PHO Services Agreement

BETWEEN

District Health Board

AND

PHO

VERSION 1

By our respective authorised signatories signing below, we agree to comply with and be bound by the terms and conditions of this Agreement

District Health Board by:

Signature

Name

Position

Date

Witnessed by:

Signature

Name

Occupation

Residence

Date

by:

Signature	**Signature**
Name	**Name**
Position	**Position**
Date	**Date**
Witnessed by:	**Witnessed by:**
Signature	**Signature**
Name	**Name**
Occupation	**Occupation**
Residence	**Residence**
Date	**Date**

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Part A Background

A.1 Context of this Agreement

(1) We have been parties to a previous agreement. The objective of that agreement was to enable the PHO to work in a collaborative relationship with the DHB, to fulfil the responsibilities of a primary health organisation to implement and deliver the Government's Primary Health Care Strategy.

(2) The Government wishes to continually improve the delivery of primary health care services through the development and implementation of the Better, Sooner, More Convenient policy and other policy initiatives related to the delivery of health care services. The policy aims to establish an integrated healthcare system with patients at the centre, in which care is delivered closer to home by trusted, motivated health professionals working together in an effective, efficient manner.

(3) In addition to including obligations relating to the delivery of primary health care services in the DHB's annual plan, the Government has promoted and encouraged the establishment of district and regional alliances, the purpose of which is to give leaders from across the local health sector greater freedom to jointly determine service priorities and models of care in their districts.

(4) At the commencement of this Agreement, we are participants in the Alliance (Alliance) and in the Alliance Leadership Team that governs the Alliance.

(5) We now wish to enter into this Agreement for the purpose of implementing the Government's current and future policy objectives relating to the delivery of health care services, which are to:

(a) ensure that primary health care services are provided on a best for patient care and best for system basis, provide for care to be provided closer to home, provide for the improvement of patient outcomes and experiences, and support the clinical and financial sustainability of the health system;

(b) clarify the roles, functions, and accountabilities of DHBs, PHOs, and Contracted Providers in delivering health care services;

(c) develop a strengthened and integrated performance and incentive framework to lift the performance of DHBs, PHOs, Contracted Providers, and the health system;

(d) provide for and encourage collaboration between DHBs, PHOs, Contracted Providers, and other primary and community partners in the delivery of integrated health care services;

(e) promote the use of alliances throughout New Zealand as a means of ensuring clinically-led service integration, and ensure that certain health care services are delivered in accordance with decisions made by the Alliance Leadership Team; and

(f) encourage innovation in the delivery of health care services.

(6) For that purpose, this Agreement sets out the respective roles and responsibilities of each of us, and the commitment that both of us have made to work together over the term of this Agreement to develop and strengthen the way in which each of us fund and deliver health care services.

A.2 Purpose of this Agreement

(1) The purpose of this Agreement is to:

(a) set out the roles and responsibilities that we each have to ensure that primary health care services are funded and delivered in our district/region in a way that is best for patient and best for system and continually meet the Government's policy objectives;

(b) provide a framework for us to work collaboratively and in good faith, in an environment of trust, openness, and transparency;

(c) ensure that the Government is able to determine whether the Services are being delivered in a way that reflects its policy objectives, including by requiring information about the delivery of Services, outcome measures and the use of funds; and by creating incentives and mechanisms to ensure that Services are provided efficiently and effectively to a high quality;

(d) strengthen the accountability of primary health organisations and Contracted Providers through the measurement of their achievement against indicators and national health targets, and the recognition of high performance, within the context of the integrated performance and incentive framework for the health care system;

(e) provide for the PHO to deliver Nationally Consistent Services;

(f) provide for the PHO to deliver certain Services as determined by the Alliance; and

(g) provide for us to enter into separate agreements for the delivery of services on a local basis that are outside the scope of the Nationally Consistent Services, and the Alliance Services.

A.3 The DHB's roles and responsibilities

(1) The DHB is responsible for providing and funding health and disability services to improve the health of its resident population under the New Zealand Public Health and Disability Act 2000, in accordance with its annual plan approved by the Minister. The DHB funds and ensures the provision of primary health care services and promotes the integration of services.

(2) As a Crown agent, the DHB must act in a manner that is consistent with the Treaty of Waitangi Principles of partnership, participation, and protection in the delivery of health and disability services, in order to address disparities in health.

(3) The DHB will work with the PHO and its Contracted Providers in:

(a) the development of the DHB's annual plan, and will seek their endorsement of relevant sections of the plan; and

(b) the implementation of the plan and the achievement of the Government's policy objectives for health care.

A.4 The PHO's roles and responsibilities

(1) The PHO is accountable to the DHB for performing its functions set out in clause A.5 and achieving the outcomes set out in clause A.6.

A.5 PHO Functions

(1) The PHO will, in our district/region:

(a) Provide the Services;

(b) facilitate and promote service development, co-ordination and integration;

(c) participate in the development of the DHB's annual plan;

(d) promote continuous quality improvement in the delivery of the Services;

(e) ensure accountability for the delivery of the Services; and

(f) Provide infrastructure, administrative, and support services in respect of the Services.

(2) In carrying out its functions, the PHO will work with the DHB to implement the DHB's annual plan and achieve the Government's policy objectives for health care.

A.6 PHO Outcomes

(1) The PHO will, in our district/region:

(a) support its Enrolled Population and other Eligible Persons to stay well;

(b) contribute to ensuring the clinical and financial sustainability of the health system;

(c) ensure that its Enrolled Population and other Eligible Persons receive quality, co-ordinated care delivered by multi-disciplinary teams, that is easy to access and is provided close to home

(d) support all population groups to achieve optimum health outcomes and reduce disparities; and

(e) achieve outcomes determined by the Alliance.

A.7 Minimum requirements

(1) The PHO will have in place appropriate structural and governance arrangements, and be able to demonstrate a high level of clinical leadership and engagement, and an advanced level of capacity and capability, in order to meet the minimum requirements relating to capability and capacity set out in Section 1 of Schedule B1.

(2) The PHO will carry out the activities specified in the minimum requirements relating to functions set out in Section 2 of Schedule B1.

A.8 How we will work together

(1) We agree to foster a long-term co-operative and collaborative relationship to enable both of us to carry out the roles and responsibilities under this Agreement, and we will both be guided by the relationship principles set out below.

(2) We will:

(a) act in accordance with the Crown's principles for action on the Treaty of Waitangi;

(b) incorporate whānau ora approaches as appropriate;

(c) support clinical leadership and, in particular, clinically-led service development;

(d) adopt a whole-of-system approach, and make decisions on a best for patient and best for system basis;

(e) conduct ourselves with honesty and integrity, and develop a high degree of trust;

(f) promote an environment of high quality, performance, and accountability, and low bureaucracy;

(g) strive to resolve disagreements co-operatively;

(h) seek to make the best use of finite resources in planning and delivery of health services to achieve optimal health outcomes for the Enrolled Population and other Eligible Persons;

(i) adopt and foster an open and transparent approach to sharing information;

(j) respect and maintain patient confidentiality;

(k) remain flexible and responsive to support the evolving health environment;

(l) develop, encourage, and reward innovation and continually challenge the delivery of health care services to achieve high-quality outcomes; and

(m) actively support and build on the successes of each of us.

Part B General terms

B.1 Term

(1) This Agreement comes into effect on 1 July 2013 (the Start Date) and continues until this Agreement is terminated in accordance with its termination provisions (the End Date).

(2) The PHO acknowledges and agrees that:

(a) the DHB has not made any promise (express or implied) that it will contract with the PHO for the provision of services, or will otherwise make available to the PHO more funding, after the End Date of this Agreement; and

(b) the PHO has no legitimate expectation that the DHB will do so.

B.2 Structure of this Agreement

(1) This Agreement is structured as follows:

(a) Part A sets out the background to this Agreement;

(b) Part B sets out the general terms that apply in respect of all Services provided under this Agreement;

(c) Part C sets out the terms that apply in respect of Nationally Consistent Services, and includes service specifications for those services;

(d) Part D sets out the terms that apply in respect of Alliance Services, and includes service specifications for those services;

(e) Part E sets out the terms that apply in respect of Local Services, and includes service specifications for those services;

(f) Part F sets out the terms relating to Funding paid by the DHB to the PHO in respect of the Services; and

(g) Part G sets out the PHO Performance Programme and provides for the development of an integrated performance and incentive framework by which the performance of the PHO and its Contracted Providers is monitored.

B.3 Minimum Requirements

(1) The PHO will comply with the minimum requirements set out in Schedule B1.

B.4 Reporting requirements

(1) The PHO will meet the reporting requirements set out in Schedule B2.

B.5 Referenced Documents

(1) This Agreement refers to a number of documents that contain further requirements for PHOs ("**Referenced Documents**"), which are listed in Schedule B3. The PHO agrees to comply with the requirements set out in each Referenced Document.

(2) The DHB will provide the PHO with copies of each Referenced Documents and all variations to each Referenced Document.

B.6 General service objectives

(1) The PHO will Provide the Services:

(a) in a way that is evidence and best practice based, to the extent possible, and in a way that will improve, maintain, and restore health and ensure access to care, and reduce health inequalities;

(b) for individuals across their life span and for families, whānau and communities taking a broad view of health, including physical, mental, cultural, social and spiritual dimensions;

(c) in co-ordination with other health and social services; and

(d) in a way that involves key stakeholders by consulting with them and ensuring that they contribute to decision-making.

(2) The PHO will monitor performance against the needs of, and agreed outcomes for, Māori, Pacific, and other populations, including:

(a) reducing barriers to accessing all primary care services;

(b) facilitation of the involvement of whānau;

(c) integration of Māori, Pacific, and other cultural values, beliefs, and practices;

(d) availability of staff to reflect the PHO's Enrolled Population at a PHO and practice level; and

(e) existence, knowledge, and use of referral protocols within the PHO's region.

B.7 Māori health

(1) The PHO:

(a) agrees that improving the health outcomes for Māori is a priority;

(b) will work with and support the DHB in the development and implementation of the DHB's Māori health plan;

(c) Will, where relevant, give effect to the DHB's Māori health plan, and annually agree specific deliverables with the DHB and Contracted Providers; and

(d) will integrate Māori participation within the PHO, including governance, service planning, development and implementation.

B.8 Population awareness

(1) The PHO will use DHB needs analysis and/or other appropriate evidence, such as information collected from enrolment or disease registers, iwi and community input, to plan and deliver Services that are appropriate for the demographic make-up and health needs of the PHO's Enrolled Population.

(2) In particular, the PHO will understand inequalities between different sub-groups of the PHO's Enrolled Population and identify gaps in Service provision and, in conjunction with the DHB, identify priorities. The PHO will also attempt to identify those who are missing out on Services.

(3) If the PHO's Enrolled Population includes rural communities, the PHO must demonstrate (in a manner reasonably required by the DHB) that the PHO provides equitable and effective access to primary health care services within those rural communities or within acceptable travel times.

B.9 Location of the Services

(1) The PHO will Provide the Services in the geographical locations set out below or as otherwise specified in this Agreement (if applicable):

(a)

(2) Unless the DHB agrees otherwise, the PHO will enrol persons into its Enrolled Population only at practices within the geographical areas for which the DHB is responsible as specified in Schedule 1 to the Act. The PHO may be required to Provide the Services at different or more limited locations as specified below:

(a)

(3) The PHO will Provide the Services only at locations within the geographical areas for which the DHB is responsible as specified in Schedule 1 to the Act.

(4) The PHO will Provide the Services at the locations specified below:

(a)

(5) The PHO may enrol persons into its Enrolled Population from outside the geographical areas for which the DHB is responsible as specified in Schedule 1 to the Act.

B.10 Independent contractor

(1) We agree that the PHO is an independent contractor to the DHB, and not an employee or agent.

(2) The PHO acknowledges that it has no authority to act on the DHB's behalf.

B.11 Subcontracting

(1) The PHO may subcontract all or any of the Services, provided that the PHO uses its best endeavours to ensure that each Contracted Provider has the qualifications or accreditations, experience, competency and availability to enable it to perform all of the subcontracted Services to the standards required under this Agreement.

(2) The PHO will ensure that every subcontract the PHO enters into pursuant to subclause (1):

(a) requires, if relevant, that Contracted Providers' Practitioners hold an annual practising certificate and a current registration from the appropriate New Zealand statutory body;

(b) imposes all obligations on the Contracted Provider necessary to enable the PHO to meet its obligations under this Agreement;

(c) provides for the DHB to exercise and enforce its rights under this Agreement in relation to the Contracted Provider's performance of its obligations under the subcontract (including in particular the DHB's right to access information held by the Contracted Provider), pursuant to the Contracts (Privity) Act 1982; and

(d) includes any mandatory clauses agreed by both of us from time to time.

(3) The PHO will notify the DHB if the PHO proposes to enter into a subcontract with a provider of First Level Services with whom the PHO has not previously contracted.

(4) Each proposed subcontract for First Level Services will come into effect no earlier than 1 July in the calendar year after the calendar year in which the PHO gave notice to the DHB under subclause (3), unless the PHO and DHB agree that the subcontract may come into effect on an earlier date.

(5) Subject to subclause (6), the PHO agrees to provide to the DHB any information the DHB reasonably requests in relation to a Contracted Provider or provider notified to the DHB under subclause (3).

(6) The PHO is not required to provide any:

(a) pricing or financial information, except information that the DHB would otherwise have access to under clauses B.25 to B.34; or

(b) information that the provision of which would be contrary to the PHO's legal obligation to maintain the privacy of Health Information or the PHO's ethical obligations with respect to clinical confidentiality.

(7) The DHB will notify the PHO if the DHB objects to a provider within 10 Business Days of receiving the notification, and will discuss with the PHO the reasons for objecting to the provider.

(8) The PHO will not enter into a subcontract with a provider if the DHB notifies the PHO that the DHB objects on reasonable grounds in relation to concerns that the DHB has about:

(a) the location at which the provider would deliver the Services if that location is not consistent with clause B.9 (if applicable); or

(b) the provider's ability to perform in any material respect, as required by this Agreement.

(9) The PHO will remain responsible for all Services subcontracted to a Contracted Provider.

(10) The PHO must include in its subcontracts with Contracted Providers the right for the PHO to recover, by way of set-off against any Payments due to the Contracted Provider, the reasonable

cost of providing Services for any period that the Contracted Provider does not provide, either itself or by means of alternative arrangements, services that the PHO has contracted the Contracted Provider to provide.

B.12 Exit of Practitioners

(1) If one of the PHO's Medical Practitioners leaves the PHO (and has not been found guilty of disgraceful conduct or a dishonesty offence), and prior to joining the PHO held an active Section 88 Advice Notice, that Medical Practitioner will remain eligible to hold that Section 88 Advice Notice even if it has expired, and will be entitled to move back onto that Section 88 Advice Notice (subject to the same conditions or limitations (if any)) on leaving the PHO, provided that the Medical Practitioner continues to practise within 3 kilometres of the Medical Practitioner's specified medical premises to which the Section 88 Notice applied.

(2) The entitlement to reactivate a Section 88 Advice Notice described in subclause (1) will devolve to another Medical Practitioner nominated by the original Medical Practitioner when the nominated Medical Practitioner takes over that part of the Enrolled Population and the practice location of the original Medical Practitioner, and the original Medical Practitioner ceases to practise in the geographic area for which the DHB purchases health services.

(3) If one of the PHO's Contracted Providers leaves the PHO (and has not been found guilty of disgraceful conduct or a dishonesty offence), and prior to joining the PHO held a number of active Section 88 Advice Notices, the Contracted Provider will remain eligible to hold that number of Section 88 Advice Notices even if they have expired, and will be entitled to reactivate those Section 88 Advice Notices (subject to the same conditions or limitations (if any)) on leaving the PHO, provided that the Contracted Provider continues to practise within 3 kilometres of the specified medical premises to which the Section 88 Advice Notices applied.

(4) If one of the PHO's Medical Practitioners leaves the PHO and that Medical Practitioner did not hold an active Section 88 Advice Notice prior to joining the PHO, he or she will not be entitled to move onto a Section 88 Advice Notice and will need to apply to the DHB under the appropriate criteria for accessing Section 88 Advice Notices.

(5) For the purpose of this clause, the term "prior to joining the PHO" includes the situation where a Medical Practitioner held a Section 88 Advice Notice immediately prior to joining a Primary Care Organisation (PCO), and joined the PHO directly from that PCO.

B.13 Prohibition on inducements

(1) Neither the PHO nor a Contracted Provider may accept any incentive or inducement from a Referred Service provider, either directly or indirectly.

B.14 Responsibility and liability for others

(1) Each of us is responsible and liable in all respects for the acts and omissions of each of our respective employees, Contracted Providers, other contractors, agents (which, without limitation, includes the Payment Agent) or other personnel in performing or complying (or failing to perform or comply) with our obligations under this Agreement.

B.15 Transfer of rights and obligations

(1) Neither of us will assign or transfer to any other person any or all of its rights or obligations under this Agreement without first obtaining the other party's written consent (which will not be unreasonably withheld).

(2) In order that the consenting party can make an informed decision about whether to consent to any such transfer, the transferring party will ensure that the proposed transferee provides the consenting party with details of their ability to perform those obligations, and any further details that the consenting party may reasonably request of the transferring party or the proposed transferee.

(3) If either of us transfers or assigns its rights or obligations under this Agreement, it will not prejudice:

(a) any other rights or remedies that either of us may have against the other arising out of any breach of this Agreement that occurred before such transfer or assignment;

(b) the operation of any provisions in this Agreement that are expressed or implied to have effect after such transfer or assignment has occurred.

(4) For the purpose of this clause, a transfer includes any change in the legal or beneficial ownership interests in the transferring party that results in a change in its effective control.

B.16 Confidentiality

(1) Except as provided in this Agreement, neither of us will disclose any Confidential Information to any person.

(2) Either of us may publish this Agreement, except for any Confidential Information contained within it, in any media or on the internet.

(3) Either of us may disclose Confidential Information only:

(a) to those involved in the provision of the Services, if necessary;

(b) to our respective professional advisors and representative agents;

(c) if disclosure is permitted or required under this Agreement;

(d) if the information is required to be disclosed to the Crown under a Crown Direction or Crown Funding Agreement;

(e) if the information is already in the public domain without being in breach of this clause;

(f) in so far as it is required to be disclosed by law, including if the DHB considers it necessary to disclose Confidential Information under the Official Information Act 1982 or otherwise under the DHB's public law obligations;

(g) if the other party has consented in writing to such disclosure; and

(h) to parties to the Alliance, for the purpose of enabling the Alliance to carry out the Alliance Activities, including monitoring Alliance Services.

B.17 Public statements

(1) Neither of us, nor either of our representatives, may, during or after the term of this Agreement, either directly or indirectly criticise the other publicly in relation to this Agreement, without first fully discussing (or taking reasonable endeavours to discuss) the matters of concern with the other in good faith and in a co-operative and constructive manner.

(2) Nothing in subclause (1) prevents either of us:

(a) discussing any matters of concern with that party's own employees, Contracted Providers, subcontractors, contractors, agents, personnel, or advisors; or

(b) from publicly commenting on public policy matters.

B.18 Use of name, logo or fact of relationship

(1) Neither of us may use the other's logo, name or the fact that there is a funding relationship between us in any advertising or for any other promotional purpose without the prior written consent of the other.

B.19 Variations to this Agreement

(1) This Agreement may be varied in the following ways:

(a) by mutual agreement;

(b) in order to give effect to any Crown Direction or law change or fees increase pursuant to clause F.26, in accordance with the procedure set out in clause B.21 (a "**Compulsory Variation**");

(c) by agreement reached following the process set out in clause B.23 (a "**Voluntary Variation**");

(d) in the case of variation to the Referenced Documents, in accordance with the procedure set out in clause B.20; and

(e) as otherwise set out in this Agreement.

(2) No variation of this Agreement will be effective unless it is in writing and:

(a) in the case of a Voluntary Variation or a mutually agreed Compulsory Variation, is signed by both of us; or

(b) in the case of a Compulsory Variation imposed by the DHB under clause B.21(5)(b), or a variation to any Referenced Documents, signed by the DHB and notified to the PHO; or

(c) as otherwise set out in this Agreement.

(3) The DHB may vary templates and formats for reports and other documents required under this Agreement as the DHB reasonably requires provided that the DHB consults with the PHO on the proposed changes and the impact of changes in accordance with the provisions of the Referenced Document entitled "PHO Service Agreement Amendment Protocol" or through any other process agreed by us.

(4) If a proposed variation to a template or format for reports will result in material additional costs to the PHO, we will discuss and endeavour to resolve the issue. If we agree, the DHB will compensate the PHO for any additional material costs that the PHO or its Contracted Providers may incur as a result of the variation. If we do not agree, either of us may refer the matter for dispute resolution under clause B.35 and until resolution, the PHO will not be required to implement the varied template or format for reports.

B.20 Varying or adding Referenced Documents

(1) We acknowledge that:

(a) the rules and procedures contained in the Referenced Documents are required to be nationally consistent; and

(b) one or more Referenced Documents may need to be varied (including deleted) or added from time to time throughout the term of this Agreement.

(2) A Referenced Document may only be varied or added in accordance with the procedure set out in the Referenced Document entitled "PHO Service Agreement Amendment Protocol".

B.21 Procedure for Compulsory Variations

(1) **Notice**: If it is likely that a Compulsory Variation will be required, the DHB will give the PHO such reasonable notice as is possible in the circumstances, which will include the details of any such variation and the DHB's proposed draft of the variation.

(2) **Form of proposed variation**: The DHB will ensure that its proposed draft of the variation will be written to give effect to the relevant Crown Direction, law change, or fees increase in a way that endeavours to minimise the adverse impact on the PHO (if any), financial or otherwise.

(3) **Compensation for Crown Direction**: If a Compulsory Variation is required to give effect to a Crown Direction and the Compulsory Variation has the potential to result in any increased costs or decreased revenue to PHOs, the DHB will:

(a) consult with the PHO on the options available to prevent or minimise any adverse financial (or other) impacts as a result of the Crown Direction; and

(b) use its best endeavours to prevent or minimise any adverse financial or other impact of the Compulsory Variation; however

(c) not be liable for any loss or additional costs suffered or incurred by the PHO unless the DHB agrees otherwise.

(4) **Agreeing the variation**: The DHB will specify a period of time that is reasonable in the circumstances, being at least 20 Business Days, unless the DHB is precluded from doing so, within which the PHO is to reply to the DHB about the proposed draft variation notified to the PHO under subclause (1). After that period has expired, or at such earlier time as may be convenient to us both, we will seek to agree on the terms of the variation to this Agreement. The DHB will consider the PHO's reply in implementing the variation, however, the PHO acknowledges that the DHB may require a uniform variation to apply to all PHOs.

(5) **Commencement of variation**: The variation will commence as set out below:

(a) if we agree on the terms of the variation, the variation will commence as soon as the relevant Crown Direction, law change or fees increase comes into effect, or at any earlier time agreed by us; or

(b) if we cannot agree on the terms of the variation before the relevant Crown Direction, law change or fees increase comes into effect, this Agreement will be deemed to be varied on the terms set out in the proposed draft of the variation referred to in subclause (1), subject to any changes to specific parts that the DHB has agreed with the PHO, as soon as that relevant Crown Direction, law change or fees increase comes into effect.

B.22 If provision of the Services is no longer viable

(1) If this Agreement has been varied in accordance with clause B.21(5)(b) and it is no longer viable, financially or otherwise, for the PHO to continue providing the Services that have been affected by the variation, the PHO may terminate this Agreement or the obligation to Provide the relevant Services, if the PHO gives the DHB prior notice of the PHO's intention to do so.

(2) The period of notice given under subclause (1) will be reasonable in the circumstances considering the impact of the Compulsory Variation on the PHO and the impact of the intended termination on the DHB.

B.23 Reviewing this Agreement – voluntary variations

(1) Subject to subclause (2), this Agreement will be subject to annual review through a national review process that will, amongst other matters, ensure that Payment rates are fair and reasonable.

(2) The following parts of this Agreement will not be reviewed as part of the national review process:

(a) Part D and the provisions of Part F that relate to Alliance Services, if the PHO has not agreed to Provide the Services described in the schedules to this Part within the scope of our Alliance Agreement;

(b) Part E; and

(c) the provisions of Part F that relate to Local Services,

(3) The national review process will commence in February of each year and follow the process described in the Referenced Document entitled "PHO Service Agreement Amendment Protocol" subject to the modifications set out in subclause (4).

(4) If the PHO Service Agreement Amendment Protocol Group is considering a variation to this Agreement but fails to make a binding decision, the matter will remain not agreed between us.

(5) If the PHO believes that it will not be able to deliver any of the Services to the extent that this Agreement requires, the PHO will notify the DHB of the extent to which the PHO is prevented from providing those Services and the reasons for that inability.

(6) Without limiting any right of either of us under this Agreement, we will then discuss the reasons why the PHO is prevented from performing those Services and will seek to reach agreement about changes to the PHO's levels of Service provision.

B.24 Notification of problems

(1) Each of us will advise the other promptly in writing of any changes, problems, significant risks, or significant issues (including suspected fraud and/or serious non-compliance with the obligations under this Agreement and those issues that could reasonably be considered to have high media or public interest), which materially reduce or affect, or are likely to materially reduce or affect, the ability of either of us to meet our respective obligations under this Agreement.

(2) Without limiting any rights under this Agreement, each of us agree to discuss with the other possible ways of remedying the matters notified.

B.25 Audit principles and processes

(1) We agree:

(a) that, under the principles of capitation, the financial risk associated with First Level Service provision is held by PHOs and their Contracted Providers. The audit provisions in this Agreement reflect the respective risk level of PHOs and DHBs;

(b) that, while not constraining the DHB's rights to Audit, the PHO is responsible for auditing performance of its Contracted Providers;

(c) we each have an interest in the appropriate performance of the standard PHO services agreement by other PHOs;

(d) that Audits will be carried out in accordance with the Referenced Document entitled "Primary Health Organisation Audit Protocol: Financial, Claiming and Referred Services";

(e) an Audit may involve a variety of activities that may include (without limitation) conducting investigations or on-site Audits of the PHO's Premises or a Contracted Provider's Premises, or surveying Service Users and Contracted Providers;

(f) any Audit process will be designed in keeping with the principles set out in clause A.8.

(2) From time to time the DHB will evaluate the Audit principles and process described in this Agreement, including seeking and considering the PHO's feedback on the Audit process.

B.26 Audit framework guiding principles

(1) If the DHB conducts an Audit under this Agreement, our respective roles in the Audit will be undertaken in accordance with the principles of natural justice, and in particular the principles set out in this clause.

(2) Audits will be conducted promptly, and include active participation from us both.

(3) Auditors will be suitably experienced, competent and carry out their work in a professional manner, and in particular:

(a) minimise disruption to the Services;

(b) take into account relevant safety considerations;

(c) display appropriate sensitivity to the privacy and dignity of Service Users seen in the course of a visit;

(d) if culturally specific Services or Contracted Providers are subject to an Audit, the Auditor must be a suitably qualified cultural auditor;

(e) if Services provided to Māori are the subject of an Audit, suitably qualified Māori must be included in the Audit team; and

(f) if clinical records are the subject of an Audit, the Auditor must be a suitably qualified clinician.

(4) Unless an exception described in clause B.28(2) applies, Audit activities will be undertaken at a time that is reasonably convenient for the PHO and any Contracted Provider involved in the Audit.

(5) Audit activities will meet all legal requirements and the requirements of this Agreement.

(6) The DHB may make copies of any part of any Record for the purposes of the Audit as provided for under section 22G(1) of the Health Act 1956, except to the extent restrained by law.

(7) The PHO may have a person present during an onsite visit.

(8) We both will provide accurate information and prompt responses to all relevant queries, unless a prompt response would prejudice the integrity of the Audit.

(9) If an Audit includes a Contracted Provider, the PHO must ensure that the principles and obligations described in this clause apply to the Contracted Provider as they apply to the PHO.

B.27 Audit of the PHO

(1) The DHB may Audit the PHO's compliance with any or all of the requirements of this Agreement.

(2) The DHB will carry out the Audit in accordance with the Referenced Document entitled "Primary Health Organisation (PHO) Audit Protocol: Financial, Claiming and Referred Services".

(3) The PHO must co-operate with the DHB, and ensure that its Contracted Providers co-operate with the DHB, including by providing the DHB and its Auditor with all reasonable assistance to ensure that any Audit is fully and properly completed to the DHB and its Auditor's satisfaction.

B.28 Notice of Audit

(1) Subject to subclauses (2) and (3), the DHB will give the PHO at least 30 Business Days notice of its intention to carry out an Audit.

(2) The DHB may give the PHO a reduced notice period that is reasonable in the circumstances (and may include less than 24 hours notice or no notice in some circumstances) if the DHB has reasonable grounds to believe that:

(a) there has been a material breach of this Agreement;

(b) a delay of 30 Business Days would unreasonably prejudice the integrity of the Audit; or

(c) a delay of 30 Business Days would unreasonably prejudice the interests of any Eligible Person.

