



**Submission to the
Queensland Competition Authority's
Medical and Disability Aids
and Equipment Pricing
Investigation**

30 September 2013

Executive summary

Assistive Technology Suppliers Australasia (ATSA) welcomes the QCA's Medical and Disability Aids and Equipment Pricing Investigation. Our submission focuses primarily on the moderately complex and complex end of the assistive technology (AT) spectrum as this is the source of most concerns about pricing.

ATSA members range from small family owned businesses to international companies. A viable and competitive AT provider sector is pivotal to ensuring choice and flexibility for people with disability in Australia, and this is particularly important because one in ten Australians (40% of people with a disability) use and rely on AT (ABS 2004: 7).

The QCA investigation posed three primary questions, and the first one was focused on whether or not there were price disparities in the cost of AT sold in Australia, and particularly in Queensland, and the cost of AT sold overseas. In preparing our submission the only evidence we found of price disparity in comparing AT pricing in Australia to 6 OECD countries was that Australian prices were 14% lower on average. This research focused exclusively on moderately complex and complex AT as this is where most concerns about pricing appear to be generated.

Consumers' pricing concerns appear to arise from a number of factors including:

- the high and cumulative costs to individuals and families with often lower than average incomes paying for multiple AT devices (and/or utilising government AT programs such as MASS), as well as home modifications and vehicle modifications
- lack of understanding of fundamental differences in costs for most Australian 'bricks and mortar' retailers (including full service AT providers) compared to internet retailers (see Productivity Commission 2011 for more details)
- little recognition of additional service provision costs specific to moderately complex and complex AT, particularly the highly skilled services provided to both individual consumers and the sector to ensure there is a good match between the individual and the AT, to support the best possible outcomes for consumers.

The AT industry is primarily a services industry, not a goods-based industry, particularly at the moderately complex and complex end of the AT pyramid. The cost of most of these services are factored into the retail price of AT, rather than being charged separately. Services to the sector by AT providers include: R&D, sourcing new products, training prescribing therapists, standards testing and compliance, and providing free AT products to Independent Living Centres and other key facilities such as spinal and rehabilitation units. In relation to effectively meeting the needs of consumers, pre-sales work includes 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, ongoing support, maintenance, repairs and spares.

Because internet retailers provide AT directly from the manufacturer to the consumer, without having to provide most of these services to the sector or to individuals, they are able to price AT 40-

50% lower. However, online purchasers must carry all of the responsibility and risk associated with ensuring that the AT meets their needs, is safe (including issues of assembly, installation and use, and fitness for purpose), and is the best AT solution for them over the long term, including sourcing adjustments, training, support, spares, maintenance and repairs locally.

The second primary question for the QCA investigation is on the causes of any price disparities found. Given Australia's lower than OECD average prices for moderately complex and complex AT, this would indicate that AT is competitively priced in Australia, and Australian full service AT providers operate efficient businesses within a relatively efficient and competitive range of business structures.

Concerns about exclusive supply arrangements and geoblocking are addressed in detail in the full submission. At a summary level, exclusive supply arrangements are commonplace throughout the retail sector in Australia and the AT sector is no exception. However, these arrangements help to ensure a wide variety of products come to the market, and there is extensive competition between similar products of different brands. It is due to these arrangements that Australians have access to a vast array of AT products from around the world to meet their needs at very competitive prices.

In relation to geoblocking, many foreign AT manufacturers actively try to prevent internet retailers from supplying items to overseas customers due to the lack of available support services (see above) and the associated risks, particularly in the complex and moderately complex range of AT.

Geoblocking does not tend to occur for simpler and less complex AT, which do not require the skills of full service AT providers to ensure a good match between the AT and the individual, and manage the attendant risks.

International manufacturers are also cognisant of the need to support an importer/distributor in the local market to maximise their penetration and volumes, particularly for complex and moderately complex AT. Few businesses would make the substantial investment required to bring a new products to market if they believed there was a risk that large numbers of consumers would bypass them and purchase offshore. And without the commitment of full service AT providers to delivering the highly skilled services essential to getting a good match between the AT and the device, consumer outcomes will decline over time.

The final major question posed in the QCA investigation is what steps could be taken by government to address any price disparities. Notwithstanding the below average pricing of moderately complex and complex AT in Australia, there is scope for some improvements to reduce pricing further. These include:

- more efficient government AT funding and procurement programs (at both the individual and bulk procurement levels): funding delays frequently require reassessment and re-trialling at significant costs for AT providers which is factored into prices; improved tendering processes to reduce excessive paperwork, measure to enable that smaller providers can compete effectively, including consideration of additional costs of providing AT in rural and remote settings
- acceptance of US Food and Drug Administration compliance certification of AT products, to minimise requirements to test against Australian or International Standards to products procured by MASS, given the small scale of the market these additional costs are difficult to

recoup without increasing prices (the US is the third largest importer of wheelchairs into Australia, behind China and Taiwan)

- reduction in the multiplicity of AT programs nationally would help reduce paperwork and costs for suppliers (and consumers, government and prescribing therapists). With over 100 programs nationally, the different rules, forms and compliance costs could be reduced through both consolidation of programs and/or more universal rules, forms and compliance requirements would help to reduce costs and their impact on prices.

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Introduction and background

Assistive Technology Suppliers Australasia (ATSA) welcomes the QCA's Medical and Disability Aids and Equipment Pricing Investigation. Given the ongoing concerns by people with disability and their families about the cost of assistive technology (AT) in Australia, an independent investigation such as this is very much needed. ATSA has been calling for an independent AT pricing investigation for several years, and was in the preliminary stages of receiving proposals from several universities when the QCA investigation was initiated.

ATSA members range from small family owned businesses to international companies. Many owners got into the AT business because they have a disability or a family member/friend does, and they saw the need to improve access to AT devices and related skilled AT services. We believe that a viable and competitive AT provider sector is pivotal to ensuring choice and flexibility for people with disability in Australia, and this is particularly important because one in ten Australians (40% of people with a disability) use and rely on AT (ABS 2004: 7).

As an industry association we have been well aware of pricing concerns for a number of years, and have responded to these issues on a case-by-case basis as they have arisen (see Case Studies 1 and 2 below). But there is a strong need for a more systematic approach to the issue, which this investigation should achieve.

Previously ATSA has found that most pricing concerns arise from a number of factors including:

- the high and cumulative costs to individuals and families with often lower than average incomes paying for multiple AT devices (and/or utilising government AT programs such as MASS), as well as home modifications and vehicle modifications
- lack of understanding of fundamental differences in supply chain costs for most Australian full service AT providers versus internet retailers (Productivity Commission 2011), particularly those in the USA
- little recognition of additional differences in supply chain and other costs specific to AT, in particular the highly skilled professional and technical services provided by AT providers that are usually incorporated into the retail price.

Most consumers' pricing concerns are typically focused on complex and moderately complex AT, and this appears to be the basis of the initiation of the QCA investigation. Our response will likewise focus primarily on this area, rather than on the mass-produced, high-volume/low-cost items such as walking frames, basic wheelchairs often used just to move a person from place to place rather than as a primary mobility aid to foster independence which are often used full time, and continence aids (noting that prices on these high-volume items have generally gone down over time).

Case Study 1

Complaint December 2010:

A parent of a young child with significant disability stated: *'In March 2008, my child's wheelchair cost \$13,000 in Australia, yet I could have bought it online from the USA for just \$3,750.'*

Investigation Results

- The total cost invoiced was \$11,846 of which the wheelchair was just one component of the AT solution and was priced at \$5,888. This was 5% below the importer's RRP at the time.
- The quoted US internet price of \$3,750 was for the base wheelchair with no options and no freight, whereas the local AT provider's price included a number of options and airfreight to Australia.
- The importer of the wheelchair advised the cost of airfreight for the wheelchair was close to \$1,000 AUD, due to its large size, and domestic freight (paid by the AT provider) would have been around \$45.
- The balance of the cost was for complex seating components (\$3,004), postural supports (\$2,663), and labour for custom wheelchair modifications, fitting and delivery (\$291).
- Labour was charged at \$85/hr plus GST for custom wheelchair modifications (1 hour billed) and \$60/hr plus GST for setup and delivery (3 hours billed).
- Despite a lengthy explanation to the parent, the claim continues to be made.

Note that this complaint was widely circulated locally and nationally to Federal and State Ministers, MPs and the media for a number of years, and still surfaces regularly.

Case Study 2

Complaint (December 2012):

A consumer contacted the US based manufacturer of highly bespoke, custom manual wheelchairs and stated: *'Prices through your Australian dealer network are double the US cost for titanium wheelchairs and triple the US cost for aluminium wheelchairs'.*

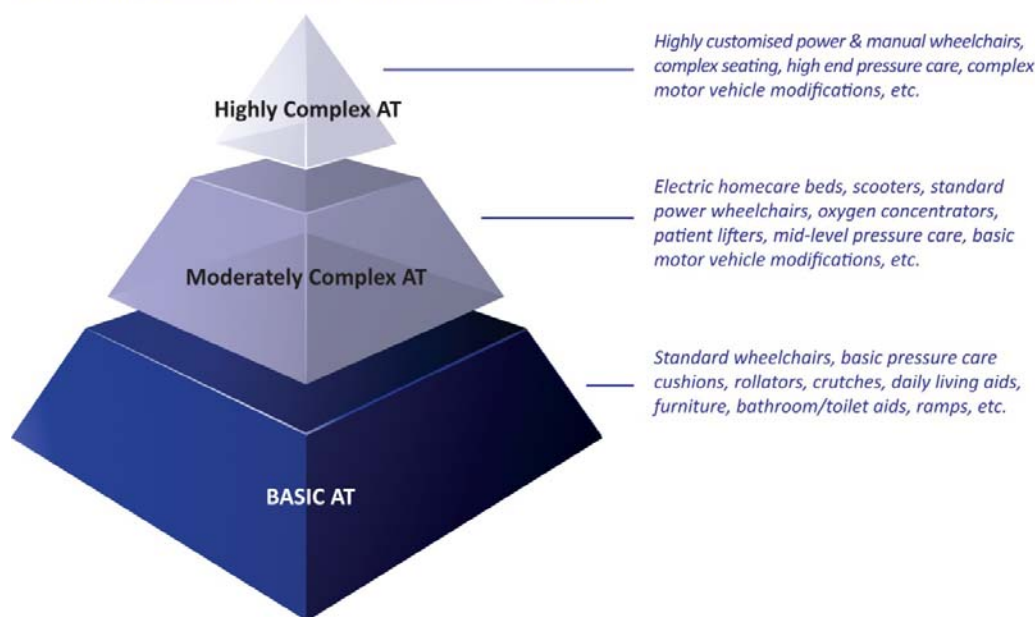
Investigation Results (prices quoted are AUD):

- When purchased in Australia, the titanium wheelchair's RRP was \$6,135 through a full service provider and \$6,290 through a similar provider in the US (including \$450 for airfreight to Australia). The US website price was \$4,530 (including \$450 for airfreight to Australia).
- When purchased in Australia, the aluminium wheelchair's RRP was \$2,550 through a full service provider and \$2,545 through a similar provider in the US (including \$450 for airfreight to Australia). The US website price was \$2,000 allowing (including \$450 for airfreight to Australia).

Figure 1 below, the AT Pyramid, provides a broad outline of AT by levels of complexity. As levels of complexity increase, costs for AT providers and prices for consumers also tend to increase. In part this is driven by the sophistication and manufacturing costs of the device, and also significantly by the levels of service required to ensure a good match between the device and the user. Importantly, although they are not illustrated in Figure 1, issues of complexity are not confined to the device, but are also vary widely in relation to the person with disability and their environment. Issues such as cognitive impairment resulting from illness or injury, severe physical limitations/deformities and intellectual disability, as well as the consumer's environment, lifestyle and aspirations can all increase the complexity of arriving at a good AT solution, the solution itself, and ongoing support. Complexity is also often compounded because some consumers' needs are not particularly stable, and this includes children who are growing in all respects (physical, mental and social) and people with progressive illnesses such as motor neurone disease and multiple sclerosis. Both the skills required and the time required increase as client complexity increases – even for 'simple' AT solutions.

Figure 1: The AT Pyramid

Individualised procurement essential at this level: low volume/high cost



Potential for bulk procurement at this level: high volume/low cost

As complexity of both the device and the consumer increase, so does the risk of not getting the 'right' solution in place which generates in poor outcomes for the consumer, and poor value for money for the funder, with equipment abandonment being a common indicator of failure. This further emphasises the importance having a highly skilled workforce as part of the Australian full service AT providers' model. While this generates costs and impacts on pricing, the benefits gained significantly outweigh the costs.

It is not uncommon for many retail goods to cost more in Australian shops than from online internet sellers (Productivity Commission 2011), and the AT sector is not immune from these inherent differences in supply chain costs and market structures. Additionally AT is often more complex and difficult to provide than other goods, as well as being a more personally and socially valued commodity than books, shoes and consumer electronics as a consequence of AT's capacity to enable people with disability to undertake activities that others take for granted. AT is vital to maximising inclusion, independence and participation in all aspects of life.

Pricing of AT is a critical issue in relation to affordability and accessibility, as are government programs that fully or partially fund AT for those that need it.

It is vital that the QCA investigation considers pricing issues within a broad context. Lower prices should not be achieved by sacrificing good outcomes for people with disability. Reduced outcomes for people with disability also increase costs and reduce savings for government in relation to reduced independence, increased need for services, increased hospital use and reduced employment.

It is no doubt possible to drive prices downwards to some degree. But lower prices are a very poor outcome if this is achieved by reducing: choice; access to highly skilled and high quality services; innovation; rural/remote access to AT devices and services; and effectively matching AT to the individual. All of which will lead to lower levels of inclusion, participation and independence of people with disability of all ages.

While programs such as MASS can increase access to AT for people of limited economic means, they can also result in the undervaluing of AT because while MASS is the purchaser it derives no utility from the transaction – as it is the consumer that derives the utility. This may account for the tendency of many government AT programs to focus on pricing-only and not consider more carefully what consumers need to derive maximum utility. The highly skilled services of AT providers are central to enabling consumers to maximise the utility they derive from their AT. A key element in the theoretical underpinnings of the international shift to 'consumer control' in schemes such as the National Disability Insurance Scheme derive in part from this disconnect and devaluing that occurs when third party funders control purchasing decisions.

Significantly, while a 'silo' program such as MASS would derive little or no utility from purchasing AT, it is clear that governments (and individuals and the community generally) do derive substantial savings from AT. There is good evidence that providing appropriate and timely aids and equipment can: improve well-being and quality of life for those with functional impairments and their families; reduce residential care admissions; reduce family carer injuries and stress; increase participation in employment and education; reduce hospital admissions; and shorten hospital stays, and reduce support service hours (AIHW 2006; Heywood & Turner 2007; Audit Commission 2000, 2002, 2004a & 2004b). For older people it has been estimated that a cumulative 1% increase in independence over 50 years would result in a 40% reduction in the costs of providing care (Audit Commission 2004b: 11). All of this would indicate that notwithstanding the initial capital costs, AT nonetheless represents good value over time if the end result is increased independence and participation by people with disability of all ages. Programs such as MASS which are limited to purchasing only AT that can be used in the home, would appear to unnecessarily limit the potential value that could be derived from more robust and wider-ranging AT solutions.

Price comparisons

Price comparisons undertaken for this submission make it clear that AT prices in Australia are lower than comparable OECD countries by approximately 14% (this is the mean of the differences across the 12 products where there were data from 3 or more countries).

The price comparison was limited however, and prices on different products and/or in different countries might result in different findings. Nonetheless, consultation with Australian AT providers (including manufacturers, importers, distributors and retailers) indicates that this is not a surprising result as most providers have anecdotal evidence about their own markets and pricing internationally, and observe that the Australian AT supply sector is generally very efficient, as well as not being very profitable for most providers.

Due to limited time and resources ATSA utilised a tightly focused approach to examining price differences in preparing this submission. The focus was on mobility (manual and power wheelchairs and scooters) and related seating and postural support products, one manufacturer also included one of their major prosthetic items – a carbon fibre foot. See Table 1 which reports on the complete data set provided by these companies.

Data for this price comparison was sought from the major importers and global manufacturers of AT: Invacare Australia; Otto Bock Australia; Permobil Australia; Pride Mobility Australia; R82 Australia; ROHO USA; Shoprider Australia; Sunrise Medical Australia and TiLite USA. All companies were asked to provide the recommended retail prices for a sample of their most popular products across the 6 countries we selected, as well as Australia. Not all companies approached were able to provide data within the timeframe required, limiting our comparisons to 18 products. Note also that one product, the Leckey EDS is a paediatric product.

Pricing for US online sales was sourced from www.sportaid.com, one of the most popular and successful online AT sellers.

