



Policy Paper on Assistive Technology in the EU



**An Roinn Leanaí, Míchumais
agus Comhionannais**
Department of Children,
Disability and Equality

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About the European Disability Forum

The European Disability Forum (EDF) is an umbrella organisation of persons with disabilities that defends the interests of over 100 million persons with disabilities in Europe.

We are an independent non-governmental organisation that brings together representative organisations of persons with disabilities from across Europe. We currently have 119 members, including European-wide organisations representing various disability groups, and national councils of persons with disabilities. Taking into account our members' memberships, we unite over 3,000 organisations.

We are run by persons with disabilities and their families. We are a strong united voice of persons with disabilities in Europe.

Method and limits of the evidence

This paper is based primarily on desk research. It draws on EU and international institutional sources, existing comparative research, national policy information and evidence supplied by organisations representing persons with disabilities and other stakeholders.

The desk research has been supplemented through targeted stakeholder consultations with organisations of persons with disabilities, assistive technology providers and users of assistive technology. In accordance with the research methodology, these consultations were also used to validate identified barriers and national frameworks and to develop individual cases illustrating how national provision and internal-market arrangements operate in practice.

Available evidence does not allow for a reliable like-for-like comparison of every aspect of assistive technology provision across all 27 EU Member States. Existing research itself identifies substantial inconsistencies in terminology, definitions, programmes and available information. Research on digital assistive technology in Europe, for example, found marked variation in national funding mechanisms and observed that digital assistive technology was often not visible as a distinct category in national policy. The World Health Organization's review of assistive technology coverage in the European Region¹ similarly found that the evidence base on need, access and coverage was incomplete and heterogeneous.

Accordingly, this paper does not fill missing national information through assumptions. It identifies recurring provision models, differences and documented examples where sufficient evidence exists. Country examples illustrate particular mechanisms or barriers; they should not automatically be interpreted as comprehensive assessments of the Member State concerned.

¹ WHO, 2021: Prevalence of coverage of assistive technology in the WHO European Region, <https://www.who.int/europe/publications/i/item/WHO-EURO-2021-3173-42931-59954>

Abbreviations

Abbreviation	Full name / description
AAC	Augmentative and Alternative Communication
AI	Artificial Intelligence
AT	Assistive Technology
CRPD / UN CRPD	United Nations Convention on the Rights of Persons with Disabilities
DAT	Digital Assistive Technology
DATEurope	Digital Assistive Technology Industry Association for Europe
EAA	European Accessibility Act
EASPD	European Association of Service providers for Persons with Disabilities
EASTIN	Global Assistive Technology Information Network
EDF	European Disability Forum
EU	European Union
GLIC	Interregional Working Group of Italian assistive technology centres
IFSBH	International Federation for Spina Bifida and Hydrocephalus
RESNA	Rehabilitation Engineering and Assistive Technology Society of North America
SMEs	Small and Medium-sized Enterprises
UN	United Nations
VAT	Value Added Tax
WHO	World Health Organization

Executive summary

Assistive technology (AT) enables many persons with disabilities to communicate, move, study, work, live independently and participate in society. However, effective access to appropriate AT remains highly unequal across the European Union. The main problem is not only whether a product exists, but whether a person can find it, afford it, obtain it without delay and receive the assessment, training, maintenance and support needed to use it effectively.

Today, AT is provided through different combinations of healthcare, social protection, education, employment and disability-support systems. Rules vary between and within Member States, and responsibility may change according to a person's age, diagnosis, employment or education status, place of residence or the intended use of the technology.

As a result, people may face repeated assessments, unclear responsibilities, long procedures and gaps when they move between services, life stages, regions or countries. These differences also create market fragmentation, making it harder for suppliers to offer their products and services across several Member States.

Key findings:

- **Availability and eligibility do not guarantee effective access.** Restricted product lists, low reimbursement ceilings, co-payments, complex procedures and long waiting times can prevent people from obtaining the solution that best meets their needs.
- **Services are as important as products.** Assessment, fitting, configuration, trials, training, maintenance, repair, follow-up and replacement are often essential. Funding only the initial product can lead to poor outcomes and wasted resources.
- **Fragmentation limits continuity and choice.** AT is often tied to a particular sector or programme instead of following the person across home, education, employment and community life.
- **Digital and mainstream technologies do not fit traditional funding systems well.** Software, subscriptions, connectivity, updates, technical support and interoperability are often excluded from schemes designed for one-off purchases of physical equipment.
- **National rules also fragment the European market.** Different eligibility criteria, reimbursement systems, product lists, procurement arrangements and market-entry procedures divide

demand into small national markets. This particularly affects specialised, low-volume and language-dependent AT.

- **Free movement can be disrupted.** People moving to another Member State may have to repeat assessments and establish new arrangements for funding, repair, maintenance, software and support, even when their functional needs have not changed.

Recommendations:

The paper does not call for one European provision system or identical national benefit levels. Member States should remain responsible for organising and financing health and social protection. EU action should instead focus on areas where coordination can clearly improve access, competition and free movement, without reducing support in countries that already provide more.

- **Develop an EU Assistive Technology Single Market Action Plan**, in consultation with representative disability organisations and the AT sector, addressing barriers faced by users and providers.
- **Establish common EU principles for effective and person-centred AT provision**, including timely access, meaningful user choice, continuity across sectors and access to assessment, training, maintenance and support.
- **Reduce fragmentation of the European AT market** through common information requirements, recognition of equivalent assessments and more transparent national reimbursement, procurement and market-access procedures.
- **Ensure cross-border access and portability**, including the portability of assessments, technical information, repair and maintenance arrangements, and digital services, licences and personalised settings.
- **Improve procurement** by considering functional needs and real-life results for the users, total cost of use, interoperability, repair, maintenance and support; not only the lowest purchase price.
- **Use European scale for niche markets** through coordinated demand, pooled procurement where appropriate, multi-country evidence, localisation support and measures helping SMEs and innovative suppliers operate across borders.
- **Strengthen the AT workforce and evidence base** through shared competencies, training and a small set of comparable indicators on unmet need, waiting times, personal costs, continuity and real-life context of users.

At national level, provision should be based on functional need and participation goals; be technology-neutral, allowing for both traditional specialised AT and digital/mainstream technologies; offer a clear point of access and accessible appeals; ensure meaningful user choice and continuity across sectors and life stages; fund the complete AT solution over its useful life; support specialist advice, trials, loans and reuse; involve persons with disabilities in decisions; and measure whether AT improves independence, participation and quality of life.

The overall objective is simple: people should be able to obtain the right assistive solution, at an affordable cost and within a reasonable time, wherever they live in the EU. Better coordination can improve user choice and outcomes, strengthen the European AT market and support free movement without imposing a single model on Member States.

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Introduction

Assistive technology is essential to the independence, participation and equality of millions of persons with disabilities. It can enable a person to communicate, move and live independently, access information, study, work, manage personal care and safety, and participate in community life. Access to appropriate assistive technology can be a precondition for exercising rights protected by the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), including rights relating to accessibility, independent living, education, employment, health and participation in society.

However, access to assistive technology remains uneven. This goes beyond whether a product exists: the systems and services through which appropriate products are identified, provided, adapted, maintained and supported are an integral part of assistive technology provision.

Within the European Union, these challenges acquire an additional dimension. In the internal market many goods and services circulate under common European rules, yet access to assistive technology remains largely shaped through separate national systems of eligibility, assessment, funding, reimbursement, procurement and service delivery. The result is not simply different levels of social protection. National provision systems can also influence which assistive technologies reach a market, which suppliers can compete, what choice users have, whether innovative products are taken up, whether services associated with effective use (e.g. adaptation, configuration, training, maintenance and follow-up) are available, and whether products or services available in one Member State can effectively reach users in another.

The question is not whether every Member State should operate an identical provision system: health, social protection, education and disability support remain areas in which national structures and competences differ considerably. Rather, the question is whether aspects of this fragmentation unnecessarily restrict effective demand, user choice, cross-border provision, competition and innovation, and whether coordinated EU action could improve access while respecting national responsibilities for organising and financing services.

This is also receiving increasing attention in EU policy. Both the November 2025 European Parliament resolution on the EU disability strategy post-2024² and the May 2026 European Commission communication about

² European Parliament resolution on the EU Strategy for the Rights of Persons with Disabilities post-2024, 2025/2057(INI),
https://www.europarl.europa.eu/doceo/document/TA-10-2025-0308_EN.html

enhancing the disability strategy³ place greater emphasis on the assistive technology market.

The forthcoming policy discussion provides an opportunity to move from recognising disparities in access to identifying which barriers can realistically be addressed through European action. This paper aims to contribute to that discussion by examining examples of national provision models and documented access barriers, analysing their interaction with the internal market, and proposing targeted measures capable of improving access to appropriate assistive technology for persons with disabilities throughout the EU.

1.1. Purpose and scope

The purpose of this paper is to identify policy measures that can improve effective access to assistive technology for persons with disabilities in the European Union.

It has four interconnected objectives:

- to examine how assistive technology is provided, financed and delivered in different Member States and identify significant differences between provision systems;
- to identify barriers experienced by persons with disabilities in obtaining assistive technology that meets their individual needs;
- to analyse how fragmentation between national systems affects the operation of the European assistive technology market, including market entry, competition, procurement, innovation and cross-border availability; and
- to develop practical recommendations for coordinated EU-level and national action.

This paper does not attempt to rank national assistive technology systems or establish a single preferred model for the EU. Nor does it assume that differences between Member States are, by themselves, failures of the internal market.

Instead, it distinguishes between three related issues.

1. Access barriers for users within national systems

Barriers include insufficient reimbursement, restrictive eligibility rules, long assessment procedures, limited product choice, gaps

³ European Commission Communication "Enhancing the Strategy for the Rights of Persons with Disabilities up to 2030", (COM(2026) 541), https://commission.europa.eu/document/download/ab0bcea9-6b3a-48c1-875c-1cc687fba6d0_en

between health, education, employment and social-service schemes, and inadequate information, training or follow-up support.

2. Fragmentation affecting effective demand

National eligibility rules, reimbursement ceilings, product lists, replacing intervals, assessment procedures and procurement arrangements determine not only what individual users receive but also the size and characteristics of the market available to manufacturers and suppliers. Where these arrangements differ substantially between Member States, providers may face multiple distinct markets rather than a European market of sufficient scale, increasing administrative, market-entry and distribution costs, potentially leading to higher prices, reduced competition and lower availability of specialised or innovative AT.

3. Barriers to market access and cross-border provision

These barriers can arise where suppliers must navigate different national approval, reimbursement, procurement or certification-related processes before users can obtain publicly supported access to their products, even where the underlying product can lawfully circulate within the EU.

This distinction is important. A low national reimbursement rate can create a serious disability-rights and affordability problem without necessarily constituting an internal-market barrier. Conversely, a reimbursement or procurement rule may have consequences extending beyond national social policy if it systematically restricts supplier entry, effective cross-border competition or user access to products legally available elsewhere in the Union.

The paper therefore examines both access for users and market conditions for providers, while retaining the ultimate policy objective of improving outcomes for persons with disabilities.

1.2. What is assistive technology?

There is no single universally applied classification of assistive technology across European policy and provision systems. This is itself relevant to the analysis: what a system defines as an assistive product can determine whether a technology falls within a reimbursement scheme, procurement framework or support programme.

The UN Convention on the Rights of Persons with Disabilities⁴ (UN CRPD) defines Universal design as “the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design”. It also states that “Universal design shall not exclude assistive devices for particular groups of persons with disabilities where this is needed”.

We can draw two conclusions from this definition. First, one of the outcomes of a universal design approach will be accessibility for persons with disabilities, this is the characteristics and functions of a product, service, system or infrastructure to enable access to persons with disabilities on an equal basis with others. And second, there should always exist the possibility of using AT.