(3) If the DHB reasonably suspects that fraudulent claiming has occurred, the DHB may enter the PHO's or any Contracted Provider's Premises and conduct an Audit at any time without prior notice.

(4) The Notice of Audit will include:

(a) the anticipated scope of the Audit;

(b) the identity of the person appointed as Auditor;

(c) the Auditor's qualifications (if any); and

(d) a declaration from the Auditor of any conflicts of interest he or she may have.

(5) If the PHO has any reasonable concerns about the focus of any Audit or any person appointed by the DHB as an Auditor, the PHO will bring those concerns to the DHB's attention within 10 Business Days of receiving the notice of intention to Audit. Subject to time constraints when the DHB is conducting an urgent Audit in the situations described in subclause (2), the DHB will discuss those concerns with the PHO and respond to it in writing regarding its concerns prior to commencing the Audit.

B.29 Access for Audits

(1) The PHO will co-operate with, and procure that the PHO's Contracted Providers co-operate with, the DHB for the purposes of, and during the course of, conducting an Audit and to allow (and/or arrange) its Auditor access at any time during Regular Hours, or at any other time by arrangement with the PHO, to the extent that the PHO is legally able to, (but not including any case in which the PHO has failed to ensure a Contracted Provider is obliged to submit to an Audit) access to:

(a) the PHO's or any Contracted Provider's Premises, including to observe the provision of the Services;

(b) Records and any other information (including Health Information), in whatever form, that relates to this Agreement, the Service Users and their families and associates;

(c) staff, Contracted Providers, subcontractors, contractors, agents or other personnel used by the PHO to provide the Services; and

(d) Service Users, their families or their associates, for interviews about the Services provided under this Agreement.

(2) The PHO will ensure that the DHB and its authorised agents have equivalent access in relation to any Services provided through a Contracted Provider, agent, or other personnel.

(3) An Audit report will:

(a) be timely;

(b) detail the facts found during the Audit;

(c) be provided in draft for the PHO's consideration and comment, and include the PHO's relevant feedback; and

(d) if appropriate, provide recommendations to identify the actions necessary for either of us to bridge the gap between the Audit criteria and the level of performance found in the Audit.

(4) If an Audit results in recommendations, we will each take reasonable steps to implement the recommendations and any agreed follow-up processes.

B.30 Specific provisions for financial Audits

(1) We acknowledge and agree that the purpose of a financial Audit is to:

(a) maintain public confidence in the spending of public health funding; and

(b) confirm that the PHO is and will continue to be a Not for Profit organisation as required by clause 1(1)(a) of Schedule B1.

(2) If the DHB has a concern regarding the PHO's financial arrangements and or financial position, it may request by notice in writing, and the PHO must provide to the DHB within 30 days of the request, a certificate from a suitably qualified person certifying the PHO's solvency, or financial or other information regarding its financial position, or arrangements relevant to assessing whether the PHO is a Not for Profit organisation.

(3) From time to time the DHB may appoint, at its cost, a suitably independent financial analyst as an Auditor to determine or assess:

(a) the correctness of the financial information the PHO provides;

(b) the PHO's overall financial position; and

(c) any other matters relevant to assessing whether the PHO is a Not for Profit organisation.

B.31 Audit of Contracted Providers by the PHO

(1) The PHO is responsible for auditing the performance of its Contracted Providers. Without limiting the generality of this clause, in particular the PHO is responsible for:

(a) auditing the Registers maintained by its Contracted Providers;

(b) auditing the information that its Contracted Providers are required to provide to the DHB, through the PHO; and

(c) carrying out clinical audits of its Contracted Providers.

B.32 Audit of Contracted Providers by the DHB

(1) The DHB may Audit the PHO's Contracted Providers' performance under this Agreement in accordance with the Referenced Document entitled "Primary Health Organisation (PHO) Audit Protocol: Financial, Claiming and Referred Services".

B.33 Audits after this Agreement is terminated

(1) The DHB may conduct an Audit after this Agreement has terminated, but only to the extent that it is relevant to the period during which this Agreement was in force.

B.34 Application of the Health Act 1956

(1) The PHO must ensure that each of its Contracted Providers is subject to the same obligations that the PHO is subject to under section 22G of the Health Act 1956 as if it was a provider under section 22G(1), so that the DHB can exercise its rights under section 22G of the Health Act in respect of any information held by any Contracted Provider as if the PHO held that information.

B.35 Resolving disputes

(1) **Court or arbitration proceedings**: We agree not to commence any court or arbitration proceedings relating to any dispute arising out of this Agreement, until we have both complied with the requirements set out in this clause, unless proceedings are necessary for preserving the rights of either of us.

(2) **Resolution by agreement**: If a dispute arises under this Agreement:

(a) the party claiming that a dispute exists must give notice to the other party specifying the nature of the dispute; and

(b) we will each act in good faith and use our best endeavours to resolve the dispute by agreement.

(3) **Mediation**: If the dispute is not settled by agreement within 21 Business Days of receipt of the notice of dispute, unless we agree otherwise in writing, we will participate in mediation with a mutually acceptable mediator appointed if necessary by the Chairperson of the New Zealand Chapter of LEADR.

(4) **Arbitration**: If the dispute is not settled by mediation within 30 Business Days of the commencement of the mediation process, unless we agree otherwise in writing, the matter will be referred to arbitration in accordance with the Arbitration Act 1996.

(5) **Obligations continue**: We will each continue to comply with our obligations in this Agreement until the dispute is resolved, except that we will meet to attempt to agree on whether:

(a) Payments may be withheld by the DHB to the extent that they are disputed, in which case the PHO is not obliged to Provide any Services for which the DHB has withheld Payment pending resolution of the dispute; or

(b) the DHB will continue to Pay the PHO for the Services, in which case the PHO must continue to Provide the Services; and

(c) any agreement will be based on what is reasonable in the circumstances, having regard to the nature of the Services and the dispute in question.

(6) **Exceptions**: This clause does not apply to:

(a) any dispute concerning whether or not any person is an Eligible Person, which will be determined by the Minister;

(b) any renegotiation, variation or termination of this Agreement on any of the grounds described in clause B.36(2)(b), B36.2(c), or B36.2(d); or

(c) any matter that is subject to a current Audit process (but not including a dispute over an Audit report if the Audit has been completed) or which has been or is referred to a Complaints Body, unless the Complaints Body directs that the matter be resolved in accordance with this clause.

B.36 Termination

(1) **Uncontrollable Events**: This clause does not apply if the failure to perform is caused by an Uncontrollable Event, which must be dealt with under clause B.40.

(2) **The DHB's rights to terminate**: The DHB may terminate this Agreement on such period of notice to the PHO as the DHB considers reasonable in the circumstances and in any case not less than 20 Business Days, if:

(a) the DHB has good reason to believe the PHO is unable, or will soon become unable, to carry out any of its material obligations under this Agreement. The DHB must consult with the PHO to the extent possible within the 20 Business Days notice period before terminating this Agreement for this reason;

(b) the DHB has reasonable grounds to believe that the health or safety of any person or population served is at risk, provided that if the risk is isolated to a Contracted Provider, the DHB may only exercise its rights under clause B.35. The DHB must consult with the PHO to the extent possible within the 20 Business Days notice period and the DHB may suspend the PHO's provision of the relevant Service while the DHB consults;

(c) the PHO fails to carry out any of its obligations in this Agreement and the failure is material and cannot be remedied;

(d) an Insolvency Event occurs; or

(e) the PHO fails to carry out any of its obligations in this Agreement and the failure is not covered by paragraph (c), and the PHO has not remedied the failure within 30 days of receiving notice of the failure from the DHB.

(3) **Termination for fraud by the PHO**: The DHB may terminate this Agreement immediately by notice to the PHO if the PHO has been formally charged with any fraudulent act.

(4) **Fraud by a Contracted Provider**: If a Contracted Provider is charged with any fraudulent act:

(a) the DHB may exercise its rights under clause B.35; and

(b) the PHO will immediately implement, or demonstrate that the PHO has, appropriate systems in place to detect and prevent such fraud.

(5) **The DHB's rights**: Nothing in this clause affects any other rights the DHB may have against the PHO.

(6) **The PHO's rights on default by the DHB**: If the DHB does not make Payments to the PHO that the DHB is required to make or if the DHB fails to carry out any of its material obligations under this Agreement, and the DHB fails to remedy the default within 20 Business Days of the PHO giving the DHB notice of the default, the PHO may do any one or more of the following:

(a) terminate this Agreement;

(b) seek specific performance of this Agreement to the extent permitted by law;

(c) seek damages from the DHB to the extent permitted by law; or

(d) seek Default Interest

(7) **Termination by agreement**: We may agree to terminate this Agreement or any part of it. An agreement to terminate will be effective only if it is in writing and signed by us both.

(8) **Termination on 6 months notice**: Either of us may terminate this Agreement by giving the other 6 months written notice.

B.37 The DHB's alternatives to termination

(1) Instead of terminating this Agreement under clause B.36, the DHB may do any or all of the following:

(a) vary or withdraw from coverage by this Agreement any of the Services if the PHO has not met its obligations;

(b) cease Payment for any such Services from the date of variation or withdrawal;

(c) require the PHO to terminate any subcontract the PHO has with a Contracted Provider for the provision of the Services under this Agreement if the Contracted Provider has failed to perform a material obligation in relation to the performance of this Agreement;

(d) require the PHO to recover any Payments to a Contracted Provider that have been made in breach of this Agreement;

(e) require the PHO to terminate any subcontract the PHO has with a Contracted Provider for the provision of the Services under this Agreement if a Payment has been made to that Contracted Provider in breach of this Agreement; or

(f) withhold Payments in accordance with clause B.38.

B.38 Withholding Payments

(1) In addition to its rights under clause B.37, the DHB may withhold further Payments or portions of Payments due under this Agreement for each of the following defaulting actions that the PHO or a Contracted Provider commits:

(a) if either the PHO or a Contracted Provider has committed a material breach of the reporting requirements under this Agreement, the DHB may withhold Payment up to 10% of the management fee Payment due;

(b) if the PHO or a Contracted Provider has failed to co-operate with the DHB or its Auditor or has not provided the DHB or its Auditor with reasonable assistance in accordance with clause B.27(3), the DHB may withhold Payment up to 10% of the PHO's management fee and/or up to 10% of any capitated Payment due to any relevant Contracted Provider, as is reasonable in the circumstances;

(c) if the PHO or a Contracted Provider is found to be in breach of this Agreement at the end of an Audit, the DHB may withhold any capitation Payments due to that Contracted Provider, up to the value of the breach, or up to 10% of the PHO's management fee if the value of the breach cannot be determined, as is reasonable in the circumstances;

(d) if the PHO has made a Payment to a Contracted Provider in breach of this Agreement, the DHB may withhold Payment of capitation Payments due to that Contracted Provider, up to the value of the inappropriate Payment that the PHO made to the Contracted Provider.

(2) Payments withheld under this clause:

(a) may be withheld from the date of non-compliance until such time that compliance occurs, or in the case of subclauses B.38(1)(c) and B.38(1)(d), until such time as the breach of Audit or the alleged inappropriate Payment to a Contracted Provider has been successfully appealed by the PHO; and

(b) will be paid on the following Payment Date once compliance has occurred.

B.39 Alternative arrangements on failure to deliver Services

(1) If the PHO fails to Provide any Services it must Provide under this Agreement, in addition to its rights under clauses B.36, B.37 and B.38, the DHB may take whatever action is reasonably necessary to make alternative arrangements for the provision of those Services, at the PHO's expense.

(2) The DHB may act under subclause (1) without giving the PHO notice if the circumstances reasonably require such action. In any other circumstance, the DHB will give the PHO at least 7 Business Days notice of the DHB's intention to make alternative arrangements for the provision of those Services under this Agreement.

(3) If the DHB gives the PHO notice requiring the PHO to pay the DHB's costs, the PHO must pay or reimburse the DHB for all reasonable costs the DHB incurs acting under subclause (1) that are not covered by the Payments withheld or ceased under clause B.38 up to a maximum of 10% of the Payments withheld or ceased.

(4) If the PHO fails to pay any such amount required under subclause (3), the DHB may set-off the amount owing to the DHB in respect of the costs incurred under this clause against any amount that the DHB owes the PHO at any time by way of Payment for the Services, in accordance with clause F.25.

B.40 Uncontrollable Events

(1) Neither of us will be in default under this Agreement if the default is caused by an Uncontrollable Event.

(2) If either of us is affected by an Uncontrollable Event, the party affected must:

(a) notify the other party of:

(i) the nature of the circumstances giving rise to the Uncontrollable Event;

(ii) the extent of the affected party's inability to perform; and

(iii) the likely duration of that non-performance;

(b) take all reasonable steps to remedy, or reduce the impact of, the Uncontrollable Event; and

(c) resume performance of the obligation affected by the Uncontrollable Event as soon as possible.

(3) The DHB may, after consulting with the PHO, make alternative arrangements for the supply of the Services during the period in which the PHO is unable to supply them as a result of an Uncontrollable Event (and for such reasonable time afterwards as may be necessary to secure an alternative provider or providers at the time the alternative arrangement is entered into).

(4) If either of us is unable to perform an obligation under this Agreement for 30 days or more because of an Uncontrollable Event, we must try to agree to what extent, if any, the obligation in question can be varied and/or continued by the affected party.

(5) Failing agreement, either of us may terminate the relevant Service or this Agreement by giving the other at least 30 days notice.

B.41 Consequences of expiry or termination

(1) The expiry or termination of all or part of this Agreement will not prejudice:

(a) any other rights or remedies that either of us may have against the other arising out of any breach of this Agreement that occurred before expiry or termination; or

(b) the operation of any clauses of this Agreement that are expressed or implied to have effect after expiry or termination.

(2) On the expiry or termination of this Agreement, each of us will return to the other all Confidential Information that belongs to the other, except that the DHB may retain such information for an Audit undertaken in accordance with this Agreement.

B.42 Insurance

(1) The PHO must have insurance to an appropriate and reasonable extent, to cover its business and assets against risks associated with the performance of and compliance with its obligations under this Agreement.

(2) The PHO must maintain such insurance throughout the duration of this Agreement and for as long afterwards as is prudent to provide for circumstances that may arise in relation to this Agreement after the End Date.

(3) The DHB may request, and the PHO must promptly provide to the DHB's Auditor, any information concerning the insurance maintained pursuant to this clause.

B.43 Warranty

(1) Each of us warrants to the other that, to the best of our knowledge and reasonable belief:

(a) all material information provided to the other is correct and not misleading in any material respect; and

(b) there is nothing currently impairing or preventing either of us from carrying out our respective obligations under this Agreement.

(2) Each of the warranties in subclause (1) is deemed to be repeated continuously throughout the term of this Agreement.

(3) If either of the warranties in subclause (1) are not true or become no longer true, each of us will, as applicable, inform the other of the change as soon as is practicable.

B.44 Notices

(1) Each notice or other communication under this Agreement must be in writing and may be made by facsimile, email, personal delivery or post at the facsimile number or address, and marked for

the attention of the person or office holder (if any), designated for the relevant purpose by the addressee from time to time by notice to the other party.

(2) Any change to a party's contact details must be notified to the other party at least 10 Business Days before the change comes into effect.

(3) A notice is not effective until the addressee receives it.

(4) A notice is deemed to be received (provided that the addresser is not aware of any failure in the communication) in the case of:

(a) facsimile or email, on the Business Day on which it is sent or, if sent after 5pm in the place of receipt or on a non-Business Day, on the next Business Day;

(b) personal delivery, when it is delivered;

(c) post, on the third Business Day after posting by fastpost or airmail.

(5) All periods of time for notice exclude the days on which the notice is given and include the days on which the period expires.

B.45 Miscellaneous terms

(1) **Compliance with law**: Each of us will comply with all statutory, regulatory and other legal requirements in so far as they are applicable to the performance of our respective obligations under this Agreement, including the Privacy Act 1993 and the Health Information Privacy Code 1994.

(2) **Waiver**: We agree that:

(a) either of us may by notice in writing to the other party, waive a specific right conferred under this Agreement; and

(b) any delay or failure to exercise a right does not constitute a waiver of that right.

(3) **Entire agreement**: This Agreement constitutes the entire agreement and understanding between us, and supersedes and replaces all prior agreements and understandings between us in relation to the provision of the Services.

(4) **Severability**: If any provision of this Agreement is found or held to be illegal, invalid or unenforceable, such determination will not affect the remainder of this Agreement, which will remain in force.

(5) **Modification**: If any provision of this Agreement is found or held to be illegal, invalid or unenforceable, we will each, if possible, take the steps necessary to make reasonable modifications to any such provisions to ensure that they are legal, valid or enforceable and, otherwise, such provisions are deemed to be modified to the extent necessary to ensure that they are legal, valid or enforceable.

(6) **Contracts (Privity) Act 1982**: Subject to Contracted Providers' and General Practitioners' ability to make Claims under this Agreement in accordance with Part F, a person who is not a party to

this Agreement may not enforce any of the provisions of this Agreement. Nothing in this Agreement confers any benefit on Eligible Persons, any Service User or on any Contracted Provider.

(7) **Trustee Liability**: If the PHO is a charitable trust, the DHB agrees that the PHO's trustees' liability under this Agreement is limited to the assets of the trust, unless the liability arises due to the trustee failing to act prudently, lawfully and in accordance with the trust deed. For the purposes of this clause, trustee means any trustee acting in its capacity as a trustee from time to time, including any former trustee.

B.46 Definitions

(1) In this Agreement, unless the context requires otherwise, the following words and phrases have the following meaning:

Act means the New Zealand Public Health and Disability Act 2000.

Access Practice means a general medical practice forming part of the PHO or the PHO's Contracted Provider that meets the Ministry's criteria for access practices, and those general medical practices are listed in clause 3 of Schedule F1.1.

After Hours means any time that does not fall within Regular Hours.

Agreement Reference Number means the unique identification number that is printed on the cover of this Agreement.

Alliance means the Alliance named in clause A.1(4) that we have agreed to participate in, as described in the Alliance Agreement.

Alliance Activities has the meaning set out in our Alliance Agreement.

Alliance Agreement means the agreement between the members of our Alliance.

Alliance Recommendation means a recommendation made by the Alliance to the DHB relating to the Alliance Services.

Alliance Services means the services described in Part D.

Audit includes inspection, monitoring, audit, investigation, review and evaluation of the PHO's performance and compliance with the terms of this Agreement in accordance with Part B.

Auditor means an audit agency or an auditor appointed to carry out an Audit.

Authorised Vaccinator means a person who is authorised to administer vaccines by a Medical Officer of Health.

Business Day means a day that is not a Saturday or Sunday on which each of our banks and the Payment Agent's bank are open for business.

Capitated Services means those Services for which the DHB Pays the PHO on a capitated basis as set out in clause F.4(1).

Care Plus Patients are Enrolled Patients who have consented to receive Care Plus Services in accordance with clause 2(2) of Schedule D4 (if applicable).

Care Plus Services are the primary health care services described in Schedule D4 for people who have high needs for primary health care services (if applicable).

Casual User means an Eligible Person who is not enrolled with the PHO but who receives Services from the PHO.

Claim means any claim for Payment submitted by the PHO (or a Contracted Provider if the PHO has agreed with the DHB that the Contracted Provider may submit claims for Services directly to the DHB pursuant to clause F.3(4)).

Commercial Information means:

(a) any information disclosed by the DHB to the PHO or by the PHO to the DHB, either before or during the course of this Agreement, or arising out of the operation of this Agreement, that the supplying party reasonably considers to be confidential taking into account all the circumstances, including the manner of and circumstances in which disclosure occurred and the way in which the information is to be used; but

(b) excludes the terms of this Agreement, unless agreed by us both as being Commercial Information.

Community Services Card or **CSC** has the meaning given to that term in the Health Entitlement Card Regulations 1993.

Complaints Body means any organisation appointed to deal with complaints relating to the Services under this Agreement:

(a) by us both by mutual agreement;

(b) by a Health Professional Authority; or

(c) by law.

Compulsory Variation means a variation to this Agreement described in clause B.21.

Confidential Information means Commercial Information and Health Information.

Contracted Provider means a health service provider (whether an organisation or individual, including any Practitioner, General Practitioner or Medical Practitioner) that the PHO subcontracts to deliver the Services, including the Contracted Provider's employees, agents and subcontractors.

Crown Direction means any direction given to the DHB by the Crown or the Minister under the Act.

Crown Funding Agreement has the meaning given to that term in the Act or the Crown Entities Act 2004.

Default Interest means the interest to be paid on late Payments in accordance with clauses F.21, F.22 and F.23.

Dep means the New Zealand (NZ) Deprivation Index used in the health sector to determine the level of deprivation and need of the population, which is measured in deciles (with decile 10 being the most deprived and decile 1 being the least deprived).

DepQuin means 2 Dep deciles (or a quintile) as follows:

(a) DepQuin 0 = Dep decile not defined;

(b) DepQuin 1 = Dep deciles 1 and 2;

(c) DepQuin 2 = Dep deciles 3 and 4;

(d) DepQuin 3 = Dep deciles 5 and 6;

(e) DepQuin 4 = Dep deciles 7 and 8;

(f) DepQuin 5 = Dep deciles 9 and 10.

Eligible Person means a person who is eligible for publicly funded health services in accordance with the current Health and Disability Services Eligibility Direction published in the *Gazette*.

End Date means the date on which this Agreement is terminated in accordance with its termination provisions, as specified in clause B.1.

Enrolled Person means a person who is enrolled with the PHO in accordance with the Referenced Document entitled "Enrolment Requirements for PHOs", and **Enrolled Patient** has the same meaning.

Enrolled Population means the population that is enrolled in accordance with the Referenced Document entitled "Enrolment Requirements for PHOs".

Establishment Enrolment Rules mean the rules set out in the Referenced Document entitled "Enrolment Requirements for PHOs".

First Level Services means the full range of primary health care services described in clause 1 of Schedule C1.

First Level Service Consultation is the provision of clinical health services as described in clauses 1(1)(a)(ii), 1(1)(b), 1(1)(c) and 1(1)(d)(i) of Schedule C1. The consultation is between a patient and a medical practitioner / registered nurse / other health professional who has appropriate training and/or qualifications.

General Medical Services¸ **General Medical Services for (or provided to) Casual Users**, and **Casual Medical Consultation** means the services described in Schedule C2.

General Practitioner means a Medical Practitioner who is employed or contracted by the PHO (including such a person who is, or is employed by, a Contracted Provider) to deliver the

Services, and who gives personal, primary and continuing care to individuals, families and a practice population.

GST means the tax imposed under the Goods and Services Tax Act 1985.

Health Information has the meaning given to that term in the Health Information Privacy Code 1994.

Health Professional Authority means any authority or body that is empowered by any statute or the rules of any body or organisation, to exercise disciplinary powers in respect of any person who is involved in the supply of health and disability services.

High Need Groups means groups of persons who are Māori, Pacific and/or persons residing in New Zealand Deprivation Index deciles 9 and 10 areas.

High Use Health Card has the meaning given to that term in the Health Entitlement Card Regulations 1993.

Immunisation Services means the services described in Schedule C3.

Immunisation Handbook means the publication produced by the Ministry, as amended by the Ministry from time to time, and includes any revised edition that replaces or succeeds that publication.

Influenza Guidelines means the guidelines for publicly funded influenza immunisation set out in the Immunisation Handbook.

Insolvency Event means that either of us:

(a) is placed into receivership or has a receiver or manager (including a statutory manager) appointed in respect of all or any of our business or property;

(b) is unable to pay its debts as they fall due;

(c) has entered into an assignment for the benefit of, or entered into or made an arrangement or composition with, its creditors;

(d) is subject to a resolution or any proceeding for liquidation other than for a bona fide reconstruction; or

(e) is subject to an event that is analogous to those listed in paragraphs (a) to (d).

Local Services means the services described in Part E.

Locum means a Medical Practitioner with a current practising certificate who provides Services in place of another Practitioner during that Practitioner's Regular Hours, and who may:

(a) provide consultation Services to the patients of the Practitioner during Regular Hours if the Practitioner is performing work other than providing ordinary Services to patients or is on temporary leave (for whatever reason);

(b) provide Services in place of more than one Practitioner during any period of time;

(c) not consult with patients of the Practitioner at the same time as the Practitioner; and

(d) not be used to extend the normal working hours of the Practitioner.

Medical Consultation means in respect of General Medical Services, an actual face to face medical consultation between a General Practitioner and an individual patient.

Medical Officer of Health has the meaning given to that term in the Health Act 1956.

Medical Practitioner means a person who is employed or contracted by the PHO (including such a person who is, or is employed by, a Contracted Provider) to deliver the Services, who is registered as a medical practitioner under the Health Practitioners Competence Assurance Act 2003 and who holds a current annual practising certificate.

Minister means the Minister of Health.

Ministry means the Ministry of Health.

Nationally Consistent Services means the services described in Part C.

NHI means National Health Index.

NIR means the National Immunisation Register.

Not for Profit, in relation to an incorporated body, means a body:

(a) that is carried on other than for the purposes of profit or gain to any proprietor, member, shareholder or person who has the ability to control the body or any associated person of a proprietor, member, shareholder or person who has the ability to control the body; and

(b) that is, by the terms of its constitution, rules, or other document constituting or governing the activities of that body, prohibited from making any distribution whether by way of money, property, or otherwise howsoever, to any such proprietor, member, shareholder or person who has the ability to control the body or any associated person of a proprietor, member, shareholder or person who has the ability to control the body;

and for the purposes of this definition:

(c) at any time persons are associated with each other in the circumstances set out in section OD8(1) of the Income Tax Act 1994;

(d) a body is controlled by another person in the circumstances set out in section OD1 of the Income Tax Act 1994;

(e) distribution does not include:

(i) any fair and reasonable payment for services performed by a person referred to in paragraph (b) or by any firm or entity of which he or she is a member, employee, or associate;

(ii) the reimbursement of expenses properly incurred on behalf of an incorporated body by a person referred to in paragraph (b) or by a firm or entity of which he or she is a member, employee or associate;

(iii) any payment by way of interest, at not more than current commercial rates, on money loaned to the incorporated body by a person referred to in paragraph (b) charged at the normal amount for such services or by a firm or entity of which he or she is a member, employee or associate,

provided that in each case, the amount paid will be relative to that which would be paid in an arm's length transaction.

Nurse Practitioner means a person who is employed or contracted by the PHO (including such a person who is, or is employed by, a Contracted Provider) to deliver the Services, who is a registered nurse approved and recognised by the Nursing Council of New Zealand to use the title Nurse Practitioner, and who holds a current annual practising certificate.

Nursing Consultation means a consultation between a Primary Health Care Nurse and an individual, group or whānau in which the Primary Health Care Nurse provides proper and necessary health services within the Primary Health Care Nurse's scope of practice. The administrative services that follow and/or form part of the Nursing Consultation are included as part of that Nursing Consultation.

Pay means the transfer of funding to the PHO or a Contracted Provider, in full or in part, for the Services provided under this Agreement, and **Payment** has a corresponding meaning.

Payment Agent means an agent engaged by the DHB to receive Claims and make Payment to the PHO on the DHB's behalf, and unless advised otherwise that Payment Agent is Sector Services.

Payment Day means those days on which the Payment Agent routinely pays Claims, being the Tuesday of every week (or next Business Day if that day is not a Business Day) or such other day as is advised from time to time.

Pharmaceutical Schedule means the document of that name issued by Pharmac from time to time.

PHO Audit Protocol means the audit protocol designed for auditing PHOs contained in the Referenced Document of the same name.

PHO Funding Formula means a formula for funding PHOs developed by the Ministry.

PHO Performance Programme means the programme of monitoring against indicators and payments to PHOs based on progress towards targets, as described in Part G (PHO Performance Programme) of this Agreement.

PIN and **Practitioner Identification Number** mean a Medical Council of New Zealand number, Nursing Council number, cervical smear taker identification number, or such other appropriate Practitioner identification number.

Population-based Health Services means the services described in clauses 1(1)(a) and 1(1)(b) of Schedule C1.

Practitioner means a person who has an appropriate professional qualification who is employed or contracted by the PHO (including such a person who is, or is employed by, a Contracted Provider) to deliver the Services, and who gives personal, primary and continuing care to individuals, family groups, whānau and a practice population, and includes a Medical Practitioner, Locum and a Nurse Practitioner.

Premises means the location from where the PHO or a Contacted Provider perform the Services or where anything relating to the Services occurs or is kept, including the location of any Records.

Primary Health Care Nurse means a registered nurse who is employed or contracted by the PHO (including such a person who is, or is employed by, a Contracted Provider) to deliver the Services, and who gives personal, primary and continuing care to individuals, whānau, communities and populations.

Primary Maternity Services has the meaning given to that term in the advice notice for maternity services under section 88 of the Act.

Priority Populations mean Māori, Pacific peoples and DepQuin 5 (Dep deciles 9 and 10) residents.

Provide includes purchasing the Services.