The foreign exchange rates used are from 27 September 2013 and were provided by Ozforex (see Appendix A), and are the commercial rates available to businesses for currency purchases of more than \$20,000 AUD. The rate used for the USA internet prices was the rate quoted by the National Bank's website on 27 September 2013, and accurately reflects what a consumer would pay when purchasing by credit card over the internet on that day.

It is notable that there are key gaps in the product range available from www.sportaid.com, namely power wheelchairs and some low volume more specialised items. This may reflect: the level of demand for these items; differences in available products internationally; and/or the difficulty in making profitable sales of these items at significantly reduced prices relative to full service AT.

As can be seen across items and across countries there are many price variations. However, overall Australia was between 37% and 13% cheaper than the mean of other OECD comparison countries on 9 of 12 products, and more expensive on 3 products ranging from 9% to 1%. Overall, Australia was 14% cheaper. For all of these means, data were available from at least 3 countries.

On 6 items comparison data were limited to only one country, this was in part due to the care taken to ensure we were comparing like items with like items. Additionally, limited availability of

identical products across multiple countries is common within the AT sector as well as the broader retail sector. As well as market forces common to all retail sectors (for instance local market preferences), a combination of government AT funding scheme rules and other regulations are likely to be a major influence on AT product availability.

Of the 6 items with only one comparison price, all were cheaper in Australia by 9-56%, with a mean across the 6 items of 27% cheaper in Australia.

The variability between recommended retail prices for AT at full service providers internationally, including Australia, are likely to be caused by a number of factors including:

- international freight costs
- type of product
- market size
- local taxes and charges
- differences in the usual costs of doing business (wages, rent, freight, insurance etc)
- differences in compliance and testing regimes
- requirements of large local AT funding schemes, as local markets are often structured around purchasing structures of governments and/or social insurance schemes as they are major purchasers of AT in most OECD countries.

Table 1: International Recommended Retail Price Comparisons of AT Products

Product	Australia	US	Canada	New Zealand	UK	Germany	Japan	US Website	OECD Mean RRP (excl Australia & US Website)	Australian RRP Relative to Mean OECD RRP*	Difference in Australian RRP from OECD RRP Mean*
Jay 2 Cushion	\$695	\$455	\$724	\$529	\$697	\$890	\$537	\$332	\$639	\$56	9%
Quickie 2 Wheelchair	\$2,222	\$2,196	\$2,820	\$1,824	\$3,184	-	\$2,713	\$1,372	\$2,547	(\$325)	-13%
QM710 MWD Power Wheelchair	\$8,897	\$11,693	\$12,285	\$9,620	\$12,518	\$15,591	\$11,841	-	\$12,258	(\$3,361)	-27%
ROHO QuadSelect High Profile Cushion	\$685	\$491	\$748	\$796	\$964	\$550	\$521	\$389	\$678	\$7	1%
ROHO Hybrid Elite Cushion	\$695	\$507	\$827	\$796	\$964	\$550	\$521	\$400	\$694	\$1	0%
ShopRider QT-3 Scooter	\$1,750	\$1,923	-	-	-	-	-	-	-	(\$173)	-9%
ShopRider RainRider	\$9,100	\$9,636	-	-	-	-	-	-	-	(\$536)	-6%
ShopRider Rocky6	\$5,800	\$6,422	-	-	-	-	-	-	-	(\$622)	-10%
ShopRider Venice	\$3,500	\$5,351	-	-	-	-	-	-	-	(\$1,851)	-35%
Permobil M300Corpus3G Power Wheelchair	\$16,582	\$23,531	\$24,672	-	\$19,317	\$26,890	\$14,367	-	\$21,755	(\$5,173)	-24%
TiLite TR Series 3 Custom Manual Wheelchair	\$3,895	\$3,637	\$4,501	\$5,677	\$3,950	\$6,040	-	\$2,665	\$4,761	(\$866)	-18%
Leckey EDS Seat Base, Backrest & Chassis	\$1,589	\$2,702	\$2,467	-	-	\$1,472	-	-	\$2,214	(\$625)	-28%
Ottobock Ventus	\$2,260	-	\$3,096	-	-	\$3,610	\$1,682	-	\$2,796	(\$536)	-19%
Ottobock B400 Power Chair	\$3,959	-	-	-	-	\$7,225	-	-	-	(\$3,266)	-45%
Ottobock Start M1 Wheelchair 40.5 Std	\$695	-	-	-	-	\$1,584	-	-	-	(\$889)	-56%
Ottobock Start M4 Wheelchair XXL	\$1,456	-	\$2,810	-	-	\$2,279	\$1,899	-	\$2,329	(\$873)	-37%
Ottobock Cloud Cushion	\$736	\$586	\$655	-	-	\$972	\$554	\$415	\$692	\$44	6%
Ottobock Trias Carbonfibre Foot	\$795	\$1,237	-	\$907	\$730	\$1,191	-	-	\$1,016	(\$221)	-22%

* Note: when there was data available from only one other country this was used to calculate the difference rather than the mean, in all other instances the mean of at least 3 other countries was utilised
All prices are in Australian currency based on exchange rates on 27 Sept 2013

Significantly, across the board internet prices were lower by comparison with all other prices, ranging from 41% to 49% cheaper than the mean recommended retail price (including Australia), with an average difference of 44% cheaper (see Table 2). Internet sales compared to Australian full service AT providers yielded a similar result: with online prices ranging from 52% to 32% cheaper, with a mean difference of 42% cheaper overall (see Table 3).

Table 2: Mean Recommended OECD Retail Prices Compared to Internet Prices

Product	OECD Mean (including AUS)	US Website	OECD Mean RRP relative to Online Price	Percentage of Difference
Jay 2 Cushion	\$647	\$332	\$315	49%
Quickie 2 Wheelchair	\$2493	\$1372	\$1122	45%
ROHO QuadSelect High Profile Cushion	\$679	\$389	\$290	43%
ROHO Hybrid Elite Cushion	\$694	\$400	\$294	42%
TiLite TR Series 3 Custom Manual Wheelchair	\$4617	\$2665	\$1952	42%
Ottobock Cloud Cushion	\$700	\$415	\$285	41%

Table 3: Australian recommended retail prices compared to Internet Prices

Product	Australia	US Website	Australian RRP Relative to Online Price	Percentage of Difference
Jay 2 Cushion	\$695	\$332	\$363	52%
Quickie 2 Wheelchair	\$2222	\$1372	\$850	38%
ROHO QuadSelect High Profile Cushion	\$685	\$389	\$296	43%
ROHO Hybrid Elite Cushion	\$695	\$400	\$295	42%
TiLite TR Series 3 Custom Manual Wheelchair	\$3895	\$2665	\$1230	32%
Ottobock Cloud Cushion	\$736	\$415	\$321	44%

The very substantial internet price differences are primarily because:

- there is no service offered through internet sales;
- the internet seller typically never even handles that AT as it is usually shipped directly from the manufacturer to the purchaser
- very positive cash flow for internet sellers as all items are paid for in advance
- warranty and spares are taken care of by the manufacturer, not the seller
- the consumer carries all the responsibility and risk in relation to whether or not it is a suitable product for them that effectively meets their needs.

See the sections below on ‘Who does what’ and ‘Can the US internet sales model work in Australia’ for more details.

AT is a service-based industry

As the above analysis indicates, while Australian full service AT providers are very competitive on prices relative to their international counterparts, pricing relative to internet sellers is much higher. Although the numerous factors which account for this are outlined above and detailed in a subsequent section of this submission, the primary difference between full service provider pricing and online pricing is service.

While the public perception of AT is that it is a goods-based industry, it is in fact a services industry based around providing goods that are well-matched to an individual's needs, goals and environment. This is particularly the case in relation to complex and moderately complex AT.

Extensive and wide ranging services are often required to achieve and maintain the matching of the device to the individual. The services required can be divided into two overlapping elements: services related directly to individuals, and services to the sector that facilitate achieving good individual outcomes.

Individual level services include:

- information and advice (including to the prescribing therapist)
- assistance selecting the 'right' product, including extensive investment in display and demonstration stock
- developing detailed specifications for an AT solution (for instance a power wheelchair may require specialised seating, postural support, electronic controls, and other options to maximise outcomes for the consumer)
- free home trials (including delivery, set-up, adjustment, instructions on use, pick-up/return)
- assembly/construction of the final AT product
- delivery, adjustments, instructions for use and maintenance
- maintenance, spares and repairs.

Services to the sector include:

- sourcing new products, including research and development of new products
- standards and compliance testing, including detailed product specifications
- training and education of prescribing therapists
- product inventory and spare parts (some of which are very time critical for vital items)
- warranties, product recalls and participation in standards development
- long term loan of products to public sector organisations such as Independent Living Centres and spinal/rehabilitation facilities.

Information and advice from AT providers are essential given the asymmetry of information in the market-place, as unlike many other goods, most prospective AT consumers will not be aware of the range of products, options and adjustment available on those products, customisations possible, what might be most suitable and beneficial to them including what some of the small differences between these items can make to consumers at an every-day level. In short, very few AT consumers are able to judge the utility of an AT device prior to purchase.

Likewise, AT prescribers (usually occupational therapists, physiotherapists and others) rely extensively on the expertise of full service AT providers to help them manage the variety and complexity of available products in relation to matching these to consumers. Most prescribers are generalists and do not work exclusively with AT, and consequently cannot possibly be across the detailed knowledge and skills required at the moderately complex and complex end of the AT market (see Summers & Walker 2013 for an extensive discussion of the complexities and skills required to provide effective AT solutions).

The heterogeneity of individuals and their environment is one of the major drivers of the extensive diversity of AT products available in Australia, and this diversity itself is one of the indicators of the robustness of competition between AT providers. The heterogeneity of individual needs and aspirations of people with disability is also why full service AT providers require highly skilled and specialised staff to deliver effective solutions as complexity increases.

These skilled staff, particularly at the complex and moderately complex end of the market, are also one of the ways AT providers differentiate themselves from each other, and are central to their success relative to their competitors in attracting and maintaining customers. Full service AT providers tend to invest considerable time and effort in skilling up their staff, even when recruiting experienced professionals such as occupational therapists it often takes several years of training by the AT provider to bring them up to the required level. AT providers also recruit relevant professionals from overseas such as rehabilitation engineers whose expertise is matching the biomechanics of the human body to available or customised AT devices (rehabilitation engineering degrees are not available from Australian universities).

Very small differences within and between products can make a tremendous difference to their suitability, safety and value for a particular individual, and the variety in the marketplace is vast. For instance, at the middle and upper end of complex wheelchairs (manual and powered) there are numerous adjustments and options that can make the difference between an 'OK' solution and a 'fabulous' solution (see Appendix B for a sample wheelchair specification form). These service costs are built into the retail price in Australia, and are often not perceived or understood by consumers only focusing on 'price'.

Importantly, a major source of the price difference between on-line sales and Australian full service AT providers is associated with the extent of skilled services provided by AT providers (to individuals with disability and the sector more broadly), as well as the usual 'bricks and mortar' costs faced by other retail sectors. For instance, many common items such as hoists, electric beds and wheelchairs are made available for in-home trials by AT providers. This includes delivery, assembly/set-up/adjustments, instructions on use, determination of detailed specifications and pick-up. These services all come at a cost, and these are built into the retail pricing of AT in Australia, rather than charged separately.

A significant contributor to these service costs is that much of this activity takes place in the consumer's home, which substantially increases costs for travel, travel time for professionals and technicians, as well as multiple delivery and pick-up costs for equipment that is trialled as well as delivery of purchased items, pick up and return of these items for adjustments, modifications, maintenance and repairs when required.

Australia's low population density (ie large land mass with less than 23M people), adds significant costs to a hands-on, service based industry, particularly in relation to servicing rural and remote communities.

Additionally, at the higher end of complexity (in relation to both the AT device and the person with disability) significant time and skills are a major part of ensuring that a highly effective and individualised/customised solution is provided. For instance, a complex wheelchair with specialised controls, customised seating/supports and related assessment, fitting/customisation, trialling and subsequent rounds of modifications may require an AT provider to invest between 5-20 hours of highly skilled labour typically, but also sometimes up to 30-40 hours. Importantly, most AT providers are only successful about 50% of the time after investing in this pre-sales work, meaning that half of the time the costs of advice, developing detailed specifications and in-home trialling do not result in a sale.

Who does what

A crucial part of understanding supply-chain and service related price differences, particularly in relation to full service AT providers versus internet sellers, is through the details of who does what. As noted above there are numerous roles that must be undertaken, both at an industry/sector level as well as at an individual consumer level to ensure good outcomes for people with disability that maximise their independence and participation, and also good outcomes for government in relation to reduced costs over time and increased revenue from participation in employment. Table 4 outlines this in more detail, particularly in relation to full service AT providers (US and Australian) and internet sellers. Some major aspects of this are discussed below.

One of the keys to understanding how the supply chain functions in Australia is the requirement by the Therapeutics Goods Administration (TGA) for all Class 1 Medical Devices to comply with quality manufacturing standards and to be listed on the Australian Register of Therapeutic Goods (ARTG). This includes wheelchairs, mobility aids, pressure care items, home oxygen devices, patient lifters, home care beds, postural supports, most mobility scooters etc.

Consequently, Australian manufacturers have to prove their manufacturing processes meet an acceptable standard to be listed on the ARTG. Processes have to be in place to administer product safety recalls for defective products.

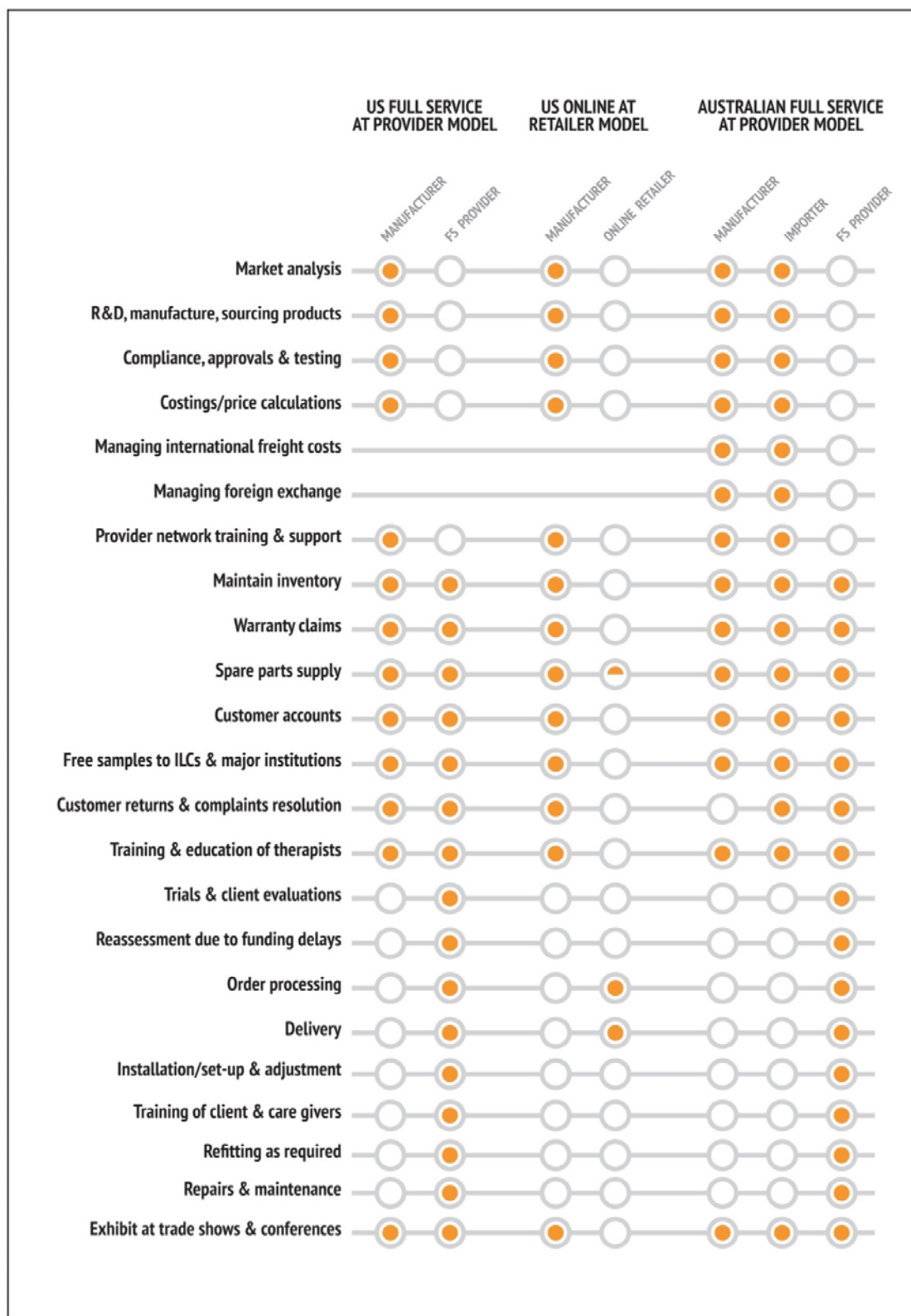
Businesses that import AT into Australia can only do so if they are registered as a 'Sponsor' with the TGA. This requires them to verify their appointment as the authorised importer by the overseas manufacturer and guarantee that the manufacturing processes comply with the TGA's quality standards. Sponsors also have an obligation to administer product safety recalls, and maintain adequate records to enable this. Importantly, in private capacity individuals can lawfully import any items of AT without any reference to the TGA.

