Response to Submissions made by Interested Parties regarding the Application to the ACCC for Authorisation AA1000577

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

Friday 12 November 2021

Responses to Specific and Relevant Issues raised in Submissions by Interested Parties placed on the ACCC Public Register

CONTENTS OF RESPONSE

PART 1 – General Response to Common Issues Raised

It is noted that there are a number of responses from various parts of the health software industry, peak or representative bodies and universities. WA Primary Health Alliance (WAPHA) have responded to those issues or concerns raised, in order to clarify our position for the ACCC to make its informed decision.

The following points respond to the most common arguments raised in the Submissions:

1. Clear Public Benefits

Points Raised by Industry: There is no public benefit to the Project. There are no unmet public benefits that require PHNs to do anything in the market. There is no reduction in public benefits if the Project is delayed.

Response:

1.1 The WAPHA Application clearly lists the public benefits that will be delivered by the Project in section 4 and includes initial references to many of these in section 2.4.1.

1.2 Since the proposed conduct does not involve the delivery of "medical or health services', PHNs are not required to only directly participate in providing a solution if there are no other providers capable of doing so. There is no requirement for there to be an "unmet" public benefit before PHNs can seek to deliver public benefits that are in line with their objectives and the PHN Programme Funding Guidelines.

1.3 The independent business case commissioned by participating PHN's was used to inform the PHN's and it justified a decision to invest in Primary Sense 2. The business case identified significant changes to the timing, scope and detail of general practice data that PHNs would have access through the Project. It is our view that the data will enable more timely and informed service design, commissioning and continuous improvement activities throughout the year, which in turn will lead to better commissioned health services and improved value for money, which are both clear public benefits to Australian citizens.

1.4 The public benefits to be gained from the use of Primary Sense are fully aligned with the purpose and roles of PHNs (as defined by under the PHN Programme) to:

i. work with general practices and other health professionals to build the capacity of the health workforce to deliver high quality care (see point 1.6, below);
ii. commission health services to meet the needs of people in their regions and address gaps in primary health care (see point 1.7, below); and
iii. integrate health services at the local level to create a better experience for people, encourage better use of health resources, and eliminate service duplication (see point 1.8, below)

1.5 The public benefits to be gained from the use of Primary Sense are also fully aligned with the objectives and priorities of PHNs (as defined in the PHN Performance and Quality Framework) to:

i. increase the efficiency and effectiveness of medical services, particularly for patients at risk of poor health outcomes (see point 1.6, below); and
ii. improve coordination of care to ensure patients receive the right care in the right place at the right time (see points 1.7 and 1.8, below).

1.6 Use of the additional data and analytics provided to them through Primary Sense will enable general practices to more easily and quickly:

i. Identify and respond to various risk factors for poor outcomes with their patients;
ii. Compare risk stratification scores for their patient populations; and
iii. Identify, monitor and compare practice and clinical quality improvement activities.

1.7 PHN use of the more detailed and timely data provided by Primary Sense will lead to:

i. improved analysis and modelling used to identify gaps in primary care;
ii. more targeted commissioned health services; and
iii. reduced strain on the hospital system through avoided preventable hospitalisation.

1.8 PHNs will also use the improved data provided through Primary Sense to:

i. Gain a more detailed and timely understanding of the community health;
ii. Identify, monitor and support response to emerging community health issues; and
iii. Improve population health analysis used to inform and drive public policy; and
iv. Improve the quality and privacy of data used for public and academic research.

1.9 The independent business case also identified significant cost savings for PHNs. As publicly funded organisations operating under contract to the Australian Government, PHNs are under an obligation to critically assess the costs and benefits of how they deliver their core functions. Any reduction in administrative overheads for organisations that exist to improve the scope, delivery and quality of primary healthcare in the community is a clear public benefit.

2. Inadequate Security and Privacy Controls

Points Raised by Industry: PHNs cannot manage data with the required level of security and privacy. Industry claims that there are no risks associated with 'commercialisation' or 'on selling' of data that needs to be addressed.

Response:

2.1 The direct suggestion that PHNs are unable to manage data appropriately is rejected. PHNs are the custodians of significant volumes of primary care data collected under current arrangements and have proven themselves to be capable in data governance and security. The $10 million investment by the Australian Government to create the Primary Health Insights data storage and analytics solution (website) for the benefit of all PHNs demonstrates both the commitment to the highest standards of data security at the PHN Programme and individual PHN level, and the capacity and capability of PHNs to manage the Primary Sense Project is a risk-assured way.

2.2 PHNs are required to manage any data collected from general practices in line with the *Privacy Act 1998* and the *Privacy Principles*, with the decision to host Primary Sense 2 within the Primary Health Insights platform motivated by the efficiencies and security control benefits noted by the Department of Health in their Submission.

2.3 The purpose and function of Primary Health Insights is described on its website. Each PHN that uses the platform has its own secure storage area (or "lockbox") to which only it has access. WAPHA, as Lead PHN, is not the custodian of other PHNs' data nor has any access to data stored in other PHNs' lockboxes except at the request of the host PHN for an emergency situation to "break glass", which is consistent with industry hosting and cyber security best practices.

2.4 Primary Health Insights is subject to annual independent Security Reviews and Penetration Tests, which have reported:

i. "the platform to be a mature security design";
ii. "no suitable attack paths for an unauthenticated user"; and
iii. "role-based access control was found to be effective at preventing an authenticated user from accessing data and functionality [they are not authorised to access]."
iv. It should be noted that this security assessment includes possible attacks from outside the platform and also between PHN lock boxes within the platform.

2.5 The Issues Paper released by the Department of Health on 1 Nov 2021 titled General Practice data and electronic clinical decision support states:

i. "[The range of current agreements] raises the potential for general practice data to be monetised for commercial research or other purposes without the knowledge of patients and GPs." *(page 7); and*
ii. "This is an issue for general practices, as many may have signed up to provide their data without full comprehension of how it is used." *(page 8).*

2.6 While current data extraction vendors may require ethics approval before they provide any third party with access to data, ethics approval is not necessarily at odds with commercialisation of data, so does not by itself remove the risk of a vendor or an "approved third party" from selling or using general practice data for commercial gain.

3. Restricted Access to Data

Points Raised by Industry: PHNs will have a monopoly over access to general practice data. Researchers will no longer be able to access general practice data. Current third-party initiatives and projects that depend on access to general practice data will fail. Companies that depend on access to general practice data through current providers will be harmed.

Response:

3.1 Even if every PHN adopted Primary Sense 2 and no general practice elected to use an alternative data extraction tool (both of which are unlikely and outside the scope of the Application), PHNs would still not have a monopoly on access to general practice data. The suggestion that PHN's have a data monopoly is an untrue and invalid statement from industry, since the data is stored on and accessed by numerous other software systems and tools, many of which involve cross-system integration among an ecosystem of providers for public benefit.