Provider Reference Number means the unique identification number that relates to the PHO as a provider of the Services, which is printed on the cover of this Agreement.

Purchase Unit Code means the purchase unit code for each service delivered by a PHO that is specified in the Referenced Document entitled “Primary Care Purchase Unit Codes”.

Record means any record or information held by the PHO, the PHO's Staff, a Contracted Provider or on the PHO's (or a Contracted Provider’s) behalf, in whatever form, including written and electronic forms, which are relevant to the provision of the Services, including Service User records and financial accounts.

Referenced Document means a document specified in Schedule B3.

Referred Services means pharmaceutical and laboratory services and such other services that can be referred by a Practitioner to other health service providers as agreed in writing with the DHB.

Register means the PHO's register of Enrolled Persons maintained in accordance with the Referenced Documents specified in clause 3(2) of Schedule B3 to Part B.

Regular Hours means the hours between 8:00am and 5:00pm on a Business Day.

Rural Premium means the premium paid to eligible PHOs in accordance with Schedule C4.

Section 88 Advice Notice means the notice entitled “Advice Notice to General Practitioners Concerning Patient Benefits and other Subsidies” issued under section 88 of the Act.

Sector Services means the business unit of the Ministry, responsible for health payments, agreements and compliance.

Service User means an Eligible Person who uses any Services, and includes a Casual User.

Services means all of the services specified in this Agreement.

Staff includes the PHO's and its Contracted Providers' employees, sub-contractors, contractors, agents and other personnel connected with the delivery of the Services.

Start Date means the date this Agreement commences, as set out in clause B.1 of this Agreement.

Treaty of Waitangi Principles means:

(a) **partnership**: working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services;

(b) **participation**: involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services; and

(c) **protection**: working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Uncontrollable Event means an event that is beyond the reasonable control of the party immediately affected by the event, but does not include an event that the party claiming could have prevented or overcome by taking reasonable care.

Urgent Care Services means the primary health care services described in clause 2 of Schedule C1.

Vaccine Episode means a visit on any given day for the administration of any number of vaccines.

Voluntary Variation means a variation to this Agreement described in clause B.19(1)(c).

Well Child/Tamariki Ora National Schedule means the Ministry publication of that name that describes the screening, surveillance, education and support services offered to all New Zealand children from birth to 5 years and their family or whānau.

Whānau ora means Māori families supported to achieve their maximum health and well-being.

B.47 Construction

(1) **Headings**: Headings appear in bold and are for convenience only and are to be ignored when interpreting this Agreement.

(2) **Part, clause, Schedule, Section**: We agree:

(a) a reference to a Part of, or Schedule to, is a reference to a Part of, or Schedule to, this Agreement;

(b) a reference to a clause is to a clause of a Part, unless stated to be a reference to a Schedule to a Part; and

(c) unless the context otherwise requires, a reference to a Section is a reference to a Section of a Part of a Schedule to this Agreement.

(3) **Varied document**: A reference to this Agreement or another document includes any variation, novation, or replacement of it.

(4) **Statutes**: A reference to a statute or other law includes regulations and other rules made under it and consolidations, amendments, re-enactments or replacements of any of them (whether before or after the date of this Agreement).

(5) **Singular includes plural**: The singular includes the plural and vice versa.

(6) **Person includes groups and successors**: The word person includes an individual, an association of persons (whether corporate or not), a trust, a state and an agency of state, in each case, whether or not having a separate legal personality, and includes the person's successors and permitted assigns.

(7) **Joint and several**: An agreement, representation or warranty in favour of 2 or more persons is for the benefit of them jointly and severally and an obligation of 2 or more persons binds them jointly and severally.

(8) **Currency**: A reference to $ or dollars is a reference to the lawful currency of New Zealand and, unless otherwise specified, all amounts payable by a party under this Agreement are to be paid in that currency.

(9) **Gender**: Words importing one gender include the other genders.

(10) **Business Day**: Anything required by this Agreement to be done on a particular day that is not a Business Day may be done on the next Business Day.

(11) **Priority of Parts**: If there is any conflict between any provisions of this Agreement (including the Referenced Documents), the order of priority will be as follows:

(a) Part A to Part G of this Agreement:

(b) the Referenced Documents.

SCHEDULE B1
MINIMUM REQUIREMENTS

Section 1 – Capability and capacity

1 Minimum requirements as to capability and capacity

(1) The PHO will have in place appropriate structural and governance arrangements, including that the PHO will:

(a) be a Not For Profit, with full and open accountability for its use of public funds and the quality and effectiveness of the Services; and

(b) have in place effective governance and management arrangements that meet best practice governance principles to manage risk, ensure that the PHO complies with its legal and financial obligations, including the terms of any agreements that the PHO has with the DHB, and ensure the PHO's ongoing financial viability and accountability.

(2) The PHO will be able to demonstrate a high level of clinical leadership and engagement by:

(a) having the necessary clinical expertise, capability, and networks to support and deliver services, including service development activities such as agreeing service standards and referral protocols, and ensuring that its Contracted Providers comply with those standards and protocols; and

(b) having the explicit support of local clinical leadership across a range of disciplines and have the ability to build and maintain effective collaborative relationships locally and nationally.

(3) The PHO will be able to demonstrate an advanced level of capability and capacity by:

(a) having the proven ability to form strategic and operational alliances with DHBs in its district/region and other provider networks to deliver transformational change in the health sector;

(b) having the necessary capability and expertise to carry out the PHO's functions effectively, efficiently and economically, and making wise use of resources, including having the ability to undertake and access strategic and service analysis and planning;

(c) having the necessary capability and expertise to effectively make and manage funding and purchasing decisions;

(d) having the capability to analyse, manage, and protect information, including by providing comparative data on provider activity, managing unexplained variation, and enabling performance improvement;

(e) having the capacity to report disaggregated information for Māori, Pacific and other populations, as part of performance monitoring arrangements and wider accountability arrangements for improving health outcomes for all population groups; and

(f) having infrastructure capability and capacity, including information platforms that support integrated health care.

(4) The PHO will be able to demonstrate compliance with:

(a) the national enrolment rules when developing and maintaining the Register;

(b) all existing Government policies and guidelines, including requirements relating to the national enrolment system and the national funding formula; and

(c) the obligations set out in this Agreement.

Section 2 – Activities

2 Minimum requirements as to activities

(1) Subject to subclause (2), the PHO will, at a minimum, undertake the activities set out in this Section 2.

(2) The activities listed in this Section are not exhaustive, and other activities appropriate to the local circumstances may be determined jointly between the DHB, PHO, and Alliance Leadership Team.

3 Provide the Services

(1) The PHO will Provide, and will contract with providers to deliver, the Services under this Agreement, and any other services agreed between the DHB and PHO, and in doing so will make the best use of system resources, provide best value and avoid duplication of services.

4 Facilitate and co-ordinate integration of the Services

(1) The PHO will:

(a) establish, maintain and invest in relationships within the area serviced and the wider region; and

(b) work collaboratively with DHBs and health and social service partners within agreed Alliance and regional processes to identify the health needs of the population, plan to meet the needs of that population, and agree how progress toward meeting those needs will be measured.

5 Promote continuous quality improvement in the delivery of the Services

(1) The PHO will:

(a) actively evaluate, monitor and manage the performance of Contracted Providers;

(b) address variation in clinical and management practice, including collecting and providing comparative data on performance; and

(c) achieve improved performance, including compliance with relevant national and local standards.

6 Effect transformational change in models of delivery and patterns of demand

(1) The PHO will:

(a) work collectively with DHBs, health and social service partners and local providers to design and develop new approaches to service delivery. This includes greater integration across primary/secondary and primary/community services, improved care co-ordination and continuity of care, patient pathways and referral protocols;

(b) achieve integration through the development and maintenance of strong relationships with local clinical leadership and wider local leadership; and

(c) understand, and ensure that its activities give consideration to:

(i) achieving Better Public Services, which is one of the Government's top 4 priorities;

(ii) the expectation that public services and other publicly funded organisations work together to make a stronger collective impact;

(iii) iwi plans for health and social services; and

(iv) the aspirations, methods and models of integrated care of whānau ora networks, and local community infrastructure such as territorial local authorities, non-governmental organisations and other community based partners.

7 Ensure accountability for the delivery of the Services

(1) The PHO will:

(a) participate in the integrated performance and incentive framework for PHOs and Contracted Providers, when the framework has been agreed nationally; and

(b) ensure transparency through public reporting of PHO performance.

8 Provide infrastructure, administrative and support services in respect of the Services

(1) The PHO will:

(a) undertake the following administrative and support functions:

(i) manage enrolment registers and ensure accurate enrolments;

(ii) make Payments;

(iii) collect, and require providers to collect, and make available data for data sharing and reporting arrangements; and

(iv) maintain information systems to collect activity and performance data;

(b) meet internationally/nationally recognised standards for:

(i) the privacy of information; and

(ii) IT, financial, business, human resource and quality systems;

(c) demonstrate support of Contracted Providers;

(d) contribute to the increased transparency of information at all levels of the system; and

(e) demonstrate the ability to develop the workforce including:

(i) quality of care improvement programmes; and

(ii) on-going professional development for all members of the primary care team; and

(f) work jointly with other PHOs and DHBs to take opportunities to share backroom functions and management support services across PHOs and with partner DHBs, as appropriate.

9 Security and preservation of Records

(1) The PHO must preserve and protect the safety, security and confidentiality of the Records in accordance with best business practice and any legal obligations.

(2) We will each have in place appropriate back-up and disaster recovery procedures to protect against loss of information.

(3) If the PHO or any Contracted Provider ceases to Provide the Services, the PHO must ensure, and must ensure that the Contracted Provider ensures, that all Records are properly preserved and, if appropriate, are able to be and on request are transferred to any replacement provider as the DHB may require.

10 Public reporting

(1) The PHO will make the following available to the public:

(a) its yearly report prepared under clause 7 of Schedule B2 to Part B; and

(b) its annual financial statements.

11 Emergency planning and response

(1) The PHO and its Contracted Providers will participate in the development of the district or regional health emergency plan (the "Plan") coordinated by the DHB and other relevant participants to ensure the PHO's clients/patients and Staff are provided for during a health emergency. The Plan will outline, to the extent practicable, the human, financial and other roles and resources that each participant, including DHB(s), PHOs and Contracted Providers, will contribute to responding to an emergency, including substitution of services to meet the health emergency.

(2) The PHO will work with the DHB and relevant participants to ensure the Plan is reviewed periodically to maintain currency.

(3) The Plan must identify how the PHO will respond to an emergency event. The PHO must take an all hazards approach to emergency planning.

(4) If requested by the DHB the PHO will be involved in processes to ensure that emergency responses are integrated, coordinated and exercised. The level of participation required will be reasonable and reflective of the nature of the services and the expected roles and services the PHO would provide in an emergency situation.

(5) The DHB will negotiate with the PHO about contributing to the PHO's costs if extraordinary funding is available to the DHB to manage an emergency.

12 Quality requirements

(1) The PHO will work to implement the following quality improvement requirements:

(a) the PHO will ensure that its Enrolled Population and Casual Users receive Services that are safe, effective, consumer centred and of acceptable quality;

(b) the DHB acknowledges that continuous quality improvement in the provision of Services by the PHO and the PHO's Contracted Providers who provide Services is best managed by the PHO and the PHO's Contracted Providers; and

(c) the PHO will follow continuous quality improvement principles, and will document, implement and evaluate systems and processes that continuously identify and strive to meet the needs of people who use them. These systems must provide assurance for:

(i) efficiency, effectiveness, acceptability, appropriateness, co-ordination and continuity in the provision of the Services to patients;

(ii) maintaining, improving and evaluating the quality of ongoing service provision including the development of new initiatives;

(iii) maintaining, improving and evaluating the quality of the PHO's processes to engage with its communities and collaborate with other health service providers;

(iv) clinical and cultural audit and peer review processes that incorporate input from relevant health professionals, services and consumers and that are based on appropriate professional/clinical standards;

(v) maintaining systems to manage risks appropriate to the degree and range of risk(s) relevant to the Services provided and ensure the security of people, drugs, equipment and buildings;

(vi) a contingency plan that manages continued delivery of the Services in the event of a major incident;

(vii) an appropriate process to deal with issues identified from consumer feedback;

(viii) a consumer complaints process;

(ix) data integrity, completeness and timely and complete recording; and

(x) focusing on clinical outcomes and control systems for unsafe and ineffective clinical practice.

13 Legal, regulatory and professional requirements

(1) The PHO will:

(a) comply with all its legal, regulatory, and contractual obligations;

(b) substantially meet and continue to improve on the quality standards, systems and guidelines of the relevant professional colleges or organisations as agreed between us both;

(c) ensure that its Practitioners and other professional employees, and its Contracted Providers' Practitioners and other professional employees, adhere to the standards of their relevant professional bodies;

(d) ensure that Practitioners, employees, Contracted Providers and any other sub-contractors, are aware of their responsibility to comply with the requirements of this Part, and have continuous quality improvement processes in place; and

(e) ensure that all buildings, plant and equipment used to provide Services are fit for their purpose and adequately maintained in safe working order.

SCHEDULE B2
REPORTING REQUIREMENTS

1 Scope of this Part and communications regarding reports

(1) This Part describes the information required to be:

(a) included on Claims and referrals;

(b) supplied by the PHO to the DHB (or its Payment Agent); and

(c) supplied by the DHB (or its Payment Agent) to the PHO.

(2) All reports required under this Agreement must be submitted in the format the DHB (or its Payment Agent) requires (if any).

(3) If the DHB (or its Payment Agent) requires a particular reporting format, the PHO will be provided with a reporting template.

(4) If the recipient of a report believes that the report raises concerns, the recipient will notify the party who prepared the report of its concerns within 20 Business Days of the receipt of the report.

(5) A report will be deemed to have been received on time and to be satisfactory unless the recipient of the report notifies the other party of any deficiencies or concerns in writing within 20 Business Days of the date the report is due (or of the date it is received in the case of any late report).

2 Practitioners

(1) The PHO will provide the information set out in this clause to Sector Services and the PHO Performance Programme secretariat immediately in respect of each Practitioner providing the Services to Enrolled Persons:

(a) NZMC number, Nursing Council number, cervical smear taker identification number, or such other appropriate PIN if the Practitioner does not hold the identification numbers referred to;

(b) name of Practitioner;

(c) practice name;

(d) practice address – physical location;

(e) practice address – postal;

(f) date joined;

(g) date left (if applicable); and

(h) locum flag (yes/no).

(2) The PHO will advise Sector Services and the PHO Performance Programme secretariat of any changes to the information listed in subclause (1) on a monthly basis. This reporting will be by way of submitting information in an electronic form to be agreed with the DHB.

(3) If any change of Practitioners occurs, the PHO will confirm to the DHB that the PHO has complied with the requirements of Enrolment Parameter 13 (Provider change of affiliation) of the Referenced Document entitled “Enrolment Requirements for PHOs”.

3 Service utilisation

(1) The PHO must report on First Level Services delivered to Enrolled Persons. The reporting will summarise on an aggregate basis the Services received by the characteristics of the Enrolled Persons and by provider type.

(2) The reports must be submitted to Sector Services (Dunedin) and the PHO Performance Programme secretariat on a quarterly basis using the format and means of electronic uploading of the data as the DHB (or its Payment Agent) advises.

(3) The PHO will provide First Level Service utilisation information on an aggregate basis until such time as the Referenced Document containing PHO Quality Indicators requires that certain information be provided at an individual transaction level.

(4) Reporting requirements in addition to those described in this clause may be agreed between us both and specified elsewhere in this Agreement.

(5) If a Service User is seen by more than one Practitioner on the same day, and the second consultation is complementary, necessary, or different, the second consultation will be reported as a separate consultation.

(6) Each First Level Service utilisation report will include information on First Level Services (non ACC) delivered to Enrolled Persons and the number of Enrolled Persons according to the following fields:

(a) age group = age of patient as at the beginning of the reporting quarter;

(b) gender = if gender is unknown convert to male;

(c) HUHC = means the person holds a High Use Health Card;

(d) DepQuin = where 5 is the most deprived and 1 is the least deprived;

(e) Ethnicity = level 2 ethnicity as described by Statistics New Zealand; and

(f) Care Plus Patient = whether or not the person is a Care Plus Patient.

(7) The PHO will complete a report on an aggregate basis (using the required format) for each of:

(a) First Level Service Consultations provided by Medical Practitioners;

(b) First Level Service Consultations provided by registered nurses or other health professionals;

(c) the number of practices/providers the service utilisation reporting in subclause (6) refers to;

(d) the total number of practices/providers within the PHO; and

(e) an explanation of any difference between the number of practices in clauses 3(7)(c) and 3(7)(d).

4 Clinical performance indicator report

(1) The PHO will report on the clinical events and diagnoses of Enrolled Persons. This reporting will summarise on an aggregate basis the clinical events and diagnoses characteristics of the Enrolled Persons.

(2) The reports must be submitted to Sector Services and the PHO Performance Programme secretariat on a quarterly basis using the format and means of electronic uploading of the data as the DHB (or its Payment Agent) specified at the Start Date.

(3) The PHO will provide clinical performance indicator information on a PHO aggregate basis.

(4) A clinical performance indicator report will include information on clinical events and diagnoses of Enrolled Persons according to the following fields:

(a) Ethnicity = level 2 ethnicity as described by Statistics New Zealand;

(b) Age group = age of patient as at the beginning of the reporting quarter;

(c) Gender = if gender is unknown convert to male;

(d) DepQuin = where 5 is the most deprived and 1 is the least deprived; and

(e) Care Plus Patient = whether or not the person is a Care Plus Patient.

(5) The PHO will complete a report on an aggregate basis (using the required format) for each of the following:

(a) number of practices included in the report;

(b) count of enrolled patients who have ever had their smoking status recorded (smoking status ever recorded);

(c) count of enrolled patients who have been diagnosed with diabetes;

(d) count of enrolled patients who have ever been diagnosed as having diabetes up to and including the last day of the reporting period (diabetes ever recorded);

(e) count of enrolled patients who have ever had a stroke up to and including the last day of the reporting period (stroke ever recorded);

(f) count of enrolled patients who have ever had a myocardial infarction up to and including the last day of the reporting period (myocardial infarction ever recorded);

(g) count of enrolled patients who have ever had heart failure up to and including the last day of the reporting period (heart failure ever recorded);

(h) count of enrolled patients with a CVD risk recorded (using a template that complies with the algorithm set out below) in the 5 years up to and including the last day of the reporting period (CVD risk recorded in the last 5 years):

The PMS must record CVD risk in accordance with "The Assessment and Management of Cardiovascular Risk" (NZ Guidelines Group, December 2003). The PMS will store the CVD risk or the CVD risk range ("mild (0-10%)", "moderate (10-15%)", "high (15-20%)", "very high (20-25%)") with the date when patient's risk was assessed;

(i) count of enrolled patients for whom a microalbuminuria test has been ordered in the 18 months up to and including the last day of the reporting period (diabetes patients recorded as having a microalbuminuria test in the last 18 months);

(j) count of enrolled patients with a positive microalbuminuria test and are on an ACE inhibitor or A2 receptor agonist in the 18 months up to and including the last day of the reporting period (diabetes patients who have had a positive microalbuminuria test and are on ACE inhibitor or A2 receptor agonist);

(k) count of enrolled patients with an HbA1C test result of 8% or less in the 12 months up to and including the last day of the reporting period (diabetes patients with HbA1C test result of 8% or less in the last year);

(l) count of enrolled adult patients with a CVD risk of 15% or more who have been prescribed statins if:

(i) the statins have been prescribed in the 12 months up to and including the end of the reporting period; and

(ii) the CVD risk has been recorded in the 5 years up to and including the end of the reporting period;

(m) count of enrolled patients who have had an Ischaemic CVD event or diagnosis of an Ischaemic CVD event (Ischaemic CVD event ever recorded);

(n) count of enrolled patients whose most recent smoking status is recorded as current smoker (current smoker status recorded);

(o) count of enrolled patients whose most recent smoking status is recorded as current smoker and who have been given brief advice in the last 12 months (brief advice to stop smoking provided); and

(p) count of enrolled patients whose most recent smoking status is recorded as current smoker and who have been given or referred to cessation support services in the last 12 months (smoking cessation support or referral provided).

5 Immunisation reporting

(1) The PHO will report on Immunisation Services delivered to Enrolled Persons. The PHO must ensure that information on immunisation episodes is transmitted electronically to Sector Services or its nominated agent for Payment purposes as detailed in clause 1(2).

(2) Ethnicity reporting will comply with Statistics New Zealand official definition (from Smith 1981), as modified by the national data policy group. The code used is Statistics New Zealand Standard Classification of Ethnicity, level 2 or as otherwise agreed.

(3) The PHO will provide information as set out in the Referenced Document entitled National Immunisation Register Requirements as documented in the agreed Information Provision appendix of the NIR Operations Manual.

(4) If the PHO is carrying out the 11 year and/or 12 year old immunisation programme, the PHO will report, by ethnicity:

(a) the number of enrolled children in year 7 at school;

(b) the number for whom consents to immunise were given;

(c) the number for whom consents were not given;

(d) the number who received Td immunisation;

(e) the number who received IPV immunisation; and

(f) the number who received HPV immunisation.

6 Rural Premium reports

(1) The PHO must meet reporting requirements agreed with the DHB, and which will as a minimum enable the DHB to report to the Ministry quarterly on:

(a) the rural workforce strategies planned or introduced;

(b) the progress and impact of those strategies; and

(c) the amount of Rural Premium funding expended.

7 Yearly report

(1) Each year the PHO will provide to the DHB a yearly report on the previous year (in hard copy form) by a date agreed by us.

(2) The report will cover the following matters:

(a) organisational structure and governance including the details of any amendments to the PHO's constitution, rules or other document constituting or governing the PHO or its activities;

(b) performance as part of the PHO Performance Programme and any additional quality indicators and targets agreed between us both; and

(c) a qualitative report on performance against the requirements in this Agreement including:

(i) evidence that the PHO has met the organisational requirements (including satisfying the definition of Not for Profit) set out in clause A.7;

(ii) service provision, including the activities undertaken to Provide the Services outlined in Part C. In particular, the PHO will report on the following activities:

A. Services provided to improve access to primary health care for High Need Groups, including activities to reduce health inequalities for Māori and Pacific peoples;

B. health promotion services and activities;

C. Referred Services management activities;

D. quality improvement activities;

(iii) consumer satisfaction and complaints summary;

(iv) issues and exceptions report;

(v) advice of the PHO's fee levels in accordance with clauses F.27 or F.28;

(vi) evidence (including ratio of Practitioners to Enrolled Population) of how the PHO achieves appropriate service levels to meet the needs of Enrolled Persons by using existing indicators, standards of practice and professional standards; and

(vii) audited financial reports.

8 Health promotion and access proposals

(1) If the PHO receives funding for health promotion or for services to improve access for High Need Groups, the PHO will:

(a) review each proposal (as approved by the DHB) on an annual basis; and

(b) following the annual review, provide 6 monthly reports, in particular, reporting on:

(i) services provided to improve access to primary health care for High Need Groups;

(ii) activities to reduce health inequalities for Māori and Pacific peoples; and

(iii) health promotion services and activities.

9 Quality indicators and targets

(1) One of the PHO's key aims is to improve the quality of health care received by the populations the PHO serves. The PHO Performance Programme is one mechanism to support and encourage quality improvement.

(2) We will each report to the other on quality improvement for primary health care services in accordance with the PHO Performance Programme.

10 The DHB's reports to the PHO

(1) The DHB will provide the PHO with the following reports in the format specified by the DHB:

(a) Quarterly Capitation Summary Report (Capitation Summary Report PCO.xls);

(b) Monthly FFS Deduction Report (FFS Deduction Report for PCOs v1_02.xls);

(c) Quarterly Register Processing Statistics Report (Register Processing Statistics Report V1_00.xls);

(d) Buyer Created Tax Invoice (BCTI); and

(e) HL7 Output.

(2) The DHB will provide quarterly performance monitoring reports as part of the PHO Performance Programme.

11 Ad hoc reports

(1) We acknowledge that as part of our commitment to establish an effective working relationship, we will each benefit from information relevant to the Services and the operation of this Agreement in order to better perform our respective obligations under this Agreement.

(2) Either of us may request information from the other from time to time in relation to the Services provided under or in relation to the operation of this Agreement.

(3) If either of us requests information described in subclause (2):

(a) the requesting party will notify the other of its reasonable information requirements, the reasons for its request, the use to which the information will be put, and any other information that the other party requires in order to satisfy its legal and ethical obligations; and

(b) the other party will use its reasonable endeavours to obtain and provide the requested information subject to any legal or ethical obligations with respect to clinical confidences.

(4) The requesting party will contribute resources to assist with the preparation of an ad hoc report if the information sought is either not already available in the form in which it has been requested, or can be made available only with the provision of staff resources not normally used by the party being requested, provided that the requesting party is not liable to make any such contribution if the other party is required to hold the information under this Agreement.

(5) Neither of us is required to provide to the other any information that it has previously provided to the other.

(6) Except as allowed under the Health Information Privacy Code 1994 neither of us will use information provided for one purpose for a different purpose without the other party's written consent.

12 Quality and timeliness of information

(1) If either of us provides the other with any information under this Agreement, the party providing the information must:

(a) ensure that such information is accurate and complete to the best of its knowledge and belief;

(b) identify any material inaccuracies or uncertainties at the time it submits the information or at such time as it discovers the inaccuracy or uncertainty; and

(c) use reasonable endeavours to provide the information in a timely manner or as agreed between the parties.

(2) The costs to the PHO associated with the provision of information specified under clause 11 will be met by the PHO and are deemed to have been included in the prices for the Services, provided that the PHO has agreed to the timeframe for the provision of the information (and such agreement will not be unreasonably withheld).

13 Summary of the reports required

(1) The following table summarises the PHO's reporting obligations under this Agreement:

Reporting Requirements	Frequency	Reported to
Details of Register (clause F.9)	Quarterly	Payment Agent
Changes to Practitioners (clause 2 of this Schedule)	Monthly	Payment Agent, PHO Performance Programme
Service utilisation (clause 3 of this Schedule)	Quarterly	Payment Agent, PHO Performance Programme
Clinical performance indicators (clause 4 of this Schedule)	Quarterly	Payment Agent, PHO Performance Programme
Immunisation Services (clause 5 of this Schedule)	Quarterly, pending development of NIR reporting requirements and thereafter in accordance with the Referenced Document entitled "National Immunisation Register Requirements"	DHB or Payment Agent

Reporting Requirements	Frequency	Reported to
Rural Premium (clause 6 of this Schedule)	Quarterly	DHB
Yearly report (clause 7 of this Schedule)	Annual	DHB
Health promotion and access proposals (clause 8 of this Schedule)	Biannually	DHB
Quality Indicators (clause 9 of this Schedule)	In accordance with the Referenced Document entitled "Indicator Definitions for PHOs"	DHB

SCHEDULE B3
REFERENCED DOCUMENTS

1 Purpose

(1) This Schedule specifies the Referenced Documents that form part of this Agreement.

2 Technical specifications

(1) The following technical specification documents are Referenced Documents:

Document Name	***Publisher***
Capitation-based Funding User Manual	Ministry of Health
HL7 Messages Standard Definition: Capitation-based Funding Electronic Registers	Ministry of Health
HealthPac Electronic Claiming	Ministry of Health

3 Business rules

(1) The business rules documents comprise 2 categories of documents:

(a) Register management; and

(b) Claims management.

(2) The following Register management rules documents are Referenced Documents:

Document Name	***Publisher***
Business Rules: Capitation-based funding	Ministry of Health
Enrolment Requirements for Primary Health Organisations	Ministry of Health
Certification of PHO Enrolment Register	Ministry of Health

(3) The following Claims management rules documents are Referenced Documents:

Document Name	***Publisher***
Primary Care Purchase Unit Codes	Ministry of Health

4 Other Referenced Documents

(1) Other documents that support PHO and DHB operations and interactions are Referenced Documents. These other Referenced Documents are listed below:

Document Name	*Publisher*
Primary Health Organisation Audit Protocol: Financial, Claiming and Referred Services	Ministry of Health
Primary Health Organisation (PHO) Service and Quality Audit Protocol	DHB Shared Services
PHO Service Agreement Amendment Protocol	DHB Shared Services
National Immunisation Register Requirements	Ministry of Health
Improving Māori Health: A guide for PHOs	Ministry of Health
Fees Review Process	DHB Shared Services
Indicator Definitions for PHOs	DHB Shared Services
Data Transfer Specification	Ministry of Health
Public Reporting Guidelines for PHOs	DHB Shared Services

5 E-enrolment

(1) Both of us and the Ministry are committed to implementing a real time patient enrolment (e-enrolment) system, the details of which will be included in this Agreement by amendments to the Referenced Document entitled Enrolment Requirements for Primary Health Organisations.

(2) The Ministry intends to secure funding for the development of an e-enrolment system by December 2013. We agree to use our best endeavours to support the implementation of an e-enrolment system.

