Response to the Submission made by the Medical Software Industry Association (MSIA) regarding the Draft Determination of the ACCC for Authorisation AA1000577

WA Primary Health Alliance Ltd for and on behalf of Participating Primary Health Networks – Primary Sense Project

Thursday 10 February 2022

Responses to Issues raised in the Submission by the MSIA placed on the ACCC Public Register dated 4 February 2022

1. Degree of Oversight

Points Raised: The Department of Health does properly oversight PHNs. The Australian Charities and Not for Profits Commission does not properly oversight PHNs. The RACGP have previously had concerns about the PIP QI process. The MSIA does not believe PHNs are properly oversighted for financial management.

Response:

1.1 Ms Hossack incorrectly implies in clauses 5 to 8 that the *PHN Performance and Quality Framework* under which the performance and behaviour of the PHNs is monitored and assessed by the Department of Health is self-contradictory (clause 6), inconsistent with a sound regulatory approach (clause 7) and ineffective (clause 8).

1.2 Ms Hossack states in clauses 8 and 12 that the "MSIA is unaware of…" or "The MSIA does not know if…" certain behaviours or actions exist or occur in relation to the oversight of PHNs. There is no obligation on the PHNs, the Department of Health, the ACNC or the ACCC to ensure that the MSIA is fully informed or properly understands all aspects of the governance of PHNs, as they are not a key stakeholder of PHNs.

1.3 WAPHA believes that the Department of Health is in a better position, as the entity with the relevant legislative and regulatory responsibility, to determine if the Framework is suitable for its intended purpose than an external organisation with a self-admitted lack of visibility into the process.

1.4 Ms Hossack states that Criteria O13 of the Framework, which requires that PHNs have an audited financial report and an unqualified auditor statement each year, is insufficient to mitigate the risk of "inappropriate or inefficient use of public money."

1.5 WAPHA notes that the Australian National Audit Office (ANAO) states on their website[1] that "The preparation of timely and accurate audited financial statements is also an important indicator of the effectiveness of an entity's financial management" and believes that ANAO is more qualified to determine what controls are effective in mitigating financial management risks than is the MSIA.

1.6 WAPHA further notes that ANAO has published notice[2] of a potential audit of '*Department of Health's performance management of Primary Health Networks*' as part of its regular cycle of performance audits across Federal Government departments and programs. This demonstrates that the Framework is also subject to additional review and oversight through established mechanisms.

1.7 Ms Hossack refers in clause 11 to statements by the RACGP that relate to data governance and privacy concerns around the PIP QI, contained in a fact sheet published approximately six months after the initial commencement of that program. This is used as apparent evidence that there is insufficient oversight of the PHNs by the Department of Health, despite the admission that "the MSIA does not know if such behaviour

[1] https://www.anao.gov.au/about/audit-process

[2] https://www.anao.gov.au/work/performance-audit/department-healths-performance-management-primary-health-networks

continues", and the fact that the Department of Health – as the owner of the PIP QI – regularly update their guidance and information for general practices about the PIP QI in response to concern, confusion or evolving requirements (most recently on 10 November 2021).

1.8 WAPHA cannot locate any more recent public statements made by the RACGP since the publication of that fact sheet that identify any ongoing or current concerns held with respect to PHNs and the PIP QI.

2. Effect on Competition

Points Raised: PHNs could charge GPs for using Primary Sense. GPs will not choose to acquire a different data extraction tool if provided with Primary Sense. Authorisation of Primary Sense will eliminate stifle innovation and cause other vendors to exit the market.

Response:

2.1 Ms Hossack states incorrectly in clause 15 that the two statements "no participant will make a profit from the project" and "Participating PHNS will provide Primary Sense 2 under a no-cost license" are inconsistent.

2.2 Ms Hossack's proposition in clause 15 that "if the only requirement is that no profit be made from the project" is irrelevant because that proposition has never been stated, implied, or supported by WAPHA or any participating PHN, and is in fact incorrect.

