



Policy Options to Facilitate the Development and Use of Assistive Technologies Designed to Support Seniors to Live Healthy, Satisfying and Independent Lives

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Participating Governments:

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Government of Nova Scotia
Government of New Brunswick
Government of Manitoba
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Government of Prince Edward Island
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Government of Northwest Territories
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Québec contributes to the Federal/Provincial/Territorial Seniors Forum by sharing expertise, information and best practices. However, it does not subscribe to, or take part in, integrated federal, provincial, and territorial approaches to seniors. The Government of Québec intends to fully assume its responsibilities for seniors within its territory.

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List of abbreviations

General

- 2SLGBTQIA+ — Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual
- AAL— Ambient Assisted Living
- AI — Artificial Intelligence
- AT — Assistive Technologies
- ASD — Autism Spectrum Disorder
- FPT — Federal/Provincial/Territorial
- GBA Plus— Gender-Based Analysis Plus
- ICT — Information and Communications Technology
- IoT — Internet of Things
- LTC — Long Term Care
- OLMC — Official Language Minority Communities

Organizations and programs

- AADL — Alberta Aids to Daily Living
- ADP — Ontario's Assistive Devices Program
- AISH — Assured Income for the Severely Handicapped
- ALL — Abilities Living Lab
- ATA-C — Assistive Technology Capacity Assessment
- CaHI — Canada Health Infoway
- CCA — Council of Canadian Academies
- CDDBP — Chronic Disease and Disability Benefits Program
- CISSS — An Integrated Health and Social Services Centre
- CIUSSH — An Integrated University Health and Social Services Centre
- CLSA — Canadian Longitudinal Study on Aging
- DND — Department of National Defence
- DSP — Disability Support Program
- EHB — Extended Health Benefits
- EIA — Manitoba's Employment and Income Assistance
- EIP on AHA — European Innovation Partnership on Active and Healthy Ageing
- ESDC — Employment and Social Development Canada
- EU — European Union
- GATE — Global Cooperation on Assistive Technology
- HELP — Health Equipment Loan Program
- IDEAL PROCESS — Inclusive Design for Equitable and Accessible Living
- IFHP — Interim Federal Health Program
- ISO — International Organization for Standardization
- LTCI — Long-Term Care Insurance
- MSDPR — Medical Equipment & Devices Program
- NDIS — National Disability Insurance Scheme
- NHS — National Health Service

- NIHB — Non-Insured Health Benefits
- ODSP — Ontario Disability Support Program
- POC — Programs of Choice
- RAMQ — Québec Régie de l'assurance maladie
- rATA — rapid Assistive Technology Assessment
- RE-AIM— Reach, Effectiveness, Adoption, Implementation, and Maintenance
- SAIL — Saskatchewan Aids to Independent Living
- SAM³ — Sensors and Analytics for Monitoring Mobility and Memory
- SAP — Newfoundland & Labrador's Special Assistance Program
- STAR — Science and Technology for Aging Research Institute
- UNICEF — United Nations Children's Fund
- WAI — Web Accessibility Initiative
- WATAP— Washington Assistive Technology Act Program
- WCAG— Web Content Accessibility Guidelines
- WHO — World Health Organization

Provinces and territories

- AB — Alberta
- BC — British Columbia
- MB — Manitoba
- NB — New Brunswick
- NL — Newfoundland and Labrador
- NS — Nova Scotia
- NU — Nunavut
- NWT — Northwest Territories
- ON —Ontario
- PEI — Prince Edward Island
- QC — Quebec
- SK — Saskatchewan
- YK — Yukon

Executive summary

Canada's rapidly growing and diverse older adult population is increasing the demand for accessible, affordable, and effective assistive technologies (AT) that support aging in place. AT (including mobility aids, hearing and vision supports, digital tools, smart-home systems, and emerging AI-enabled technologies) can significantly enhance independence, safety, wellbeing, and social participation for older adults. However, despite growing innovation in the AgeTech ecosystem (hardware or software solutions that are designed explicitly for or with the potential to provide benefit to older adults and their caregivers), access to AT in Canada remains fragmented and inequitable. This report, prepared for Employment and Social Development Canada (ESDC) as part of the Federal/Provincial/Territorial (FPT) Seniors Forum, examines current Canadian and international AT policies, barriers to access, and opportunities for coordinated action. It identifies policy options that could enable seniors and caregivers to benefit more fully from technological advancements that support healthy and independent aging.

Methodology

The analysis draws on a literature review and key informant interviews with Canadian researchers, practitioners, and advocacy organizations. Literature and expert insights were synthesized into thematic findings on AT definitions, system barriers, funding models, international comparisons, and innovation trends. While the evidence base is growing, data on AT usage, incidence, and outcomes remain limited across Canada and internationally.

Key findings

Evolving definitions and evaluation needs

AT are expanding beyond traditional mobility, hearing, and vision devices to include digital, sensor-based, cognitive-support, and AI-enabled tools that support independence, safety, and social participation. As definitions broaden, Canada lacks unified terminology, consistent data collection, and standardized evaluation frameworks. This creates challenges for measuring prevalence, understanding real-world impacts, and coordinating policy across jurisdictions.

Fragmented FPT policies and programs

AT funding in Canada is delivered through a patchwork of FPT programs with differing eligibility rules, coverage levels, and administrative processes. This fragmentation leads to inequitable access, complex navigation for seniors and caregivers, and inconsistent support across health, disability, aging, and accessibility systems. While innovation and infrastructure investments are growing, they are not yet supported by cohesive policy alignment.

International models offer useful policy design features

International jurisdictions such as the United Kingdom, Sweden, and others embed AT within universal health or social-care frameworks, often using loan systems,

refurbishment programs, and integrated assessment pathways. Although no single system is fully transferable to Canada, these models highlight design features (e.g., national entitlement frameworks, coordinated delivery, and sustainability mechanisms) that could inform Canadian approaches to improving equity, access, and system integration.

Persistent barriers affect equity and inclusion

Many older adults face affordability challenges, limited digital literacy, lack of awareness of AT options, and difficulties obtaining ongoing maintenance or support. Rural and remote populations, low-income people, culturally diverse communities, and people with disabilities encounter the most significant barriers. Stigma, usability issues, and policies that are difficult to navigate further inhibit uptake and long-term use, underscoring the need for person-centered, culturally relevant, and accessible approaches.

Innovation is strong but requires coordination and co-design

Canada's AgeTech and assistive technology innovation ecosystem is vibrant, with advances in AI, smart-home technologies, digital health tools, and AT research networks. However, scaling these innovations requires stronger integration across care settings, co-design with older adults and caregivers, improved service and workforce capacity, and policy frameworks that support interoperability, evaluation, and real-world adoption. User-centered design and meaningful participation are essential to ensuring AT is effective, acceptable, and widely adopted.

Conclusion

Canada is at a pivotal moment in shaping an equitable, coordinated approach to assistive technologies that support healthy aging. While innovation is strong, access remains inconsistent and inequitable due to fragmented policies, affordability challenges, and a lack of national standards. By aligning definitions, strengthening data systems, modernizing funding models, and embedding co-design and digital literacy into policy, governments can ensure that AT becomes a cornerstone of healthy and independent aging. A unified, evidence-informed strategy will help seniors across Canada live independently, safely, and with dignity, while supporting caregivers, health systems, and communities.

1. Introduction

1.1. Background

As Canada's older adult population continues to grow and diversify, the need for inclusive and accessible support systems becomes increasingly important. Assistive technologies¹ (AT) have the potential to enhance older adults'² ability to age in place, supporting them to live independently, safely, and with dignity in their communities.

The Federal/Provincial/Territorial (FPT) Seniors Forum discusses issues of importance to seniors,³ shares information on seniors' wellbeing, and undertakes initiatives to advance common concerns. Since its inception in 1992, the Seniors Forum has explored numerous seniors' issues, one being the role of technology. During a meeting on February 24, 2022, the FPT Ministers Responsible for Seniors approved a multi-year work plan, which included prioritizing the role of technology to enhance aging in place.

1.2. Objective

This report explores policy options that FPT governments could consider in supporting the development, accessibility, and affordability of AT for seniors and those in care roles. Drawing on Canadian and international examples and innovations, the report aims to identify strategies that reflect the diverse and intersectional needs of older adults, considering factors such as gender, ethnicity, language, socioeconomic status, and geographic location. By addressing these needs, the report seeks to promote healthier, more satisfying, and independent lives for all seniors across Canada.

¹ Assistive technologies can be defined as “any item, piece of equipment, product or system, whether acquired commercially, off-the-shelf, modified or customized, that is used to increase, maintain or improve functional capabilities of individuals with cognitive, physical or communication disabilities.” Assistive technologies are included in AgeTech, which refers to “hardware or software solutions that are designed explicitly for or with the potential to provide benefit to older adults and their caregivers.” Specifically, AgeTech can include digital health and technologies, Internet of things (IoT), medical devices/diagnostics, robotics, wearables, other sensor-based technologies and assistive technologies (e.g. walkers, hearing aids, or corrective lenses).

Assistive technologies are also important supports for social assistance, and inclusion in community and economic spheres. In this way, assistive technology can support adults to age in place, improve quality of life, and develop functional autonomy and independence in general. Because of innovations in AgeTech, “older adults and their caregivers are now able to access a wider range of tech-enabled or enhanced approaches and technologies to support a holistic approach to healthy, active, socially connected aging.” AgeTech tools are also helpful in “preventing transitions in care through improved health and wellbeing, enabling people to live well with advances in frailty and ill health, and/ or creating age-friendly communities and social structures.” (Definition drawn from FTP Working Group and (Genge et al., 2023).¹)

² Older adults can be defined as those aged 55+. This definition is for the sake of the report as there is no national definition.

³ Seniors can be defined as those aged 65+. This definition is for the sake of the report as there is no national definition.

2. Methodology

2.1. Literature review

The Project Authority and the FPT Working Group refined and confirmed research questions and key terms in conjunction with the report writers. Next, proposed data sources were gathered from reference lists provided by the FPT Seniors Forum and the FPT Working Group. Additional data sources were identified by the Project Authority in consultation with the National Research Council of Canada's Aging in Place Challenge program. All data sources were reviewed and relevant information was coded under the appropriate research question. Where research questions remained unaddressed, a second round of searching using targeted search terms took place. In total, the research team reviewed approximately 115 data sources. Finally, information was synthesized into sub-themes under each research question.

2.2. Engagement

The engagement process sought to enhance data gathered from the literature review, while potentially filling research gaps. The goal was to interview up to eight key informants.

The research team compiled a list of experts for potential inclusion, with additional input and suggestions for contacts provided by the Project Authority and the FPT Working Group. To increase the probability of response, the research team prioritized reaching out to contacts from the final list who were already known within internal networks.

In all, the research team reached out to 40 contacts and secured online interviews with six. Please see Appendix A for a list of organizations that provided input, and a short summary of the interview findings.

All key informants were briefed on the purpose of the research, provided consent to participate, and were given options for confidentiality/anonymity. Interview questions were shared beforehand for transparency, and key informants were also given the option to review and clarify their notes.

2.3. Limitations

As with all research processes, there are limitations.

Six interviews were completed. Although the research team reached out to many key informants, responses were limited.

In this project, the research team kept a confined scope and a specific definition of AT to drive the research questions. While the research team has answered the research questions to the best of their ability, there remains more research to be done in this important work.

3. Findings

This report summarizes findings across literature and key informant interviews.⁴

3.1. Defining assistive technologies, prevalence, incidence and indicators

Assistive technologies (AT) are increasingly central to how older adults in Canada live, age, and participate in society. Once defined narrowly as devices that compensate for functional loss, AT now encompasses a wide range of tools that enhance independence, safety, and social connection. This section examines evolving definitions of AT and their intersection with AgeTech, broadly defined as technology for older people; reviews current knowledge on the prevalence and incidence of AT use among seniors in Canada and comparable jurisdictions; and assesses existing (and absent) evaluation frameworks that measure tangible impact on quality of life, health, and inclusion. It concludes by outlining policy options to strengthen standardization, integration, evaluation, and equity across Canada's AT ecosystem.

3.1.1. Definitions of assistive technologies

Scholarly and policy discourse in recent years has refined and expanded definitions of AT, reflecting technological evolution, broader inclusion frameworks, and social and human rights models of disability. AT now includes digital health tools, home monitoring systems, rehabilitation and mobility supports, communication technologies, and smart or wearable technologies. The World Health Organization (WHO) definition is as follows:

“Assistive technology is the application of organized knowledge and skills related to assistive products, including systems and services. Assistive technology is a subset of health technology.

An assistive product is any external product (including devices, equipment, instruments or software), especially produced or generally available, the primary purpose of which is to maintain or improve an individual's functioning and independence, and thereby promote their well-being. Assistive products are also used to prevent impairments and secondary health conditions” (Assistive products list, 2016).

That same report also includes the International Organization for Standardization (ISO) definition:

“An assistive product is any product (including devices, equipment, instruments and software), specially produced or generally available, used by or for persons with disability for participation; to protect, support, train, measure or substitute for body functions/structures and activities; or to prevent impairments, activity limitations or participation restrictions.” (ISO 9999:2016 Assistive products for persons with disability — Classification and terminology, 2016)

⁴ See Appendix A for a summary of key informant interviews.

This report uses the definition of AT as outlined earlier. This particular definition situates AT within the broader AgeTech ecosystem described by Genge, McNeil, Debergue, and Freeman (2023), where AgeTech *“refers to hardware or software solutions that are designed explicitly for or with the potential to provide benefit to older adults and their caregivers”* and includes *“a diverse portfolio of innovations from digital health, assistive technologies, Internet of Things (IoT), medical devices/diagnostics, robotics, wearables and other sensor-based technologies”* (p. 3).

Building on WHO and related literature, AT are understood as both clinical aids and key supports for inclusion and participation. These functions support older adults to live healthy, satisfying lives while maintaining autonomy and independence. As Genge et al. (2023) highlight, older adults and caregivers *“are now able to access a wider range of tech-enabled or enhanced approaches and technologies to support a holistic approach to healthy, active, socially connected aging,”* and AgeTech tools *“can help older adults to age in place by preventing transitions in care through improved health and wellbeing, enabling people to live well with advances in frailty and ill health, and/or creating age-friendly communities and social structures”* (p. 3).

Using a broader definition of assistive technology reflects a social understanding of disability that focuses on removing barriers and supporting people’s independence, inclusion, and access to everyday life. This broader view recognizes assistive technology as part of a growing AgeTech ecosystem that includes digital health tools, smart home technologies, sensors, wearables, and robotics (Read et al., 2023; Genge et al., 2023). Canadian research shows that when people can access the assistive technologies they need, the benefits go beyond health outcomes to include stronger social participation and economic contributions (Wang & Wilson, 2022).

Seeing assistive technology within this wider ecosystem highlights the need for collaboration across health, aging, innovation, and accessibility sectors, rather than treating it as a narrow or medical issue. It also reinforces that assistive technology is not only about managing disability, but about enabling healthy aging, community inclusion, and participation in work and daily life. From a policy perspective, investing in assistive technology can therefore support broader social goals and contribute to economic growth in an aging population (Wang & Wilson, 2022; Genge et al., 2023).

Artificial Intelligence (AI) is shifting the definition landscape very quickly. AI is expanding what “assistance” means, how it is delivered, and who benefits. Traditionally, AT were conceived as tools to compensate for functional limitations. Today, AI-driven systems blur the line between assistive, adaptive, and mainstream technologies, making AT more dynamic, predictive, and personalized (Moharana et al., 2025; Pasetto de Freitas et al., 2022; Perry et al., 2024; Silvera-Tawil et al., 2025; Treviranus et al., 2025).

3.1.2. Prevalence and incidence of usage of assistive technologies among older adults

Understanding AT use among older adults is challenging because population surveys typically only capture traditional devices, such as mobility, hearing, and vision support aids. Broader AT categories are not captured in most Canadian or international data

sources. This mismatch reflects a lack of standardized definitions or reporting frameworks, which makes it difficult to track use, compare findings, or assess trends.

