Health New Zealand
Te Whatu Ora

March 2026/V4

National Primary Care Dataset

Key themes, feedback and detailed scenarios

As more feedback is received from the primary care sector, we'll continue to update this document.

Jumplinks *(click to jump to content below)*

1. Access target and unintended consequences

We've had some questions asking if an unintended consequence of the Primary Care Health Target (80% of primary care appointments are accessed within 7 days of a person booking the appointment) could:

- discourage practices from opening appointments in advance
- penalise planned care, follow ups, and chronic care
- disadvantage rural practices, elderly patients, and patients needing transport or family support

- be “gamed” by only opening books 7 days ahead
- undermine existing models like Health Care Home and pre-booking systems

Response:

- The Primary Care Health Target is still being worked through with support from the Primary Care Health Target Advisory Group. We’ll share detailed information and will hold further webinars to update the primary care sector once all the key elements of this work are completed in the coming months.

- Work is underway to develop clear inclusion and exclusion criteria so that the measure reflects real world practice and reduces the risk of unintended consequences.

- Balancing measures are being scoped to maintain focus on other important aspects of primary care health delivery, such as continuity of care, to help minimise unintended behaviours that could arise from focusing on a single access measure.

- Clear expectations on the purpose of the health target, and related service delivery that need to be maintained will be put in place.

2. What data is being collected (and what is not)

Key questions about the scope and boundaries of the dataset raised have included:

- whether consultation notes or clinical content would be included
- how encounter time is defined
- whether non patient facing work is counted
- how admin tasks, nurse work, phone calls, texts, and emails fit in
- variation in PMS coding, appointment lengths, and role codes
- What data source will be used for the start date/time and end date/time

Response:

- The National Primary Care Dataset is an administrative dataset, not a clinical one. Its purpose is to support planning, reporting, and performance, rather than to describe or assess individual clinical care or clinical decision

making.

- The first dataset is limited to general practice appointments only. The related data elements have been agreed with the Primary Care Governance Group and can be sourced here.

- Consultation notes and other clinical narrative content will not be included.

- Non-patient facing time is currently not proposed to be counted within the collection and GP appointment data collected. The intention of collecting this information is to support an understanding of people's access to their general practice team, rather than a broader range of work that contributes to patient care.

- Appointment time is included because not all appointments are delivered in standard 15 minute blocks. General practice uses a wide range of appointment lengths depending on patient need, clinician role, and model of care, and appointment duration is needed to accurately reflect this variation.

- Only general practice booking appointment data (not other sources of information like invoices) will be used to understand the start date/time and end date/time of appointments.

- Work on expansion of the dataset (e.g. health status data) will continue and will be subject to review and endorsement of the Primary Care Data Governance Group before it's introduced.

3. Trust, privacy, and security after the Manage My Health breach

Another theme has been loss of trust in data security, especially following the Manage My Health breach.

Questions reflected:

- uncertainty about who holds privacy and security risks if something goes wrong
- whether PHOs carry privacy and security responsibility
- when privacy impact assessments will be completed for the shared data and will they be shared

- concerns about patient perception

Response:

- As is the case now, practices, PHOs, vendors, and Health New Zealand each have responsibilities for protecting the information they collect, share and hold, consistent with existing data sharing arrangements across the health system.

- There are multiple layers of security and governance in place to protect the data in the National Primary Care Dataset.

- Only authorised analysts can access the information. Any identifiable details are minimised, tightly controlled, and only accessible to authorised analysts who must follow strict privacy and security requirements at times.

- Responsibility for data security sits with each party that collects, shares and holds or manages data, and will be outlined in the data sharing agreements.

- A Privacy Threshold Assessment has already been completed for the proof of concept/early adopter phase for the Primary Care Health Target, and a full Privacy Impact Assessment is underway ahead of national roll out. We will publish a privacy statement once finalised.

- The dataset is not intended to be used for surveillance, enforcement, or monitoring individual clinicians – it's for system planning, service provision and redesign, and performance understanding at an 'aggregated' level.

