STRENGTHENING PRIMARY CARE IN BC

PRELIMINARY ANALYSIS – JULY 2025

IN RESPONSE TO

THE COOPERATION AND RESPONSIBLE GOVERNMENT ACCORD 2025

Health Services Integration Division

Ministry of Health

In 2018, the Ministry of Health launched a transformational, team-based Primary Care Strategy aimed at improving access to high-quality, comprehensive, culturally safe, and person-centred primary care across British Columbia. Our goal has been to ensure that more people are connected to the care they need, when and where they need it.

Now, seven years into the implementation of this Strategy, we are enhancing our ongoing efforts to assess progress. The intent is to build on what we've learned to date to deepen our understanding of what's working well and where further shifts are needed.

As part of our ongoing commitment to transparency and accountability, we are pleased to be working with the BC Green Party to enhance performance monitoring and evaluation of the primary care system during this government's mandate as part of the Cooperation and Responsible Government Accord (CARGA). This important work will help us make the most of existing resources, identify ongoing challenges, and better plan for the future – all in pursuit of the shared goal of ensuring every British Columbian has the benefit of primary care services.

This report marks an important first step. It offers a high-level overview of system-level investments and highlights progress toward key objectives, including the number of British Columbians now attached to primary care services. This report will also begin to pinpoint areas for deeper exploration as we continue to look for new ways to support people n accessing services within their communities.

I look forward to continuing this work together – with health care providers, partners, and communities – to strengthen primary care across the province.

Sincerely,
Josie Osborne
Minister of Health

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Executive Summary

In 2018/19 the Ministry of Health launched a transformational team-based primary care strategy envisioned to fundamentally change the way primary care is delivered. At its core, the strategy is intended to increase patient attachment and access to quality, comprehensive, culturally safe, person and family-centered primary care services through the promotion of team-based care in communities throughout British Columbia. Team-based care in BC involves comprehensive, coordinated, and integrated health care provided through a supportive network of local primary care services called Primary Care Networks (PCNs). In addition to advancing team-based care, the strategy also includes targeted health human resources and compensation initiatives to further improve access and attachment, particularly in areas with heightened need such as rural and remote communities.

With many of the Primary Care Strategy's initiatives now well into implementation, the focus is increasingly shifting toward evaluation and performance measurement. As part of the 2025 Cooperation and Responsible Government Accord (CARGA) – specifically action 1b – a commitment was made to assess BC's primary care system. This July 2025 report (Report 1) is the first deliverable and provides an initial set of indicators that offer an overview of system-level investments. It also outlines progress toward key objectives, including increasing access to care and attaching all British Columbians who wish to be connected to a longitudinal primary care provider – either a family physician or nurse practitioner.

Of note, Report 1 itself is not a comprehensive performance assessment of the entire primary care system; rather, it is an initial step guided by the established Terms of Reference. Findings are based on available provincial data from validated provincial sources.

Report 1 opens with an overview of the Primary Care Strategy. Data is then presented in two broad categories: an overview of team-based care models (which includes a deeper dive into the performance of Urgent and Primary Care Centres [UPCCs] and Community Health Centres [CHCs] respectively), followed by an overview of metrics on health human resources and attachment.

Team-Based Care

Overview of Team-Based Care

- Team-based care in BC involves intentional commitment to comprehensive, coordinated, and integrated primary health care provided through a supportive network of local primary care services called PCNs. Clinics and service providers (e.g., physicians, nurse practitioners, nurses, allied health professionals, traditional wellness providers and administrative staff) are linked together through geographically based PCNs that are collaboratively planned and delivered by local partners to address unique community needs. There are presently 92 PCNs in implementation across BC.
- Under BC's Primary Care Strategy, in addition to Family Practices, there are five main service models within PCNs supporting team-based care: Urgent and Primary Care Centres, Community Health Centres, First Nation-Led Primary Care Centres, Nurse Practitioner Primary Care Clinics, and Foundry Centres.

- These service models are guided by and contribute to the Ministry's *10 Primary Care Attributes*: longitudinal care, coordinated care, timely access, extended hours, comprehensive care, team-based care, population health promotion, digital enablement, culturally safe care and equitable access.

