GUIDANCE REPORT

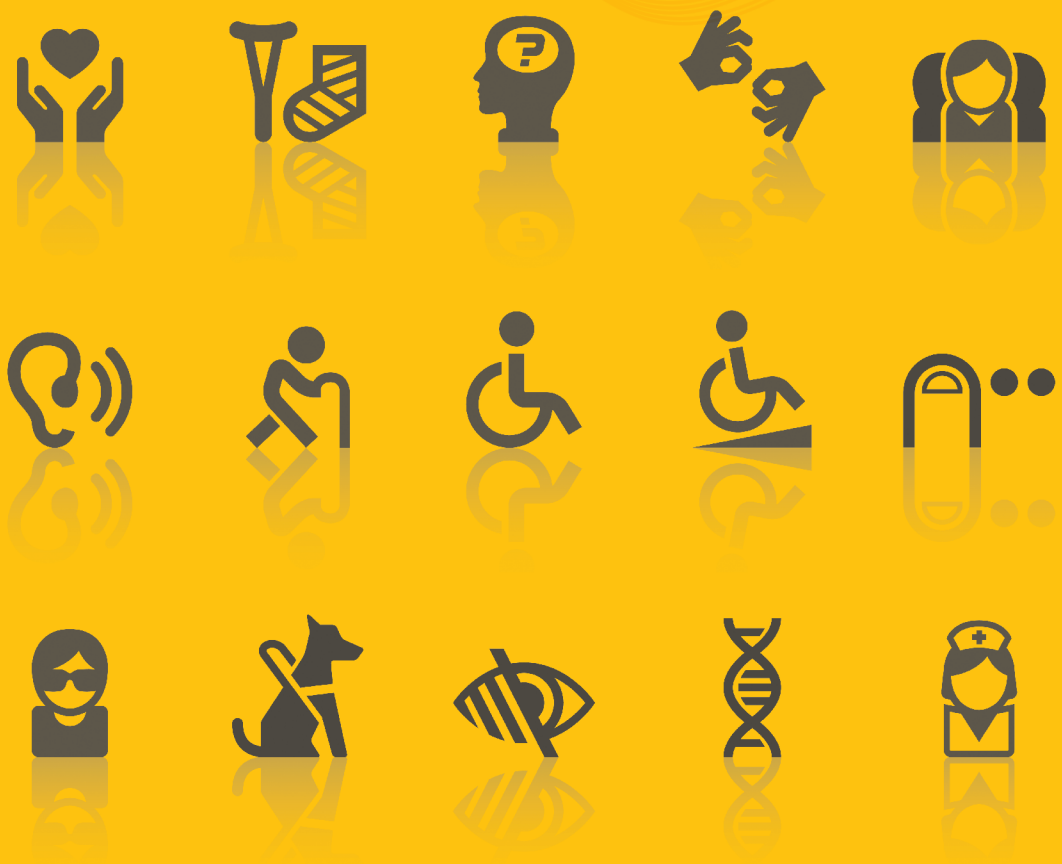
January 2019

Converge3

Integrating health, economic and equity evidence to inform policy

Toward a More Efficient and Equitable Assistive Devices Program

A Converge3 Guidance Report



About this Report

This report was prepared by Converge3. We appreciate the participation of Ontario citizens and other health system stakeholders in a knowledge user dialogue that informed the report. Converge3 receives funding from the Province of Ontario. The views expressed in this report are those of Converge3 and do not necessarily reflect those of the Province of Ontario.

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About Converge3

Converge3 is a policy research centre based in the Institute of Health Policy, Management and Evaluation at the University of Toronto that focuses on integrating health, economic and equity evidence to inform policy. The Centre is funded by the Province of Ontario and includes multiple partner organizations, including Li Ka Shing Knowledge Institute at St. Michael's Hospital, McMaster University, Ottawa Hospital Research Institute, ICES, Health Quality Ontario, Public Health Ontario, and the Ontario Ministry of Health and Long-Term Care.

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Key findings

Assistive devices are integral to the health of many Ontarians who have long-term physical disabilities. These devices — which include wheelchairs, home oxygen, hearing aids, insulin pumps and visual aids — improve quality of life and help many people to live independently. Across Canada and around the world, assistive devices are supplied and managed using a range of different approaches, each with potential health, economic and equity impacts.

To review this evidence and discuss its implications for Ontario, Converge3 identified the following policy research question in consultation with stakeholders with an interest in assistive devices: How can the Assistive Devices Program (ADP) be redesigned to be more efficient and equitable?

Converge3 commissioned two Ontario-based research groups to conduct policy research. *Assistive Devices Program: The Client Journey and Experience* is an assessment of the client experience with assistive devices in Ontario conducted by OpenLab at the University Health Network. *Regulation and Coverage of Assistive Devices in Eight High-Income Countries: Consolidation of Four Reports* and *Assistive Devices Coverage: Ontario Compared to Other High-Income Jurisdictions* are jurisdictional reviews conducted by the North American Observatory on Health Systems and Policies. Converge3 also held a knowledge user dialogue with policy-makers, service providers and ADP clients to give participants an opportunity to contribute to a broader understanding of the evidence and to provide insights based on their context and experiences.