Australian legislation regarding consumer goods requires that products are fit for purpose and covered by a minimum statutory warranty. Local AT providers cannot contract out of these obligations to reduce costs as the US internet retailers effectively do.

At the manufacturer/importer/distributor end of the supply chain, some of often hidden costs include R&D, sourcing cutting edge AT, and standards compliance and testing.

AT Providers also provide a wide range of education and training to other providers; prescribing therapists; consumers/families and their paid caregivers. Importers/manufacturers/distributors train staff in providers' businesses regarding existing and new products, their appropriate use/set-up/options/safety and so forth, as well as therapists/prescribers. Full service providers provide similar training to therapists/prescribers, as well as training purchasers of AT, their families and carers in the use of those products.

Providing AT for display and demonstration to a wide range of organisations such as Independent Living Centres, spinal units and rehabilitation centres is often done in Australia by a combination of manufacturers/importers/distributors and full service providers. Additionally, one of the major costs for full service AT providers is to maintain sufficient breadth and depth of stock for both display and trialling in their retail premises. This can be extensive given the wide range of sizes and options across product ranges.

Table 4: Who does what

Providers of complex AT have to carry an extensive suite of devices and accessories so they can trial various solutions for consumers usually with input from a prescribing therapist. For example, it is common for a provider to visit a consumer's home with a number of manual or electric wheelchairs, different types/sizes of cushions and backrests, along with additional postural supports and other accessories. Trial equipment is essentially a sunk cost as it is rarely able to be resold and needs to be constantly upgraded as newer versions are released. A medium to large provider of complex AT would carry over \$500,000 in trial items to support their business and this is in addition to inventory that is for sale.

Importantly, conducting an in-home trial is no guarantee of securing a sale and conversion rates to a sale reported anecdotally from suppliers are in the range 45-60%. The increasingly popular AT reissue programs operating in several states often use a provider's intellectual property in the form of detailed specifications to provide AT from a pool of reissue or bulk purchased equipment. Providers are typically not able to invoice the government or the consumer for this pre-sales work, so the costs of preparing these specifications that are subsequently appropriated for re-issued equipment (or from government bulk purchase stock) but not paid for, also increase prices.

Many other activities undertaken by full service AT providers have already been mentioned such as supplying detailed product information and advice to both prescribers and consumers, working with consumers and prescribers to get the 'right match' of AT to the user, developing detailed specifications, in-home trials (including delivery, set-up, adjustment, training, and removal), warranty, repairs and spares.

Finally, in relation to who-does-what, at a background and contextual level it is important to understand that the best arrangement to ensure that AT effectively meets a consumer's needs, environment and aspirations, and delivers the best possible outcomes involves a strong partnership between the consumer, the prescribing therapist and the AT provider. Each party brings essential knowledge and skills to the partnership. Notwithstanding this, there is a common tendency for people who are not directly involved at the coal-face in the day-to-day provision of AT to perceive that the prescribing therapist undertakes all of the essential activities. For example, the current Queensland Medical Aids Subsidy Scheme (MASS) program guidelines (Queensland Health 2013) attribute many activities to prescribers that are in fact undertaken by AT providers who are never mentioned in the document. Such misconceptions contribute to perceptions that AT pricing is excessive as it inadvertently ignores the costs borne by AT providers to provide the essential services required to undertake their role in the partnership.

Can the US internet sales model work in Australia?

Figure 2 of the Pearson report (page 48) depicts the “Market and Supply Chain for Aids and Equipment in Australia” (see Appendix C). Although it fails to highlight the myriad of services provided by Australian AT importers and full service providers (see Table 4 above) involved in the complex and moderately complex end of the AT market, it shows the necessary and complicated route to market for full service AT providers compared to the direct route via internet retailers.

The US internet sales model for aids and equipment is very reliant upon the consumer and the manufacturer residing in the same country, and this is largely why the model has not flourished in other world markets. Many of the normal services provided by full service AT providers (equipment trials, preparation of AT specifications, customisation, installation/setup, training of clients/care givers, debtor accounts, local spare part supply etc.) are not included when purchasing over the internet. In the US internet sales model issues arising from warranty claims, products not to specification and supply of spare parts become the responsibility of the manufacturer. This is highly problematic when the consumer is in Australia and the manufacturer is in the USA.

Many foreign AT manufacturers attempt to prevent internet retailers from supplying items to overseas customers due to the lack of available support services and the associated risks. If someone orders a customised manual wheelchair and it is not built to specification, the costs of international freight alone that would be required to effectively resolve the issue are prohibitive.

International manufacturers are also cognisant of the need to support an importer/distributor in the local market to maximise their market penetration and potential sales volumes. Few businesses would make the substantial investment required to bring a new product to market if they believed there was a risk that large numbers of consumers would bypass them and purchase offshore.

The internet sales model is very simple and therefore low cost. It is common for internet retailers to never interact directly with the consumer or physically handle the products that have been ordered. The consumer takes responsibility for finalising all product specifications and usually provides payment in full when lodging their order. The internet retailer simply checks that payment has been received and then forwards the order to the manufacturer to drop-ship the product when available. Custom products may have a 3-4 week build time and most manufacturers would offer the retailer at least a 30 day account which ensures a very cash flow positive enterprise for the internet reseller. Australian full service AT providers who supply government funded schemes generally have to wait 50-180 days to receive payment.

Internet retailers also benefit from the very large number of products that they order, as many US manufacturers base their dealer discounts purely on volume. Australia’s small market does not always consume the volumes required to obtain high volume discounts for AT importers or full service AT providers.

Other Australian supply-chain costs

Although Australian full service retailers are competitive on prices internationally, there are two persistent problems that add costs and could be improved: excessive fragmentation of government AT programs; and funding delays in some government funded AT programs leading to extra costs. Additionally, the Australian geography with its urban centric population and vast distances creates major challenges for supplying AT to regional, rural and remote communities. This are all discussed in more detail below.

Although there is little national data available, and a significant proportion of AT is purchased privately by individuals (perhaps approximately 50%) the rest is purchased through government and statutory schemes. There are approximately 100 different government and statutory AT schemes across all levels of government and across numerous government departments (Jenny Pearson & Assoc. 2013), creating significant fragmentation which results in excessive and avoidable additional costs for the supply of AT through the multiplicity program rules, forms to fill out, tendering opportunities and compliance requirements. This also significantly increases overall AT provision costs that are not part of AT pricing, particularly costs to governments of administering multiple schemes, and costs for consumers and prescribing therapists to navigate and work across all of these schemes. Importantly, paying therapists to do the extra work required through the multiplicity of schemes is done by both consumers and government depending on the particular situation, and this also represent significant opportunity costs as therapists are tied up with paperwork and compliance requirements rather than working with consumers and AT providers to arrive at good AT solutions.

Every scheme operates differently: some cover the full cost, others require consumer co-payments; some vest ownership and costs of maintenance/repairs with the state/territory/federal government, others may vest ownership with the consumer as well as responsibility for repairs/maintenance, and some use a combination; some undertake significant desk-reviews of ‘appropriateness’ of a prescription and quote for supply, others do not; many schemes do some form of contracted procurement but this also varies widely from tenders for bulk purchasing of devices, to utilisation of panels of selected providers, truncated supply chain arrangements where items are purchased directly from importers/distributors/manufacturers, and hierarchical contracting for supply (for example Rehabilitation Aids and Appliances program of the Dept. of Veterans’ Affairs).

This variety of AT programs adds substantial red-tape and paperwork costs driven by fundamental administrative inefficiencies. There are also often significant costs to AT providers in responding to an endless stream of local and national tendering opportunities, which can be very complex and very high-stakes in relation to business survival.

This market fragmentation also adds substantial cost to introducing, marketing and supporting a AT products on a national basis.

Funding and payment delays also add significant cost for full service AT providers. A therapist prescribes a particular item for a consumer, one or several full service retailers then provide advice, detailed assessment/specification (often including an in-home trial), and a quote. This is then submitted to the government funding scheme. Delays in processing and approving a quote, and subsequent payment, often require AT providers to reassess the client including developing a modified or new set of specifications and a new home trial. These delays can routinely be 6 months

and 12 to 24 months or more are not unknown, especially in schemes where consumers need to source funds for large co-payments (including MASS).

Early findings from a recent ATSA Industry Survey (Sept 2013) of NSW based AT providers indicate that 44% of all assessments performed for AT that was to be funded by EnableNSW had to be repeated due to funding delays. The estimated cost to full service AT providers for performing a reassessment varied from \$100 to \$1,000, with average cost of \$386. The large variability in cost is likely to be the result of the complexity of the AT and the clients, as well as the costs of travel required (particularly in rural/remote areas). Typically AT providers absorb this cost and it is factored into the retail pricing of AT.

The funding delays that require reassessments are an avoidable and unnecessary cost to AT providers, which increases AT prices. There are separate additional costs to government and sometimes to people with disability as must also pay for the additional cost of the prescribing therapist's involvement in the reassessment process. Consumers and their families also pay for the extra costs of repeated assessments through the extra time and effort required in these reassessments, as well as the costs of the delays in getting access to much needed AT.

Finally, the geography of Australia and its urban-centric population also imposes additional costs not faced in most other countries. Providing AT in rural and remote areas imposes very significant additional costs. If it was simply a matter of shipping an AT item to someone's front door, these extra costs would be apparent. However, given the extensive services required to provide an effective AT solution, the costs of labour, multiple trips from urban or regional centres, and/or the costs of having sufficient demonstration and display stock and keeping highly skilled labour in rural shopfront settings is significant. There is no way around this tyranny of distance and the additional costs this imposes if rural and remote communities are to have adequate access to AT. This also drives up costs in relation to maintenance and repairs as well.

Other relevant information

Briefly outlined below is some additional useful information about the provision of AT in Australia that is particularly relevant when considering the price of AT.

As noted at the beginning of this submission, our focus has been primarily on complex and moderately complex AT, and complex consumers, both of which require full service AT retailers (along with prescribing therapists and involvement of consumers themselves) to effectively meet consumers' needs. In addition, the AT market includes a substantial proportion of items and sales that are for high volume/low cost/low risk items. The real cost of off-the-shelf high volume/low cost AT has come down significantly over the past decade due to increased Asian manufacturing as nearly all of these items now imported from Asia, with its attendant low manufacturing and labour costs. Whereas mainstream Australian business costs (wages, premises, transport, red tape etc.) have continued to rise. Additionally, in Australia while most AT is exempt from GST, services, delivery and some parts are subject to GST

In 2004, Australia's largest retailer of home furnishings, white goods and electronic goods appointed a senior project team to consider establishing an AT branch of the business across Australia. After a six week in-depth study they concluded that the sector's low profitability could not justify the investment required to establish the business.

In December 2012, the world's largest AT manufacturer closed all but one of their full service AT shopfronts in Australia shedding more than 50% of their workforce and making over 70 people redundant. This was due to year-on-year multi-million dollar losses resulting from their Australian operations dating back to 2007.

In the period 2005-2008 three separate groups began purchasing large AT businesses: two multinational healthcare companies and a local consortium of investors linked to a major investment bank started purchasing AT retail business. They each had a similar vision of building much larger businesses, with greater buying power, back office efficiencies and the opportunity to control the market channel. All three new enterprises failed to succeed and were either sold off for a fraction of the purchase price, downsized and rationalised or in one instance closed down completely.

The above example of finding the market too difficult with poor profitability, along with several failed attempts by others to build major AT businesses in Australia are strong indications of how difficult the AT market is with many unexpected complexities requiring highly specialised knowledge of the sector, products and consumers, and how efficient existing AT businesses are at meeting these challenges successfully. These problems, along with the generally minimal profits to be made do not readily encourage or support new entrants to the market. Over time the very limited profits that are possible along with the inherent difficulties of the AT industry will reduce the number of full service AT providers in Australia, ultimately reducing competition and choice for consumers.

AT manufacturing in Australia continues to contract due to Australia's high level of business costs, the relatively small local marketplace and the strength of the Australian dollar. Australian manufacturers cannot compete with the R&D capacity of international competitors and many of the businesses remaining are quasi-manufacturers with an increasingly high level of imported content in their products.

Answering questions posed in the Issues Paper

Background and Scope of the Investigation

1.1 Are the definitions of disability and disability aids and equipment appropriate for use in this investigation?

ATSA's Policy Document (Sept 2012) quotes the definition from the World Health Organisation that defines AT as –

an umbrella term for any device or system that allows individuals to perform tasks they would otherwise be unable to do or increases the ease and safety with which tasks can be performed.

There is also an international standard ISO 9999:2011 (Assistive products for persons with disability – Classification and terminology).

1.2 What sources of data for expenditure on medical aids and equipment are available?

There is relatively little data available on AT expenditure in Australia. Unpublished work previously undertaken by Dr Michael Summers (one of the authors of this submission) is attached in Appendix D, and provides some additional detailed data on AT expenditure nationally, and information about numerous sources of data on AT expenditure.

Additionally the ABS does have some data on imports of 'invalid carriages' (manual and powered) but that will only show what is spent by importers. It is likely that various programs such as Lifetime Care in NSW and the National Disability Insurance Scheme (particularly form actuarial work used to structure the scheme), as well as state-based insurance schemes such as the Transport Accident Commission and WorkCover in Victoria also have data

1.3 Are there specific examples of price disparities for medical aids and equipment?

Table 1 comparing international prices for a range of popular AT devices indicates a degree of variability across major world markets. Notably, when compared to the mean of prices in other OECD countries, complex to moderately complex AT in Australia was found to be 14% cheaper on average. This would suggest that the Australian AT prices are fair and reasonable, and the supply of AT is relatively efficient. See the 'Price comparison' discussion above for more details.

In contrast, price comparisons between full service AT providers and on-line retailers found full service AT prices to be between approximately 40-50% higher. This is not an 'apples with apples' comparison, as the extensive provision of highly skilled services as part of the AT provision process accounts for this difference along with the usual additional 'brick and mortar' costs faced by all retailers in comparison with internet sellers (for example see Productivity Commission 2011).

It is also important to note that on-line AT retailers are primarily based in the USA, and are successful in part because of the large AT manufacturing base in the USA (for instance China, Taiwan and USA are the major import countries for AT in Australia). This enables on-line sellers to never handle the products which are shipped straight from the manufacturer to the consumer, with all warranty and other problems being directed to the manufacturer. See previous discussion in 'Who does what' and 'Can the US internet sales model work in Australia?' sections above for more details.

Notably, on-line sellers do not provide the full range of complex and moderately complex AT that most full service AT providers (in Australia and other countries) provide.

1.4 Are there any additional community concerns about pricing disparities for medical and disability aids and equipment?

ATSA has looked into allegations of excessive pricing over the past few years on a case-by-case basis as the complaints have arisen (see Case Study 1 and Case Study 2 above). These are similar to the concerns cited that were at the heart of the instigation of the QCA investigation.

These concerns are legitimate and important, but have more to do with the general misperception that AT is primarily a goods-based industry, rather than unfair pricing of AT in Australia. In fact AT provision for complex and moderately complex AT (and for complex clients across the full spectrum of AT) is in reality a services industry (see above section 'AT is a service based industry', 'Who does what' and 'Can the US internet sales model work in Australia?' for more information).

Price comparisons between full service AT providers and internet sellers, particularly at the complex and moderately complex end of the market, are not comparing like with like. This relates to not only the service component, but as illustrated in Case Study 1, often also misunderstandings about the additional components required for an effective AT solution. In that instance concerns were raised about a wheelchair costing over \$13,000 in Australia that could be purchased on-line from the US for \$3750 AUD. In fact the actual invoiced cost was \$11,846, of which \$5,888 was for the wheelchair that was priced in the US for \$3750 (excluding freight, taxes and other costs). Other costs were for items such as seating and postural supports (see Case Study 1 above for details).

1.5 Is there scope to rationalise or consolidate government and/or non-government programs for distributing medical and disability aids and equipment?

There are approximately 100 different government and statutory AT schemes across all levels of government and across numerous government departments (Jenny Pearson & Assoc 2013), creating significant fragmentation which results in excessive and avoidable additional costs for the supply of AT through the multiplicity program rules, forms to fill out, tendering opportunities and compliance requirements. This also significantly increases overall AT provision costs that are not part of AT pricing, particularly costs to governments of

administering multiple schemes, and costs for consumers and prescribing therapists to navigate and work across all of these schemes. Importantly, paying therapists to do the extra work required through the multiplicity of schemes is done by both consumers and government depending on the particular situation, and this also represent significant opportunity costs as therapists are tied up with paperwork and compliance requirements rather than working with consumers and AT providers to arrive at good AT solutions.