Urgent and Primary Care Centres (UPCCs)

- UPCCs are intended to increase same-day access to quality, culturally safe, patient-centred, urgently needed primary care for unattached patients as well as for attached patients that are unable to access their primary care provider on a timely basis. Some UPCCs also provide longitudinal primary care by attaching patients to primary care providers and teams.
- As of March 31, 2025, the Ministry has funded 41 UPCCs under the Primary Care Strategy, advancing progress toward the commitment of 50 UPCCs.
- Since the first UPCC opened in 2018, UPCCs across the province have provided over 3.4 million patient visits.[1] Additionally, the 19 UPCCs that currently provide longitudinal primary care have attached 27,261 patients as of January 2, 2025.[2]

CHCs

- CHCs are intended to improve access to both longitudinal and episodic primary care for priority populations – including newcomers to Canada, 2SLGBTQIA+ communities, and individuals facing mental health, substance use, or other social barriers – helping to close the province's attachment gap and advance health equity.
- Since 2020, the Ministry has funded 14 CHCs under the Primary Care Strategy, with one additional site currently in the planning phase. Strategy-Funded CHCs are funded with the expectation that they meet agreed to attachment targets.
- As of March 31, 2025, Strategy-Funded CHCs have attached over 14,000 patients.[3] Between April 1, 2024, and March 31, 2025, they have delivered over 124,000 visits.[4] Ongoing work is focused on supporting CHCs in building their patient panels toward the targets outlined in their funding agreements, while also working to expand performance metrics beyond patient care volumes to better reflect the full scope of CHCs' contributions to patient and community health.

Health Human Resources and Attachment

Primary Care Providers

- Since the launch of the Primary Care Strategy in 2018 all categories of providers (family physicians, nurse practitioners, nursing, allied health professionals, etc.) have experienced considerable growth.

[1]Derived from the Urgent Primary Care (UPCC) Patient Services Report FY 2024/25 – Period 7 (Sep 13 – Oct 10) and FY 2024/25 – Period 13 (Feb 28 – Mar 31)
[2] Compiled from self-reported UPCC Patient Services Period Reporting FY 2024/25 – Period 10 (Dec 6 – Jan 2)
[3] Compiled from self-reported CHC Patient Services Period Report FY 2024/25 – Period 10 (Dec 6 – Jan 2)
[4] Community Health Centre (CHC) Patient Services Report FY2024/25 – Period 13 (Feb 28 – Mar 31)

- New compensation models such as the Longitudinal Family Physician (LFP) payment model and New-to-Practice contracts and incentives have contributed to the growth of family physicians in British Columbia. Out of over 7,500 family physicians, over 5,000 now practice as longitudinal providers, providing attachment and continuity of care to their patients,[5] and nearly 4,300 have registered for the LFP payment model.[6]
- Similarly, a strong focus on expanding the role of nurse practitioners in British Columbia has led to the continual growth of nurse practitioners, which has more than doubled, from 500 to over 1,000, since fiscal year 2017/18.[7]
- Aligned with the 2022 Health Human Resources Strategy, the Ministry has also strengthened targeted recruitment and retention incentives and directed funding to significantly increase the number of residency positions at the University of British Columbia's (UBC's) medical school from 170 to 204 (~20% increase).[8] The Simon Fraser University Medical School is projected to open in 2026.

Attachment

- Attachment is defined as the documented existence of a clear ongoing relationship between a patient and a provider or a group of providers.
- Since the launch of the Primary Care Strategy in 2018, over 750,000 British Columbians have become newly attached to a primary care provider, and, as of June 2025, 76.0% of British Columbians have a longitudinal primary care provider.[9]

Overall, Report 1 reflects the system's shift toward team-based care, including models specifically designed to address key system-level gaps. It also demonstrates significant progress toward expanding primary care capacity, access, and attachment for British Columbians.

The next phase of work, Report 2, will build on the data presented in Report 1 and will include expanded engagement with system leaders, health organizations, and partners; deeper performance analysis; and the identification of specific actionable commitments to advance the broader goals of CARGA.

