Title: National Evaluation of Policies Governing Funding for Wheelchairs and Scooters in Canada

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Abstract

Background. Wheelchairs, scooters, and related equipment are essential for the well-being of individuals with limited mobility and impact participation, health, and quality of life. **Purpose.** Our objective was to identify and evaluate policies governing equipment funding for Canadian adults. We reviewed funding legislation and program documentation for adult Canadians (≥18 years of age) covered by their provincial, territorial, or federal health care plan. Documents were obtained online or through administrative staff. Policy evaluation was guided by the Disability Policy Lens from the Canadian Disability Policy Alliance. **Key Issues.** Coverage ranges from full funding for all individuals within the jurisdiction to programs limited by strict eligibility criteria. Each jurisdiction defines 'disability' or 'basic/essential need' differently, contributing to further funding disparities. **Implications.** Funding policies differ substantially across Canada, resulting in unequal access to equipment dependent on province or territory. We identified eligibility, funding, definitions of mobility, repair and replacement, and prescriber requirement benchmarks that represent policy targets for improved access.

Key Words

wheeled mobility; disability; *health policy; *disability; funding

Introduction

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) outlines eight general principles to promote full inclusion of individuals with

disabilities through participation in society “on an equal basis with others” (United Nations, 2006). These principles recognize the importance of individual autonomy and independence, non-discrimination, participation and inclusion, equality of opportunity, and accessibility (United Nations, 2006). Signatories, of which Canada is one, are called upon to take any measures, including relevant legislation, to bring these principles into force and to “promote availability and use of new technologies including… mobility aids, devices, and assistive technologies…” (United Nations, 2006). Article 20 speaks specifically to the right to personal mobility and independence by facilitating access to mobility devices at an affordable cost (United Nations, 2006).

Wheeled mobility equipment is critical to the well-being of individuals with limited mobility and enhances participation, health, and quality of life. These devices, including manual wheelchairs, powered wheelchairs, and scooters, and related equipment, including cushions, backrests, and customized positioning products, provide access social participation that would not otherwise be possible and may have implications for overall health (Brandt, Iwarsson & Ståhle, 2004; Lofqvist, Pettersson, Iwarsson, & Brandt, 2012; Salminen, Brandt, Samuelsson, Töytäri, & Malmivaara, 2009). The timely provision of wheelchairs, scooters, and related equipment (wheeled mobility equipment) that meets the needs of individuals with mobility limitations may also provide opportunities for risk reduction through fall prevention and appropriate postural support. Unfortunately, access to this basic right is often constrained by a number of factors related to funding challenges, including difficulty accessing necessary equipment, both in Canada and globally. Funding is a critical step in the wheelchair service delivery process and is

identified by the World Health Organization as a critical barrier for access to wheeled mobility equipment (2012).

In order to address the conditions of the UNCRPD and ensure these basic rights are met, it is incumbent on state entities to provide funding to cover these costs (World Health Organization, 2012). In Canada, there are approximately 288,800 community-dwelling individuals that currently use a wheelchair or scooter (Smith, Giesbrecht, Mortenson, & Miller, 2016). This estimate does not include any individuals that may be living in group arrangements, including residential care facilities, where it estimated that as many as one in two residents require support from a mobility aid (Shields, 2004). In addition, recent estimates suggest that as many as one in six community-dwelling Canadians that have mobility limitations do not have access to the device they require (Giesbrecht, Miller, & Smith, 2014). The mean cost of a wheelchair or scooter ranges from several hundred (US) dollars for a basic manual wheelchair to several thousand (US) dollars for a powered wheelchair (Hubbard et al., 2007). For those with the highest physical needs, this cost can reach higher than $25,000 (USD) for a powered wheelchair with all necessary accessories (Hubbard et al., 2007). Considering the median individual income in Canada was just over 32,000 (CAD) in 2013 (Statistics Canada, 2015), these costs are often impossible for an individual to manage without assistance from government funding.