With these limitations in mind, the following subsections summarize what is known from Canadian and international studies.

3.1.3. Canadian data

Prevalence estimates

Data from the Canadian Longitudinal Study on Aging (CLSA) show that AT use is common among older adults living in the community, particularly for mobility, hearing, and vision-related needs. Among more than 51,000 participants aged 45–85 (which is about 1 in 5, or 20%), reported using at least one assistive device (Ishigami et al., 2020).

Mobility aids were the most commonly used devices. About 20% of women and 15% of men reported using a mobility-related assistive device (Ishigami et al., 2020). This aligns with national disability data showing that mobility limitations increase sharply with age. In 2022, 25.5% of Canadians aged 65 years and over had a mobility disability (Mobility disabilities, 2024). Among people with a mobility disability, 52% reported using adapted features within their home, most often bathroom aids, walk-in showers or baths, and ramps or lifts (Mobility disabilities, 2024).

Vision-related assistive technology appears less common in the CLSA, possibly since eyeglasses are not classified as AT. National data help contextualize this finding. In 2022, 11.4% of Canadians aged 65 years and over had a seeing disability (Seeing disabilities, 2025). Among persons with a seeing disability, 22% reported using specialized features on a device, specialized software or apps, or other adaptations, including screen magnification software, speech-to-text or voice recognition software, and screen readers (Seeing disabilities, 2025).

When digital AT are considered more broadly, uptake remains limited among older adults with disabilities. In 2022, 66% of Canadians aged 65 years and over with disabilities reported that they did not use information and communication technology–related assistive aids, devices, or technologies, while 34% did report using them (Use of information and communication technology-related assistive aids, devices, or technologies for persons with disabilities by age group and gender, 2024). Among Canadians aged 65 years and over, pain-related (68%), mobility (63%), and flexibility (59%) disabilities were the most common types of disability, and nearly half (42%) of seniors with a disability reported four or more co-occurring disabilities (Pain-related disabilities, 2024).

Health status is strongly associated with AT use. In the CLSA, people with five or more chronic conditions had the highest prevalence of device use, with approximately 4 in 10 reporting at least one assistive device (Ishigami et al., 2020). This pattern is consistent with national data on pain and flexibility disabilities. In 2022, 27.6% of Canadians aged 65 years and over had a pain-related disability, and 23.7% had a flexibility disability

(Pain-related disabilities, 2024; Flexibility disabilities, 2024). Among persons with a flexibility disability, 68% reported using a mobility-related assistive aid, device, or technology, such as a cane, walker, or reach extender (Flexibility disabilities, 2024).

Social factors are also linked to AT use. CLSA findings show higher use among people who live alone, report infrequent social participation, or feel lonely (Ishigami et al., 2020). These patterns likely reflect higher levels of disability and fewer informal supports, rather than AT contributing to social isolation. National data similarly show that persons with more severe mobility or flexibility disabilities are more likely to receive help with everyday activities (Mobility disabilities, 2024; Flexibility disabilities, 2024).

Hearing device use follows known patterns of hearing loss. Older men are more likely to use hearing aids, with the highest use reported among men aged 65–85 who live with others (Ishigami et al., 2020). National data show that 13.6% of Canadians aged 65 years and over have a hearing disability. Among persons with a hearing disability, 51% reported using hearing-related AT (Hearing disabilities, 2025). However, taken together with Information and Communications Technology (ICT)-related AT data, these findings suggest that while some condition-specific assistive devices are widely used, broader digital AT remain underutilized among older adults with disabilities.

Gaps in the data

Together, the CLSA and the Canadian Survey on Disability provide strong evidence on the prevalence of AT use among older Canadians and the distribution of use across disability types, health status, and social factors. Both Canadian sources primarily focus on traditional AT such as mobility, hearing, and vision aids, as well as home adaptations. While the Canadian Survey on Disability includes limited information on ICT-related AT, digital and software-based AT are not comprehensively captured, and neither source provides an integrated picture of emerging or smart assistive technologies used by older adults.

As well, neither source provides incidence data, meaning they do not show when individuals begin using AT or how adoption changes over time. As a result, while the scale of AT use and unmet need is well documented, pathways into adoption and long-term patterns of use remain less understood (Ishigami et al., 2020; Use of information and communication technology-related assistive aids, devices, or technologies for persons with disabilities by age group and gender, 2024).

3.1.4. International data

Prevalence estimates

It is challenging internationally to estimate the prevalence of AT use and need. A scoping review of 103 studies from the WHO European Region found that fewer than half reported prevalence estimates, and those that did used varying definitions, data sources, and methods, making comparisons difficult (Mishra et al., 2022). Global evidence from the *WHO Global Report on Assistive Technology* provides broader context on population-level need. Based on representative surveys and modelled estimates, WHO estimates that about 31% of the global population needs at least one

assistive product when eyeglasses are included, and about 11% needs an assistive product other than spectacles, representing more than 2.5 billion people worldwide (Global report on assistive technology , 2022). Need increases sharply with age. WHO estimates that nearly two-thirds of people aged 60 years and over need at least one assistive product, reflecting the combined effects of aging, chronic disease, and functional decline (Global report on assistive technology , 2022).

Across countries included in WHO population surveys, between 10% and 69% of people reported needing assistive products, and 3% to 90% reported having access, depending on national context and level of socioeconomic development (Global report on assistive technology , 2022). Common barriers to access include high cost, limited availability, and lack of support, with many people relying on private purchase or financial help from family members (Global report on assistive technology , 2022).

Consistent with findings from Europe and Canada, international studies primarily focus on traditional assistive products such as spectacles, hearing aids, mobility aids, and basic home adaptations. Needs related to hearing and vision are more likely to be met than those related to communication, cognition, or self-care, where unmet need remains high (Mishra et al., 2022; Global report on assistive technology , 2022). Although the WHO Assistive Technology Data Portal provides country-level estimates of *need*, Canada-specific data on population *access or use* of AT are not currently available, highlighting an important data gap (Global report on assistive technology , 2022).

Incidence estimates

Reliable data on the incidence of AT use (the rate at which people newly begin using assistive products) are limited internationally. The WHO Global Report focuses on prevalence of need and access, noting that most available data are cross-sectional and do not track changes in AT use over time (Global report on assistive technology , 2022). While WHO projects that the global number of people needing assistive products will rise to 3.5 billion by 2050, driven largely by population aging, the report does not estimate adoption rates or transitions into AT use (Global report on assistive technology , 2022).

Evidence from high-income countries reflects similar limitations. Studies from the United Kingdom and Australia suggest that AT use among older adults is increasing, but do not provide numerical incidence estimates or clearly identify when individuals begin using assistive devices (Bridge et al., 2021; Sweeting et al., 2024). As in Canada, available international data are sufficient to describe the scale of need and unmet need, but not the timing or pathways of adoption.

3.1.5. Indicators and evaluation frameworks to assess the effectiveness of AT policies

Literature and key informants consistently point to fragmentation in how AT systems are evaluated, with most existing frameworks emphasizing devices or clinical outcomes rather than system integration, equity, user experience, and long-term impacts. This limits comparability across programs and jurisdictions and constrains evidence-informed

decision-making. More information on evaluation priorities with detailed frameworks and indicator sets is provided in Appendix B.

3.1.6. Key takeaways

- **Definitions of AT are expanding**, now encompassing digital, preventative, and socially enabling technologies within the larger AgeTech ecosystem.
- **Digital technology is reshaping the field**, blurring lines between assistive, adaptive, and mainstream technologies.
- **Canadian and international prevalence and incidence data are limited and inconsistent**, largely capturing only traditional devices and lacking standardized definitions
- Canadian evidence shows high use of traditional AT among older adults, particularly those with multiple chronic conditions or higher levels of disability, while digital and ICT-based assistive technologies remain underused.
- There is **no single AT evaluation framework** but established tools and standards (e.g., AAL, WCAG 2.0, rATA/ATA-C, RE-AIM, IDEAL PROCESS, CaHI) provide complementary, person-centered evaluation components (refer to Appendix B).
- Key indicators extend beyond access and utilization, including functional efficacy, safety, independent living, social participation, quality of life, user satisfaction, and older-adult-defined outcomes.
- **System integration indicators** are increasingly critical, including interoperability, assessment and prescribing capacity, navigation supports, and cross-program alignment, yet are rarely measured.

3.1.7. Policy directions for definitions and evaluation frameworks

Recommendation 1: Establish national AT definitions and evaluation standards

- Adopt a unified national definition of AT that integrates social, rights-based, functional, and digital-innovation perspectives to provide conceptual clarity across FPT and sectoral funders.
- Convene an FPT working group to harmonize terminology, core assessment concepts, and minimum data elements, recognizing that full eligibility criteria will continue to vary by jurisdiction and funder. This creates shared foundations without requiring identical benefit structures across programs.
- Develop an “AT Policy Lens,” similar to Gender-Based Analysis (GBA) Plus, that can be applied across FPT and community-funded programs to assess how policies and service models affect access and outcomes for seniors across age, disability, income, geography, language, and digital equity dimensions.
- Integrate AT policy within broader health, aging, accessibility, disability, and innovation frameworks, ensuring coherence with national accessibility goals, technology & innovation strategies, and healthy aging priorities.

Recommendation 2: Strengthen national data and evaluation systems

- Create a pan-Canadian AT data and evaluation strategy to standardize indicators of access, affordability, and effectiveness.
- Implement consistent AT data collection across health, social, and accessibility systems, including institutionalized, rural, and Indigenous populations.
- Strengthen longitudinal studies to track adoption, usage trends, and outcomes.
- Develop a national evaluation framework grounded in user-centered metrics such as autonomy, satisfaction, social participation, and health-related outcomes.

3.2. FPT Policies on assistive technologies

Financial assistance for AT in Canada is provided through a complex mix of FPT programs. While every jurisdiction recognizes the role of mobility, hearing, and vision devices in supporting independence, the structure of these programs differs significantly. At present, Canada does not have a federal or provincial funding program that provides broad, systematic coverage of AT across the lifespan. Instead, public support for AT is delivered through a patchwork of targeted financial assistance programs and often tied to specific devices, diagnoses, income thresholds, or service systems.

Appendices C & D provide a summary of FPT programs currently available, as well as relevant legislation.

3.2.1. FPT financial assistance programs for AT

The programs summarized below illustrate the types of financial supports that currently exist across federal, provincial, and territorial jurisdictions. Provinces provide limited or condition-specific supports, such as rehabilitation equipment, home monitoring technologies, or digital health tools, often delivered through separate health, disability, or seniors' programs rather than a unified AT framework. In addition, some federal initiatives provide indirect support by funding accessibility infrastructure or innovation in new technologies.

Table 1 - Types of AT programs available across Canada

Program Type	Program Description	Jurisdictions
Universal/cost-share health benefits	Public plans that fund a defined share of approved AT (often ~75% public/~25% client), usually with clinical assessment and approved device lists	ON, AB, QC, SK, PEI
Income-tested/discretionary supports	Social assistance or disability programs (or health-ministry income streams) that fund	BC, MB, ON (Ontario Disability Support Program - ODSP supplement), NB,

	medically essential equipment for low-income recipients, or on a case-by-case basis	NS, PEI, NL, QC (special benefit) ⁵
Loan programs	Government-backed or health-system equipment pools that loan devices (short- or long-term); clients don't own the equipment	MB, BC, NS, QC, PEI, (and selected NB programs)
Territorial extended health benefits	Age/condition-based extended benefits that include AT; often interact with Non-Insured Health Benefits (NIHB)	YK, NWT, NU
Population-specific programs	Full or partial coverage for defined groups (e.g., First Nations & Inuit, veterans, refugees, or federal inmates)	Federal
Employment/education-linked supports	Targeted AT for students or people working/seeking work (not usually accessible to retirees)	Federal, BC

Universal and cost-share health benefits

These programs provide predictable coverage across broad device categories but typically require clinical assessment and cost-sharing. [Ontario's Assistive Devices Program \(ADP\)](#) and [Alberta's Aids to Daily Living \(AADL\)](#) are the main exemplars; both fund most of the device cost while clients pay a portion (Assistive devices program, 2025; Alberta Aids to Daily Living (AADL), n.d.). [Québec Régie de l'assurance maladie \(RAMQ\)](#)⁶ and [Saskatchewan's Aids to Independent Living \(SAIL\)](#) provide similar benefits tied to approved lists/diagnoses (Régie de l'assurance maladie, n.d.; Saskatchewan aids to independent living).

Income-tested and discretionary supports

Where universal plans do not exist, or do not fully cover needs, income-tested programs step in. [British Columbia's Medical Equipment & Devices](#) funds medically essential items for low-income residents; [Manitoba's Employment and Income Assistance \(EIA\) – Health Needs](#) covers specified equipment when not covered elsewhere (Medical Equipment and Devices, 2025; Health needs and other benefits, n.d.). [Ontario's ODSP](#) may top up ADP co-pays for recipients, effectively bringing coverage to 100% in some

⁵ Quebec operates a publicly-funded hearing aid program through the Régie de l'assurance maladie du Québec (RAMQ), alongside additional AT loan and reimbursement programs for specific populations.

⁶

cases. [Newfoundland & Labrador's Special Assistance Program \(SAP\)](#) provides partial subsidies for specified equipment (9.6 - Assistive Devices, 2023; Programs Funded through the Department of Health and Community Services).

Loan programs

Loan pools reduce up-front costs but limit ownership and flexibility. Loan models temporarily provide devices, either short-term (to bridge recovery or waiting periods) or long-term (for ongoing use, but without ownership). These programs are highly variable. Examples include:

- BC & Yukon's [Red Cross Health Equipment Loan](#) Program is government-supported but operated by the Red Cross. It offers both short-term loans (free, usually up to three months) and long-term loans (wheelchairs, hospital beds, bathing aids) for people with chronic needs. Access depends on referrals from health professionals, and the program's reach is shaped by donated equipment availability (BC health equipment loan program).
- [Home Care equipment loans](#) in Manitoba integrate equipment loans directly into the publicly funded home-care system. Clients assessed as eligible for home care may receive mobility or communication devices on a long-term loan basis while they are in the program. Devices are returned when services end, meaning they are tied to ongoing home-care eligibility rather than universal access (Materials distribution agency, n.d.).
- [Nova Scotia's Seniors Community Wheelchair Loan Program](#) focuses narrowly on mobility, providing manual and powered wheelchairs for seniors with mobility impairments. It operates through provincial health services, with equipment provided on loan but not owned by the client (Continuing Care).

Territorial extended health benefits

The three territories, Yukon⁷, Northwest Territories, and Nunavut, approach AT through extended health benefits frameworks, rather than the universal or income-tested models common in provinces. Territorial programs are designed less as “specialized AT programs” and more as comprehensive, extended benefit schemes that integrate with federal supports and respond to geographic constraints.

Although all three rely on extended health benefits, their funding models differ. [Yukon's Chronic Disease and Disability Benefits Program](#) offers full coverage for approved devices. [NWT's Extended Health Benefits](#) provides coverage at no-cost share for Seniors (60+) for items listed in NIHB Medical Supplies, Equipment and Benefit List. [Nunavut's Extended Health Benefits](#) provide full coverage for non-Inuit seniors 65+, while Non-Insured Health Benefits (NIHB) covers Inuit seniors with its own formularies and prior approval processes (Extended health benefits).

⁷ As noted above, the Red Cross supports a loan program for AT for the Yukon as well as BC.

Federal population-specific programs

The federal government does not generally provide AT programs for all Canadians, since health services fall under provincial and territorial jurisdiction. Instead, its role is limited to groups where it has direct constitutional or statutory obligations. These include:

- First Nations and Inuit, through the [Indian Act \(R.S.C., 1985, c. I-5\)](#) and related federal health policies, administered today via the [Non-Insured Health Benefits \(NIHB\) program](#) (Non-insured health benefits for First Nations and Inuit, 2025).
- Veterans and RCMP members, under the [Department of Veterans Affairs Act \(R.S.C., 1985, c. V-1\)](#) and associated health care regulations.
- Refugees and asylum seekers, under the [Immigration and Refugee Protection Act \(S.C. 2001, c. 27\)](#) through the [Interim Federal Health Program \(IFHP\)](#); (Temporary health care coverage, 2025).
- Federal inmates, under the [Corrections and Conditional Release Act \(S.C. 1992, c.20\)](#).
- Serving members of the Canadian Armed Forces, under the [National Defence Act \(R.S.C., 1985, c. N-5\)](#) and internal Department of National Defence (DND) health policies.