[5] Ministry of Health. Report ID: RMS 8472. Provincial Attachment System Executive Report. Last accessed on 6/25/2025
[6] Ministry of Health. Report ID: RMS 4032. Longitudinal Family Physician Payment Model. Last accessed on 2025-06-25
[7] Calculated by HSIAR based on a combination of Provincial Attachment System and Medical Services Plan billing data
[8] Internal communication with Labour, Negotiations and Beneficiary Services, Physician Services, June 2025
[9] Ministry of Health. Report ID: RMS 8477. Attachment Dashboard: Snapshot. Last accessed on 6/25/2025

BC's Primary Care Strategy

In 2018/19 the Ministry of Health launched a Primary Care Strategy in response to escalating pressures within the primary care system. The Strategy was designed to address a convergence of complex and compounding challenges: a rapidly growing and aging population, increasing concerns about the ability of family practice clinics to deliver timely care, and a critical shortage of family physicians. These pressures were further intensified by systemic issues such as compensation disparities, rising overhead costs, and a shifting workforce dynamic. As many experienced physicians approached retirement, they were increasingly replaced by a new generation of practitioners seeking improved work-life balance, resulting in decreased capacity and access to longitudinal care. Without decisive action, these trends would continue to undermine the sustainability and accessibility of primary care across the province.

Envisioned to fundamentally change the way primary care is delivered, the Primary Care Strategy aims to expand patient attachment and access to high-quality longitudinal care that is comprehensive, culturally safe, and centred on individuals and families. Attachment to a longitudinal provider is central to primary care; a longitudinal relationship means that vital health information such as lab results, prescriptions, and medical history are cared for by the same provider over many years. The ability to schedule appointments and have a single Most Responsible Provider is key to a patient's well-being and quality care throughout their lifetime.

Access to care is often enabled through attachment, but attachment alone cannot meet all of a patient's needs. Episodic care – where a patient sees a provider they're not attached to – is also an essential part of the primary care system, with attachment and episodic care being complementary to one another, where autonomy of an individual's choice is at the forefront. While limited access to consistent primary care can lead to an increased reliance on episodic care, both types of care can work interchangeably to help make primary care more flexible and accessible.

At its core, the Strategy promotes team-based care, moving away from traditional solo or physician-only family practice design for communities throughout British Columbia to ensure equitable and effective primary care services. Team-based care in BC involves comprehensive, coordinated, and integrated health care provided through a supportive network of local primary care services called PCNs.

PCNs are coordinated and integrated clinical networks of primary care service providers located in a geographical area that provide care through a range of models. PCNs are enabled by a partnership between the local Divisions of Family Practice their regional health authority, local First Nations, Metis Nation BC, and other community partners.

In a PCN, team-based care reflects the intentional commitment of health care practitioners (e.g., family physicians, nurse practitioners, nurses, allied health professionals, health authority service providers, local First Nations, and community organizations) to work together as integrated primary care teams. Together, they:

- Enhance patient care.
- Support each other and work to their own strengths.

- Optimize scope of practice and support behavioural change through building interdisciplinary teams.
- Ensure patients are linked to other parts of the system, including the health authority's specialized community services programs for high risk and vulnerable population groups.
- Collectively work to increase access and attachment to primary care.

Changing how primary care is delivered takes time, commitment, and the combined efforts of many people, including patients, health-care providers, organizations, and communities, all working toward a shared vision of a better, more connected health-care system. It involves:

