

PHO Services Agreement

BETWEEN

[District Health Board]

AND

[PHO]

VERSION 4 (1 July 2016)

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

[insert name] District Health Board by:

Signature

Name

Position

Date

Witnessed by:

Signature

Name

Occupation

Residence

Date

[PHO name] by:

Signature

Signature

Name

Name

Position

Position

Date

Date

Witnessed by:

Witnessed by:

Signature

Signature

Name

Name

Occupation

Occupation

Residence

Residence

Date

Date

Contents

Part A . Background.....	1
A.1 Context of this Agreement.....	1
A.2 Purpose of this Agreement.....	1
A.3 The DHB's roles and responsibilities	2
A.4 The PHO's roles and responsibilities	2
A.5 PHO Functions.....	2
A.6 PHO Outcomes	3
A.7 Minimum requirements	3
A.8 How we will work together.....	3
Part B . General Terms	5
B.1 Term	5
B.2 Structure of this Agreement.....	5
B.3 Minimum Requirements.....	5
B.4 Reporting requirements.....	5
B.5 Referenced Documents	6
B.6 Māori health plan	6
B.7 Daily record, laboratory test, imaging, and pharmaceutical requirements.....	6
B.8 Enrolment with the PHO and Contracted Providers	6
B.9 Enrolments and Services must be in DHB's Primary Geographical Area	6
B.10 When Enrolments and Services may cross boundaries to a Secondary Geographical Area	7
B.11 Applications for Enrolments and Services in a Secondary Geographical Area	7
B.12 Consideration of applications	8
B.13 Review of decisions on applications.....	8
B.14 Subcontracting	9
B.15 Subcontracting with new Contracted Providers	9
B.16 Responsibility and liability for others	11
B.17 Section 88 Notice.....	11
B.18 Prohibition on incentives and inducements.....	11
B.19 Transfer of rights and obligations	12
B.20 Confidentiality.....	12
B.21 Public statements.....	13
B.22 Use of name, logo or fact of relationship.....	13
B.23 Variations to this Agreement.....	13
B.24 Procedure for Compulsory Variations	14
B.25 Procedure for National Voluntary Variations.....	15
B.26 Notification of problems	15
B.27 Audit of the PHO by the DHB	15
B.28 General Audit obligations.....	16
B.29 Notice of Audit	16

B.30 Carrying out an Audit.....	17
B.31 Outcome of an Audit	18
B.32 Audits after this Agreement is terminated	18
B.33 PHO financial Audits	18
B.34 Audit of Contracted Providers by the PHO	19
B.35 Audit of Contracted Providers by the DHB	19
B.36 Application of the Health Act 1956	19
B.37 Resolving disputes.....	19
B.38 Termination	21
B.39 The DHB's alternatives to termination	22
B.40 Withholding payments	22
B.41 Alternative arrangements on failure to Provide Services	23
B.42 Uncontrollable Events.....	24
B.43 Consequences of termination	24
B.44 Insurance.....	25
B.45 Warranty	25
B.46 Notices.....	25
B.47 Independent contractor	26
B.48 Miscellaneous terms	26
B.49 Construction	27
Schedule B1 Minimum Requirements	29
1..... Alliances	29
2..... Organisational governance	29
3..... Clinical leadership, engagement, and governance.....	30
4..... Māori health.....	30
5..... Service development and integration	31
6..... Service provision and reporting	32
7..... Workforce	33
8..... Quality.....	33
9..... Information management.....	34
10..... Emergency planning and response.....	35
Schedule B2 Reporting Requirements.....	37
1..... Reporting requirements.....	37
2..... Summary of the reports required	37
Schedule B3 Referenced Documents	38
1..... Purpose	38
2..... Technical specifications that are Referenced Documents	38
3..... Business rules that are Referenced Documents.....	38
4..... Audit Referenced Documents	38
5..... Other Referenced Documents.....	38

Part C . Nationally Consistent Services	40
C.1 Nationally Consistent Services	40
Schedule C1 First Level Services and Urgent Care Services	41
1..... First Level Services	41
2..... Urgent Care Services	42
3..... Provision of First Level Services and Urgent Care Services	42
4..... Access to First Level Services	43
5..... Access to Urgent Care Services	43
6..... Justification required if Services are not Provided	43
7..... Access to Population-based Health Services	43
8..... Access to Services for Casual Users	43
9..... Information about First Level Services provided to Casual Users	44
10..... Declining First Level Services.....	44
11..... Cessation of Services	44
12..... Information about access to Services.....	44
13..... Evidence of service levels	44
14..... Managing Referred Services	44
Schedule C2 General Medical Services	46
1..... Provision of and Claiming for General Medical Services.....	46
2..... When General Medical Services may be Provided	46
3..... Where General Medical Services may be Provided	46
4..... How General Medical Services may be provided	47
5..... Information about General Medical Service consultations	47
6..... Monitoring provision of General Medical Services	47
7..... Managing provision of General Medical Services.....	48
8..... Review of General Medical Service Claims	48
9..... Review of General Medical Service provisions in this Agreement	49
10..... Services that are General Medical Services	49
Schedule C3 Immunisation Services	51
1..... Service objectives	51
2..... Immunisation Services	51
3..... Quality requirements.....	52
4..... Requirements for administering vaccines	52
Schedule C4 [PLACEHOLDER]	53
1..... [insert].....	53
Schedule C5 Special Support Services for Former Sawmill Workers Exposed to PCP	54
1..... Background.....	54
2..... Providing Special Support Services to Eligible Persons	54
3..... Special Support Service components	54
4..... Annual health checks.....	54

5.....	Referred Services including genetic counselling	55
6.....	Charges for Special Support Services	55
7.....	Collection, use, and disclosure of patient information	55
8.....	Information and monitoring requirements.....	56
	Schedule C6 Health Support Services for Dioxin-Exposed People	57
1.....	Background.....	57
2.....	Providing Health Support Services to Eligible Persons.....	57
3.....	Health Support Services components	57
4.....	Annual health checks.....	57
5.....	Referred Services	58
6.....	Serum dioxin test	58
7.....	Foetal neural tube defect screening and genetic counselling.....	59
8.....	Charges for Health Support Services.....	59
9.....	Collection and use of patient information	59
10.....	Information and monitoring requirements.....	60
	Part D. Alliance Services	61
D.1	Providing management services, health promotion services, services to improve access, Care Plus Services, and Rural Funding before they are moved into the scope of our Alliance Agreement	61
D.2	Moving funding for management services, health promotion services, services to improve access and Care Plus Services into the scope of our Alliance Agreement	61
D.3	Moving Rural Funding into the scope of our Alliance Agreement	61
D.4	Conditions of moving Rural Funding into the scope of our Alliance Agreement	62
D.5	Services funded from the flexible funding pool but provided outside the scope of our Alliance Agreement	63
D.6	Variations to the flexible funding pool schedules	63
D.7	Variations to the Rural Funding schedules	63
D.8	Procedure for variations to implement Alliance Recommendations	64
D.9	Alliance dispute process	64
	Schedule D1 Management Services, health promotion services, services to improve access, and care plus services	65
1.....	Management Services	65
2.....	Health promotion services	65
3.....	Access for High Need Persons	65
4.....	Care Plus Service objectives.....	65
5.....	Assessing eligibility for Care Plus Services.....	66
6.....	Care to be delivered to Care Plus Patients	66
7.....	Reassessment for continued eligibility to receive Care Plus Services	67
8.....	Support and administrative services for Care Plus	67
9.....	Quality requirements for Care Plus Services	68
10.....	Proposed Care Plus Services.....	68
11.....	Care Plus fees assurance framework.....	68

Schedule D2 Rural funding	70
1..... Rural Funding	70
2..... Rural Funding components.....	70
3..... Workforce retention funding	70
4..... Reasonable roster funding	71
5..... Remote rural practice area funding	71
6..... The rural bonus	72
7..... Rural After Hours funding	72
8..... Rural sustainability support payments	72
9..... Priority uses of Rural Funding	72
10..... Rural workforce strategies	73
Schedule D3 Services within the Scope of our Alliance	74
1..... [Insert].....	74
Schedule D4 rural funding within the scope of our alliance.....	75
1..... Rural Funding	75
Schedule D5 Services Outside the Scope of Our Alliance	76
1..... [Insert] or [not applicable]	76
Part E . Local Services	77
E.1 Local Services	77
Schedule E1 [(Local Services)]	78
Part F . Claiming and Payments	79
F.1 Right to charge	79
F.2 Reducing financial barriers to accessing Services	79
F.3 Payment for Services	79
F.4 DHB may pay Contracted Providers directly	79
F.5 Goods and Services Tax.....	80
F.6 Claiming restrictions	80
F.7 National Enrolment Service.....	81
F.8 Claims for General Medical Services and Immunisation Services.....	81
F.9 Timing of fee for service Claims	83
F.10 Rejection of fee for service Claims.....	83
F.11 Resubmission of fee for service Claims	83
F.12 Timing of payments.....	83
F.13 Form of payment	84
F.14 Over and under payments	84
F.15 Incorrect payments	84
F.16 Default Interest on late payments	84
F.17 Notice of intention to charge Default Interest	85
F.18 Recovery of monies Claimed in breach of this Agreement and costs	85
F.19 Set-off	86

F.20 Payment rules subject to requirements in Referenced Documents	86
F.21 Payment rates increases	86
F.22 Fees framework - level policy and charges to Service Users	87
Schedule F1.1 Payment for First Level Services	92
1..... Payments for First Level Services	92
2..... Capitation payments for non-Access Practices	92
3..... Capitation payments for Access Practices.....	93
4..... Deductions to capitation payments for First Level Services	93
5..... Very low cost access payments.....	94
6..... Patient access subsidy payments	95
7..... Very low cost access sustainability support payments	96
8..... Zero fees for under 13s payments	97
9..... Zero fees for under 6s payments	98
Schedule F1.2 Payment for General Medical Services.....	100
1..... Payments for General Medical Services	100
2..... Claiming for General Medical Services	100
3..... Fees for General Medical Services	100
4..... Charging Casual Users for General Medical Services	101
5..... Deceased Casual Users and Casual Users rejecting Services.....	101
Schedule F1.3 Payment for Immunisation Services	102
1..... Payments for Immunisation Services	102
2..... One payment only	102
3..... Fees.....	102
4..... Conditions of payment.....	103
5..... Influenza vaccines	103
Schedule F1.4 [placeholder].....	104
1..... [insert].....	104
Schedule F1.5 Payment for Special Support Services for Former Sawmill Workers Exposed to PCP	105
1..... Payment for Special Support Services	105
2..... Fees and Claiming requirements	105
3..... The Claiming and payment process.....	105
Schedule F1.6 Payment for Health Support Services for Dioxin-Exposed People	106
1..... Payment for Health Support Services	106
2..... Fees and Claiming requirements	106
3..... The Claiming and payment process.....	106
Schedule F2.1 Payments for Management Services, Health Promotion Services, Services to Improve Access, and Care Plus Services	107
1..... Payments made under this Schedule before we agree to use funding to implement Alliance Recommendations	107
2..... Payments made under this Schedule after we agree to use funding to implement Alliance Recommendations	107

3.....	Management services payments	107
4.....	Health promotion services payments	108
5.....	Services to improve access for High Need Persons payments	108
6.....	Calculating expected Care Plus population	109
7.....	Payment for Care Plus Services	109
	Schedule F2.2A Payment OF Rural FUNDING	111
1.....	Rural Funding payments	111
2.....	Workforce retention funding	111
3.....	Reasonable roster funding	111
4.....	Remote rural practice areas funding	111
5.....	Rural bonuses payments	112
6.....	Rural After Hours funding payments	112
7.....	Rural sustainability support payments	112
	Schedule F2.2B [Payment OF RURAL FUNDING within the scope of our alliance]	113
1.....	[Insert].....	113
	Schedule F2.3 Payment for services outside the scope of our alliance	114
1.....	[Insert] or [not applicable]	114
	Schedule F3.1 [Payment for (Local Services)]	115
1.....	[Insert] or [not applicable]	115
	Part G. Value and High Performance Schedule	116
G.1.....	Background.....	116
G.2.....	System Level Measures and National Health Targets	117
G.3.....	Developing an Improvement Plan and Local Plans within our Alliance	118
G.4.....	Agreeing and submitting an Improvement Plan.....	119
G.5.....	Ministry approval of the Improvement Plan.....	119
G.6.....	Implementing the Improvement Plan and other obligations.....	120
G.7.....	Information requirements	121
G.8.....	Payments.....	121
G.9.....	Performance Payment for 2016/17	122
G.10....	Payments of Funding, including the Performance Payment	123
G.11....	Direct financial benefit for Contracted Providers	124
	Part H. Definitions	125
H.1	Definitions	125

Part A Background

A.1 Context of this Agreement

- (1) The Government wishes to continually improve the delivery of primary health care services through the development and implementation of the New Zealand Health Strategy and other policy and strategy initiatives related to the delivery of health care services. The New Zealand Health Strategy has five themes that guide the direction of health in New Zealand, which are:
 - (a) people powered;
 - (b) closer to home;
 - (c) value and high performance;
 - (d) one team; and
 - (e) smart system.
- (2) 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 purposes of which are to:
 - (a) give leaders from across the local health sector greater freedom to jointly determine service priorities and models of care in their districts and regions; and
 - (b) drive clinically-led service integration.
- (3) At the commencement of this Agreement, we are participants in the [name] Alliance (Alliance) and in the Alliance Leadership Team that governs the Alliance.
- (4) We have entered into this Agreement for the purpose of:
 - (a) implementing the Government's current and future policy objectives relating to the delivery of health care services, including the objectives reflected in the five themes of the New Zealand Health Strategy; and
 - (b) setting out the roles, functions, and accountabilities of DHBs, PHOs, and Contracted Providers in delivering health care services, and the commitment that we have made to work together 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;
 - (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, the achievement of the System Level Measures described in Part G – Value and High Performance, 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) continue to maintain the strong accountability of primary health organisations and contracted providers to continuously improve performance through the measurement of their achievement against quality improvement indicators and national health targets, and the recognition of this performance through the System Level Measures;
- (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, through signatures or letters, 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 and agreement 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) Schedule B1 sets out the Minimum Requirements that the PHO must meet from the Start Date of this Agreement and must continue to meet on an ongoing basis. The Minimum Requirements relate to the PHO's structural and governance arrangements, require the PHO to be able to demonstrate a high level of clinical leadership and engagement and an advanced level of capacity and capability, and require the PHO to undertake certain activities. Participation in our Alliance is intended to assist the PHO meet the Minimum Requirements.

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) work together to resolve any issues, disputes and disagreements in a manner that reflects our co-operative and collaborative relationship;
- (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 came 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 effective date of this version of the Agreement, which consolidates all previous versions of the Agreement, is the date specified on the cover page of this Agreement.

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 and Contracted Providers in respect of the Services, and claims for Services provided;
 - (g) Part G – Value and High Performance – sets out the terms relating to System Level Measures, through which the performance of the PHO and its Contracted Providers is monitored; and
 - (h) Part H sets out definitions of words and phrases used in this Agreement.

B.3 Minimum Requirements

- (1) The PHO will have the capacity and capability to comply with, and will comply with, the Minimum Requirements set out in Schedule B1.
- (2) Schedule B1 also sets out objectives that each Minimum Requirement is aimed at, however those objectives are included to provide context only, and are not requirements with which the PHO must comply.

B.4 Reporting requirements

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

B.5 Referenced Documents

- (1) The DHB and the PHO agree to comply with the requirements set out in each Referenced Document listed or described in Schedule B3.
- (2) The DHB will, on request by the PHO, provide the PHO with copies of each Referenced Document and any variations to a Referenced Document, and will make copies of each Referenced Document available on the DHB Shared Services website at www.dhbsharedservices.health.nz (or any other website advised by the DHB from time to time).

B.6 Māori health plan

- (1) We will work together to develop the DHB's Māori health plan in accordance with any relevant guidelines or other document issued by the Ministry.

B.7 Daily record, laboratory test, imaging, and pharmaceutical requirements

- (1) The PHO will comply with, and will ensure that its Contracted Providers comply with, the requirements set out in the Referenced Document entitled "Daily record, laboratory tests, diagnostic imaging services, and pharmaceutical requirements".

B.8 Enrolment with the PHO and Contracted Providers

- (1) The PHO and its Contracted Providers must comply with the requirements set out in the following Referenced Documents in respect of the enrolment of each Enrolled Person:
 - (a) the Referenced Document entitled "Enrolment Requirements for Providers and Primary Health Organisations";
 - (b) the Referenced Document entitled "Business Rules: Capitation-based funding"; and
 - (c) from the NES Start Date, the Referenced Document entitled "Business Rules: National Enrolment Service: Capitation Based Funding".

B.9 Enrolments and Services must be in DHB's Primary Geographical Area

- (1) The PHO, through its Contracted Providers, may enrol Eligible Persons at practices that are located in the DHB's Primary Geographical Area, and Provide the Services from such practices.
- (2) The PHO must Provide the Services at the location(s) specified below:

[Delete whichever options are not relevant]

 - (a) *[the DHB's Primary Geographical Area]*
 - (b) *[insert location(s)]*
- (3) The PHO, through its Contracted Providers, may enrol an Eligible Person who lives in a Secondary Geographical Area if the practice from which the Services are to be provided to the Eligible Person is located in the DHB's Primary Geographical Area.

B.10 When Enrolments and Services may cross boundaries to a Secondary Geographical Area

- (1) The PHO, through its Contracted Providers, may enrol Eligible Persons (whether they live in the DHB's Primary Geographical Area or a Secondary Geographical Area) and Provide the Services from a practice located in a Secondary Geographical Area only if:
 - (a) the PHO has submitted an application in accordance with clause B.11; and
 - (b) the application has been approved in accordance with clause B.12 or B.13.
- (2) For the purposes of this clause and clauses B.11 to B.13, the PHO is deemed to be providing the Services from a practice located in a Secondary Geographical Area if:
 - (a) the PHO, a Contracted Provider, or a subcontractor to a Contracted Provider enters into a contract or arrangement with a PHO or provider located in the Secondary Geographical Area; and
 - (b) the effect of the contract or arrangement is that the Eligible Persons who are receiving Services from practices located in the Secondary Geographical Area are enrolled with the PHO.

B.11 Applications for Enrolments and Services in a Secondary Geographical Area

- (1) If the PHO wants to Provide Services from one or more practices located in a Secondary Geographical Area in accordance with clause B.10, the PHO must apply in writing to the DHB and the DHB responsible for the Secondary Geographical Area.
- (2) The application must include the following information:
 - (a) the Secondary Geographical Area where the PHO proposes to provide Services;
 - (b) the name of each practice to which the application relates;
 - (c) the type of Services that the PHO proposes to provide in the Secondary Geographical Area;
 - (d) the reasons why the PHO considers that the DHB should approve its application, including information about how the Provision of Services by the PHO in the Secondary Geographical Area will:
 - (i) promote access equity and choice for people living in the Secondary Geographical Area;
 - (ii) better meet the needs of such people than the Services that are currently provided in the Secondary Geographical Area;
 - (iii) contribute to achieving the most effective and efficient delivery of health services in a way that meets local, regional, and national needs;
 - (iv) positively contribute towards the Government's policy objective of providing for and encouraging collaboration between DHBs, PHOs, Contracted Providers, and other primary and community partners in the delivery of integrated health care services; and

- (v) promote, or at least not discourage, the integration of health services in the Secondary Geographical Area, particularly in respect of primary and secondary health care services.
- (3) If either DHB to which an application is made requests that the PHO provide additional information in relation to its application (except financial and pricing information), the PHO must provide the information requested.

B.12 Consideration of applications

- (1) This clause applies if the DHB receives:
 - (a) an application from the PHO to provide Services in a Secondary Geographical Area; or
 - (b) an application from a PHO that is contracted with another DHB to provide Services in the DHB's Primary Geographical Area.
- (2) The DHB must consider the application and, in particular, must:
 - (a) work collaboratively with the other DHB to make a decision on the application, and attempt to reach a common position on whether the application should be approved or declined;
 - (b) have and consistently apply a transparent decision-making framework in respect of all applications it receives;
 - (c) if the DHB considers it is appropriate, consult other PHOs on the application;
 - (d) make a decision on the application no later than 20 Business Days after having received the application; and
 - (e) if the application is declined, provide the applicant PHO with the reasons for the decision.
- (3) For the purposes of this clause, an application will be declined if either DHB to which the application relates declines the application.

B.13 Review of decisions on applications

- (1) If the DHB declines an application, the applicant PHO may request a review of that decision.
- (2) The applicant PHO must advise the DHB of the grounds on which the PHO is requesting a review.
- (3) The DHB must, working collaboratively with the other DHB, complete the review and decide whether to confirm its original decision to decline the application or approve the application no later than 20 Business Days after the day on which the DHBs received the request for a review.
- (4) If the application is declined, the DHB must provide the applicant PHO with the reasons for the decision.
- (5) For the purposes of this clause, an application will be declined if either DHB to which the application relates declines the application.

