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Simon Deslauriers, Marie-Hélène Raymond, Maude Laliberté, Anne Hudon, François Desmeules, Debbie E. Feldman and Kadija Perreault

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Article abstract

In the context of long waiting time to access rehabilitation services, a large majority of settings use referral prioritization to help manage waiting lists. Prioritization practices vary greatly between settings and there is little consensus on how best to prioritize referrals. This paper describes the prioritization processes for physiotherapy services in Québec and its potential implications in terms of equity in access to services. This is a secondary analysis of a survey of outpatient physiotherapy departments (n=98; proportion of participation was 99%) conducted in 2015 across publicly funded hospitals in Québec. In many settings, persons with acute orthopaedic conditions were prioritized while chronic conditions were given a lower priority. There were 72 different combinations of prioritization criteria used in outpatient physiotherapy departments. Variability was also observed in the type of personnel involved in the prioritization process, the number of priority levels used to rank the referrals and the source of information used to prioritize referrals. These results highlight potential issues regarding equity in access to physiotherapy services: the prioritization of persons with acute conditions to the detriment of those with chronic conditions, the lack of consensus on a fair prioritization process and the importance to adequately assess patients' needs for treatment. Further research and interventions on prioritization criteria and processes are needed to ensure equitable access to physiotherapy services, especially in the public sector.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Prioritization of Referrals in Outpatient Physiotherapy Departments in Québec and Implications for Equity in Access

Simon Deslauriers[1,2], Marie-Hélène Raymond[3,4], Maude Laliberté[3,4,5], Anne Hudon[6,7], François Desmeules[3,8], Debbie E. Feldman[3,4,5], Kadija Perreault[1,2]

Résumé

Dans le contexte actuel de longs délais d'attente pour accéder aux services de réadaptation, la grande majorité des établissements utilisent la priorisation des demandes de référence pour aider à gérer les listes d'attente. Les pratiques de priorisation varient grandement d'un milieu à l'autre et il y a peu de consensus sur la meilleure façon de prioriser les demandes de référence. Cet article décrit les processus de priorisation de services en physiothérapie au Québec et leurs implications potentielles en termes d'équité dans l'accès aux services. Il s'agit d'une analyse secondaire d'une enquête menée en 2015 auprès des cliniques externes en physiothérapie (n=98 ; la proportion de participation était de 99 %) dans les hôpitaux publics du Québec. Dans de nombreux milieux, les personnes ayant une condition orthopédique aigüe étaient priorisées, tandis que les conditions chroniques recevaient une priorité moindre. Nous avons comptabilisé 72 combinaisons différentes de critères de priorisation utilisées dans les cliniques externes de physiothérapie. Nous avons également observé une variabilité dans le type de personnel impliqué dans le processus de priorisation, le nombre de niveaux de priorité utilisés pour classer les demandes de référence et la source d'information utilisée pour établir la priorisation. Ces résultats mettent en lumière des enjeux potentiels concernant l'équité dans l'accès aux services de physiothérapie : la priorisation des personnes atteintes de conditions aigües au détriment de celles atteintes de conditions chroniques, l'absence de consensus sur un processus de priorisation équitable et la nécessité d'évaluer adéquatement les besoins de traitement des patients. De futures recherches et interventions sur les critères et les processus de priorisation sont nécessaires pour assurer un accès équitable aux services de physiothérapie, en particulier dans le secteur public.

Mots clés

priorisation des demandes, physiothérapie ambulatoire, équité, accès

Abstract

In the context of long waiting time to access rehabilitation services, a large majority of settings use referral prioritization to help manage waiting lists. Prioritization practices vary greatly between settings and there is little consensus on how best to prioritize referrals. This paper describes the prioritization processes for physiotherapy services in Québec and its potential implications in terms of equity in access to services. This is a secondary analysis of a survey of outpatient physiotherapy departments (n=98; proportion of participation was 99%) conducted in 2015 across publicly funded hospitals in Québec. In many settings, persons with acute orthopaedic conditions were prioritized while chronic conditions were given a lower priority. There were 72 different combinations of prioritization criteria used in outpatient physiotherapy departments. Variability was also observed in the type of personnel involved in the prioritization process, the number of priority levels used to rank the referrals and the source of information used to prioritize referrals. These results highlight potential issues regarding equity in access to physiotherapy services: the prioritization of persons with acute conditions to the detriment of those with chronic conditions, the lack of consensus on a fair prioritization process and the importance to adequately assess patients' needs for treatment. Further research and interventions on prioritization criteria and processes are needed to ensure equitable access to physiotherapy services, especially in the public sector.

