>
<td>31</td>
<td>51</td>
<td>33</td>
<td>16</td>
<td>45</td>
<td>39</td>
<td>50</td>
</tr>
</tbody>
</table>

\(\blacksquare\) Significantly higher  \(\blacktriangleleft\) Significantly lower

There were 32% wanting to know a lot more, this level being higher for:

- Maori (45% of Maori who were aware of PHOs), especially those with children (51%)
- Pacific Peoples (57%)\(^{15}\)
- People with children aged 0-15 years living in household (44%)

The level of 22% wanting to know a little more were more over-represented among:

- Low income households (30%)
- People with no children aged 0-15 years living in household (26%)
- Aged 45-54 years (32%)

The levels did not differ significantly by type of PHO (26% in Access PHOs wanting to know a lot more and 36% in Interim PHOs).

---

\(^{14}\) This question was not asked of those who were unaware of PHOs

\(^{15}\) There are indications that it is particularly those with children, but the numbers are too small to report
**INFORMATION INTERESTED IN**

Amongst those respondents who would like to know more about PHOs/changes to the delivery of family healthcare services, there were a number of information needs identified. As can be seen from the table below, most of the comments reflected a common theme of wanting to understand what it is and how it affects them.

<table>
<thead>
<tr>
<th>INFORMATION SOUGHT</th>
<th>Sample who would like to know more</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (211)</td>
<td>W (103)</td>
<td>UW (91)</td>
<td>W (23)</td>
<td>W (43)</td>
<td>UW (217)</td>
<td>UW (102)</td>
<td>UW (43)</td>
</tr>
<tr>
<td></td>
<td>W (247)</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>How affects patients</td>
<td>50</td>
<td>39</td>
<td>59</td>
<td>27</td>
<td>30</td>
<td>52</td>
<td>53</td>
<td>37</td>
</tr>
<tr>
<td>How it works/point of it</td>
<td>47</td>
<td>46</td>
<td>46</td>
<td>51</td>
<td>46</td>
<td>43</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Services available/how affected</td>
<td>23</td>
<td>31</td>
<td>19</td>
<td>25</td>
<td>23</td>
<td>24</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Costs involved</td>
<td>17</td>
<td>17</td>
<td>18</td>
<td>15</td>
<td>21</td>
<td>17</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>Up to date info on changes-fees/prescriptions</td>
<td>12</td>
<td>11</td>
<td>13</td>
<td>10</td>
<td>19</td>
<td>12</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>How it affects families</td>
<td>11</td>
<td>12</td>
<td>14</td>
<td>6</td>
<td>7</td>
<td>12</td>
<td>22</td>
<td>0</td>
</tr>
</tbody>
</table>

- Significantly higher  
- Significantly lower

**CURRENT AND PREFERRED MEANS OF RECEIVING INFORMATION FOR THOSE WHO WANT TO KNOW MORE**

Respondents who wanted to know more tended to have higher mentions of most preferred communication channels, compared with other respondents. This included: advertising (30% vs 23%), community newspapers (21% vs 15%), other newspaper items (28% vs 20%), TV items (28% vs 23%), radio items (13% vs 9%), mail outs (2% vs 15%). They were average in mention of GPs and their practices (52% vs 56%), but they were above average in mention of brochures and information displayed in doctor's rooms (17% vs 13%).

In terms of communications to date, they are more likely to report having heard about PHOs through TV ads (13% vs 10%) and less via the doctor or their practice (23%).
7. **Service Utilisation**

7.1 **People go to for help when unwell**

Nearly all people interviewed (99%) stated they go to a family doctor/GP, Accident and Medical Centre, nurse or hospital A&E when they or a family member is unwell. Nine percent use a pharmacist and when pharmacists are combined with other health care providers such as specialists, midwives, diagnostic laboratories, dentists, and physiotherapists, the level increases to 17%. One in ten seek assistance from complementary and alternative medicine providers such as chiropractors, osteopaths, naturopaths, homeopaths, herbalists and acupuncturists.

<table>
<thead>
<tr>
<th>TYPE OF PEOPLE GO TO FOR HELP WHEN UNWELL</th>
<th>Total sample</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Other health care provider</td>
<td>9</td>
<td>6</td>
<td>12</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Complementary and alternative</td>
<td>10</td>
<td>9</td>
<td>11</td>
<td>5</td>
<td>2</td>
<td>11</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Family/friends/elders</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Traditional healers</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

| Significantly higher | Significantly lower |

Those more likely to consult other health care providers were:

- Aged 35-54 years (24%)
- Medium-high income households (21%)

Those more likely to go to complementary and alternative medicine providers were:

- Low income respondents in Access PHOs (24%)
- Respondents from Other ethnic groups who belong to Access PHOs (18%)
- Those who last visited a GP six to twelve months ago (20%)
- Females (12%)
- Aged 35-44 years (16%)

Those more likely to consult family/ friends/ elders were:

- Aged 16-24 years (23%)
- Pacific Peoples (15%)
• Maori (10%)
• High User Health Card holders (13%)
• Community Services Card holders (10%)

Those more likely to use traditional healers were:
• Maori (6%), particularly those on low incomes with children (10%)
• Pacific Peoples (6%), particularly those on low incomes with children (10%)
• Those in Access PHOs (5%)
• Those who last visited a GP 3 to 6 months before (4%)

Those who had not used a GP in the last twelve months were average on their use of most services. Ninety-seven percent of them said they did use doctors and only one percent said they used nobody.
7.2 Use of GPs

The majority (78%) had been to a doctor at some point in the past twelve months. A quarter stated they had seen a GP or family doctor about their health in the last four weeks (not including doctors in hospitals or after hours clinics). Another quarter had consulted with a doctor between one and three months ago.

<table>
<thead>
<tr>
<th>WHEN LAST SAW A GP/FAMILY DOCTOR</th>
<th>Total sample</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within last 4 weeks</td>
<td>25%</td>
<td>32%</td>
<td>19%</td>
<td>34%</td>
<td>27%</td>
<td>24%</td>
<td>18%</td>
<td>38%</td>
</tr>
<tr>
<td>More than 4 weeks and less than 12 weeks ago (3 months ago)</td>
<td>25%</td>
<td>29%</td>
<td>23%</td>
<td>18%</td>
<td>26%</td>
<td>25%</td>
<td>22%</td>
<td>39%</td>
</tr>
<tr>
<td>More than 12 weeks and less than 24 weeks (6 months) ago</td>
<td>16%</td>
<td>13%</td>
<td>17%</td>
<td>12%</td>
<td>9%</td>
<td>17%</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>More than 6 months and up to 1 year ago</td>
<td>12%</td>
<td>7%</td>
<td>17%</td>
<td>12%</td>
<td>11%</td>
<td>12%</td>
<td>18%</td>
<td>4%</td>
</tr>
<tr>
<td>More than 1 year ago</td>
<td>21%</td>
<td>20%</td>
<td>22%</td>
<td>24%</td>
<td>23%</td>
<td>21%</td>
<td>26%</td>
<td>6%</td>
</tr>
</tbody>
</table>

- Significantly higher  
- Significantly lower

Those more likely to have visited a doctor in the past 4 weeks were:
- Aged 65 years and over (38%), particularly those on low incomes (45%)
- Maori (34%), particularly those on low incomes (44%)
- Other ethnic groups on low incomes (32%)
- People with no children aged 0-15 years living in household (29%)
- High User Health Card holders (60%)
- Community Services Card holders (37%)
- In Access PHOs (32%)

The only low income group not to be over-represented among these most recent visitors to GPs were Pacific Peoples (at 29% they were slightly above the 25% average, but not significantly so).

Those significantly more likely to have visited a doctor between 1 month and 3 months ago were:
- Aged 65+ years (39%)
- Females (28%)
- Living in main urban areas (28%)
- In Access PHOs (39%), giving a total of 70% who had seen a GP in the previous 3 months (compared with 50% for the total sample)
No particular demographic group was identified as being more likely to have visited a doctor between 3 months and 6 months ago. Those significantly more likely to have visited a doctor between 6 months and twelve months ago were:

- Females (15%)
- Aged 35-44 years (19%)
- Medium-high income households (17%)
- People with children aged 0-15 years living in household (18%)
- Living in secondary minor urban areas (19%)

Those significantly more likely to have visited a doctor more than twelve months ago were:

- Males (26%)
- Aged 25-34 years (28%), or 45-54 years (27%)
- People with children aged 0-15 years living in household (26%)
- Living in secondary minor urban areas (34%)
8. **Access to Primary Health Care**

8.1 **Reduced Fees**

**Changes Sought Relating to Fees**
As noted previously, cheaper fees were the dominant change people would like to see in the way family health care services are delivered. Twenty-four percent mentioned cheaper fees in general and 6% specifically mentioned cheaper fees for children.

It was noteworthy that mention of cheaper fees in general was not significantly higher among most of the groups listed in the table below. There were also no differences in mentions of cheaper fees between those who were and were not aware of PHOs and it also did not vary in terms of time since the last visit to the GP.

