ASSESSMENT OF THE MARKET POTENTIAL FOR A NEW PHYSICAL THERAPY PRACTICE IN BC'S NORTHERN COASTAL REGIONS

by

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Abstract

British Columbia's Northern Coast has many appealing qualities for entrepreneurial-minded physical therapists looking to enter the industry. The purpose of this project is to evaluate the current market potential and make recommendations for the sustainability of a new physical therapy (PT) practice within Kitimat, Terrace, or Prince Rupert. The PT industry and local economies in this region were analyzed through a literature review. The primary objectives of this project were investigated using two methods: secondary data collection and a survey questionnaire addressing initial and returning visit fees, age demographics, revenue sources, promotion and advertising, waitlist lengths, and physical therapy services for First Nations people. The research uncovered challenges in establishing a private clinic in the North Coast such as stagnant population growth and the complexities involved in the formation of a referral network. The literature and research conducted also revealed significant opportunities, such as potential niche markets in pediatrics and service to First Nations people, and the ability to grow a customer base through diversification of revenue sources and promotional strategies. The lack of competition and economic growth opportunities make this region a viable location for a new PT business.
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List of Abbreviations

PABC  Physiotherapy Association of British Columbia
PT  Physical Therapy
MSP  Medical Services Plan
FNHA  First Nations Health Authority
NIHB  Non Insured Health Benefits
WSBC  Work Safe British Columbia
GP  General Practitioners
MOHLTC  Ministry of Health and Long-Term Care
GDP  Gross Domestic Product
ICBC  Insurance Corporation of British Columbia
LNG  Liquid Natural Gas
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Chapter I

Introduction

Physical therapy is a health care discipline directed primarily towards the prevention or alleviation of movement dysfunction in people (Physiotherapy Association of British Columbia [PABC], 2013). Graduates of this Masters-level program have a minimum of six years of post-secondary education, but often have little expertise in the business aspect of the physical therapy industry. As the chronic shortage of physical therapists in British Columbia continues (PABC, 2013), the success of new and emerging clinics is imperative. Identifying key business concepts of the current physical therapy industry that promote and foster long-term sustainability is critical for physical therapists who want to open a private practice clinic.

When looking at potential locations for a new clinic, entrepreneurs should look for underserviced communities that have a population base large enough to support a new entrant. The major communities comprising the regional districts of Skeena-Queen Charlottes and Kitimat-Stikine are prime examples of this. Prince Rupert, which is home to the majority of the population of the Skeena-Queen Charlotte Regional District, has a total population of approximately 13,000 people with only one private physical therapy clinic and one public physical therapy clinic. Kitimat and Terrace, the two major communities of the Kitimat-Stikine Regional District, have populations of approximately 9,000 and 12,000, respectively. Kitimat has no physical therapy services and Terrace has one private clinic, one hospital-based clinic, and one child development center (BC Stats, 2011).

This paper assesses the market potential for a new physical therapy practice in the
major city centers within the regional districts of Kitimat-Stikine and Skeena-Queen Charlotte. Publicly available information was assessed and compared with population sizes and the amount of current competition in order to gain further understanding of the market opportunities and challenges that may exist. Northern BC physical therapy owners provided information through the completion of a survey questionnaire that was analyzed in order to make marketing recommendations that address both the initial practice launch and long-term sustainability.
As the population ages and an increased number of health professionals near retirement, the demand for health care professionals, particularly physical therapists, continues to rise in British Columbia. Abundant literature exists regarding the BC PT industry, however little literature exists regarding the opportunities for a sustainable new practice in one of the major communities in BC’s Kitimat-Stikine or Skeena-Queen Charlotte Regional Districts. Literature was reviewed on population size, demographics, levels of competition, developing trends, and each region’s current economic situation to obtain a more accurate picture to analyze the feasibility and sustainability of a new PT clinic.

The Physical Therapy Industry

Physical therapy is a health care discipline directed primarily towards the prevention or alleviation of movement dysfunction in people (PABC, 2013). As of 2011, 43% of physical therapists worked in private health clinics, 39% in hospitals, 9% in residential and long-term care facilities, and 8% in local service centers (Service Canada, 2013). These statistics are Canada wide and are comparable with the physical therapy services offered in Prince Rupert, Terrace, and Kitimat (Appendix A).

Key market research for this sector includes knowledge of the health services offered by physical therapists and an understanding of the revenue sources within the community. Clients can access physical therapy services either publically or privately. Patients can access publically funded physical therapy services when admitted to a hospital (inpatient services), upon discharge from a hospital stay (outpatient services), and at other facilities
such as child development centers, rehabilitation centers, long-term care facilities, and prisons (Canadian Physiotherapy Association [CPA], 2012). These services are typically offered without an upfront payment required by the patient. There are also publically funded physical therapy clinics and programs within communities that are provided at no or minimal cost to the patient (Ontario Ministry of Health and Long Term Care, 2013). Clients who access private physical therapy services typically have to pay for each visit, unless they have a rehabilitation contract with Insurance Corporation of British Columbia (ICBC) or WorkSafe BC (WSBC) who pays the physical therapist. Clients who pay upfront may have complete or partial reimbursement by their extended health provider/benefits. A client can “walk in” to obtain private physical therapy services with no doctor’s referral required, and the waitlist is typically significantly shorter than a publically funded physical therapy service (PABC: Paying for Physiotherapy, 2013).

PABC bases their fee guidelines on regular reviews of provincial market rates and the Canadian Physiotherapy Association’s national cost of business study, which determines the cost per average visit (calculated by dividing a clinic’s total annual costs by the total annual number of patient visits). With this data, PABC members independently determine their rates, which they adjust according to variances in a clinic’s cost of providing service and the prevailing market. Clinic fees reflect time spent directly with the physical therapist and are charged at an hourly rate. The PABC recommends $63 for 20 minutes, $95 for 30 minutes, $143 for 45 minutes, and $190 for 60 minutes (PABC, 2013).

For a new clinic looking to establish itself in the market, it is critical for the provider to build relationships with health professionals and organizations within the service area who can inform clients of the clinic and its services, provide patient referrals to the clinic, and increase the public’s awareness of the clinic. Such health professionals and organizations
include: local physicians; health centers; consultants; physical therapy departments in local hospitals, nursing and retirement homes; sport clubs; and leisure centers (PhysioAccountant, 2014a).

To accurately estimate the sustainability of a new clinic, several factors must be considered, including the local economy’s potential for growth, the level of present competition, the population and demographics, the sources of revenue available, and industry challenges.

**Local Economies and Growth Potential**

The communities comprising BC’s North Coast rely heavily on an industrial resource-based economy, which includes mining, rail, power generation, industrial processing, transportation of goods, commercial and sport fishing, forestry, tourism, small business, government services, and health services (Halseth, 2010). Halseth (2010) highlights small and rural BC towns to make up the majority of the province’s export revenue and the economic connection between the rural and metropolitan regions. Rapid economic development in Asia has increased the Asian market’s reliance on Northern BC’s local resources. This development has increased the demand for BC’s natural resources as the North tries to keep up with serving the Asian market’s needs (Markey, Manson & Halseth, 2007). Meeting the global market’s demand, along with demand from local and Canadian markets, has generated economic growth in Northern BC (Markey, Manson & Halseth, 2007). Investments in the Asia Pacific Gateway, Port of Prince Rupert, liquid natural gas (LNG), and many other lucrative projects within the Kitimat-Stikine and Skeena-Queen Charlotte regional districts are major contributors to the future of this regions economic
Canada's Asia Pacific Gateway Strategy poses some lucrative opportunities in BC, more specifically in Prince Rupert, due to its strategic location as an import/export hub to Asian, Canadian, & US markets (Prince Rupert Port Authority, n.d.). Land surrounding Prince Rupert (more specifically, Prince Edward) has been allocated for expansion of the port and future planned development projects estimated at over $30 billion Canadian dollars (Prince Rupert and Port Edward Economic Development Coorporation, n.d.). Moreover, Prince Rupert is North America's closest port to Asia by three days and the second deepest port in the world allowing flexibility for ship sizes. The harbor is also home to a modern cruise ship terminal and an expanding container terminal, which moves commodities between Asia and the rest of North America (Prince Rupert Port Authority, n.d.).

