atsa
Assistive Technology Suppliers Australasia Inc

Submission in response to:

National Disability Insurance Agency's *Towards Solutions for Assistive Technology Discussion Paper*

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Introduction

Assistive Technology Suppliers Australasia (ATSA) welcomes the opportunity to respond to this NDIA Discussion Paper.

ATSA is a national organisation representing assistive technology (AT) suppliers, including manufacturers, importers, distributors, retailers and repairers. Our 95 members include businesses and not-for-profit organisations, and range from small family owned businesses to international organisations throughout Australia. It is estimated that, excluding AT for communication and sensory disabilities, approximately 80% of the AT in Australia passes through the hands of ATSA members.

A viable and competitive AT provider sector is pivotal to ensuring choice and flexibility for people with disability in Australia, and meeting their needs at the lowest possible costs.

According to the Queensland Competition Authority's 2014 report into AT pricing, the Australian AT market is highly evolved and very competitive with prices on average 24% lower than those in other countries (QCA 2014, pg. 48), when delivery to Australia is taken into account. For more details on AT pricing issues see Appendix A (ATSA Briefing Paper *Assistive Technology Pricing: Is it fair and reasonable?*). Australians with disability have access to most of the world's leading AT products through a network of 350-400 specialist AT retailers. The extensive diversity of products is remarkable in a market of just 22 million people.

The AT industry is as much a services industry, as it is a goods-based industry. In Australia the cost of most of these services are factored into the retail price of AT rather than being charged separately, except for some post-sales activities such as maintenance and repairs. Services to the sector by AT suppliers include: research and development, innovation, sourcing new products, training allied health practitioners, standards testing and compliance, regulatory compliance with the Therapeutics Goods Administration, and providing free AT demonstration products to Independent Living Centres and other key facilities such as brain injury, spinal cord injury and rehabilitation units.

Services to individual AT users include pre-sales activities such as provision of information, advice, detailed assessment and development of specifications for an AT solution, quotes, holding extensive stock of a wide range of AT for display and trials, configuring and adjusting the device and in-home trialling. Post-sales services include delivery, set-up, adjustment, training, and ongoing support/advice, maintenance, repairs and spares. All of these services are undertaken to ensure a good fit between the person with a disability and their AT, and often require considerable specialised expertise and experience.

An active partnership between the person with the disability, their allied health practitioner(s) and their AT supplier(s) is essential to ensuring a good outcome for the individual.

The NDIA's Discussion Paper contains many worthwhile points, particularly in relation to the importance of both ensuring Participant choice and control, and the sustainability of the NDIS. However ATSA does not endorse the overall direction of the Paper, and has some significant concerns with the proposed new AT scheme.

The Paper proposes a complete re-engineering of the AT marketplace with the primary goal of driving down AT product prices. Throughout the Paper it is argued that the model to be adopted should be one of 'managed procurement' through the use of a variety of centralised NDIA (or 3rd party) purchasing processes including open tenders, standing offer arrangements, and panel supply (see Figure 6 on pg. 19, and related discussions throughout the Paper).

Whether the proposed managed procurement approach is adopted by the NDIA, or the existing highly functional and cost effective market-based retail model is adopted, some AT suppliers will prosper and others will struggle. However, in relation to achieving the essential twin goals of consumer choice and control, and NDIS sustainability, the proposed extensive use of managed procurement will not deliver on these goals as well as the existing market-oriented retail model with appropriate safeguards. Appropriate

safeguards include quality/compliance and price surveillance by the NDIA, and requirements for an independent allied health practitioner to sign-off on high cost/high risk AT to prevent cost blowouts. Consideration should also be given to requiring all AT purchased with NDIA funds to meet relevant Australian or international standards. Existing protections through the *Competition and Consumer Act 2010*, as well as required compliance with the Therapeutic Goods Administration also add significant layers of protections for NDIS Participants in relation to AT, as does the *ATSA Code of Practice*.

This ATSA submission utilises these twin goals as the primary criteria for examining the two options managed procurement versus retail market model within a framework that considers: feasibility; costs and outcomes. In summary, some of the central problems with the proposed managed procurement approach include:

a) Participants' choice of AT will be restricted to the brands and models preferred by the NDIA (or 3rd party) unless the Participant can demonstrate that it is reasonable and necessary to purchase a different product, or the product is inexpensive/low risk and is generally available from mainstream retailers.

b) Participants will not be able to choose their existing supplier unless their supplier is successful in being awarded a contract for that particular AT product and becomes a 'preferred supplier' to the NDIA (or 3rd party). In effect the NDIA (or 3rd party) becomes the 'customer', rather than the person with a disability. This is also particularly problematic because there is a lot of knowledge and trust built up over time by many people with disability and their chosen local AT supplier(s) who have a track record of effectively meeting their needs.

   Given the highly individualised and often personally intrusive nature of identifying, developing and implementing the 'right' AT solution with a person with disability, replacing this relationship with a new NDIA 'preferred supplier' (and often multiple new NDIA 'preferred suppliers' as many people will require a wide range of AT products that different NDIA 'preferred suppliers' will have successfully tendered for) will come at a high cost both in terms of processes and increased uncertainty regarding outcomes, and an increased burden on Participants, their families and carers.

c) It is unlikely that NDIS Participants will own their AT under the managed procurement model and the proposed reissuing/recycling model. Consequently NDIS Participants are unlikely to have protections under the *Competition and Consumer Act 2010* as they will not buy and own their AT.

d) Large scale contracted supply arrangements typically advantage large suppliers over smaller, often niche suppliers, and over time this will reduce competition, product variety, innovation, services and quality and, will eventually lead to poorer outcomes for Participants (increasing NDIA costs overall) and ultimately to higher prices.

e) The data analysis on possible savings through managed procurement presented in the Paper to justify over-riding Participant choice and control through NDIA/3rd party managed procurement is significantly flawed. In particular, the claims of price savings are an illusion largely as a consequence of the not incorporating the costs of disaggregating, rebuilding and replacing the essential services currently provided by specialist AT retailers as part of the retail price of AT. There are also significant costs not incorporated regarding the loss of other vital elements such as Participant choice and control and Participants' consumer protections under the *Competition and Consumer Act 2010*.

Comparing the Proposed NDIA Model with the Existing AT Retail Model

The major issues of concern have been summarised above. Table 1 below provides an at-a-glance comparison of the NDIA's proposed centralised managed procurement model with the specialist AT retail model that is already in place. Significantly, the retail model has been around for many years and through market forces, including consumer preferences and the high level of competition, the AT retail market and associated supply chain have evolved into a relatively sophisticated and efficient service delivery system. In contrast, the proposed AT managed procurement model has not been designed, developed, or tested.