3.2 PHNs have a standard practice of working with universities and other research organisations to facilitate appropriate access to data for approved secondary purposes, and of working with research organisations and general practices to recruit participants in trials and other studies. This approach will not change due to the Project, even if the data made available to researchers may change for some PHNs.

3.3 PHNs do not provide data for unapproved secondary purposes or for any commercial gain or purpose. This position is supported by the Department of Health, who do not permit PHNs to provide data for commercial purposes under the PHN Programme.

3.4 If the operation of a commercial product is, or was planned to be, subsidised by the use of data extraction tools paid for by a PHN then there would need to be changes to their product to enable them to obtain data through other non-PHN-funded channels.

3.5 If a researcher or any other third party currently sources data for a fee from a commercial provider who in turn accesses general practice data via a data extraction tool paid for by a PHN (i.e., the data is being on-sold for commercial gain) then an alternative data source would be needed.

4. Concerns about Anti-competitive Behaviour

Points Raised by Industry: PHNs are engaging in *per se* and non-*per se* anti-competitive behaviour, including cartel conduct, price maintenance, misuse of market power, exclusive dealing, exclusionary conduct and monopoly provision.

Response:

4.1 PHNs, as not-for-profit entities, do not compete with each other for contracts or the right to work with general practices or other organisations. The quality, scope or nature of the services provided by each PHN does not change the boundary of the geographic region within which they operate or with which general practices they can engage.

4.2 The ACCC defines that "a cartel exists when business agree to act together instead of competing with each other. This agreement is designed to drive up the profits of cartel members while maintaining the illusion of competition."

4.3 PHNS do not and cannot compete, so the decision to "act together" is not "instead of competing with each other", and are not-for-profit organisations, so the agreement to invest in Primary Sense 2 together is not and cannot be "designed to drive up … profits."

4.4 The proposed conduct in the Application:

i. will not act to fix, control or maintain any price for any service provided to PHNs by a third party;

ii. is not limiting the ability of any PHN to supply to or obtain supply from any third party (except to the extent necessary for each PHN to protect the Intellectual Property held jointly as tenants-in-common);

iii. is not allocating or distributing customers or suppliers among PHNs beyond what is already in place as an inherent part of the PHN Programme that limits each PHN to operating solely within mutually exclusive geographical areas; and

iv. is not impacting on any bidding or contractual process undertaken by PHNs.

4.5 The Act defines "price maintenance" solely with in the context of resale price maintenance, and Primary Sense 2 will not be resold by the PHNs or any other party. The cost of the Project and Service will be paid on an "at cost" basis; neither WAPHA nor any other entity will make a profit from Primary Sense 2. Price maintenance is therefore not a behaviour likely to occur because of, or relevant to, the Application.

4.6 As stated in sections 2.15 to 2.19 of the Application, no PHN or general practice is required to use Primary Sense 2 exclusively or at all. The Project does not limit each PHN's autonomy to make independent purchasing decisions.

4.7 No participating PHN is taking any action that would restrict or undermine any commercial vendor from competing in the market by offering a more attractive product as per 1.1 of the *ACCC Guidelines on misuse of market power*.

4.8 The independent business case developed by the PHNs for the Primary Sense Project highlighted the current lack of competition in the provision of data extraction tools, which impacts PHNs and the delivery of their functions on behalf of the Australian Government.

4.9 The fact that not all PHNs currently use the Primary Health Insights platform – despite that project being fully funded by the Australian Government – shows that PHNs are fully independent and capable of making their own decisions as to which products or services to use, and that PHNs are not compelled to use tools developed collaboratively.

5. Clarity of the Role of Primary Health Networks (PHNs)

Points Raised by Industry: It is not the role of PHNs to develop software. PHNs are supposed to "commission services" not provide them. PHNs are funded by the government so are not allowed to compete or operate in the market. The proposed conduct is outside the scope of what PHNs were created and are funded to do.

Response:

5.1 It is a core function of PHNs to gather, securely store and use data for purposes connected with their functions on behalf of the Australian Government. The manner in which this function is performed by PHNs is not prescribed in the PHN Programme guidelines but is left to PHNs to decide for themselves based on business need.

5.2 Prior to the creation of Primary Health Insights, PHNs had a fragmented approach to data management. The Government investment in that platform explicitly acknowledged the public interest in ensuring that PHNs have access to highly secure storage and analytics capability to perform their core data and information management functions.

5.3 The Department of Health established and manages the programme that defines the role of PHNs as independent not-for-profit organisations that are funded to work with primary care providers, partners and the community to identify and meet the health care needs of the population in their regions.

5.4 The Department funds PHNs in line with a clear grant process, with funding dependent on performance against a published framework in line with national priorities set by the Australian Government as outlined in the PHN Programme Funding Guidelines.

5.5 The Guidelines state that "in the context of the PHN Programme, purchasing refers to the procurement of medical and health care services" and that the newer (and current) commissioning model "will enable a more holistic approach in which PHNs can plan and contract medical and health care services…"

5.6 Primary Sense 2 is not a "medical or health service" and is therefore neither 'purchased' nor 'commissioned' within the meaning and context of section 1.6 of the Guidelines. All references to how PHNs must operate with respect to the "commissioning of services" applies only to "medical and health services" and do not apply to the proposed conduct.

5.7 The funds expended by PHNs on data extraction or any other software products are part of their administrative overheads, which under the Guidelines PHNs have an obligation to minimise. This is the same portion of funds used by PHNs to pay for all other software or technology projects, including the licenses purchased for current data extraction tools.

5.8 The Department of Health made a public Submission in response to the Application that did not indicate the proposed conduct was out of scope of PHN permitted activities, noting instead that "*the Department is agnostic towards how PHNs collect data from general practices*" and that "the ability for PHNs and general practice to continue to be able to choose the data *extraction tool that best suits their needs will incentivise innovation and not adversely impact on competition in the delivery of data extraction services*."

6. Inadequate Stakeholder Engagement and Consultation

Points Raised by Industry: WAPHA failed to identify every Interested Party in the Application. WAPHA has not engaged with or consulted every Interested Party prior to submitting the Application. WAPHA has not provided the industry with financial, technical or other details of the Project. WAPHA has demonstrated bad faith and a lack of transparency.

Response:

6.1 WAPHA only listed in 2.6 of the Application those believed entities it believed were most likely to be directly impacted by the Project, and did not purport to identify every possible "market competitor, participant or genuine stakeholder" who may or may not play a role in the market.

6.2 Participating PHNs were not required to initiate the Authorisation process but chose to do so as a public and transparent way of informing people and organisations of the proposed Project and its potential impacts. The ACCC Authorisation process itself, is a public process and industry has an opportunity to raise its concerns.

6.3 The Project and the participating PHNs will be engaging with local general practices, professional peak bodies and other key stakeholders, but a decision was made by the Project Committee that the ACCC Authorisation process should be undertaken first to maximise transparency and reduce the timeframe for certainty around competition and commercial considerations.

6.4 Some of these engagements will need to be commercial in nature, and WAPHA and the participating PHNs have been transparent in our desire to have a degree of certainty around the Authorisation process to support both these engagements and the contractual arrangements between the PHNs that underpin the Project.