Keywords

referral prioritization, outpatient physiotherapy, equity, access

Introduction

Demand for physiotherapy services is expected to increase in the next decades due to the aging of the population and the increasing prevalence of chronic conditions [1]. In Canada, demand for publicly funded outpatient physiotherapy services is already exceeding supply and access to services is often limited by extensive waiting lists [2,3]. Some patients may not even receive services due to waiting times or restricted eligibility criteria [4], while others face long delays before receiving services. Our research team found the median waiting time for publicly funded physiotherapy services in Québec, the second most populous province in Canada, to be 140 days [3], which is higher than the reported waiting time in Ontario [2]. In 2015, there were a total of 18,245 patients on the waiting lists for these services across Québec [3]. Managing waiting lists is a challenge [5] and waiting list managers use various strategies in order to help them in this task. One of the most frequently used strategies is referral prioritization [5-7].

Used in 96% of Quebec's outpatient physiotherapy departments [3], prioritization is a priority setting process in which referrals are ordered based on pre-determined criteria (e.g., need for services, level of urgency, potential for improvement) [8]. The purpose of this process is to determine which patients should receive services first, inevitably resulting in advantaged and disadvantaged groups of patients in terms of access to care [8]. This process is considered unavoidable given the scarcity of healthcare resources in many countries [9]. Prioritization processes may also involve rationing of services, that is denying access to patients based on specified eligibility criteria [10]. Not surprisingly, prioritization processes and limited access to healthcare services raise issues regarding equity in access [7,11-15]. These issues are challenging for clinicians, managers and decision makers, knowing that "in a resource-constrained system, giving additional weight to something or someone implies that something or someone else will lose out." [16, p.5]. While the literature regarding ethics in rehabilitation is growing, few studies have addressed the prioritization processes used in physiotherapy departments. Hence, this paper describes the prioritization processes for physiotherapy services in Québec and its potential implications in terms of equity in access to services. This article does not intend to provide a detailed ethical analysis of prioritization processes but rather introduce potential issues of equity to raise awareness and guide future deliberations by decision-makers, patient representatives and bioethicists.

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Methods

This is a secondary analysis of data collected in 2015 from a survey of publicly funded hospitals offering outpatient physiotherapy services to adults with musculoskeletal disorders in Québec [3]. The survey documented access to services for persons with musculoskeletal disorders. This project was approved by the Research Ethics Board of the *Institut de réadaptation en déficience physique de Québec*.

Eligibility criteria for the participating organizations were: 1) publicly funded hospitals, 2) offering outpatient physiotherapy services with the majority of their patients being aged 18 years or older with musculoskeletal disorders. The waiting list managers were the key respondents to the survey; they were contacted by telephone to introduce the project and verify eligibility. Eligible and interested respondents were sent further information on the project and the link to the survey by email. The participants were not offered a financial compensation or another incentive to respond to the survey.

Data was collected via a web-based questionnaire (Limesurvey^{TM} v2.05+) of 25 questions regarding the characteristics of the organizations, referral prioritization processes, waiting list management strategies and access to services. The questionnaire was pretested by three respondents outside of the study population. This article presents original data on prioritization processes used in Québec's outpatient physiotherapy services. Survey questions pertaining to prioritization processes are available in Annex A.

Closed and open-ended questions from the questionnaire were analyzed respectively using statistical descriptive analyses and qualitative content analysis [17], the latter using NVivo software [18]. Quotes from respondents are included in this article to illustrate the results of the qualitative content analysis. When necessary, quotes have been translated from French to English by a bilingual member of the research team (SD). SD conducted the analyses with the collaboration of KP; each author was involved in the interpretation of the results.

Results

Prioritization criteria

Based on eligibility criteria, 98 of the 145 hospitals listed in the province of Québec were retained for the study. Ninety-seven of these organizations completed the survey (proportion of participation was 99.0%). Different criteria were used to prioritize referrals between outpatient physiotherapy departments. The most frequently used criterion was the diagnosis (reason for referral in physiotherapy) (Table 1), which was also cited as the most important criterion to consider by 75.5% of the respondents (Table 2). We assessed the combination of criteria used in each setting (the number of criteria ranged from 2 to 10) and found 72 different combinations used among the 94 outpatient physiotherapy departments that prioritized their referrals. Interestingly, no single combination was used in more than three settings.