In the European Accessibility Act⁵ (EAA), assistive technologies (AT) refer to any item, piece of equipment, service or product system (such as software) that is used to increase, maintain, substitute or improve functional capabilities of persons with disabilities. These technologies alleviate and compensate activity limitation or participation restriction of persons with disabilities. AT are specifically designed for persons with disabilities, even though some have become widely used by non-disabled people (e.g. voice control or automatic subtitles).

This paper – like the EAA – uses a broad understanding of assistive technology. It includes:

- **low-tech assistive products**, such as walking aids and magnifier glass;
- **high tech (often digital) assistive technology**, like screen readers, augmentative and alternative communication (AAC) systems, alternative input technologies and specialised software, including some mobile applications;
- **medical and rehabilitation technologies⁶**, including products like hearing aids, prostheses, certain mobility devices, and continence management products such as catheters;

⁴ <https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd>

⁵ Directive (EU) 2019/882 of the European Parliament and of the Council of 17 April 2019 on the accessibility requirements for products and services, <https://eur-lex.europa.eu/eli/dir/2019/882/oj>

⁶ This paper considers medical and rehabilitation technologies intended for regular use by individuals to support functioning, independence and participation – rather than technologies used primarily for diagnosis, treatment or rehabilitation by professionals in clinical settings.

- **mainstream products used as assistive technology**, where generally available technologies such as smartphones, tablets, smartwatches, smart-home technologies or applications fulfil disability-related functional needs; and
- the **services associated with effective use**, including assessment, fitting, adaptation, configuration, user training, technical support, maintenance, repair, follow-up (i.e., checking whether the AT remains functional, safe and appropriate over time), replacement and renewal.

The distinction between specialised assistive technology and mainstream technology is becoming increasingly difficult to maintain. Earlier European Parliament research⁷ already identified increasing integration of assistive functions into mainstream technology and noted that classification as a medical or mainstream product can have consequences for regulation and access. This trend has accelerated as smartphones, applications, software and connected services – with the increasing use of artificial intelligence – perform functions previously delivered primarily through specialised products.

For AT users, the relevant question is therefore not simply whether a technology has been formally labelled as “assistive”. It is whether an assistive solution is needed to maintain or improve functioning, independence and participation, or compensate for lack of abilities and whether the relevant provision system enables the person to obtain and use the solution that appropriately meets that need. An assistive solution may combine a physical product with software, connectivity, applications, personalised settings and human or technical support.

This person-centred approach is particularly important when considering innovation – including AT keeping pace with the rapid development of mainstream technology it works with, or digital and software-dependent AT⁸ that might be distributed remotely, updated continuously and depend on subscriptions. Provision systems based on closed or slowly updated lists risk treating the historical classification of a product as more important than its functional outcome.

⁷ European Parliamentary Research Service (EPRS), Scientific Foresight Unit (STOA), 2018: Assistive technologies for people with disabilities, PE 603.218, [https://www.europarl.europa.eu/stoa/en/document/EPRS_IDA\(2018\)603218](https://www.europarl.europa.eu/stoa/en/document/EPRS_IDA(2018)603218)

⁸ Software-dependent AT is a digital AT where the continued functioning of the assistive solution depends significantly on software: for example, an app, operating system, cloud service, subscription, firmware, AI model, or regular updates. If that software stops working or becomes incompatible, the AT may lose part or all of its functionality.

Provision systems need to consider the full solution and its total cost of use over time, while ensuring safety, suitability, value and appropriate professional support where these are required. The policy challenge is therefore to combine choice and technological neutrality with appropriate safeguards and evidence-based provision.

Assistive technology can be essential for some users (or user groups) to exercise their rights concerning independent living, personal mobility and safety, accessibility, communication, education, employment, health and participation. Depending on the person's circumstances, the same technology may support participation at home, in education, at work and in public life.

This has an important implication for provision systems. A system organised exclusively around medical diagnosis or a single institutional setting risks failing to recognise the broader role of AT across different areas of life – going beyond medical or institutional needs. Effective provision therefore needs to respond to the individual's needs, preferences, and circumstances rather than access being determined primarily by the administrative sector responsible for financing it.

1.3. Policy context

Assistive technology policy sits at the intersection of disability rights, health and social policy, accessibility, digital policy and the EU internal market. At international level, the UN CRPD establishes important obligations concerning access to assistive technology. At EU level, disability policy, accessibility legislation and internal-market rules increasingly recognise the role of AT in enabling participation and in supporting the free movement of accessible products and services.

The following sections outline the principal international and EU policy frameworks affecting the supply and provision of assistive technology.

The UN Convention on the Rights of Persons with Disabilities

All the 193 State Parties to the UN Convention on the Rights of Persons with Disabilities (UN CRPD) are bound by its General Obligations (art. 4) to promote research and development of assistive technology, as well as to provide information about them to persons with disabilities. AT is also explicitly mentioned in several articles of the Convention, namely: on Mobility (art. 20), on Habilitation and rehabilitation (art. 26), Participation in political and public life (art. 29), and International cooperation (art. 32).

However, given the intrinsic relationship between assistive technologies and accessibility, being the latter a general principle of the Convention

(article 3) and a standalone article 9, it is obvious that AT does definitely play an important role in many of the rights derived from the Convention, from living independently (art. 19), to education (art. 24), health (art. 25), employment (art. 27), and so forth.

Direct attention to assistive technology has also strengthened. The 2018 World Health Assembly Resolution WHA 71.8⁹ called on Member States to improve access to AT and encouraged international and regional cooperation in manufacturing, procurement and supply. And in September 2026, the UN General Assembly adopted by consensus its first dedicated resolution on access to assistive technology¹⁰, framing access to quality and affordable AT as a cross-cutting issue spanning health, education, employment, social protection and participation.

EU disability policy

The Strategy for the Rights of Persons with Disabilities 2021–2030 provides the principal EU policy framework for implementing the UN CRPD at European level. The Commission identifies accessibility, independent living, employment, education, health and participation among the Strategy's areas of action.

The policy context for assistive technology changed significantly recently. In November 2025, the European Parliament called on the Commission to develop legislation to establish a true single market for assistive devices and technologies¹¹. In May 2026, the Commission adopted the Communication Enhancing the Strategy for the Rights of Persons with Disabilities up to 2030¹². The enhanced Strategy places greater emphasis on implementation and tangible outcomes. Among its new actions, the Commission commits to strengthening the single market for assistive technologies and AI applications as well as to identifying and seeking to remove market barriers affecting developers and users.

The European Accessibility Act: a useful internal-market precedent

The European Accessibility Act provides an important precedent for considering assistive technology through an internal-market lens.

⁹ WHA 71.8 - Progress Indicators for access to assistive technology, <https://www.who.int/publications/i/item/WHO-MHP-HPS-ATM-2022.01>

¹⁰ United Nations General Assembly resolution on Access to Assistive Technology, A/80/L.110), <https://documents.un.org/doc/undoc/ltd/n26/214/84/pdf/n2621484.pdf>

¹¹ European Parliament resolution on the EU Strategy for the Rights of Persons with Disabilities post-2024, 2025/2057(INI), https://www.europarl.europa.eu/doceo/document/TA-10-2025-0308_EN.html

¹² European Commission Communication COM(2026) 541, https://commission.europa.eu/document/download/ab0bcea9-6b3a-48c1-875c-1cc687fba6d0_en

The EAA was adopted to improve the functioning of the internal market by reducing barriers resulting from divergent accessibility requirements for specified products and services. The Commission identifies two connected benefits of common EU accessibility rules: persons with disabilities gain access to more accessible products and services at more competitive prices, while businesses face fewer barriers to cross-border trade and gain access to greater market opportunities.

Even though, assistive technology provision raises a different set of legal and policy questions and should not simply be equated with the EAA, the economic and social/user-related logic is still relevant.

Where national fragmentation divides a potential EU market into smaller markets, providers can face duplicated administrative effort, reduced economies of scale and weaker incentives to localise or introduce niche products in at least some of the markets. Users may consequently face reduced choice, higher prices or the complete absence of products that are available elsewhere.

The key question explored in this paper is therefore whether some aspects of assistive technology provision could benefit from a similar principle of European coordination aiming to reduce fragmentation.

A partially harmonised environment

The EU already influences important aspects of the environment in which assistive technology is developed, placed on the market, procured and used. Depending on the type of technology, relevant EU frameworks can concern product safety¹³ and medical devices, accessibility requirements, public procurement¹⁴, competition and State aid, data protection, artificial intelligence¹⁵, taxation and the free movement of goods and services.

Some assistive technologies are also medical devices and therefore fall under the Medical Devices Regulation¹⁶. The Regulation sets EU-wide requirements for safety, conformity assessment and market placement, but does not determine whether a product is reimbursed or provided through national AT systems.

The systems determining whether a person can actually obtain assistive technology remain predominantly national and highly fragmented.

¹³ See for example: General Product Safety Regulation (Regulation (EU) 2023/988), <http://data.europa.eu/eli/reg/2023/988/oj>

¹⁴ See for example: Public Procurement Directive (Directive 2014/24/EU), <http://data.europa.eu/eli/dir/2014/24/oj>

¹⁵ See for example: AI Act (Regulation (EU) 2024/1689), <http://data.europa.eu/eli/reg/2024/1689/oj>

¹⁶ Regulation (EU) 2017/745 of the European Parliament and of the Council of 5 April 2017 on medical devices, <https://eur-lex.europa.eu/eli/reg/2017/745/oj>

Aspects include:

- eligibility for publicly supported assistive technology, including whether eligibility is based on diagnosis, disability status or functional need;
- methods of needs assessment and prescription;
- the existence and composition of reimbursable-product or approved-product lists;
- reimbursement amounts and co-payment requirements;
- procurement and supplier-selection systems;
- mechanisms allowing or restricting users to pay an additional amount for a preferred product;
- coverage of assessment, fitting, training, maintenance, upgrade and technical support, repair, follow-up, replacement and renewal;
- replacement and renewal cycles;
- responsibility for provision across healthcare, social services, education and employment;
- availability and accessibility of procedures to review or appeal decisions on eligibility, funding or the assistive technology provided; and
- rules governing whether a technology provided through one pathway can follow the individual into another setting.

Many of these problems have been identified by EDF earlier, highlighting complex administrative procedures, insufficient flexibility, lack of information and choice, disparities in national provision systems and national certification-related barriers; and calling for an EU-wide market in which persons with disabilities can select appropriate, affordable and high-quality assistive technology.¹⁷

Now, the policy question can be formulated more precisely:

Which elements of national diversity constitute legitimate differences in social policy, and which create avoidable fragmentation that prevents persons with disabilities and assistive technology suppliers from benefiting fully from the European internal market?

¹⁷ EDF Position Paper, February 2021: A disability perspective into our closest technologies, <https://www.edf-feph.org/content/uploads/2021/05/2021-EDF-position-on-Assistive-Technologies-1.pdf>

From availability to effective access

A product being legally available on the European market does not mean that a person who needs it has effective access to it.

Effective access depends on a chain of interconnected conditions. A person needs to know that a solution exists; be able to obtain an appropriate assessment where necessary; meet eligibility requirements; access sufficient financing; choose from suitable products; receive the product within a reasonable time; and obtain the fitting, configuration, training, maintenance and follow-up necessary to use it effectively.

The World Health Organization's (WHO) 5P framework – people, policy, products, provision and personnel – reflects this systemic understanding of assistive technology.¹⁸

For this reason, the paper uses effective access rather than product availability as its primary perspective, meaning a European assistive technology environment in which a person's location does not unnecessarily determine whether an appropriate solution exists, can reach them, or is financially affordable.

The opportunity for EU action

The EU does not need to replace national assistive technology systems in order to have a meaningful impact. The focus is rather whether European action can make those systems work better together.