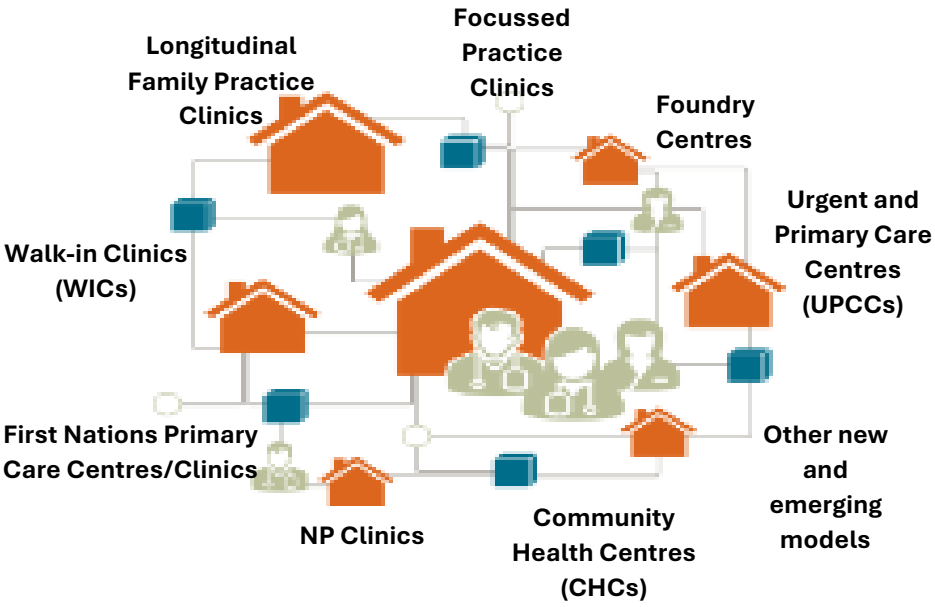
- Focusing on key priorities that can make the biggest difference.
- Shifting power so leadership is more shared, distributed and inclusive.
- Engaging a wide range of stakeholders in meaningful ways.
- Making coordinated changes across different systems and services.

One important part of this shift has been towards a team-based care approach. Team-based care is a model grounded in strong evidence and can improve access and add capacity to the system. But it's not a replacement for the role of a family physician or nurse practitioner. Instead, interdisciplinary teams work together with a family physician or nurse practitioner. The Strategy is investing in building diverse, collaborative team-based care to support practice and behavioral change and to inform new ways of working together. When done right, this leads to deep, lasting changes in how people think, act, and deliver care, resulting in a sustainable primary care system.

There are several team-based care models within PCNs:

- Family Practice Clinics include family practices that enable patients to access continuous, comprehensive and team-based primary care. Family practices serve as the foundation for PCNs.
- Urgent and Primary Care Centres (UPCCs) provide same-day primary care services for urgent non-life-threatening illnesses or injuries. Some UPCCs can also provide longitudinal primary care to attached patients.
- Community Health Centres (CHCs) deliver services with a focus on reaching priority populations within the community, advancing health equity. They provide access to medical and social services.
- First Nations-led Primary Care Clinics (FNPCCs) meet the health needs of Indigenous Peoples blending both western and traditional approaches to health and look to the knowledge of Elders within the care team.
- Nurse Practitioner Primary Care Clinics (NPPCCs) can diagnose and treat medical conditions, interpret tests, prescribe medications, refer the patient to a specialist and lead and coordinate care.

- Foundry Centres provide primary care services including speciality care, for youth aged 12-24 years.



Despite the challenges of a global health-care crisis, significant investments to improve access and attachment to primary care have been made. The Ministry invested more than $579M in FY2024/25 to support Primary Care Strategy implementation and has committed over $627M in FY2025/26, to increase access to primary care services in communities throughout BC, and recruit and retain team-based care teams with the goal to attach everyone in BC who wants a family doctor or nurse practitioner.

Part 1: Team-Based Care Models

Part 1 begins with a high-level overview of team-based care models that have been supported through BC's Primary Care Strategy. It also outlines the *Primary Care Attributes* that all models are expected to demonstrate. This overview is followed by a more detailed analysis of the performance of two key models: Urgent and Primary Care Centres (UPCCs) and Community Health Centres (CHCs).

1.1. Team-Based Care Models in BC

BC's 92 PCNs link health-care teams and community organizations to streamline and coordinate patient services through developing unified systems connecting Family Practices with each other and with other primary care services, like UPCCs, CHCs, FNPCCs, NNPCCs, Foundry, and regional health authority community programs.

The total number of operational clinics funded through the Primary Care Strategy (as of March 31, 2025) are outlined in Table 1. Since this time, additional clinics have become operational and/or have implementation actively underway.

