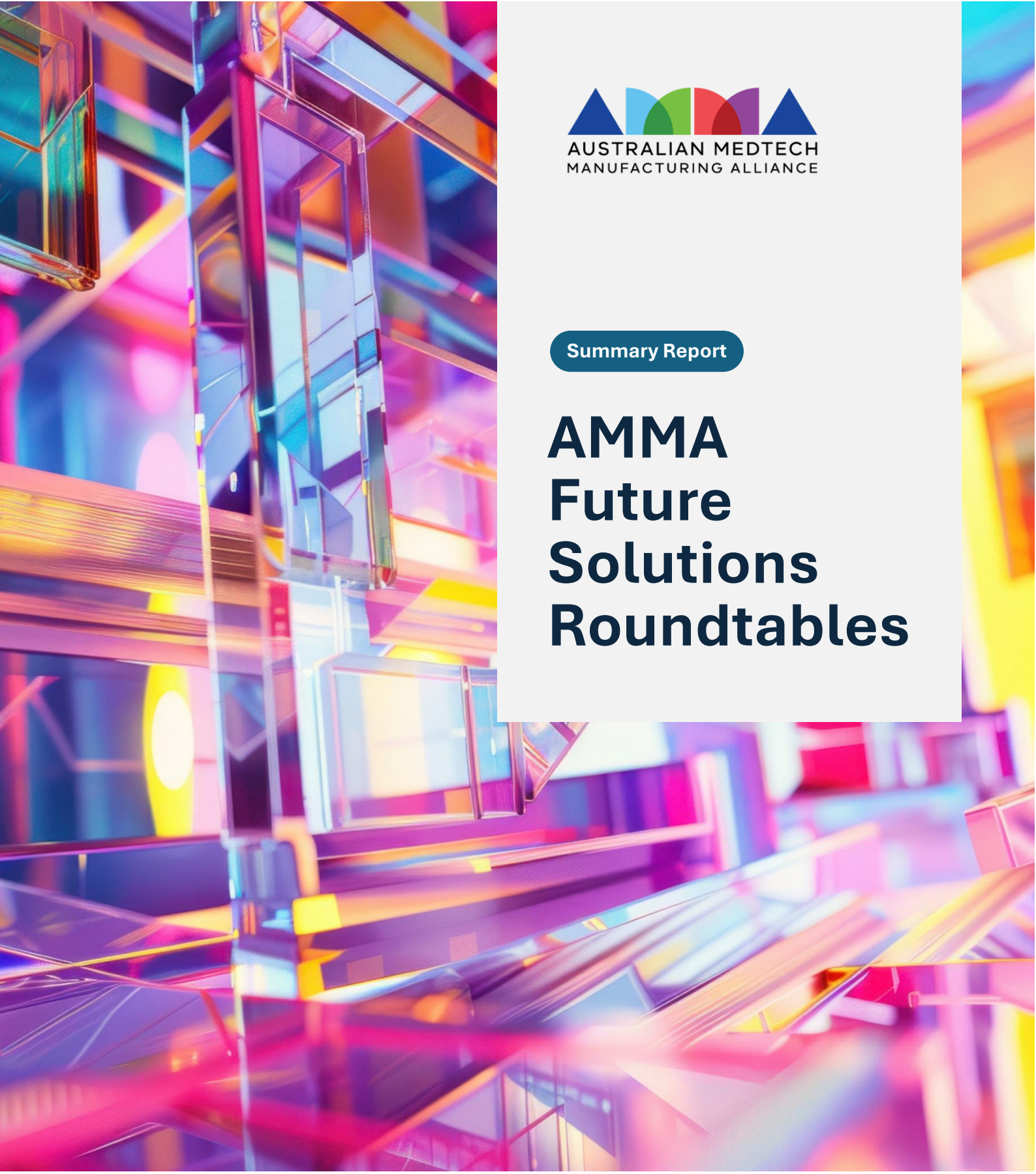

AUSTRALIAN MEDTECH MANUFACTURING ALLIANCE

Summary Report

AMMA Future Solutions Roundtables

Delivered by

MTPConnect
Australia's Life Sciences Innovation Accelerator

BioMelbourne Network
Progressing BioIndustry

Supported by

VICTORIA State Government

These roundtables were held as part of the **AMMA Medtech Showcase** on 16 October 2025 and were facilitated by Carla Zampaglione (Sento Solutions). The roundtables brought health and industry together to explore unmet needs and practical steps to strengthen partnerships across Victoria's health system.

This report summarises key themes and perspectives raised in discussion. It is a synthesis prepared by AMMA and does not necessarily reflect the views of any individual participant, facilitator, or organisation, nor constitute endorsement of any product, policy position, or recommendation.

About AMMA

The Australian Medtech Manufacturing Alliance (AMMA) is dedicated to addressing the critical challenges facing local SME medtech manufacturers, with a focus on enhancing procurement pathways and increasing the share of locally-made medtech in Australia's healthcare system.

Launched under the leadership of BioMelbourne Network in October 2024, AMMA is a partnership of peak industry bodies, backed by a network of industry and health champions and supported by seed funding from the Victorian Government's Department of Jobs, Skills, Industry and Regions (DJSIR).

Victoria serves as the pilot state for this important, solutions-driven program, setting the foundation to drive a national agenda for medtech innovation and manufacturing.