B.14 Subcontracting

- (1) The PHO may subcontract all or any of the Services, provided that the PHO uses its best endeavours to ensure that any Contracted Provider who is a Practitioner, or any Practitioner employed or contracted by a Contracted Provider to provide the Services, has the qualifications, accreditation, experience, competency and availability necessary to enable it to perform the subcontracted Services in accordance with this Agreement.
- (2) The PHO will ensure that each subcontract it enters into in accordance with subclause (1):
 - (a) requires, if relevant, that the Contracted Provider's Health Practitioners hold an annual practising certificate and are registered with 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;
 - (d) provides that the PHO has the right to recover, including by way of set-off against any payments due to the Contracted Provider who is a Practitioner, or any Practitioner employed or contracted by a Contractor Provider to Provide the Services, 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; and
 - (e) includes any clauses that we agree from time to time must be included in all subcontracts.
- (3) The DHB may require the PHO to:
 - (a) 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 this Agreement;
 - (b) terminate any subcontract the PHO has with a Contracted Provider for the provision of the Services under this Agreement if the Contracted Provider has Claimed a payment in breach of this Agreement unless the payment was Claimed in breach because of an honest error or oversight, and the breach is of minor consequence; and
 - (c) recover any payments to a Contracted Provider that were made in breach of this Agreement.

B.15 Subcontracting with new Contracted Providers

- (1) The PHO will:
 - (a) 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, including by giving the DHB the following information about the provider:

- (i) the provider's name;
 - (ii) the location or locations from which the provider will provide the Services; and
 - (iii) the demographic profile of the provider's enrolled population (if the provider has an enrolled population);
 - (b) if the provider is proposing to provide the Services from a Secondary Geographical Area, complete and provide to the DHB and the other relevant DHB an application in accordance with clause B.11; and
 - (c) subject to subclause (2), provide the DHB with any other information that the DHB reasonably requests in relation to the provider.
- (2) The PHO is not required to provide the DHB any:
- (a) pricing or financial information, except information that the DHB would otherwise have access to under clauses B.27 to B.36; 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.
- (3) If the DHB receives a notification under subclause (1) that relates to a provider that has previously contracted with another PHO, the DHB must advise the PHO the provider previously contracted with that the DHB has received such a notification.
- (4) The DHB will notify the PHO if the DHB objects to a provider within 20 Business Days of receiving the notification under subclause (1), and will discuss with the PHO the reasons for objecting to the provider.
- (5) The PHO or Contracted Provider 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 provider's ability to perform the Services in any material respect as required by this Agreement; or
 - (b) if the provider is proposing to provide the Services from a Secondary Geographical Area, the location at which the provider would Provide the Services, provided that the DHB has considered the application with the other relevant DHB as set out in clause B.12, and reviews its decision on the application in accordance with clause B.13 if requested by the PHO.
- (6) Each subcontract the PHO or a Contracted Provider enters into 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 (1), unless the PHO and DHB agree that the subcontract may come into effect on an earlier date.

B.16 Responsibility and liability for others

- (1) Each of us is responsible and liable in all respects for the acts and omissions of our employees, Contracted Providers, contractors, agents (including the Payment Agent) and other personnel in performing or complying (or failing to perform or comply) with our obligations under this Agreement, including in relation to the Provision of Services.

B.17 Section 88 Notice

- (1) As set out in clause F.6(5), a Contracted Provider who is entitled to receive a payment for services under this Agreement and a Section 88 Notice must Claim under this Agreement and may not make a claim under the Section 88 Notice.
- (2) 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 contracting with or being employed by the PHO or a Contracted Provider, held an active Section 88 Notice, that Medical Practitioner will remain eligible to hold that Section 88 Notice even if it has expired, and will be entitled to move back onto that Section 88 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.
- (3) The entitlement to reactivate a Section 88 Notice described in subclause (2) 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 DHB's geographic area.
- (4) 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 contracting with or being employed by the PHO or a Contracted Provider held one or more active Section 88 Notices, the Contracted Provider will remain eligible to hold the same number of Section 88 Notices even if they have expired, and will be entitled to reactivate those Section 88 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 Notices applied.
- (5) If one of the PHO's Medical Practitioners leaves the PHO and that Medical Practitioner did not hold an active Section 88 Notice prior to contracting with or being employed by the PHO or a Contracted Provider, he or she will not be entitled to move onto a Section 88 Notice and will need to apply to the DHB under the appropriate criteria for accessing Section 88 Notices.
- (6) For the purpose of this clause, the term "prior to joining the PHO" includes the situation where a Medical Practitioner held a Section 88 Notice immediately prior to joining a Primary Care Organisation (PCO), and joined the PHO directly from that PCO.

B.18 Prohibition on incentives and inducements

- (1) The PHO and its Contracted Providers must not, either directly or indirectly, accept gifts, hospitality, or any other benefit from a Referred Service provider if doing so could reasonably be

seen as an incentive or inducement that places the PHO or Contracted Provider under an obligation to give preference to the Referred Service provider.

B.19 Transfer of rights and obligations

- (1) Neither of us will assign nor transfer to any other person any or all of our rights or obligations under this Agreement without first obtaining the other party's written consent (which will not be unreasonably withheld).
- (2) The transfer or assignment of either of our rights or obligations under 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 the transfer or assignment; or
 - (b) the operation of any provisions in this Agreement that are expressed or implied to have effect after the transfer or assignment has occurred.
- (3) 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.20 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.21 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 using 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.22 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 relationship between us in any advertising or for any other promotional purpose without the prior written consent of the other.

B.23 Variations to this Agreement

- (1) This Agreement may be varied, including by the addition, amendment, or removal of a Referenced Document, in the following ways:
 - (a) in order to give effect to any Crown Direction, law change, or payment rate increase pursuant to clause F.21, in accordance with clause B.24 (a Compulsory Variation);
 - (b) by agreement reached in accordance with clause B.25 (a National Voluntary Variation);
 - (c) in respect of Alliance Services, in accordance with clauses D.6 to D.9;
 - (d) in respect of Local Services, by mutual agreement which must be in writing and signed by both of us; and
 - (e) as otherwise set out in this Agreement.
- (2) 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 in accordance with the PSAAP Protocol or through any other process we agree.
- (3) 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.37 and until resolution, the PHO will not be required to use the varied template or format for reports.

B.24 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 the 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 is written to give effect to the relevant Crown Direction, law change, or fee 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 variation has the potential to result in 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 variation on the PHO; and
 - (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:** Unless the DHB is precluded from doing so because there is insufficient time to seek the PHO's comments before the relevant Crown Direction, law change, or fees increase comes into effect, the DHB will specify a period of time that is reasonable in the circumstances, being at least 20 Business Days, within which the PHO must provide its comments on the proposed draft of the variation (if any) to the DHB. After that period has expired or the PHO has provided its comments, we will seek to agree on the terms of the variation. The DHB will consider the PHO's comments, 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 on the day that 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 that the DHB has agreed with the PHO, on the day that the relevant Crown Direction, law change or fees increase comes into effect.
- (6) **If provision of the Services is no longer viable:** If this Agreement is varied in accordance with subclause (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, the period of such notice to be reasonable in the circumstances, considering the impact of the variation on the PHO and the impact of the termination on the DHB.

B.25 Procedure for National Voluntary Variations

- (1) Subject to subclause (2), this Agreement will be reviewed by the PSAAP Group through a national review process that considers proposals to vary the PHO Services Agreement, in accordance with the PSAAP Protocol. The review 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;
 - (b) Part E; and
 - (c) the provisions of Part F that relate to Local Services.
- (3) If the PSAAP Group makes a binding decision to approve a proposal to vary this Agreement in accordance with the PSAAP Protocol, the variation will commence on the date agreed by the PSAAP Group and notified to the DHB and the PHO by the PSAAP Group Secretariat.
- (4) If this Agreement is varied in accordance with subclause (3), and the PHO believes that it will not be able to deliver any of the Services as required by this Agreement because of the variation:
 - (a) 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; and
 - (b) without limiting either of our rights under this Agreement, we will discuss the reasons why the PHO is prevented from performing those Services and will seek to agree on changes to the PHO's level of Service provision.

B.26 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, serious non-compliance with an obligation under this Agreement, and 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 will discuss with the other possible ways of remedying the matters notified, and will work together to resolve the matters in a manner that reflects our collaborative and co-operative relationship and the relationship principles set out in clause A.8.

B.27 Audit of the PHO by the DHB

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

- (2) The DHB will carry out each Audit in accordance with:
 - (a) the requirements set out in clauses B.28 to B.33; and
 - (b) the relevant Audit Protocol.

B.28 General Audit obligations

- (1) We agree that, for any Audit, we will comply with the following obligations:
 - (a) we will both participate in the Audit in a manner consistent with the principles of natural justice, and the principles set out in this clause;
 - (b) the PHO will co-operate with the DHB and ensure that its Contracted Providers co-operate with the DHB, and will provide 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;
 - (c) the Audit will be conducted promptly, and include active participation from us both; and
 - (d) we both will provide accurate information and prompt responses to all relevant queries, unless a prompt response would prejudice the integrity of the Audit.
- (2) If an Audit includes a Contracted Provider, the PHO must ensure that the Contracted Provider complies with the obligations described in this clause as if this clause applied to the Contracted Provider as it applies to the PHO.

B.29 Notice of Audit

- (1) Subject to subclauses (2) and (3), the DHB will give the PHO at least 30 Business Days' notice of the DHB's intention to carry out an Audit, except that the DHB and PHO may agree that the Audit will be carried out on a day that is less than 30 Business Days from the date of notice.
- (2) The DHB may give the PHO less than 30 Business Days' notice or no notice of the DHB's intention to carry out an Audit, provided that:
 - (a) the amount of notice given by the DHB is reasonable in the circumstances; and
 - (b) the DHB has reasonable grounds to believe that:
 - (i) there has been a material breach of this Agreement;
 - (ii) a delay of 30 Business Days would unreasonably prejudice the integrity of the Audit;
or
 - (iii) 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 without giving notice.

- (4) The notice of Audit will include:
 - (a) the anticipated scope of the Audit;
 - (b) the name of the Auditor or Auditors;
 - (c) the Auditor's or Auditors' qualifications (if any); and
 - (d) a declaration from the Auditor or Auditors of any conflicts or potential conflicts of interest.
- (5) The DHB will ensure:
 - (a) that any Auditor it appoints is suitably experienced, competent, has an appropriate background given the nature of the Services Provided and the type of Audit being conducted, and carries out his, her, or its work in a professional manner; and
 - (b) that if the content of clinical records is being audited for clinically-related matters, the Auditor or member of the Audit team who Audits the clinical records is a suitably qualified clinician.
- (6) If the PHO has any reasonable concerns about the scope of an Audit or any person or agency appointed as an Auditor, except in relation to an Audit conducted in accordance with subclause (2) or (3), the PHO may bring those concerns to the DHB's attention in writing within 10 Business Days after receiving the notice of Audit, and the DHB will discuss those concerns with the PHO and respond to it in writing before commencing the Audit.

B.30 Carrying out an Audit

- (1) An Audit may involve a variety of activities including, without limitation, conducting investigations or on-site audits at the PHO's or a Contracted Provider's Premises, and surveying Service Users and Contracted Providers.
- (2) The DHB will ensure that an Audit is carried out in a way that:
 - (a) minimises disruption to the Services;
 - (b) takes into account relevant safety considerations; and
 - (c) displays appropriate sensitivity to the privacy and dignity of Service Users seen in the course of an onsite audit.
- (3) The PHO and each Contracted Provider who is a subject of an Audit will co-operate with the DHB for the purposes of, and during the course of, the Audit and will allow or arrange for the Auditor to have access to:
 - (a) the PHO's and 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 relate to the Services and this Agreement, the Service Users and their representatives (if relevant); and
 - (c) the PHO and Contracted Provider's Staff.

- (4) The PHO and its Contracted Providers will take reasonable steps to ensure that the Auditor has access to Service Users and their representatives (if relevant), for interviews about the Services.
- (5) In respect of onsite audits at the PHO or a Contracted Provider's Premises, we agree that:
 - (a) the Auditor may visit the Premises and have access to the Records at any time during Regular Hours, or any other time agreed by the PHO or Contracted Provider; unless an exception described in clauses B.29(2) and B.29(3) applies, the onsite audit will be undertaken at a time that is reasonably convenient for the PHO and Contracted Provider; and
 - (b) the PHO and the Contracted Provider may have a person present during an onsite audit.
- (6) The DHB may make copies of any Record for the purposes of an Audit, except to the extent that it is prohibited from doing so by law.

B.31 Outcome of an Audit

- (1) The DHB will provide the PHO with a draft and a final Audit report in accordance with the relevant Audit Protocol.
- (2) If an Audit results in recommendations, we will each take reasonable steps to implement the recommendations and any agreed follow-up processes.

B.32 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.33 PHO financial Audits

- (1) We acknowledge and agree that the purpose of a PHO financial Audit is to:
 - (a) monitor the use of public funding paid to the PHO, including funding paid for Services Provided under this Agreement;
 - (b) confirm that the PHO is and will continue to be a Not for Profit organisation; and
 - (c) identify whether the PHO is solvent.
- (2) If the DHB has a concern regarding the PHO's use of funding, whether the PHO is a Not for Profit organisation, or solvency, the DHB may request by notice to the PHO, and the PHO must provide to the DHB within 20 Business Days after receipt of the notice, a certificate from a suitably qualified person certifying information about the PHO's use of funding, the PHO's solvency, or 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 about its use of public funding;
 - (b) any other matters relevant to assessing whether the PHO is a Not for Profit organisation; and

- (c) whether the PHO is solvent.

B.34 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 enrolment of persons on the NES 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.35 Audit of Contracted Providers by the DHB

- (1) The DHB may Audit a Contracted Provider's provision of Services in accordance with:
 - (a) the requirements set out in clauses B.27 to B.31 and clause B.35; and
 - (b) the relevant Audit Protocol
- (2) For the purposes of an Audit carried out in accordance with subclause (1):
 - (a) the requirements in the clauses listed in subclause (1)(a) and the Audit Protocol apply to the Contracted Provider in the same way that they apply to the PHO; and
 - (b) unless the context otherwise requires, all references to the PHO in those clauses and the Audit Protocol are read as references to the Contracted Provider.

B.36 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 the Contracted Provider 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.37 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 either party reasonably considers that proceedings are necessary to preserve its rights.
- (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 of the nature of the dispute; and

- (b) we will each use our best endeavours to resolve the dispute by agreement, including by working together to resolve the dispute in a manner that reflects our collaborative and co-operative relationship and the relationship principles set out in clause A.8.
- (3) **Mediation:** If the dispute is not settled by agreement within 20 Business Days after receipt of the notice of dispute, unless we agree otherwise in writing, we will participate in mediation, and the following provisions apply:
 - (a) the mediation will be conducted under the LEADR New Zealand Incorporated ("LEADR") standard mediation agreement;
 - (b) if we do not agree on a mediator within 5 Business Days after receipt of the notice of mediation, the mediator will be appointed by the chair of LEADR (or his or her nominee) at the request of either of us; and
 - (c) we will share the costs of the mediator's fees equally.
- (4) **Arbitration:** If the dispute is not settled by agreement within 30 Business Days after the appointment of the mediator, unless we agree otherwise in writing, the dispute will be referred to arbitration and the following provisions apply:
 - (a) the arbitration will be conducted by a single arbitrator under the Arbitration Act 1996; and
 - (b) if we do not agree on an arbitrator within 5 Business Days after receipt of the notice of arbitration, the arbitrator will be appointed by the President of the New Zealand Law Society (or his or her nominee) at the request of either of us.
- (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 if they are disputed, in which case the PHO is not obliged to Provide any Services for which the DHB has withheld payments 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 clauses B.38(2)(b), B.38(2)(c), or B.38(2)(e);
 - (c) any dispute as to whether a service is a General Medical Service, or whether any amount, and if so what amount, is payable by the DHB for a General Medical Service; or

- (d) any matter that is subject to a current Audit, except a dispute over an Audit report if the Audit has been completed; or
- (e) any matter that 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.38 Termination

- (1) **Uncontrollable Events:** This clause does not apply if a failure to perform is caused by an Uncontrollable Event, which must be dealt with under clause B.42.
- (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;
 - (b) the DHB has reasonable grounds to believe that the health or safety of any person or Enrolled Population is at risk, except that if the risk is isolated to a Contracted Provider, the DHB may not terminate this Agreement under this paragraph (b), but may require the PHO to terminate its subcontract with the Contracted Provider.
 - (c) the PHO fails to carry out any of its obligations in this Agreement and the failure is material and cannot be remedied;
 - (d) 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 20 Business Days of receiving notice of the failure from the DHB; or
 - (e) an Insolvency Event occurs.
- (3) **DHB will engage with the PHO before termination:** Before giving notice of termination of this Agreement under subclauses (2)(a) to (2)(e), the DHB must advise the PHO of its intention to terminate this Agreement. The DHB and the PHO will discuss the DHB's intention to terminate in a manner that reflects our collaborative and co-operative relationship and the relationship principles set out in clause A.8.
- (4) **Health and safety risk:** If the DHB advises the PHO that it intends to terminate this Agreement under subclause (2)(b):
 - (a) the DHB may immediately require the PHO to cease Providing the relevant Services and, in that event, the DHB will not pay the PHO for those Services; and
 - (b) if the DHB decides that the PHO should recommence Providing the relevant Services, the DHB will pay the PHO for providing the Services from the date that Service Provision recommences.
- (5) **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 a fraudulent act.

- (6) **Fraud by a Contracted Provider:** If a Contracted Provider is formally charged with a fraudulent act:
- (a) the DHB may require that the PHO immediately cease paying the Contracted Provider to provide Services, in which case;
 - (i) if the Contracted Provider is found guilty, the DHB may require the PHO to terminate its subcontract with the Contracted Provider; but
 - (ii) if the Contracted Provider is found not guilty or the proceedings are discontinued, the PHO may recommence paying the Contracted Provider to Provide the Services;
 - (b) the PHO will immediately demonstrate that the PHO had appropriate and reasonable systems in place to detect and prevent such fraud; and.
 - (c) nothing in this subclause prevents the DHB from exercising any other rights it may have under this Agreement that relate to the Contracted Provider.
- (7) **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 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 terminate this Agreement.
- (8) **Our rights:** Nothing in this clause affects any rights that either of us may have against the other.
- (9) **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.
- (10) **Termination on 6 months' notice:** Either of us may terminate this Agreement by giving the other 6 months' notice.

B.39 The DHB's alternatives to termination

- (1) Instead of terminating this Agreement under clause B.38, the DHB may do either or both of the following:
- (a) vary or withdraw from coverage by this Agreement any of the Services, and
 - (b) cease paying for those Services from the date of variation or withdrawal.

B.40 Withholding payments

- (1) The DHB may withhold all or part of a payment 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 a reporting requirement in this Agreement, the DHB may withhold up to 10% of any management fee payments that are or become due;
 - (b) if the PHO or a Contracted Provider has failed to co-operate with the DHB or an Auditor or has not provided the DHB or an Auditor with reasonable assistance in accordance with

clause B.28, the DHB may withhold up to 10% of the PHO's management fee and/or up to 10% of any capitation payments that are or become due to the PHO or a 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 the PHO or Contracted Provider, up to the value of the breach, or up to 10% of any management fee payments that are or become due if the value of the breach cannot be determined, as is reasonable in the circumstances;
 - (d) if the PHO made a payment to a Contracted Provider that the Contracted Provider Claimed in breach of this Agreement, the DHB may withhold payment of any capitation payments that are or become due to that Contracted Provider, up to the value of the payment that was Claimed in breach of this Agreement.
- (2) A payment withheld under this clause will be paid to the PHO if:
- (a) in respect of a payment withheld under subclause B.40(1)(a) or B.40(1)(b), the PHO remedies the non-compliance or is found to have complied with the relevant requirement as an outcome of the dispute resolution process in clause B.37; and
 - (b) in respect of a payment withheld under subclause B.40(1)(c) or B.40(1)(d), it is found as an outcome of the dispute resolution process in clause B.37 that there was no breach or Claim made in breach of this Agreement.
- (3) A payment to be repaid to the PHO under subclause (2) will be repaid on the Payment Day after the day of such agreement or determination.

B.41 Alternative arrangements on failure to Provide Services

- (1) If the PHO fails to Provide any Services, the DHB may do one or more of the following:
- (a) cease paying the PHO for those Services;
 - (b) take whatever action is reasonably necessary to make alternative arrangements for the provision of the Services; and
 - (c) seek payment from the PHO of the reasonable costs to the DHB of the alternative arrangements, in accordance with subclause (3).
- (2) The DHB will give the PHO notice if it takes any action in accordance with subclause (1), at least 7 Business Days before taking such action, unless the circumstances reasonably require that less notice be given, in which case the DHB may give the PHO less notice or no notice.
- (3) If the DHB gives the PHO notice requiring the PHO to pay the DHB's reasonable costs, the PHO must pay or reimburse the DHB for its reasonable costs, provided that if the DHB has ceased payments under subclause (1)(a), the maximum amount the PHO must pay or reimburse the DHB is 10% of the payments ceased.