Part C Nationally Consistent Services

C.1 Nationally Consistent Services

(1) The PHO will Provide the Nationally Consistent Services described in the schedules to this Part, in accordance with this Agreement.

(2) The DHB will Pay the PHO for Nationally Consistent Services provided in accordance with this Agreement, in accordance with Part F.

C.2 Supplying pharmaceuticals

(1) The PHO will comply with the terms of the Pharmaceutical Schedule that sets out the terms and conditions under which pharmaceuticals are supplied to Practitioners.

(2) The Pharmaceutical Schedule provides for the supply of pharmaceuticals to a Practitioner for personal administration to Service Users. That method of obtaining pharmaceutical supplies is only to be used to provide treatment to Service Users in an emergency, or to provide immediate treatment before supplies can be obtained in the ordinary way.

C.3 Declining First Level Services

(1) The PHO will ensure the immediate safety of any person who is not eligible for First Level Services or who is declined First Level Services in accordance with this Agreement.

C.4 Daily record

(1) The PHO must ensure that every Practitioner who provides First Level Services or General Medical Services for which Payment is claimed under this Agreement keeps a comprehensive and readily accessible daily record in respect of every Service User that includes the following:

(a) the name and the usual place of residence of the Service User;

(b) the place where the Services were provided (if different from the usual place of work of the Practitioner);

(c) the date on which the Services were provided;

(d) a record of the clinical history of the Service User and of the treatment given or services rendered;

(e) the pharmaceuticals prescribed; and

(f) the laboratory services authorised.

C.5 Laboratory tests

(1) The PHO must ensure that all referrals for laboratory tests issued by Practitioners, whether electronic or hard copy include the following details:

(a) practitioner’s council or identification number;

(b) practitioner type;

(c) practitioner's name;

(d) practitioner's PAN or other provider index (where we both agree that this is required);

(e) date of referral;

(f) patient name and address;

(g) NHI number;

(h) patient date of birth (if there is no NHI number);

(i) patient gender (if there is no NHI number);

(j) name of test or test code;

(k) the appropriate purchaser, if it is not the DHB; and

(l) practitioner's signature (or electronic equivalent).

C.6 Prescriptions for pharmaceuticals

(1) The PHO must ensure that all prescriptions for pharmaceuticals issued by Practitioners, whether electronic or hard copy, include the following details:

(a) practitioner's council or identification number;

(b) practitioner type;

(c) practitioner's name;

(d) practitioner's PAN or other provider index (where we agree that this is required);

(e) date prescribed;

(f) patient name and address;

(g) NHI number;

(h) patient date of birth (if there is no NHI number) and if the patient is under 12 years of age;

(i) patient gender (if there is no NHI number);

(j) patient category;

(k) Community Services Card status (yes or no);

(l) High Use Health Card status(yes or no);

(m) name of pharmaceutical;

(n) dosage;

(o) frequency of dosage;

(p) quantity or total days supply;

(q) special instructions (if applicable);

(r) practitioner's signature (or electronic equivalent);

(s) the appropriate purchaser, if it is not the DHB;

(t) endorsement requirements (if required); and

(u) recommending specialist and date of recommendation (if required).

(2) If more than one pharmaceutical is prescribed for a Service User at the same time and the subsidy for one or more of the pharmaceuticals will be paid by a different purchaser, the pharmaceuticals may not be set out on one prescription form, and a separate prescription form must be filled out per purchaser.

SCHEDULE C1
FIRST LEVEL SERVICES AND URGENT CARE SERVICES

1 First Level Services

(1) The PHO will Provide First Level Services to enable individuals and communities to benefit from services to:

(a) improve their health through:

(i) health promotion to the Enrolled Population, linking to public health programmes at a national, regional and local level and utilising such programmes to target specific populations;

(ii) health education, counselling and information provision about how to improve health and prevent disease and interventions or treatments that treat risk factors; and

(iii) intersectoral linkages and relationships to improve health;

(b) maintain their health through:

(i) ongoing health and development assessment and advice;

(ii) appropriate evidence based screening, risk assessment and early detection of illness, disease and disability;

(iii) use of recall and reminder systems and as appropriate referral to national programmes (including but not limited to Well Child/Tamariki Ora National Schedule, National Cervical Screening Programme and Breast Screen Aotearoa);

(iv) interventions to assist people to reduce or change risky and harmful lifestyle behaviour;

(v) family planning services, provision of contraceptive advice and sexual health services;

(vi) Immunisation Services;

(vii) working with public health providers in the prevention and control of communicable diseases for individuals and families/whānau and reporting to relevant public health providers; and

(viii) ongoing care and support for people with chronic and terminal conditions to reduce deterioration, increase independence and reduce suffering linking, if relevant, with appropriate service providers;

(c) restore their health by providing:

(i) health information to enable and assist people to care for themselves and take responsibility for their health and their family/whānau's health;

(ii) urgent medical and nursing services (including stabilisation and resuscitation, assessment and diagnosis, and treatment and referral as necessary);

(iii) assessing the urgency and severity of presenting problems through history taking, examination and investigation and diagnosing if possible;

(iv) recommending and, if appropriate, undertaking treatment options and carrying out/referring for appropriate interventions and procedures, including but not limited to prescribing, minor surgery and other general practice procedures, counselling, psychological interventions, advising, and imparting information; and

(v) referral for diagnostic, therapeutic and support services (support services are those services which may be required for individuals to maintain maximum independence, including but not limited to personal care and domestic assistance); and

(d) co-ordinate care, and in particular:

(i) co-ordinating an individual's rehabilitation process and participating if appropriate in providing recovery orientated services to restore normal functioning;

(ii) developing collaborative working relationships with community health services, DHB and Non-Government Organisation public health providers, ACC and relevant non-health agencies to help to address intersectoral issues affecting the health of their Enrolled Populations; and

(iii) establishing links with a range of primary and secondary health care providers and developing initiatives to enable patient centric, co-ordinated care that meets the needs of individuals, their family or whānau.

2 Urgent Care Services

(1) The PHO will Provide Urgent Care Services, which are those First Level Services that must be provided urgently because they cannot be safely deferred.

3 Provision of First Level Services and Urgent Care Services

(1) First Level Services and Urgent Care Services may be provided by teams including General Practitioners, Nurse Practitioners, registered nurses and a range of other health professionals who have appropriate training and qualifications.

(2) The PHO may Provide access to First Level Services and Urgent Care Services by telephone triage services and e-consultations using e-technologies, but must Provide access to those Services by face to face consultation if clinically indicated.

(3) The PHO will Provide First Level Services and Urgent Care Services that are sufficient to meet demand.

4 Access to First Level Services

(1) The PHO will ensure that First Level Services are available to 95% of its Enrolled Population during Regular Hours within 30 minutes travel time.

5 Access to Urgent Care Services

(1) The PHO will Provide all Service Users with access to Urgent Care Services on a 24-hour a day, 7 day a week basis for 52 weeks a year, in accordance with clause 3.

(2) The PHO must ensure that Urgent Care Services are available to 95% of its Enrolled Population:

(a) within 30 minutes travel time during Regular Hours; and

(b) within 60 minutes travel time during After Hours.

(3) In order to meet its obligations set out in this clause, the PHO must ensure that if it or its Contracted Providers are unable to Provide Urgent Care Services, the PHO or its Contracted Providers put in place alternative arrangements for continued provision of Urgent Care Services.

6 Justification required if Services are not provided

(1) The PHO will provide justification if any of the requirements set out in clauses 4 and 5 cannot be met.

(2) The justification must include details of alternative arrangements for providing access to First Level Services or Urgent Care Services as agreed between us.

7 Access to Population-based Health Services

(1) The PHO will Provide access to Population-based Health Services to all Enrolled Persons during Regular Hours. The PHO is not expected to be the sole provider of Population-based Health Services, which may be provided by a range of Practitioners and health workers.

(2) Unless levels and types of service provision are specifically agreed between us, the PHO and Contracted Providers and Practitioners will decide the extent and type of specific services that the PHO and they will provide to groups and individuals.

8 Access to Services for Casual Users

(1) The PHO must ensure that Casual Users have access to the same standard of care as the PHO's Enrolled Population.

(2) The PHO will Provide First Level Services described in clauses 1(1)(b), 1(1)(c), and 1(1)(d) to Casual Users, if required.

(3) The PHO must encourage a Casual User who is enrolled elsewhere to return to his or her usual provider. A Casual User who is not enrolled must be informed of the benefits of enrolment and encouraged to enrol with a provider or PHO of his or her choice.

9 Cessation of Services

(1) The PHO will ensure that it provides First Level Services and Urgent Care Services in accordance with this Schedule.

(2) In the event of a temporary or permanent cessation of those Services by it or any of its Contracted Providers, the PHO will ensure that it or the relevant Contracted Provider has put in place alternative arrangements for continued provision of First Level Services and Urgent Care Services.

10 Information about access to Services

(1) The PHO will advise its Enrolled Population about how and when they can access First Level Services and Urgent Care Services provided by the PHO, and will have information available for Casual Users on how to access Urgent Care Services.

11 Evidence of service levels

(1) The PHO will provide documented evidence, including the ratio of Practitioners to Enrolled Population, of how the PHO achieves appropriate service levels to meet population need by using existing applicable indicators, standards of practice and professional standards.

12 Managing Referred Services

(1) The PHO will manage Referred Services for its Enrolled Population, including by:

(a) monitoring and reviewing Referred Services;

(b) providing feedback to referrers;

(c) monitoring against best practice and relevant quality indicators;

(d) using facilitators and educators to encourage adoption of best practice;

(e) using peer groups to encourage best practice; and

(f) supporting other agreed initiatives.

SCHEDULE C2
GENERAL MEDICAL SERVICES

1 General Medical Services

(1) The PHO may Provide the General Medical Services described in clause 2 to Casual Users.

(2) Subject to subclause (3), General Medical Services will be provided to an individual only if initiated by the request of the patient or the patient's caregiver or agent if the patient is unable to make the decision for themselves.

(3) General Medical Services may be initiated by the General Practitioner if:

(a) the General Practitioner initiates the service to ensure the provision of appropriate medical care and/or specific health education, health screening, follow-up or recall services to patients of his/her practice population (e.g. for cervical screening); or

(b) the General Practitioner provides medical services in medical emergencies.

2 Services that are General Medical Services

(1) General Medical Services are all proper and necessary Casual Medical Consultations provided to the individual patients of a General Practitioner either personally or by a Locum or under any other arrangements approved by the DHB, and include the following Services:

(a) medical services that are by custom and practice recognised as being part of the services usually provided by General Practitioners;

(b) family planning and pregnancy counselling services;

(c) 24 hour, 7 day Urgent Care Services;

(d) minor surgical procedures such as those under local anaesthetic;

(e) disease prevention strategies;

(f) notification of communicable diseases;

(g) investigation and referral for necessary diagnostic tests, pharmaceuticals, community and specialist services;

(h) health education about lifestyle risk factors and chronic diseases to prevent the development of disease, recurrences and deterioration in disease state; and

(i) well child services in accordance with the Well Child/Tamariki Ora National Schedule ("Tamariki Ora") if it is known that the item of service has not already been performed by another provider. If the services may be claimed, they are to be detailed in the Daily Record and in the Tamariki Ora record (if possible), and the services must be provided free to the patient. The DHB will advise all Medical Practitioners in a region where well child services have been purchased through alternative contract arrangements.

(2) General Medical Services do not include Services that are within any of the following classes:

(a) specialist medical services as defined in the Section 88 Advice Notice;

(b) Primary Maternity Services and all related services caused by or related to pregnancy;

(c) services for which cover (as defined in the Accident Compensation Act 2001) is available under the Accident Compensation Act 2001;

(d) medical services provided by any General Practitioner to his or her dependants or his or her partner or the dependants of his or her partner or to other persons from whom or in respect of whom he or she is not entitled to recover any payments under the Section 88 Advice Notice;

(e) medical services provided by any General Practitioner under an agreement made by him or her with a friendly society or branch registered under the Friendly Societies and Credit Unions Act 1982;

(f) medical services involved in any medical examination of which the sole or primary purpose is the obtaining of a medical certificate (for production to some other person) as to the condition of health of the person examined, other than medical services in relation to certificates given for 'sickness benefits' from a friendly society or for the purpose of benefits under Part 1 of the Social Security Act 1964 – excluding medical services for which payment is made to the General Practitioner by the Ministry of Social Development;

(g) medical services provided by a General Practitioner for the purposes of, or incidental to, extraction of teeth by them;

(h) medical services in respect of laboratory diagnostic services;

(i) medical services which are diagnostic imaging services;

(j) medical services provided by means of advice given by telephone, telegram, facsimile, internet, e-mail or letter, except in circumstances specifically approved by the Medical Officer of the DHB for the purposes of the Section 88 Advice Notice;

(k) medical services not provided by a General Practitioner in person;

(l) medical services provided otherwise than in an emergency in any factory or shop (within the meaning that was given to those terms by the Health and Safety in Employment Act 1992) to a person employed in that factory or shop and provided pursuant to an arrangement made by or on behalf of the General Practitioner with the employer of the person in receipt of those services or the agent of the employer;

(m) medical services which consist only of the administration of a vaccine for which a Payment for immunisation is payable under this Agreement;

(n) medical services of a substantially similar nature offered by a General Practitioner to a group of patients at the same time (unless specifically approved by the DHB);

(o) medical services if no service of substance is provided by the General Practitioner and for which the patient would not reasonably expect to pay;

(p) if only the provision of a repeat prescription, and no other service, is provided;

(q) separate claiming for more than one General Medical Service when they are provided during a single Casual Medical Consultation with an individual patient;

(r) Well Child Services (unless detailed in the Section 88 Advice Notice);

(s) General Medical Services provided to patients in the care of the provider arm of a DHB or long stay institution, if the DHB or long stay institution is fully funded for the provision of medical care;

(t) if only the provision of a death certificate and no other service is provided;

(u) such services as may be determined by the DHB after reference to the advisory committee established under the Section 88 Advice Notice, and notice to the General Practitioner, not to be General Medical Services for the purposes of the Section 88 Advice Notice, either absolutely or in special circumstances as defined by the Ministry; and

(v) medically-unwarranted minor cosmetic procedures or circumcisions.

(3) For General Practitioners in rural areas who can claim a rural bonus under this Agreement, General Medical Services for Casual Users include Casual Medical Consultations made by telephone providing the patient is located 16km or further from the General Practitioner's place of practice at the time of consultation.

3 General provisions

(1) The PHO may Provide General Medical Services to Eligible Persons who are not enrolled with the PHO.

(2) General Medical Services may also be provided by other service providers to the PHO's Enrolled Population.

(3) The terms and conditions of the Section 88 Advice Notice apply to all services provided to and Payments made for Casual Users, subject to the provisions of this Agreement.

SCHEDULE C3
IMMUNISATION SERVICES

1 Service objectives

(1) The PHO will Provide the Immunisation Services set out in this Schedule as part of achieving:

(a) the national target of 95% immunisation coverage in children;

(b) a 75% coverage rate of eligible patients as specified in the Influenza Guidelines receiving influenza vaccine; and

(c) an increased proportion of adults receiving tetanus vaccine at age 45 and 65 years.

2 Service components

(1) The PHO will deliver:

(a) all Immunisation Services to children and adults as per the National Immunisation Schedule issued by the Ministry of Health;

(b) non-schedule vaccines to relevant high-risk groups, as per the Immunisation Handbook; and

(c) the immunisation episode scheduled at age 11 (year 7) and at age 12 (year 8) if it is not given through a school programme.

(2) In addition, the PHO will:

(a) provide opportunistic immunisation of children who are Casual Users, and inform, if available, their usual vaccinator/provider of this within 2 Business Days;

(b) refer any child who is overdue for an immunisation event and who has not responded to at least 3 contacts, to either an appropriate immunisation outreach service, a well child service, or the local immunisation co-ordinator;

(c) undertake regular audits of itself and its Contracted Providers;

(d) promote immunisation using evidence-based information, ensuring its Enrolled Population is able to make decisions about immunisation based on informed consent;

(e) assist with epidemic control and other situations if co-ordinated action is required;

(f) ensure that a decision by parents/guardians not to immunise their children is recorded and the Practitioner acts in accordance with this decision; and

(g) maintain at all times an effective cold chain so as to ensure potency of all vaccines administered.

(3) Terms used in this Schedule such as immunisation on time, overdue, non-responder, and declined are defined in the national standardised terminology for immunisation audit developed by the Immunisation Advisory Centre.

3 Quality requirements

(1) The PHO must meet the Immunisation Standards set out in the Immunisation Handbook, including standards for organisations offering vaccination services and standards for vaccinators, any relevant legislation (including regulations) and reporting of adverse events.

4 Requirements for administering vaccines

(1) A vaccine must be administered through a Medical Practitioner or an Authorised Vaccinator, or by a registered nurse acting under the direction of a Medical Practitioner.

5 Approved immunisation programmes

(1) The immunisation programmes that are currently approved for the purposes of this Schedule are detailed in the Immunisation Handbook.

SCHEDULE C4
RURAL SERVICES

Section 1 - Rural Primary Healthcare Premium

1 Purpose of the premium

(1) If the PHO's geographical areas specified in clause B.9 include rural communities, the DHB will Pay the PHO a Rural Premium.

(2) The Rural Premium is a flexible resource that PHOs use to support:

(a) the retention and recruitment of a skilled primary health care workforce to serve rural communities; and

(b) locally devised solutions to primary health care workforce issues impacting on achieving sustainable and accessible primary health care services in rural areas.

2 Definition of a rural community

(1) For the purposes of this Schedule, a "rural community" is:

(a) a community served by a General Practitioner who scores 35 or more on the Rural Ranking Scale; or

(b) an equivalent rural area served by a General Practitioner or a nurse to which the DHB has assigned a notional rural ranking score.

3 Rural Premium Components

(1) The Rural Premium is made up of 3 parts:

(a) workforce retention funding, which is a flexible resource for supporting and retaining the primary health care team;

(b) reasonable roster funding, which is a targeted resource aimed at those experiencing onerous on call arrangements; and

(c) remote practice area funding, which is additional funding on account of a pre-existing special funding arrangement to support a remote practice.

(2) Each of those parts is described in clauses 4, 5 and 6.

4 Workforce retention funding

(1) As part of the Rural Premium, the DHB will Pay the PHO workforce retention funding according to a formula based on degrees of remoteness (indicated by the rural ranking score of the General Practitioners).

(2) For some remote rural localities served by rural nurses with General Practitioner back-up (eg Stewart Island), a national rural ranking score will be applied by the DHB to the nurse). Similarly,

for rural doctors who have not been allocated a rural ranking score, the DHB can allocate a notional rural ranking score for workforce retention funding purposes based on the same criteria.

(3) The current workforce retention funding allocation formula and the PHO's rural workforce retention funding is specified in clause 1 of Schedule F1.4.

(4) The workforce retention funding is a flexible resource to assist with retention and recruitment of all primary healthcare workers serving rural communities.

(5) The PHO may apply the funding to a range of strategies to create favourable working conditions including, but not limited to:

(a) enabling practitioners to have time off duty;

(b) creating a supportive professional working environment;

(c) ensuring access to continuing professional development and peer support;

(d) paying financial incentives; and

(e) ensuring that practitioners have the ability to enter and leave rural practice with minimal restrictions.

(6) The PHO is bound to the terms of any existing agreement between it (and its General Practitioners and/or Contracted Providers) and the DHB. However, after the expiry of any such agreement, the PHO may determine what workforce retention assistance it provides to its General Practitioners and Contracted Providers.

(7) We may agree that the DHB retains all or part of the workforce retention funding to continue to arrange retention strategies for the PHO's primary health care workforce.

5 Reasonable roster funding

(1) Reasonable roster funding is a targeted resource applied to rural localities where, for geographical reasons, General Practitioners and nurses providing First Level Services are experiencing onerous on call arrangements.

(2) The DHB pays funding to improve roster arrangements to the practices and Contracted Providers specified in clause 2 of Schedule F1.4 (if any).

(3) The PHO may change the level of support provided to practices and Contracted Providers who receive reasonable roster funding in order to enhance cost effective roster arrangements, provided that the new arrangements continue to support reasonable rosters and meets the access standards regarding After Hours care.

6 Remote practice areas

(1) A remote rural practice is characterised by high points on the rural ranking scale and/or a former special area to which salaried primary health care services continue to be provided.

(2) If there is a current special funding arrangement for a remote practice area, and this special funding arrangement exceeds the capitation Payment for the PHO's Enrolled Population for the remote practice area, the DHB will Pay the PHO the difference between the two amounts.

(3) The DHB will Pay the PHO the total amount for remote practice areas specified in the table set out in clause 3 of Schedule F1.4 in addition to the capitation Payment on behalf of the Enrolled Population(s) of the practice area(s) specified in that table.

(4) If the PHO or its practices have received additional funding on account of a current special funding arrangement to support a remote practice, the PHO may make service changes or funding adjustments that promote cost effective service delivery to the remote practice area provided that the PHO continues to support sustainable and accessible services to that remote community and support favourable working conditions including time off duty for the primary health care team serving that community.

(5) If the DHB provides the primary health care services to the remote practice area, the PHO agrees that the DHB may retain the funding.

(6) The PHO cannot introduce patient charges in the areas specified below without first obtaining Ministerial agreement which should be sought through the DHB:

(a)

7 Priority uses of rural primary health care premium

(1) In order for the PHO to meet its obligations set out in clauses 3 to 11 of Schedule C1, the PHO will agree with the DHB the priority uses of the Rural Premium.

(2) Priority uses may include:

(a) supporting reasonable rosters;

(b) stabilising the rural practice team if a rural community is at risk of being without services within the access standards;

(c) supporting practice teams serving remote communities;

(d) addressing heavy workloads, particularly if the doctor to Enrolled Population ratio exceeds 1: 2000; and

(e) encouraging workforce innovations that promote sustainable services, for example: opportunities for nurses practising in rural primary health care settings to enhance their skills; and development of Nurse Practitioners in rural settings with prescribing rights.

8 Collaboration over rural workforce strategies

(1) Subject to the PHO's obligations under the Commerce Act 1986, it may collaborate with other PHOs or other agencies to develop joint, district wide or regional initiatives.

Section 2 - Rural Bonus

9 Claims for rural bonuses

(1) A rural bonus may be claimed by General Practitioners whose score on the rural ranking scale is 35 or above and who:

(a) comply with the requirement to Provide First Level Services for patients at all times; and

(b) Provide First Level Services to a practice population; and

(c) participate regularly in an on-call roster.

(2) The DHB will undertake a review of General Practitioners' rural ranking scores on an annual basis.

(3) General Practitioners' rural bonus will be calculated annually on the basis of the reviewed rural ranking score.

(4) The PHO may not alter the amount of rural bonus payable to an eligible General Practitioner.

10 Applications for a rural bonus

(1) The DHB will supply the PHO with application forms for the rural bonus by 15 March in each year, and the PHO will lodge applications for the rural bonus with the DHB by 15 April in each year (unless the DHB, at its sole discretion, decides to extend that date).

(2) The DHB will, within 1 month after the last date for lodging applications, advise each eligible General Practitioner who has lodged an application of the dollar amount of his or her rural bonus for that financial year.

11 Adjustments to rural bonuses

(1) A General Practitioner may during the course of a financial year apply to the DHB for a rural bonus or an adjustment to the rural bonus payable to that General Practitioner if his or her score has increased. Any increase in Payment during that financial year will be made at the DHB's sole discretion.

(2) The DHB may, during the course of a financial year, reduce the amount of rural bonus payable to a General Practitioner, if his or her score decreases.

12 Medical Consultations by telephone

(1) For General Practitioners in rural areas eligible for a rural bonus, the benefits payable for the provision of General Medical Services for Casual Users are payable if the Casual Medical Consultation is made by telephone, providing the patient is located 16km or further from the General Practitioner's place of practice at the time of the Casual Medical Consultation.

(2) Rural bonuses will not be payable in any other circumstances, unless approved in extreme circumstances.

(3) Specified call centre services or other similar projects do not qualify for a rural bonus.

13 Review of rural ranking scale

(1) The DHB may review the current rural ranking scale criteria to clarify interpretation and ensure national consistency, in consultation with relevant rural provider organisations.

SCHEDULE C5
SPECIAL SUPPORT SERVICES FOR FORMER SAWMILL WORKERS EXPOSED TO PCP

1 Purpose

(1) This service specification for the Special Support Service for Former Sawmill Workers Exposed to PCP (the Special Support Service) sets out the background, service objectives, eligibility criteria and access processes, annual health checks and referred service components and quality requirements, fee schedule, payment process and user charges, and information and reporting requirements of the Special Support Service.

2 Background

(1) Between the 1950s and the 1980s, pentachlorophenol (PCP) was used in the sawmill industry as an anti-sapstain agent and a preservative. Recent published, peer-reviewed evidence suggests that some former sawmill workers who were exposed to high levels of PCP may experience health effects that could be attributed to historical exposure to PCP.

(2) Given the historical exposure and the estimation of the impact of exposure, the Government committed to establishing an early intervention-focused special support service for former sawmill workers exposed to PCP. In June 2010 the Ministry announced it would establish a Special Support Service for Former Sawmill Workers Exposed to PCP.

3 Service objectives

(1) The Special Support Service is a comprehensive new service designed to assess the health needs of individuals who may have been exposed to PCP while working in New Zealand sawmills between the 1950s and 1980s, and to facilitate access to services to support individual's wellness. Overall, it aims to support improvements in the health of eligible individuals. It will also support the achievement of national health objectives and health targets including early interventions to reduce morbidity, better management of non-communicable diseases and long-term conditions, and improved access to care through the delivery of effective evidence-based and co-ordinated primary health care services.

(2) The specific objectives of the Special Support Service are to:

(a) promote healthy lifestyles, reduce the impact of modifiable diseases, and support the early detection of diseases;

(b) ensure that every Eligible Person is able to access the Special Support Service;

(c) ensure the Special Support Service meets the needs of the eligible population, and that they support the Special Support Service and are engaged in its implementation; and

(d) ensure that the Special Support Service responds to change, learning and emerging evidence.

4 Eligibility and access processes

(1) Individuals who apply must meet the general Eligibility Direction for access to publicly funded health and disability services.

(2) People who consider that they may be eligible to access the Special Support Service must apply to the National Secretariat. Application forms may be obtained by writing to, or telephoning the National Secretariat of the Special Support Service for Former Sawmill Workers Exposed to PCP at the Ministry of Health, P.O. Box 5013 Wellington, or by calling 0800 288 588 or by visiting the website (www.moh.govt.nz/dioxins).

(3) It is estimated that approximately 7,900 people may be eligible for the Special Support Service. There are likely to be concentrations of potentially eligible individuals in regions like the Bay of Plenty, Waikato, Lakes, and Canterbury if the sawmilling industry is (or was) a key employer. These figures are approximate and will remain uncertain until applications are received and processed.

5 Special Support Service components

(1) The Special Support Service will comprise a free health check and the following Referred Services:

(a) lifestyle improvement services, including smoking cessation, green prescriptions or other available physical activity focused programmes, and dietary information and advice.

(b) primary mental health services for mild to moderate mental health conditions.

(c) genetic counselling services.

(2) Eligible Persons will be entitled to a free annual health check. The first free health check will be a full health assessment that may comprise the following:

(a) a general health assessment that looks at, for example, gender, age, occupation, type of work, body mass index, blood pressure, medical history, smoking status, diet, physical activity, alcohol use, and other drug use;

(b) brief advice on smoking cessation, alcohol, nutrition, and physical activity;

(c) advice on the association between PCP and dioxin exposure and health outcomes;

(d) a review to identify any health outcomes with suggestive or sufficient evidence of an association with PCP exposure. For example, non-Hodgkin's lymphoma, soft tissue sarcoma, some neurological and neuropsychological effects, respiratory effects, possible liver effects, dermatological effects, and issues with fever;

(e) a review to identify any health outcomes with suggestive or sufficient evidence of an association with dioxin exposure. For example, hypertension, type II diabetes, cancers of the respiratory system, prostate cancer, soft tissue sarcoma, non-Hodgkin's lymphoma, Hodgkin's disease, multiple myeloma, AL Amyloidosis, chronic lymphocytic leukaemia,

early onset transient peripheral neuropathy, porphyria cutanea tarda, and spina bifida in offspring;

(f) a review for psycho-social outcomes and unmet mental health needs;

(g) a review for other health outcomes. For example, cardiovascular, gastrointestinal, musculoskeletal, skin, nervous system conditions, and respiratory conditions;

(h) if indicated, specific screening through current tests or programmes;

(i) if indicated, referral to other components of the Special Support Service; and

(j) if indicated, referral to other health services if the Eligible Person meets the other health services eligibility criteria.

(3) The first free health check will be overseen by the Eligible Person's nominated General Practitioner. The Eligible Person's nominated General Practitioner may deliver the first free health check in conjunction with any other members of the primary health care team as they deem appropriate.