Converge3 identified several policy options that can provide guidance to stakeholders interested in evidence-based approaches to making the ADP more efficient and equitable:

- The ADP is currently a publicly administered program. Maintaining the current administration of the ADP within the Ministry of Health and Long-Term Care as a provincial program potentially strengthens the bargaining power of the ADP should it engage in price negotiations, since it would be a large, centralized purchaser. There was a consensus among stakeholders that shifting administration to private providers or adopting a regional administration model would not make the ADP more equitable or improve the client experience.
- While several jurisdictions have age-related restrictions, stakeholders felt that implementing such restrictions in Ontario would have negative equity implications. Stakeholders had mixed opinions about implementing income-based eligibility. More data-intensive analyses and modeling are needed to determine the effects of income-based eligibility rules.
- Policy options to improve coverage include conducting rigorous technology assessments more consistently, delisting some devices currently covered by the ADP, introducing rigorous price negotiation and implementing a voucher system. Stakeholders also advocated that vendors be required to provide loan programs for devices.

Assistive devices are integral to the health of many Ontarians who have long-term physical disabilities. These devices improve quality of life and help many people to live independently. This Converge3 Guidance Report addresses the following question: How can the Assistive Devices Program be redesigned to be more efficient and equitable?

- ADP policies regarding cost-sharing and the role of the ADP as first or last payer offer the potential for efficiency gains and enhanced coverage but also the possibility of a net loss in equity for people who lose eligibility or incur extra costs.
- The client experience can be enhanced by improving communication, streamlining applications, reducing duplication of application processes for multiple devices and renewals and increasing transparency regarding potential conflicts of interest.

Introduction

Assistive devices are integral to the health of many Ontarians who have long-term physical disabilities. These devices — which include wheelchairs, home oxygen, hearing aids, insulin pumps and visual aids — improve quality of life and help many people to live independently. An examination of the policies surrounding assistive devices has also been identified as a priority in Converge3's conversations with stakeholders.

The provincial government provides support and funding to Ontario residents who require these devices through the Assistive Devices Program (ADP). In 2016-17, Ontario spent more than $450 million on the ADP[1] and costs are expected to rise as the population ages. Meanwhile, clients of the program have expressed concerns about issues such as unclear eligibility criteria, program flexibility and the burden of cost-sharing.

Ontario is one of many jurisdictions dealing with these issues. Across Canada and around the world, assistive devices are supplied and regulated using a range of different approaches, each with potential health, economic and equity impacts. Evidence about the experiences of these jurisdictions — together with insights from those who plan, administer and use the program — can provide valuable guidance to efforts to improve Ontario's program.

To review this evidence and discuss its implications for Ontario, Converge3 identified the following policy research question in consultation with stakeholders with an interest in assistive devices:

How can the Assistive Devices Program (ADP) be redesigned to be more efficient and equitable?

About Converge3 Guidance Reports

Converge3 guidance reports address specific topics by combining policy research with contextual and experiential evidence. The reports are intended to support evidence-informed policy and are developed using a multi-step process:

Determining the policy question
Policy research questions are identified through ongoing consultation with the Ontario Ministry of Health and Long-Term Care, the Ontario Ministry of Children, Community and Social Services and other health system stakeholders including patients and members of the public.

Gathering the evidence
Converge3 commissions policy research from Ontario-based research institutes. This research is published as separate evidence reports and informs the development of our guidance reports.

Engaging stakeholders
Evidence reports and draft guidance reports are used by stakeholders in knowledge user dialogues to gather perspectives and feedback, which are incorporated into the final reports.

Disseminating findings
All reports are shared through the Converge 3 website (converge3.ca) to inform a wide range of stakeholders with an interest in contributing to stronger health policy in Ontario.

In 2016-17, Ontario spent more than $450 million on the ADP and costs are expected to rise as the population ages.

Previous reports

This guidance report builds on several previous analyses of the ADP that were conducted between 2003 and 2017. These reports highlighted concerns of both clients, the Auditor General of Ontario, and external auditors.

For example, clients wanted the ADP to have clear eligibility criteria, funding models that provide clients with flexibility in acquiring devices, and fewer restrictions on what clients can purchase.[2] Auditors suggested that centralized purchasing, price review and data analytics to minimize duplication would enhance the ADP.[3,4] They also called for more strategic approaches to finding devices and managing contracts. For example, they suggested that instead of establishing program-approved prices for vendors, the ADP could negotiate contracts directly with manufacturers and have them compete on prices in order to have their devices listed. Reports also suggested that the ADP explore opportunities to collaborate with other government agencies and departments such as the Workplace Safety and Insurance Board and Veteran Affairs Canada when negotiating with manufacturers.[2]

Gathering the evidence

To inform this guidance report, Converge3 commissioned two Ontario-based research groups to conduct policy research. Their research responded to the information needs of stakeholders and focused on understanding key aspects of existing assistive devices programs: mandates, decision processes, eligibility criteria, the range of devices covered, the extent of coverage, funding mechanisms and client experiences.

