MSIA
MEDICAL SOFTWARE
INDUSTRY ASSOCIATION

4 February 2022

Mr. Darrell Channing
Director, Competition Exemption
Australian Competition and Consumer Commission
23 Marcus Clarke Street
Canberra ACT 2601

By email: exemptions@accc.gov.au

Submissions of the Medical Software Industry Association Limited (MSIA) in response to the draft determination of the ACCC dated 17 December 2021 in application for authorisation AA1000577 (Draft Determination)

Dear Mr Channing,

1. We refer to the Draft Determination.

2. The MSIA takes this opportunity to submit that a number of conclusions reached by the ACCC are unsupported

3. The MSIA's position is that the authorisation ought not be granted or, in the alternatively, if it were to be granted, it should be granted for a period of two to three years.

4. In this submission:

   (a) **Applicant** means WA Primary Health Alliance Ltd and includes the unincorporated joint venture formed between WA Primary Health Alliance Ltd and the Participating Primary Health Networks.[1] It may subsequently include any other PHNs which may join the unincorporated joint venture.[2]

   (b) **Extraction Tool** means a piece of software which is capable of extracting data from GP Clinics or Other Clinics.[3]

   (c) **GP Clinics** means those clinics of general practitioners which are affiliated or can be affiliated with a PHN.[4]

   (d) **Independent Providers** means software providers that can provide Extraction Tools and exclude the Applicant.[5]

1 The Application dated 14 September 2021 (**Application**) at paragraph 2.1.7 and Schedule 1, Part A.
2 Application at Schedule 1, Part B.
3 Application at paragraphs 2.1.1 to 2.1.3.
4 In essence, this refers to 5,999 clinics and 23,827 clinicians Australia wide which are affiliated with a PHN identified in the Application at paragraph 3.1.2.
5 In particular, this refers to Pen CS Pty Ltd and Melbourne East General Practice Network Limited as identified in the Application at paragraph 2.1.3.

(e) **Other Clinics** means those clinics of general practitioners that are not GP Clinics.[6]

(f) **PHN** means Primary Health Network and incorporates both "Participating Primary Health Networks" and Primary Health Networks which are eligible to join the Primary Sense Project.[7]

**DEGREE OF OVERSIGHT**

5. The Draft Determination concludes that the performance of each PHN is periodically assessed against published performance framework and such oversight reduces the risk that PHNs will use government money inappropriately / inefficiently or undertake activities beyond their remit.[8] The Draft Determination does not otherwise address this issue.

### The PHN Performance and Quality Framework (the Framework)

6. The ACCC identifies that PHNs are required to operate under the Framework.[9] The MSIA observes that a key principle which underpins the Framework is that *"The Framework should focus on minimising reporting requirements for PHNs and gathering information that is useful for assessing performance and quality"*.[10] If the ACCC relies upon the Framework for the purpose of concluding that the Department of Health will, through the Framework maintain such oversight to mitigate this risk entirely, then in the MSIA's view, this would require a level of oversight which is contrary to a fundamental principle underpinning the Framework itself.

7. For example, some of the criteria which the Framework identifies which may relate to some form of financial oversight are:

   (a) Criteria O13, which only requires as a matter of criteria that each PHN has an audited financial report and an unqualified auditor statement;[11]

   (b) Criteria O15, which only requires as a matter of criteria that each PHN attempts to address all complaints referred to it by the Department,[12]

   outside of which, a large number of the criteria to assess the PHNs performance are measured by whether they have met their own strategic targets. This is inconsistent with a regulatory approach required to mitigate a specific risk.

8. The MSIA is unaware of how complaints or issues relating to funding have previously been handled. In this context, and in the absence of historical information as to how financial management has been overseen by the Federal Government, there is no support for the conclusion that there is oversight from the Department of Health sufficient to mitigate the risk of inappropriate or inefficient use of public money.

### External regulation from the *Australian Charities and Not-for-Profits Commission* (ACNC)

6 In essence, this refers to 2,464 clinics and 7,484 clinicians Australia wide which are affiliated with a "corporation", "Other" or "AMS", as identified in the Application at paragraph 3.1.2.
7 Draft Determination at paragraph 1.1 and Application at Schedule 1.
8 Draft Determination, at paragraph 4.38.
9 Draft Determination, at footnote 6.
10 *PHN Program Performance and Quality Framework*, at section 1.3, page 6.
11 Framework, at page 40.
12 Framework, at page 41.