Possible areas for examination include improving information and transparency; developing common principles for person-centred provision; facilitating cross-border recognition or access; reducing unnecessary duplication in national product-approval arrangements by harmonising information requirements; improving procurement practices; generating comparable data; supporting localisation and innovation; and identifying ways in which reimbursement systems can preserve national financing decisions while creating fewer barriers to cross-border competition and user choice.

However, harmonisation is not automatically beneficial. A European minimum product list, for example, could become a ceiling and encourage systems with broader provision to reduce their offer. Similarly, a highly centralised procurement model may reduce prices for some standard products while narrowing user choice or making market participation less attractive for smaller and innovative providers. An unrestricted

¹⁸ WHO/UNICEF, 2022: Global report on assistive technology.
<https://www.who.int/publications/i/item/9789240049451>

reimbursement model may promote choice but create other challenges concerning affordability, quality assurance or expenditure.

The objective should consequently be targeted harmonisation and coordination where European added value can be demonstrated, rather than uniformity for its own sake.

2. Assistive Technology provision in the EU

Assistive technology provision in the EU does not follow a single model. Instead, access is organised through a combination of healthcare, social protection, education, employment and disability-support systems, often involving different public authorities, insurers, local bodies, service providers and non-governmental organisations.

A person may qualify for one type of assistive technology through health insurance, another through an employment scheme, and another through education or social services. Responsibility can change according to the person's age, employment status, educational status, diagnosis, degree of disability, place of residence, residence status or length of residence, or intended use of the product.

For users of AT, this can produce fragmented pathways, repeated assessments and applications, uncertainty about which authority is responsible, differences in eligibility and available products, delays in receiving support, and gaps in continuity when circumstances change (for example when moving between education institutions, employment and retirement, or between regions). For suppliers, it can fragment effective demand into multiple administrative markets governed by different rules. Both dimensions are relevant to the analysis in later chapters.

2.1. Institutional models of assistive technology provision

Structure of entities providing assistive technology

Assistive technology provision in Europe can be organised around several institutional models, often operating in combination.

Public health or social-service provision

In this model, public authorities directly organise or finance the provision of assistive products and related services. Responsibility may rest with a national health service, a social protection authority, regional administrations, municipalities or a combination of these.

Decentralisation can bring services closer to users and permit local adaptation. However, where entitlements, budgets, procurement or

specialist capacity differ locally, it may also produce geographical variation.

Ireland provides a particularly well-documented recent example. A 2026 WHO assessment¹⁹ describes Irish AT services as a patchwork of statutory and voluntary provision shaped by geography, organisational structure and historical funding patterns. Local management decisions, staffing and procurement practices affect what is available, and WHO identifies significant geographical inequities, particularly in rural areas.

The Irish assessment therefore recommends a more coordinated national approach, including a unified strategy, central coordination and regional hubs.

This illustrates an important policy distinction. Decentralised delivery is not necessarily problematic in itself. The problem arises when location determines access to products, specialist assessment or follow-up more strongly than the person's need.

Insurance-based provision

In a second model, health or social insurance organisations play a central role in determining coverage and financing.

Germany is an example of a system in which statutory health insurance is an important source of AT funding, supplemented by other schemes according to the purpose of the technology. A study by the Digital Assistive Technology Industry Association for Europe (DATEurope) identifies statutory health insurance as the principal funding mechanism, while also documenting programme-specific funding through other sources such as pension insurance and workers' compensation.²⁰

The existence of several potential payers can widen the range of possible support, but it can also create uncertainty over responsibility: accessing assistance can involve a bureaucratic burden as it is not always clear which insurance system is responsible, which can result in overall inefficiency and in excessive burden for the users.

Mixed provision

In practice, many systems combine public provision, insurance, local authorities, employment schemes and disability benefits.

¹⁹ WHO, 2026: Assistive technology capacity assessment in Ireland, <https://www.who.int/europe/publications/i/item/9789289062909>

²⁰ Smith EM, Huff S, Layton N. (2023) Funding for Digital Assistive Technology in Europe. Report prepared for DATEurope. <https://dateurope.com/wp-content/uploads/2024/04/DATEurope-Report-Final.pdf>

Finland combines provision through the Social Insurance Institution (Kela), regional or municipal medical-aid services, employment-related schemes and private insurance. Kela can support AT for people studying or working, while other provision mechanisms cover people outside those pathways.

France combines reimbursement through national health insurance with disability-related personal benefits that may help finance costs not covered through the principal reimbursement system.

Such arrangements demonstrate why simple labels such as “public” or “insurance-based” do not fully describe AT provision. What matters to the user is how these systems interact when a single technology has relevance across several areas of life.

Specialist assistive technology centres

A further model involves specialist AT centres that may complement public or insurance provision by providing independent expertise, assessment, trials, training and follow-up.

The WHO provides a documented example through **Italy’s** GLIC network of independent assistive technology centres, describing these centres as multidisciplinary, non-commercial organisations providing information, training, assessment and follow-up support to users and also supporting professionals in health, social care and education.²¹

Such centres can help address a problem that purely reimbursement-based systems cannot solve: funding a product is not the same as identifying the right product.

This distinction becomes increasingly important for complex or digital or highly personalised technologies.

Service scope: health, social services, education and employment

AT provision frequently follows sectoral pathways rather than the person's life as a whole.

The same person may require technology for:

- personal and independent living;
- education;
- employment;
- communication;
- mobility;

²¹ WHO/UNICEF, 2022

- healthcare or rehabilitation; and
- participation in community life.

Yet, the responsible authority may differ depending on the purpose for which the technology is required.

As mentioned earlier, in **Finland**, for example, AT for work or study may be funded through the Social Insurance Institution, while other AT can be provided through medical-aid services. Employment-related insurance schemes may provide an additional source.

Germany similarly combines health-insurance funding with employment, pension and workers' compensation pathways.

The issue is particularly visible in education. In some countries technology intended for school may be funded through education systems, while responsibility becomes less clear where the device is personal and needed beyond the school environment. As a result, in some cases parents may be left to finance technology themselves.²²

The fragmentation is not merely administrative. A school may finance a device needed in the classroom but not for use at home. An employment authority may finance workplace technology but not technology primarily classified as supporting independent living. A health system may reimburse a medically classified product but not a mainstream device capable of fulfilling the same functional purpose.

The result can be that eligibility follows institutional boundaries rather than user needs.

Person-centred versus setting-based provision

An important distinction is between provision organised around the person and provision organised around the setting or administrative programme.

Person-centred provision begins with the individual's functional needs, goals, preferences and environments. Setting-based provision begins with the responsibilities of a particular institution: school, employer, health service, municipality or insurer.

A communication device may be required at school, at home and in the community. A screen reader may be needed for education, employment and private communication. A powered wheelchair may enable mobility in the home, the workplace and public space.

²² Smith-Huff-Layton, 2023

Where funding is tied to a particular setting, a user may need to navigate several systems for what is functionally the same need.

The WHO European scoping review found that AT provision systems were frequently described in the literature as fragmented and poorly coordinated. Users also reported difficulty understanding how to navigate provision systems. Long procedures, particularly for funding approval and fitting, were another recurring barrier.²³

The same review identified improved coordination and single-point access systems for referral, trials, procurement, fitting, information and advice as potential facilitators of access.

For EU policy, this distinction may be more useful than trying to identify a single “best” national model. The relevant question is whether national systems provide continuity around the individual, even when several authorities remain responsible for financing different elements.

2.2. Financing and coverage

Funding models

The DATEurope study²⁴ provides a useful framework for analysing AT financing in Europe, identifying these mechanisms:

- universal coverage,
- limited universal coverage;
- programme-specific coverage;
- personal allowances;
- charitable provision; and
- combinations of these models.

EU countries generally rely on several mechanisms simultaneously, and no country demonstrated universal coverage of digital assistive technology.

Limited universal coverage

Under this model, a broad population can access publicly supported AT, but coverage is limited by factors such as:

- eligible product categories;

²³ WHO, 2021: Prevalence of coverage of assistive technology in the WHO European Region, <https://www.who.int/europe/publications/i/item/WHO-EURO-2021-3173-42931-59954>

²⁴ Smith-Huff-Layton, 2023

- reimbursement levels;
- co-payments;
- diagnosis;
- disability severity;
- age;
- employment status;
- approved supplier arrangements; or
- maximum funding amounts.

Limited universal coverage can provide a stable entitlement framework, but its effectiveness depends heavily on what is included and on whether reimbursement reflects the real cost of an appropriate product. For example, reimbursement may effectively limit users to the lowest-cost option within a category, even where a different product would better meet their individual needs.

Programme-specific coverage

Programme-specific funding provides AT to defined groups or for specific purposes, such as employment, education or habilitation and rehabilitation.

This can be valuable because it allows funding to respond to particular circumstances. However, if different programmes cover different populations or settings and a user can qualify for a technology in one context but not another, this can create gaps when the same person requires different forms of support across different settings, such as home, school or work.

Such systems can also create transition problems – for example when a student leaves education, a person changes employment status, or an individual moves from paediatric to adult medical services.

Personal allowances

Personal allowances or disability-related cash benefits can give users greater control over how support is spent.

France and **Estonia** are examples where allowance-based mechanisms can complement other forms of AT provision.

The principal advantage is flexibility. Rather than being restricted exclusively to products selected through a central procurement catalogue, the individual may have greater scope to select the solution that best meets their needs.

However, the effectiveness of an allowance depends on its value, eligibility criteria and whether users receive adequate information and professional support in making decisions. If the allowance does not keep pace with market prices, the flexibility may exist only in theory.

Charitable provision

Where public schemes do not cover a product, charities and organisations of persons with disabilities may provide equipment or contribute to costs.

Such provision can fill important gaps, particularly for innovative or specialised and highly individualised technologies. However, it cannot provide an equitable substitute for rights-based public provision because access depends on the existence, resources and eligibility criteria of individual organisations, and it is on the users to identify these charities.

The DATEurope research²⁵ found charitable provision to be particularly important for digital AT in areas where public funding remained limited, as they can also assist population groups that otherwise do not meet eligibility criteria. But at the same time, they are sensitive to change due to economic forces.

A recurring pattern therefore emerges: the more fragmented or restrictive the public system, the greater the likelihood that users must combine several funding sources or rely on private and charitable resources.

Public funding, co-payment and user contributions

The existence of public funding does not establish that AT is affordable.

The WHO European review identified financial affordability as a major access barrier. It found examples of products that were only partially funded, as well as associated expenditure — such as batteries, maintenance, repairs and travel to assessment or fitting centres — that was often not reimbursed.

Co-payment therefore has to be considered in relation to the full cost of obtaining and using an appropriate technology.

A reimbursement system may formally cover a hearing aid, wheelchair or communication device while leaving the user to pay:

- the difference between the reimbursement ceiling and actual product price;
- additional features required for the person's functional needs;
- maintenance or repair;

²⁵ Smith-Huff-Layton, 2023

- batteries or consumables;
- software licences;
- upgrades;
- travel for assessment or fitting; or
- specialist training.

These costs can influence which technology a person ultimately receives.

The policy question is therefore not simply “Is this product reimbursed?”, but “Does the financing mechanism enable access to an appropriate and usable solution without disproportionate personal expenditure?”

Reimbursement levels and product choice

Reimbursement ceilings can also shape the market.

If reimbursement is set at a level that only supports basic models, more advanced products may technically be available but effectively excluded from publicly funded demand.

This has two consequences:

- For the user, choice is limited by the reimbursement system rather than by the range of legally available products.
- For suppliers, the size of the effective market for higher-performing or innovative products is reduced.

Procurement by provider versus self-purchase

Another important distinction concerns whether the public authority purchases the product directly or whether the user selects and purchases a product which is then reimbursed or subsidised.