6.5 There is no obligation on WAPHA or any participating PHN to provide individual vendors or any peak or affiliated representative industry body with any information on the suitability, security, functionality or cost of Primary Sense 2 before embarking on the project. As with any other software product Primary Sense 2 must only demonstrate its value to those paying for or using its capabilities. PHN's are using Primary Sense 2 for its own purposes as the PHN cooperative owns the software.

7. Scope of Primary Sense is too wide

Points Raised by Industry: Primary Sense 2 will affect all vendors in the medical software market. PHNs exert undue influence over general practice software decisions due to their control of ePIP funding.

Response:

7.1 The following diagrams outlines the limited part of the general practice software market where Primary Sense 2 operates in terms of its functional scope:

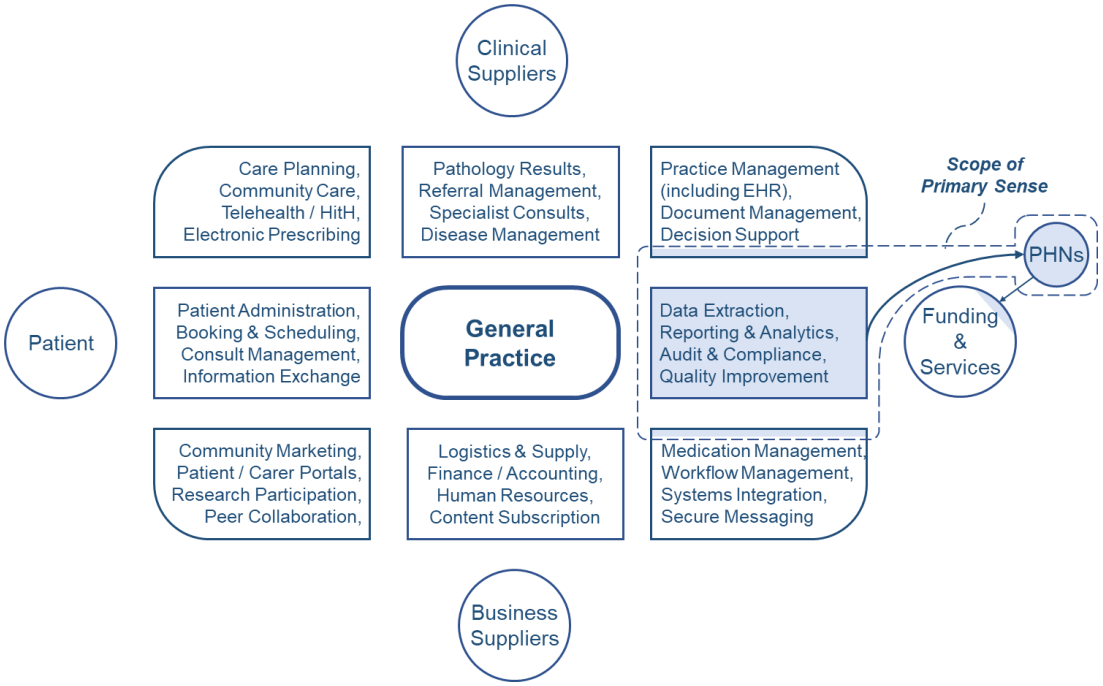

Diagram: *Scope of General Practice (GP) software market and limited scope coverage of Primary Sense 2*

7.2 Key points to note in the above diagram include:

i. Primary Sense 2 does not operate within the functional scope of the software offered by the majority of commercial providers operating within the larger general practice software market, such as most members of the Medical Software Industry Association (MSIA);

ii. Primary Sense 2 does not provide all possible functionality desired or used by general practices even within the functional scope that it does cover;

iii. The functionality of Primary Sense 2 is directed solely at enabling or supporting PHNs in their three primary roles (as defined by the Department of Health).

iv. PHNs have no role in the funding of general practices, except indirectly through their role as regional data custodians of PIP QI, or their role in supporting general practices to improve the quality of the data they record that may improve their ability to confidently claim against various MBS items.

7.3 PHNs are not involved in the ePIP nor have any influence over whether general practices qualify under that program. None of the current data extraction tools used by PHNs are, or are required to be, conformant to ePIP requirements and neither will Primary Sense seek conformance. These tools exist for different purposes and operate differently than do those, which are mostly clinical information systems, listed in the ePIP Register.

8. Perceived Impact on the Market

Points Raised by Industry: The proposed conduct will prevent the market from operating normally. An Authorisation will destroy the market. An Authorisation will prevent investment in the market. Providing Primary Sense 2 for free will stop general practices buying other tools. The purpose of the Project is to gain market share without competition.

Response:

8.1 The natural operation the market is outline in the Five Forces Framework, proposed in 1979 by Michael Porter in the Harvard Business Review and still referred to today. It includes 'Bargaining Power of Buyers", "Threat of Substitute Products or Services" and "Threat of New Entrants" as normal and expected 'forces' that act on a market.

8.2 The decision by participating PHNs to invest in Primary Sense 2 is therefore fully in line with natural supply/demand forces which drive change in markets due to competition, and do not act to preserve the status quo for existing suppliers or their market share.

8.3 As stated in the Application in sections 2.1.15 to 2.1.19, the use of Primary Sense 2 will not be mandated to PHNs or general practices, and any vendor will continue to have the opportunity to demonstrate that their product offers value for money.

8.4 Neither investment in nor ownership of Primary Sense 2 by participating PHNs prevents any other organisation from seeking to demonstrate that their product delivers better value for money through better functionality, performance and outcomes and/or cost.

8.5 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 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.

8.6 Based on publicly available information 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.

8.7 Participating PHNs are not selling into the market or obtaining market share but are choosing to supply for themselves an internally-developed product which they own as tenants-in-common and which is not available from the market.

8.8 The increased choice of data extraction tools for PHNs explicitly describes an increase in competition in the market for these choices. The fact that more than half of all PHNs have chosen to participate in the Project indicates a strong desire from the main paying customers in the general practice data extraction market for this increase in choice.

9. Inadequate Capability of PHNs

Points Raised by Industry: PHNs cannot develop software. PHNs cannot manage a Project of this size. PHNs have poor or unclear governance. The Project is going to fail because the current version of Primary Sense is not already in use by multiple PHNs.

Response:

9.1 A number of Submissions claim there is insufficient capacity or maturity within PHNs to successfully deliver the Project, and this is rejected. The PHN Programme has been in existence for over six years and is continuously evolving and maturing, with an annual investment by the Australian Government of more than $1.2 billion. The majority of these funds are under the administration of the participating PHNs, who have repeatedly demonstrated that they are capable of effective stewardship of resources at this scale.

9.2 The procurement or development of software and systems is a part of the normal business of PHNs in carrying out their responsibilities under the PHN Programme, and has been done successfully in the past by individual PHNs acting alone and more recently by the majority of PHNs supporting and implementing a national PHN project (Primary Health Insights).