9. For completeness, the MSIA identifies that another, alternate source of oversight may be from the ACNC. The MSIA observes that the ACNC was not consulted as part of this process.[13] Nevertheless, it does not appear that the ACNC would investigate such an issue unless it also constituted a breach of the *Australian Charities and Not-for-profits Commission Act 2012* (Cth).[14]

10. The MSIA considers that if there is a separate framework which considers this issue or, if the PHNs provide a demonstrated history of how this issue has been historically managed, then this would provide the ACCC with material upon which it could more appropriately base its conclusion.

### Observed behaviour[15]

11. The MSIA observes that the Royal Australian College of General Practitioners (**RACGP**) has previously identified the following:

> *"Although the PIP QI was launched in August, there remains a number of outstanding issues for general practices wanting to participate, including:*
>
> - *lack of clarity regarding privacy obligations for general practices and PHNs*
>
> *…*
>
> - *inadequate data-sharing agreements that do not provide details of risks and data security obligations*
>
> *…*
>
> *Many PHNs have been collecting general practice data for some time and have existing agreements and processes in place with practices. These existing arrangements generally collect more data than is required for the PIP QI. The RACGP is aware some PHNs are attempting to replicate these arrangements for PIP QI purposes.*
>
> *General practices have been incorrectly advised they need to provide all of their data to receive the PIP QI.*[16]

12. The MSIA does not know if such conduct continues but observes such concerns underpin the need for objective and rigorous supervision. The MSIA does not consider this is achieved by the Framework or the ACNC.

## EFFECT ON COMPETITION

### Clarification

13. The MSIA seeks the following clarifications from the ACCC.

### Price of PHNs supplying to GP Clinics

14. The ACCC identifies that:

    (a) no participant will make a profit from the project;[17] but

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13 Refer to: List of parties consulted at https://www.accc.gov.au/public-registers/authorisations-and-notifications-registers/authorisations-register/wa-primary-health-alliance-ltd-and-participating-primary-health-networks-%E2%80%93-primary-sense-project (Accessed 31.01.2022).

14 Refer to: https://www.acnc.gov.au/raise-concern/concerns-about-charities/what-acnc-can-investigate and https://www.acnc.gov.au/raise-concern/concerns-about-charities/what-acnc-can-not-investigate (accessed 31.01.2022).

15 The information in this section is based entirely upon the *Practice Incentives Program Quality Improvement Incentive (PIP QI) fact sheet*, circulated by the Royal Australian College of General Practitioners (2020).

16 *RAGCP*, *Practice Incentives Program Quality Improvement Incentive (PIP QI) fact sheet* (2020).

17 Draft Determination, at paragraph 4.41.

(b) Participating PHNs will provide Primary Sense 2 under a no-cost licence.[18]

15. In the context of the market for the supply of Extraction Tools to GP Clinics, these two statements are inconsistent because, if the only requirement is that no profit be made from the project, then this allows PHNs to provide Primary Sense 2 to GP Clinics at cost, and therefore not under a no-cost licence.

16. The MSIA raises the issue because whether or not Primary Sense 2 will be charged at cost or at no-cost to GP Clinics is relevant to the submissions it makes in this document.

## Acquisition side of the market for data extraction software tools to GP clinics

17. The ACCC has identified the following areas of competition:[19]

(a) the supply and acquisition of data extraction software tools to and by PHNs;

(b) the supply of data extraction software tools to GP clinics; and

(c) the supply of clinical decision support software tools to GP clinics.

18. It is unclear whether the ACCC intended not to consider the acquisition side of the market for Extraction Tools to GP Clinics. In the MSIA's view, the decision-making process of GP Clinics to acquire Extraction Tools is relevant to competition. Extraction Tools will only be developed where there is a user requirement and a commercial incentive to innovate and develop. It is irrelevant that there are suppliers technically capable of providing Extraction Tools if the consumer base is unwilling to acquire them or unwilling to acquire them for a price.

19. The MSIA raises this clarification because, the decision making process of GP Clinics is paramount to predicting not just the impact to the market for the supply and acquisition of Extraction Tools to and by PHNs, but also to the market for the supply of Extraction Tools to GP Clinics.