Central or provider-led procurement

Provider-led procurement can offer advantages (e.g. volume discounts, simplified administration, standardised maintenance), but it can also restrict user choice if contracts cover only a limited range of products or suppliers, and it can lead to variation in what is available across regions.

This is relevant for all AT, but especially significant for highly individualised products where suitability depends on the user's functional needs, environment, preferences and previous experience.

A practical example from **Ireland**, related to continence products shows that users may prefer a product better suited to their condition or comfort but find that it is not available because the health service supplies

products through approved procurement arrangements. In such situations users may purchase alternatives privately.

User purchase and reimbursement

A reimbursement model can give users greater freedom to select among suppliers and products.

However, user choice is only meaningful if:

- reimbursement is sufficient;
- the user has access to reliable information;
- assessment and trial services are available;
- various suppliers operate in the market;
- users have access to training and maintenance and follow-up are available; and
- upfront payment requirements do not exclude lower-income users.

A system based solely on consumer choice can therefore be as problematic as an overly restrictive procurement system if the necessary support infrastructure is absent.

The objective should not be to choose one procurement model for all AT. Instead, funding and procurement should be proportionate to the characteristics of the product and the importance of individual matching.

2.3. Service delivery

Assistive technology provision is a process rather than a single transaction.

It includes several steps²⁶: selection and assessment, fitting or customisation, training, and follow-up including repair, maintenance and evaluation of outcomes. Failure at any stage can undermine the value of the solution itself.

Assessment and prescription

Assessment is particularly important where AT must be matched to complex functional needs.

A purely medical assessment may also be too narrow where the purpose of AT is participation rather than treatment.

²⁶ WHO, 2026; UNICEF, 2022: Framework for building capacity for assistive technology and alternative augmentative communication for children, <https://www.unicef.org/eca/media/30341/file/Framework%20for%20building%20capacity%20for%20assistive%20technology.pdf>

An appropriate assessment may need to consider:

- the person's functional abilities and needs;
- activities they wish to perform;
- the environments in which the technology will be used;
- compatibility with other technology;
- communication or language needs;
- physical fit and anatomical requirements, where relevant;
- age and other relevant individual characteristics;
- user preference;
- previous experience;
- maintenance, repair and support requirements;
- the user's capacity to learn the usage of the technology; and
- available support.

In **Spain**, for example, researchers raised concerns that AT assessment in many regions has focused on physical characteristics and funding considerations, rather than broader psychosocial, lifestyle and environmental factors.²⁷

Allocation: eligibility, product selection and funding

Following assessment, systems determine whether the user qualifies for support and which product can be provided.

The systems in Member States can be different in various aspects:

- **Personal eligibility:** Eligibility may depend on disability status, diagnosis, age, income, employment status or other criteria.
- **Product eligibility:** Even where the individual qualifies, the preferred technology may not appear on the relevant reimbursement or procurement list.
- **Available funding:** The user may receive full funding, partial reimbursement, a fixed allowance or support up to a maximum ceiling.

²⁷ T. Pousada García et al., 2019: Improving assistive technology services through outcome measures and global knowledge sharing in order to make the best match of person and technology. In: WHO 2019: Global perspectives on assistive technology: proceedings of the GReAT Consultation 2019, World Health Organization, Geneva, Switzerland, 22–23 August 2019. Volume 1, <https://www.who.int/publications/i/item/9789241516853>

- **Who chooses the product:** Selection may rest primarily with the user, a clinician, an AT specialist, an insurer, a procurement body or some combination of these actors.

These decisions determine the difference between formal entitlement and effective access.

Product trials

The ability to test a product before permanent allocation can be particularly important for complex or expensive AT. However, typically there is no funding support for trials, and suppliers are often unwilling to loan devices for the time required for an appropriate assessment/trial by the user.

The Enable **Ireland** Assistive Technology Loan Library is a promising model. In 2024, it recorded 566 loans, and 25% of products trialled were judged unsuitable for purchase, avoiding nearly €90,000 in unnecessary expenditure.

It demonstrates that greater user choice and personalised assessment need not conflict with cost control. Trialling can improve both user outcomes and spending efficiency by preventing unsuitable purchases.

Training, support and follow-up

Effective provision does not end when a solution is delivered. Users may need training and ongoing practical or technical support and maintenance, as well as follow-up that checks whether the solution remains appropriate and effective over time.

Users may need support to:

- learn how to operate the product effectively and safely;
- configure digital features;
- integrate the product into daily routines;
- troubleshoot problems;
- maintain or repair equipment;
- manage software updates or changes in compatibility; and
- reassess needs as circumstances change.

Lack of these services can result in abandonment of otherwise suitable technology.²⁸

²⁸ UNICEF, 2022 – Framework

Effective provision also depends on sufficient AT competence among the professionals who assess, recommend, configure and support solutions. This, in turn, requires training and support to professionals,

The **Italian** GLIC network provides one example of a service model in which information, assessment, training and follow-up are combined rather than treated as separate functions.

The policy implication is important: funding only the initial product can create false economy – meaning that apparent short-term savings may lead to higher costs later – if the solution cannot be used effectively or sustainably without associated services.

For suitable low-risk or digital AT, parts of assessment, onboarding, configuration and technical support may also be provided remotely. Remote and hybrid models can widen access, but should complement rather than replace in-person specialist support where fitting, clinical assessment or hands-on intervention is required.

2.4. Conclusions

The available evidence does not support a complete or directly comparable mapping of every AT system in all 27 Member States.

It does, however, support several important conclusions.

1. There is no single European AT provision model

Member States use different combinations of national health services, insurance systems, social protection, regional and local authorities, education systems, employment programmes, personal allowances and non-governmental provision.

2. Most systems contain multiple funding pathways

The same country may offer general health coverage, employment-specific schemes, education support and disability benefits simultaneously.

This can broaden access, but it can also make systems difficult to navigate.

3. The purpose and setting in which AT is used can determine entitlement

AT may be funded differently depending on whether it is considered healthcare, educational support, workplace accommodation or independent-living support.

This creates risks of gaps and duplication, especially for technologies used across several settings.

4. Geography can affect access even within the same Member State

There can be significant geographical variations in AT provision resulting from differences in service infrastructure, staffing and procurement.

For example, in **Ireland** the WHO assessment²⁹ identifies geographical disparities in provision – and recommends national standards for eligibility and procurement. **Belgium** provides another example of provision differentiated by territory: responsibility for assistive products and other individual disability-related support is decentralised, resulting in different provision arrangements in Flanders, Wallonia and Brussels.

5. Formal product coverage does not equal effective access

Reimbursement ceilings, restricted product lists, co-payment, assessment delays, lack of trials, limited specialist services, lack of training and inadequate maintenance can all prevent a formally covered technology from meeting the user's needs.

6. Digital and mainstream technologies fit poorly within many traditional provision systems

Digital assistive technology is often minimally visible in national policies and frequently reliant on programme-specific, personal or private funding.³⁰

This creates a growing mismatch between the speed of technological development and the administrative categories through which AT is funded, as well as provision models built around one-off purchases of stable physical products.³¹

7. Services matter as much as products

Assessment, fitting, trials, training, maintenance, support and follow-up are necessary parts of effective AT provision. Systems which focus only on initial reimbursement or procurement risk providing technology that is technically available but functionally ineffective or unsustainable over time.

²⁹ WHO, 2026

³⁰ Smith-Huff-Layton, 2023

³¹ Banerjee D, Lobnig S, Milligan M. (2024). Accessible Mobile Phones: Bridging the Gap in AT Provision and Service Delivery. In: Assistive Technology Outcomes & Benefits (ATOB), 2024, v. 18, p. 84-99, https://www.atia.org/wp-content/uploads/2024/04/ATOB_V18_FINAL-1.pdf

2.5. Implications for EU policy

The diversity described in this chapter affects not only users' access but also the effective demand available to AT providers. Their implications for competition, cross-border supply and the functioning of the internal market are examined in Chapter 4.

3. Barriers to access for users

Access to assistive technology depends on more than whether a product exists. Users must be able to identify an appropriate solution, qualify for support, obtain sufficient funding, receive the product within a reasonable time and access the training, maintenance and support needed to use it effectively.

The WHO identifies recurring barriers in Europe relating to affordability, availability, fragmented provision, limited information and insufficient professional capacity. It also cautions that evidence differs considerably between countries and functional areas.³²

3.1. Availability barriers

Limited product choice

National reimbursement lists, procurement contracts, approved-product catalogues and reimbursement ceilings can limit the products effectively available to users, even where a wider range exists on the European market.

In some countries users are restricted to a narrower range of (cheaper or standard) products that might not fully meet their needs. For example, **Croatia** has been described as providing mainly basic assistive products through public health-insurance coverage³³, while in **Ireland** procurement arrangements can restrict the available range of products³⁴.

In the hearing-aid sector, publicly supported systems may provide a basic device while limiting the possibility to select or top up for another solution. A 2022 stakeholder survey³⁵ identified particularly low reimbursement in **Czechia, Greece, Italy, Portugal, Romania,**

³² WHO, 2021

³³ Smith-Huff-Layton, 2023

³⁴ WHO, 2026

³⁵ EFHOH, 2022: State of provision of Hearing Aids in Europe, <https://efhoh.org/wp-content/uploads/2022/12/Hearing-Aids-Reimbursement-2022-launch-edition.pdf> See 2026 updated report: <https://efhoh.org/2026/10/new-efhoh-report-state-of-hearing-aids-and-cochlear-implants-provision-in-europe-2026-reveals-persistent-inequalities-in-access-to-hearing-care-across-europe/>

Slovenia and Spain, while countries such as **Austria, Denmark, Germany** and **France** were reported to apply lower hearing-loss thresholds for the eligibility for reimbursement.

Availability problems can also concern entire categories of AT. Digital AT (DAT) is poorly represented in many national policies and funding mechanisms. (See in 4.5. Technology-related barriers).

Newer technologies, mainstream devices performing an assistive function, software or subscription-based solutions may therefore fall outside systems designed around traditional equipment.

The relevant policy principle is not unlimited product choice, but access to a product that appropriately meets the assessed functional need.

Delays and waiting times

Lengthy assessment, approval and procurement procedures can significantly reduce effective access. Application processes in Member States are frequently described as complicated, bureaucratic and time-consuming.

Examples include **Portugal** with lengthy AT provision procedures³⁶, **Ireland**, with waiting lists and delays in several AT pathways³⁷, and **Bulgaria**, where users of reimbursed catheter products may need to navigate complex procedures and, particularly outside larger cities, travel to obtain products.³⁸

Delay can affect education, employment, communication, discharge from hospital, independent living or safety. It can be particularly harmful for people with degenerative conditions and for children whose needs and physical characteristics may change as they grow. By the time the AT is provided, it may no longer be appropriate or useful. Waiting time should therefore be regarded as an access outcome, not only as an administrative indicator.

3.2. Information barriers

Information on available AT

Users need accessible information both on which technologies exist and on which of them are actually available through their national system.

³⁶ EPRS-STOA, 2018 – Part I: Regulatory, health and demographic aspects

³⁷ WHO, 2026

³⁸ IFSBH, 2026: Country Evidence from IFSBH Members Access to Catheters and Continence Management Products in Europe, <https://ifglobal.org/wp-content/uploads/2026/09/Country-Evidence-from-IFSBH-Members-Access-to-Catheters-and-Continence-Management-Products-in-Europe.pdf>

Information must be accessible and provided in accessible formats (e.g. easy to read) and communication (e.g. using sign language).

However, limited information on available and publicly funded AT is in itself a recurring European barrier. This can be particularly difficult where responsibilities are divided between several authorities. For example, in **Ireland** AT provision is spread across health, education, housing and social protection systems, while in **Italy** regional differences and bureaucracy have been identified as barriers to navigating provision.