BC statistics in 2012 (most recent) labeled China to be BC's second largest international export trading partner. This partnership is growing at a rapid rate with 18.3% of BC's commodity exports shipped to mainland China of over 5.7 billion Canadian dollars (BC Stats: A "Fact Sheet" for Mainland China, 2012). This growth is anticipated to drive development along the Asia Pacific Gateway, primarily at its origins in Prince Rupert. In addition to a major highway servicing the transportation of goods to and from the port, Canadian National Railway services both Canadian and US markets from Prince Rupert (Asia Pacific Foundation of Canada, 2014).

These favourable transportation logistics give the North Coast significant advantages. An economic impact study by InterVISTAS Consulting (2012) suggested operations at the Port of Prince Rupert may support up to a total of 4 780 jobs equivalent to 4 550 person-years of employment province-wide. Of this employment, 2 330 jobs (equal to 2 220 person years) are directly related to the port. Because jobs related to the port extend far beyond
Prince Rupert, the total also includes both indirect employment of approximately 1,280 person-years and induced employment of approximately 1,050 person-years (InterVISTAS Consulting, 2012). The Port of Prince Rupert generates direct employment in Prince Rupert and contributes significantly to BC's economy.

The significance of the port in terms of the provincial economy is also demonstrated by the direct economic impact of the port's generation of tax revenues to all levels of government. Total taxes paid on an annual basis by employers, employees and port users, are estimated at $69 million per year. The municipal government also benefits from the Port of Prince Rupert through the collection of property taxes and tax payments amounting to over $4 million paid by the port and its tenants (InterVISTAS Consulting, 2012). In addition to Prince Rupert's local infrastructure upgrades, many industrial projects and major investments are also taking place in the District of Kitimat: Kitimat Liquefied Natural Gas Terminal (estimated $4.5 billion), Northern Gateway Pipeline (estimated $6.5 billion), Rio Tinto Alcan Modernization ($3.5 billion), and Port of Prince Rupert expansion (estimated $650 million) (District of Kitimat, 2014).

Kitimat's economic development has increased significantly over recent years due to LNG projects (LNG storage and marine on-loading facilities). The development of these facilities in Kitimat will allow access to the LNG markets in the Asia-Pacific. The location of the Kitimat LNG is optimal due to its close proximity to the Asia Pacific markets and the accessible harbour being deep, ice-free, and not requiring dredging or a breakwater (Kitimat LNG, 2013). Kitimat LNG has stated that the construction phase of the project will create many permanent job opportunities that will be filled locally where possible, and will sustain and enhance local business. Kitimat LNG will stimulate the British Columbia energy industry over the long term, which will result in the development of associated services and supplies.
in the region (Melman, 2013). The project is anticipated to generate significant economic development opportunities in the North Coast (Kitimat LNG, 2013).

The literature surrounding port development, the Asia-Pacific gateway, LNG, and other major projects in the North indicate enormous investments and rapid economic development. The connection between these opportunities and the successful entrance of a PT practice remains less clear. What these opportunities suggest is economic growth and in turn population growth and a larger customer base which can feed the development and sustainability of a new practice.

Industry Analysis

The physical therapy industry can be examined using Porter's Five Forces (Appendix B). Porter's five forces is a framework used to analyze an industry and aid in the development of a business strategy. It draws upon an industries economic background to develop the five forces that determine the competitive concentration and attractiveness of a given market. The five forces are: threat of new entrants, threat of new substitutes, buyer power, supplier power, and the degree of rivalry (Porter, 2008).

The threat of new entrants refers to attractiveness and difficulty for new entrants to enter a market in a given industry (Porter, 2008). Typically, if an industry produces high profits it will attract new firms, however, this results in numerous new entrants, which ultimately reduces the profitability for all firms in the industry (Porter, 2008). The educational qualification of a Canadian physical therapist is presently in the process of changing from a four-year baccalaureate program to a Masters degree (PABC, 2013a). Additionally, a person must be registered with the College of Physical Therapists of British Columbia in order to practice physical therapy in British Columbia (Canadian Physiotherapy
Association, n.d). The costs of entering the PT industry are not substantial as little equipment is required at the initial startup stage (PhysioAccountant, 2014a).

The threat of substitutes occurs when products or services (outside of the common product) increase the tendency of customers to switch to alternatives (Porter, 2008). For instance, a bottle of water could be considered a substitute for Pepsi, whereas Coke would be considered a competitor's similar product, rather than a substitute product. In the Canadian physical therapy industry, substitutes can include services provided by chiropractors, massage therapists, doctors, kinesiologists, acupuncturists and naturopaths (Sheppard, 1997). Nurses (in hospital settings) have been known to provide treatments traditionally practiced by PT's, such as 'chest physiotherapy' in intensive care. Furthermore, rather than referring clients to a PT, there are some doctors who perform certain treatments (heat treatments and manipulations), which have historically been traditional areas of practice by physical therapists (Sheppard, 1997).

Buyer power can be described as a consumer's ability to put a business or corporation under pressure. This ability will also influence the consumer's sensitivity to changes in price (Porter, 2008). Porter (2008) explains that a business can implement certain measures to decrease customer bargaining power. For example, Airline's do this through implementing reward programs, such as AIR MILES™. In the PT industry, insurance coverage and the uncertainty of demand can influence the degree of buyer power. Firstly, insurance coverage can influence the clients demand for services (Holyoke, 2009). For example, a client who is covered through their health insurance may request for more services than a client who pays out of pocket for the same treatment. Secondly, clients generally do not plan on needing treatment because they do not know when they will become ill or require PT treatment. Theses uncertainties in combination with the "need" for treatment will limit the degree of
buyer power between the consumer and the provider. Additionally, health practitioners are generally more knowledgeable regarding the technical aspects of PT treatment and patients are reliant on this medical expertise, thus influencing demand. However, advancements in technology and the Internet have improved the accessibility of information. Patients can self diagnose and even compare service providers much easier, and this may increase the buyer power of patients in the future (Holyoke, 2009).

Porter (2008) explains, suppliers can exercise their power over a business when there are few substitutes, and that bargaining power of suppliers can also include services (such as expertise). In regards to the PT industry, there are generally three categories of suppliers: suppliers of equipment, services of labour, and suppliers of patients. If suppliers of equipment are not readily available and the cost of the required equipment is high, suppliers are able to exert bargaining power concerning price, quality, and terms. Conversely, if equipment is widely available and inexpensive, supplier power is less. The power of suppliers of labour largely depends on the clinics strengths and their position in the market. Suppliers holding a monopoly position in their local market will have more power than if the market were saturated and market share equally distributed between many competitors (Holyoke, 2009). Lastly, the supply of patients can often come from referrals from general practitioners and through word of mouth. Sheppard (1997) describes the substantial supplier power of doctors, due to their status as a source of referrals, and their ability to make recommendations to clients. New physical therapy clinics rely heavily upon the medical community for referrals, therefore, building a reputation of quality with doctors and the community is extremely important (PhysioAccountant, 2014b).

The amount of competitive rivalry in an industry is a determinant of the industries level of competitiveness (Porter, 2008). Sheppard (1997) explains that public and private
physical therapists do not generally compete for the same clients because the initial orientation is usually quiet different. Sheppard acknowledged, in situations where a geographical area becomes saturated with one area of expertise, clinics may experience a higher degree of rivalry as they compete for the clientele associated with their specialization.

Another common tool used in the analysis of an industry is a PESTEL analysis (Appendix C). A PESTEL analysis is a common external analysis tool used when conducting market research, and provides an overview of the various macro-environmental factors that a business should take into consideration. The PESTEL analysis includes six factors (political, economic, social, technological, environmental, and legal), and is a beneficial strategic tool in understanding market successes and failures and strategic positions (Chartered Institute of Personnel and Development, 2014). In consideration of the sustainability of new and existing PT clinics, a PESTEL analysis was conducted to identify important external factors. PT clinics should be aware that political changes, such as new tax regulations and economic downturn, may influence consumer expenditures and clinic visits. Changes to a revenue source’s policy, such as heightened WCB regulations, may lead to a safer workplace and reduce the overall number of claims and need for PT services. Changes in lifestyle trends and levels of social inequality may influence the frequency of PT services rendered. Finally, the evolution of technology, such as the ability to access business information online, is growing dramatically. The acceptance of smartphones, tablets and other mobile platforms has greatly increased the depth that consumers can receive and find information. These advancements in technology may have a profound impact on a clinics ability to reach out to customers.

