

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. We will highlight new or updated information when it's added.

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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. 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 a 'two-way sharing' Data Access and Use 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.

