

**Review Article**

**A SCOPING REVIEW OF NEED AND UNMET NEED FOR COMMUNITY-BASED PHYSIOTHERAPY IN CANADA**

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**ABSTRACT**

To investigate need and unmet need for community-based physiotherapy services (CBPTS) for Canadian adults. The scoping review was completed between May-September 2015. The methodology proposed by Arksey and O'Malley and the recommendations to advance scoping studies by Levac *et al.* were followed. The definitions of normative, felt, comparative, and expressed need were used to categorize need and the dimensions of availability, affordability, and acceptability was used to categorize unmet need. Two reviewers (SW, JS) independently reviewed 2265 abstracts and selected 191 articles for full-text review. Data extraction and thematic analyses were completed on 24 articles. Comparative need and service availabilities were the most frequent type and reason identified for need and unmet need respectively. Individuals from rural communities and persons living with chronic conditions more frequently identified barriers to accessing CBPTS. Unmet need for CBPTS exists in Canada. Physiotherapists must consider innovative service delivery models in order to maximize population health outcomes and minimize stress on health care systems like the Canadian population ages.

**Keywords:** Unmet need, Access, Service delivery, Health care equity, Scoping review

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**INTRODUCTION**

Health equity is the absence of systematic disparities in health between groups with different levels of social advantage/social disadvantage [1]. The Rio Political Declaration on Social Determinants of Health affirms that health inequities between and within countries are unacceptable and largely avoidable [2]. The promotion of health equity is essential to sustainable development, quality of life, and well-being for all [2]. Rehabilitation services are an essential aspect of health service delivery, and the application of physiotherapy services (PTS) yields better health outcomes [3]. Timely access to health services, which include promotion, prevention, treatment and rehabilitation, is critical to promote and sustain health [4]. Globally, approximately 50% of people with a disability cannot afford needed health care [5], 150 million people incur financial catastrophe as a consequence of seeking health services, and another 100 million are pushed below the poverty line [4].

Physiotherapy (PT) is a health profession that assists individuals to "develop, maintain, and restore maximum movement and function throughout the lifespan" [6]. PT encompasses health prevention, treatment/intervention, habilitation and rehabilitation related to the maximizing quality of life and movement potential [6]. Evidence to support the effectiveness of PTS ranges from high-quality systematic reviews to case reports in the management and treatment of musculoskeletal, neurological and cardiorespiratory conditions [7-10] as well in acute injury and chronic disease management [11-13]. It is important to determine who requires, and who has access to, PTS in order to achieve equitable access to health services

Need for health care can be defined differently based on who identifies the need. For example, an individual may perceive a need for a health care service, but a health professional may determine the service is not needed. Bradshaw [14] proposed a taxonomy of social need that included 4 domains: normative (when an individual and/or group fall(s) below an identified standard), felt (when the population and/or individual is asked if they feel they require a service), expressed (when individuals demand a service), and comparative (compares characteristics of those who receive a service and recognizes that if people with similar characteristics need a service but do not receive it, need exists). However, the

framework by Bradshaw [14] does not explain why need was not addressed. McIntyre *et al.* [15] proposed an access framework to understand the opportunities and constraints that influence health care seeking behaviors of individuals in different settings [15]. This framework identified three access domains: availability (physical access to services), affordability (ability to pay for services) and acceptability (fit between provider and patient). When considered together, these frameworks may provide a comprehensive understanding of unmet need (i.e. who is reporting unmet need, and why is it being reported).

In Canada, the percentage of people reporting an unmet need (UN) for health care rose from 4.2% in 1994/1995 to 12.5% in 2000/01 [16]. Canadian studies have identified population groups with an increased likelihood of reporting UN for health care. These groups include women, people in worse health, persons <69 y, persons with higher education, persons with lower income, and individuals without prescription drug coverage [16-19]. Current research related to access and use of PTS in Canada is varied and does not provide a comprehensive understanding about who does not receive needed PTS or the reasons why UN for PTS exists. The objective of the present study was to describe the current evidence for the unmet need for community-based physiotherapy services (CBPTS) for Canadian adults, and why this need exists. To achieve this objective, a scoping study was conducted.