European product information already exists through resources such as the Global Assistive Technology Information Network (EASTIN). EASTIN is a network of national AT information organisations that provides a free multilingual search engine aggregating information from national databases on thousands of assistive products, including product descriptions, technical specifications, manufacturers and ISO 9999 codes.³⁹

However, the existence of an AT database does not necessarily mean that users are aware of it or routinely use it. This could be helped by awareness raising and dissemination of existing information resources.

Another significant gap is often information on the procedure or pathway to access AT: who is responsible, what is reimbursed, what criteria apply and what procedure must be followed.

Personalised information on appropriate AT

General product information is not enough where technology needs to be matched to the individual.

Complex mobility equipment, hearing technologies, communication systems and some digital AT require specialist assessment or trialling.

Different service models can help. In **Italy**, specialist AT centres within the GLIC network provide information, assessment, training and follow-up support.

Access to independent and person-centred advice is especially important where the alternative is relying mainly on suppliers or a narrow list of already familiar products.

³⁹ Worldwide Search Engine on Assistive Products:
<https://www.eastin.eu/en/searches/products/index>

AT usage

Effective access does not end when the product is delivered. Training, fitting, configuration, maintenance, technical support, repair and follow-up may all be necessary.

This is particularly relevant for complex and digital AT. In **Ireland**, gaps have been identified in professional AT training, repair and maintenance arrangements, and funding for software subscriptions and related support.

A device may therefore be funded while important elements needed to use it effectively are not.

Funding only the product can create formal access without effective access.

AT personnel and training

Provision often depends on professionals with the knowledge and skills to assess needs, recommend appropriate solutions, configure or fit products and provide training and follow-up. (One of the P's in the WHO 5P framework.)

Limited professional knowledge can become an access barrier. For example, in **Greece** limited AT expertise among some assessors has been reported, while in **Ireland** specialist AT expertise and trial opportunities were found to be unevenly distributed.⁴⁰

There is broad consensus that many countries lack professionals with adequate knowledge and expertise in AT, and there are relatively few dedicated education and training programmes in this field.⁴¹ Shortages of trained personnel, uneven access to specialist expertise and limited AT training within professional education can result in inadequate information, inappropriate or underused solutions, geographical inequalities and delays.

Unlike the United States, where RESNA (the Rehabilitation Engineering and Assistive Technology Society of North America) operates an Assistive Technology Professional certification, there is currently no equivalent EU-wide professional certification framework specifically for AT practitioners.

⁴⁰ WHO, 2026; Smith-Huff-Layton, 2023

⁴¹ WHO/UNICEF, 2022; Manship S, Hatzidimitriadou E, Moore J, Stein M, Towse D, Smith R. (2024). The experiences and perceptions of health-care professionals regarding assistive technology training: A systematic review. In: Assistive Technology, 36(2), 123–146, <https://doi.org/10.1080/10400435.2023.2219294>

3.3. Affordability barriers

Insufficient reimbursement

Public funding does not necessarily mean that AT is affordable.

Users may face co-payments and uncovered costs for maintenance, repairs, batteries, travel and other elements of AT use. Country examples show substantial variation:

- in **Cyprus**, maximum subsidy amounts can leave users paying the remaining cost of AT themselves;
- in **France**, products on approved reimbursement lists may still require user contributions, although disability-related allowances can supplement these costs;
- in **Greece**, limited public funding for AT has been reported;
- in **Bulgaria**, stakeholder evidence indicates that the catheter reimbursement ceiling may leave users with significant out-of-pocket costs.

The full cost of AT may also include software licences, subscriptions and upgrades. This is particularly relevant to digital AT and increasingly challenges reimbursement systems designed around a one-off purchase.

Funding gaps between sectors

AT often supports more than one area of life, while funding remains divided between health, education, employment and social services.

Examples include **Denmark**, where school and workplace AT are funded through different pathways; **Finland**, where work/study AT and general medical-aid provision are separated; and **Germany**, where different insurance and employment-related schemes may apply according to the purpose of the AT.

In **Belgium (Flanders)**, separate reimbursement schemes for self-catheterisation and nurse-assisted catheterisation cannot be combined, creating difficulties for children who need different support arrangements at home and at school.

The underlying issue is that the funding pathway changes while the functional need does not.

3.4. Administrative barriers

Eligibility and assessment criteria

National systems necessarily need criteria to determine access to public support, but these criteria may be based on diagnosis, disability severity, age or administrative status rather than functional need.

For example, **Estonia** uses age, disability severity and work capacity within its reimbursement framework; **Greece** uses the Disability Certification Centre to determine the type and level of support; and **Finland** distinguishes between people who are working or studying and those using general medical-aid services.

Assessment can also become unnecessarily burdensome if straightforward AT requires multiple professional approvals. A proportionate system should distinguish between products requiring specialised clinical assessment and those that can be accessed through simpler routes.

Age-related and status-related restrictions

Eligibility can depend on age, employment, education or work capacity even where the functional need itself does not change.

Examples include:

- **Belgium**, where some regional disability-related support is linked to having entered the scheme before the age of 65;
- **Estonia**, where reimbursement can vary according to age, disability severity and capacity to work;
- **Finland**, where Kela (the Social Insurance Institution) provides AT specifically for people who are working or studying, while other users access medical-aid provision through different services;
- **Denmark**, where school and employment AT are provided through separate programme-specific pathways;
- **Germany**, where statutory health insurance is supplemented by other routes such as pension and workers' compensation schemes.

The 2022 hearing-aid report also found more generous support for children and young people than adults in several surveyed countries.

These differences can create sharp changes in support at transitions between education, employment, adulthood and older age.

Complex procedures

Multiple funding pathways can broaden provision but also make it difficult to navigate.

Examples include **Germany**, where several insurance and programme-specific funding routes coexist; **Finland**, where responsibility differs according to employment or study status; and **Ireland**, where several departments and services may be involved.

Regional variation can add another layer regarding bureaucracy or product availability, among other things (e.g. in **Italy**, **Spain** and **Ireland**).

Administrative complexity can reinforce inequality because users with greater knowledge, time or family support may be better able to navigate fragmented systems.

3.5. Technology-related barriers

Backward compatibility and upgrades

Digital and connected assistive technologies can create new barriers when upgrades, compatibility requirements or changes in product design disrupt functions that users already rely on. Hearing aids provide a clear example: assistive listening systems are often used to enhance the users' ability to understand in public spaces. When manufacturers remove established connectivity options and introduce newer technologies, users can face difficult trade-offs. (E.g., a preferred hearing aid supporting either the established telecoil system or a newer Bluetooth broadcast-audio solution, but not both.)

New solutions can improve functionality, but may also require compatible devices, apps, regular updates, pairing procedures, batteries and sufficient digital skills. Software updates can themselves introduce uncertainty, particularly where users depend on a stable configuration for communication or independent living. Some AT users consequently rely on peer support groups to exchange information about whether particular updates are safe to install.

The policy issue is therefore not simply access to newer technology, but continuity of access to essential functions. Digital AT should remain usable across upgrades and transitions, with appropriate backwards compatibility, clear information about changes and support for users who may not have the technical capacity to manage updates independently.

Similar legislative solutions already exist in the EU for specific product groups.⁴²

Exclusion of mainstream technologies

The boundary between specialised AT and mainstream technology is increasingly blurred. Smartphones, tablets, smartwatches, voice assistants and mainstream software can perform functions previously associated mainly with specialised AT.

Yet, traditional funding systems may exclude such products because they are not classified as assistive devices or resulted in inconsistent recognition of accessible mainstream technology (e.g. in **Portugal**).⁴³

The solution is not to reimburse consumer products automatically, simply because they have accessibility features. Rather, funding systems should be able to cover a mainstream product where an individual assessment shows that it is necessary to meet the person's assistive technology needs, or that it can be an essential part of the assistive solution addressing the individual needs.

Exclusion of innovative, digital and software-dependent assistive solutions

Traditional reimbursement systems can struggle to accommodate software-dependent AT, subscription models, cloud and AI services and rapidly changing digital products and solutions.

Digital AT is largely invisible as a distinct category in national policies. In **Ireland**, funding of DAT is particularly visible in workplace and education programmes; in **Hungary**, the subsidised assistive-product framework examined did not include DAT; and in **Greece**, limited funding and assessor knowledge were identified as barriers.⁴⁴

This can create a lag between technologies becoming available on the market and provision systems recognising them.

It can also leave recurring costs – such as licences, connectivity, updates and technical support – and costs of compatibility – with operating systems, mainstream devices and proprietary platforms – outside funding arrangements designed for a one-off purchase.

⁴² For example, EU ecodesign rules under Commission Regulation (EU) 2023/1670 require manufacturers of smartphones and tablets to keep certain spare parts available for at least 7 years, and to provide operating-system updates for at least 5 years after a model is no longer placed on the market. <https://eur-lex.europa.eu/eli/reg/2023/1670/oj>

⁴³ EDF, 2021

⁴⁴ Smith-Huff-Layton, 2023

Furthermore, software updates or changes in connectivity standards can alter accessibility or functionality after procurement, while vendor lock-in can make it difficult to change provider without losing personalised settings, data or compatible accessories.

Open-source solutions and language limitations

Open-source AT solutions can widen the range of available solutions and may be particularly valuable for needs that are poorly served by commercial markets.⁴⁵ However, they may not fit reimbursement models based on purchasing a conventional commercial product, because the main costs can lie in configuration, localisation, training and support.

Language-dependent technologies such as speech recognition, text-to-speech and AAC may also require substantial localisation investment (beyond translation, including vocabulary, accents, symbol systems and appropriate language data). Smaller language markets may therefore be commercially less attractive without an EU-scale support.

However, current evidence is weaker for open-source AT and localisation, and does not support a reliable country comparison for either issue.

3.6. Key findings

The examples show that various barriers arise through different national mechanisms:

- **Availability is determined by provision systems as well as the market.** A product may exist but remain effectively inaccessible because of reimbursement, procurement or eligibility rules.
- **Affordability depends on the full AT package.** Co-payments, maintenance, software and support can make formally covered technology unaffordable.
- **Administrative and sectoral fragmentation creates discontinuity.** Users can lose access when responsibility changes between health, education, employment or other systems.
- **Traditional provision models are struggling to accommodate digital, software-dependent and mainstream technology, recurring costs, updates and interoperability costs.**

⁴⁵ Thanks to these initiatives, many people with disabilities have access to free or very low-cost assistive technologies. Examples include the NVDA screen reader and the growing number of assistive devices that can be produced through 3D printing.

- **Effective access requires services as well as products**, including appropriate assessment, information, training, ongoing support and maintenance, follow-up and timely replacement or renewal.

4. Barriers within the EU internal market

Many assistive products can circulate within the EU under common rules on product safety, medical devices and other aspects of market placement. However, the systems determining whether users can actually obtain them – eligibility, reimbursement, approved-product lists, procurement and service delivery – remain predominantly national.

This creates a distinction between legal market access and effective access to publicly supported national AT markets. A product may be lawfully sold throughout the EU while having little effective demand in a Member State because it is not reimbursed, is outside an approved product category or cannot be supplied through contracted providers.

This is a broader AT market problem: fragmented funding and provision divide what could be a large collective market into smaller product-, user- and sector-specific markets. Manufacturers may consequently have limited information about demand, while certification, registration and inconsistent specifications can increase barriers to market entry.

Differences between national AT delivery systems create disparities for users and industry and prevent AT from fully benefiting from the EU single market. Differences between national funding programmes should be assessed where they may affect pricing, availability or the free movement of goods and services.⁴⁶

4.1. Fragmentation of eligible demand and reimbursement systems

Different allocation and eligibility rules

The number of people who need AT is not necessarily the same as the number who can actually buy it – either because they are eligible for reimbursement or can pay for the AT themselves.