These programs function similarly to extended health benefits by providing comprehensive coverage for eligible individuals, but each have their own formulas, approval processes, and limits. They do not all offer identical supports. For example:

- NIHB covers a broad range of mobility, hearing, and vision aids, but excludes some therapeutic equipment and requires prior approval.
- Veterans Affairs' [Programs of Choice \(POC\)](#) provides extensive coverage, though benefits vary by entitlement category (Treatment Benefits – Programs of Choice (POC), 2025).
- IFHP offers temporary, full coverage for refugees until provincial benefits begin.
- Correctional Services of Canada (CSC) and Canadian Armed Forces Health Services cover essential devices internally, with varying approval thresholds (Health Services, 2024; Health, support and casualty services, 2025).

Key informants identified the variability of what is covered between health authorities and provinces, noting that there can even be variation of funding within provinces.

Some key informants cited significant funding gaps:

“In [province], funding for tilt wheelchairs is nonexistent.”

“If a person can afford at-home care, then they are able to rent the advanced equipment. But if they go to long-term care, then the family has to pay for the AT.”

“Whether or not insurance covers things is a huge barrier. Provincial insurance is not keeping up with the advancements with AT – things are happening too fast.”

“[Province] tends to be a ‘land of pilots.’ There are lots of startups with good ideas, but they don’t materialize as products people can get access to. It’s hard to find funding for AT, since pathways for scaling new AT across the system is cumbersome.”

Employment and education-linked supports

These programs target individuals who are studying or are in the workforce. Federally, the [Canada Student Grant](#) and [Opportunities Fund](#) can fund AT and accommodations (Canada student grant for full-time students, 2025; Opportunities fund for persons with disabilities, 2025); in BC, [WorkBC Assistive Technology Services](#) provides workplace-related AT (Assistive technology services, n.d.). (These programs are not generally available to retirees.)

Accessibility and innovation initiatives (not direct benefits)

In addition to benefit programs that help individuals acquire AT, governments invest in innovation and infrastructure to expand future access and reduce environmental barriers. These initiatives do not directly fund devices for individuals, but they serve three purposes:

- Supporting technology development: funding research and commercialization of new adaptive devices.
- Scaling promising practices: piloting projects to test service models and technologies before wider adoption.
- Building accessible environments: upgrading infrastructure to reduce reliance on and accommodate individual devices.

Provinces have also experimented with innovation pilots. For instance, [Alberta’s Locator Device Pilot](#) tested GPS wearables for people with dementia, [Nova Scotia’s CAPABLE pilot](#) combined home modifications and adaptive tools with health supports, [and British Columbia’s Long-Term Care at Home \(LTC@Home\) program](#) equips seniors’ homes with remote monitoring and virtual-care technologies (Alberta Health Services, 2015; Supports to help seniors stay in their homes, 2023; Long-term care services, 2025).

3.2.2. Stakeholder engagement for inclusive AT policies

Across the literature, direct participation by seniors, caregivers, paid care workers, and industry reveals barriers that top-down approaches miss (e.g., affordability, stigma, and navigation complexity) and strengthens legitimacy, equity, and uptake of resulting policies (Mattison et al., 2017; Fang et al., 2019). Iterative, participatory approaches also build ownership of policy choices and tie decisions to what older adults define as meaningful outcomes (Ebuenyi, 2023)

Across studies, several mechanisms of engagement are identified:

Iterative co-design frameworks (e.g., IDEAL PROCESS, human-centered design, and participatory research approaches), show that involving older adults, caregivers, providers, and industry at multiple points creates legitimacy and ownership of resulting policies (Ebuenyi, 2023).

Standards and guidelines like the W3C Web Accessibility Initiative (WAI) provide specific guidance on how Web Content Accessibility Guidelines (WCAG) 2.0 applies to older people, noting the overlapping needs of older people and people with a disability (Developing websites for older people: How web content accessibility guidelines (WCAG) 2.0 applies, 2018). In their design guidelines, they strongly encourage involving users early and continuously in design, not just at the end (Involving users in web projects for better, easier accessibility, 2020). The guidance encourages structured but flexible participation methods, including workshops, interviews, and usability testing. By combining standards and lived experience, the W3C shows how designing can bridge technical requirements with real-world perspectives.

Frontline integration through provider participation and feedback loops showed that engaging clinicians and aligning incentives shaped feasibility and reach. It also highlighted the role of paid care workers and providers as critical informants on implementation constraints (Bhatia et al., 2021).

Dialogue among system actors and industry through structured engagement processes (e.g., multi-stakeholder working groups, iterative evidence reviews, and co-design sessions) helped reconcile competing priorities (i.e., priorities user needs versus system-level evidence requirements) by supporting more adaptive and staged evaluation models (Desvequx, 2017; Bhatia et al., 2021).

Standardization alliances (such as cross-sector collaborations involving standards bodies, developers, researchers, and policy actors) and **living-lab style collaboration** (i.e., real-world testing environments where technologies are trialed with older adults, caregivers, and providers) both created clearer and more predictable pathways to scale while maintaining responsiveness to local needs. Living-lab style collaboration was also associated with clearer pathways to scale while maintaining responsiveness to local needs (Abhari et al., 2024)

Equity-focused participatory approaches deliberately included groups facing intersecting disadvantages (e.g., low income, rurality, disability), using methods such as deliberative dialogues and knowledge cafés to co-produce solutions and embed digital literacy into meaningful activities (Fang et al., 2019; Mattison et al., 2017).

Taken together, these findings suggest that governments can effectively engage stakeholders through structured, repeated, and equity-focused processes that combine citizen deliberation, iterative co-design, accessible standards, and ongoing multi-sector dialogue. Seniors and caregivers contribute perspectives on lived experience and values; paid care workers provide insights into practical feasibility; and industry partners support standardization, evaluation, and scaling. The combination of these mechanisms strengthens both the inclusivity and sustainability of AT policy.

3.2.3. Key takeaways

- FPT AT programs often struggle to keep pace with the rapidly evolving and expanding field of AT, resulting in definitions and eligibility criteria that do not consistently reflect **modern, digital and emerging forms** of AT.

- FPT AT programs **have fragmented AT funding**. There is variation in coverage, eligibility, and device types, which makes it difficult for older adults to navigate entitlements.
- Many seniors and low-to-middle-income individuals **face financial barriers and unmet needs**, especially for advanced or digital AT.
- **Innovation and infrastructure support** is growing, as governments are investing in pilots, technology development, and accessible environments to expand future AT access.
- **Inclusive, iterative engagement** with seniors, caregivers, providers, and industry enhances usability, legitimacy, and sustainability to ultimately improve policy.

3.2.4. Policy recommendations for FPT Policy:

Recommendation 3: Expand and modernize AT funding and coverage

- Building on Recommendation 1, broaden eligibility criteria for provincial/territorial assistive device programs to reflect the full spectrum of contemporary AT, including traditional devices as well as digital, sensor-based, cognitive-support, and AI-enabled technologies that demonstrably improve function, safety, or independence, using the national AT definition and evaluation standards established in Recommendation 1 to guide eligibility and reimbursement decisions based on demonstrated functional, safety, independence, or caregiver-support outcomes. Introduce targeted subsidies for both low-income and “missing middle” seniors, ensuring affordability across income brackets and reducing unmet need.
- Invest in navigation tools to help older adults understand the benefits they are entitled.
- Align reimbursement approaches to more accurately reflect real costs, while recognizing regional variability in pricing, availability, service delivery models, and market conditions.
- Embed caregiver and user training, setup, and support costs within funding mechanisms to promote sustained use, reduce abandonment, and improve user confidence and safety.

3.3. International policy comparisons

To explore potential directions for Canadian assistive technology (AT) policy, this section examines how other countries organize and fund their AT systems, support education and digital literacy, and address access disparities. Each jurisdiction’s approach reflects its own governance, financing, and demographic context, but together they highlight design features relevant to Canadian policy solutions.

3.3.1. International policies as effective funding models for adaptation to the Canadian context

To broaden the understanding of policy options for Canada, the research team examined how several countries structure AT funding within their health, disability, and aging systems. These models differ in governance, financing, and delivery, but each demonstrates mechanisms that help ensure more equitable and sustainable access. Rather than identifying “best practices,” the focus is on policy design features that enable these systems to function effectively in their respective contexts, and the potential insights they offer for Canada. Effectiveness within this section is subjective and is not based on evaluative research findings.

United Kingdom – National Health Service (NHS) – Integrated universal provision	
Description	Under the NHS, AT such as wheelchairs, prosthetics, hearing aids, and communication aids are treated as core health benefits provided at no cost to users following clinical assessment (Global report on assistive technology , 2022). Funding is drawn from the NHS national budget and administered through local NHS Trusts, which act as regional commissioning and service-delivery authorities. These Trusts manage procurement, refurbishment, and repair, often coordinating with local authorities that co-fund home adaptations and environmental supports. In recent years the NHS has also begun piloting expanded coverage of digital and remote-care technologies that function as assistive supports in the community. Across England, dozens of pilot schemes are introducing remote monitoring and self-reporting digital tools via the NHS App, enabling patients to share key health information (such as vital signs) with clinicians from home and supporting long-term condition management outside traditional settings. These pilots, including government-backed trials in areas such as motor neuron disease and other chronic care pathways, are intended to inform broader integration of digitally enabled care within NHS services (Department of Health and Social Care & NHS England, 2025).
What makes it effective	• National entitlement with local flexibility: universal access defined nationally, delivered through local NHS Trusts accountable for outcomes • Cross-sector integration: coordination across health, rehabilitation, and social-care services • Sustainability mechanisms: refurbishment and reuse programs managed by Trusts reduce costs and environmental waste • Governance clarity: national standards (NHS England) ensure quality while permitting regional adaptation (Mishra et al., 2022)

United Kingdom – National Health Service (NHS) – Integrated universal provision	
Implementation Considerations for Canada	• Canada lacks a single national health insurer, making it difficult to establish a unified entitlement framework • In the UK, AT provision relies on coordination between the national NHS and local authority–led social care systems; a similar model in Canada would require strong cross-sector and intergovernmental coordination • While the NHS model minimizes out-of-pocket costs and promotes equity, wait times for non-urgent AT can be lengthy, highlighting a trade-off between equitable access and system responsiveness • Provincial variation in AT coverage is significant, and a national refurbishment program would require cross-jurisdictional coordination and common standards • Yet, Canada’s universal health system already defines certain devices as insured (e.g., prosthetics) in some provinces and the federal role in Veteran’s Affairs and NIHB programs resembles a federal entitlement

Sweden – Decentralized municipal responsibility within national health coverage	
Description	Sweden embeds AT within its universal healthcare framework ⁸ . Municipalities and county councils share funding and delivery responsibilities; devices are typically loaned rather than owned, and co-payments are capped at modest levels (Mishra et al., 2022). Regional AT centres coordinate assessment, distribution, and maintenance, linked closely to homecare and rehabilitation services.
What makes it effective	• Local delivery and accountability: Municipal control ensures responsiveness to local needs while maintaining universal access • Loan-based provision: Centralized inventories reduce costs and support environmental sustainability • Integrated service delivery: AT provision is closely linked to home modification, physiotherapy, and occupational therapy
Implementation Considerations for Canada	• Municipal responsibilities for healthcare are limited in most provinces, and local tax bases vary substantially • Implementing a national loan-based model would require significant harmonization of procurement, eligibility, and recycling processes across jurisdictions • Provinces already delegate elements of home-care, rehabilitation, and equipment provision to regional

⁸ AT definitions in Sweden are embedded in regional practice and service guidance rather than consolidated legislation.

	authorities, suggesting some compatibility with Swedish-style local delivery
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Australia – Individualized insurance-based funding through the NDIS	
Description	The National Disability Insurance Scheme (NDIS) is a disability-focused (not age-based) program that provides personalized budgets that participants use to purchase AT, home modifications, and related supports. Funding decisions are made through standardized assessments, and national price limits and provider/quality safeguards (United Nations Children’s Fund, 2022). Older adults not eligible for the NDIS may access AT supports through <i>My Aged Care</i>, with efforts to coordinate across systems to reduce service gaps.
What makes it effective	• User-directed budgets enhance autonomy • National governance ensures consistency across states • Integrated assessment process links AT with social, community, and employment supports
Implementation Considerations for Canada	• Canada already uses individualized funding in some areas (e.g., Ontario’s direct funding for home care, individualized disability funding in BC and Alberta), suggesting partial compatibility with user-directed AT funding models • Implementing a national insurance-style program is not the primary challenge; rather, Canada’s key implementation issue lies in achieving interoperability across existing aging and disability funding systems, which would require intergovernmental coordination similar to Medicare/Medicaid or Employment Insurance (EI) • The division between aging and disability funding streams is already a pain point in Canada and could be exacerbated without careful design

Japan – Integration through Long-Term Care Insurance (LTCI)	
Description	Japan’s LTCI, introduced in 2000, covers AT (often framed as welfare equipment/AT plus home adaptations, with rental models common and caregiving supports for adults aged 65+ (and for those aged 40+ with age-related conditions). It is funded jointly through taxes and mandatory insurance premiums and administered locally by municipal governments within a national entitlement framework (Global report on assistive technology , 2022). Certified care managers assess eligibility and coordinate procurement and training.
What makes it effective	• Dedicated, sustainable funding stream • Predictable eligibility pathway (care-need certification) that links assessment to funded supports • Integration of AT with preventive and home-care services • Local delivery under national standards

Implementation Considerations for Canada	Canada lacks a universal long-term care insurance framework, meaning that adapting a Japan-style model would require new legislative and financing mechanisms, shared federal–provincial funding, and coordination with existing benefits such as the Disability Tax Credit and provincial AT programs
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United States – Hybrid public–private coverage with state innovation

Description	The U.S. combines multiple mechanisms: Medicare (age-linked) and Medicaid (means-tested) reimburse medically necessary durable medical equipment; the Assistive Technology Act (serves all ages) funds state-level programs that operate device-loan banks, refurbishment centres, and low-interest financing (United Nations Children’s Fund, 2022). Federal funding ensures a minimum level of coordination, while states tailor delivery to local needs.
What makes it effective	- Federal coordination with state flexibility - Reuse and financing programs that increase affordability - Partnerships between public agencies and non-profits that extend reach to underserved populations
Implementation Considerations for Canada	Canada lacks a national equivalent to the U.S. AT Act. Scaling device-loan banks or financing programs nationally would therefore likely sit outside insured health services and require federal investment or a coordinated provincial effort with common minimum standards and local tailoring

European Union (EU) – Co-funding innovation and accessibility regulation

Description	EU programs such as the AAL Joint Programme, Horizon Europe, and the European Accessibility Act co-fund projects that link technology innovation with aging and inclusion outcomes (Mantovani & Turnheim, 2016; Alexandru & Ianculescu, 2017). Member states, research institutions, and private partners share costs, and projects are evaluated on both technical and social-impact indicators.
What makes it effective	Cross-sector collaboration between research, policy, and practice - Co-design with users to improve adoption Shared European standards that enhance interoperability and scalability
Implementation Considerations for Canada	While Canada does not have supranational governance comparable to the EU, the Accessible Canada Act and emerging national accessibility standards (e.g., CAN/ASC – EN 301 549:2024-Accessibility requirements for ICT products and services and CAN-ASC-6.2:2025 – Accessible and Equitable Artificial Intelligence Systems) provide a growing foundations for pan-Canadian accessibility and interoperability

	Unlike the EU’s directive-based approach, scaling innovations nationally still requires interprovincial agreements and voluntary harmonization, as well as federal convening and funding levers, rather than binding supranational directives
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Although these systems differ in structure, the features most associated with equitable access are:

- Predictable, entitlement-based funding that treats AT as essential, not discretionary.
- Integration with health and social-care delivery to streamline access and maintenance.
- Mechanisms for accountability and sustainability, such as loan banks and national reporting.