Table 1. Prioritization criteria used in outpatient physiotherapy departments (n=94)

	n hospitals (%)	n missing (%)
Diagnosis (reason for referral)	93 (98.9)	
Date of receipt of referral (chronological order)	81 (86.2)	
Level of acuity (time since onset of the condition)	64 (68.1)	3 (3.2)
Current functional independence	62 (66.0)	1 (1.1)
Level of urgency specified by referent	60 (63.8)	1 (1.1)
Potential for rehabilitation	49 (52.1)	3 (3.2)
Age of client	38 (40.4)	2 (2.1)
Type of professional making the referral (e.g., orthopaedic surgeon, family physician)	35 (37.2)	2 (2.1)
Funding source (e.g., workers' compensation board, automobile insurance)	34 (36.2)	1 (1.1)
Referral source (e.g., within or outside facility)	32 (34.0)	1 (1.1)
Other criterion (previous physiotherapy episode, risk of deterioration, absence from work, etc.)	18 (19.1)	

Table 2. Most important prioritization criterion considered by outpatient physiotherapy departments (n=94)

	n hospitals (%)
Diagnosis (reason for referral)	71 (75.5)
Current functional independence	11 (11.7)
Level of acuity (time since onset of the condition)	4 (4.3)
Type of professional making the referral	2 (2.1)
Other criterion	6 (6.4)

Through open-ended questions, many respondents reported that acute orthopaedic conditions were given the highest priority and that access for certain clienteles was very limited, such as persons with chronic conditions: “Only orthopaedic postoperative cases and post-fractures are prioritized and seen at the outpatient clinic. All other referrals are referred to private clinics or placed on the waiting list in case of availability for an assessment and advice with an exercise program. The waiting list is more than a year for these cases and only a very small percentage is seen.” (R92) Among criteria mentioned in the “other” category in Table 1 is that of being a staff member from the hospital, which was reported in five settings. One respondent specified in the survey: “Employees from our CSSS (Health and Social Services Centre) who are on sick leave and referred to physiotherapy are ranked at least ‘semi-urgent’. This prioritization comes from an administrative request in order to reduce costs of salary insurance.” (R33)

Other aspects of the prioritization processes

The type of personnel involved in the prioritization process varied between departments. The clinical coordinator was involved in 60.6% of the departments while a clinician took part in the prioritization process in 57.4% of settings. Reception staff and administrators were also involved in the process in 35.1% and 18.1% of the departments, respectively.

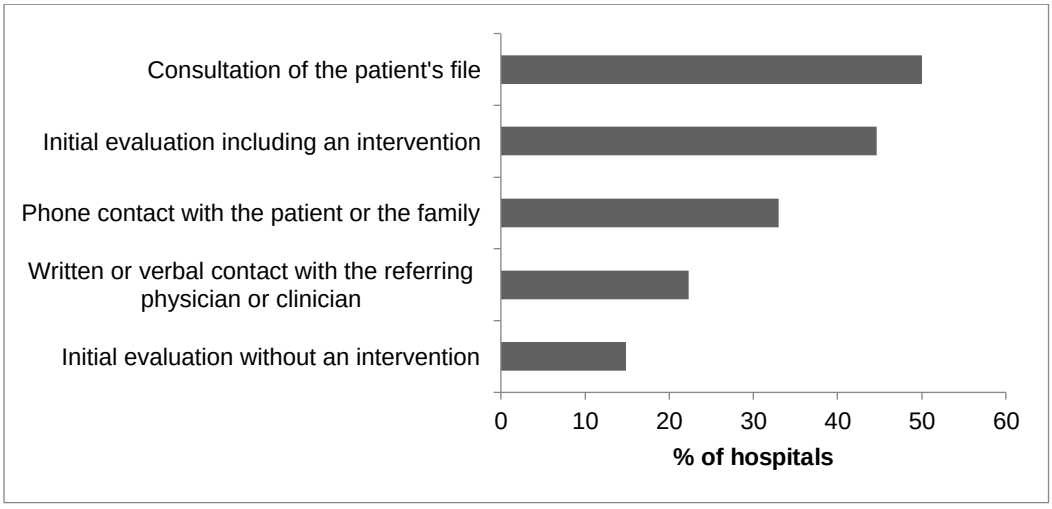
Seventy-six percent (n=74) of surveyed outpatient physiotherapy departments used priority levels (e.g., P1, P2, P3 or urgent, semi-urgent, chronic) to rank referrals. However the number of levels varied between departments, ranging from 2 to 6 (mean=3.49; standard deviation=1.04; n=71) (Table 3). A few hospitals that did not use priority levels ranked their referrals according to a score (n=6) or a percentage (n=4) based, for example, on an evaluation form.

