

PRIMARY HEALTH ORGANISATION AGREEMENT

Version 17.0

between

«DHB_NAME» DHB

Contact: «CONTRACTDEPUTY_NAME»

and

«PROVIDER_NAME»

«CONTRACT_DESCRIPTION»

«PROVIDER_ADDRESS»
«PROVIDER_ADDRESS2»
«PROVIDER_CITY»
Ph: «PROVIDER_PHONE»
Fax: «PROVIDER_FAX»

Contact: «PRVDRCONTACT_NAME»

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Part A. Key Terms and Execution

A.1 Parties to this Agreement

- A.1.1 We are the **DHB** District Health Board, responsible for providing and funding health and disability services to improve the health of our resident population under the New Zealand Public Health and Disability Act 2000.
- A.1.2 As Crown agents, we are required to 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.
- A.1.3 You are **[name]** a primary health organisation (PHO) established to provide primary health care services to meet the needs of your Enrolled Population.

A.2 Agreement for Services

- A.2.1 In this Agreement:
- (a) you agree to:
 - (i) deliver to Eligible Persons the primary health care services described in Part H and Part J, in accordance with this Agreement (the Services); and
 - (ii) undertake the associated tasks and management services required by this Agreement;
 - (b) we agree to Pay you in accordance with Part F and Part J; and
 - (c) we acknowledge that our Payments to you under this Agreement do not cover the full cost to you of delivering the Services and you may charge co-payments in accordance with the Schedule F4 to Part F and Schedule J2 to Part J.
- A.2.2 You may provide the Services yourself (i.e. be a provider) or you may subcontract others to deliver all or part of the Services as you consider appropriate in accordance with clause D.2. In either case, you are ultimately responsible for ensuring the Services are provided in accordance with this Agreement.
- A.2.3 You agree not to claim and to ensure that your Contracted Providers do not claim under any Section 88 Advice Notice for Services delivered under this Agreement.

A.3 Term

Use one of the following clauses

- A.3.1 This Agreement comes into effect on [insert date], (the Commencement Date) and continues until all of the Schedules attached to Part J have expired, or until this Agreement is terminated in accordance with its termination provisions. *evergreen clause*

This Agreement comes into effect on [insert date], (the Commencement Date) and expires on [insert date] (the Termination Date), unless terminated earlier in accordance with its termination provisions. *fixed term clause*

A.3.2 You acknowledge and agree that:

- (a) we have not made any promise (express or implied) that we will contract with you for the provision of services, or will otherwise make available to you more funding, after the expiry or termination of this Agreement; and
- (b) you have no legitimate expectation that we will do so.

A.4 This Agreement and other documents

- A.4.1 This Agreement refers to a number of other documents that contain further requirements for PHOs. You agree to comply with the requirements of the documents specified in Schedule A1 to this Part A (the Referenced Documents).
- A.4.2 We will provide you with copies of all Referenced Documents and variations to any Referenced Documents.

A.5 Completing the negotiations of the final PHO Agreement

- A.5.1 We both acknowledge that this Agreement is a transition PHO service agreement and is the result of negotiation between the Ministry of Health, DHBs, Māori Stakeholders and agents (including IPAC/First Health/CareNET and Health Care Aotearoa) for existing and intending PHOs.
- A.5.2 We both acknowledge that this Agreement has resolved many of the outstanding issues which were unresolved in the first interim PHO service agreement (agreed to between the Ministry of Health, DHBs and representatives of the primary health provider sector in December 2002). Nevertheless, a number of significant issues regarding the provision of services by PHOs are still unresolved in this Agreement. We both agree to resolve the remaining issues which are listed in Schedule J4 through the process outlined in clause J.10 of Part J.
- A.5.3 Each of us agrees to appoint an agent to resolve the outstanding issues listed in Schedule J4 through the process described in the Referenced Document entitled "Transitional PHO Agreement Amendment Protocol". We both agree to give priority to completing that process by 31 December 2004.
- A.5.4 The Ministry of Health requires all DHBs to contract with PHOs on the basis of the standard PHO agreement. We both therefore agree:
 - (a) if the final PHO agreement is finalised prior to the expiry of the Termination Date , we both will give priority to entering into negotiations with a view to replacing this Agreement with the final PHO agreement as soon as practicable; and
 - (b) that any subsequent agreement that might replace this Agreement after its expiry shall be on the terms of the final PHO agreement.
- A.5.5 If this Agreement has not been replaced by the final PHO agreement under either of the circumstances in clause A.5.4 by 31 December 2004, then either of us may terminate this Agreement upon giving not less than three month's notice in writing to the other.

A.6 Execution

A.6.1 By our respective authorised signatories signing below, we both agree to comply with and be bound by the terms and conditions of this Agreement.

[REDACTED] District Health Board by:

Signature

Name

Position

Date

Witnessed by:

Signature

Name

Occupation

Residence

Date

PROVIDER NAME [PHO] by:

Signature

Signature

Name

Name

Position

Position

Date

Date

Witnessed by:

Witnessed by:

Signature

Signature

Name

Name

Occupation

Occupation

Residence

Residence

Date

Date

SCHEDULE A1

Referenced Documents

1. Purpose

- 1.1 This Schedule A1 to Part A specifies the Referenced Documents that form part of this Agreement.
- 1.2 Referenced Documents may be added or varied in accordance with clause D9.3 of this Agreement.

2. Technical specifications

- 2.1 The technical specification documents and their key reference data are listed below:

<i>Document Name</i>	<i>Version</i>	<i>Publisher</i>
Capitation-based Funding: User Information Guide	3.8	Primary Health Care Team, Ministry of Health
CBF User Manual	1.0	Primary Health Care Team, Ministry of Health
HL7 Messages Standard Definition: Capitation-based Funding Electronic Registers	3.09	HealthPAC, Ministry of Health
Electronic Claiming Message Standard Definition	Standard Version v1.45	HealthPAC, Ministry of Health

- 2.2 The purpose of each of the technical specification documents is described below:

<i>Document Name</i>	<i>Purpose</i>
CBF User Information Guide	This is an overview of the CBF system including a checklist of minimum system requirements.
CBF User Manual	This describes how to use the CBF system.
HL7 Messages Standard Definition: Capitation-based Funding Electronic Registers	This describes the data elements and the format for transmitting the information to HealthPAC.
Electronic Claiming Message Standard Definition	This describes the process and data for claiming for casual (non-enrolled) General Medical Services and Immunisation

3. Business rules

3.1 The business rules documents comprise two categories of documents:

- (a) Register management; and
- (b) Claims management.

3.2 Register management rules

(a) The Register management rules documents and their key reference data are listed below:

Document Name	Version	Publisher
Business Rules: Capitation-based funding	3.3.6	HealthPAC, Ministry of Health
Enrolment Requirements for Primary Health Organisations	2.2	HealthPAC, Ministry of Health
Certification of PHO Register	1.1	HealthPAC, Ministry of Health

(b) The purpose of the Register management rules documents is described below:

Document Name	Purpose
CBF Business Rules	This provides a description of the business rules governing capitation.
Enrolment Requirements for PHOs	This provides a description of the operational policy and related requirements.
Certification of PHO Register	This document provides a template for certification of the PHO register to be faxed to the Payment Agent

3.3 Claims Management

(a) The Claims management rules documents and their key reference data are listed below:

Document Name	Version	Publisher
PHO Purchase Unit Codes	1.0	HealthPAC, Ministry of Health

(b) The purpose of these documents is described below:

Document Name	Purpose
PHO Purchase Unit Codes	This list the purchase unit codes used for Claims submitted by PHOs and

Document Name	Purpose
	Contracted Providers.

4. Other Referenced Documents

- 4.1 A number of other Referenced Documents (including documents that are yet to be developed) support PHO and DHB operations and interactions. These other Referenced Documents and their key reference data are listed below:

Document Name	Version	Publisher
Primary health care audit protocol: Financial, claiming and referred services	1.0	Ministry of Health
PHO Quality Indicators	Yet to be developed	Ministry of Health
Transitional PHO Agreement Amendment Protocol	1.3	Ministry of Health
National Immunisation Register Requirements	1.0	Ministry of Health
Guidelines on reaching agreement on holiday areas exempted from NHI requirements	To be finalised	HealthPAC, Ministry of Health
Improving Māori Health: A guide for PHOs	1.0	Primary Health Care Team, Ministry of Health

- (b) The purpose of the other Referenced Documents is described below:

Document Name	Purpose
Primary health care audit protocol: Financial, claiming and referred services	This contains the audit protocol for Audits by DHBs of PHOs and/or Contracted Providers under Part G of this Agreement.
PHO Quality Indicators	This will set out the national set of quality indicators for measuring PHO performance.
Transitional PHO Agreement Amendment Protocol	This describes the protocol for amending Parts A – I of this Agreement and amending or adding Referenced Documents
National Immunisation Register Requirements	This contains the reporting requirements and business rules for PHOs collecting and reporting immunisation data to the NIR.

Part B. Definitions and Construction

B.1 Definitions

B.1.1 Nature of this clause

Words and expressions used in this Agreement with initial capital letters have the defined meanings set out in this Part B.

B.1.2 References to the parties

We, us, our means **[DHB]** District Health Board;

You, your means **[PHO name]**;

We both, us both means both you and we;

Either of us means either you or we;

Neither of us means neither you nor we.

B.2 Definitions applying to all Parts

B.2.1 In this Agreement, unless the context requires otherwise:

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

Access Practice means a general medical practice(s) forming part of your PHO or your Contracted Provider(s) that meets the Ministry of Health's criteria for access practices and those general medical practice(s) are listed in clause J.7 of Part J.

Advisory Committee means an advisory committee described in clause D.15, which may advise on any complaints or issues regarding any aspects of this Agreement.

Agreement means this agreement between us both comprising Parts A to J and including the Referenced Documents.

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

Audit includes inspection, monitoring, audit, investigation, review and evaluation of your performance and compliance with the terms of this Agreement in accordance with Part G.

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

Business Day means a day on which your bank, our bank and our Payment Agent's bank are open for business.

Capitated Services means those Services for which we Pay you on a capitated basis as set out in clauses F.4.1 and F.5.1 of Part F.

Care Plus Patients are Enrolled Patients who have consented to receive Care Plus Services in accordance with Clause 2.2 of Schedule H3.

Care Plus Services are primary health care services as described in Schedule H3 for people who have high needs for primary health care services.

Casual Users means Eligible Persons not enrolled with you who receive the Services from you.

CBF stands for Capitation Based Funding.

Claim means any claim for Payment submitted by you (or a Contracted Provider where you have agreed with us that that Contracted Provider may submit claims directly pursuant to clause F.3.4) for the Services delivered under this Agreement.

Code of Health and Services Consumers' Rights 1994 means the code issued under the Health and Disability Commissioner Act 1994.

Commencement Date means the date this Agreement commences, as set out in clause A.3.1 of this Agreement.

Commercial Information:

- (a) means any information disclosed by us to you or by you to us, either before or during the course of this Agreement, or arising out of the operation of this Agreement, that is agreed by us both as being confidential or that may reasonably be considered to be confidential taking into account all the circumstances, including the manner of and circumstances in which disclosure occurred; but
- (b) excludes the terms of this Agreement, unless agreed by us both as being Commercial Information.

Community Services Card (or CSC) means an entitlement card issued to a person eligible for it who is within the definition of a Group 1 cardholder as defined by 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;
- (c) by law; or
- (d) as an Advisory Committee in accordance with clause D.15.

Compulsory Variation means a variation to this Agreement described in clause D.9.1(b).

Confidential Information means Commercial Information and/or Health Information.

Consult means to comply with the following process either with you on a one-to-one basis, or a single process with all PHOs, the primary health care sector as a whole, or with such other audiences (including you) that may be appropriate, and includes a process whereby the Ministry of Health conducts a Consultation in our place:

- (a) each of us must state our proposals and views to the other and carefully consider each response to them;
- (b) each of us must act in good faith and not predetermine any matter;

- (c) each of us must give the other adequate opportunity to consult any other interested party;
- (d) the obligation of either of us to Consult will be discharged if the other refuses or fails to participate in the consultation in accordance with these requirements;
- (e) the consultation must take place within a reasonable time frame;

and a **Consultation** has a corresponding meaning.

Contracted Provider means any health service provider (whether an organisation or individual, including any Practitioner, General Practitioner or Medical Practitioner) you subcontract to deliver the Services, including its employees, agents and subcontractors.

Crown has the meaning given in the Act.

Crown Direction means any direction given to us by the Crown (by the Minister of Health under section 32 of, or otherwise under, the Act).

Crown Funding Agreement means an agreement between us and the Minister of Health pursuant to section 10 of the Act.

Default Interest means the interest to be paid on late Payments in accordance with clause F.12.

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

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

- DepQuin 0 = Dep decile not defined;
- DepQuin 1 = Dep deciles 1 and 2;
- DepQuin 2 = Dep deciles 3 and 4;
- DepQuin 3 = Dep deciles 5 and 6;
- DepQuin 4 = Dep deciles 7 and 8;
- DepQuin 5 = Dep deciles 9 and 10.

DHB means a District Health Board established under the Act.

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 New Zealand Gazette.

Enrolled Person means a person who is enrolled with you in accordance with the Referenced Document entitled "Enrolment Requirements for PHOs" as set out in clause 3.2 of Schedule A1 to Part A, and **Enrolled Patient** has the same meaning.

Enrolled Population means the population that is enrolled in accordance with the Referenced Document entitled "Enrolment Requirements for PHOs" as set out in clause 3.2 of Schedule A1 to Part A.

Essential Primary Health Care Services means the Services described in Part H.

Establishment Enrolment Rules mean the rules entitled "Enrolment Requirements for PHOs" as set out in clause 3.2 of Schedule A1 to Part A.

First Level Services means the Services described in clause H.4.3.

General Medical Services is defined in Schedule H2 to Part H.

General Practitioner means a Medical Practitioner who is employed or contracted by you (including such a person who is, or is employed by, a Contracted Provider) to deliver the Services, and who gives personal, primary and continuing care to individuals, families and a practice population.

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

Health Information means the following information or classes of information about an identifiable individual:

- (a) information about the health of that individual, including his or her medical history;
- (b) information about any disabilities that individual has, or has had;
- (c) information about any health services or disability services that are being provided, or have been provided, to that individual;
- (d) information provided by that individual in connection with the donation, by that individual, of any body part or any bodily substance of that individual or derived from the testing or examination of any body part, or any bodily substance of that individual; or
- (e) information about that individual which is collected before or in the course of, and incidental to, the provision of any health service or disability service to that individual.

Health Information Privacy Code 1994 means the code relating to privacy of Health Information issued under section 46 of the Privacy Act 1993.

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

HealthPAC is a business unit of the Ministry of Health, responsible for health payments, agreements and compliance.

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

High Use Health Card means a high use health card, as defined in the Health Entitlement Card Regulations 1993.

Immunisation Services means the services described in Schedule H1 to Part H.

Immunisation Handbook means the publication produced by the Ministry of Health entitled the Immunisation Handbook dated January 2002, as amended by the Ministry of Health from time to time, and includes any revised edition that replaces or succeeds that publication.

Independent Vaccinator means a person who has received appropriate training and is authorised to administer vaccines by a Medical Officer of Health.

Influenza Guidelines means the guidelines for publicly funded influenza immunisation set out in section 13.5 of the Immunisation Handbook.

Insolvency Event means where either of us:

- (a) is placed into receivership or have had a receiver or manager (including a statutory manager) appointed in respect of all or any of your 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).

Locum means a Medical Practitioner (with a current practising certificate) who provides the Services in place of another Practitioner during that Practitioner's normal working hours. A Locum may:

- (a) work providing consultation Services to the patients of the Practitioner during those working hours if the Practitioner is performing work other than providing ordinary Services to patients or is on temporary leave (for whatever reason);
- (b) provide Services in place of more than one Practitioner during any period of time;
- (c) not consult with patients of the Practitioner at the same time as the Practitioner; and
- (d) not be used to extend the normal working hours of the Practitioner.

Māori Health Action Plan means the plan developed by you pursuant to clause H.9.

Māori Principles/Tikanga means Māori beliefs, values, concepts and practices.

Māori Stakeholders means Māori with relevant expertise – can include but not restricted to: iwi, hapu, whanau consumers, Māori communities, Māori-led PHOs, Māori providers, Māori clinicians, Māori health managers, Māori organisation, PHOs with partnership arrangements with local iwi and Māori.

Medical Consultation means in respect of General Medical Service provided to Casual Users, an actual face to face medical consultation between a General Practitioner and an individual patient, or a telephone consultation as specified in Clause 5.8 of Schedule 2 of the Section Advice 88 Notice, in which the General Practitioner provides proper and necessary medical services in a rural environment. The administrative services that follow and / or form part of the face to face consultation are included as part of that single General Medical Service.

Medical Officer of Health means a person designated as such by the Director General of Health under the Health Act 1956.

Medical Practitioner means a person who is employed or contracted by you (including such a person who is, or is employed by, a Contracted Provider) to deliver the Services, who is registered as a medical practitioner under the Medical Practitioners Act 1995 and who holds a current annual practising certificate.

MeNZB Programme means the national immunisation programme to control the meningococcal B epidemic.

MeNZB Vaccine means the meningococcal B vaccine licensed for use in New Zealand.

NGO means non-government organisation.

NHI means a National Health Index number.

NIR means the national immunisation register.

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

- (a) which is carried on other than for the purposes of profit or gain to any proprietor, member, shareholder or person who has the ability to control the body or any associated person of a proprietor, member, shareholder or person who has the ability to control the body; and
- (b) which is, by the terms of its constitution, rules, or other document constituting or governing the activities of that body, prohibited from making any Distribution whether by way of money, property, or otherwise howsoever, to any such proprietor, member, shareholder or person who has the ability to control the body or any associated person of a proprietor, member, shareholder or person who has the ability to control the body.

and for the purposes of this definition:

- (c) at any time persons are associated with each other in the circumstances set out in section OD8(1) of the Income Tax Act 1994;
- (d) a body is controlled by another person in the circumstances set out in section OD1 of the Income Tax Act 1994;
- (e) **Distribution** does not include:
 - (i) any fair and reasonable payment for services performed by a person referred to in paragraph (b) or by any firm or entity of which he or she is a member, employee, or associate;
 - (ii) the reimbursement of expenses properly incurred on behalf of an incorporated body by a person referred to in paragraph (b) or by a firm or entity of which he or she is a member, employee or associate;
 - (iii) any payment by way of interest, at not more than current commercial rates, on money loaned to the incorporated body by a person referred to in paragraph (b) charged at the normal amount for such services or by a firm or entity of which he or she is a member, employee or associate,

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

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

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

Pay means the transfer of funding to you, in full or in part, for the Services you provide under this Agreement, and the word **Payment** has a corresponding meaning.

Payment Agent means an agent engaged by us to receive Claims and make Payment to you on our behalf, and unless advised otherwise that Payment Agent is HealthPAC.

Payment Day means those days on which our Payment Agent routinely makes payment of 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.

Pharmac means the Pharmaceutical Management Agency established under section 46 of the Act.

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

PHO means a primary health organisation.

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

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

PHO Minimum Requirements mean the minimum requirements for PHOs contained in the Ministry of Health's document entitled "A Guide for Establishing Primary Health Organisations".

PIN stands for Practitioner identification number, and means a MCNZ number, Nursing Council number, cervical smear taker identification number, or such other appropriate Practitioner identification number.

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

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

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

Primary Health Care Strategy means the health sector strategy of that name launched in February 2001 by the Minister of Health.

Priority Populations mean Māori, Pacific peoples and Quintile 5 (Deprivation 9 & 10) residents.