4. Consent, opt out, and patient choice

We've heard feedback seeking clarification on who can opt out, how, and with what consequences of the National Primary Care Dataset, along with how that will be different to the Shared Digital Health Record opt out and consent process.

Key areas we've heard for clarification include:

- difference between practice opt out and patient opt out
- what opting out and opting back on (or vice versa) options there are for practices
- whether opting out affects funding
- how SDHR opt out works compared to NPCD

Response:

- In relation to patient and healthcare worker consent to share data with Health NZ for the **National Primary Care Dataset** - we are using existing settings for the sharing of administrative health information, collected by GP practices in their Patient Management Systems (PMS), for inclusion in this dataset. This means that this data can be shared with Health NZ in a way that does not require changes to consent for patients or healthcare workers.

- It is still important that patients and general practice teams have access to information to help them understand how their data is being used by Health NZ. We will be sharing more information with practices, to share with PHOs and Practices and help answer any questions they have from their patients.

- In relation to general practice agreement to share that data with us - Health NZ needs agreement from practices before that data can be included in the National Primary Care Dataset.

- The date for practices to indicate if they want to opt out of sharing data to the National Primary Care dataset is now 31 March 2026.

- Once a practice has opted on and started sharing data, they are not locked in permanently.

- Between April and the end of June, any general practice that has 'opted on' to share data can notify us they wish to opt-off. Their Contingent Capitation will cease on the next available first day of the month. (i.e. 1 May, 1 June, 1 July etc).

- From 1 July, under the Primary Health Services Agreement (PHOSA), practices can choose to opt off data sharing at set points during the year, which occur twice a year, subject to a notice period. Opt out options also exist if there are changes to the dataset that is agreed to be collected.

- In March we will be asking PHOs to support general practices to sign an interim general practice Information Sharing Agreement to allow data collection to begin in April.

- It is separate from the Access and Use Agreement, that will include two-way sharing and how information is accessed and used. Once finalised, we

will ask PHOs to support general practices to sign this more comprehensive 'two-way sharing' agreement.

This part of the process will cover the requirements for both the National Primary Care Dataset and the Shared Digital Health Record, ensuring general practice don't have to carry them out twice.

- The data sharing agreement will sit alongside already available information, including the Data Access Framework and encounter data definition, that have been endorsed by the Primary Care Data Governance Group, to allow practices to review the necessary information in time for opt-off confirmation by 31 March.

- Consent and agreement for the **Shared Digital Health Record** operates differently. Because it is sharing detailed health records (safely and securely between health services) it does include patient level opt out options, allowing patients to choose whether their information is shared through that system, and to what level. More information on the Shared Digital Health Record can be found here.

- The Shared Digital Health Record will also require practices to sign Access and Use Agreements once those agreements are finalised.

- The Shared Digital Health Record is not linked to practice funding.

5. Purpose and future use of the data

Clarification on "why Health NZ wants this data" and "what it might be used for later" were also common themes:

- fear data could be used to force behaviour or attach funding penalties
- worry about future scope creep
- concern that targets could become financial levers
- If this dataset will eventually mean there is one (versus multiple) data sharing stream with Health NZ

Response:

- Governance arrangements are in place to oversee how the data is used. The Primary Care Data Governance Group includes sector representation, which is intended to ensure that decisions about data use are informed by

primary care and PHO perspectives.

- No individual clinical data is available through this dataset. The information collected does not allow for monitoring of individual clinicians or detailed clinical activity, and it is not intended to be used to assess individual practitioner performance.

- At this time, there is no funding impact tied to the Primary Care Health Target and performance.

- In relation to other existing Health NZ data sharing arrangements - the intention is that initial data sharing agreement supports the data collection related to the encounter and appointment data as agreed by the Primary Care Data Governance Group. The broader Data Access and Use Agreement provides a clear framework for wider data sharing through the inclusion of specific schedules related to specific dataset collections. It is intended that practices could choose which specific schedules, and therefore related datasets they agree to share.