Every scheme operates differently: some cover the full cost, others require consumer co-payments; some vest ownership and costs of maintenance/repairs with the state/territory/federal government, others may vest ownership with the consumer as well as responsibility for repairs/maintenance, and some use a combination; some undertake significant desk-reviews of ‘appropriateness’ of a prescription and quote for supply, others do not; many schemes do some form of contracted procurement but this also varies widely from tenders for bulk purchasing of devices, to utilisation of panels of selected AT providers, truncated supply chain arrangements where items are purchased directly from importers/distributors/manufacturers, and hierarchical contracting for supply (for example Rehabilitation Aids and Appliances program of the Dept. of Veterans’ Affairs).

This variety of AT programs adds substantial red-tape and paperwork costs driven by fundamental administrative inefficiencies. There are also often significant costs to AT providers in responding to an endless stream of local and national tendering opportunities, which can be very complex and very high-stakes in relation to business survival.

This market fragmentation also adds substantial cost to introducing, marketing and supporting AT products on a national basis.

In short, yes there is scope for consolidation. The establishment of the NDIS would appear to assist with this, and is certainly a good start. However, the myriad of state and other schemes are likely to continue to exist without direct attempts at consolidation. For example, in most major state AT schemes provide assistance to people of all ages. The NDIS is only going to provide AT to those under 65, and also only to those who are eligible for the scheme. The state schemes will need to continue to exist to meet the needs of those not eligible for the NDIS. But it may be that the NDIS will develop a strong national scheme for AT which can then be modelled or leveraged into a larger national scheme. In the meantime, efforts to unify systems, forms and rules could be achieved at a smaller scale without actual consolidation, and other processes such as the joint tender being run for AT in Victoria and South Australia could be undertaken.

1.6 Will there be scope under Disability Care Australia to use government procurement to make non-subsidised aids and equipment available to consumers in competition with retail outlets?

The NDIS should remain a funder of supports and not a service provider. As indicated throughout this submission, AT provision is primarily about the highly skilled and complex services necessary to get a good match between the individual and the AT. The NDIA

(National Disability Insurance Agency) has taken a clear stand that it will not become a provider of goods or services, but rather it is an insurance scheme to provide funding equitably for reasonable and necessary goods and services to meet the needs of people with significant disabilities.

Additionally, given the commitment of the NDIA to consumer control, they are taking an individualised approach to procurement based on individual needs and aspirations, and utilising client care plans to determine services and allocated individual budgets. This is unlikely to give NDIS any particular purchasing power in the AT market as individualised purchasing does not lend itself to the potential procurement efficiencies of bulk purchasing.

However, the NDIS approach is likely to lead to major savings beyond that achievable through minor reductions in AT prices that could be achieved through bulk purchasing of some AT, and similarly if other government schemes were to adopt a similar individualised approach focused on maximising client outcomes similar savings could be achieved.

Improved outcomes for consumers through AT can increase participation in employment as well as reduced hospital and residential care admissions, and reduced injuries to family caregivers and professional carers (see 'Introduction and Background above for more details), thus both generating income for government and cost savings for government and individuals and their families.

The focus on 'price' as opposed to 'client outcomes' continues to be problematic, particularly as it is clear that AT pricing in Australia for complex and moderately complex AT is comparable, and typically lower than in other OECD countries by an average of 14% (see Table 1 above).

1.7 Do stakeholders expect that retail options for medical and disability aids and devices will expand as Disability Care Australia is implemented?

Retail options for AT may expand as the NDIS is implemented. However, as noted above in the 'Other relevant information' section, full service AT provision is a difficult market both in terms of complexity and low profits. This does not make it attractive to new entrants, and as outlined in the section, there are major examples of capable business with strong track records failing when trying to enter the AT market.

There are already numerous successful different business models and business structures amongst existing full service AT providers, and for all of them one of the keys to success is to have the skilled staff required to ensure that the AT is well matched to the client. And as noted in the 'Who does what' section above, there are a very wide range of tasks that must be undertaken at both an individual and sector level to achieve this, and using existing prices as an indicator, it would suggest that existing models do this relatively efficiently and effectively.

However, it does seem likely that with more funding available for AT through the NDIS, that there will be growth in full service AT provision – existing operations may expand and new providers may enter the market. The primary difficulty is likely to be the training and

recruiting of highly skilled staff necessary to provide the high level of services required to successfully match the AT to the individual. Currently most full service AT providers find they must train their own staff (even when recruiting experienced occupational therapists and physiotherapists), and this often takes several years to obtain full competency (see Summers and Walker 2013 for more details on the need to accredit AT prescribers and providers).

A major concern with more funding available is the likely advent of unscrupulous and/or unskilled AT retailers entering the market. There are already instances of AT being imported and sold that is not registered on the ARTG, and if more funding becomes available this may increase. Unskilled staff are also likely to be part of this problem. Hence the importance of implementing a national accreditation scheme, as nothing currently exists to differentiate the competent AT providers from incompetent.

1.8 What role do health care professionals have in determining the source and choice of aids and equipment and in ensuring value for money in purchases?

A prescribing health care professional has a duty of care to try to achieve the best possible outcomes for their client. Acting as a gatekeeper for funding bodies is a conflict of interest.

Most health care professionals are generalists and often do not have extensive knowledge of the range of available AT and options. A therapist will usually have an idea of what they want to achieve for a client and the AT provider then works with the therapist and client to identify a suite of AT that achieves the objectives. As a rule, more complex AT depends to a greater extent on the skills of the AT provider to get it right.

As noted above, given the asymmetry of information about both what AT products are available and the potential utility of those different products for different individuals, consumers (and funders) are inevitably dependent on both prescribing therapists and AT providers to fill those information gaps. This is no different than many other products in the healthcare market place, and emphasises the importance of professionalism, the importance of structurally separating prescription from supply of AT to minimise conflicts of interest, and professional codes of conduct. All relevant professions involved in AT – occupational therapy, physical therapy, etc – have codes of conduct in place which they work to whether they are in the role of prescribers or working as an AT provider, and likewise ATSA members sign up to a code of practice when become members – see <http://www.atsa.org.au/CodeofPractice.aspx> for a copy. Additionally, the development and implementation of a national credentialling and accreditation system for AT practitioners and providers would help to ensure that those involved in prescribing and supplying complex and moderately complex AT had the requisite skills and knowledge, as well as essential business practices for AT providers (e.g. all AT meets relevant international or Australian standards, complaints systems are in place, etc.).

Experienced AT prescribers often know which AT provider in a particular area might best be able to meet the needs of the consumer. While this may give rise to concerns about ‘capture’ of prescribers by AT providers, it is in fact an effective means of increasing the efficiency of the AT provision process and reducing costs borne by consumers, prescribers and AT

providers through facilitating the most effective pathway to a good AT solution for that individual consumer. As long as the prescribing therapist does not profit from the relationship with a particular AT provider, and acts effectively as the consumers agent, this is not problematic.

The more common problem is when the prescribing therapist is in fact acting as an agent for a government funder and meeting the funder's needs and expectations, rather than those of the consumer.

At a background and contextual level it is important to understand that the best arrangement to ensure that AT effectively meets a consumer's needs, environment and aspirations, and delivers the best possible outcomes involves a strong partnership between the consumer, the prescribing therapist and the AT provider. This is particularly the case for complex and moderately complex AT, and also when consumers' themselves present a range of complexities (e.g. impaired cognitive function, challenging environments, particular goals and aspirations, etc.). Each party provides essential knowledge and skills to the partnership. Notwithstanding this, there is a common tendency for people who are not directly involved at the coal-face in the day-to-day provision of AT to perceive that the prescribing therapist undertakes all of the essential activities. For example, the current Queensland Medical Aids Subsidy Scheme (MASS) program guidelines (Queensland Health 2013) attribute many activities to prescribers that are in fact undertaken by AT providers who are never mentioned in the document. Such misconceptions contribute to perceptions that AT pricing is excessive as it inadvertently ignores the costs borne by AT providers to provide the essential services required to undertake their role in the partnership

Price Disparities

1.9 What factors must be taken into account in comparing prices?

The central issue in comparing prices are (a) to ensure like is being compared with like and (b) that the comparison takes into account often hidden elements such as differences in supply urban versus rural and remote communities; differential costs between Australian capital cities (rent, distance, cost of living, size of the community/market, etc.).

As indicated above in Tables 3: AT prices in Australia relative to those in other OECD countries for full service AT providers is generally favourable with Australian prices 14% lower than the mean.

Likewise, comparisons of OECD price means and Australian prices for full service AT providers makes it clear that internet prices are approximately 40-50% lower. The explanations for this are relatively straightforward: (a) internet sellers provide none of the essential services to ensure a good match between the AT and the individual, and minimise the risk of poor outcomes and wasted expenditure; and (b) internet sellers are not subject to the typical bricks and mortar costs incurred by shopfront retailers such as full service AT providers (see Productivity Commission 2011 for details on typically differences in costs).

Supplying AT is a service-based business that deals with many disadvantaged and vulnerable individuals as well as the more general population. As the complexity of the AT increases, so does the degree of skill and knowledge required to properly specify, customise, combine products, setup/install and train users and care givers. These services are generally all included in the retail price and are in addition to the usual business costs of wages, rent, freight, red tape etc as well as market size. It is a flawed approach to consider online prices as a guide to best value when the essential services cannot be included nor is the full range of AT necessarily available (see above sections on ‘AT is a services industry’, ‘Who does what’ and ‘Can the US internet sales model work in Australia?’) for more detailed information on this issue.

1.10 What additional non-price factors are important when purchasing medical and disability aids and equipment?

The primary factor to consider is what is necessary to achieve the best outcomes for consumers, and what is the most effective and efficient way to achieve this.

As discussed extensively above, access to high level skills and knowledge are paramount as the complexity of AT increases in order to ensure a good match between the AT and the individual and their environment. Poor value is achieved unless positive outcomes for consumers are delivered and total lifetime costs of the AT are considered. This in turn leads to increased revenues for government, and reduced costs over time.

Rural and remote communities present particular challenges given the degree of services required to get good AT matches between the individual, their environment and the AT. AT pricing must take the extra costs of doing this into account to be meaningful, without reducing access in these communities.

Similarly, it is essential to consider the life-time costs of AT being purchased. If an AT user has a fairly quiet lifestyle, is not particularly active and does not live in a challenging environment, a cheaper lightweight aluminium manual wheelchair may be the most cost effective solution. In contrast, someone with a much more active lifestyle and a more challenging environment might need a titanium wheelchair, which may cost 30% more initially, but as it may last twice as long as an aluminium chair, it is in fact a cheaper solution over time. The same is true with many ‘consumables’ such as batteries for motorised wheelchairs and high quality tires versus low quality tires – but the key is matching the item the consumer and their environment relative to lifetime costs, which is a key part of the skills AT providers bring to the situation.

It is no doubt possible to drive prices downwards to some degree. But lower prices are a very poor outcome if this is achieved by reducing: choice; access to highly skilled and high quality services; innovation; rural/remote access to AT devices and services; and effectively matching AT to the individual. All of which will lead to lower levels of inclusion, participation and independence of people with disability of all ages.

There is good evidence that providing appropriate and timely aids and equipment can: improve well-being and quality of life for those with functional impairments and their families; reduce

residential care admissions; reduce family carer injuries and stress; increase participation in employment and education; reduce hospital admissions; and shorten hospital stays, and reduce support service hours (AIHW 2006; Heywood & Turner 2007; Audit Commission 2000, 2002, 2004a & 2004b). For older people it has been estimated that a cumulative 1% increase in independence over 50 years would result in a 40% reduction in the costs of providing care (Audit Commission 2004b: 11). All of this would indicate that notwithstanding the initial capital costs, AT nonetheless represents good value over time if the end result is increased independence and participation by people with disability of all ages. Programs such as MASS which are limited to purchasing only AT that can be used in the home, would appear to unnecessarily limit the potential value that could be derived from more robust and wider-ranging AT solutions.

1.11 Is there evidence of excessive Australian prices as a result of exclusive supply arrangements?

There is no evidence of excessive Australian prices when comparing like with like (see Table 1), and in fact Australian prices are approximately 14% lower than the comparable OECD average.

Exclusive supply arrangements are common practice in many retail sectors in Australia and there is little evidence that they reduce competition and increase prices, and AT is no different, and AT pricing along with the very high variety of AT available in Australia which represents a very small market internationally. For example there are almost 40M people in California, compared to 23M in Australia. Additionally, AT prices are lower than the OECD average, notwithstanding the relatively high wages and other business costs in Australia compared to many OECD countries. Together the pricing and the variety of products would indicate that existing arrangements are relatively efficient given the nature of the Australian market.

The relatively small size of the Australian market has resulted in only a handful of international companies operating through fully-owned Australian subsidiaries. A significant amount of AT is imported through smaller, private businesses each of which handles a number of different international brands. Competition is strong between the multitude of brands available to meet a particular need. It is not dissimilar to the motor vehicle industry, where although Hyundai is the only company to import their particular brand of car, they have to compete in the market with the likes of Mazda, Toyota, Holden, etc.

Many less complex or lower cost AT items which require minimal AT provider service input to achieve good client outcomes are available from multiple retailers in a given locality, and this may include pharmacies, and mainstream generalist chains such as Aldi and Bunnings.

1.12 Is there evidence of 'geoblocking' being applied to the global sourcing of medical and disability aids and equipment?

Many foreign AT manufacturers actively try to prevent internet retailers from supplying items

to overseas customers due to the lack of available support services and the associated risks, particularly in the complex and moderately complex range of AT. If someone orders a customised manual wheelchair and it is not built to specification, the costs of international freight alone, necessary to resolve the issue are prohibitive. Geoblocking does not tend to occur for simpler and less complex AT, which do not require the skills of full service AT providers to ensure a good match between the AT and the individual, and manage the attendant risks.

International manufacturers are also cognisant of the need to support an importer/distributor in the local market to maximise their penetration and volumes, particularly for complex and moderately complex AT. Few businesses would make the substantial investment required to bring a new product to market if they believed there was a risk that the consumer would bypass them and purchase offshore. And without the commitment of full service AT providers to delivering the highly skilled services essential to getting a good match between the AT and the device, consumer outcomes will decline over time.

1.13 Is there evidence of differential pricing where suppliers specify price on application and do not publically disclose prices?

Many importers do publish recommended retail prices and detailed script forms with full pricing for items such as custom manual or power wheelchairs (see Appendix B). However, particularly at the moderately complex and complex level of AT, a large amount of AT is configurable or customisable which makes pricing difficult.

It is not always possible to provide a price prior to the extensive pre-sales work full service AT providers undertake with the consumer and their prescribing therapist to identify the appropriate AT solution involving moderately complex and/or complex AT, including the development all the relevant specifications and an associated quote (which may well include a complex array of specification not only in relation to the wheelchair frame itself for instance, but also for the pressure care cushion, postural supports, electronic controls as well as numerous options to maximise utility such as means to carry bags, transport oxygen, secure storage for money and other items, easy access to mobile phone, etc.), as well as considering how each AT device will interact with each other.

There is also a small range of AT which is ordered relatively rarely and usually quoted based on the exchange rate of the day.

1.14 Should there be government programs to assist consumers in comparing prices of products?

The database of 'Suppliers of Supports' that is being developed by the NDIS will be valuable for consumers who are looking for a directory of approved AT providers. The network of Independent Living Centres also has some worthwhile information on products and AT providers for those products, and ATSA has been engaging with them to improve what

information is available.

There is currently no effective way to inform consumers on the degree of skill and capability of an AT provider which are paramount as AT complexity increases, and the same is true of AT prescribers at the more complex end of the spectrum, hence ATSA's ongoing advocacy for the establishment of AT practitioner and provider accreditation (see Summers and Walker 2013).

In relation to establishing government programs to assist consumers in monitoring AT prices, this may be possible at the 'simple' end of the AT spectrum regarding high volume mass produced low cost AT, but it is likely to comparing like with like will be a significant problem as construction methods and overall quality between items that appear similar can be significantly different – affecting the real value of the item in relation to lifetime costs.

In relation to moderately complex AT and complex AT, the privileging of 'price' as a primary focus is problematic. As already discussed extensively throughout this submission, at this end of the AT market a major requirement for effective AT provision for complex and moderately complex AT are the services full service AT providers deliver to both individual consumers and the AT sector more broadly. These services are typically factored into the price of the device, and without these services, getting a good match between the AT and the individual is unlikely to be successful.

If price is the sole determinant this will lead to perverse incentives to drive down prices at the expense of achieving good outcomes for consumers, and the attendant savings to government and the community more broadly.

Also, given that there is no evidence of excessive AT prices in relation to full service AT providers at the moderately complex and complex end of the AT spectrum (see Table 1), it would appear to be unnecessary to create an AT price monitoring scheme.

