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DISCUSSION PAPER

The Future of Primary Health Care in BC:

We can and must do better

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The Future of Primary Health Care in BC: We can and must do better

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About the author

Marcy Cohen has been involved in social justice work as a professional and volunteer for most of her adult life. She has over 35 years of experience working as health and social policy researcher, educator and advocate. Now retired, Marcy continues to support the work of BC Policy Solutions and the BC Health Coalition. She has become increasingly interested in researching and understanding the health and cost saving benefits of building a stronger, more team-based and prevention system of primary and community care in BC.

About BC Policy Solutions

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Primary care is the foundation of our healthcare system. It is where people first go for health services. At its best it brings together doctors, nurses, allied health professionals and community health workers to provide everything from preventative care to support for mental health and long-term conditions, making sure patients get the timely care they need over time.

Introduction

This discussion paper is intended as a companion document to the Future of Primary Care in BC webinar series. The webinar series was designed to highlight positive examples of what is working well on the ground in communities across BC and in jurisdictions like Ontario and Oregon that have more fully embraced system change and the shift to team-based primary care.

In BC there is a small, but growing number of communities that have established not-for-profit team-based primary care clinics with the goal of developing more collaborative, coordinated and prevention-oriented approaches to primary care not only for their clinic's patients but for everyone living in their community/region. This includes developing new programs to support community members with limited or no access to primary care. Over time, however, many of these organizations have also come to realize that their local improvement efforts would be far more sustainable if there was an overarching province-wide evidence-based process to support primary care transformation.

The first goal of this paper is to provide that broader, more in-depth evidence-based analysis of key facilitators and barriers to primary care transformation, drawing on evidence from other jurisdictions that are further along in their improvement journey and from successes here in BC. This paper highlights the importance of developing an evidence-based, learning health systems approach to primary care transformation and includes an analysis of both progress made and shortcomings in how BC's Ministry of Health (MOH) rolled-out its 2018 primary care transformation strategy. The paper concludes with recommendations of next steps to move forward building on what is working well on the ground and identifying where new approaches are required.

The second goal is to stimulate a broader discussion within the Ministry of Health and regional health authorities, primary care organizations, provider/practitioner groups and community organizations about the next steps needed to simultaneously increase timely access to quality, team-based primary care and to rein in escalating health care costs. The paper highlights how to make better use of the province's considerable

investments in primary care since 2018. It also acknowledges that new priority investments are needed for rural and remote communities and underserved populations across the province because to date MOH investments for these communities and populations have either been too limited or ineffective.

While external threats to BC's economy and rising provincial deficits might make this seem like a difficult moment for system change, inaction will only make the situation worse. If BC fails to optimize existing investments in primary care and increase timely access to quality team-based care for those most at risk of ill health, the overall costs of health care in BC will continue to accelerate while quality, equity and access will continue to decline.

There is, fortunately, a clear path to move forward if we focus on what research

evidence tells us is needed to simultaneously improve health outcomes, equity and the cost-effectiveness and scale-up those approaches that are already moving in this direction. This includes the small but growing not-for-profit primary sector highlighted in the webinar series—not-for-profit team-based physician-led clinics, community health centres (CHCs), nurse practitioner-led clinics, Indigenous-led primary care services and integrated primary care and social support organizations such as Foundry BC. There are many others—both [inside the health system](#) and in the [broader community](#)—who understand the value of having a more accessible, higher quality, team-based care system of primary care and who have much to contribute and need to be included in these discussions moving forward.

1. Setting the stage for building a high-performing primary care system in BC

Today in BC far too many people do not have on-going access to a regular doctor, nurse practitioner (NP) or primary care team. Even for those who do have a doctor or NP, access has become increasingly difficult with many waiting two to three weeks—or even months—before they can get an appointment. This means that an increasing number of British Columbians rely on walk-in clinics (either in-person or virtual), urgent care and hospital emergency services for issues that could be more effectively dealt with, and at much lower cost, if they had timely access to a doctor, NP or medical team

they have known over time (often referred to as longitudinal care). The [negative health consequences](#) of long delays are particularly acute for vulnerable populations living with multiple chronic physical and/or mental health challenges. Additionally, in an increasing number of rural and remote communities, people only have intermittent access to a [revolving door of primary care providers](#) and no access to longitudinal care or [mental health services](#).



Evidence from multiple studies shows that improved access to longitudinal care results in:

... reduced mortality rates, fewer hospital admissions, fewer emergency department (ED) visits, reduced health care costs...better uptake of preventive care, better medication adherence, more appropriate prescribing and improved quality of life.

In 2018, BC's Ministry of Health (MOH) launched a strategy to transform primary care.

The centrepiece of the strategy is to shift away from physicians working on their own to a team-based Patient Medical Home (PMH), model that would serve as the "cornerstone of an integrated system of primary care and community care." This shift is based on ground-breaking research, led by Dr. Barbara Starfield, showing that health systems with a strong primary care orientation have better health outcomes, reduced health inequalities, lower medication use and lower overall health care costs.

Starfield identified four key pillars of effective primary care:

1. First point of Contact.
2. Continuity (also referred to as longitudinal care).
3. Comprehensiveness.
4. Coordination.

Together, these pillars (also referred to as care standards) describe a system where patients can access care when they need it, see providers who know them over time, receive a broad range of services under one

roof and have their care connected across the health system.