The importance of context in the evaluation of funding in any particular jurisdiction cannot be underestimated. For example, in the UK, funding differences between jurisdictions resulted in a disparity in access to these important devices (White & Lemmer, 1998). Canada is a federation that governs according to federal and provincial

legislation in a total of fourteen jurisdictions: federal, 10 provinces, and 3 territories. To date, Canada has not adopted any specific legislation pertaining to persons with disabilities, although there has been recent movement towards the development of federal accessibility legislation which may help to further inform these discussions. While there are certain rights protected under the Canadian Charter of Rights and Freedoms, the inclusion of individuals with disabilities is addressed only in the context of equal protection of the law. It does not specify the inclusion of individuals with disabilities within their communities or the mechanisms to achieve full inclusion and participation.

For health related matters, Canada operates a national health insurance program governed by the Canada Health Act (CHA) (1985). The objective of the CHA is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (1985, c.6, s3). As specific funding for health care falls under provincial jurisdiction according to the Constitution Act of 1867, this is facilitated by a series of health transfer payments from the federal government to the provinces and territories for allocation according to the principles of public administration, comprehensiveness, universality, portability, and accessibility (Canada Health Act, 1985). The principle of comprehensiveness ensures that costs for medically necessary services (those provided by hospitals and medical practitioners) are covered, but it leaves the services of associated health care providers and other costs up to the provincial governments to determine (Canada Health Act, 1985). As a result, the provision of health services varies widely across jurisdictions, and there is no requirement in the federal legislation to provide

funding for community-based services or to cover the cost of assistive devices, including wheeled mobility equipment.

There has been minimal attention in the scientific literature to the funding for wheeled mobility equipment despite the potential of funding issues to impact every step of the service delivery process (Eggers et al., 2009). A survey conducted in Australia of powered wheelchair and scooter users found that the purchase of over two thirds of devices are self-funded, with approximately 15% funded through government-based programs in combination with fees from users (Edwards & McCluskey, 2010), while the remaining are funded by government or private health insurance plans. A similar review of provision of wheeled mobility equipment by the National Health Service (UK) found that the lack of funding for outdoor powered wheelchairs challenges users who required a powered device for daily mobility and further limited users to the purchase of indoor devices only (White & Lemmer, 1998). This report also identified resource management issues, including equality of access for all persons, as a critical factor which contributes to effective service provision.

Rehabilitation practitioners (occupational or physical therapist) that are working with individuals on addressing their mobility needs typically initiate the process of obtaining funding. The rehabilitation practitioner may be engaged in seeking available funding sources, justifying the individual's need to obtain funding, and advocating for appropriate equipment if funding is denied. Obtaining funding is often the largest barrier to addressing the individual's mobility needs and, at times, may even inform if the practitioner even engages in an assessment process with the individual. Furthermore, obtaining funding is a time consuming procedure, and individuals may wait for months or

even years prior to obtaining necessary equipment. Mortenson and Miller identified funding as a factor that impacts the choice in wheeled mobility equipment; consideration of available funding has the potential to limit individuals' choices with respect to the equipment which best suited their needs (2008). As a result, the rehabilitation practitioner is placed in an undesirable 'gatekeeper' position, by limiting the choices available to those that fit the funding model, rather than recommending the best mobility device to suit the individual's needs (Mortenson & Miller, 2008).

The *Disability Policy Lens was* developed by the Canadian Disability Policy Alliance (http://www.disabilitypolicyalliance.ca/researc/disability-policy-lens/) to provide a structure to evaluate the policies affecting people with disabilities. The Lens consists of nine questions that characterize the approach to disability policy (Figure 1). These questions do not necessarily evaluate the effectiveness of policy but, rather, probe key issues about how policy is framed. They represent decisions that were made by policy makers, whether intentionally or not, about who disabled people are, what they need, and what their relationship is to the broader society. Research is needed that applies the Disability Lens to explore those policies that support mobility choices for individuals with limitations in personal mobility. This information will highlight the differences in approach by jurisdiction, their potential impact on individuals with disabilities, and contribute to the development of policy that will promote equitable participation for all individuals (Mortenson, Hammell, Luts, Soles, & Miller, 2015).