National eligibility criteria can depend on:

- diagnosis or recognised disability status;
- disability severity;

⁴⁶ Smith-Huff-Layton, 2023

- age;
- employment or education status;
- insurance coverage;
- income; or
- the purpose for which the AT is required.

Examples presented in Chapter 3 include **Estonia**, where reimbursement can vary according to age, disability severity and capacity to work; **Finland**, where specific Kela funding is linked to work or study; and **Greece**, where separate employment-related AT funding exists alongside health and social-welfare provision.

From the user's perspective, these rules determine access. From the provider's perspective, they determine the size of the eligible market.

A product potentially needed by thousands of people across Europe may therefore face quite different levels of publicly financed demand between countries. For niche AT in particular⁴⁷, splitting a relatively small user population into separate national and programme-specific markets can affect whether suppliers enter a country, establish distribution or provide local support.

Different product lists and reimbursement levels

Even where a user qualifies for support, the product itself may need to be included in a national reimbursement list, approved catalogue or procurement arrangement. Such systems are legitimate tools for controlling expenditure and product quality. However, differences between Member States can also divide the market.

For example:

- **Hungary**: DATEurope found a subsidised national medical-device list providing assistive technology at variable subsidy rates, but no digital AT on the list reviewed.
- **Italy**: AT can be funded through the National Health Service, generally at reimbursement rates linked to public tenders and local health authorities; plus, regional differences have been reported in implementation.
- **Greece**: the national health-insurance system covers only a limited range of assistive products, and for those it generally reimburses 75% of the eligible cost. (Although additional support is available

⁴⁷ An example for niche AT is specialised AAC devices, as the number of potential users in any single country may be relatively small.

through purpose-specific programmes, including employment-related schemes.)⁴⁸

Different reimbursement levels also affect which products suppliers can offer within publicly supported systems. Low ceilings may make higher-performing or more specialised products dependent on user co-payment or private purchase.

A particularly relevant case, showing a direct chain from reimbursement conditions to supplier participation and user choice: in **Bulgaria** several catheter suppliers withdrew from the reimbursement system in 2026 because of the low reimbursement ceiling, reducing the range of reimbursed products.⁴⁹

Reimbursement and the total cost of use

Comparing reimbursement amounts alone can be misleading. The total cost of use may include assessment, fitting, configuration, licences or subscriptions, connectivity, training, technical support, maintenance or repair, upgrades and eventual replacement. If one national system covers these elements while another expects the supplier or user to absorb them, providers face different economic conditions even where nominal product reimbursement appears similar.

This is particularly relevant for complex wheelchairs, hearing aids, prostheses, AAC systems, digital and software-dependent AT.

Avoiding a common product ceiling

A single EU reimbursement list might appear to solve fragmentation, but it could create new problems. The agreed structure for this paper notes stakeholder concern that an EU minimum list – for example based on the WHO Priority Assistive Products List⁵⁰ – could become a ceiling and encourage countries with broader provision to reduce support.

The stronger opportunity is therefore likely to be harmonising processes and information requirements, rather than defining one restrictive European list of reimbursable products.

Different assessment methodologies

National assessment systems also shape demand by determining what is considered an appropriate assistive solution.

⁴⁸ Smith-Huff-Layton, 2023

⁴⁹ IFSBH, 2026

⁵⁰ WHO, 2016: Priority Assistive Products List, WHO/EMP/PHI/2016.01, <https://www.who.int/publications/i/item/priority-assistive-products-list>

Differences can concern:

- who may assess or prescribe AT;
- whether a medical diagnosis is required;
- whether functional and participation needs are considered;
- whether mainstream products qualify;
- whether users can trial alternatives; and
- how frequently reassessment occurs.

A medically oriented system may favour established medical or specialised products and give less weight to how AT supports a person's rights to participate in education, employment, independent living and community life. A more functional assessment may allow a broader range of solutions, including mainstream or digital technologies.

European Parliament research had already identified substantial national variation in AT information, prescription, assessment, delivery and financing mechanisms.

These differences influence the products recommended to users and therefore the effective demand available to suppliers.

Information and support influencing demand

Demand is also shaped by what users and professionals know.

New or less established products may be technically available but rarely recommended if assessors are unfamiliar with them. This can favour incumbent suppliers and products already embedded in procurement or reimbursement systems.

Country evidence in Chapter 3 regarding DAT illustrates this.

Independent information, trial services and specialist AT centres can therefore affect not only user choice but market competition by making alternative products visible.

The issue is not simply generating more demand, but ensuring that public demand reflects functional need rather than familiarity with a limited range of established products.

Effects of fragmented demand

The evidence suggests several likely effects of fragmented national demand.

Smaller effective markets

AT frequently serves relatively small user groups. National eligibility, product lists and funding rules can reduce those groups further.

Fragmentation is a key AT market weakness because the sector is viewed as numerous small categories rather than as a collective market.

This is particularly relevant for:

- specialised communication technologies;
- refreshable Braille technologies;
- highly customised mobility products;
- products for rare conditions; and
- language-dependent digital AT.

Small markets can support fewer suppliers and provide weaker incentives for market entry, localisation or ongoing support.

Higher national adaptation costs

Operating in several Member States may require suppliers to adapt to different:

- reimbursement procedures;
- approved-product systems;
- procurement documentation;
- pricing arrangements;
- service requirements; and
- languages.

Some differences are necessary because national systems and responsibilities differ. The potential internal-market issue is that requirements can be different among Member States while serving essentially the same purpose.

European Parliament research previously highlighted a lack of coordination, classification, information-sharing and validation concerning AT and questioned whether more transparent acceptance procedures could be developed while retaining national procurement systems.

Provider consultations should establish which national requirements generate the greatest cost and whether these costs prevent entry into smaller markets.

Limited scalability for niche AT

Fragmentation is likely to matter most where the potential market is small from the outset.

A non-EU market analysis by the WHO (concerning Georgia) shows that small-volume specialised AT markets can have limited economies of scale and low returns on investment.⁵¹ Even though it is not about EU Member States, it illustrates the economic mechanism: low volumes, fragmented demand and funding thresholds can restrict supply and investment in specialised markets, and highlights a relevant question: whether European rather than national scale is needed to make some specialised AT markets viable.

4.2. Fragmentation of market access

Fragmented demand determines the size of the potential market. Providers may also face separate barriers when attempting to enter publicly supported AT systems.

Administrative barriers and approval processes

A distinction is necessary between:

1. **EU market-placement requirements**, determining whether a product may legally be sold; and
2. **national procedures for access to publicly supported AT provision**, determining whether it can be reimbursed, procured or supplied through national schemes.

Different national procedures for access to publicly supported AT markets can create additional barriers on the AT single market after a product has already met applicable EU market-placement requirements.⁵² These may involve:

- inclusion on a reimbursement or approved-product list;
- supplier accreditation;
- product coding;
- price negotiations;
- evidence of functional or clinical benefit;
- participation in procurement procedures; and

⁵¹ WHO, 2025: Assistive technology market assessment report: Georgia, WHO/EURO:2025-12387-52161-80102, <https://iris.who.int/items/184e322e-54e6-457d-880d-db44a9f25ad6>

⁵² EDF, 2021

- service or maintenance obligations.

EU legislation could harmonise core information requirements for national AT market access and require mutual recognition of equivalent assessments and evidence, as well as the transparency of procedural timelines without affecting Member States' decisions on eligibility and reimbursement levels.

Slow product-list updates

National approval systems may also disadvantage innovation where approved lists or catalogues change slowly.

This can create two successive stages:

- a product becomes legally available on the EU market;
- it subsequently waits to enter national publicly supported provision.

For fast-changing software and digital AT, the second stage may be particularly problematic.

Procurement barriers

Public procurement is one of the strongest links between national AT provision and market structure.

Well-designed procurement can:

- aggregate demand;
- reduce prices;
- establish quality requirements;
- create predictable purchasing volumes; and
- attract competition.

WHO recommends competitive tendering, transparent specifications and consistent procurement requirements and notes that greater consistency across sectors and markets could make participation easier for suppliers and support pooled purchasing. However, procurement can also restrict access.

Price versus functional performance

The lowest-cost product is often not the product that best meets the user's needs.

Procurement that prioritises acquisition price over functional performance can result in narrow product ranges and insufficient solutions, and reduce incentives to offer more specialised or innovative solutions.

This is visible in **Ireland**, where procurement arrangements have been identified as one of the factors influencing available product choice. Stakeholder evidence from other Member States similarly reports cases where users purchase alternatives privately because their preferred product is outside the publicly contracted range.⁵³

As this can create false savings if unsuitable products are later abandoned, replaced or require additional support, procurement should consider the total cost of use rather than the initial purchase price alone.

AT procurement should therefore consider:

- functional outcomes;
- individual suitability;
- total cost of use over the expected life of the solution (lifecycle costs);
- maintenance and repair;
- interoperability and backward compatibility;
- training and support, including the continuity of software or service support.

For digital and connected AT, procurement should also consider minimum support periods, security and accessibility updates, data or configuration portability (to a different vendor or provider), and arrangements for migration or service continuity if a supplier or cloud service is discontinued.

Supplier concentration and smaller providers

Framework contracts and supplier qualification can provide administrative efficiency, but long or closed arrangements may disadvantage new entrants and SMEs.

This matters because much of the AT market is dominated by SMEs, outside sectors such as hearing aids and cochlear implants.

Procurement design can therefore influence whether innovative or niche suppliers can compete.

Relevant questions for provider consultation include:

- whether framework contracts remain closed for long periods;
- whether new products can be added;
- whether tenders allow participation by smaller providers;

⁵³ IFSBH, 2026

- whether language requirements have limited their participation;
- and whether an individual exception is possible when contracted products do not meet assessed needs.

Limited cross-border provision

A functioning single market should make it easier for products and suppliers from one Member State to reach users in another. For AT, however, cross-border sale does not always equal cross-border access.

Some AT can be supplied relatively easily across borders, such as certain software or standard products. Other technologies require local:

- assessment;
- fitting;
- installation;
- training;
- maintenance;
- repair; or
- professional support.

Cross-border provision is therefore particularly dependent on the type of AT.

Cross-border market access for providers

A provider may be legally entitled to sell a product throughout the EU but still need to navigate separate national procedures. When equivalent requirements are repeated in several Member States, the resulting cost can discourage entry into smaller markets.

Remote distribution, configuration and support may reduce some barriers for software and other digital AT, but local fitting, repair or professional-service obligations remain essential for many products. The relevant question is which requirements genuinely need to remain national, and which could be made more transparent, comparable or mutually recognised.

Cross-border access for users: purchase and national reimbursement

A user may be able to buy a product from another Member State but be unable to obtain national reimbursement for it.

A **Lithuanian** example describes users seeking an advanced product through neighbouring Latvia because it is unavailable nationally, while the

absence of Lithuanian reimbursement and distribution appears to reinforce each other.⁵⁴

Where an appropriate product is available elsewhere in the EU, but national arrangements prevent effective access without a proportionate justification, the internal-market dimension is particularly strong. Limited access to appropriate and affordable products within European provision systems may also encourage users to seek lower-cost alternatives through online or non-EU markets. Where such products are not lawfully placed on the EU market or do not comply with applicable EU safety and conformity requirements, this may create additional risks for users.

Portability when users move

Cross-border access also concerns users who relocate for work, study or family reasons.

In some publicly funded provision systems, certain assistive product can remain the property of the public authority or service provider rather than the individual user.⁵⁵ This can limit the user's ability to take the product permanently to another Member State, and can create uncertainty over responsibility for maintenance, repair and replacement.