In addition to being summarized in this report, those research findings are also published in three evidence reports available on our website (converge3.ca) or by following the links below:

- **Understanding the client experience** *Assistive Devices Program: The Client Journey and Experience* is an assessment of the client experience with assistive devices in Ontario conducted by OpenLab at the University Health Network. The assessment used surveys and in-depth interviews to gather views of clients and caregivers.
- **Comparing Ontario to other jurisdictions** *Regulation and Coverage of Assistive Devices in Eight High-Income Countries: Consolidation of Four Reports* and *Assistive Devices Coverage: Ontario Compared to Other High-Income Jurisdictions* are jurisdictional reviews conducted by the North American Observatory on Health Systems and Policies. The reviews compare Ontario's program and policies to those in Australia, Germany, Italy, Netherlands, New Zealand, Norway, the United Kingdom and other Canadian provinces.

Knowledge user dialogue

In addition to commissioning policy research, Converge3 incorporates the perspectives of stakeholders in order to interpret and apply that evidence. To gather these perspectives, Converge3 held a knowledge user dialogue with policy-makers, service providers and ADP clients. We provided participants with a draft of this guidance report as the basis for a facilitated discussion about the available evidence and potential policy options and implications. This discussion was an opportunity for participants to contribute to a broader understanding of the evidence and to provide insights based on their context and experiences. The dialogue followed the Chatham House Rule to enable a full and open discussion.

What we learned: A summary of the commissioned policy research

How are assistive devices programs administered?

In Ontario, the ADP is a public, provincial program administered by the Ministry of Health and Long-Term Care. In most Canadian jurisdictions outside of Ontario, assistive devices programs are also administered by provincial departments. However, a regional administration model has been adopted in two provinces: Manitoba and Newfoundland and Labrador. In Manitoba, assistive devices programs are administered by regional health authorities under the home and community care services sector; this may help to focus the devices program on supporting independent living at home. Newfoundland and Labrador uses its regional health authorities to deliver a provincial audiology program.

Some countries surveyed in the jurisdictional reviews have explored alternatives to national or sub-national administration and coverage. For example, in Norway, a commission suggested shifting responsibility for the procurement of simple and frequently used assistive technologies from the state to municipalities.

Non-governmental organizations (NGOs) are involved in several jurisdictions to varying degrees, primarily to provide supplementary coverage and occasionally in program administration. For example, the state of Western Australia outsources the commission and administration of devices to non-governmental providers. In the United Kingdom, NGOs provide consultation services to clients and the National Health Service (NHS) Choices website refers individuals to NGOs.

Who is eligible?

In Ontario, individuals are eligible for the ADP if they have a valid Ontario health card and a physical disability that lasts six months or longer.

Equipment cannot be required exclusively for sports, work or school. The program does not cover fees for equipment available under the Workplace Safety and Insurance Board or to certain veterans. There are also specific eligibility criteria for each device category. Clients must see a healthcare professional to be assessed and to determine the appropriate device.

Across Canada, eligibility policies vary. Nunavut and the Yukon limit eligibility to specific diseases. Other jurisdictions limit eligibility based on disability severity, most commonly when a jurisdiction has a vision or hearing program that provides devices to individuals with specified levels of hearing or vision impairment. These programs usually operate separately from assisted devices programs. Across Canada, eligibility is determined by age and income in about half of the jurisdictions. England was the only country included in the review of international jurisdictions that used income as an eligibility criterion.

Internationally, all jurisdictions other than Australia require individuals conducting assessments to be registered with the program or connected to the government authority providing the program (for example, in Norway, the assessor is often an occupational therapist from the local authority).

The client journey report indicates that not all eligible individuals know that they qualify for ADP support. Furthermore, experiences with the application process vary, with some individuals reporting that the assessors and vendors sometimes don't fill out forms correctly, resulting in delays and frustrations.

The client journey report indicates that not all eligible individuals know that they qualify for ADP support. Furthermore, experiences with the application process vary, with some individuals reporting that the assessors and vendors sometimes don't fill out forms correctly, resulting in delays and frustrations. Clients also expressed frustration that the process for renewal can be burdensome and sometimes feels unnecessary given the long-term nature of clients' disabilities.

What devices are covered?

Ontario provides generous device coverage (more than 8000 separate pieces of equipment). This may be more generous than other Canadian jurisdictions.

The ADP may consider listing a new product if it

- supports the mandate of the program to increase the client's independence;
- has, where applicable, been tested for safety, undergone clinical trials, and has user manuals and pricing details;
- can be personalized and recommended based on an assessment by a healthcare professional;
- is customized to address a disability;
- is approved by Health Canada; and
- is not funded by another government program.