While Starfield's research provided the evidence for *why* primary care standards are important, operationalizing her four pillars required intentional system design with researchers working as practice facilitators, supporting primary care practitioners to improve care quality, workflow efficiency and organizational health. These researchers identified 10 essential building blocks needed to create a high performing system where Starfield's four pillars could be fully realized. To identify these building blocks, the researchers relied on their own experience as practice facilitators, what they learned by visiting 23 primary care organizations that were well-recognized as successful innovators and reviewing the existing literature on primary care improvement. Their findings influenced the rollout of BC's Patient Medical Home model and remain a blueprint for leaders in primary care practice in BC and internationally.

This research points to the importance of the dynamism that is created when bottom-up and top-down approaches to system change are combined. By encouraging and supporting local innovation and improvement strategies based on internationally recognized care standards, like Starfield's four pillars, it becomes possible to introduce system change in ways that takes into account local conditions such as population health needs, existing community infrastructure, leadership capacity and geographic realities.

Applying these lessons to BC speaks to the importance of having engaged and

collaborative leadership capacity at both the local and provincial level.

At the local level, clinics need practice facilitators/peer mentors to support practitioners with the processes and tools they need to be successful in implementing new approaches to care. These practice facilitators in turn must be connected to a broader, locally based leadership team with the capacity to identify and address the barriers to collaboration and systems change requiring local action and solutions.

At the provincial level, developing evidence-based performance metrics such as same day access, reductions in avoidable use of emergency services and better integration of primary care and community health services should be prioritized. Tracking progress in implementing these performance measures depends on the creation of a provincially integrated and interoperable Electronic Health Record (EHR) to ensure that primary care practices and communities across BC have the data they need to drive meaningful change.

This kind of transparency means practitioners can identify where to focus their local improvement efforts. These improvement processes, in turn, are greatly enhanced when there are ongoing opportunities to learn from other practices and/or practice facilitators, including opportunities to communicate with provincial leaders on challenges being experienced on the ground and the potential solutions to address these challenges.

Primary care systems that have an ongoing commitment to improvement based on the

best available research evidence (including what is already working well on the ground)—are known as [Learning Health Systems](#) (LHS). In these systems information is transparently shared through regular reporting, practice facilitation and peer learning. Learning Health Systems are increasingly recognized as the essential mechanism for driving [Quality Improvement](#) (QI) in primary care.

On paper BC's 2018 strategy had the right guiding principles, including Stanfield's four pillars of effective care. Where the MOH fell short was not recognizing that to implement system change, these guiding principles need to be clearly defined as care standards with specific targets for improvement that can be measured and tracked over time. As a result of this lack of understanding, the MOH did not develop the needed infrastructure—performance metrics, improvement targets, an interoperable Electronic Health Record (EHR)—to support practitioners and communities with on-the-ground implementation. This meant it has been impossible to know how and to what extent the very significant investments in primary care transformation over the last eight years moved the system in a positive direction and where modifications were needed along the way.

By embedding a Learning Health System framework and a comprehensive Quality Improvement strategy moving forward BC could foster a collaborative work culture where every team member works to their full scope, forms meaningful relationships with their colleagues and patients, focuses on prevention as well as treatment and supports



timely access both to their own services as well as to other health and social support programs their patients require. In short, it would create the conditions to realize Starfield's four pillars of effective primary care across BC.

2. Missed opportunities in the rollout of BC's Patient Medical Home Strategy

The unrealized promise of a locally integrated system of primary and community care

The foundational goal of the 2018 primary care transformation strategy was to reduce the silos in primary care by creating an integrated system of primary care and community care in communities across BC.

An approach in line with this goal would be to integrate episodic primary care services—tailored to the needs of the local community—with longitudinal primary care, not-for-profit team-based primary care clinics and/or community social service organizations located in those same communities. Instead, the MOH created a separate stream of stand-alone funding for Urgent and Primary Clinics (UPCCs) run by health authorities (HAs), with no connection to the primary care organization in the communities where they are located.

A parallel, yet entirely different process was initiated to provide the funding needed to shift from physician-only family practices to the Primary Medical Home (PMH) team-based model of care. To build out the PMH, the Ministry of Health established Primary Care

Networks (PCNs) in communities across BC bringing together solo and group physician practices. There was no requirement, however, to expand the representation on PCNs over time to include community-governed and health-authority-run primary care clinics or community-based social service organizations that are so essential to supporting the needs of low-income, vulnerable populations and communities.

Moreover, because Primary Care Networks are networks and not formally structured not-for-profit primary care organizations, they do not have the capacity to raise, hold or disburse funds. This means they do not have the community mandate or legal structure needed to initiate new programs to address gaps in access and service provision or to support local primary care organizations with the infrastructure increasingly needed. This includes support in areas such as human resources, information technology, Quality Improvement and facilities acquisition and management (see section four for further discussion of the Next Steps for Primary Care Transformation in BC).

The failure to optimize team-based care under the Primary Care Network leadership

The role of Primary Care Networks has remained largely operational rather than strategic and improvement focused. Instead of driving systemic shift toward optimized team-based care, most Primary Care Networks have functioned primarily as funding conduits for communities to hire nurse practitioners, nurses and allied health professionals (e.g., clinical counsellors, social workers and pharmacists).

This process significantly increased the number and role of nurse practitioners (NP) in primary care, who like physicians can now operate as independent contractors and have overhead funding attached to the practices they join. The integration of other team members has, however, been much more limited and problematic. Registered nurses (RNs), licensed practical nurses (LPNs) and allied health professionals, recruited through the Primary Care Networks, remain health authority employees. This creates tremendous operational inefficiencies with team members reporting to more than one organization with different practice requirements and securing approval to modify these requirements are opaque and time consuming. Worse, due to space constraints, inadequate overhead funding and in-clinic unwillingness to embrace co-location, in many communities these professionals continue to work out of health authority offices rather than being embedded within the practice. This unique BC arrangement relegates them to being a “referral source” rather than allowing them to

function as fully integrated, side-by-side team members.