**Aboriginal Population Size in BC**

The Canadian First Nation population’s health status has been rapidly deteriorating in
recent decades, and currently experience poor quality of life and lower life expectancy than the general Canadian population (Wilson & Rosenberg, 2002; Harris et al, 2002). Within British Columbia’s general population, the lowest life expectancy was found in the Northern regions, and the life expectancy of BC’s First Nations to be more than five years lower than the general population (British Columbia Provincial Health Officer 2009). BC’s Aboriginal population presents with rates of obesity and hospitalizations for chronic illnesses and injuries to be over double than the general population (Garner et al., 2010; Foulds, Bredin, & Warburton, 2012; Public Health Agency of Canada, 2011). Foulds et al 2012, who recently evaluated BC Aboriginal populations physical activity and health status, indicated initiatives are needed to help improve the health status of BC’s First Nation population, with special emphasis on rural, northern, and on-reserve populations.

Provinces and territories are responsible for delivering health care services to Aboriginal people, guided by the provisions of the Canada Health Act. Health care services to all Canadian’s include insured hospital care and primary health care, such as physicians and other health professional services. Health Canada’s Non-Insured Health Benefits (NIHB) program provides coverage for a limited range of goods and services when they are not insured elsewhere (Health Canada, 2013). The NIHB provides coverage for benefit claims for a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention, mental health counseling, and medical transportation for eligible First Nations and Inuit people (Health Canada, 2013). Many First Nations and Inuit people have health coverage under more than one benefit plan, such as from their province or territory (a public plan), their employer (a private plan) and the NIHB Program. All plans can be used when claiming for benefit expenses, and when making claims under more than
one plan is called "coordination of benefits." The NIHB program will cover any remaining amount not covered by the other plan(s), up to the program's maximums (Health Canada, 2013).

Sources of Revenue

WorkSafe BC. WorkSafe BC is dedicated to promoting workplace health and safety for the workers and employers of British Columbia. In the event of work-related injuries or disease, WorkSafe BC works with the affected parties to provide return-to-work rehabilitation, compensation, health care benefits, and a range of other services (WorkSafe BC, 2014a). The goal of physical therapy treatment is to assist injured workers and aid them in reaching the functional levels required to return to work in a safe, durable, and timely manner (WorkSafe BC, 2014d).

WorkSafe BC (2014b) lists four fee categories (per hour): stream 1 is listed as $32.42 - $62.75, stream 2 is $32.42 - $51.75, stream 3 is $27.15 - $37.62, and stream 4 is $27.15 - $37.62. Stream 1 does not require a referral from a physician (it may be self-referred or employer-referred) and it carries a maximum of 22 visits within an 8 week period. Streams 2-4 have no predetermined treatment timeline, however must be referred by a physician. In addition to the four fee categories, the provider may claim other report and fee codes ranging from $1.27 - $374.54, which includes photocopies ($1.27 per page as requested), and comprehensive medical review reports of the injured worker's history ($374.54) at the request of a board officer (WorkSafe BC, 2014b).

When working with clients through WorkSafe BC, it is the physical therapist's responsibility to confirm the worker's claim status. If the claim is pending at the time of the initial visit and subsequently not accepted, the physical therapist must invoice the initial visit and when a pending status becomes accepted, the physical therapist must reimburse the
worker for 100% of physical therapy costs paid prior to the date the claim was accepted, and then invoice WorkSafe BC directly according to the approved fee amounts (WorkSafe BC, 2014c). A physical therapist may not charge any additional fees (for example, therabands, user fees, administrative fees, ice packs, etc.) to an injured worker who has a claim accepted by WorkSafe BC (WorkSafe BC, 2014c).

**Hospitals.** The majority of hospitals in Canada are owned and operated by non-profit organizations. Hospitals in Canada receive the largest block of provincial health funding and this money funds procedures insured by provincial health plans. Physical therapy services provided in the hospital are insured services under the Canadian Health Act and provided to the insured person at no charge. However, there is no legal obligation for a hospital to provide physical therapy services, and it is the hospital’s choice as to whether services are provided. Privatization of physical therapy in hospitals generally begins when the services needed go beyond the reach of provincial health insurance plans (for example, outpatient physical therapy services in many hospitals). Patients requiring the services that are outside provincial health plans must pay a user fee or turn to a private physical therapy clinic for coverage (Holyoke, 2009).

In a study of physical therapy services in Ontario, it was found that the Ministry of Health and Long-Term Care (MOHLTC) was encouraging hospitals to cut outpatient physical therapy services in an effort to lessen the overall number of patients and reduce the hospital’s overall costs. Holyoke (2009) explained that the number of patients that a hospital services does not directly affect revenue. The study also found that the MOHLTC had advised hospitals that there was a need to generate revenues, which may influence future decisions to offer physical therapy services outside insured inpatient and outpatient programs. The study concluded that there was a general reluctance for hospitals to offer
physical therapy services to generate revenue.

**Veterans Affairs Canada.** In acknowledgment of their service, retired or disabled former members of the Canadian Armed Forces as well as active members are entitled to receive physical therapy services. The federal government determines the fee amounts and administers these fees through a private insurance company. Veterans are eligible to claim $50.35 for their initial visit and $40 for returning visits and all physical therapy services provided require a physician referral. The Veterans Affairs program is relatively small in comparison with other sources of revenue (Veterans Affairs Canada, 2014).

**ICBC insurance.** Insurance Corporation of British Columbia (ICBC) physical therapy claims are for clients who have filed a personal injury claim as a result of a motor vehicle accident. Physical therapy treatment must be pre-approved from an ICBC adjuster. If clients do not have pre-approval they can still start their physical therapy treatments, but may be required by the clinic to pay a private fee until the clinic obtains physical therapy approval from the ICBC adjuster. Clinics can bill ICBC up to the maximum approved ICBC claim allotment for physical therapy and may charge the client additional fees in order to recover the costs of services (PABC, 2013). A doctor’s referral may be required to claim physical therapy benefits from ICBC. All authorized motor vehicle related invoices for physical therapy treatment are processed in five rate categories. ICBC fee categories range from $17.65 to $35.90 per visit depending on the type of visit and the services provided (ICBC, 2003).

**Employer payments.** It is not uncommon for larger employers to purchase physical therapy services for their injured employees. Some employers may arrange for a physical therapist under contract to provide treatments at the employer’s place of work, whereas others (usually very large companies) may hire a physical therapist so that their services are
available at all times. The practice of hiring a physical therapist is often seen in professional sports. Due to the fact that employer payments involve private contracts, very little is known about the specific terms and conditions as this information is not publically available.

**Private health insurance.** Extended health insurance plans provide health care coverage for physical therapy services when they are not insured under public plans (for example, MSP). Private health insurance plans normally have a maximum coverage amount for physical therapy services, and these maximums vary with the plan type. Holyoke (2009) explained that in Canada these maximums could range from $200 to $1000 per year. It is normally the client’s responsibility to claim for fees paid to the service provider. The amount covered under the extended medical plan varies based on the policies established in the plan. If an employer is paying for the policy, the employer may have the option to choose either a standardized plan or a personalized plan. In the literature reviewed, it was found that the practice of billing private insurance companies is more direct than billing for other sources of revenue such as WorkSafe, ICBC, and MSP (Holyoke, 2009). With private insurance there is no requirement to obtain consent from the insurer in order to advance with the treatment, due to the fact the client has already established that they have insurance for the physical therapy services.