The proposed price of the product should be comparable with prices across Canada. As well, funding of the product should be aligned with current government priorities.

Ontario will not cover a device that

- is not cost-effective;
- is a common/mainstream product used by the general population;
- will be exclusively used for therapy or treatment purposes;
- will be exclusively used for a diagnostic or monitoring procedure;
- is a home or vehicle improvement and/or modification;
- will be exclusively used for work, education or recreation purposes;
- will be used for cosmetic purposes only;
- will be implanted within the body;
- is required for daily self-care activities (e.g., transferring, dressing, toileting or bathing);
- is to be used exclusively to address a safety need; and
- is for short-term use.

The ADP has criteria for removing devices from the list, primarily related to safety, non-use or a finding that a device is not cost-effective. Across Canada, assistive devices vendors have to apply to each province or territory's assistive devices program to have a device listed as one of the publicly funded devices. The specifics of this process were unclear for most jurisdictions.

The ADP will only pay for equipment that is purchased from registered vendors. The exception is for clients receiving funding via grants. These clients are not required to purchase their device from an ADP registered vendor. The journey report indicates that some clients feel constrained by

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limited choices, questioning why they need to purchase devices through specific vendors and why they cannot have self-directed funds.

Internationally, some jurisdictions provide device coverage only for a limited amount while allowing for more client choice. In both England and Germany, individuals receive a voucher for the value of the device they would have received through the government program and can use the voucher to cover the cost of a device of their choice. If the cost is greater than the value of the voucher, individuals pay the difference themselves. Australia's disability program is based on an insurance model, in which eligible individuals receive a package of funding to buy the services identified in their individualized plan. In the Netherlands, choice limitation due to contracting and benefits design has been noted as a concern. In Norway, there appears to be very broad coverage, with no assistive device denied, including devices used for sport.

In Ontario, devices are not loaned or recycled. In Saskatchewan, Manitoba and New Brunswick, assistive devices programs offer full funding for devices that are loaned from a pool. The client journey report indicates that some people use loaned equipment privately, particularly when they are ineligible for the ADP. Many clients requested loaner or rental programs for devices, which could be especially useful in times of urgent need, when devices need repair or when clients are traveling. Clients noted that such a program is in use for ventilators and would be especially useful for devices that will be outgrown.

What payment models exist?

In Ontario, the ADP functions primarily on a cost-sharing model. The ADP covers 75% of the total cost of equipment such as artificial limbs, orthopedic braces, wheelchairs and breathing aids. For other equipment such as hearing aids, the ADP contributes a fixed amount of the total cost. For ostomy supplies, breast prostheses and needles and syringes for seniors, the ADP pays a grant directly to the person. For the Home Oxygen Program, the ADP pays 100% of the ADP price for oxygen and related equipment for seniors aged 65 or older. The same is true for individuals aged 64 years or younger who are on social assistance, residing in a long-term care facility or who are receiving professional services through LHIN home and community care. ODSP pays the client's portion of the cost of approved devices for clients who receive ODSP support. Several non-profit and charitable organizations (such as Easter Seals Ontario, March of Dimes Ontario, War Amps, Kiwanis and the Lions Clubs) also assist individuals with out-of-pocket costs.

The client journey report indicates that cost is a barrier for some people; in their survey, 73% of respondents reported that the need for extra funding has had an impact on their ability to get a device and 62% said that they have had to go without a device due to costs.

Internationally, there are considerable variations in approaches to payment. A program may offer full support for some devices or require some form of cost sharing (e.g., co-payment) for other devices. In Germany, clients have to pay the difference between a reference price and the

In both England and Germany, individuals receive a voucher for the value of the device they would have received through the government program and can use the voucher to cover the cost of a device of their choice.

selling price of the device. In the United Kingdom, for devices categorized as "Simple Aids to Daily Living," users can choose both the retailer and the specific item of equipment they wish to own; they can also "top up" with their own funds and opt for more expensive models. Australia, Germany and the Netherlands have some form of cost-sharing for assistive devices. In Italy, New Zealand and Norway, most assistive devices are made available free of charge.

First or last payer: What models are used?
In Ontario, the ADP has no requirement that individuals exhaust other insurance for devices before accessing the ADP. As noted above, individuals receiving workplace insurance and some veterans are ineligible for the ADP.

In British Columbia, Saskatchewan, Quebec, New Brunswick and the Northwest Territories, individuals receiving support from another benefit program are not eligible for additional assistive devices programs. In New Brunswick and the Northwest Territories, public programs are clearly the payer of last resort; that is, devices will only be funded if individuals are not covered by any other supplementary health benefit plan, agency or private insurance plan. British Columbia, Alberta and the Yukon have similar clauses stating that if a client has access to other programs or private insurance they will not be eligible for the publicly supported assistive devices programs.