(4) While the first free health check is comprehensive, it is expected that the subsequent free annual health checks will be more focused on specific health needs. The Special Support Service can be provided by a combination of registered medical practitioners, registered practice nurses and any other members of the primary health care team as appropriate.

(5) Subsequent free health checks will continue to address the health needs identified in the first free health check, and any other health needs identified in subsequent annual health checks.

(6) The exact content of each free annual health check will be guided by the Eligible Person's medical history, current health needs, evidenced-based best practice and the clinical judgement of the health practitioner.

(7) Individualised care plans may be used at the discretion of the health practitioner.

(8) It is expected that Eligible Persons will be enrolled at the practice if their nominated General Practitioner is located as per the principles of the Primary Health Care Strategy.

6 Eligibility and access to Referred Services

(1) To be eligible for referral to the Referred Services the patient must first meet the general eligibility criteria for that service if it is already publicly funded, for example, mental health services for mild to moderate mental illness and lifestyle improvement services.

7 Genetic counselling

(1) An Eligible Person may be referred for genetic counselling as part of an annual health check.

(2) An Eligible Person may not be charged for being referred for genetic counselling

(3) Eligible Persons can only be referred for genetic counselling by a General Practitioner.

8 Other Referred Services

(1) If in the course of conducting the free annual health check the General Practitioner and/or practice nurse considers it appropriate they can refer the patient to the following Referred Services which may be provided at no cost to the patient, or in some cases there may be a cost to the patient:

(a) lifestyle improvement services, including smoking cessation, green prescriptions, and dietary information and advice; or

(b) mental health services for mild to moderate mental health conditions.

9 Collection and use of patient information

(1) The nominated General Practitioner who provides a free annual health check to an Eligible Person must advise them at the time of the check that the patient information specified in the information and monitoring section of this Schedule will be provided to the Ministry, and may be used by the Ministry to monitor and evaluate the provision of services.

(2) Table 1 summarises who would have access to particular categories of personal information and for what purposes.

10 Information and monitoring requirements

(1) The following information must be collected if it is required in the claiming process:

(a) NHI number;

(b) Eligible Person's full name;

(c) Eligible Person's date of birth;

(d) whether the claim is for the first health check or a subsequent annual health check;

(e) duration of the annual health check;

(f) date of the annual health check;

(g) the Referred Services that the Eligible Person was referred to;

(h) name of the general practice; and

(i) name and registration of the nominated General Practitioner.

(2) The monitoring information will contribute to:

(a) management planning;

(b) decisions about the future administration and governance of the Special Support Service; and

(c) the periodic review of the Special Support Service.

(3) Table 2 shows how the monitoring and reporting requirements will be used to measure the specific objectives of the Special Support Service and the source and frequency of the reporting requirements.

(4) In addition to the above monitoring framework, an independent evaluation of the Special Support Service will be completed in the third year of operation. Nominated General Practitioners may be asked to participate in the independent evaluation. If requested to participate, the PHO agrees not to unreasonably withhold its consent to participate in the independent evaluation.

11 Duration and review of the Special Support Service

(1) It is intended that the Special Support Service be ongoing, however, the Ministry reserves the right to review, at any time after implementation, the Special Support Service.

Table 1					
Function	**Purpose of collection**	**Source of and information required**	**Storage and security**	**Access**	**Unique identifier**
Communications	To communicate with eligible individuals about application, the specifics of the Special Support Service, any amendments to its scope or access criteria, or any other related issue	Information required: Name and contact details Source: Application form	Eligibility database Stored for as long as is required for the stated purpose	National Secretariat (MOH) Facilitation Service	Not required
	To inform descendants about information on the Special Support Service, or any other related issue	Information required: Name and contact details Source: Provided by the person	Mailing list (existing) Stored for as long as is required for the stated purpose	Ministry of Health	Not required
Administration	To assess applications for eligibility	Information required: Full name, date of birth, contact details, NHI number, name of nominated health practitioner, eligibility criterion, and any additional information to support application including evidence Source: Application form	Data entered onto eligibility database; hard copies filed Stored for as long as is required for the stated purpose	National Secretariat (MOH) Appeals Panel	Not required
	To advise of outcomes of eligibility assessment process	Information required: Full name, contact details Source: Application form	Eligibility database Stored for as long as is required for the stated purpose	National Secretariat (MOH)	Application number

Table 1					
Function	**Purpose of collection**	**Source of and information required**	**Storage and security**	**Access**	**Unique identifier**
	To send first and subsequent entitlement letters to eligible people	Information required: Full name, contact details, date of birth, NHI number, date of previous health check (out-years only) Source: Application form and GP claim form	Eligibility database Stored for as long as is required for the stated purpose	National Secretariat (MOH) Sector Services	Existing NHI number
	To advise nominated practice of successful applicants and to provide information on the proposed Service or any other related issue	Information required: Contact details, date of birth, NHI number, date of previous health visit (out-years only) Source: Application form	Eligibility database Stored for as long as is required for the stated purpose	National Secretariat (MOH) Nominated GPs	Existing NHI number

Function	**Purpose of collection**	**Source of and information required**	**Storage and security**	**Access**	**Unique identifier**
Administration (continued)	To pay GPs for services delivered	Information required: NHI number of patient, patient's full name and date of birth, duration and date of health check-up, name of the practitioner, practice, registration number Source: GP claim form	Eligibility database Stored for as long as is required for the stated purpose	National Secretariat (MOH) Sector Services	Existing NHI number

Function	Purpose of collection	Source of and information required	Storage and security	Access	Unique identifier
	To consider appeals from unsuccessful applicants	Information required: Full name, date of birth, contact details, NHI number, name of nominated health practitioner, eligibility criterion, any more information to support application including evidence Source: Application form	Eligibility database Stored for as long as is required for the stated purpose	National Secretariat (MOH) Appeals Panel	Not required
Monitoring	To provide sufficient information through which to monitor service uptake and attrition to inform ongoing policy development	Information required: NHI number of patient, duration and date of health check-up, name of practitioner, practice, registration number, services patient referred to, eligibility criteria, reasons for withdrawal Source: claim form/information from PHOs, application form, service withdrawal letters	Eligibility database Stored for as long as is required for the stated purpose	National Secretariat (MOH)	Not required
		Aggregated data	NA	Ministry of Health PHOs DHBs DHB Shared Services	NA

Table 2			
Performance measure	**Indicator**	**Reporting requirements**	
		Data source and frequency	**Reporting unit**
People are accessing the free annual health check	Number accessing Wellness Check: • Total • Eligibility criteria • Ethnicity • DHB of domicile	Free annual health check Entitlement and Claim forms/ information from PHOs.	Pre-filled data: • Full name • NHI number • Provider name Additional data required: • Date of check-up
Contracted Providers are referring people to component services	Number referred to: • Health promoting activities • Mental health services • Genetic counselling • By DHB	Free annual health check Entitlement and Claim forms/ information from PHOs.	Referrals to: • Health promoting activities • Mental health services • Genetic counselling
Contracted Providers are referring people to other specific diagnostic and treatment services	Number • By DHB	Free annual health check Entitlement and Claim forms/ information from PHOs.	Referrals to other specific services
Cost efficiency	Cost by: • DHB • Service components • Number of people accessing Wellness Check • Duration of check-up • Type of practitioner	Free annual health check Entitlement and Claim forms/ information from PHOs.	Duration of check-up Name and registration number of practitioner

SCHEDULE C6
HEALTH SUPPORT SERVICES FOR DIOXIN-EXPOSED PEOPLE

1 Purpose

(1) This Health Support Service for Dioxin Exposed People (the Health Support Service) specification sets out the background, service objectives, eligibility criteria and access processes, annual service and referred service components and quality requirements, fee schedule, payment process and user charges, and information and reporting requirements of the Health Support Service.

2 Background

(1) Between 1962 and 1987, Ivon Watkins Dow (IWD) manufactured the herbicide 2,4,5-T at its plant in Paritutu, New Plymouth. A dioxin (TCDD: 2,3,7,8-tetrachlorodibenzopara-dioxin) is formed during the manufacture of 2,4,5-T and remains as a contaminant in the product.

(2) It is generally accepted that dioxin is a carcinogen. People living in Paritutu have long been concerned about dioxin exposure from IWD plant emissions. A serum dioxin study conducted by ESR in 2005 showed that some residents and ex-residents of Paritutu had blood serum levels of TCDD significantly above those of the general New Zealand population.

(3) The Ministry has concluded that the dioxin levels found among a group of Paritutu residents may have health consequences for individuals and may cause increased rates of disease, in particular cancer, on a population basis. The extent of the increased cancer mortality risk is difficult to precisely determine, but is estimated that it may be up to 10% above the national cancer mortality rate for highly exposed Paritutu residents.

(4) Given the historical exposure and the estimation of the impact of exposure, the Government committed to establishing an early intervention-focused health support service for people exposed to dioxin from the former IWD plant.

3 Health Support Service objectives

(1) The Health Support Service responds to the community's concerns about the potential health impacts of exposure to dioxin from emissions from the IWD plant at Paritutu during the time of manufacture of 2,4,5-T. The Health Support Service is a comprehensive service designed to assess the health needs of individuals who may have been exposed to dioxin from the former Ivon Watkins Dow factory in Paritutu, New Plymouth, and to facilitate access to services to support individual's wellness. Overall, it aims to support improvements in the health of eligible individuals. It will also support the achievement of national health objectives and health targets including early interventions to reduce morbidity, better management of non-communicable diseases and long-term conditions, and improved access to care through the delivery of effective evidence-based and co-ordinated primary health care services.

(2) The specific objectives of the Health Support Service are to:

(a) promote healthy lifestyles, reduce the impact of modifiable diseases, and support the early detection of diseases;

(b) ensure that every Eligible Person is able to access the Health Support Service;

(c) ensure that the Health Support Service meets the needs of the eligible population, and that they support the Health Support Service and are engaged in its implementation; and

(d) ensure that the Health Support Service responds to change, learning and emerging evidence.

4 Eligibility and access processes

(1) Individuals who apply must meet the general Eligibility Direction for access to publicly funded health and disability services.

(2) People who consider that they may be eligible to access the Health Support Service must apply to the service Secretariat. Application forms may be obtained by writing to, or telephoning the Secretariat of the Health Support Service For Dioxin Exposed People at the Ministry of Health, P.O. Box 5013 Wellington, or by calling 0800 288 588 or by visiting the website (www.moh.govt.nz/dioxins).

(3) It is estimated that approximately 6,000 people may be eligible and that about 50% of eligible people may be residing in the Taranaki district. These figures are approximate and will remain uncertain until applications are received and processed.

5 Health Support Service components

(1) The Health Support Service will comprise a free annual health check and the following Referred Services:

(a) lifestyle improvement services, including smoking cessation, green prescriptions or other available physical activity focused programmes, and dietary information and advice.

(b) primary mental health services for mild to moderate mental health conditions.

(c) foetal neural tube defect screening (if relevant).

(d) genetic counselling services.

(e) serum dioxin testing (in some cases).

(2) Eligible Persons will be entitled to a free health check. The first free health check will be a full health assessment that may comprise the following:

(a) a general health assessment that looks at, for example, gender, age, occupation, type of work, body mass index, blood pressure, medical history, smoking status, diet, physical activity, alcohol use, and other drug use;

(b) brief advice on smoking cessation, alcohol, nutrition, and physical activity;

(c) advice on the association between dioxin exposure and health outcomes;

(d) a review to identify any health outcomes with suggestive or sufficient evidence of an association with dioxin exposure. For example, hypertension, type II diabetes, cancers of

the respiratory system, prostate cancer, soft tissue sarcoma, non-Hodgkin's lymphoma, Hodgkin's disease, multiple myeloma, AL Amyloidosis, chronic lymphocytic leukaemia, early onset transient peripheral neuropathy, porphyria cutanea tarda, and spina bifida in offspring;

(e) a review for psycho-social outcomes and unmet mental health needs;

(f) a review for other health outcomes. For example, cardiovascular, gastrointestinal, musculoskeletal, skin, nervous system conditions, and respiratory conditions;

(g) if indicated, specific screening through current tests or programmes;

(h) if indicated, referral to other components of the Health Support Service;

(i) if indicated, referral to other health services if the Eligible Person meets the other health services eligibility criteria.

(3) The first free health check will be overseen by the Eligible Person's nominated General Practitioner. The Eligible Person's nominated General Practitioner may deliver the first free health check in conjunction with any other members of the primary health care team as they deem appropriate.

(4) While the first free health check is comprehensive, it is expected that the subsequent free annual health checks will be more focused on specific health needs. The services can be provided by a combination of registered medical practitioners, registered practice nurses and any other members of the primary health care team as appropriate.

(5) Subsequent free annual health checks must continue to address the health needs identified in the first free health check, and any other health needs identified in subsequent annual health checks.

(6) The exact content of each free annual health check will be guided by the Eligible Person's medical history, current health needs, evidenced-based best practice and the clinical judgement of the health practitioner.

(7) Individualised care plans may be used at the discretion of the health practitioner.

(8) It is expected that Eligible Persons will be enrolled at the practice if their nominated General Practitioner is located as per the principles of the Primary Health Care Strategy.

6 Eligibility and access to Referred Services

(1) To be eligible for referral to the Referred Services set out in subclause (2), the patient must meet the general eligibility criteria for that service if it is already publicly funded, for example, mental health services for mild to moderate mental illness and lifestyle improvement services.

(2) The Referred Services are smoking cessation, green prescriptions, dietary information and advice, mental health services for mild to moderate mental health conditions, serum dioxin testing, neural tube defect screening for pregnant women, and genetic counselling services.

7 Serum dioxin test

(1) An Eligible Person can only be referred for a serum dioxin test once the following requirements are met:

(a) the Eligible Person is fully informed about the serum dioxin test (e.g. the Eligible Person has had the limitations and benefits of the serum dioxin test, the testing procedure, and interpretation of results fully explained);

(b) the Eligible Person has not previously had a serum dioxin test;

(c) the Eligible Person's General Practitioner is satisfied that the serum dioxin test is not an unnecessary risk to the person and will assist with improving the Eligible Person's wellbeing (including an assessment for unmet mental health needs); and

(d) the Eligible Person's General Practitioner has applied for and received confirmation from the service Secretariat, that the application for a serum dioxin test has been successful.

(2) The following administrative process for accessing publicly funded serum dioxin test must be followed:

(a) the Eligible Person must have a consultation with the nominated General Practitioner as described in subclause (1); and

(b) after discussion with the Eligible Person, the General Practitioner will either:

(i) refer the Eligible Person to a mental health counsellor to identify and address any concerns. The mental health counsellor refers the Eligible Person back to their General Practitioner for consideration for serum dioxin testing; or

(ii) apply directly to the service Secretariat for the Eligible Person to be referred for a serum dioxin test.

(3) The service Secretariat will notify the General Practitioner, the Eligible Person and the mental health counsellor (if appropriate), of the outcome of the application and, if access is approved, arrange for laboratory appointment and serum analysis.

(4) An Eligible Person may not be charged for being referred for a serum dioxin test, for the serum dioxin test, or for meeting their nominated General Practitioner to be informed and advised about the results of the serum dioxin test.

8 Foetal neural tube defect screening or genetic counselling

(1) An Eligible Person may be referred for a foetal neural defect screen or genetic counselling or both as part of an annual health check.

(2) In relation to foetal neural defect screening, an Eligible Person may include:

(a) a pregnant woman if the biological father of the unborn child is an Eligible Person (whether or not the pregnant woman is an Eligible Person)

(b) a child of an Eligible Person (whether or not the child is an Eligible Person).

(3) An Eligible Person may not be charged for being referred for foetal neural defect screening or genetic counselling.

(4) Eligible Persons can only be referred for foetal neural defect screening by a General Practitioner, registered midwife, obstetrician, or family planning practitioner.

(5) Eligible Persons can only be referred for genetic counselling by a General Practitioner.

9 Other Referred Services

(1) If in the course of conducting the free annual health check the General Practitioner and/or practice nurse considers it appropriate they can refer the patient to the following Referred Services which may be provided at no cost to the patient, or in some cases there may be a cost to the patient:

(a) lifestyle improvement services, including smoking cessation, green prescriptions, and dietary information and advice; and

(b) mental health services for mild to moderate mental health conditions.

10 Collection and use of patient information

(1) The nominated General Practitioner who provides a free annual health check to an Eligible Person must advise them at the time of the check that the patient information specified in the information and monitoring section of this Schedule will be provided to the Ministry, and may be used by the Ministry to monitor and evaluate the provision of the Health Support Service.

(2) Table 1 summarises who would have access to particular categories of personal information and for what purposes:

Table 1					
Function	**Purpose of collection**	**Source of and information required**	**Storage and security**	**Access**	**Unique identifier**
Communications	To communicate with eligible individuals about application, the specifics of the Service, any amendments to its scope or access criteria, or any other related issue	Information required: Name and contact details Source: Application form	Eligibility database Stored for as long as is required for the stated purpose	Service Secretariat (MOH)	Not required
	To inform descendants about information on the Service, or any other related issue	Information required: Name and contact details Source: Provided by the person	Mailing list (existing) Stored for as long as is required for the stated purpose	Ministry of Health	Not required
Administration	To assess applications for eligibility	Information required: Full name, date of birth, contact details, NHI number, name of nominated health practitioner, eligibility criterion, and any additional information to support application including evidence Source: Application form	Data entered onto eligibility database; hard copies filed Stored for as long as is required for the stated purpose	Service Secretariat (MOH) Appeals Panel	Not required
	To advise of outcomes of eligibility assessment process	Information required: Full name, contact details Source: Application form	Eligibility database Stored for as long as is required for the stated purpose	Service Secretariat (MOH)	Application number
	To send first and subsequent entitlement letters to eligible people	Information required: Full name, contact details, date of birth, NHI number, date of previous health check (out-years only) Source: Application form and GP claim form	Eligibility database Stored for as long as is required for the stated purpose	Service Secretariat (MOH) Sector Services	Existing NHI number

Table 1					
Function	**Purpose of collection**	**Source of and information required**	**Storage and security**	**Access**	**Unique identifier**
	To advise nominated practice of successful applicants and to provide information on the proposed Service or any other related issue	Information required: Contact details, date of birth, NHI number, date of previous health visit (out-years only) Source: Application form	Eligibility database Stored for as long as is required for the stated purpose	Service Secretariat (MOH) Nominated GPs	Existing NHI number

Function	**Purpose of collection**	**Source of and information required**	**Storage and security**	**Access**	**Unique identifier**
Administration (continued)	To pay GPs for services delivered	Information required: NHI number of patient, patient's full name and date of birth, duration and date of health check-up, name of the practitioner, practice, registration number Source: GP claim form	Eligibility database Stored for as long as is required for the stated purpose	Service Secretariat (MOH) Sector Services	Existing NHI number
	To consider appeals from unsuccessful applicants	Information required: Full name, date of birth, contact details, NHI number, name of nominated health practitioner, eligibility criterion, any more information to support application including evidence Source: Application form	Eligibility database Stored for as long as is required for the stated purpose	Service Secretariat (MOH) Appeals Panel	Not required

Function	Purpose of collection	Source of and information required	Storage and security	Access	Unique identifier
Monitoring	To provide sufficient information through which to monitor service uptake and attrition to inform ongoing policy development	Information required: NHI number of patient, duration and date of health check-up, name of practitioner, practice, registration number, services patient referred to, eligibility criteria, reasons for withdrawal Source: claim form, application form, service withdrawal forms	Eligibility database Stored for as long as is required for the stated purpose	Service Secretariat (MOH)	Not required
		Aggregated data	NA	Ministry of Health PHOs DHBs DHB Shared Services	NA

11 Information and monitoring requirements

(1) The following information must be collected if it is required in the claiming process:

(a) NHI number;

(b) Eligible Person's full name;

(c) Eligible Person's date of birth;

(d) whether the claim is for the first health check or a subsequent annual health check;

(e) duration of the annual health check;

(f) date of the annual health check;

(g) the Referred Services that the Eligible Person was referred to;

(h) name of the general practice; and

(i) name and registration of the nominated General Practitioner

(2) The monitoring information will contribute to:

(a) management planning;

(b) decisions about the future administration and governance of the Health Support Service; and

(c) the periodic review of the Health Support Service.

(3) Table 2 shows how the monitoring and reporting requirements will be used to measure the specific objectives of the Health Support Service and the source and frequency of the reporting requirements:

Table 2

Performance measure	**Indicator**	**Reporting requirements**	
		Data source and frequency	**Reporting unit**
People are accessing the free annual health check	Number accessing Wellness Check: • Total • Eligibility criteria • Ethnicity • DHB of domicile	Free annual health check Entitlement and Claim forms	Pre-filled data: • Full name • NHI number • Provider name Additional data required: • Date of check-up
Contracted Providers are referring people to component services	Number referred to: • Health promoting	Free annual health check Entitlement and Claim forms.	Referrals to: • Health promoting

Table 2			
Performance measure	**Indicator**	**Reporting requirements**	
		Data source and frequency	**Reporting unit**
	activities • Mental health services • Genetic counselling • Serum dioxin tests • By DHB	Serum Dioxin Referral and Serum Dioxin Follow-up consultation forms	activities • Mental health services • Genetic counselling • Serum dioxin tests
Contracted Providers are referring people to other specific diagnostic and treatment services	Number • By DHB	Free annual health check Entitlement and Claim forms. Serum Dioxin Referral and Serum Dioxin Follow-up consultation forms	Referrals to other specific services
Cost efficiency	Cost by: • DHB • Service components • Number of people accessing Wellness Check • Duration of check-up • Type of practitioner	Free annual health check Entitlement and Claim forms. Serum Dioxin Referral and Serum Dioxin Follow-up consultation forms	Duration of check-up Name and registration number of practitioner

(4) In addition to the monitoring described above, an independent evaluation of the Health Support Service will be completed in the third year of operation. Nominated General Practitioners may be asked to participate in the independent evaluation. If requested to participate, the PHO agrees not to unreasonably withhold its consent to participate in the independent evaluation.

12 Duration and review of the Health Support Service

(1) It is intended that the Health Support Service be ongoing, however, the Ministry reserves the right to review, at any time after implementation, the Health Support Service.

Part D Alliance Services

D.1 The Services

(1) The PHO will Provide the Services described in the schedules to this Part, as described in the schedules to this Part and in accordance with this Agreement.

(2) The PHO may agree to Provide the Services described in the schedules to this Part within the scope of our Alliance Agreement, to enable local services configurations.

(3) The DHB will Pay the PHO for the Services described in the Schedules to this Part as set out in Part F until such time as we agree flexible funding pool arrangements.

(4) We agree to comply with any reporting requirements set out in the Schedules to this Part.

(5) The PHO has also agreed to Provide the Services described in Schedules D5 and D6, which are outside and inside the scope of our Alliance Agreement.

(6) The DHB will Pay the PHO for the Services described in Schedules D5 and D6. In respect of these Services, the PHO agrees to comply with the reporting requirements set out in Schedules D5 and D6.

D.2 Variations to implement Alliance Recommendations

(1) If the PHO is Providing the Services described in the schedules to this Part within the scope of our Alliance Agreement, this Part, the Schedules to this Part (except Schedules D5 and D6), and the relevant Schedules in Part F may be varied in accordance with the procedure set out in clause D3.

(2) If the PHO has not agreed to Provide the Services described in the schedules to this Part within the scope of our Alliance Agreement, the Schedules to this Part and the relevant Schedules in Part F may be varied in accordance with clause B.19.

D.3 Procedure for variations

(1) If the DHB wishes to vary this Part, the Schedules to this Part (except Schedules D5 and D6), or the relevant Schedules in Part F to implement an Alliance Recommendation, the DHB will:

(a) draft a variation that the DHB considers accurately and effectively implements the Alliance Recommendation; and

(b) give the PHO notice of the proposed variation, and the proposed draft of the variation, as soon as reasonably possible in the circumstances.

(2) The DHB agrees to use its best endeavours, acting in good faith, to agree on the terms of the variation, and to ensure that the terms of the variation accurately and effectively implement the Alliance Recommendation.

(3) The PHO may notify the DHB if the PHO disputes:

(a) the variation, in accordance with the Alliance dispute process set out in clause D4 because the PHO does not agree that the proposed draft of the variation accurately and effectively implements the Alliance Recommendation; or

(b) the Alliance Recommendation, because the PHO does not agree that it was made in accordance with the Alliance Leadership Team's decision-making criteria set out in clause 1.3 of Schedule 3 of the Alliance Agreement, or it conflicts with the PHO's obligations under clause 2.7 of the Alliance Agreement.

(4) To avoid doubt, the PHO may not notify the DHB of a dispute for any other reason.

(5) Unless a dispute is notified by the PHO in accordance with this clause, the DHB's proposed draft of the variation, or a variation that we have otherwise agreed, will come into effect on a date specified in the DHB's notice of proposed variation given under clause D.3(1)(b), which may not be less than 20 Business Days after our notice of the proposed variation.

D.4 Alliance dispute process

(1) If the PHO wishes to notify a dispute under clause D.3(3), it must do so no later than 20 Business Days after the notice of the proposed variation is given under clause D.3(1)(b).

(2) If a dispute is notified by the PHO under clause D.3(3), the dispute will be resolved in accordance with the dispute resolution procedure set out in clause 17 of the Alliance Agreement, as if it were a dispute under that Agreement.

(3) If a dispute is notified by the PHO under clause D.3(3)(b), we agree that the variation will not come into effect until our Alliance Leadership Team gives us notice that the dispute has been resolved and confirms the Alliance Recommendation.

D.5 Variations to Schedule D5 and D6 by mutual agreement

(1) Schedules D5 and D6 may be varied by mutual agreement between us in accordance with the procedure set out in clause B.19.

SCHEDULE D1
MANAGEMENT SERVICES

1 Management Services

(1) The PHO will Provide any management services and carry out any management tasks necessary to Provide the Services in accordance with this Agreement.

SCHEDULE D2
HEALTH PROMOTION SERVICES

1 Health promotion services

(1) The PHO will agree with the DHB the health promotion activities the PHO will undertake as follows:

(a) the PHO will work with whānau, hapū, iwi, consumers and other groups within its community, relevant public health service providers and regional public health units to plan and deliver health promotion programmes;

(b) programmes must be consistent with population health objectives and public health programmes at national, regional and local levels;

(c) the PHO will submit to the DHB for approval, its proposed health promotion strategy demonstrating how health promotion funding will be used to achieve desired health promotion outcomes;

(d) the DHB agrees to consider the PHO's proposal and respond promptly to the PHO no later than 20 Business Days after receiving the proposal; and

(e) the DHB will consult with the Ministry on the proposed health promotion activities.

SCHEDULE D3
SERVICES TO IMPROVE ACCESS

1 Access for High Need Groups

(1) The PHO will agree with the DHB the services and activities the PHO will undertake to improve access to primary health care services for High Need Groups in its Enrolled Population as follows:

(a) the PHO will design services and activities to improve access to primary health care services for High Need Groups in its Enrolled Population that may include outreach services in appropriate places and delivery approaches tailored for particular groups;

(b) the PHO will submit to the DHB for approval, its proposed services and activities demonstrating how access funding will be used to improve access to primary health care services; and

(c) the DHB will consider the proposal and respond promptly to the PHO no later than 20 Business Days after receiving the PHO's proposal.

SCHEDULE D4
CARE PLUS SERVICES

1 Service Objectives

(1) The PHO will Provide Care Plus Services as described in this Schedule to contribute to the objectives of:

(a) improving health and independence or minimising deterioration in health and independence;

(b) relieving suffering;

(c) maintaining people in their own environment and avoiding unnecessary hospitalisation; and

(d) reducing inequalities in health status between health population groups.

2 Assessing Eligibility for Care Plus Services

(1) The PHO will offer Care Plus Services only to an Enrolled Person who:

(a) is assessed by a Practitioner who usually delivers their First Level Services as being expected to benefit from “intensive clinical management in primary health care” (at least 2 hours of care from one or more members of the primary health care team) over the following 6 months; and either

(b) has 2 or more chronic health conditions so long as each condition is one that:

(i) is a significant disability or has a significant burden of morbidity; and

(ii) creates a significant cost to the health system; and

(iii) has agreed and objective diagnostic criteria; and

(iv) continuity of care and a primary health care team approach has an important role in the management of that condition; or

(c) has a terminal illness (defined as someone who has advanced, progressive disease, whose death is likely within 12 months); or

(d) has had 2 acute medical or mental health related admissions in the past 12 months (excluding surgical admissions); or

(e) has had a total of 6 First Level Service and/or casual general practice consultations and/or emergency department visits within the last 12 months; or

(f) is on active review for elective health services.

(2) The PHO will Provide Care Plus Services only to patients who have given their informed consent to receiving Care Plus Services.

3 Care to be delivered to Care Plus Patients

(1) The PHO will deliver the following services to each Care Plus Patient as part of a coordinated programme of care for that individual:

(a) assessment (review of the Care Plus Patient's current health status, including pharmaceutical review if necessary);

(b) development of an individual care plan including jointly agreed goals and expected outcomes to form the basis of a continuum of care across the care team (the “care plan”);

(c) delivery of care according to the care plan and in response to individual needs as they arise; and

(d) ongoing reassessment and adjustment of the care plan at least annually.