<table>
<thead>
<tr>
<th>Changes Would Like to See</th>
<th>Total Sample</th>
<th>Low Income</th>
<th>Medium to High Income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other Ethnic Groups</th>
<th>People with Children</th>
<th>Older People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheaper fees</td>
<td>24%</td>
<td>24%</td>
<td>25%</td>
<td>22%</td>
<td>20%</td>
<td>25%</td>
<td>26%</td>
<td>16%</td>
</tr>
<tr>
<td>Cheaper fees for children</td>
<td>6%</td>
<td>4%</td>
<td>8%</td>
<td>3%</td>
<td>2%</td>
<td>7%</td>
<td>13%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Significantly higher  ● Significantly lower

Mention of cheaper fees for children was higher among people with children (13%), particularly those from Other ethnic groups (15%). It was also more mentioned by those on medium to high incomes (8%), but less among Pacific Peoples (2%). Outside of the groups, mention of cheaper children's fees was more frequent among those with personal incomes under $15,000. Those in Access PHOs were less likely to mention wanting to see cheaper fees (18%), no doubt reflecting the greater presence of cheaper fees at these practices already (discussed further in a later section).

**Put Off Visits Because of Cost**
A little more than one in every ten people surveyed (12%) needed to see a GP or family doctor about their own health at some point in the last twelve months, but did not get to see one.

Of those who did put off a visit, 29% agreed that the last time it happened the decision was influenced either "totally" or "a lot" by cost. Another 11% also agreed it was influenced by cost, but to a lesser extent or they were unsure as to what extent. When extrapolated to the total sample, these figures equate with 3% who put off at least one visit mainly because of cost and 1% partly because of cost.
Those significantly more likely to have put off seeing a GP mainly because of cost were:

- Pacific Peoples (12% of all Pacific Peoples)
- People with both under 5s and 5 to 15 year olds (10%)

It can be seen from the table above that those on low incomes were not significantly more likely to have put off a visit. Those who had put off a visit mainly because of cost were just as likely as other people to have visited the doctor in the last 3 months, suggesting they are people with a greater need to use the doctor. However, these people had low awareness of PHOs (17% compared with 44% for the total sample). There was no difference by type of PHO they were enrolled in.

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16 With such low percentages, the numbers are not large enough to accurately report results for low income within ethnicity groups.
AWARENESS OF CHEAPER FEES WITH PHOs

Of the 44% who were aware of PHOs, only 19% mentioned that cheaper health care was an advantage for patients if their general practice or family doctor belonged to a PHO. However, the level rose to 46% among those in Access PHOs. It was low for Interim PHOs (11%) and as would be expected in between for Mixed PHOs (22%). The mention of cheaper health care was also higher among Maori (37% of those aware of PHOs) and Pacific Peoples (31%), but the other groups did not report higher mentions of this benefit. Those who had been to a GP within the last 3 months were also higher in mentions of cheaper health care (25%), as were holders of Community Service Cards (26%). Within the 19% mentioning cheaper healthcare were 2% who mentioned cheaper for children and a similar proportion who mentioned cheaper for older people.17

CONCERN WITH INCREASED COSTS ASSOCIATED WITH PHOS

There was a very small proportion of respondents who thought the PHOs would be associated with greater costs. Two percent of those who were aware of PHOs mentioned greater costs to see the doctor, which rose to 6% for Maori who were aware of PHOs. One percent mentioned extra costs if you have to use a doctor outside of your PHO and two percent were concerned that there would be fixed costs for consultations, with no flexibility.

AWARENESS OF CHEAPER FEES FROM COMMUNICATIONS

Among the 27% who recalled PHO advertising, 9% mentioned lower costs of seeing the doctor, or lower costs for certain groups. There were some other comments that may have related to costs but where the respondents did not make this clear. For example, 7% mentioned that it was a change for the better/ a fairer system and 4% mentioned that PHOs had advantages for families. The 9% recalling reduced costs from the communications rose to 29% among those in Access PHOs and was 16% among those with children. This suggests there may have been more promotions undertaken or associated with the Access PHOs, who have a real benefit to promote with their cheaper fees. Other PHOs may feel they have fewer benefits to promote, but this is something that can be explored in the qualitative research the Ministry is undertaking with primary care providers.

AWARENESS OF FEE CHANGES BEING IMPLEMENTED AT GENERAL PRACTICE

Of the 20% who were aware of changes in their general practice, 21% mentioned decreased fees, but 26% mentioned increased fees. These figures equate with 5% and 6% of those who had visited a GP in the last twelve months18. Once again, those in Access PHOs had high awareness of decreased fees (59% of those who were aware of changes in their general practice), while in Interim PHOs it

17 These categories could include some of the same people.

18 78% had visited a GP in the last 12 months.
was 4% and in Mixed 27%. The 59% for Access PHOs translates to 13% of those who had visited a GP in the last twelve months.

Decreased fees were also more mentioned by those on low incomes (31% of those aware of changes at their general practice) and those who were aware of PHOs (27%).

Recall of cheaper fees did not vary significantly by time since last visiting the GP, although this may have been in part because of the smaller sample sizes answering this question. Among those who had been to a GP in the last 3 months, 25% mentioned reduced fees, compared with 14% among the others.\textsuperscript{19}

Increased fees, which were mentioned by 26% of those aware of changes in their general practice, was more mentioned among:

- Respondents in the South Island (49%)
- Other ethnic groups with children (48%)
- Those on medium to high incomes (32%), particularly those with household incomes over $70,000 (35%)
- Those aged 35 to 44 years (52%)

\textsuperscript{19} This difference was significant at the 90% confidence level, but the 95% level is being used in reporting this study.
EXPERIENCE OF REDUCED FEES

Level of fees
The table below shows the level of usual fees compared with what was paid on the most recent visit. This shows the mean had decreased $3 and the median had decreased $5.

<table>
<thead>
<tr>
<th>FEES</th>
<th>Fee on Most Recent Visit</th>
<th>Usual Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (794)</td>
<td>W (790)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Nothing</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>$1-$9</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>$10-$14</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>$15-$19</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>$20-$29</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>$30-$39</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>$40-$49</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>$50 or higher</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Don't know</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Refused</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>$32</td>
<td>$33</td>
</tr>
<tr>
<td>Median</td>
<td>$33</td>
<td>$35</td>
</tr>
</tbody>
</table>

Fig 1 below shows that the fees being paid at Access PHOs are markedly lower than at Interim or Mixed\(^{20}\). The graph shows the mean values, but the median values show a similar, although more pronounced, pattern. The median fee last paid at an Access PHO was $15, while it was $40 at an Interim and $35 at a Mixed\(^{21}\). The median usual fee at an Access PHO was $19, compared with $40 at an Interim and $38 at a Mixed.

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\(^{20}\) As noted in the Methods Overview chapter, those PHOs classified as Mixed had 31% that were predominantly Access and 69% Interim, based on the weighted data (unweighted 48% were Access and 52% Interim).

\(^{21}\) The Mixed fee was not significantly different for the most recent visit, but all the other fees reported were significantly different.
The fees being paid also show a good match to household income; in accord with the aims of government policy, the lower the income, the lower the fees being paid. Figure 2 shows the means, but the medians also show the same pattern, increasing from $25 to $40\textsuperscript{22}.

\textsuperscript{22} It was not possible to analyse the fees by equivalised income, which takes into account the number in the household, as the survey did not ask total numbers in the household.
to the more recent users being the type of people who usually attract lower fees. The fee they usually pay (mean of $32 and median of $31) was similarly high compared with the others (mean of $36 and median of $38).

It can be seen from the table that fees were lower for Maori and Pacific Peoples, but this is in large part a product of them being more often in Access PHOs. For example, the mean fee on the most recent visit for Maori in Access PHOs was $13, while it was $27 for Maori not in Access PHOs. Likewise with Pacific respondents, those in Access PHOs reported last paying $13 while those not in Access PHOs reported $24. A similar pattern was also evident for those from Other ethnic groups ($17 in Access and $35 for the others). Low income respondents in Access PHOs reported last paying $15 while low income people not in Access PHOs last paid twice the amount ($31). Likewise older people in Access PHOs last paid $18 while those of similar age not in Access PHOs paid $32.

While those with children were paying average fees, among those in Access PHOs the fees were lower ($14). Considering all those with children, those with children aged both under 5 and 5 to 15, were paying less ($26 mean fee on last visit). Those with Community Service Cards ($23) and High User Cards ($21 mean fee on last visit) were other groups paying less.