How can the client experience be improved?
The client journey report indicates several ways in which the client experience of accessing the ADP could be improved. Many clients found it difficult to understand which devices are covered. Some expressed discomfort when the assessor and vendor are the same individual, raising the potential for a conflict of interest. Clients who require multiple devices reported additional challenges in coordinating approval and coverage across multiple assessors and vendors.

Some clients reported that the process from applying to receiving a device could be very long, sometimes up to one year. Some of these delays relate to waiting for devices, which can take as long as six months to arrive once they have been ordered. Several clients requested an online portal with tracking of devices. Many clients expressed frustration that when they need to renew their device, they have to repeat the entire process each time.

Internationally, jurisdictions differ in the amount, level of detail and presentation of online information regarding the processes for reimbursement of devices and ways of obtaining devices. The English National Health Service provides detailed online information on most devices, whereas the Netherlands suggests that most users look for personal advice, especially that of their provider, rather than guidance from online sources.

What we learned: A summary of our knowledge user dialogue

On options for program administration

There was a consensus among participants in the knowledge user dialogue that the ADP needs to change to address long waiting times, encourage innovation by manufacturers, improve purchasing power and keep up with rapid technological change by including modern "high-tech" devices on the list of approved devices.

However, there was strong agreement that changing administration from a public and centralized model to one that relies more on private administration would not accomplish these goals. In fact, participants were concerned that adding intermediaries – such as non-governmental organizations and charities – would exacerbate the administrative challenges associated with the ADP, rather than relieve them. Participants felt that many not-for-profit and private organizations do not have the capacity to administer such programs. They also noted that in jurisdictions that engage private partners, there is a perception that these models do not work well. However, these models have not been rigorously evaluated.

Participants were also very reluctant to support regional administration models, for several reasons. They suggested regional administration could increase disparities in access to the ADP because some regions will have more administrative capacity to help clients than other regions. Regionalization could also lead to fragmented care if clients need to access services in more than one region. Many clients strongly prefer a single point of contact for ADP. Finally, it was suggested that a regional approach could hinder the development of a culture of innovation, which is best promoted by strong central coordination.

Participants felt that neither private nor regional administration would address many of the problems encountered by clients who need multiple devices. In fact, for these clients, the ability to obtain ADP services from a single source was seen as a significant way to improve the program.

Participants felt enhanced access was best achieved through a central, publicly administered system and that alternatives might fragment services. Similarly, participants suggested that better communication is needed between assessors, vendors and administrators to help clients navigate the ADP, and that communication would be worsened by fragmented services.

Participants noted that the ADP has the potential to use the data it collects more effectively. For example, the ADP could use actuarial methods to forecast its budget based on known trajectories of diseases and could use these models to determine coverage.

On eligibility

Participants considered the possibility of containing costs by restricting eligibility to the ADP. There was a consensus among participants that unlike eligibility based on need, age-based eligibility for devices would not benefit clients and might have negative equity implications. Participants felt that income-related eligibility might also have negative equity implications if individuals were unable to access devices because their income was too high. Conversely, income-related eligibility may have positive equity implications if it means that existing resources are used to fund more devices for low-income individuals. This result — more devices being covered for the same cost to the public — would therefore be an efficiency gain. However, this gain may be less than anticipated if

Some participants saw benefits in shifting the ADP away from being the first payer, including expanded access. For example, they argued that cost savings for the public payer could be used to offset out-of-pocket costs for people without private insurance by lowering co-payment levels.

the extra cost of administering an income-based system is high. Implementing income-related eligibility may be challenging as it would require access to additional data (such as individual income tax data), which could have cost and privacy implications.

Many participants endorsed the idea of client self-referral to the ADP. While there was less enthusiasm for initial self-reported assessment, which was thought to be difficult for clients, many participants endorsed streamlining renewal of devices for clients whose needs have not changed.

On coverage

Participants discussed the feasibility of improving client choice through a client voucher system, in which clients receive vouchers to purchase devices with fewer restrictions than the current ADP list. Participants noted that this model could allow for a "living list" in which the most technologically advanced devices are available and suggested that market competition could drive down prices. However, they also noted that this model may lead to a loss of product servicing by vendors. There was also concern that some clients, who are not able to obtain lower prices, may be disadvantaged; not all clients can effectively advocate for themselves. As a result, any voucher system may have to require that individuals buy devices from a program-approved list with set prices.

Participants noted that some vendors and clinics loan devices to clients for a trial period before purchasing, but there is no consistent approach to these processes and they may vary by region. Several participants advocated for a loan program that is provided by vendors, rather than by the ADP, and that is mandated as part of the contractual agreement with the ADP. However, not all devices would be suitable for loan, as some are custom-built. Participants noted that in some programs in the United States, a device can be loaned for 13 weeks after which a client can decide to purchase it; this may help clients to adjust to new devices. Participants also noted that vendor contractual obligations could also include refurbishment and ongoing service of devices.