Table 3. Number of priority levels in outpatient physiotherapy departments (n=71)

	n hospitals (%)
2 Levels	11 (14.9)
3 Levels	29 (39.2)
4 Levels	19 (25.7)
5 Levels	9 (12.2)
6 Levels	3 (4.1)

The sources of information used to prioritize physiotherapy referrals varied. Half of the physiotherapy departments always or often consulted the patient’s file and 44.7% always or often conducted a face-to-face initial evaluation with the patient that included an intervention (Figure 1).

Figure 1: Sources of information used (always or often) to prioritize referrals in outpatient physiotherapy departments (n=94)



More than one answer was possible.

Challenges for waiting lists managers and other decision makers regarding prioritization

Although our survey questionnaire did not specifically address the challenges related to priority setting, several challenges emerged in the answers to open-ended questions. Some respondents reported that patients treated in their department have increasingly complex conditions that take longer to treat, thus reducing patient flow and increasing waiting time. “Over the last few years, the complexity of cases has increased. Doctors no longer send referrals for simple fractures to our department. Instead, we receive more and more complex, multi-joint cases with numerous complications. Therefore, our volumes are unchanged but the therapists need more time per patient because of the complexity of each case.” (R14)

This problem appears to be exponential, as the waiting time increases the complexity of the patients' conditions: "One thing is for sure, since the last ten years, waiting times have considerably increased and it is quickly becoming a vicious circle: the longer the delay before treatment, the more chronic the problem has become and the longer the rehabilitation will be." (R66) The increase in demand for services combined with financial restrictions was also an issue for waiting list managers: "The volume of orthopaedic interventions will probably be on the rise in the next months, but budgetary constraints will not permit the addition of resources…access will then be even more difficult." (R70)

Respondents mentioned that the demand also increased for inpatient physiotherapy services, diverting clinical resources from outpatient services: "Outpatient clientele is always the first to be cut as soon as there is an overflow [of patients] in inpatient wards but we still manage to see high priority clients." (R24) In this context, respondents worried about the lack of alternative resources for hospital-based outpatient physiotherapy: "Thirty years ago, when I first started [working as a physical rehabilitation therapist] in the public sector, the clientele we treated was around 75% outpatient and 25% inpatient. Nowadays, the portrait is opposite. This situation is prevalent in many centres. When there won't be any more access for the outpatient clients, which resource will they turn to?" (R5)

Discussion

Our survey results allowed us to describe prioritization processes in Québec's outpatient physiotherapy departments. Answers to open-ended questions provided additional insight on these processes as well as on challenges related to priority setting. These findings raise issues related to equity in access to physiotherapy services. Equity is defined as the absence of systematic and avoidable disparities in health associated with socio-demographic characteristics [19,20]. Equity derives from the principles of fairness and social justice [19]. Based on the survey, we identified three potential issues of equity in access that will be discussed below: the priority given to clienteles with acute conditions to the detriment of others, the lack of consensus on a fair prioritization process and the need to adequately assess patients' needs for treatment.

Leaving chronic patients behind

The first issue related to equity in access is the frequent use of the level of acuity as a criterion for prioritization. While the results of our survey indicate that a majority of outpatient physiotherapy departments in Québec used the diagnosis as their most important criterion to prioritize referrals, level of acuity was also frequently considered. Furthermore, in many settings, postoperative conditions were systematically prioritized over chronic conditions, thus compromising access to physiotherapy for the latter [21]. Studies from Ontario and Australia found that the most frequent prioritization criterion for physiotherapy was the acuity of the condition. This approach also favours patients with acute conditions to the detriment of patients with chronic conditions who are given the lowest priority [5,22]. Understandably, anyone with a new onset of a condition or injury should receive appropriate care (if needed) as promptly as possible. Accessible and effective care can ensure a more rapid and positive recovery, which can, in the long run, be more efficient for the whole system. However, in contexts where resources are limited and where demand exceeds the provision of services, such as in Québec's outpatient physiotherapy departments, prioritizing persons with acute conditions can have consequences particularly for persons with chronic conditions, such as those with chronic pain, whose quality of life is reportedly among the lowest observed for any other medical condition [24,25]. Persons with chronic pain have higher rates of sick leave compared to those with acute pain [26] and also have substantial levels of disability, activity limitations and psychiatric comorbidity [27]. Their low health status and quality of life would suggest that they have a high need for treatment, but current prioritization processes impede them from receiving required services in time, as they are systematically at the bottom of the list. Although access to private physiotherapy services is an option for a proportion of the population, many persons with chronic pain are unable to afford private services because of a lower socioeconomic status or unemployment due to pain [28-31].