Table 1 Operational Primary Care Initiatives with Most Responsible Providers Across BC as of March 31, 2025*

Primary Care Initiative	BC Total	Fraser	Interior	Northern	Vancouver Coastal	Vancouver Island
UPCC	**41**	10	11	2	7	11
CHC	**11**	3	1	-	3	4
FNPCC	**3**	-	1	1	1	-
NPPCC	**3**	1	-	-	-	2
Foundry**	**17**	3	4	2	4	3

**A Most Responsible Provider is a family physician or nurse practitioner who attaches patients and provides longitudinal care. The Most Responsible Provider has overall responsibility for directing, coordinating care and management of patients.*

***For Foundry Centres, the Ministry funds the family physicians and nurse practitioners only.*

Collectively these initiatives are guided by and contribute to *10 Primary Care Attributes*.

1. **Longitudinal Care:** Delivery of longitudinal primary care to everyone within a PCN via attachment to a primary care provider or enrollment to a clinic (where applicable).
2. **Coordinated Care:** Coordination of primary care across all parts of the health system, including, for example, community service programs, specialist care, diagnostic services, emergency services, hospital care, facility-based care.
3. **Timely Access:** Access to episodic or longitudinal primary care within 24 hours for urgent, non-life-threatening conditions, and within 7 days for non-urgent appointments.
4. **Extended Hours:** Availability of extended clinic service hours for in-person primary care services during weekdays (5 pm to 8 pm), weekends (9 am to 5 pm) and statutory holidays (9 am to 5 pm); and access to virtual services after-hours.
5. **Comprehensive Care:** Access to a full-range of comprehensive primary care services including clinical screening, diagnostic testing and treatment provided through different clinical settings (e.g., community-based clinics, virtual care services, mobile outreach, long-term care facilities, in-patient care facilities).
6. **Team-Based Care:** Intentional commitment to health care practitioners from different professional backgrounds (e.g., physicians, nurse practitioners, nurses, allied health professionals, traditional wellness providers and administrative staff) working together as integrated primary care teams within clinics and across the network.
7. **Population Health Promotion:** Commitment to improving population health outcomes at a community level through collaboration in primary care and with other sectors.
8. **Digital Enablement:** Support innovation and improvements in care, and in particular, information continuity across care settings and team members, through the adoption of provincially/regionally endorsed digital technology solutions.
9. **Culturally Safe Care:** Commitment to truth, reconciliation, and humility, ensuring provision of care that is culturally safe, addresses and eliminates racism and discrimination, and respects the dignity, well-being, and unique health care needs of Indigenous Peoples.

10. **Equitable Access:** Removal of systemic barriers to ensure everyone is supported in achieving good health and wellbeing, regardless of age, ability, socio-economic status, ethnicity, gender, sexuality, or geographic location.

Effective teamwork is a critical enabler of safe, high-quality care and supports a patient's ongoing relationships with their primary care provider. PCNs and the team-based care model are designed to provide comprehensive shared care through strong interdisciplinary teams of health care providers. Moving to this integrated system involves new ways of practicing for many health care providers.

1.1.1. Performance Measurement within the Primary Care Strategy

As the Primary Care Strategy continues to mature, the Ministry is working with partners to strengthen ongoing performance monitoring while also optimizing the investments made to ensure that every British Columbian receives high quality primary care services in a timely manner.

Key performance indicators and metrics for UPCCs and CHCs discussed in this report will include:

- **Attachment:** the number of patients currently and permanently attached to a site for longitudinal primary care. Attachment is a key metric as it demonstrates how many individuals in British Columbia have an ongoing relationship with a Most Responsible Provider. The Ministry is working to connect all British Columbians who would like to be attached with a family physician or nurse practitioner.
- **Patient visits:** the number of patients receiving clinical care per day at a site. Total patient visits is a measure of access to primary care; increasing the volume of visits per day means more individuals can see a primary care team when they need care.
- **Patient encounters:** the number of health-care providers (e.g., family physicians, nurse practitioners, nurses, allied health professionals, traditional wellness providers, etc.) seen by patients while receiving care at a site within each patient visit. Patient encounters serve as an indicator of team-based care; when primary care teams work together to their optimized scope of practice, clinics can operate more efficiently.