Finally, it is apparent from previous failed attempts by governments with programs such as 'Fuel Watch' or 'Grocery Watch' that building an effective and accurate price watch tool is extremely problematic and resource intensive, often for little gain. The extraordinary variety of AT in the Australian market, and the relatively small scale of the market further compounds the problems of 'how to do it' in a cost effective and meaningful way.

Sources of Price Disparity

1.15 Are the costs of shipping manufactured goods or their components to Australia higher than the costs of shipping to comparable countries?

We cannot say for sure, however it is likely that the costs of freight from either Europe or the US to Australia would be greater than for freight between Europe and the USA. Most low cost AT is now manufactured in Asia and it is likely that freight would be similar to other world markets.

1.16 To what extent does the cost of labour in Australia influence price disparities for medical

aids and equipment?

Given that we were unable to identify price disparities when comparing like for like with full service AT providers internationally (except that Australian prices are on average 14% lower – see Table 1), the question is perhaps not quite the right question.

That Australian full service AT providers who deliver moderately complex and very complex AT to consumers are able to do so at lower prices than other OECD countries, within the context of typically higher labour costs is notable. This give rise to the question of ‘how do they do it?’ The simple answer is that it is done by running extremely efficient businesses, and by cutting profit margins to a minimum. As indicated elsewhere, there is significant anecdotal evidence that providing AT in Australia is not particularly profitable (see the section on ‘Other relevant information’ for more details and examples).

Labour costs are significant as the provision of moderately complex and complex AT is heavily reliant and services provided by AT providers to individual consumers and the sector more broadly (see ‘AT is a service industry’ and ‘Who does what’ above for more details). However, cutting labour costs would require either deskilling or reducing a highly skilled labour force that is essential to generating good outcomes for consumers. Significantly, these skills are in short supply, and AT businesses invest heavily in recruiting, training and retaining these staff, even when recruiting skilled and experienced professionals such as occupational therapists and physiotherapists, and also sourcing rehabilitation engineers trained overseas.

The significance of labour costs (as well as bricks and mortar costs) to provide these services can be seen in the very significant price differences of AT sourced online with no services provided, when compared to the pricing through full service AT providers in Australia and across OECD countries. Online prices are approximately 40-50% lower, as a consequence (see Tables 2 and 3 above), but online purchasers must carry all of the responsibility and risk associated with ensuring that the AT meets their needs, is safe (including issues of assembly, installation and use, and fitness for purpose), and is the best AT solution for them over the long term, including sourcing adjustments, spares, maintenance and repairs locally. Equipment abandonment is a common result of poor matching of AT to the individual, and is likely to be higher with online sourced AT that is moderately complex or complex, than when sourced through a full service AT provider, generating additional waste and inefficiency.

1.17 Do Australian standards for therapeutic goods raise the cost of aids and equipment?

In relation to the Australian AT market overall the price impact of compliance with Australian and/or International Standards Organisation (ISO) standards are minimal, as most products are imported and as they are sold in other markets which also require standards testing to ISO the overall cost is amortised internationally. There are some costs in relation to documenting compliance with Australian or ISO standards, and additional costs for Australian manufacturers who do standards testing to sell products locally and internationally.

One of the major issues in relation to standards compliance is unique to Queensland, and this does have implications for pricing in Queensland given the costs to AT providers. Many products sourced from the US (which is the third largest source of manual and power wheelchairs in Australia) have not been tested to ISO or Australian standards, and instead must meet the rigorous requirements of the US Food and Drug Administration quality standards. To provide these products through MASS in Queensland, providers must undertake additional product testing to certify compliance with Australian standards. Given the relatively small scale of the Queensland MASS program relative to the extensive range of AT involved, this cost is not easily amortised across numerous sales to amortise the costs down to a very low level, and hence generate some price impacts.

1.18 Do differentials in the cost of aids and equipment between countries reflect the exercise of market power?

As noted elsewhere, given that AT prices in Australia for moderately and complex AT are on average 14% lower than the OECD average (see Table 1), this would indicate that AT is competitively priced in Australia and Australian full service AT providers operate efficient businesses within a relatively efficient and competitive range of business structures.

Most of the major global AT brands compete aggressively along with the diminishing pool of local manufacturers in the Australian market. Most types of technology can be sought from multiple brands and this engenders a great deal of competition. Australia is unique in offering many brands from both European and US manufacturers. The 4 larger global AT manufacturers (Invacare, Otto Bock, Pride Mobility and Sunrise Medical) operate wholly owned subsidiaries in Australia whereas many other brands are imported by smaller, private companies such as Shoprider, Dejay Medical and Seating Dynamics.

For the majority of different types of AT the consumer has a wide range of brands to choose from. Many items of low cost/complexity AT are also available pharmacies and some items are increasingly available through mainstream shops such as Bunnings and Aldi, as well as through websites such as Ebay.

Most brands of complex and moderately complex AT are available through a network of retailers who are responsible for providing the additional services required to properly supply AT. There are fewer retailers of the more complex types of AT due to the highly specialised skills and knowledge and the relatively small number of consumers.

1.19 If there is market power in the supply of medical aids and equipment, how is it sustained?

We do not believe there is an issue with market power and competition due to the reasons outlined above. With Australian prices 14% lower on average comparable OECD prices for moderately complex and complex AT sources from full service AT providers, it is clear that that market power is minimal or non-existent and has little negative impact on prices.

1.20 Are there regulations that raise costs for businesses that manufacture or import or distribute medical aids and equipment?

See the previous response above to question 1.17 regarding standards.

Additionally, there are a number of regulations in the Australian Road Rules and Department of Infrastructure guidelines that are way behind the contemporary AT technologies and these can also have an impact.

Australia's inflexible industrial relations laws make it difficult and more costly for any business that needs to employ staff.

Unique to AT providers is the insistence by many government funders that AT must be fully trialled and only after the successful trial can a funding application be lodged. While ATSA strongly supports the importance and need for trials of moderately complex and very complex AT, the way that this is structured under many government funding schemes for AT is often very problematic and inefficient.

It can take months or years for funding to become available once the application has been lodged which generally means the whole assessment and trial process has to be repeated at a significant cost.

Also unique to Queensland is the requirement for AT providers to include a video of the trial when funding is required for a power wheelchair from MASS. This incurs extra costs that must be incorporated into the retail price of these items, and there would appear to be little gained through the exercise as the prescribing therapist is present during trials and is then in a position to vouch for the appropriateness of the AT.

1.21 Can price differentials be explained by other factors?

As noted elsewhere, with Australian prices 14% lower on average comparable OECD prices for moderately complex and complex AT sources from full service AT providers, this indicates that prices are competitive in Australia and that AT providers are generally very efficient and effective in relation to their OECD counterparts. This achievement is particularly impressive given the high labour component at this end of the AT market, and the high costs of labour in Australia.

Pricing differentials in relation to online retailers are significant, but this is accounted for by the lack of service to ensure a good match between the AT and the consumer at a pre-sales level, as well as extensive services available post-sales regarding delivery and installation/set-up, adjustments, warranties, repairs, and spares. See answers to previous questions for more details as well as the sections 'AT is a service industry', 'Who does what' and 'Can the US internet sales model work in Australia' for more details.

The variability between recommended retail prices for AT at full service providers internationally, including Australia (see Table 1 for pricing details on some common AT

products at the moderately complex and complex end of the spectrum), are likely to be caused by a number of factors including:

- international freight costs
- type of product
- market size
- local taxes and charges
- differences in the usual costs of doing business (wages, rent, freight, insurance etc)
- differences in compliance and testing regimes
- requirements of large local AT funding schemes, as local markets are often structured around purchasing structures of governments and/or social insurance schemes as they are major purchasers of AT in most OECD countries.

Enhancing Efficiency and Competition in Medical and Disability Aids and Equipment Markets

1.22 What impact have government procurement programs had on the competitive structure of medical and disability aids and equipment markets?

In general they have reduced competition and choice for the consumer by limiting what is funded, what products/brands are on a given tender, adding unnecessary costs, building in delays and making the industry less profitable and appealing to new competitors.

For example, the DVA now has a panel of 4 major contractors for supply of AT, one of whom is an insurance company with no known prior expertise in supplying AT. Each contractor has a national network of sub-contractors who do the actual work on the ground to supply the AT. This means there is another step in the supply chain that was not previously there and this adds cost.

Contracts and tenders can be an expensive exercise to bid for and often preclude smaller, more efficient businesses from participating. Contracts and tenders have the potential to reduce the number of businesses competing and can be particularly damaging for consumers in rural/regional locations.

There is an ongoing debate about restricting choice for people with disability by limiting what products are available to be funded which is often the result of a tender process. As noted elsewhere (particularly in response to questions about the NDIS), individualised procurement models, while foregoing some potential savings that traditional bulk procurement approaches can achieve in relation to price, are more likely to generate a strong match between the individual and the AT solution, and ultimately generate more substantial savings and additional revenue through the community and economy, than the sparse and often false savings through bulk purchasing procurement arrangements. This is particularly true for moderately complex and complex AT, where the service component is significant and unavoidable cost factored into the AT price, as it is central in achieving good outcomes for consumers.

1.23 How could the efficiency and effectiveness of government procurement programs be improved and expanded to provide more benefits to stakeholders?

Although ATSA is a strong supporter of efforts by governments to increase the efficiency of procurement and reduce costs and ultimately prices, there is currently little evidence to support the claim that existing bulk procurement initiatives such as the MASS tender for wheelchairs have been successful. While existing procurement programs can point to achieving some lower prices on some items, this has typically been at the expense of variety and choice of AT, and frequent failures to achieve the strong match between the individual and the AT required to achieve good long term outcomes cost effectively. This is particularly the case in relation to moderately complex and complex AT.

Additionally, rural and remote full service AT providers are particularly vulnerable to bulk procurement strategies that value only price, and do not take into consideration the additional costs of service provision in rural and remote communities. While ATSA believes that bulk purchasing arrangements are often well suited to the mass produced, high volume, low cost and low risk AT, if urban providers have all of these contracts, it is difficult for rural and remote providers to survive as they need to be able to sell a full range of AT to survive. ATSA believes that such bulk procurement processes should exclude rural and remote provision, or make specific arrangements to avoid stripping rural and remote communities of local AT providers.

Additionally, procurement processes need to consider what is needed to get good outcomes for consumers as their primary purpose. For example, procurement processes that favour large AT providers over smaller providers, urban providers over rural providers, will reduce choice and availability of AT and the requisite skills at a local level, and potentially ultimately drive up prices over time as more providers leave the market and there are no incentives for new providers to enter the market (see 'Other relevant information' section for a more detailed discussion on barriers to market entry). The degree of detail demanded by many government tenders is a real cost to business, particularly in smaller markets and for smaller AT providers.

Delays in funding AT after assessments, specifications and trialling have been completed create significant additional costs in regards to having to repeat the process again. As noted above, these costs can range from \$100 to \$1000 depending on a range of factors. Improved funding systems with reduced delays, which are particularly problematic in schemes which require co-funding by the consumer such as MASS, has the potential to reduce prices and improve procurement processes. Additionally, some government programs are simply very slow to pay invoices, making AT providers effectively bankers for government, minimising this would also assist in lowering costs and reducing prices.

Care must be taken to ensure that government procurement programs do not overlook the extensive service component provided by full service AT providers, and typically incorporated into the price of the AT. For example, if bulk procurement tendering focuses on complex and moderately complex AT, there must be clear provision for who and how the pre-sales services required to get a good AT match will be funded, as well as post-sales services such as training, adjustments, ongoing advice and support, maintenance, and spares will be provided (see above

sections on ‘AT is a service industry’ and ‘Who does what’ for more details). Most bulk AT procurement systems currently operating throughout Australia are not functioning particularly well in regards to ensuring that these essential services are funded and provided, and over time we are seeing increased problems for consumers and reduced outcomes as a consequence.

In some state systems, there is increasing evidence that government bulk purchasing schemes are organised in such a way that the theft of the intellectual property of full service AT providers is required to enable the schemes to operate. There are more and more instances where a prescribing therapist and consumer seek out the expertise of a full service AT provider to assist in selecting the appropriate AT, including development of detailed specifications and quotes, and in home trials. Then this intellectual property is used to provide equipment from a government bulk procurement stockpile or from re-issued AT. This is particularly problematic as the work done by the AT provider comes at a significant cost, and yet there are no processes or structures in place to reimburse the provider for these costs. This is not a sustainable practice, and procurement systems must be designed with the ‘real’ costs of providing well matched AT to consumers factored into the process and the price.

One mechanism for minimising this problem would be to institute a funding pre-approval process. This would require the consumer and prescribing therapist who are expecting to seek support from schemes like MASS to first get a unique identifying number denoting that MASS has approved the seeking of a quote. This approval would be based on a guarantee that the AT will subsequently be purchased from a full service AT provider, and not procured from bulk purchase stock or re-issue stock. This in turn would assure AT providers that they have a fair chance of actually getting paid for all of the pre-sales work they undertake in relation to advice, assessment and developing specifications and quotes for complex and moderately complex AT. If the AT provider is not ultimately successful, it simply means that another AT provider was better able to meet the consumer’s needs effectively and efficiently and hence made the sale. A process like this is currently in operation in New Zealand, and appears to be very effective.

Finally, procurement strategies must be structured so that they encourage rather than stifle innovation and adoption of new devices and technologies. Restrictive lists of ‘eligible equipment’ work against innovation, and there are numerous examples of where this actually increases costs and reduces outcomes for consumers.

1.24 Is the Disability Care Australia approach to provision of aids and equipment likely to result in reduced or greater price disparities?

Given that there is little evidence of price disparities between full service AT providers in Australia and their counterparts in the OECD (see Table 1 above), it seems unlikely that the NDIS will increase or reduce price disparities. Governments and statutory authorities are major purchasers of AT in most OECD countries, and while the efficiency of procurement processes by these purchasers no doubt has some impact on prices, it would appear to be negligible overall.

If the NDIS ultimately results in a nationally consistent AT purchasing system that avoids the delays caused by slow approval systems, unresponsive bureaucracies and insufficient funding there could be real cost savings. However where high service levels are required, the time involved and the high degree of skills and knowledge needed will always be a major cost factor.

Some businesses have expressed concern about individualised purchasing by consumers within the NDIS that necessitate the establishment of thousands of new debtors and may increase the risk of consumer non-payment. Controls are likely to be required to ensure funds planned for AT are not expended elsewhere.

There are no indications at this early stage that NDIS will utilise bulk purchasing arrangements to manage costs, as whole structure is underpinned by strong emphasis on consumer control and choice. But this may change over time in an effort to reduce costs, especially for high volume/low cost/low risk items.

As indicated throughout this submission, AT provision is primarily about the highly skilled and complex services necessary to get a good match between the individual and the AT. The NDIA (National Disability Insurance Agency) has taken a clear stand that it will not become a provider of goods or services.

1.25 Will the advantages of increased consumer choice provided by direct funding of individuals offset the advantages of group purchasing through government programs?

Improved outcomes for consumers through AT can increase participation in employment as well as reduced hospital and residential care admissions, and reduced injuries to family caregivers and professional carers (see 'Introduction and Background' above for more details), thus both generating income for government and cost savings for government and individuals and their families. And individualised procurement is more likely to lead to a strong match between the individual the AT, thus generating improved outcomes.

Individualised control results in decisions about AT being made by the person who will gain the most utility from the AT – the consumer. By shifting the decision to the consumer the focus will move from narrow and inappropriate consideration primarily focused on 'price' to decisions driven by expected outcomes for the consumer.

Bulk procurement programs by government may make savings in relation to 'price', but there is no evidence that they result in better matching of AT to individuals to maximise outcomes, and thus may actually increase costs overall. Anecdotally there is increasing evidence to the contrary, with the judgements of prescribing therapists and consumers being superseded by desk-reviews undertaken by people who have never met the consumer, as well as opportunity for appropriate matching reduced through reduced product variety via bulk purchasing arrangements.

An individualised procurement approach (such as with the NDIS) is likely to lead to major savings beyond that achievable through minor reductions in AT prices that could be achieved

through bulk purchasing of some AT. The evidence that this is indeed the case, is the primary foundation for the NDIS and its individualised approach.

The focus on ‘price’ as opposed to ‘client outcomes’ continues to be problematic, particularly as it is clear that AT pricing in Australia for complex and moderately complex AT is comparable, and typically lower than in other OECD countries by an average of 14% (see Table 1 above).

1.26 Do the price disparities found by the Productivity Commission for consumer goods differ from price disparities for medical and disabilities aids and equipment?

As noted throughout, Australian prices for moderately complex and complex AT from full service providers is on average 14% cheaper than comparable OECD countries (see Table 1). The main price disparity is between full service AT providers and internet sellers, with internet sellers being 40-50% cheaper on average (see Tables 2 and 3).