Fees paid by South Island respondents ($33) were at a similar level to those in the North Island ($32 mean fee on last visit).
<table>
<thead>
<tr>
<th>FEES</th>
<th>Sample visited GP in last 12 months</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (748)</td>
<td>W (285)</td>
<td>UW (306)</td>
<td>UW (227)</td>
<td>UW (211)</td>
<td>UW (353)</td>
<td>UW (330)</td>
<td>UW (129)</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>USUAL FEE</td>
<td>Mean</td>
<td>$33</td>
<td>$28</td>
<td>$38</td>
<td>$25</td>
<td>$21</td>
<td>$35</td>
<td>$34</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>$35</td>
<td>$27</td>
<td>$40</td>
<td>$25</td>
<td>$20</td>
<td>$37</td>
<td>$38</td>
</tr>
<tr>
<td>MOST RECENT FEE</td>
<td>Mean</td>
<td>$32</td>
<td>$28</td>
<td>$36</td>
<td>$23</td>
<td>$20</td>
<td>$34</td>
<td>$32</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>$33</td>
<td>$28</td>
<td>$40</td>
<td>$20</td>
<td>$15</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>MOST RECENT FEE FOR THOSE WHO HAVE VISITED IN LAST 3 MONTHS</td>
<td>UW (521)</td>
<td>UW (220)</td>
<td>UW (174)</td>
<td>UW (162)</td>
<td>UW (155)</td>
<td>UW (235)</td>
<td>UW (211)</td>
<td>UW (115)</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>$30</td>
<td>$26</td>
<td>$35</td>
<td>$20</td>
<td>$17</td>
<td>$32</td>
<td>$30</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>$30</td>
<td>$25</td>
<td>$40</td>
<td>$16</td>
<td>$15</td>
<td>$30</td>
<td>$30</td>
</tr>
</tbody>
</table>

NB: The bases are those who provided fee data (i.e. excludes the don't knows)

- Significantly higher
- Significantly lower
Payment of reduced fees
These data are limited in the information they can provide about fee reductions. As this was not the main purpose of this study, there were few questions on fees. Further research is planned by the Ministry which will examine this issue more thoroughly.
Of the 78% of respondents who had been to a doctor in the last twelve months, 15% reported paying less on their most recent visit compared with what they normally pay. However some of these people were aware that it was because they were on ACC or gave other reasons that were not related to the fee reductions associated with the PHCS, such as visits for check-ups and dressings. When these people are removed there were 8% who reported paying less. That is, there were 8% of those who had visited a doctor in the last 12 months who reported fee reductions that could possibly be linked with the PHCS fee reductions. However we only measured reductions between the most recent fee and the usual fee. If people were regular users of primary health care they may have been relating to the fee reductions resulting from the PHCS as their usual fees. Therefore the 8% may be an understatement of the proportion who have been impacted by the PHCS fee reductions.
However, it must be remembered that in the previous section there were only 5% who reported reduced fees as a change they had noted at their general practice over the last twelve months. In other words, even if more than 8% have received reduced fees, there were only 5% who thought to mention it as a change they had noted.
Within the 8% mentioning reduced fees that could possibly be linked with PHCS, there were half of them (4%) who gave a reason that was clearly linked with PHCS (the fee decrease was because the practice was part of a PHO, or the government had increased payments they make to doctors or PHOs). The 8% included 2% who did not know the reasons for the decrease.
The 8% mentioning reduced fees which could be linked with PHCS was higher among those in Access PHOs (18%, compared with 3% in Interim and 12% in Mixed). It was also higher among those who had visited their GP within the last 3 months (10%, compared with 5% for the others), the last 3 months being a period when there was a greater likelihood of PHCS fee reductions being in place. In accord with their higher presence in Access PHOs, Maori (14%) and Pacific respondents (15%) were more likely to report paying less than usual (for reasons that could possibly be linked to PHCS). The level was higher in the North Island (11%) than the South Island (2%).
Among other groups, the levels were 6% for low income, 10% for medium-high income, 7% for Other ethnic groups, 7% for people with children, and 8% for older people.

Size of fee reductions
Of those who reported fee reductions that could possibly be linked to the PHCS changes, 41% reported a reduction of up to $15, 36% a reduction between $16 and $20 and 23% reported a larger reduction. The mean reduction was $17 and the median $20.

Payment of increased fees
At the same time that 15% reported paying less on their most recent visit to the doctor, 14% reported increases. Some of these were due to reasons that were
unrelated to general price increases, such as coming off ACC, or double consultation. If these are removed, there were 11% who reported fee increases. The main reason given was that the standard fee had increased (6%), the other main group being those who were unsure of the reasons for the fee increase (4%). Within Access PHOs only 1% reported fee increases of this type, while in Interim PHOs the level was 17%. Lower mentions by Maori and Pacific Peoples (both 6%) are consistent with the low level for Access PHOs.

As shown in the table below, while fee reductions are reaching some of the groups, at least as many are reporting fee increases. The proportion in the South Island reporting these types of fee increases (12%) was similar to the proportion in the North Island (11%).

### FEE DECREASES/INCREASES

<table>
<thead>
<tr>
<th>Sample visited GP in last 12 months</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>UW (794) W (790)</td>
<td>%</td>
<td>UW (327) W (391)</td>
<td>%</td>
<td>UW (239) W (82)</td>
<td>%</td>
<td>UW (229) W (36)</td>
<td>%</td>
</tr>
<tr>
<td>UW (293) W (236)</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UW (321) W (576)</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UW (296) W (296)</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UW (140) W (162)</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reported fee decrease that could be linked to PHCS

<table>
<thead>
<tr>
<th>Reported fee decrease that could be linked to PHCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

Reported fee increase that could be related to price increases

<table>
<thead>
<tr>
<th>Reported fee increase that could be related to price increases</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
</tr>
</tbody>
</table>

![Significantly higher](significantly_higher.png)

![Significantly lower](significantly_lower.png)

### Size of fee increases

The size of the fee increases was less than the fee decreases. Of those reporting increases that could be related to price increases, 62% reported an increase of up to $5, while 29% reported increases of between $6 and $15 and 9% increases greater than this. The mean fee increase was $7 and the median $5.
8.2 Other Access Issues

Changes Sought Relating To Access Issues
Apart from cheaper fees, the main changes respondents wanted in the delivery of family health care services were less waiting time at the practice (7%) and being able to get an appointment when they needed one (3%).
There were 37% who did not seek any changes and a further 10% who were unsure. So in total there were 53% who did want some changes.
Those wanting less waiting time were:
- Low income Māori with children (18%)
- Pacific Peoples (12%), particularly those on low incomes with children (15%)
- Those with children aged only under 5 years (15%)
- Those in main urban areas (8%)
- People in Access PHOs (11%)

Those more concerned with getting an appointment when they needed one were:
- Those with household incomes over $70,000 (6%)

Other Comments Relating To Access Issues
The main things respondents cited as advantages and disadvantages that PHOs provided in terms of access to primary health care services related to access to health professionals and continuity of care. These are addressed in later sections.
Apart from fees, there were no access issues coming through in the communications. Likewise there were no changes in service provision at general practices that are not covered in other sections.

Putting Off Visits To Doctor For Non-Cost Reasons
As noted previously, there were 12% who put off visits to doctors at least once in the last twelve months. There were 7% who put off the visit for reasons that were not related to cost. The other reasons were not asked about in the survey, in part because they might have been sensitive and personal issues. However, this is a group of people who are not accessing services when they need them.
They were more likely to be:
- People in Access PHOs (15%)
- Māori (12%), particularly those on low incomes with children (16%)
- Other ethnic groups on low incomes with children (18%)
- Aged 25 to 34 years (12%)
- People living in rural areas (13%)
They were unlikely to be older people (2%).
9. **CONFIDENTIALITY OF INFORMATION**

9.1 **CONFIDENTIALITY OF INFORMATION**

**COMMENTS RELATING TO CONFIDENTIALITY**

Only one person mentioned wanting more privacy with personal health information when asked what changes they wanted to family health care services. There was no mention of this issue when reporting on understanding of PHOs, advantages of PHOs, changes at their general practice, or messages from the communications. One percent mentioned concerns with lack of confidentiality of records, as a disadvantage of PHOs.
9.2 National Health Index (NHI)

Awareness of National Health Index (NHI Number)

A quarter of all survey respondents (25%) stated they had previously heard of the National Health Index or NHI number. There were 14% who said they knew what it was used for, however this reduced to 10% who gave one of the correct responses, these being:

- Identify patients uniquely (7% or 52% of people who said they knew what the NHI was used for)
- National record of everyone’s health (3%/23%)
- To identify and track medical records for each person (3%/22%)

Other incorrect reasons given were:

- Record of use of hospital services (2%/8%)
- Brings all their health information together in one place (2%/12%)

<table>
<thead>
<tr>
<th>NATIONAL HEALTH INDEX</th>
<th>Total sample</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UW (1018)</td>
<td>W (1018)</td>
<td>UW (427)</td>
<td>UW (308)</td>
<td>UW (298)</td>
<td>UW (477)</td>
<td>UW (470)</td>
<td>UW (151)</td>
</tr>
<tr>
<td>Heard of NHI</td>
<td>25</td>
<td>22</td>
<td>30</td>
<td>19</td>
<td>14</td>
<td>26</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Correctly know what</td>
<td>10</td>
<td>8</td>
<td>12</td>
<td>7</td>
<td>7</td>
<td>22</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>used for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

Those more likely to be aware of the National Health Index were:

- In Interim PHOs (32%)
- Medium-high income households (30%)
- People with children aged 0-15 years living in household (29%), particularly those from other ethnic groups (32%)
- Females (28%)
- Aged 45-54 years (31%)

Those more likely to correctly describe the purpose of the National Health Index were:

- Females (12%)
- Aged 25-34 years (14%)
- Medium-high income households (12%)
- People with children aged 0-15 years living in household (14%), particularly those from Other ethnic groups (16%)
Those more likely to be unaware of the National Health Index were:

- Those in Access PHOs (83%)
- Males (77%)
- Aged 65 years and over (87%)
- Maori (81%)
- Pacific Peoples (84%), particularly those on low incomes (92%)
- People with no children aged 0-15 years living in household (76%)
- Community Services Card holders (81%)
9.3 Authorising Transfer of Records When Changing GPs

Around one eighth of people who had visited a doctor in the last year (12%) had switched to a new GP/family doctor in that time period. Those more likely to have changed were:

- Maori (21% of those who had visited a GP in the last year), especially those on low incomes with children (32%)
- People with children aged under 5 years only living in household (24%)
- High User Health Card holders (24%)

The levels did not differ significantly by type of PHO (15% for Access and 12% Interim).