## GP Clinics will opt only to acquire Primary Sense 2

20. For the reasons set out below, the MSIA submissions is that if the proposed conduct is authorised, the only viable choices for a GP Clinic is to acquire a Extraction Tools from their PHN for free.

21. The ACCC's view is that if the conduct is authorised, GP Clinics will decide to:[20]

(a) **(Option 1: PHN Supply**) Acquire an Extraction Tool through their PHN.[21] The MSIA submits that in the future this may either be:

(i) Primary Sense 2 from their PHN at no cost;[22] or

(ii) A Extraction Tool from an Independent Provider through their PHN at a cost which is not zero.[23]

(b) (**Option 2: Direct Supply**): Acquire an Extraction Tool directly from an Independent Provider;

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18 Draft Determination, at paragraph 2.11; See also, Application at paragraph 2.1.17.
19 Draft Determination, at paragraph 4.4.
20 Draft Determination, at paragraph 4.48.
21 Draft Determination, at paragraph 2.4, page 3.
22 The clarification set out in paragraph [14] to [16] is relevant to this.
23 As it is accepted by the ACCC that it is likely that PHNs will cease to provide Extraction Tools from Independent Providers at no cost. See Draft Determination, at paragraph 4.48.

(c) (**Option 3: Practice Management Supply**): Acquire an Extraction Tool through the supplier of their practice management service provider; or

(d) (**Option 4: No Supply**): Not acquire any data extraction tool.

Option 1: The supply of third-party data extraction tools from a PHN is illusionary

22. The ACCC and the Applicant agree on the following conclusions:

(a) PHN's presently purchase a licence for Extraction Tools and provide those Extraction Tools to GP Clinics to use at no cost;[24] and

(b) The Participating PHNs (and any eligible PHNs that subsequently join the Applicant) will be able to provide Primary Sense 2 to their affiliated GP Clinics under a no cost licence.[25]

23. It does not appear any PHN[26] 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. The ACCC has concluded that free access to third-party data extraction tools will be lost.[27]

24. The MSIA submits that this is the only conclusion which can be reached because it is highly unlikely and uncommercial for PHNs to continue to provide free access to the Extraction Tools of Independent Providers because it would erode any benefits which the Applicant asserts would be gained (or lost if the authorisation is not granted).[28]

25. Therefore, in the future, where the proposed conduct is authorised, it is highly unlikely that the PHNs will supply any Extraction Tools other than Primary Sense 2.

Option 2: Direct Supply will become uncommercial

26. The Applicant and the ACCC appear to be in agreement that in the future, PHNs will supply Primary Sense 2 at no cost.[29] The MSIA is unaware of any submission from Independent Providers that they will provide their solution to GP Clinics directly, at no cost.

27. Therefore, the MSIA considers that where a GP Clinic is faced with a decision to acquire an Extraction Tool from a PHN for free (as is submitted to be the case in Option 1)[30] or from an Independent Provider for a cost (as is understood to be the case above),[31] a reasonably commercial consumer will opt for the free tool.

28. This decision is further supported by the payments which may be made to a GP Clinics under the Practice Incentive Program Quality Improvement Initiative (**PIP QI**).[32]

29. Under the PIP QI system, in order to be eligible, the GP Clinic must:[33]

(a) submit an "eligible data set" to their PHN; and

(b) undertake continuous quality improvement activities in partnership with their local PHN.

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24 Draft Determination, at paragraph 2.4, See also the Application at paragraph 2.1.2.
25 Draft Determination, at paragraph 2.11 and Application at paragraph 2.1.17.
26 This is also despite the fact that WA Primary Health Alliance Ltd is an entity which consists of 3 PHNs and has submitted material to the ACCC as part of this process.
27 Draft Determination, at paragraph 4.48.
28 See Application at paragraphs 2.3.1(b), 2.3.1(c), 4.1.1 and 4.2.2.
29 Draft Determination at paragraph 2.4; see also Application at paragraph 2.1.2.
30 See paragraphs [22] to [25].
31 See paragraph [26].
32 The ACCC considers this in the Draft Determination at paragraph 2.3.
33 *Practice Incentives Program Quality Improvement Incentive Guidelines* (2019), at page 5.

30. Whilst in order for a data set to be considered an "eligible data set" it must comply with the technical specifications determined by the Department of Health,[34] because the reporting is received and aggregation conducted by the PHN, they are the only logical decision maker for whether a data set is considered an "eligible data set".

