

Māori Providers: Primary health care delivered by doctors and nurses

The National Primary Medical Care
Survey (NatMedCa): 2001/02

Report 3

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Appendix A: Log of Visits

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National Primary Medical Care Survey

Practitioner Study ID Number _____ (F) **LOG OF VISITS** Questionnaire Number _____

Please complete this log for all patients. Fill in the visit form ONLY for the fourth patient.
Start Here →

<p style="text-align: center;">Patient One</p> <p>Gender male <input type="checkbox"/> female <input type="checkbox"/></p> <p>Date of birth: day mth yr _____</p> <p>Ethnicity: <small>(see options on cover, tick the space or spaces that apply)</small></p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/></p> <p>Com'ty Services Cd yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>High user card yes <input type="checkbox"/> no <input type="checkbox"/></p>	<p style="text-align: center;">Patient Two</p> <p>Gender male <input type="checkbox"/> female <input type="checkbox"/></p> <p>Date of birth: day mth yr _____</p> <p>Ethnicity: <small>(see options on cover, tick the space or spaces that apply)</small></p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/></p> <p>Com'ty Services Cd yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>High user card yes <input type="checkbox"/> no <input type="checkbox"/></p>
<p style="text-align: center;">Patient Three</p> <p>Gender male <input type="checkbox"/> female <input type="checkbox"/></p> <p>Date of birth: day mth yr _____</p> <p>Ethnicity: <small>(see options on cover, tick the space or spaces that apply)</small></p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/></p> <p>Com'ty Services Cd yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>High user card yes <input type="checkbox"/> no <input type="checkbox"/></p>	<p style="text-align: center;">Patient Four</p> <p>Gender male <input type="checkbox"/> female <input type="checkbox"/></p> <p>Date of birth: day mth yr _____</p> <p>Ethnicity: <small>(see options on cover, tick the space or spaces that apply)</small></p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/></p> <p>Com'ty Services Cd yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>High user card yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>Please complete report for this visit.</p>