[Insert Figure 1 Here]

The objective of this review was to identify and evaluate the framing of key issues in the federal and provincial policies governing wheeled mobility equipment funding for

adults in Canada. In particular, we aimed to determine how provincial policies differ from one another with respect to eligibility, provision guidelines, coverage limitations, and other relevant criteria guided by the Disability Policy Lens.

Approach

We undertook a review of the legislation and program documentation pertaining to funding of wheelchairs, scooters, and associated products (wheeled mobility equipment) for adult Canadians (aged 18 or older) covered by their provincial health care plans. Wheeled mobility equipment encompassed manual and powered wheelchairs, scooters, and additional related equipment including cushions, backrests, and other components or positioning devices which are required for use of the wheelchair or scooter. Within each province, we identified the relevant legislative or ministerial body responsible for funding for access to wheeled mobility equipment. We included programs in the review, which provided wheeled mobility equipment to members of the public covered by their provincial health plan or a relevant federal body (e.g., First Nations). We excluded programs, which were specific to individuals injured at work (i.e. Workers Compensation), individuals injured in vehicular accidents, and private or employer paid health care plans (e.g., Veterans, Blue Cross) as these are not available to all citizens through their public health coverage. We were interested primarily in coverage which is provided by the governments for all individuals in a given health region to align with the stipulations put forth in the UNCRPD and impacted by the Canada Health Act.

In this evaluation, we have focused exclusively on the 'program of last resort' offered by the federal or provincial government that provides coverage for mobility devices when no supplementary or auxiliary coverage is available. With regard to

relationships with other policies potentially affecting the individual, there will most certainly be relationships with other policies within the jurisdiction, such as workers compensation, auto insurance, employment, and labour policy. There will also be overlap with private sector insurance and the corporate policies governing that coverage. It is beyond the scope of this review to provide details about these intersections; however, we caution the interested reader to note that they will undoubtedly exist.

The Disability Policy Lens frames our evaluation. Specifically, there are three sets of questions that help us to look more closely at how policies governing support for mobility devices differ between jurisdictions: Who is included/excluded from consideration, and which individuals decide who qualifies as disabled? (Question 2 - Eligibility); Who wins and who loses when the policy is implemented, and how is the allocation of scarce resources affected by this policy? (Question 8 - Stakeholders); and How did this policy come into effect? (Question 9 - History). We do not explore history in any detail here; but if the intention was to seek change in a particular policy or a particular jurisdiction, it would be most advantageous to understand how the policy came to be, and what forces within the jurisdiction shaped it.

The stakeholders for policy governing support for mobility devices (Question 8) are typically consumers (i.e., people with disabilities themselves), vendors (i.e., public and private sector agents who distribute and service mobility devices), and authorizers (i.e., designated professionals with the authority to prescribe equipment specifications). As one might imagine, their interests are not always in accordance with one another, and structures within the policy may give preferential consideration to the interests of one over another.

Finally, perhaps the most contentious issue in any disability policy is eligibility (Question 2). What kind of disability renders one eligible to receive benefits, and who makes the designation as to eligibility? This was the primary focus of the evaluation across jurisdictions. For each specific program identified, we collected data relating to recipient eligibility criteria, prescriber requirements, devices funded and specific funding limits, repairs and maintenance, replacement time, and other information which had a notable impact on the coverage provided (e.g., exclusions, definitions). Following data collection, each set of program guidelines was reviewed by a practitioner experienced in the provision of wheeled mobility equipment in the relevant province, as a form of data verification for accuracy and completeness. We then compared details of each of the provincial programs, specifically considering the impact on a variety of stakeholders, including older adults and non-insured persons. Finally, we identified a set of benchmark practices that may be used to guide effective and equitable service provision in the future.