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

Purchase Unit Code mean the purchase unit code for each service delivered by a PHO that is specified in the Referenced Document entitled "PHO Purchase Unit Codes" as set out in clause 3.3 of Schedule A1 to Part A.

Record means any record or information held by you, or by your Staff, by a Contracted Provider or on your (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 Documents mean the documents specified in Schedule A1 to Part A that describe procedural matters for funding and making a Claim and other business rules and requirements that apply to all PHOs. Referenced Documents form part of this Agreement.

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

Register means your register of Enrolled Persons maintained in accordance with the Referenced Documents specified in clause 3.2 of Schedule A1 to Part A.

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

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

Services means the services specified in Part H and Part J of this Agreement.

Staff includes your or your Contracted Providers’ employees, sub-contractors, contractors, agents and other personnel connected with the delivery of the Services.

Strategic Plan means our strategic plan for providing or buying Government funded health care services for the population of the specific geographical area for which we are responsible under the Act.

Termination Date means either:

- (a) the date specified in clause A.3.1 upon which this Agreement will terminate or the date upon which this Agreement is terminated in accordance with its termination provisions (whichever is the earlier); or
- (b) where no date is specified in clause A.3.1, the date upon which all of the Schedules to Part J have expired or the date upon which this Agreement is terminated in accordance with its termination provisions, whichever is the earlier.

Treaty of Waitangi Principles means:

- (a) **partnership:** working together with iwi, hapu, whanau 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;
- (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. An Uncontrollable Event does not include any risk or event that the party claiming could have prevented or overcome by taking reasonable care.

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

Voluntary Variation means a variation to this Agreement described in clause D.9.1(a).

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

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

Whare tapa wha means the four dimensions of Māori Health.

B.3 Construction of general references

B.3.1 Headings

Headings appear in bold and are for convenience only and are to be ignored when interpreting this Agreement.

B.3.2 Part, clause, Schedule, Appendix

(a) A reference to a Part, Schedule or Appendix is a reference to a Part of, Schedule to or Appendix to this Agreement.

(b) A reference to a clause is to a clause of a Part, unless stated to be a reference to a Schedule to a Part.

B.3.3 Varied document:

A reference to this Agreement or another document includes any variation, novation, or replacement of it.

B.3.4 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).

B.3.5 Singular includes plural

The singular includes the plural and vice versa.

B.3.6 Person includes groups and successors

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

B.3.7 Joint and several

An agreement, representation or warranty in favour of two or more persons is for the benefit of them jointly and severally and an obligation of two or more persons binds them jointly and severally.

B.3.8 Currency

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

B.3.9 Gender

Words importing one gender include the other genders.

B.3.10 Business Day

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

B.3.11 Priority of Parts

Where there is any conflict between any provisions in this Agreement (including the Referenced Documents), the order of priority will be as follows:

- (a) clauses J8 and J10 of Part J;
- (b) Part A to I of this Agreement;
- (c) the Referenced Documents; then
- (d) the remaining clauses of Part J.

Part C. Relationship and Service Delivery Principles

C.1 Nature of this Part C

- C.1.1 This Part C is intended to assist with the interpretation and implementation of all other provisions of this Agreement by:
- (a) providing the context for the operation of this Agreement;
 - (b) clarifying the objectives and intentions of the parties; and
 - (c) describing how the parties intend to interact with each other.

C.2 Objective of this Agreement

- C.2.1 The objective of this Agreement is to provide a basis for the parties to work together in a collaborative and equal relationship to improve health outcomes and reduce health inequalities for New Zealanders in support of the declared objectives of the Primary Health Care Strategy, He Korowai Oranga – Maori Health Strategy and the New Zealand Health Strategy.

C.3 Relationship principles

- C.3.1 We both acknowledge that our relationship is fundamental in achieving both of our objectives in entering into this Agreement.
- C.3.2 We both agree to foster a long-term co-operative and collaborative relationship to enable us both to achieve our respective objectives efficiently and effectively. We both agree that the following relationship principles will guide each of us in our dealings with each other under this Agreement. Further, we both acknowledge that strategies to improve the health of Maori as a result of accessing their choice of quality primary health care services, are essential to equity of health outcome for all.
- (a) The way in which we both respond to Māori issues will reflect the Treaty of Waitangi Principles of partnership, participation and protection. These principles will guide the operational policies and practices of PHOs including PHO service provision.
 - (b) We both agree to observe the principles of natural justice in giving effect to this Agreement.
 - (c) You acknowledge that we are subject to, and must comply with, the strategic and policy directions of the Crown. Equally, we acknowledge that you have your own strategic and policy directions.
 - (d) We recognise your right to maintain your clinical and business autonomy.
 - (e) We both agree that clinical interventions should be based on the best evidence available at the time.
 - (f) We both will respect and maintain patient confidentiality.

- (g) We both recognise and value the other's skills and expertise and commitment to high quality performance.
- (h) We both will negotiate and implement agreements in good faith and respect, and trust the other to work together to find solutions to problems.
- (i) We both will communicate directly with each other, openly and in a timely manner (including in relation to any request by either of us to review any aspect of this Agreement).
- (j) We both will work in a co-operative and constructive manner, and where appropriate undertake joint projects.
- (k) We both will encourage continuing quality improvement and innovative service development to achieve the health gain objectives of us both to the extent possible within available funding.
- (l) We both agree that risks will be borne by the party best placed to manage the risk.
- (m) We will Pay you fairly for services that you are required to provide under this Agreement.
- (n) We both acknowledge the importance of national consistency in PHO business rules and in Parts A to I of this Agreement.

C.4 Meetings

- C.4.1 We both acknowledge that holding regular meetings is important for developing and maintaining an effective working relationship. Accordingly, we both agree to make appropriate personnel available as might be reasonably required by either of us to discuss matters arising in relation to this Agreement, including:
- (a) how the contractual relationship is functioning and how the Services are being delivered;
 - (b) whether there are aspects of the functioning of the relationship or the delivery of the Services that either of us could improve;
 - (c) how such improvement might be implemented; and
 - (d) wider primary care sector issues that are relevant to you, which may include issues relating to implementation of the Government's primary care strategy.

Part D. General Terms Governing our Relationship

D.1 Independent contractor

D.1.1 We both agree that you are an independent contractor to us, and not an employee or agent. We are not liable to pay any sums due to your employees under law (such as holiday pay or sick pay) and you have no authority to act on our behalf.

D.2 Subcontracting

D.2.1 You may subcontract all or any of the Services provided you use your best endeavours to ensure that any Contracted Provider has the qualifications or accreditations, experience, competency and availability to enable it to perform all of the subcontracted Services to the standards required under this Agreement.

D.2.2 You will ensure that every subcontract you enter into pursuant to clause D.2.1:

- (a) requires, where relevant, that Contracted Providers' Practitioners hold an annual practising certificate and a current registration from an appropriate New Zealand statutory body; and
- (b) imposes all obligations on the Contracted Provider necessary to enable you to meet your obligations under this Agreement; and
- (c) provides for us to exercise and enforce our rights under this Agreement in relation to the Contracted Provider's performance of its obligations under the subcontract (including in particular our right to access information held by the Contracted Provider), pursuant to the Contracts (Privity) Act 1982.

D.2.3 You will notify us when you propose to enter into a subcontract with a provider whom you have not previously contracted with under this Agreement.

D.2.4 Subject to clause D.2.5, you agree to provide to us any information we reasonably request in relation to any Contracted Provider or proposed contracted provider (notified to us under clause D.2.3).

D.2.5 You are not required to provide any:

- (a) pricing or financial information, except that information which we would otherwise have access to under Part G;
- (b) information that the provision of which would be contrary to your legal obligation to maintain the privacy of personal health information or your ethical obligations with respect to clinical confidentiality.

D.2.6 We will notify you if we have any objections to your proposed provider within ten (10) Business Days of receiving your notification. We will discuss with you our reasons for objecting to any proposed provider.

D.2.7 You will not enter into a subcontract with a provider where we notify you that we object on reasonable grounds in relation to concerns we have about:

- (a) that provider's location for delivering Services where that location is not consistent with clause J.3; or
- (b) that provider's ability to perform in any material respect, as required by this Agreement.

D.2.8 You will remain responsible for all Services subcontracted to another provider.

D.3 Responsibility and liability for others

D.3.1 Each of us respectively is responsible and liable in all respects for the acts and omissions of our respective employees, Contracted Providers, other contractors, agents (which without limitation shall include the Payment Agent) or other personnel in performing or complying (or failing to perform or comply) with each of our obligations under this Agreement.

D.4 Transfer of rights and obligations

D.4.1 Neither of us will assign or transfer to any other person any or all of its rights or obligations under this Agreement without first obtaining the other party's written consent (which will not be unreasonably withheld).

D.4.2 In order that the consenting party can make an informed decision about whether to consent to any such transfer, the transferring party will ensure that the proposed transferee provides the consenting party with details of their ability to perform those obligations, and any further details that the consenting party may reasonably request of the transferring party or the proposed transferee.

D.4.3 If either of us does transfer or assign its rights or obligations under this Agreement, it will not prejudice:

- (a) any other rights or remedies that either of us may have against the other arising out of any breach of this Agreement that occurred before such transfer or assignment;
- (b) the operation of any provisions in this Agreement that are expressed or implied to have effect after such transfer or assignment has occurred.

D.4.4 The term "transfer" in this clause D.4 is deemed to include any change in the legal or beneficial ownership interests in the transferring party that results in a change in its effective control.

D.5 Exit of Practitioners

D.5.1 If one of your Medical Practitioners leaves you (and has not been found guilty of disgraceful conduct or a dishonesty offence), and prior to joining you held an active Section 88 Advice Notice, that Medical Practitioner will remain eligible to hold that Section 88 Advice Notice (notwithstanding that it may have expired) and will be entitled to move back onto that Section 88 Advice Notice (subject to the same conditions or limitations (if any)) upon leaving your organisation, provided that the Medical Practitioner concerned continues to practice within three kilometres of the Medical Practitioner's specified medical premises to which the Section 88 Notice applied or as otherwise agreed with us and set out in J.13.

D.5.2 The entitlement to reactivate a Section 88 Advice Notice described in clause D.5.1, will devolve to another Medical Practitioner nominated by the original Medical Practitioner when the nominated Medical Practitioner takes over that part of the Enrolled Population and the practice location of the original Medical Practitioner, and the original Medical Practitioner ceases to practice in the geographic area for which we purchase health services.

- D.5.3 If one of your Contracted Providers leaves you, and prior to joining you held a number of active Section 88 Advice Notices, that Contracted Provider will remain eligible to hold that number of Section 88 Advice Notices (notwithstanding that they may have expired) and will be entitled to reactivate those Section 88 Advice Notices (subject to the same conditions or limitations (if any)) upon leaving your organisation, provided that the Contracted Provider concerned continues to practice within three kilometres of the specified medical premises to which the Section 88 Advice Notices applied or as otherwise agreed with us and set out in J.13.
- D.5.4 If one of your Medical Practitioner leaves you and that Medical Practitioner did not hold an active Section 88 Advice Notice prior to joining you, he or she will not be entitled to move onto a Section 88 Advice Notice and will need to make application to us under the appropriate criteria for accessing Section 88 Advice Notices.
- D.5.5 The phrase “prior to joining you” used in this clause D.5, includes the situation where a Medical Practitioner held a Section 88 Advice Notice immediately prior to joining a Primary Care Organisation (PCO), and joined you directly from that PCO.

D.6 Confidentiality

- D.6.1 Except as provided under this Agreement, neither of us will disclose any Confidential Information to any person. Either of us may publish this Agreement, except for any Confidential Information contained within it, in any media, including publication on the Internet.
- D.6.2 Either of us may only disclose Confidential Information:
- (a) to those involved in the provision of the Services, where necessary;
 - (b) to our respective professional advisors and representative agents;
 - (c) where disclosure is permitted or required under this Agreement, including under the Audit provisions of Part G;
 - (d) which is required to be disclosed to the Crown under any Crown Directions or Crown Funding Agreement;
 - (e) which is already in the public domain without being in breach of this clause D.6;
 - (f) in so far as it is required to be disclosed by law, including where we consider it necessary to disclose Confidential Information under the Official Information Act 1982 or otherwise under our public law obligations;
 - (g) where the other party has consented in writing to such disclosure.

D.7 Public statements

- D.7.1 Neither of us, nor either of our representatives, may, during or after the term of this Agreement, either directly or indirectly criticise the other publicly in relation to this Agreement, without first fully discussing (or taking reasonable endeavours to discuss) the matters of concern with the other in good faith and in a co-operative and constructive manner.

D.7.2 Nothing in clause D.7.1 prevents either of us:

- (a) discussing any matters of concern with that party's own employees, Contracted Providers, subcontractors, contractors, agents or other personnel or with that party's own advisors; or
- (b) from publicly commenting on public policy matters.

D.8 Use of name, logo or fact of relationship

D.8.1 Neither of us may use the other's logo, name or the fact that there is a funding relationship between us in any advertising or for any other promotional purpose without the prior written consent of the other.

D.9 Variations to this Agreement

D.9.1 This Agreement may be varied in the following ways only:

- (a) by mutual agreement or agreement reached following the process for review as set out in clause D.13 (a "Voluntary Variation");
- (b) in order to give effect to any Crown Direction, any law change or fees increase pursuant to clause F.15 of Part F, in accordance with the procedure set out in clause D.11 (a "Compulsory Variation");
- (c) in the case of variation to the Referenced Documents, in accordance with the procedure set out in clause D.9.3; and
- (d) in the case of adding the national set of quality indicators and targets to this Agreement in accordance with clause I.12 of Part I.

D.9.2 No variation of this Agreement will be effective unless it is in writing and:

- (a) in the case of a Voluntary Variation or a mutually agreed Compulsory Variation, is signed by us both; or
- (b) in the case of a Compulsory Variation necessarily imposed by us under clause D.11.6(b), or a variation to any Referenced Documents, signed by us and notified to you.

D.9.3 We may vary templates and formats for reports and other documents required under this Agreement, as we may reasonably require provided that we Consult with you on the proposed changes and the impact of changes in accordance with the provisions of the Referenced Document entitled "Transitional PHO Agreement Amendment Protocol" as specified in clause D.10.2 or through any other process agreed by both of us.

D.9.4 When our proposed variations to templates and formats for reports will result in material additional costs to you, we both will discuss and endeavour to resolve the issue. Where we both agree, we will compensate you for any additional material costs which you or your Contracted Providers may incur as a result of such variations. Where we do not both agree, any dispute between us will be referred to dispute resolution under clause D.16 and until resolution you will not be required to implement the varied template or format for reports.

D.10 Varying or adding Referenced Documents

D.10.1 We both acknowledge that:

- (a) the rules and procedures contained in the Referenced Documents are required to be nationally consistent; and
- (b) Referenced Documents may need to be varied (including deleted) or added from time to time throughout the term of this Agreement.

D.10.2 A Referenced Document may only be varied or added in accordance with the procedure set out in the Referenced Document entitled "Transition PHO Agreement Amendment Protocol " specified in clause 4.1 of Schedule A1 to Part A.

D.10.3 To avoid any doubt, the process described in that Referenced Document does not replace our or the Ministry of Health's obligation to Consult and any such Consultation is in addition to participating in the procedure set out in that Referenced Document.

D.11 Procedure for Compulsory Variations

D.11.1 Notice

Where it is likely that a Compulsory Variation will be required, we will give you such reasonable notice as is possible in the circumstances, which notice will include the details of any such variation and our proposed draft of the variation of this Agreement.

D.11.2 Form of proposed variation

We agree that our proposed draft of the variation referred to in clause D.11.1 above will be written to give effect to the relevant Crown Direction, law change or fees increase in a way that endeavours to minimise the adverse impact on you (if any), financial or otherwise.

Compensation for Crown Direction

D.11.3 Where the Compulsory Variation is required to give effect to a Crown Direction and that Compulsory Variation has the potential to result in any increased costs or decreased revenue to PHOs, we will Consult with you on the options available to prevent or minimise any adverse financial (or other) impacts as a result of the Crown Direction.

D.11.4 We will use our best endeavours to prevent or minimise any adverse financial or other impact of the Compulsory Variation, but in any case we shall not be liable for any loss or additional costs suffered or incurred by you unless we agree otherwise.

D.11.5 Agreeing the variation

We will specify a period of time that is reasonable in the circumstances, being at least twenty (20) Business Days unless we are precluded from doing so, within which you are to reply to the proposed draft of the variation notified to you under clause D.11.1. After that period has expired, or at such earlier time as may be convenient to us both, we both will seek to agree on the terms of the variation to this Agreement. We will consider your reply in implementing the variation, however, you acknowledge that we may require a uniform variation to apply to all PHOs.

D.11.6 Commencement of variation

- (a) Where we both agree on the terms of the variation to this Agreement, the variation will commence as soon as the relevant Crown Direction, law change or fees increase comes into effect, or at any earlier time agreed between us both.

- (b) Where we both 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 our proposed draft of the variation referred to in clause D.11.1, subject to any changes to specific parts that we may have agreed with you, as soon as that relevant Crown Direction, law change or fees increase comes into effect.

D.12 Where provision of the Services is no longer viable

- D.12.1 Where this Agreement has been varied in accordance with clause D.11.6(b) and where it is no longer viable, financially or otherwise, for you to continue providing the Services that have been affected by that variation, you may terminate this Agreement or the obligation to provide the relevant Services, provided that you give us prior written notice of your intention to do so.
- D.12.2 The period notice given under clause D.12.1, will be reasonable in the circumstances considering the impact of the Compulsory Variation on you and the impact of your intended termination on us.

D.13 Reviewing this Agreement

- D.13.1 We both agree that Parts A to I of this Agreement will be subject to annual review through a national review process that will, amongst other matters, ensure that Payment rates (including the management fee) are fair and reasonable.
- D.13.2 That national review process will commence in February of each year and follow the process described in the Transitional PHO Agreement Amendment Protocol (or any other Referenced Document that replaces that transitional protocol document) subject to the modifications set out in clauses D.13.3.
- D.13.3 Where the PHO Agreement Amendment Protocol Group is considering a variation to any of Parts A to I of this Agreement and fails to reach a binding decision of the Group, the matter will remain not agreed between us both and will not be referred to the Director General of Health.
- D.13.4 Where you believe that you will not be able to deliver any of the Services described in this Agreement to the extent that this Agreement requires, you will notify us of the extent to which you are prevented from providing those Services and the reasons for that inability.
- D.13.5 Without limiting any right of either of us under this Agreement, we both will then discuss the reasons why you are prevented from performing those Services and we both will seek to reach agreement about changes to your levels of Service provision.

D.14 Notification of problems

General obligation to discuss and remedy problems

- D.14.1 We both agree to advise the other party promptly in writing of any changes, problems, significant risks, or significant issues (including suspected fraud and/or serious non-compliance with the obligations under this Agreement and those issues that could reasonably be considered to have high media or public interest), which materially reduce or affect, or are likely to materially reduce or affect, the ability of either of us to meet our respective obligations under this Agreement.
- D.14.2 Without limiting any rights under this Agreement we both agree to discuss with the other possible ways of remedying the matters notified.

Management Services

- D.14.3 We acknowledge that you may be prevented from performing the full extent of management services required under this Agreement, due to reasons including the level of management fee funding.
- D.14.4 Where you believe that you will not be able to perform, or perform to the full extent, the management tasks and services required under this Agreement, you will notify us of the extent to which you are prevented from providing those tasks and services and the reasons for that inability.
- D.14.5 Without limiting any rights under this Agreement, we both will discuss the matters relating to your inability to perform as required and seek to reach agreement about what management tasks you may delay or not perform to the full extent required in this Agreement.
- D.14.6 Where we can not reach agreement as anticipated in clause D.14.5, the matter will be referred to the dispute resolution process described in clause D.16.