AMMA Showcase 2025 Partners

MTPConnect

MTPConnect is Australia's Life Sciences Innovation Accelerator – an independent, not-for-profit organisation championing growth of Australia's vibrant medical products sector. MTPConnect operates accelerator programs to support the development of cutting-edge medical technology, biotechnology and pharmaceutical innovations.

BioMelbourne Network

BioMelbourne Network is the peak body in the Victorian health technologies industry, driving engagement and growth in research, innovation, commercialisation and manufacturing through local and international networks for more than 23 years.

Supported by the Victorian Government

The Department of Jobs, Skills, Industry and Regions is focused on growing Victoria's prosperity, building the productive capacity of our economy and increasing participation – by creating more opportunities for people through skills and jobs; helping businesses and industries to thrive; and building vibrant communities and regions.

AMMA Medtech Showcase 2025 Exhibitors

AMMA Future Solutions Roundtables

Background

On 16 October 2025, the AMMA Medtech Showcase and Pathway to Market program finale convened Victoria's medtech ecosystem at PARKROYAL Monash Melbourne for a landmark day of connection, learning, and collaboration. The event featured 25 Victorian SME medtech manufacturers as exhibitors (page 4) and attracted more than 150 participants from across health services, government, industry, and the broader innovation ecosystem, including representatives from 15 hospitals and health networks.

Event at a glance

- 180 Registrants
- 25 Victorian Medtech exhibitors, including 10 companies from the Pathway to Market program
- 15 Hospitals and health services

Three Sessions

1. The Power of Strategic Procurement Plenary
2. Immersive Showcase with Lightning Pitches
3. Future Solutions Roundtables

Across the day, participants explored a central question: how can Victoria's health system better harness local medtech capability to deliver greater value, resilience, and innovation? Through a combination of plenary discussion, live product demonstrations, and facilitated roundtables, the program examined both the strength of Victoria's medtech sector and the systemic barriers that limit its full integration into routine health procurement. This report summarises the roundtable discussions, which explored three issues fundamental to the future growth of local medtech manufacturing:

- Topic 1: Using local capability to build resilient and efficient supply chains
- Topic 2: Embedding value beyond cost in strategic sourcing
- Topic 3: Developing partnership models to support the adoption of new technologies

Key Findings

Across all three discussions, participants described an administratively robust procurement environment operating under significant strategic and operational constraints. While policy frameworks articulate the importance of value, innovation, sustainability, and local capability, participants highlighted practical challenges implementing these objectives within current procurement settings. Contributing factors included short-term financial pressures, fragmented governance, risk management requirements, and limited visibility of local manufacturing capability.

Taken together, the discussions revealed a shared view: Victoria's health procurement system has the people, policy settings, and intent to buy locally and support innovation, but there remain gaps in the mechanisms, incentives, and system settings required to deliver this consistently and at scale.

Participants identified 15 recurring themes that together point to a coherent reform agenda. These themes indicate the pathway to greater resilience and value lies in:

- Improved visibility and collaboration, underpinned by better data,
- re-engineered tender levers,
- defined and coordinated pathways for technology adoption, and
- a cultural shift that recognises long-term system value alongside immediate cost pressures.

The following sections provide a record of insights from each roundtable topic. To hear more perspectives from the day, listeners can also tune in to Episode 202 of the MTPConnect Podcast, recorded with exhibitors at the Showcase.

At a Glance: Roundtable Key Theme Summaries

Key Themes – Summary Table	
Topic 1 - Using local capability to build resilient & efficient supply chains Participants indicated there's a will to buy local but flagged visibility gaps, single-supplier risks, and rigid access points, calling for increased visibility of local suppliers, clearer demand signals from health, procurement flexibility, selective dual-sourcing to strengthen continuity without sacrificing probity and incentives for buying locally manufactured products.	
1.1 Limited visibility of local capability and suppliers	**Description:** Local suppliers exist across some, but aren't routinely visible at the moments buyers scope categories, write specs, or assess substitutions so purchasing defaults to known (often international) SKUs. **Actions:** Build a governed, regularly updated local supplier & product catalogue; incorporate assurance mechanisms to build buyer confidence; improve local firm visibility during category planning and at backorder triggers; host showcases and product walk-throughs for priority categories.
1.2 Fragmented planning, data & policy execution	**Description:** Critical demand–supply signals (spend, backorders, usage, local substitutes) are siloed across buyer groups, health services and industry, preventing a shared picture to target localisation or manage risk. **Actions:** Stand up a one-stop shop with demand–supply intelligence dashboard; share market data and priority demands with manufacturers to stimulate market response; run a simple demand–supply overlay to identify opportunity areas and use the insights in procurement planning and industry development policy.
1.3 Contract rigidity & long procurement cycles	**Description:** Infrequent panel refreshes, long tenures and tight scopes restrict SME entry and slow adoption of better/local products between cycles, even when performance or continuity justifies change. **Actions:** Enable rolling refresh and mid-term triggers; right-size documentation and insurance requirements for low-risk categories.
1.4 Logistics and continuity of supply	**Description:** Distance, customs, shipping delays and global component shocks heighten lead-time risk; sole-supplier concentration amplifies outage/recall impacts. **Actions:** Identify vulnerable products; engage multiple suppliers and dual-source where feasible to protect continuity.
1.5 Local content targets	**Description:** Participants strongly backed progressive, auditable local-content targets linked to industry readiness to grow qualified domestic supply and improve continuity. **Actions:** Set and incentivise progressive targets for locally manufactured products tied to supplier readiness; track and publicly report local-content metrics; publish an annual outcomes summary of categories where using local capability improved continuity/quality to link targets to health-system value.