2.3 As emphasised in the Application and WAPHA's several Responses to the Submissions from Interested Parties earlier in this process, PHNs are not-for-profit organisations. The costs shared among Participating PHNs for the Primary Sense Project will be on a cost recovery basis only and will be funded from within existing PHN funding sources. No funding is required or will be requested from any GP for the use of Primary Sense.

2.4 For the purposes of clarity, Primary Sense will be provided at no charge to any GP Clinic that elects to use it, which is the same situation that exists with other commercial data extraction tools currently provided at no charge to GP Clinics by PHNs.

2.5 Ms Hossack's statements in clauses 18 and 19 are correct in describing the operation of a normal competitive market. A consumer base must be willing to pay for a product for a market to exist. However, as per our previous Responses, it is WAPHA's belief that the onus is on a vendor to demonstrate that their product delivers value for money.

2.6 The statement made by Ms Hossack in clause 23 that "It does not appear that any PHN provided any submission on their future behaviour and whether they would continue to provide Extraction Tools provided by Independent providers to their GP Clinics at no cost" is incorrect, and it appears that the MSIA has not read the Responses provided by WAPHA and posted to the Register by the ACCC dated 12 November 2021.

2.7 Clause B2.3 of WAPHA's *Response to Clarifications Requested by ACCC* stated "It is unlikely that a PHN would choose to fund the use of more than one data extraction tool per general practice, even if they provide each general practice a choice as to which tool they use. This would not be an efficient use of allocated funding."

2.8 Clause G3.3 of WAPHA's *Response to Submissions by Interested Parties* stated "WAPHA refutes the statement by MediSecure that there is a "contradiction inherent in the argument that participating PHNs can choose to use Primary Sense 2 and a commercially provided data extraction tool." Gold Coast PHN has been doing exactly that for the past four years, and there are other PHNs that currently offer general practices a choice of more than one data extraction tool which they will support. It is true that it is unlikely that a PHN would offer to fund more than one data extraction tool per general practice (as that would not be efficient), that was not the intended meaning of the statements made in sections 2.1.15 to 2.1.19 of the Application."

2.9 In line with the previous Response referred to above, Ms Hossack's statement in clause 25 is correct to a degree, and WAPHA has clearly stated that while they are able to do say and may choose to do so, it is unlikely that those PHNs which elect to provide Primary Sense for free to their GP Clinics would also choose to provide those same GP Clinics with a second tool also for free.

2.10 Ms Hossack's statement in clause 25 is also incorrect to a degree, as previously stated in clause B2.1 of WAPHA's *Response to Clarifications Requested by ACCC* stated "There are many reasons why a PHN may choose to support and offer more than one data extraction tool for use by general practices. These include (but are not limited to) a desire to offer choice, a need to support programmes explicitly tied to functionality delivered by a specific product, or desire to use or make available functionality provided by separate tools." Clause G3.3 referred to in point 2.8, above, also stated that there are PHNs that already offer their GP Clinics the choice of a free license for one of two different extraction tools at their preference.

2.11 Ms Hossack's statement in clause 27 presents a false dichotomy. GP Clinics will not face a choice of using Primary Sense for free or choosing to continue to pay for a tool from a different vendor. GP Clinics are free to do both, but in either case they would need to be convinced that a product they must pay for offers them value for money.

2.12 Ms Hossack's statements in clauses 28 to 32 are both largely incorrect and demonstrate a lack of understanding of the PIP QI process. The definition of an "eligible data set" is not subject to determination by a PHN but is clearly defined by the Department of Health with specific, detailed file specifications available for download[3] from the Department's website and covered by the PIP QI Eligible Data Set Data Governance Framework[4]. PHNs have a responsibility to ensure that PIP QI data sets provided by GP Clinics meet the specifications defined by the Department but have no leeway to in determining what those specifications are.

2.13 WAPHA refutes Ms Hossack's implication in clause 32 that PHNs manipulate the PIP QI process to favour data submissions made through extraction tools they provide, and that by extension GP Clinics that do not use Primary Sense would be disadvantaged in receiving payments under that scheme. PHNs, including WAPHA, already receive and process PIP QI submissions from many GP Clinics that provide their eligible data sets directly as JSON files rather than through the data extraction tool provided by their PHN.