Even in primary care settings with interdisciplinary teams working under one roof, there is an inadequate commitment to team development that supports nurses and allied health professionals to develop the skills and competencies (i.e., a scope of practice) required in a primary care setting. This is because as health authority employees their work experience is primarily in acute and long-term care, where the required skills and competencies are different from what is needed in primary care.

This has resulted in a range of sub-optimal outcomes, including some of these professionals working below their full scope of practice and others delivering only their highest scope work with very few patients. Because this transition lacked a Learning Health System (LHS) framework, there was no built-in capacity to identify these operational bottlenecks in real-time, incorporate relevant evidence and make the iterative adjustments needed to maximize the cost-effectiveness and Quality Improvement potential of team-based care.



The Nurse-In-Practice program: a positive model to build on

The one exception is the relatively small Nurse-in-Practice program¹, also a ministry of health-funded initiative, supporting the integration of registered nurses (RNs) and licensed practical nurses (LPNs) into primary care clinics operated by physicians, nurse practitioners and non-profit agencies that did not receive funding through Primary Care Networks. In the Nurse-in-Practice program, clinics employ nurses directly within their practices. Yet, [the design and on-going implementation](#) supports are provided by the Nurses and Nurse Practitioners of British Columbia (NNPBC), the professional association supporting all BC nurses.

The NNPBC recognized that access to comprehensive clinical governance and practice support is not common in community-based primary care but so essential to [quality, safety and workforce stability](#). The program they proposed to the MOH included five streams of service² to support RNs and LPNs working in the Nurse-in-Practice program as well as those working in PMHs. The ministry of health only provided funding to support the NNPBC to implement some of what they proposed and only for the Nurse-in-Practice program and not PMHs. In 2026, NIPC was expanded at no additional cost to include nurses practicing in Community Health Centres .

The MOH's funding includes supports for RNs and LPNs to onboard into a clinic, integrate into teams and better understand their scope and the benefits of optimizing their scope in the context of primary care. This support is provided through two well-regarded programs established by the NNPBC. The first is the Practice Excellence Support Program that focuses on providing mentoring and coaching opportunities to support nurses to improve their practice and patients' experience of care. The second is the Primary Care Nursing Network, an on-line Community of Practice, open to RNs and LPNs, who are employed in clinics where they often work on their own. The Network provides them with regular opportunities to meet with nurses from other clinics, share experience, learn from their peers and access an online library of evidence-informed nursing practice tools and resources.

The MOH did not, however, provide the funding requested to support the RNs and LPNs in the Nurse-in-Practice program to access the clinical education, competency and Quality Improvement training they need to maintain and develop their professional skills or optimize their scope. Funding for clinical education and other training is well established in acute care settings, but not in primary care.

In addition the funding requested to support physicians—to understand the full range of skills and competencies that RNs and LPNs employ, learn how to integrate them into their practice and understand nursing specific policies required as employers of nurses in BC—was not funded.

The Nurse-in-Practice program, and particularly the more-comprehensive version of that program, could be scaled up to support RNs, RPNs and LPNs working in the many different types of primary care settings across BC. The NNPBC would be well suited to facilitate this work and through this process ensure that nursing resources are better utilized to improve care quality and cost effectiveness.

¹ Pat Telford, the Provincial Director of Nursing Initiatives in Primary Care for the Nurse, Nurse Practitioners of BC (NNPBC). February 4th 2026

² Angela Wignall, CEO NNPBC, interview May 7 and 14, 2026

At an overall systems level, however, it is important to understand that the shift to team-based care in BC is still in its infancy. The proportion of other team members recommended by some researchers is closer to two or more full-time equivalent (FTE) positions for every physician or nurse practitioner FTE. This is in contrast to the current situation in BC, where there is, just over a third of a team member FTE for every physician or nurse practitioner FTE³.

Added to this, because Primary Care Network funding from the Ministry of Health has been fully allocated there is no on-going capacity for Primary Care Networks to add new team members other than physicians and nurse practitioners (although in a much more limited way). This will increase BC's reliance on family physicians despite the current and anticipated on-going shortage of family doctors.

Family Physician-led organizations, nurses, allied health professionals and health-related community-based organizations continue to advocate for a shift to a team in primary care. For example, in the submission to the MOH's review of CHCs in 2025, the Family Doctors of BC argued that:

...all BC payment models must evolve to support team-based, integrated care, ensuring that the care patients receive is not dependent on the physician's compensation model. By aligning compensation models

with other supports for team-based care, we can strengthen collaboration, expand physician workforce capacity and improve patient outcomes.

This consensus exists not only because of the shortage of family physicians but also because of the growing recognition that other team members—with different skills and competencies— are far less expensive, critical to improving timely access, managing chronic health challenges, connecting to social support services and addressing mental as well as physical health concerns. This includes registered nurses, licensed practical nurses, clinical pharmacists, social workers, clinical counsellors, dietitians, peer counsellors, First Nations Elders, multi-cultural brokers and more.

How a physician-only funding model replaced the promise of team-based care

The many missed opportunities in terms of how the Ministry of Health and the Primary Care Networks rolled out the Patient Medical Home team-based model severely limited the potential and the level of commitment to this model. This may explain, in part, why in the first-ever review of primary care in BC released by the Ministry of Health in July 2025 there is no reference to the Patient Medical Home model, the centrepiece of the government's primary care transformation plan in 2018.