Key Themes – Summary Table

Topic 2 - Embedding value beyond cost in strategic sourcing: Shift from price-first to outcomes-first by redefining value, standardising evidence and tender templates, and aligning incentives so lifecycle, reliability and sustainability drive decisions aligned with clinician input.

2.1 Price as default due to misaligned KPIs and incentives	**Description:** Savings-led performance indicators, cash-year budgets and templates that don't require lifecycle/outcome data make upfront price the lowest risk option even where total cost and patient outcomes demonstrate superior long-term value. **Actions:** Create a best-practice network; define and use simple value statements alongside price; measure and make outcomes visible; include total-cost-of-ownership metrics in budgeting to counter short-termism.
2.2 Clinical and end-user participation	**Description:** Clinical needs are not consistently embedded at key decision points. **Actions:** Increase patient advisory, early clinical review and product evaluation committee input; ensure joint clinical–procurement involvement for higher-impact categories supported by appropriate resourcing.
2.3 Evidence, data & lifecycle economics	**Description:** Lack of a simple, shared value framework and comparable evidence drives reversion to unit price; outcomes are siloed or distrusted; HTA-style methods are not adapted to purchasing medtech. **Actions:** Implement a statewide policy on value-based procurement; define a practical value-assessment framework; establish a standardised system to record and share validated outcomes data for procurement use.
2.4 Change management & capability	**Description:** Habit, perceived risk and limited change capacity stall value-based choices; incumbents persist unless the transition is actively managed. **Actions:** Run focused pilots to demonstrate viability; upskill workforce in value-based procurement approaches.

Key Themes – Summary Table

Topic 3 - Partnership models for adopting new technologies: Establish a predictable idea → pilot → scale pathway, backed by shared evidence, clear demand signals, dedicated capability and forums that turn collaboration into purchase orders.

3.1 No clear, predictable pathway from idea to scaled adoption	**Description:** Product pilots are ad-hoc; contract blackout periods and heavy documentation stall momentum; research funding isn't aligned with health purchasing priorities; decision pathways and funding responsibilities are unclear. **Actions:** Reward facilities for trialling new tech; provide a transparent product evaluation pathway: standardise and reduce key decision makers; simplify processes, insurance requirements and red tape; define a pathway from trials to commercialisation.
3.2 Evidence & data sharing deficits	**Description:** Trial results and economic/operational evidence exist in pockets but aren't discoverable or comparable across services blocking innovation adoption. **Actions:** Establish a network to share trial outcomes and evidence; mandate reporting on innovation outcomes.
3.3 Problem definition & demand signalling	**Description:** Innovators lack a clear, current view of unmet needs; challenge-style signalling helps align solutions to priority problems. **Actions:** Publicise a list of unmet needs and challenge briefs, ideally using an online portal.
3.4 Resource & capability constraints in health	**Description:** Services lack capacity for intake, triage, pilot design and evidence packaging. **Actions:** Separate and resource innovation adoption; embed commercialisation into hospitals.
3.5 Collaboration platforms & precincts	**Description:** Purpose-built cross-sector forums and precincts accelerate problem framing, co-design and adoption while building trust. **Actions:** Health can partner with companies on innovation; establish cross sector forums/working group to connect purchasers and innovators; run hospital/health-based supplier showcases.
3.6 Education & culture building	**Description:** Medtech literacy and visible case studies reduce perceived risk and speed expansion of partnership models. **Actions:** Set policy to communicate between health and industry, embedding medtech considerations in health strategy; include local medtech in undergrad/postgrad education; publish practical case studies of successful adoption.

Topic 1: Using Local Capability to Build Resilient and Efficient Supply Chains

1. Topic Overview

Australia's health system depends heavily on imported health technologies, from consumables and PPE to diagnostics, devices, and components. At the same time, Victoria and Australia have established and emerging medtech manufacturers, regional capabilities, and advanced manufacturing infrastructure that remain underutilised by health services.

Topic 1 explored two guiding questions:

- How can local manufacturing and supply capability contribute to stronger, more reliable, and more efficient health supply chains?
- What needs to change within systems, processes, and relationships to make that possible?

2. Summary of Findings

Discussions under Topic 1 (tables 1-5) described a health procurement system that is operationally reliable in steady state, but vulnerable to disruption. Across the discussions, participants framed the opportunity as embedding local capability into standard procurement and planning processes, rather than relying on ad-hoc or crisis-driven measures.

Centralised arrangements, long-term contracts, and defined standards help ensure baseline product availability, predictable pricing, and compliance. However, reliance on a narrow set of overseas suppliers, limited entry points to panels, and a strong focus on headline price constrain agility, innovation, and the use of capable local firms.

Participants highlighted that where local suppliers exist and meet required standards, they can strengthen resilience, shorten lead times, improve service and customisation, and deliver economic, environment, social and governance (ESG) value. These benefits, however, are often not visible or not competitively assessed on these dimensions.