4 Reassessment for continued eligibility to receive Care Plus Services

(1) The PHO will reassess for continued eligibility in accordance with this clause.

(2) The PHO will review each Care Plus Patient annually within at most 15 months from the date at which they were last assessed as being eligible to receive, or to continue to receive Care Plus Services to determine whether they continue to be eligible to receive Care Plus Services.

(3) At this annual review an individual is eligible to continue to receive Care Plus Services and be designated as Care Plus Patients only if he or she:

(a) is explicitly assessed as continuing to benefit from the higher level of primary care;

(b) has received at least 4 clinical contacts within the previous 12 months; and

(c) has given his or her informed consent to continue to receive Care Plus Services.

(4) If a person who is a Care Plus Patient changes to a different provider of First Level Services, the person can continue being a Care Plus Patient only if his or her new Contracted Provider re-assesses them according to clauses 2(1) and 2(2) and the Contracted Provider has available funding.

5 Support and administrative Services for Care Plus

(1) The PHO will Provide the following support and administrative Services:

(a) support for Contracted Providers to identify individuals eligible for Care Plus Services;

(b) liaising with DHBs to assist with identifying individuals eligible for Care Plus Services;

(c) support for the delivery of Care Plus Services through, for example, employing or contracting additional Practitioners or providers to work with Contracted Providers;

(d) coordinating with other relevant health care providers to arrange improved access to diagnostic testing and other supporting services;

(e) administrative systems to pay and monitor providers of Care Plus Services; and

(f) provision of documentation to support implementation such as care plan templates and patient information;

(g) management and delivery of reporting requirements;

(h) on-going training and quality improvement systems (see clause 6) for relevant staff including those working as part of Contracted Providers; and

(i) systems to ensure that, as much as is feasible, available Care Plus funding is applied to Provide Care Plus Services to the full expected number of Care Plus Patients (according to clause 2(1)).

6 Quality requirements

(1) The PHO will work to ensure that:

(a) if current best practice evidence-based national guidelines are agreed and available to guide the management of specific chronic conditions, providers use them when delivering Care Plus Services;

(b) the cultural and psychosocial context of the Care Plus Patient are considered at all levels of the person's participation in the services and the Care Plus Services are consistent with care models that appropriately meet their needs. For example, services for Māori are consistent with the PHO Māori Health Action Plan;

(c) Care Plus Services are based on the principle of partnership between the individual receiving care and the team delivering the care, and that providers of Care Plus Services ensure Care Plus Patients are involved in making informed choices about the care that they receive;

(d) a record is kept of all Care Plus Services with a Care Plus Patient including those that do not involve a face to face consultation; and

(e) there are suitable linkages and communications between all providers of care to Care Plus Patients including between providers of First Level Services and other primary health care providers and with providers of secondary services and of disability support services.

7 Proposed Care Plus Services

(1) The PHO will submit to the DHB for approval, a proposal to deliver Care Plus Services that includes the PHO's funding requirements and how it will meet the requirements of subclauses 3(1) to 3(3) of Schedule F2.4.

(2) If the DHB approves the proposal, the PHO will deliver Care Plus Services in accordance with this Schedule.

SCHEDULE D5
SERVICES OUTSIDE THE SCOPE OF OUR ALLIANCE

1

SCHEDULE D6
SERVICES INSIDE THE SCOPE OF OUR ALLIANCE

1

Part E Local Services

E.1 Local Services

(1) The PHO will Provide the Local Services described in the Schedules to this Part, in accordance with this Agreement.

(2) The DHB will Pay the PHO for Local Services provided in accordance with this Agreement, in accordance with Part F.

SCHEDULE E1
LOCAL SERVICES

Part F Payment

F.1 Contracted Providers' rights to charge

(1) The PHO and its Contracted Providers may charge Service Users in accordance with clause F.27 or F.28.

F.2 Need to reduce financial barriers to access

(1) We both support the Government's policy of reducing financial barriers to access to the Services for all Service Users.

F.3 Payment for Services

(1) Subject to clause F.3(4), the DHB will Pay the PHO for providing the Services according to the terms and conditions of this Agreement in accordance with the terms set out in this Part F. Accordingly all references in this Agreement to the PHO's rights to Claim or restrictions on the PHO Claiming under this Agreement apply to the PHO or Contracted Providers as the case requires.

(2) The DHB will Pay capitated Payments directly to the PHO.

(3) Subject to subclause (4), the DHB will Pay all fee for service Payments directly to the PHO and the PHO will ensure that Contracted Providers do not Claim fee for service Payments from the DHB.

(4) We may agree in writing that the DHB may make fee for service Payments directly to the PHO's Contracted Providers. The DHB will Pay each Contracted Provider directly for the Services that the Contracted Provider has delivered under this Agreement provided:

(a) the PHO has authorised the DHB to do so under this clause;

(b) the Contracted Provider has a payee number approved by the PHO for the purposes of Payment under this Agreement; and

(c) all Claims for Payment for the Services are made under the Agreement Reference Number.

(5) All Claims by the PHO and Contracted Providers must be made under this Agreement.

F.4 Services funded on a capitated basis

(1) Subject to clause F.5, the DHB will fund the Services described in Schedule C1 on a capitated basis in accordance with Schedule F1.1.

F.5 Services funded on a fee for service basis

(1) The following services will be funded by the DHB on a fee for service basis:

(a) General Medical Services, which will be funded by the DHB in accordance with Schedule F1.2;

(b) Immunisation Services (unless otherwise agreed), which will be funded by the DHB in accordance with Schedule F1.3. .

F.6 Funding of Alliance Services and Local Services

(1) The DHB will fund:

(a) Alliance Services in accordance with the relevant schedules to this Part; and

(b) Local Services in accordance with the relevant schedules to this Part.

F.7 Goods and Services Tax

(1) Unless this Agreement expressly provides otherwise:

(a) all prices listed in this Agreement are exclusive of GST;

(b) all Payments made under this Agreement will be made inclusive of GST.

F.8 Claiming restrictions

(1) **Services must have been provided in New Zealand**: The PHO may not Claim, and the DHB will not Pay the PHO, for Services the PHO has delivered to an Eligible Person who was not in New Zealand at the time the Services were provided.

(2) **Services provided to non-Eligible Persons**: If the PHO provides the Services to a person that the PHO knows is not an Eligible Person the PHO may not Claim Payment from the DHB for those Services.

(3) **Claims for Services provided to non-Eligible Persons**: If the PHO Claims for Services provided to a person that the PHO knows is not an Eligible Person, the DHB will withhold or recover Payment for those Services provided to that person.

(4) **No cost or volume shifting**: We agree:

(a) the PHO must not knowingly be a party to any arrangement that results in the DHB effectively having to Pay more than once for the provision of the same Services; and

(b) unless otherwise agreed, neither of us will operate in a way that shifts costs or volumes between the Services that would result in additional costs to either of us. This does not preclude movements of individuals between providers for reasons of good clinical practice.

(5) **No double Payment**: The PHO may not Claim or receive from the DHB any Payment specified in this Agreement:

(a) if the PHO is entitled to receive Payment for those services, either directly or indirectly, under any other agreement or arrangement with the DHB; or

(b) to the extent that the PHO is entitled to receive Payment for those services, either directly or indirectly, from any other organisation or Government body or agency (including, but not limited to, the Accident Compensation Corporation).

F.9 Format and timing of Claims

(1) For Capitated Services the PHO must submit Registers in accordance with the requirements set out in the Referenced Documents set out in clause 3 of Schedule B3.

(2) Each Register submitted for Payment must be accompanied with a certification signed by the PHO's Chief Executive Officer (or senior manager).

(3) The certification must be in the same format as the template in the Referenced Document entitled "Certification of PHO Enrolment Register" and must be faxed to the Payment Agent and the original retained by the PHO for Audit purposes.

(4) For other Services, the PHO must submit Claims in accordance with this Agreement at least monthly but not more than once a week.

(5) All Claims must specify the correct Purchase Unit Code for the Service being Claimed. Purchase Unit Codes are listed in the Referenced Document entitled "Primary Care Purchase Unit Codes".

F.10 Claims for General Medical Services for Casual Users and Immunisation Services

(1) The PHO must ensure that each Claim for General Medical Services for Casual Users and Immunisation Services includes the following details:

(a) practitioner's council number;

(b) practitioner's name;

(c) practitioner's PAN or other provider index (if we agree that this is required);

(d) date of the Service;

(e) patient name;

(f) date of birth;

(g) National Health Index number;

(h) patient category;

(i) Community Services Card number if applicable (if Access Practices provide Services to Casual Users);

(j) High Use Health Card number if applicable;

(k) practitioner's signature (or electronic equivalent);

(l) GMS category; and

(m) immunisation types and date of immunisation (if applicable).

(2) If the DHB (or its Payment Agent) Pays the PHO for General Medical Services for Casual Users or Immunisation Services, the PHO will ensure that the DHB has the right to access any

information in relation to the Claims or the Services for the purpose of verifying the Claim, notwithstanding that it was collected from the PHO as part of the process of making Claims.

F.11 Rejection of Claims

(1) The DHB may reject a Claim or any part of a Claim if the DHB believes on reasonable grounds that a Claim or any part of a Claim is incomplete, or includes inaccurate information, or does not comply with claiming restrictions or requirements.

(2) The DHB will reject and withhold a Payment only for that part of a Claim that it believes is incorrect. The remaining parts of the Claim will be paid by the DHB.

(3) If the DHB rejects part of a Claim for a capitation Payment, the DHB will inform the PHO within 5 Business Days of the PHO having submitted the original Claim to enable the PHO to review the rejection and resubmit the part Claim if appropriate. If the DHB rejects part of a Claim for General Medical Services provided to Casual Users, the DHB will inform the PHO within 15 Business Days of the PHO having submitted the original Claim to enable the PHO to review the rejection and resubmit the part Claim if appropriate.

F.12 Resubmission of Claims

(1) A Claim, or part of a Claim, may be resubmitted by the PHO, if it is duly corrected.

(2) If a resubmitted Claim results in the PHO owing money to the DHB, the DHB may recover that money in accordance with clause F.25.

F.13 Time limit for receiving fee for service Claims

(1) All fee for service Claims must be received by the DHB within 6 months after the date on which the service is provided.

F.14 Timing of Payments

(1) Each Payment for Capitated Services will be made on the 15th day of each month for Capitated Services provided during that month in accordance with the Referenced Document entitled "Business Rules: Capitation-based funding".

(2) Each Payment for Claims will be made 10 Business Days after the PHO submits the electronic Claim for fee for service services provided in the previous month.

(3) Each Payment for other Services will be made in accordance with the Schedules to this Part.

(4) If a Payment made under this clause is due to be made on a day that is not a Payment Day, that Payment will be made on the first Payment Day after on the day on which the Payment is due.

F.15 Electronic formats only

(1) All Claims must be submitted in electronic format.

(2) No manual claims will be accepted for Payment.

F.16 Form of Payment

(1) The DHB will Pay the PHO by lodging funds into the bank account advised by the PHO.

(2) The PHO may change the bank account into which the funds are to be lodged on 10 Business Days prior notice to the DHB.

F.17 Validity of payments

(1) If the DHB believes on reasonable grounds that a Claim is partially valid and partially invalid, the DHB will Pay the PHO for the valid portion only and reject the invalid portion.

F.18 Over and under Payments

(1) If at any time it becomes apparent that the DHB has overpaid the PHO, the PHO will, without prejudice to any other rights the DHB has, immediately repay the amount overpaid by the DHB.

(2) If at any time it becomes apparent that the DHB has underpaid the PHO, the DHB will, without prejudice to any other rights the PHO has, immediately Pay to the PHO the amount underpaid by the DHB.

F.19 Submission of Register

(1) If the PHO fails to submit its Register in accordance with the requirements of the Referenced Document entitled “Business Rules: Capitation-based funding” the DHB will Pay the PHO according to the Register submitted for the previous quarter less a deduction set in accordance with that Referenced Document.

F.20 Incorrect Payments

(1) Subject to subclause (5), if the PHO has reasonable evidence that a Payment that the DHB has made to the PHO is incorrect, the PHO will notify the DHB and its Payment Agent of the error (together with a description of the suspected error and the evidence the PHO has in support of it).

(2) The DHB will discuss the PHO's concerns with the PHO within 20 Business Days of such notification.

(3) We and the Payment Agent will, within a reasonable timeframe agreed between the DHB and the PHO, work together in good faith to:

(a) identify the reasons for the underpayment;

(b) quantify the error (including the adjustments required to correct the Payment); and

(c) agree to a resolution of the problem including the agreed adjustment(s) and the Payment date.

(4) If the error has, or may have, national implications and if the DHB agrees a solution to correct the error, the DHB will ensure that the Payment Agent notifies all PHOs of the nature of the error to give each PHO the opportunity to assess the financial impact of the issue on itself.

(5) Notification of an error in a Payment by either party to the other must be made within 6 months of the date of the Payment, unless it is reasonable in the circumstances for a longer period to apply.

Default Interest on late Payments

F.21 Ability to charge Default Interest

(1) Subject to clause F.23, if either of us does not Pay any amount due to the other under this Agreement, the party owed the Payment (or the Payment Agent if the DHB is owed), may charge the other party interest from the date Payment was due until the amount due is Paid (Default Interest).

(2) If either of us owes any amount as a result of any error in relation to a Claim or a Payment, the due date for the Payment of this amount will be 1 month after notice to the party owing the Payment.

F.22 Rate of Default Interest

(1) The Default Interest rate will be 2 percentage points per annum above the index lending rate charged by Westpac for the period involved and will be calculated on a daily basis.

F.23 Notice of intention to charge

(1) In order for the due party to claim, and the defaulting party to be liable to pay Default Interest, the due party must give notice to the defaulting party (and the Payment Agent if applicable) of its intention to claim Default Interest within 6 months after the date Payment was due.

(2) A notice given by the PHO under this clause must include the following details:

(a) the PHO's name (as shown on the cover of this Agreement);

(b) the Agreement Reference Number;

(c) the PHO's payee number;

(d) the DHB to which the PHO is contracted; and

(e) the details of the payment that the Default Interest relates to.

F.24 Recovery of overpayments and costs of Audit

(1) If monies have been Claimed by the PHO in breach of this Agreement, all such monies and, subject to subclause F.24(4), the costs of any Audit or that relate to the attendances or time involved by the DHB or its agent and incurred as a consequence of that Claim (if any), are deemed to be a debt owing by the PHO to the DHB that is repayable on demand.

(2) Before the DHB seeks to recover any such debt, the DHB must give the PHO notice of the DHB's intention to recover from the PHO.

(3) A notice given by the DHB under subclause (2) must include the following details:

(a) the DHB's name (as shown on the cover of this Agreement);

(b) the Agreement Reference Number; and

(c) the amount and details of the overpayment that the DHB believes the PHO has received in breach of this Agreement, and any related costs.

(4) The DHB will not seek to recover costs under this clause if the inappropriate Claim is the result of an occasional error or oversight, honestly made, and which is of minor consequence.

F.25 Set-off

(1) This clause applies if the PHO owes the DHB any amount under this Agreement, including:

(a) an amount overpaid by the DHB under clause F.18(1); or

(b) a debt owed to the DHB under this Agreement.

(2) The DHB (or its Payment Agent) will give the PHO notice of its intention to set-off the amount owed by the PHO against any amount that the DHB owes to the PHO at any time, to enable the PHO to review and discuss with the DHB the DHB's reasons for the intended set-off.

(3) If there is a dispute in relation to any proposed set-off, the matter will be resolved pursuant to the dispute resolution process provided in clauses B.24 or B.35.

(4) The DHB will exercise its power of set-off only if:

(a) the PHO has agreed in writing to the set-off being made; or

(b) the PHO has not provided the DHB with satisfactory assurance that the amount in question will be repaid if, as a result of resolving the dispute with regard to the amount, that process finds in the DHB's favour.

(5) If the DHB sets-off an amount pursuant to subclause (4)(b) and, as a result of resolving the dispute with regard to the amount, that process does not find in the DHB's favour, the DHB will repay the PHO the amount of the set-off plus Default Interest pursuant to clause F.21.

(6) If the DHB exercises the power of set-off conferred by this clause, the PHO will be deemed to have made payment to the DHB to the extent of the set-off.

F.26 Payment rates increases

(1) The Ministry prescribes Payment rates for Nationally Consistent Services. If the Ministry increases funding for any such Services on a national basis, the DHB will:

(a) follow the process described in clause B.21 in relation to the Ministry's terms and conditions for that Payment rate increase; and

(b) increase the Payment rates specified in the Schedules to this Part in accordance with the Ministry's prescription.

F.27 Fees level policy and charges to service users

(1) **Application of this clause**: This clause applies to those Contracted Providers who:

(a) demonstrate how increased funding will translate into reduced fees for specified patients;

(b) agree to publication, as agreed between the DHB and the PHO, of full fee information by named practice for those age bands if the funding set by Government is intended to subsidise low or reduced cost access to First Level Services; and

(c) comply with this clause.

(2) **Ability to charge Service Users**: The PHO may charge Eligible Persons for health services including those funded in part by the DHB, unless expressly agreed otherwise in this Agreement.

(3) **Fees Framework**: For the purposes of this clause:

(a) a “standard General Practitioner consultation fee” for First Level Services within Regular Hours:

(i) includes any normal tests or examinations carried out as part of that consultation; and

(ii) is the fee that the patient would pay if he or she paid on the date on which the consultation occurred before discounts or surcharges; and

(b) “Fees Review Committees” are regional committees established in accordance with the Referenced Document entitled "Fees Review Process".

(4) **Purpose of the fees framework**: The fees framework sets out the framework that will apply to the patient fees charged by health providers if the funding set by Government is intended to subsidise low or reduced cost access to First Level Services.

(5) **Principles of the fees framework**: The principles and agreements on which the fees framework is based are as follows:

(a) the DHB supports the right of the PHO's Contracted Providers or the PHO to set the fees that it charges Eligible Persons;

(b) the DHB expects that the PHO's Enrolled Patients will have access to low or reduced cost primary health services from the PHO or its Contracted Providers;

(c) the PHO recognises the DHB's requirement to have certainty that the increased payments to health providers that are made under any services agreement, which subsidise a patient’s fees, will be reflected in low or reduced costs to patients;

(d) the PHO will ensure that those increased subsidy payments will result in low or reduced fees charged by its Contracted Providers to Enrolled Patients and that those fees are fair to the providers and reasonable for the patients; and

(e) it is the Government’s intention to regularly adjust PHO funding to maintain its value.

(6) **Flow through of funding increases**: We each acknowledge that the Ministry instructs the DHB in relation to the requirements for PHOs and their Contracted Providers to ensure that increased subsidy payments translate into low or reduced costs to patients

(7) **Notifying fees and fee increases**: If the PHO or one of its Contracted Providers decides to increase the level of standard General Practitioner consultation fees if the funding set by Government is intended to subsidise low or reduced cost access to First Level Services at any time during the term of this Agreement, the PHO will, as soon as is reasonably practicable after the decision to increase the fees is made, preferably before the increase takes effect or at the time of increase and in any event within 2 weeks after the increase takes effect, notify the DHB of:

(a) the fee increases (stating previous and new standard General Practitioner consultation fees for each age group);

(b) the name of the Contracted Provider that increased its fees or the identifier of the Contracted Provider that the PHO used when consulting with the DHB in accordance with subclause (4); and

(c) when the fees were last increased.

(8) **Reporting requirement:** The requirement in this clause to notify standard General Practitioner consultation fee increases is a reporting requirement.

(9) **Statements of Fee Increase Levels**: The DHB will:

(a) annually, or more frequently, notify the PHO of the levels of standard General Practitioner consultation fees increases the DHB considers reasonable. Fee increases that are higher than the levels notified are not necessarily unreasonable; and

(b) will use a suitable independent body to determine these levels. The DHB will instruct the independent body to engage with the sector in this process and to refer to the Referenced Document entitled "Fees Review Process".

(10) A Contracted Provider already charging low standard General Practitioner consultation fees will be exempt from the Fees Review Committee process so long as its increased fees are at or below the level of standard General Practitioner consultation fees identified in the most recent statement notified under subclause F.27(9)(a) as being the ceiling for automatic qualification as being low.

(11) The DHB will consider reasonable any increase in a general practice standard consultation fee by taking into consideration current, and all prior statements of reasonable fee increase, and all prior fee increases for the same periods. This will be calculated by compounding all prior years' unused portions of the percentage increases considered reasonable as calculated for any individual practice in the Statement template for each year. The table below illustrates this:

	A	**B**	**C**	**D**	**E**
Year	**Statement increase**	**Carried forward from**	**Total Annual Statement**	**Actual increase**	**Unused percentage**

		prior year and adjusted by current %*	Reasonable Fee Increase	applied by practice XYZ	to carry forward to next year
1	5.50%	zero	5.50%	4.00%	1.50%
2	4.20%	1.56%	5.76%	4.50%	1.26%
3	6.10%	1.33%	7.43%	7.00%	0.43%
4	3.70%	0.45%	4.15%	4.00%	0.15%

* calculated by multiplying percentage number in column E for previous year by percentage number in column A of current year (i.e. 1.5% x 1.042 = 1.56%).

(12) **Referring Fee Increases to a Fees Review Committee**: If the fee increase notified under subclause F.27(12)(a) is:

(a) less than or equal to the levels of reasonable fee increases notified pursuant to subclause F.27(9)(a), the DHB will not refer the increase to the Fees Review Committee.

(b) greater than the levels of reasonable fee increases notified pursuant to subclause F.27(9)(a), the DHB may refer the matter to the Fees Review Committee.

(13) If the DHB intends to refer the matter to the Fees Review Committee, the DHB may discuss with the PHO the reasons for the fees increase, consider any information the PHO wishes to present to support the fees increase, and then determine if the fees increase will be formally referred to the Fees Review Committee. In such circumstances, the DHB must:

(a) complete its consideration of the matter within 1 month of the fees increase being notified under subclause F.27(7), and

(b) notify the PHO of its decision to refer the fees increase to a Fees Review Committee at the same time the referral is made.

(14) If the DHB's consideration of the matter and referral (if any) to the Fees Review Committee is not completed within 1 month, the fees increase is deemed to be reasonable.

(15) We each agree to participate in the Fees Review Committee process as set out in subclauses F.27(16) to F.27(28).

(16) **Regional Fees Review Committees**: Regional Fees Review Committees will be established and operate in accordance with this subclause and the Referenced Document entitled "Fees Review Process". A Fees Review Committee is not a Complaints Body.

(17) The objectives of the fees review process are to:

(a) ensure the sustainability and viability of First Level Services in General Practice and other primary health care services with providers retaining the right to set their own fees; and

(b) give DHBs certainty that the increased funding continues to be reflected in low or reduced costs that are fair and reasonable to patients and providers.

(18) The fees review process will operate in accordance with the following principles so that it is, and is seen to be:

(a) objective, so that all parties can see that recommendations are based on clear, explicit and straightforward procedural rules and terms of reference;

(b) consistent, with the procedural rules and terms of reference applied in the same way in all parts of the country and over time; and

(c) timely, so that PHOs and their Contracted Providers are able to manage changing costs to ensure sustainability of services.

(19) All reviews will be completed by the issue of a recommendation within 1 month of the PHO having produced its evidence to the Fees Review Committee. If a review is not completed by the issue of a recommendation within 1 month of the PHO providing evidence to the committee, the fees increase is deemed to be reasonable.

(20) **Fees Review Committees**: Regional Fees Review Committees will be established pursuant to the Referenced Document entitled "Fees Review Process" and will comprise 3 people independent of DHBs, PHOs and providers who will be selected for their expertise in the business of general practice and accounting/business management.

(21) The role of each Fees Review Committee is to make a recommendation as to whether increases to standard General Practitioner consultations fees that are formally referred to it under subclause (12) are fair and reasonable to patients and providers. In formulating its recommendation, the Fees Review Committee must take into account the fees charged by Contracted Providers and other PHOs, the need to ensure the viability and sustainability of the health provider that is the subject of the fee review, and any other evidence provided by either of us to support the fee levels.

(22) The recommendation of the Fees Review Committee will be made by consensus whenever possible and must include the Committee's comments on the information taken into account and its reasons for the recommendation. If such consensus is unable to be reached, both the majority's recommendation and the minority's view will be notified to each of us.

(23) Any information provided to the Committee by the PHO or a Contracted Provider will be treated as Confidential Information. Such information will not be disclosed to any person other than members of the relevant Fees Review Committee without the prior written consent of the PHO and the Contracted Provider to which the information relates.

(24) If the recommendation of the Fees Review Committee is not acceptable to either the DHB or the PHO:

(a) either party may within 5 Business Days escalate the matter to the combined chairs of the regional Fees Review Committees (or other Committee member nominated for that purpose) to facilitate a resolution acceptable to the parties; and

(b) if an acceptable resolution has not been achieved within a further 10 Business Days, the matter is to be managed in accordance with clause B.35.

(25) While processes under clause B.35 continue, the DHB acknowledges that the PHO and its Contracted Provider are not obliged to alter any increased fees. The DHB acknowledges that the charging of increased fees does not give rise to a disputed payment by the DHB to the PHO for the purposes of clause B.35(5).

(26) To avoid doubt, all remedies under the Agreement are reinstated on resolution of the processes under clause B.35.

(27) To avoid doubt, this clause prevails in the event of any conflict between this clause and the Fees Review Process Referenced Document.

(28) All parties involved in any fees review process are bound by clause B.17 of this Agreement.

(29) **Services for persons who are not Eligible Persons**: If the PHO provides the Services to a person the PHO knows is not an Eligible Person, the PHO may charge and recover from the person the cost to the PHO of providing the Services.

(30) **No co-payments for Immunisation Services**: The PHO will not charge a co-payment for Immunisation Services for which it receives Payment under this Agreement.

(31) **Children under 6 years**: The DHB expects that neither the PHO nor any Contracted Provider will charge a co-payment in most situations to children under 6 years between the hours of 8am and 8pm, 7 days a week. The DHB believes this will result in near universal access to free medical care for children under 6 years of age.

(32) **Notification of fees**: Eligible Persons in the local community need readily accessible information about the fees that are charged by the PHO or the PHO's Contracted Providers.

(33) The PHO must display and ensure that Contracted Providers display a list of its charges to Service Users in a place where Service Users can readily see the charges.

(34) In addition, the DHB will agree with the PHO on a mechanism for each Contracted Provider to provide Eligible Persons in the local community with ready access to full fee information.

(35) **Community Services Card Holders**: The PHO will ensure that, for its Enrolled Population, fees established under subclauses F.27(2) to F.27(28) are set irrespective of whether the patients or their families have a Community Services Card.

F.28 Fees level policy and charges to service users

(1) **Application of this clause**: This clause applies to those Contracted Providers who have not agreed to the terms contained in clause F.27 and who are not entitled to the payments rates specified in clause 2(2) of Schedule F1.1, and who are instead paid at the rates specified in clause 2(1) of Schedule F1.1.

(2) **Ability to charge Service Users**: The PHO may charge Eligible Persons for health services including those funded in part by the DHB, unless expressly agreed otherwise in this Agreement.

(3) **Fees Framework**: The purpose of this clause is to set out the framework that will apply to the patient fees charged by health providers funded in accordance with Access funding. Specifically:

(a) the DHB expects that the PHO's Enrolled Patients will have access to low or reduced cost primary health services from the PHO or its Contracted Providers. The PHO recognises the DHB's requirement to have certainty that the increased payments to health providers that are made under any services agreement, which subsidise a patient's fees, will be reflected in low or reduced costs to patients;

(b) the PHO will ensure that those increased subsidy payments will result in low or reduced fees charged by its Contracted Providers to Enrolled Patients and that those fees are fair to the providers and reasonable for the patients;

(c) before entering into this Agreement, the PHO consulted with the DHB in relation to the level of patient fees to be charged for standard consultations by the PHO and the PHO's Contracted Providers. The PHO advised the DHB of the fees that are intended to be charged by each of the PHO's Contracted Providers for a standard consultation. The PHO provided the DHB with supporting documentation demonstrating how the fees have been informed by the currently known level of fees in the region, and how increased subsidy payments translate into low or reduced costs to patients, being both fair and reasonable to patients and providers;

(d) if it is necessary for the PHO to increase the level of fees at any time during the term of this Agreement, the PHO will advise the DHB of those increases and the reasons for those increases;

(e) we both acknowledge that it is the Government's intention to regularly adjust PHO funding to maintain its value;

(f) if the DHB considers that the level of fees being charged by the PHO or the PHO's Contracted Providers for a standard consultation is unreasonable, the DHB may give notice to the PHO that the DHB wishes to refer the matter to a fee review committee. Such fee review committee will be established and comprised of 4 people: 2 people nominated by the DHB, a member nominated by the PHO, and a member nominated by the PHO to represent the relevant health providers;

(g) the role of the fee review committee is to make a recommendation as to whether the fees for standard consultations are fair and reasonable to patients and providers. In formulating its recommendation, the fee review committee must take into account the fees charged by contracted health providers and other PHOs that are funded under the Access funding formula, the need to ensure the viability and sustainability of the health providers that are the subject of the fee review, and any other evidence provided by either of us to support the fee levels;

(h) the recommendation of the fee review committee will be made by consensus. If such consensus is unable to be reached, the individual views of each member will be notified to us both; and

(i) if the recommendation of the Fee Review Committee is not acceptable to either of us, then the matter is to be managed in accordance with clause B.35.