For the majority (85%) of the 12% of respondents who changed their regular GP or family doctor in the last year, their new doctor had obtained their records from the previous doctor. Just over half of these (53%), recalled signing something to give permission for their new doctor to obtain their records from their previous doctor. A fifth (20%) claimed they did not sign for their records to be handed over to their new doctor, and 11% were unsure if they had given their permission. The remaining 15% either said their new doctor did not have their records, or they were unsure if the new doctor had obtained their health records.

No particular demographic group was identified as being more likely to recall having given signed permission.
10. MAORI FINDINGS

This chapter brings together all the key findings relating to Maori, particularly the ways in which they differ from the total sample answering each question.

UNDERSTANDING OF PRIMARY HEALTHCARE AND AWARENESS OF PHOS

- **Less** likely to be aware of PHOs (31% vs 44% of all people)
- **More** likely to state their usual GP/ family doctor does belong to a PHO (52% vs 32% of those aware of PHOs)\(^{23}\)

SUPPORT FOR COMPONENTS OF PRIMARY HEALTHCARE STRATEGY

- **More** likely to have visited another GP/ family doctor that is not part of their usual practice in the last twelve months (22% vs 10% of all those who believed their GP/ family doctor belonged to a PHO)
- **More** likely to strongly support their family doctor/ GP focussing on providing services that keep people well (75% vs 66% of all people)
- **More** likely to strongly support the greater use of a range of healthcare professionals providing services where they have the skills to do so (65% vs 54%)
- **More** likely to have seen a practice nurse during last GP/ family doctor’s visit (37% vs 28% of all those who have been to a doctor in the last twelve months)
- **More** likely to want PHOs to involve the community more in deciding which services to provide (85% vs 70% of all those aware of PHOs)
- **More** likely to want to tell PHOs about which services to provide through board meeting with community groups (20% vs 10% of all those who would like more community involvement in PHO decisions regarding services)

COMMUNICATIONS

- **More** likely to state brochures/brochures/ fridge magnets (22% vs 15% of all people) or brochures in doctors rooms (17% vs 13%) as the best means of communicating to them about PHOs/ changes to delivery of family healthcare services
- **Less** likely to state advertising (17% vs 23%) or other newspaper items (not community newspaper) (13% vs 20%) as the best means of communicating to them about PHOs

\(^{23}\) In these summary tables, the percentages are based on the last base mentioned
• **More** likely to have **seen or heard advertising** about PHOs/ other changes to the delivery of family healthcare services (42% vs 27%)

• **More** likely to have a **positive impression** of the advertisements (50% vs 20% of those who had seen or heard PHO advertising), particularly, **good/ positive move/ logical** (40% vs 10%)

• **More** likely to want **more information** about PHOs (67% vs 55%), particularly **a lot more information** (45% vs 32%)

**SERVICE UTILISATION**

• **More** likely to go to **family/ friends/ elders** when they or a family member is unwell (10% vs 6% of all people)

• **More** likely to use **traditional healers** (6% vs 2%)

• **Less** likely to consult a **pharmacist** (4% vs 9%)

• **Less** likely to go to **complementary & alternative medicine providers** (5% vs 10%)

• **More** likely to have visited a **GP/ family doctor in the last 4 weeks** (34% vs 25%)

**ACCESS TO PRIMARY HEALTHCARE**

• **More** likely to specify **cheaper healthcare** as an advantage for patients whose GP/ family doctor belongs to a PHO (37% vs 19% of those aware of PHOs)

• **More** likely to mention **increased fees** as a concern associated with PHOs (6% vs 2%)

• Likely to **pay less** on both a typical visit to the GP (mean of $25 vs $33) and the most recent ($23 vs $30)

• More likely to **report paying less than usual** on the last occasion (for reasons that could possibly be linked to PHCS) (14% vs 8%)

• More likely to have put off a visit to a doctor for non-cost reasons (12% vs 7%)

**CONFIDENTIALITY OF INFORMATION**

• **Less** likely to be **aware** of the National Health Index (19% vs 25% of all people)

• **More** likely to have **changed** their regular GP/ family doctor in the last twelve months (21% vs 12% of those who had been to a doctor in the last twelve months)
11. Pacific Peoples Findings

This chapter brings together all the key findings relating to Pacific Peoples.

Understanding of Primary Healthcare and Awareness of PHOs

- Less likely to be aware of PHOs (18% vs 44% of all people)
- More likely to state their usual GP/ family doctor does belong to a PHO (51% vs 32%)

Support for Components of Primary Healthcare Strategy

- More likely to want PHOs to involve the community more in deciding which services to provide (91% vs 70% of all those aware of PHOs)
- More likely to want to tell PHOs about which services to provide through community groups (20% vs 8% of those who would like more community involvement in PHO decisions regarding services)
- More likely to want to tell PHOs about which services to provide through telephone/ call centre/ hotline/ 0800 (24% vs 7%) and less through surveys (12% vs 29%)

Communications

- Less likely to state many of the options for best means of communicating to them about PHOs/ changes to delivery of family healthcare services
- More likely to have heard about PHOs/ changes to the delivery of family healthcare services through their GP/ doctor in person (40% vs 27% of those aware of PHOs)
- More likely to want more information about PHOs (83% vs 55%), particularly a lot more information (57% vs 32%)

Service Utilisation

- More likely to go to family/ friends/ elders (15% vs 6% of all people), or traditional healers (6% vs 2%) when they or a family member is unwell
- Less likely to go to family doctor/ GP/ hospital/ A&E/ nurse (94% vs 99%), other healthcare providers (3% vs 9%), complementary & alternative medicine providers (2% vs 10%)
ACCESS TO PRIMARY HEALTHCARE

- **More** likely to have put off seeing a doctor in the last twelve months mainly because of cost (12% vs 3% of all people)

- **More** likely to specify **cheaper healthcare** as an advantage for patients whose GP/family doctor belongs to a PHO (31% vs 19% of those aware of PHOs)

- **Less** likely to have noticed **increased fees** at their GP/family doctor over the last twelve months (6% vs 26% of those who noticed changes in the last twelve months)

- Likely to **pay less** on both a typical visit to the GP (mean of $21 vs $33) and the most recent ($20 vs $30)

- More likely to **report paying less than usual** on the last occasion (for reasons that could possibly be linked to PHCS) (15% vs 8%)

- **More** likely to specify **less waiting time at the practice** as a change they would like to the delivery of family healthcare services (12% vs 7% of all people)

- **More** likely to specify **doctor less available** as a disadvantage for patients whose GP/family doctor belongs to a PHO (20% vs 7% of those aware of PHOs)

CONFIDENTIALITY OF INFORMATION

- **Less** likely to be **aware** of the National Health Index (14% vs 25% of all people)

- **Less** likely to be aware of the **purpose** of the National Health Index (8% vs 14%)
12. Other Ethnic Groups Findings

While the Other Ethnic Groups differed significantly on many measures, their actual levels of mentions were still similar to the Total Sample figures and did not justify comment. This was in part because of the large size of the group, however it also reflects the fact that these respondents did have a very average profile.
APPENDIX A - RESEARCH METHODS

This appendix provides additional and more detailed information on the research methods, to support the Research Methods Overview chapter of the report.

NATIONAL BENCHMARK SURVEY
A CATI (computer assisted telephone interviewing) method was used because it was the most cost-effective approach. It does enable high levels of call backs and provides a high degree of monitoring of interviewer quality.

The disadvantage of any phone-based method is that people without landline phones and those with unlisted numbers are not included. The level of access to households with a telephone, from the 2001 Census, reflects the lower access for Maori (88%) and Pacific peoples (87%), compared with the total population (96%). It is acknowledged that Maori and Pacific peoples often have a preference for face-to-face interviews, however this was not viable given the size of the available budget.

SAMPLE SIZE
The target sample size was 1000, with 300 in each of the Maori and Pacific peoples quotas. These proportions were as recommended by the Ministry, and they provided larger sub-samples for analysis purposes. The final sample sizes were 1018 total and 308 Maori and 298 Pacific Peoples (these totals include a small number who were both Maori and Pacific).

DATA COLLECTION
Field work was between 19 March and 2 May. Interviews were undertaken primarily in the evenings, from 5pm to 9pm and weekends from 10am to 5pm, extending to 7pm if necessary.

The Maori and Pacific supplementary interviews were all undertaken by Maori and Pacific interviewers. All respondents in the general sample were offered the opportunity to be interviewed by a Maori or Pacific interviewer if they were Maori or a Pacific person.