Canada already has several mechanisms that reflect aspects of these models, including provincial AT benefits, equipment loan programs, individualized funding in some jurisdictions, and federally administered programs such as Veterans Affairs and the Non-Insured Health Benefits program. These existing structures demonstrate that elements of predictable funding, integrated delivery, and sustainable device management are already present within the Canadian context.

Key informants reinforced the international evidence that entitlement-style and loan-based systems improve equity and uptake.

“It’s important to focus on the individual right to live a life of dignity and independence - not just the view of reducing costs or keeping people in their homes and out of hospital. Canada should link its policies to a broader rights-based approach.”

3.3.2. International education awareness and digital literacy campaigns

AT adoption improves when users and providers have the knowledge and support to use technologies confidently and effectively. Several countries have introduced education and awareness initiatives that build user confidence, expand digital literacy, and integrate AT into everyday care and community life.

United Kingdom – Integrating digital literacy and user training through the NHS and community partners	
Description	The UK embeds user education and awareness within the NHS and its broader digital inclusion strategy. The Good Things Foundation , supported by NHS Digital, operates programs like Learn My Way and Digital Health Hubs , which offer one-to-one coaching and peer learning for older adults, including on AT. Clinical commissioning groups fund patient training as part of AT service delivery (Mishra et al., 2022).

United Kingdom – Integrating digital literacy and user training through the NHS and community partners

What makes it effective	• Partnership between national digital-health policy and community delivery • Ongoing, relational learning rather than one-off sessions • Integration with existing NHS referral pathways
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Sweden – Continuous follow-up and rehabilitation-centre-based learning

Description	Sweden’s municipal AT centres provide device fitting, ongoing user education, and refresher sessions. Training is led by occupational therapists and physiotherapists and includes family or caregivers. Municipal staff receive standardized national training modules on AT categories and assessment tools (Mishra et al., 2022).
What makes it effective	• Mandatory follow-up visits reinforce correct use • National training standards maintain service consistency • Integration with rehabilitation reduces duplication

Australia – Education embedded in individualized AT plans

Description	Under Australia’s NDIS, funding covers devices as well as training for users and caregivers to ensure safe operation. The NDIS Quality and Safeguards Commission sets minimum provider training standards and requires education to be documented in each participant’s plan. Further, the federal Be Connected program funds digital-literacy workshops in community hubs for older adults, complementing NDIS supports (United Nations Children’s Fund, 2022).
What makes it effective	• Training is an explicitly funded line item • National quality assurance ensures consistency • Integration with general digital-literacy programs increases reach

Japan – Family and caregiver training under Long-Term Care Insurance

Description	Japan’s LTCI model includes in-home education for users and family caregivers. Certified care managers coordinate instruction on equipment use and maintenance, while municipal welfare centres run senior technology clubs that introduce low-cost digital tools for daily living (Mishra et al., 2022).
What makes it effective	• Training is an explicitly funded line item • National quality assurance ensures consistency • Integration with general digital-literacy programs increases reach

United States – State-level training, reuse programs, and peer education	
Description	Each United States state operates an Assistive Technology Act Program, many of which offer device-loan libraries, demonstration centres, and training workshops. Programs such as TechOWL Pennsylvania and Washington Assistive Technology Act Program (WATAP) combine professional and peer-led instruction, both in person and online. Federal funding supports accessible training materials in multiple languages and formats (United Nations Children’s Fund, 2022).
What makes it effective	• Consistent federal framework with flexible local delivery • Emphasis on demonstration and peer mentoring • Inclusion of underserved populations through reuse programs

European Union – Awareness through living labs and reference sites	
Description	The AAL Joint Programme and European Innovation Partnership on Active and Healthy Ageing (EIP on AHA). These programs fund living labs and reference sites that serve as demonstration hubs for older adults, caregivers, and service providers (Mantovani & Turnheim, 2016). These sites double as education centres where stakeholders test technologies and share lessons across regions.
What makes it effective	• Co-design with users • Visible, experiential learning environments • Cross-country knowledge exchange

Across jurisdictions, effective education and awareness strategies share three features:

- Learning is embedded in service delivery, not separate from it.
- Training extends to caregivers and peers, recognizing that AT is often used in shared environments.
- Digital literacy and AT awareness are linked through community and national initiatives.

In Canada, key informants emphasized that *“a lot of education focuses on academics and industry, but we need to be educating healthcare providers.”* They pointed to the value of extending training to caregivers and peers, noting:

“Have publicly funded demonstration sessions of the technology available to increase exposure ... some of this equipment is stigmatized just because of how it looks.”

These observations mirror the international finding that learning embedded in service delivery and peer-led demonstration is key to sustained adoption.

Canada’s current landscape aligns with international approaches that integrate education, digital literacy, and AT use. Many provincial AT and rehabilitation programs already include user and caregiver training, and community organizations offer digital-

skills programming that supports broader technology confidence. National initiatives, such as federal digital-literacy funding through programs like [Connected Canadians/Canadiens Branchés](#), add further momentum. Although these activities span sectors, together they suggest that Canada has a meaningful base of education and awareness infrastructure comparable to more coordinated models abroad.

3.3.3. International approaches to address AT access disparities

Canada faces persistent AT access barriers for rural and northern residents, Indigenous Peoples, low-income households, newcomers, and those with multiple complex disabilities (Global report on assistive technology , 2022; Enhancing equitable access to virtual care in Canada: Principle-based recommendations for equity, 2021). These disparities stem from cost barriers, variable provincial eligibility criteria, limited local service capacity, and inconsistent digital infrastructure, creating unequal opportunities to access technology-enabled care (AGE-WELL, 2017; Mattison et al., 2017; Wang & Wilson, 2022). To explore how these inequities may be addressed, this section examines international models that improve equitable access to AT, focusing on governance, outreach, and affordability mechanisms that could inform Canadian policy development.

United Kingdom – Monitoring equity through national data and targeted outreach	
Description	The UK’s NHS uses national equity dashboards to track variation in access to AT (e.g., powered mobility, communication aids) by region, age, and socioeconomic status (Mishra et al., 2022). NHS England’s Specialised Commissioning process funds regional “hub” services where local capacity is low, and outreach clinics are delivered in rural and coastal areas to improve geographic reach.
What makes it effective	• Centralized data collection linked to funding decisions • Outreach embedded in existing health structures • Transparent publication of regional equity reports

Sweden and Norway – Regional delivery and mobile outreach for geographic equity	
Description	Nordic countries combine decentralized administration with mobile service teams that bring assessment, fitting, and repair directly to remote communities. Mobile assistive-technology clinics operate under regional health authorities and are coordinated through municipal home-care services (Mishra et al., 2022).
What makes it effective	• Co-location with existing home-care programs • Cost sharing between municipalities and regions • On-site maintenance that minimizes downtime for users

Japan – Local tailoring through municipal administration under Long-Term Care Insurance	
Description	Under Japan's LTCI, municipalities administer benefits, allowing for local adaptation to demographic and cultural needs (Global report on assistive technology , 2022). Municipalities coordinate with welfare organizations and volunteer networks to ensure that AT reaches older adults living alone or in isolated rural areas.
What makes it effective	• Affordable access through reuse and financing • Federal support for consistency • Strong partnerships with non-profit and community organizations

European Union – Legal frameworks and accessibility standards to monitor equity	
Description	The European Accessibility Act (2019) and the EIP on AHA require member states to monitor access and outcomes for persons with disabilities and older adults across income and geographic lines (Mantovani & Turnheim, 2016). EU programs also fund demonstration projects in low-resource regions to test scalable community models.
What makes it effective	• Binding accessibility standards • Performance indicators tied to funding • Continuous evaluation of inclusion outcomes

Low- and Middle-Income Country Models – Local manufacturing and repair ecosystems	
Description	In several low- and middle-income countries, supported by WHO and UNICEF (United Nations Children's Fund)'s GATE initiative (Global Cooperation on Assistive Technology), local production and repair workshops have reduced costs and improved sustainability (United Nations Children's Fund, 2022; Assistive devices in low-income countries: Adaptability and recent innovations, 2017). Examples include community-based wheelchair and orthotics workshops in Vietnam and Tanzania that employ local technicians trained through international standards.
What makes it effective	• Affordability through local fabrication • Culturally appropriate design • Local job creation supporting system sustainability

Across jurisdictions, the most consistent lessons for reducing disparities are:

- Support equity monitoring built into governance, linking data to funding and accountability.
- Use mobile, community-based, and regionally administered programs to reach populations national models miss.

- Ground affordability and sustainability in local solutions (e.g., reuse networks, repair workshops).
- Use inclusive design and co-development with communities to ensure cultural and linguistic relevance.

Key informants across Canadian jurisdictions described parallel challenges:

“Policies are great but it’s so staggered, based on where you live,” and “rural areas face barriers on all fronts. Poor cell service, higher food and fuel costs, and long travel distances.”

Those working in Indigenous and northern settings noted that:

“Sometimes in communities most of the funding is provided by band leaders; funds can be mismanaged or take a long time to get approved; depends if the band leader is in tune with their community’s needs.”

Others highlighted:

“Indigenous folks, newcomers and street-involved people might not always have a health card and have a hard time accessing home support or funding for AT; even people who have been living in Canada for years can still not have a health card.”

These voices align closely with international evidence stressing decentralized delivery, mobile outreach, and locally tailored partnerships.

Canada demonstrates elements of these approaches through provincial outreach teams, regional rehabilitation services, community-led programs in northern and Indigenous communities, and non-profit-operated loan and reuse centres. Digital-inclusion initiatives delivered through libraries, settlement agencies, and community organizations also echo aspects of the international focus on local proximity and targeted support. Together, these practices indicate that Canada has emerging pathways that mirror international equity-oriented models and could be built upon.

3.3.4. Key takeaways

- International evidence shows that **effective AT systems share several key features**: predictable, entitlement-based funding; integration with health and social care; and ongoing education and outreach to support confident use.
- Countries including **the United Kingdom, Sweden, Japan, and Australia** provide strong models for accessible, sustainable, and person-centered systems.
- Successful programs combine universal access, **with local flexibility, clear governance, and built-in mechanisms for accountability and reuse**
- **Education and digital literacy** are treated as core components of AT service delivery, with training extended to caregivers and peer networks.

- **Equity-focused strategies**, such as mobile outreach in Nordic countries, municipal delivery in Japan, and data-driven equity monitoring in the UK, ensure that underserved populations are not left behind.
- Canada could strengthen its AT system by **adopting national standards, embedding training in service delivery, and linking funding to equitable outcomes across regions.**

3.3.5. Policy recommendations drawn from international examples

Recommendation 4: Enhance awareness, navigation, and digital literacy

- Establish a national AT information and navigation architecture, supported by provincially and territorially tailored entry points, to link seniors, caregivers, service providers, and funders. This phased approach would accommodate current jurisdictional variation while advancing alignment with national AT definitions, standards, and terminology (outlined in Recommendation 1).
- Support public outreach campaigns, demonstration sites, and equipment loan or trial programs through dedicated funding, partnerships with community organizations, and locally delivered programming to reduce stigma and promote healthy and independent aging.
- Simplify administrative and application processes by working with older adults and caregivers through co-design and usability testing to develop plain-language, multilingual, and accessible information materials.
- Expand digital and technology literacy programs for seniors and caregivers to improve uptake and confidence.

Recommendation 5: Strengthen human and technical support infrastructure

- Invest in a pan-Canadian training framework, delivered through provincial and territorial systems, for relevant health and other professionals as well as community-based technology facilitators.
- Fund mobile, in-home, and community-based support models for device setup, maintenance, and troubleshooting.
- Ensure culturally and linguistically appropriate outreach and after-sales support to reduce device abandonment.

3.4. Equity and inclusion considerations

Older adults in Canada face financial, technical, and system-level barriers that limit access to, effective use of, and ongoing support for AT. High costs for purchase, repair, and upgrades and fragmented funding exacerbate these challenges, particularly for equity-deserving groups (e.g., Indigenous, rural, and northern residents, newcomers, low-income seniors) and for those with multiple or complex disabilities. This section outlines some of these barriers and their impacts on older adults' access to and use of AT.

3.4.1. Barriers Canadian seniors face in accessing, using, and maintaining assistive technologies

Canadian seniors face multiple barriers to accessing, using, and maintaining AT that support aging in place, independence, and quality of life. According to the 2022 Canadian Survey on Disability, 22.7% of persons with disabilities reported unmet needs for assistive aids or devices (McDiarmid, 2025). Further, those aged 65 years and older (25.6%) were more likely to have unmet needs than their younger counterparts (McDiarmid, 2025).

Affordability

Affordability was frequently cited as a barrier to AT. Many older adults live on fixed or limited incomes, and the cost of purchasing, repairing, or upgrading AT (e.g., hearing aids, mobility aids, smart home systems, and communication tools) can be prohibitively high (Wang et al., 2022). For example, in Canada, 23% of persons with a hearing disability needed a hearing aid but did not have one, while 72% cited costs as a reason (Statistics Canada, 2025).

Studies and key informants report that inconsistent public funding, low-income cut-offs, or low insurance coverage prevents many seniors, especially low-income individuals, from accessing AT, that could improve their independence (Labrecque, 2024); (Wang et al., 2022). Further, as many key informants revealed, even when government subsidies or charitable programs exist, they are often fragmented and vary widely across provinces and territories, resulting in uneven financial support.

Usability and design issues

Many AT are not developed with sufficient input from older adults or consideration of age-related changes in vision, dexterity, cognition, or hearing. Consequently, seniors may find these devices unintuitive, complex, or physically difficult to use. For example, in Internet of Things (IoT) in smart homes, Yamout et al. (2024) share that poorly designed interfaces, confusing instructions, and frequent software updates can discourage adoption and lead to device abandonment. These challenges are compounded when technologies require familiarity with digital ecosystems, such as smartphones, Wi-Fi networks, or cloud-based platforms, which may be unfamiliar to older adults with limited digital literacy (Tsertsidis et al., 2019).

Lack of awareness and information

As confirmed by key informants, many seniors and their caregivers are unaware of the AT available, where to obtain it, or how to access financial assistance (Wang et al., 2022). Limited outreach from health and social service providers and the absence of centralized information hubs, leave potential users disconnected from resources (Tsertsidis et al., 2019). Further, navigating paperwork and applications to access AT can be confusing for seniors, especially if they must do it by themselves.

The knowledge gap is particularly pronounced in rural and remote areas, where fewer service providers or community organizations are available to provide guidance (Alberta Health, 2017); (Wang et al., 2022). As key informants shared, without adequate

information, seniors may rely on word-of-mouth or online searches, which can result in the purchase of inappropriate, low-quality, or unsafe products.

Maintenance and ongoing technical support

AT often requires regular maintenance, software updates, or troubleshooting to remain functional. However, seniors frequently report limited access to affordable repair or support services, and technical issues (such as software incompatibilities, network failures, or battery replacements that can render devices unusable) leading to frustration and eventual disuse (Zuppo, 2012). Difficulties in setting up digital devices for home health monitoring, limited device control, and issues with device synchronization, reliability, and stability are also reported by seniors (Kondratova et al., 2023). Some studies note that even when support is available, it is often delivered online or through automated systems that are inaccessible to individuals with low digital confidence or cognitive impairments. In such cases, the absence of human-centered support services can exacerbate technology abandonment and increase reliance on caregivers (Yamout et al., 2024).

Policy and system fragmentation

In Canada, jurisdictional differences between FPT programs result in inconsistent eligibility criteria, funding models, and service delivery approaches (Durocher et al., 2017). Many seniors find navigating multiple service sectors, and their varying rules and procedures, frustrating and confusing (Wang et al., 2022). Because AT is not universally covered under Canada's public healthcare, out-of-pocket expenses can be prohibitive, especially for seniors on fixed incomes. This lack of national coordination creates barriers for seniors who move between regions or require multiple forms of assistive support spanning healthcare, housing, and social systems.