When such imbalance in prioritization results in patients with chronic conditions having to wait many months and even years before receiving services, if they receive services at all, there is a violation of the *fair-opportunity rule.* According to Beauchamp and Childress, the fair-opportunity rule prescribes that "no persons should be denied social benefits on the basis of undeserved disadvantageous properties" [23, p.248]. Following this principle, one would assume that patients with chronic pain are not responsible for the duration of their pain and therefore do not deserve this "disadvantageous property". Hence, they should not be denied the opportunity to benefit from timely physiotherapy services. Thus, prioritization decisions leading to lengthy waiting time and inadequate access to physiotherapy services for persons with chronic conditions likely represent a barrier to equitable access. These results provide the basis for a larger ethical deliberation on how to prioritize persons with chronic conditions, an ambitious analysis that is beyond the scope of this article.

Lack of consensus on a fair and adequate prioritization process

Another issue deriving from our findings and that of other researchers [5,7,22] is the great variability in prioritization processes used between clinical settings, an indicator of the lack of consensus on a fair and adequate process. According to Lewis et al. [32], variability in the management of waiting lists represents a threat to equity. For instance, the variability in the prioritization processes most likely results in patients with equivalent needs not being given the same priority level if they ask for services in different physiotherapy departments. This situation is in conflict with an important principle of equity in healthcare, that is an "equal access to care for people in equal need" [33, p.2]. Our results indicate that there were many

different combinations of criteria used in outpatient physiotherapy departments, none of them being used in more than three settings. This variability regarding prioritization criteria also emerges in the literature and reflects divergent recommendations from experts. For example, according to Norheim [34], two criteria can guide the process of priority setting: the severity of the condition (or prognosis *without* the intervention) and the potential outcomes (or prognosis *with* the intervention). Brown and Pirotta [22] argue that an ethical prioritization process should be based on the patients' needs rather than their potential to benefit from the intervention, since predicting how patients will respond to treatment might be more difficult and less accurate than assessing their current needs. Pineault [35] suggested that the priority should be established based on the severity of the condition, the capacity of the system to manage the condition and the feasibility of the interventions. For instance, physiotherapy waiting list managers might consider the patient's needs (level of disability, restrictions in activities of daily living, etc.) as well as the effectiveness and feasibility of interventions available to treat the patient's condition. Hence, for conditions of equal severity, they could choose to prioritize those for which scientific evidence supports the effectiveness of physiotherapy, such as neck pain [36] or rehabilitation post-hip arthroplasty [37], as opposed to conditions for which evidence is lacking, such as ruptured Achilles' tendon [38] or shoulder adhesive capsulitis [39]. These various examples translate into the absence of consensus regarding the choice of prioritization criteria to use in various settings, leading us to suggest the need to reflect on further standardization of prioritization criteria across outpatient physiotherapy departments.

While prioritization is a strategy that can help achieve *vertical equity* (i.e., proportionately unequal interventions for different needs [41]), a better standardization of these processes across the province and within settings could ensure that *horizontal equity* is also considered (i.e., equal intervention for equal needs [41]). Formal prioritization tools may help standardize prioritization processes. Raymond et al. [6] recommended that such tools should include a combination of objective criteria along with a few subjective criteria that would leave room for clinical judgment. This approach is reflected in the Guidance for Priority Setting in Health Care (GPS-Health) tool that was designed to help decision-makers consider equity criteria in priority setting processes [16]. These criteria include, among others, the severity of the condition, the potential of the intervention, as well as financial and social benefits resulting from the intervention [16]. Socio-demographic criteria are also considered with the intent to reduce health disparities associated with income, age gender or ethnicity [16]. This tool ensures that equity criteria are given consideration to complement cost-effectiveness analyses that often influence decisions.

In addition to the variability of the criteria used in each setting is the variability of the definitions used for a single criterion [22]. For this reason, the Steering Committee of the Western Canada Waiting List Project [40] proposed definitions of key terms. Severity was defined as "the degree or extent of suffering, limits to activities or risk of death" [40, p.858]. The need (considered equivalent to the level of urgency) was defined as the "severity in addition to considerations of the expected benefit and the natural history of the condition." [40, p.858] Despite the proposed definitions, a practical evaluation of these concepts across clinical settings remains challenging. For example, the level of suffering of one patient may be highly multidimensional and a physical, psychological and social evaluation may be required.