It may also be part of the reason why in October 2022, instead of expanding funding to support the team-based Patient Medical Home model, the Ministry of Health

³ BC, Ministry of Health, July 2025, Strengthening Primary Care in BC: Preliminary Analysis, pages 18-19. This calculation is based on table 8, page 19 the total number of FTEs for nurses, allied health professionals, pharmacists, indigenous health and administrative staff (1690) in comparison to Table 6, the total number physician and NP FTE (5928)



negotiated a new compensation model exclusively for physicians: the Longitudinal Family Physician (LFP) payment model. The goal of the LFP payment model was to make family practice [a more attractive option for physicians](#) by significantly increasing the compensation level for family physicians, adding payment for hours of direct and indirect clinical care, an annual amount to recognize panel size (the number of patients a physician is responsible for), complexity and reducing what was widely recognized as the onerous reporting requirements in the fee-for-service payment model.

While it is a step in the right direction, the LFP model retains a key hallmark of the old fee-for-service system in that a core part of its compensation is based on volume, incentivising shorter visits and lower patient complexity.

Therefore, like fee-for-service, LFP is not a model that sufficiently supports [the increasing number of people living with complex chronic health and social challenges](#). For people with complex challenges, the evidence clearly shows the benefits of both longer patient visits and access to an interdisciplinary primary care team to better manage chronic health conditions, reduce reliance on more expensive, and often less effective, emergency and hospital services (for further discussion see section three, The Value of a Health Equity Approach: Lessons from Ontario).

Because of the MOH's lack of transparency related to how the complexity measure is constructed and for what purpose, it is impossible for researchers and public

agencies with responsibility for overseeing primary care to incorporate this measure in their evaluation of how the LFP is impacting access, care quality and cost-effectiveness.

The LFP payment model is effectively moving BC's primary care system away from team-based care. Under the LFP physicians are compensated for indirect patient care and clinical administration at the same rate as they are for direct patient care. Also no oversight or accountability mechanism has been put in place to ensure family physicians are not taking on work that could be done as, or more effectively, by far-less expensive administrative or clinical staff. This becomes even more of a challenge now that the PCN funding to add new team members has been exhausted.

In 2014, BC's Auditor General [examined](#) the oversight, quality and cost effectiveness of physicians' payment models and concluded that the BC government does not know if physician services are high-quality and offer good value for the money spent. The same could be said of the LFP today.

The only performance measure or care standard used to evaluate the success of the LFP is patient attachment—a formalized affiliation between a patient and a regular primary care provider. However, attachment is not an equivalent measure to access. For example, a person can be attached to a physician or nurse practitioner but not have timely access to them and instead go to the nearest walk-in clinic, urgent care clinic or hospital emergency room.

[Research](#) shows that a greater focus on performance measures related to timely

access (Starfield's "first point of contact"), instead of attachment alone, has the potential to reduce patient visits, wait times, no shows, clinician stress and emergency room visits while improving care continuity and clinician productivity. There is also [research](#) suggesting that nurses have a skill set that is better suited to facilitating timely access than physicians.

Ministry of Health plans to end support for BC's only primary care team-based funding model

In December 2025, the Ministry of Health [announced](#) it would shift the eight clinics currently funded under Population-Based Funding (PBF) to the LFP by September 30, 2026.

BC's Population-Based Funding model is a capitated payment arrangement where health care providers receive a fixed, predetermined amount of money per patient for a specific period (usually annually) from the government. It has some advantages over the LFP because the funding is not tied to physicians' compensation nor volume or time spent with patients, but on patients' medical complexity. Under this model, clinics can hire team members other than physicians and nurse practitioners to support patients with a broad range of chronic health challenges, provide holistic prevention-oriented care and focus on providing timely (same or next day) access as well as attachment.

Population-based funding has been in place for almost 30 years, but has never been evaluated despite [efforts of Population-Based](#)

[Funded physicians](#) to have the Ministry of Health conduct a detailed cost benefit analysis of the payment model in 2012 and the commitment made by the ministry to compare population-based funding to the LFP model in 2024.

Given that the LFP funding model does not support team-based care, timely access or preventive care and population-based funding does, instead of simply discarding the model it should be evaluated and potentially modified and improved. There are, for example, more updated models of how capitated funding formulas are calculated, including in [Sweden](#) and [England](#) that more accurately reflect patient needs. These formulas factor in the [social determinants of health](#) and health equity (i.e., not just medical complexity) and should be considered in any evaluation of BC's Population-Based Funding model as well as any modifications being considered for the LFP.

No payment model is perfect and different models are more or less effective in different contexts. This is why many jurisdictions have multiple payment models for primary care, with salary and [blended-capitation models being most common in team-based settings](#). [An evaluation](#) of two team-based primary care clinics in Alberta, that use an alternative capitated funding model, points to the value of considering capitation as well as salaried models, for funding team-based primary care. The two clinics evaluated had 35% fewer emergency department visits, 30% fewer hospital admissions and 17% fewer appointments with non-family medicine providers/specialists. The proportion of GDP



spent on specialists saved the Alberta government \$120 million over 10 years.

It is helpful to acknowledge that while increasing payment options for primary care providers is fundamental, it is only one part of the overall transformation process.

Primary care transformation also requires better accountability mechanisms and improvement strategies, a team-based delivery system and digital infrastructure to all be working in sync. This is clearly illustrated in a [2023 research study](#) comparing Canada to other countries that have close to 100% attachment levels. The study found that those countries:

have stronger contractual agreements and accountability requirements for family physicians [...] and their family physicians are paid by capitation or salary, work in interprofessional teams and have excellent digital tools and information systems.