- (4) If the PHO fails to pay any amount it is required to pay under subclause (3), the DHB may set-off the amount owing to the DHB against any amount that the DHB owes the PHO at any time by way of payment for the Services, in accordance with clause F.19.

B.42 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) perform 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 provision of the Services during the period in which the PHO is unable to Provide the Services as a result of an Uncontrollable Event, and for such reasonable time afterwards as the DHB had to agree with the alternative provider in order for the DHB to be able to procure the alternative provider to Provide the Services .
- (4) If either of us is unable to perform an obligation under this Agreement for 20 Business 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 or continued to be performed by the affected party.
- (5) If we do not reach an agreement under subclause (4) within 2 months after receipt of the notice under subclause (2), either of us may terminate the relevant Service or this Agreement by giving the other at least 20 Business Days' notice.

B.43 Consequences of termination

- (1) The 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 termination of this Agreement, each of us will return to the other all documents, information, and software that belongs to the other and relate to the Services Provided under this Agreement (unless the owner has agreed that the other party may continue to use the documents, information,

or software), except that the DHB may retain such information for an Audit undertaken in accordance with this Agreement.

B.44 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 and its Auditor may request, and the PHO must promptly provide, any information concerning the insurance maintained in accordance with this clause.

B.45 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.46 Notices

- (1) Each notice given under this Agreement must be given in writing by facsimile, email, personal delivery or post, to the facsimile number or address advised by the other party from time to time, and marked for the attention of the other party's contact person (if any).
- (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 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.

- (4) Each period of time for notice excludes the days on which the notice is given and includes the day on which the period expires.

B.47 Independent contractor

- (1) We agree that the PHO is an independent contractor to the DHB, and not an employee, agent, or subsidiary.
- (2) The PHO acknowledges that it has no authority to act on the DHB's behalf.

B.48 Miscellaneous terms

- (1) **Compliance with law:**
 - (a) Each of us will comply with all statutory, regulatory and other legal requirements applicable to the performance of our obligations under this Agreement, including the Privacy Act 1993 and the Health Information Privacy Code 1994.
 - (b) The PHO will, in accordance with section 17(c) of the Vulnerable Children Act 2014:
 - (i) adopt, as soon as practicable, a child protection policy (in respect of the provision of children's services within the meaning of section 15 of that Act) that complies with section 19 of that Act; and
 - (ii) review that policy within 3 years of its adoption, and at a minimum once every 3 years following that initial review; and
 - (iii) if we agree, make a copy of the policy available on the PHO's website.
- (2) **Waiver:** We agree that:
 - (a) either of us may by notice 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:** A person who is not a party to this Agreement may not enforce any of the provisions of this Agreement, and nothing in this Agreement confers any benefit on any Eligible Person, Service User, or Contracted Provider, subject to:
- (a) Contracted Providers' and General Practitioners' ability to make Claims under this Agreement in accordance with Part F; and
 - (b) other PHOs' ability to apply to the DHB to provide services in its Primary Geographical Area in accordance with clauses B.9 to B.12.
- (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.49 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:** We agree:
- (a) a reference to a Part of, or Schedule to, is a reference to a Part of, or Schedule to, this Agreement; and
 - (b) a reference to a clause is to a clause of a Part or a Schedule to a Part.
- (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, whether or not the person has 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 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 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 H of this Agreement:
 - (b) the Referenced Documents.

SCHEDULE B1 MINIMUM REQUIREMENTS

1 Alliances

Objective:
The PHO has, with the DHB, formed an Alliance, which is providing increasingly integrated and co-ordinated health care services to improve health outcomes for our populations.
Requirements:
To achieve this objective the PHO will: (a) be in a district or regional Alliance; and (b) have agreed and signed the Alliance Agreement.

2 Organisational governance

Objective:
The PHO's governance and management arrangements are in line with New Zealand recognised practice, including full and open accountability for use of public funds.
Requirements:
To achieve this objective the PHO will: (a) be a Not For Profit organisation; (b) have a documented governance framework that meets the requirements of the Referenced Document entitled "PHO Governance Guidance" (when that document is agreed in accordance with this Agreement); (c) manage risk in a way appropriate to the Services provided, including managing the safety of people and the security of medicines, equipment and buildings; and (d) have in place appropriate and reasonable systems to prevent and detect fraud in respect of funding provided under this Agreement.

3 Clinical leadership, engagement, and governance

Objective:
The PHO can demonstrate that arrangements to ensure clinical leadership and engagement, including an established clinical governance framework, are in place.
Requirements:
To achieve this objective the PHO will: (a) ensure that currently practising clinicians are involved in key decision making; (b) engage with, and have the support of, clinicians from a range of disciplines who deliver the Services; and (c) have a documented clinical governance framework that sets out how clinical service delivery will be managed within the PHO and with Contracted Providers and Practitioners.

4 Māori health

Objective:
The PHO is committed to improving the health outcomes for Māori as a priority.
Requirements:
To achieve this objective the PHO will: (a) give effect to the aspects of the DHB's Māori health plan referred to in clause B.6 that relate to the activities of and Provision of Services by the PHO and its Contracted Providers, and annually agree specific deliverables in relation to those activities and the Services; and (b) integrate Māori participation within the PHO, including governance, service planning, development and implementation.

5 Service development and integration

Objective:
The PHO is working collaboratively with the DHB, including as part of our Alliance, to improve integration of services, care co-ordination and continuity of care to make a stronger collective impact with other publicly funded services.
Requirements:
To achieve this objective the PHO will undertake strategic and service analysis and plan collaboratively with DHBs and health and social service partners to deliver transformational change by: (a) identifying and planning to meet the health needs and priorities of the PHO's Enrolled Population; (b) identifying and understanding the reasons for inequalities between different sub-groups of the PHO's Enrolled Population (c) identifying gaps in Service provision, including those who are missing out on Services; (d) considering Government priorities and other relevant information, for example, DHB needs analysis and iwi plans, when making decision about Services; (e) considering the aspirations, methods and models of integrated care of Whānau Ora networks; (f) working 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; (g) considering local community infrastructure when making decisions, including that of territorial local authorities, non-governmental organisations, and other community-based partners; (h) designing, developing and implementing new approaches to referral protocols, service standards and delivery, using evidence-based best practice approaches, when possible; (i) managing and maintaining information platforms that support integrated care; (j) facilitating and co-ordinating the integration of the Services within the area serviced and the wider region by: (i) establishing and maintaining collaborative relationships with both national and local groups; (ii) delivering further integration of primary-secondary services and primary-community services; and (iii) supporting continuity of care, including using patient pathways and referral protocols; and (k) establishing how progress toward meeting the identified health needs and priorities will be measured.

6 Service provision and reporting

Objective:
In Providing the Services, the PHO makes the best use of system resources, provides best value and avoids duplication of the Services.
Requirements:
To achieve this objective the PHO will: (a) Provide, including by contracting with providers to deliver, the Services and any other services agreed between us; (b) Provide Services for individuals, families, whānau and communities across their lifespan, in a way that: (i) considers physical, mental, cultural, social and spiritual dimensions; (ii) is evidence and best practice based, to the extent possible; (iii) will improve, maintain, and restore health; (iv) ensures access to care; and (v) reduces health inequalities for Māori, Pacific and other high need populations; (c) demonstrate that the PHO provides equitable access to primary health care services within the Rural Community and within acceptable travel times (if the PHO's Enrolled Population includes a Rural Community); and (d) make available to the public its yearly report prepared in accordance with the Referenced Document entitled "Reporting Requirements" as part of its commitment to demonstrate full and open accountability for its use of public funds and the quality and effectiveness of the Services.

7 Workforce

Objective:
The PHO supports and develops a workforce to deliver the Services.
Requirements:
To achieve this objective the PHO will: (a) ensure that the PHO and its Contracted Providers' Practitioners: (i) adhere to the standards of their relevant professional bodies; and (ii) are aware of their responsibility to comply with those requirements; (b) monitor the availability of its Practitioners and Staff, and those of its Contracted Providers, to ensure that Services will be delivered in an appropriate way, taking into account the characteristics and health needs of the PHO's Enrolled Population; and (c) deliver on-going professional development for Contracted Providers who provide Services under this Agreement.

8 Quality

Objective:
The PHO's Enrolled Population and Casual Users receive Services that are safe, effective, consumer centred and of acceptable quality.
Requirements:
To achieve this objective the PHO will: (a) document, implement and evaluate systems and processes to continuously improve delivery of services. These systems and processes must demonstrate that the PHO is: (i) maintaining, improving and evaluating the quality of ongoing service provision including the development of new initiatives; (ii) maintaining, improving and evaluating the quality of the PHO's processes to: A. engage with its communities and collaborate with other health service providers; and B. undertake clinical and cultural audit processes (incorporating peer review) that include input from relevant health professionals, services and consumers; and (iii) focusing on clinical outcomes and control systems for unsafe and ineffective clinical practice; (b) actively evaluate, monitor and manage its own performance and that of its Contracted

Providers, including:

- (i) addressing unexplained variation in clinical and management practice, including collecting and providing comparative data on performance;
- (ii) achieving improved performance, including compliance with national and local standards and protocols as agreed between the DHB and PHO;
- (iii) monitoring performance against the needs of, and agreed outcomes for, Māori, Pacific, and other populations set out in the DHB's annual plan; and
- (iv) progress made in:
 - A. reducing barriers to accessing health care services;
 - B. facilitation of the involvement of whānau; and
 - C. integration of Māori, Pacific, and other cultural values, beliefs, and practices;
- (c) ensure all its general practices can demonstrate they have met the Foundation Standards by 30 June 2017;
- (d) have effective processes to manage consumer feedback and complaints relating to the PHO and its Contracted Providers; and
- (e) ensure that all buildings, plant and equipment used to provide Services are fit for purpose and adequately maintained in safe working order.

9 Information management

Objective:

The PHO collects, analyses, manages, shares and protects information to support the delivery of the Services.

Requirements:

To achieve this objective, the PHO will:

- (a) preserve and protect the safety, security and confidentiality of the Records;
- (b) have in place appropriate back-up and disaster recovery procedures to protect against loss of information;
- (c) ensure that all Records kept by Contracted Providers are properly preserved and, are able to be transferred to any replacement provider as the DHB may require, if the PHO or a Contracted Provider ceases to Provide the Services;
- (d) collect, and require its Contracted Providers to collect, and make available data to comply with any data sharing and reporting arrangements;

- (e) ensure data integrity and timely and complete recording of clinical information;
- (f) have information systems that support integrated health care;
- (g) use comparative data on provider activity to manage unexplained variation and enable performance improvement;
- (h) manage and maintain information systems to meet the reporting requirements in this Agreement including requirements relating to:
 - (i) ensuring accurate enrolments that comply with the requirements in the Referenced Document entitled "Enrolment Requirements for Providers and Primary Health Organisations" and the Referenced Document entitled "Business Rules: National Enrolment Service: Capitation Based Funding";
 - (ii) collecting activity and performance data in accordance with the Referenced Document entitled "Reporting Requirements"; and
 - (iii) the provision of disaggregated information about Māori, Pacific and other populations, as part of performance monitoring arrangements and wider accountability arrangements for improving health outcomes for all population groups; and
- (i) manage and maintain information systems to ensure that payments are timely and accurate.

10 Emergency planning and response

Objective:

The PHO works collaboratively with the DHB and others as appropriate to plan for and respond to health emergencies.

Requirements:

To achieve this objective the PHO will (and will ensure that its Contracted Providers will):

- (a) 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 Enrolled Persons, patients, and Staff are provided for during a health emergency;
- (b) ensure that the Plan (if there is one):
 - (i) outlines, to the extent practicable, the human, financial and other roles and resources that each participant, including DHBs, PHOs and Contracted Providers, will contribute to responding to an emergency, including substitution of services to meet the health emergency; and
 - (ii) identifies how the PHO will respond to an emergency event, and reflects that the PHO will take an all hazards approach to emergency planning;
- (c) if there is no Plan, put in place its own arrangements to meet the requirements set out in

paragraph (b);

- (d) work with the DHB and relevant participants to ensure the Plan and/or PHO arrangements are reviewed periodically to maintain currency;
- (e) participate in processes to ensure that emergency responses are integrated, coordinated and exercised. The level of participation required of the PHO 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; and
- (f) have a contingency plan to manage continued delivery of the Services in the event of a health emergency.

SCHEDULE B2 REPORTING REQUIREMENTS

1 Reporting requirements

- (1) The PHO must submit the reports set out in the Referenced Document entitled "Reporting Requirements" in the manner, to the standard, and within the timeframes set out in that Referenced Document.

2 Summary of the reports required

- (1) The following table summarises the PHO's reporting obligations set out in this Agreement and the Referenced Document entitled "Reporting Requirements":

Reporting Requirements	Frequency of reports	Reported to
Changes to Practitioners (clause 2 of the Reporting Requirements)	Quarterly	Payment Agent, DHB
First Level Service utilisation reports (clause 3 of the Reporting Requirements)	Quarterly	Payment Agent, DHB
Clinical performance indicator reports (clause 4 of the Reporting Requirements)	Quarterly	Payment Agent, DHB
Immunisation Services reports (clause 5 of the Reporting Requirements)	Quarterly, pending development of National Immunisation Register reporting requirements and thereafter in accordance with the Referenced Document entitled "National Immunisation Register Requirements"	Payment Agent, DHB
Rural Funding reports (clause 7 of the Reporting Requirements)	Quarterly or as set out in this Agreement	DHB
Yearly reports (clause 8 of the Reporting Requirements)	Annually	DHB

SCHEDULE B3 REFERENCED DOCUMENTS

1 Purpose

- (1) This Schedule lists or describes the Referenced Documents that form part of this Agreement.

2 Technical specifications that are Referenced Documents

- (1) The following technical specifications are Referenced Documents:

<i>Document Name</i>	<i>Publisher</i>
HL7 Messages Standard Definition	Ministry of Health
HealthPac Electronic Claiming Specification	Ministry of Health

3 Business rules that are Referenced Documents

- (1) The following business rules documents are Referenced Documents:

<i>Document Name</i>	<i>Publisher</i>
Business Rules: Capitation-based funding	Ministry of Health
Enrolment Requirements for Providers and Primary Health Organisations	Ministry of Health
Certification of PHO Enrolment Register form	Ministry of Health
Business Rules: National Enrolment Service: Capitation Based Funding (which will apply only from the NES Start Date)	Ministry of Health
First Level Services Claims and Payments	Ministry of Health
Primary Care Purchase Unit Codes	Ministry of Health

4 Audit Referenced Documents

- (1) Any document that is an Audit Protocol is a Referenced Document.
- (2) Any document relating to Audits that we agree from time to time in accordance with clause B.23 is a Referenced Document.

5 Other Referenced Documents

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

<i>Document Name</i>	<i>Publisher</i>
PHO Service Agreement Amendment Protocol	DHB Shared Services
Reporting Requirements	DHB Shared Services
Daily record, laboratory tests, diagnostic imaging	DHB Shared Services

<i>Document Name</i>	<i>Publisher</i>
services, and pharmaceutical requirements	
National Immunisation Register Requirements	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

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.

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 Services, 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 and 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 that 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) Subject to subclause (2), the PHO must ensure that First Level Services and Urgent Care Services are provided by one or more members of a General Practice Team
- (2) In order to meet its obligations set out in subclause (1), the PHO must ensure that if a general practice team providing First Level Services and Urgent Care Services does not have the skills of both Medical Practitioners and Nurses, the PHO or the relevant Contracted Provider puts in place alternative arrangements for the provision of those Services as agreed by us, which will apply until those skills are secured.
- (3) The PHO may Provide First Level Services and Urgent Care Services by face to face consultations, telephone consultations, or consultations provided using e-technologies, but must Provide those Services by face to face consultations if clinically indicated.
- (4) 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 that are provided by a face to face consultation 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 that are provided by a face to face consultation 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 the PHO itself or any one or more of its Contracted Providers are unable to provide Urgent Care Services, the PHO or the relevant Contracted Providers put in place alternative arrangements for the 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.
- (2) Unless levels and types of service provision are specifically agreed between us, the PHO, Contracted Providers and Practitioners will decide the extent and type of specific Population-based Health Services that they will provide to groups and individuals.

8 Access to Services for Casual Users

- (1) The PHO and its Contracted Providers will Provide First Level Services described in clauses 1(1)(b), 1(1)(c), and 1(1)(d) to a Casual User, if clinically indicated, and may claim for providing those services if the Casual User is one of the types of Casual User listed in clause 1(2) of Schedule C2, and the PHO or Contracted Provider has complied with the requirements in Schedule C2.
- (2) The PHO and its Contracted Providers must ensure that Casual Users have access to the same standard of care as their Enrolled Populations.

- (3) The PHO and its Contracted Providers must encourage a Casual User to whom it provides Services in accordance with subclause (1) and who is enrolled with another provider to return to the provider with which he or she is enrolled.
- (4) The PHO and each Contracted Provider must inform a Casual User to whom it provides Services in accordance with subclause (1) and who is not enrolled with a provider of the benefits of enrolment, and encourage the Casual User to enrol with a provider of his or her choice.

9 Information about First Level Services provided to Casual Users

- (1) The PHO and its Contracted Providers must ensure that if First Level Services are provided to a Casual User who is enrolled with another contracted provider, the Health Practitioner providing the services will, in accordance with the provisions of the Health Information Privacy Code 1994, provide information about the consultation to the provider with whom the Casual User is enrolled.
- (2) The information described in subclause (1) must be provided:
 - (a) no later than 2 Business Days after the consultation; and
 - (b) in accordance with any agreed national standards.

10 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.

11 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.

12 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.

13 Evidence of service levels

- (1) The PHO will, if requested by the DHB or Ministry, 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.

14 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 Provision of and Claiming for General Medical Services

- (1) The PHO and its Contracted Providers may Provide General Medical Services to any person.
- (2) However, the PHO and its Contracted Providers may Claim, in accordance with Part F and Schedule F1.2, only for General Medical Services:
 - (a) that are provided by a Health Practitioner; and
 - (b) that are provided in accordance with this Schedule to a Casual User who:
 - (i) is a child or young person aged 17 years or under; or
 - (ii) holds a Community Services Card; or
 - (c) holds a High Use Health Card.

2 When General Medical Services may be Provided

- (1) The PHO and its Contracted Providers must ensure that General Medical Services for which a Claim is or will be made are provided only if the services are requested by the patient, or the patient's caregiver or representative if the patient is unable to make the decision, unless:
 - (a) the Health Practitioner considers it necessary to provide the services because it is a medical emergency; or
 - (b) the services are provided to a patient who is a regular patient of the Health Practitioner who has been offered the opportunity to enrol with the PHO and the Contracted Provider and has chosen not to enrol, and it is clinically indicated and appropriate to initiate provision of the services; or
 - (c) otherwise agreed in writing by the DHB and PHO.

3 Where General Medical Services may be Provided

- (1) The PHO and its Contracted Providers must ensure that General Medical Services for which a Claim is or will be made are provided at one of the following locations:
 - (a) one of the Health Practitioner's Usual Places of Practice; or
 - (b) the patient's temporary or permanent place of residence; or
 - (c) a location at which services of the type described in clause 2(1)(a) (services required because it is a medical emergency) are required to be provided; or
 - (d) any other location agreed in writing by the DHB, the PHO, and (if relevant) the Contracted Provider.

4 How General Medical Services may be provided

- (1) The PHO and its Contracted Providers may provide General Medical Services for which a Claim is or will be made only by a face to face consultation, and may not Claim for General Medical Services provided by telephone or using e-technologies.
- (2) Despite subclause (1), a Rural Practitioner may Claim for any General Medical Services provided by telephone or using e-technologies, provided that the Casual User is located 16km or further from the General Practitioner's Usual Place of Practice at the time of the consultation.

5 Information about General Medical Service consultations

- (1) The PHO and its Contracted Providers must ensure that if General Medical Services for which a Claim is or will be made are provided to a patient who is enrolled with another contracted provider, the Health Practitioner providing the services will provide information about the consultation to the provider with whom the patient is enrolled by electronic means, provided that such disclosure is permitted or required by law, including under the Health Information Privacy Code 1994.
- (2) The information described in subclause (1) must be provided:
 - (a) no later than 2 Business Days after the consultation; and
 - (b) in accordance with any agreed national standards.