Qualifying respondents were people in the household who make decisions about which family doctor or health care services they or others are going to use. If there was more than one qualifier there was a random selection, based on the person who had the last birthday.
SAMPLE SELECTION

General sample
The general sample was randomly selected from electronic versions of the white pages. This sampling frame did not include unlisted numbers or listed mobile phones.

Maori supplementary sample
This was randomly selected from both Maori and General electoral rolls, as both rolls give people the opportunity to identify whether they are of Maori descent. The selected names were then matched to phone numbers, where possible, by Telecom. These households were then contacted and asked if there were any Maori living in the household. This allowed them to determine whether they considered themselves Maori or not. Within households there was random selection from the qualifying Maori members.

Pacific supplementary sample
The sampling frame was Statistics New Zealand mesh blocks with 40% or more Pacific Island households. Within these mesh blocks, addresses were randomly selected and then, where possible, matched to phone numbers. Pacific interviewers then rang these numbers to ascertain if there were Pacific peoples living in the households. Within households there was a random selection from qualifying persons. This method did have a bias towards Pacific peoples who live in areas of high Pacific concentration. However, randomly ringing numbers from all the white pages to find Pacific peoples was not a cost effective option. If there were no Pacific qualifiers, the household was asked if there were any Maori qualifiers and these were included in the Maori quota.

SAMPLE STRATIFICATION
Stratification was used to ensure that the sample was representative within strata. The sample selection within strata was random.

General sample
The strata for the main survey was as listed below, reflecting both regional distribution and level of urbanisation. The sample was drawn from each strata in accord with the proportion of the population in that region (based on 2001 Census).

- Auckland urban area
- Wellington urban area
- Christchurch urban area
- Other main urban areas - Upper North Island (Whangarei, Hamilton, Tauranga, Rotorua)
- Other main urban areas - Lower North Island (Gisborne, Napier/Hastings, New Plymouth, Wanganui, Palmerston North, Kapiti)
• Other main urban areas - South Island (Nelson, Dunedin, Invercargill)
• Secondary urban areas (10,000 to 29,999 people)
• Minor urban areas (1,000 to 9,999 people)
• Rural areas (less than 1,000 people)

Maori supplementary sample
The electoral roll data identifies the Territorial Local Authorities people reside in, so the supplementary Maori sample was stratified into two groups: greater Auckland region (North Shore City, Auckland City, Waitakere City, Manukau City, Papakura District), and the rest of New Zealand. As with the general sample, the proportion in the two strata was in accord with the 2001 Census.

Pacific supplementary sample
This was stratified into Auckland and the rest of New Zealand.

QUOTAS
Apart from ethnicity, a gender quota was imposed to ensure at least 40% were male from within each ethnic group. To reach these targets did require having some interviewers contacting only for qualifying males. In the final sample composition, Maori were 39% males, Pacific Peoples were 42% and Other ethnic groups 42%.
RESPONSE RATES
To obtain a high response rate, at least 15 calls, and often more, were made to try and obtain interviews with selected households and respondents. The final status of the calls is as listed below.

<table>
<thead>
<tr>
<th>FINAL STATUS OF CALL</th>
<th>General Sample</th>
<th>Maori and Pacific Supplementary Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed full phone interview</td>
<td>457</td>
<td>561</td>
</tr>
<tr>
<td>Refusal</td>
<td>286</td>
<td>157</td>
</tr>
<tr>
<td>Answering machine</td>
<td>22</td>
<td>30</td>
</tr>
<tr>
<td>Engaged on last call</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>No answer/ unable to contact</td>
<td>53</td>
<td>88</td>
</tr>
<tr>
<td>Unable to answer/ ill/ absent</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Language barrier</td>
<td>60</td>
<td>64</td>
</tr>
<tr>
<td>Disconnected number/ number changed</td>
<td>118</td>
<td>127</td>
</tr>
<tr>
<td>Fax machine (for 5 consecutive calls)</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Quota full</td>
<td>52</td>
<td>-</td>
</tr>
<tr>
<td>Non-qualifier/quota full</td>
<td>-</td>
<td>1125</td>
</tr>
<tr>
<td>Non-qualifier</td>
<td>208</td>
<td>443</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,272</strong></td>
<td><strong>2,609</strong></td>
</tr>
</tbody>
</table>

In accord with Ministry of Health policy, a weighted response rate was calculated. This takes into account the fact that only some of those who refused and had other outcomes would have qualified for the interview.

The response rate was calculated as:

- \( \frac{\text{Eligible responding}}{\text{Eligible responding} + \text{estimated eligibles from the unknowns}} \)

The estimate eligibles from the unknowns was calculated as:

- \( \text{Unknowns} \times \frac{\text{Eligible responding}}{\text{not eligible} + \text{Eligible responding}} \)

Unknowns were those categories listed in lines 2 to 7 above. It should be noted that
those classified as fax machines were where a fax was reached on five consecutive occasions and it was therefore deemed to be a dedicated fax line and was not included in the qualifying phone numbers.

In the general study "Non-qualifiers" included some business numbers (25), but were mainly households with no males who fulfilled the selection criteria, which were contacted by interviewers who were on male only quotas. In the Maori and Pacific sample, it included these groups, but was mainly households with no Maori or Pacific peoples present who were qualifiers. It became apparent at the stage of analysis that some interviewers had classified most of these people as "Quota full" instead of "Non-qualifiers".

"Quota full" was used when calls had been made to a number but the quota for that region had been reached before the minimum 15 calls had been made. In this case

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24 This equation would normally include eligible non-responding, but questions were not
the required number of calls was made and if people qualified and agreed to participate they were thanked and told that the quota was full. Efforts were made to not open new numbers near the end of the survey to avoid this situation as much as possible, but unfortunately on one weekend late in the survey new numbers were opened up when they were not meant to be. This had the effect of lowering the response rate as some of these extra numbers resulted in refusals etc.

If the level of Non-qualifiers reported above are used, the response rate for the General sample was 61% and for Maori and Pacific it was 74%, providing an overall response rate of 68%.

If an estimate is made that 1000 of the 1125 Maori/Pacific "Quota Full" were in fact "Non-qualifiers", this changes the Maori/Pacific response rate to 86% and the overall rate to 73%, which could be considered the best estimate of the overall response rate.

In total 5542 calls were made to obtain the 1,272 households contacted for the General sample, averaging 4.3 calls per household. For Maori and Pacific there were 10,194 calls made to the 2,609 households, averaging 3.9 calls. This figure will be lower than for the General because so many of the households were established as being non-qualifiers and therefore further calls were not necessary to try and reach the qualifying respondent.

QUALITY ASSURANCE PROCEDURES

Pre-testing
The survey was pre-tested to ensure the questions were understood and working as intended.

IQS Accredited
The Phoenix Research CATI centre is IQS accredited, this being the recognised industry quality standard.

Interviewer briefing and debriefing
Phoenix had only their best available interviewers work on this project, particularly with a view to maximising response rates. Interviewers received a detailed briefing from Dr Allan Wyllie who had overall responsibility for the project within Phoenix Research. Anyone added to the interviewing team after the initial briefings watched a video of the briefing and was briefed by a senior CATI staff member who had attended the main briefing. The briefings entailed going through each question, using the data projector. Interviewers were also given typed briefing notes. The briefing included discussion of response rates and how to maximise these. Following the briefing, interviewers undertook practice interviews among themselves and with friends, until they felt sufficiently familiar and confident with the survey to go live.
**Monitoring of interviewing**

One of the main benefits of the CATI system is the ability to monitor all the calls, as they are being undertaken from a central location. The shift supervisor monitored calls during the shift. In addition to this, two 'call catchers' recorded all interviews and these could be monitored at any time following the interview. This allowed for more thorough and systematic monitoring than was possible during interviewing. It also meant that if there were any problems identified with any interviewer, all their interviews could be checked. A minimum of 10% of each interviewer's work was checked via the call catchers.

**WEIGHTING**

**Adjusting for probability of selection**

Weighting was necessary to adjust for people in households with larger numbers of potential qualifying persons having less chance of being selected. Therefore the data were weighted by the number of eligible persons in the household. Maori data were weighted by the number of qualifying Maori in the household and likewise for Pacific peoples. In households contacted when only males were being selected, the weighting was based on the number of eligible males in the household. If Maori males were being contacted, the weighting was based on the number of Maori males.

Most households had between one and four eligible persons. To avoid individuals having undue influence on the results, the 22 people from household of more than four eligible persons was treated as a four person household for weighting purposes.

**Post-stratification to obtain a representative sample**

It was also necessary to weight the data to ensure that the final sample was as representative as possible to the New Zealand population. The weighting variables were:

- Ethnicity (Maori, Pacific peoples, Other)
- Age (16 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years and 65 years and over)

**Weighting method**

The weights were calculated using the formula below.

The weight assigned to the $i$th respondent in the $h$th stratum (or weighting cells) was equal to $w_{hi} = \frac{W_h}{\sum_{	ext{respondent in } h\text{th stratum}} \frac{1}{\pi_{hi}}} \cdot \frac{1}{\pi_{hi}}$, where $\pi_{hi}$ denoted the selection probability of that respondent and $W_h$ denoted the proportion of respondents in the $h$th stratum from the Statistics New Zealand 2001 Census data.