The study also notes that Canada spends less of its total health budget on primary care than the average among Organisation for Economic Cooperation and Development (OECD) countries (5.3% v. 8.1%). Although we spend more than the average in OECD countries, when you look at [overall health care spending as a proportion of GDP](#) (11.3% vs 9.3%).

3. The value of a health equity approach: Lessons from Ontario

The continued reliance on funding mechanisms that reward volume more than complexity does not provide adequate support for people living with chronic physical and/or mental health conditions. And yet, managing care for people living with chronic conditions—such as heart disease, diabetes, asthma, depression, dementia and mood disorders—is increasing and recognized as the [central challenge](#) in primary care provision in BC, Canada and around the world.

Chronic conditions have a [socio-economic gradient](#), meaning that individuals and communities with lower incomes and social status are more likely to live with one or more chronic conditions and to experience worse health outcomes. Multimorbidity—the co-occurrence of two or more chronic

physical and/or mental health conditions—is common for many people and is associated with outsized negative impact on mortality, complexity of managing chronic conditions and health care costs. To get a better sense of growing complexity and inequities over time in BC, Statistics Canada looked at the growth of multimorbidity from 2001/-02 to 2019/-20[32] and found in BC that:

- *More than 25% of adults and 60% of seniors met criteria for multimorbidity in 2019/2020, with the largest relative increases over the past two decades occurring among younger adults.*
- *The prevalence of complex multimorbidity (five or more conditions) doubled from 2001/2002 to 2019/2020, affecting about*

4% of adults and approximately 20% of seniors in 2019/2020.

- *Multimorbidity risk was higher in lower-income quintiles, relative to higher-income quintiles and these disparities were larger for complex multimorbidity (five or conditions), relative to standard multimorbidity (two or more conditions).*

Over the last 20 years in BC there has been growing recognition in primary care of the importance of developing strategies to proactively manage chronic physical health challenges like heart disease and diabetes. There has, however, been far less acknowledgment of the need for primary care to address chronic mental health conditions like anxiety disorders, depression, schizophrenia and dementia. This, despite the fact that a significant portion of people with chronic physical health conditions are also living with chronic mental health challenges, making it critical that primary care has the capacity to respond to the whole person.

There is also very little acknowledgement in primary care of the socio-economic gradient in either physical or mental health and how that intersects with race, gender and age. This is problematic because understanding the health equity dimension in chronic conditions is key to determining the range and types of primary care interventions required to improve health outcomes for those populations and communities most at risk of ill health. This includes people living in rural and remote communities and

vulnerable, low-income, racialized and Indigenous populations across BC.

This is why in the webinar on mental health we talked about the importance of mental health being recognized as core service in primary care and emphasized the importance of focusing the social determinants of health in developing treatment options (i.e., supported employment) to improve health outcomes for people living with chronic mental health challenges. This is further supported by evidence from Oregon, where they developed a state-wide learning health systems approach to primary care transformation with a strong focus on health equity. One of their most successful initiatives was an investment in mental health—or what they call behavioral health—as a core service. This led to significant reductions in costs in specialized mental health care, far surpassing their investment in behavioral health primary care services.

Community Health Centres well positioned to address growing complexity and health inequities⁴

Research shows that interdisciplinary team members can play a key role in improving health outcomes by supporting people to better manage their chronic mental and physical health challenges.

Community Health Centres (CHCs)—a salaried model of interprofessional team-based care—are a case in point. Research from Ontario and the US shows that CHCs have been more successful than other primary care models in improving patient

⁴ <https://bcpolicy.ca/primary-care/#session2>



outcomes (most noticeably in mental health) and cost savings based on their equity and prevention-oriented approach. They have done this by focusing staffing resources (i.e. nurses and clinical counselors) not only on supporting people to better manage chronic health conditions but also by connecting them to preventive services through social workers, multicultural health brokers, community developers, peer counselors and First Nations Elders, who focus on the [social determinants of health](#).

Since 1982, Ontario CHCs have been supported by a provincial not-for-profit organization that has evolved over time to become the [Alliance for Healthier Communities](#), the leading voice for the community-governed, equity-focused and team-based primary care sector in Ontario. Today, as well as CHCs, the Alliance includes nurse practitioner- and Indigenous-led primary care clinics and a small number of Family Health Teams (FHT) where doctors are contracted to work with not-for-profit organizations that employ interprofessional teams of nurses and allied health professionals. The Alliance supports 120, often very large, community-based primary care organizations with multiple sites. The number of not-for-profit FHTs is even greater with 184 organizations across the province most of whom are not members of the Alliance.

Not-for-profit team-based primary care organizations—both Alliance members and FHTs—are at the centre of the Ontario government's ambitious \$2.1 billion [Primary Care Action Plan](#) led by Dr. Jane Philpott, a physician and former federal minister of

health. The goal of the Action Plan is to ensure that by 2029 everyone living in Ontario will be attached to a physician or nurse practitioner working in a clinic close to where they live.

Ontario's attachment initiative is unique because the CHC model inspired how Dr. Philpott conceptualized and is rolling out the Action Plan. As a result, interprofessional teams—[traditionally focused on marginalized populations](#)—are now seen as an essential resource for all primary care organizations, supporting patients living with complex and/or chronic health and social challenges to access the primary care services they require. This approach is also valued because of its potential to free up physicians' and nurse practitioners' time to attach more patients.

In implementing this transformative approach to address the attachment challenge, Ontario's Ministry of Health recognized [the leadership potential of the team-based, not-for-profit sector](#) in two ways:

The first was their decision to only provide attachment funding to organizations that are part of the team-based, not-for-profit sector or who are creating new team-based, not-for-profit organizations. This reflects the government's recognition of the sector's capacity for leadership to support the entire community, not only their own patients, and in this role facilitate access to interprofessional team-based care for both underserved and unattached community members.