Table 1: Comparing key features of the Proposed Managed Procurement Model with the Existing Market-oriented Retail Model

	NDIA/3rd Party Managed Procurement	Market-oriented Retail Model *(including incorporating essential safeguards to ensure quality and prevent cost-blowouts)*
Participant Choice and Control	Choice of products and suppliers will be determined by the NDIA/3rd party, except in exceptional circumstances or for mainstream retail products.	Participants can choose any product that meets quality/compliance guidelines and is 'reasonable and necessary', and select the AT supplier that best meets their needs.
Readiness	Yet to be clearly designed, funded, developed and implemented.	Ready now, except for well-structured price monitoring by NDIA, and rules in place to require independent allied health practitioners to sign-off on high cost/high risk AT purchases.
Commensurate with rest of NDIS	No, will require separate rules, structures, processes as the proposal is to treat Participants who need AT (and AT procurement) differently from those who need other NDIS services.	Yes, easily incorporated into market-oriented structure and front/back-of-house NDIA processes for other NDIS services.
National delivery capacity	Will have to be designed, funded, built and tested, and then continually reviewed and revised, and to achieve this the establishment of a costly 'independent entity within or external to the NDIA' (pg. 17) is proposed.	National capacity in place, including ability to grow capacity for supply to rural and remote communities as market-based economic incentives to do so will overcome previous barriers due to existing underfunded centralised state/territory based funding structures. Also, AT products are currently available that are appropriate for rough terrain and wet/dry environments.
Product availability	Complex structures and processes to undertake national tenders for selecting which AT products and suppliers will be made available to Participants need to be identified, established, implemented and delivered to provide a 'sufficient' (pg. 17) range of products. These national tender processes will have to be repeated regularly for different market segments/products and repeated over time. Rigid bureaucratic procurement structures and processes stifle innovation.	Ready now to supply vast range of products across Australia, and any growth in demand through the NDIS can easily be managed over time as the NDIS is rolled out. Also, innovative and new products are continually sourced routinely on an ongoing basis due to existing AT retail market-based incentives. Likewise, innovation in the supply chain, including how associated services are delivered to AT users and other stakeholders, are continually changing and evolving to further improve user outcomes and economic efficiency.
Service availability	Discussion Paper notes that a 'well-integrated continuum of services' (pg. 15) is needed, but how this will be done has yet to be determined or costed. Ground-up development, establishing organisational frameworks, recruiting staff, implementation and review of proposed services will need to be undertaken, along with complex tendering processes similar to those outlined above in relation to AT products. Disaggregating these services from the supply of AT	All services provided by suppliers to ensure a good fit between the Participant and their AT are currently available, and can easily be grown in line with the roll-out of the NDIS (see the brief description of the extensive range of services provided by suppliers on pg. 2 and in Figure 1 of this submission). Although the range of services provided that are included in the retail price of AT are extensive, the robust competition between specialist AT retailers means that these are delivered on an

	products is likely to result in poorer Participant outcomes and increase costs. In relation to lower outcomes this separation results in less clarity about who is responsible for what when problems arise, and is a much more complex/less seamless AT sourcing experience for Participants. These poorer outcomes will result in higher long-term NDIA costs, and short-term problems such as increased equipment abandonment. Costs will also rise because separating services from supply is less efficient overall – taking more time and effort for all stakeholders. Also, more transactions result in more transaction costs, and in more opportunity for profiteering.	individual basis as efficiently as possible and keep overall AT costs low. In retail settings there are strong incentives to deliver high quality services at the lowest possible cost. Current workforce requirements for highly skilled allied health and technical staff within specialist AT retailers are being met, with no significant shortages identified. And specialist AT retailers have capacity to train (or import, as in the case of rehabilitation engineers) new allied health and technical staff as demand increases over time. In a market-oriented retail model there are major incentives for AT retailers to provide the highest possible level of professional advice/support to Participants, as this is a major point of 'difference' between different retailers, and is a key driver in relation to consumer choice between AT retailers.
Increasing Participants' AT knowledge and skills to support AT selection decision-making	As with other services, this will need to be developed, implemented and funded. Although an outline of key elements of this is provided in the Discussion Paper, it has not been costed, and the Paper implies that there are not already significant services in place to successfully achieve this.	Services already provided by AT suppliers including large scale AT Expos, online product information, showrooms, expert one-to-one advice and information are already available from specialist AT suppliers, and are paid for through the retail price of AT products. These services from suppliers, as well as advice and information from allied health therapists, Independent Living Centres, and AT users' own efforts to become well informed about AT have resulted in many AT users become moderately or highly expert users in relation to their own AT requirements. Significantly, numerous niche AT businesses have been established by people with disability as a consequence of the expertise they developed as AT consumers. Further support and investment by the NDIA in expanding and strengthening these activities would be welcome.
Quality, safety and consumer protections	Ideally this would be covered by the same framework that is used for all other NDIS services. However, as can be seen from the quote below, the recent NDIS discussion paper *Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework*, the primary framework for NDIA will be structured around a market-oriented system: 'Where payments are retrospective and contracts for support are individualised…[and suppliers are] 'competing on price, quality and customer experience… [and have] to earn the trust and loyalty of clients so they become repeat customers' (NDIS 2015: pg 3). With a managed procurement model for AT rather than a market model as executed for the rest of the NDIS, a separate set of rules and regulations to	AT suppliers who are local manufacturers or importers must already comply with the Therapeutic Goods Administration requirements regarding Class 1 Medical Devices as product 'sponsors'. Additionally the NDIA could easily mandate that any AT purchased with NDIA funds by consumers must comply with any relevant Australian or international standards, or other relevant product accreditation (such as the FDA in the USA, which also regulates AT products). In a market-oriented AT system where Participants purchase and own their AT, or rent their AT directly from an AT supplier, they will be covered by the *Competition and Consumer Act 2010.*

	manage quality and provide safeguards for AT provision will have to be developed, implemented and enforced – all at additional costs and time delays. No detailed discussion of what this might look like is provided in the AT Discussion Paper. However, it notes that under the managed procurement model product quality and safety will have to be tested (pg. 10). Also, the importance and potential use of competency frameworks and codes of practice are mentioned (pg 22). Although there is mention in the AT Discussion Paper of the robust protections Australians receive under the *Competition and Consumer Act 2010 (pg. 22,)* there is no discussion of if or how this might apply when Participants do not own or purchase their AT within the proposed managed procurement framework.	Participants should be encouraged to seek out and utilise suppliers who are compliant with a code of practice (such as the ATSA *Code of Practice*), and/or other accreditation programs (see Summers & Walker 2013), which will also help to ensure the quality of the services they receive from AT suppliers.
Innovation	Centralised procurement models stifle innovation, although the Discussion Paper does outline some possible innovation supports these are not costed, and appears to suggest that the NDIA become the primary investor in AT innovation in Australia (pgs. 20-21).	Robust market-oriented environments reward and encourage innovation, and new AT products are currently brought to market in Australia routinely. However this approach does require innovations to be commercially viable (e.g. products must 'pay their own way' or at least warrant the risk and investment made by suppliers to develop, import, distribute, support and retail the products).
Sustainability	As already noted above, day-to-day costs are likely to increase as a consequence of separating the services specialist AT suppliers currently provide from the purchase of the AT product, and this will greatly reduce if not overtake the anticipated 25% price savings (see detailed discussion in 'Cost Modelling Problems' and Figure 1 below). Poorer Participant outcomes and the stifling of innovation will also increase longer term costs to the NDIA. Over consolidation of the market-place through excessive use of managed procurement (included the proposed expansion of large scale managed procurement to aged care and DVA) will lead to reduced competition and ultimately higher prices, less diversity and less choice over time.	Potential concerns regarding potentially excessive AT pricing should be tempered with the evidence that AT prices in Australia are low when well conducted systematic international comparisons have been undertaken, in contrast to occasional anecdotal evidence of excessive prices in Australia. Concerns about controlling NDIA costs in relation to AT could be addressed effectively through the use of price-benchmarking (already in place by NDIA); price surveillance coupled with capacity to discipline retailers who demonstrably profiteer; and a requirement for high cost/high risk AT to be signed-off on by an independent allied health professional.