Stigmatization

Social and psychological factors play a critical role in shaping technology adoption among seniors. Feelings of stigma, frustration, or fear of failure can reduce willingness to use AT, especially when devices highlight loss of ability rather than empowerment. Technologies may be rejected if they symbolize frailty, dependence, or “being old.” As one key informant described,

“Some of this equipment is stigmatized just because of how it looks. You're independent your whole life, then something happens and then you need a walker or a cane. And suddenly, you feel like an ‘old person,’ and this [AT] is a physical representation of that.”

As Astell et al. (2020) note in their research, stigma associated with disability can threaten self-image, contributing to fear of judgment or internalized ageism. Many participants saw technology as something to be used only when absolutely necessary, often adopting a “not yet” attitude, even when AT could help. Further, those with impairments may not see themselves as “old” or in need of help, and thus can resist devices that suggest otherwise (Astell et al., 2020).

Privacy

Some older adults are concerned about surveillance and privacy risks associated with smart technologies, especially for health monitoring or fall detection (Tsersidis et al., 2019). In one study on the adoption of smart home technologies, seniors found health monitoring too intrusive, citing fears of being watched (“Big Brother” effect); anxiety from excessive data (e.g., blood pressure readings); and the potential misuse of personal health data (e.g., affecting insurance eligibility); (Balta-Ozkan et al., 2017). Another study found that privacy concerns contributed to 45.2% of seniors abandoning smart wearables (Fournier et al., 2020).

Equity-deserving communities

Community	Examples of barriers to healthcare and AT
Indigenous	• Can have limited access to health services and technology if in a rural or remote location • Mistrust of Western medical systems; outsider-developed technologies can feel colonial or inappropriate (Alberta Health, 2017); (Jacklin et al., 2020) • Increasing virtual care has resulted in the loss of in-person encounters, which reduces opportunities for culturally safe care that reflects Indigenous perspectives of health and wellness (Barriers and strategies to equity in digital health programs and services, 2023)
Rural, northern, and remote	• Infrastructure gaps, transportation difficulties, limited internet connectivity, and fewer service providers (Zuppo, 2012); (Ahmmed et al., 2022) • High costs for technology (Barriers and strategies to equity in digital health programs and services, 2023)
Racialized	• Disproportionately affected by systemic barriers (e.g., affordability, internet access in their communities); structural racism and historical harms contribute to lower access and trust in digital health tools (Barriers and strategies to equity in digital health programs and services, 2023) • May not see themselves reflected in system design; encounter implicit bias or stereotyping by providers (Enhancing equitable access to virtual care in Canada: Principle-based recommendations for equity, 2021)
Men and women	• Data shows that while women are often more likely to need AT, men often have a higher rate of access to these supports (McDiarmid, 2025). • Some studies show that while women can perceive AT as essential for social interaction, data has indicated that only men experienced enhanced

	social participation (McGuinness, E., Patel, D., Patrick, M., & Austin, V, 2025)
Official language minority communities (OLMC), immigrants/newcomers, and those with uncertain citizenship status	• Communication, cultural, and tech literacy barriers can delay diagnosis, impair care coordination, and limit access to community supports (Alberta Health, 2017); (Barriers and strategies to equity in digital health programs and services, 2023) • Experience language barriers; may lack private space or equipment and rely on shared or limited household technology (Barriers and strategies to equity in digital health programs and services, 2023) • Security and surveillance fears were especially high among undocumented individuals (Barriers and strategies to equity in digital health programs and services, 2023)
2SLGBTQIA+ people	• May face stigma, discrimination, or isolation, especially in long-term care settings (Alberta Health, 2017) • May face a lack of gender-affirming care; often excluded from demographic data collection (Enhancing equitable access to virtual care in Canada: Principle-based recommendations for equity, 2021)
People living on low income or experiencing homelessness	• Vulnerable to delayed diagnosis, inadequate support, and poor health outcomes (Alberta Health, 2017) • Lack of access to devices, internet, and data plans; virtual care can reduce transportation costs and time off work, but many are excluded due to affordability challenges (Barriers and strategies to equity in digital health programs and services, 2023) • Struggle with lack of privacy, safe spaces, or consistent access to devices and internet (Barriers and strategies to equity in digital health programs and services, 2023)

3.4.2. Infrastructure, services, and policies to improve AT access for equity-deserving communities and those with multiple or complex disabilities

Affordability

Literature suggests that policy frameworks should actively address systemic barriers by providing equitable funding, reducing financial obstacles, and embedding AT services within integrated health and social care systems (Tsertsidis et al., 2019). Further research posits that policy frameworks should therefore standardize eligibility requirements, expand coverage for home-accessibility equipment, and increase reimbursement rates to reflect actual costs (Labrecque, 2024).

Additionally, equity-oriented policy should move beyond “low-income only” models and consider the “missing middle” (individuals who do not qualify for income-based assistance but cannot afford devices out-of-pocket) (Durocher et al., 2017). National and provincial coordination was also named as needed to harmonize funding streams, reduce duplication, and ensure that AT aligns with health and social care priorities (Mattison et al., 2017).

Increasing awareness

Key informants recommended proactively providing seniors with information to support aging in place (e.g., having brochures in doctors’ offices or community spaces where seniors often visit). Publicly funded demonstration sessions were suggested to increase exposure and reduce stigma around AT. Further, trials of AT equipment was said to combat fear, reduce financial barriers, and promote aging in place. One key informant explained,

“I find that some patients that I have are hesitant about trying medical equipment, sometimes because of the stigma, where they think, ‘if I have too much medical equipment in my house, it’s kind of like a hospital.’ So, being able to trial the equipment without having to sink any money into it helps people realize that this equipment can be useful, and it can promote them aging in place and staying at home longer in a safe manner.”

Co-design and partnership

Literature also notes that building partnerships between governments, universities, and community organizations is vital to co-develop services and infrastructure that meet diverse needs (Mattison et al., 2017). Human-centered, culturally appropriate design approaches can enhance privacy and security design for greater technology acceptance by older users, as well as participation in the co-design and co-development of personalized, safe, and user-friendly AT (Fournier et al., 2022); (Tsertsidis et al., 2019); (Yamout et al., 2024).

As described by a key informant,

“Involve frontline care staff, elderly people living in the community, and families of people who have lived experience to inform policies, specifically related to funding equipment.”

With regard to technology development research with Indigenous communities, it was suggested to:

- Develop solutions, with, not for, Indigenous communities;
- Emphasize addressing historical harms and fostering equity and trust;
- Recognize that relationship building takes time;
- Follow local protocols;
- Understand that every Indigenous community is unique in culture, experience, and needs;

- Encourage community involvement, especially Elders, throughout the entire process; and
- Adapt technologies locally, ensuring they are user-friendly and personable (Jacklin et al., 2020).

Collaborative service models that link governments, Indigenous organizations, health authorities, and community groups help ensure programs meet diverse needs. Peer-support initiatives, such as seniors teaching other seniors how to use technology, increase confidence and sustain engagement (Kondratova et al., 2023).

Equity-deserving populations were also named as specific groups that should be consulted to create evidence-based policies. Confirmed by key informants, developing standards and guidelines that consider the social determinants of health, systemic barriers, and accessibility challenges faced by diverse populations was seen as helpful to inform policy and program design.

Support and training

Literature and key informant interviews suggest that adequate and standardized training, technical support, and maintenance services tailored for diverse users are critical to improving adoption and sustained use of AT (Zuppo, 2012); (Allegue, 2025). Culturally-sensitive and linguistically-appropriate outreach, education, and training programs further ensure inclusion and accessible participation, improving user confidence and reducing device abandonment (Tsertsidis et al., 2019).

Seniors with multiple and complex disabilities

Key informants noted that seniors with multiple and complex disabilities often lack insight into their functional difficulties, including activities they may not recognize as unsafe. Those with certain cognitive issues (e.g., Alzheimer's, dementia) can be less likely to use AT. Age-related changes, such as vision and hearing loss or fine motor difficulties, which correlate with physical competencies required to make full use of technologies (Kondratova et al., 2023), or disability-related challenges, such as a lack of accessible platforms (e.g., screen readers, captioning) and physical and sensory limitations (Enhancing equitable access to virtual care in Canada: Principle-based recommendations for equity, 2021) further impede technology use. Key informants emphasized that community supports are critical for access and inclusion. Data also shows that increased disability severity was associated with a higher probability of unmet AT needs (McDiarmid, 2025).

3.4.3. Caregiver and seniors-serving organization roles to support the effective use of AT

Co-design and participatory development

Caregivers and seniors-serving organizations are essential in facilitating the adoption, effective use, and co-development of AT for older adults. Their involvement enhances usability, ensures that technologies meet real-world needs, and supports long-term sustainability. Without adequate caregiver training and community-based education, the

burden of technology management often falls on family members, potentially limiting long-term adoption and satisfaction (Yamout et al., 2024).

Despite their importance, caregivers' perspectives are not always incorporated into technology development. As confirmed by interviews, many technologies remain designed primarily for end-users, without sufficient consideration of the caregivers' needs, constraints, and experiences (Allegue, 2025). Including caregivers in AT design ensures solutions are practical, relevant, and responsive to both users and care providers. This collaborative model creates safer living environments, enhances cognitive and physical health management, and strengthens community connectedness (Allegue, 2025). Co-creation practices recognize caregivers as both end-users and essential contributors in shaping AT solutions.

Further, caregivers often act as intermediaries who introduce, set up, and maintain AT for older adults. Their attitudes, familiarity, and confidence with technology strongly influence seniors' acceptance and ongoing use (Tsertsidis et al., 2019). The presence of a supportive caregiver can significantly reduce anxiety and resistance to new technologies, particularly when older adults lack digital literacy or prior experience (Marcotte, 2023).

Training and capacity building

Effective AT adoption relies on targeted training and support for caregivers and service organizations. Evidence shows that digital literacy interventions for older adults are most successful when caregivers and organizational staff are included in the learning process (Marcotte, 2023). Training should address both technical competencies and strategies for integrating technology into daily care routines to ensure consistent and confident use.

Reducing caregiver burden

AT can alleviate caregiver workload by automating or simplifying care tasks, such as monitoring, communication, and safety. Tools like remote monitoring systems, fall detection devices, and adaptive technologies have been shown to decrease caregiver stress and physical strain (Marashinghe, 2016). However, these benefits are contingent on technologies being user-friendly, reliable, and compatible with caregivers' existing workflows (Allegue, 2025).

Role of seniors-serving organizations

Seniors-serving organizations are key intermediaries in supporting community-level AT adoption. They provide training, information, and referral services to connect seniors and caregivers with appropriate technologies (Lok Yi Wong et al., 2021).

Social and emotional support

The concept of "warm experts" highlights the social dimension of caregivers. Trusted individuals, often family caregivers or staff from seniors-serving organizations, offer emotional reassurance and hands-on assistance that encourage sustained technology

use (Marcotte, 2023). This interpersonal support helps mitigate feelings of isolation or frustration that can otherwise lead to technology abandonment.

3.4.4. Key takeaways

- Older adults face financial, technical, awareness, usability, maintenance, policy, privacy, and stigma-related **barriers that reduce access to and sustained use of AT**. These challenges are amplified for equity-deserving populations and those with complex disabilities.
- Indigenous, rural/remote, racialized, low-income, newcomers, 2SLGBTQIA+, and other equity-deserving older adults face unique structural and systemic barriers, including **limited services, mistrust, digital literacy gaps, language issues, and affordability challenges**.
- **Affordability and policy fragmentation creates issues**. High costs, inconsistent public funding, fragmented provincial programs, and lack of national coordination prevent many seniors from acquiring necessary AT, creating inequities in access across regions and income levels.
- **Co-design, awareness, and human-centered approaches are needed to improve adoption**. Engaging seniors, caregivers, and communities in technology design, offering trials and demonstrations, and culturally sensitive, participatory approaches enhance usability, privacy, trust, and uptake of AT.
- **Caregivers and community organizations are essential** to: provide technical, emotional, and practical support for seniors; promote the adoption of AT; reduce technology abandonment; and help seniors maximize the benefits of AT. Use of AT can also help reduce caregiver burden.

3.4.5. Recommendations to support equity and inclusion

Recommendation 6: Promote dignity, privacy, and social acceptance

- Mandate privacy-by-design and informed consent standards for connected and AI-enabled technologies.
- Encourage inclusive, aesthetic, and user-centered design that supports dignity and empowerment rather than dependency.
- Promote peer-to-peer learning and storytelling initiatives to reduce stigma and normalize technology use.

Recommendation 7: Advance equity and infrastructure for underserved communities

- Embed intersectional equity indicators in AT policy and reporting.
- Expand broadband and digital infrastructure in rural, northern, and remote regions.
- Create culturally grounded, community-led programs that improve AT access for Indigenous, 2SLGBTQIA+, newcomer, racialized, and low-income seniors.

3.5. Innovations and technologies

This section explores best practices, promising innovations, and the role of public policy in AT development and adoption.

3.5.1. Best practices in assistive technologies that support aging in place

Canada is making progress in developing and using assistive technologies (AT) that help older adults live safely and independently at home.

Inclusive design, co-design, and real-world testing

As noted in section 3.4.2, inclusive design and co-design approaches are integral to innovation that actively involve older adults and caregivers in testing technologies. Specific examples in community labs and living labs include:

- Simon Fraser University's Science and Technology for Aging Research (STAR) Institute,
- Carleton University's Abilities Living Lab (ALL), and
- AGE-WELL Sensors and Analytics for Monitoring Mobility and Memory (SAM³) National Innovation Hub).

Real-world trials allow older adults to provide feedback, which helps consider devices for usability, safety, and real-life "fit" before wider rollout (The Kite Research Institute, n.d.; envisAGE Collaborative Projects, 2025; AGE-WELL National Innovation Hub, n.d.; Carleton University, n.d.; Tsertsidis et al., 2019; Zuppo, 2012).

Co-design supports identity-sensitive technologies by creating devices that feel mainstream rather than medical, reducing stigma and encouraging use, allowing AT to become tools for independence instead of symbols of decline (Astell et al., 2020).

Holistic and multidisciplinary approaches

Best practice in AT development frames healthy, satisfying and independent aging beyond physical safety to include cognitive health, emotional well-being, social connection, and participation in community life. This leads to multidisciplinary approaches, including:

- Home modifications and environmental changes
- Behavioural coaching and fall-prevention strategies
- Memory and reminder tools
- Smart medication packaging and monitoring
- Links to virtual care, rehabilitation, and caregiver support

These approaches treat AT as part of a wider support system, not a stand-alone gadget (Tsertsidis et al., 2019).

While some Canadian initiatives (e.g., SAM³) reflect the international shift toward age-friendly, integrated care, holistic approaches in Canada remains developing.

Digital literacy, equity, and accessibility

As noted in section 3.4, older adults from equity-deserving groups can experience weak internet, high device/data costs, and limited digital literacy.

Confirmed by interviews, some innovative solutions from organizations are:

- Providing community-based digital literacy training and peer-to-peer support,
- Offering multilingual materials and culturally tailored outreach, and
- Using libraries, malls, and community centres as accessible “digital help” hubs.

Tools such as the AccessATCanada Navigation Portal help find funding and services by device type, location, and eligibility (Assistive technology made easy: Exploring the AccessATCanada navigation portal, 2024). Further, virtual care platforms, including provincial portals and remote-doctor services, demonstrate that technology can support relationship-based care (AGE-WELL, 2017).

Privacy, identity, and personalization

Research on smart home adoption shows that visible cameras, wearables, or persistent alerts can create resistance or distrust (Balta-Ozkan et al., 2017). Best practices emphasize passive, less intrusive monitoring, such as radar-based or non-wearable sensors that support safety without constant observation (Fournier et al., Designing for privacy and technology adoption by older adults, 2022).