(4) **Arrangements for interim practices receiving access funding for particular groups**: The principles outlined in subclause (3) apply to fees charged for specific patient groups by the PHO or the PHO's Contracted Providers that are funded in accordance with the Interim funding formula until such time as the PHO receive Access level funding for these specific groups of the PHO's Enrolled Population.

(5) **Services for persons who are not Eligible persons**: If the PHO provides the Services to persons whom the PHO know are not Eligible Persons the PHO may charge and recover from those persons the cost to the PHO of providing those Services.

(6) **No co-payments for Immunisation Services**: The PHO will not charge a co-payment for Immunisation Services for which it is receiving Payment under this Agreement.

(7) **Children under 6 years**: The DHB expects that neither the PHO nor any Contracted Provider will charge a co-payment in most situations to children under 6 years between the hours of 8am and 8pm, 7 days a week. The DHB believes this will result in near universal access to free medical care for children under 6 years of age.

(8) **Notification of fees**: The PHO must display and ensure that Contracted Providers display a list of its charges to Service Users in a place where Service Users can readily see the charges.

(9) **Community Services Card Holders**: The PHO will ensure that for its Enrolled Population, fees established under subclause (3) are set irrespective of whether the patients or their families have a Community Services Card.

SCHEDULE F1.1
PAYMENT FOR FIRST LEVEL SERVICES

Payment for First Level Services delivered to Enrolled Persons

1 Capitation Payments for First Level Services delivered to Enrolled Persons

(1) Capitation Payments for Nationally Consistent Services (excluding the services described in Part C that are paid on a fee for service basis) are based on the following factors:

(a) age (6 groupings: 0-4, 5-14, 15-24, 25-44, 45-64, 65+);

(b) gender; and

(c) High Use Health Card status.

2 Capitation Payments for non-Access Practices

(1) Subject to subclause (2), the DHB will Pay the PHO for Nationally Consistent Services delivered by non-Access Practices according to the numbers of Enrolled Persons in each category at the annual rate specified in the table below:

Non-Access First Contact		**HUHC**	
Age Group	Gender	N	Y
00-04	F	$379.5512	$581.3764
	M	$403.8948	$581.3764
05-14	F	$97.7192	$372.7652
	M	$92.6136	$372.7652
15-24	F	$113.5972	$359.0852
	M	$62.5208	$359.0852
25-44	F	$99.8224	$359.0852
	M	$64.5268	$359.0852
45-64	F	$136.7252	$393.2844
	M	$102.1188	$393.2844
65+	F	$235.6176	$421.7832
	M	$203.1940	$421.7832

(2) The DHB will Pay the PHO in accordance with the table below for each Contracted Provider to which clause F.27 applies with respect to the funding levels for each age group:

Non-Access First Contact		**HUHC**	
Age Group	Gender	N	Y
00-04	F	$379.5512	$581.3764
	M	$403.8948	$581.3764
05-14	F	$97.7192	$372.7652
	M	$92.6136	$372.7652
15-24	F	$113.5972	$359.0852

	M	$62.5208	$359.0852
25-44	F	$99.8224	$359.0852
	M	$64.5268	$359.0852
45-64	F	$136.7252	$393.2844
	M	$102.1188	$393.2844
65+	F	$235.6176	$421.7832
	M	$203.1940	$421.7832

3 Capitation Payments for Access Practices

(1) The DHB will Pay the PHO for First Level Services and other associated services described in Schedule C1 delivered by the Access Practices listed in subclause (2) according to the numbers of Enrolled Persons in each category at the annual rate specified in the table below:

Access First Contact		**HUHC**	
Age Group	Gender	N	Y
00-04	F	$388.9272	$581.3764
	M	$409.4856	$581.3764
05-14	F	$123.1080	$372.7652
	M	$115.2308	$372.7652
15-24	F	$113.5972	$359.0852
	M	$62.5208	$359.0852
25-44	F	$99.8224	$359.0852
	M	$64.5268	$359.0852
45-64	F	$136.7252	$393.2844
	M	$102.1188	$393.2844
65+	F	$235.6176	$421.7832
	M	$203.1940	$421.7832

(2) At the Commencement Date the following practices (if any) deliver Services to a subset of the PHO's Enrolled Population and meet the Ministry's criteria for Access Practices, and accordingly will be funded according to the Access Practice funding formula set out in this clause:

(a)

(3) The list of Access Practices set out in this clause may be varied by mutual agreement in accordance with clause B.19(a).

4 Deductions to capitation Payments for First Level Services delivered to Enrolled Persons

(1) If a Claim for a fee for service for General Medical Services for an Enrolled Person is submitted (regardless of which provider makes that Claim) an amount equivalent to the General Medical Services Payment set out in Schedule F1.2 will be deducted from the PHO's capitation Payment at the next monthly Payment date so long as not more than 3 such Claims have been submitted for that Enrolled Person in that month.

(2) To avoid doubt, the DHB will not make any deduction under subclause (1) for the fourth or subsequent Claim submitted for an Enrolled Person for First Level Services as a Casual User in a month.

(3) The DHB will provide the PHO with reports about Enrolled Persons who are provided with First Level Services as a Casual User by a health service provider who is not part of the PHO, to assist the PHO to minimise deductions made under subclause (1).

5 Very low cost access payments

(1) The DHB will Pay the PHO a very low cost access Payment in accordance with this clause.

(2) A very low cost access Payment is made up of an individual practice component, which the DHB will Pay the PHO in respect of each individual practice (an "**Eligible Practice**") of a PHO that charges the very low fees specified in subclause 5.(4)(b) and for whom the PHO and the DHB meet the conditions specified in subclauses 5.(4)(a)(iv) and 5.(4)(c). This component of the very low cost access Payment is specified in the Table below:

Individual practice component of very low cost access Payment – annual rates excluding GST		
Age Bands	Gender	
00-04	F	$98.6468
	M	$103.8604
05-14	F	$30.7632
	M	$28.7948
15-24	F	$28.3400
	M	$15.5976
25-44	F	$24.9032
	M	$16.0980
45-64	F	$34.1092
	M	$25.4760
Over 65	F	$58.7808
	M	$50.6920

(3) The PHO must pass on the full amount of the individual practice component of the very low cost access Payment to its Eligible Practices.

(4) The PHO is entitled to the individual practice component of the very low cost access Payment in any given payment quarter only if:

(a) the PHO:

(i) has entered into the most current version of the PHO Services Agreement. If the PHO Services Agreement has been varied during a payment quarter, the PHO must have agreed to the variation by a date determined by the DHB;

(ii) is participating in the PHO Performance Programme;

(iii) has notified the DHB of the names of all of the PHO's member practices, together with the unique practice identifier for each practice, that the PHO is satisfied meet the conditions specified in subclause (b);

(iv) has given notification at least 15 Business Days before the commencement of the date of register submission as defined in the Referenced Document entitled "Business Rules: Capitation-based funding";

(b) the PHO has at least one member practice that charges fees for each standard consultation at or below the following amounts:

(i) zero fees ($0) for Enrolled Persons aged 0 to 5 years;

(ii) $11.50 for Enrolled Persons aged 6 to 17 years; and

(iii) $17.50 for Enrolled Persons aged 18 years and over;

(c) the DHB has:

(i) notified the Ministry of the information notified by the PHO under clause subclause (a)(iii);

(ii) in the case of a very low cost access Payment given notification under subclause (c)(i) 10 Business Days before the commencement of the date of register submission as defined in the Referenced Document entitled "Business Rules: Capitation-based funding"; and

(d) any practice wishing to join the Very Low Cost Access scheme is a practice with an enrolled population of 50% or more high needs populations (Māori and Pacific peoples and those living in Dep decile 9 – 10 areas) and has the DHB's agreement.

(5) To avoid doubt:

(a) in respect of the individual practice component of the very low cost access Payment, each individual practice must continue to comply with the conditions specified in subclause (4)(b) until the end of the payment quarter to which the very low cost access Payments relate;

(b) if any of the PHO's practices do not comply with paragraph (a), the DHB may exercise its rights under clause F.24 to recover from the PHO such of the following amounts in respect of which the PHO or one of the PHO's member practices have failed to comply for the relevant payment quarter:

(i) the entire individual practice component of the very low cost access Payment for that payment quarter that relates to the practice or practices that have failed to comply:

(6) The DHB will not Pay a very low cost access Payment to the PHO unless the conditions specified in subclause (4) have been complied with.

(7) Nothing in this clause prevents the PHO or any of the PHO's member practices from foregoing a very low cost access Payment by not complying with a condition for qualifying for a payment under this notice.

(8) We both acknowledge that the Ministry has advised DHBs that clause F.27(7) applies to:

(a) the very low cost access Payment specified in subclause (2); and

(b) the fees thresholds specified in subclause (4)(b).

6 Payment for zero fees for under sixes

(1) Subject to this clause, the DHB will Pay the PHO an "Under 6s" Payment in respect of the PHO's eligible practices (as detailed in subclause (3)) in accordance with the Table Below:

Annual rates for Under 6s Payment excluding GST		
Age Bands	Gender	$amounts per enrolee (excluding GST)
00-04	Female	$73.9848
	Male	$77.8956
05-14	Female	$2.3076
	Male	$2.1596
15-24	Female	$0.0000
	Male	$0.0000
25-44	Female	$0.0000
	Male	$0.0000
45-64	F	$0.0000
	M	$0.0000
Over 65	F	$0.0000
	M	$0.0000

(2) The PHO will pass on the full amount of the Under 6s Payment to the PHO's eligible practices.

(3) The PHO is entitled to and will be paid the Under 6s Payment in any given payment quarter only if all of the following criteria are met:

(a) the PHO:

(i) has entered into the most current version of the standard PHO Services Agreement and, if the Agreement has been varied during a payment quarter, the PHO must have agreed to the variation by a date determined by the DHB;

(ii) is participating in the PHO Performance Programme;

(iii) has notified the DHB of the names of all the PHO's member practices (together with the unique practice identifier for each practice) that the PHO is satisfied meet the conditions specified in paragraph (b);

(iv) gave such notification 15 Business Days before the commencement of the date of register submission as defined in the Referenced Document entitled "Business Rules: Capitation-based funding";

(b) the PHO has at least 1 member practice that continuously throughout any quarter in respect of which the Under 6s payment is sought charges zero fees for each standard consultation for children aged under 6 years of age (from birth up to and including the day before a child's 6th birthday) ("**Eligible Practice**"), and which member practice is not receiving Very Low Cost Access Payments pursuant to clause 5. The Eligible Practice must charge zero fees for each standard consultation from the date of the first visit when the child is enrolled. This is expected to occur from the date that the parent or caregiver signs the enrolment form for the child.

(c) the DHB has notified the Ministry of the information notified by the PHO under paragraph(a)(iii) at least 10 Business Days before the commencement of the date of register submission as defined in the Referenced Document entitled "Business Rules: Capitation-based funding";

(4) Despite clause 7, the Under 6s Payment will be made quarterly.

(5) If any of the PHO's Eligible Practices do not charge zero fees for each standard consultation for enrolled children aged under 6 years continuously throughout any quarter in respect of which the Under 6s payment is sought the DHB may exercise its rights under clause F.24 to recover from the PHO the entire Under 6s Payment for that payment quarter that relates to the practice or practices that have failed to comply.

(6) The DHB will not Pay an Under 6s Payment to the PHO unless the conditions specified in subclause (3) have been complied with.

(7) Nothing in this clause prevents the PHO or any of the PHO's member Eligible Practices from foregoing an Under 6s Payment by not complying with a condition for qualifying for a payment under this notice. To avoid doubt, Under 6s Payments are voluntary - PHO practices voluntarily opt in to Under 6s Payments each payment quarter by notifying their PHO by the notification date and can voluntarily opt out at the end of each payment quarter by notifying their PHO of their decision to opt out by the notification date for the next payment quarter. We agree that this clause may only be varied by agreement in accordance with clause B.19(1)(a) or B.19(1)(b) and not by compulsory variation under clause B.21.

(8) We both acknowledge that the Ministry has advised DHBs that clause F.27(7)applies to the Under 6s Payment specified in clause subclause (2).

7 Monthly Payments

(1) All amounts payable to the PHO under this Schedule will be paid in equal monthly instalments in advance.

SCHEDULE F1.2
PAYMENT FOR GENERAL MEDICAL SERVICES

1 General provision

(1) The PHO may Provide General Medical Services to Eligible Persons who are not enrolled with the PHO. General Medical Services may also be provided by other service providers to the PHO's Enrolled Population.

(2) The DHB will pay for General Medical Services on a fee for service basis in accordance with this Schedule.

(3) The terms and conditions of the Section 88 Advice Notice apply to all services provided to and Payments made for Casual Users, subject to the provisions of this Agreement.

2 Entitlement to Claim

(1) Subject to the provisions of this Schedule, the PHO on behalf of each General Practitioner who provides General Medical Services to Casual Users as part of a Casual Medical Consultation may claim from the DHB the relevant Payment set out in clause 3(5), together with such travelling allowances (if any) as the DHB agrees with the PHO in writing.

(2) If the PHO, on behalf of a General Practitioner, is entitled in accordance with this Schedule to receive from the DHB any amount in respect of any General Medical Services provided or any pharmaceutical requirements supplied or any travelling expenses incurred, neither the PHO nor the General Practitioner may demand or accept or be entitled to recover that amount from the Casual User or any other person responsible for the Casual User’s debts.

(3) If any question arises as to whether any service provided by a General Practitioner is included in the expression “General Medical Services”, or as to whether any amount, and if so what amount, is payable by the DHB, that question will be decided by the DHB.

3 General Medical Services

(1) Each time the PHO or one of its General Practitioners provides a Casual Medical Consultation to any Eligible Person who holds either a Community Services Card or High Use Health Card, or a dependent child, the PHO will be entitled to receive from the DHB the relevant fee per Casual Medical Consultation described in clause 3(5).

(2) If the Casual User is covered under more than one fee in clause 3(5), the higher fee will be paid.

(3) A General Medical Services fee cannot be claimed by the PHO if the Casual Medical Consultation service is to be paid for under another fee, benefit, subsidy or alternative payment arrangements. For example, immunisation, under the maternity services benefit, or if the Casual Medical Consultation is in respect of personal injury (as that term is defined in the Accident Compensation Act 2001).

(4) A General Medical Services fee will be paid only if the requirements for making a Claim for Payment and NHI number requirements set out in clause F.10 have been complied with.

(5) The following table states the rates payable for General Medical Services:.

		Fee $ Per Medical Consultation (Excl GST)
1	A child, under 6 years of age	$31.11
2	Holder of current Community Services Card	$13.33
3	A child, 6 years of age or over, of holder of a Community Service Card	$17.78
4	Holder of current High Use Health Card who is not a child	$13.33
5	A child, 6 years of age or over, who is a holder of current High Use Health Card	$17.78
6	A child, 6 years of age or over, who is not within Community Services Card or High Use Health Card categories above	$13.33

4 NHI number requirements for General Medical Services Claims for Casual Users

(1) The DHB will Pay a Claim for General Medical Services provided to Casual Users only if at least 70% of that Claim specifies a valid NHI number for each Casual User or if the DHB has not met the requirements of clause 6.

(2) If the DHB has met the requirements of clause 6 and less than 70% of a Claim specifies valid NHI numbers for each Casual User, the DHB will reject all Claims that do not contain a valid NHI number.

(3) Despite a Claim being rejected by the DHB in accordance with clause F.11(3), the DHB will Pay that Claim for General Medical Services provided to Casual Users in accordance with clause 4(1) if:

(a) the DHB has rejected part of the Claim in accordance with clause F.11(3) because the NHI number details of 1 or more Casual Users in respect of which the Claim was made was incorrect;

(b) the PHO has resubmitted that Claim in accordance with clause F.12 and has met the requirements of clause F.13; and

(c) the NHI numbers details have been correctly amended by the PHO, and the inclusion of the corrected NHIs means that the PHO's original Claim (now amended) now meets the 70% threshold for specified NHIs set out in clause 4(1) ,

5 Deceased Casual Users and Casual Users rejecting Services

(1) If the PHO provides General Medical Services for any non-Enrolled Person elsewhere than at the place of practice or residence of the General Practitioner, and that person has died before the arrival of the General Practitioner or rejects the General Medical Services of the General Practitioner, then, for the purposes of this Agreement, that person is deemed to be a Casual User and the General Practitioner is deemed to have provided General Medical Services for that person.

6 Access to NHI numbers

(1) The DHB will ensure that the PHO and the PHO's Contracted Providers can gain sufficient access to facilities (including telephone, fax and internet access) to obtain individuals' NHI numbers so that the threshold targets for claims in clause 4 and for immunisation claims in clause 4 of Schedule F1.3 can be met.

(2) For the purpose of this clause, sufficient access to facilities means:

(a) 90% of all phone or fax requests made to the DHB's designated agent for this purpose are responded to within 2 Business Days, provided that requests are for no more than 40 records per practice per day; and

(b) 90% of all scheduled electronic batch matching requests are returned completed within 4 Business Days of the date received, provided the electronic file or files supplied are in a format acceptable to the DHB's agent.

SCHEDULE F1.3
PAYMENT FOR IMMUNISATION SERVICES

1 Payments for Immunisation Services

(1) The DHB will pay the PHO, in lieu of any other Payment that the PHO might otherwise be entitled to receive under this Agreement, the Payment specified in clause 3, for administering:

(a) a vaccine supplied by the DHB's authorised agent, in the course of an immunisation programme approved by the DHB; and

(b) an influenza vaccine purchased from a supplier nominated by the Ministry in writing from time to time.

(2) Subject to clause 2, the DHB will Pay the PHO for each occasion on which a vaccine or vaccines is administered to a Service User according to any immunisation programme approved by the DHB.

2 One Payment only

(1) Nothing in this Schedule entitles the PHO to receive more than the relevant fee specified in clause 3 if more than 1 vaccine is administered on the same occasion.

(2) Subject to subclause (3), neither the PHO nor a Contracted Provider may demand or accept or be entitled to recover from the Service User or any other person, any fee in respect of the Services for which a fee is payable under this Schedule.

(3) If any other Service other than immunisation is provided by the PHO or a Contracted Provider at the same time as the consultation for the Immunisation Service then the PHO or the Contracted Provider may charge for that other Service. A simple check of fitness (without clinical indication) for immunisation is considered part of the Immunisation Service.

3 Fees

(1) The DHB will Pay the PHO $19.59 (GST exclusive) for administering a Vaccine Episode on the childhood immunisation schedule as detailed in the Immunisation Handbook, other than the influenza vaccine.

(2) The DHB will Pay the PHO $19.59 (GST exclusive) plus the purchase cost (inclusive of GST) of the vaccine from the nominated supplier, for administering the influenza vaccine to eligible people as defined by the Influenza Guidelines, between the time the vaccine becomes available each year (usually February or March) until 30 June of that same calendar year.

4 NHI number requirements

(1) The DHB will Pay a Claim for Immunisation Services provided that 85% of single Claims making up the PHO's whole immunisation Claim, have valid NHI numbers or if the DHB has not met the requirements of clause 6 of Schedule F1.2.

(2) If the DHB has met the requirements of clause 6 of Schedule F1.2 and the proportion of NHI numbers in a whole Claim is less than 85%, those single Claims that do not have NHI numbers will not be paid.

5 Conditions of Payment

(1) The DHB will Pay the fees set out in this Schedule only if:

(a) the immunisation has not already been given or a reasonable effort has been made to check whether the immunisation has not been given; and

(b) the fee is claimed in accordance with the claiming and NHI number requirements of this Agreement;

(c) the Claim complies with the information requirements set out in clause F.10; and

(d) the Claim is from a medical practitioner or an authorised non-medical vaccinator employed within a PHO.

6 Influenza vaccines

(1) The cost of the influenza vaccine will be advised by the Ministry from time to time, and any change to the vaccine cost will be advised by the DHB as soon as practicably possible prior to the commencement of the programme.

(2) The Influenza Guidelines may vary from time to time. The Ministry will consult with the sector on any change to such guidelines.

(3) The Ministry will advise the PHO of the supplier from whom the vaccine is to be purchased and the price as required from time to time.

7 Other immunisations

(1) The DHB will pay the following fees to the PHO for administering a vaccine to the persons set out below:

(a) a Service User who is a household or sexual contact of a person with acute Hepatitis B or a carrier of Hepatitis B; or

(b) a Service User who is a household contact of a person with Measles, Mumps or Rubella.

SCHEDULE F1.4
PAYMENT FOR RURAL SERVICES

1 Workforce retention funding

(1) The following table sets out the workforce retention funding allocation formula:

Rural ranking score	$ per capita **(Per capita relates to Enrolled Patients excluding casual visitors)** GST exclusive
35-40	$7.72
45-50	$11.60
55-65	$15.46
70 +	$19.31

(2) The PHO's rural workforce retention funding is calculated as $……..:

Rural ranking score	No of Enrolled Patients	$ amount
35-40		$
45-50		$
55-65		$
70 +		$
Total		**$**

(3) If the PHO was established part way through a financial year, the PHO will receive workforce retention funding on a pro-rata basis minus the amount the DHB has already expended on workforce retention strategies for the PHO's primary health care team in that financial year.

2 Rural reasonable roster funding

(1) The DHB has contracted funding to improve roster arrangements to the practices and Contracted Providers specified in the following table (if applicable):

Practices /providers	$ amount

3 Remote practice areas

(1) Subject to subclause (2), the DHB will Pay the PHO a total of $ in addition to the capitation Payment on behalf of the Enrolled Population(s) of the following remote practice area(s).

A	B	C	D
Remote practice area	Amount previously spent on primary health care service delivery	PHO capitation Payment for Enrolled Population of remote practice area	Extra funding to support remote practice (that is, the $ amount that B exceeds C)*

(2) If the amount in column B does not exceed the amount in column C, this provision does not apply.

(3) If the Enrolled Population of the remote practice area increases, the PHO will not receive increased capitation funding until the amount in column C exceeds the amount in column B.

(4) The PHO must not introduce patient charges in the following areas without first obtaining Ministerial agreement, which should be sought through the DHB:

SCHEDULE F1.5
PAYMENT FOR SPECIAL SUPPORT SERVICES FOR FORMER SAWMILL WORKERS EXPOSED TO PCP

1 Payment for Special Support Services

(1) Subject to the terms set out in Schedule C5, the following payments apply:

(a) the first free health check fee will be $220 (GST exclusive); and

(b) the fee for all subsequent free annual health checks will be $75 (GST exclusive).

2 Fees and claiming requirements

(1) An adjustment to these fees as determined by the Ministry will be applied annually effective from 1 July of each year.

(2) A nominated General Practitioner may not claim under this Schedule if:

(a) the nominated General Practitioner is entitled to have the claim satisfied (whether directly or indirectly) under any other arrangement with the Ministry or a DHB; or

(b) the Services that relate to the claim have been provided by a General Practitioner in his or her capacity as an employee of a DHB.

3 The claiming and payment process

(1) Eligible Persons are required to nominate a General Practitioner on their application form.

(2) Once eligibility has been approved, the Eligible Person will be sent a Confirmation of Eligibility Letter confirming that eligibility has been approved and their nominated General Practitioner will be sent an Eligibility and Entitlement Information pack. The Eligibility and Entitlement Information pack will contain:

(a) confirmation that the patient is eligible for the Service;

(b) advice and information about the Service; and

(c) instructions on how to claim payment for the annual health checks.

(3) The Confirmation of Eligibility Letter will advise the Eligible Person that to receive their first free health check they must arrange for the check with their nominated General Practitioner and present their Confirmation of Eligibility Letter when they attend for their first health check.

(4) To claim the fee for the first free health check the nominated General Practitioner must complete the information requirements on the Entitlement and Claim form and send it to:

Health Support Service Secretariat
Ministry of Health
PO Box 5013
WELLINGTON

(5) The Secretariat of the Special Support Service will check the claim, enter the monitoring data, and forward the claim to Sector Services for processing.

(6) The Secretariat of the Special Support Service will send nominated General Practitioners the second and subsequent free annual health check Entitlement and Claim forms.

4 Purchase Unit Code

(1) The Purchase Unit for this Service is RM00108 – Physical Environment (Health services for people exposed to hazardous substances).

SCHEDULE F1.6
PAYMENT FOR HEALTH SUPPORT SERVICES FOR DIOXIN-EXPOSED PEOPLE

1 Payment for Health Support Services

(1) Subject to the terms set out in Schedule C6, the following payments apply:

(a) the first free health check fee will be $220 (GST exclusive); and

(b) the fee for all subsequent free annual health checks will be $75 (GST exclusive).

2 Fees and claiming requirements

(1) An adjustment to these fees as determined by the Ministry will be applied annually effective from 1 July of each year.

(2) A nominated General Practitioner may not claim under this schedule if:

(a) the nominated General Practitioner is entitled to have the claim satisfied (whether directly or indirectly) under any other arrangement with the Ministry or a DHB; or

(b) the Services that relate to the claim have been provided by a General Practitioner in his or her capacity as an employee of a DHB.

3 The claiming and payment process

(1) Eligible Persons are required to nominate a General Practitioner on their application form.

(2) Once eligibility has been approved, the Eligible Person will be sent a Confirmation of Eligibility Letter confirming that eligibility has been approved and their nominated General Practitioner will be sent an Eligibility and Entitlement Information pack. The Eligibility and Entitlement Information pack will contain:

(a) confirmation that the patient is eligible for the Service;

(b) advice and information about the Service; and

(c) instructions on how to claim payment for the annual health checks.

(3) The Confirmation of Eligibility Letter will advise the Eligible Person that to receive their first free health check they must arrange for the check with their nominated General Practitioner and present their Confirmation of Eligibility Letter when they attend for their first health check.

(4) To claim the fee for the first free health check the nominated General Practitioner must complete the information requirements on the Entitlement and Claim form and send it to:

Health Support Service Secretariat
Ministry of Health
PO Box 5013
WELLINGTON

(5) The Secretariat of the Health Support Service will check the claim, enter the monitoring data, and forward the claim to Sector Services for processing.

(6) The Secretariat of the Health Support Service will send nominated General Practitioners the second and subsequent free annual health check Entitlement and Claim forms.

4 Purchase Unit Code

(1) The Purchase Unit for this Service is RM00108 – Physical Environment (Health services for people exposed to hazardous substances).

SCHEDULE F2.1
PAYMENT FOR MANAGEMENT SERVICES

1 Management services

(1) The annual management services fee will be calculated per Enrolled Person as set out in this Schedule.

(2) If the number of Enrolled Persons in the PHO is 40,000 or less, and the DHB has approved the PHO's Management Services Plan, the rate is:

(a) $15.5928 per person up to 20,000 persons; and

(b) $0.8992 per person from 20,001 to 40,000 persons.

(3) If the number of Enrolled Persons in the PHO is 75,000 or less, the rate is:

(a) $11.0960 per person up to 20,000 persons; and

(b) $5.3960 per person from 20,001 to 75,000 persons.

(4) If the number of Enrolled Persons in the PHO is 75,001 or above then the rate is $518,700.00 plus $6.0596 per person over 75,000 enrollees.

2 Monthly Payments

(1) The annual management services fee will be paid to the PHO in equal monthly instalments in advance.

SCHEDULE F2.2
PAYMENT FOR HEALTH PROMOTION SERVICES

1 Health promotion Services

(1) If the DHB approves the PHO's proposal to deliver health promotion services under clause 1 of Schedule D2, the DHB will Pay the PHO for health promotion services according to the numbers of Enrolled Persons in each category at the annual rate specified in the table below:

Health Promotion	Non High Use Health Card Holders	
	Māori/Pacific	Non Māori/Pacific
Deprivation deciles 1-8	$2.6068	$2.1724
Deprivation deciles 9-10	$3.0412	$2.6068

2 Monthly Payments

(1) The health promotion services fee will be paid to the PHO in equal monthly instalments in advance.