D.15 Use of Advisory Committees

- D.15.1 Either of us may refer to an Advisory Committee for it to investigate, consider, advise and/or provide recommendations in relation to any disputes, complaints or issues regarding any aspect of this Agreement as that party considers appropriate.
- D.15.2 The Advisory Committee will comprise an appropriate number of members who have appropriate experience in relation to the matter in question in order to provide relevant and objective advice. We both will endeavour to agree to the persons on any Advisory Committee. Failing such agreement, each of us may appoint two persons to the Advisory Committee (or such other number of members as we both agree).
- D.15.3 We both agree to participate in any Advisory Committee process as may be reasonably required, including attending meetings of, producing information for, and answering the questions of the Advisory Committee.
- D.15.4 Any referral to an Advisory Committee is without prejudice to, and does not amount to a waiver of or preclude either of us from exercising any other right either of us has under this Agreement including in relation to failure to perform, our rights of Audit under Part G or to terminate this Agreement.
- D.15.5 The party who referred the matter may withdraw that matter from consideration by an Advisory Committee at any time.
- D.15.6 We both must consider any advice or recommendation of an Advisory Committee with an open mind but are not bound to follow any advice or recommendation given.
- D.15.7 All costs arising from referring a matter to, or consideration of a matter by an Advisory Committee will be allocated to either of us or us both in such proportion as the Advisory Committee may consider appropriate.

D.16 Resolving disputes

D.16.1 Court or arbitration proceedings

We both agree not to commence any court or arbitration proceedings relating to any dispute arising out of this Agreement, until we both have complied with this clause D.16, unless proceedings are necessary for preserving the rights of either of us.

D.16.2 Resolution by agreement

If a dispute arises under this Agreement:

- (a) the party claiming that a dispute exists must give written notice to the other party specifying the nature of the dispute; and
- (b) we will both act in good faith and use our best endeavours to resolve the dispute by agreement.

D.16.3 **Mediation and arbitration**

- (a) If the dispute is not settled by agreement within twenty-one (21) Business Days of receipt of the notice of dispute, then unless we both agree otherwise in writing, we both agree to participate in mediation with a mutually acceptable mediator appointed if necessary by the Chairperson of the New Zealand Chapter of LEADR.
- (b) If the dispute or difference is not settled by mediation within thirty (30) Business Days of the commencement of that mediation process, then unless we both agree otherwise in writing, the matter will be referred to arbitration in accordance with the Arbitration Act 1996.

Obligations continue

D.16.4 We both will continue to comply with all our obligations in this Agreement until the dispute is resolved, except that we both will meet to agree upon whether:

- (a) Payments may be withheld by us to the extent that they are disputed, in which case you are not obliged to provide any Services for which we have withheld Payment pending resolution of the dispute; or
- (b) we will continue to Pay you for the services, in which case you are obliged to continue to provide the Services.

D.16.5 Such agreement to be reached based on what is reasonable in the circumstances having regard to the nature of the Services and the dispute in question.

D.16.6 **Exceptions**

This clause D.16 does not apply to:

- (a) any dispute concerning whether or not any person is an Eligible Person, which will be determined by the Minister of Health;
- (b) any renegotiation, variation or termination of this Agreement on any of the grounds described in sub-clauses (b), (c) or (d) of clause D.17.2; or
- (c) any matter which is subject to a current audit process (but not including a dispute over an audit report where the audit has been completed) or which has been or is referred to a Complaints Body unless the Complaints Body directs that the matter be resolved in accordance with this clause D.16.

D.17 Termination

D.17.1 **Uncontrollable Events**

This clause does not apply where the failure to perform is caused by an Uncontrollable Event, which must be dealt with under clause D.20.

Our rights to terminate

D.17.2 We may terminate this Agreement on such period of written notice to you as we consider reasonable in the circumstances and in any case not less than twenty (20) Business Days, where:

- (a) we have good reason to believe you are unable, or will soon become unable, to carry out any of your material obligations under this Agreement. We must Consult with you to the extent possible within the twenty (20) Business Days' notice before terminating this Agreement for this reason; or
- (b) we have reasonable grounds to believe that the health or safety of any person or population served is at risk, provided that where the risk is isolated to a Contracted Provider, we may only exercise our rights under clause D.16. We must Consult with you to the extent possible within the twenty (20) Business Days notice and we may suspend your provision of the relevant Service while we Consult; or
- (c) you fail to carry out any of your obligations in this Agreement and the failure is material and cannot be remedied; or
- (d) an Insolvency Event occurs; or
- (e) you fail to carry out any of your obligations in this Agreement and the failure is not covered by sub-paragraph (c), and you have not remedied this failure within thirty (30) days of your receiving written notice of the failure from us.

D.17.3 Termination for fraud

- (a) We may terminate this Agreement immediately on written notice to you where you have been formally charged for any fraudulent act.
- (b) Where any Contracted Provider is charged for any fraudulent act:
 - (i) we may exercise our rights under clause D.16; and
 - (ii) you will immediately implement, or demonstrate that you have appropriate systems in place to detect and prevent such fraud.

D.17.4 Nothing in this clause D.17 affects any other rights we may have against you.

D.17.5 Your rights on our default

If we do not make Payments to you which we are required to make or where we fail to carry out any of our material obligations under this Agreement and we fail to remedy the default within twenty (20) Business Days of you giving us written notice of the default, you may do any one or more of the following:

- (a) terminate this Agreement;
- (b) seek specific performance of this Agreement to the extent permitted by law;
- (c) seek damages from us to the extent permitted by law; or
- (d) seek Default Interest.

D.17.6 Termination by agreement or on six month's notice

- (a) We both may agree to terminate this Agreement or any part of it. No agreement to terminate shall be effective unless it is in writing and signed by us both.
- (b) Subject to clause A.5.5, either of us may terminate this Agreement by giving the other six month's notice in writing, provided that we may not terminate this Agreement under this clause D.17.6 during the non-termination period specified in clause J.9.1 of Part J.

D.18 Our alternatives to termination

D.18.1 Instead of terminating this Agreement under clause D.17, we may do any or all of the following:

- (a) vary or withdraw from coverage by this Agreement any of the Services where you have not met your obligations; or
- (b) cease Payment for any such Services from the date of variation or withdrawal; or
- (c) require you to terminate any subcontract you may have with a Contracted Provider for the provision of the Services under this Agreement where that Contracted Provider has failed to perform a material obligation in relation to the performance of this Agreement; or
- (d) require you to recover any Payments to a Contracted Provider that have been made in breach of this Agreement; or
- (e) require you to terminate any subcontract you may have with a Contracted Provider for the provision of the Services under this Agreement where a Payment has been made to that Contracted Provider in breach of this Agreement.

D.18.2 Withholding Payments

- (a) In addition to our rights under clause D.18.1, we may withhold further Payments or portions of Payments due under this Agreement for each of the following defaulting actions that you or a Contracted Provider may commit. Where:
 - (i) you or a Contracted Provider commit a material breach of the reporting requirements under this Agreement, we may withhold Payment up to 10% of your management fee Payment due;
 - (ii) you or a Contracted Provider, have failed to co-operate with us or our Auditor and/or have not provided us or our Auditor with reasonable assistance in accordance with clause G.1.2, we may withhold Payment up to 10% of your management fee and/or up to 10% of any capitated Payment due to any relevant Contracted Provider, as is reasonable in the circumstances;
 - (iii) you or a Contracted Provider are found to be in breach at the end of an Audit, we may withhold management fees and/or any capitation Payments due to that Contracted Provider, up to the value of the breach, or up to 10% of your management fee where the value of the breach can not be determined, as is reasonable in the circumstances;
 - (iv) you have made a Payment to a Contracted Provider in breach of this Agreement, we may withhold Payment of capitation Payments due to that Contracted Provider, up to the value of the inappropriate Payment that you made to the Contracted Provider.
- (b) Payments withheld under this clause D.18.2:
 - (i) may be withheld from the date of non-compliance until such time that compliance occurs, or in the case of sub clauses D.18.2 (a) (iii) and D.18.2 (a) (iv), until such time as the breach of Audit or the alleged inappropriate Payment to a Contracted Provider has been successfully appealed by you; and
 - (ii) will be paid on the following Payment Date once compliance has occurred.

D.19 Alternative arrangements on failure to deliver Services

- D.19.1 Where you fail to deliver any services described in Parts H or J to Service Users under this Agreement, in addition to our rights under clauses D.17 and D.18, we may take whatever action is reasonably necessary to make alternative arrangements for the provision of those healthcare services, at your expense.
- D.19.2 We may act under clause D.19.1 without giving you notice where the circumstances reasonably require such action. In any other circumstance, we will give you seven (7) Business Days notice, in writing, of our intention to carry out your obligations under this Agreement.
- D.19.3 When we give you notice requiring you to pay our costs, you must pay or reimburse us for all reasonable costs we incur acting under clause D.19 and which are not covered by the Payments withheld or ceased under clause D.18 up to a maximum of 10% of the Payments withheld or ceased.
- D.19.4 Where you fail to pay any such amount required under clause D.19.3, we may set off the amount owing to us in respect of the costs incurred under this clause D.19 against any amount that we owe to you at any time by way of Payment for the Services, in accordance with clause F.14.

D.20 Uncontrollable Events

- D.20.1 **No default**
Neither of us will be in default under this Agreement if the default is caused by an Uncontrollable Event.
- D.20.2 **Obligations of the affected party**
Where 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 that party's inability to perform; and
 - (iii) the likely duration of that non-performance;
 - (b) take all reasonable steps to remedy, or reduce the impact of, the Uncontrollable Event; and
 - (c) resume performance of the obligation affected by the Uncontrollable Event as soon as possible.
- D.20.3 **Alternative arrangements**
We may, after consulting with you, make alternative arrangements for the supply of the Services during a period in which you are unable to supply them as a result of an Uncontrollable Event (and for such reasonable time afterwards as may be necessary to secure an alternative provider or providers at the time the alternative arrangement is entered into).
- D.20.4 **Variation or termination of Services**
- (a) If either of us is unable to perform an obligation under this Agreement for thirty (30) days or more because of an Uncontrollable Event, we both must seek to agree to what extent, if any, the obligation in question can be varied and/or continued by the party whose performance is prevented.

- (b) Failing agreement, either of us may terminate the relevant Service or this Agreement after giving the other at least thirty (30) days prior written notice.

D.21 Consequences of termination

D.21.1 Any termination of this Agreement 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 termination; or
- (b) the operation of any clauses of this Agreement that are expressed or implied to have effect after termination.

D.21.2 Upon termination we will both return to the other all Confidential Information either of us may hold that belongs to the other, except that we may retain such information for an Audit undertaken in accordance with Part G.

D.22 Insurance

D.22.1 You must have insurance to an appropriate and reasonable extent, to cover your business and its assets against risks associated with the performance of and compliance with your obligations under this Agreement. You 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 Termination Date.

D.22.2 We may request, and you must promptly provide to our Auditor, any information concerning the insurance maintained pursuant to clause D.22.1.

D.23 Warranty

D.23.1 Warranty

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.

D.23.2 Warranties continuing

Each of the warranties in clause D.23.1 are deemed to be repeated continuously throughout the term of this Agreement.

D.23.3 Change of circumstances

If any of the warranties in clause D.23.1 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.

D.24 Notices

D.24.1 Form of notice

Each notice or other communication under this Agreement is required to be in writing and may be made by facsimile, email, personal delivery or post at the facsimile number or address, and marked for the attention of the person or office holder (if any), designated for the relevant purpose by the addressee from time to time by notice to the other party.

D.24.2 Change of contact details

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

D.24.3 When notice effective

No communication is to be effective until the addressee receives it. A communication is deemed to be so received (where the addresser is not aware of any failure in the communication) in the case of:

- (a) facsimile or email, on the Business Day on which it is sent or, if sent after 5pm in the place of receipt or on a non-Business Day, on the next Business Day;
- (b) personal delivery, when it is delivered;
- (c) post, on the third Business Day after posting by fastpost or airmail.

All periods of time for notice exclude the days on which they are given and include the days on which they expire.

D.25 Miscellaneous terms

D.25.1 Compliance with law

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

D.25.2 Waiver

- (a) Either of us, as applicable, may by notice in writing to the other party, waive a specific right conferred under this Agreement.
- (b) Any delay or failure to exercise a right does not constitute a waiver of that right.

D.25.3 Entire agreement

- (a) Subject to clause D.25.3(b), this Agreement constitutes the entire agreement and understanding between us both, and supersedes and replaces all prior agreements and understandings between us both in relation to the provision of the Services.
- (b) We agree that the agreements listed in clause J.5 of Part J continue to apply to those aspects of the Services to which they relate.

D.25.4 Severability

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

D.25.5 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.

D.25.6 Contracts (Privity) Act 1982

Subject to Contracted Providers' and General Practitioners' ability to make Claims under this Agreement in accordance with Part F, no person who is not a party to this Agreement may

enforce any of the provisions of this Agreement. Nothing in this Agreement shall confer any benefit on Eligible Persons, any Service User or on any Contracted Provider.

D.25.7 Trustee Liability

If you are a charitable trust, we agree that your trustees' liability under this Agreement is limited to the assets of the trust, except in any case where 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 their capacity as a trustee from time to time, including any former trustee.

Part E. General Requirements for Delivering the Services

E.1 Introduction

E.1.1 This Part E describes the general requirements for PHOs to deliver (or arrange the delivery of) the Services under this Agreement.

E.2 Organisational requirements

E.2.1 You must continue to ensure, and be able to demonstrate to our satisfaction that:

- (a) you are a Not for Profit body with full and open accountability for the use of public funds and the quality and effectiveness of the Services, and your constitutional document includes rules to this effect;
- (b) your communities, iwi and consumers are involved in your governing processes and you are responsive to your communities; and
- (c) all Contracted Providers and Practitioners can influence your decision-making.

E.3 Maori Participation

E.3.1 You will integrate Māori participation, as appropriate and further defined in a Schedule to Part J and the Māori Health Referenced Document, including in all levels of governance, service planning, development and implementation within your organisation. To ensure effective Māori participation, you will involve key Māori Stakeholders (see Māori Health Referenced Document). This will include:

- (a) consultation with and ensuring that key Māori Stakeholders contribute to decision-making. Consultation with Māori will be guided by the Ministry of Health Kawe Korero: Guidelines for Communicating with Māori (1997);;
- (b) development of a monitoring strategy, that reviews and evaluates whether Māori needs are being met, including:
 - (i) reducing barriers to Māori accessing all primary care services;
 - (ii) facilitation of the involvement of whanau;
 - (iii) integration of Maori values and beliefs and cultural practices;
 - (iv) availability of Maori staff to reflect your Enrolled Population at a PHO and practice level;
 - (v) existence, knowledge and use of referral protocols with Maori services within your region;
 - (vi) education and training for staff on Maori health policy and strategies;
 - (vii) education and training of staff in Maori values and beliefs and cultural practices; and
 - (viii) support and development of Maori workforce.

E.4 Location of the Services

- E.4.1 You will provide the Services in the geographical locations specified in clause J.3 of Part J or in accordance with any Schedule to Part J with respect to specific Services.

E.5 Register requirements

- E.5.1 You will comply with the requirements for maintaining the register of your Enrolled Population contained in the Referenced Documents entitled "CBF Business Rules" and "Enrolment Requirements for PHOs" (as set out in clause A3.2 of Schedule A1 to Part A).

E.6 Supplying pharmaceuticals

- E.6.1 You will comply with the terms of the Pharmaceutical Schedule issued by Pharmac setting out the terms and conditions under which pharmaceuticals are supplied to Practitioners.
- E.6.2 The Pharmaceutical Schedule provides for the supply of pharmaceuticals to a Practitioner for personal administration to Service Users. That method of obtaining pharmaceutical supplies is only to be used to provide treatment to Service Users in an emergency, or to provide immediate treatment before supplies can be obtained in the ordinary way.

E.7 Declining Services

- E.7.1 You will ensure the immediate safety of persons who are not eligible for the Services or who are declined the Services in accordance with this Agreement.

E.8 Administration standards and record keeping

- E.8.1 We both must operate under sound financial and business management principles, procedures and practices.
- E.8.2 We both must maintain full and proper financial and business Records in accordance with generally accepted accounting principles, procedures and practices and best business practice generally and any legal obligations applicable to you.

E.9 Security and preservation of Records

- E.9.1 You must preserve and protect the safety, security and confidentiality of the Records in accordance with best business practice and any legal obligations applicable to you.
- E.9.2 We both will have in place appropriate back-up and disaster recovery procedures to protect against loss of information.
- E.9.3 If you or any Contracted Provider, cease to provide the Services under this Agreement, you (or the Contracted Provider) must ensure that all Records are properly preserved and, where appropriate, are able to be and, on request, are transferred to any replacement provider as we may require.

E.10 Daily record

- E.10.1 You must ensure that every Practitioner who provides any First Level Services or General Medical Services for which Payment is claimed under this Agreement shall keep a comprehensive and readily accessible daily record in respect of every Service User, which shall include the following:
- (a) the name and the usual place of residence of the Service User;
 - (b) the place where the Services were provided (if different from the usual place of work of the Practitioner);
 - (c) the date on which the Services were provided;
 - (d) a record of the clinical history of the Service User and of the treatment given or services rendered;
 - (e) the pharmaceuticals prescribed; and
 - (f) the laboratory services authorised.

E.11 Prohibition on laboratory referrer inducements

- E.11.1 Neither you nor a Contracted Provider may accept any incentive or inducement from a laboratory service provider, either directly or indirectly, where that incentive or inducement is prohibited under our service agreements with laboratory service providers.

E.12 Public reporting

- E.12.1 You will make the following available to the public:
- (a) your annual report prepared under clause I.9 of Part I; and
 - (b) your annual financial statements.

Part F. Payment for the Services

F.1 Providers' rights to charge

F.1.1 We both agree that you and your Contracted Providers retain the right to charge Service Users in accordance with Schedule F4.

F.2 Need to reduce financial barriers to access

F.2.1 We both support the Government's policy of reducing financial barriers to access to the Services for all Service Users.

F.3 Payment for Services

F.3.1 Subject to clause F.3.4, we will pay you for providing the Services according to the terms and conditions of this Agreement in accordance with the terms of this clause F.3. Accordingly all references in this Agreement to your rights to Claim or restrictions on your Claiming under this Agreement apply to you or Contracted Providers as the case requires.

F.3.2 We will Pay directly to you:

- (a) capitated Payments; and
- (b) management fees.

F.3.3 Subject to clause F.3.4 we will Pay all fee for service Payments directly to you and you will ensure that Contracted Providers do not Claim for fee for service Payments from us.

F.3.4 We both may agree in writing that we may make fee for service Payments directly to your Contracted Providers.

F.3.5 All Claims by you and/or Contracted Providers for the Services, must be made under this Agreement.

F.4 Services funded on a capitated basis

F.4.1 Subject to clause F.4.2, we will fund the Services described in Part H on a capitated basis in accordance with Schedule F1 to this Part F.

F.4.2 We will fund the Services listed below as set out in clauses F.5 and F.6:

- (a) health promotion services; and
- (b) Services to improve access for High Need Groups; and
- (c) the Services described in the Schedules to Part H (General Medical Services for Casual Users and Immunisation Services).