In addition, strong privacy design and data control helps reinforce independence and normalcy rather than disability or decline (Aging in Place challenge program, 2025). Personalization is also crucial; several Canadian initiatives are developing tools to match technology to a person’s sensory abilities, home environment, cultural context, and comfort with technology (Assistive technology made easy: Exploring the AccessATCanada navigation portal, 2024; Aging in Place challenge program, 2025).

3.5.2. Current state of innovation in Canada

The Council of Canadian Academies (CCA) research on innovation reports that Canada’s industrial research and development spending is concentrated in engineering, ICT, and medicine, with 11% of Canada’s business enterprise expenditures on research and development devoted to medical and health sciences (The State of Science, Technology, and Innovation in Canada, 2025).

One metric to measure levels of innovation can be found within patent filing. Within the top 20 patent offices (ranked by number of AT patent applications filed from 1998 to 2019), Canada places 10th for cognition AT, 10th for conventional communication AT, and 13th for emerging communication AT (WIPO Technology Trends 2021: Assistive technology, 2021).

At the same time, Canada’s AgeTech and AT landscape is active, evolving, and shaped by a mix of:

- Research networks and innovation hubs
- Small and medium-sized companies
- Community and non-profit organizations
- Health-care and social-care partners

Some innovations fall under AT (e.g., robotic mobility aids, smart wheelchairs, adaptive input devices) (Science and Technology for Aging Research (STAR) Institute, 2019), while others are broader AgeTech tools (e.g., VR-based exercise games, platform adapters that make websites easier to use for people with visual or cognitive impairments) that still support aging in place (The Kite Research Institute, n.d.).

Access and affordability expand through open-source and low-cost AT solutions, such as customizable switches, styluses, and keyguards. These innovations often come from community-based maker movements and volunteer teams, promoting capacity building and public awareness (Science and Technology for Aging Research (STAR) Institute, 2019).

3.5.3. Promising innovations

Examples of promising innovation ecosystems across the country point to progress in some areas.

The **social connection** arena is seeing digital technologies and ambient technologies (unobtrusive, context-aware systems using sensors) influence safety monitoring and reductions in loneliness (Clayton & Astell, 2022; Aging in Place challenge program, 2025), (envisAGE Collaborative Projects, 2025), (MNP LLP, 2021; Science and Technology for Aging Research (STAR) Institute, 2019).

Innovations that support **community participation and civic engagement** have developments in digital platforms focussed on media, wellness, and activity (AGE-WELL National Innovation Hub, n.d.) (Agboji et al., 2025) (Welcome to the SENSE-MD Information Hub, n.d.).

Economic inclusion and daily-life independence AT are adaptive and open-source to support participation in work, education, and daily tasks. They help people take part in remote work, volunteering, or online learning, and to manage finances and daily responsibilities (Science and Technology for Aging Research (STAR) Institute, 2019), (Mohammadnejad et al., 2024).

Innovations that bridge the **digital divide** and build **technological literacy** help improve confidence and AT use (Science and Technology for Aging Research (STAR) Institute, 2019).

Promising innovations	Examples
Social connection	- Smart-home and ambient systems quietly monitor safety (e.g., movement, activity patterns, doors or stoves left open) while supporting communication with caregivers and family through built-in messaging and video options. - Voice assistants and simple video-calling tools help older adults contact family, friends, and service providers, reducing isolation and making day-to-day interactions easier.

	• Robotic and AI-based companions can reduce loneliness, provide comfort, and support daily routines, especially for people in long-term care or living alone.
Community participation and civic engagement	• Digital platforms are being used to help older adults stay informed and involved in community and civic life (i.e., tools that make it easier to follow local issues, join discussions, or access community programming from home). • Wellness and activity platforms (such as those used to support group programs, clubs, and cognitive-stimulation activities) offer scalable ways to promote engagement and reduce apathy and isolation in both community and facility settings. • Transport-related technologies (e.g., smart wheelchairs and age-friendly autonomous mobility systems) help people navigate their communities safely, attend appointments, and participate in public spaces.
Economic inclusion and daily-life independence	• Input devices (e.g., sip-and-puff controls, adapted keyboards and mice) make computers and communication tools usable for people with mobility or dexterity limitations. • Hearing and communication supports make virtual meetings and customer interactions more accessible. • Antivibration gloves, designed for people with tremors (such as those associated with Parkinson’s disease or essential tremor), stabilize hand movements, making activities like eating, writing, or using a smartphone easier. They also reduce the need for one-to-one assistance or home-care visits, especially in rural or remote areas.
Digital divide and technological literacy	• Intergenerational technology training, seniors-teaching-seniors initiatives, and structured digital-literacy workshops help older adults build confidence with technology and use AT more effectively. These programs often improve more than just technical skills; they help participants feel more connected and less intimidated by digital environments, which can support broader social inclusion.

Integrated Ecosystems and Inclusive Design

A growing area of promise is integrated “ecosystems” that connect health, social, and community services through interoperable platforms and Internet-of-Things (IoT) solutions. When monitoring systems, communication platforms, and service providers can “talk to each other,” supports for aging in place can be more responsive and coordinated (Tsertsidis et al., 2019).

These systems work best when older adults and caregivers participate in their design and evaluation, supporting everyday routines, respecting privacy, and reflecting diverse cultural and community contexts (AGE-WELL SAM3 National Innovation Hub, 2025).

Conclusion

Despite these advances, significant challenges remain. Adoption is uneven, especially in long-term care and other regulated settings, and many older adults still face barriers related to cost, digital literacy, and privacy concerns (Tsertsidis et al., 2019). Large-scale or longitudinal evaluations are limited and do not clearly demonstrate improvements in quality of life, health outcomes, or system efficiency (Assistive technology made easy: Exploring the AccessATCanada navigation portal, 2024; Inclusive Design Research Centre (IDRC) , 2025).

As noted in sections 3.2 and 3.4 and confirmed by interviews, Canada's innovation ecosystem is growing in some areas, yet availability and access are inconsistent across regions and populations. There is momentum, but not yet a universal or equitable pathway for scaling.

3.5.4. Role of public policy to stimulate the development, adoption, and scaling of AT

As Canada's population ages, public policy can help ensure that AT are accessible, affordable, and truly useful for older adults. Because AT ranges from simple mobility aids to AI-enabled systems, policy needs to look beyond device-by-device subsidies and toward whole-system approaches.

Standardize definitions, service models, and delivery standards

Policy requires a shared language and service framework to align funding, regulation, evaluation, and integration of AT. As shared by a key informant, the WHO GATE 5P framework (People, Policy, Products, Provision, Personnel) offers a useful organizing rubric described here:

“To achieve universal, equitable access to assistive technology, actions are required in each area of the 5P framework. This means for example, ensuring a person-centred approach to reviewing and strengthening policy frameworks, addressing the need for affordable, quality products and a reliable supply chain, creating effective and accessible service provision models, and building the capacity of the workforce to support those who need assistive technology in their access.” (Global Cooperation on Assistive Technology (GATE), n.d.).

Reviews of AT service provision show that, while there is no single global standard, common stages (assessment, selection, fitting, training, and maintenance) consistently appear and could structure national and provincial policies (Layton et al., 2024). Clinical guidelines also shows that AT is often under-specified, with inconsistent terminology and detail (Callaway et al., 2025). Clearer, more consistent standards can reduce fragmentation and offer better guidance to providers and innovators.

Expand eligibility, funding, and procurement of integrated AT

Public programs can better match innovation by widening what “counts” as AT while still applying clear guardrails. A common approach in the literature is that AT should be eligible for public funding if it meets two conditions: (1) it demonstrably improves function, safety, independence, or participation for the user; and (2) it aligns with

accessibility and AgeTech goals rather than just being a mainstream consumer gadget (Baudin et al., 2020).

Policies can embed these guardrails by:

- Covering both traditional devices (such as walkers and hearing aids) and newer digital or sensor-based tools, but only when they support function and independence for older adults in measurable ways (Baudin et al., 2020).
- Linking eligibility to clear functional criteria and evidence of benefit, rather than relying on narrow lists of pre-approved devices. This maintains flexibility while keeping a standard for what qualifies as AT (Baudin et al., 2020)
- Using public procurement to ensure quality, safety, interoperability, and cost-effectiveness, rather than simply expanding the market (Mastracci, et al., 2024).

These safeguards align with literature advocating for AT as essential health and social supports, and aim to reduce unmet need that results from outdated or fragmented delivery models (Layton et al., 2024).

Build workforce capacity and support service delivery infrastructure

While some newer consumer technologies are designed to be “plug and play,” many AT, especially those used by older adults with complex health conditions, still require competent assessment, customization, training, and follow-up. Research on technology adoption consistently finds that these human supports are among the strongest predictors of sustained use (Dequanter et al., 2022; Schroeder et al., 2023).

Drawing on these insights, governments and funders can:

- Fund training and support services as integral parts of AT programs, not add-ons.
- Invest in professional capacity, credentialing AT specialists and equipping home-care and rehabilitation providers to deliver hands-on assistance.
- Embed AT into primary and community care, enabling clinicians to prescribe and monitor use.
- Require user-centred design and evaluation, linking AT funding to accessibility, satisfaction, and measurable outcomes (e.g., reduced falls or ER visits).

This shifts policy from focusing on devices alone to supporting the services and people that make those devices effective over time.

Institutionalizing co-design and user-centred review

Finally, policy can ensure that seniors, caregivers, and people with disabilities have a formal role in shaping AT systems. Canadian research shows that meaningful co-design improves usability, trust, and long-term uptake (Jeyakumaran et al., 2024) This requires:

- Representative advisory councils and governance structures that include older adults and caregivers
- Ongoing feedback loops, not one-time consultations
- Transparent communication about decisions and trade-offs

Co-design also plays a role in reducing stigma and increasing the acceptability of AT. When older adults influence form, function, and aesthetics, devices are more likely to be perceived as empowering tools rather than medical markers of decline (Zhang et al., 2023; Jeyakumaran et al., 2024).

Embedding co-design principles into funding, procurement, and evaluation frameworks helps ensure that publicly supported technologies are not only evidence-based but also aligned with user priorities such as independence, confidence, and social participation.

3.5.5. Key takeaways

- Canada has a **vibrant and growing AT ecosystem**, driven by research, industry, and community initiatives, with innovations supporting healthy, satisfactory and independent aging. However, **access, adoption, and evaluation remain uneven**, limiting equitable scaling and impact.
- **Involving older adults and caregivers** in the design, testing, and real-world trials of AT ensures devices fit daily routines, cultural contexts, and personal preferences, increasing acceptability and reducing stigma.
- **Holistic, multidisciplinary approaches enhance aging in place.** Successful AT integrates physical safety, cognitive health, emotional well-being, and social participation, linking devices with home modifications, behavioural coaching, rehabilitation, and caregiver supports.
- **Equity, digital literacy, affordability and accessibility remain critical barriers.** Rural, low-income, and culturally diverse populations face challenges in accessing, understanding, and using AT, prompting initiatives like community digital literacy programs and multilingual resources.
- **Privacy, personalization, and non-intrusive monitoring foster trust.** Designing AT that respects user control over data and employs subtle monitoring increases adoption, while tailoring technology to individual needs improves sustained use.
- **Public policy plays a central role in scaling and integration.** Policies can standardize service models, expand eligibility and funding, support workforce capacity, and embed co-design principles to ensure AT is effective, equitable, and aligned with user priorities.

3.5.6. Policy recommendations to promote innovation

Recommendation # 8: Foster co-design, participation, and innovation partnerships

- Institutionalize co-design across AT development, procurement, and evaluation processes by meaningfully engaging with seniors, caregivers, and equity-deserving groups.
- Continue supporting partnerships among governments, postsecondary institutions, industry, and community organizations to develop inclusive innovation ecosystems.

4. Policy Recommendations

4.1. Policy directions for definitions and evaluation frameworks

Recommendation 1: Establish national AT definitions and evaluation standards

- Adopt a unified national definition of AT that integrates social, rights-based, functional, and digital-innovation perspectives to provide conceptual clarity across FPT and sectoral funders.
- Convene an FPT working group to harmonize terminology, core assessment concepts, and minimum data elements, recognizing that full eligibility criteria will continue to vary by jurisdiction and funder. This creates shared foundations without requiring identical benefit structures across programs.
- Develop an “AT Policy Lens,” similar to GBA Plus, that can be applied across FPT and community-funded programs to assess how policies and service models affect access and outcomes for seniors across age, disability, income, geography, language, and digital equity dimensions.
- Integrate AT policy within broader health, aging, accessibility, disability, and innovation frameworks, ensuring coherence with national accessibility goals, technology & innovation strategies, and healthy aging priorities.

Recommendation 2: Strengthen national data and evaluation systems

- Create a pan-Canadian AT data and evaluation strategy to standardize indicators of access, affordability, and effectiveness.
- Implement consistent AT data collection across health, social, and accessibility systems, including institutionalized, rural, and Indigenous populations.
- Strengthen longitudinal studies to track adoption, usage trends, and outcomes.
- Develop a national evaluation framework grounded in user-centered metrics such as autonomy, satisfaction, social participation, and health-related outcomes.

4.2. Policy recommendations for FPT Policy:

Recommendation 3: Expand and modernize AT funding and coverage

- Building on Recommendation 1, broaden eligibility criteria for provincial/territorial assistive device programs to reflect the full spectrum of contemporary AT, including traditional devices as well as digital, sensor-based, cognitive-support, and AI-enabled technologies that demonstrably improve function, safety, or independence, using the national AT definition and evaluation standards established in Recommendation 1 to guide eligibility and reimbursement decisions based on demonstrated functional, safety, independence, or caregiver-support outcomes. Introduce targeted subsidies for both low-income and “missing middle” seniors, ensuring affordability across income brackets and reducing unmet need.
- Invest in navigation tools to help older adults understand the benefits they are entitled to.

- Align reimbursement approaches to more accurately reflect real costs, while recognizing regional variability in pricing, availability, service delivery models, and market conditions.
- Embed caregiver and user training, setup, and support costs within funding mechanisms to promote sustained use, reduce abandonment, and improve user confidence and safety.

4.3. Policy recommendations drawn from international examples

Recommendation 4: Enhance awareness, navigation, and digital literacy

- Establish a national AT information and navigation architecture, supported by provincially and territorially tailored entry points, to link seniors, caregivers, service providers, and funders. This phased approach would accommodate current jurisdictional variation while advancing alignment with national AT definitions, standards, and terminology (outlined in Recommendation 1).
- Support public outreach campaigns, demonstration sites, and equipment loan or trial programs through dedicated funding, partnerships with community organizations, and locally delivered programming to reduce stigma and promote healthy and independent aging.
- Simplify administrative and application processes by working with older adults and caregivers through co-design and usability testing to develop plain-language, multilingual, and accessible information materials.
- Expand digital and technology literacy programs for seniors and caregivers to improve uptake and confidence.

Recommendation 5: Strengthen human and technical support infrastructure

- Invest in a pan-Canadian training framework, delivered through provincial and territorial systems, for relevant health and other professionals as well as community-based technology facilitators.
- Fund mobile, in-home, and community-based support models for device setup, maintenance, and troubleshooting.
- Ensure culturally and linguistically appropriate outreach and after-sales support to reduce device abandonment.

4.4. Recommendations to support equity and inclusion

Recommendation 6: Promote dignity, privacy, and social acceptance

- Mandate privacy-by-design and informed consent standards for connected and AI-enabled technologies.
- Encourage inclusive, aesthetic, and user-centered design that supports dignity and empowerment rather than dependency.
- Promote peer-to-peer learning and storytelling initiatives to reduce stigma and normalize technology use.

Recommendation 7: Advance equity and infrastructure for underserved communities

- Embed intersectional equity indicators in AT policy and reporting.
- Expand broadband and digital infrastructure in rural, northern, and remote regions.
- Create culturally grounded, community-led programs that improve AT access for Indigenous, 2SLGBTQIA+, newcomer, racialized, and low-income seniors.

4.5. Policy recommendations to promote innovation

Recommendation # 8: Foster co-design, participation, and innovation partnerships

- Institutionalize co-design across AT development, procurement, and evaluation processes by meaningfully engaging with seniors, caregivers, and equity-deserving groups.
- Continue supporting partnerships among governments, postsecondary institutions, industry, and community organizations to develop inclusive innovation ecosystems.