SCHEDULE F2.3
PAYMENT FOR SERVICES TO IMPROVE ACCESS

1 Services to improve access for High Need Groups

(1) If the DHB approves the PHO's proposal to deliver services to improve access to High Need Groups under clause 1 of Schedule D3, the DHB will Pay the PHO for those services according to the numbers of Enrolled Persons in each category at the annual rate specified in the table set out below:

		Non High Use Health Card Holders			
Services to Improve Access		Māori/Pacific		Non Māori/Pacific	
Age Group	Gender	Deprivation deciles 1 - 8	Deprivation deciles 9 - 10	Deprivation deciles 1 - 8	Deprivation deciles 9 - 10
00-04	F	$74.0248	$148.0496	$0.0000	$74.0248
	M	$77.9372	$155.8756	$0.0000	$77.9372
05-14	F	$23.4308	$46.8620	$0.0000	$23.4308
	M	$21.9324	$43.8636	$0.0000	$21.9324
15-24	F	$21.6208	$43.2416	$0.0000	$21.6208
	M	$11.8996	$23.7992	$0.0000	$11.8996
25-44	F	$18.9992	$37.9988	$0.0000	$18.9992
	M	$12.2816	$24.5628	$0.0000	$12.2816
45-64	F	$26.0224	$52.0460	$0.0000	$26.0224
	M	$19.4364	$38.8728	$0.0000	$19.4364
65+	F	$44.8452	$89.6908	$0.0000	$44.8452
	M	$38.6744	$77.3480	$0.0000	$38.6744

2 Monthly Payments

(1) The services to improve access for high needs groups fee will be paid to the PHO in equal monthly instalments in advance.

SCHEDULE F2.4
PAYMENT FOR CARE PLUS SERVICES

1 Calculating expected Care Plus population

(1) Subject to subclause (2), in the months of April, July, October and January in each year, the DHB will calculate and report to the PHO the number of people in each population category to whom the DHB expects the PHO to Provide Care Plus Services.

(2) The DHB will make those calculations from the register that the PHO submits in accordance with clause F.9(1) by applying the percentages shown in the table below for each age, gender, ethnicity and deprivation category to the equivalent number of Enrolled Persons in each category, summing the resulting numbers in each category, and subtracting from the resulting total the number of Enrolled Persons with High Use Health Cards:

		Māori or Pacific		**Not Māori or Pacific**	
Age	**Gender**	**Deprivation <5**	**Deprivation 5**	**Deprivation <5**	**Deprivation 5**
0-4	Female	2.3%	2.6%	1.5%	2.2%
	Male	2.0%	3.1%	1.7%	1.9%
5-14	Female	1.3%	1.4%	1.1%	1.2%
	Male	0.9%	1.6%	0.7%	0.8%
15-24	Female	3.3%	3.4%	1.4%	2.5%
	Male	1.6%	1.7%	0.5%	1.5%
25-44	Female	3.8%	4.3%	2.4%	2.6%
	Male	3.1%	3.6%	1.3%	1.6%
45-64	Female	13.8%	13.9%	4.8%	8.5%
	Male	15.9%	16.7%	6.0%	9.3%
65+	Female	29.2%	33.8%	18.4%	22.4%
	Male	37.2%	41.0%	21.2%	24.7%

2 Payment for Services

(1) Each month, as detailed in the table below, the DHB will Pay the PHO for Care Plus Services depending on the total number of Care Plus Patients in the PHO's current Register compared to the number of Care Plus Patients the DHB expected the PHO to have during the previous quarter according to clause 1(1):

Level	Percentage of expected number of Care Plus Patients as calculated in clause 1.1 of this Schedule (x)	Percentage of full Care Plus Services funding in clause 2.2 of this Schedule
One	0% ≤ X < 50% of total	50%
Two	50% ≤ X < 55% of total	55%
Three	55% ≤ X < 60% of total	60%
Four	60% ≤ X < 65% of total	65%
Five	65% ≤ X < 70% of total	70%
Six	70% ≤ X < 75% of total	75%
Seven	75% ≤ X < 80% of total	80%
Eight	80% ≤ X < 85% of total	85%
Nine	85% ≤ X < 90% of total	90%
Ten	90% ≤ X < 95% of total	95%
Eleven	95% ≤ X of total	100%

(2) For the purposes of the table set out in subclause (2), the DHB will calculate the full Care Plus Services funding as $244.0852 (excl GST) multiplied by the expected number of Care Plus Patients in an Access Practice and/or a non-Access Practice.

(3) If, 9 months after the PHO began to Provide Care Plus Services and each quarter thereafter, the PHO has not reached at least 50% of the number of Care Plus Patients that the DHB expected the PHO to have according to clause 1(1) , the DHB will review and adjust the PHO's funding for Care Plus.

(4) The Purchase Unit for Care Plus Services is PHOC0011.

3 Care Plus fees assurance framework

(1) The PHO recognises the DHB's requirement to have certainty that increased Payments to health providers for Care Plus Patients, which subsidises patient fees, will be reflected in low or reduced costs to patients, and those fees are fair to the Contracted Providers and reasonable for Care Plus Patients.

(2) The PHO recognises the DHB's requirement to have certainty that Payments to Contracted Providers for Care Plus Services will be applied to the provision of services to patients identified as qualifying for Care Plus Services.

(3) The DHB acknowledges that some of the funding for Care Plus Services will be applied to services to patients which are not standard consultations (e.g. care plan, outreach), administration and management, and that this will be taken into account in its assessment of the PHO's proposal.

(4) As part of the PHO's proposal for delivering Care Plus Services, the PHO advised the DHB of the PHO's funding arrangements for Care Plus Services in sufficient detail to demonstrate to the DHB how the PHO met all the requirements of clauses 3(1) to 3(3).

(5) If, during the term of this Agreement, the PHO significantly or substantially changes the funding arrangements for Care Plus Services advised to the DHB, the PHO will advise the DHB in a timely manner of the change and the reasons for the change.

(6) If, after receipt of the advice in subclause (5), the DHB considers the funding arrangements no longer meet the requirements of subclauses (1) to (3), the DHB will meet with the PHO with the aim of finding a mutually agreed resolution to the matter.

SCHEDULE F3.1
PAYMENT FOR LOCAL SERVICES

Part G Integrated Performance and Incentive framework

G.1 New integrated performance and incentive framework

(1) We agree to work together in good faith and use our best endeavours to agree a new integrated performance and incentive framework.

(2) The framework in this Part applies until we agree a new framework, and the new framework is implemented in accordance with the contract variation procedures in Part B.

(3) We agree that Schedule G1 records the intended objectives and content of the new integrated performance and incentive framework, and the process by which the framework will be developed.

G.2 Referenced Documents and definitions

(1) This Part operates in combination with the following Referenced Documents:

(a) Indicator Definitions for PHOs:

(b) Data Transfer Specification:

(c) Public Reporting Guidelines for PHOs.

(2) In addition to the defined terms set out in Part B, in this Part, unless the context requires otherwise:

Benchmarks mean the equitable benchmarks, calculated for the PHO in accordance with the population-based RSM funding formulae and set out in the document entitled “Referred Services Management – Technical Formula Summary”, that identify a more equitable distribution of resources for pharmaceutical and diagnostic services. The expenditure benchmarks set by these formulae assist with setting Targets for the financial indicators forming part of the National Indicators.

CQI means continuous quality improvement.

Indicator Baseline Data means the measure of the PHO's position for each National Indicator prior to entry to the Programme. This measure is used in the first Target setting process. Thereafter, the actual result for each National Indicator for the prior Performance Period becomes the Indicator Baseline Data for the next Target setting process.

National Indicators mean the core set of national performance indicators contained in the Referenced Document entitled “Indicator Definitions for PHOs”.

Performance Payments mean the 6 or 12 monthly payments calculated in accordance with the weighting against each National Indicator set out in the Referenced Document entitled “Indicator Definitions for PHOs” and for which the PHO is eligible when it participates in the Programme, and has achieved progress towards its Targets.

Performance Period means a 6 month period commencing on either 1 January or 1 July.

PHO Performance Plan means the PHO's plan for participating in the Programme, described in clause G.8.

Programme means the PHO Performance Programme described in this Part.

Programme Prerequisites means the prerequisites to participate in the Programme as specified in the Referenced Document, “Indicator Definitions for PHOs”.

RSM means Referred Services Management and refers to pharmaceuticals and diagnostic services accessed through the primary health care team (usually the General Practitioner).

Targets means the targets for achieving progress on National Indicators (set in accordance with the Referenced Document entitled "Indicator Definitions for PHOs”).

G.3 Programme overview

(1) This clause provides an overview of the key components of the Programme. Each is specified in more detail in this Part.

(2) The Programme is based on a set of core National Indicators. National Indicators focus on a range of areas and some may include expenditure Benchmarks.

(3) To ensure the Programme is responsive to each PHO, Targets will be set in accordance with the Referenced Document entitled “Indicator Definitions for PHOs” to measure progress against each National Indicator in relation to the PHO's Indicator Baseline Data.

(4) Annual Targets and the strategies the PHO will use to achieve the Targets are set out in the PHO Performance Plan if the PHO has been participating in the Programme for less than 12 months, or agreed in writing by the DHB if the PHO has been participating in the Programme for greater than 12 months. Targets for the second 6 month Performance Period of an annual cycle will be adjusted according to the guidelines specified in the Referenced Document entitled “Indicator Definitions for PHOs”. All adjusted Targets must be approved by the DHB.

(5) The PHO's performance will be measured against its Targets on a 6 monthly basis. The PHO will be eligible to receive Performance Payments when it achieves progress towards and/or meet the Targets.

(6) The Programme will monitor and report quarterly on the PHO's progress towards achieving Targets.

(7) Performance Payments will be made on the basis of progress towards Targets on a 6 or 12 monthly basis.

(8) The PHO's Targets and PHO Performance Plan will be reviewed annually unless otherwise agreed.

G.4 Programme principles

(1) The following principles underpin the Programme:

(a) **Equity**: improving access with an emphasis on equity of health outcomes and reducing health disparities;

(b) **Quality**: through CQI based on evidence and best practice;

(c) **Affordability**: with clear targeting decisions and outcomes affordable to key stakeholders in the sector;

(d) **Sustainability**: with a policy direction and framework that is enduring over time; and

(e) **Collaboration**: with involvement and co-ordination of the sector, shared objectives and common goals.

G.5 Programme objectives

(1) The Programme seeks to support, promote and achieve improvement in the delivery of health services by PHOs consistent with the principles described in clause G.4.

(2) The Programme provides an opportunity to build clinical governance capability within PHOs as well as:

(a) further develop a population health model;

(b) provide a national platform to support PHOs and DHBs to achieve the performance requirements of the Programme;

(c) use information to improve performance;

(d) promote and improve multi-disciplinary teamwork;

(e) promote a CQI approach throughout the PHO; and

(f) focus on achieving desired population health outcomes.

G.6 Programme strategies

(1) National Indicators serve as a mechanism to measure progress against various population priorities and outcomes in a nationally consistent way so that the sector can:

(a) improve the quality and consistency of health care provided;

(b) gain feedback on clinical decision-making in comparison with evidence-based guidelines;

(c) provide information in a consistent format to enable discussion and debate about the best way to deliver health care;

(d) provide feedback on national population priorities and relative inequalities in health;

(e) encourage and acknowledge improvements in outcomes and quality practice;

(f) improve the quality of utilisation in terms of what is prescribed and ordered, and for whom; and

(g) align the use of pharmaceuticals, diagnostic services and other referred services more closely to evidence-based guidelines and population need, thus improving resource use and achieving health gains within the resources available.

G.7 National Indicators

(1) The Programme is based on a core set of National Indicators.

(2) The National Indicators focus on:

(a) national priority areas and specific therapeutic areas to support evidence based guidelines within a continuous quality improvement framework;

(b) population health initiatives as defined by the Ministry;

(c) service utilisation by specific population groups;

(d) development of PHO capacities to ensure effective operations;

(e) availability of information to support population health and quality interventions; and

(f) national population-based formulae for setting Benchmarks.

(3) The National Indicators create a balanced portfolio in line with the principles of the Programme.

G.8 PHO Performance Plan

(1) The PHO will implement its Performance Programme in accordance with its PHO Performance Plan agreed with the DHB.

(2) The PHO Performance Plan will demonstrate how the PHO will implement the Programme and include:

(a) the PHO's organisational approach to clinical governance;

(b) a broad-based approach, including establishing and maintaining the PHO Performance Plan with implementation and review guided through a PHO clinical governance function;

(c) processes to ensure the appropriate people have access to detailed information and analysis on utilisation patterns and performance against National Indicators;

(d) personalised feedback to Contracted Providers on their utilisation and outcome patterns compared with peers and alignment with evidence based guidelines;

(e) some or all of the activities described in clause G.13;

(f) a description of:

(i) the multi-disciplinary composition of the clinical governance group;

(ii) decision making and change management processes; and

(iii) how the PHO's Board oversees the PHO's clinical governance processes;

(g) the Targets against each National Indicator;

(h) planned utilisation review activities and other performance management and monitoring arrangements;

(i) any other complementary activities the PHO is participating in;

(j) how any Performance Payments will be used; and

(k) the other requirements set out in the Referenced Document entitled “Performance Plan Template”.

G.9 Annual review of PHO Performance Plan

The DHB will review the PHO's PHO Performance Plan annually as part of the annual Target review described in clause G.3(8), and the PHO will amend the PHO Performance Plan as agreed by us.

G.10 National Indicator Targets

(1) A Target for progress against each National Indicator for each of the 2 subsequent Performance Periods will be set in accordance with the Referenced Document entitled “Indicator Definitions for PHOs”. This excludes any National Indicator for which Targets will be for a 12 month period.

(2) Annual Targets will on entry to the Programme be recorded in the PHO's PHO Performance Plan, or agreed in writing by the DHB if the PHO has been participating in the Programme for greater than 12 months. Targets for the second 6 month Performance Period of an annual cycle will be adjusted according to the guidelines specified in the Referenced Document entitled “Indicator Definitions for PHOs”. All adjusted Targets must be approved by the DHB.

(3) The weightings and national funds applied to each National Indicator will remain nationally consistent to ensure a base level of equity and focus on national priorities.

(4) We agree to meet and review the PHO's Targets against each National Indicator as follows:

(a) In the first year of the PHO's participation in the Programme, Targets will be reviewed after 9 months from the PHO's commencement in the Programme, allowing for a full 6 months of data. Any new Targets for the next Performance Period (second 6 months) will be effective from the commencement of the next Performance Period. Targets for the following year will be determined using data from the previous 12 months (noting that the following year’s Targets may not be confirmed until after the next Performance Period has begun).

(b) Thereafter, for each of 2 subsequent Performance Periods will be set on the annual review date and be effective from the commencement of the next Performance Period (1 January or 1 July).

G.11 Utilisation review and feedback

(1) Utilisation review and feedback is a key strategy for achieving progress against Targets. We agree that primary care practitioners require feedback on their patients' health care utilisation, education on best practice, and population outcomes to:

(a) improve service delivery;

(b) improve health outcomes;

(c) achieve more equitable patterns of utilisation across population groups;

(d) highlight the utilisation patterns and requirements of high needs populations to help address inequalities;

(e) outline expenditure patterns; and

(f) ensure utilisation is in accordance with evidence based guidelines.

G.12 National resources

(1) The DHB will ensure that national resources (in respect of pharmaceutical prescribing and ordering of laboratory tests at both a practitioner and aggregate levels) are available for PHOs to support the requirements described in clauses G.7(2)(c) and G.7(2)(d), including:

(a) utilisation reports; and

(b) best practice educational materials.

The PHO may use these resources in a manner to suit its Contracted Providers, its facilitation methods and clinical governance framework. The PHO may undertake (or outsource) its own local analysis to supplement national resources.

G.13 Multi-faceted strategies

(1) The PHO will adopt a comprehensive, multi-faceted performance management approach that includes a mix of functions and activities (either in house or outsourced) and use, in addition to the activities described in clauses G.8(2)(c) and G.8(2)(d), some or all the following key activities, the precise mix and emphasis of which will be determined by the PHO:

(a) clinical facilitator visits and/or peer review groups to discuss diagnostic and treatment patterns, disease management strategies, and alignment with evidence based guidelines;

(b) programmes to implement relevant national guidelines;

(c) bulletins to Contracted Providers and Practitioners on best practice;

(d) incentives to encourage practitioner participation and performance; and

(e) electronic decision support to facilitate delivery of care to the individual patient that aligns with evidence based guidelines.

(2) The PHO may include alternative approaches if there is local evidence to suggest different approaches and alternatives to the activities listed in subclause (1).

G.14 Data reporting requirements

(1) The PHO will submit the following reports specified in Schedule B2 by the dates set out in the table below:

(a) Practitioner report (clause 2 of Schedule B2);

(b) Service utilisation report (clause 3 of Schedule B2);

(c) immunisation report (clause 5 of Schedule B2); and

(d) clinical performance indicator report (clause 4 of Schedule B2).

Service Date From	Service Date To	Report Submitted by
1 October	31 December	20 January
1 January	31 March	20 April
1 April	30 June	20 July
1 July	30 September	20 October

(2) As set out in the Referenced Document entitled “Indicator Definitions for PHOs”, the PHO will ensure that the data to measure progress against Indicators from sources other than the reports set out above is provided in accordance with the applicable reporting requirements.

G.15 Measuring performance against Targets

(1) The PHO's actual performance against its Targets in each Performance Period will be measured by the DHB's nominated agent via the PHO Performance Programme database.

(2) The database has been designed to:

(a) collate National Indicator data;

(b) report on performance against Targets; and

(c) calculate the Performance Payments.

(3) Quarterly reports on the PHO's progress towards Targets for National Indicators will be made available to the PHO and the DHB on the following dates.

Performance Quarter	Due Date
January – March	20 May
April – June	20 August
July – September	20 November

October – December	20 February

(4) The PHO Performance Programme quarterly and 6 monthly indicators reports will include report content showing aggregate numerator and denominator information to the report recipients as follows:

Report Recipients	Report Content				
	Practitioner	Practice	PHO	DHB	National
PHOs	Yes	Yes	Yes	Yes	Yes
DHBs		Yes (anonymous but able to be tracked)	Yes	Yes	Yes
Shared Support Agencies		Yes (anonymous but able to be tracked)	Yes	Yes	Yes
Ministry of Health			Yes	Yes	Yes
Public			Yes	Yes	Yes

(5) The report content is subject to the level of data available for each indicator.

(6) Public availability of performance data is further described in subclause G.22.

G.16 Performance Payments

(1) The PHO is eligible to receive Performance Payments when it meets the Programme Prerequisites and achieves progress towards and/or meets Targets.

(2) Performance Payments are based on a weighting against each National Indicator contained in the Referenced Document entitled “Indicator Definitions for PHOs”. The weightings:

(a) include higher weightings for high need populations; and

(b) reflect the equal weighting between equity, quality and affordability.

(3) To acknowledge shifts towards Targets against Benchmarks, a PHO whose expenditure is above its Benchmark will receive a Performance Payment if it moves its expenditure closer to the Target. A PHO that maintains its expenditure at or below its Benchmark will receive the full Performance Payment for that National Indicator.

(4) Subject to subclause (5), the PHO will receive Performance Payments for achieving progress towards its Targets on a percentage basis. If the PHO meets all Targets, its Performance Payment will be a maximum of $5.33 (excluding GST) per annum per Enrolled Person, as defined in the Referenced Document entitled "Enrolment Requirements for Primary Health Organisations".

(5) The majority of Targets and associated Performance Payments are for a 6 month Performance Period. New National Indicators (and their Targets) will be for a 12 month period.

G.17 Payment of Performance Payments

(1) Every 6 months, as detailed in the table below, the DHB will calculate and pay the PHO the Performance Payment instalment in accordance with clause G.16:

Performance Period	Payment due date
January – June	15 September
July – December	15 March

(2) The DHB will provide to the PHO a Buyer Created Tax Invoice (BCTI) for the Performance Payment.

(3) The Purchase Unit Code for the Performance Payments if PHOM0010.

(4) The PHO may only apply its Performance Payments in accordance with its PHO Performance Plan.

(5) The DHB's nominated agent will make available, at the PHO's request, the more detailed data (subject to data access outlined in subclause G.15(4)) used to calculate any indicator result and Performance Payment.

(6) The following clauses apply to the payment of any Performance Payments under this Part:

(a) clause F.16;

(b) clause F.18; and

(c) clause F.20.

G.18 Narrative reports and monitoring meetings

(1) The PHO will provide 6 monthly narrative reports to the DHB, including:

(a) the PHO's activities to implement its PHO Performance Plan;

(b) how the PHO has applied the Performance Payments; and

(c) issues arising in the implementation of the PHO's PHO Performance Plan.

(2) The DHB and the PHO agree to meet 9 months after the commencement date of the PHO's participation in the Programme, and thereafter will meet 6 monthly, to discuss the PHO's participation in the Programme and progress towards Targets.

G.19 The PHO will continue to meet Programme Prerequisites

(1) The PHO acknowledges that meeting the Programme Prerequisites is essential to support the Programme's monitoring and reporting framework. The PHO agrees to use its best endeavours to ensure that it continues to comply with the Programme Prerequisites.

(2) If the PHO believes it will not be able to comply with any of the Programme Prerequisites, the PHO will notify the DHB of the extent of the non-compliance and the reasons for that inability.

(3) Without limiting any rights under this Agreement, the PHO and the DHB will then discuss why the PHO is not able to comply with any of the Programme Prerequisites, and will seek to reach agreement to enable the PHO's continued participation in the Programme.

G.20 Alternative reporting and calculation processes

(1) If for any reason there are no data available to support the PHO Performance Programme database and payment system required to implement the procedures in this Part, we agree to:

(a) endeavour to identify the reason why data are not available;

(b) share relevant information we each have indicating the PHO's progress against Targets; and

(c) discuss and endeavour to agree on an appropriate level of Performance Payments.

(2) If the data is not available for reasons beyond the PHO's control, and the DHB has been unable to resolve the issue by the Payment Day (as specified in subclause G.17(1)), the DHB will Pay the PHO 75% of the maximum payment due for the Performance Period on the Payment Day.

(3) Subject to subclauses G.20(4) and G.20(5), the DHB will Pay the PHO the balance of the payment due to it (that is the total amount based on actual performance less the amount already paid under subclause G.20(2)) together with the PHO's next Performance Payment.

(4) Subject to subclause G.20(5), if the DHB has been unable to provide the PHO with a performance report within 20 Business Days of the report due date, the DHB acknowledges that the PHO will not have had sufficient data to manage its operation of the Programme, and accordingly the DHB will pay the PHO the remaining 25% of the total possible Performance Payment regardless of its actual performance for the Performance Period.

(5) If the reason the DHB has been unable to provide the PHO with a performance report is due to the PHO or its Contracted Provider(s) not supplying the required information in accordance with this Agreement, then:

(a) the DHB will provide the PHO with its performance report within 10 Business Days after receiving the data from the PHO; and

(b) if the quarter affected by the data delay aligns with a Performance Period and therefore affects the DHB's ability to calculate the PHO's Performance payment in accordance with clauses G.16(2)E and G.17(2), the DHB will pay the PHO for its performance in that Performance Period on the 15th of the following month, subject to the data being received by the 20th day of the month. If the data is received after the 20th day of the month, then payment will be made on the following month in accordance with the DHB's Payment Agent’s processing timeframes.

G.21 Future Indicator direction

(1) National Indicators will be developed and changed over time. The following provides a non-binding indication of likely future indicator direction.

(2) Future clinical indicators will contain more emphasis on the prevention and treatment of chronic conditions, particularly diabetes, cardiovascular disease and cancer (all priorities within the Primary Health Care Strategy).

(3) The data to support future National Indicators will be sourced from practice management systems.

(4) It is likely that the financial indicators will be expanded to include other diagnostic services.

(5) A further access indicator/s is likely to be added.

G.22 Public availability of initial performance data

(1) Public reporting is seen as an opportunity for the PHO to:

(a) increase its sense of ownership in, and accountability for the PHO's performance; and

(b) increase its profile within the community.

(2) After 15 months participation in the Programme, the DHB may make available to the public the PHO's performance data. This data will identify the PHO if the PHO is the only PHO within a DHB region. The DHB will provide the PHO with an opportunity to comment on its data prior to release.

G.23 Compliance with clauses F.27 and F.28

(1) For the purposes of subclause (e) of the definition of Programme Prerequisites, “compliance with the fees agreement set out in clauses F.27 and F.28 to Part F” means:

(a) that increased subsidy payments will result in low or reduced fees charged by the PHO and its Contracted Providers to Enrolled Patients and that those fees are fair to the providers and reasonable for the patients;

(b) if it is necessary to increase the level of fees at any time during the term of the Agreement, the PHO will advise the DHB of those increases and the reasons for those increases;

(c) if a fees increase is referred to a Fees Review Committee under clause F.27, the PHO will nominate a member to represent it, and a member to represent the relevant health providers;

(d) if the matter of a fee increase is referred to the dispute resolution processes in this Agreement, the PHO will participate in the dispute resolution process as required;

(e) the PHO will not charge a co-payment for Immunisation Services for which it (or a Contracted Provider) is receiving Payment under this Agreement;

(f) the PHO must display and ensure that Contracted Providers display a list of its charges to Service Users in a place where Service Users can readily see the charges;

(g) the PHO (and its Contracted Providers) will charge a lower fee for Services provided to Enrolled Persons who:

(i) are not included in the groups specified in clause F.27 or F.28; and

(ii) hold Community Services Cards or High Use Health Cards,

and the lower fees will be in accordance with the subsidy rates set out for Casual Users in clause 3(5) of Schedule F1.2; and

(2) The PHO will ensure that its Enrolled Population fees established under clause F.27 or F.28 are set irrespective of whether the patients or their families have a Community Services Card.

G.24 Exit from the Programme

(1) If after at least 18 months participation in the Programme, the PHO considers that it is no longer viable, financially or otherwise, for it to continue participating in the Programme, the PHO may give notice of its intention to exit from participation in the Programme, provided that the PHO gives the DHB 20 Business Days prior notice of its intention to do so.

(2) We agree that:

(a) the PHO may not give notice to exit under subclause (2) until the expiry of the 18 month minimum participation period; and

(b) the provisions of clause B.24 apply to the PHO's obligations under the Programme, and the PHO will notify the DHB promptly of any issues or problems arising in respect of the PHO's participation in the Programme and seek to remedy the matters notified before issuing any notice to exit under subclause G.24(2).

(3) If, due to changes in the national Programme, the DHB does not wish to continue to fund the Programme, it may give notice of its intention to terminate this Part for all PHOs affected by the change, provided that the DHB gives the PHO 6 months prior notice of its intention to do so.

SCHEDULE G1
DEVELOPMENT OF THE INTEGRATED PERFORMANCE AND INCENTIVE FRAMEWORK

1 Introduction

(1) We agree that the new integrated performance and incentive framework ("the **Framework**"):

(a) will be developed during 2013;

(b) will replace the existing PHO Performance Programme by 1 July 2014; and

(c) the objectives and content of the Framework, and way in which the Framework will be developed and agreed, are as set out below.

2 Objectives of the Framework

(1) The intent of the Framework is to drive greater clinical integration, improved performance and the delivery of care closer to home.

(2) While the Framework will focus on PHO and practice performance, it will be grounded in a 'whole of system' approach recognising that improved patient outcomes, as well as the clinical and financial sustainability of the health system requires (inter alia) both vertical and horizontal coordination and integration.

3 Content of the Framework

(1) PHO and provider performance will be measured using a small number of indicators. The intent is for there to be a 'line of sight' in terms of what DHBs, PHOs and practices are required to achieve and report on, thereby providing a 'whole of system' view.

(2) If appropriate, existing measures will remain. The development of any new indicators will consider the lead in required for implementation. Those indicators will be reflected in the monitoring arrangements for both PHOs and DHBs, which reinforces their joint accountability for improved primary health care performance.

(3) A three-tier Framework is envisaged along with accompanying elevated levels of access rewards. Performance will be encouraged and rewarded through a mix of financial and non-financial incentives. The mix of incentives includes:

(a) increasing and reorienting pay for performance; and

(b) extending the flexible funding pool for PHOs that meet certain performance criteria, and increasing the range and quality of services that can be accessed through primary care.

(4) The Framework will incorporate existing primary care audit processes, and will be aligned with the existing monitoring and intervention Framework that applies to DHBs. It is likely to include, but not be limited to:

(a) mandatory accreditation of practices;

(b) both financial and non-financial incentives;

(c) focus on encouraging local alliance arrangements;

(d) existing PHO Performance Programme measures;

(e) new measures that are yet to be developed;

(f) national health targets;

(g) operational rules for the Framework;

(h) monitoring and management arrangements; and

(i) governance arrangements.

4 Development of the Framework

(1) Nominations have been received from the sector for representation to contribute to two groups to provide advice to the Ministry as follows:

(a) an Expert Group to develop the Framework at a conceptual and strategic level, including giving consideration to the monitoring and management arrangements and on-going governance arrangements; and

(b) a wider technical group to review the output from the Expert Group and focus at a more detailed level how the Framework will be populated (indicators and incentives).

(2) The Ministry is due to report back to Cabinet on the development of the Framework in June 2013 and is aiming to complete the Framework by October 2013 for implementation by 1 July 2014.

5 Approval of the Framework

(1) Once developed and agreed by the Minister of Health, the Framework will be presented to the PHO Services Agreement negotiating parties.