**Out of pocket payers.** Out of Pocket Payers (OPP) refers to patients who purchase their own physical therapy services. If the client is uninsured or has already exceeded the limits of their extended health insurance plan, they will have to pay the entire cost of the physical therapy services provided. The service provider establishes the fee for the services and the patient makes the decision whether to accept services at the established fee. OPP as a source of revenue has many positive qualities to providers, in that it offers ease of billing and little regulatory constraints on the ability of the provider to charge fees as they see fit.
**MSP.** Medical Services Plan (MSP) is a provincial government program that provides basic medical benefits and pays for medically required services of physicians and surgeons. All residents of BC are required to enroll with MSP (BC Ministry of Health, 2014) and in some circumstances employers pay MSP premiums on behalf of their employees (InterVISTAS Consulting Group, 2012). Physical therapy is not covered by MSP except for MSP beneficiaries with premium assistance status (Ministry of Health, 2013). In 2002, physical therapy treatments were delisted from MSP (excluding those on MSP premium assistance). If a client has premium assistance they may qualify for coverage up to a limit of 10 visits per year. It is common that MSP pays only up to $23 per visit and private clinics may charge clients for the amount exceeding the MSP maximum claim amount (BC Ministry of Health, 2013).

Many supplementary benefits practitioners choose to opt-out of the Medical Services Plan (MSP). This means they are allowed to charge patients more for a service than is set out in the MSP payment schedule. Physicians enrolled with MSP may choose to be opted-in or opted-out. Opted-in physicians are paid directly by MSP for their services. A physician who is opted-in to MSP may not charge a patient for an insured benefit. Opted-out physicians bill patients directly for their services, then the patients may claim reimbursement from MSP. Opted-out practitioners (all supplementary service providers) must advise their patients that they have opted out, how much is reimbursed, and how much the patient will be paying in addition to the MSP fee (BC Ministry of Health, 2013).

**Challenges for New Entrants**

New migrants to BC are expected to fill one-third of job openings to 2020 (WorkBC, 2012). The BC 2010-2020 Labour Market Board report indicated that the number of new labour market entrants (individuals leaving the education system and entering the labour
market for the first time) is expected to decline steadily throughout the period of 2010 to 2020 (WorkBC, 2012). This reduction in educated labour is likely to include qualified physical therapists practicing physical therapy in Northern BC. Attrition may be managed through increasing the number of graduates in master level physical therapy programs. In Northern BC, the University of Northern British Columbia, in conjunction with the University of British Columbia, is in the development stages of a northern physical therapy cohort. Additionally, the WorkBC (2012) report indicated reliance on migrants for new labour supply over the outlook period.

Running a successful clinic requires sufficient qualified staff in order to allow for sustainability and economies of scale as business grows. Depending on the market segment, specialized services may be required, which could be challenging to provide based on the shortage of PT’s forecasted by the BC labour market board. Some physical therapists are turning to university teaching positions (WorkBC, 2014d), which will further reduce the number of PT’s working in the public and private sector. The number of new PT graduates presently entering the field in BC is increasing; however it is not enough to satisfy long-term demand, as presently forecasted (Service Canada, 2011). Physical therapists are in such demand in BC that positions within organizations (eg. Northern Health Authority) have removed job postings because they have little or no chance of having the positions filled. There are 2,500 registered physical therapists in British Columbia, with an average age of 45. The PABC reported that the vast majority of PT’s want to retire at 55. Analysts are predicting that demand will increase even more in the next five to ten years due to a large number of retirements (Canada Visa, 2013). These findings are consistent with the information and demand forecasts presented in the British Columbia Labour Market Outlook report for 2010-
2020.

Although the North Coast provides ample opportunities for a new start up, this in itself is not enough to ensure success. It can be costly to establish a viable practice within the physical therapy industry due to the time and effort involved in establishing a reputation and a client base. Clients may self-refer on the basis of recommendation or location (convenience), or may be recommended to a specific practice by other health and medical practitioners. A new business needs to establish a positive reputation both in the general community and in the health and medical communities. Being part of community initiatives will bring awareness to a business’s brand. Before a clinic can make a successful attempt at opening, they must first determine their market position (Kotler et al., 2008). In order to determine an effective market position, a new entrant would want to consider whether they will compete on cost (offering general PT services) or whether they will differentiate their services (offering specialized services). New entrants need to be aware of who their customers are, and how they will achieve competitive advantage in their industry. Analyzing these types of factors allows a business a clear indication of their target customer and will aid a new entrant in determining its unique selling position.

Expertise: Physical Therapy and Business

A physical therapy practice is a potential business opportunity in the eyes of many physical therapy graduates; however, private practice can be a frightening and complicated undertaking for a relatively new PT with a lack of business skills. The majority of new graduates and even seasoned PT’s have spent most of their careers developing their skills to provide PT services and have saved little time to learn the business proficiencies needed to launch and run a successful PT clinic. Entrepreneurial PT’s with little business background may find it challenging to know where to start. Even for those with a business background,
many important questions need to be considered: What is private practice? How can I make a living? Can I start a private practice from scratch? Should I buy an existing practice? Do I need partners? What does it take to succeed?

Although there are opportunities that make this industry attractive, new entrants will need to be prepared and aware of what is required in order to overcome the inherent challenges of entering the private sector. Most physical therapists carry a relatively low level of business expertise and have little interest in running the business aspect of a practice. A large factor in failed practice can be attributed to PT's who did not have enough knowledge of the business aspect of their endeavour (PhysioAccountant, 2014b).

Chapter III
Methodology

The primary objectives of this project were answered through two methods of data collection:

1. Secondary data collection and literature review
2. Survey questionnaire

Secondary Data Collection and Literature Review

The first method involved a systematic data collection of publically available information. In order to determine the first objective (market potential for a new PT practice within the communities of Prince Rupert, Terrace, and Kitimat), information was obtained regarding population metrics, socio-economic indicators, and competition levels. The sources of data collection mentioned below were used to determine the market potential (size of the market, market trends, and growth potential) in the communities described above.

1. Publicly available Information/literature (journals, published articles etc.)
2. BC Statistics
3. Statistics Canada
4. Health Canada
The statistical data obtained from the sources above was entered into a data extraction form, which was developed in a Microsoft Excel spreadsheet. The quantitative data entered into the Microsoft Excel spreadsheet was analyzed using charts and graphs to look for any important trends in the results.

**Survey Questionnaire**

Approval for the survey component of the project was obtained from UNBC’s Research Ethics Board on Sept 26, 2013. Each question in the survey was designed to address the project’s second objective (marketing recommendations). The questions included fill in the blanks, yes/no questions, open multiple choice, a constant sum question, and a Likert matrix table. The questionnaire was composed of 10 main questions and an “additional comments” section, totaling two pages in length. To ensure the questions were easy to understand, feasible, and appropriate, the survey questionnaire was pilot-tested on a non-biased private physiotherapy clinic owner. Feedback was obtained and the survey questionnaire was revised for the final time.

**Physiotherapy Clinics**

Areas outside of the North Coast were included in the survey analysis to increase the statistical accuracy due to the lack of data and competition in these areas. Physical therapy clinics north, northwest, and within Prince George were identified using PABC’s clinic search engine, YellowPages, and Google online search. Twenty physical therapy clinics
within Prince George, Vanderhoof, Smithers, Dawson Creek, Fort St. John, McBride, and Terrace were identified.

Data Collection, Extraction and Analysis

Survey packages were assembled with an information letter, consent form, survey questionnaire, and a pre-paid postage envelope. Of the twenty packages mailed to potential participants, ten returned the completed consent form and survey, two were returned as clinic addresses did not exist, and eight did not respond.

A follow-up call to the potential participating clinics was made one to two weeks after the survey packages were mailed out to introduce the project coordinator, the study, and to address any questions or concerns.

The data from each of the clinic’s completed survey was entered anonymously into a data extraction form, which was developed in a Microsoft Excel spreadsheet. The quantitative data from the survey findings was analyzed using charts and graphs to look for any significant trends in the findings.
Chapter IV

Results

Secondary Data Collection Results

Data was collected to perform a statistical analysis on the Kitimat-Stikine and Skeena-Queen Charlotte Regional Districts to assess the market potential of a new physical therapy clinic. Primary areas of interest included trends in population size, population growth, population demographics, and social inequalities.