Please enter address here for patient number 4

Questionnaire number _____

number _____ Street _____

Town/Suburb _____

COMPLETE REPORT FORM →

Appendix B: Visit Report

Practitioner ID Number _____	NATMEDCA	(G) VISIT REPORT	Questionnaire number _____
1	Date of visit - day _____ month _____ year _____	3	Was there a hidden agenda apart from the reason(s) for visit? yes <input type="checkbox"/> no <input type="checkbox"/>
2	REASON FOR VISIT (persons own words) 1. _____ 2. _____ 3. _____ 4. _____	4	How would you assess this person's social circumstances? good <input type="checkbox"/> average <input type="checkbox"/> poor <input type="checkbox"/> threatening <input type="checkbox"/> unknown <input type="checkbox"/>
5		5	What is this person's marital status? separated <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> never married <input type="checkbox"/> married <input type="checkbox"/> de facto <input type="checkbox"/>
6	Please include all issues (well person care, psycho-social difficulties, practitioner identified issues etc.) as problems and mention all interventions under treatment (scripts, immunisation, smears, certification, reassurance, counselling etc.) *Please give Drug name, dose, interval, duration as on prescription DIAGNOSIS/PROBLEM 1 _____ Status of problem: new <input type="checkbox"/> short-term FU <input type="checkbox"/> long-term FU <input type="checkbox"/> Long-term with flare-up <input type="checkbox"/> preventative <input type="checkbox"/> *Action, treatment, drugs for this problem: DIAGNOSIS/PROBLEM 2 _____ Status of problem: new <input type="checkbox"/> short-term FU <input type="checkbox"/> long-term FU <input type="checkbox"/> Long-term with flare-up <input type="checkbox"/> preventative <input type="checkbox"/> *Action, treatment, drugs for this problem: DIAGNOSIS/PROBLEM 3 _____ <input type="checkbox"/> short-term FU <input type="checkbox"/> long-term FU <input type="checkbox"/> Long-term with flare-up <input type="checkbox"/> preventative <input type="checkbox"/> *Action, treatment, drugs for this problem: DIAGNOSIS/PROBLEM 4 _____ Status of problem: new <input type="checkbox"/> short-term FU <input type="checkbox"/> long-term FU <input type="checkbox"/> Long-term with flare-up <input type="checkbox"/> preventative <input type="checkbox"/> *Action, treatment, drugs for this problem:	7	
INVESTIGATIONS ORDERED <input type="checkbox"/> FBC <input type="checkbox"/> Culture <input type="checkbox"/> Pap Smear <input type="checkbox"/> Sed rate <input type="checkbox"/> Fe etc, B12, FA <input type="checkbox"/> ECG <input type="checkbox"/> Serum glucose <input type="checkbox"/> Plain X-Ray <input type="checkbox"/> Creatinine/urea <input type="checkbox"/> Contrast etc <input type="checkbox"/> Liver function <input type="checkbox"/> Ultrasound <input type="checkbox"/> Lipids <input type="checkbox"/> Spirometry <input type="checkbox"/> Thyroid <input type="checkbox"/> Other _____		DISPOSITION Follow-up within 3/12? yes <input type="checkbox"/> no <input type="checkbox"/> Referred on? yes <input type="checkbox"/> no <input type="checkbox"/> To specialist (enter speciality) _____ Sent to Acute Assessment Unit or Emergency Dept. yes <input type="checkbox"/> no <input type="checkbox"/>	
GENERAL AND EVALUATION (worst problem) Is person new to practice? yes <input type="checkbox"/> no <input type="checkbox"/> Is patient new to practitioner? yes <input type="checkbox"/> no <input type="checkbox"/> Is practice usual source of care? yes <input type="checkbox"/> no <input type="checkbox"/> Number visits to practice in previous 12 months: _____ Has/will person see nurse today? yes <input type="checkbox"/> no <input type="checkbox"/> Has/will person see doctor today? yes <input type="checkbox"/> no <input type="checkbox"/> Source of payment? Cash/GMS <input type="checkbox"/> ACC <input type="checkbox"/> Duration of visit? shorter <input type="checkbox"/> average (10-15min) <input type="checkbox"/> longer <input type="checkbox"/> Was patient (child's caregiver) fluent in English? yes <input type="checkbox"/> no <input type="checkbox"/> Practitioner perception of urgency of this visit? ASAP <input type="checkbox"/> today <input type="checkbox"/> this week <input type="checkbox"/> this month <input type="checkbox"/> Severity? life threatening <input type="checkbox"/> intermediate <input type="checkbox"/> self-limiting <input type="checkbox"/> NA <input type="checkbox"/> Disability? Extent: none <input type="checkbox"/> minor <input type="checkbox"/> major <input type="checkbox"/> Type: temporary <input type="checkbox"/> permanent <input type="checkbox"/> Uncertainty as to diagnosis or management? none <input type="checkbox"/> low <input type="checkbox"/> medium <input type="checkbox"/> high <input type="checkbox"/> General rapport achieved? low <input type="checkbox"/> medium <input type="checkbox"/> high <input type="checkbox"/>			

Appendix C: Practitioner Questionnaire

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National Primary Medical Care Survey