Cost Modelling Problems

The strong push in the Discussion Paper for a managed procurement model is based on an extrapolation of claimed cost savings from several existing state bulk procurement programs. While it appears that the cost modelling undertaken by the actuaries was relatively sophisticated, the overall conceptual framework upon which that modelling was based appears to be overly simplistic and ultimately quite problematic. The lack of substantial details regarding the data utilised or the numerous assumptions and formulae within the actuarial modelling, means that there is no capacity to directly check calculations and independently verify the results. It is also noteworthy that after 12 months of trial site operations no data from those trials is presented in the Discussion Paper regarding AT costs, and publicly available results for the first year of operation (see NDIA 2014a and 2014b) present no evidence of AT cost blow-outs for the NDIA and indicate that costs to date are well within expectations and previous modelling.

Given the significance of the decisions being made, this lack of transparency is a significant problem and raises considerable uncertainty about the underlying evidence being utilised to inform the proposed use of managed procurement for AT on a massive scale – noting that while the current focus is on the NDIS, it is proposed that this model will be expanded to include AT in aged care, the DVA and potentially other Commonwealth funded AT (pg. 11).

Notwithstanding this lack of detail, some very significant problems are apparent. As noted previously, the reported savings of 25%[1] from some AT products in several state programs have been extrapolated into the NDIA proposal. Superficially this seems acceptable. However, it requires some major leaps in logic to get there that do not hold up to scrutiny. Some of the most significant leaps include:

- Each of the state programs operates quite differently.
- The savings claimed by the state programs have never been independently evaluated, and is focused only on AT 'price' savings with no evaluation of processes or outcomes, including economic costs/benefits at a systemic level to capture any cost shifting, service reduction and impact on outcomes for people with disability and their families. None of the short-comings of these procurement programs are mentioned.
- The claimed savings in the state programs are not based on across-the-board managed procurement of AT, but only on a very limited number of AT products (typically those perceived to be 'simple' low cost/low risk items). This is very different from the 'across the spectrum' of AT products used in actuarial modelling presented in the Discussion Paper.
- The Discussion Paper states that panel supply arrangements have never been tried in relation to AT procurement in Australia. Given that panel supply is never clearly defined in the Paper it is hard to know if this is true, but it would appear that the DVA uses a panel supply model that (unlike the Discussion Paper) includes the essential specialist AT retailer services that are associated with providing AT products – with no evidence of actual savings to date based on an independent review conducted in 2014, as does the TAC in Victoria. So it is difficult to see how these claims of savings can be extrapolated to the model being proposed in the Paper, and it is not clear what the links are between the other managed procurement models proposed and these claimed savings.
- There is a very big difference between a few relatively small-scale managed procurement programs operating across diverse geographic areas that provide the basis for the claimed savings, and a massive national managed procurement program. In many of the state managed procurement programs costs have simply been shifted to people with disability, allied health practitioners and suppliers; and/or services, quality and choice have been reduced to achieve short-term 'price-savings'. Indeed after several years and the a growing awareness and understanding of the

[1] Throughout this submission ATSA uses the figure of 25% as the claimed savings from the proposed managed procurement program as this incorporates what appears to be a realistic estimate of the costs of running the procurement program. See the discussion below on 'Establishment and Running Costs'.

problems created by tendering just for AT products, one of the major state programs is now seeking expressions of interest/tenders for some of the essential services that specialist AT retailers normally provide along with AT products, but were not part of earlier tenders process for AT products.

- On page 12 the Discussion Paper notes a 'net added value of 25%' from the managed procurement processes used for some products by some states. No explanation is given about why or how this then transforms into 37% savings on retail prices (pg. 14). Our best guess, based on extrapolating the common business definition of 'added value' to this context is that the 25% figure incorporates the average costs of running the state procurement programs, implying that those costs are about 12%.

- Claimed savings in the modelling are all based on comparing the prices paid via managed procurement to a retail price for an identical item (pg. 14). Retail prices of AT products vary depending on the different business model of the AT retailer based on issues such as location, level of specialisation, range of products and size of the business. No clarity is provided about how the retail prices utilised for price comparisons were established, just that they were 'obtained' (pg. 12).

As indicated indirectly in many places throughout the Discussion Paper, the move to a large scale managed procurement model with a focus on only purchasing AT products at the lowest possible price will require a not yet developed 'well-integrated continuum of services' to replace the many essential services that specialist AT retailers currently provide within the AT retail price to ensure a good match between the individual and their AT. Notably, it is never mentioned that this will have to also be funded, and no cost estimates are undertaken or included to determine what if any real savings might be achieved by deconstructing and re-assembling an already very efficient and effective market-based service delivery structure and associated processes.

Services specifically mentioned in the Discussion Paper that will need to be developed (and funded) include: generating innovation (pg. 20), product testing (pg. 10), provide information and advice (pg. 10), provide display equipment/exemplars (pg. 10), and trialling equipment (pg. 10). Additionally, it is proposed that a centralised structure and associated processes will need to be developed and funded to refurbish/reissue of AT (pgs. 14-15), which is also already done routinely by many specialist AT retailers as part of their AT rental programs.

Essentially what is being proposed in the Discussion Paper is that the expected 25% savings on AT prices will be achieved by purchasing AT products separately from the services that are now commonly bundled into the existing AT retail price. That 25% 'savings' represents the lion share of specialist AT retailers' margins (which vary but typically average about 35%), from which the provision of these essential services is funded. There is little capacity for retail prices to be further reduced from their already highly competitive and very low levels.

Given the very high cost of some AT there are frequent perceptions that outrageous levels of profits are being made, although the Queensland Competition Authority (2014) found no evidence to support this view. Additionally, in 2012 IbisWorld examined the wheeled mobility sector of the AT industry and found that the average profitability was 0.9% for the previous 5 years. See also the ATSA (2014) briefing paper *Assistive Technology Pricing: Is it fair and reasonable?* in Appendix A and the more detailed background paper (2014) of the same name, which provide an extensive overview of supply chain issues in relation to AT, including additional international price comparison research which found that based on comparing recommended retail prices across 6 OECD countries and Australia, that on average Australian prices were 14% lower. This 2014 ATSA work includes an extensive discussion of services provided by AT suppliers and also outlines often poorly understood issues regarding purchasing AT via the internet.

Figure 1 below illustrates the problem with the conceptual framework and subsequent analysis presented on AT prices in the Discussion Paper. The claimed cost savings via managed procurement are only achievable by not accounting for the provision of the services currently included in the AT retail price that are essential to ensuring a good fit between the individual and their AT.