European Parliament research has previously linked differences in AT eligibility and entitlement with barriers to portability and relocation between Member States⁵⁶. A person may need to repeat assessment, establish a new entitlement or make new arrangements even where their functional need and existing AT remain unchanged.

A possible area for EU coordination would be the portability of assessment and technical information, even where funding entitlements remain national.

Ireland's AT passport initiative provides a useful example. It creates a digital, person-centred record of an individual's AT use, preferences and support requirements, with the aim of reducing repeated assessments and improving continuity when users move between services or regions.⁵⁷ A similar tool could be explored at EU level, allowing relevant AT information to travel with the person across borders – even without recognising a funding entitlement in another Member State.

Frontier workers present a particularly complex case. Although they are generally insured in the country of employment, EU social-security

⁵⁴ IFSBH, 2026

⁵⁵ For example, in Denmark, Finland, Ireland and Sweden.

⁵⁶ EPRS-STOA, 2018

⁵⁷ WHO, 2026

coordination allows them to access healthcare both there and in their country of residence (using the S1 form procedure). For assistive technology, this can create uncertainty because assessment, prescription, reimbursement, ownership and follow-up may be governed by different national systems.

A frontier worker may therefore interact simultaneously with two healthcare systems while depending on an assistive product whose provision pathway is not easily divisible between them. Questions can arise over which system assesses the need, finances the product, owns it, provides maintenance or replacement, and what happens if the product is used daily on both sides of the border.

Taxation

Taxation also affects AT affordability and illustrates the difference between EU and national competences.

The EU VAT framework permits reduced rates for certain disability-related equipment, but Member States retain choices over the rates applied within that framework. This can lead to different tax treatment of AT between countries and may also create distinctions between specialised AT and mainstream technologies performing the same function.

The EU also provides specific rules for VAT exemptions on certain disability-related goods imported from outside the Union under defined conditions.

Taxation is therefore relevant to AT market policy. Any recommendation on tax harmonisation would require separate fiscal analysis. For the present paper, the key point is that different tax treatment can contribute to differences in final AT prices and can depend on how the product is classified.

4.3. Key findings

The evidence supports the following main conclusions.

- **The EU AT market is only partially integrated.** Products may circulate legally across the Union while national reimbursement, eligibility and procurement arrangements divide effective demand into separate markets.
- **National provision rules shape supplier behaviour as well as user effective access.** Reimbursement ceilings, product lists and procurement can determine whether a supplier enters or remains in a market.

- **Fragmentation matters most for small and specialised markets.** Niche AT, digital products and language-dependent technologies have less ability to absorb duplicated national market-entry and localisation costs.
- **Procurement can either strengthen or weaken the market.** Coordinated purchasing can create scale and competition, while narrow or price-led frameworks can restrict user choice, SMEs and innovation.
- **The strongest case for EU action concerns barriers with a cross-border or market effect,** rather than differences in national benefit levels. Potential areas include unnecessary duplication of market-access procedures, cross-border supply and reimbursement, procurement practices, transparency and portability of relevant information.

In general, Member States have the competence and responsibility for deciding how their health and social protection systems are organised and how much AT support they finance. EU-level action could instead focus on reducing unnecessary differences in the procedures and market requirements surrounding the national decisions – for example through more consistent product information, recognition of equivalent evidence, transparent market-access procedures and better cross-border portability – allowing providers and users to benefit more fully from the internal market.

5. Case studies of access and market fragmentation

The cases in this chapter illustrate how national provision arrangements can affect access to assistive technology and, in some circumstances, interact with the EU internal market. They do not all constitute direct internal-market failures. Some primarily demonstrate problems within national provision systems, which can lead to demand distortion and market fragmentation. Others show more direct cross-border or market effects.

5.1. Cross-border access barriers

Case 1 – Reimbursement and market availability reinforce each other

Evidence supplied by the International Federation for Spina Bifida and Hydrocephalus (IFSPH) provide a particularly relevant case involving an advanced continence-management product in Lithuania.

Standard catheter products are reported to be generally available and reimbursed. However, a specific bowel-irrigation system is reportedly not available through the Lithuanian healthcare system and has no national distributor. According to the Lithuanian organisation, reimbursement is not provided because the product is unavailable on the national market, while distributors are reluctant to market the product without reimbursement.

Some Lithuanian users therefore purchase the product privately, and IFSPH has explored access through a pharmacy in neighbouring Latvia.

The case illustrates a reimbursement–market availability loop: absence from the national provision system reduces the commercial incentive to enter the market, while the absence of a national supplier is itself used as a reason for non-reimbursement. A product available in one Member State remains difficult to access in another despite the existence of the EU internal market.

Case 2 – Cross-border portability when moving between Member States (conceptual case)

A person who relies on assistive technology may face disruption when moving from one Member State to another for work, study or residence. In practice, a person may arrive in another Member State with an established functional need, a completed assessment and technology already in use, but still must establish entitlement under the new national system. Existing assessments may not be recognised, and responsibility for replacement, maintenance, repair, consumables or software support may change. For digital AT, continuity may also depend on licences, subscriptions, personalised settings, cloud services or access to technical support.

This case illustrates a cross-border continuity problem rather than a simple reimbursement problem: it is about the lack of recognition and transferability of relevant assessment and technical information, clearer responsibility for ongoing support, and arrangements that reduce unnecessary interruption to maintenance, repair and digital services.

The practical consequence of moving between Member States is interruption of access to essential AT. The issue has a direct relationship with free movement.

5.2. Product availability barriers

Case 3 – Reimbursement conditions contributing to supplier withdrawal

The IFSBH evidence from Bulgaria provides an unusually clear connection between reimbursement policy and supplier behaviour.

Bulgaria reportedly introduced reimbursement for clean intermittent catheterisation in 2021. The National Health Insurance Fund reimburses up to €36 per month, but only for products appearing on its reimbursement list and supplied by contracted companies. According to IFSBH's Bulgarian member evidence, several suppliers withdrew from the reimbursement system in 2026 because of the low reimbursement ceiling, reducing the number of reimbursed catheter brands available to users.

The same source reports that €36 can cover approximately 100 non-lubricated catheters per month but only around 15 hydrophilic catheters. Families requiring more appropriate or higher-cost products may therefore face substantial private expenditure. As a result, users in Bulgaria were considerably more likely to finance catheters themselves than respondents in countries such as Germany, Italy, the Netherlands and Denmark.

This case demonstrates a direct chain between reimbursement conditions, reduced commercial viability, reduced competition and product choice, and lower effective access for users.

5.3. Portability barriers between sectors

In these cases, portability refers to continuity across administrative pathways within a Member State, rather than cross-border portability between Member States.

These cases show how systems can fund a product in one part of a person's life while failing to support the same functional need in another. They are primarily provision-system failures. Their EU internal-market policy relevance is whether common principles on person-centred AT provision could reduce fragmentation without harmonising national benefit systems.

Case 4 – Providing an assistive device without the surrounding services

The 2026 WHO assessment of Ireland⁵⁸ contains detailed, fictional AT user narratives based on its consultation process.

“Liam” is an eight-year-old child with autism and limited verbal communication attending mainstream education. His AAC device was funded through the education system. The device itself was described as high quality and significantly improved his communication.

However, several gaps remained, beyond providing the device itself. The application process was lengthy and required multiple professional reports. There was limited coordination between health and education services, with no clear responsibility for training and follow-up. The software required an annual subscription that was not covered, and responsibility for repairs was unclear. School staff were supportive but had received limited specialist AT training.

The case demonstrates the need to recognise the whole AT package, rather than only the initial product purchase. This is particularly relevant to modern digital AT, where the real value of the hardware may depend on software subscriptions and ongoing configuration.

Case 5 – Transition from specialist rehabilitation into the community breaks continuity of AT support

Another WHO user narrative from Ireland concerns “Aisling”, a 35-year-old woman with an acquired brain injury transitioning from specialist inpatient rehabilitation to independent community living.

During rehabilitation, her need for a wheelchair, cognitive aids, environmental controls and home modifications was identified. She received a high-quality wheelchair through the health system.

After discharge, however, she had to navigate separate health, housing and social protection arrangements without a single coordinating framework, fragmented funding, difficulties of accessing equivalent AT expertise in the community and inadequately structured follow-up.

⁵⁸ WHO, 2026

In this case, the issue is the lack of service portability: specialist AT support does not automatically follow the person from institutional rehabilitation into community life.

5.4. Innovative and digital AT barriers

Case 6 – An AI-based communication device available elsewhere but not recognised for reimbursement

In this anecdotal case⁵⁹, a parent of a child with cerebral palsy identified an AAC device using artificial intelligence to anticipate communication needs.

The product was neither available nor recognised as assistive technology in the parent's country and was therefore not reimbursable. Beyond that, importing it privately resulted in paying full VAT, while an organisation or institution would have received a VAT reduction.

The case presents several issues: the innovative assistive solution entered the EU market faster than the national reimbursement system; the product was only available cross-border, in another Member State; and the need for niche assistive technology put the user in a vulnerable situation.

5.5. Mainstream technologies as assistive technology

Case 7 – A function provided by a mainstream device is only recognised when delivered by specialised AT

Aisling's Irish case (Case 5) has another aspect as well: mainstream digital products such as voice assistants and reminder applications needed to support independent living were not covered through public AT funding – even though her wheelchair, a more traditionally recognised assistive product, was.

Ciarán's WHO Ireland narrative provides another related example. As a young person with vision impairment entering university, he needs a combination of screen magnification, accessible reading tools and navigation aids. The right combination of assistive solutions cannot be provided across academic, transport and sporting environments. Mainstream and digital tools could provide the adequate assistive solutions, but they are not covered by the relevant assistive technology framework.

⁵⁹ EDF, 2021

6. Policy gaps and opportunities

Assistive technology is influenced by many EU and national policies but is not addressed through a coherent European framework. The preceding chapters identify several gaps that cannot be addressed through national provision reforms alone. These mainly concern the interaction between national AT systems, the internal market and cross-border mobility. This chapter identifies where greater EU coordination or targeted action could add value while leaving decisions on eligibility, benefit levels and the organisation of provision with Member States.

6.1. Gaps in AT policy

Fragmented provision

AT can support healthcare, education, employment, independent living and participation, yet provision is often organised separately within these sectors. As shown in previous chapters, a person's entitlement can change depending on the administrative pathway or setting through which the technology is needed.

WHO recommends organising AT provision around the person and their environment rather than the disease, impairment or source of financing.

There are currently no shared EU principles on issues such as continuity across sectors, timely access, user choice, trialling, maintenance and support, or the inclusion of mainstream and digital technologies.

A partially integrated AT market

EU legislation can determine whether products may circulate within the internal market, but legal availability does not guarantee effective access.

A product legally available in several Member States may remain inaccessible to users elsewhere because it is not reimbursed, falls outside an approved category, is unavailable through contracted suppliers or exceeds the national funding ceiling.

The result is a partially integrated AT market: products can cross borders more easily than the funding and provision arrangements required for users to obtain them.

The Commission's enhanced Strategy for the Rights of Persons with Disabilities up to 2030 explicitly identifies accessible and affordable AT and AI, including the removal of market barriers for developers and users, as an area for EU action. This provides a clear basis for addressing such downstream barriers.

Lack of transparency

Both users and providers face difficulties understanding national AT systems.

Users may know that a product exists but not whether it is reimbursed, which authority is responsible, what amount is covered or whether it may be purchased from another Member State.

Providers may similarly struggle to identify national reimbursement, product-list and procurement procedures.

The main information gap is therefore not simply information about products. It is comparable information about how AT becomes accessible in each Member State.

EU coordination could improve transparency by making information available on responsible authorities, funding pathways, eligibility, reimbursement, assessment, procurement and appeal procedures. It could also support funding bodies by making information on product prices, service costs and the effective total cost of AT more transparent across Member States.