Across the discussions, there was convergence on practical directions to address these challenges: improve visibility of local capability, share demand and backorder data, better leverage technology to streamline processes, adjust evaluation settings to better recognise system value (as further explored in topic 2), create clearer and more frequent access pathways for SMEs (in addition to those focused on innovation as discussed in topic 3), and clarify how health services can work constructively with local manufacturers within existing probity and policy frameworks.

3. Why Local Matters

Participants consistently identified several reasons why integrating local suppliers into health supply chains is important, when those suppliers meet required standards:

- Resilience and continuity of supply. Shorter lead times, reduced exposure to international shipping, customs and time zones, and the ability to engage multiple local suppliers were viewed as practical ways to reduce backorders and stockouts. Several groups identified high-backorder or high-cost/high-usage items as clear opportunities to explore local alternatives.
- Assured quality, safety, and oversight. Strong Australian regulatory frameworks and the ability to audit local facilities were seen as advantages in managing product quality, particularly in light of COVID-era experiences with inconsistent quality of imported products and recalls. Knowing that materials are "tested, controlled and correct" and that issues can be rapidly investigated was noted as a benefit of proximity.
- Clinical fit, responsiveness, and innovation. Local suppliers can respond quickly to questions, issues, and design modifications; understand local clinical contexts; and co-develop niche or customised products. Participants reported that open communication, shared time zones, and ease of access to decision-makers improves troubleshooting and product evolution.
- Economic and social benefits. Use of local manufacturers supports jobs, tax revenue, regional economies, and broader sovereign capability. These impacts were explicitly raised as reasons to consider local options where they are competitive and suitable.
- Environmental and ESG outcomes. Reduced freight and logistics requirements, potential to design for reuse or repair, and better alignment with ESG expectations (including those emerging in public procurement) were noted as additional advantages.

Overall, local capability was viewed not as a symbolic preference but as a practical lever to improve reliability, accountability, and long-term system value.

4. System Strengths & Positive Foundations

Participants also identified existing strengths that can be leveraged:

- Centralised procurement and scale efficiencies. State-wide contracts such as those via HealthShare Victoria (HSV) and aggregated purchasing were recognised for delivering bulk/pallet pricing, fixed pricing, "free into store" arrangements, and administrative efficiency when done well. Some participants noted hospitals "generally have what they need" under these arrangements.
- Regulatory and quality frameworks. Regulatory compliance and clear standards were seen as core strengths of the Australian system, providing a robust baseline for assessing products, including those from local suppliers.
- Existing visibility tools and data sources. The ICN-Victoria medtech directory, internal demand forecasting, centralised stock management, and existing catalogues were acknowledged as useful building blocks, even if not yet fully integrated or complete.
- Operational infrastructure. Established ordering systems, traceability processes, and mechanisms for central stockholding and redistribution in emergencies were viewed as sound infrastructure.
- Signals of cultural and policy support. Participants noted growing interest among staff in prioritising local options, early policy incentives, and examples of successful local partnerships and pilots, show both appetite and precedent for change.

These strengths suggest that progress can be achieved by evolving and better connecting current systems.

5. Key Themes and Proposed Actions

Theme 1.1: Limited visibility of local capability and suppliers

Roundtable Insight: Where local manufacturers exist, they are not easily visible to buyers and proactive local engagement is not embedded in procurement routines. In practice this contributes to ongoing reliance on international suppliers and limits competition.

> Exemplar statements: *"Health services are not aware of the smaller companies "... "Improved communication of locally produced devices/products" ... "Need a widely available catalogue. Have a dataset that updates – more power to make decisions – more visibility."..." Centralised catalogue or information sharing platform"..."Limited number of Australian manufacturers"*

Interpretation: This is a workflow and communication problem, not a single-directory issue. Visibility tools are fragmented (lists, ad-hoc spreadsheets, industry directories) and sit outside the day-to-day steps where buyers scope categories, write specs, and compare options. Without an up-to-date, searchable catalogue that ties products to evidence of readiness (regulatory status, reference sites, service coverage) and prompts at key decision points, procurement defaults to familiar SKUs, often from international incumbents. That default is apparent in the roundtable comments e.g. "reliant on international supply" and "lack of competition". Fixing this requires a living catalogue, integrated into e-purchasing systems, and assurance signals that de-risk choosing local.

Actions:

- Build a "living" (governed and regularly updated) local supplier & product catalogue.
- Incorporate assurance mechanisms to build buyer confidence to reduce perceived risks of trying local (e.g. standard one-page "readiness" cards per product).
- Ensure that local supplier information is available during pre-specification and category planning, and when a product hits back-order or shortage so category managers and clinical advisors have visibility of local options for rapid exploration.
- Host showcases and product walk-throughs for priority categories.

Theme 1.2 Fragmented planning, data & policy execution

Roundtable Insight: Critical procurement data (volume, back-orders, high-spend lines, local availability) exist but sit in silos across HSV, health services, and industry so there is no shared demand–supply picture to prioritise localisation and manage risk.

> Exemplar statements: *"Publish the back-order list to create local supply opportunity" ... "Need to analyse supply + demand data."... "One stop shop (to provide) supply & demand analysis with better data"... manufacturing hubs that match local/regional needs with local manufacturers for them to promote as a system for HSV procurement"... "Review critical products and identify those that would be a viable candidate for local manufacturing"*

Interpretation: This is a coordination and governance gap. Multiple parties already hold valuable fragments of information. HSV has panel, spend and back-order signals, health services have usage data, outages and set clinical priorities; industry can identify feasible local substitutes. Because these datasets are not governed together or standardised, category planning defaults to historical suppliers and

global catalogues and supply-chain vulnerabilities are not well understood. The result is reactive purchasing and missed chances to align local capability with evidenced demand (e.g., recurring back-orders, recalls or products with chronic supply risk). Establishing a demand–supply intelligence dashboard or portal would let decision-makers see where local manufacture or dual-sourcing is practical and high-value.