F.5 Services funded on a capitated basis with prior approval

- F.5.1 Where we approve your proposal in accordance with clauses H.5.2 and H.5.3 respectively, to deliver the following services we will Pay you for those services on a capitated basis in accordance with Schedule F1 to this Part F:
- (a) services to improve access for High Need Groups; and
 - (b) health promotion services.
- F.5.2 Where we approve your proposal to provide Care Plus Services in accordance with clause H.5.5, we will Pay you for those services on a capitated basis in accordance with Schedule F7 to this Part F.

F.6 Services funded on a fee for service basis

- F.6.1 The following services will be funded by us on a fee for service basis in accordance with Schedule F2 to this Part F:
- (a) Immunisation Services (unless otherwise agreed) in accordance with Schedule F2 to this Part F; and
 - (b) General Medical Services for Casual Users in accordance with Schedule F3 to this Part F.

F.7 Other services or Payment

- F.7.1 Other services or Payments will be funded or paid by us in accordance with the PHO specific terms and conditions contained in Part J.

F.8 Goods and Services Tax

- F.8.1 Unless this Agreement expressly provides otherwise:
- (a) all prices under this Agreement are exclusive of GST;
 - (b) all Payments under this Agreement will be made inclusive of GST.

F.9 Claiming restrictions

- F.9.1 **Services must have been provided in New Zealand**
You may not Claim, and we will not Pay you, for Services you have delivered to any Eligible Person who was not in New Zealand at the time the Services were provided to them.
- F.9.2 **Services provided to non-Eligible Persons**
- (a) Where you provide the Services to persons whom you know are not Eligible Persons you are not entitled to Claim Payment from us in relation to providing those Services.
 - (b) If you Claim for Services provided to a person whom you know is not an Eligible Person, we will withhold or recover Payment for those Services provided to that person.

F.9.3 No cost or volume shifting

- (a) You must not knowingly be a party to any arrangement that results in us effectively having to Pay more than once for the provision of the same Services.
- (b) Unless otherwise agreed, neither of us will operate in a way that shifts costs or volumes between the Services that would result in additional costs to either of us. This does not preclude movements of individuals between providers for reasons of good clinical practice.

F.9.4 No double Payment

You are not entitled to Claim or receive from us any Payment specified in this Agreement:

- (a) where you are entitled to receive Payment for those services, either directly or indirectly, under any other agreement or arrangement with us; or
- (b) to the extent that you are entitled to receive Payment for those services, either directly or indirectly, from any other organisation or Government body or agency (including, but not limited to, the Accident Compensation Corporation).

F.10 Claiming requirements

F.10.1 Format and timing of Claims

- (a) For Capitated Services you must submit Registers in accordance with the requirements set out in the Referenced Documents set out in clause 3 of Schedule A1 to Part A.
- (b) Each Register submitted for Payment as per clause F.10.1(a), must be accompanied with a certification signed by your Chief Executive Officer (or senior manager). The certification should be in the same format as the template in the Referenced Document entitled "Certification of PHO Register" and must be faxed to the Payment Agent and the original retained at the PHO for Audit purposes.
- (c) For other services (General Medical Services for Casual Users, Immunisation Services and any other services specified in Part J) you must submit Claims in accordance with this Agreement at least monthly but not more frequently than once a week.
- (d) All Claims must specify the correct Purchase Unit Code for the relevant service being Claimed. Purchase Unit Codes are listed in the Referenced Document entitled "PHO Purchase Unit Codes" set out in clause 3.3 of Schedule A1 to Part A.

Rejection of Claim

- F.10.2 We reserve the right to reject a Claim or any part of a Claim where we believe on reasonable grounds that a Claim or any part of a Claim is incomplete or includes inaccurate information or where the Claim does not comply with claiming restrictions or requirements.
- F.10.3 We will only reject and withhold Payment for that part of a Claim that we believe is incorrect. The remaining parts of the Claim will be paid by us.
- F.10.4 In the event of our rejecting part of a Claim for a capitation Payment, we will inform you within five (5) Business Days of your having submitted the original Claim to enable you to review the rejection and resubmit the part Claim if appropriate. In the event of our rejecting part of a Claim for General Medical Services provided to Casual Users, we will inform you within fifteen (15) Business Days of your having submitted the original Claim to enable you to review the rejection and resubmit the part Claim if appropriate.

F.10.5 Resubmission of Claim

Claims, or part of a Claim, may be resubmitted, duly corrected. Where such a resubmitted Claim results in your owing money to us, we may recover that money in accordance with clause F.14.

F.10.6 Time limit for receiving fee for service Claims

All fee for service Claims must be received by us within six months after the date when the service is provided.

F.11 Payment

F.11.1 Timing of Payments

- (a) Payment will be made on the 15th day of each month for Capitated Services provided during that month in accordance with the Referenced Document entitled "CBF Business Rules".
- (b) Payment for Claims will be made ten (10) Business Days after you submit your electronic Claim for fee for service services provided in the previous month.
- (c) Payment will be made for other services in accordance with the PHO specific terms and conditions in Part J.
- (d) Payment will be made on the next Payment Day.

F.11.2 Electronic formats only

All Claims must be submitted in electronic format. No manual claims will be accepted for Payment.

F.11.3 Form of Payment

We will Pay you by lodging funds into the bank account that you specify. You may change the bank account into which your funds are to be lodged on ten Business Days' prior written notice to us.

F.11.4 Payment variations

Where we believe on reasonable grounds that a Claim is partially valid and partially invalid, we will Pay you for the valid portion only and reject the invalid portion.

F.11.5 Over or under-Payment

- (a) If at any time it has become apparent that we have overpaid you, you will without prejudice to any other rights we have, immediately repay the amount overpaid by us.
- (b) If at any time it has become apparent that we have underpaid you, we will without prejudice to any other rights you have, immediately Pay to you the amount underpaid by us.

F.11.6 If you fail to submit your Register in accordance with the requirements of the Referenced Document entitled "Business Rules: Capitation-based funding" we will Pay you according to the Register submitted for the previous quarter less a deduction set in accordance with that Referenced Document.

- F.11.7 (a) Subject to sub clause (e) of this clause F.11.7, where you have reasonable evidence that a Payment(s) we have made to you is incorrect, you will notify us and our Payment Agent of the error (together with a description of the suspected error and the evidence you have in support of it).
- (b) We agree to discuss your concerns with you within 20 Business Days of such notification.
- (c) The parties (including our Payment Agent) will work together in good faith to:
- (i) identify the reasons for the underpayment;
 - (ii) quantify the error (including the adjustments required to correct the Payment); and
 - (iii) agree to a resolution of the problem including the agreed adjustment(s) and the Payment date,
- within a reasonable timeframe agreed to by the parties.
- (d) Where the error has, or may have, national implications and where we agree a solution to correct the error, we will ensure that our Payment Agent notifies all PHOs of the nature of the error to give them the opportunity to assess the financial impact of the issue on their PHO.
- (e) Notification of an error in a Payment must be made within six-months of the date of the Payment, unless it is reasonable in the circumstances for a longer period to apply.

F.12 Default Interest on late Payment

F.12.1 Ability to charge Default Interest

- (a) Subject to clause F.12.3, where either of us does not pay any amount due to the other under this Agreement, the party owed the payment (or our Payment Agent where we are owed), may charge the other party interest from the date payment was due until the amount due is paid (Default Interest).
- (b) Where 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 one month after written notice to the party owing the payment.

F.12.2 Rate of Default Interest

The Default Interest rate will be 2 percentage points per annum above the index lending rate charged by Westpac Trust for the period involved and shall be calculated on a daily basis.

F.12.3 Notice of intention to charge

- (a) In order for the due party to claim, and the defaulting party to be liable to pay the Default Interest, the due party must give written notice to the defaulting party (and the Payment Agent if applicable) of its intention to claim Default Interest within six months after the date payment was due.
- (b) Any notice from you under this clause must detail:
- (i) your name (as shown on the cover of this Agreement);
 - (ii) the Agreement Reference Number;
 - (iii) your payee number;

- (iv) the DHB that you are contracted with (i.e., us);
- (v) the details of the payment that the Default Interest relates to.

F.13 Recovery of overpayments and costs of Audit

- F.13.1 In the event that moneys have been Claimed by you in breach of this Agreement all such moneys and, subject to clause F.13.3, all costs of any Audit, or that relate to the attendances or time involved by us or our agent and incurred as a consequence of that Claim, (if any), are deemed to be a debt owing by you to us that is repayable on demand.
- F.13.2 Before we seek to recover any such amounts, we must give you written notice of our intention to recover from you. Any notice to you under this clause must detail:
- (a) our name (as shown on the cover of this Agreement);
 - (b) the Agreement Reference Number; and
 - (c) the amount and details of the overpayment which we believe you have received in breach of this Agreement, and any related costs.
- F.13.3 We will not seek to recover costs under this clause F.13 where the inappropriate Claim is the result of an occasional error or oversight, honestly made, and which is of minor consequence.

F.14 Set-off

Power of set-off

- F.14.1 Where you owe us any amount under this Agreement, including:
- (a) in the case of overpayment under clause F.11.5(a); or
 - (b) in the case of any debt you owe us under this Agreement,
- we (or our Payment Agent on our behalf) will give you notice of our intention to set-off the that amount against any amount that we owe to you at any time, to enable you to review and discuss with us our reasons for the intended set-off.
- F.14.2 Where we are in dispute in relation to any proposed set-off, the matter will be resolved pursuant to the dispute resolution process provided in clauses D.14.3 or D.16.
- F.14.3 We will exercise our power of set-off only if:
- (a) you have agreed in writing to the set-off being made; or
 - (b) you have not provided us with satisfactory assurance that the amount in question will be repaid if, as a result of resolving our dispute with regard to the amount, that process finds in our favour.
- F.14.4 If we set-off an amount pursuant to (b), and as a result of resolving our dispute with regard to the amount, that process does not find in our favour, we will repay you the amount of the set-off plus Default Interest pursuant to clause F.12.
- F.14.5 **Set-off deemed to be payment**
Where we exercise the power of set-off conferred by this clause you will be deemed to have made payment to us to the extent of the set-off.

F.15 Payment rates increases

- F.15.1 We both acknowledge that the Ministry of Health prescribes Payment rates for Services described in Parts A - I of this Agreement. Where the Ministry of Health increases funding for any such Services on a national basis, we will:
- (a) follow the process described in clause D.11 in relation to the Ministry of Health's terms and conditions for that Payment rate increase; and
 - (b) increase the Payment rates specified in the Schedules to this Part F in accordance with the Ministry of Health's prescription.

SCHEDULE F1.

Payment for Capitated Services

1. **First Level Services delivered to Enrolled Persons**

Capitation Payments for First Level Services delivered to Enrolled Persons

1.1 Capitation Payments for First Level Services and other associated services described in Part H (excluding the services described in the Schedules to Part H that are paid on a fee for service basis) are based on the following factors:

- (a) age (6 groupings: 0-4, 5-14, 15-24, 25-44, 45-64, 65+);
- (b) gender;
- (c) ethnicity (2 groupings: "Maori or Pacific" and "Other") (for health promotion services and services to improve access for High Need Groups only);
- (d) deprivation (2 groupings: NZ Deprivation Index Deciles 1-8 and NZ Deprivation Index Deciles 9-10) (for health promotion services and services to improve access for High Need Groups only);
- (e) High Use Health Card status;
- (f) Community Services Card status (for services delivered other than by Access Practices).

Capitation Payments for non-Access Practices

1.2(a) Subject to clause 1.2(b) of this Schedule F1, we will Pay you for First Level Services and other associated services described in Part H (but not including health promotion services and services to improve access for High Need Groups) delivered by non-Access Practices according to the numbers of Enrolled Persons in each category at the annual rate specified in the table in this clause 1.2(a).

Service	First Contact Services					
	Age Group	Gender	CSC	High user		
0 – 4	F			\$308.12		
	M			\$327.88		
5 – 14	F			\$79.33	\$302.61	
	M			\$75.18	\$302.61	
15-24	F			Y	\$78.90	\$291.50
				N	\$36.09	\$291.50
	M	Y	\$42.38	\$291.50		
		N	\$20.79	\$291.50		
25 – 44	F	Y	\$72.61	\$291.50		
		N	\$7.32	\$291.50		
	M	Y	\$43.16	\$291.50		

Service	First Contact Services			
Age Group	Gender	CSC	Non high user	High user
		N	\$5.91	\$291.50
45 – 64	F	Y	\$88.74	\$319.27
		N	\$12.22	\$319.27
	M	Y	\$67.96	\$319.27
		N	\$9.57	\$319.27
65+	F	Y	\$126.85	\$342.40
		N	\$15.42	\$342.40
	M	Y	\$112.98	\$342.40
		N	\$14.10	\$342.40

(b) We will Pay you in accordance with the table in this clause 1.2(b) provided you have complied with Schedule F4. For the avoidance of doubt this means that, in accordance with clause 2.4 of Schedule F4, before entering into this Agreement, you consulted with us in relation to the level of patient fees to be charged for standard consultations by you and your Contracted Providers. You advised us of the fees that are intended to be charged by each of your Contracted Providers for a standard consultation to Enrolled Patients aged over 64 and you provided us with supporting documentation demonstrating:

- (i) how the fees have been informed by the currently known level of fees in the region; and
- (ii) how increased subsidy payments translate into low or reduced costs to patients, being both fair and reasonable to patients and providers.

Service	First Contact Services				
Age Group	Gender	CSC	Non high user	High User	
0-4	F		\$308.12	\$471.96	
	M		\$327.88	\$471.96	
5-14	F		\$79.33	\$302.61	
	M		\$75.18	\$302.61	
15-34	F		Y	\$78.90	\$291.50
			N	\$36.09	\$291.50
	M	Y	\$42.38	\$291.50	
		N	\$20.79	\$291.50	
25-44	F	Y	\$72.61	\$291.50	
		N	\$7.32	\$291.50	
	M	Y	\$43.16	\$291.50	
		N	\$5.91	\$291.50	
45-64	F	Y	\$88.74	\$319.27	
		N	\$12.22	\$319.27	
	M	Y	\$67.96	\$319.27	
		N	\$9.57	\$319.27	
65+	F	Y	\$191.27	\$342.40	
		N	\$191.27	\$342.40	
	M	Y	\$164.95	\$342.40	
		N	\$164.95	\$342.40	

Capitation Payments for Access Practices

- 1.3 We will Pay you for First Level Services and other associated services described in Part H (but not including health promotion services and services to improve access for High Need Groups) delivered by the Access Practices listed in clause J.7 according to the numbers of Enrolled Persons in each category at the annual rate specified in the table below.

Age	Gender	Non-High Use Health Card holder	High Use Health Card holder
0-4	F	\$315.73	\$471.96
	M	\$332.42	\$471.96
5-14	F	\$99.94	\$302.61
	M	\$93.54	\$302.61
15-24	F	\$92.22	\$291.50
	M	\$50.75	\$291.50
25-44	F	\$81.04	\$291.50
	M	\$52.38	\$291.50
45-64	F	\$110.99	\$319.27
	M	\$82.90	\$319.27
65+	F	\$191.27	\$342.40
	M	\$164.95	\$342.40

Deductions to capitation Payments for First Level Services delivered to Enrolled Persons

- 1.4 Where a Claim for a fee for service for General Medical Services for an Enrolled Person is submitted (regardless of which provider makes that Claim) an amount equivalent to the General Medical Services Payment (set out in Schedule F3 to Part F) will be deducted from your capitation Payment at the next monthly Payment date so long as not more than three such Claims have been submitted for that Enrolled Person in that month.
- 1.5 For the avoidance of doubt, we will not make any deduction under clause 1.4 for the fourth or subsequent Claim submitted for an Enrolled Person for First Level Services as a Casual User in a month.
- 1.6 We will provide you with reports on Enrolled Persons who are provided with First Level Services as a Casual User by a health service provider not part of your PHO, to assist you to minimise deductions made under clause 1.4.

2. Management services

- 2.1 The annual management services fee will be calculated per Enrolled Person according to the table below, commencing on 1 January 2004:

(a) if your number of Enrolled Persons is 75,000 or below:

Numbers of Enrolled Persons	Management fee per Enrolled Person
Up to 20,000	\$9.61
20,001 to 75,000	\$4.67

(b) if your number of Enrolled Persons is 75,001 or above:

Numbers of Enrolled Persons	Management fee per Enrolled Person
Up to 20,000	\$6.41
20,001 to 75,000	\$5.83
75,001 and above	\$5.25

3. Health promotion and services to improve access for High Need Groups

3.1 Health promotion

Where we approve your proposal to deliver health promotion services under clause H.5.3 of Part H, we will Pay you for health promotion services according to the numbers of Enrolled Persons in each category at the annual rate specified in the table below.

Age	Gender	CSC	Non High Use Health Card holders			
			Maori/Pacific		Non Maori/Pacific	
			Dep 1-8	Dep 9-10	Dep 1-8	Dep 9-10
0-4	F	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
	M	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
5-14	F	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
	M	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
15-24	F	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
	M	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
25-44	F	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
	M	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
45-64	F	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
	M	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22

			Non High Use Health Card holders			
			Maori/Pacific		Non Maori/Pacific	
Age	Gender	CSC	Dep 1-8	Dep 9-10	Dep 1-8	Dep 9-10
65+	F	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22
	M	Y	\$2.22	\$2.59	\$1.85	\$2.22
		N	\$2.22	\$2.59	\$1.85	\$2.22

3.2 Services to improve access for High Need Groups

Where we approve your proposal to deliver services to improve access to High Need Groups under clause H.5.2 of Part H, we will Pay you 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			
		Maori/Pacific		Non Maori/Pacific	
Age	Gender	Dep 1-8	Dep 9-10	Dep 1-8	Dep 9-10
0-4	F	\$63.15	\$126.29	\$0.00	\$63.15
	M	\$66.48	\$132.97	\$0.00	\$66.48
5-14	F	\$19.99	\$39.98	\$0.00	\$19.99
	M	\$18.71	\$37.42	\$0.00	\$18.71
15-24	F	\$18.44	\$36.89	\$0.00	\$18.44
	M	\$10.15	\$20.30	\$0.00	\$10.15
25-44	F	\$16.21	\$32.41	\$0.00	\$16.21
	M	\$10.48	\$20.95	\$0.00	\$10.48
45-64	F	\$22.20	\$44.40	\$0.00	\$22.20
	M	\$16.58	\$33.16	\$0.00	\$16.58
65+	F	\$38.25	\$76.51	\$0.00	\$38.25
	M	\$32.99	\$65.98	\$0.00	\$32.99

4. Monthly Payments

4.1 All amounts payable to you under this Schedule F1 will be paid in equal monthly instalments in advance.

SCHEDULE F2.

Payment for Immunisation Services

1. Payments for Immunisation Services

- 1.1 You will be entitled to receive, in lieu of any other Payment that you might otherwise be entitled to receive under this Agreement, the Payment specified in clause 4 of this Schedule F2, for administering:
- (a) in the course of an immunisation programme approved by us, a vaccine supplied by our authorised agent; and
 - (b) an influenza vaccine purchased from a supplier nominated by the Ministry of Health in writing from time to time.
- 1.2 Subject to clause 3 of this Schedule F2, we will Pay you for each occasion on which a vaccine or vaccines is administered to a Service User according to any immunisation programme approved by us.

2. Requirements for administering vaccines

- 2.1 Vaccines must be administered through a Medical Practitioner, Independent Vaccinator or by a registered nurse acting under the direction of a Medical Practitioner.