Figure 1: A more complete modelling of costs is required

Current Retail Model

AT Product + Associated Essential Services[1] = AT Retail Price

AT Pricing as done in Discussion Paper via managed procurement

AT Product @ 25% savings on AT Retail Price + Associated Essential Services[1] = unknown/unspecified cost

[1]Associated Essential Services commonly included in the AT Retail Price but not costed and accounted for in the proposed Managed Procurement Model costings include:

- Therapeutic Goods Administration compliance
- Standards testing and sourcing reliable/fit-for-purpose products
- Sourcing and underwriting costs and risks of bringing new and innovative products to market
- AT Product showrooms (350-400 nationally)
- Provision of demonstration products to Independent Living Centres, rehabilitation centres, etc
- Product exhibitions/Expos
- Demonstration stock
- Information and advice, including highly skilled allied health practitioner and other staff
- Home/workplace trials [often including AT product adjustment/configuration, delivery and pick-up (which can include considerable distances travelled and associated staff time), Participants and caregivers trained in its safe use, and success of the trial evaluated and modification or other options explored as a consequence. Multiple trials with different products and often different specialist AT suppliers to get the 'right' solution. Other related costs include involvement of independent allied health practitioner and Participant's and carers' time/effort]
- Delivery, including adjustment/configuration, training Participants and caregivers in safe use
- Post-delivery follow-up, adjustment, advice/support
- Stocking spare parts and having skilled staff on hand for repairs and maintenance
- Fulfilling product warranties and *Competition and Consumer Act 2010* obligations

Re-issuing AT

ATSA has long been a strong supporter of AT re-issuing. As noted in the Discussion Paper, there are significant benefits to be gained in relation to reducing waste and increasing economic efficiency.

Many specialist AT retailers already routinely re-issue AT, particularly within the context of their rental programs.

ATSA's support of re-issuing has always included the caveat that re-issuing must be carefully done to ensure that it does not compromise (a) safety; (b) ensuring the AT re-issued is the most appropriate solution for the individual; and (c) that the re-issuing scheme is economically viable and self-sustaining.

Figure 3 in the Discussion Paper is not helpful as it combines the projected savings from both the proposed managed procurement processes and the proposed AT reissuing/recycling program. Consequently it is difficult to desegregate the two separate sets of claimed savings, and to see what each of these might look like independently of each other. The implication throughout the Discussion Paper is that a strong AT re-issuing program is only possible if the NDIA/3rd party owns the AT rather than Participants.

In relation to the proposals in the Discussion Paper, it would appear that AT ownership by Participants is being sacrificed to support untested large-scale centralised national AT re-issuing. It is not at all clear what evidence is being used to support the assumption that Participants are more or less likely to 'return' their AT products for re-issuing if they do or do not own it. Anecdotally there is clear evidence that within the DVA's AT rental scheme that it is not uncommon for veterans or their families to dispose of or sell the AT on to someone else – not out of maliciousness or greed, but they simply forget that they do not actually

own the AT. Likewise, there are AT users who no longer need a particular AT item and want to find a way to get it out of their homes and into the hands of others who can use it – but there are few well-structured options unless their local AT retailer is interested in purchasing it and cleaning/refurbishing it, or the owner simply sells it or gives it away (with all of the attendant potential health hazards regarding 'cleanliness' , safety and suitability).

Rather than labouring under the false assumption that NDIA/3rd party rather than Participant ownership is a pre-requisite for effective AT re-issuing, consideration of ways to ensure that NDIA Participants are well aware of the value of their AT, its potential for re-issuing, and the environmental and economic benefits of making the AT they no longer need or use available to others – and then making the 'return' process as easy as possible, is much more likely to be effective.

Importantly, all NDIS Participants will engage in regular reviews with their Planners. It is expected that for those who need and use AT, that this review would include consideration of how effective their existing AT is for them currently – creating options to identify AT that is no longer being used (and this available for return and reissuing if appropriate), as well as identify different or new AT solutions to help Participants achieve their goals. Consequently Participant ownership of their AT is not likely to be a major barrier to re-issuing, and the associated benefits of ownership in relation to empowerment, easily solving day to day problems that arise with the supplier of their choice, and protections available under *Australian Competition and Consumer Act 2010* do not have to be sacrificed to achieve good recycling outcomes.

Also, given the emphasis on choice and control in the NDIS there is no discussion or evidence presented in the Discussion Paper about what Participants think about the provision of 2nd or 3rd hand AT. This includes consideration of cultural and individual sensitivities in relation to 2nd hand AT that was once used by someone who has died. Sensitivities and preferences regarding re-use of AT products are significant issues as any one of the many specialist AT retailers who currently re-issues AT can attest. There are also significant Therapeutic Goods Administration requirements that must be carefully adhered to regarding equipment refurbishment and reissue.

Re-issuing AT is a vital element for the national provision of AT within the NDIS, and should be part of the AT model within the NDIS. However, better evidence about its real economic and environmental benefits needs to be developed to support decisions about the best way to do this. Some of the key questions that need to be answered include: (a) should it be a centralised or decentralised model or something in-between; (b) what information, structures and processes within the NDIA – such as the work of NDIA Planners and information to Participants about the value of re-issuing are vital to ensure that un-used AT is made available for re-issuing; and (c) does Participant ownership of AT promote/discourage return of AT that is no longer being used, and at a broader cost/benefit level this must be done within the context of careful consideration of the personal, social and economic benefits of Participant ownership versus NDIA/3rd Party ownership. If the NDIA/3rd Party owns the AT then there are significant legal liabilities to ensure the AT is safe and appropriate.

Establishment and Running Costs

The Discussion Paper includes estimates of some very modest establishment and running costs for the new managed procurement entity within or outside the NDIA (pg. 14). These costs seem remarkably low and no evidence base is provided about how these figures were established. Additionally, there is no cost stated for the extensive development that will need to be undertaken by the NDIA to support and manage the proposed managed procurement entity (internally or externally) that sits outside the rules and systems being established to operate the broader market-based individualised funding and sourcing of services underway for the rest of the NDIS. What is proposed will drive significant bureaucratic and administrative inefficiencies because the rules of the rest of the NDIS will not apply in relation to AT, and a separate rules and processes will need to be developed, implemented and maintained.

If the entity running the managed procurement program is external to the NDIA, it raises serious practical and logistical questions in relation to setting up and running new and separate financial and data collection systems and how these will be integrated with NDIA Planners and other parts of the NDIA infrastructure and back-of-house services. Also the extensive and complex tendering processes that will need to be established and implemented, and regularly repeated (including NDIA involvement and monitoring) will be expensive and slow. There is no discussion of these challenges, not just in relation to the potential costs to the new entity's operations and overheads, but also to the NDIA in relation to Planners and systems integration and ultimately to Participants in relation to having to deal with yet another large bureaucracy with different rules and requirements.