A scoping review maps key concepts within a research area by assembling multiple sources and types of available evidence [20-21]. The emphasis of a scoping study is on comprehensive coverage and includes identifying high-level conceptual observations [20-21]. To complete this scoping study the methodology proposed by Arksey and O'Malley's [22] and the recommendations to advance the methodology of scoping studies by Levac *et al.* [20] were followed. Specifically, the stages followed were: 1) identify a research question, 2) identify relevant studies, 3) select studies for detailed analysis 4) chart the data 5) collate, summarize the results [20, 22].

**Identify the research question**

The questions that guided this scoping review are, "Who is reporting the need for CBPTS in Canada?" and "What types of unmet needs are being reported for CBPTS by Canadian adults?"

**Identify relevant studies**

A systematic search of the literature was used to identify a comprehensive set of articles related to the unmet need for CBPTS in Canada.

**Keywords.** Electronic keyword searching was completed in each database using each of the following words independently: physiotherapy” “physical therapy” “rehabilitation” “unmet need” “unmet health care need” and “perceived need”. The individual searches were then combined and results further limited with the parameters of “adult” (defined as individuals who were 19 y of age or older), “English language” and “Canada”

**Databases.** Seven electronic databases AMED (1985-May 2015), CINAHL (1987-2015), MEDLINE (1946 to May Week 1 2015), EMBASE (1996-April 06, 2015), Ovid Healthstar (1966–April 2015), PEDro and Health System Evidence (<http://www.Mcmaster-healthforum.org/health-system-evidence-en>) were searched in May 2015.

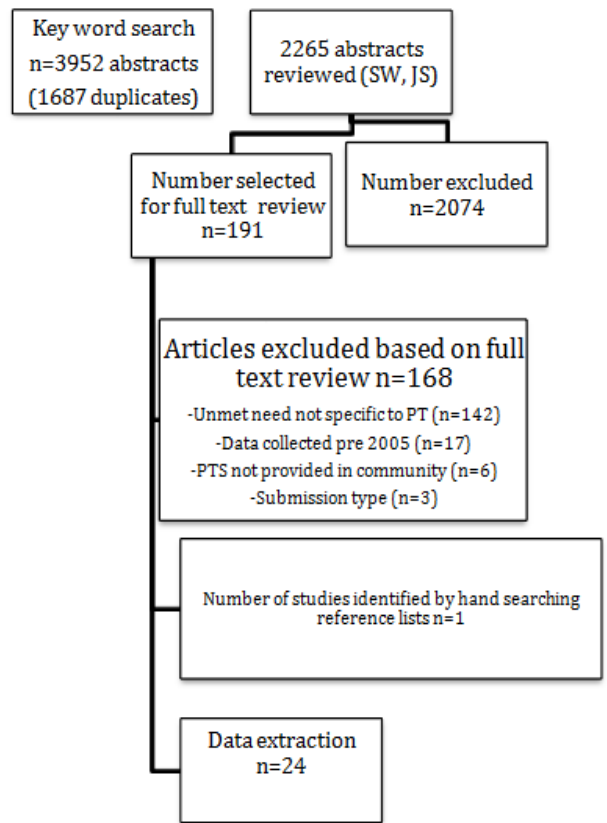
**Years.** The electronic search of the literature was limited to articles published in 2004 or later in an effort to gain a current perspective on unmet need.

**Study selection**

A total of 3952 abstracts were identified (AMED n=192, CINHL n=180, EMBASE n=1782, HealthStar n=919, MEDLINE n=879, PEDro = 0, Health Systems Evidence = 0), with 1687 duplicates, leaving 2265 for review. Two reviewers (SW, JS) independently reviewed each abstract to determine if the article should be considered for subsequent review. To be included in a full-text review, the abstract had to describe original research and report need or UN for CBPTS specifically in Canada. Articles that identified a needed health services that could be addressed by physiotherapy (i.e. within physiotherapy’s scope of practice in Canada), but did not clearly indicate a role for a physiotherapist were excluded. Studies that reported on physiotherapy services for children only or in institutions were also excluded to increase sampling specificity.