3. One Payment only

- 3.1 Except as provided for in clause 3.4 of this Schedule F2, nothing in this Schedule F2 shall entitle you to receive more than the relevant fee specified in clause 4 of this Schedule F2 in respect of administering more than one vaccine on the same occasion.
- 3.2 Subject to clause 3.3 of this Schedule F2, neither you nor a Contracted Provider shall demand or accept or be entitled to recover from the Service User or any other person, any fee in respect of the Services for which a fee is payable under this Schedule F2.
- 3.3 If any other Service other than immunisation is provided by you or a Contracted Provider at the same time as the consultation for the Immunisation Service then you or the Contracted Provider may charge for that other Service. A simple check of fitness (without clinical indication) for immunisation is considered part of the Immunisation Service.
- 3.4 You are entitled to receive a fee for administering MeNZB Vaccine when it is administered on the same occasion as another approved vaccine.

4. Fees

- 4.1 We will Pay you \$16.00 (GST exclusive) for administering a Vaccine Episode on the childhood immunisation schedule as detailed in the Immunisation Handbook, other than the influenza vaccine.
- 4.2 We will Pay you \$16.00 (GST exclusive) plus the purchase cost (inclusive of GST) of the vaccine from the nominated supplier, for administering the influenza vaccine to eligible people as defined by the Influenza Guidelines, between the time the vaccine becomes available each year (usually February or March) until 30 June of that same calendar year.

4.3 We will Pay you \$16.00 (GST exclusive) for administering a MeNZB Vaccine Episode.

5. NHI Requirements

5.1 We will Pay a Claim for Immunisation Services provided 85% of single Claims making up your whole immunisation Claim, have valid NHI numbers or where we have not met the requirements of clause 6 of Schedule F3.

5.2 Where we have met the requirements of clause 6 of Schedule F3 and the proportion of NHI numbers in a whole Claim is less than the 85% target specified above, those single Claims that do not have NHI numbers will not be paid.

6. Conditions of Payment

6.1 We will Pay the fees set out in this Schedule F2 provided that:

- (a) the immunisation has not already been given or a reasonable effort has been made to check whether the immunisation has not been given; and
- (b) the fee is claimed in accordance with the claiming and NHI number requirements of this Agreement; and
- (c) the Claim complies with the information requirements set out in clause 1.2 of Part I.

7. Influenza vaccines

7.1 The cost of the influenza vaccine will be advised by the Ministry of Health from time to time, and any change to the vaccine cost will be advised by us as soon as practicably possible prior to the commencement of the programme.

7.2 The Influenza Guidelines may vary from time to time. The Ministry of Health will consult with the sector on any change to such guidelines.

7.3 The Ministry of Health will advise you of the supplier from whom the vaccine is to be purchased and the price as required from time to time.

8. Other immunisations

8.1 A fee will be paid by us for administering a vaccine or vaccines to the persons set out below:

- (a) a Service User who is a household or sexual contact of a person with acute Hepatitis B or a carrier of Hepatitis B; or
- (b) a Service User who is a household contact of a person with Measles, Mumps or Rubella.

9. Approved immunisation programmes

9.1 The immunisation programmes that are currently approved for the purposes of this Schedule F2 are detailed in the Immunisation Handbook.

9.2 The Group B Meningococcal Immunisation Programme (MeNZB Programme) as described by us and the Ministry of Health is approved for the purposes of this Schedule F2.

10. Meningococcal Immunisation Programme- PHO Coverage Quality Payments

- 10.1 Notwithstanding the Payment arrangements for Services outlined in Schedule F2 clause 4, and the Services described in Schedule H1, we agree to make quality Payments to you according to this clause 10 where the agreed coverage rates are reached or exceeded.
- 10.2 We both agree that the target coverage rates as described in clause 10.2 of Schedule F2, are to be measured 7 months after the commencement of the MeNZB Programme in the district, are:
- (a) 80% of Enrolled Patients in the target population under 5 years of age are fully vaccinated according to the MeNZB Programme; and
 - (b) 90% of Enrolled Patients in the target population under 5 years of age are fully vaccinated according to the MeNZB Programme.
- 10.3 The number of children that the coverage rate will be measured against will be according to the PHO Register submitted for the quarter immediately prior to the commencement of the MeNZB Programme unless otherwise agreed in writing between us both. Should we both agree that the population has changed significantly when the coverage rate is measured, then the Payment will be adjusted according to the following formula:
- $$\begin{array}{r} \text{Amount to Pay at claim date} \\ = \end{array} \quad \frac{\text{Amount left to be paid} \quad \times \quad \text{population at claim date}}{\text{population at start}}$$
- 10.4 The number of fully vaccinated children will be determined by us from the information reported to the NIR database. We will make the information used available to you.
- 10.5 The maximum quality Payment that can be made to you is equivalent to the 90% coverage rate. We will make that Payment as follows:
- (a) we agree to make a one off advance Payment on receipt of your invoice equivalent to 40% of the maximum Payment, in advance of the commencement of the MeNZB Programme in your district; and either
 - (b) a further 30% of the maximum Payment will be paid at 7 months if you reach the 80% coverage rate target described in clause 10.2 of this Schedule F2; or
 - (c) a further 60% of the maximum Payment will be paid at 7 months if you reach the 90% coverage rate target described in clause 10.2 of this Schedule F2.
- 10.6 You will utilise the advance Payment under clause 10.5 of this Schedule F2 to ensure the implementation of the MeNZB Programme in your district is supported to maximise the coverage rate. The implementation of the MeNZB Programme is to be complemented by your Health Promotion Programme and any other community based services provided by you.
- 10.7 We agree to provide the following at no charge to you in order to support you in the implementation of the MeNZB Programme:
- (a) a Group B Meningococcal vaccine licensed for use in New Zealand and delivered to you according to the storage and transportation requirements for the vaccine;
 - (b) a public awareness campaign in the general media;
 - (c) processes and systems to support claiming and transmission of MeNZB vaccination data to the NIR;
 - (d) information and promotion resources for the public;

- (e) a Primary care resource handbook for MeNZB for general practices;
- (f) a referral and outreach programme to support the MeNZB Programme.

SCHEDULE F3.

General Medical Services provided to Casual Users

1. General provisions

- 1.1 You may provide General Medical Services (defined in Schedule H2 to Part H) to Eligible Persons who are not enrolled with you. General Medical Services may also be provided by other service providers to your Enrolled Population. General Medical Services will be paid for on a fee for service basis in accordance with the fees outlined in this Schedule F3.
- 1.2 The terms and conditions of the Section 88 Advice Notice shall apply to all services provided to and Payments made for Casual Users, subject to the provisions of this Agreement.

2. Entitlement to Claim

- 2.1 Subject to the provisions of this Schedule F3, you on behalf of each General Practitioner who provides General Medical Services to Casual Users as part of a Medical Consultation shall be entitled to claim from us the relevant Payment as prescribed and defined in clause 1.1 of this Schedule F3, together with such travelling allowances (if any) as we may agree with you in writing.
- 2.2 Where you on behalf of a General Practitioner are entitled in accordance with this Schedule F3 to receive from us any amount in respect of any General Medical Services provided or any pharmaceutical requirements supplied or any travelling expenses incurred, neither you nor the General Practitioner may demand or accept or be entitled to recover that amount from the Casual User or any other person responsible for the Casual User's debts.
- 2.3 If any question arises as to whether any service provided by a General Practitioner is included in the expression "General Medical Services", or as to whether any amount, and if so what amount, is payable by us, it shall be decided by us after the matter has been referred to an Advisory Committee under clause D.15.

3. General Medical Services

- 3.1 Each time you or one of your General Practitioners provides a Medical Consultation to any Eligible Person who is either the holder of a Community Services Card or High Use Health Card, or a dependent child, you will be entitled to receive from us the relevant fee per Medical Consultation as described in clause 3.5 of this Schedule F3.
- 3.2 Where the Casual User is covered under more than one fee in clause 3.5 of this Schedule F3 then the higher fee will apply.
- 3.3 No General Medical Services fee can be claimed by you if the Medical Consultation service is to be paid for under another fee, benefit, subsidy or alternative payment arrangements. For example, immunisation, under the maternity services benefit, or where the Medical Consultation is in respect of personal injury (as that term is defined in the Injury Prevention, Rehabilitation, and Compensation Act 2001).
- 3.4 No General Medical Services fee will be paid unless the requirements for making a Claim for Payment and NHI number requirements set out in clause I.2 of Part I have been complied with.
- 3.5 The following table states the rates payable for General Medical Services as at the Commencement Date.

		Fee \$ Per Medical Consultation (Excl GST)
1	A child, under 6 years of age	\$31.11
2	Holder of current Community Services Card	\$13.33
3	A child, 6 years of age or over, of holder of a Community Service Card	\$17.78
4	Holder of current High Use Health Card who is not a child	\$13.33
5	A child, 6 years of age or over, who is a holder of current High Use Health Card	\$17.78
6	A child, 6 years of age or over, who is not within Community Services Card or High Use Health Card categories above	\$13.33

4. NHI requirements for GMS Claims for Casual Users

- 4.1 We will Pay a Claim for General Medical Services provided to Casual Users if at least 70% of that Claim specifies a valid NHI number for each Casual User or where we have not met the requirements of clause 6 of Schedule F3.
- 4.2 Where we have met the requirements of clause 6 of Schedule F3 and less than 70% of a Claim specifies valid NHI numbers for each Casual User, we will reject all Claims that do not contain a valid NHI number.
- 4.3 If:
- (a) we have rejected part of a Claim for General Medical Services provided to Casual Users in accordance with clause F.10.4 because the NHI details of one or more of the Casual Users in respect of which the Claim was made was incorrect; and
 - (b) you have resubmitted that Claim in accordance with clause F.10.5 and have met the requirements of clause F.10.6; and
 - (c) such NHI details have been correctly amended by you, and the inclusion of the corrected NHIs means that your original Claim (now amended) now meets the 70% threshold for specified NHIs set out in clause 4.1 of this Schedule F3,
- then we will Pay that Claim in accordance with clause 4.1 of this Schedule F3.

5. Deceased Casual Users and Casual Users rejecting Services

- 5.1 Where you provide General Medical Services for any non enrolled person elsewhere than at the place of practice or residence of the General Practitioner, and that person has died before the arrival of the General Practitioner or rejects the General Medical Services of the General Practitioner, then, for the purposes of this Agreement, that person shall be deemed to be a Casual User and the General Practitioner shall be deemed to have provided General Medical Services for that person.

6. Access to NHI numbers

- 6.1 We will ensure that you and your Contracted Providers can gain sufficient access to facilities (including telephone, fax and internet access) to obtain individuals' NHI numbers so that the threshold targets for claims in clause 4 and for immunisation claims in clause 5 of Schedule F2 can be met. Sufficient access to facilities for the purposes of this clause means:
- (a) 90% of all phone or fax requests made to our designated agent for this purpose are responded to within 2 working days, provided that requests are for no more than 40 records per practice per day; and
 - (b) 90% of all scheduled electronic batch matching requests are returned completed within 4 working days of the date received, provided the electronic file or files supplied are in a format acceptable to our agent.

SCHEDULE F4

Fees Level Policy and Charges to Service Users

1. Ability to charge Service Users

- 1.1 You are entitled to charge Eligible Persons for health services including those funded in part by us except where expressly agreed otherwise in this Agreement.

2. Fees Framework

- 2.1 The purpose of this Schedule F4 is to set out the framework that will apply to the patient fees charged by health providers funded in accordance with Access funding.
- 2.2 We expect that your Enrolled Patients will have access to low or reduced cost primary health services from you or your Contracted Providers. You recognise our requirement to have certainty that the increased payments to health providers that are made under any services agreement, which subsidise a patient's fees, will be reflected in low or reduced costs to patients.
- 2.3 You will ensure that those increased subsidy payments will result in low or reduced fees charged by your Contracted Providers to Enrolled Patients and that those fees are fair to the providers and reasonable for the patients.
- 2.4 Before entering into this Agreement, you consulted with us in relation to the level of patient fees to be charged for standard consultations by you and your Contracted Providers. You advised us of the fees that are intended to be charged by each of your Contracted Providers for a standard consultation. You provided us with supporting documentation demonstrating how the fees have been informed by the currently known level of fees in the region, and how increased subsidy payments translate into low or reduced costs to patients, being both fair and reasonable to patients and providers.
- 2.5 The level of fees to be charged for a standard consultation are identified in Schedule J2 of this Agreement. If it is necessary to increase the level of fees at any time during the term of this Agreement, you will advise us of those increases and the reasons for those increases.
- 2.6 We both acknowledge that it is the Government's intention to regularly adjust PHO funding to maintain its value.
- 2.7 If after the Commencement Date, we consider that the level of fees being charged by you or your Contracted Providers for a standard consultation is unreasonable, we may give notice to you that we wish to refer the matter to a fee review committee. Such fee review committee will be established and comprised of four people: two members nominated by us, a member nominated by you and a member nominated by you to represent the relevant health providers.
- 2.8 The role of the fee review committee shall be to make a recommendation as to whether the fees for standard consultations are fair and reasonable to patients and providers. In formulating its recommendation, the fee review committee shall take into account the fees charged by contracted health providers and other PHOs that are funded under the Access funding formula, the need to ensure the viability and sustainability of the health providers that are the subject of the fee review, and any other evidence provided by either of us to support the fee levels.
- 2.9 The recommendation of the fee review committee will be made by consensus. If such consensus is unable to be reached, the individual views of each member will be notified to us both.
- 2.10 If the recommendation of the fee review committee is not acceptable to either of us, then the matter is to be managed in accordance with clause D.16 (resolving disputes).

3. Arrangements for interim practices receiving access funding for particular groups

- 3.1 The principles outlined in clauses 2.1 to 2.10 of this Schedule F4 apply to fees charged for specific patient groups by you or your Contracted Providers that are funded in accordance with the Interim funding formula at such time as you receive Access level funding for these specific groups of your Enrolled Population.

4. Services for persons who are not Eligible Persons

- 4.1 Where you provide the Services to persons whom you know are not Eligible Persons you may charge and recover from those persons the cost to you of providing those Services.

5. No co-payments for Immunisation Services

- 5.1 You will not charge a co-payment for Immunisation Services for which you are receiving Payment under this Agreement.

6. Children under 6 years

- 6.1 We expect that neither you nor any Contracted Provider will charge a co-payment in most situations to children under 6 years between the hours of 8am and 8pm, seven (7) days a week. We believe this will result in near universal access to free medical care for children under 6 years of age.

7. Notification of fees

- 7.1 You must display and ensure that Contracted Providers display a list of your (or their) charges to Service Users in a place where Service Users can readily see the charges.

8. Holders of Community Services Cards and High Use Health Cards

- 8.1 You (and your Contracted Providers) will charge a lower fee for Services provided to Enrolled Persons who:

- (a) are not included in the groups specified in clause 2 and 3 of this Schedule F4; and
- (b) hold Community Services Cards or High Use Health Cards,

and those lower fees will be in accordance with the subsidy rates set out for Casual Users in clause 3.5 of Schedule F3.

9. Community Services Card Holders

- 9.1 You will ensure that for your Enrolled Population fees established under clause 2 and 3 of this Schedule F4 are set irrespective of whether the patients or their families have a Community Services Card.

SCHEDULE F5

Rural Primary Health Care Premium

1. Purpose of the premium

- 1.1 If your geographical areas specified in clause J.3 of Part J include rural communities, we will Pay you a rural primary health care premium (the "Rural Premium").
- 1.2 The purpose of the Rural Premium is to enable you to retain and recruit a skilled primary health care workforce to serve rural communities.
- 1.3 The Rural Premium is designed as a flexible resource to support locally devised solutions to primary health care workforce issues impacting on achieving sustainable and accessible primary health care services in rural areas.

2. Definition of a Rural Community

- 2.1 For the purposes of the Rural Premium, a rural community is defined as:
 - (a) a community served by a General Practitioner who scores 35 or more on the Rural Ranking Scale (Refer to Schedule F6); or
 - (b) a General Practitioner or nurse in an equivalently rural area to whom we have assigned a 'notional' rural ranking score.

3. Rural Premium Components

- 3.1 The Rural Premium is made up of three parts:
 - (a) workforce retention funding – a flexible resource for supporting and retaining the primary health care team;
 - (b) reasonable roster funding – a targeted resource aimed at those experiencing onerous on call arrangements; and
 - (c) remote practice area - additional funding on account of a pre-existing special funding arrangement to support a remote practice.
- 3.2 Each of these components is described in clauses 4, 5 and 6 respectively, below.

4. Workforce retention funding

- 4.1 As part of the Rural Premium, we will Pay you workforce retention funding according to a formula based on degrees of "remoteness" (indicated by the rural ranking score of the General Practitioners¹).
- 4.2 The current workforce retention funding allocation formula and your rural workforce retention funding is specified in clause 1 of Schedule J3 of Part J.
- 4.3 The workforce retention funding is a flexible resource to assist with retention and recruitment of all primary healthcare workers serving rural communities.

¹ For some remote rural localities served by rural nurses with GP back-up, eg Stewart Island, a national rural ranking score will be applied by the DHB to the nurse(s). Similarly, for rural doctors who have not been allocated a rural ranking score, the DHB can allocate a 'notional' rural ranking score for workforce retention funding purposes based on the same criteria.

- 4.4 You may apply the funding to a range of strategies to create favourable working conditions including, but not limited to:
- (a) time off duty;
 - (b) a supportive professional working environment;
 - (c) access to continuing professional development and peer support;
 - (d) financial incentives; and/or
 - (e) the ability to enter and leave rural practice with minimal restrictions.
- 4.5 If you were established during the 2003/04 financial year, you will receive rural workforce retention funding on a pro rata basis minus the amount we have already expended on workforce retention strategies for your primary health care team in that financial year. For example, if a PHO encompassing a rural area is established half way through the financial year, it will be entitled to receive 50 percent of the workforce retention funding based on audited patient register numbers (minus any funding the DHB has already expended on retention strategies for the area covered by the PHO).
- 4.6 You are bound to the terms of any existing agreement between us and your General Practitioners and/or Contracted Providers. However, after the expiry of any such agreement, you may determine what workforce retention assistance you provide to your General Practitioners and/or Contracted Providers.
- 4.7 You may agree with us that we retain all or part of the workforce retention funding to continue to arrange retention strategies for your primary health care workforce.
- 4.8 For the 2003/04 transition year, where you were established on or after 1 January 2003, your rural practices should receive no less funding than they received in 2002/03 as a result of the general allocation method not including any discretionary or one off targeted Payments made to practices during 2002/03.

5. Reasonable roster funding

- 5.1 Reasonable roster funding is a targeted resource applied to rural localities where, for geographical reasons, General Practitioners and nurses providing First Level Services are experiencing onerous on call arrangements.
- 5.2 Reasonable roster funding was paid by us to eligible practices/providers (those experiencing 1:1 – 1:3 rosters) in 2002/03 and for the 2003/04 year.
- 5.3 During 2003/04 you may not reduce the level of funding allocated to those practices/providers in the shared roster area without the agreement of Contracted Providers.
- 5.4 We paid funding to improve roster arrangements to the practices / Contracted Providers specified in clause 2 of Schedule J3 to Part J.
- 5.5 From July 2003, providers whose shared roster area reduces to 1:3 or less will need to apply to you for funding to improve rosters. You are expected to use some of your rural primary health care premium for this purpose.
- 5.6 From July 2004, reasonable roster funding that was previously paid by us to eligible practices/providers, will be paid to you as part of the rural premium. From July 2004, you may change the level of support provided to practices/providers receiving reasonable roster funding in order to enhance cost effective roster arrangements, so long as the new arrangements continue to support reasonable rosters and meets the access standards regarding out of hours care.