31. Consequentially, the PHNs are a critical feature in determining whether or not a GP Clinic is or will be eligible to receive an incentive payment under the PIP QI regime. Therefore, the position of PHNs is integral to whether GP Clinics are eligible to receive incentives under the PIP QI system.

32. The reason this is raised by the MSIA is because, in the MSIA's view, this fact is relevant to the decision of a GP Clinic about the acquisition of an Extraction Tool. It is reasonable, if not likely, that a reasonably commercial consumer that wishes to take advantage of the PIP QI regime will opt to use Primary Sense 2 instead of an Extraction Tools from an Independent Provider because if it acquires Primary Sense 2, it will mean it will maximise:

    (a) the likelihood of acceptance of an eligible data set by the PHN (and therefore of payment) because the PHNs have a role in the development of Primary Sense 2 and whether a submitted data set from another Extraction Tool qualifies as an "eligible data set"; and

    (b) the value of the PIP QI payment.[35]

33. In these circumstances, it is not simply that the no cost model renders Independent Providers uncompetitive (because there is no information to suggest they will provide their Extraction Tools for free), it renders their offering uncommercial from the perspective of a GP Clinic.

Option 3: Practice Management Supply of a data extraction tool is uncommercial if not free.

34. The ACCC identifies it is open that some practice management software can provide an Extraction Tool to GP Clinics.[36]

35. Similarly with Option 2 as identified above, unless a practice management software provider can provide an Extraction Tool to a GP Clinic for free, GP Clinics will not engage with this option for the same reason as identified in Option 2. The MSIA understands that some practice management software may be able to provide Extraction Tools for free but this is not widely or publicly available and it is uncertain as to the degree of uptake from GP Clinics.

Option 4: If there is a solution offered for free, then there is no reason not to acquire

36. It is open to a GP Clinic to refuse to acquire any Extraction Tool but, this is unlikely given the existence of the PIP QI regime. If there is no cost associated with acquiring Primary Sense 2 from a PHN, any GP Clinic would not need to expend any money on Extraction Tools in order to receive an incentive payment from the PIP QI regime. Accordingly, there is no logical reason why a GP Clinic would opt not to acquire Primary Sense 2.

Conclusion: The only viable option is PHN Supply

37. For the reasons set out above, there are compelling reasons why a GP Clinic would opt to select "Option 1" and acquire Primary Sense 2 from a PHN directly. Accordingly, the impact of the

[34] *Practice Incentives Program Quality Improvement Incentive Guidelines* (2019); Practice Incentives Program Eligible Data Set Data Governance Framework (2019); PIP QI Improvement Measures – Technical Specifications V1.2 (2020)

[35] This is because if it acquires a data extraction tool from another provider, that GP Clinic will need to pay money for that tool which will mean part of the incentive payment is to offset that cost. Conversely, acquiring a data extraction tool for free will mean that the GP Clinic does not incur the cost and therefore can retain a greater benefit from the incentive payment.

[36] Draft Determination at paragraph 2.4, page 4.

proposed authorisation is not simply a temporary distortion which may be cured by innovation, but a permanent dislocation.

### PHNs will not choose to support more than one data extraction tool

38. It is understood that PHNs may choose to support more than one Extraction Tool for various reasons, including a desire to offer choice to GP Clinics[37] but it is unlikely that a PHN would supply two Extraction Tools to the same GP Clinic.[38]

39. No PHN has provided any submissions into whether this will occur. The MSIA considers if there is no desire by GP Clinics to acquire an Extraction Tool from an Independent Provider[39], then there is no reason for the PHNs to acquire such Extraction Tools from Independent Providers. Accordingly, it is unlikely in the MSIA's view that PHN will continue to acquire Extraction Tools from Independent Providers over anything longer than the short term.

### Temporary anti-competitiveness cannot be cured by innovation

40. The ACCC considers that in a competitive market, existing providers should have commercial incentives to improve their product offerings.[40] The MSIA agrees with this proposition but submits that if the proposed conduct is authorised, there will be no commercial incentive on Independent Providers to innovate.