Findings

Funding for wheeled mobility equipment varies widely across Canada, ranging from coverage which is limited to specific groups (British Columbia, Nova Scotia, New Brunswick, and Newfoundland and Labrador), to cost-shared or means-tested programs (Alberta and Ontario), to fully covered loan or purchase programs for any individual with coverage under his or her provincial health coverage (Territories, Saskatchewan, Manitoba, Quebec). Table 1 outlines the programs and any relevant legislation that was reviewed. Further information regarding relevant provincial Legislation and Regulation (including those outside the scope of this review) is published by the Canadian Disability Policy Alliance (McColl, Roberts, Smith, & Miller, 2015).

Table 2 provides province-by-province information regarding recipient eligibility criteria and identifies a colour coded "stoplight" ranking system based on the type of coverage provided. Provinces ranked "Green" offer access to wheeled mobility equipment to any individual that has provincial health coverage and a need for a wheelchair or scooter, without cost-share or income testing. Provinces ranked "Amber", similarly, offer access to all that hold provincial health coverage but have an income test or cost-share associated with provision. Provinces ranked "Red" have funding programs limited to those that qualify for a specific program (e.g. income support) or specific diagnostic groups.

Table 3 provides province-by-province policy in each of the following key areas: devices funded and specific limits, repairs and maintenance, replacement time, and prescriber requirements.

[Insert Table 1 Here]

Table 1 shows that approximately half of the 'programs of last resort' which fund wheelchairs and scooters are governed by legislation in their respective jurisdictions. Nova Scotia, New Brunswick, Manitoba, Nunavut, and the Northwest Territories have no explicit legislation guaranteeing funding for wheeled mobility equipment. In the Yukon Territory, legislation covers one of two funding programs; however, the other is not covered.

[Insert Table 2 Here]

Table 2 shows that all provinces and territories provide some level of basic coverage for manual wheelchairs. However, this is often dependent on program criteria, which may include associated age limits (seen in Table 1). In general, the type of manual

wheelchair (standard, lightweight, ultralight) is dependent on the assessed need for the individual and the frequency and duration of use. Funding for powered wheelchairs is typically provided to individuals who cannot propel manual wheelchairs and often requires the individual to be capable of safely and independently operating the device as well as an accessible residence. Scooters are not provided in the majority of provinces and territories.

[Insert Table 3 Here]

Each province also differs in its definition of what is considered basic or essential use for mobility devices. At the most basic, devices are considered essential for mobility if they are used primarily within the home or to access the home (Ontario Assistive Devices Program (ADP)), while most other provinces and territories acknowledge use within the community as essential for individual mobility and will provide devices for community access regardless of specific use within the home.

Eligibility to prescribe devices also varies across the country; however, all programs require prescription by a regulated health professional as outlined in Table 3.

Critical Discussion and Implications for Practice

This study set out to discover details of policy governing funding for wheelchairs, scooters, and related equipment in 14 jurisdictions across Canada (10 provinces, 3 territories, and the federal government). We found that:

- Canadians do not have equal access to funding for wheelchairs, scooters, and related equipment across jurisdictions. Within jurisdictions, funding often varies for members of different groups (e.g., older adults, residential care, individuals with chronic conditions).

- Coverage ranges from full funding for necessary equipment for any individual who is eligible for health insurance coverage to funding which is limited to those who meet eligibility criteria of a specific program (e.g., income or disability support programs).
- The requirement for an income test or cost-sharing arrangement is inconsistently applied across the country. Approximately half of the jurisdictions do not require any financial contribution on behalf of the wheelchair user.
- The definitions of 'disability' and 'basic/essential need' vary substantially between jurisdictions. While some jurisdictions consider access to the home and community to be essential for access to mobility device funding, others will fund devices only if they are used to access the home environment.