These performance measurements reflect one of the key priorities outlined in the provincial mandate, to "ensure every British Columbian has access to primary care, continue connecting more and more people to family health-care providers, and ensure that care can be delivered in person through standards established in consultation with the College of Physicians and Surgeons and Doctors of BC." However, these performance measures themselves do not directly examine patient complexity, availability of services, or patient satisfaction.

Work is currently underway to enhance the CHC model by incorporating a measure of panel socio-demographic characteristics. Preliminary data may be available for inclusion in Report 2 this fall. While this addition does not provide the full picture, it will offer valuable depth and context to better understand the populations served by CHCs and their corresponding health care needs.

1.2. Urgent and Primary Care Centres (UPCCs)

All UPCCs are health authority owned and operated except for three contracted sites: Medical Arts in Nanaimo, REACH in Vancouver, and Edmonds in Burnaby. Key UPCC service model attributes include:

- **Comprehensive care:** UPCCs are a key clinical service model that contribute to a PCN, providing comprehensive primary care services in a specific geography. All UPCCs provide urgent and episodic primary care, and some UPCCs may provide longitudinal primary care by attaching patients to primary care providers.
- **Extended hours:** Sites are or are actively working towards being open after hours on weekdays as well as weekends, with many sites open during standard business hours plus statutory holidays.
- **Team-based care model for staffing:** Clinical staffing varies by site but typically includes family physicians, nurse practitioners, registered nurses, and allied health professionals (e.g., social workers and clinical counselors).

Table 2 Primary Care Strategy-Funded UPCCs

UPCC	PCN Community	Opening Year	Population Served
Vancouver Island			
Westshore UPCC	Western Communities	2018	General urban population
Nanaimo Medical Arts UPCC	Nanaimo	2019	General urban population
James Bay UPCC	Victoria	2020	General urban population
North Quadra UPCC	Saanich Peninsula	2020	General urban population
Esquimalt UPCC	Western Communities	2021	General urban population
Downtown Victoria UPCC	Victoria	2021	General urban population
Gorge UPCC	Victoria	2022	General urban population
Comox Valley UPCC	Comox Valley	2023	General urban population
Peninsula After Hours Primary Care Clinic	Saanich Peninsula	2024	General urban population
Campbell River Primary Care Access Clinic	Campbell River	2024	General urban population
Central Nanaimo UPCC	Nanaimo	2024	General urban population
Fraser			
Surrey-Whalley UPCC	Surrey-North Delta	2018	General metro population
Ridge Meadows UPCC	Ridge Meadows	2019	General metro population
Edmonds UPCC	Burnaby	2019	General metro population
Abbotsford UPCC	Abbotsford	2020	General urban population
Surrey-Newton UPCC	Surrey-North Delta	2020	General metro population
Metrotown UPCC	Burnaby	2022	General metro population
Port Moody UPCC	Fraser Northwest	2022	General metro population
Langley UPCC	Langley	2024	General metro population
Chilliwack UPCC	Chilliwack and Fraser Health Rural	2024	General urban population
Mission UPCC	Mission	2024	General urban population
Vancouver Coastal			
Vancouver City Centre UPCC	Vancouver	2018	General metro population
North Vancouver UPCC	Vancouver	2019	General metro population
REACH UPCC	Vancouver	2020	General metro population

UPCC	PCN Community	Opening Year	Population Served
Northeast UPCC	Vancouver	2021	General metro population
Southeast UPCC	Vancouver	2022	General metro population
Richmond City Centre UPCC	Richmond	2022	General metro population
Richmond East UPCC	Richmond	2024	General metro population
Interior			
Kamloops South Shore Urgent Primary Care and Learning Centre	Thompson	2018	General urban population
Vernon UPCC	Shuswap North Okanagan	2019	General urban population
Kelowna UPCC	Central Okanagan	2019	General urban population
Castlegar UPCC	Kootenay Boundary	2020	General rural population
West Kelowna UPCC	Central Okanagan	2020	General urban population
Penticton UPCC	South Okanagan Similkameen	2021	General urban population
Cranbrook UPCC	East Kootenay	2021	General rural population
Ashcroft UPCC	Interior Rural and Remote	2022	General rural population
Rutland UPCC	Central Okanagan	2023	General urban population
Kamloops North Shore UPCC	Thompson	2023	General urban population
Williams Lake UPCC	Central Interior Rural Division	2025	General rural population
Northern			
Quesnel UPCC	Northern Interior Rural	2018	General urban population
Prince George UPCC	Prince George	2019	General urban population