6 Monitoring provision of General Medical Services

- (1) The DHB will provide the PHO with reports about the number of Claims that the PHO and its Contracted Providers make for General Medical Services that include the following information:
 - (a) the name, date of birth and NHI number of each Service User in respect of whom a Claim was made;
 - (b) the date of each consultation;
 - (c) the location at which General Medical Services were provided;
 - (d) the Practitioner Identification Number of the Health Practitioner that provided the consultation; and
 - (e) the time of each consultation.
- (2) The PHO must monitor:
 - (a) the number of Claims that it and its Contracted Providers make for General Medical Services, taking into account any reports provided under subclause (1);
 - (b) the accuracy of Claims for General Medical Services made by its Contracted Providers; and
 - (c) the number of Claims for General Medical Services provided to its Enrolled Persons that are made by other PHOs or providers, including taking into account any report about deductions to capitation payments provided by the DHB to the PHO in accordance with clause 4(3) of Schedule F1.1.

7 Managing provision of General Medical Services

- (1) The PHO and its Contracted Providers must ensure that if General Medical Services are provided for which a Claim is or will be made, the Health Practitioner encourages the patient to return to the contracted provider with whom the patient is enrolled, or if the patient is not enrolled, to enrol with a contracted provider of the patient's choice.
- (2) The PHO must, having regard to the information it obtains in accordance with clause 6 manage the provision of General Medical Services by its Contracted Providers to ensure that continuity of care is maintained and to minimise fragmentation in the delivery of primary health care services.

8 Review of General Medical Service Claims

- (1) A Contracted Provider may request the PHO to review a reduction in the Contracted Provider's Net GMS Claims Position if:
 - (a) the Contracted Provider's Net GMS Claims Position in a month is less than the average monthly Net GMS Claims Position of the Contracted Provider in the year ending 30 June 2014, by an amount that is equal to or greater than 0.5% of the amount the Contracted Provider was paid for delivering First Level Services in accordance with Schedule F1.1 for that month, excluding deductions made under clause 4 of Schedule F1.1; where
 - (b) Net GMS Claims Position

means

the total amount of payments made to the Contracted Provider under Schedule F1.2 for General Medical Services Claims,

minus

the total amount of deductions made under clause 4 of Schedule F1.1 for General Medical Services Claims made in respect of a Contracted Provider's Enrolled Population.
- (2) If the PHO receives a request under subclause (1), the PHO must:
 - (a) carry out a review of the Claims and deductions;
 - (b) engage with the DHB if required to understand the reasons for the increase; and
 - (c) respond to the Contracted Provider with the PHO's finding no later than 20 Business Days after the date of the Contracted Provider's request.
- (3) If the PHO's review finds that the increase described in subclause (1) is directly attributable to the changes to General Medical Services provisions in this Agreement that came into effect on 1 July 2014 ("**GMS changes**") then:
 - (a) despite clause 4 of Schedule F1.1, the maximum amount that may be deducted from future payments to the PHO for First Level Services will be an amount calculated as follows:

the total amount deducted from the PHO in respect of the Contracted Provider between 1 July 2013 and 1 July 2014

divided by 12; and

- (b) for each month of the quarter commencing 1 July, 1 October, 1 January or 1 April in which the review request was received, the DHB will pay the PHO an amount calculated as follows:

the actual amount deducted from the Contracted Provider in accordance with clause 4 of Schedule F1.1

minus

the amount calculated in accordance with subclause (a).

- (4) Clause 8(3)(a) will cease to apply when the matter is resolved between the DHB, PHO and Contracted Provider.
- (5) We agree to participate in a review of this clause before 30 June 2017, which will consider whether the effect of the GMS changes is such that this clause should expire on 30 June 2017.

9 Review of General Medical Service provisions in this Agreement

- (1) We agree that we will participate in a review of the provisions of this Agreement relating to General Medical Services to be undertaken by the PSAAP Group in accordance with clause B.25(1) if either the DHB or PHO considers that a review is necessary, including if either party has concerns about the number of Claims for General Medical Services made by the PHO's Contracted Providers, or made in respect of a Contracted Provider's Enrolled Persons.

10 Services that are General Medical Services

- (1) Subject to subclause (2), General Medical Services are all First Level Services provided in order to maintain health, restore health, and coordinate care, as described in clauses 1(1)(b), 1(1)(c), and 1(1)(d) of Schedule C1.
- (2) General Medical Services do not include the following services:
- (a) medical services if no service of substance is provided by the Health Practitioner and for which the patient would not reasonably expect to pay;
 - (b) the provision of recall and reminder notifications;
 - (c) specialist medical services that involve the application of special skill and experience of a degree or kind that Health Practitioners cannot reasonably be expected to have;
 - (d) Primary Maternity Services and all related services caused by or related to pregnancy;
 - (e) medical services provided by a Health Practitioner to his or her dependants, his or her spouse or partner, or the dependants of his or her spouse or partner;

- (f) medical services provided by a Health 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;
- (g) services for which cover under the Accident Compensation Act 2001 is available;
- (h) medical services of which the sole or primary purpose is for the patient to obtain a medical certificate for production to some other person as to the condition of the patient's health, except that General Medical Services do include medical services provided 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 unless those services are paid for by the Ministry of Social Development;
- (i) medical services provided by a Health Practitioner for the purposes of, or incidental to, extraction of teeth by the Health Practitioner;
- (j) medical services in respect of laboratory diagnostic services;
- (k) medical services that are diagnostic imaging services;
- (l) medical services provided, other than in an emergency, in any workplace (as that term is defined in the Health and Safety at Work Act 2015) to any employee there and provided pursuant to an arrangement made by or on behalf of the Health Practitioner with the employer of the person receiving the services or the agent of the employer;
- (m) medical services that consist only of the administration of a vaccine;
- (n) medical services of a substantially similar nature offered by a Health Practitioner to a group of patients at the same time;
- (o) the provision of a repeat prescription if no other medical service is provided;
- (p) Well Child Services;
- (q) 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 to Provide medical care;
- (r) the provision of a death certificate if no other medical service is provided; and
- (s) medically unwarranted minor cosmetic procedures or circumcisions.

SCHEDULE C3 IMMUNISATION SERVICES

1 Service objectives

- (1) Immunisation is a public health prevention measure that aims to prevent diseases through vaccination. The objective of the National Immunisation Programme is to control or eliminate vaccine-preventable diseases such as polio, measles, pertussis (whooping cough) and rubella through the provision of safe and effective vaccination programmes across all communities.
- (2) The PHO will Provide the Immunisation Services set out in clause 2 of this Schedule as part of achieving the following immunisation measures:
 - (a) 95% of all children aged 8 months are fully immunised;
 - (b) 95% of 2 year olds are fully immunised; and
 - (c) at least 75% of adults aged 65 years and older are vaccinated annually against influenza, including 75% of Maori aged 65 years and older, and all children and adults at high risk of contracting influenza due to an on-going chronic medical condition are identified and vaccinated annually against influenza.

2 Immunisation Services

- (1) The PHO will Provide the following Immunisation Services to Enrolled Persons:
 - (a) immunisations that are part of the National Immunisation Programme and are set out in the National Immunisation Schedule in the New Zealand Pharmaceutical Schedule issued by PHARMAC ("National Immunisation Schedule") in accordance with the Immunisation Handbook;
 - (b) immunisations that are not on the National Immunisation Schedule to special risk groups, in accordance with the Immunisation Handbook; and
 - (c) the immunisation episodes scheduled for 11 year olds (year 7) and 12 year olds (year 8) if they are not provided through a school programme.
- (2) In addition, the PHO will:
 - (a) Provide opportunistic immunisations that are set out in the National Immunisation Schedule to children who are Casual Users, and record the vaccination in the National Immunisation Register within 2 Business Days of the immunisation;
 - (b) refer any child who is overdue for an immunisation and who has not responded to at least 3 contacts to an appropriate immunisation outreach service, a Well Child Service, or the local immunisation co-ordinator;
 - (c) undertake regular audits of the provision of Immunisation Services by itself and its Contracted Providers;

- (d) promote immunisation using evidence-based information, and ensure its Enrolled Population is able to make informed decisions about immunisation;
- (e) assist with epidemic control and other situations if co-ordinated action is required;
- (f) ensure that a decision by parents or guardians not to immunise their children is recorded and the Health Practitioner acts in accordance with that decision; and
- (g) maintain at all times an effective cold chain in accordance with the requirements set out in the Ministry's National Guidelines for Vaccine Storage and Distribution, so as to ensure potency of all vaccines administered.

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, comply with any relevant legislation (including regulations), and report adverse events.

4 Requirements for administering vaccines

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

SCHEDULE C4
[PLACEHOLDER]

1 **[insert]**

SCHEDULE C5

SPECIAL SUPPORT SERVICES FOR FORMER SAWMILL WORKERS EXPOSED TO PCP

1 Background

- (1) Between the 1950s and the 1980s, pentachlorophenol ("PCP") was used in the sawmill industry as an anti-sapstain agent and a preservative. In June 2010 the Ministry announced it would establish a special support service for former sawmill workers exposed to PCP. Those services are described in this Schedule ("Special Support Services").
- (2) The Special Support Services are comprehensive services 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 each individual's wellness.

2 Providing Special Support Services to Eligible Persons

- (1) The PHO and its Contracted Providers must Provide Special Support Services to each person that the Ministry determines is eligible for Special Support Services (an "Eligible Person"), and who requests Special Support Services from the PHO or the Contracted Provider.

3 Special Support Service components

- (1) The Special Support Services comprise an annual health check described in clause 4, and may also include one or more of the Referred Services described in clause 5.

4 Annual health checks

- (1) The first annual 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 health outcomes;
 - (d) a review to identify any health outcomes with suggestive or sufficient evidence of an association with PCP exposure such as 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 psycho-social outcomes and unmet mental health needs;
 - (f) a review to identify other health outcomes such as 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 Referred Services described in clause 5; and

- (i) if indicated, referral to other health services if the Eligible Person meets the other health services eligibility criteria.
- (2) Each subsequent annual health check will:
 - (a) be more focused on specific health needs; and
 - (b) continue to address the health needs identified in the first health check, and any other health needs identified in subsequent annual health checks.
- (3) Each annual health check must be overseen by the Eligible Person's nominated General Practitioner, but may be provided by members of a General Practice Team as the General Practitioner deems appropriate.
- (4) The content of each annual health check must be guided by the Eligible Person's medical history, current health needs, evidenced-based best practice, and the clinical judgement of the Practitioner.

5 Referred Services including genetic counselling

- (1) A PHO or Contracted Provider or General Practitioner may, in the course of an annual health check, refer an Eligible Person to the following Referred Services, if it is appropriate to do so:
 - (a) genetic counselling;
 - (b) lifestyle improvement services, including smoking cessation, green prescriptions, and dietary information and advice; and
 - (c) mental health services for mild to moderate mental health conditions.

6 Charges for Special Support Services

- (1) The PHO and its Contracted Providers must not charge an Eligible Person for:
 - (a) any annual health check; or
 - (b) genetic counselling services.
- (2) The PHO and its Contracted Providers may charge an Eligible Person for a Referred Service other than a Referred Service referred to in subclause (1), unless:
 - (a) the Referred Service is available free of charge to persons who meet any eligibility criteria for the service; and
 - (b) the Eligible Person meets the eligibility criteria.

7 Collection, use, and disclosure of patient information

- (1) The PHO and its Contracted Providers must ensure that an Eligible Person who receives Special Support Services is advised that Health Information about the person relevant to the ongoing provision of the services will be provided to the Ministry, and may be used by the Ministry to provide the person with information about the services and to monitor and evaluate the services.

8 Information and monitoring requirements

- (1) The PHO and its Contracted Providers must collect the following information about each Eligible Person to whom it provides Special Support Services, and provide the information to the Ministry:
 - (a) NHI number;
 - (b) full name;
 - (c) date of birth;
 - (d) whether the service is the person's first health check or a subsequent health check;
 - (e) duration of the health check;
 - (f) date of the health check;
 - (g) the Referred Services that the Eligible Person was referred to (if any);
 - (h) name of the PHO or Contracted Provider; and
 - (i) name and registration of the Eligible Person's nominated General Practitioner.

SCHEDULE C6

HEALTH SUPPORT SERVICES FOR DIOXIN-EXPOSED PEOPLE

1 Background

- (1) People living in Paritutu have long been concerned about dioxin exposure from Ivon Watkins Dow ("IWD") plant emissions. 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.
- (2) The Government has established an early intervention-focused health support service for people exposed to dioxin from the former IWD plant. Those services are described in this Schedule ("Health Support Services").
- (3) The Health Support Services are comprehensive services 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 each individual's wellness.

2 Providing Health Support Services to Eligible Persons

- (1) The PHO and its Contracted Providers must Provide Health Support Services to each person that the Ministry determines is eligible for Health Support Services (an "Eligible Person"), and who requests Health Support Services from the PHO or the Contracted Provider.

3 Health Support Services components

- (1) The Health Support Services comprise an annual health check provided to an Eligible Person, and may also include the Referred Services described in clauses 5 to 7.

4 Annual health checks

- (1) The first annual 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 such as 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 to identify psycho-social outcomes and unmet mental health needs;

- (f) a review to identify other health outcomes such as 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 Referred Services described in clauses 5 to 7;
 - (i) if indicated, referral to other health services if the Eligible Person meets the other health services eligibility criteria.
- (2) Each subsequent annual health check will:
- (a) be more focused on specific health needs; and
 - (b) continue to address the health needs identified in the first health check, and any other health needs identified in subsequent annual health checks.
- (3) Each annual health check must be overseen by the Eligible Person's nominated General Practitioner, but may be provided by members of the General Practice Team as the [PHO or Contracted Provider or General Practitioner] deems appropriate.
- (4) The content of each annual health check must be guided by the Eligible Person's medical history, current health needs, evidenced-based best practice, and the clinical judgement of the Practitioner.

5 Referred Services

- (1) A PHO or Contracted Provider may, in the course of an annual health check, refer an Eligible Person to the following Referred Services, if it is appropriate to do so:
- (a) serum dioxin testing as set out in clause 6;
 - (b) foetal neural tube defect screening and genetic counselling as set out in clause 7;
 - (c) lifestyle improvement services, including smoking cessation, green prescriptions, and dietary information and advice; and
 - (d) mental health services for mild to moderate mental health conditions

6 Serum dioxin test

- (1) An Eligible Person may be referred for a serum dioxin test if:
- (a) the Eligible Person has not previously had a serum dioxin test;
 - (b) the Eligible Person has been fully informed about the serum dioxin test at a consultation with his or her nominated General Practitioner, including the limitations and benefits of the serum dioxin test, the testing procedure, and the results are fully explained;
 - (c) the Eligible Person has been referred to a mental health counsellor to identify and address any concerns, and the mental health counsellor has referred the Eligible Person back to the General Practitioner for consideration for serum dioxin testing;

- (d) 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 person's wellbeing; and
 - (e) the Eligible Person's General Practitioner has, on behalf of the person, applied to the Ministry for the person to be referred for a serum dioxin test, and received confirmation from the Ministry that the application has been approved.
- (2) If the Ministry approves an application, the Ministry will arrange a laboratory appointment and serum analysis.

7 Foetal neural tube defect screening and genetic counselling

- (1) The following persons may be referred for a foetal neural defect screen or genetic counselling or both as part of an annual health check:
- (a) an Eligible Person:
 - (b) 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); and
 - (c) a child of an Eligible Person (whether or not the child is an Eligible Person).
- (2) A person can be referred for foetal neural defect screening only by a General Practitioner, registered midwife, obstetrician, or family planning Practitioner.
- (3) A person can be referred for genetic counselling only by a General Practitioner.

8 Charges for Health Support Services

- (1) The PHO and its Contracted Providers must not charge an Eligible Person for:
- (a) any annual health check;
 - (b) being referred for a serum dioxin test, for the test itself, or for meeting his or her nominated General Practitioner to be informed and advised about the results of the test; or
 - (c) foetal neural defect screening or genetic counselling.
- (2) The PHO and its Contracted Providers may charge an Eligible Person for a Referred Service other than a Referred Service referred to in subclause (1), unless:
- (a) the Referred Service is available free of charge to persons who meet any eligibility criteria for the service; and
 - (b) the Eligible Person meets the eligibility criteria.

9 Collection and use of patient information

- (1) The PHO and its Contracted Providers must ensure that an Eligible Person who receives Health Support Services is advised that Health Information about the person relevant to the ongoing provision of the services will be provided to the Ministry, and may be used by the Ministry to

provide the person with information about the services and to monitor and evaluate the provision of the services.

10 Information and monitoring requirements

- (1) The PHO and its Contracted Providers must collect the following information about each Eligible Person to whom it provides Health Support Services, and provide the information to the Ministry:
 - (a) NHI number;
 - (b) full name;
 - (c) date of birth;
 - (d) whether the service is the Eligible person's first health check or a subsequent health check;
 - (e) duration of the health check;
 - (f) date of the health check;
 - (g) the Referred Services that the Eligible Person was referred to (if any);
 - (h) name of the general practice; and
 - (i) name and registration of the Eligible Person's nominated General Practitioner.

Part D Alliance Services

D.1 Providing management services, health promotion services, services to improve access, Care Plus Services, and Rural Funding before they are moved into the scope of our Alliance Agreement

- (1) Until we agree otherwise in accordance with clause D.2:
 - (a) the PHO will Provide management services, health promotion services, services to improve access, and Care Plus Services in accordance with Schedule D1 and this Agreement; and
 - (b) the DHB will pay the PHO for Providing each of those Services in accordance with Part F and Schedule F2.1.
- (2) Until we agree otherwise in accordance with clause D.3:
 - (a) the DHB will pay Rural Funding to support Rural Contracted Providers in accordance with Part F and Schedule F2.2A; and
 - (b) the PHO must use the Rural Funding to support Rural Contracted Providers in accordance with the requirements set out in Schedule D2.

D.2 Moving funding for management services, health promotion services, services to improve access and Care Plus Services into the scope of our Alliance Agreement

- (1) We may agree that the PHO will cease Providing management services, health promotion services, services to improve access, and Care Plus Services in accordance with Schedule D1, and instead use some or all of the funding that the DHB pays the PHO for those Services to implement Alliance Recommendations, in which case:
 - (a) Schedule D3, Part H, and any other relevant clauses in this Agreement may be varied to reflect the Alliance Recommendations in accordance with clause D.6(1), and will come into force on the date that we agree;
 - (b) Schedule D1 will expire on the date Schedule D3 comes into force;
 - (c) the Services described in Schedule D3 will become Alliance Services that must be Provided by the PHO in accordance with that schedule and this Agreement; and
 - (d) the DHB will pay the PHO an amount known as the flexible funding pool for Providing the Alliance Services, in accordance with Part F and Schedule F2.1.

D.3 Moving Rural Funding into the scope of our Alliance Agreement

- (1) Subject to clause D.4, we may agree that the DHB will cease Providing Rural Funding in accordance with Schedule D2, and instead the DHB will pay Rural Funding to the PHO in accordance with Alliance Recommendations, in which case:

- (a) Schedule D4 (except clause 1), Schedule F2.2B, Part H, and any other relevant clauses in this Agreement may be varied to reflect the Alliance Recommendations in accordance with clause D.6(1), and will come into force on the date that we agree;
- (b) Schedule D2 (except for clause 9) and Schedule F2.2A (except for clause 9) will expire on the date Schedule D4 comes into force;
- (c) the DHB will pay the PHO Rural Funding in accordance with Part F, clause 9 of Schedule F2.2A, and Schedule F2.2B; and
- (d) the PHO must use the Rural Funding in accordance with clause 9 of Schedule D2, Schedule D4, and this Agreement.

D.4 Conditions of moving Rural Funding into the scope of our Alliance Agreement

- (1) We may agree that the PHO will provide Rural Funding for use in accordance with Alliance Recommendations under clause D.3 only if we are satisfied that each of the following conditions have been met:
 - (a) we are satisfied that the Alliance engaged all Rural Contracted Providers when determining its recommendations;
 - (b) the decision to use Rural Funding in accordance with Alliance Recommendations has the support of:
 - (i) at least 75% of Rural Contracted Providers; and
 - (ii) Rural Contracted Providers whose Enrolled Population is at least 75% of the Enrolled Population of all Rural Contracted Providers; and
 - (c) the Alliance Recommendations provide that Rural Funding will be used to meet the following objectives for Rural Services:
 - (i) people in Rural Communities have equitable health outcomes, appropriate access to First Level Services and Urgent Care Services, and receive continuity of care;
 - (ii) rural primary health care services are sustainable;
 - (iii) the rural primary health care workforce has safe workloads;
 - (iv) Rural General Practice Teams have access to appropriate clinical support and workforce development opportunities
 - (v) Rural primary healthcare services are delivered by the right people, at the right time, and in the right place.

D.5 Services funded from the flexible funding pool but provided outside the scope of our Alliance Agreement

- (1) We may agree that the PHO will Provide, and the DHB will provide funding for, Services that are outside the scope of our Alliance Agreement and are therefore not Alliance Services, but are funded from the flexible funding pool. Those Services, if any, are set out in Schedule D5.
- (2) The PHO will provide the Services described in Schedule D5 (if any) in accordance with that schedule and this Agreement.
- (3) The DHB will pay the PHO for the Services described in Schedule D5 (if any) in accordance with Part F and Schedule F2.3.