The second was the decision by the Ontario government to solicit only one application

from each locally based [Ontario Health Team](#) (OHT)—a government funded partnership linking the local hospital with primary care and other community-based health services to improve coordination and where possible integrate services. This requirement is intended to force conversations and collaboration between different types of team-based not-for-profit primary care organizations and over time create a more collaborative and integrated system of primary care provision in local communities across Ontario.

It is also a clear recognition by the government of the leadership capacity of the team-based not-for-profit primary care sector, particularly the Alliance for Healthier Communities based on their community connections, collaborative decision-making expertise and equity-focused delivery strategy.

The building blocks for system change

The decision by the government to turn to the not-for-profit team-based sector and ask the sector to play a central leadership role in their new attachment initiative, builds on years of work led by the Alliance for Healthier Communities and the Ontario Association of CHCs before it. The recognition of the Association, and then the Alliance, as system change leaders is based on their advocacy work to address the health inequities experienced for the communities they serve, who are at greater risk of ill health because of their race, gender and socio-economic status.

Five developments were particularly important in this journey:

- **Being identified as a sector:** Initially, because CHCs developed in response to locally identified needs and service gaps, they were more focused on their uniqueness rather than what they shared in common. Understanding the value of their shared commitment to team-based, equity-focused care and community governance and then deciding to operate as a sector meant they could speak with one voice, make decisions together and play a stronger advocacy role with the government.
- **Taking control of data:** Initially, responsibility for data management rested with the MOH but in the early 2000's they gave this responsibility to the Association and then the Alliance. This made it possible to adopt a common electronic health record (EHR) and have sector leaders and service providers responsible for the development of data standards, performance targets and service goals. This shift increased the sector's capacity to use this information for reporting, accountability and system planning. It also made it possible for the Alliance to become a Learning Health System and use the available research evidence to guide their system improvement strategies.
- **Adopting a [Health and Wellbeing Model](#):** Creating a comprehensive roadmap for service delivery and ensuring it was embraced by the Alliance membership, made it possible to map their model of care to an evaluation



framework. This was the first evaluation framework focused on team-based primary care in Ontario and helped the government understand the value of the sector as system innovators and problem solvers. It also prompted other types of primary care clinics—NP led clinics, Family Health Teams (FHT)—to join the Association which led to their name change.

- **Creating collaborative decision-making structures:**

To support this system transformation and improvement work, the Alliance developed a committee structure led by trusted sector leaders and supported by Alliance staff. These committees include a strategy group, a performance management and research group and a data management group. They also have four equity groups that meet regularly, executive directors' meetings to address emerging challenges, Board-to-Board meetings and an annual conference open to all members.

- **Initiating strategies to support neighbourhood health and spoke models:**

Solo family physician practices in Toronto approached Alliance members several years ago and asked them to support their patients who needed access to team-based care. This led to the creation of a program that was successfully rolled out in many communities across the province. The Alliance also developed a [TeamCare](#) prototype for how to make this partnership work. It also set the stage for the Alliance's [Neighbourhood Health](#) hub

and spoke model. This is where well-established team-based, not-for-profit primary care organizations support their own patients, who have medically and socially complex conditions, and work collaboratively with solo and group family practices (the spokes) to provide these supports to their patients. In many applications for attachment funding, Alliance members are prioritizing the Home Health hub model.

The Alliance for Healthier Communities is clearly playing a key leadership role in developing an evidence-based, equity-focused approach to primary care transformation that has the potential to increase coordination and integration within Ontario's primary care system and further strengthen the leadership role of the not-for-profit team-based sector. And yet, despite these positives, there are contradictions and challenges in how the attachment initiative is being rolled out, including that the only metric the government is focusing on is attachment, rather than timely access. This is particularly problematic for the populations and communities they serve who are most at risk of ill health. To address this shortfall the Alliance will be discussing this issue at their [2026 annual conference](#).

4. Next steps for primary care transformation in BC

Valuing the leadership potential of the not-for-profit, team-based primary care sector in BC

Over the last 10 years, a small but growing team-based not-for-profit primary care sector has emerged in BC. This sector includes, but is not limited to: CHCs, not-for-profit team-based physician-led clinics, nurse practitioner-led clinics, Indigenous-led primary care services and the [Foundry model](#) of integrated support for youth mental health and wellness. Most of these initiatives grew from the ground up with communities and healthcare leaders working together to improve access to quality care for everyone in their communities and better support, recruit and retain the workforce they needed to be successful.

Beginning in 2018, many of these organizations received funding either directly from BC's Ministry of Health (MOH) and/or through the PCN process. Fourteen new CHCs were funded by the MOH. The MOH also funded the BC Association of Community Health Centres (BCACHC), a provincial organization that supports CHCs across BC with the potential to expand its reach and provide an array of services for the broader community-based, not-for-profit primary care sector.

At the local level, many of these not-for-profit organizations (both non-profit societies and co-operatives)—have the potential to become community hubs, taking a leadership role to create a more-integrated, accessible and

prevention-oriented system of primary care in the communities where they are located. The value of the not-for-profit structure and mandate in creating this hub model is two-fold:

First is the combination of community governance structure and a team-based delivery model that supports a culture of collaboration and mutual support both within their organization and in relation to the broader community including other local health care services, community-based social support services, affordable housing providers, municipal governments, etc.