1.2.2. UPCC Performance Measurement

Since the first UPCC opened in 2018, UPCCs across the province have provided **over 3.4 million patient visits**.[1]

According to health authority reported data, the 19 UPCCs currently providing longitudinal primary care have attached 27,967 patients as of March 31, 2025.[2,10]

Table 3 UPCC Patient Visits and Attachment by Health Authority (From April 1, 2024, to March 31, 2025)

Health Authority	Number of UPCCs	Total Visits	Visits by patients who are unattached	Visits by patients attached outside UPCCs	Visits by patients attached to UPCCs	Total Attachment
Vancouver Island	11	205,878	107,136	45,159	53,583	11,099
Fraser	10	259,994	106,899	117,459	35,636	6,237
Vancouver Coastal	7	174,898	66,008	107,700	1,190	462
Interior	11	224,655	99,234	82,796	42,625	10,169

[10] January 2, 2025, is the most recent reliable attachment data available to the Ministry at this time due to an ongoing transition in the reporting mechanism for attachment data

Northern	2	32,904	28,087	4,817	0	-
Total	**41**	**898,329**	**407,364**	**357,931**	**133,034**	**27,967**

Note: Visit volumes represent all patient visits and not just visits by those patients attached to the UPCCs in a region. Not all UPCCs attach patients.

Analysis is focused on whether there has been an overall increase in UPCC access versus workload expectations. Visits are measured at the site level instead of at the individual FTE level, e.g., the number of visits an individual clinician may provide. Based on provider/staffing capacity across sites, UPCCs were expected to provide a minimum of 700,000 episodic primary care patient visits from April 1, 2024, to March 31, 2025. An episodic primary care visit is when a patient presents for a health concern, where neither the provider nor the patient expects attachment. In the context of UPCCs this means all visits for patients who are either unattached or attached outside of the UPCC. From April 1, 2024, to March 31, 2025, UPCCs across the province provided 765,295 episodic care visits, surpassing the established target.[11]

The visit data for UPCCs demonstrates that while attachment to primary care providers is increasing throughout the province, there are still barriers to accessing care (e.g., scheduling of timely appointments with their primary care provider). As a result, patients who are attached are still accessing urgent and episodic primary care services at UPCCs and Emergency Departments.

UPCCs provided 1,497,444 direct patient-provider encounters from April 1, 2024, to March 31, 2025. Of these encounters, over half (775,885) were provided by RNs.[11] This means that patients accessing care at UPCCs are likely to receive some of their care from a registered nurse and that UPCCs are effectively leveraging optimized scopes of practice across their multi-disciplinary team members to increase access to care.

1.3. Community Health Centres (CHCs)

CHCs under the Primary Care Strategy are community-led and governed primary care centres operated by not-for-profit/co-operative organizations that provide integrated health and community/social services. Key CHC service model attributes include:

- **Addressing the social determinants of health:** CHCs partner with organizations working to improve the health and well-being of a community to provide services that address the social determinants of health.
- **Providing access to high quality primary care for priority populations:** CHCs prioritize attaching populations that are disproportionately impacted by social, structural and ecological inequities and injustices.
- **Demonstrating a commitment to health equity:** CHCs employ a health equity approach, establish processes for identifying populations experiencing health inequities, and engage these populations to inform service planning.
- **Effectively utilizing an interdisciplinary team:** CHCs provide person, family, and community-centred primary care delivered by an interdisciplinary team working to their optimized scope of practice. Compared to other models, CHC teams have relatively large complements of allied health professionals.