The weighting did not take account of the fact that respondents had more than one chance of selection from the three different sampling frames, however the probability
of being selected more than once is infinitesimal. There was also no allowance made for the fact that males had a greater probability of selection due to the quotas to obtain at least 40% male.

**Ethical Issues**
This study received approval from the ethics committees in all regions.
APPENDIX B - CONFIDENCE INTERVALS

The following are a selection of results with confidence intervals provided, to give some indication of the accuracy of the data. It should be noted that these confidence intervals, like the significance testing, have not taken into account any design effects.

<table>
<thead>
<tr>
<th>CONFIDENCE INTERVALS BASED ON TOTAL SAMPLE</th>
<th>Total sample</th>
<th>Low income</th>
<th>Medium to High income</th>
<th>Maori</th>
<th>Pacific Peoples</th>
<th>Other ethnic groups</th>
<th>People with children</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=</td>
<td>446</td>
<td>149</td>
<td>222</td>
<td>34</td>
<td>9</td>
<td>397</td>
<td>167</td>
<td>85</td>
</tr>
<tr>
<td>%</td>
<td>43.8</td>
<td>50.5</td>
<td>43.3</td>
<td>31.4</td>
<td>18.0</td>
<td>46.1</td>
<td>41.2</td>
<td>48.8</td>
</tr>
<tr>
<td>95% confidence interval</td>
<td>3.05</td>
<td>5.13</td>
<td>4.7</td>
<td>5.18</td>
<td>4.36</td>
<td>4.47</td>
<td>4.45</td>
<td>7.97</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-visit to doctor mainly influenced by cost</th>
<th>n=</th>
<th>35</th>
<th>16</th>
<th>14</th>
<th>7</th>
<th>6</th>
<th>24</th>
<th>26</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>3.4</td>
<td>5.5</td>
<td>2.7</td>
<td>6.6</td>
<td>12.3</td>
<td>2.8</td>
<td>6.5</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>95% confidence interval</td>
<td>1.11</td>
<td>2.34</td>
<td>1.54</td>
<td>2.77</td>
<td>3.73</td>
<td>1.48</td>
<td>2.23</td>
<td>0.5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strongly support focus on well health</th>
<th>n=</th>
<th>669</th>
<th>213</th>
<th>344</th>
<th>82</th>
<th>28</th>
<th>563</th>
<th>279</th>
<th>96</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>65.7</td>
<td>72.3</td>
<td>67.0</td>
<td>75.2</td>
<td>59.5</td>
<td>65.3</td>
<td>68.6</td>
<td>54.9</td>
<td></td>
</tr>
<tr>
<td>95% confidence interval</td>
<td>2.92</td>
<td>4.59</td>
<td>4.46</td>
<td>4.82</td>
<td>5.57</td>
<td>4.27</td>
<td>4.2</td>
<td>7.94</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heard of NHI</th>
<th>n=</th>
<th>251</th>
<th>65</th>
<th>153</th>
<th>20</th>
<th>7</th>
<th>226</th>
<th>119</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>24.6</td>
<td>22.0</td>
<td>29.7</td>
<td>18.6</td>
<td>14.6</td>
<td>26.2</td>
<td>29.2</td>
<td>11.2</td>
<td></td>
</tr>
<tr>
<td>95% confidence interval</td>
<td>2.26</td>
<td>4.25</td>
<td>4.33</td>
<td>4.35</td>
<td>4.01</td>
<td>3.95</td>
<td>4.11</td>
<td>5.03</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total sample</td>
<td>Low income</td>
<td>Medium to High income</td>
<td>Maori</td>
<td>Pacific Peoples</td>
<td>Other ethnic groups</td>
<td>People with children</td>
<td>Older people</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------</td>
<td>------------</td>
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<td>----------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>United Way (UW)</td>
<td>358</td>
<td>126</td>
<td>168</td>
<td>105</td>
<td>55</td>
<td>219</td>
<td>154</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Women (W)</td>
<td>446</td>
<td>149</td>
<td>222</td>
<td>34</td>
<td>9</td>
<td>397</td>
<td>167</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td><strong>Believe their usual doctor does belong to a PHO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>n=</strong></td>
<td>140</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>31.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>95% confidence interval</strong></td>
<td>4.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prompted recall of PHO advertising</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>n=</strong></td>
<td>122</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>27.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>95% confidence interval</strong></td>
<td>4.62</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Want to know a lot more</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>n=</strong></td>
<td>141</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>31.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>95% confidence interval</strong></td>
<td>4.82</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C - GLOSSARY

DESCRIPTIONS OF PRIMARY CARE PROVIDERS
In the introduction to the survey, respondents were told that, "We are doing a study on the way that health care services are provided by family doctors and other health professionals".
Once they had answered some initial questions, respondents were all provided with a description of "general practices". The definition provided was: "By general practice we mean the places where family doctors are based, which can include nurses and other staff."
Other terms used interchangeably in the questionnaire and report are: "family health care", "family doctor", "GP", "family doctor's practice". The wording variations were to provide the best fit with the specific questions and keep the questions sufficiently comprehensible for respondents.

OTHER TERMS USED
• PHCS/ Primary Health Care Strategy: The government strategy of which PHOs are the key delivery mechanism (see Introduction chapter for more detail)
• Low income: Household income of $40,000 or under, which approximated the median household income in the 2001 Census25
• Medium to High Income: Household income over $40,000
• Older people: Aged 65 years and over
• People with Children: Those with any children aged 0 to 15 years
• Other ethnic groups: People who are neither Maori nor Pacific peoples
• Access and Interim PHOs: The two types of PHOs, with Access currently receiving higher levels of government funding to allow them to subsidise fees to a higher level
• Respondent: Person who took part in the survey
• Unprompted recall: Those mentioning having seen or heard advertising when asked how they have heard about PHOs
• Prompted recall: Those who recall advertising unprompted plus those who recall seeing or hearing advertising when asked directly whether they have seen or heard any.
• Well health: The wording of the question asking about a greater focus on well health was as follows: "The changes involving PHOs are supposed to lead to a number of changes in the way general practices operate. One of the aims is to have more focus on keeping people well, not just dealing with people when they are sick. This might mean that your family doctor’s practice would offer things like regular check-ups, classes for people with

25 It was not possible to include equivalised income analyses, which take into account the number of people sharing the household income, as the total number of people in the household was not included in the questionnaire.
diabetes, and help with weight reduction. How much do you support or oppose your family doctor’s practice providing these sorts of services to keep people well?"

- Urban areas: Areas of population of 30,000 or more
- Secondary urban areas: Areas of population 10,000 to 29,999 people
- Minor urban areas: Areas of population 1,000 to 9,999 people
- Rural areas: Areas of population less than 1,000 people
APPENDIX D - QUESTIONNAIRE

PHO National Benchmark Survey - March 2004

Good morning/afternoon/evening, I am [Q0IV] calling on behalf of the Ministry of Health. They have asked us at Phoenix Research to interview the public about changes being made to the way health care services are provided by family doctors and other health professionals. Have you got a minute now so I can see if there is anyone in your household who may be able to help us?

Q99HLD. We would like to talk to a person in your household who makes decisions about which family doctor or health care services they or others are going to use. How many people are there in your household aged over 15 who make these sorts of decisions?

_Interviewer Note: Options for encouraging participation:

You don’t need to know anything about these things, we just want ordinary people.
A copy of the results will be available to anyone who takes part.
This is an important survey and we need to speak with as many people as possible from those who are randomly selected, so the findings are representative of all New Zealanders_

Q99A. Of the people who do make health care decisions, which one had the last birthday?
_Ask to speak with them_

Q99G. _Code gender of person to be interviewed_
1. Male
2. Female

Q99INT. The interview will usually take between 10 and 15 minutes, depending on how much you know about the changes that are taking place. The survey is voluntary and confidential (your answers will be combined with those of many others). For quality control purposes some of my calls may be monitored by my supervisor.

Would you be willing to take part in this interview?

Q99M. If you are Maori or a Pacific person and you would prefer, we can arrange for you to be interviewed by a Maori or Pacific interviewer.
1. Continue interview
2. Would prefer Maori interviewer
3. Would prefer Pacific interviewer

Q99D. Before we begin, can I just check that you are aged over 15 years.
1. Yes, continue
2. No

_IF "No"

Q99C1. Could I please speak with the person who had the last
birthday who is aged over 15 years and makes decisions about which family doctor or health care services they or others are going to use?

Q1A. What types of people do you go to for help when you or a family member is unwell?

_Do not Read, Probe to no_

1. Family doctor/GP
2. Nurse
3. Pharmacist/chemist
4. Naturopath
5. Homeopath
6. Acupuncturist
7. Chinese traditional healers eg. medicine specialist/ Chinese herbalist
8. Maori Traditional healers eg. tohunga, roanga
9. Pacific Traditional healers
10. Community elders
11. Parents or other family members
12. Friends/acquaintances
13. Other (specify)

__________

14. **Don't know**
15. **Refused**

Q1B. If you could change the way family health care services are delivered, what changes would you like to see?