In addition to the typical bricks and mortar costs found to contribute to price differences with online retailers by the Productivity Commission, the highly skilled services provided by full service AT providers to both the individual and the sector to ensure a good match between the individual and the AT accounts for much of this price difference. The extent of this work along with the highly skilled nature of the work is significant in relation to provision of moderately complex and complex AT, and is essential to ensuring the efficient and effective provision of AT to individuals with very different needs, aspirations and environments. See the extensive discussion of these issues in responses to above questions, as well as the above sections ‘AT is a service industry’ and ‘Who does what’.

1.27 What are the barriers to competition and price reductions for the distribution of aids and equipment?

There are no major barriers to providing AT at a fair and realistic price in Australia for moderately complex and complex AT, as the comparisons with OECD full service AT providers indicate.

There are nonetheless a number of areas where improvements would assist in the potential to achieve better prices. These include, in no particular order of importance or priority:

- more effective and efficient government procurement programs (see above for details)
- more flexible industrial relations laws
- reduced use of master contractors structures in tenders such as the Department of Veterans Affairs which add layers and costs to the supply chain
- updated regulations in the Australian Road Rules and Department of Infrastructure guidelines relating to powered mobility
- lower Australian wages

- recognition and acceptance of standards testing done in the US to Federal Drug Administration requirements.

1.28 What are the barriers to competition and price reductions in the retailing of aids and equipment?

There are no major barriers to providing AT at a fair and realistic price in Australia for moderately complex and complex AT, as the comparisons with OECD full service AT providers indicate.

There are nonetheless a number of areas where improvements would assist in the potential to achieve better prices. These include, in no particular order of importance or priority:

- more effective and efficient government funding and procurement programs (see above for details)
- more flexible industrial relations laws
- reduced use of master contractors structures in tenders such as the Department of Veterans Affairs which add layers and costs to the supply chain
- updated regulations in the Australian Road Rules and Department of Infrastructure guidelines relating to powered mobility
- lower Australian wages
- recognition and acceptance of standards testing done in the US to Federal Drug Administration requirements
- avoidance of market distortions by government agencies seeking to become quasi AT suppliers/retailers

1.29 Do stakeholders believe that regulatory reforms for the retail sector generally would help reduce price disparities for medical and disabilities aids and equipment?

Only if the reforms were to reduce the degree of unbeneficial regulation and red tape.

1.30 What role do pharmacies play in the retail supply of medical and disability aids and equipment? Could this role be increased to provide greater choice & value for money?

AT provision is a minor part of the business of some pharmacies through the retailing and/or hiring basic items of AT. Like all bricks and mortar retailers, pharmacies have to maximise revenues/margins achieved through sales in relation to the floor space required to market a product. The large floor space required for many items of AT makes them unattractive to retailers in high rent areas (i.e. shopping centres) where most pharmacies are located. The penetration of major retail chains such as Bunnings, Aldi and some pharmacies into the basic AT market has served to cannibalise the marketplace and makes specialist AT retailers less profitable threatening the ongoing provision of the high level of services provided by full service

AT providers in relation to complex and moderately complex AT.

Additionally, pharmacies are not well resourced to provide anything other than very basic AT, as their staff are usually on skilled in very simple service elements such as adjusting the height of a crutch or walking frame to the correct level. They lack the depth and breadth of skills available from full service AT providers, which as noted elsewhere are uncommon skills requiring significant specialised training over long periods of time in AT specific environments.

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Appendices

Appendix A: Forex commercial foreign exchange rates AT price worksheet

Appendix B: Wheelchair specification sheet example

Appendix C: Australian AT supply chain

Appendix D: Estimated national AT expenditure

Appendix A: Forex commercial foreign exchange rates AT price worksheet

Exchange Rates as at 27th Sept 2013		\$1.0000	\$0.9335	\$0.9609	\$1.1242	£0.5810	€ 0.6911	¥91.1400	\$0.8968
FOREX Prices		Australia	US	Canada	New Zealand	UK	Germany	Japan	US Web
Jay 2 Cushion		\$695	\$425	\$696	\$595	£405	€ 615	¥49,500	\$298
Quickie 2 Wheelchair		\$2,222	\$2,050	\$2,710	\$2,050	£1,850	N/A	¥250,000	\$1,230
QMT710 MWD Power Wheelchair		\$8,897	\$10,915	\$11,805	\$10,815	£7,273	€ 10,775	¥1,091,000	N/A
ROHO QuadSelect High Profile Cushion		\$685	\$458	\$719	\$895	£560	€ 380	¥48,000	\$349
ROHO Hybrid Elite Cushion		\$695	\$473	\$795	\$895	£560	€ 380	¥48,000	\$359
ShopRider QT-3 Scooter		\$1,750	\$1,795	-	-	-	-	-	-
ShopRider RainRider		\$9,100	\$8,995	-	-	-	-	-	-
ShopRider Rocky6		\$5,800	\$5,995	-	-	-	-	-	-
ShopRider Venice		\$3,500	\$4,995	-	-	-	-	-	-
Permobil M300Corpus3G Power Wheelchair		\$16,582	\$21,966	\$23,707	-	£11,223	€ 18,584	¥1,323,733	N/A
TiLite TR Series 3 Custom Manual Wheelchair		\$3,895	\$3,395	\$4,325	\$6,382	£2,295	€ 4,174	-	\$2,390
Lecley EDS Seat Base, Backrest & Chassis		\$1,589	\$2,522	\$2,371	-	-	€ 1,017	-	-
Ottobock Ventus		\$2,260	-	\$2,975	-	-	€ 2,495	¥155,000	-
Ottobock B400 Power Chair		\$3,959	-	-	-	-	€ 4,993	-	-
Ottobock Start M1 Wheelchair 40.5 Std		\$695	-	-	-	-	€ 1,095	-	-
Ottobock Start M4 Wheelchair XXL		\$1,456	-	\$2,700	-	-	€ 1,575	¥175,000	-
Ottobock Cloud Cushion		\$736	\$547	\$629	-	-	€ 672	¥51,000	-
Ottobock Trias Carbonfibre Foot		\$795	\$1,155	-	\$1,020	£424	€ 823	-	-

Appendix B: Wheelchair specification form example

ORDERING INFORMATION: Phone: (02) 9678 6600 • Fax: (02) 9678 6655 • Email: orders@sunrisemedical.com.au
ACCOUNT INFORMATION

Account:	_____	Ship To:	_____
Date:	_____	Name:	_____
PO#:	_____	Address:	_____
Therapist:	_____	City / State:	_____
Customer Name:	_____	Postcode:	_____
Rep Name & Phone:	_____	Phone:	_____

This is an interactive order form when used in an MS Excel application. Please note selections must be made in order, starting from Page 1. To activate it, simply change the "0" to "1". This will highlight the selection for you. Text boxes will pop up as you go through the script, with reminders of what you are able to do.

NOTE: Rather than not making any selections, either select "Omit" or write "Omit" next to it so that we know it isn't an option.
This form can be printed & used manually if required.

QUICKIE QM-710™ BC

0	172PC67	Quickie QM-710 BC With ASAP II Seat	\$6,152
		See Fig 1.1	
		Base Package Includes:-	
		RNET 90A Expandable Drive Control	
		136kg 10kph 4-Pole Motor Package	
		ASAP II Rehab Seat Frame	
		14" Drive Wheels with flat free insert	
		8A Dual Mode (Compact) CTE	

FIGURE: 1.1 QM-710™ BC

QUICKIE QM-710™ SC

0	172PC68	Quickie QM-710 SC for SPOT Tilt or Recline	\$6,152
		See Fig 1.2	
		Base Package Includes:-	
		RNET 90A Expandable Drive Control	
		136kg 10kph 4-Pole Motor Package	
		ASAP II Rehab Seat Frame	
		14" Drive Wheels with flat free insert	
		8A Dual Mode (Compact) CTE	

FIGURE: 1.2 QM-710™ SC

QUICKIE QM-710™ MPC

0	172PC69	Quickie QM-710 MPC SPOT Tilt / Recline	\$6,152
		See Fig 1.3	
		Base Package Includes:-	
		RNET 90A Expandable Drive Control	
		136kg 10kph 4-Pole Motor Package	
		Recline Seat Frame	
		14" Drive Wheels with flat free insert	
		8A Dual Mode (Compact) CTE	

FIGURE: 1.3 QM-710™ MPC (Shown with optional Seat Elevator)

2. BASE CHAIR OPTIONS

SHROUD COLOUR			
0	172EZ01	Candy Apple Red	\$0
0	172EZ02	High Gloss Black	\$0
0	172EZ03	Candy Blue	\$0
0	172EZ04	Silver	\$0
0	172EZ05	Copper	\$0

PRE-SET SEAT FRAME ANGLE			
0	172FA10	0°	\$0
0	172FA3	3°	\$0
		(N/A with Lift)	
0	172FA4	6°	\$0
		(N/A with Tilt, Recline or Lift)	
0	172FA5	9°	\$0
		(N/A with Tilt, Recline or Lift)	

USER WEIGHT			
0	172WG06	Less than 68kg	\$0
0	172WG13	68 - 90kg	\$0
0	172WG14	91 - 113kg	\$0
0	172WG03	113 - 136kg	\$0

SEAT HEIGHT			
Measured in the front. Obtain a Quote to verify estimated STFH.			
0	172HT44	Lowest STFH	\$0
0	172HT45	+1" STFH	\$0
		(N/A with Lift / Tilt Combination)	
0	172HT46	+2" STFH	\$0
		(N/A with Lift / Tilt Combination)	

DRIVE WHEEL			
0	172DW37	14" Cast Wheel Solid Inserts (Knobby)	\$0
0		14" Cast Wheel Pneumatics (Knobby)	\$0

MOTOR PACKAGE			
0		10Kph Standard Package	\$0
0		8Kph High Torque Package	\$616

TRANSIT OPTION			
0	172TO25	4 Point Transit Package (N/A with Vent)	\$0
0	172TO40	Omit Transit	\$0
WHEEL LOCKS			
0	172WL42	Wheel Locks	\$154
VENTILATOR OPTIONS			
N/A with Transit Option or Lift Module			
0	172VT7	Articulating Vent Tray	\$1,606
0	172VT4	Fixed Vent Tray (Pulmonetic LTV Models) (N/A with Recline)	\$505

STFH MATRIX			
Seating Type & Power Option Combinations	Seat-to-Floor Height at 0 Tilt		
	Lowest	+1"	+2"
ASAP II No power seating	17.5"	19.5"	20.5"
ASAP II Lift only	19.0"	20.5"	21.5"
ASAP II Tilt only	19.0"	20"	21"
ASAP II Tilt & Lift	21.5"	N/A	N/A
Power Recline Only Seat	16.5"	18.5"	19.5"
Power Recline & Lift Seat	18.0"	19.5"	20.5"
Tilt & Power Recline Seating	17.0"	18.5"	19.5"
Lift / Tilt & Power Recline Seat	20.0"	21.5"	N/A
Adding seat angle will increase STFH by 1" for each incremental change.			
Actual STFH may vary by 0.5"			

3. BATTERIES & CHARGERS			
BATTERIES (GEL CELLS)		BATTERY CHARGER	
0	MK 73 AH Batteries Pair	0 172BJ19	8A Dual Mode (Compact) CTE \$0
		0 172BJ3	Omit Charger -\$62

4. ELECTRONICS			
DRIVE CONTROL OPTIONS		SWITCH MOUNT BRACKET	
0	RNET Expandable Drive Control (90A)	STD	
0	172J70	Std LED Joystick for Expandable Controls	\$0
0	172J88	Joystick with Toggle, Spd Pot, Stereo Jacks & Colour Display	\$396
0	172J95	Omit Joystick for use with Omni	\$0

RNET JOYSTICK			
0	172J70	Std LED Joystick for Expandable Controls	\$0
0	172J88	Joystick with Toggle, Spd Pot, Stereo Jacks & Colour Display	\$396
0	172J95	Omit Joystick for use with Omni	\$0

LED JOYSTICK AS ATTENDANT CONTROL (Mounted on Back Cane)			
<i>Includes a 1 hour labour charge</i>			
0		As Standalone (no user joystick)	\$456
0		Addition - chair also has client joystick	\$1,124

COMPACT JOYSTICK			
0		RNET compact joystick with 2 switches & mount, including external mounting port, if required.	\$2,849
0		Chin	
0		Right Hand Side	
0		Left Hand Side	

JOYSTICK MOUNT (FIXED or SWING AWAY)			
0	172JM10	Fixed Mount	\$0
0	172JM11	Swing Away Mount	\$325

JOYSTICK MOUNT (LOCATION)			
<i>Height Adjustable</i>			
0	172HM1	Right Side Mount	\$0
0	172HM2	Left Side Mount	\$0

JOYSTICK HANDLE (OPTIONAL)			
0	172JH1	Ball Handle	\$105
0	172JH2	Foam Ball Handle	\$105
0	172JH4	T-Handle	\$105
0	172JH6	Goalpost	\$105

RNET OMNI & OUTPUT OPTIONS			
<i>Choose All That Apply</i>			
0	172ON1	RNET OMNI Input Control Module & Display w/ built-in infrared & armrest mount. Choose mount below. (Required for Specialty Input Devices)	\$847
0	172ON2	RNET Output Module (ECM)	\$1,617
0	172ON3	RNET Bluetooth Mouse-mover	\$770

OMNI MOUNT			
<i>If used with a Joystick, it must be mounted on the opposite side.</i>			
0	172DS03	Swing Away Left Side OMNI Mount	\$362
0	172DS04	Swing Away Right Side OMNI Mount	\$362

SWITH INPUTS FOR JOYSTICKS or OMNI			
<i>Drive or Mode / Profile Control</i>			
0	172DSW22	Stereo to 2 Mono Splitter	\$91
0	172DSW6	Ribbon Switch	\$145
0	172DSW1	Buddy Button Switch	\$116
0	172DSW2	Disc Switch	\$245
0	172DSW9	Wobble Switch	\$770
0	172DSW4	Micro Light Switch	\$116
0	172DSW24	Egg Switch - Black	\$116
0	172DSW21	Dual Toggle Switch Only	\$262
0	172DSW19	Penta Switch with DB9 Connector	\$305
0	172DSW20	CA5 5 Switch Adapter with DB9 Connector	\$231
0	172DSW23	4-way Toggle Switch with 5th Button DB9 Connector	\$262

SPECIALTY DRIVER CONTROL OPTIONS			
<i>Requires OMNI. All packages must also select OMNI.</i>			
<i>Only with solid backs</i>			

0	172II	Quick Sip n' Puff System (Includes headrest & removeable mount)	\$2,803
0		ASL Head Array Package (Adult) (Includes headrest & removeable mount)	\$4,389
0	172II03	ASL Head Array Package (Peadiatric) (Includes headrest & removeable mount)	\$4,389
0	172II04	Switch-It Head Array Package (Adult) (Includes headrest & removeable mount)	\$4,389
0	172II05	Switch-It Head Array Package (Peadiatric) (Includes headrest & removeable mount)	\$4,389
0	172ID36	ASL Porportional Mini Joystick Chin / Lip Control Package Mini Joystick (Includes headrest & removeable mount)	\$4,605
0	172ID37	ASL Porportional Mini Joystick Midline with Gatlin Package (Includes headrest & removeable mount)	\$4,605
0	172ID45	Quickie Proportional Chin Control Package (Includes headrest & removeable mount)	\$3,927

ATTENDANT CONTROL			
0	172OA02	Attendant Control for RNET	\$996

ATTENDANT MOUNTING LOCATION			
0	172DN1	Mounting Location: Right Back Cane	\$0
0	172DN2	Mounting Location: Left Back Cane	\$0

ELECTRONIC PROGRAMMERS			
0	172PR5	RNET PC Programmer with Dongle	\$693
0	172PR6	DTT (Hand Held Programmer)	\$847

SWING AWAY CHIN MOUNT			
0		Manual Swing Away Option	\$616
0		Powered Swing Away Option	\$3,542
0		Operate with a Buddy Button	N/C
0		Swing Away Direction	\$0
0		Left	
0		Right	
0		ASL Mini Joystick Mount Bracket	N/C
0		PG Compact Joystick Mount Bracket	N/C

5. SEAT TYPE

0	172ST56	Quickie ASAP II (Adjustable Seating & Positioning) (Choose Seat Frame Size Platform)	\$0	0	172ST57	Power Recline Seat Frame (G) (Not Width Adjustable)	\$0
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ASAP II FRAME SIZE

Each Frame is width & depth adjustable withing a given range

0	172FU17	Adjustable 12 x 12" to 16 x 19" (A)	\$0
0	172FU18	Adjustable 16 x 12" to 20 x 20" (B)	\$0
0	172FU19	Adjustable 18 x 16" to 22 x 22" (C)	\$0

NOTE: If you have Tilt & Recline with shear, you must select the Power Recline Seat Frame.