Second is the legal mandate that empowers them to raise, hold and disburse funds to enhance the health and wellness of everyone living in the local community and/or region. This creates the capacity to do more than simply respond to individual concerns of the patients at their clinic, but to, as well, play a key coordinating and leadership role in bringing together service providers and key community leaders to address emerging health challenges and service gaps. This could be as simple as creating a new referral pathway between organizations to make it easier for patients to access the services they need in a timely manner, to developing new programs and innovative approaches to service delivery to address access gaps for the entire community and/or tailored to the needs of a specific underserved, higher needs population.

Crucially, this mandate also allows hub organizations to build the shared



infrastructure required to anchor a local/regional ecosystem of primary and community care. This could include facilitating systemic Quality Improvement by training administrative staff for enhanced roles and empowering nurses and allied health professionals to work to their full scope of practice. It can also include centralizing essential operational functions like IT, human resources and facilities management, and even acting as a safety net by stepping in to stabilize local clinics facing closure.

These capabilities set the not-for-profit sector apart from the long-established business model where family practices operate as small businesses owned by a physician or group of physicians and more recently corporations that employ physicians. These businesses do not have the community mandate, legal structure or organizational capacity to act as hub organizations.

There are, however, team-based Primary Medical Homes that would likely be interested in becoming physician-led, not-for-profit organizations and potentially hubs in their community. Others could benefit from being connected to a local hub and having access to the infrastructure support they need related to quality improvement, IT, human resources and facilities management. It could also—following the model in Ontario—enable their patients, particularly those with chronic health and social challenges, to access team-based interventions they require to maintain or improve their health outcomes

and reduce the likelihood of requiring emergency and hospital care.

While the development of local non-profit primary care hub organizations is still in its infancy in BC, it is moving forward in a number of communities and could be further enhanced if the original vision in 2018 of BC's PMHs model—as the cornerstone of an integrated system of primary care and community care in BC—was revisited and reimagined. Evidence from this and other reports suggest that BC's investments in primary care transformation could be more effectively utilized. This points to the value of beginning with a strategy that focuses on optimizing recent investments in primary care. This would entail building on what is already working well in each of the models—Patient Medical Homes, Urgent and Primary Care Centres, Community Health Centres, Nurse and Indigenous-led clinics, the Foundry model, the Nurse-in-Practice program—and linking and integrating these models and services where possible. With this as a foundation, it is possible to begin the journey of building a Learning Health Systems improvement strategy for BC's primary care system.

We can't forget, however, that many people in our province who are at the greatest risk of ill health—people living in rural and remote communities and vulnerable populations across the province—lack access to the longitudinal, comprehensive and coordinated primary care they so desperately need. To date MOH investments in these populations and communities have been limited, which

means that there is not a solid foundation to build on. Therefore, as a province, we must prioritize new investments for these communities and populations.

To achieve patient-centred care, especially for those with complicated challenges, empowering not-for-profit team-based models must be the key strategy of the Ministry of Health moving forward.

Bridging the gap between evidence and policy: a Learning Health System

To effectively utilize the recent investments in primary care, BC must first bridge the gap between policy and evidence.

In 2025, the Ministry of Health released the first-ever review of primary care that included two reports, one released in [July](#) and the other in [December](#). These reports created considerable momentum and interest in moving forward with the next stage of primary care transformation but also identified significant shortcomings in the current approach. Most notably the omission of PMHs, the centrepiece of the 2018 transformation plan, the stalled expansion of team-based care due to exhausted PCN funding and the discount between health authority-run UPCCs and community-based primary care. Also problematic is the inability of currently deployed team members to work to their full scope or be integrated into teams because they were recruited and remain health authority employees.

BC needs a structured way to dismantle silos and improve care quality and cost

effectiveness without disrupting the care that clinics deliver every day.

A Learning Health System framework, outlined at the beginning of this paper, offers precisely that kind of structured approach. [Other jurisdictions](#) have demonstrated that with a Learning Health System it is possible to combine research evidence with lessons from what is working well on the ground, share this knowledge across the system and use it to develop and refine improvement strategies over time. Because change is iterative, and improvements never end, this approach relies on practice facilitators/peer mentors embedded within teams to guide adaptation on the ground so that practitioners can remain focused on serving their patients.

Provincial leaders need to shift away from viewing Starfield's four pillars as guiding principles and instead see them as care standards that define what "quality" means in primary care. The Ministry of Health could track progress throughout the province to meet these standards by setting explicit service delivery goals, informed by applied research and with reasonable timelines for the system to achieve them. As part of setting service delivery goals, it is important to prioritize key evidence-based performance metrics such as same-day access, reductions in avoidable use of emergency services and improved integration of primary and community health services.

To support and empower primary care practices to improve, two things are required. First is a provincially integrated and interoperable Electronic Health Record (EMR) so that primary care practices and



communities across BC can see where they are doing well and where there is need for improvement. Second is a provincial network of local practice facilitators/peer mentors to support practitioners with the processes and tools they need to be successful in implementing new, more-effective approaches to improve patients' experience of care, workforce stability, access, etc. This information could also help the MOH identify barriers to improvement and work collaboratively with researchers and primary care leaders, who share a common commitment to a Learning Health System approach, to address challenges along the way.

With this kind of transparent, data-driven approach to improvement, it is also possible to move beyond "provincial averages" that often mask places that are doing well and should be seen as models to replicate as well as those having difficulties because they are supporting smaller, high-needs populations and communities.

BC requires disaggregated data for rural, remote communities and underserved populations across the province that are anchored in Starfield's four pillars. This would make it possible to measure performance against rural-specific indicators (e.g., emergency transfer delays, ER closures, travel burden, intermittent access to primary care) and population-specific metrics (e.g., cultural safety, gender-affirming care, trauma-informed care).