Another concern regarding the prioritization process is its reliability [8,42], which also relates to its variability. Prioritization processes with low or moderate reliability increase the variability in the priority given to patients with hypothetically identical needs, increasing the risk of inequities in access to services. A study assessed the inter-rater reliability of a telephone prioritization process for occupational therapy and physiotherapy referrals in Australia and found a moderate agreement (weighted kappa=0.6) and a proportion of 30% of referrals for which different priority levels were assigned by the two raters [43]. A specific training designed to increase the reliability of this prioritization process did not improve the inter-rater agreement [44]. Another study found a better inter-rater reliability (ICC=0.79; 95% CI: 0.68-0.86) for a prioritization process that included a 30 minute in-person evaluation for referrals to outpatient physiotherapy in Québec [45]. Overall, however, the reliability of prioritization processes is seldom assessed.

Again, the variability in prioritization processes and the absence of consensus in the literature highlights the need for bioethicists to work with decision-makers to establish a prioritization process based on a thorough ethical analysis.

Are the prioritization processes able to adequately assess patients' needs?

An appropriate and comprehensive assessment of the patients' clinical condition is most likely a necessary condition to achieve equitable prioritization. This idea is associated with another question that emerged from our survey results: What source(s) of information should prioritization processes be based on in order to accurately assess the patients' condition? Information relevant for the prioritization can be gathered from the patient's file, a face-to-face assessment, a phone contact with the patient or a discussion with the referring physician or clinician. Again, our results revealed variability in the sources of information used to prioritize physiotherapy referrals and face-to-face evaluation was used in less than half of departments. Joseph et al. [46] conducted a systematic review on various methods used for musculoskeletal triage and concluded that face-to-face evaluation was effective in assessing the condition of patients as it gives the possibility to conduct a physical and functional examination and to consider body language. It also resulted in high levels of satisfaction from the patients and the clinicians, and allowed the clinician to provide an intervention (e.g., education, exercises, self-management advice) and even discharge patients after the initial evaluation [46,47]. Telephone assessment of a patient's condition was considered highly accurate, but concerns were reported especially when assessing persons with complex conditions without being able to conduct a physical examination [46]. The possibility of obtaining written or verbal information with the referring physician or clinician may be limited due to the difficulties in sharing information between different settings (e.g., between medical clinics and hospitals) [46]. The choice of method used to obtain the information needed to prioritize referrals also depends on multiple variables (e.g., human

resources and physical space available, quantity of referrals) that are context-dependent. We emphasize that equitable access to health care services is likely to depend on an appropriate assessment of the patients' condition, including their need for treatment.

We also found that different types of personnel were involved in the prioritization processes, the most frequent being clinical coordinators or clinicians. These different types of personnel may assess patients' conditions from a different perspective and may not always be in the best position to adequately prioritize them. Administrators and clinical coordinators likely face budgetary and organizational constraints that may influence their prioritization decisions. Also of possible concern is the involvement of reception staff in waiting list prioritization in more than a third of settings in our survey. These employees do not have the clinical training necessary to assess the severity of a patient's condition or the potential outcomes of treatment for example, depending on which criteria are chosen for the prioritization [50]. Hence, the choice of prioritization criteria used in each setting and the assessment of the patients' condition may be influenced by the skills and professional values of the person responsible for the prioritization processes.

The variability in the sources of information used to prioritize referrals and the personnel involved in these processes lead us to question whether the patients' needs for treatment are adequately considered. This issue has implications regarding equitable access to services, thus reinforcing the need to examine prioritization contexts with an ethical lens.