(C) PRACTITIONER QUESTIONNAIRE

Practitioner Study ID number _____

Practice Study ID Number _____

Medical Practitioners please complete this box

<p>1. Age at last birthday (years) _____</p> <p>2. Gender – Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>3. What is your ethnicity: (tick the space or spaces that apply to you)</p> <p>(1) New Zealand European <input type="checkbox"/></p> <p>(2) Maori <input type="checkbox"/></p> <p>(3) Samoan <input type="checkbox"/></p> <p>(4) Cook Island Maori <input type="checkbox"/></p> <p>(5) Tongan <input type="checkbox"/></p> <p>(6) Niuean <input type="checkbox"/></p> <p>(7) Chinese <input type="checkbox"/></p> <p>(8) Indian <input type="checkbox"/></p> <p>(9) Other <input type="checkbox"/></p> <p>4. How many years in this practice _____</p> <p>5. Total years in General Practice _____</p> <p>6. Post Graduate Qualifications</p> <p>(a) M/FRNZCGP <input type="checkbox"/></p> <p>(b) Overseas M/FRNZCGP equivalent <input type="checkbox"/></p> <p>(c) Dip Obs <input type="checkbox"/></p> <p>(d) Dip Anaesth <input type="checkbox"/></p> <p>(e) Other <input type="checkbox"/> (specify) _____</p> <p>7. Are you a member of the NZ Medical Association? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>8. How many hours per month do you spend on CME / MOPS? _____ hours</p>	<p>9. Where did you obtain your medical degree?</p> <p>(a) New Zealand <input type="checkbox"/></p> <p>(b) Australia <input type="checkbox"/></p> <p>(c) United Kingdom <input type="checkbox"/></p> <p>(d) Asia <input type="checkbox"/></p> <p>(e) North America <input type="checkbox"/></p> <p>(f) Other <input type="checkbox"/> (specify) _____</p> <p>10. What are your employment arrangements during regular day-time for your standard office hours?</p> <p>(a) Self-employed <input type="checkbox"/> (b) Salaried <input type="checkbox"/></p> <p>11. (a) Do you provide after hours cover? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>(b) If yes, how often do you provide cover on week nights? (e.g. 1 in 5 nights)? _____</p> <p>(c) If yes, how often do you cover at the weekend? (e.g. 63 hours every 3 weeks)? _____</p> <p>12. What are your after-hours employment arrangements?</p> <p>(a) Self-employed <input type="checkbox"/> (c) Not applicable <input type="checkbox"/></p> <p>(b) Salaried <input type="checkbox"/></p> <p>13. (a) Do you provide medical care to rest homes? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>(b) If yes, do you claim GMS for rest home visits? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>14. Number of half days worked per week _____</p> <p>15. Average number of day-time patients per week _____</p> <p>16. Do you undertake obstetric deliveries? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>17. (a) Do you provide telephone consultations in place of face-to-face consultations? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>(b) If yes, please estimate the number of hours per week for telephone consultations _____</p>
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Appendix D: Nurse Questionnaire

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National Primary Medical Care Survey

(D) NURSE QUESTIONNAIRE

Practitioner Study ID number _____

Practice Study ID Number _____

Nurses and Midwives please complete this box

<p>1. Age at last birthday(years) _____</p> <p>2. Gender – Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>3. What is your ethnicity? (tick the space or spaces that apply to you)</p> <p>(1) New Zealand European <input type="checkbox"/></p> <p>(2) Maori <input type="checkbox"/></p> <p>(3) Samoan <input type="checkbox"/></p> <p>(4) Cook Island Maori <input type="checkbox"/></p> <p>(5) Tongan <input type="checkbox"/></p> <p>(6) Niuean <input type="checkbox"/></p> <p>(7) Chinese <input type="checkbox"/></p> <p>(8) Indian <input type="checkbox"/></p> <p>(9) Other <input type="checkbox"/></p> <p>4. How many years in this practice? _____</p> <p>5. How many years as an Independent Practitioner? _____</p> <p>6. What are your Post Graduate Qualifications? (specify) _____</p>	<p>7. How many hours per month do you spend on CME? _____ hours</p> <p>8. Are you a member of:</p> <p>(a) NZNO <input type="checkbox"/> (c) College of Midwives <input type="checkbox"/></p> <p>(b) College of Nursing <input type="checkbox"/> (d) Other <input type="checkbox"/> (specify) _____</p> <p>9. Where did you qualify?</p> <p>(a) New Zealand <input type="checkbox"/></p> <p>(b) Australia <input type="checkbox"/></p> <p>(c) United Kingdom <input type="checkbox"/></p> <p>(d) Asia <input type="checkbox"/></p> <p>(e) North America <input type="checkbox"/></p> <p>(f) Other <input type="checkbox"/> (specify) _____</p> <p>10. What are your employment arrangements?</p> <p>(a) Self employed/profit sharing <input type="checkbox"/></p> <p>(b) Salaried <input type="checkbox"/></p> <p>11. Number of half days worked per week? _____</p> <p>12. Average number of patients per week? _____</p> <p>13. Are you a Registered Nurse? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>14. Are you a Registered Midwife? yes <input type="checkbox"/> no <input type="checkbox"/></p>
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Appendix E: Practice Nurse Survey

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National Primary Medical Care Survey