6. Remote practice areas

- 6.1 A remote rural practice is characterised by high points on the rural ranking scale and/or a former special area to which salaried primary health care services continue to be provided.
- 6.2 Where there is a current special funding arrangement for a remote practice area, and this special funding arrangement exceeds the capitation Payment for your Enrolled Population for the remote practice area, we will Pay you the difference between the two amounts.
- 6.3 We will Pay you the total amount for remote practice areas specified in the table set out in clause 3 of Schedule J3 to Part J in addition to the capitation Payment on behalf of the Enrolled Population(s) of the practice area(s) specified in that table.
- 6.4 Where you or your practices has/have received additional funding on account of a current special funding arrangement to support a remote practice, you may make service changes and/or funding adjustments that promote cost effective service delivery to the remote practice area provided that you continue to support sustainable and accessible services to that remote community and support favourable working conditions including time off duty for the primary health care team serving that community.
- 6.5 Where we provide the primary health care services ourselves to the remote practice area, you agree that we may retain the funding.
- 6.6 You cannot introduce patient charges in the areas specified in clause 3.3 of Schedule J3 to Part J without first obtaining Ministerial agreement which should be sought through us.

7. Priority uses of rural primary health care premium

- 7.1 In order for you to meet your obligations under clause H.3 of Part H, you will agree with us the priority uses of the Rural Premium.
- 7.2 Priority uses may include:
- (a) supporting reasonable rosters;
 - (b) stabilising the rural practice team where a rural community is at risk of being without services within the access standards;
 - (c) supporting practice teams serving remote communities;
 - (d) addressing heavy workloads, particularly where the doctor to Enrolled Population ratio exceeds 1: 2000;
 - (e) encouraging workforce innovations that promote sustainable services, for example: opportunities for nurses practising in rural primary health care settings to enhance their skills; and development of Nurse Practitioners in rural settings with prescribing rights.

8. Collaboration over rural workforce strategies

- 8.1 Subject to your obligations under the Commerce Act 1986, You may collaborate with other PHOs or other agencies to develop joint, district wide or regional initiatives.

SCHEDULE F6

RURAL BONUS

1. Claims for rural bonuses

- 1.1 A rural bonus may be claimed by General Practitioners whose score on the rural ranking scale (Refer to: Appendix 11 to the Section 88 Advice Notice) is 35 or above and who:
- (a) comply with the requirement to provide or arrange for the provision of General Medical Services for patients at all times; and
 - (b) provide a comprehensive general practice service to a significant practice population; and
 - (c) participate regularly in an on-call roster.
- 1.2 We will undertake a review of General Practitioners' rural ranking scores on an annual basis. General Practitioners' rural bonus will be calculated annually on the basis of the reviewed rural ranking score.
- 1.3 You do not have discretion to alter the amount of rural bonus payable to an eligible General Practitioner.

2. Applications for a rural bonus

- 2.1 We will supply you with application forms for the rural bonus by 15 March in each year and you will lodge applications for the rural bonus with us by 15 April in each year (unless we at our sole discretion, decide to extend that date).
- 2.2 We will, within one month after the last date for lodging applications, advise each eligible General Practitioner who has lodged an application of the dollar amount of their rural bonus for that financial year.

3. Adjustments to rural bonuses

- 3.1 A General Practitioner may during the course of a financial year apply to us for a rural bonus or an adjustment to the rural bonus payable to that General Practitioner if his or her score has increased. Any increase in Payment during that financial year will be made at our sole discretion.
- 3.2 We may, during the course of a financial year, reduce the amount of rural bonus payable to a General Practitioner, if his or her score decreases.

4. Medical Consultations by telephone

- 4.1 For General Practitioners in rural areas eligible for a Rural Bonus as defined in this Schedule F6, the benefits payable for the provision of Medical Services are payable where the Medical Consultation is made by telephone providing the patient is located 16km or further from the General Practitioner's place of practice at the time of Medical Consultation.
- 4.2 rural bonuses will not be payable in any other circumstances, except where approved in extreme circumstances.
- 4.3 Specified call centre services or other similar projects do not qualify for rural bonus pursuant to this Schedule F6.

5. Review of rural ranking scale

- 5.1 We may undertake a review of the current rural ranking scale criteria to clarify interpretation and ensure national consistency, in consultation with relevant rural provider organisations.

SCHEDULE F7

PAYMENT FOR CARE PLUS SERVICES

1 Calculating expected Care Plus population

- 1.1 In the months of April, July, October and January in each year we will calculate and report to you the number of people in each population category to whom we expect you to provide Care Plus Services. We will make these calculations from the register that you submit (see clause F.10.1(a)) by applying the percentages shown in the following table 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.

Age	Gender	Maori or Pacific		Not Maori or Pacific	
		Deprivation <5	Deprivation 5	Deprivation <5	Deprivation 5
0-4	Female	2.3%	2.6%	1.5%	2.2%
	Male	2.0%	3.1%	1.7%	1.9%
5-14	Female	1.3%	1.4%	1.1%	1.2%
	Male	0.9%	1.6%	0.7%	0.8%
15-24	Female	3.3%	3.4%	1.4%	2.5%
	Male	1.6%	1.7%	0.5%	1.5%
25-44	Female	3.8%	4.3%	2.4%	2.6%
	Male	3.1%	3.6%	1.3%	1.6%
45-64	Female	13.8%	13.9%	4.8%	8.5%
	Male	15.9%	16.7%	6.0%	9.3%
65+	Female	29.2%	33.8%	18.4%	22.4%
	Male	37.2%	41.0%	21.2%	24.7%

2 Payment for Services

- 2.1 Each month, as detailed in the table below, we will Pay you for Care Plus Services depending upon the total number of Care Plus Patients in your current Register and the number in certain high need categories compared to the number of Care Plus Patients we expected you to have during the previous quarter according to clause 1.1 of this Schedule F7:

Level	Percentage of expected number of Care Plus Patients	Percentage of full Care Plus Services funding in clause 2.2 of this Schedule F7
One	From nil to 49 percent of total	50 percent
Two	From 50 to 64 percent of total	64 percent
Three	From 65 to 79 percent of total	80 percent
Four	80 percent or above of total and 70% of Maori and/or Pacific subgroup and Deprivation 5	100 percent

- 2.2: For the above table we will calculate the full Care Plus Services funding as follows:
- \$199.51 (GST excl) multiplied by the expected number of Care Plus Patients in an Access Practice, and/or \$211.75 (GST excl) multiplied by the expected number of Care Plus Patients in an Interim Practice.
- 2.3 If after one year, you have not enrolled 50 percent of the expected Care Plus Patients, we will meet with you to discuss whether or not the Care Plus Services will continue. If we are able to agree the matter we may discontinue or reduce the funding for Care Plus Services.
- 2.4 The Purchase Unit for Care Plus Services is PHOC0011.

3 Care Plus fees assurance framework

- 3.1 You recognize our requirements to have certainty that increased Payments to health providers for Care Plus Patients which subsidizes patient fees will be reflected in low or reduced costs to patients and those fees are fair to the Contracted Providers and reasonable for Care Plus Patients.
- 3.2 You recognize our requirement to have certainty that Payments to Contracted Providers for Care Plus Services will be applied to the provision of services to patients identified as qualifying for Care Plus Services.
- 3.3 We acknowledge that some of the funding for Care Plus Services will be applied to services to patients which are not standard consultations (e.g. care plan, outreach), administration and management and that this will be taken into account in our assessment of your proposal.
- 3.4 As part of your proposal for delivering Care Plus Services you advised us of your funding arrangements for Care Plus Services in sufficient detail to demonstrate to us how you met all the requirements of clauses 3.1 to 3.3 of this Schedule F7.
- 3.5 If during the term of this Agreement you significantly or substantially change the funding arrangements for Care Plus Services advised to us, you will advise us in a timely manner of the change and the reasons for the change.
- 3.6 If after receipt of the advice in clause 3.5 of this Schedule F7, we consider the funding arrangements no longer meet the requirements of clause 3.1 to 3.3 of this Schedule F7, then we will meet with you with the aim of finding a mutually agreed resolution to the matter.

4 Reviewing this Schedule

- 4.1 We both acknowledge that the arrangements in this Schedule F7 are transitional and that we will review them through the process described in the Referenced Document entitled "Transitional PHO Agreement Amendment Protocol" and that we will give priority to completing that review by 31 October 2005.

Part G. Audit

G.1 Full and open accountability

- G.1.1 We may Audit your compliance with any or all of the requirements of this Agreement.
- G.1.2 You (and Contracted Providers) must co-operate with us and provide us and our Auditor with all reasonable assistance to ensure that any Audit conducted by us or our Auditor under this Part G is fully and properly completed to our and our Auditor's satisfaction.

G.2 Audit Principles

- G.2.1 We both agree that, under capitation, the financial risk associated with First Level Service provision is now held by PHOs and their Contracted Providers. The audit provisions in this Part G reflect the respective risk level of PHOs and DHBs and acknowledge that, while not constraining our rights to Audit under this Part G, you are responsible for auditing performance of your Contracted Providers.
- G.2.2 We both have an interest in the appropriate performance of the standard PHO agreement by other PHOs.
- G.2.3 Both of us agree that Audits will be carried out in accordance with the document entitled "Primary Healthcare Audit Protocol" which, when finalised, will form part of this Agreement by becoming a Referenced Document pursuant to the process described in clause D.9.3.
- G.2.4 You are responsible for auditing the performance of your Contracted Providers. Without limiting the generality of this clause, in particular you are responsible for:
- (a) auditing the Registers maintained by your Contracted Providers;
 - (b) auditing the information that your Contracted Providers are required to provide to us, through you;
 - (c) clinical audit of your Contracted Providers.
- G.2.5 We may Audit you and your Contracted Providers performance under this Agreement in accordance with the provisions of the Primary Healthcare Audit Protocol. Without limiting the generality of this clause, in particular we may Audit:
- (a) your compliance with the information provisions of this Agreement;
 - (b) your compliance with the requirements to provide quality health plans;;
 - (c) your compliance with the requirements under this Agreement to develop a Māori Health Action Plan in line with nationwide and DHB Māori health policy (see Part H.9);
 - (d) your compliance with the Establishment Enrolment Rules;
 - (e) your GMS Claims for visits by Casual Users.

G.3 Audit activities and processes

- G.3.1 Audits may involve a variety of activities that may include (without limitation) conducting investigations or on-site Audits of your Premises or any Contracted Provider's Premises, or surveying Service Users and Contracted Providers.
- G.3.2 Any Audit process will be designed in-keeping with the relationship principles set out in clause C.3 of Part C.
- G.3.3 From time to time we will evaluate the Audit principles and process described in this Part G including seeking and considering your feedback on the Audit process.

G.4 Audit framework guiding principles

We both agree that, where we conduct an Audit under this Agreement, our respective roles in any Audit will be undertaken in accordance with the principles of natural justice, and in particular the following principles:

- G.4.1 Audits are conducted promptly, and include active participation from us both.
- G.4.2 Appropriate notice of an Audit (including the anticipated scope of the Audit) is given pursuant to clause G.5.2 of this Part G.
- G.4.3 Auditors are suitably experienced, competent and carry out their work in a professional manner, and in particular:
- (a) minimise disruption to the Services;
 - (b) take into account relevant safety considerations;
 - (c) display appropriate sensitivity to the privacy and dignity of Service Users seen in the course of a visit;
 - (d) where culturally specific Services or Contracted Providers are subject to an Audit, the Auditor must be a suitably qualified cultural auditor;
 - (e) where Services provided to Māori are the subject of an Audit, suitably qualified Māori must be included in the Audit team; and
 - (f) where clinical records are the subject of an Audit, the Auditor must be a suitably qualified clinician.
- G.4.4 Except where the exceptions described in paragraphs (a) to (c) of clause G.5.2 apply, Audit activities will be undertaken at a time that is reasonably convenient for you and any Contracted Providers involved in the Audit.
- G.4.5 Audit activities must meet all legal requirements and the requirements of this Agreement.
- G.4.6 We may make copies of any part of any Record for the purposes of the Audit (as provided for under section 22G(1) of the Health Act 1956), except to the extent restrained by law.
- G.4.7 You may have a person present during an on site visit.
- G.4.8 We both will provide accurate information and prompt responses to all relevant queries, unless a prompt response would prejudice the integrity of the Audit.

- G.4.9 Audit reports will:
- (a) be timely;
 - (b) detail the facts found during the Audit;
 - (c) be provided in draft for your consideration and comment, and include your relevant feedback;
 - (d) where appropriate, provide recommendations to identify the actions necessary for either of us to bridge the gap between the Audit criteria and the level of performance found in the Audit.
- G.4.10 Where Audits result in recommendations, either or us both will take reasonable steps to implement them and any agreed follow-up processes.
- G.4.11 Where any Audit includes a Contracted Provider, the principles and obligations described in this clause G.4 apply to the Contracted Provider as they apply to you.

G.5 Audit requirements

G.5.1 Access for Audits

You agree to co-operate with us for the purposes of, and during the course of, conducting an Audit and to allow (and/or arrange) our Auditor or Auditors to access at any time during business hours, or at any other time by arrangement with you, to the extent that you are legally able to (but not including any case where you have failed to ensure Contracted Providers are obliged to submit to an Audit):

- (a) your or any Contracted Provider's Premises, including to observe the provision of the Services;
- (b) Records and any other information (including Health Information), in whatever form, that relates to this Agreement, the Service Users and their families and associates;
- (c) Staff, Contracted Providers, subcontractors, contractors, agents or other personnel used by you to provide the Services;
- (d) Service Users, their families or their associates, for interviews about the Services provided under this Agreement.

You further agree to ensure that we and our authorised agents have equivalent access in relation to any Services provided through any Contracted Provider, agent or other personnel.

G.5.2 Notice of Audit

We will give you thirty (30) Business Days' prior written notice of our intention to carry out an Audit, except where we have reasonable grounds to believe that:

- (a) there has been a material breach of this Agreement; or
- (b) a delay of thirty (30) Business Days would unreasonably prejudice the integrity of the Audit; or
- (c) a delay of thirty (30) Business Days would unreasonably prejudice the interests of any Eligible Person,

in which case a reduced notice period may be given which is reasonable in the circumstances (and may include less than 24 hours notice or no notice in some circumstances). Where we reasonably suspect that fraudulent claiming has occurred, we may enter your or any Contracted Provider's Premises and conduct an Audit at any time without prior notice.

G.5.3 Other information

The Notice of Audit will also include:

- (a) the identity of the person or persons appointed as Auditor;
- (b) their qualifications, (if any); and
- (c) a declaration from such person or persons of any conflicts of interest he or she may have.

G.5.4 Where you have any reasonable concerns about the focus of any Audit or any person appointed by us as an Auditor, you will bring those concerns to our attention within ten (10) Business Days of receiving our notice of intention to Audit. Subject to time constraints when we are conducting an urgent Audit in the situations described in clause G.5.2, we will discuss those concerns with you and respond to you in writing regarding your concerns prior to commencing the Audit.

G.6 Audits after this Agreement is terminated

G.6.1 Audits may continue to be conducted under this Part G after this Agreement has terminated, but only to the extent that it is relevant to the period during which this Agreement was in force.

G.7 Specific provisions for financial and minimum requirements Audits

G.7.1 We both acknowledge and agree that the purpose of any financial Audit is to:

- (a) maintain public confidence in the spending of public health funding;
- (b) confirm you meet (and continue to meet) the requirements of being a Not for Profit organisation described in clause E.2.1; and/or
- (c) ensure you comply (and continue to comply) with the other PHO Minimum Requirements.

G.7.2 Where we have a concern regarding your financial arrangements and or financial position, we may request by notice in writing, and you must provide to us within thirty (30) days of such request a certificate from a suitably qualified person certifying your solvency, or financial or other information regarding your financial position or arrangements relevant to assessing whether you meet the requirements of being a Not for Profit organisation.

G.7.3 From time to time we may appoint, at our cost, a suitably independent financial analyst as an auditor to determine or assess:

- (a) the correctness of the financial information you give us;
- (b) your overall financial position; and
- (c) any other matters relevant to assessing whether you have met the requirements of a Not for Profit organisation and the other PHO Minimum Requirements.

G.8 Application of the Health Act 1956

- G.8.1 You must ensure that Contracted Providers are subject to the same obligations that you are subject to under section 22G of the Health Act 1956 (Inspection of records) as if they were “providers” under section 22G(1), so that we are able to exercise all our rights under section 22G of the Health Act in respect of any information held by any Contracted Provider as if you held that information.

Part H. Establishment Service Specifications for Essential Primary Health Care Services

H.1 Application

H.1.1 This Part H describes a minimum set of Essential Primary Health Care Services that we expect you to provide to your Enrolled Population.

H.1.2 The requirements of this Part H apply to all Services delivered under this Agreement.

H.2 Service objectives

You are required to work towards the following objectives:

H.2.1 General

Essential Primary Health Care Services will be evidence and best practice based (where possible) and will aim to improve, maintain and restore health and ensure access to care. They should be provided for individuals across their life span, for families, whanau and communities taking a broad view of health, including physical, mental, cultural, social and spiritual dimensions. Services should be co-ordinated with other health care services and will aim to reduce health inequalities.

H.2.2 Maori health

- (a) With reference to He Korowai Oranga: The Maori Health Strategy, you are expected to contribute to improvements in whanau ora, and to the reduction in Maori health inequalities. Specific Maori health priorities are outlined in the strategy under Maori Health and Disability Priorities.
- (b) You will work with iwi, Maori communities and providers to develop and implement a Maori Health Action Plan that outlines how you will contribute to improving outcomes for Maori for the Services contained in this Part H.
- (c) You will be provide evidence of how you work with iwi, Maori communities and providers to develop and implement the Maori Health Action Plan and to demonstrate how implementation of the Plan has improved health outcomes and/or access for Maori.
- (d) You agree that improving the health status for Māori and reducing health inequalities is a priority. You agree to establish and implement a Māori Health Action Plan that gives effect to this. In developing this Action Plan, you will take into account the strategic direction for Māori health as set down by the Ministry of Health and DHBs. These frameworks, policies and plans include:
 - (i) New Zealand Public Health and Disability Act;
 - (ii) New Zealand Disability Strategy;
 - (iii) He Korowai Oranga – Māori Health Strategy;
 - (iv) Whakatataka Māori Health Action Plan;
 - (v) Inequalities Framework;
 - (vi) New Zealand Health Strategy;
 - (vii) Primary Health Care Strategy; and
 - (viii) specific local DHB requirements negotiated from time to time with us and specified in a schedule to Part J of this Agreement.

H.2.3 Pacific health

Where you provide services for Pacific communities (in particular, where we have specific Pacific accountabilities) you will, with reference to the Pacific Health and Disability Action Plan, work with Pacific communities and providers in planning and delivering services to contribute to the reduction in Pacific peoples' health inequalities.

H.3 Access

- H.3.1 You will provide access to First Level Services on a 24-hour a day, 7 day a week basis for 52 weeks a year for all Service Users.
- H.3.2 First Level Services must be available for 95% of your Enrolled Population during:
- (a) the normal Business Day within 30 minutes travel time; and
 - (b) after hours within 60 minutes travel time.
- H.3.3 Justification must be provided when the requirements of clause H.3.2 cannot be met. The justification should include details of alternative arrangements for providing access to First Level Services as agreed between us both.
- H.3.4 You will advise the Enrolled Population and have information available for Casual Users about how and when they can access First Level Services provided by you.
- H.3.5 You will work to ensure the provision of First Level Services is sufficient to meet demand. First Level Services are ideally provided by teams including General Practitioners and registered nurses (including Nurse Practitioners). You will provide documented evidence (including ratio of Practitioners to Enrolled Population) of how you achieve appropriate service levels to meet population need by using existing applicable indicators, standards of practice and professional standards.
- H.3.6 Access to population-based health services (clauses H.4.1 and H. 4.2 of this Part H) will be to all Enrolled Persons within normal business hours. You are not expected to be the sole provider of these population-based services that may be provided by a range of Practitioners and health workers. Except where levels and types of service provision are specifically agreed between us both (e.g. the target of 95% coverage for childhood immunisation), you and Contacted Providers and Practitioners will decide the extent and type of specific services that you and they provide to groups and individuals.
- H.3.7 Casual Users will have access to the same standard of care as your Enrolled Population.