Ways ahead to improve prioritization processes

In light of the three issues discussed above, it appears that waiting list prioritization is a challenging process that has implications for equity in access to publicly funded outpatient physiotherapy services [51]. While this article is not intended to provide an in-depth ethical analysis, we have identified several conceptual frameworks and ethical concepts and tools that may be useful to bioethicists and decision makers interested in deliberating and improving prioritization processes. A well-known model that could guide the reflection on prioritization processes is the Accountability for Reasonableness (A4R) framework proposed by Daniels and Sabin [52]. In their work, the authors describe four conditions for a fair and legitimate decision-making process regarding priority setting: publicity, relevance, appeals and enforcement. The *publicity* condition emphasizes the importance of a transparent communication of the decisions made and their rationales. The *relevance* condition prescribes that the decisions are guided by evidence, arguments and principles that were reached by consensus among stakeholders. The *appeals* condition ensures that there is an opportunity to contest and revise the decisions over time. The *enforcement* condition refers to the establishment of suitable policies or regulations to oversee the first three conditions. Gibson et al. [53] suggested a fifth condition to be added to the A4R framework: the *empowerment* condition. This condition encourages stakeholders to participate on an equal basis and aims to minimize power differences in the decision-making process. In practice, the A4R conditions are rarely met in the context of hospital priority setting [54], leaving considerable room for improvement. For example, transparency in priority setting could be increased by communicating to patients their priority level on the waiting list or making the department's prioritization criteria and the reasons for choosing these criteria publicly available. In order to adhere to the relevance and empowerment conditions, patient-partners could also be involved as stakeholders in reviewing or creating referral prioritization tools in collaboration with clinicians and researchers.

Sibbald et al. [51] examined how researchers, decision makers and patients define *successful* priority setting. Their study revealed ten elements of success pertaining to the processes and the outcomes of priority setting, including the engagement of different stakeholders in a transparent decision-making process, an effective communication strategy, the consideration of stakeholders' values and a mechanism to review or appeal the decisions [51]. Again, these elements may guide reflection about the validity and the pertinence of prioritization processes in physiotherapy departments, something that may be undertaken at a local, regional or provincial level. For example, discussions about the positive and negative implications of choosing a specific criterion over another should be encouraged. Consensus among stakeholders may be reached through various approaches such as focus groups or Delphi methods.

The *equity-efficiency trade-off* has been identified as another concept to consider when determining priority in healthcare [55,56]. This concept is defined as the "degree to which society is willing to sacrifice efficiency for fairness or equity" [55, p.95]. This interaction is also referred to by the World Health Organization as the relation between *fairness* and *benefit maximization* (i.e., the maximization of overall benefits across the entire population) [41]. A decision maker concerned with *fairness* would aim to achieve a fair distribution of benefits across the population of patients. In the context of physiotherapy waiting lists, the services could be prioritized based on patients' needs, for example. In contrast, a decision maker concerned with *benefit maximization* would aim to provide the highest total benefits across the population of patients. For instance, access to physiotherapy services could be prioritized based on the potential for rehabilitation and the efficiency of interventions. These two principles must be carefully weighed and balanced in a transparent and informed debate [41,48].

Based on another perspective, prioritization processes are governed (often unconsciously) by many possible paradigms of distributive justice: utilitarianism, libertarianism, communitarianism and egalitarianism [23,49]. Universal publicly funded health systems such as Canada's, Australia's or the UK's are traditionally oriented towards egalitarianism (equal distribution of services and burdens), but utilitarianism (maximizing the benefits for the greatest number of persons) is gaining ground with the recent focus on efficiency and cost containment over the last decades [49,57]. For example, an egalitarian approach could seek to prioritize patients with the highest burden and greater needs, or even consider the first-come, first-served principle for physiotherapy services allocation [49,58]. Conversely, utilitarian prioritization would aim to prioritize, for instance, patients for

whom physiotherapy is known to provide the most cost-effective outcomes or those who have the highest potential for improvement in terms of quality-adjusted life years [49]. Another example of a utilitarian-based approach is when priority is given to treatment of staff members, a situation described in our survey results. Such decisions may be driven by the instrumental value of the injured staff members, considering that prioritizing them is beneficial for other patients who receive services in the same setting [58]. However, in some physiotherapy departments, this prioritization criterion is motivated by concerns about salary insurance costs.

Using these theoretical concepts and frameworks for ethical guidance, decision makers and other stakeholders may be better equipped to identify which paradigms their organization adheres to and reflect on the underlying values that guide their decisions regarding prioritization. By making these values explicit, decision makers can support more coherent and relevant decisions. Such frameworks may also serve as stepping-stones for a comprehensive ethical analysis of prioritization processes.

Conclusions

This paper highlights potential equity issues regarding prioritization processes: the priority given to persons with acute conditions to the detriment of persons with chronic conditions, the lack of consensus on a fair prioritization process and the need to adequately assess patients' needs for treatment. We introduce several concepts and frameworks that could help bioethicists, researchers, decision makers, patients representatives and the different stakeholders concerned by access to physiotherapy services to reflect on the fairness of prioritization of physiotherapy referrals in the context of extensive waiting lists. Ultimately, access to physiotherapy services needs to be based on criteria and processes that ensure equity for all.