9.3 The PHNs have already demonstrated their ability to work with the private sector to develop and implement at-scale technology systems such as Primary Health Insights, and the Primary Sense Project will follow a similar approach.

9.4 The Application states clearly in 2.1.4 and 2.1.5 that Primary Sense 1 already exists and has been in use by the Gold Coast PHN and general practices in the Gold Coast since 2018, and in 2.1.7 it is made clear that the term “Primary Sense 2” refers to a scaled-up version of the existing Primary Sense application, not the development of a completely new or even substantially different application.

9.5 PHNs operate under multiple levels of internal, collaborative and external governance and advisory boards, and maintain the highest standards of probity and integrity. The Project is additionally governed by a Project Committee consisting of senior executives from participating PHNs.

9.6 PHNs operate under the PHN Performance and Quality Framework as a condition of being funded under the PHN Grant Programme, as well as under the reporting and other obligations inherent in being a not-for-profit organisation registered with the Australian Charities and Not-for-profits Commission (ACNC).

9.7 Gold Coast PHN has never released Primary Sense 1 to the market but have engaged with their PHN peers since 2019 to demonstrate a product developed for their own use, as is common practice for non-competing not-for-profit organisations in the same space.

9.8 Gold Coast PHN never had the intention to act as a software provider to other PHNs but has approached other PHNs to gauge interest in leveraging Primary Sense 1 for their own purposes and at their own cost. One possible model was outlined in a prospectus released in 2019 but was not adopted or developed further. The current Project is based on a different technical and collaborative approach.

10. Urgency for Interim Authorisation

Points Raised by Industry: There is no reason for an Interim Authorisation. WAPHA plans to use the Interim Authorisation to rollout Primary Sense 2 before any final Decision is issued.

Response:

10.1 The Application is clear in section 2.4.1(h) that "the Applicant does not intend to enter into the bi-lateral contracts referred to as Contract B, nor provide the Primary Sense Service on Primary Health Insights for any PHN, until such time as a substantive authorisation is granted."

10.2 The interim authorisation requested in 2.4.1 of the Application is to provide confidence and certainty to participating PHNs and external stakeholders who must be engaged during the Development Phase so targeted timeframes can be met.

10.3 Delay in the Project does not only impact on the timeframe for PHNs who wish to "commence the transition … to Primary Sense at the end of the second quarter in 2022" and reduce the need to renew current licenses for the 2022-23 financial year, but would also impact on PHNs who plan to commence their transition later during 2022-23.

10.4 Delay in commencing a PHN's transition has a flow on impact to completing that transition. Until a transition is completed the PHN may be required to continue to pay unused licenses for commercial data extraction tools (whether or not that they planned on doing so). Since those licenses are paid annually, delays that push the timeframe over an annual renewal date will result in higher costs for the PHN – either in 2022 or later, depending on when they start transition.

11. PHN Investment Decision

Points Raised by Industry: PHNs should only purchase software from the market. PHNs must use a tender process. WAPHA has not provided the business case for the Project. There is no business case for the project. The current market is already meeting all PHN needs.

Response:

11.1 The Department stated in their Submission that PHNs "are free to make software procurement decisions independently that best meet their individual needs and circumstances."

11.2 As the largest buyers of general practice data extraction tools, PHNs have the right to either source these from the market or to develop internal capabilities separately or collaboratively. There is no obligation or requirement for PHNs to obtain goods, services or capabilities from external vendors (other than for medical and health care services).

11.3 The participating PHNs made the decision to invest in Primary Sense 2 on the basis of a properly developed Business Case which led their Boards to agree that the Project will deliver value for money and assist them in meeting their objectives and priorities.

Part 2 – Specific Reponses to Additional Issues in Individual Submissions

The following pages contain additional brief comments relevant to individual Submissions that have not already been adequately addressed by the General Responses.

A. Interested Party: Department of Health (Australian Government)
Submission Date: 27 Sep 2021

A1. Role of PHNs

A1.1 WAPHA notes the role the Department of Health plays in funding PHNs in line with a clear grant process, with funding dependent on performance against a published performance framework in line with national priorities set by the Australian Government as outlined at https://www.health.gov.au/initiatives-and-programs/phn.

A2. Software procurement

A2.1 WAPHA agrees with the Department that the ability for PHNs and general practices to choose the data extraction tool that best suits their needs does incentivise innovation, and this is reflected not only by the Project but also the work undertaken by commercial vendors and other organisations to develop data extraction tools to meet specific and generic use cases across the healthcare landscape.

A3. Data privacy

A3.1 WAPHA is pleased that the Department supports the intention of the participating PHNs to not offer the use of any data collected from general practices for any commercial gain or purpose, and notes this has been the practice of PHNs since their inception and is independent of the systems used to extract, store or report on data.

B. Interested Party: Outcome Health
Submission Date: 29 Sep 2021

B1. Skewing of competition

B1.1 WAPHA disagrees with Outcome Health that the Project will skew competition "through the use of Government funds to underwrite the development of one vendor" and notes that the development of Outcome Health's POLAR product was also largely funded by the PHNs, as noted in their Submission which acknowledges that the PHNs currently using POLAR "have invested time and resources into co-design, building and implementation of the product."

B2. Seeking to gain an advantage

B2.1 WAPHA agrees with Outcome Health that the participating PHNs are seeking to gain an advantage through this procurement decision but seek to stipulate that this is not a competitive advantage but rather a co-operative one.

B2.2 WAPHA notes that none of the listed participating PHNs are currently customers of Outcome Health, and that Outcome Health and any other vendor have been and are free to seek to demonstrate in a competitive manner that their product delivers better value than PHNs can deliver to themselves through the Project.

B3. Primary Health Insights

B3.1 WAPHA notes that Primary Health Insights is a separate service than Primary Sense, and that Primary Health Insights continues to be vendor-neutral with respect to data extraction vendors. Primary Sense is not a subsidiary of Primary Health Insights.

B4. Cost saving and superior functionality

B4.1 WAPHA's "claims throughout the application" are based on over four years of experience by the Gold Coast PHN in using Primary Sense, on an independent assessment of Primary Sense commissioned by WAPHA in 2020 and undertaken by Deloitte Consulting, and a subsequent Business Case developed for the participating PHNs by Deloitte Consulting.

B4.2 The statements made in WAPHA's Application reflect the opinions of the participating PHNs based on the evidence collected and assessed by them, as would be the case for any business decision made by any independent organisation.

B5. Local technology sector and support for small business

B5.1 WAPHA acknowledges the efforts made by Outcome Health and similar vendors to support Government programs such as PIP QI as well as to develop functionality to assist in managing the impact of the COVID-19 pandemic in Australia.

B5.2 WAPHA does not agree with Outcome Health that "in an environment where PHNs are providing funding via their government grants to underwrite this type of functionality there is a strong risk of market failure".