It was interesting to note the variability in legislation supporting programs across the country. Although legislation is available in many jurisdictions, a few provinces, and all territories, do not enjoy the same protection. Similar to other countries, including Australia, Canadian jurisdictions differ with respect to eligibility and specific implementation of the programs, including variation by state and territory for eligibility, preferred items, cost ceilings, payment systems, and prescriber requirements (Barbara & Curtin, 2008). Each of these differences has the potential to impact individuals with disabilities in differing ways. One instance where this impact is clear is the global eligibility criteria. In the majority of Canadian jurisdictions, individuals are eligible for coverage for wheeled mobility equipment at any age and regardless of their employment

status; however, there are notable exceptions. In British Columbia, for example, individuals are only eligible as long as they have coverage through the employment and income assistance program. This places individuals who are employed, students, or those over the age of 65 at a disadvantage, as they are not eligible for this program. In Prince Edward Island, there is a similar disadvantage for individuals over the age 65. It has been suggested that policies which limit access to wheeled mobility equipment by age amounts to ageism in prescription, which actually curbs, rather than facilitates, use and participation (Mortenson, Clarke, & Best, 2013). This is of particular concern given that the need for wheelchairs increases with age. In fact, recent data from the Canadian Survey on Disability confirms the use of wheelchairs by proportion of the community-dwelling population increases in older age, reaching just over 4% of this population after age 75 (Smith, Miller, & Giesbrecht, 2015). Clinicians working with older adults or those who are turning 65 may, therefore, need to consider the impact the loss of funding may have on their clients' abilities to obtain the necessary equipment, in addition to the time required to obtain said funding prior to one's 65th birthday.

Across Canada, jurisdictions differ in terms of requirements for financial hardship or income tests or a cost-sharing arrangement. In their study of occupational therapy and equipment funding schemes, Barbara and Curtin urge providers and policy makers to challenge the concept that financial hardship makes a person more eligible for mobility device support than someone with an income (2008). There are a number of jurisdictions (e.g., Prince Edward Island, Newfoundland and Labrador) where funding is only provided to individuals with no other means of support; these programs are often overly restrictive and fail to consider the impact of disability-associated costs, including the

costs of high-tech mobility devices such as powered wheelchairs. For example, a $20,000 powered wheelchair may be cost prohibitive for an individual with a personal income of $40,000 annually, despite being well above the income threshold for eligibility for many social services programs. This is particularly true when other disability-related costs are considered. As a result, individuals with high disability related costs, including those associated with accessible housing and other medical needs, may not have access to critical funding to access wheeled mobility equipment to promote mobility, health, and well-being. In other areas, there is a cost-sharing system in place which has addressed some of these issues. Alberta's Alberta Aids to Daily Living (AADL) program provides 75% funding for any individual (not income-based), with the wheelchair user covering 25%, up to a maximum of $500 per family. One hundred per cent coverage is provided for individuals who are eligible for an income-tested cost-share exemption. The ADP program in Ontario is similar; however, 100% coverage is only available to those eligible for the Ontario Disability Support Program (ODSP). While this scheme works for many, there are still challenges for those who may not meet the strict criteria for the AADL exemption (income greater than $21,000 for an individual) or the ODSP program (e.g., older adults, post-secondary students), and are required to pay 25% of the cost of their device.

Clinicians engaging in client-centred practice often consider the costs their clients are able to bear and the funding available to them, as well as the capacity of the necessary equipment and how these devices may work within their clients lives. Scooters are often a less expensive alternative to powered wheelchairs but frequently are not covered by provincial or territorial health plans. While scooters are more challenging with respect to

accessibility in the home, they may come with lower stigma and enhanced community access. Clinicians may find this contributes to societal concerns with respect to safety. Since scooters are often not covered, this could result in higher numbers of individuals who acquire these devices without assessment by a regulated health professional. In Ontario, where scooters are provided through the ADP program, an assessment is required by an ADP prescriber, which increases the likelihood that issues of safety and cognition are assessed prior to obtaining a device. This has been identified as a concern in Australia, where powered wheelchair users are far less likely to have purchased their own device than scooter users (Edwards & McCluskey, 2010). In fact, two thirds of scooter users did not consult a health professional when purchasing their devices, which may lead to higher accident and injury rates (Edwards & McCluskey, 2010). Legislation and funding programs which encourage assessment through coverage of devices may help to alleviate some of these concerns within the community. Additional funding programs and access to regulated health professionals would also help alleviate the burden on clinicians already working in this area and promote enhanced client-centred care.