On first vs. last payer models

In their consideration of options to improve efficiency and cost savings, participants discussed the possibility of moving away from the ADP as the first payer for devices. However, participants noted such a change could have consequences for how private insurers behave. For example, some insurers may decide against covering certain devices if they are required to be the first insurer. Others may decide to not insure assistive devices at all.

Some participants envisioned a role for the ADP in which the program provides clients with technical details regarding their needs. Clients could then use these specifications to negotiate directly with vendors. Participants felt that this arrangement was only feasible if the ADP was the first payer.

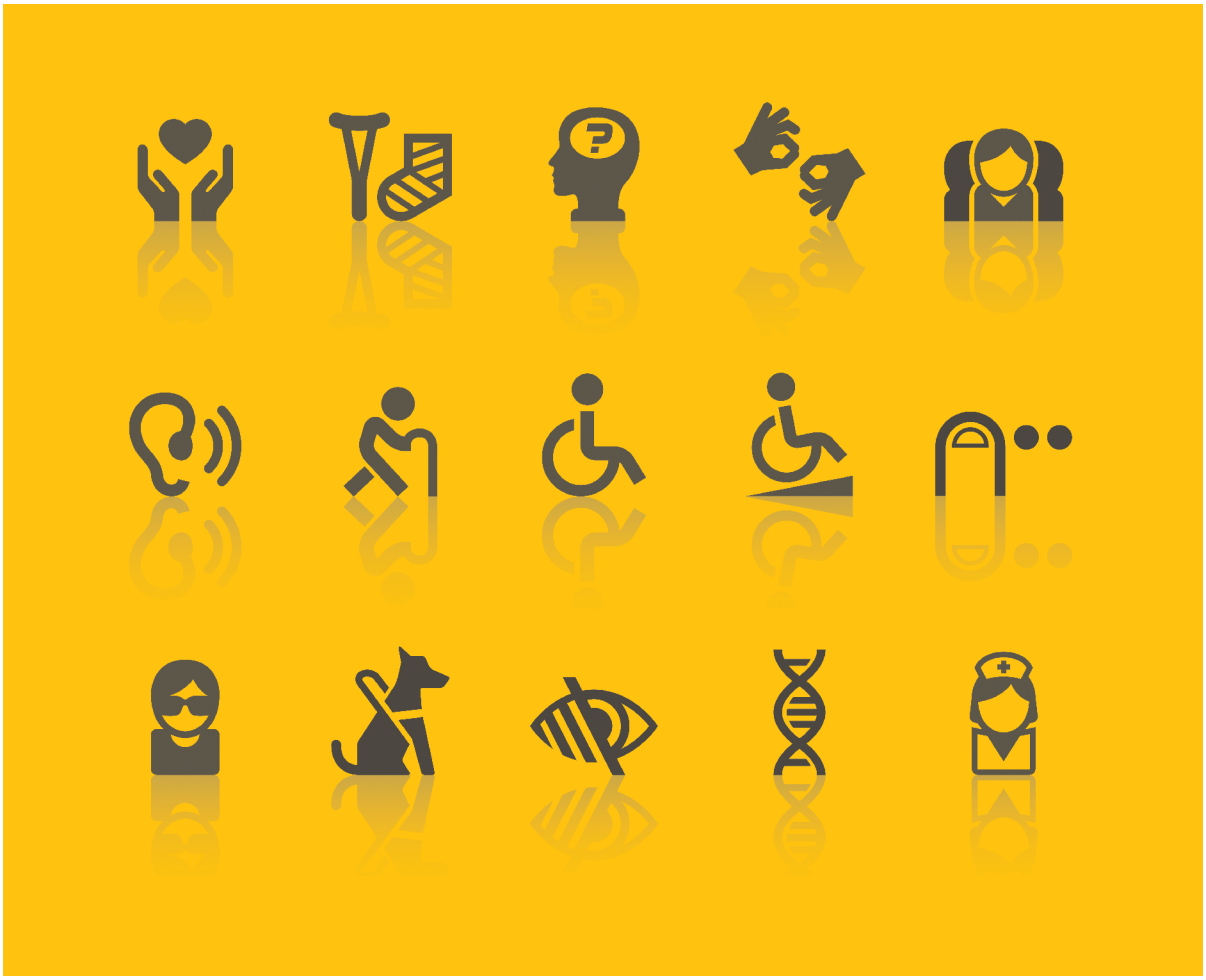
Some participants saw benefits in shifting the ADP away from being the first payer, including expanded access. For example, they argued that cost savings for the public payer could be used to offset out-of-pocket costs for people without private insurance by lowering co-payment levels. Some participants also felt that having the ADP as first payer led to inflated costs since there was little incentive for private insurers to negotiate lower costs.

Participants suggested that the ADP could learn some lessons from private insurers. For example, private insurers have mechanisms to decide how much each insurer pays when clients have coverage from more than one insurer.