B5.3 PHNs funding for data extraction tools comes from the same source regardless of the supplier, as has been the case for many years. Vendors and organisations across Australia have developed tools for their own purposes or target markets even though current data extraction tool vendors paid by PHNs who "are providing [this] funding via their government grants."

B6. Urgent exemption

B6.1 WAPHA have not claimed "clinical requirement" as the basis for any urgency.

C. Interested Party: Pen CS
Submission Date: 29 Sep 2021 & 1 Oct 2021

C1. No urgency

C1.1 WAPHA refutes the statement made by Pen CS in clause 1.2 of their Submission, and the conclusions they propose as a result in clauses 1.3 and 1.4.

C1.2 WAPHA's Application states clearly at 2.4.1(a) that interim authorisation is sought for "the period from 1 September 2021 until 30 April 2022" and at 2.4.1(c) that it seeks to "plan and commence the transition of some of the Participating PHNs to Primary Sense 2 at the end of the second quarter in 2022".

C1.3 The intent to "plan and commence transition" under Contract B stated at 2.4.1(c) is therefore clearly outside of the requested interim authorisation period for Contract A at 2.4.1(a), since the interim authorisation would conclude in April 2022 (the beginning of the second quarter of 2022) and the work to "plan and commence transition" under Contract B would occur "at the end of the second quarter in 2022".

A1.1 The omission of a key part of 2.4.1(c) in clause 1.2 of their Submission appears designed by Pen CS to deliberately obscure this clear difference in the Application.

C2. There will be public detriment

C2.1 The current business model employed by Pen CS appears to largely rely on PHNs to pay for licenses that will be used for free by general practices. However, PHNs are not the only paying customers for Pen CS software and nothing prevents Pen CS or any other vendor from marketing and selling their software directly to general practices or other potential clients, and the Project will not alter those circumstances.

C3. Access & interoperability

C3.1 WAPHA notes that contrary to the implication in clause 5.1 of Pen CS' Submission, the participating PHNs are not required to publicly disclose the contents of contracts between them. Nevertheless, WAPHA asserts that Contract A referred to in the Application does address how IP ownership is managed if a PHN leaves the UJV.

C3.2 WAPHA seeks to correct Pen CS' incorrect statement in clause 5.3 of their Submission that "the owner of the "tenancy" [is] the most important aspect of control and ownership of any data residing within [a] Microsoft [Azure] platform." This statement indicates a lack of understanding of how access control and security operate within the Microsoft Azure environment.

C3.3 Ownership of an Azure tenancy does not confer any ownership of data stored on that tenancy. Ownership, custodianship and access to data should be – and within the Primary Health Insights platform, is – managed through a mutually agreed and understood Data Governance Framework between all parties involved.

C3.4 Ownership of an Azure tenancy does not necessarily confer control of data stored on that tenancy. Access to data is managed through security controls and permissions assigned to user accounts, including Role-Based Access Control (RBAC), Access Control Lists (ACLs), Network Security Groups (NSGs) and User Defined Routing (UDR). All these controls are incorporated into Primary Health Insights and will provide additional security for Primary Sense once the application is hosted on that platform.

C4. Frankness

C4.1 WAPHA notes that information on how Primary Sense currently operates is publicly available on the Primary Sense website, which specifically mentions in the FAQ page that it uses the "ACG Johns Hopkins Risk Stratification tool". WAPHA and participating PHNs cannot reasonably be accused of not disclosing information that is readily and publicly available on the internet.

C4.2 WAPHA further notes that a significant amount of information on the Johns Hopkins ACG system is available on its own dedicated website.

C4.3 Primary Sense does use Johns Hopkins ACG but it is not the only or "underlying" algorithm used to map, analyse or report on data, and the fact that neither PenCS nor Outcome Health use that engine is one of the things that makes Primary Sense different from other available data extraction tools.

C4.4 The decision to use or not use any particular algorithm or engine within a software product is a business decision, and whether or not it is a good decision will be determined by how prospective users of the software respond. The participating PHNs are aware of the use of Johns Hopkins ACG in Primary Sense and the proposed value it offers to PHNs and general practices.

C4.5 The usefulness of the Johns Hopkins ACG tool is supported by academic research. A paper published earlier this year on 'A systematic review of risk stratification tools internationally used in primary care settings' (available here) concluded that "based on application frequency, statistical validity, and used diagnosis coding systems, we suggest the ACG as the best model for use", noting that the research and conclusion were within the primarily European context of the researchers.

C5. Exclusion

C5.1 WAPHA rejects the claim made by Pen CS in clause 8.4 of their Submission that the "purpose of the proposed conduct is to wipe out the competition and to create a monopoly provider".

C5.2 The statements in 2.1.14 of the Application that "Participating PHNs cannot use Primary Sense 2 in competition with the Primary Sense Service and set up a separate primary data health platform to provide Primary Sense 2 to the PHNs" serve to preserve the existing and intended non-competitive relationship between PHNs. The described behaviour be a "monopoly" in the supply of Primary Sense 2 but does not create a monopoly with respect to data extraction tools more generally.

C5.3 WAPHA is unsure of the genesis or relevance of clause 8.5 in Pen CS' Submission. The Application does not refer to any "proposed manager of Primary Sense 2" and notes that staffing decisions made by WAPHA and other participating PHNs are internal matters that are not pertinent to the Application.

C6. Poor outcomes

C6.1 WAPHA notes in relation to Pen CS' statement in clause 9.2 of their Submission that there is no requirement to "demonstrate that [Primary Sense] is any different from the current market offerings" as part of the Application, but notes that clause 6.5 of their Submission already identifies at least one way in which Primary Sense differs from current market offerings through the use of the Johns Hopkins ACG tool.

C6.2 WAPHA believes that increased choice will spur competition in the market, and that the normal and healthy response of the private sector will innovation as suppliers seek to demonstrate to the PHNs that their products represent better value for money. The Department's submission indicates that they share WAPHA's opinion.

C6.3 The Application does not list the "following items" in clause 9.5 of Pen CS' Submission as public benefits to be delivered by the Project, and therefore there is no obligation on WAPHA to provide evidence that the Project will deliver them as public benefits.

C7. Additional items

C7.1 Pen CS have not identified how the statements in their additional Submission relate to the Application, but instead they appear to stand alone as statements about their own products and commercial behaviour.

C7.2 WAPHA acknowledges that Pen CS does not "charge [most] GP practices directly for the supply of CAT Plus software" but notes that this is only because Pen CS does charge the PHNs for the supply of this software.

C7.3 WAPHA notes that Pen CS supplies and charges for its software products directly to a range of organisations apart from PHNs, including Aboriginal Medical Services and general practices that have elected to pay additional licensing fees to Pen CS for extra software that their particular PHN may not pay for (such as Topbar).

D. Interested Party: Webstercare
Submission Date: 30 Sep 2021

D1. Objection

D1.1 WAPHA notes that Webstercare have not identified the nature of their interest in the Application, nor how the granting of the requested Authorisation could impact them.