D.6 Variations to the flexible funding pool schedules

- (1) If we reach an agreement under clause D.2(1) relating to the flexible funding pool, Schedule D3, Part H, and any other relevant clauses in this Agreement relating to the flexible funding pool may be varied to reflect Alliance Recommendations in accordance with the procedure set out in clause D.8.
- (2) If we have not reached an agreement under clause D.2(1), Schedule D1, the relevant schedules in Part F, Part H, and any other clauses in this Agreement may be varied in accordance with clause B.23.

D.7 Variations to the Rural Funding schedules

- (1) Subject to subclause (2), if we reach an agreement under clause D.3(1) relating to Rural Funding, Schedule D4 (except clause 1), Schedule F2.2B, Part H, and any other relevant clauses in this Agreement may be varied to reflect Alliance Recommendations in accordance with the procedure set out in clause D.8.
- (2) We may vary this Agreement under subclause (1) only if we are satisfied that each of the following conditions have been met:
 - (a) we are satisfied that the Alliance engaged all Rural Contracted Providers when determining the variation;
 - (b) the variation has the support of:
 - (i) at least 75% of Rural Contracted Providers; and
 - (ii) Rural Contracted Providers whose Enrolled Population is at least 75% of the Enrolled Population of all such Contracted Providers; and
 - (c) the variation provides that Rural Funding will be used to meet the objectives for Rural Services listed in clause D.4(1)(c).
- (3) If we have not reached an agreement under clause D.3(1), Schedule D2, the relevant schedules in Part F, Part H, and any other clauses in this Agreement relating to Rural Funding may be varied in accordance with clause B.23.

- (4) Clause 9 of Schedule D2, clause 8 of Schedule F2.2A, and Schedule D5 may be varied in accordance with clause B.23.

D.8 Procedure for variations to implement Alliance Recommendations

- (1) If we wish to vary Schedule D3, Schedule D4, the relevant schedules in Part F, Part H, or any other relevant clauses in this Agreement 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 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 D.9 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 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.8(1)(b), which may not be less than 20 Business Days after our notice of the proposed variation.

D.9 Alliance dispute process

- (1) If the PHO wishes to notify a dispute under clause D.8(3), it must do so no later than 20 Business Days after the notice of the proposed variation is given under clause D.8(1)(b).
- (2) If a dispute is notified by the PHO under clause D.8(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.8(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.

SCHEDULE D1

MANAGEMENT SERVICES, HEALTH PROMOTION SERVICES, SERVICES TO IMPROVE ACCESS, AND CARE PLUS 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.

2 Health promotion services

- (1) The PHO will agree with the DHB the health promotion activities that 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 activities;
 - (b) activities 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 will 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.

3 Access for High Need Persons

- (1) The PHO will agree with the DHB the services and activities that the PHO will undertake to improve access to primary health care services for High Need Persons 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 Persons in its Enrolled Population, which 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.

4 Care Plus Service objectives

- (1) The PHO will Provide Care Plus Services 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.

5 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 the Enrolled Person's 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
 - (i) has 2 or more chronic health conditions so long as each condition is one that:
 - A. is a significant disability or has a significant burden of morbidity;
 - B. creates a significant cost to the health system;
 - C. has agreed and objective diagnostic criteria; and
 - D. continuity of care and a primary health care team approach has an important role in the management of that condition;
 - (ii) has a terminal illness (defined as someone who has an advanced, progressive disease, whose death is likely within 12 months);
 - (iii) has had 2 acute medical or mental health related admissions in the past 12 months (excluding surgical admissions);
 - (iv) has had at least 6 First Level Service Consultations and/or General Medical Service consultations and/or emergency department visits within the last 12 months; or
 - (v) is on active review for elective health services; and
 - (b) has given his or her informed consent to receiving Care Plus Services.

6 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.

7 Reassessment for continued eligibility to receive Care Plus Services

- (1) The PHO will reassess for continued eligibility of each Care Plus Patient in accordance with this clause.
- (2) The PHO will review each Care Plus Patient annually and no later than 15 months from the date at which he or she was last assessed as being eligible to receive, or to continue to receive, Care Plus Services to determine whether he or she continues 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 a Care Plus Patient 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 provider re-assesses the patient in accordance with clauses 5(1)(a) and 5(1)(b) and the provider has available funding.

8 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 the DHB 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;
 - (f) provision of documents 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 for relevant staff including those working for a Contracted Provider; 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 5(1)).

9 Quality requirements for Care Plus Services

- (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, Contracted 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;
 - (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.

10 Proposed Care Plus Services

- (1) The PHO may submit to the DHB a proposal to deliver Care Plus Services that includes the PHO's funding requirements and how it will meet the requirements set out in clause 11(1) .
- (2) If the DHB approves the proposal, the PHO will deliver Care Plus Services in accordance with this Schedule.

11 Care Plus fees assurance framework

- (1) The PHO recognises that:
 - (a) the DHB expects that paying for Care Plus Services will result in Care Plus Patients being charged low or reduced fees, but also that those fees are fair to the Contracted Providers; and
 - (b) the DHB's requires certainty that payments to Contracted Providers for Care Plus Services will be applied to the provision of Care Plus Services to patients identified as qualifying for Care Plus Services.
- (2) The DHB acknowledges that some of the funding for Care Plus Services will be applied to services to patients that 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.
- (3) As part of the PHO's proposal for delivering Care Plus Services, the PHO will advise the DHB of the PHO's funding arrangements for Care Plus Services in sufficient detail to demonstrate to the DHB that the PHO meets the requirements set out in subclause (1).

- (4) 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 notify the DHB in a timely manner of the change and the reasons for the change.
- (5) If, after receipt of a notice in accordance with subclause (4), the DHB considers the funding arrangements no longer meet the requirements set out in subclause (1), the DHB will meet with the PHO with the aim of finding a mutually agreed resolution to the matter.

SCHEDULE D2 RURAL FUNDING

1 Rural Funding

- (1) Rural Funding is a flexible resource that PHOs, Rural Contracted Providers, and Rural Practitioners use to meet the following objectives:
 - (a) people in Rural Communities have equitable health outcomes, appropriate access to First Level Services and Urgent Care Services, and receive continuity of care;
 - (b) rural primary health care services are sustainable;
 - (c) the rural primary health care workforce has safe workloads;
 - (d) Rural General Practice Teams have access to appropriate clinical support and workforce development opportunities
 - (e) Rural primary healthcare services are delivered by the right people, at the right time, and in the right place.
- (2) For the purposes of this Agreement, the rural ranking score of a Rural Practitioner will be the rural ranking score that was assigned to the Rural Practitioner on 30 June 2014.

2 Rural Funding components

- (1) Rural Funding is made up of the following components:
 - (a) workforce retention funding as described in clause 3, which is a flexible resource for recruiting, supporting, and retaining General Practice Teams of Rural Contracted Providers;
 - (b) reasonable roster funding as described in clause 4, which is a targeted resource aimed at Rural Contracted Providers experiencing onerous on call arrangements;
 - (c) remote rural practice area funding as described in clause 5, which is additional funding paid because of pre-existing special funding arrangements to support remote Rural Contracted Providers;
 - (d) the rural bonus as described in clause 6, which is paid to Rural Practitioners;
 - (e) rural After Hours funding as described in clause 7, which is paid to the PHO to support the provision of Urgent Care Services during After Hours by Rural Contracted Providers; and
 - (f) rural sustainability support payments as described in clause 8, which are paid to Rural Contracted Providers that are using Rural Funding in accordance with Alliance Recommendations.

3 Workforce retention funding

- (1) The DHB will pay the PHO workforce retention funding in accordance with a formula that is based on degrees of remoteness, and is indicated by the rural ranking score of the PHO's Rural

Practitioners. The formula, and the amount of funding that the DHB will pay the PHO, is specified in clause 2 of Schedule F2.2A.

- (2) The PHO may apply the workforce retention funding to a range of strategies to create favourable working conditions for its Rural Contracted Providers, including but not limited to:
 - (a) enabling Rural 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 Rural Practitioners can enter and leave practices with minimal restrictions.
- (3) 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.

4 Reasonable roster funding

- (1) The DHB will pay reasonable roster funding in respect of Rural Contracted Providers that we agree are experiencing onerous on-call arrangements (if any), in accordance with clause 3 of Schedule F2.2A.
- (2) The PHO may change the level of support it provides to Rural 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 ensure that access to Urgent Care Services is provided in accordance with clause 5 of Schedule C1.

5 Remote rural practice area funding

- (1) For the purpose of this clause, a remote rural practice area is an area with one or more Rural Contracted Providers whose Rural Practitioners have scored high points on the rural ranking scale, or that is a former special area where salaried primary health care services continue to be provided.
- (2) If there is a special funding arrangement for a remote rural practice area and the amount the PHO is entitled to under the special funding arrangement is greater than the capitation payment the DHB pays the PHO for the Enrolled Population of the remote practice area, the DHB will pay the PHO the difference between the two amounts in accordance with clause 4 of Schedule F2.2A.
- (3) If the PHO has been paid remote rural practice funding, the PHO may make service changes or funding adjustments that promote cost effective service delivery in the remote practice area, provided that the PHO continues to support the provision of sustainable and accessible services to the Rural Community and favourable working conditions, including time off duty for Rural Practitioners who provide Services to the Rural Community.
- (4) If the DHB provides primary health care services to a remote practice area, the PHO agrees that the DHB may retain the remote rural practice area funding for that area.

- (5) The PHO must not introduce patient charges in the remote rural practice areas specified below (if any) without first obtaining Ministerial agreement, which should be sought through the DHB:

(a) [insert area]

6 The rural bonus

- (1) A rural bonus may be Claimed by each of the PHO's Rural Practitioners who:
- (a) provide First Level Services and access to First Level Services to an Enrolled Population as set out in this Agreement; and
 - (b) participate regularly in an on-call roster.
- (2) The PHO may apply for one or more of its Rural Practitioners to receive a rural bonus, and the DHB will pay a rural bonus to eligible Rural Practitioners, in accordance with clause 5 of Schedule F2.2A.
- (3) A rural bonus will not be paid in any other circumstances, unless approved by the DHB in extreme circumstances.
- (4) The provision of specified call centre services or other similar projects do not qualify for a rural bonus.

7 Rural After Hours funding

- (1) The DHB will pay the PHO rural After Hours funding in accordance with clause 6 of Schedule F2.2A.
- (2) The PHO will use the rural After Hours funding to support the provision of Urgent Care Services by Rural Contracted Providers during After Hours, in a manner agreed by the DHB and PHO.

8 Rural sustainability support payments

- (1) If we agree that Rural Funding can be used in accordance with Alliance Recommendations and vary Schedule D4 and Schedule F2.2B in accordance with clause D.3, the DHB will pay the PHO a rural sustainability support payment.
- (2) The DHB will pay and the PHO will use the rural sustainability support payment in accordance with the relevant provisions in Schedule D.4 and Schedule F2.2B.

9 Priority uses of Rural Funding

- (1) In order for the PHO to meet its obligations set out in clauses 3 to 5 of Schedule C1, the PHO will agree with the DHB the priority uses of Rural Funding.
- (2) Priority uses may include:
- (a) supporting reasonable rosters;
 - (b) stabilising the rural General Practice Team if a Rural Community is at risk of not being provided with access to First Level Services as required by clauses 4 and 5 of Schedule C1;

- (c) supporting General Practice Teams serving remote Rural Communities;
- (d) addressing heavy workloads, particularly if the General Practitioner to Enrolled Population ratio is more than 1:2000; and
- (e) encouraging workforce innovations that promote sustainable services, including for example opportunities for nurses practising in rural primary health care settings to enhance their skills, and development of Nurse Practitioners with prescribing rights in rural settings.

10 Rural workforce strategies

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

**SCHEDULE D3
SERVICES WITHIN THE SCOPE OF OUR ALLIANCE**

1 [Insert]

(1) [insert]

SCHEDULE D4

RURAL FUNDING WITHIN THE SCOPE OF OUR ALLIANCE

1 Rural Funding

- (1) Rural Funding is a flexible resource that PHOs, Rural Contracted Providers, and Rural Practitioners use to meet the following objectives:
- (a) people in Rural Communities have equitable health outcomes, appropriate access to First Level Services and Urgent Care Services, and receive continuity of care;
 - (b) rural primary health care services are sustainable;
 - (c) the rural primary health care workforce has safe workloads;
 - (d) Rural General Practice Teams have access to appropriate clinical support and workforce development opportunities
 - (e) Rural primary healthcare services are delivered by the right people, at the right time, and in the right place.

SCHEDULE D5
SERVICES OUTSIDE THE SCOPE OF OUR ALLIANCE

1 **[Insert] or [not applicable]**

(1) [insert]

Part E Local Services

E.1 Local Services

- (1) The PHO will Provide the Local Services described in the schedule 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 Claiming and Payments

F.1 Right to charge

- (1) The PHO and its Contracted Providers may charge Service Users in accordance with the fees framework set out in clause F.22.

F.2 Reducing financial barriers to accessing Services

- (1) We both support the Government's policy of reducing financial barriers to accessing the Services for all Service Users.

F.3 Payment for Services

- (1) Subject to clause F.4(1), the PHO may Claim and 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.
- (2) Specifically, the DHB will pay:
 - (a) capitation payments for First Level Services, in accordance with Schedule F1.1, and may also pay very low cost access payments, patient access subsidy payments, very low cost access sustainability support payments, zero fees for under 13s payments, and zero fees for under 6s payments for First Level Services, in accordance with Schedule F1.1;
 - (b) for General Medical Services on a fee for service basis in accordance with Schedule F1.2;
 - (c) for Immunisation Services on a fee for service basis in accordance with Schedule F1.3;
 - (d) for Special Support Services and Health Support Services on a fee for service basis in accordance with Schedules F1.5 and F1.6;
 - (e) for Alliance Services in accordance with the relevant schedules to this Part;
 - (f) for Local Services in accordance with the relevant schedules to this Part; and
 - (g) for other Services in accordance with the relevant schedules to this Part.
- (3) If the PHO is required to contribute towards the management of a health emergency as anticipated by Minimum Requirement 10, and funding is made available to the DHB to manage the emergency. the DHB will negotiate with the PHO about contributing to the PHO's costs.

F.4 DHB may pay Contracted Providers directly

- (1) We may, by agreement in writing, agree that the DHB may make fee for service-patient subsidy payments directly to a Contracted Provider for Services that are Provided by the Contracted Provider.
- (2) If we reach such an agreement, the PHO must ensure that its subcontract with the Contracted Provider provides that the Contracted Provider is bound by the obligations in this Part on the basis that, unless the context otherwise requires, all references to the PHO are read as references to the Contracted Provider.

- (3) A Contracted Provider may Claim and the DHB will pay fee for service-patient subsidy payments directly to a Contracted Provider only if:
 - (a) the Contracted Provider has a payee number approved by the PHO for the purposes of receiving payments under this Agreement; and
 - (b) all Claims include the reference number of this Agreement.
- (4) The PHO must ensure that its Contracted Providers do not themselves Claim payments from the DHB unless permitted to do so in accordance with this clause.

F.5 Goods and Services Tax

- (1) Unless this Agreement expressly provides otherwise:
 - (a) all amounts listed in this Agreement are exclusive of GST; and
 - (b) all payments made under this Agreement will be made inclusive of GST.

F.6 Claiming restrictions

- (1) **Services must have been provided in New Zealand:** The PHO may not Claim, and the DHB will not pay, for Services Provided to an Eligible Person who was not in New Zealand at the time the Services were Provided.
- (2) **Claims for Services provided to non-Eligible Persons:** If the PHO Provides Services to a person who is not an Eligible Person, the DHB will be liable to pay Claims for those Services only if:
 - (a) the PHO assessed the person's eligibility in accordance with the requirements set out in the Referenced Document entitled "Enrolment Requirements for Providers and Primary Health Organisations", and can demonstrate that it took reasonable steps to establish that the person was an Eligible Person and entitled to enrol in a PHO; and
 - (b) the PHO or the relevant practice is not required to remove the person from the Register or, from the NES Start Date, the National Enrolment Service, in accordance with the requirements set out in the Referenced Document entitled "Enrolment Requirements for Providers and Primary Health Organisations".
- (3) **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 services and results in additional costs to either of us. This does not preclude movements of individuals between providers for reasons of good clinical practice.
- (4) **No double payment:** Subject to subclause (5), the PHO may not Claim or receive a payment under this Agreement for services if the PHO is entitled to receive payment for those, either directly

or indirectly, under any other agreement or arrangement with the DHB or any other organisation, Government body, or agency, including the Accident Compensation Corporation.

- (5) **Section 88 Notice claims:** A Contracted Provider who is entitled to receive a payment for services both under this Agreement and under a Section 88 Notice must Claim under this Agreement, and may not make a claim under the Section 88 Notice.

F.7 National Enrolment Service

- (1) The parties acknowledge that the National Enrolment Service will be operational from the NES Start Date, and that:
- (a) from 1 July 2016 to the NES Start Date, they will each comply with the requirements set out in the Referenced Document entitled "First Level Services Claims and Payments"; and
 - (b) from the NES Start Date, they will each comply with the requirements relating to the National Enrolment Service as set out in this Agreement.
- (2) **Transitional provisions:** The PHO will continue to submit a Register each quarter to the last day of the quarter that is two quarters after the quarter in which the NES Start Date occurs (or any other date agreed by the PSAAP Group), and will:
- (a) ensure that each Register complies with the requirements set out in the Referenced Document entitled "HL7 Messages Standard Definition" and "Business Rules: Capitation-based funding"; and
 - (b) provide a copy of a certificate signed by the PHO's Chief Executive Officer or senior manager in the form of the Referenced Document entitled "Certification of PHO Enrolment Register"; and
 - (c) retain the original of the certificate for Audit purposes.

F.8 Claims for General Medical Services and Immunisation Services

- (1) The PHO must ensure that each Claim for General Medical Services and Immunisation Services is:
- (a) made electronically;
 - (b) includes the Purchase Unit Code for the Service to which the Claim relates; and
 - (c) complies with the requirements set out in the Referenced Document entitled "Electronic Claiming Specification".
- (2) The PHO must ensure that each Claim includes the following details in respect of each patient to whom the Claim relates:
- (a) Health Practitioner's Practitioner Identification Number;
 - (b) Health Practitioner's name;
 - (c) Health Practitioner's health practitioner index number (if the Health Practitioner has been assigned such a number);

- (d) Health Provider index organisation number;
 - (e) the time and date of the Service;
 - (f) the location at which the Service was provided;
 - (g) patient's name;
 - (h) patient's date of birth;
 - (i) patient's NHI number;
 - (j) patient's category;
 - (k) patient's Community Services Card number if applicable (if Access Practices provide Services to Casual Users);
 - (l) patient's High Use Health Card number if applicable;
 - (m) Health Practitioner's signature (or electronic equivalent);
 - (n) GMS category (if applicable); and
 - (o) immunisation types and date of immunisation (if applicable).
- (3) If the DHB pays the PHO for General Medical Services or Immunisation Services, the PHO will ensure that the DHB has the right to access any information in relation to the relevant Claims or the Services for the purpose of verifying the Claims, including the Daily Record.
- (4) The DHB will ensure that the PHO and its Contracted Providers are able to obtain the NHI numbers of each Casual User to whom General Medical Services and Immunisation Services are provided by contacting the DHB's Payment Agent by telephone, fax, or the internet, and specifically will ensure that:
- (a) 90% of all phone and fax requests are responded to within 2 Business Days, provided that requests are for no more than 40 records per Contracted Provider per day; and
 - (b) 90% of all scheduled electronic batch matching requests are returned completed within 4 Business Days after the date of the request, provided the electronic file or files supplied are in a format acceptable to the Payment Agent.
- (5) The DHB will pay an entire Claim for General Medical Services or Immunisation Services that is made in accordance with this Part, subject to subclause (6).
- (6) This subclause and subclause (7) apply if:
- (a) the DHB has complied with the requirement in subclause (4) to provide the NHI numbers in respect of the Casual Users to whom the Claim relates; and
 - (b) a valid NHI number is provided for less than 98% of the Casual Users to whom the Claim relates.

- (7) The DHB will reject the part of the Claim for which the NHI numbers of the Casual Users have not been provided.
- (8) If part of a Claim for General Medical Services is rejected by the DHB, the DHB will subsequently pay that part of the Claim if the PHO:
 - (a) resubmits the Claim in accordance with clause F.11; and
 - (b) has provided additional NHI numbers for the Claim so that valid NHI numbers have been provided for at least 98% of the Casual Users to whom the Claim relates.