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Édition/Editors: Stanislav Birko & Aliya Affdal
Évaluation/Peer-Review: Soren Holm & Anonymous

Affiliations
[1] Centre for Interdisciplinary Research in Rehabilitation and Social Integration (CIRRIS), Quebec, Canada
[2] Département de réadaptation, Faculté de médecine, Université Laval, Quebec, Canada
[3] École de réadaptation, Faculté de médecine, Université de Montréal, Montreal, Canada
[4] Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal (CRIR), Montreal, Canada
[5] Institut de recherche en santé publique de l'Université de Montréal (IRSPUM), Montreal, Canada
[6] School of Public Health and Health Systems, University of Waterloo, Waterloo, Canada
[7] Faculty of Law, Civil Law Section, University of Ottawa, Ottawa, Canada
[8] Maisonneuve-Rosemont Hospital Research Centre, Montreal, Canada

Correspondance / Correspondence: Simon Deslauriers, simon.deslauriers.1@ulaval.ca

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Annex A

Survey questions pertaining to prioritization processes

Procédez-vous à une priorisation des demandes de consultation en physiothérapie pour la clientèle externe?

☐ Oui
☐ Non *(passez à la question Q16)*

De façon habituelle, quelle(s) personne(s) est(sont) directement impliquée(s) dans l'attribution du niveau de priorité des demandes de consultation?

☐	Gestionnaire
☐	Conseiller/coordonnateur clinique
☐	Clinicien (pht ou T.R.P.)
☐	Réceptionniste/ secrétaire
☐	Autre : _____

Utilisez-vous un outil formel pour prioriser les demandes de consultation (p. ex. formulaire, liste de critères)?

☐ Oui
☐ Non *(passez à la question Q13)*
☐ Je ne sais pas

Commentaires : _____

Utilisez-vous des niveaux de priorité (p. ex. P1, P2, P3,…) pour catégoriser vos demandes de consultation?

☐ Oui. *Précisez combien de niveaux de priorité*: _____
☐ Non

Commentaires : _____

Dans votre milieu, en vue de prioriser les demandes de consultation, utilisez-vous les procédures suivantes?

	Toujours	**Souvent**	**À l'occasion**	**Jamais**	**Je ne sais pas**
Consultation du dossier du client (papier ou électronique)					
Contact écrit ou verbal avec le référant (intervenant à l'origine de la référence)					
Contact téléphonique avec le client ou la famille					
Rencontre d'évaluation avec le client, **sans intervention initiale** (p. ex. exercices, enseignement)					
Rencontre d'évaluation avec le client, **incluant une intervention initiale** (p. ex. exercices, enseignement)					
Autre					

a) Pour chacun des items ci-dessous, lesquels sont pris en considération pour prioriser les demandes de consultation dans votre milieu?

	Oui	**Non**	**Je ne sais pas**
Âge du client			
Niveau d'indépendance fonctionnelle			
Potentiel de réadaptation			
Raison de consultation (diagnostic)			
Durée écoulée depuis l'apparition de la condition (aigüe ou chronique)			
Date de réception de la demande de consultation (ordre chronologique)			
Niveau d'urgence de la demande spécifié par le référant			
Source de référence (c.-à-d. références de l'interne vs autres milieux)			
Type de professionnel référant (p.ex. orthopédiste vs médecin de famille)			
Organismes qui paient pour les services (p. ex. CSST/SAAQ/assurances)			
Autre(s) : _____			

Commentaires : _____

b) Parmi la liste précédente, veuillez identifier lequel (1 seul) des items est le plus important pour attribuer le niveau de priorité?

☐	Âge du client

	Niveau d'indépendance fonctionnelle
	Potentiel de réadaptation
	Raison de consultation (diagnostic)
	Durée écoulée depuis l'apparition de la condition (aigüe ou chronique)
	Date de réception de la demande de consultation (ordre chronologique)
	Niveau d'urgence de la demande spécifié par le référant
	Source de référence (c.-à-d. références de l'interne vs autres milieux)
	Type de professionnel référant (p.ex. orthopédiste vs médecin de famille)
	Organismes qui paient pour les services (p. ex. CSST/SAAQ/assurances)
	Autre
	Je ne sais pas

Commentaires : _____

Merci pour vos précieuses réponses. Avez-vous des commentaires?