H.4 Service components

You will provide Services to enable individuals and communities to benefit from services to:

- H.4.1 Improve their health through:
- (a) 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;
 - (b) health education, counselling and information provision about how to improve health and prevent disease and interventions or treatments that treat risk factors; and
 - (c) intersectoral linkages and relationships to improve health.

H.4.2 Maintain their health through:

- (a) ongoing health and development assessment and advice;
- (b) appropriate evidence based screening, risk assessment and early detection of illness, disease and disability;
- (c) use of recall and reminder systems and as appropriate referral to national programmes (including but not limited to Well Child Tamariki Ora National Schedule, national Cervical Screening Programme & Breast Screen Aotearoa);
- (d) interventions to assist people to reduce or change risky and harmful lifestyle behaviour;
- (e) family planning services, provision of contraceptive advice and sexual health services;
- (f) immunisation (see Schedule H1 to this Part H);
- (g) 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;
- (h) ongoing care and support for people with chronic and terminal conditions to reduce deterioration, increase independence and reduce suffering linking, where relevant, with appropriate service providers.

H.4.3 Restore their health by providing the following First Level Services:

- (a) health information to enable and assist people to care for themselves and take responsibility for their health and their family/whānau's health;
- (b) urgent medical and nursing services, (including stabilisation and resuscitation, assessment and diagnosis, treatment and referral as necessary);
- (c) assessing the urgency and severity of presenting problems through history taking, examination and investigation and diagnosing where possible;
- (d) recommending and, where appropriate, undertaking treatment options and carrying out/referring for appropriate interventions and procedures, including but not limited to prescribing, minor surgery and other general practice procedures, counselling, psychological interventions, advising, and imparting information;
- (e) referral for diagnostic, therapeutic and support services (support services are those services which may be required for individuals to maintain maximum independence, including but not limited to personal care and domestic assistance).

H.4.4 Co-ordinate care, and in particular:

- (a) co-ordinating an individual's rehabilitation process and participating where appropriate in providing recovery orientated services to restore normal functioning;
- (b) 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;
- (c) 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 whanau.

H.5 Service processes

H.5.1 Population awareness

- (a) You will use DHB needs analysis and/or other appropriate evidence, such as information collected from enrolment or disease registers, iwi and community input to plan and deliver services which are appropriate for the demographic make-up and health needs of your population. In particular, you will understand inequalities between different sub-groups of your Enrolled Population and identify gaps in service provision and in conjunction with us, identify where priorities lie. You will also attempt to identify those who are missing out on services.
- (b) Where your Enrolled Population includes rural communities, you must demonstrate (in the manner reasonably required by us) that you provide equitable and effective access to primary health care services within those rural communities or within acceptable travel times.

H.5.2 Access for High Need Groups

You will agree with us the services and activities you will undertake to improve access to primary health care services for High Need Groups in your Enrolled Population as follows:

- (a) You will design services and activities to improve access to primary health care services for High Need Groups in your Enrolled Population that may include outreach services in appropriate places and delivery approaches tailored for particular groups.
- (b) You will submit to us for our approval, your proposed services and activities demonstrating how access funding will be used to improve access to primary health care services.
- (c) We agree to consider your proposal and respond promptly to you within at least twenty (20) Business Days of receiving your proposal.

H.5.3 Health promotion services

You will agree with us the health promotion activities you will undertake as follows:

- (a) You will work with whanau, hapu, iwi, consumers and other groups within your community, relevant public health service providers and regional public health units to plan and deliver health promotion programmes. Programmes must be consistent with population health objectives and public health programmes at national, regional and local levels.
- (b) You will submit to us for our approval, your proposed health promotion strategy demonstrating how health promotion funding will be used to achieve desired health promotion outcomes.
- (c) We agree to consider your proposal and respond promptly to you within at most twenty (20) Business Days of receiving your proposal.
- (d) We will consult with the Ministry of Health Public Health Directorate on the proposed health promotion activities.

H.5.4 Managing Referred Services

- (a) You are responsible for managing Referred Services for your Enrolled Population. These management functions include:
 - (i) monitoring and reviewing Referred Services of referrers;
 - (ii) providing feedback to referrers;
 - (iii) monitoring against best practice and relevant quality indicators;

- (iv) using facilitators and educators to encourage adoption of best practice;
- (v) using peer groups to encourage best practice;
- (vi) supporting other agreed initiatives.

H.5.5 Care Plus Services

- (a) You will submit to us for our approval, a proposal to deliver Care Plus Services that includes your funding requirements and how you will meet the requirements of clauses 3.1 to 3.3 of Schedule F7.
- (b) Where we approve your proposal to deliver Care Plus Services, you will deliver Care Plus Services in accordance with Schedule H3.

H.6 Settings

- H.6.1 Services may be provided in your or Contracted Providers' Premises, health care clinics, the individuals' home or workplace, schools and any other setting that is appropriate to meet the needs of the individual and their family/whanau.

H.7 Services linkages

- H.7.1 You will actively work with providers from relevant service areas to consider how best to co-ordinate the care of your Enrolled Population. Co-ordination of all services will ensure appropriateness, effectiveness, accessibility and availability. You will seek and practice co-operative care co-ordination with a wide range of providers and other agencies.

H.8 Quality requirements

You will work to implement the following quality requirements to the extent possible within the funding available.

H.8.1 Quality improvement

- (a) You will ensure your Enrolled Population and Casual Users receive services that are safe, effective, consumer centred and of acceptable quality.
- (b) We acknowledge that continuous quality improvement in the provision of Services by you and your Contracted Providers who provide the Services is best managed by you and your Contracted Providers.
- (c) You will follow continuous quality improvement principles. You will document, implement and evaluate systems and processes that continuously identify and strive to meet the needs of people who use them. These systems must provide assurance for:
 - (i) efficiency, effectiveness, acceptability, appropriateness, co-ordination and continuity in the provision of the Services to patients;
 - (ii) maintaining, improving and evaluating the quality of ongoing service provision including the development of new initiatives;
 - (iii) maintaining, improving and evaluating the quality of your processes to engage with your communities and collaborate with other health service providers;
 - (iv) clinical and cultural audit and peer review processes that incorporate input from relevant health professionals, services and consumers and that are based on appropriate professional/clinical standards;

- (v) maintaining systems to manage risks appropriate to the degree and range of risk(s) relevant to the Services provided and ensure the security of people, drugs, equipment and buildings;
- (vi) a contingency plan that manages continued delivery of the Services in the event of a major incident;
- (vii) an appropriate process to deal with issues identified from consumer feedback;
- (viii) a consumer complaints process;
- (ix) data integrity, completeness and timely and complete recording;
- (x) focusing on clinical outcomes and control systems for unsafe and ineffective clinical practice.

H.8.2 Cultural values

- (a) You will work with communities to ensure the Services are delivered in a culturally appropriate and competent manner, ensuring that the integrity of each individual's culture is acknowledged and respected and that the particular needs of the community are catered for. You will work to reduce barriers to access or communication and work with communities to ensure the Services delivered are safe for all people.
- (b) You will endeavour to incorporate Maori Principles/Tikanga into the service delivery process.
- (c) Where you provide the Services for Pacific communities, you will demonstrate how those communities are involved in developing, monitoring and evaluating the Services provided to those communities.

H.8.3 Legal, regulatory and professional requirements

- (a) You must comply with all the relevant legal, regulatory and contractual obligations.
- (b) You must substantially meet and continue to improve on the quality standards, systems and guidelines of the relevant professional colleges or organisations as agreed between us both.
- (c) Practitioners and your (or a Contracted Provider's) other professional employees must adhere to the standards of their relevant professional body.
- (d) You must ensure that Practitioners, employees, Contracted Providers and any other sub-contractors, are aware of their responsibility to comply with the requirements of this Part H, and have continuous quality improvement processes in place.
- (e) All buildings, plant and equipment used in service provision must be fit for their purpose and adequately maintained in safe working order.

H.8.4 Service specific quality requirements

The quality requirements for specific services are described in the Schedule for that service contained in Part J.

H.9 Māori Health Action Plan

Developing a Māori Health Action Plan

- H.9.1 You agree to develop a Māori Health Action Plan and have it agreed to by us within the first 6 months from the signing of this Agreement. As part of developing that plan, you agree to work with us and key Māori Stakeholders to determine your yearly operational Māori health priorities and identify those services that you will deliver as explicit contributions to Māori health gain priorities.

- H.9.2 You agree to fund those activities as part of your overall requirements using Services to Improve Access and Health Promotion. You may also identify and use other revenue streams to fund those activities.
- H.9.3 You agree to monitor and evaluate your performance against performance indicators identified within your Māori Health Action Plan and report back to us in a timely fashion (see section I.10).
- H.9.4 Your Māori Health Action Plan will:
- (a) outline a clear strategy based on national and our Māori health strategy and policies (as set out in section H2.2);
 - (b) reflect the key priorities for Māori health as established by us in accordance with our DHB District Annual Plan and identify the consultation process with key Māori Stakeholders; and
 - (c) identify the consultation process with key Maori Stakeholders.
- H.9.5 Within the six months following approval of your Māori Health Action Plan, you will:
- (a) implement the activities described in your Māori Health Action Plan;
 - (b) work with key Māori Stakeholders as described in your Māori Health Action Plan;
 - (c) monitor Māori health initiatives and health gains identified in your Māori Health Action Plan; and
 - (d) identify the planning, review, monitoring and performance evaluation processes.
- H.9.6 You will actively seek feedback from iwi and Māori communities by appropriate methods as described in the Ministry of Health's document in Kawe Korero: Guidelines for Communicating with Māori (1997), to improve your organisation's responsiveness to Māori.
- H.9.7 You will agree with us performance measures on which you will report as part of your reporting requirements.

Implementation and Review

- H.9.8 Within the following six months after the period referred to in clause 9.5, you will:
- (a) implement the activities described in your Māori Health Action Plan;
 - (b) work with Key Māori Stakeholders as described in your Māori Health Action Plan; and
 - (c) monitor Māori health initiatives and health gains identified in your Māori Health Action Plan.
- H.9.9 The Māori Health Action Plan will be reviewed annually in consultation with us and amended accordingly.

SCHEDULE H1:

Immunisation Services

1. Service objectives

- 1.1 You will provide the following Services as part of achieving:
- (a) the national target of 95% immunisation coverage in children;
 - (b) a 75% coverage rate of eligible patients as specified in the Influenza Guidelines receiving influenza vaccine;
 - (c) an increased proportion of adults receiving tetanus vaccine at age 45 and 65 years; and
 - (d) a national target of 90% immunisation coverage of MeNZB vaccination for children and young people, in all ethnic groups, aged 6 weeks up to 20 years of age as part of the MeNZB Programme. You will support the MeNZB Programme for children and young people enrolled in schools by referral to the appropriate school based programme where possible.
- 1.2 You will support the MeNZB Programme for children and young people enrolled in schools by referral to the appropriate school based programme where possible.

2 Service components

- 2.1 You will deliver:
- (a) all Immunisation Services to children and adults as per the National Immunisation Schedule 2002 issued by the Ministry of Health;
 - (b) non-schedule vaccines to relevant high-risk groups, as per the Immunisation Handbook; and
 - (c) the immunisation episode scheduled at age 11 (year 7) if it is not given through a school programme.
- 2.2 Subject to licensure, you will deliver the MeNZB Vaccine to:
- (a) All children enrolled in your PHO aged 6 weeks and up to 5 years of age and children and young people aged 5 years and up to 20 years who are not eligible for the Meningococcal B school immunisation programmes. A young person who receives the first vaccine prior to reaching the age of 20 years may continue to be vaccinated after the age of 20 years for the 2nd and 3rd episode, provided the vaccination date of service is within the programme timeframe.
 - (b) Any eligible child or young adult referred to you who is not able to be vaccinated through the Meningococcal B school immunisation programme because of a medical contraindication.
 - (c) Any child or young person referred to you by public health nursing services, other primary care providers or outreach services approved by us.
- 2.3 In addition, your Immunisation Services will:

- (a) provide opportunistic immunisation including MeNZB vaccination of children who are Casual Users, and inform, where available, their usual vaccinator/provider of this within two (2) Business Days;
- (b) refer any child who is overdue for any immunisation event including MeNZB vaccination (see clause 2.3) and who has not responded to at least three contacts, to either an appropriate immunisation outreach service, a well child service, or the local immunisation co-ordinator;
- (c) undertake regular audit of yourself and Contracted Providers;
- (d) promote immunisation using evidence-based information, ensuring your Enrolled Population are able to make decisions about immunisation based on informed consent;
- (e) assist with epidemic control and other situations where co-ordinated action is required;
- (f) ensure that a decision by parents/guardians not to immunise their children is recorded and the Practitioner acts in accordance with this decision; and
- (g) maintain at all times an effective cold chain so as to ensure potency of all vaccines administered.

2.4 Definitions for immunisation on time, overdue, non-responder, declined, etc., are set out in the national standardised terminology for immunisation audit developed by the Immunisation Advisory Centre (IMAC) (these are currently being reviewed for consistency with the National Immunisation Register).

3. Quality requirements

3.1 Your Immunisation Services must meet the Immunisation Standards 2002 as set out in Appendix 3 of the Immunisation Handbook 2002, including standards for organisations offering vaccination services and standards for vaccinators, any relevant legislation (including regulations) and reporting of adverse events.

SCHEDULE H2:

General Medical Services

1. General Medical Services

1.1 You may provide the following General Medical Services to Casual Users:

- (a) all proper and necessary Medical Consultations provided to the individual patients of a General Practitioner either personally or by a Locum or under any other arrangements approved by us. Services to an individual will only be initiated by the request of the patient or the patient's caregiver or agent where the patient is unable to make the decision for themselves. These Services include:
 - (i) such medical services as are by custom and practice recognised as being part of the services usually provided by General Practitioners;
 - (ii) family planning and pregnancy counselling services;
 - (iii) 24 hour, seven day urgent services;
 - (iv) minor surgical procedures such as those under local anaesthetic;
 - (v) disease prevention strategies;
 - (vi) notification of communicable diseases;
 - (vii) investigation and referral for necessary diagnostic tests, pharmaceuticals, community and specialist services;
 - (viii) health education about lifestyle risk factors and chronic diseases to prevent the development of disease, recurrences and deterioration in disease state;
 - (ix) well child services in accordance with the Well Child – Tamariki Ora National Schedule ("Tamariki Ora") where it is known that the item of service has not already been performed by another provider. Where the services may be claimed, they are to be detailed in the Daily Record and in the Tamariki Ora record (where possible), and the services are to be provided free to the patient. We will advise all Medical Practitioners in a region where well child services have been purchased through alternative contract arrangements;
- (b) but does not include services that are within any of the following classes:
 - (i) specialist medical services as defined in the Section 88 Advice Notice;
 - (ii) medical services provided within the definition of maternity services as defined in the Section 88 Advice Notice or as defined in any other notice issued pursuant to section 88 of the Act covering the provision of maternity services and all related services caused by or related to pregnancy;
 - (iii) services for which cover (as defined in the Injury Prevention, Rehabilitation, and Compensation Act 2001) is available under the Injury Prevention, Rehabilitation, and Compensation Act 2001;
 - (iv) medical services provided by any General Practitioner to his or her dependants or his or her partner or the dependants of his or her partner or to other persons from whom or in respect of whom he or she is not entitled to recover any payments under the Section 88 Advice Notice;
 - (v) medical services provided by any General Practitioner under an agreement made by him or her with a friendly society or branch registered under the Friendly Societies and Credit Unions Act 1982;
 - (vi) medical services involved in any medical examination of which the sole or primary purpose is the obtaining of a medical certificate (for production to some other

person) as to the condition of health of the person examined, other than medical services in relation to certificates given for 'sickness benefits' from a friendly society or for the purpose of benefits under Part 1 of the Social Security Act 1964 – excluding medical services where payment is made to the General Practitioner by the Ministry of Social Development (Work and Income New Zealand);

- (vii) medical services provided by a General Practitioner for the purposes of, or incidental to, extraction of teeth by them;
 - (viii) medical services in respect of laboratory diagnostic services;
 - (ix) medical services which are diagnostic imaging services;
 - (x) medical services provided by means of advice given by telephone, telegram, facsimile, internet, e-mail or letter, except in circumstances specifically approved by the Medical Officer of the DHB for the purposes of the Section 88 Advice Notice;
 - (xi) medical services not provided by a General Practitioner in person;
 - (xii) medical services provided otherwise than in an emergency in any factory or shop (within the meaning that was given to those terms by the Health and Safety in Employment Act 1992) to a person employed in that factory or shop and provided pursuant to an arrangement made by or on behalf of the General Practitioner with the employer of the person in receipt of those services or the agent of the employer;
 - (xiii) medical services which consist only of the administration of a vaccine for which a Payment for immunisation is payable under this Agreement;
 - (xiv) medical services of a substantially similar nature offered by a General Practitioner to a group of patients at the same time (except where specifically approved by the DHB);
 - (xv) medical services where no service of substance is provided by the General Practitioner and for which the patient would not reasonably expect to pay;
 - (xvi) where only the provision of a repeat prescription, and no other service, is provided;
 - (xvii) separate claiming for more than one General Medical Service when they are provided during a single Medical Consultation with an individual patient;
 - (xviii) Well Child Services (unless detailed in the Section 88 Advice Notice);
 - (xix) General Medical Services provided to patients in the care of the provider arms of a DHB or long stay institution, where that DHB or long stay institution is fully funded for the provision of medical care;
 - (xx) where only the provision of a death certificate and no other service is provided;
 - (xxi) such services as may be determined by the DHB after reference to the advisory committee established under the Section 88 Advice Notice, and notice to the General Practitioner, not to be General Medical Services for the purposes of the Section 88 Advice Notice, either absolutely or in special circumstances as defined by the Ministry of Health.
- (c) Notwithstanding any other provisions of this definition, General Medical Services may be initiated by the General Practitioner where:
- (i) the General Practitioner initiates the service to ensure the provision of appropriate medical care and/or specific health education, health screening, follow-up or recall services to patients of his/her practice population (e.g. for cervical screening); and/or
 - (ii) the General Practitioner provides medical services in medical emergencies.

- (d) For General Practitioners in rural areas who can claim a rural bonus under Schedule F6 of this Agreement, General Medical Services include Medical Consultations made by telephone providing the patient is located 16km or further from the Practitioner's place of practice at the time of consultation.

SCHEDULE H3: CARE PLUS SERVICES

1. Service Objectives

- 1.1 You will provide Care Plus Services as described in this Schedule H3 to contribute to the objectives of:
- (a) improving health and independence or minimizing deterioration in health and independence;
 - (b) relieving suffering;
 - (c) maintaining people in their own environment and avoiding unnecessary hospitalisation;
 - (d) reducing inequalities in health status between health population groups.