F.9 Timing of fee for service Claims

- (1) The PHO must submit all fee for service Claims:
 - (a) at least monthly but not more than once a week;
 - (b) for General Medical Services Claims, no later than 60 days after the date on which the services were provided; and
 - (c) for Claims for all other Services for which Claims must be made, no later than 6 months after the date on which the services were provided.

F.10 Rejection of fee for service Claims

- (1) The DHB may reject all or part of a Claim if the DHB believes on reasonable grounds that the Claim or part of the Claim is incomplete, inaccurate, or does not comply with the terms of this Agreement.
- (2) If part of a Claim is incomplete, inaccurate, or non-compliant, the DHB may reject only that part of the Claim, and will pay the remaining parts of the Claim.
- (3) If the DHB rejects part of a Claim for General Medical Services, the DHB will inform the PHO of that no later than 15 Business Days after the PHO submitted the Claim.

F.11 Resubmission of fee for service Claims

- (1) The PHO may resubmit a rejected Claim, or part of a Claim, if it is 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.19.

F.12 Timing of payments

- (1) The DHB will pay:
 - (a) for First Level Services, on the 15th day of each month for First Level Services provided during that month, in accordance with the Referenced Document entitled "Business Rules: National Enrolment Service: Capitation Based Funding";
 - (b) a fee for services Claim no later than 10 Business Days after the PHO submits its Claim; and
 - (c) for other Services, in accordance with the relevant schedules to this Part.

- (2) If a payment made under this clause is due to be made on a day that is not a Payment Day, the payment will be made on the first Payment Day after the day on which the payment is due.

F.13 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 by giving 10 Business Days' notice to the DHB.

F.14 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.15 Incorrect payments

- (1) Subject to subclause (5), if the PHO has reasonable evidence that a payment that the DHB has made is incorrect, the PHO will notify the DHB and its Payment Agent of the suspected error, and will provide a description of the suspected error and the PHO's evidence of the error to the DHB.
- (2) The DHB will discuss the PHO's concerns with the PHO no later than 20 Business Days after receiving a 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 incorrect payment;
 - (b) quantify the error (including the adjustments required to correct the payment); and
 - (c) agree to a resolution of the problem, including what amount is owed by either of us and the date on which that amount will be paid.
- (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.

F.16 Default Interest on late payments

- (1) Subject to clause F.17, 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 the date of notice given under clause F.17.
- (3) The Default Interest rate will be 2 percentage points per annum above the average New Zealand dollar 90 day bank bill rate (rounded up to the nearest second decimal place) as appearing at 11:00 or as soon as practicable after that time on the relevant day on page BKBM of the Reuters screen (or its successor or equivalent page), and will be calculated on a daily basis.

F.17 Notice of intention to charge Default Interest

- (1) In order for a 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 no later than 6 months after the date that the 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.18 Recovery of monies Claimed in breach of this Agreement and costs

- (1) If monies have been Claimed by or paid to the PHO or a Contracted Provider in breach of this Agreement, all such monies and, subject to subclause F.18(3), the costs of any Audit and the costs incurred by the DHB and its Payment Agent as a consequence of that Claim or payment (if any), including by not limited to the costs of recovering the debt, 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 the debt from the PHO that includes 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.
- (3) The DHB may recover the costs of an Audit and the DHB and Payment Agent's costs, unless the monies Claimed or paid in breach of this Agreement were Claimed or paid in breach because of an honest error or oversight, and the breach is of minor consequence.

F.19 Set-off

- (1) This clause applies if the PHO owes the DHB any amount under this Agreement or a previous agreement between the parties, including:
 - (a) an amount overpaid by the DHB under clause F.14(1); or
 - (b) a debt owed to the DHB under this Agreement.
- (2) The DHB may set-off the amount owed by the PHO against any amount that the DHB owes to the PHO at any time, provided that:
 - (a) the DHB gives the PHO at least 10 Business Days' notice of its intention to exercise its power of set-off, the amount it intends to set-off, and when the set-off will occur, so that the PHO can review and discuss with the DHB the DHB's reasons for the intended set-off; and
 - (b) if the PHO dispute the set-off within 10 Business Days after receipt of the notice, the dispute will be resolved in accordance with the dispute resolution process set out in clause B.37.
- (3) If the DHB sets-off an amount pursuant to subclause (2) and it is determined through a dispute resolution process that the DHB should not have set-off the amount, the DHB will repay the PHO the amount of the set-off plus Default Interest.
- (4) 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.20 Payment rules subject to requirements in Referenced Documents

- (1) Despite anything else in this Agreement, clauses F.14 to F.19 apply in respect of payments made for First Level Services in accordance with Schedule F1.1 subject to any requirements set out in the Referenced Documents entitled "Business Rules: National Enrolment Service: Capitation Based Funding" and "Enrolment Requirements for Providers and Primary Health Organisations".

F.21 Payment rates increases

- (1) We acknowledge that the Ministry prescribes the amount payable by the DHB to the PHO for Nationally Consistent Services and some Alliance Services, and agree that if the Ministry increases funding for any such Services on a national basis, the DHB will:
 - (a) follow the process described in clause B.24 in relation to the Ministry's terms and conditions for that payment rate increase; and
 - (b) amend the relevant payment rates specified in the Schedules to this Part to incorporate the funding increase.
- (2) We acknowledge that it is the government's intention to:
 - (a) regularly adjust the amounts payable for First Level Services to maintain the value of those payments; and
 - (b) work with the sector to ensure the sustainability of general practice.

- (3) We agree that the Ministry will increase, on an annual basis, the payment rates for very low cost access, Immunisation Services, zero fees for under 13s, and zero fees for under 6s by the amount required to compensate practices providing those Services for not being able to increase their patient co-payments, and that such amount will be no less than the reasonable fee increase amount specified in the Annual Statement.

F.22 Fees framework – level policy and charges to Service Users

- (1) **Application of this clause:** This clause applies to the PHO and its Contracted Providers who:
- (a) demonstrate how increased funding will translate into reduced fees for specified patients; and
 - (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 and its Contracted Provider 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 is the framework that will apply to the patient fees charged by contracted providers if the funding set by the 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 and its Contracted Providers to set the fees that they charge Eligible Persons;
 - (b) the DHB expects that the PHO’s Enrolled Persons 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 contracted 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 Persons and that those fees are fair to the Contracted 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 standard General Practitioner consultation fees if the funding set by the Government is intended to subsidise low or reduced cost access to First Level Services at any time during the term of this Agreement, including very low cost access funding, zero fees for under 13s funding, and zero fees for under 6s funding, the PHO will, as soon as is reasonably practicable after the decision to increase the fees is made, and 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 fees increase (stating previous and new standard General Practitioner consultation fees for each age group);
 - (b) the name or the identifier of the Contracted Provider that increased its fees; 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) **Annual Statement of fee increase levels:** The DHB will:
- (a) at least annually, notify the PHO of the levels of standard General Practitioner consultation fees increases that the DHB considers reasonable. Fee increases that are higher than the levels notified are not necessarily unreasonable; and
 - (b) 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 Annual Statement notified under subclause (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 Annual Statements, 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 Annual Statement template for each year. The table below illustrates this:

	A	B	C	D	E
Year	Annual Statement increase	Carried forward from prior year and adjusted by current %*	Total Annual Statement Reasonable Fee Increase	Actual increase applied by practice XYZ	Unused percentage 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. $1.5\% \times 1.042 = 1.56\%$).

- (12) **Referring fee increases to a Fees Review Committee:** If the fee increase notified under subclause F.22(7) is:
- (a) less than or equal to the levels of reasonable fee increases notified pursuant to subclause F.22(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.22(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 (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 has not referred a fee increase notified to it under subclause (7) to the Fees Review Committee within 1 month after the date the DHB received notice of the fee increase, the fee increase is deemed to be reasonable.
- (15) We each agree to participate in the Fees Review Committee process as set out in subclauses (16) to (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 Fees Review 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 of us:
- (a) either party may, within 5 Business Days, escalate the matter to the 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.37.
- (25) While processes under clause B.37 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.37(5).
- (26) To avoid doubt, all remedies under the Agreement are reinstated on resolution of the processes under clause B.37.
- (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.24 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) **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.
- (32) 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.
- (33) 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.
- (34) **Community Services Card Holders:** The PHO will ensure that, for its Enrolled Population, fees established under subclauses (2) to (28) are set irrespective of whether the patients or their families have a Community Services Card.

SCHEDULE F1.1 PAYMENT FOR FIRST LEVEL SERVICES

1 Payments for First Level Services

- (1) The DHB will pay the PHO the following payments for Providing First Level Services for each year starting on 1 July:
 - (a) a capitation payment in accordance with clauses 2 to 4;
 - (b) a very low cost access payment in accordance with clause 5 (if applicable);
 - (c) a patient access subsidy in accordance with clause 6 (if applicable);
 - (d) a very low cost access sustainability support payment in accordance with clause 7 (if applicable);
 - (e) a zero fees for under 13s payment in accordance with clause 8 (if applicable); and
 - (f) a zero fees for under 6s payment in accordance with clause 9 (if applicable).
- (2) Each payment will be paid in monthly instalments.
- (3) From the NES Start Date, each payment will be based on:
 - (a) information about the PHO's Enrolled Population held on the National Enrolment Service and determined at 00:00 hours on the first day of the month to which the payment relates; and
 - (b) if necessary, information on enrolment registers provided by PHOs.
- (4) However, the parties acknowledge that any amount paid in respect of a month in accordance with subclause (3) may not be the actual amount payable to the PHO, and agree that adjustments may be made in respect of monthly payments as set out in the Referenced Document entitled "Business Rules: National Enrolment Service: Capitation Based Funding".

2 Capitation payments for non-Access Practices

- (1) For each Enrolled Person who is enrolled with a non-Access Practice, the DHB will pay the PHO the relevant annual rate specified below:

		Annual rate	
Enrolled Person		High User Health Card	
Age Group	Gender	N	Y
00-04	F	\$390.2776	\$579.8064
	M	\$415.3092	\$579.8064
05-14	F	\$100.4808	\$383.3000
	M	\$95.2308	\$383.3000
15-24	F	\$116.8076	\$369.2332
	M	\$64.2876	\$369.2332
25-44	F	\$102.6436	\$369.2332
	M	\$66.3500	\$369.2332

45-64	F	\$140.5892	\$404.3988
	M	\$105.0048	\$404.3988
65+	F	\$242.2760	\$433.7032
	M	\$208.9368	\$433.7032

3 Capitation payments for Access Practices

- (1) For each Enrolled Person who is enrolled with an Access Practice, the DHB will pay the PHO the relevant annual rate specified below:

		Annual rate	
Enrolled Person		High User Health Card	
Age Group	Gender	N	Y
00-04	F	\$399.9184	\$597.8064
	M	\$421.0580	\$597.8064
05-14	F	\$126.5872	\$383.3000
	M	\$118.4876	\$383.3000
15-24	F	\$116.8076	\$369.2332
	M	\$64.2876	\$369.2332
25-44	F	\$102.6436	\$369.2332
	M	\$66.3500	\$369.2332
45-64	F	\$140.5892	\$404.3988
	M	\$105.0048	\$404.3988
65+	F	\$242.2760	\$433.7032
	M	\$208.9368	\$433.7032

4 Deductions to capitation payments for First Level Services

- (1) Subject to subclause (2), if another PHO or a provider submits a Claim for General Medical Services for an Enrolled Person, an amount equivalent to the amount Claimed will be deducted from the PHO's next capitation payment after the Claim was received.
- (2) The DHB will not make any deduction under subclause (1) for:
- (a) the fourth or subsequent Claim for General Medical Services submitted for an Enrolled Person in a calendar month; or
 - (b) from the NES Start Date, Claims for General Medical Services made in respect of an Enrolled Person who is a new born with the enrolment code "B" in the first three months after the person's enrolment, in accordance with the Referenced Document entitled "Business Rules: National Enrolment Services: Capitation Based Funding".
- (3) The DHB will provide the PHO with reports about Enrolled Persons provided with General Medical Services to assist the PHO to minimise deductions made under subclause (1) that include the following information:
- (a) the name, date of birth and NHI number of each Enrolled Person in respect of whom a Claim was made;

- (b) the date of each consultation;
 - (c) aggregated information about the locations at which General Medical Services were provided;
 - (d) the type of Health Practitioner who provided the consultation; and
 - (e) the time of each consultation.
- (4) The PHO may provide information from the reports described in subclause (3) to its Contracted Providers.

5 Very low cost access payments

- (1) For each Enrolled Person who is enrolled with a practice that meets the eligibility criteria specified in subclause (2) ("**Eligible VLCA Practice**"), the DHB will pay the PHO the relevant annual rate specified below:

Enrolled Person		
Age Group	Gender	Annual Rate
00-04	F	\$105.2756
	M	\$110.8392
05-14	F	\$53.1680
	M	\$52.5392
15-24	F	\$30.1816
	M	\$16.6116
25-44	F	\$26.5212
	M	\$17.1440
45-64	F	\$36.3256
	M	\$27.1316
65+	F	\$62.6004
	M	\$53.9860

- (2) From the NES Start Date, a practice will be an Eligible VLCA Practice if, for the relevant month:
- (a) the practice charges fees for each standard consultation at or below the following amounts:
 - (i) zero fees (\$0) for Enrolled Persons aged 0 to 12 years;
 - (ii) \$12 for Enrolled Persons aged 13 to 17 years; and
 - (iii) \$18.00 for Enrolled Persons aged 18 years and over; and
 - (b) subject to subclause (4), at least 50% of the practice's Enrolled Persons are High Needs Persons; and
 - (c) the Ministry has determined, in its sole discretion, that the practice should be an Eligible VLCA Practice, and gives notice to the DHB of its decision.
- (3) The PHO must, no later than 10 Business Days before the last day of each month, advise the DHB and the Payment Agent if any practices that were Eligible VLCA Practices in that month do not

want to participate in the VLCA programme and will not receive payments in accordance with this clause in the next month.

- (4) A practice that does not have an Enrolled Population that is made up of at least 50% High Needs Persons on the first day of a month is deemed to be an Eligible VLCA Practice for that month, provided that the practice:

- (a) meets the other requirements set out in subclause (2); and
- (b) received a very low cost access payment in the previous month;

unless the Ministry and DHB determine, in their sole discretion, that because of significant changes to the size and character of the practice's Enrolled Population since the practice first received a very low cost access payment, the practice is not deemed to be an Eligible VLCA Practice.

- (5) The PHO must pay the amount that the PHO receives for each Enrolled Person under subclause (1) to the Eligible VLCA Practice with which the Enrolled Person is enrolled.

- (6) To avoid doubt:

- (a) nothing in this clause prevents the PHO or a practice from foregoing a very low cost access payment by not complying with this clause; and
- (b) if a practice foregoes, or for any other reason does not receive, a very low cost access payment, the practice must meet the criteria in subclause (2) if it wishes to become an Eligible VLCA Practice.

6 Patient access subsidy payments

- (1) This clause applies if:

- (a) a practice is created ("New Practice") as the result of the merger of one or more practices, one of which had received a very low cost access payment in the month immediately before the merger ("Former VLCA Practice");
- (b) the New Practice is not an Eligible VLCA Practice for the purposes of clause 5; and
- (c) the Former VLCA Practice gave notice to the Ministry and DHB of the merger at least 3 months before the merger.

- (2) The Ministry and DHB may decide, in their sole discretion, that the New Practice will be paid a patient access subsidy payment.

- (3) The DHB will pay the patient access subsidy payment to the PHO, which must pay that amount to the New Practice.

- (4) The PHO must pay each patient access subsidy payment to a New Practice on the condition that, for the month to which the payment relates, the New Practice:

- (a) will charge zero fees for Enrolled Persons aged 0 to 12 years;

- (b) will spend the payment on improving the ability of High Needs Persons to access First Level Services, as agreed with the Ministry and DHB; and
 - (c) will not spend the payment on capital investments.
- (5) The patient access subsidy payment will be:

the amount of the very low cost access payment that was paid to the Former VLCA Practice in the month immediately before the merger (or a higher amount, if agreed by the Ministry)

minus the amount that the New Practice is entitled to receive as a zero fees for under 13s payment in accordance with clause 8 or a zero fees for under 6s payment in accordance with clause 9 for that month, in respect of the members of the New Practice's Enrolled Population who were enrolled with the Former VLCA Practice.
- (6) To avoid doubt:
 - (a) nothing in this clause prevents a New Practice from foregoing a patient access subsidy payment by not complying with the requirements of this clause; and
 - (b) if at any time a New Practice does not comply with the requirements of this clause, the DHB will cease to pay the PHO a patient access subsidy in respect of the practice, and will have no further obligation to make patient access subsidy payments in respect of the practice.

7 Very low cost access sustainability support payments

- (1) The DHB will pay the PHO a very low cost access sustainability support payment to support its Eligible VLCA Practices that have an Enrolled Population made up of at least 50% High Needs Persons as at 1 July of each year (or any other percentage notified by the Ministry), and that the PHO considers are most in need of support.
- (2) The amount of the very low cost access sustainability support payment to be paid by the DHB to the PHO will be the amount determined by the Ministry before 1 July of each year and advised by the Ministry to the DHB and PHO.
- (3) The PHO must distribute the amount it receives under subclause (1) to one or more of the Eligible VLCA Practices described in subclause (1), and may allocate and divide the amount among one or more of those practices in any way, provided that it consults the DHB and the practices about the allocation.
- (4) The DHB and PHO will together work with each practice that receives funding under subclause (3) to assist it to develop and implement a tailored sustainability support plan to make the practice more financially sustainable and have a more sustainable workforce, including by providing the practice with assistance (which may be additional financial assistance) as set out in the plan.
- (5) The PHO will provide the DHB with the following information about payments made under this clause:
 - (a) the name of each practice that receives funding under subclause (3), and the amount of funding received by each practice;

- (b) details of the assistance provided by the DHB and PHO to assist each practice to develop and implement a sustainability support plan, including any additional financial assistance provided; and
- (c) any other information reasonably requested by the DHB.

8 Zero fees for under 13s payments

- (1) The DHB will pay the PHO a payment ("**Under 13s Payment**"), calculated on the basis of the annual rate specified below for each Enrolled Person specified below who is enrolled with a practice that meets the eligibility criteria specified in subclause 8(2) ("**Eligible Under 13s Practice**"):

Enrolled Person		Annual rate
Age Group	Gender	
00-04	Female	\$78.9564
	Male	\$83.1300
05-14	Female	\$45.7956
	Male	\$45.6380

- (2) From the NES Start Date, a practice is an Eligible Under 13s Practice if, for the relevant month:
- (a) the practice charges zero fees for a standard consultation for a child aged under 13 years of age who is an Enrolled Person; and
 - (b) the practice has not received a very low cost access payment in accordance with clause 5.
- (3) The PHO must, no later than 10 Business Days before the last day of each month, advise the DHB and the Payment Agent if:
- (a) any practices that were Eligible Under 13s Practices in that month are no longer Eligible Under 13s Practices; or
 - (b) any practices that were not Eligible Under 13s Practices in that month will be Eligible Under 13s Practices in the next month.
- (4) The PHO must pay the amount that the PHO receives for each Enrolled Person to the Eligible Under 13s Practice with which the Enrolled Person is enrolled.
- (5) To avoid doubt:
- (a) a practice that does not comply with the conditions set out in subclause 8(2) will cease to be an Eligible Under 13s Practice and will cease receiving payments from the beginning of the following month; and
 - (b) nothing in this clause prevents the PHO or a practice from foregoing an Under 13s Payment by not complying with this clause, and an Eligible Under 13s Practice may voluntarily opt out at the end of each month by notifying the PHO of its decision to opt out by the Register submissions date for the month.

- (6) We agree that:
- (a) if, in our DHB district, the average rate of utilisation of First Level Services by children aged 6 to 12 who are Enrolled Persons exceeds 2.0 First Level Service Consultations per child per year over a 6 month period, we will undertake a local review to identify the reasons for the increased utilisation rate;
 - (b) if the national rate of utilisation of First Level Services by children aged 6 to 12 who are Enrolled Persons exceeds 2.0 First Level Service Consultations per child per year over a 6 month period, we will participate in a review of the Under 13s Payment provisions in this clause 8, to be undertaken by the PSAAP Group in accordance with clause B.25; and
 - (c) if the national rate of utilisation of First Level Services by children aged 6 to 12 who are Enrolled Persons exceeds 2.2 First Level Service Consultations per child per year over a 6 month period, we will participate in an urgent review of the Under 13s Payment provisions in this clause 8, to be undertaken by the PSAAP Group in accordance with clause B.25, which will include a re-negotiation of the annual rate specified in subclause 8(1), acknowledging that we cannot commit the Ministry to future payments.
- (7) For the purpose of subclause (6), "6 month period" means a period from 1 July to 31 December (inclusive) and 1 January to 30 June (inclusive) in any year.