Lack of comparable data

Reliable comparative European data on AT are limited, and there are substantial gaps in evidence on AT need, access and coverage, as well as significant differences in how AT is defined, reflected in policy and addressed through funding programmes.⁶⁰

There is also little systematic information about whether the AT provided actually meets users' needs. Research on AT outcomes emphasises that counting products supplied does not show whether they improve participation or independence.⁶¹ At the same time, there are estimates of high abandonment rates of supplied AT.⁶²

EU monitoring could therefore focus on a small number of meaningful indicators, such as unmet AT need, waiting times, out-of-pocket expenditure, access to trials and repair, and user-reported outcomes.

⁶⁰ WHO, 2021; Smith-Huff-Layton, 2023

⁶¹ Bell D, Layton N, Smith RO, Scherer MJ, Smith EM. (2024). Developing a Holistic Process to Measure Assistive Technology Outcomes. Assistive Technology Outcomes. In: Assistive Technology Outcomes & Benefits (ATOB), 2024, v. 18, p. 1-19, https://www.atia.org/wp-content/uploads/2024/04/ATOB_V18_FINAL-1.pdf

⁶² Federici S, Meloni F, Borsci S. (2016). The abandonment of assistive technology in Italy: a survey of National Health Service users. Eur J Phys Rehabil Med. 2016 Aug;52(4):516-26. Epub 2016 Jan 19. PMID: 26784731.

Digital and mainstream AT do not fit traditional systems well

Many funding systems were designed around durable physical equipment. Digital AT increasingly involves software, subscriptions, mainstream hardware, cloud services and AI.

Digital AT is poorly reflected in many national policies, which can result in funding gaps for subscriptions, mainstream technologies and newer digital solutions.

Provision systems therefore need to become more technology-neutral. The relevant question should be whether a technology is necessary to meet an assessed functional need, rather than whether it has traditionally been classified as AT.

Cross-border portability

A person moving to another Member State may need to repeat assessments or establish new arrangements for maintenance, consumables, software or replacement equipment. For digital AT, software licences, subscriptions and dependence on particular platforms or cloud services can create additional continuity and portability challenges. Where an assistive solution relies on personalised settings or user data, moving between providers or systems may also require those data and configurations to be transferable.

The current evidence is not sufficient to determine the scale of the problem, but the issue is relevant to free movement.

A realistic first step could be better portability of assessment and technical information – similar to Ireland's AT passport –, together with examination of cross-border repair, maintenance and continuity of associated digital services, while Member States remain responsible for their own eligibility and funding decisions.

6.2. Where EU action could add value

The evidence supports targeted EU action rather than a single harmonised European AT provision system.

Common principles for AT provision

The EU could develop common principles based on the UN CRPD and WHO's person-centred approach. These could include:

- provision based on functional need and participation goals;
- information on available AT and on AT provision in accessible formats;
- timely access and meaningful user choice;

- continuity across sectors and life stages;
- continuity of access to essential functions, interoperability and compatibility with other technologies and environments on which the user depends⁶³;
- access to trials where appropriate;
- necessary training, maintenance and support;
- consideration of digital, software-dependent, mainstream and open-source solutions; and
- involvement of persons with disabilities and their organisations.

These principles would define what effective provision should achieve without prescribing national benefit levels.

Transparency and reduced duplication

The EU could support comparable information on national AT access systems, product and service prices and effective costs.

In order to avoid providers having to submit equivalent information or repeat assessments in several Member States, EU legislation could establish common information requirements and mutual recognition. This would reduce administrative costs without harmonising reimbursement decisions.

Better procurement

Procurement can reduce prices through purchasing power, but poorly designed contracts can restrict user choice and exclude smaller or innovative suppliers.

EU-level AT procurement guidance could encourage greater use of functional performance, user outcomes, total cost of use, interoperability and backward compatibility, repair, maintenance and support rather than purchase price alone.

Pooling demand may also be useful for certain standard or low-volume products, particularly in smaller markets, while highly personalised AT requires greater flexibility.

⁶³ EASPD, 2021: Technology in Social Care and Support Services - A policy paper from the Person-centred Technology Membership Forum of EASPD, https://easpd.eu/fileadmin/user_upload/Publications/easpd-privacy_003.pdf

Cross-border and niche markets

The EU should examine whether users can effectively obtain eligible AT from suppliers in another Member State, particularly where suitable products are unavailable domestically.

European-scale measures may also be especially useful for niche AT markets, including support for multi-country evidence generation, innovation, localisation support and shared market information.

This is particularly relevant where individual national markets are too small to sustain competition or investment.

6.3. Limits to harmonisation

EU action should not seek uniformity for its own sake.

The evidence does not support harmonising:

- national AT benefit levels;
- overall public expenditure;
- national health or social protection structures; or
- a single mandatory European reimbursement list.

A European minimum product list could become a ceiling for countries that currently provide broader support. This concern is already reflected in the agreed structure of this paper.

EU coordination should therefore follow a non-regression principle: measures should improve access and remove unnecessary barriers without limiting Member States that offer broader support.

EU intervention is strongest where a problem has a clear European dimension – for example where it affects cross-border access, fragments the internal market, suppresses competition or innovation, disadvantages smaller markets or undermines free movement.

6.4. The opportunity for EU policy

The disability movement and the main EU institutions have already placed accessible and affordable AT and the removal of related market barriers on the EU policy agenda.

The opportunity for EU policy is therefore to help translate this commitment into a concrete policy direction based on three connected objectives:

Improve effective access for users.

People should be able to obtain appropriate AT within a reasonable time and at an affordable cost, together with the support needed to use it effectively.

Improve the functioning of the European AT market.

Providers should face fewer unnecessary barriers to offering appropriate products across Member States, particularly in small, niche and innovative markets.

Support free movement and cross-border portability.

People should be able to move, work, study or live across Member States without unnecessary disruption to the AT they rely on, including continuity of relevant assessment and technical information, maintenance, support and other arrangements needed for continued use.

The policy direction can be summarised in five principles:

- 1. Person before programme:** Provision should follow functional need rather than administrative silos.
- 2. Function before product label:** Specialised, mainstream and digital technologies should be considered according to the assistive function they provide.
- 3. Outcomes before volume:** Success should be measured by whether AT improves participation and independence.
- 4. European scale where it adds value:** Cross-border cooperation and common procedural requirements should reduce unnecessary fragmentation.
- 5. Promote coordination to reduce barriers without harmonising benefit levels:** While EU action would reduce unnecessary fragmentation, Member State's responsibility for benefit levels and their ability to provide broader support should be preserved.

7. Recommendations

7.1. EU-level recommendations

- **Adopt an EU AT Single Market Action Plan.** Based on the outcomes of the Commission's "Assistive technologies and AI: from lab to market" initiative, in consultation with representative disability organisations and the AT sector, to address barriers faced both by providers seeking to enter national markets and by users seeking effective access across borders. The Action Plan should

apply technology-neutral principles across EU AT policy and funding, procurement guidance and market-support measures, ensuring that digital, software-based, open-source, AI-enabled or mainstream solutions are not disadvantaged in favour of traditional specialised AT.

- **Develop a European Commission Recommendation on person-centred AT provision.** Establish common principles covering the key elements of effective AT provision across Member States, while respecting national competence for the organisation and financing of support.
- **Harmonise information requirements for national market access.** Adopt EU legislation establishing common requirements for technical, functional, outcome and service information that providers must submit to enter national reimbursement, approved-product or procurement systems, while leaving substantive reimbursement and procurement decisions to Member States.
- **Introduce mutual recognition where equivalent assessments already exist.** Adopt EU legislation to ensure that Member States avoid repeating equivalent product, technical or user assessments carried out in another Member State where this adds no additional protection.
- **Improve cross-border access, free movement and portability.** Clarify and remove unjustified barriers to users purchasing eligible AT cross-border and to providers serving them. Examine portability of assessments, repair and maintenance, and – for digital AT – licences, subscriptions, personalised settings, data and cloud services.
- **Develop EU guidance for AT-sensitive procurement.** Procurement should consider functional performance, user outcomes, total cost of use, interoperability, open standards, backward compatibility and support, rather than lowest purchase price alone. It should also enable participation by SMEs and innovative suppliers.
- **Use European-scale market shaping for niche AT.** Support coordinated or pooled procurement, multi-country evidence generation and demand aggregation where small national markets cannot sustain adequate product choice or supplier competition –

including measures that help SMEs and start-ups scale across Europe.

- **Create a European transparency framework for AT provision.** Provide comparable information on national authorities, reimbursement pathways, eligibility, product-list procedures, procurement, cross-border access and, where feasible, product and service prices and effective costs. Existing resources such as EASTIN should be used rather than duplicated.
- **Support localisation and innovation for smaller markets.** Use EU research and innovation funding to support language localisation, low-volume products and technologies serving small user populations where national markets alone are insufficient.
- **Establish a small set of EU indicators on AT access, market performance, AT outcomes and social impact,** including unmet need, waiting time, out-of-pocket costs, supplier availability, cross-border access, continuity of support and user outcomes, validated and agreed by users and other relevant stakeholders. Indicators should measure participation and effectiveness, not only the number of products supplied.
- **Strengthen AT workforce capacity across Europe.** Develop a common competency framework for AT practitioners and explore mechanisms for recognising relevant AT expertise and competencies across Member States. EU cooperation should also support exchange of training resources, good practice and specialist knowledge, particularly in areas where expertise is scarce.

7.2. Member State recommendations

- **Base AT provision on functional need,** rather than unnecessarily restrictive age, diagnosis, employment-status or product-category rules.
- **Make AT policy technology-neutral and solution-focused.** Ensure that digital AT, software, open-source solutions, subscriptions, AI-enabled solutions and mainstream technologies used for an assessed disability-related need can be considered alongside traditional specialised AT.

- **Ensure continuity across health, education, employment and independent-living systems**, so that AT follows the person rather than the administrative programme.
- **Provide meaningful user choice**, including access to alternatives where the standard reimbursed or procured product does not meet assessed needs.
- **Fund the complete AT solution over its useful life**, including necessary assessment, fitting, software, subscriptions, training, technical support, maintenance, repair, replacement and renewal.
- **Involve persons with disabilities and their representative organisations** in AT policy and service design, procurement, reimbursement review and monitoring.
- **Ensure user involvement in individual AT assessment and selection.**
- **Establish a single point of access to AT provision**, so that users are not required to identify which authority, funding scheme or service is responsible for meeting their AT needs. A clear entry point, that can direct requests to the appropriate services, enable users to follow their progress and, where appropriate, provide a named professional or service responsible for coordinating the AT pathway across sectors.
- **Strengthen access to specialist AT advice, loan, trial and reuse schemes.** Support AT centres offering independent specialist advice to users, as well as loan schemes that allow users to trial products before permanent provision and provide rapid temporary access where needed. Such schemes may also support the collection, refurbishment, reuse and redistribution of AT, improving efficiency and environmental sustainability.
- **Ensure accessible and timely appeal mechanisms**, so that users are able to challenge decisions concerning AT eligibility, assessment, product selection, funding or reimbursement through procedures that are accessible, transparent and completed within a reasonable timeframe.
- **Measure the outcomes and social impact of AT provision**, using the data to assess whether AT meets users' needs and improves participation, independence and quality of life, and using the findings to improve provision and funding decisions.

- **Invest in AT workforce capacity and training**, in order to ensure an adequate supply of professionals with the knowledge and competencies needed to assess, recommend, configure and support AT – including through dedicated education, continuing professional development and specialist training opportunities.

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Editor: Alejandro Moledo, EDF Deputy Director & Head of Policy.

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The European Disability Forum
Mundo Madou
Avenue des Arts 7-8
1210 Brussels, Belgium.

www.edf-feph.org

info@edf-feph.org