41. This is because in this case, the majority of the market (being the GP Clinics)[41] are or will be able to use Primary Sense 2 for free. Therefore, the best commercial incentive available is for Independent Providers to compete in this segment of the market is to develop a product which is competitive and can be provided at close to no cost. This reality makes any innovation uncommercial and unjustifiable. Accordingly, it is unlikely that such innovation will be forthcoming.

### Temporary anti-competitiveness cannot be cured by directly supplying to Other Clinics

42. The ACCC considers that it is open to Other Clinics to acquire an Extraction Tool directly from an Independent Provider.[42] For the reasons set out below, this is not a viable option.

43. First, it is not a resolution, nor is it a reason for behaviour to be considered competitive (as opposed to anti-competitive) if it is open for the remainder of the market to compete for the remaining 30% of the market. The size of any given market is an important consideration considering investment in software development and innovation and the decision to provide on-going maintenance and support. It may be that a market size of 30% compared to the current size is so unattractive that Independent Providers decide to discontinue their current offering or consider their current offerings at "end-of-life". Consequentially, in the MSIA's view, the ACCC's conclusion in this respect is inappropriate.

44. Second, there are fundamental differences between the needs of a PHN and the needs of GP Clinics or Other Clinics such that an Extraction Tool which is designed for a PHN is not immediately transferable (or valuable) to a GP Clinic or Other Clinic.

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37 Draft Determination at paragraph 2.11.
38 Refer to the Applicant's response to clarifications dated 12 November 2021 at sections B2.1 to B2.4 (inclusive), page 5.
39 As is expected to be the case, see paragraphs [21] to [37].
40 Draft Determination at paragraph 4.20.
41 Draft Determination at paragraph 2.4; See also Application at paragraph 3.1.3.
42 Draft Determination at paragraph 4.50, page 17.

45. MSIA's feedback from industry on this issue is that fundamentally, PHNs are intended to focus on the optimal provision of healthcare on a population basis whereas GP Clinics (or Other Clinics) are focussed on an optimising healthcare outcomes for individuals. Due to these differing perspectives, there may be healthcare initiatives that may optimise population healthcare outcomes but would provide no benefit or even cause detriment to certain individuals.

46. As a consequence of these different objectives, the way that PHNs use the data is very different to the needs of a general practitioner such as:

    (a) General practitioners may use Extraction Tools to compare and over time improve relative performance of practitioners within a practice and against external performance indicators as set by Federal and State governments, clinical colleges (such as the Australian Medical Associations and the Royal Australian College of General Practitioners) and international best practice. The MSIA does not expect that the PHNs share this objective because their performance is measured against different criteria;[43]

    (b) PHN based Extraction Tools may focus on geographic population health impacts and needs, whereas individual general practitioners use information they may have to obtain clinical decision support for individual patients.

    (c) PHNs are interested in supporting lower-performing practices where that may fit within that PHN's priority areas. Without considering each individual PHN's objectives, the ACCC cannot draw a conclusion whether all PHNs possess this objective or whether they share this objective at the same time. It does not appear that the Framework supports such an objective.[44]

47. Due to the different data needs of the two groups (PHNs on one side and GP Clinics or Other Clinics on the other), Extraction Tools will extract different data and, where there is reporting functionality, present different information so as to meet those different needs. For example:

    (a) the reports provided by PHNs to GP Clinics may highlight the population needs and can focus on items such as data quality, screening and high level disease categories whereas reports that a GP Clinic (or Other Clinic) may want more specific information that relate to their patients or their individual clinic;

    (b) the reports that GP Clinics may want, would highlight individual patients that are at key clinical risk of a particular issue. PHNs, because their focus is broader, may interpret and use this same information through a broader lens and may look at the same critical risks and how they may be mitigated across a population, rather than an individual.

48. Consequentially, GP Clinics (and Other Clinics) may use Extraction Tools to identify specific individuals who may need additional support and interventions. This is generally not understood to be needed by PHNs because their focus is to optimise healthcare costs on a population basis.

49. The MSIA observes that if the Applicant seeks to develop Primary Sense 2 in this manner, then this may even increase costs to the public whereas the intention is to reduce these costs.

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[43] Such as those set out in the *PHN Program Performance and Quality Framework*.

[44] *PHN Program Performance and Quality Framework*.