9 Zero fees for under 6s payments

- (1) This clause applies only to practices that:
- (a) received under 6s payments immediately before 1 July 2015; and
 - (b) at no time after 1 July 2015 opted out of under 6s payments nor opted in to Under 13s Payments in respect of a month.
- (2) The DHB will pay the PHO a payment ("**Under 6s Payment**"), calculated on the basis of the annual rate specified below for each Enrolled Person specified below who is enrolled with a practice that meets the eligibility criteria specified in subclause (3) ("**Eligible Under 6s Practice**"):

Enrolled Person		Annual rate
Age Group	Gender	
00-04	Female	\$78.9564
	Male	\$83.1300
05-14	Female	\$2.4580
	Male	\$2.3004

- (3) From the NES Start Date, a practice is an Eligible Under 6s Practice if, for the relevant month:
- (a) it meets the requirements in clause 9(1);
 - (b) the practice charges zero fees for a standard consultation for a child aged under 6 years of age who is an Enrolled Person; and
 - (c) the practice has not received a very low cost access payment in accordance with clause 5.

- (4) The PHO must, no later than 10 Business Days before the last day of each month, advise the DHB and the Payment Agent if:
 - (a) any practices that were Eligible Under 6s Practices in that month will not be Eligible Under 6s Practices in the next month; or
 - (b) any practices that were not Eligible Under 6s Practices in that month will be Eligible Under 6s Practices in the next month.
- (5) The PHO must pay the amount that the PHO receives for each Enrolled Person to the Eligible Under 6s Practice with which the Enrolled Person is enrolled.
- (6) To avoid doubt:
 - (a) a practice that does not comply with the conditions set out in subclause (3) will cease to be an Eligible Under 6s Practice and will cease receiving payments from the beginning of the following month; and
 - (b) nothing in this clause prevents the PHO or a practice from foregoing an Under 6s Payment by not complying with this clause, and an Eligible Under 6s Practice may voluntarily opt out at the end of each month by notifying the PHO of its decision to opt out by the Register submissions date for the next month.

SCHEDULE F1.2 PAYMENT FOR GENERAL MEDICAL SERVICES

1 Payments for General Medical Services

- (1) The DHB will pay the PHO for General Medical Services provided in accordance with Schedule C2 on a fee for service basis, in accordance with this Schedule.

2 Claiming for General Medical Services

- (1) If a Health Practitioner provides General Medical Services, the PHO may Claim:
- (a) the relevant fee set out in clause 3(1); and
 - (b) any travel allowances that the DHB agrees with the PHO in writing.
- (2) If a question arises as to whether a service provided by a Health Practitioner is a General Medical Service, or whether any amount, and if so what amount, is payable by the DHB, that question will be decided by the DHB.
- (3) The PHO may not Claim for General Medical Services if:
- (a) the services are funded or paid for under another fee, benefit, subsidy, or alternative payment arrangement; or
 - (b) the Health Practitioner who provided the services did not keep a Daily Record in respect of the services.
- (4) The PHO:
- (a) may not submit more than one Claim for General Medical Services if those services were provided as part of a single consultation with a patient, even if the services were provided by more than one Health Practitioner; and
 - (b) acknowledges that administrative services provided in relation to a single consultation form part of the consultation, and that the PHO may not submit a separate Claim for providing those services.

3 Fees for General Medical Services

- (1) The DHB will pay the fee specified below for General Medical Services provided to the category of Casual User specified below:

	Casual User	Fee per consultation (Excluding GST)
1	A child under 6 years of age	\$31.11
2	A child or young person aged 6 to 17 years who is the dependent of a holder of a Community Services Card	\$17.78
3	A child or young person aged 6 to 17 years who is the dependent of a holder of a High	\$17.78

	Casual User	Fee per consultation (Excluding GST)
	Use Health Card	
4	A child or young person aged 6 to 17 years who is not the dependent of a holder of a Community Services Card or High Use Health Card	\$13.33
5	A person aged 18 years or over who holds a Community Services Card	\$13.33
6	A person aged 18 years or over who holds a High Use Health Card	\$13.33

4 Charging Casual Users for General Medical Services

- (1) If the PHO is entitled to make a Claim in accordance with this Schedule, the PHO, Contracted Provider, or Health Practitioner may only charge the Casual User an amount (i.e a co-payment) that is no more than:
- (a) the fee usually charged to Casual Users for the service provided;
 - (b) plus the fee usually charged to Casual Users for travel costs incurred (if any);
 - (c) minus the total amount that the PHO or Contracted Provider is entitled to Claim under this Schedule (including any travel costs).

5 Deceased Casual Users and Casual Users rejecting Services

- (1) If a Health Practitioner is asked to Provide General Medical Services to a Casual User other than at the Health Practitioner's Usual Place of Practice, but the patient dies before the arrival of the Health Practitioner or rejects the General Medical Services, the Health Practitioner is deemed to have provided General Medical Services to the patient for the purposes of this Agreement.

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 under this Agreement, the payment specified in clause 3, for administering to a Service User:
 - (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 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 Immunisation Services for which a fee is payable under this Schedule.
- (3) If the PHO or a Contracted Provider provides a Service other than an Immunisation Service at the same time as the consultation for the Immunisation Service, the PHO or Contracted Provider may charge for the 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 \$20.14 (GST exclusive) for administering any vaccine (except the influenza vaccine) listed in the National Immunisation Schedule in the New Zealand Pharmaceutical Schedule issued by PHARMAC, as detailed in the Immunisation Handbook, in accordance with that schedule.
- (2) The DHB will pay the PHO \$20.14 (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 March) until 31 July or the end of the immunisation season of that same calendar year (whichever is the latter).
- (3) The DHB will pay the PHO \$20.14 (GST exclusive) for administering the vaccine specified below to the person specified below:
 - (a) a Hepatitis B vaccine to 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 measles, mumps, and rubella vaccine to a Service User who is a household contact of a person with measles, mumps or rubella.

4 Conditions of payment

- (1) The DHB will pay the PHO in accordance with clause 3 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 Claim is from a Medical Practitioner or an Authorised Vaccinator employed or contracted by the PHO or a Contracted Provider.

5 Influenza vaccines

- (1) The cost of the influenza vaccine will be advised by the Ministry from time to time, and the DHB will advise the PHO of any change to the vaccine cost as soon as practicably possible after the change.
- (2) The Influenza Guidelines, and who is eligible for an influenza vaccine, may be varied from time to time by the Ministry, in consultation with the sector.
- (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.

SCHEDULE F1.4
[PLACEHOLDER]

1 **[insert]**

SCHEDULE F1.5
PAYMENT FOR SPECIAL SUPPORT SERVICES FOR FORMER SAWMILL
WORKERS EXPOSED TO PCP

1 Payment for Special Support Services

- (1) The DHB will pay the PHO and its Contracted Providers the following fees for Special Support Services provided in accordance with Schedule C5:
 - (a) \$220 (GST exclusive) for the first annual health check; and
 - (b) \$75 (GST exclusive) for each subsequent annual health check.
- (2) The fees specified in this clause may be varied by the Ministry with effect from 1 July of each year.

2 Fees and Claiming requirements

- (1) A PHO or Contracted Provider may Claim for Special Support Services only if the PHO or Contracted Provider was nominated by the Eligible Person to provide the services.
- (2) Neither the PHO nor a Contracted Provider may make a Claim for Providing Special Support Services if:
 - (a) the PHO or Contracted Provider is entitled to have the claim satisfied (whether directly or indirectly) under any other arrangement with the Ministry or a District Health Board; or
 - (b) the Services were provided by a General Practitioner in his or her capacity as an employee of a DHB.

3 The Claiming and payment process

- (1) The PHO or Contracted Provider may Claim for Special Support Services by completing the entitlement and claim form provided by the Ministry, and sending the form to:

Health Support Service Secretariat
Ministry of Health
PO Box 5013
WELLINGTON
- (2) On receipt of an entitlement and claim form, the Ministry will send the PHO or Contracted Provider the second and subsequent annual health check entitlement and claim forms.

SCHEDULE F1.6
PAYMENT FOR HEALTH SUPPORT SERVICES
FOR DIOXIN-EXPOSED PEOPLE

1 Payment for Health Support Services

- (1) The DHB will pay the PHO and its Contracted Providers the following fees for Health Support Services provided in accordance with Schedule C6:
 - (a) \$220 (GST exclusive) for the first annual health check; and
 - (b) \$75 (GST exclusive) for each subsequent annual health check.
- (2) The fees specified in this clause may be varied by the Ministry with effect from 1 July of each year.

2 Fees and Claiming requirements

- (1) A PHO or Contracted Provider may Claim for Health Support Services only if the PHO or Contracted Provider was nominated by the Eligible Person to provide the services.
- (2) Neither the PHO nor a Contracted Provider may make a Claim for providing Health Support Services if:
 - (a) the PHO or Contracted Provider is entitled to have the claim satisfied (whether directly or indirectly) under any other arrangement with the Ministry or a District Health Board; or
 - (b) the Services were provided by a General Practitioner in his or her capacity as an employee of a DHB.

3 The Claiming and payment process

- (1) The PHO or Contracted Provider may Claim for Health Support Services by completing the entitlement and claim form provided by the Ministry, and sending the form to:

Health Support Service Secretariat
Ministry of Health
PO Box 5013
WELLINGTON
- (2) On receipt of an entitlement and claim form, the Ministry will send the PHO or Contracted Provider the second and subsequent free annual health check entitlement and claim forms.

SCHEDULE F2.1
PAYMENTS FOR MANAGEMENT SERVICES, HEALTH PROMOTION SERVICES,
SERVICES TO IMPROVE ACCESS, AND CARE PLUS SERVICES

1 Payments made under this Schedule before we agree to use funding to implement Alliance Recommendations

- (1) Until we agree to use some or all of the funding that the DHB pays the PHO to Provide management services, health promotion services, services to improve access, and Care Plus Services to implement Alliance Recommendations in accordance with clause D.2(1), the DHB will pay the PHO the following payments to Provide the Services described in Schedule D1:
- (a) management service payments in accordance with clause 3;
 - (b) health promotion service payments in accordance with clause 4;
 - (c) services to improve access payments in accordance with clause 5; and
 - (d) Care Plus Service payments in accordance with clauses 6 and 7.

2 Payments made under this Schedule after we agree to use funding to implement Alliance Recommendations

- (1) If we have agreed to use funding to implement Alliance Recommendations in accordance with clause D.2(1), the DHB will pay the PHO an amount known as the flexible funding pool to provide:
- (a) the Alliance Services listed in Schedule D3; and
 - (b) the Services outside the scope of our Alliance listed in Schedule D5 (if any).
- (2) The flexible funding pool is made up of the amounts that the DHB is required to pay the PHO under clauses 3 to 7.

3 Management services payments

- (1) The annual management services fee will be calculated per Enrolled Person as set out in this Schedule, and paid to the PHO in equal monthly instalments in advance.
- (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) \$15.8748 per person up to 20,000 persons; and
 - (b) \$0.9156 per person from 20,001 to 40,000 persons.
- (3) If the number of Enrolled Persons in the PHO is between 40,001 and 75,000, the rate is:
- (a) \$11.2968 per person up to 20,000 persons; and
 - (b) \$5.4936 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 \$528,084.00 plus \$6.1692 per person over 75,000 enrollees.

4 Health promotion services payments

- (1) If the DHB has approved a proposal from the PHO to deliver health promotion services, 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:

Category of Enrolled Person	Non High Use Health Card Holders	
	Māori/Pacific	Non Māori/Pacific
Dep 1-8	\$2.6700	\$2.2252
Dep 9-10	\$3.1148	\$2.6700

- (2) The health promotion services fee will be paid to the PHO in equal monthly instalments in advance.

5 Services to improve access for High Need Persons payments

- (1) If the DHB approves the PHO's proposal to deliver services to improve access to High Need Persons, 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	\$75.8232	\$151.6460	\$0.0000	\$75.8232
	M	\$79.8304	\$159.6620	\$0.0000	\$79.8304
05-14	F	\$23.9996	\$48.0004	\$0.0000	\$23.9996
	M	\$22.4648	\$44.9292	\$0.0000	\$22.4648
15-24	F	\$22.1460	\$44.2916	\$0.0000	\$22.1460
	M	\$12.1884	\$24.3772	\$0.0000	\$12.1884
25-44	F	\$19.4608	\$38.9216	\$0.0000	\$19.4608
	M	\$12.5796	\$25.1596	\$0.0000	\$12.5796
45-64	F	\$26.6548	\$53.3104	\$0.0000	\$26.6548
	M	\$19.9084	\$39.8172	\$0.0000	\$19.9084
65+	F	\$45.9344	\$91.8696	\$0.0000	\$45.9344
	M	\$39.6140	\$79.2268	\$0.0000	\$39.6140

- (2) The services to improve access for High Needs Persons fee will be paid to the PHO in equal monthly instalments in advance.

6 Calculating expected Care Plus population

- (1) Subject to subclause (2), in 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 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%

7 Payment for Care Plus 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 Enrolled Population compared to the number of Care Plus Patients the DHB expected the PHO to have during the previous month according to clause 6(1):

Level	Percentage of expected number of Care Plus Patients as calculated in clause 6(1) of this Schedule (x)	Percentage of full Care Plus Services funding in clause 7(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%

Level	Percentage of expected number of Care Plus Patients as calculated in clause 6(1) of this Schedule (x)	Percentage of full Care Plus Services funding in clause 7(2) of this Schedule
Four	$60\% \leq X < 65\%$ of total	65%
Five	$65\% \leq X < 70\%$ of total	70%
Six	$70\% \leq X < 75\%$ of total	75%
Seven	$75\% \leq X < 80\%$ of total	80%
Eight	$80\% \leq X < 85\%$ of total	85%
Nine	$85\% \leq X < 90\%$ of total	90%
Ten	$90\% \leq X < 95\%$ of total	95%
Eleven	$95\% \leq X$ of total	100%

- (2) For the purposes of the table set out in subclause (1), the DHB will calculate the full Care Plus Services funding as \$248.4984 (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 month 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 6(1) , the DHB will review and adjust the PHO's funding for Care Plus.

SCHEDULE F2.2A PAYMENT OF RURAL FUNDING

1 Rural Funding payments

- (1) The DHB will pay each Rural Funding component payment:
 - (a) in equal quarterly payments, from 1 July 2015 to the day before the NES Start Date; and
 - (b) in equal monthly payments, from the NES Start Date.

2 Workforce retention funding

- (1) For each Enrolled Person who is a member of a Rural Community, is enrolled with a Rural Contracted Provider, and receives First Level Services from a Rural Practitioner, the DHB will pay the PHO the amount calculated by reference to the rural ranking score of the Rural Practitioner, as specified below:

Rural ranking score of Rural Practitioner	\$ per Enrolled Person GST exclusive
35-40	\$7.72
45-50	\$11.60
55-65	\$15.46
70 +	\$19.31

- (2) 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 Rural Contracted Providers in that financial year.

3 Reasonable roster funding

- (1) The DHB will pay reasonable roster funding to the Rural Contracted Providers that we agree are experiencing onerous on-call arrangements.
- (2) The amount of reasonable roster funding paid will be the amount that we agree with each such Rural Contracted Provider.

4 Remote rural practice areas funding

- (1) For each remote rural practice area the DHB will pay the PHO an amount, being:

the amount the PHO was entitled to be paid for the area under the special funding arrangement;

minus the amount that the PHO receives as capitation payments for the members of the Enrolled Population who live in the area.
- (2) If the amount that the PHO was entitled to be paid under the special funding arrangement is less than the amount that the PHO receives as capitation payments, the DHB will make no remote rural practice area funding payments to the PHO in respect of that area.

5 Rural bonuses payments

- (1) The DHB will supply the PHO with application forms for rural bonuses by 15 March each year, and the PHO will lodge applications for the rural bonus on behalf of its Rural Practitioners with the DHB by 15 April in each year (unless the DHB, at its sole discretion, extends that date).
- (2) The DHB will calculate the amount of each Rural Practitioner's rural bonus on the basis of the Rural Practitioner's rural ranking score.
- (3) The DHB will, within 1 month after the date by which applications had to be lodged, advise each eligible Rural Practitioner who applied for a rural bonus of the amount of his or her rural bonus for that financial year.
- (4) The PHO may not alter the amount of rural bonus payable to an eligible Rural Practitioner.

6 Rural After Hours funding payments

- (1) The amount of rural After Hours funding paid by the DHB will be the amount determined by the Ministry at 30 June 2014.

7 Rural sustainability support payments

- (1) If we have agreed that Rural Funding can be used in accordance with Alliance Recommendations and have varied Schedule D4 and Schedule F2.2B in accordance with clause D.3, the DHB will pay the PHO a rural sustainability support payment, in accordance with the relevant provisions in Schedule D4 and Schedule F2.2B.

SCHEDULE F2.2B
[PAYMENT OF RURAL FUNDING WITHIN THE SCOPE OF OUR ALLIANCE]

1 **[Insert]**

(1) [insert]

SCHEDULE F2.3
PAYMENT FOR SERVICES OUTSIDE THE SCOPE OF OUR ALLIANCE

1 [Insert] or [not applicable]

(1) [insert]

SCHEDULE F3.1
[PAYMENT FOR (LOCAL SERVICES)]

1 **[Insert] or [not applicable]**

(1) [insert]

Part G Value and High Performance

G.1 Background

- (1) The New Zealand Health Strategy has two parts: *Future Direction* and *Roadmap of Actions 2016*. The *Future Direction* outlines a new high-level direction for New Zealand's health system over the ten years to 2025, to ensure that *all New Zealanders live well, stay well, get well*.
- (2) The Government expects the public health system to continue to focus on delivering high-quality health services, improving performance where it matters most. Stronger partnerships and changing approaches will allow the health system to manage the challenges of an ageing population and a growing burden of long-term disease in a fiscally constrained environment.
- (3) The Strategy identifies five strategic themes for the changes that will take the health system toward the future envisioned.
- (4) One of these five themes is value and high performance. This theme aims to place a greater focus on health outcomes, equity, and meaningful results. To do this, the accountability of all stakeholders within the health system must be reoriented to reflect this focus and take a continuous quality improvement approach to service development and delivery. The performance and planning system must support the overall strategic direction, and services at all levels of the system should provide high-quality care as a result of ongoing programmes of monitoring and improvement.
- (5) The *Roadmap of Actions* sets out 27 areas for action over five years to implement the Strategy. Two of these actions are:
 - (a) develop and implement a **monitoring framework focused on health outcomes**, with involvement from the health and disability system, service users, and the wider social sector. This work will build on the Integrated Performance and Incentive Framework ("IPIF") and results-based accountability and aims to increase equity of health outcomes, quality and value; and
 - (b) work with the system to develop a **performance management** approach that makes use of streamlined reporting at all levels, to make the whole system publicly transparent.
- (6) Building on the *one team* theme, the Ministry intends to continue to co-develop the parts of this outcomes monitoring framework with the sector including primary care and PHOs. While the governance of this outcomes framework supporting *value and high performance* is still to be determined, the Ministry intends appropriate participation of stakeholders including primary care clinicians and PHOs. The work done by primary care to date in developing IPIF will form a sound basis for this future work as yet more aspirational and system-wide measures and performance approach are developed.
- (7) As 2014/15 and 2015/16 have been transitional years from the old PHO Performance Programme to IPIF, 2016/17 is the first year of a broader system-wide view of performance.
- (8) During the update of the Strategy, the Ministry and the sector co-developed a suite of System Level Measures that provide system-wide view of performance. These System Level Measures engage

the health sector more broadly (professions, settings, and health conditions) than the previous measures.

- (9) The performance of individual clinicians and/or provider organisations, through health activities and processes, are measured by contributory measures. These individual groups must work as *one team* (another of the Strategy's five themes) to improve system level performance. The System Level Measures also resonate with the *care closer to home*, *people powered*, and *smart system* themes of the Strategy.
- (10) This Part G sets out how we will participate in the implementation of the System Level Measures, including the role of our Alliance, the development of an Improvement Plan (and associated Local Plans), and the funding available to the PHO and its Contracted Providers to support development of capacity and capability, particularly in respect of system-level measure milestones.

G.2 System Level Measures and National Health Targets

- (1) We agree that there are six system level measures that will begin from 1 July 2016 ("System Level Measures"):
 - (a) three measures for which milestones will be agreed by our Alliance, and that the achievement of those milestones will be financially incentivised, as set out in this Part G, being:
 - (i) number of acute hospital bed days per capita;
 - (ii) ambulatory sensitive hospitalisations rates for 0 to 4 year olds; and
 - (iii) patient experience of care;
 - (b) one measure for which our Alliance will agree a milestone in accordance with this Part G but that will not be financially incentivised in the 2016/17 Financial Year (but may be financially incentivised in future Financial Years), being:
 - (i) amenable mortality rates; and
 - (c) two measures that will be co-developed during the 2016/17 Financial Year by the Ministry and the sector and so will have neither milestones nor financial incentives for the 2016/17 Financial Year, but will have milestones (and may have financial incentives) in future Financial Years:
 - (i) youth access to and utilisation of youth appropriate health services; and
 - (ii) number of babies who live in a smoke-free household at six weeks post-natal.
- (2) We also agree that there are two national health targets from 1 July 2016 that will be financially incentivised as set out in this Part G ("National Health Targets"), being:
 - (a) better help for smokers to quit; and
 - (b) increased immunisation for 8 month olds.