The reviewers did not screen for the level of evidence [21]. To ensure agreement and consistency in the application of the inclusion criteria during the abstract review, two reviewers (SW, JS) compared results of the first 300 abstracts. Kappa (k), a chance-corrected measure of agreement between the two reviewers on their selection of abstracts [23] was k= 0.91 (95% CI 0.85-0.98) for the first 300 abstracts. Overall kappa was calculated to be k=0.89 (95% CI 0.85–0.92).

The two reviewers initially disagreed on the inclusion of 43 abstracts in the full-text review. Differences were resolved with discussion related to the inclusion criteria (18/43 included). The final number of articles selected for full-text review was 191 (fig. 1). Of the articles selected for full-text review, 23 were selected for data extraction based on the stated inclusion criteria. A hand search of the reference list from the 23 articles identified one additional article that was included in the data extraction for a total of 24 included articles.



n = number of articles

**Fig. 1: Study selection**

**Chart the data**

Three reviewers collaboratively developed a data extraction form (SW, JS, JR) [20]. The context of need, and where available the reason for restricted access [15], was captured on this form for 24 studies using the categories identified by Bradshaw [14] and McIntyre et al. [15]. The three reviewers (SW, JS, JR) then independently completed data extraction for the first five full-text reviews. The data extracted from this process by each reviewer was compared to ensure the consistent capture of concepts. Discussion between the three reviewers during this phase of the data extraction led to a revised data extraction form, and the decision to include only articles that discussed outpatient physiotherapy services to facilitate comparing themes between articles (Appendix 1). One reviewer (SW) completed the data extraction for all 24 studies using the revised data extraction form. Table 1 describes the included articles.

**Table 1: Description of included studies**

Author and date	Study design	Intervention	Location	Condition	Bradshaw type(s) of need [14]	Access domain(s) [15]	Rural vs. Urban
Bassel et al. [42]	CS	Online survey individuals with systemic sclerosis	Canadian wide	Systemic sclerosis	Comparative Normative	Affordability	n/a
Bowen et al. [46]	CS	Online survey-facilities with pulmonary rehab	Ontario	Those eligible for pulmonary rehab	Comparative Normative Expressed	Availability	n/a
Brooks et al. [43]	CS	Mail survey-facilities with pulmonary rehab	Canada-wide survey excluding 3 Territories; PEI and NFLD; responses indicated no programs	Those eligible for pulmonary rehab–i.e. Chronic Obstructive Pulmonary Disease (COPD)	Comparative Expressed	Availability Affordability	n/a