6. Practical implementation and support

Practical questions about how this will actually work on the ground, have focused on:

- support for practices
- where definitions and formulas will be published
- whether practices can see their own data
- Could PHOs "umbrella" practices under a single agreement

Response:

- PHOs have a key support role in helping practices navigate how this will work in practice. This includes supporting practices to understand the data sharing arrangements, working through questions about agreements, and acting as a point of connection between practices and Health NZ.

- Health NZ will also continue to keep the sector updated on developments.

- Definitions for the first phase of the dataset, including what data elements are included and how data will be used and accessed (including

practices), have been published and shared with the sector.

- For the purposes of National Primary Care Dataset the information agreements are between Health NZ and each practice (or multi-site entity), not PHOs, due to legal and privacy requirements.

7. Feedback from the Primary Care Data Governance Group on the interim Information Sharing Agreement

We've had questions about what feedback the Primary Care Data Governance Group provided on the interim general practice Information Sharing Agreement (ISA) for the Primary Care Health Target, and how that feedback has been addressed.

Key areas of feedback included:

- the scope and purpose of the interim ISA
- liability and risk for practices
- the role of third parties and subcontractors
- Māori data sovereignty and governance
- privacy, security, and technical safeguards
- clarity about the endorsement and governance process

Response:

- The Primary Care Governance Group is a PSAAP appointed group and includes the following membership:
    - Kim Sinclair-Morris (Pegasus – PHO rep)
    - Dr Angus Chambers (GenPro - contracted providers rep)
    - Dr Vivien Verheijen (Consumer rep)
    - Tureia Moxon (Te Kahui Hauora - Māori PHOs rep)
    - Dr Jo Scott-Jones (Pinnacle – contracted provider rep)
- The interim ISA is focussed on the data required to calculate the Primary Care Health Target. It is separate from the broader Data Access and Use Agreement, which will cover wider two-way data sharing and future use.
- The Data Governance Group raised concerns about liability settings, particularly the initial proposal for a very low liability cap. Following

discussion, the agreement was amended to include a higher reciprocal liability cap of $5,000, reflecting a balance between practice level risk and the limited scope of the data being shared.

- Questions were raised about third-party involvement and subcontractor risk. It was clarified that Health NZ is responsible for its subcontractors, that existing contractual obligations apply, and that the interim ISA relies on established arrangements with vendors. Broader warranty settings will be addressed through the future, more comprehensive agreement.
- The Group sought assurance that the data being shared would be limited and appropriately protected. The ISA confirms that only deidentified appointment and encounter data is used for statistical and reporting purposes, with no clinical notes or treatment content included.
- Technical and security safeguards were discussed and confirmed, including encryption, masking, controlled access, and alignment with Health NZ security standards. Access to the data is restricted to authorised roles only.
- Māori data sovereignty was specifically raised. Input from Māori health governance has informed the wider data access and use framework, and those principles have been applied through the Privacy Impact Assessment process for this work.
- GenPro and GPNZ in their role as primary Care representative bodies have also provided independent legal feedback on the ISA.

8. Common queries post interim PCHT ISA sharing

Q1: What are the possible additional costs general practices may incur as part of this data collection work?

A: Health NZ does not anticipate additional costs to practices related to data collection processes.

While Health NZ is not anticipating many practices will do, but if they do seek legal advice, practices would have related costs. This clause clarifies that neither party is paying the costs of the other party in entering into the agreement.

Q2: What is the definitive list of the data that Health NZ will collect as part of the ISA agreement?

A: At this stage, information shared by practices will fall under the headings within Appendix 2 and the data elements listed are the set being requested from practices. The comment that the elements are “intended to be indicative only”

was included to signal that these elements reflect our current understanding and immediate needs, but we recognise there may be some limitations and some iteration of the detailed data elements required as the Health Target is finalised. We will share with practices any adjustments that may be needed to the information collected in order the calculate the health target as per Ministers approval. We expect this will remain within the headings within Appendix 2.

Q3: How will NHI data be used and how is this related to data matching? And at what points in the data collection process is data identifiable and deidentified?

A: For data collected through this agreement, it will be collected at NHI level to enable matching with NES.