6. SEAT SIZE

Seat Size Matrix. Seat type is chosen in section 5.

A = ASAP II Seat Frame
(Adjustable from 12x12 to 16X19)

B = ASAP II Seat Frame
(Adjustable from 16X12 to 20X20)

C = ASAP II Seat Frame
(Adjustable from 18X16 to 22X22)

		ASAP II Seat Width											
		12"	13"	14"	15"	16"	17"	18"	19"	20"	22"		
Seat Depth	12"	A	A	A	A	A,B	B	B	B	B			
	13"	A	A	A	A	A,B	B	B	B	B			
	14"	A	A	A	A	A,B	B	B	B	B			
	15"	A	A	A	A	A,B	B	B	B	B			
	16"	A	A	A	A	A,B	B	B,C	B,C	B,C	C		
	17"	A	A	A	A	A,B	B	B,C	B,C	B,C	C		
	18"	A	A	A	A	A,B	B	B,C	B,C	B,C	C		
	19"	A	A	A	A	A,B	B	B,C	B,C	B,C	C		
	20"					B	B	B,C	B,C	B,C	C		
	21"							C	C	C	C		
22"							C	C	C	C			

G = Recline Seat (not adjustable)

		Recline Seat Width					
		16"	17"	18"	19"	20"	22"
Seat Depth	16"	G	G	G	G	G	G
	17"	G	G	G	G	G	G
	18"	G	G	G	G	G	G
	19"	G	G	G	G	G	G
	20"	G	G	G	G	G	G

SEAT WIDTH			
0	172R21	Seat Width: 12"	\$0
0	172R22	Seat Width: 13"	\$0
0	172R23	Seat Width: 14"	\$0
0	172R24	Seat Width: 15"	\$0
0	172R5	Seat Width: 16"	\$0
0	172R6	Seat Width: 17"	\$0
0	172R7	Seat Width: 18"	\$0
0	172R8	Seat Width: 19"	\$0
0	172R9	Seat Width: 20"	\$0
0	172R25	Seat Width: 22"	\$0

SEAT DEPTH			
0	172RF20	Seat Depth: 12"	\$0
0	172RF21	Seat Depth: 13"	\$0
0	172RF22	Seat Depth: 14"	\$0
0	172RF23	Seat Depth: 15"	\$0
0	172RF5	Seat Depth: 16"	\$0
0	172RF6	Seat Depth: 17"	\$0
0	172RF7	Seat Depth: 18"	\$0
0	172RF8	Seat Depth: 19"	\$0
0	172RF24	Seat Depth: 20"	\$0
0	172RF26	Seat Depth: 21"	\$0
0	172RF25	Seat Depth: 22"	\$0

7. SEAT CUSHIONS

Please refer to the Jay Retail Price Book for a full list of our Jay Cushions & write this as a separate line item on your PO.

0	172CU1	2" Cushion	\$120
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8. POWERED SEATING

POWER SEATING OPTIONS (SC & MPC MODELS)			
0	172PJ2	Quickie SPOT 50° CG Tilt	\$2,803
0	172PA6	Recline with Power Shear Reduction Only	\$5,256
0	172PA7	Tilt & Recline with Power Shear Reduction	\$9,235

POWERED SEAT ELEVATOR - 9" TRAVEL			
0	172PA8	Power Seat Elevate (adds 3" to STFH)	\$2,988

POWERED SEATING CONTROL METHOD

For use with power seating actuators. Switch activations stand-alone & does not require thru drive electronics

0	172EO10	Switch Control 1 actuator with dual toggle & mount (For operating Tilt or Lift)	\$0
0	172EO11	Switch Control 1 actuator with buddy button & mount (For operating Tilt or Lift)	\$0

POWERED SEATING CONTROL METHOD CONT.

0	172EO12	Switch Control 2 - 3 Actuator with 4-way Toggle Switch & Mount. (Capable of operating combo of Tilt / Lift or legs only)	\$0
0	172EO13	Thru Drive 1 Actuator (For operating Tilt or Lift through Joystick)	\$0
0	172EO14	Thru Drive 2+ Actuator (ISM module) (ISM is standard if selecting the Lights & Indicators Package below) (For operating more than one actuator through Joystick)	\$996

POWERED SEATING CONTROL METHOD

For use with switch control powered seating

0	172EY01	Switch Mount Right	\$0
0	172RF25	Switch Mount Left	\$0

9. BACKREST & BACK OPTIONS							
BACKREST FRAME TYPE				BACK TYPE (UPHOLSTERY OR SOLID)			
0	172BT8	Angle Adjustable (ASAP II Seat Only)	\$0	0	172BU1 Upholstery (N/A with tilt or recline)	\$0	
0	172BT98	Manual Recline 40° (ASAP II Seat Only) (Not width adjustable)	\$655	0	172BU70 Tension adjustable upholstery Ballistic Nylon (With 1" width adjustment) (N/A with tilt or recline)	\$485	
0	172TB89	Power Recline (Power Recline Seat Only)	\$0	0	172BU71 Tension adjustable upholstery 3DX Vented. (With 1" width adjustment) (N/A with tilt or recline)	\$508	
MANUAL RECLINE ADJUSTMENT METHOD OPTION (ASAP II)				0	172BU76 SPOT Curved (ASAP II Only) (N/A with power recline)	\$0	
Back Height is set at 23"				0	172BU77 Jay SPO Posterior Positioning (ASAP II Only) (N/A with power recline)	\$696	
0	172MN01	Tool	\$0	0	172BU79 Power (Power Recline Seat Only)	\$0	
0	172MN02	Knob (N/A with dual post arms)	\$0	JAY 3 OPTION (ASAP II)			
ANGLE ADJUSTABLE BACKREST OPTIONS (ASAP II)				0	172JB01 Jay J3 (N/A with recline unless prior approval) (Please write as a separate line item on your PO)	See J3 OF	
N/A with manual recline				BACK HEIGHT			
N/A with power recline				Required for SPOT Curved, SPO Backs & Recline Backs			
0	172DO8	Non Folding backrest	\$0	Limited combinations of widths			
0	172DO9	Folding backrest (ASAP II only)	\$169	Measured from pan to top of solid back.			
CANE ANGLE (ASAP II)				0	172B132 14" (N/A with power recline seating)	\$0	
0	172BP40	Straight Back Cane Post	\$0	0	172B36 16" (N/A with power recline seating)	\$0	
TOWEL BAR DEPTH (ASAP II)				0	172B38 18" (N/A with power recline seating)	\$0	
0	172QT03	Shallow (N/A with upholstery backs)	\$0	0	172B40 20" (N/A with power recline seating)	\$0	
0	172QT04	Deep (Extends 4" from back canes for deep backs)	\$0	0	172B42 22" (Available on all back types)	\$0	
BACK CANE (ASAP II)				0	172B44 24" (Available on all back types)	\$0	
Upholstery Height Measured Pan to top of upholstery				0	172B140 26" (Available on all back types)	\$0	
0	172B1	Low - 15.5"	\$0	0	172B141 27" (Only available on power recline)	\$0	
0	172B5	Medium - 17.5"	\$0	0	172B142 28" (Only available on power recline)	\$0	
0	172B9	Tall - 19.5"	\$0	10. HEADREST OPTIONS			
POWER RECLINE BACKREST PRESENT HOME ANGLE				Available with on-chair solid backs. Headrests for Jay 3 Backs need to be ordered on the J3 Back Order Form			
0	172QK1	90°	\$0	0	Whitmyer Linx Headrest 8" Plush	\$424	
0	172QK2	95° (Default)	\$0	0	Whitmyer Linx Headrest 10" Plush	\$424	
0	172QK3	100°	\$0	0	172HE66 Plush Head Support Pad 10" x 4.5"		
172HE65 Plush Head Support Pad 8" x 4.5"							
11. POSTURAL SUPPORTS							
ALL postural supports are sold as EACH.							
Must select both left and right for a pair.							
SWING AWAY LATERAL THORACIC SUPPORT - LEFT				SWING AWAY LATERAL THORACIC SUPPORT - RIGHT			
0	Swing Away Lateral Thoracic Support 4x5" - Left		\$396	0	Swing Away Lateral Thoracic Support 4x5" - Right	\$396	
0	Swing Away Lateral Thoracic Support 4x6" - Left		\$396	0	Swing Away Lateral Thoracic Support 4x6" - Right	\$396	
LONG THIGH SUPPORT WITH REMOVEABLE MOUNT				CHEST STRAP			
Available with Cantilever Arms				0	172ZR03 Padded Chest Strap	\$393	
N/A with Manual Recline Back, Dual Post, Single Post or Cantilever w/ 2pt Locking Arms				SWING AWAY KNEE ADDUCTOR SUPPORTS - LEFT			
0	Long Thigh Support - Left - Removeable		\$396	Available only with fixed & power centre mount legrests.			
0	Long Thigh Support - Right - Removeable		\$396	N/A with Dual Post Armrest.			
SWING AWAY KNEE ADDUCTOR SUPPORTS - LEFT				SWING AWAY KNEE ADDUCTOR SUPPORTS - RIGHT			
Available only with fixed & power centre mount legrests.				Choose Pad Size & Arm Size			
0	Pad Size		\$496	0	Pad Size		\$496
0	172KB5	Knee Adductor Pad Small - Left		0	172KB6	Knee Adductor Pad Small - Right	
0	172KB7	Knee Adductor Pad Large - Left		0	172KB8	Knee Adductor Pad Large - Right	
0	S/A Arm Size		\$496	0	S/A Arm Size		\$496
0	172XX04	Swing Away Short - Left		0	172XX05	Swing Away Short - Right	
0	172XX06	Swing Away Long - Left		0	172XX07	Swing Away Long - Right	

12. ARMREST & ARMPAD OPTIONS

Please choose either Option A or Option B

0 Option A: Armrest Options for ASAP II Seating

0 Option B: Armrest Options for Power Recline Seating

12A. ARMREST OPTIONS FOR ASAP II SEATING

ARMREST MOUNTING FOR ASAP II (NO TILT OR RECLINE)				ARMREST MOUNTING FOR ASAP II (WITH TILT)			
Dual Post Armrests				Dual Post Armrests			
0	172EG01	Short Dual Post Flip Back 10" Height	\$0	0	172EG09	Short Dual Post Flip Back HT Adj. 10 - 15"	\$0
0	172EG21	Long Dual Post Flip Back 10" Height	\$0	0	172EG23	Long Dual Post Flip Back HT Adj. 10 - 15"	\$0
0	172EG02	Short Dual Post Flip Back HT Adj. 10" - 15"	\$231				
0	172EG22	Long Dual Post Flip Back HT Adj. 10" - 15"	\$231				
Cantilever Armrests				Cantilever Armrests			
<i>Adjustable length armpad included (Choose pad below, except for Low Arm Option)</i>				<i>Adjustable length armpad included (Choose pad below, except for Low Arm Option)</i>			
<i>N/A with Manual Recline Back</i>				<i>N/A with Manual Recline Back</i>			
0	172EG03	Standard Cantilever Arm with 2 Point Locking Post (9" - 10" Ht Range) (N/A with seat depths below 16")	\$216	0	172EG10	Standard Cantilever Arm with 2 Point Locking Post (9" - 10" Ht Range) (N/A with seat depths below 16")	\$0
0	172EG04	Standard Cantilever Arm with 2 Point Locking Post (11" - 12" Ht Range) (N/A with seat depths below 16")	\$216	0	172EG11	Standard Cantilever Arm with 2 Point Locking Post (11" - 12" Ht Range) (N/A with seat depths below 16")	\$0
0	172EG05	Standard Cantilever Arm 9" - 12" Height Range	\$0	0	172EG12	Standard Cantilever Arm 9" - 12" Height Range	\$0
0	172EG06	Low Cantilever Arm 7" - 10" Height Range (Choose ASAP II Pad type & size below)	\$0	0	172EG13	Low Cantilever Arm 7" - 10" Height Range (Choose ASAP II Pad type & size below)	\$0
Single Post Armrests				Omit Armrest			
0	172EG07	Single Post Height Adjustable - Standard	\$231	0	172EG20	Omit Armrest & Mounts	\$0
0	172EG08	Single Post Height Adjustable - Low	\$231				

ARMPAD OPTIONS FOR ASAP II

Pad type / size options for Dual Post / Single Post / Low Cantilever

Left Armpad				Right Armpad			
0	172AE01	Desk Length Waterfall (10")	\$0	0	172AB01	Desk Length Waterfall (10")	\$0
0	172AE02	Full Length Waterfall (14")	\$0	0	172AB02	Full Length Waterfall (14")	\$0
0	172AE03	Desk Length Standard (10")	\$0	0	172AB03	Desk Length Standard (10")	\$0
0	172AE04	Full Length Standard (14")	\$0	0	172AB04	Full Length Standard (14")	\$0

Pad type / size options for Standard Cantilever Arm

Left Armpad				Right Armpad			
0	172AE11	Full Length Cantilever (14")	\$0	0	172AB11	Full Length Cantilever (14")	\$0
0	172AE10	Desk Length Cantilever (10")	\$0	0	172AB10	Desk Length Cantilever (10")	\$0

12B. ARMREST OPTIONS FOR POWER RECLINE SEATING

ARMREST FOR POWER RECLINE SEATING			
<i>Recline Seat Frame Only</i>			
0	172EG16	Standard Ht Reclining Armrest Short (10.8" - 14")	\$385
0	172EG17	Tall Ht Reclining Armrest Short (12.8" - 16")	\$385
0	172EG18	Standard Ht Reclining Armrest Long (10.8" - 14")	\$385
0	172EG19	Tall Ht Reclining Armrest Long (12.8" - 16")	\$385

Omit Armrest			
0	172EG20	Omit Armrest & Mounts	\$0

RECLINING ARMPAD OPTIONS

Standard Reclining Armpad - Left			
0	172EG05	Reclining Armpad (16")	\$0
Standard Reclining Armpad - Right			
0	172AB05	Reclining Armpad (16")	\$0

Ottobock Reclining Armpad - Left			
<i>Power Recline Seat Only</i>			
0	172AE08	Small Forearm Pads (8")	\$123
0	172AE06	Medium Forearm Pads (11.5")	\$123
0	172AE07	Large Forearm Pads (14")	\$123

Ottobock Reclining Armpad - Right			
<i>Power Recline Seat Only</i>			
0	172AB08	Small Forearm Pads (8")	\$123
0	172AB06	Medium Forearm Pads (11.5")	\$123
0	172AB07	Large Forearm Pads (14")	\$123

Ottobock Hand Pad Options - Left			
0	172OL01	MD Flat Hand Pads (4½" x 7")	\$85
0	172OL02	LG Flat Hand Pads (5½" x 9")	\$85

Ottobock Hand Pad Options - Right			
0	172OR01	MD Flat Hand Pads (4½" x 7")	\$85
0	172OR02	LG Flat Hand Pads (5½" x 9")	\$85

13. HANGERS & FOOTRESTS FOR ASAP II

Hanger & Extension Tube Options (See Footplate Compatibility in the brackets)

NON POWERED SWING AWAY LEGRESTS

Sold as Pairs

0	172H95	65° Swing Away	(A, B, C)	\$0
0	172H2	70° Swing Away	(A, B, C)	\$0
0	172H94	75° Tapered Swing Away	(E)	\$0
0	172H6	90° Swing Away	(B, C) (5.5 - 9")	\$0
0	172H138	Manual ELR S/A	(A, B, C, D)	\$370

(Available with Fixed Centremount, choose below)

POWERED ELEVATING LEGRESTS

0	172H125	Centremount Power ELR with Articulation	(F, G, H)	\$1,441
0	172H126	S/A Power ELR with Articulation (PR)	(B)	\$1,441

(N/A for 12" or 13" wide)

(Available with Fixed Centremount, choose below)

FIXED CENTRE MOUNT LEGRSTS (INCLUDE FOOTPLATE)

0	172H134	Fixed Centre Mount Short		\$0
0	172H135	Fixed Centre Mount Long		\$0

OMIT HANGERS

0	172H144	Omit Hangers		\$0
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HANGER EXTENSIONS (SEE RANGE LISTED IN MATRIX BELOW)

NOTE: Not all extension tubes will be available. Depending on seat height, some extension tube options may not offer enough ground clearance.