Will the entity have to comply with existing NDIA rules and policies? Currently with the various state/territory AT programs delivering AT on behalf of the NDIA, these programs are not required to operate under the NDIA's rules and policies. For example, AT suppliers registered with the NDIA but delivering AT to NDIA participants through various state/territory programs are not paid within 24-48 hours of invoicing as per the NDIA's commitment to all NDIA registered suppliers. Instead invoices are typically paid within 30-90 days as per the business rules of the state/territory AT program involved (which increases costs for suppliers and impacts on AT retail prices). Likewise, Participants must also contend with the state/territory AT program rules and structures/processes currently, as well as NDIA rules and systems.

Sorting all this out will be slow and costly for all stakeholders including the NDIA, and the projected costs for this – both within the NDIA and within the new managed procurement entity appear to be grossly underestimated. The Discussion Paper (pg. 14) estimates establishment and running costs for the first year at $2.5 million and ongoing running costs of $1.5 million. With an estimated annual purchase of almost $300 million in AT products (and eventually also some significant expenditure for yet-to-be-costed related AT services as described throughout this submission), the estimated running costs of 0.5% appears to be completely unrealistic. A more accurate estimate can be derived from what the states/territories are currently being paid to provide AT within the NDIA which are estimated to be between 10-15%, or the estimated cost of running the small scale state managed procurement programs which are also 10-15%. Ten percent running costs for $300 million would be $30 million, and 15% would be $45 million.

The difference between the 'reported average net value of 25%' (pg. 12) from the small scale state procurement programs appears to include the costs of running those programs, in contrast to the claimed 37% price savings on AT retail prices via the large scale managed procurement which does not include operating costs (pg. 14). This difference of 12% appears to verify that a projected ongoing operating cost for a large scale national managed procurement program would be between 10-15%. This is also why this ATSA submission has used the figure of 25% as the claimed savings from the proposed managed procurement model, rather than 37%, throughout this submission.

Conclusions

The major flaws in the cost modelling and the overall lack of comparison with any other possible AT delivery models in the Discussion Paper makes any significant decision-making based on the Paper impossible. A more evidence-based and rigorous examination of different options is essential, ideally in the format of an Options Paper. If managed procurement is such an attractive option, why is it not being considered for other NDIS services?

To support provision of better information and evidence for decision-making the remaining time available in the NDIS trial sites should be urgently utilised to test different models of AT provision. These trials should be rigorously evaluated to examine the outcomes, costs and benefits for all AT stakeholders (Participants, their families, allied health practitioners, AT suppliers and the NDIA). There are relatively straightforward opportunities to do this, such as running a full retail model in the ACT and comparing it to one of the other sites utilising a 3rd party provider such as EnableNSW. If this is done it is vital that the process includes an in-depth examination of all costs for all stakeholders and outcomes for Participants, and would ideally include the use of a health economics framework.

ATSA does not support the proposal in the Discussion Paper for a paternalistic large-scale managed procurement model. The evidence upon which this proposal is based is significantly flawed, with only the costs of AT products being presented in the cost modelling. The costs of developing and replacing the associated essential services currently provided by specialist AT retailers as part of the AT retail price AT have not been incorporated in the actuarial modelling. Also a more accurate estimate of establishment and running costs for the managed procurement entity will be required when comparisons with other AT delivery models is undertaken.

The proposed managed procurement model is a very high risk approach that will significantly compromise both Participant choice and control and the sustainability of the NDIS. Rebuilding and replacing the services currently provided by AT retailers within the AT retail price will likely far exceed the projected savings of 25% through managed procurement of only AT products. Additionally, the consequences of separating these essential services from the provision of the AT product greatly increases risks of poorer outcomes and associated higher costs, as well as additional burdens on NDIS Participants. This approach will require a significant level of bureaucracy to run and manage over time, as well as significant costs and delays while the system is being developed and implemented.

In contrast, a market-oriented retail model in line with procurement and service delivery processes for the rest of the NDIS, can be readily implemented and requires minimal bureaucratic involvement, and is likely to cost less overall than the proposed managed procurement model when all costs and benefits are considered. Basic safeguards to minimise risk of cost blowouts are relatively straightforward to develop and implement, and should include AT price-benchmarking (already in place); ongoing monitoring of AT purchases for any evidence of excessive pricing and appropriate investigation and enforcement measures; requiring independent allied health practitioner sign-off on high cost/high risk AT; and requiring all AT purchased with NDIA funds to be compliant with relevant Australian or international standards or FDA (USA) requirements whenever these are applicable. More details on this can be found in the 2014 ATSA briefing paper *Supporting Choice and Control: Assistive Technology Funding Reforms* which is included here in Appendix B.

The NDIS and other jurisdictional agencies are investing substantially to reform disability supports from the traditional, failed, block-funded model, into a market-oriented model where people with disability have choice and control over what supports they require and where they obtain them. ATSA fully endorses this move, which is significantly at odds with the approach proposed in this Discussion Paper, where choice of AT and suppliers will largely be vested in the NDIA or other third party.

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APPENDICES

Appendix A: ATSA Briefing Paper – *Assistive Technology Pricing: Is it fair and reasonable?*

Appendix B: ATSA Briefing Paper – *Supporting Choice and Control: Assistive Technology Funding Reforms*

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Assistive Technology Pricing: Is it fair and reasonable?

Briefing Paper

Introduction

Available evidence demonstrates that AT prices in Australia are both fair and reasonable, and relatively low in comparison to prices elsewhere. Prices set by Australian AT retailers are a reflection of the costs of the products they sell, and the essential services they provide that are often included as part of the retail price.

Prices for AT from Australian retailers are usually higher than prices from internet-only AT retailers operating out of the USA. These internet-only AT retailers provide no services, and the consumer carries all risks regarding fit, appropriateness, assembly, adjustment, proper use, and sourcing spare parts. Australian consumers purchasing from international websites often have difficulty enforcing warranties and are not protected by Australian consumer laws.

The wide range of services provided by AT manufacturers, importers, distributors and retailers are essential to ensuring a good fit between the individual and their AT, particularly at the moderately to highly complex end of the AT pyramid. Any substantial efforts to further reduce AT retail prices are likely to reduce the provision of these essential services to both AT consumers and their therapists/prescribers, which in turn will result in worse outcomes for consumers and higher costs and lower productivity over time.

This briefing paper is a short summary of the extensive evidence about AT pricing and the supply chain presented in detail in ATSA's background paper *Assistive Technology Pricing: Is it fair and reasonable?* For more details on any of the evidence or issues raised here, please see the background paper at www.atsa.org.au.

Background

Concerns are sometimes raised that the prices charged by specialist assistive technology (AT) retailers in Australia are high relative to prices in other countries. These concerns lead to questions about whether the commercial retail market-place for AT in Australia (and the associated AT supply chain) is truly effective in delivering the best possible prices for private and public purchasers. Government funding and procurement programs for AT also appear to be making many major public policy decisions based on perceptions of excessively high prices for AT.

AT is particularly important because it is a primary enabler, assisting one in 10 Australians of all ages to undertake activities that others take for granted. Ensuring a good match between the individual and their AT is vital. The retail prices of AT products include the costs of an extensive range of services provided by AT suppliers (manufacturers, importers, distributors and retailers) to help ensure a good match.