Actions:

- Stand up a demand–supply intelligence dashboard.
- Share market data and priority demands with manufacturers to stimulate market response.
- Run a simple demand–supply overlay to find candidates to prioritise for support, incorporating into procurement planning and to evaluate using site trials where appropriate. This can be achieved by analysing weighted demand tables overlaid by weighted supply table to identify hotspots (scored by spend, outage risk, and local readiness etc.).

Theme 1.3 Contract rigidity & long procurement cycles

Roundtable Insight: Current panel structures and long contract tenures create narrow entry windows and limited flexibility, which constrains SME access, dampens competition and slows the adoption of better or local products between cycles. For some products, like point-of-care diagnostics, there is no purchasing structure.

> Exemplar statements: *"Long time between opportunities to get on supply panels" … "Good: State contracts e.g. HSV – bulk/pallet pricing, free into store, fixed pricing. Pain: State contracts… limits vendors… "limits innovation (in some circumstances), exemptions rarely approved."… "Provide more regular windows for local products to be included on the HSV contracts"… "Remove bureaucratic layers that inhibit small players from participating"*

Interpretation: Panel contracting can deliver valuable scale and price stability, but the operating model is inflexible by design. Long tenures, infrequent refresh cycles, and tightly scoped categories reduce competitive pressure and lock out SMEs. Even when performance, supply risk, or clinical fit change mid-term, exemptions are rarely approved, so better options (including local products) wait until the next cycle which may be up to a decade away. The net effect is slowed innovation diffusion, higher exposure to overseas supply shocks, and missed chances to diversify suppliers. A shift toward more flexible and right-sized contracting could preserve probity while improving responsiveness, cost-effectiveness and deliver fairer access for SMEs.

Actions:

- Introduce mechanism to allow mid-tender entry, rolling refresh for panels or mid-term review triggers with advance notice so new suppliers can participate.
- Right-size documentation for low-risk categories. Calibrate insurance, financials and evidence requirements to category risk; provide standard templates to lower transaction cost for SMEs.

Theme 1.4 Logistics and continuity of supply

Roundtable Insight: Distance, customs, shipping delays, globally stretched supply chains and upstream component shocks (e.g., chips, specialist resins) create recurrent lead-time risk for Victorian health services. When supply is concentrated with a single vendor, outages and recalls cascade faster and recovery options are limited.

> Exemplar statements: *"Geographical challenges lead to limitations with shipping [and] vulnerability to supply chain challenges."... "Delays in time/ time zones / shipping/ customs." ..."Surety of supply / Continuity in supply by engaging multiple local suppliers = resilience."*

Interpretation: The room repeatedly linked supply fragility to concentration risk despite aggregation being a core strategic pillar for central purchasing bodies across Australia. When a category is awarded to a sole supplier or stock is restricted to a sole supplier for practical purposes, any recall, backlog, or long overseas lead time leaves hospitals exposed. Australia's geographical location and small share of the global medtech market further weakens our priority in global queues. Identifying vulnerabilities and strategically engaging local suppliers to diversify supply chains can reduce risk and enable rapid response to shocks.

Actions:

- Identify and proactively manage vulnerable products.
- Engage multiple suppliers in vulnerable categories to ensure continuity of supply.

Theme 1.5 Local content targets

Roundtable Insight: Participants supported stronger tools to grow domestic supply including clear targets and transparent measurement, implemented in a way that supports open competition. Many in the room emphasised that any quota or mandate must be sequenced with supplier readiness.

> Exemplar statements: *"Legislate local content." ... "Government to legislate percentage of Australian manufactured products." ... "Staged, increasing proportions of local procurement from public service." ... "Need a local content quota like defence." ... "Limited number of Australian manufacturers." ... "Lack of competitively priced local suppliers."... "regulation on purchasing locally is easy for large companies with dedicated regulatory affairs staff. Not possible for smaller companies if they want to source efficiently - rather go abroad"*

Interpretation: There was a highly consistent message across the tables that the system won't organically shift from import-dominant supply to a balanced domestic mix without clear targets and support mechanisms that lower the transaction cost of buying local when it meets clinical, quality, and continuity needs. Participants framed this less as protectionism and more as a capability-building: make room for qualified Australian suppliers, set progressive, category-specific targets as policy aims linked to industry readiness; and report local content and outcomes publicly. Support this process by creating predictable entry points where clinically equivalent local products can compete on total value (per topic 2 discussions). The emphasis was on progressive, lightweight, auditable mechanisms that strengthen resilience while keeping probity and value-for-money intact.

Actions:

- Set and incentivise progressive targets for purchase of locally manufactured products linked to industry readiness.
- Track and publish local-content metrics.
- Publish an annual summary of categories where local-capability use improved continuity or service quality so targets are tied to measurable health-system value.