Question 2 of the Disability Policy Lens speaks to the definition of disability, weighing who is included and excluded from consideration, and which individuals are responsible for making the decision as to who qualifies as disabled. There is a wide variety in the definition of disability, ranging from a condition which persists a minimum of three months, to other definitions which require longer-term use of the device at a minimum of one to two years. Typically, individuals who require devices for shorter-term use have access to community programs through organizations such as the Red Cross, which operates the Health Equipment Loan Program (HELP) in most provinces and

territories or the Community Care Access Centre loan programs in Ontario. All of the definitions largely fall within a biomedical model of disability and none address the environmental issues that may necessitate the use of a mobility device. In fact, a number of provinces have provisions that limit access to a device if the environment is not suitable, without providing an alternative funding source to alter the environment. Organizations like the Canada Mortgage and Housing Corporation can provide limited funds for renovations, and there are a variety of non-profit entities which provide charitable funds towards this aim. However, these are typically reserved for individuals who own their homes, further limiting the potential of these programs to have impact. As a result, those who rent their homes are not eligible for this funding and, therefore, are required to obtain accessible housing, which is often at a premium, or advocate for changes to current housing prior to obtaining a wheeled mobility equipment. This advocacy role often falls to practitioners, including occupational therapists, which places additional strain on limited health care funding. While advocacy is often considered part of client-centred practice, the requirement to engage in lengthy periods of advocacy on behalf of clients may take away time that could be allocated to other client-centred activities that promote independence and occupational engagement in the community.

There is also substantial variation in which individuals are eligible to prescribe wheeled mobility equipment. In many areas, a physician or nurse practitioner must be the final authority on provision of this equipment. This is contrasted with jurisdictions where occupational therapists and physical therapists are called upon to use discipline- specific expertise to assess and recommend appropriate equipment. The inclusion of rehabilitation professionals in the assessment and prescription process is ideal, because it allows for a

thorough client-centred assessment of all the relevant functional concerns, ranging from the physical capacity to operate the device, to the cognitive and perceptual needs of the user (Greer, Brasure, & Wilt, 2012; Mortenson et al., 2005). In addition, rehabilitation clinicians are well placed to assess the environment where the device will be used and the potential social and participation implications (Greer et al., 2012; Karmarkar et al., 2012). However, there have been concerns raised about the use of these clinicians as gatekeepers for funding programs, which may result in therapists being perceived as barriers to obtaining devices and compromising the therapeutic relationship (Barbara & Curtin, 2008; Mortenson et al., 2015). There may also be a fundamental incompatibility between established standards of client-centred practices, which require therapists to provide the most appropriate service for the client, and prescribing guidelines, which a funding agency may require the professional to follow (Barbara & Curtin 2008). Furthermore, the disparity in access to devices across the country means that therapists working in different jurisdictions are not able to adhere to the same standards of practice for wheelchair provision, and does not support the development or application of national standards of care. Ultimately, ensuring devices are provided through collaboration between the client and appropriate health professional will benefit the client, who will receive the device that best meets his or her needs, and the population at large, through improved safety and accountability.

Finally, we would like to address the issue of residence. Although most provinces and territories provide funding for all individuals regardless of place of residence, some jurisdictions do not provide funding for wheeled mobility equipment for individuals living in residential or long-term care. There is evidence to suggest that approximately

50% of all individuals living in long-term care require a mobility support device for daily mobility (Shields, 2004). As a result, these funding policies impact a significant number of individuals in these environments. Many of these jurisdictions have provided direction to those ministries responsible for long-term care to provide these devices within the confines of the long-term care environment. Unfortunately, this may not come with additional funding, and many individuals do not have devices appropriate for their needs. Clinicians working in residential care (where clients are unable to obtain coverage through provincial programs) may find that they are required to adhere to additional institutional policies, which limit their ability to provide the appropriate device to enable independence. This has the potential to significantly impact the independence, participation, quality of life, and well-being of these individuals.