Canestro <i>et al.</i> [44]	CS	Online survey-facilities with cancer rehab	Canada-wide survey–no responses from BC and NS	Cancer	Comparative Normative	Availability Affordability	Rural
Cott <i>et al.</i> [24]	CS	1. Key informant interviews with experts in primary care and rehabilitation in Ontario 2. Mail survey to Primary care providers to investigate use/barriers to using rehabilitation	Ontario	Not specific	Comparative Normative Expressed	Availability Affordability	Rural
DeLaurir <i>et al.</i> [34]	CS	Telephone survey-wait times using mock client case	Quebec	OA RA	Comparative Normative Expressed	Availability Acceptability	n/a
Easley <i>et al.</i> [35]	QUAL	Interviews with breast cancer survivors	Atlantic Canada (PEI, New Brunswick, Nova Scotia, NLFD)	Breast Cancer	Comparative Felt Expressed	Availability Affordability	Rural
Feldman <i>et al.</i> [36]	CS QUAL	Review of paper cases–(RA and OA) by physicians and rheumatologists Patient interviews about experiences of health care and perceived need for OT/PT services and other	Quebec	Arthritis	Normative Felt Expressed	Availability Acceptability	n/a
Goodridge <i>et al.</i> [37]	chart review	Identified patients who had COPD/lung cancer as underlying cause of death and analyzed service provision	SASK	COPD/lung cancer–palliative stages	Comparative	Availability	Rural
Gordon, <i>et al.</i> [48]	Health policy	Semi-structured interviews with 33 physical therapists from different settings across Ontario	Ontario	Not specific	Normative	Affordability	n/a
Hollis <i>et al.</i> [38]	CS QUAL	Four staged study: focus groups with therapists, analysis of workload statistics, interviews and survey	SASK Alberta	Not specific	Comparative	Availability	n/a
Johnson <i>et al.</i> [47]	CS	Mail survey patients with scleroderma	Canada-wide	Scleroderma	Comparative	Availability	n/a
Landry <i>et al.</i> [25]	Two phase, Prospective cohort	Telephone interviews with individuals who were receiving physiotherapy prior to and following partial delisting	Ontario	Not specific	Comparative Felt	Affordability	n/a
Landry <i>et al.</i> [26]	Policy analysis	Triangulated multiple sources to develop an overview of PT funding in Ontario	Ontario	Not specific	Comparative	Availability Affordability	n/a
Landry <i>et al.</i> [27]	Policy analysis	Literature search to explore factors that influence service demand in Ontario, Canada, international context Key informant interviews people who had knowledge and experience in Ontario's rehabilitation sector	Ontario	Not specific	Comparative	Availability	n/a
Landry <i>et al.</i> [28]	CS	Mail survey-hospitals with designated rehab beds in Ontario	Ontario	Not specific	Comparative Normative	Availability Affordability	n/a
Ma <i>et al.</i> [29]	CS	Online survey-dialysis facilities to investigate available rehabilitation	Ontario	Chronic kidney disease	Comparative	Availability Affordability	n/a
Miedema <i>et al.</i> [39]	QUAL	Patient interviews with breast cancer survivors	Atlantic Canada (PEI, New Brunswick, Nova Scotia, NFLD)	Breast Cancer	Comparative Felt	Availability Affordability	Rural
Miller Mifflin <i>et al.</i> [45]	Program Evaluation	Creation and pilot testing of a wait list prioritization tool	Baffin Region, Canadian Artic	Not specific	Comparative Expressed	Availability	Rural
Passalent <i>et al.</i> [30]	Cohort	Mail survey-community rehabilitation managers, professional practice leaders, or senior therapists of all publicly funded outpatient and	Ontario	Chronic conditions (general)	Comparative Expressed	Availability Affordability	

Passalent et al. [31]	CS	community sites that provide OT/PT services to adults > 19 yrs of age 1. Semi-structured interviews with key informants who were working in management positions in OT/PT settings 2. Same as Passalent [30]	Ontario	Chronic conditions (general)	Comparative Expressed	Availability Affordability	Rural
Paul et al. [32]	Cohort	Interviews with clients and providers one year after delisting PT services	Ontario	Not specific	Comparative Normative Felt	Affordability	n/a
Randall et al. [33]	Health policy analysis	1. Key informant interviews with individuals familiar with home care reform 2. Telephone surveys with CCAC and agencies who provided home care	Ontario	Not specific	Comparative	Availability Affordability	Rural Difficult to hire HCP
Roots et al. [40]	QUAL Cohort	Interviews with HCP who practice in rural northern BC	Northern Rural BC	Not specific	Comparative	Availability	Rural

BC = British Columbia CS = cross sectional CCAC = Community Care Access Centre, HCP = health care providers NFLD = Newfoundland NS = Nova Scotia, n/a = not applicable OA = osteoarthritis OT = occupational therapy, PT = physiotherapy PEI = Prince Edward Island, QUAL = qualitative RA = rheumatoid arthritis SASK = Saskatchewan, yrs. = years

### Collate and summarize findings

Each article was reviewed and categorized into one or more of the 4 domains from Bradshaw's taxonomy [14]. The articles were reviewed for the second time and categorized according to the domains of access presented in McIntyre et al.'s framework [15]. Themes that emerged related to classifying the articles using the taxonomy and framework were summarized and discussed between all authors. Descriptive numerical summaries and qualitative analysis [20] were also used to summarize findings.

### RESULTS

**Geographic distribution:** Unmet need for CBPTS was identified across Canada. Of the 24 articles selected for full-text review, the majority (n=12) described unmet need in the province of Ontario [24-33]; seven described unmet need in other provinces [34-41]; four included data from multiple provinces [42-44]; and one was from Nunavut (a Canadian Territory) [45].