D2. Delivery timeframes, creation of precedents and lack of transparency

D2.1 WAPHA seeks to correct the apparent misconception held by Webstercare that PHNs are not private organisations. PHNs are independent, not-for-profit organisations that may be funded by the Government under a grant programme but are not public organisations as a result or subject to all government policies or practices.

D2.2 WAPHA asserts that "other health-related organisations" will continue to operate in line with their governance structures, internal policies and (for public organisations) relevant legislation or regulations, regardless of the final Authorisation decision.

D2.3 WAPHA emphatically agrees with Webstercare's statement in the fourth dot point of their Submission that "the customer should be front and centre, not the software developer" and notes that PHNs are currently the largest group of paying customers in the primary health care data extraction software market.

E. Interested Party: Medical Software Industry Association Ltd
Submission Date: 1 Oct 2021, 8 Oct 2021 and 1 Nov 2021

E1. Amalgamation of Response

E1.1 Since the initial submissions by the MSIA dated 1 Oct 2021 and 8 Oct 2021 appear to have been superseded by the comprehensive submission dated 1 Nov 2021, WAPHA will respond to the final submission dated 1 Nov 2021 only.

E2. Executive Summary

E2.1 WAPHA maintains that the Authorisation process is a part of 'the usual operation' of the *Competition and Consumer Act 2010* and that the participating PHNs are not seeking protection from its normal and intended purpose or operation.

E2.2 As stated in section 5.2 of the Application, WAPHA maintains that the Project does not prevent any current or emerging vendor of extraction tools from continuing to sell to participating PHNs, or from directly marketing their products to general practices and other organisations on the basis of demonstrated value for money.

E2.3 WAPHA notes that the figures referenced by the MSIA from the Standish Foundation CHAOS Report 2015, that "National IT projects have a record of failure approaching 90% with just over 10% being on time and on budget" are not the data from that report most applicable to the Project.

E2.4 According to the Standish Group's definition in their Special CHAOS Report on Digital Transformation Project, the Primary Sense Project would be classified Small to Moderate in size, and the CHAOS Report 2015 lists success rates for projects of that size between 24 - 61%.

E2.5 The CHAOS Report also identifies the top three 'Factors of Success' most likely to contribute to project success as being 'Executive Sponsorship', 'Emotional Maturity' (how people in an organisation work together) and 'User Involvement' – all of which are present in the Project.

E2.6 WAPHA notes that comments made by the MSIA with respect to the "capability or capacity [of Primary Sense] to meet these high [security and privacy] standards" as a "sub-standard tool", as well as the quality of PHN staff or Project resources not being of "such calibre" are unsubstantiated, derogatory and untrue.

E3. The Issue

E3.1 WAPHA notes numerous errors of fact and inference in the MSIA's statements regarding "the waste of over $20M in one PHN alone". The following statements have been provided by the CEO of Brisbane North PHN and included here in full:

1) Statement from the Submission: "The North Brisbane PHN was funded by Minister Roxon just under $20M to procure software"
    a. Response:
        i. This statement is incorrect;
        ii. Brisbane North PHN was never "funded by Minister Roxon just under $20M to procure software";

iii. Under its prior trading name Partners 4 Health Ltd, now trading as Brisbane North PHN, was a “PCEHR Wave 1” pilot site and received $4.39M from the Australian Government Department of Health;

iv. The $4.39M received by the business was to test key health information exchanges between healthcare providers as part of the effort to test national eHealth infrastructure and standards.

2) Statement from the Submission: “but instead supported a new company established by its deputy CEO to develop software”

   a. Response:

      i. This statement is incorrect;

      ii. One of the subcontractors engaged by the business to aid in the delivery of the “PCEHR Wave 1” pilot project was Health Industry Exchange Ltd (HIE);

      iii. No current or former executive of Brisbane North PHN (Partners 4 Health Ltd) has or has ever had any ownership interest in, or role with, HIE;

      iv. HIE, along with other independent commercial vendors, was selected through a properly governed procurement process and was specifically listed as an approved subcontractor by the Department of Health in the government funding agreement;

      v. HIE provided eHealth infrastructure including systems to support the secure exchange of health information between primary and tertiary healthcare providers, patient enrolment and matching services, project management and IT support.

3) Statement from the Submission: “it failed with no outputs”

   a. Response:

      i. This statement is incorrect;

      ii. The PCEHR Wave 1 pilot project was completed on time and on budget;

      iii. The work undertaken by Partners 4 Health Ltd (which now trades as Brisbane North PHN) was cited numerous times by Commonwealth agencies as demonstrating success;

      iv. The specific work subcontracted to HIE Ltd delivered the required equipment and services which were installed and in use for several years as part of the pilot project;

      v. The PCEHR Wave 1 pilot project concluded according to contractual timelines, and the lessons learned from the project were used to inform the development of the My Health Record initiative which is still in operation today

E3.2 WAPHA seeks to correct the statement by the MSIA that Primary Sense was developed and used by the Gold Coast PHN “in competition with the Gold Coast Integrated Care programme”. The Gold Coast PHN were a major partner in that programme and contributed significantly throughout the programme’s lifecycle, including coordinating the provision of data from and to general practices.

E3.3 WAPHA notes the statement made by the MSIA regarding the possibility that "providers may have exited" the market due to the introduction of Primary Sense by PHNs is unsupported. There is already "a free product being offered" for data extraction to general practices and contrary to this resulting in vendors leaving the market the MSIA's own submission indicates that "many companies are considering participation".

E3.4 There is no "government funded discount made available to [PHNs]" related to Primary Sense being requested, considered or proposed by PHNs, the Department of Health, or any other government agency.

E4. Why the Application ought be refused

E4.1 WAPHA notes errors of fact and inference in the MSIA's statement in dot point two of their first reason. As previously noted, PHNs have no role in the ePIP, and their role in PIP QI does not include any "responsibility for authorising" payments.

E4.2 Under the PIP QI, each PHN is responsible for verifying only that participating general practices have submitted their PIP Eligible Data Set, and the PHNs are obligated to accept any such file that meets the specifications, regardless of which software system or data extraction tool was involved in producing it.

E4.3 If general practices feel "compelled to use the PHN product" due to the PHN's role in PIP QI this would already be an issue with the current data extraction tools. It is highly unlikely that the introduction of Primary Sense as an additional or alternate tool provided by their PHN would by itself create this incorrect belief.

E4.4 There are a significant number of general practices around Australia that already participate in PIP QI, provide eligible data sets to their PHN, and receive their payments from the Commonwealth without using the current data extraction tools offered for free from their PHN.

E4.5 WAPHA refutes the claim made by the MSIA in their fourth reason that it has "shown bad faith in not adding the health software peak body into its Application" and disagrees that "the MSIA … is most likely the most affected stakeholder." While the MSIA has made clear statements about how it believes the Application could impact some of its members, it has not identified any way in which the MSIA itself could be impacted. The only vendors known to WAPHA and the participating PHNs to be operating in the market that could be directly impacted by Primary Sense were clearly identified in the Application. Those two vendors represent <2% of the membership of the MSIA.