It would also make it possible to look at communities and populations that are doing better than expected to identify the strategies

that led to positive outcomes (e.g., leadership strategy, team composition and structure, approach to quality improvement, community engagement, linkages to other parts of the health system).

BC does not need to reinvent the wheel. The province can adapt proven models from other jurisdictions such as:

- **Ontario's shared data and equity metrics:** Through initiatives like the Alliance for Healthier Communities and [POPLAR](#)—Ontario's primary care practice-based learning and research network—established as an Equity, Performance, Improvement and Change (EPIC) framework to achieve high-impact Quality Improvement. This relies on shared data platforms, common electronic medical record (EMR) standards and evidence-based performance targets.
- **Oregon's accountability and mentorship programs:** The Oregon Health Authority created [care standards](#) anchored in Starfield's four pillars, explicitly linking them to accountability mechanisms. They also rely on a not-for-profit consulting organization and the state to provide on-site technical mentoring by experienced practitioners.
- **Oregon's population-based integration:** Oregon's population-based approach to integrating mental and physical health in primary care led to [significant cost reductions](#). BC should replicate this model and fully empower allied health professionals.

By aligning academic research, clear government mandates and a structured Learning Health System, BC can transform its primary care investments into a sustainable, equitable and high-performing system.

Engaging the research community

A constructive first step to engage the research community would be to incorporate a robust, applied research focus into the MOH's primary care review processes based on a Learning Health Systems approach. Partnering with academic researchers as well as [Health Quality BC](#), would help ensure that the barriers and facilitators to system change and priority areas for improvement are more clearly defined, well understood and transparently shared. This means that as a province we will be better equipped to address the core gaps and silos in our current approach and optimize both health care outcomes and cost effectiveness.

The overall goal of this research will be to identify and build upon what is working well on the ground (i.e., in line with the evidence) in BC's team-based primary care models—Patient Medical Homes, Urgent and Primary Care Centres, Community Health Centres, Nurse and Indigenous-led clinics, the Foundry model, the Nurse-in-Practice program. And then working with key primary care and community leaders and the ministry of health to develop an improvement plan for expanding what is working well on the ground and integrating and linking services wherever possible. It would also involve identifying where entirely new approaches to service delivery are required because of the huge gaps in available services, particularly in

rural and remote regions of the province and for high-needs vulnerable populations across BC.

This would include but not be limited to:

- Building on the Nurse-in-Practice program:** Analyze the Nurse-in-Practice program as a Learning Health System approach to quality improvement for nursing and potentially for other team members working in BC's primary care system. In the Nurse-in-Practice program, nurses have access to practice support, peer mentoring and educational resources and tools. There are other aspects of the program that if fully implemented would facilitate these nurses to work to the full scope of their practice. This program would be a good starting point to identify the challenges and potential solutions to support nurses and allied health professionals working in PMHs, but who remain health authority employees and for multiple reasons are unable to work to their full scope or integrate with a primary care team.
- Clarifying UPCC roles in a more Integrated Primary Care System:** Address the lack of clarity regarding the benefits, cost-effectiveness and priority populations served by UPCCs. It would be helpful to understand how similar UPCC services are to walk-in clinics, the extent to which they support vulnerable populations and the variation in services across the province. It is also important to follow-up on the fact that [more than one half of the services in UPCCs are provided by nurses](#), not physicians, to better understand the type of services they



provide, the populations they serve, and the potential to expand nursing roles in episodic primary care. Most importantly, it is critical to analyze the potential benefits of integrating UPCCs with longitudinal primary care organizations in the communities where they are located and identifying UPCCs (and other episodic primary care services) that are moving in this direction or are interested in being part of a more integrated approach to primary care delivery.

- **Optimizing team ratios:** It would be useful to analyze the health authority, community-based primary care practices and not-for-profit organizations with higher than average non-physician-to-physician ratios to determine the impact on access, chronic disease management and cost-effectiveness for diverse patient populations. This could be the first step to identifying the potential quality of care, access, health equity and cost savings advantages of increasing the ratio of non-physician-to-physician/NP providers.
- **Benchmarking performance:** Research jurisdictions that have successfully implemented team-based models to identify the care standards, performance metrics, improvement strategies, digital information systems and funding models they deployed to reach their goals. This research should begin with the models identified in this discussion paper and the [BC Policy Solutions webinar series](#), including the Ontario OurCare outreach and [related research](#), the collaborative and Learning Health System approach of

Ontario's Alliance for Healthier Communities and Oregon's state-wide learning health system improvement strategy.

This applied research agenda provides some potential starting points for developing a more consistent, evidence-based plan for moving to the next phase of primary care transformation. It includes focusing on making better use of existing resources to integrate care, optimize scope of practice, expand team-based staffing levels and adopt new or modified team-based funding models. It also means identifying where new approaches are required.

There are encouraging signs that the conditions for progress exist. The new medical school at Simon Fraser University has expressed a strong interest in working collaboratively with BC's academic health research community to support the ministry of health to move to the next stage of primary care transformation. This interest reflects the Medical School's commitment to [fostering research and innovation](#) to support primary care transformation and ensure the next generation of family physicians can work in team-based, equity-focused and community-engaged primary care settings.

There is, also, a notable alignment among primary care practitioners—including the [Family Doctors of BC](#), the [College of Family Physicians of BC](#), the [Association of Nurses and Nurse Practitioners of BC](#) and community health care leaders—on the direction of change needed. This alignment does not mean the work ahead will be easy. It will require sustained effort to bring respective

organizations and their members to understand why these changes are critical and to show how meaningful engagement in the research and improvement process can make a tangible difference in health care delivery.

The foundation of shared purpose is there, however, and that is no small thing.

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