5. Conclusion

Canada stands at a pivotal moment in advancing AT as tools for equity, inclusion, and aging in place. Evidence shows that while innovation is strong, progress remains uneven. Fragmented policies, inconsistent funding, and lack of standardized evaluation frameworks continue to limit equitable access and measurable outcomes.

Addressing these gaps requires additional research in the field, alongside coordinated, national action that aligns health, accessibility, aging, and innovation portfolios. A unified, evidence-driven approach, grounded in affordability, accountability, and inclusion, will enable AT to become a cornerstone of Canada's strategy for supporting seniors to live independently, safely, and with dignity.

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7. Appendices

Appendix A - Key informant interview summary

A total of six key informants were interviewed. The organizations spoken to include:

- AGE-WELL
- Aging Research Centre of Newfoundland and Labrador – Memorial University of Newfoundland and Labrador
- Alliance for Equality of Blind Canadians (AEBC)
- Centre for Aging + Brain Health Innovation (CABHI)
- Centre for Health and Innovation in Aging – Mount Royal University
- Vancouver Coastal Health

Key findings and high level themes pulled from the interviews are presented below.⁹

7.1. FTP Polices

7.1.1. Strengths

Key informants noted several examples of strengths in FPT policies on AT:

- There is a general high technical understanding of AT, including the tools and infrastructure.
- There are federal programs that support research development for opportunities to accelerate technology.
- There are provincial programs that reduce the cost burden of purchasing AT. For example, in BC, there is a Red Cross program that provides free equipment loans for patients or community (with restrictions). People can rent equipment on a short-term basis (3-6 months) to test and see if it works for them, which helps promote aging in place.

“Policy can help by paving over the breadth and depth of variability for people looking to access ATs.”

“I find that some older adults are hesitant about trying medical equipment, sometimes because of the stigma, where it's like, ‘if I have too much medical equipment in my house, it's kind of like a hospital.’ So, being able to trial the equipment without having to sink any money into it helps people realize that this equipment can be useful, and it can promote them aging in place and staying at home longer in a safe manner.”

⁹ Additional information on the key informant interview process can be found in the Methodology section of this report.

7.1.2. Gaps

Key informants also shared gaps in policies:

- AT definitions, funding, and availability differ across Canada which results in inequitable access.
- Access to AT spans multiple jurisdictions; navigating that landscape is difficult.
- There is limited funding for AT equipment. Most often, older adults or family members have to pay for medical equipment, with limited cost coverage from insurance.
- Rural communities can be unaware of AT options, or have limited access to AT due to physical distance and extra costs associated.
- A majority of education focusses on academics, industry, and researchers, but healthcare providers need more training on how to support the use of AT.
- AT start-ups are innovative and show promise, but lack of funding prevents products from making it to the market.
- The Canada Health Act should be updated with improvements regarding AT access and use.
- Provinces tend to be risk-averse with sharing health data; there is good work being done across the country and data/best practices should be shared so everyone can benefit and make improvements.

“Everyone is on a trajectory of aging [...] but it tends to (in a policy and access realm) be thought more on the disability side. There’s a framing that’s more human rights centered – it’s a level of being able to participate in daily activities. It’s not just seniors or people with disabilities.”

“It’s important to focus on the individual right to live a life of dignity and independence – not just the view of reducing costs, or keeping people in their homes and out of hospital. Canada should link its policies to a broader rights-based approach.”

7.2. Engaging key players

Key informants suggested to:

- Involve frontline care staff (e.g., community health nurses, long-term care, public healthcare), older adults, caregivers, and families of people who have lived experience.
- Meet with people in ways that work best for them (e.g., convenient locations or accessible spaces including online, ensure participants have reliable internet).
- Ensure key players are compensated fairly and thanked genuinely for their time and energy; make key players feel like valued participants with important expertise.

- Understand that qualitative data and storytelling is valuable.
- Get access to patient testimonials on AT; it will help show the real-life impacts and life-changing improvements for older adults.
- The government should work more closely with private companies as there is a lot of innovation happening in those spaces. It is critical to take what they are doing and learning and expand it into the public space to create partnerships. This should be facilitated through policy that will encourage working together as opposed to seeing each other as competitors.

“Policy development has the best chance of producing a meaningful output and impact when the people it’s intended to support are involved in the process. It’s the co-creation and early engagement model that is particularly important.”

“Ask for genuine information - for people to tell stories. Doing tick box questions only reinforces what the person asking the questions wants to hear.”

7.3. Indicators and evaluation frameworks

Key informants shared that:

- Possible frameworks to draw from could include: RE-AIM, the Canada Health Infoway (CaHI) Benefits Evaluation Framework, or the WHO-GATE 5P.
- Indicators need to be specific to different sectors of AT.
- Options for indicators could include: health-related quality of life; number of readmissions to hospital, ER or healthcare provider visits; number of transitions from home to assisted living facilities; scales for measuring Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs); chronic disease progression; level of caregiver burnout; client/clinician satisfaction; increased access to care; or decreased financial burden to purchase AT.
- Alongside indicators, it is important to consider the larger question of what outcomes people are hoping for AT use.
- Frameworks should cover the big picture and include AT adoption, implementation, and maintenance pieces.

- Scaled and longitudinal studies can be useful to gather data; however long term studies can be difficult with older populations.

"It [frameworks] hits on so much. You have mobility aids and cognitive aids and it's such a broad thing, that to narrow in on one indicator, I don't think it's ever going to work. But at least if we have consistent indicators across say, niches of devices, maybe that would help standardize it some way."

"The framework that you should land on needs to be well-rounded and everyone needs to be represented. Because if you're advancing the implementation/ adoption of AT, you can't just think about the caregiver. You also have to think about the end user themselves, or the system, or government. Everyone plays a role, especially in a public system, and you need to ensure that there's some return on investment or carrot at the end of the tunnel."

7.4. Barriers to access AT

Key informants commented on barriers to AT access, such as:

- Lack of knowledge of which AT exists.
- The high cost of equipment, limited insurance coverage, and funding barriers.
- Difficulty navigating the system to access AT.
- Older adults generally have a lower understanding of technology and AT can be intimidating as they are sometimes expected to learn quickly with little guidance. Within this, it was also noted that stereotypes that older adults cannot or will not learn how to use technology, can result in them being dismissed in conversations of adopting or using AT.
- Stigma surrounding use of AT.
- Older adults can experience fear and distrust if they feel they are constantly being monitored by AT.
- Strict building policies where the Strata or building manager will not allow modifications for AT (e.g. grab bars if a hole needs to be drilled).
- Lack of durability of products, and repair for AT can be expensive.

Some barriers mentioned for specific equity-deserving groups included:

- Systems of discrimination (e.g., ableism, homophobia, transphobia, misogyny) that should be taken into consideration when analyzing how different groups receive access to AT, or care in the health system writ large.
- Limited access for those in rural or remote locations.
- Indigenous people, newcomers, or street-involved people may not always have a health card.

"Most people are looking at accessibility as a ceiling, not a floor."

- Newcomers who are older may have lower likelihood of learning Canada's official languages, and can experience barriers of understanding or translation issues that prevent access or proper use of AT.
- Preconceived notions of disability can prevent people from receiving care and AT that attends to their intersectional identities.

Barriers noted for those with multiple or complex disabilities included:

- Lack of insight into their functional difficulties or cognitive issues (dementia, Alzheimer's) may mean older adults can be less likely to use AT.
- Lack of community supports and social isolation can result in unsafe practices by older adults who do not realize they are at risk.

7.5. Improving AT access for equity-deserving communities

"If you make something disability-friendly, it's better for everyone."

Suggestion for improvement included:

- Increased financial support.
- Improving wait times, access to primary caregivers, access to referrals, and access to scans and tests.
- Being proactive with providing information to older adults for planning for aging in place (e.g. having brochures in doctor's offices) and increasing awareness of AT equipment that is available.
- Increasing awareness by having publicly-funded demonstration sessions of the AT available, plain language community awareness campaigns, or promotion through community physicians.
- Promoting AT in places where older adults gather.
- Less paperwork for older adults to be approved for equipment funding and more autonomy for healthcare workers other than doctors to prescribe AT safely.
- More community supports that include paid positions, not solely volunteers.

7.6. Role of caregivers and senior-serving organizations

Key informants confirmed that family, caregivers and senior-serving organizations play a vital-role in supporting the use of AT, noting:

- Caregivers and families are concerned about health and prompt older adults to use AT, set them up with devices and supports, and often cover the cost of AT.
- Senior-serving organizations often have a depth and breadth of experts who can bring their lived experience and important expertise to conversations of improving access to AT.

Some challenges within caregiver's roles were named as follows:

- Caregivers can act as gatekeepers to an older adult's access to AT. Supporting caregiver's needs alongside older adults is crucial.
- Paid and unpaid caregivers are not always fully supported to help older adults adopt and use AT. Training and information is needed for caregivers to feel comfortable to use AT.
- A revolving door of caregivers for an older adults can lead to inconsistencies in care.

"The greater the family involvement, the bigger the buy-in is from seniors. And the better follow-up for using equipment and using it consistently."

7.7. Best practices to support aging in place

Key informants shared best practices, including:

- Support and educate families and caregivers, who play a large role in the adoption, procurement, and follow-through with AT.
- Have older adults demo the equipment on a trial basis. This will help them understand the need for equipment, and help them get comfortable with using it.
- Create more fluid and adaptable policies that take into consideration the diversity of needs for those who use and support use of AT.
- Streamline system navigation to access AT.
- Create localized hubs or networks of information and support that older adults can access.
- Increase social interactions and supports for older adults to be in community. Ensure that community spaces for interaction are physically accessible.
- Design AT under the Universal Design principles, and co-create products with input from those with lived experience.
- Focus on an individual's right to a life of dignity and independence, as opposed to AT from a predominantly cost perspective – this loses the humanity component. Focus on prevention and healthy living, as opposed to being reactive once an older adult starts experiencing problems with aging.

7.8. Promising innovations

"The most promising tech is stuff that people can afford and is accessible."

Key informants named established and promising innovations in the world of AT:

- AT such as: fall devices, nanny cams, walk-in showers, chair lifts, timer stoves, bidets, apartment-friendly wall bars, biometrics, or speech-to-text.
- Other innovations such as: Steadiwear, NovaSense, Swift Medical, Xandar Kardian, Linggo, Molecular You, Braze Mobility, and Cosm Medical.

- The care concept of the Hogeweyk Dementia Village in the Netherlands.

"We see these pockets of success or pilots, but if there isn't a mechanism to support their funding, then how do we get these people access to the AT? And this is what comes through in this paper, is lobbying and additional funding for government."

Appendix B - Evaluation frameworks

7.9. Framework building blocks

Across the sources reviewed, the research team identified a small set of usable building blocks rather than one comprehensive “AT evaluation framework.” These blocks help policymakers judge integration, accessibility, and workforce feasibility.

Ambient Assisted Living (AAL) standards

The AAL literature defines a family of technologies that help older adults live safely and independently (e.g., home sensors, fall detection, remote monitoring, communication aids). Two recurring reference points are:

- **AALIANCE2**, a European roadmap/standardization initiative that sets out architecture, interface, and conformity expectations useful as procurement and interoperability yardsticks; and
- **universAAL**, an open platform/reference specification that enables plug-and-play across AAL devices and services.

These standards do not list indicators, but serve as practical conformance anchors for evaluations that claim “integration at scale” (Blackman et al., 2016; Abhari et al., 2024). They can ensure more dependable linkages (e.g., wearables linked to emergency services or home sensors linked to care teams) and interoperability means less vendor lock-in.

Digital accessibility benchmark (WCAG 2.0)

Because AT programs increasingly rely on digital portals and forms, WCAG 2.0 offers testable criteria for whether seniors and caregivers can find, understand, and use program information (Developing websites for older people: How web content accessibility guidelines (WCAG) 2.0 applies, 2018).

Policy-process and monitoring approaches

IDEAL PROCESS (Inclusive Design for Equitable and Accessible Living) pairs two WHO tools to look at outcomes and capacity: rATA (rapid Assistive Technology Assessment) provides population-level indicators of need, access, and unmet need for assistive products (via a short household survey), while ATA-C (Assistive Technology Capacity Assessment) evaluates system capacity across governance, financing, products, service provision, workforce, and information (Ebuenyi, 2023). Together, rATA answers, “Are people getting what they need?” and ATA-C answers, “Can the system sustainably deliver it?”

7.10. Frameworks suggested by key informants

One key informant noted 2 frameworks to draw from:

- [RE-AIM](#): A framework to guide the planning and evaluation of programs according to the 5 key RE-AIM outcomes: Reach, Effectiveness, Adoption, Implementation, and Maintenance.
- [Canada Health Infoway \(CaHI\) Benefits Evaluation Framework](#): Specifically for digital health domain areas, this framework is intended to focus on the relationship between the implementation of an effective solution, the adoption of that solution, and the resulting impacts.

As noted by a key informant,

“The framework that you should land on needs to be well-rounded and everyone needs to be representative. Because if you’re advancing the implementation/ adoption of AT, you can’t just think about just the caregiver. You also have to think about the end user themselves, or the system, or government. Everyone plays a role, especially in a public system and you need to ensure that there’s some ROI or carrot at the end of the tunnel.”

7.11. Indicators

The literature identifies a range of indicators that can be used to assess the integration, accessibility, and impact of AT and AgeTech within health and social systems. These include:

- those explicitly described in the evidence base; and,
- those that emerge from system gaps, implementation challenges, and user experiences documented in the studies.

Only some indicators have been applied in real-world AT or AAL evaluations, and where available, the evidence on outcomes is summarized below.

7.11.1. Indicators explicitly named in the literature

Several sources identify concrete indicators that policymakers and system leaders can use to monitor AT access, equity, and outcomes. These include:

Indicator	Indicator description	Outcome measured
Utilization and equity tracking	Indicators include the share of encounters delivered using technology, stratified by sociodemographic factors such as age, income, rurality, and health condition (Bhatia et al., 2021). Differences in uptake and continued use by sociodemographic characteristics	Equitable uptake of assistive technologies; identification of gaps in access across population groups; sustained use over time rather than one-time adoption (Bhatia et al., 2021). Reduction in disparities in functional ability, safety, and participation among older adults and persons with disabilities (Bhatia et al., 2021;

		Global report on assistive technology , 2022)
Access and affordability	System-level indicators include unmet need, out-of-pocket costs, wait times, and equity gaps across income, geography, and disability status (Mattison et al., 2017).	Reduced unmet need for assistive technology, improved affordability, and timely access to appropriate devices and services (Global report on assistive technology , 2022; Mattison et al., 2017)
Digital accessibility	WCAG 2.0 conformance scores provide an indicator of accessibility for portals, forms, and digital interfaces (Developing websites for older people: How web content accessibility guidelines (WCAG) 2.0 applies, 2018).	Usable and accessible digital environments that enable people with disabilities to independently access services, information, and communication tools (Developing websites for older people: How web content accessibility guidelines (WCAG) 2.0 applies, 2018).
Ambient Assisted Living (AAL) outcome themes	Studies identify consistent outcome domains such as safety (e.g., fall alerts, hazard detection), ability to remain at home, quality of life, social participation, and linkage to health and social services (Blackman et al., 2016).	Improved safety, ability to remain living at home, enhanced quality of life, and better connection to health and social services (Blackman et al., 2016).
Functional efficacy of AT	Extent to which an assistive device or system enables a user to perform intended daily activities more effectively, safely, and independently than they could without the technology (Global report on assistive technology , 2022; Borgnis et al., 2023).	Improved performance in daily activities such as mobility, self-care, communication, and independent living.
User satisfaction with AT (QUEST 2.0)	Satisfaction with assistive devices and related services (Demers et al., 2002).	High satisfaction with assistive devices and related services, leading to sustained use and reduced device abandonment.
Social participation and quality of life	The extent to which assistive technology enables individuals to engage in social, family, and community activities they value, while supporting overall well-being, autonomy, and satisfaction with daily life (Borgnis et al., 2023).	Increased participation in family, community, and social life and improved overall quality of life.