**Gender differences:** None of the articles investigated gender differences related to the unmet need for CBPTS.

### Themes identified using Bradshaw's taxonomy [14]

**Comparative Need.** Articles that compared populations or geographic concerns related to accessing CBPTS were grouped together under the theme of comparative need (table 1). This was the most common theme (n=21) (table 2) [24-35, 37-38, 40-44, 46-47] identified when the articles were reviewed using the concepts from Bradshaw's Taxonomy

[14]. A number of studies (n=5) [29, 38, 43, 44, 46] identified that where an individual with a specific chronic condition lived could impact access to CBPTS. Four of the articles compared access to specific services across Ontario [29-31, 46]. One article [38] combined data from Alberta and Saskatchewan. In general, the delivery of CBPTS for individuals with chronic conditions was identified as being inconsistent within and between provinces. In addition, individuals with chronic conditions were disadvantaged in access to CBPTS compared to individuals without a chronic condition (CC) [30-32, 38].

A statistically significant association between access to services and self-rated health (SRH) was also identified in a study from Ontario [25]. In this study, participants who required physiotherapy services and received them were more likely to report good health (OR 10.72, 95% CI 2.20-52.25) compared to individuals who had previously received, but no longer could access physiotherapy services despite a self-reported need for the service [25].

**Felt Need.** Articles where individuals reported a perceived need for CBPTS were grouped together under the category of felt need [14]. In total, five articles (tables 1 and 2) were identified: two were from Ontario [25, 32], two from the Atlantic Provinces (Prince Edward Island, New Brunswick, Nova Scotia, and Newfoundland) [35, 39] and one from Quebec [36]. Cost and lack of service availability were the two common themes identified as reasons why individuals with chronic conditions reported difficulty in relation to accessing PTS [32, 35, 36, 39]. One study also identified a lower level of self-efficacy was associated with perceived need for rehabilitation services (adjusted odds ratio 0.84, 95% CI 0.72-0.99, p-value 0.04) [36].

**Table 2: Article counts according to Bradshaw's taxonomy [14] and MCINTYRE et al. access framework [15]**

Dimension	Bradshaw's taxonomy [14]				McIntyre et al.'s access framework [15]		
	Comparative	Normative	Felt	Expressed	Availability	Affordability	Acceptability
N (%)	21 (88%)	9 (38%)	5 (20%)	6 (25%)	20 (83%)	15 (63%)	2 (8%)

Note: Total number of articles is > 24 as many included multiple concepts

**Expressed Need.** Expressed need exists when an individual takes action in order to address their perceived need (i.e. booking an appointment with a health care provider) [14]. In health services, waiting lists are often used to measure expressed need [14]. Nine articles (tables 1 and 2) included in this scoping review discussed expressed need [24, 30, 31, 34-36, 43, 45, 46]. Eight of the nine articles identified a waiting list for CBPTS in different regions of Canada [24, 30, 31, 34, 35, 43, 45, 46]. Additionally, all of the articles identified that adults with chronic conditions were a part of the waiting lists. However, differences in wait times between adults with and adults without a chronic condition were not specifically

investigated. A theme related to specific chronic conditions or geographic areas within the articles was not identified.

**Normative Need.** A normative need exists when the need is defined by an expert such as a health professional, or when an individual or group of individuals falls below an identified standard [14]. The normative need is dynamic, and may change with new knowledge or changed societal views [14]. In this scoping study, the main factors associated with normative need were a policy change, and changes in funding models [24, 27, 32, 38]. These factors were typically identified through key informant interviews with physiotherapists

(PTs), other health care providers and/or individuals with knowledge about the health care system to with a focus on service access. Physiotherapists specifically commented on the policy decision to partially delist PTS in Ontario (n=5) that impacted individuals' ability to access CBPTS (tables 1 and 2) [25-27, 32, 48].

One paper also identified that normative need differed depending on the practice patterns of specific providers. Feldman [36] used simulated cases to examine differences in referral patterns by family physicians and rheumatologists to PTS. For example, younger, female family physicians practicing in cities that had rehabilitation centers referred patients diagnosed with osteoarthritis more frequently to rehabilitation [36]. In addition, university-affiliated, rheumatologists who were female and who trained in Quebec referred patients with rheumatoid arthritis more frequently to rehabilitation [36].