(E) PRACTICE NURSE SURVEY

Practice Nurse Study ID number _____

Practice Study ID Number _____

BACKGROUND INFORMATION

1. Age at last birthday (years) _____
2. Gender male female
3. What is your ethnicity? (tick the space or spaces that apply to you)
 - (1) New Zealand European
 - (2) Maori
 - (3) Samoan
 - (4) Cook Island Maori
 - (5) Tongan
 - (6) Niuean
 - (7) Chinese
 - (8) Indian
 - (9) Other
4. What were your initial qualifications?
(a) RGN (b) RGON (c) RCpN (d) EN (e) RM (f) BA/BHSc/BN (g) Other
5. Please give any post-graduate qualifications _____
6. How long have you worked as a nurse? (approx. full time equivalent years) _____
7. How long have you worked as a practice nurse? (approx. full time equivalent years) _____
8. Please indicate if you have a membership in a Professional Organisation.
(a) NZNO (b) College of Nursing (c) Other (please specify) _____ (d) None

ACTIVITIES

9. How many hours do you work at the practice in an average week? hrs/wk _____
10. Approximately how many hours do you spend on the following duties in an average week?
(use decimals if appropriate eg 2.3 hrs)
 - (a) Direct Patient contact _____ hrs
 - (b) Patient contact by phone _____ hrs
 - (c) Administration _____ hrs
 - (d) Housekeeping _____ hrs
 - (e) Other duties _____ hrs (specify)

11. (a) Do your clients make appointments specifically to see you? yes no

(b) If yes, how many appointments would you take in an average week? _____

12. How long is usually allocated for a nurse appointment? _____ minutes

13. Does your practice charge a fee for nurse appointments? yes no

14. What practice nurse clinics are offered at your practice?

- | | | | |
|-------------------|--------------------------|------------------|--|
| (a) None | <input type="checkbox"/> | (e) Smears | <input type="checkbox"/> |
| (b) Hypertension | <input type="checkbox"/> | (f) Asthma | <input type="checkbox"/> |
| (c) Diabetes | <input type="checkbox"/> | (g) Immunisation | <input type="checkbox"/> |
| (d) Contraception | <input type="checkbox"/> | (h) Antenatal | <input type="checkbox"/> |
| | | (i) other | <input type="checkbox"/> (specify) _____ |

15. Which of the following patient-contact duties do you *carry out*? (A)
and which may be undertaken without *immediate* doctor referral? (B)

ACTIVITY TYPE	CARRY OUT (A)		INDEPENDENTLY (B)	
	yes	no	yes	no
(a) Immunisations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Child Care Advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Cervical Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Dressings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Suturing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Group Education Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Dietary/Lifestyle Advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Repeat Prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Blood Taking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Home Visiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Many thanks for helping us by completing this questionnaire.

For information on the Survey, phone:

Antony Raymont, Medical Director on 09 483 4555 or 0800 007925, 021 998 118

The contribution of Rose Lightfoot in selecting these questions is acknowledged.

Appendix F: Practice Questionnaire

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National Primary Medical Care Survey

(A) PRACTICE QUESTIONNAIRE

Practice Study ID Number _____

Please tick the appropriate box(es).

ACCESS

1. Please indicate the standard day, half days closed, and extra hours the practice is open.

(a) standard day (eg 8.30am – 5.00pm) Open _____ Close _____

(b) half days closed (eg Wed. pm) _____

(c) extra hours (eg Thursday evening or Saturday morning) _____

2. Does the practice use a booking system?

yes no

3. What booking interval is usual?

_____ minutes

4. (a) Do practitioners in the practice make home visits?

yes no

(b) If yes, what is the average number of home visits made per week? _____

5. What after-hours arrangements does the practice have? (tick all that apply)

(a) Provides own after-hours cover

(b) Member of collective after-hours service

(c) Sign out to after-hours service

(d) Other (please specify) _____

6. Does the practice/local GP organisation undertake any of the following?

(a) Formal community needs assessment yes no

(b) Locality service planning yes no

(c) Inter-sectoral case management yes no

SERVICES PROVIDED

7. What screening programmes with dedicated recall and follow up systems are provided?

(a) Cervical smear

(c) Mammogram

(b) Diabetes

(d) Other (please specify) _____

EQUIPMENT

12. Does the practice have the following equipment on site?

- (a) ECG machine yes no
- (b) Equipment for intubation yes no
- (c) Xray facilities yes no
- (d) Autoclave yes no
- (e) Baby Scales yes no
- (f) Liquid Nitrogen yes no
- (g) Defibrillator yes no
- (h) Cautery Machine yes no
- (i) Proctoscope yes no

MIX OF PERSONNEL

13. Please indicate the number of FTE workers in the following categories:

(please use Full Time Equivalents eg 0.5 = 2.5 days/week; when one person performs more than one role, please estimate amount of time for each. Rough data is better than none at all!)