- (3) We agree that:
- (a) each of the four System Level Measures described in subclauses (1)(a) and (1)(b) is described in the measures library located at the Health Quality Measures New Zealand website ("Measures Library");
 - (b) a description of the two System Level Measures to be developed as described in subclause (1)(c) will in the future be included in the Measures Library; and
 - (c) the National Health Targets are described in the Reference Document entitled "Indicator Definitions for PHOs".
- (4) We agree that the primary care performance funding provided by the Ministry, from which payments will be made to the PHO as described in clause G.8 to G.10, will be used to build capacity and capability in primary care to contribute towards the achievement of the System Level Measures and National Health Targets.

G.3 Developing an Improvement Plan and Local Plans within our Alliance

- (1) We agree that we will, as part of our Alliance, work together to develop an improvement plan ("Improvement Plan") and one or more local plans ("Local Plans") for each Financial Year.
- (2) The Improvement Plan will set out:
- (a) improvement milestones (each a "Milestone") as follows:
 - (i) in the 2016/17 Financial Year, an improvement milestone to be achieved for each of the four System Level Measures described in subclauses G.2(1)(a) and (b); and
 - (ii) in every other Financial Year, an improvement milestone to be achieved for each of the six System Level Measures described in subclauses G.2(1)(a), (b) and (c);
 - (b) for each Milestone, a set of contributory measures.
- (3) We agree that:
- (a) each Milestone will be a number that is based on our district's trend data and baseline and that is appropriate given the needs and priorities of our communities and health services. Our Alliance will have the freedom to determine the process for developing these Milestones;
 - (b) contributory measures for each Milestone will be selected by our Alliance from the Measures Library, and that such measures will be appropriate given the needs and priorities of our communities and health services and the Milestone to which the measures relate; and
 - (c) we will develop our Improvement Plan in accordance with any guidelines issued by the Ministry.
- (4) Each Local Plan will set out:
- (a) a quantitative goal for 30 June of the relevant Financial Year for each contributory measure that our Alliance wishes to achieve;

- (b) the specific activities that will be undertaken by the DHB, the PHO, the PHO's Contracted Providers, and the other members of our Alliance as relevant, so that the goals for the contributory measures are achieved;
- (c) information about our Alliance's investment logic for those activities. We will discuss and agree the individual contributions (dollars or resource) that will be made by the DHB and PHO to the implementation of the jointly agreed Improvement Plan;
- (d) information about the continuous quality improvement ("CQI") processes that our Alliance will use to monitor implementation of the Local Plans; and
- (e) a local reporting and monitoring framework.

G.4 Agreeing and submitting an Improvement Plan

- (1) We agree that once our Alliance has agreed an Improvement Plan and Local Plan(s):
 - (a) we must both sign the agreed Improvement Plan and each Local Plan; and
 - (b) we must ensure that any members of our Alliance who are likely to be responsible for undertaking or contributing to an activity described in a Local Plan also sign the agreed Improvement Plan and relevant Local Plan.
- (2) The DHB will, once the Improvement Plan is agreed by our Alliance and signed as set out in subclause (1), submit the plan to the Ministry for its approval as part of the DHB's quarterly reporting process by no later than the following date (the "Due Date"):
 - (a) for the 2016/17 Financial Year; 20 October 2016; and
 - (b) for every other Financial Year, 30 May of the previous Financial Year.
- (3) The submitted Improvement Plan will include all signatures required under subclause (1).
- (4) We acknowledge that our Local Plan(s) do not need to be submitted to or approved by the Ministry, but agree that we will provide our Local Plan(s) to the Ministry if requested by the Ministry.

G.5 Ministry approval of the Improvement Plan

- (1) We acknowledge that if our Alliance's Improvement Plan is submitted by the Due Date, the Ministry expects that it will assess and provide feedback on our Alliance's Improvement Plan between the date that it is submitted and the following date (the "Feedback Date"):
 - (a) for the 2016/17 Financial Year, 20 November; and
 - (b) for every other Financial Year, 20 June of the previous Financial Year..
- (2) We agree that we, through our Alliance, will take all practical steps to amend and resubmit the plan to reflect any material feedback.

- (3) We also acknowledge that the Ministry has advised that:
- (a) it expects to have made a decision on the Improvement Plan, and will take all reasonable steps to have done so, by the following date (the "Intended Approval Date"):
 - (i) for the 2016/17 Financial Year, 30 November; and
 - (ii) for every other Financial Year, 30 June of the previous Financial Year.
 - (b) as set out in clause G.10(1), the PHO will be paid payment 2 on 15 December (for the 2016/17 Financial Year) or 15 July (for every other Financial Year) if the Improvement Plan is submitted by the Due Date and either:
 - (i) the Ministry has not advised us by the Feedback Date that material changes need to be made to the plan; or
 - (ii) the Ministry has approved the plan by the Intended Approval Date; and
 - (c) the Ministry will not unreasonably withhold approval of the Improvement Plan.
- (4) If our Alliance uses its best endeavours, but its members are unable to agree to, an Improvement Plan and have the Improvement Plan signed in accordance with clause G.4(1) by the Feedback Date, the Ministry will facilitate a resolution between the members of our Alliance that results in an Improvement Plan for submission to the Ministry.
- (5) The Improvement Plan is required by the DHB's annual plan and as such will be made publicly available by the Ministry or the DHB once it has been approved, including by being published on the internet.

G.6 Implementing the Improvement Plan and other obligations

- (1) We agree that we will, through our Alliance, implement our Improvement Plan and Local Plan(s) as soon as it is practical for us and the relevant members of our Alliance to do so, including that the PHO will work with its Contracted Providers as necessary to undertake the activities described in the Local Plan(s).
- (2) We agree that we will, through our Alliance, collect, manage, and analyse information about our Alliance's progress towards achieving the Milestones and goals for our contributory measures (including comparative analysis of provider contributions to System Level Measures).
- (3) We also agree that we will, as part of our Alliance:
- (a) take all reasonable steps to meet each System Level Measure and the National Health Targets in each quarter; and
 - (b) work with the Ministry during the 2016/17 Financial Year to co-develop the two System Level Measures described in clause G.2(1)(c) (relating to access to youth health services and babies living in a smoke-free household).

G.7 Information requirements

- (1) We agree that we will provide the Ministry with the following information:
 - (a) for Quarter Two and Quarter Three, we will advise the Ministry as to whether our Alliance is likely to achieve the Milestone for each System Level Measure in Quarter Four and, if our Alliance is unlikely to do so, we will advise the Ministry as to what steps will be taken to try to ensure that the Milestone is achieved (which could include changes to our Local Plan(s)); and
 - (b) for Quarter Four, we will advise the Ministry as to whether we have achieved the Milestone for each System Level Measure and, if we have not achieved a Milestone and, the reasons for that.
- (2) The information described in subclause (1) will be provided to the Ministry by the DHB as part of the DHB's quarterly planning and reporting process.
- (3) We agree that, if requested by the Ministry, we will provide information to the Ministry about our agreed contributory measures, Local Plan(s), activities, and goals, including any information or data collected by our Alliance.

G.8 Payments

- (1) The DHB will pay the PHO up to three payments each Financial Year as set out below. The total amount of funding that will be available to be paid to the PHO will be calculated as follows ("Funding"):

\$5.33 (GST exclusive) or any higher amount specified by the Ministry

x the number of Enrolled Persons in the DHB's Primary Geographical Area at the end of the quarter to which the relevant payment relates.
- (2) The DHB will pay the Funding to the PHO as set out below and in clauses G.9 and G.10:
 - (a) **payment one:** 25% of the Funding will be paid to the PHO by the DHB in order to assist the PHO to build its capacity and capability, and the capability and capacity of its Contracted Provider, so that each Milestone is achieved;
 - (b) **payment two:** 50% of the Funding will be paid to the PHO when the Ministry has approved our Alliance's Improvement Plan in accordance with clause G.5. This will support PHO and its Contracted Providers to build their capacity and capability to implement the plan; and
 - (c) **payment three:** 25% of the Funding will be available to be paid to the PHO for achieving the Milestones for the System Level Measures and for achieving the National Health Targets ("Performance Payment").

G.9 Performance Payment for 2016/17

- (1) The amount of the Performance Payment paid by the DHB to the PHO in the 2016/17 Financial Year will be determined as follows:

	System Level Measure	Proportion of Performance Payment that will be paid if the Milestone for the Measure is achieved
1	Acute hospital bed days per capita	20%
2	Ambulatory sensitive hospitalisation rates for 0 to 4 year olds	20%
3	Patient experience of care	20%
	National Health Target	Proportion of Performance Payment that will be paid if the National Health Target is achieved
4	Better help for smokers to quit	20%
5	Increased immunisation for 8 month olds	20%

- (2) We agree that any changes to how the amount of the Performance Payment that will be paid to the PHO is determined, including if additional System Level Measures are financially incentivised, will be made in accordance with clause B.23 (Variations to this Agreement).
- (3) Except as provided in subclauses (4) and (5), the PHO will receive no payment in respect of a Milestone or a National Health Target that our Alliance does not meet in Quarter Four.
- (4) If our Alliance does not achieve a Milestone in Quarter Four, the DHB will nevertheless calculate and pay the Performance Payment as if the Milestone had been achieved if the Ministry advises that it is satisfied:
- (a) that the PHO and its Contracted Providers took all reasonable steps that it could to ensure that the Milestone was achieved;
 - (b) with the reasons given in accordance with G.7(1)(b) as to why the Milestone was not achieved; and
 - (c) that the Milestone was closer to being achieved in Quarter Four than it was on the first day of Quarter One.
- (5) If the PHO's Level of Achievement in Quarter Four in respect of a National Health Target is not more than 10 percentage points below the National Health Target that is set out in the Referenced Document entitled "Indicator Definitions for PHOs", the DHB will pay the PHO, in respect of each National Health Target, an amount calculated as follows:

the amount that the PHO would have received if it had met the National Health Target;

x the PHO's Level of Achievement in respect of the National Health Target.

- (6) For the purposes of subclause (5) "Level of Achievement" means the PHO's achievement in Quarter Four in respect of the National Health Target, calculated in accordance with the health target definition for the National Health Target that is set out in the Referenced Document entitled "Indicator Definitions for PHOs" and expressed as a percentage.

G.10 Payments of Funding, including the Performance Payment

- (1) Each payment of Funding due to the PHO under clauses G.8 and G.9 will be paid on the dates specified below in each Financial Year:

	Payment	Date
1	Payment 1 (capacity and capability payment)	15 July of the relevant Financial Year
2	Payment 2 (further capacity and capability payment on approval of our Alliance's Improvement Plan)	<u>For the 2016/17 Financial Year</u> By 15 December if the Improvement Plan is submitted by 20 October and: - the Ministry does not advise that material changes need to be made to the plan by 20 November; or - the plan is approved by the Ministry by 30 November OR If the Improvement Plan is submitted after 20 October, payment 2 will be paid by the 15th day of the month after the month in which the plan is approved by the Ministry. <u>For every other Financial Year</u> 15 July if the Improvement Plan is submitted by 30 May and: - the Ministry does not advise that material changes need to be made to the plan by 20 June; or - the plan is approved by the Ministry by 30 June

		OR If the Improvement Plan is submitted after 20 May, payment 2 will be paid by the 15 th day of the month after the month in which the plan is approved by the Ministry.
3	Payment 3 (Performance Payment)	15 September of the following Financial Year

- (2) The DHB will also pay the PHO any incentive payments due for the period from 1 April 2016 to 30 June 2016 under version 3 of this Agreement on 15 September 2016.
- (3) The DHB will provide the PHO with a Buyer Created Tax Invoice for each payment that it pays under this Part G.
- (4) The DHB will, at the PHO's request, provide the PHO with information about the data used to calculate any of the PHO's payments.
- (5) We agree that the provisions set out in Part F apply to all payments made under this Part.

G.11 Direct financial benefit for Contracted Providers

- (1) The PHO must ensure that at least 50% of any payment that it receives under this Part G is used to directly financially benefit its Contracted Providers.

Part H Definitions

H.1 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 practice that is contracted to a PHO or a Contracted Provider, and is determined to be an access practice by the Ministry.

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(3) 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 that are provided within the scope of our Alliance.

Annual Statement means the statement of fee increase levels made under clause F.22(9).

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

Audit Protocol means any document that sets out protocols relating to audits, and may include the Referenced Documents entitled "Primary Health Organisation (PHO) Audit Protocol: Quality & Service Audits" and "Primary Health Organisation (PHO) Audit Protocol: Financial, claiming and referred services", any Referenced Document that replaces one of those documents, or any other relevant Referenced Document.

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, a Sunday, or a public holiday as that term is defined in the Holidays Act 2003.

Care Plus Patients means Enrolled Persons who have consented to receive Care Plus Services in accordance with clause 5 of Schedule D1 (if applicable).

Care Plus Services means the primary health care services described in Schedule D1 for people who have high needs for primary health care services (if applicable).

Casual User, in relation to a PHO, means an Eligible Person who is not enrolled with the PHO but who receives Services from the PHO and, in relation to a Contracted Provider, means an Eligible Person who is not enrolled with the Contracted Provider but who receives Services from the Contracted Provider.

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 in accordance with clause F.4(1).

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 would reasonably be considered 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 we agree that the terms are 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.24.

Confidential Information means Commercial Information and Health Information.

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

Crown Direction means a 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.

Daily Record means the daily record required to be kept in accordance with the Referenced Document entitled "Daily record, laboratory tests, diagnostic imaging services, and pharmaceutical requirements".

Default Interest means the interest to be paid on late payments in accordance with clauses F.16, and F.17.

Dep means the New Zealand 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 Nurse means a person who is employed or contracted by the PHO or a Contracted Provider to deliver the Services, registered with the Nursing Council of New Zealand in the enrolled nurse scope of practice, and holds a current annual practising certificate.

Enrolled Person means an Eligible Person who is enrolled with the PHO and a Contracted Provider in accordance with the Referenced Document entitled "Enrolment Requirements for Providers and Primary Health Organisations".

Enrolled Population means the Eligible Persons enrolled with a PHO and a Contracted Provider in accordance with the Referenced Document entitled "Enrolment Requirements for Providers and Primary Health Organisations".

Financial Year means the year from 1 July of a year to 30 June of the following year.

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 described in clauses 1(1)(a)(ii), 1(1)(b), 1(1)(c) and 1(1)(d)(i) of Schedule C1 to an Enrolled Person by a member of a General Practice Team.

Foundation Standard means the standards issued by the Royal New Zealand College of General Practitioners, and updated by them from time to time.

General Medical Services means the services described in clause 10 of Schedule C2.

General Practice Team means a multidisciplinary team whose members have the complementary knowledge and skills of Medical Practitioners and Nurses, who may include other Practitioners, and who work together to provide primary health care to improve the health of the Enrolled Population.

General Practitioner means a Medical Practitioner who is employed or contracted by the PHO or a Contracted Provider to Provide the Services.

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 Practitioner means a person who:

- (a) is registered under the Health Practitioner Competence Assurance Act 2003 with the relevant authority under that Act;
- (b) holds an annual practising certificate;
- (c) is working within his or her scope of practice; and
- (d) is employed or contracted by the PHO or a Contracted Provider as part of a General Practice Team to Provide the Services.

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

High Needs Persons means persons who are Māori, Pacific or persons residing in New Zealand Deprivation Index decile 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 and 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 Practitioner with a current practising certificate who provides Services in place of another Practitioner.

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

Medical Practitioner means a person employed or contracted by the PHO or a Contracted Provider to deliver the Services, who is registered with the Medical Council of New Zealand as a practitioner of the profession of medicine, and who holds a current annual practising certificate.

Minimum Requirements means the minimum requirements that the PHO must meet set out in Schedule B1.

Minister means the Minister of Health.

Ministry means the Ministry of Health.

National Enrolment Service means the enrolment service hosted by the Ministry that comprises a master enrolment register with links to other core services, which is used to assess patient demographics, eligibility and entitlement for funded healthcare.

NES Start Date means the date agreed by the PSAAP Group as being the date from which the National Enrolment Service will be operational.

National Immunisation Register means the information system that holds the immunisation records of children, and that is maintained by the Ministry.

National Voluntary Variation means a variation to this Agreement described in clause B.23(1)(b).

Nationally Consistent Services means the services described in Part C.

NHI means National Health Index.

Not for Profit, in relation to a PHO, 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;
- (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
- (c) includes a PHO that is registered as a charitable entity under the Charities Act 2005

and for the purposes of this definition:

- (a) persons are associated if they are associated under the Income Tax Act 2007;
- (b) a body is controlled by another person in the circumstances set out in section CW 42(5) of the Income Tax Act 2007; and
- (c) 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 a 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 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 means a Nurse Practitioner, a Registered Nurse, or an Enrolled Nurse.

Nurse Practitioner means a person who is employed or contracted by the PHO or a Contracted Provider to deliver the Services, who is registered with the Nursing Council of New Zealand as a practitioner of the profession of nursing, whose scope of practice permits the performance of nurse practitioner functions, and who holds a current annual practising certificate.

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 by the DHB 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.

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

Practitioner means a person who has an appropriate professional qualification who is employed or contracted by the PHO or a Contracted Provider to provide the Services and includes a Health Practitioner.

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

Premise means the location from where the PHO or a Contracted Provider Provides the Services or where anything relating to the Services occurs or is kept, including the location of any Records.

Primary Geographical Area means the geographical area for which the DHB is responsible as set out in Schedule 1 of the Act.

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

Provide includes purchasing the Services.

PSAAP Group means the group established in accordance with the PSAAP Protocol to consider and make decisions and recommendations on proposals to vary the PHO Services Agreement.

PSAAP Protocol means the Referenced Document entitled "PHO Service Agreement Amendment Protocol".

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".

Quarter One means the period from 1 July to 30 September of the relevant Financial Year.

Quarter Two means the period from 1 October to 31 December of the relevant Financial Year.

Quarter Three means the period from 1 January to 31 March of the relevant Financial Year.

Quarter Four means the period from 1 April to 30 June of the relevant Financial Year.

Record means any record or information held by the PHO, a Contracted Provider, the PHO's or Contracted Provider's Staff, 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 services, laboratory services, and diagnostic imaging services, and any other services that can be referred by a Practitioner to other Practitioners as agreed in writing with the DHB.

Register means the PHO's or Contracted Provider's register of Enrolled Persons maintained in accordance with the Referenced Documents entitled "Enrolment Requirements for Providers and Primary Health Organisations", "Business Rules: Capitation-based funding".

Registered Nurse means a person who is employed or contracted by the PHO or a Contracted Provider to deliver the Services, who is registered with the Nursing Council of New Zealand as a practitioner of the profession of nursing whose scope of practice permits the performance of general nursing functions, and who holds a current annual practising certificate.

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

Rural Community means:

- (a) a community that:
 - (i) is a rural, a minor urban, or a secondary urban area as defined by Statistics New Zealand; and
 - (ii) is at least 30 kilometres or at least 30 minutes journey time as calculated by AA Maps from a hospital that is a level 3 base hospital; and
 - (iii) has a population of 15,000 people or less; or
- (b) a community that the DHB (or our Alliance, if we have agreed that Rural Funding will be used in accordance with Alliance Recommendations) determines is a rural community for the purposes of this Agreement.

Rural Contracted Provider means a Contracted Provider who is a Rural Practitioner, or who employs or contracts one or more Rural Practitioners.

Rural Funding means the funding paid to PHOs, Rural Contracted Providers, Rural Practitioners, and Contracted Providers, in accordance with Schedules D2 and F2.2A, or Schedules D4 and F2.2B (as the case may be).

Rural Practitioner means:

- (a) a General Practitioner:
 - (i) whose practice is located in and provides Services to the members of a Rural Community; and
 - (ii) who scores at least 35 points on the rural ranking scale; or
- (b) a General Practitioner or a Nurse that the DHB or our Alliance determines is a Rural Practitioner for the purposes of some or all of the provisions of this Agreement.

Secondary Geographical Area means a geographical area for which another DHB is responsible under Schedule 1 of the Act.

Section 88 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 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.

System Level Measures has the meaning given to that term in clause G.2(1).

Treaty of Waitangi Principles means the following principles:

- (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 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.

Usual Place of Practice means a location at which the PHO or a Contracted Provider provides Services, and in respect of which a Practitioner has been assigned a health practitioner index number.

Well Child Services means services provided in accordance with the Well Child/Tamariki Ora National Schedule published by the Ministry, which 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 that families, including Māori and Pacific families, are supported to achieve their maximum health and well-being.