50. Therefore, in order for existing providers to supply directly to Other Clinics, it is likely that further innovation will be required. In respect of GP Clinics, this submission has already addressed why this innovation is uncommercial and unviable.[45]

51. In respect of the component of the market that is not associated with a PHN (i.e. the other Clinics, comprising of the remaining 30% of the market), it is uncertain whether any Independent Providers would incur the level of innovation required in order to compete amongst themselves in this segment. For example, in the case of Pen CS which supplies 85% of the PHNs,[46] this equates to supplying approximately 5,099 clinics or 20,252 clinicians.[47] It is unclear whether Pen CS would incur the level of expenditure and innovation required if its best competitive situation (being one where it achieves 100% market share of the Other Clinics) is servicing 2,464 clinics and 7,484 clinicians.[48] In essence, Pen CS' best position is one where it services less than half the number of clinics and clinicians compared to the current situation.[49]

### Market exits are likely

52. For the reasons set out above, the authorisation of the proposed conduct is:

    (a) likely to result in GP Clinics procuring Primary Sense 2 through their PHN;[50]

    (b) unlikely to result in Independent Providers innovating to compete for GP Clinics because it is uncommercial to do so whilst PHNs can provide a competing product for free;[51] and

    (c) unlikely that Independent Providers will innovate to compete for Other Clinics because the segment of the market is so small that even a complete market share of this segment is worse than the current scenario.[52]

53. As the ACCC identifies, Independent Providers have other product offerings beyond data extraction tools.[53] The MSIA considers that in the above circumstances, it is more likely that the Independent Providers will either exit the market for:

    (a) Extraction Tools in order to deploy resources in other software products instead; or

    (b) medical software entirely.[54]

### Barriers to entry were not considered

54. Given the possible exit of existing market participants, regard should be had to whether the Independent Providers can be replaced by new participants which requires an assessment of the barrier to entry.

55. The MSIA considers a hypothetical competitor seeking to enter the market (**Incoming Participant**) would face the following practical challenges:

    (a) Develop the solution to be provided which may involve either:

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45 See paragraphs [40] and [41].
46 Draft Determination at paragraph 2.5.
47 This is identified by multiplying 5,999 and 23,827 being the number of clinics and clinicians identified by the applicant in Application at 3.1.2, by 85%.
48 These figures are identified by adding the number of clinics and clinicians excluding PHNs in Application at paragraph 3.1.2.
49 This also assumes, in the case of Pen CS, that it has no current sales to Other Clinics; if it does, then the value of the best case scenario is less.
50 See paragraphs [20] to [37].
51 See paragraph [40] and [41].
52 See paragraph [42] to [51].
53 Draft Determination at paragraph 4.50, page 17.
54 This is more likely to occur if the providers other products do not make up a significant portion of its revenue.

(i) The need to obtain intellectual property licences where an incoming provider wants to utilise existing software which may exist in Australia or overseas; or

(ii) Invest significant sums to develop their own software.

(b) Where the Incoming Participant develops their own software, such development would require the development of a range of PHN specific tools such as PIP-QI reports, compatibility with state-based systems and individual PHN reporting requirements. Such tools may require bespoke development and, in some cases, are required to be externally certified or accredited.

(c) Where the Incoming Participant acquires the license of a foreign software, such software would require consideration and possible further development to meet the needs and requirements of the Australian medical software industry. This may in addition to the development of PHN specific tools identified above.

(d) Negotiate access to and licensing of practice management software providers (such as Medical Director or Best Practice Software. This would incur both:

(i) upfront costs in the form of initial costs of negotiation and if agreed, the costs of labour in ensuring whatever solution is being sold can coexist with those platforms; and

(ii) ongoing costs in the form of ongoing maintenance and support to ensure the solution remains available when either the Incoming Participant or the practice management software providers amend their product;

(e) Implement data-security and privacy controls to ensure the Incoming Participant's solution complies with regulatory and legislative requirements that vary within each jurisdiction (at a state or federal level);

(f) Prove to the GP Clinics (and Other Clinics), PHNs and the Department of Health that the extraction tool that is proposed to be provided can extract and communicate the correct information for the purpose of any PIP QI payments. It is observed that this would require the endorsement of PHNs who would be producing a competing product. It is unclear how an ownership stake in a competing product would impact this process;

(g) Market the software to GP Clinics (and Other Clinics);

(h) Establish a help desk which contains sufficient support capability and capacity to operate 24 hours a day;

(i) Maintain financial viability in circumstances where the burden placed upon software providers by regulators and consumers are frequently changing, uncontrollable, increasing and often increasing require frequent updates to a software solution.