The data will then be encrypted, stored and used in deidentified format. Only selected few analysts will access NHI identifiable data in this process.

Q4: What are the liability costs for Health NZ and general practices as outlined in the ISA agreement?

A: Liability is capped in this PCHT ISA at $5,000 (Clause 2.3 b). The parties' aggregate liability under and/or arising out of or in connection with this Agreement in contract, tort (including negligence), breach of statutory duty or otherwise is limited to $5,000. The cost between PHO and PMS vendor will be covered in the agreement between them.

Q5: What are the compliance with privacy law requirements (including HISO) for general practices?

A: Compliance with Privacy Law is an existing legal obligation on all health practitioners. Whilst Health NZ may assist practices by providing recommended Privacy Materials, this does not replace the need for practitioners and practices to familiarise themselves with their legal obligations and to ensure that the collected, storage and use of patient information is authorised by the health consumer. Health NZ recommends that legal advice is sought if the practice is in any doubt as to whether they understand and are complying with Privacy Law.

The HISO framework is in place today and practices would need to consider them and assess how they align with the standards in their context. HNZ & MOH sent a letter a few weeks ago to remind organisations that support the delivery of healthcare about expectation for managing information. One of these expectations is that organisations must comply with the NCSC Minimum Cyber Security Standards, using the Capability Maturity Model Level 2 (CS-CMM 2).

While in the interim this is broad approach for the purposes of the ISA, Health NZ is working with a primary care sector group on developing a related assessment tool that is suitable for practices to utilise in their assessment. This is anticipated to be introduced in the broader Access and Use Agreement process.

Q6: What are the levels of data access for general practices and PHOs?

A: The levels of access for general practices and PHOs are outlined in the Data Access Framework here.

Q7: Who external to Health NZ reviewed the interim ISA?

A: In addition to members of the Primary Care Data Governance Group, GPNZ and GenPro with their legal counsel have reviewed the ISA.

The members of the Data Governance Group are:

- Kim Sinclair-Morris (Pegasus – PHO rep)
- Dr Angus Chambers (GenPro - contracted providers rep)
- Dr Vivien Verheijen (Consumer rep)
- Tureia Moxon (Te Kahui Hauora - Māori PHOs rep)
- Dr Jo Scott-Jones (Pinnacle – contracted provider rep)

Q8: Is there any performance funding related to this work and is the Contingent Capitation related to performance at all?

A: As per the PHOSA, contingent capitation is associated to Participating Practices and not related to health target results.

Q9: Will Contingent Capitation continue?

A: Contingent capitation is not time limited. If there are changes this will be through the usual PSAAP process.

Q10: What are the options for practices to opt-in and opt out of data sharing?

A: From 1 July, practices can opt in (or out) every 6months in line with the notice periods in the PHOSA Part G7.

Between April and the end of June, any general practice that has 'opted on' to share data can notify us if they wish to opt-off. Their Contingent Capitation will

cease on the next available first day of the month. (i.e. 1 May, 1 June, 1 July etc).

Q11: How will transition to the more comprehensive Access and Use Agreement work?

A: There is no deadline currently set for the signing of the Access and Use Agreement. When the Access and Use Agreement is finalised a transition plan will be developed and confirmed with the sector.

Q12: What will happen if a practice 'opts in' but doesn't sign an ISA?

A: If a practice has not opted out, this indicates they are opting in to data sharing. In these cases, we would expect PHOs to talk with the practice to understand why they have not signed the ISA, whether they need any support, or whether they would prefer to opt off. If there are any extenuating circumstances affecting their ability to sign the ISA, we ask PHOs to let us know so we can discuss a way forward.

Q13: Who is the Nominated Agent for Health NZ?

A: Health NZ currently nominated agent for the Health Target reporting is DataCraft. If there are changes Health NZ will communicate this outside of the ISA.

Q14: Why is the word 'reasonably' included in the ISA?

A: The word "reasonably" has been taken from the Health Information Privacy Code. It appears in Rule 11(2)(c)(ii), which allows information to be used for statistical purposes as long as it will not be published in a form that could reasonably be expected to identify an individual. Health NZ is keeping this wording to align with the Privacy Code.