E4.6 WAPHA notes with concern the numerous statements made by the MSIA throughout their submission challenging not only the capability and capacity of the PHNs, but also their integrity, honesty, and ethics. This is within the context of a submission where the MSIA has demonstrated a lack of understanding of the role, purpose, function, governance and policy environment of PHNs, who the MSIA also acknowledged as being the primary customers of several of their members and a key part of the primary healthcare ecosystem.

E4.7 WAPHA notes that the repeated references by the MSIA in their response to the ePIP demonstrates a lack of understanding of both the information contained in the Application and the role and function of both the PHNs and the ePIP itself.

F. Interested Party: Touchstone Life Care
Submission Date: 1 Oct 2021

F1. Impact on Initiatives

F1.1 WAPHA acknowledges the benefits of digital advanced care planning and the role that Touchstone Life Care has played in developing and expanding this area.

F1.2 WAPHA is unaware of the nature of the "initiatives [Touchstone] has been discussing with PHNs" or "are developing to meet the needs of the Australian Digital Health Agency." No such initiatives have been identified to WAPHA by the participating PHNs.

F1.3 Touchstone Life Care will continue to be able to enter into data sharing agreements with general practices.

F1.4 The language used by Touchstone in their Submission such as "our work towards the development of", "initiatives we have been discussing" and "those we are developing" implies that at least some Touchstone products are not yet in use or in the market, and so if changes are required by the introduction of Primary Sense 2 there is still time for this to occur.

G. Interested Party: MediSecure
Submission Date: 1 Oct 2021 & 29 Oct 2021

G1. Urgency

G1.1 WAPHA notes that MediSecure's statement, "unless substantive authorisation is granted before 30 April 2022…" indicates MediSecure may not be aware the ACCC operates under a legislative requirement to return a decision on any Authorisation request within no more than six months. Since the Application was lodged on 14 September 2021, the final decision will be made no later than the 14 March 2021.

G2. Public Interest

G2.1 WAPHA responds to MediSecure's statement that "the absence of arguments presented by WAPHA that suggests the status quo currently harms the public interest" by noting that there is no requirement or expectation by the ACCC to do so, and that new products enter vibrant and healthy markets all the time.

G2.2 WAPHA agrees with MediSecure's statement that "the balance of public interest is best served by ensuring any data extraction tool migration occurs only once" and confirms that this is the intent, and will be the result, of the Application.

G2.3 WAPHA responds to MediSecure's comments in relation to "longitudinal data sets" by noting that data extraction tools extract historical data as part of normal operations. When a new data extraction tool is implemented within a general practice – be it Primary Sense or any other – the first extraction process includes historical data in line with the data sharing agreement. This does not introduce any breaks in a longitudinal data series, but creates a new, internally consistent longitudinal data series.

G2.4 Adoption of Primary Sense by a PHN does not involve any data migration nor any mapping of data extracted from one system into the data model of the other that is relevant to this Application, and so the "tool migration" does not require any "data transformation schema from old to new data models", except as it might relate to the internal analytics practices of PHNs (which in any case must constantly adapt to changes in the data models provided by existing data extraction tools).

G3. Market Harm

G3.1 WAPHA notes that Contract A already includes provisions that identify how a participating PHN can leave the unincorporated joint venture and how Contract B will manage the rights and obligations of PHNs if one seeks to leave during the term.

G3.2 WAPHA notes that MediSecure's statement regarding the "public benefit argument [that is] centred on cost reductions" demonstrates a lack of understanding of the current data extraction tool market. PHNs already provide these tools to general practices for free, and any "cost reduction" is solely within the PHN itself, not to the general practices. As both a customer of the market, and publicly funded not-for-profit organisation with contractual obligations to be as efficient as possible, PHNs have both the right and the responsibility to seek "cost reduction."

G3.3 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.

G3.4 WAPHA notes that MediSecure's objections to the Interim Authorisation have not identified any impact to themselves as an organisation, and WAPHA therefore cannot comment on any such potential impacts.

G4. Approval to act in a concerted manner to gain presence in an established market

G4.1 WAPHA seeks to clarify MediSecure's statement in the first dot point of their second Submission that the Project provides "a direct benefit to one of the market incumbents (Primary Care Gold Coast Limited)." The only "direct benefit" received by Gold Coast PHN is a reduction in its ongoing costs to maintain and operate Primary Sense 1 alone.

G4.2 Gold Coast PHN have not received any payment or consideration from the other PHNs in exchange for participating in the Project or assigning the Intellectual Property in Primary Sense to the unincorporated joint venture, and are contributing to the costs of the Project in the same manner as any other participating PHN.

G4.3 WAPHA notes that cost containment is a valid business motivator for most actions, particularly for PHNs that have a contractual obligation under the PHN Programme Funding Guidelines to be as efficient as possible in their use of funds for administrative purposes, and is unsure why MediSecure appears to imply otherwise.

G4.4 WAPHA refutes the claim made by MediSecure that the Project has "the expressed intent to disrupt … the market for clinical decision support software." The real-time alerts and notifications provided by Primary Sense operate within the same context as

related functionality provided by commercial data extraction tool vendors which depends on those tools being installed, noting that PenCS' Topbar is expressly defined as a 'clinical decision support system' as is Outcome Health's WALRUS 'decision support tool'.

G5. Primary Health Insights

G5.1 Primary Health Insights storage does include "data extracted by the incumbents of the data extraction market" but Primary Health Insights has no functionality related to data extraction from general practices. No "performance improvements within Primary Health Insights itself" can affect the timeliness, quality or nature of the data made available to be ingested into the platform, whether by Primary Sense or other tools.

G5.2 The rationales for the proposed conduct outlined in section 2.3 of the Application cannot be addressed through "management of service level agreements with the incumbents" as suggested by MediSecure as they relate to differences in how Primary Sense operates in comparison to current products, not in how it performs.

G6. Impeding the ability of GP clinics to use other data extraction tools

G6.1 PHNs can already choose to provide a data extraction tool from one provider and not the other. The vendors of the current tools are expected to seek to increase their market share by convincing PHNs to offer their product for free to general practices instead of that of their competitor, but this would leave general practices in the same situation of needing to pay for their current product themselves if they wished to continue using it.

G7. Reasons for the proposed conduct

G7.1 WAPHA seek to correct MediSecure, in that the PHNS do not "argue that the proposed conduct is required to enable PHNs to deliver on their objectives", but rather that the Project supports PHNs to meet their objectives better. The Application has not implied at any time that PHNs are currently "failing to meet their objectives".

G7.2 MediSecure's assumption that "Primary Health Insights must have already addressed … data mapping standards, rules and approaches" is incorrect, as Primary Health Insights cannot only be used to store and analyse the data that is made available to it but cannot change the nature or quality of that data prior to ingestion.

G7.3 Section 2.3.1(e) of the Application refers to the fact that the current data extraction tools include proprietary mappings and algorithms which are not transparent to the PHNs, and which are part of the data extracts received. Primary Health Insights cannot reverse engineer these mappings and algorithms, nor could PHNs contractually use it to do so even if that were possible.

