

# Commentary on Shah et al.<sup>1</sup>

Do Canadians have equitable access to physiotherapy services? In their article “Mapping Physiotherapy Use in Canada in Relation to Physiotherapist Distribution,” Shah and colleagues paint a portrait of the availability and use of physiotherapy services by health region.<sup>1</sup> Their analysis is insightful, and their findings suggest ways in which equity is not being satisfied. For example, they provide evidence that fewer physiotherapists are available in rural and remote regions. Coupled with geographic barriers and increased travel times, this situation tends to align with a low level of physiotherapy service use in these locales. From an equity perspective, this is especially concerning because, as the authors note, rural and remote communities experience a higher rate of chronic diseases for which physiotherapy care is particularly helpful. Thus, this mapping of physiotherapy availability and use by Shah and colleagues can help inform important discussions in the profession about equitable access to physiotherapy services for all Canadians.

The story of equity and access in the profession is obviously more complex than simple physiotherapist distribution, something of which the authors are clearly aware. In 1981, Pechansky and Thomas described the five *As* of access: availability, affordability, accessibility, accommodation, and acceptability.<sup>2</sup> Underlying the analysis by Shah and colleagues is the reality that where few physiotherapists are situated, fewer services will be available, and access will be impeded.<sup>1</sup> However, equitable access is also subject to the four other *As*.

The second *A* prompts the question, are the costs of services affordable to patients? This issue is highly relevant to physiotherapy services given that, in most locales, private clinics provide a high proportion of non-hospital-based outpatient physiotherapy services. If services are not covered by private or third-party insurance, patients will need to pay out of pocket. At the aggregate level, usage of physiotherapy services is thus likely to vary according to a region's affluence; where these services are not affordable – for example, in economically disadvantaged areas – access could be restricted as a result of affordability barriers.

The third *A*, touched on earlier in discussing the time to travel to reach physiotherapy services, is accessibility: what barriers exist to people's being able to physically access a service? The fourth *A*, accommodation, is associated with how well the organization of services corresponds to patients' needs, such as scheduling of appointments (e.g., whether services are offered in the evenings or on weekends) or the capacity to address linguistic barriers. Finally, acceptability refers to the degree of comfort patients feel with a service and their level of trust and confidence in the service provider.

Against this wider backdrop of features that influence access, the mapping conducted by Shah and colleagues can draw policy-makers' attention to those regions in which use of physiotherapy services is low. In low use–high or medium availability situations, policy-makers should consider how accessibility, affordability, accommodation, and acceptability pose barriers to the uptake of physiotherapy services. The policy response should then be directed at addressing the identified source or sources of low use. As Shah and colleagues note,<sup>1</sup> if accessibility is a barrier, innovative approaches such as telerehabilitation might provide part of the answer. The same reflections are needed in low use–

low availability regions, but here one might expect availability to be a key equity barrier, although it is unlikely to be the only one.

To encourage availability, as Shah and colleagues report,<sup>1</sup> promoting recruitment and making efforts to limit attrition from the profession will be crucial. Critical analysis is also needed to understand why physiotherapists are not available: are positions left unfilled in these settings because of recruitment difficulties, or do the positions not exist? Are there market and economic forces limiting entrepreneurs from establishing clinics? In addition, it is worth considering how problems of access give rise to other concerns for the profession, such as wait lists. The source of wait lists is a lack of availability of physiotherapy services relative to the community's need for them. How best to manage wait lists for outpatient physiotherapy services remains contested and raises distinct issues of equity and fairness.<sup>3</sup>

Shah and colleagues offer some hypotheses to explain high use–low availability regions,<sup>1</sup> including the possibility that people travel to adjacent regions to receive services. This explanation is indeed plausible. Further research might examine these regions in greater depth to determine the sources of this pattern, including whether there are lessons to be gleaned, such as innovative practices that optimize the use of limited services.

Access to physiotherapy services is a complex phenomenon and one that warrants scrutiny and proactive responses. There are indeed many things that policy-makers, managers, and members of the physiotherapy profession can do to improve physiotherapy access in Canada. Shah and colleagues' mapping is important and helps to clarify how availability relates to physiotherapy use at the health region level.<sup>1</sup> It thus reinforces the importance of working toward improving access to physiotherapy services for all Canadians, especially those who live in areas that are currently underserved.

As we have described in this commentary, in addition to availability, concerns about affordability, accessibility, accommodation, and acceptability require careful attention. Important conversations have begun around equity in the profession.<sup>4</sup> Let's keep them going.

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