Older-adult-defined outcomes	(e.g., dignity, autonomy, feeling safe)	Outcomes that reflect what older adults value in daily life, supporting person-centred and culturally responsive AT evaluation (Ebuenyi, 2023).
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7.11.2. Indicators demonstrated in AT/AAL studies and reported outcomes

A subset of indicators has been applied in empirical AT and AAL studies, with clear evidence of impact. These include:

Indicator	Explanation
Safety	Safety indicators (including fall detection, environmental hazard sensing, and emergency alerts) are among the most commonly used in evaluations. Studies report reduced hospital admissions, earlier discharge, and delayed transitions to long-term care for users of first-generation alarm systems (Blackman et al., 2016). Second- and third-generation systems demonstrate improved detection of falls, wandering, and hazards such as gas leaks, benefiting older adults with cognitive impairment (Blackman et al., 2016).
Ability to remain at home / independent living	AAL systems have been evaluated for their impact on independent living. Evidence shows that alarm systems and home sensors can delay long-term care entry and support continued residence at home (Blackman et al., 2016). Technologies supporting activities of daily living, such as cognitive support tools, have reduced the need for caregiver supervision and enabled greater independence (Blackman et al., 2016).
Quality of life and social participation	Studies using robotic companions, telepresence devices, and communication technologies report improvements in social connectedness, cognitive stimulation, and overall engagement (Blackman et al., 2016). Broader Information and Communications Technology (ICT) use is also associated with reduced social isolation and lower depression among older adults (The impact of internet connectivity and technological tools on reducing seniors' social isolation and loneliness during the pandemic and beyond, 2025).
Older-adult-defined outcomes	Participatory evaluations using approaches such as the IDEAL PROCESS have been shown to increase alignment between older adults' priorities and selected outcome measures, enhancing empowerment and meaningful involvement (Ebuenyi, 2023).
Utilization tracking	Although applied primarily in digital health rather than AT-specific studies, utilization indicators have been used to monitor uptake, access, and equity in technology-enabled care. For example, virtual-care utilization in Ontario increased from 1.8% of visits in 2019 to 70% in 2020 following policy changes due to COVID (Bhatia et al., 2021), demonstrating how social policy and measures that prioritized virtual care support utilization

7.12. Indicator integration into the healthcare system

The literature highlights several indicators that help assess how well AT are integrated into health and social systems. These indicators fall into two broad groups:

- those that are directly measurable and appear in empirical studies or policy guidance; and
- those that emerge from documented system gaps, implementation challenges, and structural factors described across the sources.

Together, they provide a comprehensive picture of how AT can support system performance, clinical workflows, and service access.

7.12.1. Indicators identified in the literature as relevant to system integration

These indicators appear directly in the literature and are feasible to measure:

Indicator	Explanation
Utilization of technology-enabled encounters	Tracking how often technology is used in service delivery (and by whom) illuminates patterns of access, uptake, and sustainability. Studies of virtual care uptake in Ontario demonstrate how utilization monitoring can show technology adoption, distribution across population groups, and changes linked to policy shifts (Bhatia et al., 2021).
Provider participation and engagement	Monitoring clinicians' use of AT-enabled pathways, and participation changes in response to reimbursement or policy levers, can signal feasibility, acceptance, and operational readiness within the system (Bhatia et al., 2021).
System outcomes influenced by AT	Evidence from AAL studies shows that technologies reduce avoidable hospital admissions, enable earlier discharge, and support older adults to remain at home for longer - outcomes that reflect meaningful system integration and reduced demand on institutional care (Blackman et al., 2016; Boger et al., 2017).
User-defined outcomes aligned with system objectives	Empowerment, participation, functioning, and other outcomes prioritized by older adults contribute to a more person-centred system and are measurable using participatory approaches such as those demonstrated in the IDEAL PROCESS (Ebuenyi, 2023).

7.12.2. Additional indicators suggested by system gaps and implementation challenges

Across the sources, several further indicators emerge as important for understanding system integration, even if they are not yet routinely measured in AT studies (Global Alliance of Assistive Technology, 2022). These reflect real barriers described by older adults, caregivers, clinicians, and system actors.

Indicator	Explanation
Interoperability and data exchange	The extent to which assistive technologies can securely exchange data with clinical, administrative, and service delivery systems. This indicator reflects system readiness to support continuity of care, interdisciplinary coordination, and outcome tracking across settings, addressing widely identified gaps in data sharing and use in AT systems (Global Alliance of Assistive Technology, 2022; Abhari et al., 2024; Blackman et al., 2016).
Assessment, prescribing, and navigation capacity	The availability and consistency of trained assessors, prescribing authority, and navigation supports across AT programs. This indicator captures the degree to which fragmented pathways, unclear roles, and limited workforce capacity create barriers to timely and equitable access to assistive technology (Global Alliance of Assistive Technology, 2022; Mattison et al., 2017; Genge et al., 2023).
Cross-program alignment	The degree of alignment in eligibility criteria, assessment processes, and benefit coverage across ministries, funders, and service providers. This indicator reflects the extent to which AT systems reduce fragmentation and support coordinated, system-wide delivery and outcome measurement (Global Alliance of Assistive Technology, 2022).



Appendix C - Provincial, and Territorial AT programs currently available

Source: (AGE-WELL, 2017). Updated by research team – Jan 2026

Province/Territory	Main Program(s)	Devices Covered	Eligibility Highlights	Funding Model	Notes
BC*	Medical Equipment & Devices Program (MSDPR)	Medically essential equipment (e.g., wheelchairs, walkers, beds, lifts)	Low-income residents with disabilities, including seniors; requires medical prescription and approval	Income-tested; full or partial funding depending on assessed need	More limited than ON/AB universal models; tied to income eligibility <i>*replaces BC AIL program</i>
BC*	Red Cross Health Equipment Loan Program (HELP) (provincially supported)	Mobility and daily living aids (wheelchairs, walkers, hospital beds, bathing aids, etc.)	Residents with referral from a regulated health professional; long-term program requires physician order and additional criteria	Loan model (short-term free loans; long-term loans with administrative fees)	Widely used; equipment loaned, not owned; capacity depends on donations
BC*	WorkBC Assistive Technology Services	Workplace AT, ergonomic devices, communication/hearing tech	People with disabilities seeking employment	Government-funded through WorkBC	Employment-linked; supplements other BC programs
Alberta	Alberta Aids to Daily Living (AADL)	Mobility, communication, hearing, vision	Requires prescription and assessment	75% government, 25% client	Covers wide range but wait times and co-pays are barriers.

Province/Territory	Main Program(s)	Devices Covered	Eligibility Highlights	Funding Model	Notes
Alberta*	Assured Income for the Severely Handicapped (AISH) – Health-related personal benefits	Medical equipment not covered by AADL (CPAP devices/supplies, wheelchair/scooter maintenance, orthotics, hearing aid batteries, etc.)	AISH recipients (income-tested disability program)	Income-tested; full coverage of approved items	Supplements AADL; helps fill gaps for low-income recipients
Saskatchewan	Saskatchewan Aids to Independent Living (SAIL)	Mobility, hearing, communication	Residents with valid health card	Full or partial	Limited coverage of cognitive/mental health AT.
Manitoba	Manitoba Home Care Program	Mobility, communication	Home care clients only	Loan model (short/long-term)	Some assistive tech loaned through health regions.
Manitoba	Employment and Income Assistance (EIA) – Health Needs	Assistive devices, mobility aids, hearing aids/batteries, customized seating, wheelchair lifts/ramps, etc. (if not covered elsewhere)	EIA recipients (income-tested)	Full coverage if eligible	Provides coverage when not available through Home Care or other benefits
Ontario	Assistive Devices Program (ADP)	Broad: mobility, communication, hearing, vision, some cognitive	Medical need + prescription	75% funded, 25% user	One of the most comprehensive; clear device categories.
Ontario*	Ontario Disability Support	Supplements ADP devices; covers co-pays and gaps	ODSP clients with qualifying disabilities (ODSP is income-tested)	Supplementary; can bring coverage up to 100%	Important for low-income; fills ADP gaps

Province/Territory	Main Program(s)	Devices Covered	Eligibility Highlights	Funding Model	Notes
	Program (ODSP)				
Quebec	RAMQ (Regie de l'assurance maladie) programs	Mobility, hearing, vision	Must be on official list; specific diagnoses	Fully or partially funded	Provincial lists define approved devices; communication aids limited.
Quebec	Social Assistance – Special Benefits	Specified medical items with prior authorization	Income-tested recipients of last-resort assistance	Full coverage for authorized items	Supplements RAMQ programs; case-by-case
Quebec	Assistive devices programs	Vision, hearing, mobility, language impairment, intellectual impairment	Persons with a physical or intellectual disability or an autism spectrum disorder (ASD) assessed by health professional	Full coverage loan model	Persons with a temporary handicap are not eligible
Quebec	Daily living and domestic assistance program		Persons with physical or intellectual disability or ASD; must receive assistance from an integrated health and social services centre (CISSS) or integrated university health	Full coverage with one device exception	User responsible for the insurance of the device

Province/Territory	Main Program(s)	Devices Covered	Eligibility Highlights	Funding Model	Notes
			and social service centre (CIUSSS)		
New Brunswick	Health Services, Social Development	Hearing, mobility (limited)	Disability and income-tested	Case-by-case	Many needs unmet or referred to charities.
Nova Scotia	Seniors' Pharmacare, Hearing & Speech Nova Scotia	Hearing, mobility, communication	Seniors and those with medical referral	Full or partial	Services for children stronger than for adults.
Nova Scotia*	Seniors Community Wheelchair Loan Program	Wheelchairs (manual/power)	Seniors assessed by health professional	Loan model	Important but limited scope; equipment loaned not owned
Nova Scotia*	Disability Support Program (DSP) – Special Needs	Orthotics, prosthetics, other special needs devices	Adults with disabilities, including seniors	Income-tested	Helps with device costs beyond health programs
PEI	Disability Support Program	Limited (mobility mostly)	Case-by-case assessment	Discretionary	Lacks structured AT program; limited device funding.
PEI	AccessAbility Supports	Technical aids/assistive devices (beyond mobility)	Residents with disabilities, assessed need	Income-tested	Broader scope than DSP; more structured device support.
PEI	Seniors Hearing Aid Rebate Program	Hearing	Seniors assessed by health professional	Income-tested	Mostly reactive, not proactive service model.
PEI	Canadian Red Cross Short	Mobility	Referral by health professional	Loan model	Important but limited scope;

Province/Territory	Main Program(s)	Devices Covered	Eligibility Highlights	Funding Model	Notes
	Term Health Equipment Loan Program				equipment loaned short term, not owned.
Newfoundland & Labrador	Special Assistance Program (SAP)	Hearing, mobility (some)	Seniors or persons with disabilities	Partial subsidies	Mostly reactive, not proactive service model.
Yukon	Chronic Disease and Disability Benefits Program (CDDBP)	Mobility, hearing, communication devices	Must be diagnosed with a chronic disease or disability	Full coverage for approved devices	No formal AT program; services are embedded in broader health benefits.
Northwest Territories (NWT)	Extended Health Benefits (EHB) Program	Mobility, communication, hearing	Seniors (60+)	Full or partial	Full coverage for items listed under NIHB.
Nunavut	Extended Health Benefits (EHB) , Non-Insured Health Benefits (NIHB – federal for Inuit)	Basic mobility aids, hearing aids, vision (limited)	Based on Inuit status (NIHB) or chronic conditions (EHB)	Mostly federal NIHB for Inuit; territorial EHB for others	Limited infrastructure; access challenges due to geography and provider shortages.

* Connotes new or changed program (i.e., not included in original AgeWell summary)

Appendix D - Federal AT programs & legislation

Source: (AGE-WELL, 2017). Updated by research team – Sep 2025

Federal Government Programs					
Veterans Affairs Canada – Treatment Benefits (POC)	Veterans and RCMP members	Aids for daily living, hearing aids, prosthetics, mobility devices, vision aids, OT/PT/SLP services	Full or partial (grid-based)	Must have Veterans Affairs Health Card; coverage depends on entitlement group (A or B)	Preauthorization required; administered via Medavie Blue Cross
<u>NIHB – Non-Insured Health Benefits (Health Canada)</u>	Registered First Nations and Inuit	Mobility aids, hearing aids, orthotics, prosthetics, vision devices (limited), supplies	Full (if not covered elsewhere)	Must be a registered First Nations person or recognized Inuk; coverage secondary to private/territorial plans	Extensive exclusions (e.g., therapy equipment, cosmetic devices); access varies by location
<u>Interim Federal Health Program (IFHP)</u>	Refugees, asylum seekers, victims of trafficking	Hearing aids, mobility aids, prosthetics, orthotics, personal aids	Full (no co-payments allowed)	Must qualify for IFHP coverage; access ends once provincial coverage is obtained	Prior approval needed; devices must be on approved grid
<u>Correctional Services Canada – Health Services</u>	Inmates in federal correctional institutions	Wheelchairs, scooters, braces, hearing aids, other basic AT	Full (internal system)	Must be an inmate in a federal correctional facility	Some devices require clinical manager's approval
<u>National Defence and Canadian Armed Forces</u>	Active and Reserve CAF members	Mobility aids, vision/hearing aids, prosthetics, orthotics	Full (limits apply)	Must be Regular Force or eligible Reserve Force member	Base Surgeons can approve up to \$15,000/year

– Health Services					
Canada Student Grant – Equipment for Students with Disabilities	Post-secondary students with permanent disabilities	Vision/hearing/communication devices; assistive software	Grant (up to \$8,000/year)	Must be enrolled at a designated institution and receive student financial aid	Requires documentation of disability and cost justification from qualified professional
Canada Post – Literature for the Blind	Blind individuals and institutions	Braille, audio books, tactile materials (mailing only)	Free postal service	Must qualify as blind or visually impaired	

*Connotes new or changed program from original AgeWell summary

Federal Government Legislation Governing AT Programs			
Program Name	Ministry / Department Responsible	Governing Legislation / Regulation	Notes
Veterans Affairs – Treatment Benefits (POC)	Veterans Affairs Canada	- <i>Department of Veterans Affairs Act</i> (RSC 1985, c V-1) - <i>Veterans Health Care Regulations</i> (SOR/90-594) - <i>Canadian Forces Members and Veterans Re-establishment and Compensation Act</i> (SC 2005, c 21) - <i>Compensation Regulations</i> (SOR/2006-50)	Legislation establishes entitlements and treatment benefits; linked to disability coverage.
Interim Federal Health Program (IFHP)	Immigration, Refugees and Citizenship Canada (IRCC)	- <i>Immigration and Refugee Protection Act</i> (SC 2001, c 27) - <i>Order Respecting the Interim Federal Health Program</i> (SI/2012-26)	Provides temporary AT coverage for eligible refugee claimants and protected persons.

		- IFHP Policy Document (internal guidance)	
Non-Insured Health Benefits (NIHB)	Health Canada (First Nations and Inuit Health Branch)	- <i>Indian Act</i> - <i>Indian Health Policy</i> (1979)	NIHB provides AT coverage to eligible First Nations and Inuit individuals.
Correctional Services Canada – Health Services	Public Safety and Emergency Preparedness (CSC)	- <i>Corrections and Conditional Release Act</i> (SC 1992, c 20) - <i>Corrections and Conditional Release Regulations</i> (SOR/92-620)	Governs inmate healthcare, including provision of AT within correctional institutions.
Canadian Armed Forces – Health Services	Department of National Defence	Internal policies under <i>National Defence Act</i> and medical directives; specific policies not publicly codified	Policy-based approach; Base Surgeons have delegated authority for AT provisioning.
Canada Student Grant – Equipment for Disabilities	Employment and Social Development Canada (ESDC)	- <i>Canada Student Financial Assistance Act</i> - <i>CSFA Regulations</i> (not cited explicitly in the report)	Grants legislated through broader student aid framework.