_If necessary explain:_ By ‘family health care services’ we mean the sorts of services that are currently provided by family doctors, nurses and others who work in the community, not at hospitals

_Probe fully_ Do not Read

1. No changes wanted
2. Being able to get an appointment when you need one
3. Less waiting time at the practice
4. More time with the doctor
5. Cheaper fees
6. More Maori doctors/staff
7. More Pacific doctors/staff
8. Home visits
9. Other (specify)
10. Cheaper fees for children under (specify) age

__________

11. Refused
12. Don’t know
13. Refused

Q2. Have you heard of _PHOs_ or Primary Health Organisations?

1. Yes
2. No
3. Don’t know
4. Refused

IF 2-4 IN Q2 GO Q6A
IF 1 IN Q2 GO Q3A

Q3A. What do you understand a PHO to be?

_Probe fully. Do not read_

1. A combination/group of different (doctors) practices
2. An organisation of health care providers
3. A new way of providing health care
4. Other (specify)
5. **Don't know**
6. **Refused**

**Q3B.** I will now read out a basic explanation of PHOs provided by the Ministry of Health. PHOs are a group of doctors, nurses and people trained and skilled in health care who are working together, often from several different practices or surgeries, with the aim of providing a better health service for you and your family.

If participant now says they were mistaken in saying they had heard of PHOs, code 1

Don't read

1. Mistaken in saying they had heard of PHO
2. Continue interview

IF 1 IN Q3B GO Q6A

**Q4.** In this questionnaire we will sometimes talk about general practices. By general practice we mean the places where family doctors are based, which can include nurses and other staff. Does the general practice or family doctor you usually go to belong to a PHO?

- Interviewer Note: Can have more than one usual doctor,

so code Yes if any belong

1. Yes, do belong
2. Think belong
3. Think don't belong
4. No, don't belong
5. Other (specify)
6. Unsure/don't know
7. Refused

**Q5A.** I now want to ask you about any advantages and disadvantages of PHOs that you know of. So firstly, what advantages are there for patients if their general practice or family doctor belongs to a PHO?

- Probe fully. Do not read

1. Provide cheaper health care/fees (specify Q5A1)
2. Provide wider range of health services
3. Prevent illnesses before they happen/ keep people healthy
4. Greater community involvement/consultation
5. More time with the doctor during appointments
6. Other (specify Q5A2)

7. Not aware of any advantages/ Don't know
8. Refused

GO Q5B

**Q5b.** And what disadvantages are there for patients if their general practice (or family doctor) belongs to a PHO?

- Probe fully. Do not read

1. Not supposed to use other doctors
2. Not allowed to use other doctors
3. More paper work/ forms to fill in
4. Confusing/difficult to understand
5. Other (specify)

6. Not aware of any disadvantages/ Don't know
7. Refused

GO Q6B

*Ask those who answer no/don't know/refused to knowing about PHOs in Q2
Q6A. In this questionnaire we will sometimes talk about general 
practices. By general practice we mean the places where 
family doctors are based, which can include nurses and other 
staff. Over the last 12 months, have there been any changes to 
the services that your general practice or family doctor 
provides, or the way in which they provide them? 
_Interviewer note: can be using more than one GP, so changes_ 
_to any are included_

1. Yes
2. No
3. Don’t know
4. Refused

IF 1 IN Q6A GO Q7 
GO Q18B

Q6B. Over the last 12 months, have there been any _changes_ to the 
services that _your_ general practice or family doctor provides 
or the way in which they provide them? Please include any of 
the previous changes that you listed as advantages or 
disadvantages if these _do_ apply to _your_ general practice? 
_Interviewer note: can be using more than one GP, so changes_ 
_to any are included_

1. Yes
2. No
3. Don’t know
4. Refused

IF 1 IN Q6B GO Q7 
GO Q8JMP

Q7. What are these 
(_changes_ to the services that _your_ general practice or 
family doctor provides _or the way in which they provide them)? 
_Probe to no, do not read_

1. Reduced fees
2. Open longer hours
3. Have a community health worker
4. See nurse more often
5. Other (specify)
6. **Don’t know**
7. **Refused**

IF 1 IN Q3B GO Q18B 
IF 2-4 IN Q2 GO Q18B 
IF 1 OR 2 IN Q4 GO Q8 
GO Q12

*Ask those who are aware that their doctor is part of a PHOs (coded 1-2 in Q4), those not aware of 
PHOs go to Q14, others go to Q12

Q8. In the last 12 months have you visited any general practice 
or family doctor that was _not_ part of the same practice as 
your _regular_ doctor and was _not_ part of an after hours 
clinic or hospital?

1. Yes
2. No
3. Don’t Know
4. Refused

IF 2 IN Q8 GO Q12
Q9. Did these other people do anything to encourage you to join their own practice or PHO?
1. Yes
2. No
3. Don't know
4. Refused

*Sources of information*

Q12. In what ways have you heard about PHOs and other changes in the ways family healthcare is delivered?
   _ Probe to no, do not read_
1. From GP/doctors in person
2. From receptionist at doctors practice
3. From nurses at doctors practice
4. From other staff at doctors practice
5. From brochures/information displayed in doctors rooms
6. From information sent in mail from doctor's practice
7. TV ads
8. Radio ads
9. Cinema ads
10. Billboards
11. Other advertising (specify Q12A1)
12. Community newspapers
13. Other newspapers
14. TV items/news
15. Radio items/news
16. Information on community notice boards (eg in supermarkets, kindergartens)
17. From friends/acquaintances
18. Marae
19. Church
20. Other (specify Q12A2)
21. Don't know
22. Refused
23. None

GO Q12JMP

If 7-11 IN Q12 GO Q15

Q13. Have you seen or heard any _advertising_ about PHOs or other changes in the way family health care is delivered?
1. Yes
2. No
3. Don't know
4. Refused

IF 2-4 IN Q13 GO Q18A

Q15. What are your feelings and impressions about the advertising that you have seen or heard for PHOs or other changes in the ways family health care is delivered?
   _Probe fully_

Q16A. What do you feel this advertising was trying to tell people?
   _Probe fully_

Q18A. What are the _best_ ways for you to be told about PHOs or other changes in the way health care is delivered?
   _If necessary probe on who in doctors practice_
   Any other _best ways_? _Probe to no, do not read_
1. From advertising
2. From GP/doctor
3. From receptionist at doctor's practice
4. From nurse at doctor's practice
5. From other staff at doctor's practice
6. From brochures/information displayed in doctors rooms
7. From information sent in mail from doctor's practice
8. Community newspapers (items, not ads)
9. Other newspapers (items, not ads)
10. Email
11. Internet
12. TV items (not ads)
13. Radio items (not ads)
14. Information on community notice boards (eg in supermarkets, kindergartens)
15. From friends/acquaintances
16. Marae
17. Church
18. Other (specify)
19. Don't know
20. Refused

GO Q20A

Q18B. What are the best ways for you to be told about changes in how family health care is delivered?
   _Probe on who in doctors practice if necessary._
   _Probe to no, do not read_
1. From advertising
2. From GP/doctor
3. From receptionist at doctor's practice
4. From nurse at doctor's practice
5. From other staff at doctor's practice
6. From brochures/information displayed in doctors rooms
7. From information sent in mail from doctor's practice
8. Community newspapers (items, not ads)
9. Other newspapers (items, not ads)
10. Email
11. Internet
12. TV items (not ads)
13. Radio items (not ads)
14. Information on community notice boards (eg in supermarkets, kindergartens)
15. From friends/acquaintances
16. Marae
17. Church
18. Other (specify)
19. Don't know
20. Refused

IF 2-4 IN Q2 GO Q22A
IF 1 IN Q3B GO Q22A

Q20A. Do you want to find out more about PHOs and the changes to the way family health care is delivered?
1. Yes
2. No
3. Don't know
4. Refused

IF 2-4 IN Q20A GO Q21A

Q20C. Do you want to know a little or a lot more?
   _Read_
1. A little more
2. A lot more
3. Don't know
4. Refused

**Q20D. What do you want to know more about?**
_Probe fully_

**Q21A. Would you like to see PHOs involving the community more in the decisions about what services should be provided?**
1. Yes
2. No
3. Don't know
4. Refused

IF 2-4 IN Q21A GO Q22A

**Q21B. In what ways, if any, would you like to be able to tell PHOs about the services you would like them to provide?**
_Probe to no.  Don't read_
1. None/ Don't personally want to inform PHO
2. Write to PHO
3. Through my family doctor/GP
4. Through health support groups e.g. Cancer Society, Heart Foundation
5. Through community groups I or others belong to
6. Elect member to boards of PHOs
7. Get board to meet with community groups Iwi etc.
8. Other (specify)
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9. Don't know
10. Refused

**Q22a. Have you heard of the National Health Index or NHI number?**
1. Yes
2. No
3. Don't know
4. Refused

IF 1 IN Q22A GO Q22B
IF 1 IN Q2 GO Q23A
GO Q23PRE

**Q22B. Do you know what it is used for?**
1. Yes
2. No
3. Don't know
4. Refused

IF 1 IN Q22B GO Q22C
IF 1 IN Q2 GO Q23A
GO Q23PRE

**Q22C. What would that be?**
_Probe fully.  Do not read_
1. To identify patients uniquely
2. Brings all their health information together in one place
3. To prevent people being given the wrong medication or care
4. To identify and track medical records for each person
5. To easily move medical records from one doctor to another
6. Record of use of hospital services
7. National record of everyone's health
8. Other (specify)
9. ***Don't know***
10. ***Refused***
Q23PRE. I will now read out a basic explanation of PHOs provided by the Ministry of Health. PHOs are a group of doctors, nurses and people trained and skilled in health care who are working together, often from several different practices, with the aim of providing a better health service for you and your family.