The best AT selection decisions are made in the context of an active partnership between the AT user, their therapist/prescriber and the AT supplier. This is particularly true when the AT and/or the context of its use is moderately to highly complex.

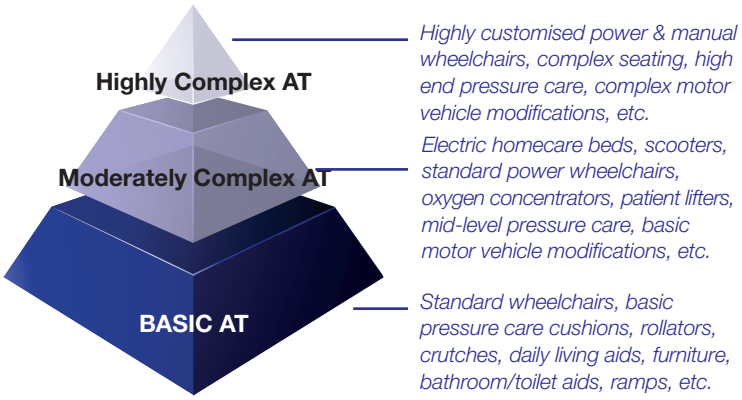
A viable and competitive AT supplier sector is pivotal to ensuring choice and effective AT solutions for AT users at the best possible prices. But price must not be the sole determinant of AT purchasing as this creates perverse incentives to drive down prices at the expense of achieving good outcomes for consumers, and the attendant savings to government and the community these good outcomes provide.

Not withstanding the general impression that AT suppliers are all about 'aids and equipment, hardware and gadgets', it is largely a service-based industry – particularly in relation to moderately and highly complex AT (see the AT Pyramid). These services are extensive and described in detail in both the pricing background paper and the briefing paper *Assistive Technology in Australia*. Some of these services include product development, testing and manufacturing at the back-end through to advice and education, in-home trials, fitting the product to the consumer, customisation and repairs/maintenance at the front-end.

All of these services are ultimately aimed at ensuring the best possible match between the AT and the individual, and many of them are incorporated into the retail pricing of specialty AT retailers.

Typically the level of supplier services required to get a good match increase as the complexity of the AT and the complexity of the goals and environment of AT user increases.

The AT Pyramid



AT Price Comparisons

Valid price comparisons are based on comparing like-with-like. In its 2014 investigation into AT pricing in Australia, the Queensland Competition Authority (QCA 2014, p 35) identified the following elements that must be considered to ensure like-for-like comparisons:

- 'differences in product specifications
- differences in supplier services
- [foreign currency] exchange rates
- customs duty and taxes
- delivery charges, including handling and insurance
- warranties
- transaction costs
- discounts and special offers
- other factors such as convenience and timeliness.'

Consequently, price comparison research is inherently complex and difficult – and the details matter.

Three sets of recent price comparison results are summarised below, with the first two drawn directly from the QCA's work, and the last one is based on research by ATSA. More detailed discussion of the work done by the QCA and ATSA can be found in the background paper.

The QCA sourced comparative pricing data regarding 'lowest available prices' from the websites of AT retailers. The lowest prices from USA and UK internet AT retailers are from 'internet-only' retailers, meaning that there are no shop-front overheads and no services provided to purchasers, with the purchaser taking all risks and responsibility to ensure that the AT is the best AT solution for them, including assembly, adjustment and learning how to use it. In contrast, Australian websites selling AT are all underpinned by brick-and-mortar AT retailers, with the

associated assistance and protections for consumers and costs to AT retailers that this entails.

The QCA compared prices for 24 products, and also prices for these same products plus delivery costs to Australia. Delivery costs are particularly important because most AT is manufactured overseas, and AT is of no value if consumers do not actually have it. Excluding delivery costs, overseas prices were 38% lower. When delivery costs were included, Australian prices were 24% lower compared to overseas prices.

In relation to the QCA price comparisons, it is important to note that:

- The overseas prices are from internet-only AT sellers, not full-service AT retailers as is the case for the Australian internet prices utilised.
- As noted by the QCA (2014, p iv): 'Australia is a high cost country — Purchasing Power Parity analysis [for a broad basket of consumer goods] shows that general price levels, expressed in Australian currency terms, are 20 per cent higher here than in relevant comparator countries. The difference in relation to the United States is around 30 per cent.' The differences in AT prices (excluding delivery costs) simply reflect these purchasing parity realities for most retail products sold in Australia, especially as most of the lowest prices used in the QCA research were from the USA.
- Although QCA did factor in exchange rates, the figures used were the official exchange rates without currency exchange commissions. Consumers purchasing goods from overseas typically pay a currency exchange commission ranging from 5–10%. When this amount was incorporated into the comparison calculations, on average undelivered AT was 28–33% cheaper overseas; and delivered AT was 29–34% cheaper in Australia.

The price comparison work by QCA for 'delivered' AT demonstrates clearly that Australian AT prices are not high, and are somewhere between 'low' and 'average' when compared to prices overseas. The evidence is even more convincing when taking into account: the additional expense of air-freight costs for some AT; currency exchange commissions; the low overheads, lack of services and resulting low prices of overseas internet-only AT sellers relative to full-service AT retailers in Australia; and purchasing power parity analysis. Also, for fullservice retailers in Australia the costs of all pre-sales work such as trials are only recouped when a sale is actually made, which anecdotally is reported to occur for about 50-60% of trials.

As part of its submission to the QCA's AT pricing investigation, ATSA undertook an international comparison of recommended retail prices for a sample of AT (see ATSA 2013). ATSA found that AT prices in Australia are lower on average than across 6 comparable OECD countries by approximately 14%. This result is based on the average of the differences across the 12 products compared where there were data from 3 or more countries. For the 6 products where there was only 1 overseas price for comparison, Australian prices were 27% cheaper.

Prices on different products and/or in different countries might have resulted in different findings. Additionally, while recommended retail prices are a good indicator, these are not 'enforceable' and actual retail prices may be higher or lower. However the congruency of ATSA's findings with the QCA's findings supports the validity and reliability of both price comparison methods used.

Also, consultation with Australian AT suppliers (including manufacturers, importers, distributors and retailers) indicates that these results reflect their own knowledge and experiences. Most suppliers have extensive anecdotal evidence about their own markets and pricing internationally. They also frequently comment that the Australian AT supply sector is generally very efficient, as well as not being very profitable for most suppliers – largely as a consequence of the high levels of competition and the levels of services required to support good consumer outcomes.

The lack of profitability in the sector is a significant indicator of the robust level of competition between AT suppliers – an Ibis*World* (2012) analysis of the wheeled mobility segment of the Australian AT market found that average profitability was only 0.9% over the previous 5 years.

Why the Perception of Excessively High AT Prices in Australia?

Given that the available evidence does not support claims that AT prices are excessive in Australia, it is important to consider why these perceptions persist. Numerous factors are probably involved including over-simplistic price comparisons between AT prices on overseas internet-only AT retailers and full-service AT retail shops in Australia; sensationalist media reports; the ongoing invisibility of many of the services incorporated into Australian AT retail prices; and the high costs of AT that is moderately to highly complex.