#### **Themes identified using MCINTYRE *et al.*'s framework [15]**

**Availability.** Availability is the physical access to CBPTS (i.e. are clinics open when people are to seek care—such as before or after work or on weekends) [15]. Availability was the most common domain when the studies were categorized using McIntyre *et al.*'s Framework (n=20) (tables 1 and 2) [24, 26-31, 33-40, 43-47]. The main theme identified in relation to availability was that individuals from rural communities reported CBPTS were not available [24, 31, 33, 35, 37, 39, 40, 44, 45]. This finding was reported in different rural communities, across different provinces and was not population specific.

**Affordability.** Affordability, or the ability to pay for services including consideration of third party insurance coverage [15], was identified in 15 articles (tables 1 and 2) [24-26, 28-33, 35, 39, 42-44, 48]. Eight of the articles identified adults with a chronic condition reported affordability as a barrier to receiving CBPTS [28, 29-32, 34, 41-43]. These studies included data from multiple provinces and for a variety of chronic conditions. One study from Ontario also reported individuals with a chronic condition were four times more likely to receive PTS in publicly versus privately funded settings [24].

**Acceptability.** Acceptability, or the fit between the provider and patient, including attitude towards and expectations of each other [15], was the least frequently identified category identified when the articles were sorted according to McIntyre *et al.*'s framework (n=2) (tables 1 and 2) [34, 36]. Acceptability was primarily identified through asking health care providers if they perceived need for rehabilitation (including PT) for a specific client [36], or by asking clinical sites if they would provide PT services for individuals with specific conditions [34]. None of the articles asked clients, or potential clients, about their expectations of physiotherapy or their attitude towards CBPTS. A consistent theme related to geographic area or condition was not identified between the papers.

Canada has thirteen provincial and territorial health care systems that operate within a national legislative framework, the Canada Health Act [49]. An underlying premise of the delivery of health care in Canada is that access to medically necessary health care should be based on need rather than on the ability to pay [26]. In practice "medically necessary" need is broadly defined and covers the vast majority of physician services [49]. Provincial governments are not required to insure health services provided outside the hospital and have the flexibility to make funding changes to community-based services [48]. Thus, the extent of public coverage for CBPTS varies across provinces and territories [49].

This scoping review identified that need for CBPTS exists in Canada for adults with a variety of health conditions and in different geographic regions. The need was also identified by different perspectives (i.e. the individual vs. a health care provider). The most common barriers to accessing CBPTS noted in this scoping study were service availability and affordability. Despite national variation in the organization, delivery, and funding of health care, this scoping review identified that individuals with chronic conditions and from rural communities more frequently reported unmet needs for CBPTS across Canada. For example, individuals with a CC had longer wait times for CBPTS compared to persons without a CC [30-32, 38] and

affordability was frequently identified as a reason why adults with a CC did not receive CBPTS [29,30-33,35,42-44]. In addition individuals from rural communities were more likely to report a lack of service availability [24, 31, 33, 35, 37, 40, 41, 44, 45].

These findings highlight systematic disparities between groups of Canadians related to access to CBPTS which may be wide reaching. Three of every five Canadians aged 20 y or older have a chronic disease, and four of every five persons are at risk of developing a chronic condition [50]. Chronic diseases are also a major contributor to reduced quality of life, loss of productivity, and increased hospitalization and health care costs, as well as premature death in Canada [50]. In addition, in 2011, approximately 18.9% of Canadians lived in rural areas [51]. Thus, pan-Canadian opportunities exist to reduce unmet need for CBPTS for specific populations and reduce health disparities across the country. Specifically, an evaluation of how CBPTS are provided within the context of each provincial and territorial health care system in order to identify innovative solutions for addressing the unmet need is required.

Two papers [34, 36] in this scoping review identified acceptability as a barrier to access CBPTS. However, neither of these studies directly involved current or potential clients of physiotherapy services. The importance of understanding clients' perspectives related to use health care services, and exploring if these preferences are addressed in the delivery of rehabilitation services has been previously noted. For example, Van Til *et al.* [52] highlighted the need to understand the barriers patients experience in relation to rehabilitation and how to overcome these barriers. The profession of physiotherapy values client centered care, however, by not investigating acceptability from the client's perspective, a fundamental component of client-centered care is being overlooked. This oversight may result in system changes that do not match client expectations and could instead increase existing unmet need in specific populations.