Others suggested that cost savings would be minimal since the large majority – an estimated 70% of Ontarians – do not have private insurance. They also noted that if the ADP is the last payer, administrative costs may be significant for both administrators and for clients, who would have to prove they have exhausted other sources. Clients may also face additional burdens if they need to pay first and then be reimbursed, or if their private insurance follows a defined contribution model (which could be challenging to reconcile with the current ADP structure). Participants noted that some groups, such as children and the elderly, would likely need full coverage, as they are unlikely to have access to private insurance.

Participants suggested that the ADP could learn some lessons from private insurers. For example, private insurers have mechanisms to decide how much each insurer pays when clients have coverage from more than one insurer. Similarly, the ADP could look to how insurers determine coverage and co-payments.

Guidance to improve efficiency and equity



Throughout our policy research and dialogue with stakeholders, Converge3 focused on identifying policy options that could help Ontario's Assistive Devices Program become more economically viable and provide more equitable service to those who use, or need, the program. The options presented below are intended to frame a broader evidence base, including the user perspective, as part of current policy development processes within government. They may also be used by stakeholders who wish to engage in evidence-based advocacy for change.

Guidance to improve efficiency and equity:

1. Models for program administration

The ADP is currently a publicly administered, provincial program. Regional models and models that involve non-governmental organizations have been explored in several other Canadian and international jurisdictions to varying degrees as a means to improve efficiency and reduce costs. A variety of options are available regarding ADP administration:

- **Maintain current administration:** Maintaining the current administration of the ADP within the Ministry of Health and Long-Term Care as a provincial program potentially strengthens the bargaining power of the ADP should it engage in price negotiations, since it would be a large, centralized purchaser.
- **Shift administration to private providers:** Maintaining public financing while shifting administration to private providers may result in program savings if this move is associated with lower administrative costs. Of note, jurisdictions in the review that worked with private providers did so with not-for-profit, non-governmental organizations and charities. In general, they relied on such organizations for only some components of programs. No jurisdiction has large-scale private administration. There was a consensus among stakeholders at the knowledge user dialogue that shifting administration to private providers would not make the ADP more equitable or improve the client experience.
- **Shift administration to regional level:** Shifting some administration to the regional level has been implemented in several jurisdictions with the purported, but unproven, benefit of enhancing the ability of the program to tailor services to local conditions. Such considerations may be particularly important for rural, remote and Northern communities in Ontario. However, stakeholders at the knowledge user dialogue felt that regionalization would increase fragmentation and decrease equity of access to devices and services.
- **Develop device-specific rules:** Device-specific administration rules allow the administration of each class of devices to be optimized to specific characteristics. This approach may enhance equity, but may be unnecessary and costly if rules do not vary significantly between device classes.

Guidance to improve efficiency and equity:

2. Determining eligibility

Ontario currently has generous eligibility criteria. There are no restrictions related to age or income and few eligibility restrictions related to disability severity or diagnosis. As a result, Ontario's eligibility criteria include more individuals than other Canadian jurisdictions, but are concordant with criteria found in many European countries, Australia and New Zealand. A number of policy options are available:

- **Restrict eligibility:** Restricting eligibility is one option for curtailing growth in ADP spending. Several policy options relating to eligibility are available should tighter restrictions be desired. Most notable would be restricting eligibility due to age, income or both. However, both of these restrictions may have significant equity effects. For example, many individuals who accessed disability services in Australia are young (the median age was 35). While corresponding data are not available for Canada, some devices, such as insulin pumps, are commonly used by adolescents and young adults. Income restrictions may also have equity impacts; in the client journey report, even some high-income earners reported cost-related challenges in paying for devices. Stakeholders at the knowledge user dialogue did not endorse eligibility based on age and had mixed opinions about income-based eligibility. More data-intensive analyses and modeling are needed to determine the effects of income-based eligibility rules.
- **Re-evaluate the role of the assessor:** In contrast, broader access to assistive devices could be granted by re-evaluating the role of the assessor. Currently, individuals in Ontario must be assessed by a health care professional to determine eligibility. While this is consistent with national and international standards, some clients advocate for self-reported assessments to determine eligibility. Self-report is unlikely to be feasible for initial assessment, which requires a complex understanding of both clients' needs and available devices. However, it may be appropriate for diagnoses where the level of disability is likely to remain constant over time and could lead to both administrative savings and enhanced client experience. Stakeholders in the knowledge user dialogue generally supported both client self-referral and self-reported assessment for renewal of devices.