0	172E16	High Mount Hanger		\$0
0	172E1	Short		\$0
0	172E2	Medium		\$0
0	172E5	Long		\$0
0	172E21	Omit Extension		\$0

Lower Leg Length Matrix (measured seat pan to the top of the footplate surface)				
Hanger Type	High Mount	Short	Medium	Long
65° Swing Away	7-14"	13.5- 16"	16-18.5"	18-20.5"
70° Swing Away	7-14"	13.5- 16"	16-18.5"	18-20.5"
75° Tapered S/A	7-14"	13.5- 16"	14.5-19"	15-18"
90° Swing Away	5.5-9" Footplate mounts to front of hanger.			
Manual ELR S/A		12.5-17"	14.5-19"	17-21"
Power ELR S/A		12-14"	14-17"	16.5-19"
Fixed Cntrmnt		12.5"-15.5"		14.5"-19.5"
Power Cntrmnt	13.5-18.5"			16.5-21.5"

FOOTPLATE (PR)

0	A - Composite with Heel Loop	(PR)	\$0
0	B - Adult Angle Adjust with heel loop for use with		\$125
	65° & 70° hanger & ELR	(PR)	
0	B - Adult Angle Adjust with heel loop for use with		\$125
	90° hanger	(PR)	
0	C - Kids angle Adjust with Leg Strap for use with		\$125
	65° & 70° hanger & ELR	(PR)	
0	C - Kids angle Adjust with Leg Strap for use with		\$125
	90° hanger	(PR)	
0	D - Aluminium	(PR)	\$46
0	E - 1 Piece Angle Adjust. Footplate with Leg Strap	(PR)	\$300
0	F - Centremount Single Footplate		\$0
0	G - Centremount Dual Footplate Heel Loop		\$323
0	H - Centremount High Mount Footplate		\$323

FOOTREST ACCESSORIES

0	172SA01	Toe Loop (PR)	\$40
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(Only available on Option B)

0	172LS14	Extra Leg Strap	\$40
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Footplate Matrix									
Hanger Type	A	B	C	D	E	F	G	H	
65° Swing Away	X	X	X						
70° Swing Away	X	X	X						
75° Tapered S/A					X				
90° Swing Away		X	X						
Manual ELR S/A	X	X	X	X					
Power ELR S/A		X							
Fixed Cntrmnt						X			
Power Cntrmnt						X	X	X	

14. ACCESSORIES

WHEELCHAIR TRAY TABLE

0	Swing Away Tray Table 16"	\$311
0	Swing Away Tray Table 17"	\$311
0	Swing Away Tray Table 19"	\$311
0	Swing Away Tray Table 20"	\$311
0	Swing Away Tray Table 22"	\$311

BACKPACK

0	172S1	Black Utility	\$65
0	172A2	Black / Charcoal Kids	\$65

POSITIONING BELT

0	172EJ01	Auto Style Buckle	\$0
0	172EJ02	Belt 2" Aircraft Buckle	\$54
0	172EJ03	Belt 2" Aircraft Buckle Padded	\$111

LIGHTS & INDICATORS

0	LED Lights & Indicators	\$1,871
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(Includes light joystick & ISM. No need to select above)

UNIVERSAL TABLET MOUNT

0	PCMOUNT	Universal Tablet Mount	\$246
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ADDITIONAL COSTS

0	26000-01	Labour 1hr (incl. GST)	\$110
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TOTAL COST FOR LABOUR: \$0

NET COST OF CHAIR ONLY: \$0

TOTAL COST OF CHAIR & LABOUR: \$0

Have you remembered to order:-

- JAY cushion or Back - see applicable order forms & Jay Retail Price Book
- Whitmyer - see applicable order form & Whitmyer Short Ordering Guide
- ART - see relevant price list

NOTE: All additional items, incl. Jay, Whitmyer, spare parts etc. should be put on your PO, & will be charged at RRP less discount.

OTHER products also available for purchase include:-

Sunlift Hoists & Slings, Scooters, Power Wheelchairs, Manual Wheelchairs (including Positioning), Guardian, Breezy, Quickie Parts

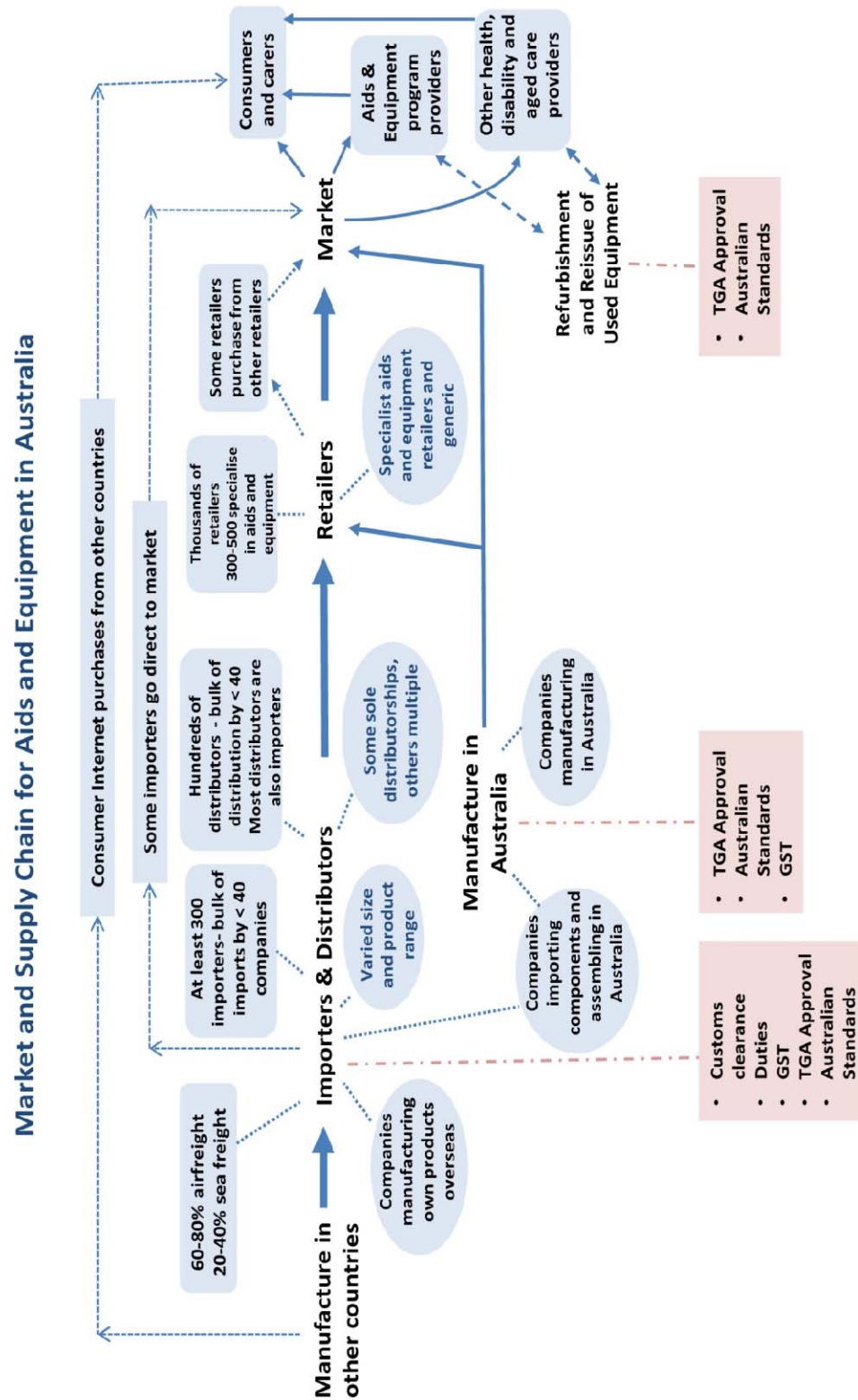
DISCLAIMER: Not all features & options offered are compatible with all configurations of the wheelchair.



Download a QR reader to your Smartphone to access Quickie QM-710 product page.



Appendix C: Australian AT supply chain



Source: Jenny Pearson & Assoc. 2013, pg 48

Appendix D: Estimated National AT Expenditure Data

(Note that this material was developed originally by Dr Michael Summers, who as at the time the Senior Policy Advisor for MS Australia, this material was produced in November 2011)

Methodology for Arriving At Australian National Assistive Technology and Home, Vehicle and Workplace Modifications Expenditure

There are currently a range of terms used to describe assistive technology (AT), including but not limited to: aids and equipment, aids and appliances, and goods and equipment. We have chosen to use the term AT.

Table 1 below gives a summary of Australian national expenditure on assistive technology and home, vehicle and workplace modifications by listing the major areas of expenditure which comprised our total estimated national expenditure figure. Table 1 summarises known expenditure nationally. More specific detail about the findings including the source of figures is provided in Tables 2 to 6 and the accompanying notes.

Caution must be used when considering these figures. Little data is systematically collected, locally or nationally. And the data that is collected is often limited or uncertain, particularly in regards to what constitutes AT, and how the data has been collected. Additionally, as can be seen in Table 6 – there are numerous areas of expenditure for which there is no data available, and some other tables include estimates derived from smaller local data sets.

This is a work in progress, and any suggestions, additions, etc are more than welcome

Table 1. Summary: National Expenditure on Assistive Technology

Major Areas of Expenditure	Program	Expenditure (\$M)	Financial Year(s)
Government Disability	State/territory aids & equipment programs, plus Commonwealth employment and education programs, and continence assistance	471	2006-2009
Government Health	Hospital Discharge and health insurance premiums	479	2007-2008
Government Aged Care	EACH, EACH-D, HACC (home mods), & DVA	27	2008-2010
Total Government		977	27% of total expenditure
Individuals/Households	Personal expenditure	2264	2007-2008
Insurance	Private Health Insurance	325	2007-2008
Insurance	Workers Compensation and Compulsory Third Party Traffic Accident Insurance	45	2007-2008
Charitable	Philanthropic & NGO	unknown	This is one of the largest of many unknown areas of expenditure, see Table 5 below
Total Non-Government		2,634	73% of total expenditure
National Annual Total		3,611	

Table 2: Details: Government Disability-related Expenditure

Agency Type	Program Type	Expenditure (\$M)	Financial Year	Source & Notes
State/Territory Departments of Health/Human Services	Various across states and territories	118	Derived from various years: 2006-2009	Price Waterhouse Coopers 2009, <i>Disability Investment Group: National Disability Insurance Scheme Final Report</i> , Department of Families, Housing, Community Services and Indigenous Affairs: Canberra, pg 174. Most of these programs are for those under 65, but there are some exceptions such as Victoria. Note that the Continence Assistance Scheme included by PWC is accounted for separately in this table
Commonwealth Dept of Health and Ageing	Continence Aids and Assistance Scheme	41	2009-2010	SCRGSP (Steering Committee for the Review of Government Service Provision) 2010, <i>Report on Government Services 2011</i> , Productivity Commission, Canberra, Table 13A.5. CAAS was replaced by Continence Aids Payment Scheme (CAPS) in July 2010, and is now located in Commonwealth Dept of Human Services.
Commonwealth Dept of Health and Ageing	Australian Hearing Services/Office of Hearing Services	300	2006-2007	Budget Statements – Department of Health and Ageing for 2006-07, pgs 111-115. Expenditure will have gone up substantially since then.
Commonwealth Department of Education, Employment, and Workplace Relations	Employment Assistance Fund	10	2008-2009	Confidential Source, unconfirmed Previously known as the Workplace Modification Scheme
Commonwealth Department of Education, Employment, and Workplace Relations	Higher Education Disability Support Program	2	2008	http://www.deewr.gov.au/highereducation/programs/equity/hedisabilitySupportProgram/Pages/Home.aspx website accessed 24/11/11, which states that just over \$5M was spent in calendar year 2008 on ‘support and equipment’ and other disability access goals in higher education from the Additional Support to Students with Disabilities, from the Higher Education Disability Support Program.. \$2M has been arbitrarily allocated here to AT, Previously a confidential source had stated expenditure by this program on AT was \$10M.
TOTAL		471		

Table 3: Details: Government Health-related Expenditure

Major Areas of Expenditure	Program	Expenditure (million)	Financial Year	Source & Notes
Department of Health and Ageing (DoHA) and State/Territory Health Departments	Hospital Discharge	331	2007-08	Australian Institute of Health and Welfare 2009, <i>Health expenditure Australia 2007–08</i> , series no. 37. cat. no. HWE 46, pg 115, Table A3.
Department of Health and Ageing (DoHA)	Private Health Insurance Premium Rebate	148	2007-08	Australian Institute of Health and Welfare 2009, <i>Health expenditure Australia 2007–08</i> , series no. 37. cat. no. HWE 46, pg 115, Table A3.
TOTAL		479		

Table 4: Details: Government Aged Care-related Expenditure

Agency Type	Program Type	Expenditure (million)	Financial Year	Source & Notes
Commonwealth Department of Veterans Affairs	Rehabilitation Appliances Program	2	2007-08	Australian Institute of Health and Welfare 2009, <i>Health expenditure Australia 2007–08</i> , series no. 37. cat. no. HWE 46, pg 27.
State & Territory Departments of Ageing/Human Services	Home and Community Care (HACC) – Home Modifications	18	2008-09	Commonwealth Dept of Health and Ageing, 2010, <i>Home and Community Care Program, 1 July 2008 to 30 June 2009, Annual Report</i> , pg 49 and 51, Tables A6 and A7 (number of clients served x average expenditure per client).
Commonwealth Dept of Health and Ageing	Extended Aged Care at Home (EACH)	5	2009-10	No national or state level data available. This estimate created on basis of data from the largest Commonwealth funded community aged care provider in Victoria which allocated an average of \$875 per EACH and EACH-D package in 2009-10. This was extrapolated based on total number of packages nationally of 5250 as of end June 2010.
Commonwealth Dept of Health and Ageing	Extended Aged Care at Home – Dementia	2	2009-10	No national or state level data available. This estimate created on basis of data from the largest Commonwealth funded community aged care provider in Victoria which allocated an average of \$875 per EACH and EACH-D package in 2009-10. This was extrapolated based on total number of packages nationally of 2300 as of end June 2010.
TOTAL		27		NOTE: expenditure is much higher than this, but little data available, see Table 6 below.

Table 5. Non-Government Expenditure

Source		Expenditure (million)	Financial Year	
Individual/Households	Personal expenditure	2,264	2007-2008	<p>Australian Institute of Health and Welfare 2009, <i>Health expenditure Australia 2007–08</i>, series no. 37. cat. no. HWE 46, pg 115, Table A3.</p> <p>Note that this figure is derived by AIHW from the ABS Household Expenditure Survey 2003-04, cat.no. 6535.0.55.001, for the purchase and rental of ‘therapeutic goods and appliances’.</p> <p>Note: This probably does not include co-payments made for equipment purchased through government schemes, or costs of vehicle and home modifications, but may include things such as spectacles.</p>
Insurance	Private Health Insurance	325	2007-2008	Australian Institute of Health and Welfare 2009, <i>Health expenditure Australia 2007–08</i> , series no. 37. cat. no. HWE 46, pg.35.
Insurance	Workers Compensation and Compulsory Third Party Traffic Accident Insurance	45	2007-2008	Australian Institute of Health and Welfare 2009, <i>Health expenditure Australia 2007–08</i> , series no. 37. cat. no. HWE 46, pg 115, Table A3.
TOTAL		2,634		

Table 6: Known Unknown Expenditure Areas

Major Areas of Expenditure	Program	Source & Notes
Philanthropic and NGO's	Various	Many philanthropic organisations regularly assist individuals and organisations to purchase AT (Rotary is one of many philanthropic organisations that does this), and similarly many organisations such as Yooralla, Scope and MS Australia regularly purchase or assist individuals with co-payments to purchase AT.
Superannuation cashed out early by Individual/Household	Vehicle modifications, home modifications, major equipment purchases	Anecdotally it is clear that people regularly cash in their super to fund home mods, vehicle mods and equipment purchases. The scale of this is likely to be substantial, and data is probably available.
Commonwealth/States & Territories	Young People in Residential Aged Care (YIPRAC)	Some YIPRAC funds are/have been used to purchase AT for young people in nursing homes, and also to prevent admissions to residential aged care.
State/Territory Depts of Education	Programs For Students With Disabilities	
State/Territory Depts of Housing	Home Modifications for Public Housing Tenants With Disabilities	
Commonwealth Dept of Human Services	Commonwealth Rehabilitation Service Australia	Industry Commission, <i>Aids and Appliances for People with Disabilities</i> , Report No. 3, 18 July 1990, pg. 226, states that \$3M was spent on AT in 1989-90. But this data too out of date to be meaningful
Commonwealth Dept of Health and Ageing	Transition Care Packages	
Commonwealth DVA	Major Home Modifications	
Commonwealth Dept of Health and Ageing	Residential Aged Care (high and low)	
Various State/Territory Government Departments	Individualised service delivery funding packages in disability services,	
State/Territory Aged Care	HACC	HACC funds home mods, vehicle mods, aids for self care, reading, communication, support, mobility, medical care and 'other goods & equipment), but expenditure/cost data is only collected and reported for home modifications (reported above). Excluding the over 34,000 instances of home mods, there were over 31,000 instances of equipment provision in these other areas in 2008-09 (see DoHA 2010, <i>HACC Annual Report 2008-2009</i>)

Various state/territory and federal programs often fund all or some of these costs, along with private purchase and/or private household contributions – costs generally unreported. Vehicle modifications, home modifications, major equipment purchases. Individual/Household/Govt programs