2 Service Components

2.1 Assessing Eligibility for Care Plus Services

You will only offer Care Plus Services to an Enrolled Person who:

- (a) is assessed by a Practitioner who usually delivers their First Level Services as being expected to benefit from “intensive clinical management in primary health care” (at least two hours of care from one or more members of the primary health care team) over the following six months; and either
 - (b) has two or more chronic health conditions so long as each condition is one that:
 - (i) is a significant disability or has a significant burden of morbidity; and
 - (ii) creates a significant cost to the health system; and
 - (iii) has agreed and objective diagnostic criteria; and
 - (iv) continuity of care and a primary health care team approach has an important role in the management of that condition; or
 - (c) has a terminal illness (defined as someone who has advanced, progressive disease, whose death is likely within twelve months); or
 - (d) has had two acute medical or mental health related admissions in the past twelve months (excluding surgical admissions); or
 - (e) has had a total of six First Level Service and/or casual general practice consultations and/or emergency department visits within the last twelve months; or
 - (f) is on active review for elective health services.
- 2.2 You will provide Care Plus Services only to patients who have given their informed consent to receiving Care Plus Services.

2.3 Care to be delivered to Care Plus Patients

You 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 their current health status, including pharmaceutical review where 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.

2.4 Reassessment for continued eligibility to receive Care Plus Services

- (a) You will review each Care Plus Patient annually within at most fifteen months from the date at which they were last assessed as being eligible to receive, or to continue to receive Care Plus Services to determine whether they continue to be eligible to receive Care Plus Services.
- (b) At this annual review individuals are only eligible to continue to receive Care Plus Services and be designated as Care Plus Patients if they:
 - (i) are explicitly assessed as continuing to benefit from the higher level of primary Care; and
 - (ii) have received at least four clinical contacts within the previous 12 months; and
 - (iii) have given their informed consent to continue to receive Care Plus Services.
- (c) If a person who is a Care Plus Patient changes to a different provider of First Level Services, they will be able to continue being a Care Plus Patient only if their new Provider re-assesses them according to clauses 2.1 and 2.2 of this Schedule H3 and the provider has available funding.

2.5 Support and administrative Services for Care Plus

You will provide the following support and administrative Services:

- (a) support for Contracted Providers to identify individuals eligible for Care Plus Services;
- (b) liaising with DHBs to assist with identifying individuals eligible for Care Plus Services;
- (c) support for the delivery of Care Plus Services through, for example, employing or contracting additional Practitioners or providers to work with Contracted Providers;
- (d) coordinating with other relevant health care providers to arrange improved access to

diagnostic testing and other supporting services;

- (e) administrative systems to pay and monitor providers of Care Plus Services;
and
- (f) provision of documentation to support implementation such as care plan templates and patient information;
- (g) management and delivery of reporting requirements;
- (h) on-going training and quality improvement systems (see clause 1.1(i) of this Schedule H3) for relevant staff including those working as part of Contracted Providers;
- (i) systems to ensure that, as much as is feasible, available Care Plus funding is applied to provide Care Plus Services to the full expected number of Care Plus Patients (according to clause 2.1 of Schedule H3) quality requirements.

2.6 You will work to ensure that:

- (a) where current best practice evidence-based national guidelines are agreed and available to guide the management of specific chronic conditions, providers use them when delivering Care Plus Services;
- (b) the cultural and psychosocial context of the Care Plus Patient are considered at all levels of the person's participation in the services and the Care Plus Services are consistent with care models that appropriately meet their needs. For example, services for Maori are consistent with the PHO Maori Health Action Plan;
- (c) Care Plus Services are based on the principle of partnership between the individual receiving care and the team delivering their care that providers of Care Plus Services ensure Care Plus Patients are involved in making informed choices about the care 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.

Part I. Reporting Requirements

I.1 Scope of this Part I and communications regarding reports

- I.1.1 This Part I describes the information required to be:
- (a) included on Claims and referrals;
 - (b) supplied by you to us (or our Payment Agent); and
 - (c) supplied by us (or our Payment Agent) to you.
- I.1.2 All reports required under this Agreement must be submitted in the format we (or our Payment Agent) require (if any). If we (or our Payment Agent) require a particular reporting format, you will be provided with a reporting template.
- I.1.3 Where the recipient of a report under this Agreement believes that any report or the content of the report raises concerns, that party agrees to notify the party who prepared the report of such deficiency and/or concerns within 20 Business Days of the receipt of the report.
- I.1.4 Reports will be deemed to have been received on time and to be satisfactory unless the recipient of the report notifies the other party of any deficiencies and/or concerns in writing within 20 Business Days of the date the report is due (or of the date it is received in the case of any late report).

I.2 Claims for GMS for Casual Users and Immunisation Services

- I.2.1 Your Claims for General Medical Subsidy for Casual Users and Immunisation Services must include the following details:
- (a) Practitioner's council number;
 - (b) Practitioner's name;
 - (c) Practitioner's PAN or other provider index (where we agree that this is required);
 - (d) Date of the Service;
 - (e) Patient name;
 - (f) Date of birth;
 - (g) National Health Index number;
 - (h) Patient category;

- (i) Community Services Card number if applicable (where Access Practices provide Services to Casual Users);
- (j) High Use Health Card number if applicable;
- (k) Practitioner's signature (or electronic equivalent);
- (l) GMS category; and
- (m) Immunisation types and date of immunisation (where applicable).

I.2.2 If we (or our Payment Agent) Pay you for General Medical Services or Immunisation Services, you will ensure that we have the right to access any information in relation to your Claims or the Services, notwithstanding that it was collected from you as part of the process of making Claims.

I.3 Laboratory tests

I.3.1 All referrals for laboratory tests issued by Practitioners, whether electronic or hard copy must include the following details:

- (a) Practitioner's council or identification number;
- (b) Practitioner type;
- (c) Practitioner's name;
- (d) Practitioner's PAN or other provider index (where we both agree that this is required);
- (e) Date of referral;
- (f) Patient name and address;
- (g) National Health Index number;
- (h) Patient date of birth (where no NHI);
- (i) Patient gender (where no NHI);
- (j) Name of test or test code;
- (k) The appropriate purchaser, if it is not us; and
- (l) Practitioner's signature (or electronic equivalent).

I.4 Prescriptions for pharmaceuticals

I.4.1 All prescriptions for pharmaceuticals issued by Practitioners, whether electronic or hard copy, will include the following details:

- (a) Practitioner's council or identification number;

- (b) Practitioner type;
- (c) Practitioner's name;
- (d) Practitioner's PAN or other provider index (where we agree that this is required);
- (e) Date prescribed;
- (f) Patient name and address;
- (g) National Health Index number;
- (h) Patient date of birth (where no NHI number) and where Patient is under 12 years of age;
- (i) Patient gender (where no NHI number);
- (j) Patient category;
- (k) Community Services Card status (yes or no);
- (l) High Use Health Card status(yes or no);
- (m) Name of pharmaceutical;
- (n) Dosage;
- (o) Frequency of dosage;
- (p) Quantity or total days supply;
- (q) Special instructions (if applicable);
- (r) Practitioner's signature (or electronic equivalent);
- (s) The appropriate purchaser, if it is not us;
- (t) Endorsement requirements (when required); and
- (u) Recommending specialist and date of recommendation (when required).

I.4.2 Where more than one pharmaceutical is prescribed for a Service User at the same time and the subsidy for one or more of the pharmaceuticals will be paid by a different purchaser then the pharmaceuticals may not be set out on one prescription form. A separate prescription form must be filled out per purchaser.

I.5 Practitioners

I.5.1 You will provide the details set out in the table below to HealthPAC (Agreement Administration Team) immediately in respect of all Practitioners providing the Services to Enrolled Persons.

- I.5.2 You will advise HealthPAC (Agreement Administration Team) of any changes to any of the following details for these Practitioners, on a monthly basis. This reporting will be by way of submitting information in an electronic form to be agreed with us:
- (a) NZMC number, Nursing Council number, cervical smear taker identification number, or such other appropriate Practitioner identification number (PIN) where the Practitioner does not hold the identification numbers referred to;
 - (b) Name of Practitioner;
 - (c) Practice Name;
 - (d) Practice Address – physical location;
 - (e) Practice Address – postal;
 - (f) Date Joined;
 - (g) Date Left (if applicable); and
 - (h) Locum Flag (yes/no).
- I.5.3 Where any change of Practitioners occurs, you will confirm to us that the requirements of Enrolment Parameter 13 (Provider change of affiliation) of the Referenced Document entitled “Enrolment Requirements for PHOs” have been fulfilled.

I.6 Service utilisation

- I.6.1 Subject to clause I.6.8, you are required to report on First Level Services delivered to Enrolled Persons. This reporting will summarise on an aggregate basis the Services received by the characteristics of the Enrolled Persons and by provider type.
- I.6.2 The reports must be submitted to HealthPAC (Dunedin) on a quarterly basis using the format and means of electronic uploading of the data as we (or our Payment Agent) specified at the Commencement Date.
- I.6.3 You will provide First Level Service utilisation information on an aggregate basis until such time as the Referenced Document containing PHO Quality Indicators (referred to in clause 4.1 of Schedule A1) requires that certain information be provided at an individual transaction level.
- I.6.4 Reporting requirements in addition to those described in this clause I.6 may be agreed between us both and specified in Part J.
- I.6.5 When a Service User is seen by more than one Practitioner on the same day, if the reason for the consultation is complementary, necessary or different, then this should be reported as a separate consultation.
- I.6.6 First Level Service utilisation reports will include information on First Level Services (non ACC) delivered to Enrolled Persons and the number of Enrolled Persons according to the following fields:

- (a) age group = age of patient as at the beginning of the reporting quarter;
 - (b) gender = if gender is unknown convert to male;
 - (c) HUHHC = means the person holds a High Use Health Card;
 - (d) DepQuin; where 5 = the most deprived and 1 is the least deprived;
 - (e) Ethnicity = Level 2 ethnicity as described by Statistics New Zealand;
 - (f) Community Services Card holder status (not applicable for Access Practices);
 - (g) Care Plus Patient = whether or not the person is a Care Plus Patient.
- I.6.7 You will complete a report on an aggregate basis (using the required format) for each of:
- (a) Medical Consultations provided by Medical Practitioners;
 - (b) consultations provided by registered nurses/other;
 - (c) the number of practices/providers the service utilisation reporting in clause 1.6.6 refers to;
 - (d) the total number of practices/providers within your PHO; and
 - (e) an explanation of any difference between the number of practices in clause 1.6.7(c) and clause 1.6.7(d).
- I.6.8 You are required to provide utilisation information unless a Contracted Provider's practice management and/or your systems are incapable of coding for deprivation levels, in which case you will agree with us your plan to upgrade such coding systems and a timeframe in which you will meet the service utilisation reporting requirements.

I.7 Immunisation reporting

- I.7.1 You will report on Immunisation Services delivered to Enrolled Persons. You must ensure that information is transmitted on immunisation episodes electronically to HealthPAC or its nominated agent for Payment purposes as detailed in clause I.1.2.
- I.7.2 Ethnicity reporting will comply with Statistics New Zealand official definition (from Smith 1981), as modified by the national data policy group. The code used is Statistics New Zealand Standard Classification of Ethnicity, level 2 or as otherwise agreed.
- I.7.3 When the immunisation information to be provided to a regional and/or NIR has been agreed according to the processes described in clause D.9.3 for adding Referenced Documents and the NIR is being implemented in the area in which you provide Services, then you will provide information as set out in the Referenced Document for NIR reporting referred to in clause 4.1 of Schedule A1 to Part A. as documented in the agreed Information Provision appendix of the NIR Operations Manual.

I.7.4 Until such time as the NIR is operating in your area, you will report aggregated immunisation data quarterly to us as follows (in the template required by us or our Payment Agent):

PHO Denominator	Immunisation Status*
Number of children, by ethnicity, enrolled in PHO at a set date between 6 months and one year	Number of fully vaccinated children between 6 months and 1 year in PHO (ie received DTaP -IPV3/HepB, and Hib-HepB2), by ethnicity
Number of children, by ethnicity, enrolled in PHO at a set date between 16 months and 2 years	Number of children in PHO between 16 months and 2 years received MMR1 and DTaP/Hib, by ethnicity
Number of children in PHO, by ethnicity, at a set date between 4 and 5 years of age (ie under 5 years)	Number of children in PHO between 4 and 5 years given MMR2/DTaP-IPV4, by ethnicity
	* specify antigen for coverage not vaccine if parents request different antigens from scheduled vaccine.

I.7.5 If you are a South Island PHO carrying out the 11 year old immunisation programme, you will report, by ethnicity:

- (a) the number of enrolled children in year seven at school;
- (b) the number for whom consents to immunise were given;
- (c) the number for whom consents were not given;
- (d) the number who received Td immunisation; and
- (e) the number who received IPV.

I.8 Rural Premium reports

I.8.1 You must meet reporting requirements agreed to with us, and which will as a minimum enable us to report to the Ministry of Health quarterly on:

- (a) the rural workforce strategies planned or introduced;
- (b) the progress/impact of those strategies; and
- (c) the amount of rural premium funding expended.

I.9 Yearly report

- I.9.1 Each year, you will provide to us a yearly report on the previous year (in hard copy form) by a date agreed to by us both.
- I.9.2 The report will cover the following matters:
- (a) Organisational structure and governance including the details of any amendments to your constitution, rules or other document constituting or governing you or your activities.
 - (b) Performance against the national set of quality indicators and targets developed under clause I.12 and any additional quality indicators and targets agreed between us both and specified in Schedule J1 to Part J.
 - (c) Qualitative report on performance against the requirements in this Agreement including:
 - (i) evidence that you have met the organisational requirements (including satisfying the definition of Not for Profit) of clause E.2 of Part E;
 - (ii) service provision including the activities undertaken to provide the Services outlined in Part H. In particular, you will report on the following activities:
 - (A) Services provided to improve access to primary health care for High Need Groups, including your activities to reduce health inequalities for Maori and Pacific peoples;
 - (B) health promotion services and activities;
 - (C) Referred Services management activities;
 - (D) quality improvement activities;
 - (iii) consumer satisfaction and complaints summary;
 - (iv) issues and exceptions report;
 - (v) advice of your fee levels in accordance with Schedule F4 to Part F;
 - (vi) evidence (including ratio of Practitioners to Enrolled Population) of how you achieve appropriate service levels to meet the needs of Enrolled Persons by using existing indicators, standards of practice and professional standards; and
 - (vii) audited financial reports.

I.10 Māori Health Action Plan

- I.10.1 Within twelve months of the Commencement Date, you will:
- (a) provide evidence of how you have worked with key Māori Stakeholders and providers to develop and implement the Māori Health Action Plan as required under clause H.9 of Part H;
 - (b) detail the method of obtaining feedback on the Māori Health Action Plan from key Māori Stakeholders;
 - (c) report on health initiatives and health gains for Māori in accordance with your Māori Health Action Plan;
 - (d) report on any suggested methods by which your performance with regards to Māori Health will be enhanced.
- I.10.2 Once you have completed the annual review required by clause H.9.9, you will provide six monthly reports to us providing:
- (a) details on ongoing implementation of health initiatives in your Māori Health Action Plan;
 - (b) evidence of health gains, or likely or known contributors to health gains, for Māori; and
 - (c) reports on the performance measures agreed with us and specified in your Māori Health Action Plan.

I.11 Health promotion and access proposals

- I.11.1 Where you receive funding for health promotion or for services to improve access for High Need Groups pursuant to clause F.5, you will:
- (a) review each proposal (as approved by us) on an annual basis; and
 - (b) following the annual review, provide six monthly reports, in particular, reporting against:
 - (i) services provided to improve access to primary health care for High Need Groups;
 - (ii) activities to reduce health inequalities for Maori and Pacific peoples; and
 - (iii) health promotion services and activities.

I.12 Quality indicators and targets

- I.12.1 One of your key aims is to improve the quality of health care received by the populations you serve. At present, there are no consistent, national standards for measuring the quality of primary health care. In order to establish a national approach to measuring quality in primary health care, the Ministry of Health will refer a proposed new Referenced Document for agreement pursuant to the PHO Service Agreement Protocol Group process under clause D.9.3, that will describe:
- (a) a set of quality indicators and targets;
 - (b) the way that they will be used to measure quality; and
 - (c) the best means for collecting, analysing and storing the required information.

I.13 Our reports to you

- I.13.1 We will provide to you the following reports (in the format specified) published by HealthPAC, Ministry of Health:
- (a) Quarterly Capitation Summary Report (Capitation Summary Report PCO.xls);
 - (b) Monthly FFS Deduction Report (FFS Deduction Report for PCOs v1_02.xls);
 - (c) Quarterly Register Processing Statistics Report (Register Processing Statistics Report V1_00.xls);
 - (d) Buyer Created Tax Invoice (BCTI);
 - (e) HL7 Output.

I.14 Ad hoc reports

- I.14.1 We both acknowledge that as part of our commitment to establish an effective working relationship, we both will require information relevant to the Services and the operation of this Agreement in order to better perform our respective obligations under this Agreement.
- I.14.2 Where either of us holds information as described in clause 1.14.1 in relation to the Services or this Agreement, that party will use its reasonable endeavours to make it available to the other as the party requesting the information might reasonably require.
- I.14.3 Neither of us is required to provide to the other, any information that it has previously provided to the other.
- I.14.4 Either of us may request additional information from the other from time to time in relation to the Services provided under, or operation of, this Agreement.
- I.14.5 Where either of us makes a request for information described in clause I.14.4:
- (a) the requesting party will notify the other of its reasonable information requirements, the reasons for its request and the intended usage of the information gathered;
 - (b) the other party will use its reasonable endeavours to obtain and provide the requested information subject to any legal obligation to maintain the privacy of personal health information or ethical obligations with respect to clinical confidences.
- I.14.6 The requesting party will contribute resources to assist with the preparation of an ad hoc report where the information sought is either not already available in the form in which it has been requested, or can be made available only with the provision of staff resources not normally used by the party being requested, provided that the requesting party is not liable to make any such contribution where the other party is required to hold the information under this Agreement.

I.15 Quality and timelines of information

- I.15.1 Where either of us provides the other with any information under this Agreement, the party providing the information must:
- (a) ensure that such information is accurate and complete to the best of its knowledge and belief;
 - (b) identify any material inaccuracies or uncertainties at the time it submits the information or at such time as it discovers the inaccuracy or uncertainty; and
 - (c) use reasonable endeavours to provide the information in a timely manner or as agreed between the parties.
- I.15.2 The costs to you associated with the provision of information specified under this clause I.15 shall be borne by you and are deemed to have been included in the prices for the Services as detailed in the Payment terms set out in Part F, provided

that you have agreed to the time frame for the provision of the information (and such agreement will not be unreasonably withheld).

I.16 Summary of your reports

I.16.1 For the purposes of clarity the following table summarises your reporting obligations under this Part I.

Reporting Requirements	Frequency	Reported to
Details of patient register (clause F.10)	Quarterly	Our Payment Agent
Changes to Practitioners (clause I.5)	Monthly	Our Payment Agent
Service Utilisation (clause I.6)	Quarterly	Our Payment Agent
Immunisation services (clause I.7)	Quarterly, pending development of NIR reporting requirements and thereafter in accordance with the Referenced Document for NIR reporting referred to in clause 4,1 of Schedule A1 to Part A.	Us or our Payment Agent
Rural Premium (clause I.8)	Quarterly	Us
Yearly Report (clause I.9)	Annual	Us
Māori Health Action Plan (clause I.10)	Biannually	Us
Health Promotion and Services to Improve Access (clause I.11)	Biannually	Us
Quality Indicators (clause I.12)	In accordance with the Referenced Document for quality indicators referred to in clause 4.1 of Schedule A1 to Part A.	Us