Topic 2: Embedding Value Beyond Cost in Strategic Sourcing

1. Topic Overview

Health procurement operates under high scrutiny to maintain service continuity, meet probity requirements, and deliver savings. In this environment, price becomes the dominant, and often default, proxy for "value", despite existing policy frameworks (HSV Purchasing Policies, value-based procurement (VBP) principles and value-based healthcare ambitions) that formally endorse whole-of-life value, quality, outcomes, risk, and sustainability.

Topic 2 brought together procurement leaders, policymakers, and industry to examine how buying decisions can also consider quality, reliability, and patient outcomes - not just cost. It explored what would need to change in current procurement processes to make this practical and fair for both health services and local suppliers.

2. Summary of Findings

Across all five tables (tables 6–10), participants described a procurement system that is procedurally robust but strategically constrained and biased toward upfront price: budgeting cycles, savings-led KPIs and siloed data make "lowest cost" the safest decision, even when lifecycle economics and patient outcomes argue otherwise.

Participants expressed clear appetite to shift to value-based procurement, surfacing concrete strengths and practical models to achieve this: real-world examples where lifecycle and outcome thinking delivered better results, references to international and interstate frameworks, and specific suggestions for portals, frameworks, and performance metrics.

The consistent message was to move from high-level policy intent to operational translation by establishing shared definitions, consistent evaluation frameworks, accessible data, structured clinical involvement, and incentives that back procurement teams when they choose genuine value over lowest price.

3. Why Value-Based Procurement Matters

Participants framed VBP as a way to make existing spend work harder for patients and the health system.

- Improved patient and clinical outcomes. Examples (e.g. infection-reducing consumables, powder-free gloves, standardised wipes, implants with lower failure rates) showed that products selected on performance and suitability can reduce harm, rework, and length of stay, even where unit prices are higher.
- Total cost of ownership and efficiency. Many contributions highlighted overall lifetime cost benefits: maintenance, training, downtime, failure rates, waste, disposal, and change-management burden. When these are counted, the cheapest offers often prove more expensive.
- Reliability and resilience. Including service support, warranty, local technical backup, and performance history helps prevent backorders, equipment failures, and clinical disruption.
- Sustainability and ESG. Remanufacturing, eco-friendly products, reduced waste and freight, and alignment with environmental targets were repeatedly presented as integral components of value.
- Fairer competition and innovation. Clear value criteria give local and SME suppliers a viable basis to compete on quality, responsiveness, and innovation rather than just price.

By building total-cost-of-ownership, patient outcomes, product reliability and performance into decisions, VBP was seen as a practical mechanism for health services to turn procurement from a transactional cost centre into a strategic lever for continuity, quality, and resilience.

4. System Strengths & Positive Foundations

Participants pointed to several strengths that can be leveraged:

- Australian policies already reference broad value. Current frameworks acknowledge lifecycle value, outcomes, and ESG; the missing step is consistent operationalisation.
- Clinically led product choices, joint purchasing, and sustainability-oriented tenders have delivered measurable savings and outcome improvement, evidence that VBP works when applied.
- A procedurally robust base with mature governance, clear probity processes and systems that can deliver savings at scale, all of which are assets that can be repurposed to reward value.
- Clinical registries, health economics expertise, and HTA findings exist and can be drawn into procurement decisions.
- Growing awareness of sustainability and innovation, which was considered by multiple tables as a core dimension of value.

Several practical exemplars were also raised as models to adapt, not copy:

- EU approaches that consider lifecycle, maintenance and sustainability in scoring, with participants referencing models from Switzerland, England, Ireland.
- Western Australia's "Health Ready" concierge model that gives innovators a probity-safe pathway to engage.
- The introduction of MRI and CT in early days in the US, where technology advances in MRI tech improved adoption due to better possible service design.

These foundations indicate the challenge is alignment and integration, not building an entirely new system.

5. Key Themes and Proposed Actions

Theme 2.1 Price as default due to misaligned KPIs and incentives

Roundtable Insight: In practice, price dominates as the system default for health purchasing. Annual budget cycles, savings-focused performance metrics, and reporting requirements reinforce short-term financial decisions over lifecycle and outcome considerations.

> Exemplar statements: *"Budgets only financial, short term"... 'cost-based business' with little opportunity for broader thoughts"..." currently value = lowest price"... "No incentive or reward." / "not measured... no KPI."*

Interpretation: The system is behaving as designed. Annual savings targets, cash-year budgets, and templates that don't address total-cost-of-ownership enable price to stand in for value and the safest, audit-proof choice. In that context, choosing the cheapest compliant bid minimises audit exposure and cycle time, even if it increases downstream costs (downtime, changeover waste, service delays) or misses clinical benefits. The system can be rebalanced by ensuring outcomes metrics are measured and visible at key decision points and during category reviews.

Actions:

- Establish a best practice network. Convene key stakeholders to workshop specific topic/area and share best practice standards.
- Agree on a definition of value. Use value-statements or similar to capture simple total cost of ownership, reliability/service and outcome proxies so price is one factor, not the sole determinant.
- Measure outcomes and make results visible.
- Include total cost of ownership metrics in procurement budgets to enable purchasers to counter short-termism.

Theme 2.2 Clinical and end-user participation

Roundtable Insights: Participants suggested that value improves when clinical and end-user input is visible at the right moments, recognising that capacity constraints and siloed structures result in under-representation of clinical requirements or dependency on individual champions in purchasing decisions.