Population Size

Census data (BC Stats, 2011) tallied the total population of British Columbia to be 4,499,139. The two regional districts of interest along the north coast of British Columbia, Kitimat-Stikine and Skeena-Queen Charlotte, have populations of 37,999 and 19,664, respectively. The two major cities in Kitimat-Stikine Regional District are Kitimat (population 8,987) and Terrace (population 11,320), which contain just over 50% of the region’s population. Prince Rupert (population 12,185), Skeena-Queen Charlotte’s largest city, holds 65% of that region’s population (Figure 1). The unincorporated areas comprising the remaining portions of both districts are tremendously dispersed throughout the regions’ extensive geographical area.
Population Growth

Over the past five years the North Coast has experienced relatively inactive population growth. Table 1 highlights the population growth from 2008-2012 in the Skeena-Queen Charlotte and Kitimat-Stikine regions and their respective major cities (BC Stats, 2011). Between the years 2011 and 2012 the percent change in population was -0.6% in the Skeena-Queen Charlotte and 0.0% in Kitimat-Stikine. The city with the largest population increase was Terrace with 1.1% and the city with the highest decline in population was Kitimat with -1.0%.

Table 1: Population Growth Change over a Five Year Period.

<table>
<thead>
<tr>
<th>Name</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2011-2012 % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skeena-Queen</td>
<td>19,624</td>
<td>19,460</td>
<td>19,490</td>
<td>19,495</td>
<td>19,375</td>
<td>-0.6</td>
</tr>
<tr>
<td>Charlotte</td>
<td>12,831</td>
<td>12,860</td>
<td>12,989</td>
<td>12,943</td>
<td>12,913</td>
<td>-0.2</td>
</tr>
<tr>
<td>Prince Rupert</td>
<td>39,131</td>
<td>39,472</td>
<td>39,628</td>
<td>39,729</td>
<td>39,722</td>
<td>0.0</td>
</tr>
<tr>
<td>Kitimat-Stikine</td>
<td>9,182</td>
<td>9,237</td>
<td>9,175</td>
<td>9,104</td>
<td>9,009</td>
<td>-1.0</td>
</tr>
<tr>
<td>Kitimat</td>
<td>11,553</td>
<td>11,688</td>
<td>11,926</td>
<td>12,052</td>
<td>12,182</td>
<td>1.1</td>
</tr>
</tbody>
</table>

With the exception of Terrace, the major cities in these regions (Kitimat and Prince Rupert) have declined in population size. Although these declines are minimal, it is still
cause for concern considering recent economic developments were anticipated to increase employment and bring in new residents to these communities.

Population Demographics

According to census data (BC Stats, 2011), children aged 0-14 years old make up approximately 19% of the population of the cities of Prince Rupert, Kitimat, and Terrace. Overall in BC children aged 0-14 made up 15% of the population, indicating that these two regional districts have a child population that is 4% higher than the provincial average.

Appendices D – H (demographic comparisons) illustrate the whole age analysis in comparison with BC.

![Bar chart showing percentage of children aged 0-14 years in British Columbia, Terrace, Kitimat, and Prince Rupert.]

Figure 2: Percentage of Children Aged 0-14 years in British Columbia, and in the Major Cities in the Kitimat-Stikine and Skeena-Queen Charlotte Regional Districts

With a higher percentage of youth in the North Coast regional districts, there was a significant increase in teenage pregnancies in this region among 15-19 year olds. Both the Kitimat-Stikine and Skeena-Queen Charlotte regional districts reported a 60% rate of teenage pregnancy, which is 37% higher than the provincial average of 23% (BC Stats, 2011). For these two North Coast regional districts, the percentage of children aged 0-14 and percentage of teenaged (15-19 years old) pregnancies are significantly higher than the provincial average.
In 2006, the Aboriginal population within the Skeena-QC was 7,985 and Kitimat-Stikine was 12,275 (Statistics Canada, 2006). Combining this information and total regional population statistics from 2006, 41% of the Skeena-QC and 33% of the Kitimat-Stikine populations are First Nations people. Of BC’s total population, 5% are First Nations people. These two North Coast regional districts have a 36% (Skeena-QC) and 27% (Kitimat-Stikine) higher First Nations population than the provincial average.

![Bar chart showing percentage of Aboriginal population in Skeena-QC, Kitimat-Stikine, and British Columbia compared to BC.]

Figure 3: Percentage of the Aboriginal Population in the Skeena-Queen Charlotte and Kitimat-Stikine Regional Districts Compared to BC (BC Stats, 2006).

**Social Inequality**

Social inequalities such as potential indicators of health problems (Table 2) and unemployment data (Appendix I) among the two North Coast districts were analyzed in comparison with British Columbia as a whole using statistical data collected from BC Stats socio-economic profile. The average life expectancy is lower in the Kitimat-Stikine and Skeena-QC regions with an average age of 78, compared to the average age of 82 for British Columbia as a whole. In this region, there are significantly higher hospitalization rates and
alcohol sales. The unemployment rates are 5% higher among the North Coast, compared to BC’s unemployment rates (11.9% among North Coast and 5.9% among BC). There are also significantly higher infant mortality rates in these regions. The Skeena-QC Regional District has a 5.90 infant mortality rate, compared to BC’s 3.70, which is almost double the provincial average. There is a clear trend shown in Table 2, that the Kitimat-Stikine and Skeena-QC regions have significantly more health-related problems when compared to the rest of BC.

Table 2: Potential Indicators of Health Problems

<table>
<thead>
<tr>
<th>Potential Indicators of Health Problems</th>
<th>Kitimat-Stikine</th>
<th>Skeena-QC</th>
<th>BC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization Rates (Injury)</td>
<td>9.60%</td>
<td>7.80%</td>
<td>4.40%</td>
</tr>
<tr>
<td>Life Expectancy (Years)</td>
<td>78</td>
<td>78</td>
<td>82</td>
</tr>
<tr>
<td>Alcohol Sales (Liters Consumed per population 19+)</td>
<td>141</td>
<td>161</td>
<td>104</td>
</tr>
<tr>
<td>Infant Mortality Rate*</td>
<td>4.40</td>
<td>5.90</td>
<td>3.8</td>
</tr>
</tbody>
</table>

*Note: The infant mortality rate is calculated as the number of deaths of children less than one year of age per 1,000 live births in the same year.

After completing a further statistical review (Stats Canada, 2011) comparing the two regional districts with BC, there were some other significant trends. Although the distribution of ages within the compared populations was mostly similar, the 0-14 age category was significantly different along with the rates of teenage pregnancy. The distribution of Aboriginal populations were not comparable, nor the social equality between these regions. As BC appears to be growing in population, there are two regional districts that are not contributing to this growth.

Survey Results

The data presented below was collected from the twelve question survey results from ten private physical therapy clinics across Northern BC. The data was analyzed for any
trends that would provide information on BC’s market potential for a new clinic, and to provide marketing recommendations to new and existing clinics. Key trends in initial and returning visit fees, age demographics, revenue sources, promotion and advertising, waitlist lengths, and physiotherapy services to First Nations people are outlined.

**Initial and Returning Visit Fees**

On the completed surveys, clinic owners outlined clinic visits to be of various lengths. Some clinics provide an initial visit of 30 minutes in length, while others have an initial visit of 60 minutes. With the time variability, each clinic charges different amounts. This is reflected in the number of visits a clinic has per week (Figure 4).

![Figure 4: Number of Services Per Week Compared to Visit Price for Participating Physical Therapy Clinics](image)

Of the ten clinics, the highest initial visit price was $90 (25 visits/week), the highest returning visit price was $80 (8 visits/week), the lowest initial and returning visit price was $50 and $45 (224 visits/week), respectively. Figure 4 illustrates the trend between the number of services provided and the price charged per initial and returning visits. The higher
the price for initial and returning visits, the less services provided per week, and the lower the price for initial and returning visits, the more services provided per week.

**Age Demographics**

Of the ten clinics, the percentage of a clinic’s caseload aged 0-18 years ranged from 0-31%, with an average of 15%. Caseloads of clients aged 19-65 years ranged from 44-94%, with an average of 66%. Clients aged over 65 years ranged from 1-40% of physical therapists’ caseloads, with an average of 19% (Figure 5).