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[3] https://www1.health.gov.au/internet/main/publishing.nsf/Content/46506AF50A4824B6CA25848600113FFF/$File/PIPQI-Eligible-Data-Set-JSON-Specification-v1.1.pdf

[4] https://www1.health.gov.au/internet/main/publishing.nsf/Content/46506AF50A4824B6CA25848600113FFF/$File/PIP%20Eligible%20Data%20Set%20Data%20Governance%20Framework%202021.pdf

No evidence has been provided by Ms Hossack to substantiate or even support this accusation.

2.14 For purposes of clarity, and as clearly stated by the Department of Health, there is no obligation on any GP Clinic to use the data extraction tool provided by their PHN – be that Primary Sense or any other tool – in order to be eligible to collect PIP QI payments, and no PHN has ever discriminated against any GP Clinic in processing PIP QI datasets on the basis of the tool used to produce or submit that dataset.

2.15 Ms Hossack's implications in clauses 27 and 35 that no "reasonably commercial consumer" would ever choose to pay for an "Extraction Tool from an Independent Provider" if access to Primary Sense is free does a disservice to the vendors of other products. As acknowledged in WAPHA's previous Responses, and in point 2.10 above, using the term "Extraction Tool" is misleading as the functionality provided by these systems extends significantly beyond simply extracting data and supplying it to a PHN. While the onus is on the vendor to demonstrate value for money from their product, there are already GP Clinics that choose to pay for their own license for an "Extraction Tool" instead of accepting a free license from their PHN. This is because they choose not to provide the range of data that PHN's request in exchange for the free license, but still see value for money in the other functionality the tool provides.

2.16 As stated in clause 8.6 of WAPHA's *Response to Submissions by Interested Parties,* "Based on publicly available information[5] the license cost of commercial data extraction tools is low enough that it should not by itself be a barrier to individual general practices considering its use, should they believe the products offer value for money in and of themselves and independent of any connection to a PHN."

2.17 Ms Hossack's statement in clause 36 is incorrect and further demonstrates a lack of understanding of both the PIP QI framework and the business of general practice. Within Western Australia alone there are at least 50 GP Clinics that "refuse to acquire any Extraction Tool" but instead rely on the functionality delivered by their Practice Management Software (such as Best Practice or Medical Director) to generate their PIP QI eligible data sets, and who continue to receive PIP QI funding payments.

2.18 Accordingly, and on the basis of the numerous errors of fact and logic identified in points 2.6 to 2.16, above, the conclusion drawn by Ms Hassock in clause 37 is also incorrect.

2.19 Ms Hassock's statements in clauses 38 and 39 have already been addressed in points 2.6 to 2.11, above.

2.20 Ms Hassock's statement in clause 41 demonstrates both a lack of understanding of the market, but also that WAPHA's previous Responses have not been read. The "majority of the market" is not GP Clinics but the PHNs, in that PHNs are currently the largest segment of the market that actually pays for Extraction Tools.

2.21 Clause 8.5 of WAPHA's *Response to Submissions by Interested Parties* stated that "If participating PHNs believe an alternative to Primary Sense 2 available in the market offers better value for money, then transitioning to that product would be a sound

[5] https://users.pencs.com.au/admin/public/store/shopfront.aspx

business decision. Participating PHNs have already demonstrated their willingness to adopt a new or different product when they believe it is in their best interests to do so."

2.22 The current market already has a significant majority of PHNs supplying GP Clinics with an Extraction Tool from only one vendor (Pen CS). This has not prevented other vendors from developing and introducing effective and valuable tools into the PHN market (such as Outcome Health) or to meet the needs of other segments of the market (such as the University of Melbourne). This disproves Ms Hossack's assertion in clause 41 that in a market where many PHNs supply only one Extraction Tool to GP Clinics that "it is unlikely that such innovation will be forthcoming."

2.23 Ms Hossack's statements in clauses 44 to 48 demonstrate not only a lack of understanding of the role and function of PHNs, but also a failure to read any of the descriptions of the functionality provided by Primary Sense in WAPHA's Application or previous Responses.