Limitations

As this paper is primarily a report on legislation and program guidelines, we were unable to address thoroughly the implications of the funding disparities on the key stakeholders, particularly wheelchair and scooter users and clinicians that are responsible for provision of wheeled mobility equipment. Further research could aim to explore the implications of funding policies on these stakeholder groups.

While we made every attempt to complete a comprehensive review of all available provincial and federal sources of funding for wheelchairs and scooters, recent changes in legislation of program offerings in each of the jurisdictions may not be reflected in this review. In addition, we were unable to explore the intersection of funding programs where there may be overlap, as we focused solely on programs of last resort. In some provinces, there may be programs not offered at the health system or ministry level

(e.g. community agencies) that provide access to these devices. Although we attempted to address all programs where funding was allocated to the provision of wheelchairs and scooters from government sources, it is possible we have overlooked small programs, or those which are not formalized at the provincial or federal level. Finally, we were unable to provide comparison to funding available in jurisdictions outside Canada. International comparison of available funding for wheelchairs and scooters may provide additional context that could be relevant to policy makers in Canada and should be considered as a future research direction.

Recommendations

Based on our evaluation of the available funding programs, in the context of the Disability Policy Lens, and with a view towards achieving the articles in the UNCRPD, we are providing a set of benchmark recommendations to guide continued development of wheeled mobility equipment funding policies in Canada. To meet the criteria set forth in the UNCRPD, it is incumbent on federal and provincial lawmakers (particularly those responsible for health and social services) to enact legislation which provides comprehensive access to mobility devices for individuals with disabilities. Policy makers that are developing or amending new or current policy to meet this Convention should consider the following recommendations when establishing policy direction and funding allocation. Clinicians who engage in wheelchair and scooter provision may use these recommendations to advocate to national, local, and regional representatives on behalf of their clients. Furthermore, clinicians may wish to cite current evidence on the benefits of wheelchair and scooter use when advocating for funding for individual clients. Those recommendations are as follows:

1) Eligibility: Wheeled mobility equipment funding should be provided to all individuals who are covered by the provincial or territorial health insurance program, regardless of age, residence, or health condition.
2) Funding: Full coverage should be provided for eligible devices based on assessed need; including, but not limited to, manual wheelchairs (standard, lightweight, and ultra-lightweight), powered wheelchairs, and scooters.
3) Basic or Essential Mobility: Wheeled mobility equipment should be provided to individuals for access to the home and community to promote participation and quality of life.
4) Repair and replacement: Policies for repair and replacement should be based on the expected lifespan of the device, with provisions for individuals who have a significant change in need.
5) Prescriber requirements: Prescription should include collaboration between the client and a registered occupational or physical therapist with expertise in the provision of wheeled mobility equipment. The assessment process should include consideration of the physical, affective, and cognitive needs of the client, and issues specific to the environment of use. Therapists should make recommendations for the best possible device to meet the client needs and be kept at arms-length, or as far as possible, from the funding decision process.

Conclusion

Funding policies differ substantially across Canada for wheelchairs, scooters, and related equipment, resulting in unequal access to this important equipment dependent on the province or territory where the individual lives. This disparity in access may lead to

reduced independence, well-being, and quality of life for individuals with mobility limitations and does not meet the conditions set forth and ratified by Canada in the UNCRPD. Policies should include provision of wheeled mobility equipment by occupational or physical therapists for all individuals covered by the provincial or territorial health insurance program and be provided through a client-centred process which addresses multiple factors including physical needs, cognition, intended use, and the environment.

Key Messages

- We reviewed policies related to funding for wheelchairs, scooters, and related equipment in Canada and provided province-by-province comparisons that may be used by occupational therapists or other clinicians to advocate for changes to funding guidelines.
- Funding for wheelchairs, scooters, and related equipment ranges across jurisdictions in Canada, resulting in unequal access to these critical devices.
- Many Canadians may not have access to appropriate wheelchairs, scooters, and related equipment, which has implications for health and well-being of Canadians with mobility limitations.

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