Q15: Will Health NZ provide periodic access summaries, security reports and defined escalation steps for inappropriate access?

A: The agreement does not provide for routine access summaries or periodic security reports to be shared. It does set out that Health NZ is responsible for ensuring its nominated agent complies with all privacy and security obligations, including applying appropriate technical and organisational security measures in line with good industry practice and the HISO 10029 Health Information Security

Framework.

Any inappropriate access or other security incident involving the nominated agent is treated as a security incident under the agreement, with Health NZ responsible for notification, cooperation, and response.

Q16: Is there the ability to immediately terminate the agreement and data sharing if required?

A: A party may terminate the Agreement with immediate effect by notice to the other party if the other party materially breaches the Agreement

Q17: Why is health identifier information being collected?

A: Collecting clinician identifier codes will allow Health NZ to more reliably distinguish between clinical and administrative appointments. This will be important for the measurement of the health target that is focused on appointments with general practice team members.

Q18: Why is data for non-enrolled patients being collected if it is not being retained?

A: Data is being collected for all patients and then combined with enrolment data to confirm their enrolment status. The Primary Care Health Target is then only reporting on those with confirmed enrolled status.

Q19: If the intent is to measure performance against the 7-day access target, what are the consequences for practices that do not meet this target?

A: Understanding the performance against the health target will support practices, Health NZ and PHOs to understand where there may be issues with access to general practice from a more informed position. There are limitations with the existing measures and data sets. This information will also support an understanding of where improvement to services might be needed and what support that might needed to achieve that.

Q20: What is the "appointments outcome measure," and what is the intended use of this information?

A: The appointments outcome measure is a reference to the Primary Care Health Target. Q1 (reporting from July, August and September) will be reported on publicly at the end of the year.

Q21: If they are tracking when appointments are created/booked, how will this impact practices delivering planned care, and how will this affect reported performance?

A: The Primary Care Health Target does not prescribe how practices manage triage or templates and the health target definition still being finalised.

The current plan for the target measurement is to use existing data to reduce the inclusion of planned care appointments e.g. appointments booked out more than 6-8weeks in advance may be excluded.

Q22: Why is encounter duration being collected, and what is the intended use of this data?

A: Collecting encounter duration will allow Health NZ to more reliably distinguish between clinical and administrative appointments. While the health target definition is still being finalised, there are considerations being made about the inclusion or exclusion of very short durations appointments that may not align with the purpose of the health target.

Q23: Will same day urgent care appointments be included in the collection and measurement?

A: While the health target definition is still being finalised, it is expected that appointments that are booked for the same day will be included. There may be other inclusion or exclusion criteria that may apply depending on the type of interaction with the patient

Q24: Can patients opt-out of this data collection?

A: Opt-out for patients is not planned for this data collection We are using existing settings for the sharing of administrative health information, collected by GP practices in their Patient Management Systems (PMS), for inclusion in this dataset. This means that this data can be shared with Health NZ in a way that does not require changes to consent for patients or healthcare workers.

Q25: Should general practices adjust their approach to how they input information into their appointment books to support effective data collection for the target?

A: Health NZ is aiming to utilise existing data for the health target. Any changes a practice chooses to make to improve access are at the discretion of the practice, not mandated by Health NZ. However, in the medium term, Health NZ is planning to work with the sector on ongoing improvement in data quality.

Q26: Who is responsible for validating that it is only data from consenting practices that is extracted, and how is that managed?

A: Only practices that signed the ISA will be participating in data sharing, no data will be extracted from practices who have not signed ISA. Health NZ will implement a periodic audit process related data extraction valid access agreements.

Q27: What happens to the funding allocated to practices that choose not to opt in?

A: As outlined in the PHOSA, up to $60 million a year is available for this funding. If some practices or PHOs choose not to opt in, and not all of the $60 million is paid out, the leftover funding will be used by Health NZ for other primary care initiatives. Health NZ will let itsprimary care partners know what those plans are before making that decision.