The issue of internet versus full-service AT retailers has already been considered above. In relation to sensationalist media reports, of those which ATSA has been able to investigate, none have withstood scrutiny (see Case Studies A and B in the background paper).

The invisibility of many of the services incorporated into the retail price of AT persists. ATSA continues to highlight this range of services in its work such as in our briefing paper: *Assistive Technology in Australia*. Additionally there has been some examination of the potential value/risk of separating out these services and charging for them separately. The general consensus by AT suppliers is that such a move would likely increase the overall costs of AT because: (a) high levels of competition in relation to AT retail prices constantly forces AT retailers to find ways to provide these services as effectively and efficiently as possible; (b) 'de-coupling' these services would increase paperwork, the number of transactions required, and could reduce the strong links between consumer outcomes, suppliers' services and AT products.

Prices at the lower end of the AT complexity have consistently dropped in recent decades, largely due to improved manufacturing technologies and low labour costs in countries such as China.

However, prices for more complex AT products have continued to rise. A powered wheelchair with complex controls and customised seating can retail for between $15,000 and $40,000, depending on the details of the products and services provided. Many of these products are manufactured in North America and Europe, where labour and other costs have continued to rise, and this combined with the ongoing costs of innovation, product development, and safety testing/standards have kept product costs high.

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Supporting Choice and Control: Assistive Technology Funding Reforms
Briefing Paper

Introduction

A new model for assistive technology (AT) provision is required as the previous role of government as the AT selection agent, purchaser and owner on behalf of people with disability of all ages is not congruent with consumer choice and consumer-directed care in both disability and aged care service provision.

Linking funding to individuals, their needs and their choices, and away from centralised command-and-control bulk purchasing structures to competitive open-market fee-for-service retail structures is underway for all disability services in preparation for the full rollout of the NDIS (Joint Parliamentary Standing Committee on NDIS 2014). Previous service models driven by top-down decision-making processes have not delivered optimal outcomes for consumers and cannot provide long-term cost savings for governments (Prod. Comm. 2011).

Effective and affordable provision of AT to those who need it is essential to their quality of life, increasing participation in social and economic life, and reducing overall costs to the community and governments. Utilisation of a market-oriented retail model for supplying AT for purchase and rental is the most effective and efficient way of ensuring good matches between individuals and their AT, and optimal outcomes at a cost-effective price with a minimum of red tape and delays.

A retail model for providing AT through both businesses and not-for-profit organisations aligns completely with the broader shift to consumer choice and consumer-directed care in government-funded services in disability and aged care. Good value for government can readily be achieved as AT retail prices in Australia are on average between 24% (Queensland Competition Authority (QCA) 2014) and 14% (ATSA 2014a) cheaper than those in other countries when like-for-like comparisons are undertaken.

A retail model for AT would require a minimum of government intervention through some simple measures to ensure transparency and accountability, and modest supports/incentives in particular areas such as rural and remote service delivery where market failure is likely. The QCA (2014) and Jenny Pearson and Associates (2013) both cited evidence indicating that individualised purchasing can achieve lower prices for government AT funding programs. Over-use of bulk purchasing also leads to reduced competition and diversity, higher prices and less innovation over time (QCA 2014).

Individualised funding and consumer directed decision-making in a highly competitive AT retail environment will promote choice and quality, and keep prices low.

Background

AT is a primary enabler, supporting one in ten Australians of all ages (ABS 2004) to undertake many activities others take for granted in their daily lives. Effective AT provision can reduce long-term care costs and healthcare costs, and increase participation in employment and education (Audit Commission 2000, 2004; AIHW 2006; Heywood & Turner 2007).

AT products are used for personal care, daily living, communication and mobility, and include home and vehicle modifications. AT varies from simple and inexpensive devices such as canes and aids to open cans, through to very complex and high-tech equipment such powered wheelchairs with customised seating and controls.

The major state/territory AT programs, such as MASS in QLD, are the primary source of AT funding for many people who cannot privately fund their own AT, utilise the DVA's RAP program, or access specific programs such as the Commonwealth's Hearing Services Program. Details of state/territory AT programs vary widely, but all are based on frameworks developed to fairly ration scarce resources with the government acting as the agent, purchaser and owner on behalf of the person requiring the AT. Figures vary, but typically 35–40% of the funding in the state/territory programs goes to people under 65, and the balance to those over 65.

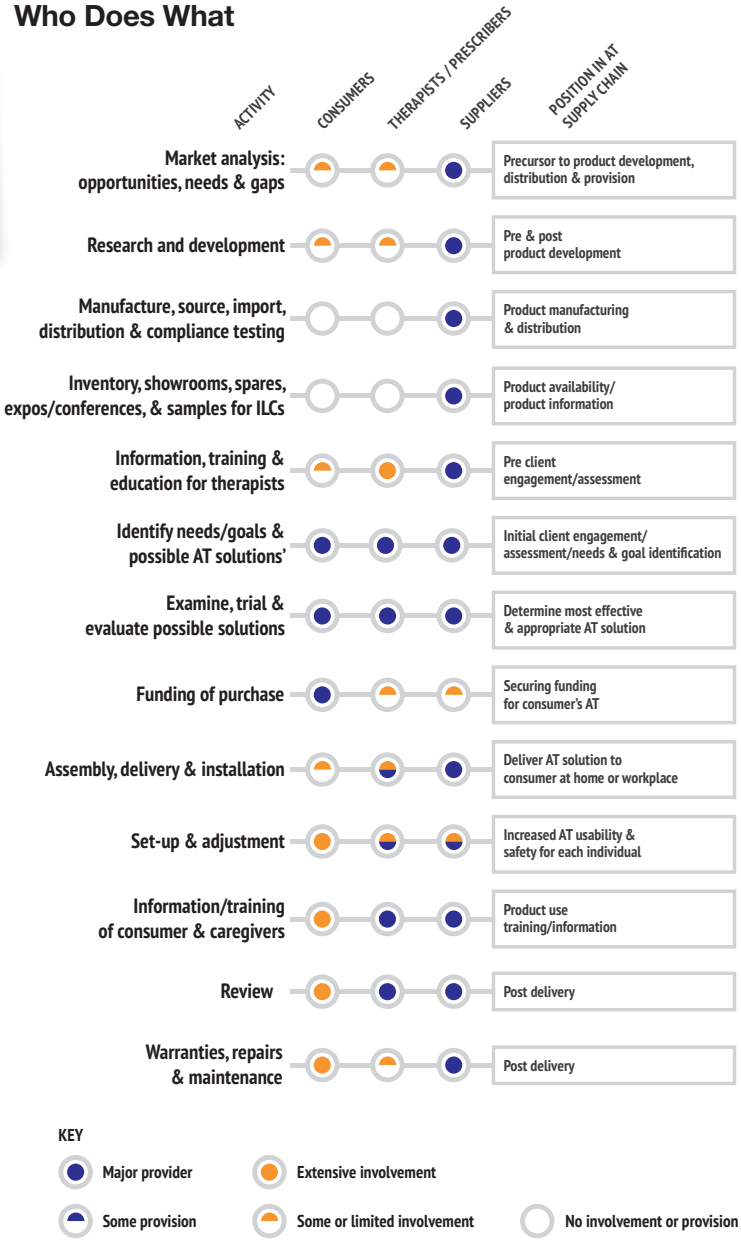
AT in Australia

Individuals are often capable of selecting their own AT, particularly in relation to relatively simple AT, and sometimes also more complex AT especially when a consumer has considerable experience and knowledge of AT. However, given the extensive range of AT products available, new products coming onto the market, and the unique requirements of many individuals who may use 7–10 different AT items (Layton 2010), achieving the right match between the individual, their environment, goals/aspirations and their AT is usually a complex process.