Q23A. The changes involving PHOs are supposed to lead to a number of changes in the way general practices operate. One of the aims is to have more focus on keeping people well, not just dealing with people when they are sick. This might mean that your family doctor’s practice would offer things like regular check ups, classes for people with diabetes, and help with weight reduction. How much do you support or oppose your family doctor’s practice providing these sorts of services to keep people well? Would that be...

_Read_

1. Strongly support
2. Support
3. Support a little
4. Neither support not oppose
5. Oppose a little
6. Oppose
7. Strongly oppose
-----
9. **This already happens in my practice**
10. **Don't know**
11. **Refused**

Q23B. Another aim is to encourage greater use of a range of health professionals, not just your doctor, to provide services for you, where they have the skills to do so. For example, a nurse might see you for a regular health check or help with weight reduction. How much do you support or oppose the greater use of a range of health professionals?

_Read_

1. Strongly support
2. Support
3. Support a little
4. Neither support not oppose
5. Oppose a little
6. Oppose
7. Strongly oppose
-----
9. **This already happens in my practice**
10. **Don't know**
11. **Refused**

GO Q25A

*Fees

Q25A. In the _last 12 months_, has there been any time when you needed to see a GP or family doctor about your health, but _didn't_ get to see one?

1. Yes
2. No
3. Don't know
4. Refused
IF 2-4 IN Q25A GO Q26

Q25B. The last time this happened, was this decision influenced by the _cost_ of visiting the doctor?
1. Yes
2. No
3. Don't know
4. Refused

IF 1 IN Q25B GO Q25C
GO Q26

Q25C. How much was it influenced by cost? Was it ...
_Read_
1. Totally
2. A lot
3. Somewhat
4. A little
5. Not at all
6. **Don't know**
7. **Refused**

Q26. When was the last time you saw a GP or family doctor about your own health, not counting doctors in hospitals or after hours clinics? (in NZ)
_Read if necessary_
1. Within the last 4 weeks
2. More than 4 weeks ago and less than 12 weeks (3 months)
3. More than 12 weeks ago and less than 24 weeks (6 months)
4. More than 6 months and up to 1 year ago
5. More than 1 year ago
6. Don't use a doctor
7. **Don't know/Not sure**
8. **Refused**

If 5-8 IN Q26 GO Q41

Q28. How much were you charged on this last visit, not counting prescription charges?
_Enter to nearest dollar_
_Code 'D' for Don't know_
_Code 'R' for Refused_

IF D OR R IN Q28 GO Q32

Q29. Was this the amount that you usually pay?
1. Yes
2. No
3. Don't know
4. Refused

IF 2 IN Q29 GO Q30
GO Q32

Q30. How much do you usually pay?
_Enter to nearest dollar_
_Code 'D' for Don't know_
_Code 'R' for Refused_

Q31. What were the reasons for the change (in amount paid) on this last visit?
_Probe fully. Do not read_
1. On ACC/ no longer on ACC
2. Pregnant/no longer pregnant
3. Because part of PHO
4. Government increased payments they make to doctor/PHO
5. Consultation longer/shorter than usual
6. Standard fee increased
7. Casual visit- not usual doctor (not enrolled here)
8. Other (specify)
-----
9. **Don't know**
10. **Refused**

**Q32.** On this last visit, who else did you talk with in the practice? (Do not include doctor or receptionist). Probe to no, do not read

1. Practice nurse
2. Community Health Worker (including Maori and Pacific Community Health Workers)
3. Other (specify)
-----
4. **No one else**
5. **Don't know**
6. **Refused**

If 1-3 IN Q32 GO Q33
GO Q34

**Q33.** Was there a charge for this?

1. Yes
2. No
3. Don't know
4. Refused

**Q34.** Have you changed your regular (GP or family) doctor in the last 12 months?

1. Yes
2. No
3. Don't know
4. Refused

IF 1 IN Q34 GO Q35
GO Q41

**Q35.** Does your new doctor have a copy of the records from your old one?

1. Yes
2. No
3. Don't know
4. Refused

IF 1 IN Q35 GO Q36
GO Q41

**Q36.** Did you sign something to give your new doctor permission to obtain your old records?

1. Yes
2. No
3. Don't know
4. Refused

*Demographics

**Q41.** Finally we have some questions for our statistics. Could you please tell me which of the following age groups you come into.
Q42A. How many children do you have aged under 5 years whose health care you are responsible for?
   _Interviewer Note: If they mention more than 2 children, check that they are not including children_ 
   _that they work with_

Q42B. And how many children do you have aged 5 to 15 years whose health care you are responsible for?
   _If they mention more than 4 children, check they are not_ 
   _including children that they work with_

Q43. How many other adults’ health care are you responsible for, not counting yourself and anything you do as part of your work?
   _Interviewer note Adults are aged 16 years and over_

Q44. Which ethnic group do you belong to?
   _Probe to no. Code all mentions_
   1. NZ European
   2. Maori
   3. Samoan
   4. Cook Island Maori
   5. Tongan
   6. Niuean
   7. Other Pacific (specify)
   8. Chinese
   9. Indian
   10. Other (such as Dutch, Japanese) - (specify)
   11. Refused

Q45. What would be the total income that you yourself got from ALL SOURCES, before tax, in the last twelve months?
   _Read if necessary (begin by asking if more or less than _
   _$25 to $30 000 and then work up or down accordingly)_
   1. Loss
   2. Zero
   3. $1 - $5,000
   4. $5,001 to $10,000
   5. $10,001 to $15,000
   6. $15,001 to $20,000
   7. $20,001 to $25,000
   8. $25,001 to $30,000
   9. $30,001 to $40,000
   10. $40,001 to $50,000
   11. $50,001 to $70,000
   12. $70,001 to $100,000
   13. $100,001 or more
   14. Refused
   15. Don’t know

Q46. What would be the total income that THE HOUSEHOLD got from ALL SOURCES, in the last twelve months?
   _Read if necessary (begin by asking if more or less than _
   _$30 to $40,000 and then work up and down accordingly)_
   1. Loss
2. Zero
3. $1 - $5,000
4. $5,001 to $10,000
5. $10,001 to $15,000
6. $15,001 to $20,000
7. $20,001 to $25,000
8. $25,001 to $30,000
9. $30,001 to $40,000
10. $40,001 to $50,000
11. $50,001 to $70,000
12. $70,001 to $100,000
13. $100,001 or more
14. Refused
15. Don't know

Q47A. Do you have a High User Health Card?
1. Yes
2. No
3. Don't know
4. Refused

Q47B. Do you have a Community Services Card?
1. Yes
2. No
3. Don't know
4. Refused

Q48. So that we can identify how our sample is spread across the country, could you please tell me your street address, including the town or city.
Address: _[Q48ADD]_
_NEED to get names of streets or roads,
_RD or PO Box numbers not acceptable_
_If long road, get distance and direction_
_from nearest town e.g. SH1, 4km SW of Geraldine_
_Code 'R' if refused to give address_

GO Q49

Q49. So that we can see how our sample is spread across the different medical practices, would you be willing to tell us the name and street of the medical practice or doctor you usually attend? They will _not_ have any access to the information from this interview.
1. Yes (specify)
2. No/Refused

Q50A. The Ministry of Health may be doing further research on topics related to what we have just talked about. Would you be willing to be called again in the future?
1. Yes
2. No
3. Don't know
4. Refused

IF 1 IN Q50A GO Q50B
GO Q51

Q50B. Could you please give me your name, so they know who to ask for?
Name: _[Q50NAM]_
_First name will be enough if they don't want to give_
_full name_
GO Q51

Q51. Would you like to be sent a copy of the research results when they become available? Alternatively you can access them from the Ministry of Health website (www.moh.govt.nz).
   If Yes: Record name and mailing address:
   Name: [Q51NAM]
   Address: [Q51ADD]
   Enter ‘N’ for No report required.

GO Q52

*and option to not record name and keep going to Q52

Q52. Finally I'd just like to remind you that I'm [Q0IV] from PHOENIX Research. If you have any queries at all about this survey, please feel free to phone PHOENIX Research during office hours on 0800 2 PHOENIX. That is the same as 0800 274 636.
   If you have any queries about PHOs or the changes to health services, you can call 0800 252 464 during office hours.
   Thanks again for your time.
   Interviewer note: If the person needs to speak with a researcher, put them through to Allan Wyllie (ext 102).
   If they wish to speak specifically with the Ministry of Health, they can call Bridget Caird on 04 496 2199.