> Exemplar statements: *"Clinical requirements not adequately considered." ..."Clinicians don't have capacity to advocate to procurement."... "Patient advisory involvement as part of the evaluation process."... "Sustain/increase clinical and supply chain involvement."*

Interpretation: Overall comments indicate that stringent evaluation processes and time pressure push procurement toward document-led processes. The result is that the clinical context, particularly local considerations (e.g. workflows, maintenance, training, site constraints), may not always be captured early enough or fed back quickly post-award.

Actions:

- Increase patient advisory, early-clinical feedback, product evaluation committee input and supply chain involvement in procurement decisions, supported by appropriate resourcing.

Theme 2.3 Evidence, data & lifecycle economics

Roundtable Insight: Participants indicated that price dominates because there's no simple, shared way to evidence value. Lifecycle costs aren't consistently captured, outcomes data are siloed or distrusted, and HTA-style methods aren't adapted to medtech or incorporated in purchasing assessments, so buyers fall back to unit price.

> Exemplar statements: *"How to measure value/patient outcome?"…"distrust of vendor data and thus health services collect data themselves."* …*"Data flow - are you able to compare products across multiple occasions?"… "hard to find data."…"Measure outcome of tender categories via clinical outcomes as priority."*

Interpretation: Without a consistent value framework and comparable data, evaluation defaults to what is visible and auditable: unit price. Participants are asking for a practical, low-burden approach that (i) standardises what "value" means at tender and award, (ii) incorporates total cost of ownership (maintenance, downtime, waste, training, "cost of failure"), and (iii) surfaces basic outcome signals in a way clinicians and procurement can both trust.

Proposed Actions

- Implement a statewide policy for adoption of value-based procurement.
- Create a simple framework for how value/benefits (other than cost) are measured.
- Establish a standardised system to record and share validated outcomes data leveraging existing systems.

Theme 2.4 Change management & capability

Roundtable insights: Participants indicated buying for value stalls not for lack of options, but due to habit, risk aversion, and limited change capacity so incumbents persist and value cases are reinterpreted through a "price-only" lens unless transition is actively managed.

> Exemplar statements: *"Resistant to change and risk averse (culturally)"… "risk appetite to incentivise this"… "hard to change habit"* … *"satisfaction with current solution."*

Interpretation: This is classic adoption friction where individuals default to the familiar, especially under risk and time pressure. Without a clear change management plan and support (training, timelines, accountability), buying for value is too hard. A shift towards buying for value can be achieved by working with end users to demonstrate effectiveness and prove patient outcomes, alongside education programs on VBP principles to support adoption.

Proposed actions:

- VBP pilot to demonstrate viability of approach.
- Upskill workforce on VBP basics.

Topic 3: Partnership models for adopting new technologies

1. Topic Overview

Adopting new technologies in Victoria's health system is slow, complex, and often unpredictable; even when innovations are clinically sound and aligned with system priorities. Health services juggle safety, probity, and budget constraints; innovators navigate diffuse decision-makers, complex evaluation and approvals, and unclear demand signals.

Topic 3 explored how partnership models and system settings could make tech adoption safer, faster, and fairer, particularly for local innovators and SMEs, while maintaining robust governance and clinical assurance.

2. Summary of Findings

Across tables 11–14 participants described an innovation system that encourages medical research and pilots but lacks a predictable pathway to commercial adoption. Momentum is routinely blocked by complex tender processes, unclear decision rights, and fragmented funding in a system where no one owns the full adoption journey. Evidence that could de-risk decisions exists in pockets but isn't shared in comparable formats, so services often default to incumbency or price. Innovators also build in the dark: there is no consistent, updated list of unmet needs to guide proposals, while hospitals lack dedicated capability to progress promising solutions. Where structured forums, precincts and showcases exist, co-design and adoption move faster, and confidence grows when medtech literacy and practical case studies are embedded in training. Participants identified a path forward through a coordinated model: a transparent, standardised evaluation route, a supported innovation adoption pathway, shared evidence and demand signals, resourced innovation/commercialisation units linked to health services, and enabling contracts that convert successful trials into scalable procurement.

3. Why Structured Innovation Partnerships Matter

Participants consistently framed structured partnerships and clear pathways as essential to:

- De-risking adoption: joint design, shared evaluation criteria, and staged contracts can protect safety and probity while enabling learning.
- Focusing on real problems: unmet-needs lists and clinician-led priorities directing industry to validated system pain points.
- Scaling what works: coordinated procurement and shared evidence reduce duplication and help proven solutions spread beyond a single "champion site".
- Supporting local industry and SMEs: predictable routes to trial and adoption justify investment, strengthen sovereign capability, and diversify supply.

4. System Strengths & Positive Foundations

Discussions highlighted clear system strengths and foundations that can be built upon:

- Existing innovation networks, precincts and prior initiatives (e.g. Medical Device Partnering Program, Monash Foundations of Medtech programs).
- World-leading innovation precincts, accelerators and medical research.
- Demonstrated success of co-designed solutions (custom products improving surgical throughput, partnerships with local manufacturers during COVID).
- Policy interest in local manufacturing and innovation, including willingness to consider local-content levers.
- Examples of transparent, challenge-led models from other jurisdictions (RADx-style approaches, joint purchasing) that can be adapted.

Partnership models were positioned not as "nice-to-have", but as core infrastructure for innovation.