56. In the MSIA's submission, an Incoming Participant to the market for GP Clinics would likely examine that market depth (being the number of consumers), the current competitors before concluding upon whether the required investment is feasible. Where the proposed conduct is authorised, an Incoming Participant would identify that a key competitor, being the Applicant:

(a) is largely, if not entirely, supported by Government funding and is not confined by the same financial covenants which are imposed on other entities that seek to acquire capital;

(b) is a key stakeholder in incentive schemes for GP Clinics (such as the PIP QI regime) and therefore has an entrenched relationship with GP Clinics;

(c) has formed a large, unincorporated joint venture spanning multiple States (and potentially nationally) giving it a significant geographic footprint; and

(d) is a significant consumer itself in the market (but one that would be self-sufficient).

57. These factors would act as a strong disincentive from the Incoming Participant's perspective to enter into the market to provide Extraction Tools to GP Clinics. Further, if the market for Extraction Tools to Other Clinics is too small or too invaluable to support the cost of meeting the barriers identified above, an Incoming Participant will avoid the market entirely.

58. It is also necessary to consider whether there is a history of successful entry.[55] In this case the Applicant and the ACCC has identified that there are two providers other than the Applicant, Outcome Health and Pen CS.[56] The ACCC has identified that that Outcome Health has been established for 20 years and Pen CS for 28 years.[57] The ACCC concludes that this means that they will be able to operate during periods of change. The MSIA submits that this also means that no other entity has successfully managed to establish itself in this time which indicates that the barriers to entry are high.

59. The ACCC did not consider the barriers to entry in the market except that there are numerous private sector companies who have expressed interest in creating new data extraction tools.[58] Merely expressing an interest is not the same as entering. Unless there has been investment in overcoming the barriers to entry, such interest is, in the MSIA's view, meaningless.

60. The MSIA submits further that if there is any interest, a reasonably commercial investigation of the market will identify these issues and no investment would materialise. It is possible that such entrants may enter the market for Other Clinics but this does not place any competitive strain on the Applicant because the Applicant does not propose to sell Primary Sense 2 to Other Clinics and so is irrelevant to considering the impact on the market for Extraction Tools for GP Clinics.[59]

**SUMMARY AND CONCLUSION**

61. The onus is on an applicant to satisfy the ACCC that the authorisation should be granted.[60] If the market is foreclosed upon in respect of 70% of its consumers (as is expected to be the case)[61], the anti-competitive effect must be considered substantial. For the reasons set out herein, the anti-competitive detriments are so severe that, in the MSIA's view, the Applicant has not discharged this burden.

55 *Eastern Express Pty Ltd v General newspapers Pty Ltd* (1992) 35 FCR 43, 62.
56 Application at paragraph 2.1.3; see also Draft Determination at paragraph 2.5.
57 Draft Determination at paragraph 4.50, page 17; see also https://www.pencs.com.au/about-us/.
58 Draft Determination at paragraph 4.50, page 17.
59 See Application at paragraph 2.1.17 and Draft Determination at 2.11.
60 Re Queensland Co-operative Mining Association ltd and Defiance Holdings (1976) 25 FLR 169.
61 As the GP Clinics associated with PHNs comprise 70% of the market, see Application at paragraph 3.1.3.

62. In the alternative, the MSIA submits that a duration of 5 years is inappropriate when the degree of PHNs moving away from Pen CS and Outcome Health is unclear.[62] It would be more appropriate to allow the conduct for 2 or 3 years so that the impacts to Pen CS and Outcome Health in this sector can be measured. If one of the Independent Providers exit the market in this time, then plainly, this submission will carry truth.

63. Further, the Australian Medical Association recommends vigilance as there is a potential for PHNs to develop in ways which are inimical to good health provision, for example by evolving into powerful fundholding bodies purchasing general practitioner services directly for a population group.[63]

64. In the MSIA's view, a longer authorisation only risks a situation whereby the time the ACCC returns to consider this matter, a market failure would have already occurred.

Faithfully

Emma Hossack

[62] Draft Determination at paragraph 4.50 page 17.
[63] Australian Medical Association - Primary Health Networks – 2015. Revised 2021.