![Physiotherapy Clinics presented from East to West](image)

**Figure 5: Participating Clinics Arranged from East to West, with Age Demographics**

The age demographics of each clinic were arranged from east to west to analyse for trends in the age of clientele accessing services. Clinics located farthest west of the participating clinics in Northern BC, reveal a higher percentage of clientele aged 0-18, on average. The participating clinic farthest west has the highest percentage of clientele 0-18 at 31%.

**Revenue Sources**

When research participants reported their sources of revenue in the survey questionnaire, many participants amalgamated the categories of extended health coverage,
out of pocket payer, and MSP and reported one total. As a result, extended health coverage, out of pocket payer, and MSP were analyzed and reported as a single source of revenue, as the data could not be accurately reported from its single source. For those participants who did report the 3 revenue sources separately, extended health coverage and out of pocket payer sources were the majority. Clinics that reported MSP as a separate source (in 6 surveys), indicated that it made up only 0-15% of their revenue.

Average revenue sources used by the ten clinics showed that 2% used the hospital, 9% used ICBC, 16% used WSBC, 68% used a combination of extended health, OPP, and MSP, 3% used long term disability, 2% used a company contract, and less than 1% used Veteran/RCMP coverage (Table 3). One clinic reported the hospital made up 10% of their revenue source while eight clinics reported 0%. One clinic reported ICBC made up 30% of their revenue source while six reported less than 10%. All ten clinics reported using a combination of extended health, OPP, and MSP, and two clinics reported 100% of their revenue came from this source. One clinic reported 21% of their revenue came from a company service contract and one clinic reported 27% of their revenue came from a long-term disability contract between WCB and the Canadian Government. Two clinics reported they provide pro-bono service (no revenue generated).
Table 3: Distribution of Revenue Sources

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Hospital (%)</th>
<th>ICBC (%)</th>
<th>WCB (%)</th>
<th>Extended Health/OPP/MSP (%)</th>
<th>Veteran/RCMP (%)</th>
<th>Company Contract (%)</th>
<th>Long Term Disability (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>2</td>
<td>20</td>
<td>77</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>50</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>10</td>
<td>25</td>
<td>65</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>30</td>
<td>30</td>
<td>40</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>9</td>
<td>23</td>
<td>47</td>
<td>0</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td>18</td>
<td>20</td>
<td>36</td>
<td>0</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>90</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Average</td>
<td>2</td>
<td>9</td>
<td>16</td>
<td>68</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Figure 6 illustrates the direct relationship between the higher number of revenue sources being used by clinics and the higher number of services the clinic provides per week. Of the ten clinics, two reported having only one source of revenue corresponding with less than 25 services per week. Seventy-one percent of clinics using three or more sources of revenue had more than 100 services per week. The clinic with the highest number of services per week (250 services/week) collects from four revenue sources.
Figure 7: Distribution and Percentages of Promotion and Advertising Strategies used by Clinic Participants.

Figure 7 displays the usage of promotion and advertising strategies expressed as a percentage. Website (26%) and newspaper (22%) advertisements were found to be the most popular methods of advertising. Radio (4%), awareness lectures (4%), television advertisements (4%) and coupons (4%) were used the least to promote clinics.

Figure 8: Clinic Participants’ Ranking of Effectiveness for Each Form of Promotion and Advertising Used
Figure 8 displays level of effectiveness (based on the clinic’s perception) regarding the promotional and advertising strategies described above. Newspaper advertising was the most effective (2 very effective and 4 somewhat effective). The second most effective advertising strategy was website. Five clinics reported their website was somewhat effective, 1 said very effective, and one clinic said not effective. Two clinics reported not having a website and one clinic did not provide an effectiveness rating for the website category. Only one clinic reported social media (Facebook/Twitter) as very effective and one clinic reported social media (Twitter) as not effective. One clinic reported lectures in the community (other category) regarding the importance of physical therapy were a very effective form of advertising and promotion.

**Physical Therapy Clinic Waitlists**

Of the ten clinic participants, 50% indicated that their clinic does not have a waitlist for clients to access services. The other 50% of clinics indicated a one to six week waitlist, with an average of three weeks.

**Physical Therapy Services Accessed by First Nations People**

In order to assess what percentage of First Nations people are accessing physical therapy services in Northern BC, clinics were asked to estimate the amount of First Nations clientele their clinic provided PT services to. Unless there is a funding source connected to a First Nations band or community it is very difficult for a clinic to provide an accurate estimate. Participating clinics indicated anywhere from 0-10% of their caseload were First Nations clients, with an overall average of 5%. Two clinics indicated 0% of their caseload to be First Nations people, three clinics indicated 10%, and the other five were in between this range.
Chapter V

Conclusion

The increase or decrease in a city’s population is an important indication of economic growth and demand. The City of Terrace has shown an active increase in population over the past 5 years (from 11,553 to 12,182) and a 1.1% positive change between 2011 and 2012. This suggests an active economy and a growing customer base. The cities of Kitimat and Prince Rupert have expressed relatively stagnant population growth from 2008 to 2012. Although these cities have experienced little population growth, the benefits of major recent economic developments in liquefied natural gas and port expansion are anticipated to increase the population, bring in new jobs, and stimulate local economies. However, these developments are in their early stages and it is difficult to forecast their economic sustainability, therefore new entrants should be cautious when entering these locations.

Although economic activity may be difficult to forecast in the long term, the present levels of competition may provide an indication of sustainability. Terrace and Prince Rupert both have only one private clinic, and Kitimat presently has no privately owned PT clinics. Terrace has a hospital, health unit, and child development centre offering public PT services, and Kitimat and Prince Rupert each have a hospital but no additional public PT services. Terrace, Kitimat, and Prince Rupert have significantly lower levels of competitors in the private sector in comparison to other BC communities with similar populations. Competition from public services (hospital, health centers, and child development center) is on par with other cities in BC. At present population and competition levels, Terrace, Kitimat, and Prince Rupert are believed to have sufficient market share available for new entrants to establish themselves in the industry. A sufficient customer base and low levels of competitors are not enough to ensure sustainability of a new practice. New entrants must
carefully determine their strategic position and competitive strategy to achieve sustainability in the industry.

The literature included in this report suggests there are many attractive qualities to recruit both new immigrants and BC residents looking for employment to the North Coast PT industry; however, these attractive qualities may not be enough on their own. The North Coast’s natural beauty, affordable housing, and lucrative economic prospects will do very little to solve recruitment challenges without an effective recruitment strategy. In order for PT clinics to achieve economies of scale and scope they need to ensure they have the necessary operational resources to grow. One of the primary barriers to growth is the potential shortage of skilled medical labour, as forecasted by recent labour market board reports. A recruitment strategy is therefore recommended in order to help mitigate this issue and allow for growth and sustainability. Additionally, clinics that choose to differentiate their strategic position by offering specialized services should strongly consider how they intend to recruit these specialists. Patients who rely on specialized services will have no choice but to look elsewhere should a clinic experience turnover. A clinic that is known for offering specialized services could experience a significant loss in revenue and market share should they not be able to fill the specialized position in a timely manner. Survey results indicated 20% of the clinics did not have a website and 80% of clinics did not utilize social media as a form of marketing. These findings suggest underutilization of technology as a form of communication. Today’s Y and millennial generations, which makes up the majority of recent PT graduates, have a strong aptitude to communicate online and through various forms of social media. Implementing a recruitment strategy through a clinic website and through social media may be advantageous to a clinic’s recruitment strategy.

Inequality plays a primary role in social and health related problems experienced in
societies (Wilkinson & Pickett, 2011). The results of this study indicate much higher levels of inequality in the Kitimat-Stikine and Skeena-QC regions in comparison with the provincial average. Some of these inequalities, such as high rates of teenage pregnancy (37% higher than the BC average), may be a contributing factor to the larger population of infants and children in these regions. A greater level of inequality experienced in the North Coast is consistent with larger amounts of health related issues, such as higher hospitalization rates, and shorter life expectancy. If levels of inequality continue at present rates, more medical resources (including physical therapy) will likely be required in order to help alleviate associated health issues.