Worker Category	Number of FTE Staff
a. Manager	
b. Reception staff	
c. Administrative staff	
d. Doctor	
e. Nurse	
f. Community worker	
g. Midwife	
h. Other (specify) _____	

14. Please indicate the number of staff according to the following ethnicity categories.

- (a) New Zealand European _____
- (b) Maori _____
- (c) Samoan _____
- (d) Cook Island Maori _____
- (e) Tongan _____
- (f) Niuean _____
- (g) Chinese _____
- (h) Indian _____
- (i) Other _____

QUALITY MANAGEMENT

15. Does the practice have a written policy on complaints? yes no
16. Does the practice have a written policy on critical events investigation procedures? yes no
17. Does the practice have a written training policy for staff? yes no
18. Does the practice have a written development policy for staff? yes no
19. Does the practice have a written policy for ongoing quality management (eg "RNZCGP quality programme, CHASP")? yes no
20. Does the practice utilise a formal peer review process? yes no
21. Does the practice utilise evidence-based protocols and / or guidelines? yes no

INFORMATION SYSTEMS

22. Please indicate which of the following information systems are used by the practice?

- (a) Computerised age/sex register yes no
- (b) Computerised patient records yes no
- (c) Family-based records yes no
- (d) Computerised disease register yes no
- (e) Computer-based recall system(s) yes no

23. What percentage of patients have NHI numbers allocated? _____%

SITE INFORMATION

24(a). What is the geographical location of the practice?

- (1) Large City (Auckland)
- (2) City (100-500k pop.)
- (3) Town (30-100k pop.)
- (4) Small Town (<30k pop.)

(b). Is the practice in a rural location? yes no (if no, go to question 25)

(c). If yes, What is the rural ranking score? _____ score (see enclosed rural ranking score sheet)

25. Is the practice in the central business district? yes no

26. Please estimate the ethnic/cultural characteristics of the people seen at the practice:

- (a) % New Zealand European _____
- (b) % Maori _____
- (c) % Other Polynesian _____
- (d) % Other ethnic groups _____
- (e) % English as a second language _____

FINANCIAL AND COMMERCIAL INFORMATION

27. Please indicate which of the following best describes the practice. (choose only one)

- (a) Accident and Medical Centre
- (b) Health Care Aotearoa affiliated
- (c) Independent Practice Association (IPA) affiliated
- (d) Independent practice Inc. (including CareNet)

28. Please indicate which of the following government subsidy payment systems apply to your organisation. (tick all that apply)

- (a) GMS claims for individual consultations.
- (b) Capitation
- (c) Holding pharmaceutical budget
- (d) Holding investigation budget

29. What is the standard charge for a patient visit ? (please fill in each box below)

	CSC	HUHC	No Card
Child <6	\$ _____	\$ _____	\$ _____
Child >6	\$ _____	\$ _____	\$ _____
Adult	\$ _____	\$ _____	\$ _____

30. (a) For what percentage of visits are patient fees reduced? _____%

(b) For what percentage of visits are patient fees waived? _____%

31. Is there any category of consultation for which there is no charge (eg contraceptive advice)?

(please specify) _____

HISTORY

32. When was the practice established? year _____

33. What were the key reasons / events leading to the establishment of the practice?

34. Who are the key sponsors now? (tick as many as apply)

(a) None (b) Union (c) Community Organisation (d) Other

name _____

35. What is the legal structure of your practice?

(a) Sole trader (d) Incorporated society
(b) Partnership (e) Limited liability company
(c) Community trust (f) Other (please specify)

MANAGEMENT STRUCTURE AND COMMUNITY PARTICIPATION

36. (a) Does the practice organisation have a separate management committee? yes no

(if no, go to question 36)

(b) If yes, is there patient representation on the committee? yes no

(c) What appointment / election procedures are used for the management committee?

37. What role does the practice professional staff play in the following:

(a) Clinical organisation? (e.g. scheduling) _____

(b) Financial management? _____

38. Are you a "Maori provider"? (ie eligible for Maori provider funding) yes no