2.24 The statement in clause 45 that "PHNs are intended to focus on the optimal provision of healthcare on a population basis whereas GP Clinics … are focused on optimising healthcare outcomes for individuals" again creates a false dichotomy and implies a non-existent difference of objective.

2.25 The two key goals[6] of PHNs are "improving the efficiency and effectiveness of health services for people, particularly those at risk of poor outcomes" and "improving the coordination of health services, and increasing access and quality support for people." Both goals have people – patients and practitioners – rather than abstract "populations" at their centre.

2.26 The three key roles[7] of PHNs are to "commission health services to meet the needs of people in their regions and address gaps in primary health care", "work closely with general practitioners (GPs) and other health professionals to build the capacity of the health workforce capacity to deliver high-quality care", and "integrate health services at the local level to create a better experience for people, encourage better use of health resources, and eliminate service duplication." As with the goals, these roles focus on the impact on individuals, not just populations or funding.

2.27 PHNs do perform population health analysis and research to inform their Health Needs Analysis and provide a basis from which to identify where potential gaps in primary health care delivery may be adversely impacting individual patient outcomes. These are in turn to inform the design and commissioning of improved health services for individuals, and to support quality improvement activities with GPs to improve individual patient health outcomes.

2.28 Primary Sense provides GP-focused reports, notifications and alerts that identify the needs of individual patients or specific patient cohorts within the practice, and does not focus solely on population health statistics as stated by Ms Hassock in clauses 45 to 48.

[6] https://www.health.gov.au/initiatives-and-programs/phn/what-phns-are

[7] https://www.health.gov.au/initiatives-and-programs/phn/what-phns-are

2.29 Ms Hossack's statement in clause 51 appears to confuse maintaining competition within a market (the subject of the Authorisation) with maintaining the market share of a specific provider within that market (which is not a focus of the Authorisation).

2.30 In response to Ms Hossack's statements in clauses 52 and 53, while noting that many of the provided "reasons set out above" have been refuted, WAPHA acknowledges that an Independent Provider may choose to exit the market if they believe that they are no longer able to compete effectively. As stated in clause 8.1 of WAPHA's *Response to Submissions by Interested Parties*, both the "Threat of Substitute Products" and the "Threat of New Entrants" are standard commercial forces operating in a healthy market.

2.31 Ms Hassock's statements in clauses 54 to 60 are a self-admitted hypothetical scenario containing assertions and claims that are, with one exception, not supported by any evidence or external validation. Accordingly, the "*Barriers to entry were not considered*" section of this Submission represent only the unsubstantiated opinion of the MSIA.

2.32 Ms Hossack's statement in clause 58 is supported by the facts, that there have been few (albeit some) entrants into the PHN and/or GP data extraction market in the past twenty years, perhaps the most notable being the University of Melbourne in their support of the NPS MedicineWise service, and this may mean that barriers to market entry are high. It is WAPHA's opinion, however, that using that situation to argue against the entry into the market by a new provider is counter intuitive.

3. Summary and Conclusion

Points Raised: The ACCC's Draft Determination is inappropriate. PHNs may change their role or function in the future and so should not be allowed to operate in the market.

Response:

3.1 Ms Hossack's statement in clause 61 is correct that "the onus is on an applicant to satisfy the ACCC that the authorisation should be granted." It is WAPHA's belief that the ACCC has undertaken the Authorisation process properly and in issuing their Draft Determination has deemed WAPHA as the Applicant to have satisfied them of this. The MSIA's view to the contrary is irrelevant.

3.2 Ms Hossack's statement in clause 62 again appears to confuse maintaining competition within a market (the subject of the Authorisation) with maintaining the market share of a specific provider within that market (which is not a focus of the Authorisation). There are many reasons why a vendor may choose to (or be forced to) exit a market, and asserting that any such hypothetical exit would be solely due to the Authorisation is inaccurate and misleading.

3.3 Ms Hossack's statement in clause 63 regarding the AMA's views on PHNs are irrelevant as they do not refer to the substance of the Application or Authorisation, but instead reflect the repeated statements in this and previous Submissions by the MSIA regarding their negative opinion of the role, governance, reliability and existence of PHNs.