One paper [25] also reported an association between self-rated health (SRH) and access to physiotherapy services. This finding is a concern as SRH is an independent and strong predictor of mortality, morbidity and health outcomes, and is an indicator of a population's overall well-being [41]. As a result, differences in SRH between individuals who can and cannot access CBPTS may provide a rationale for addressing access barriers to facilitate improved overall health for Canadians. More research is required to understand this potential association better.

#### **Implications for future policy and research development**

Additional research is required to understand unmet need for CBPTS in Canada better. Future research should focus on understanding the specific context of unmet need for CBPTS by individuals with chronic conditions, and persons who reside in rural communities. Gender difference related to unmet need has been established in previous research for other health services, and future analyses should also determine whether this difference exists in relation to CBPTS. The results of this research will assist with the future planning of health care resource distribution to ensure equitable access to CBPTS for Canadians regardless of geographic location and medical history. Future policy decisions and health system planning related to CBPTS should also consider what type of need exists as well as how need and access interact. This consideration will ensure services are not only available to individuals in need but that the services are delivered in a manner acceptable to the end user and reflect their ability to use those services [15].

#### **Limitations**

There are limitations to the findings of this study. First, the inclusion criteria identified papers reviewed in this study may have excluded studies that would have contributed to a broader understanding of need and UN for PTS in Canada. For example, this scoping review did not consider services for children or persons requiring institutional care. In addition, a complete assessment of the grey literature was not undertaken, and as a result, the data presented are limited to findings published in academic journals. However, only 24 articles identified in the academic literature specifically discussed unmet need for CBPTS in Canada. This is consistent with other findings,

which also note a lack of global data about the need for rehabilitation services [2,4,5,53]. Thus, it is possible that need and UN for PTS in Canada is broader than has been captured by this research. The results of this scoping review should be considered an exploratory attempt to understand unmet need and the reasons why need exists. It will form the foundation for additional research.

## CONCLUSION

This scoping review has identified that there are different types of need [14], and different reasons why [15], an unmet need exists for CBPTS across Canada.

Adults with chronic conditions and adults who lived in rural communities frequently reported an unmet need for CBPTS. The access domains of availability and affordability [15] were the most frequent reasons to explain why adults were not able to access CBPTS. This scoping review is the first to explore reasons for need and unmet need for access to CBPTS for adults in Canada across multiple populations and conditions. The findings provide a foundation for future research investigating need and unmet need for PTS to achieve health care equity.

## Key messages

### What is already known on this topic?

In Canada, the percentage of people reporting an unmet need (UN) for health care rose from 4.2% in 1994/1995 to 12.5% in 2000/01 [16]. Canadian studies have identified population groups with an increased likelihood of reporting UN for health care. These groups include women, people in worse health, persons <69 y, persons with higher education, persons with lower income, and individuals without prescription drug coverage [16-19]. Studies to date related to access and use of PTS in Canada have not undertaken a consistent approach and do not provide a comprehensive understanding about who does not receive needed PTS- or the reasons why UN for PTS exists.

### What this study adds?

This study is the first scoping review to investigate need and UN for community-based physiotherapy services (CBPTS) across multiple populations and conditions in Canada. The findings from this scoping review identify opportunities for physiotherapists to modify and enhance service delivery to work towards achieving health care equity for all Canadians.

## Recommendations

Future research by scientists, clinicians and policy makers at the provincial/territorial level is required with a focus on understanding the context of unmet need for CBPTS by individuals with chronic conditions; persons who reside in rural communities and gender differences. For example focus groups could be conducted with individuals diagnosed with a chronic condition in order to understand past experiences with CBPTS and explore any barriers to access. In addition, CBPTS utilization statistics could be collected at the provincial level to investigate the number of women compared to men, and individuals with compared to individuals without a chronic condition who access CBPTS.

Future investment in CBPTS by funders and policy makers must consider, and address inequities in access to CBPTS

## CONFLICT OF INTERESTS

The authors do not have any conflict of interest

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