Guidance to improve efficiency and equity:

3. Determining coverage

While Ontario currently has clear criteria for determining which devices are covered, the processes by which these criteria are implemented are not consistent. Furthermore, the list of devices is long and may therefore be inefficient to administer. Some devices may be of little benefit and could be removed from the list. Finally, coverage could also address the cost of devices in innovative ways. Several policy options, which are not exclusive of one another, are available for determining what devices should be covered in order to ensure cost effectiveness and enhanced client choice:

- **Conduct technology assessments:** A rigorous health technology assessment process provides an evidence-informed approach to determining coverage. For example, a Health Quality Ontario process that includes a determination of cost-effectiveness has been used to determine coverage for some devices, particularly high cost items such as insulin pumps and respiratory devices for sleep apnea. This approach could also address the concern of stakeholders at the knowledge user dialogue who felt that the ADP needs to keep up with rapid technological change and include modern "high-tech" and "smart" devices on the list of approved devices.
- **Delist devices:** Delisting obsolescent devices, devices that are rarely used or devices that are no longer cost-effective could improve program administration and potentially reduce costs with relatively few health or equity effects.
- **Negotiate prices:** Price negotiation based on value-based costing principles offers the potential for significant cost reductions. This process could be expanded to include coordinated price negotiations with other government agencies, including the Workplace Safety and Insurance Board.
- **Create a voucher system:** The ADP currently has a process for registering vendors. Limiting the number of vendors potentially strengthens the bargaining power of the ADP, but some individuals feel that this unfairly constrains individual choice. A voucher system has been adopted in several jurisdictions, most notably the United Kingdom, to provide more choice for clients. Such a system would maximize client choices for those able to pay the "top-up" amounts, but may have equity implications and could significantly limit the ability of the ADP to negotiate lower prices. Stakeholders in the knowledge user dialogue had mixed opinions about a voucher system in Ontario. While it could enhance choice, particularly for newer devices, it could also lead to disparities in access for some clients.
- **Create a loan program:** Many clients advocate for a loan program for devices. A loan program could significantly advance equity, save money and refurbishing costs (depending on the nature of the device) and reduce administration costs. This is particularly true for devices that children outgrow, that individuals no longer need due to death or advanced disability, or for when individuals' own devices are under repair. Most stakeholders in the knowledge user dialogue felt that loan programs should be provided by vendors, perhaps through contractual obligations.

Guidance to improve efficiency and equity:

4. Cost-sharing and payments

The ADP currently requires cost-sharing for most devices for individuals who do not receive disability support. Typically the ADP covers 75% of the cost of most devices, although there are significant exceptions to this rule. There seems to be no strong foundation for the 75% threshold. The ADP also functions as the first payer for devices. However internationally, most assistive devices programs have been established outside of public or social health insurance systems, although there are some exceptions. These include Australia (which has specifically adopted an insurance model) and Norway (which provides near universal coverage). A number of jurisdictions, including several provinces and territories in Canada, require individuals to exhaust other coverage prior to accessing public programs, although it is not clear how strictly such rules are applied. These approaches provide several policy options:

- **Review cost-sharing policy:** The client journey report indicates that some individuals, even those with moderate to high incomes, can find the cost-sharing component to be prohibitive. A higher or lower cost-sharing component could have both economic and equity implications, but these effects are uncertain.
- **Shift to payer of last resort:** Shifting the ADP to be the payer of last resort has several implications. The cost of funding devices may decrease but administration costs, particularly those related to verification of insurance status, may increase. The net cost saving is therefore uncertain – especially because most Ontarians do not have private insurance. Furthermore, a shift to payer of last resort may considerably weaken the ability of the ADP to negotiate price reductions with vendors. As noted in the knowledge user dialogue, making private insurers the first payer may also result in insurers changing their coverage rules or deciding not to insure some devices. Finally, a shift to last payer may have equity implications for individuals who have high private deductibles or co-pays and may further complicate and delay the approval process for all individuals. Stakeholders in the knowledge user dialogue had mixed views about the ADP becoming last payer.

Guidance to improve efficiency and equity:

5. The client experience

Clients of the ADP report numerous frustrations with the program, including difficulty in understanding eligibility criteria, insufficient flexibility in what devices they can purchase, complex renewal processes and long waits to receive devices. Several administrative changes could improve the ADP client experience:

- **Enhance communication:** Enhanced communication regarding eligibility and how to apply may increase accessibility to ADP for many Ontarians.
- **Streamline application process:** A process review to streamline applications may significantly improve the time from application to receipt of a device.
- **Reduce duplication for multiple devices and renewals:** Clients who require multiple devices and clients who are applying for device renewals report that there is unnecessary duplication in accessing devices.
- **Increase transparency:** Transparency regarding potential conflicts of interest between prescribers, assessors and vendors, particularly when they are the same party, could enhance client trust in the program.

Next steps

Converge3 provides stakeholders with policy options that are evidence-based with a consideration of economic and equity implications. Stakeholders, whether internal to government or from the broader assistive devices community, will decide which policy options are best aligned with their interests. As such, Converge3 presents stakeholder feedback regarding policy options but does not endorse or recommend any specific strategy.

Stakeholders should also recognize that while some policy options can be implemented relatively easily, others will require additional analyses and careful consideration to determine costs, feasibility and acceptability. Converge3 welcomes the opportunity to work with stakeholders to examine all options more fully, including options that we may have missed in this report. Our goal is to contribute actively to evidence-informed decision making that improves health and equity for all Ontarians while increasing efficiency within the health care system.

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Integrating health, economic and equity evidence to inform policy

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