Consequently, notwithstanding the general impression that AT suppliers are all about 'aids and equipment, hardware and gadgets', the industry is largely service-based, focused on ensuring a good match between the individual and their AT. These services are particularly important in relation to moderately and highly complex AT. An active partnership between the consumer, their allied health therapist and the AT supplier which utilises all of their combined expertise and knowledge is usually essential to achieving the best outcomes (RESNA 2011; Martin et al. 2011).

Many of Australia's 350–400 specialist AT retailers employ highly skilled allied health professionals and provide showrooms. A substantial proportion of the retail price of AT goes to covering the costs of providing these and other services to ensure a good match between the person and the AT, such as in-home trials, consultation/advice/product selection, extensive demonstration stock, delivery, set-up, fitting/adjusting, modification/customisation, training and evaluation. See the 'Who Does What' figure, and also ATSA's briefing papers *AT in Australia* (2014b) and *AT Pricing – Is it fair and reasonable?* (2014c) for more details.

Who Does What



Ensuring good consumer outcomes and value for money

Major issues to consider in relation to an effective and efficient AT retail model include:

- information asymmetry – independent information and advice
- pricing transparency and accountability
- quality assurance, credentialing and accreditation
- minimising impacts and sources of market failure
- evaluating consumer outcomes over time.

Information asymmetry

Information asymmetry is a common cause of market failure, as effectively functioning markets require both buyers and sellers to have the same information about products, their quality, their uses and the outcomes of their use. Previously, independent allied health professionals provided advice to government AT purchasers about the appropriateness of a particular AT item for an individual in the form of a 'prescription' to the government funder.

The role of 'prescribing therapists' should be transformed to focus on providing advice, information and support to individual consumers to assist them in selecting the most appropriate AT for their needs, goals and environment. Limited availability of these professionals to do this work is currently a common source of delay, and delays result in poor outcomes and higher costs.

In addition to independent allied health professionals, other major sources of information for consumers include the national network of Independent Living Centres (ILC), including their AT database, as well as other international databases and related decision-making aids such as www.asksara.dlf.org.uk, and information available from AT manufacturers and retailers. Also, people who utilise AT frequently share their experiences with each other, both online and in person.

In Australia there is significant scope for increasing the breadth, depth and accuracy of the existing ILC database. ATSA has proposed a model to the ILCs for doing this, and while the proposed approach would shift a considerable proportion of the responsibility and costs to AT suppliers for keeping the database up to date, the ILCs continue to struggle to find adequate funding to undertake essential redevelopment of the database.

Pricing transparency and accountability

The NDIA has already produced a publicly available price guide for AT, to assist their planners to identify appropriate price ranges for different AT items. Many of the higher cost and more complex items require a quote from a supplier, and if the quote is well outside the expected price range a review process is triggered. Such processes, along with the resulting data collected on AT purchases through the NDIS over time and across the nation, and the ability to monitor pricing patterns and related anomalies, should provide strong safeguards that can be replicated in relation to aged care. Sanctions such as de-registering AT suppliers that are registered with the NDIA could be applied.

Additionally, given these will be individual purchases, not based on commercial-in-confidence bulk-purchasing contracts, pricing information obtained this way could be made public, and thus be very transparent regarding prices for AT products and services across the nation.

With individualised purchasing, AT retailers would also have a much stronger incentive to publicise their prices – otherwise consumers are likely to go elsewhere. This pricing information will ideally contain an explanation of what services are and are not included in the retail price of the AT item. For instance, a pressure care cushion that is an exact replacement for an effective but worn-out cushion is likely to be sold straight off the shelf at a lower price than an identical one that requires a degree of service to determine the consumer's needs, use, right type and size, and instructions on use.

Quality assurance, credentialing and accreditation

Consumers purchasing AT in Australia are covered by our very robust Australian Consumer Law (see the box for details). However, consumers are not covered by these laws when the AT is purchased and owned on their behalf by the state/territory AT funding schemes, or when they purchase AT overseas through the internet or other means.

Consumer rights in Australian Consumer Law

Products purchased must:

- be of acceptable quality
- match the description, sample or demonstration model
- be fit for their purpose
- legally belong to the seller
- not have any outstanding money owing on them
- have spare parts and repairs available for a reasonable amount of time after your purchase unless otherwise stated.

Most AT items sold in Australia are Class 1 Medical Devices, and are regulated by the Therapeutic Goods Administration (TGA), and local manufacturers or importers are required to ensure that these are listed with the TGA before making them available for purchase in Australia. Also, there are national and international standards applicable to most AT. As a fundamental requirement and whenever applicable, any AT purchased with government funding should be listed with the TGA and compliant with the relevant standards.

All of ATSA's members are required to uphold the *ATSA Code of Practice* (see www.atsa.org.au). Additionally, ATSA has proposed the establishment of an AT-specific accreditation and credentialing scheme to certify the expertise and quality of AT suppliers (many of whom are already compliant with ISO 9001) and AT professionals working at the more complex end of AT, including independent allied health therapists and those employed by suppliers (Summers & Walker 2013). Further investment in developing AT accreditation and credentialing is unlikely to occur until there is a commitment from major AT funders such as the NDIA to utilise such a framework.

Minimising impacts and sources of market failure

Currently the most apparent source of market failure is the non-commercial viability of providing AT (including maintenance and repairs) in rural and remote areas. The low population density makes supporting such specialised services problematic – a difficulty common to many other areas of service provision. This issue must be addressed and possible solutions evaluated, such as acknowledging these additional costs for AT products and services in the prices paid for AT in rural and remote areas, or through other financial incentives.

A significant part of any approach will involve ensuring the availability of services by allied health professionals with AT skills to provide independent advice and information to consumers and their families/communities in rural and remote areas. Solutions might include not separating this advice from AT provision itself, and managing any potential conflicts of interest via other means, as well as teleconferencing and other electronic means of directly accessing this expertise.

Evaluating consumer outcomes

It is essential that consumer outcomes in relation to AT provision are evaluated in the short and long term. Linking these outcomes to AT provision processes and associated costs is vital to testing and improving service delivery processes, and to making informed decisions about what really makes a difference – especially relative to consumer outcomes and associated costs.

There is a paucity of AT research in Australia, and implementing the NDIS and Aged Care Reforms provides an ideal and rare opportunity to gather evidence about what does and does not work, for all stakeholders – individuals, their families, the community, funders and providers.

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