The consistent message across tables was that Victoria has the innovation assets and intent, but needs coherent pathways, enabling contracts, shared funding mechanisms, and explicit cultural licence to turn pilots into sustainable adoption.

5. Key Themes and Proposed Actions

Theme 3.1 No clear, predictable pathway from idea to scaled adoption

Roundtable Insights: Participants described ad-hoc pilots, contract blackout periods delaying innovation adoption, unclear decision-making, and fragmented funding with processes that differ across states and territories. Incentivising adoption, best practice networks and incorporating VBP principles were highlighted as key drivers for change.

> Exemplar statements: *"Novel tech decoupled from tender process."... "contract blackout – innovating faster than contracts allow."... "difficult to get to decision makers."... "funding buckets are in silos"..."... "lack of hospital resources and workforces shortages to review new technology"... " reward facilities for trialling new tech"*

Interpretation: The current pathway is episodic rather than engineered. Without a published route from pilot approval to commercial access, innovation stalls. Decision rights are unclear, documentation is heavy for SMEs, and good ideas are lost before they reach a purchasing mechanism. This could be addressed through a supported and predictable pathway. Practical fixes include incentives for health services, clear decision-making processes, dedicated innovation streams and lightweight contracting that would convert ad-hoc wins into repeatable adoption while maintaining probity.

Actions

- Reward facilities for trialling new tech
- Transparent product evaluation pathway – standardise and reduce key decision makers
- Simplify processes, insurance requirements and red tape
- Define a pathway from trials to commercialisation

Theme 3.2 Evidence & data sharing deficits

Roundtable insights: Clinical, operational, and economic evidence exists in pockets but is not easily discoverable across services; without shared formats and reporting, purchasing decisions revert to incumbents.

> Exemplar statements: *"If hospitals had access to data on successful/not successful trials…" "strong evidence to back up your tech."…"missing data linkage"*

Interpretation: Teams repeatedly rebuild the case for adoption because results are siloed. There is no lightweight, comparable evidence pack that travels across sites, and no central repository to avoid duplicating trials. Normalising a minimum data standard (clinical endpoints, operational metrics, total cost of ownership proxies) and making de-identified results searchable would reduce uncertainty, shorten cycle times, and allow value, not just price, to be assessed quickly.

Actions

- Establish network to share trial outcomes and evidence
- Mandate reporting on innovation outcomes

Theme 3.3 Problem definition & demand signalling

Roundtable Insight: Suppliers often build in the dark; participants wanted a clear, updated list of unmet needs and challenge briefs so proposals match real clinical/operational gaps.

> Exemplar statements: *"Publicise annually a clear list of unmet needs within the healthcare sector." … "let companies know what is needed and develop around them."*

Interpretation: Unfocused development wastes capacity on both sides. Transparent, unmet-needs signalling could concentrate innovation on priority problems and set the expectations for evidence and evaluation up front. Demand signalling also enables staged funding (from challenge to trial to first deployment) and gives buyers a defensible rationale for engaging early with solutions aligned to system goals.

Actions

- Publicise an annual list of unmet needs and challenge briefs within the healthcare sector

Theme 3.4 Resource & capability constraints in health

Roundtable Insight: Limited clinical capacity for intake, triage, pilot administration, and evidence synthesis slows or stops otherwise viable technologies.

> Exemplar statements: *"Separate team who looks at innovations – outside of business as usual teams." …"commercialisation office embedded into hospitals"…"more staff in hospitals for innovations."*

Interpretation: Core operations dominate attention and without dedicated roles and resourcing, innovation competes unsuccessfully with daily pressures. Embedding small, skilled commercialisation/innovation units inside health services creates a single front door for intake,

standardises pilot design and measurement, and ensures evidence is packaged in a way procurement and finance can use.

Actions

- Separate and resource innovation adoption for medtech
- Embed commercialisation into hospitals

Theme 3.5 Collaboration platforms & precincts

Roundtable Insights: Where structured, cross-sector forums and precinct collaboration exist, problem articulation, co-design, and adoption move faster and with fewer misfires.

> Exemplar statements: *"a forum for industry, researchers, hospital/procurement… cross discipline, cross sector"…"Health innovation precincts – Monash Heart, Scoresby… AMMC; SCV innovation have both finished"…"AMMA/AHSPO organise events… supplier display/showcase."…" established partnerships with industry"*

Interpretation: Regular, purpose-built collaboration forums reduce search costs, align expectations early, and surface integration issues before tendering. The relational trust built in these environments improves the odds that trials translate to scalable procurement.

Actions

- Health to engage with companies on innovation
- Establish cross sector forums/working group to connect purchasers and innovators.
- Hospital/health-based supplier showcases

Theme 3.6 Education & culture building

Insight: Embedding medtech literacy and sharing real case studies reduces perceived risk of local technology and accelerates adoption.

> Exemplar statements: *"Embed medtech in all training programs… undergrad/postgrad"*

Interpretation: Risk aversion is partly a knowledge gap. Building a common language of evidence, lifecycle value, and implementation mechanics across clinical, procurement, and finance roles makes change less threatening and more executable. Publishing succinct case studies including what worked, what didn't and what it cost creates practical playbooks that services can replicate without re-learning the same lessons.

Actions

- Set policy to communicate between health and industry and embed local medtech in health strategy.
- Include medtech in undergrad/postgrad education.
- Publish practical case studies of successful adoption.