When entering the PT market, a new entrant must decide their strategic position. A new entrant may decide to offer general PT services and compete on price or decide to differentiate their services by offering highly specialized services and/or target a specific demographic. Demographic data in conjunction with survey questionnaire results demonstrates potential opportunities for new entrants targeting a specific demographic. The higher percentage of youth aged 0-14 suggests a potential niche market in pediatric care. Survey results indicated the participating clinic in Terrace has the highest percentage of clientele from age 0 to 18 at 31%. This is interesting considering Terrace also has a child development centre. The fact that Terrace has a public competitor (child development centre) servicing a demographic representing 31% of the private clinic’s services reinforces the potential need for PT services in pediatric care. This further suggests even more market potential for pediatric services in Prince Rupert and Kitimat who do not have child development centres. It should be noted child development centres typically service very young children (ages 0-5).
Another niche market could be servicing BC’s First Nations population. Population statistics (BC Stats, 2011) showed that the Skeena-Queen Charlotte and Kitimat-Stikine Regional Districts make up 41% and 33% of their respective regional population. Furthermore, survey results revealed on average only 5% of PT clientele are First Nations people. This could indicate that a significant amount of the First Nations population is either underserviced or not utilizing PT services. It is not the intent of this report to suggest potential solutions to increasing the availability of PT services to First Nations clientele, but rather highlight that this demographic may be underserviced. Establishing a positive relationship with local First Nations communities in order to understand their medical needs is a potential recommendation for clinics looking to extend their services to this demographic.

PABC recommends specific price points for BC’s physical therapy clinics. These price points range from $63 for 20 minutes to $190 for 60 minutes. Our research findings indicated price points much lower than the PABC recommendations. Of the ten clinics surveyed, the highest initial visit cost was $90 and the lowest was $50, however it is unknown how long the session length was for these price points. As indicated in the results, the levels of social inequality among the North Coast region are much higher than the provincial average. This may be reflected in the current price points indicated by the participating clinics. As such, it would be recommended for a new entrant to choose a price point similar to the existing clinics/competitors, as opposed to price points recommended by PABC.

As clinics use a higher number of revenue sources, it was shown that the number of clinic visits also increase. This could suggest that as clinics diversify their sources of revenue they also increase their potential market share and customer base. However, if a
clinic was to include an additional revenue source, it is imperative to understand the various fee structures and documentation required. It is therefore recommended that new entrants explore all potential sources of revenues and ensure they have the resources and expertise needed for efficient and timely billing.

Fifty percent of the clinics indicated having a wait list averaging three weeks. This may indicate the clinics have maximized their operational resources and require additional PT service providers in order to achieve economies of scale. Where recruitment of physical therapists is difficult, clinic owners should consider contracting supplementary services such as kinesiologists, massage therapists, or physical therapy assistants, where appropriate, to help reduce waiting times. These findings support the previously recommended recruitment strategy.

Marketing strategies are extremely important in order for a new entrant to build and maintain a customer base. Based on the results, clinics only found a few of their marketing strategies to be effective, the most effective being newspaper ads and websites. However, it was not evident that one promotion or advertising strategy was significantly more effective than another. The fact that only two clinics reported using social media suggests social media is an underutilized marketing tool. The effectiveness indicated in the results was variable. This could be due to the user’s familiarity with how to use Facebook or Twitter as an effective marketing strategy. When used correctly, the power of social media can significantly expand a business’s customer base. One clinic indicated presenting community lectures regarding physical therapy, as a very effective form of advertising and promotion. Bringing awareness to the local communities about the importance of physical therapy can easily be achieved through Facebook, Twitter, and the local clinic’s website. In addition, it
would be advantageous for clinics to combine methods of marketing, such as linking their website and social media together.

There are undoubtedly challenges in establishing a PT business in the North Coast. The current stagnant population growth and formation of a referral network with the northern medical community are cause for concern and should not be taken lightly. After studying the statistics and trends within the regional districts of the Kitimat-Stikine & Skeen-Queen Charlotte, there are significant opportunities. The lack of competition per population and economic growth opportunities make this industry sector worth looking into further and a viable prospect for a new PT business.

Limitations

Limitations of this project involved the survey questionnaire component of the data collection. Limitations included sample size and the lack of available data, measures used to collect data, self reported data, and limitations of the researcher.

Sample size and the lack of available data. Methodological limitations of data collection include a project’s sample size. A small sample size provides difficulty in finding significant relationships within the data. Statistical tests normally require a larger sample size to ensure a representative distribution of the population that allows the results to be generalized or transferred. The sample size of this project targeted two regional districts: Kitimat - Stikine and Skeena - Queen Charlotte. Two private PT clinics existed in these regional districts and only one of the two clinics participated and completed the survey questionnaire. Due to the lack of data, the methods required modification to increase the geographic area to include recruitment of more private PT clinics. This increased the sample size and therefore the pool of data used to determine trends and meaningful relationships. The geographic locations of participating clinics outside of the Kitimat - Stikine and Skeena -
Queen Charlotte regional districts included northern communities such as Smithers, Prince George, Vanderhoof, Dawson Creek, and Fort St John (serving as a proxy). Obtaining data from sources not representative of the project’s scope and regional districts of interest posed significant limitations to this project. The data used to make recommendations for the sustainability of a new entrant within the two regional districts was not obtained solely from those two districts. Furthermore, the attitudes, values, and beliefs may differ from community to community, and this may influence the degree of acceptance concerning the mentioned recommendations. The intent of the proxy was to obtain enough quantitative and qualitative data in order to determine possible trends and make recommendations concerning the sustainability of a new entrant. The Project Lead concluded PT clinics within northern cities shared more common business practices and socio-economic indicators when compared to a provincial evaluation.

Methods used to collect the data. This project used a survey questionnaire to collect data on current patient demographics, marketing practices, and sources of revenue of private PT clinics within northern BC. With the current shortage of physiotherapists in northern BC, it was indicated that private PT clinic owners invited to participate were very busy and time may be a constraint. Therefore, a survey was chosen to collect data to allow for flexibility, and therefore increasing attractiveness to participate. This method of data collection holds limitations that may have been avoided through other methods, such as a phone interview. For instance, a phone interview would have allowed more in depth answers, instant clarification of questions, and may have uncovered other valuable information that was unknown of the PT industry. This may have allowed for a more thorough analysis of the questions used to address the project’s objectives.

Self-reported data. Data collected using the survey questionnaire was ‘self reported
data’ by participating PT clinic owners. Self reported data is a limitation as it cannot be independently verified and may contain sources of bias. Participants may have used selective memory (remembering or not remembering experiences or events that occurred at some point in the past), may have exaggerated or underestimated data (the act of representing outcomes or embellishing events as more significant than is actually suggested from other data), or may have provided incorrect data through human error.

Possible limitations of the Project Lead. Limitations include access to research participants and longitudinal effects. The survey questionnaire component of the data collection was dependent on having access to the owners or managers of private PT clinics. Knowledge of PT clinics was obtained through an online search, which may not have captured all service providers. Due to the time constraints of some businesses, participation was denied or data collected was incomplete. Limitations also included the time available to investigate, analyze, and make changes to the data collection methods. This limitation was primarily due to the time constraints of the MBA project completion date.
References


http://www.canadavisa.com/physiotherapists-3142.html


market: the case of the physiotherapy market in Ontario. Unpublished doctoral
dissertation, University of Toronto, Toronto, Canada.