G7.4 Contrary to MediSecure's assumption, PHNs do not "undertake their commissioning cycle responsibilities on an annual basis" nor do they only "commission services on an annual basis"' public health service commissioning is in fact an ongoing activity.

G7.5 Neither the website page referred to by MediSecure in their footnote nor the PHN Programme Funding Guidelines state or infer that commissioning is an annual process, or that health services are only commissioned once a year.

G8. 'Buy-back of licenses

G8.1 Medisecure have misinterpreted section 3.1.8(b) of the Application, as the 'buy-back' of licenses refers to action by general practices, not PHNs, and refers to a possible decision by general practices to continue paying for the use of their current data extraction tool if a license for that product is no longer provided for free by the PHN.

G8.2 This does not "undermine the cost savings for PHNs argument" in section 2.3.1(b) of the Application and does not mean that PHNs will "use [their] postulated cost savings to 'buy back' licenses from the incumbents [they] seek to displace."

H. Interested Party: Best Practice Software
Submission Date: 1 Oct 2021

H1. GC PHN "Primary Sense" Project

H1.1 WAPHA acknowledges that it has not yet contacted Best Practice (or any other practice management software vendor) in relation to Primary Sense 2. Best Practice and other similar vendors are key stakeholders for the Project and WAPHA as Lead PHN plans to enter commercial agreements appropriate to the intended scale of Primary Sense 2 with appropriate vendors. Vendor contracts with the GC PHN does not extend to any other PHN by default.

H1.2 A decision was made by the Project Committee that the ACCC Authorisation process should be undertaken prior to entering any commercial discussions so as to maximise transparency and reduce the timeframe for certainty around competition and other commercial considerations.

H1.3 The Intellectual Property assigned by the Gold Coast PHN to the unincorporated joint venture referred to in section 2.1.8 of the Application specifically excludes "Third Party Contracts or Licenses which are … otherwise available commercially" and does not include the transfer of any agreements for access to Best Practice systems.

H1.4 WAPHA acknowledges that the "data extracted via the Primary Sense tool is far more than what is required for GPs to qualify for the PIP [QI]" but notes that the intent of the PIP QI is not for every general practice to provide only the minimum PIP Eligible Data Set (although that is all they must do in terms of data provision to qualify for PIP QI).

H2. Market Activity

H2.1 WAPHA acknowledges and agrees with Best Practice that "if practices do not wish to pay for or install a separate data extraction tool, they can still qualify for their PIP" by using functionality provided by practice management systems such as is provided by Best Practice. However, the purpose of Primary Sense 2 is not limited to PIP QI.

H2.2 The first component of PIP QI qualification is "participating in continuous quality improvement activities in partnership with their local Primary Health Network (PHN) and notes that "practices can choose to focus their [CQI] activities on other areas [than the PIP Quality Improvement Measures]" which "must be informed by their clinical information system data and meet the needs of their practice population."

H2.3 PHNs use comprehensive data extracted from general practice clinical information systems, such as Best Practice, combined with other data sets and information to which they have access to analyse practice activities in relation to their relevant practice populations, and work closely with practice staff to identify, implement and monitor the impact of various Continuous Quality Improvement activities.

H2.4 This has been a function of PHNs since the beginning of the PHN Programme in 2015, long before the PIP QI was introduced in 2019, and PHNs' role in general and use of data extracted from general practices is similarly much broader in scope than PIP QI.

H3. Creation of an Additional National Health Data Bank

H3.1 WAPHA notes the concerns raised by Best Practice around the a "nation-wide Health Data Bank controlled by PHNs" but clarifies that data collected by PHNs from general practices does not duplicate the content or purpose of the My Health Record.

H3.2 The purpose and role of the My Health Record is very precise in legislation, and the use of data in it is limited to the provision of healthcare to the record's owner. By contrast, the PHNs collect only de-identified data from general practices.

H3.3 The primary and secondary purposes defined in the Data Sharing Agreements between each PHN and individual general practices support uses to which the My Health Record data cannot be put. This includes specific functions for which the PHN Programme was created including population health, informing public health policy, and improving the integration of health services in the community.

I. Interested Party: University of Melbourne
Submission Date: 12 Oct 2021

I1. University technologies and programs

I1.1 WAPHA and the participating PHNS do not currently fund or use technologies developed by the University of Melbourne to extract data from general practices, and the introduction of Primary Sense 2 as another tool used by PHNs will not by itself reduce or restrict the ability of the University to promote or implement its products.

I1.2 Primary Sense 2 is not being proposed for use in any of the areas or programs identified by the University where their technologies are currently in place.

J. Interested Party: Royal Australian College of General Practitioners
Submission Date: 14 Oct 2021 & 3 Nov 2021

J1. Use of general practice data and consultation with general practices

J1.1 WAPHA and the participating PHNs agree with the statements made by the RACGP in their Submission.

J1.2 Primary Sense 1 was developed in close consultation with general practitioners on the Gold Coast and is in part overseen by a Clinical Advisory Group that includes local practitioners as well as University researchers and other clinical experts.

J1.3 As stated on their website, Gold Coast PHN "has worked closely with local GPs and researchers to develop Primary Sense™ to ensure reports are both high quality and practical in a general practice setting and align with the Royal Australian College of General Practitioners (RACGP) Standards and clinical guidelines."

J1.4 The development and operation of Primary Sense 2 will also be informed by consultation and engagement with professional peak bodies such as the RACGP, and any PHN that plans to adopt and roll out Primary Sense 2 will engage and consult with their general practices as part of their local planning, preparation and use of the tool.

J2. Change within general practices

J2.1 WAPHA and the participating PHNs acknowledge that any decision by a PHN to provide Primary Sense 2 instead of (rather than as well as) a currently provided data extraction tool will have an impact on general practices.

J2.2 The introduction of Primary Sense 2 does not create this change management issue, as PHNs are currently able to change the product they provide for free to general practices and alternate vendors regularly attempt to persuade PHNs to do so. The impact noted by the RACGP would have to be managed properly by a PHN regardless of which tool was currently in use or which tool was proposed to be offered instead.

J2.3 Feedback from general practices and practitioners in the Gold Coast currently using Primary Sense is very positive.

K. Interested Party: Australasian Association for Academic Primary Care
Submission Date: 29 Oct 2021

K1. Use of data in research

K1.1 WAPHA acknowledges the concerns of the Association in their Submission but clarifies that Primary Sense 2 will not give PHNs "a monopoly and control of general practice data."

K1.2 Neither the Primary Sense 2 product nor service will control how PHNs use or enable data extracted from general practices to be used for research. Like the current data extraction tools used by PHNs, its role with respect to research will solely be to provide data to the PHNs who have existing processes and policies in place to assess and support requests for access to data by researchers.

K1.3 PHNs have a long history of working and collaborating with researchers, and Primary Sense 2 will not change that dynamic or the value seen in it by PHNs.