ICBC. (2003). Fee schedule. Retrieved from:

InterVISTAS Consulting Group. (2012). Port of Prince Rupert: economic impact study
impact-study-2012/pdf

Retrieved from Ministry of Health website:

Kitimat LNG. (2013). Kitimat LNG: the project. Retrieved from:
http://www.kitimatlngfacility.com/index.aspx

management. (1st Canadian ed.). Canada: Pearson Education. Inc.


on BC economic growth. Retrieved from: http://bcoilandgas.com/lng-potential-for-
dynamic-impact-on-b-c-economic-growth/

Ontario Ministry of Health and Long Term Care. (2013, December 20). Changes to Publicly

http://bcphysio.org/content/icbc-changes-therapy-approval-process-effective-immediately

PABC. (2013a). *Become a member of PABC.* Retrieved from:

http://www.bcphysio.org/content/become-member-pabc

PABC. (2013b). *Paying for physiotherapy.* Retrieved from:

http://www.bcphysio.org/content/paying-physiotherapy

PABC. (2013c). *Recommended fees.* Retrieved October 22, 2013, from:

http://www.bcphysio.org/content/recommended-fees


PhysioAccountant. (2014a). *Practice Startups.* Retrieved from:


www.worksafe-bc.com/health_care_providers/Assets/PDF/physio_billing_guide.pdf
WorkSafe BC. (2014b). *Fee schedule.* Retrieved from:


www.worksafebc.com/health_care_providers/Assets/PDF/physio_billing_guide.pdf

WorkSafe BC. (2014d). *Your physiotherapist and you.* Retrieved from:

http://www.worksafebc.com/publications/how_to_work_with_the_web/Assets/PDF/your_physiotherapist_and_you.pdf
Appendices

Appendix A: Distribution of primary employment areas of physical therapists in Canada (Stats Canada 2011).
Appendix B: Porter’s 5 Force Model

### Threat of New Entrants (Low - Mod)

- Relatively low-medium barriers to entry.
- Time length to achieve qualification decreases threat (4 year under-graduate and 2 year graduate degree)
- Current intake levels at university are experiencing greater demand than resources available.
- Market saturation (location dependent) may decrease threat of entry and vice-versa.
- Established clinics may have tied up referral sources.
- Lower startup costs compared to other industries. Increases threat of new entrants.
- Population levels relative to current competition in Northern BC indicate room for new entrants.
- Niche markets/specialization can compete where many competitors offering general services.
- Industry benchmark low regarding invested capital into marketing, R&D, and advertising.

<table>
<thead>
<tr>
<th>Supplier Power (Mod)</th>
<th>Degree of Rivalry (Mod)</th>
<th>Buyer Power (Mod)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abundance of suppliers varies based on location. Increase in competition decreases supplier power as buyers have choice (unless specialized service).</td>
<td>Mod competition overall. Competition from smaller local competitors vs. larger established chains (CBI). Companies do not shift competitive strategy to areas competitors succeed in. Competitors stick to what they know. Degree of competition is higher where town/city provides attractive qualities to health care professionals.</td>
<td>Differentiation and specialization minimizes buyer power. Buyer power increase when city/town has more competition (more choice). As customers secure funding from government buyer power increases. Customers “need” for services vs. “want” decreases buying power.</td>
</tr>
<tr>
<td>Low-Mod switching costs to customer. Buyer may bear cost difference of initial/returning visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location increases supplier power if clinic is only service provider available.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Threat of Substitutes (Low – mod)

- Services provided by chiropractors, massage therapists, doctors, acupuncturists and naturopaths.
Appendix C: PESTEL

| Political | • New tax regulations may influence consumer expenditures  
|           | • Changes to “payer” organizations (i.e. MSP) |
| Economical | • Economic crisis affects disposable income. Consumers may not feel they have enough funds to pay for health insurance |
| Social | • Change of trends and lifestyles. Health conscious - Baby boomers more active  
|         | • Aboriginal social inequalities are influencing the health and well being of themselves and their children |
| Technological | • Smartphone applications are changing the way things can be marketed  
|             | • IT process improvements. Takes less time to process service claims with revenue sources |
| Environmental | • Increasing consumer preference for services that adopt environmentally conscious attitudes |
| Legal | • Government policies and taxation laws  
|       | • Heightened WCB safety regulations have influenced the work place making it more safe, leading to reduced claims and PT services due to workplace injury  
|         | • Legal consequences if failure to comply with College of Physical Therapists of British Columbia (CPTBC) |
Appendix D: Population and percentages of age demographics representing the Skeena-Queen Charlotte regional district and its major city (BC Stats 2011).

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<tbody>
<tr>
<td>0-17</td>
<td>4,383</td>
<td>19</td>
<td>22.5</td>
<td>18.5</td>
</tr>
<tr>
<td>18-24</td>
<td>2,152</td>
<td>14</td>
<td>11</td>
<td>9.8</td>
</tr>
<tr>
<td>25-64</td>
<td>10,594</td>
<td>55</td>
<td>54.4</td>
<td>56.4</td>
</tr>
<tr>
<td>65+</td>
<td>2,353</td>
<td>12</td>
<td>12.1</td>
<td>15.3</td>
</tr>
<tr>
<td>Total</td>
<td>19,482</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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</table>

Appendix E: Population and percentages of age demographics representing the Kitimat-Stikine regional district and its major cities (BC Stats 2011).

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>9,087</td>
<td>20</td>
<td>17</td>
<td>23.2</td>
<td>18.5</td>
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<tr>
<td>18-24</td>
<td>4,571</td>
<td>14</td>
<td>12</td>
<td>11.7</td>
<td>9.8</td>
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<tr>
<td>25-64</td>
<td>20,875</td>
<td>53</td>
<td>58</td>
<td>53.2</td>
<td>56.4</td>
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<tr>
<td>65+</td>
<td>4,687</td>
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<td>13</td>
<td>12</td>
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<tr>
<td>Total</td>
<td>39,220</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
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</table>

Appendix F: Prince Rupert gender and age demographic distribution (%) compared to the age demographic distribution (%) of British Columbia (BC Stats 2011).

<table>
<thead>
<tr>
<th>Age Demographics</th>
<th>Male</th>
<th>Female</th>
<th>Prince Rupert Age Distribution (%)</th>
<th>British Columbia Age Distribution (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>1,205</td>
<td>1,200</td>
<td>19.2</td>
<td>15.4</td>
</tr>
<tr>
<td>15-24</td>
<td>930</td>
<td>850</td>
<td>14.2</td>
<td>12.6</td>
</tr>
<tr>
<td>25-44</td>
<td>1,460</td>
<td>1,590</td>
<td>24.4</td>
<td>26.3</td>
</tr>
<tr>
<td>45-64</td>
<td>1,930</td>
<td>1,840</td>
<td>30.2</td>
<td>30.0</td>
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<tr>
<td>65+</td>
<td>720</td>
<td>770</td>
<td>11.9</td>
<td>15.7</td>
</tr>
<tr>
<td>Total</td>
<td>6,250</td>
<td>6,265</td>
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<td>100</td>
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Appendix G: Kitimat gender and age demographic distribution (%) compared to the age demographic distribution (%) of British Columbia (BC Stats 2011).

<table>
<thead>
<tr>
<th>Age Demographics</th>
<th>Male</th>
<th>Female</th>
<th>Kitimat Age Distribution (%)</th>
<th>British Columbia Age Distribution (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>710</td>
<td>685</td>
<td>16.7</td>
<td>15.4</td>
</tr>
<tr>
<td>15-24</td>
<td>545</td>
<td>455</td>
<td>12.0</td>
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<tr>
<td>25-44</td>
<td>895</td>
<td>945</td>
<td>22.0</td>
<td>26.3</td>
</tr>
<tr>
<td>45-64</td>
<td>1,590</td>
<td>1,395</td>
<td>35.9</td>
<td>30.0</td>
</tr>
<tr>
<td>65+</td>
<td>530</td>
<td>585</td>
<td>13.4</td>
<td>15.7</td>
</tr>
<tr>
<td>All Ages</td>
<td>4,280</td>
<td>4,060</td>
<td>100</td>
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Appendix H: Terrace gender and age demographic distribution (%) compared to the age demographic distribution (%) of British Columbia (BC Stats 2011).

<table>
<thead>
<tr>
<th>Age Demographics</th>
<th>Male</th>
<th>Female</th>
<th>Terrace Age Distribution (%)</th>
<th>British Columbia Age Distribution (%)</th>
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</thead>
<tbody>
<tr>
<td>0-14</td>
<td>1,190</td>
<td>1,115</td>
<td>20.0</td>
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<tr>
<td>15-24</td>
<td>845</td>
<td>800</td>
<td>14.3</td>
<td>12.6</td>
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<td>25-44</td>
<td>1,345</td>
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<td>45-64</td>
<td>1,570</td>
<td>1,660</td>
<td>28.1</td>
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<tr>
<td>65+</td>
<td>685</td>
<td>820</td>
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<tr>
<td>All Ages</td>
<td>5,635</td>
<td>5,855</td>
<td>100</td>
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Appendix I: Unemployment rates among the North Coast regional districts and British Columbia (BC Stats 2012).

North Coast: 11.90%
BC: 6.90%