[11] Urgent Primary Care Centre (UPCC) Patient Services Report. FY 2024/25 – Period 13 (Feb 28 – Mar 31)

For a summary of CHC funding parameters, see Appendix A.

"Community Health Centre" is a common term used in health services, therefore there are many organizations that utilize the term outside of the Primary Care Strategy. Although there is no central list of CHCs across British Columbia, it is estimated that there are approximately 180 Community Health Centres, of which less than half provide primary care services.

The Ministry funds comprehensive primary health care of 15 CHCs through the Primary Care Strategy. Strategy-Funded CHCs occupy an important space within their PCN communities, as CHCs provide care for priority populations (e.g., populations that have previously experienced barriers to receiving adequate primary care), in addition to addressing the social determinants of health by providing access to social supports. As CHCs are community governed, they are uniquely positioned to increase access to care for hard-to-reach populations in their community.

Table 4 Strategy-Funded CHCs

CHC Name	PCN Community	Opening Year	Population Served
Vancouver Island			
Island Sexual Health	Victoria	2021	- 2SLGBTQIA+ communities, individuals seeking gender-affirming care, people living with HIV, and those at risk of HIV acquisition or other sexual health concerns
Westshore CHC	Western Communities	2022	- People who have experienced inequities in accessing health care due to the social determinants of health, with particular priority focus on mental health and substance use, Indigenous populations, and gender affirming care
Luther Court CHC	Victoria	2022	- Older adults and those living with mental health conditions
Laichwiltach CHC	Campbell River	2025	- Indigenous people in the catchment area, including Urban and Away-From-Home Indigenous people living in Campbell River
Urban Indigenous CHC*	Port Alberni	TBD	- Indigenous and non-Indigenous people residing in the city center, low-income populations, street-entrenched people, those affected by mild to moderate mental health and substance use disorders, and those who may not be comfortable accessing care through existing services
Fraser			
Umbrella CHC	Fraser Northwest	2020	- Immigrants, refugees, and other migrants (including temporary agricultural workers)
Eizabeth Fry Health Centre	Surrey North Delta	2023	- Vulnerable women and children within the Surrey North Delta catchment area and those that are referred or existing clients of EFry Greater Vancouver services and programs across the lower mainland
Roots CHC	Surrey North Delta	2022	- Vulnerable and multi-barriered newcomers and refugees, with special priority for those who have been living in Canada for less than three years - Priority is given to individuals facing language or cultural barriers, lacking MSP, or impacted by social determinants of health. Services are available regardless of geographic location or

CHC Name	PCN Community	Opening Year	Population Served
			existing attachment to a primary care provider, with a focus on residents of Surrey and North Delta
Vancouver Coastal			
RISE CHC	Renfrew Collingwood	2020	- Populations of focus include: newcomers (immigrants), those with mental health challenges. those with substance use challenges, low-income, homeless and/or hard to house, LGBTQ2S+, youth, isolated seniors, Indigenous, sex workers
Bowen Island CHC	North Shore	2024	- All unattached people on Bowen Island. The Bowen Island population is considered to be more complex due to its rurality (e.g., barriers to travel) and lack of ongoing access to primary care
Santé Ouest FCHC	Vancouver	2024	- Francophone people of all ages living in the Lower Mainland
Interior			
Rutland CHC	Central Okanagan	2023	- Target populations include: Indigenous Peoples, newcomers, and women
STEPS CHC*	Thompson-Valley	2025	- Target populations include: women, children, Indigenous, gender-diverse
Lower Columbia CHC*	Kootenay Boundary	TBD	- High-priority groups, including those who are unhoused or precariously housed, frail elderly, individuals with diverse gender identities or sexual orientations, youth with mental health needs, and people living with chronic disease, cancer, or complex care needs—particularly those marginalized by race, age, gender, sexuality, or socioeconomic inequities
Northern			
CINHS	Prince George	2023	- Those who self-identify as Indigenous, including First Nations, Inuit, or Métis; Indigenous moms and babies seeking prenatal or postnatal care; and Indigenous youth in need of health services - Services are also intended for individuals living with or at risk of HIV or HCV, and for those living on or close to the street

**Note: these CHCs are in implementation and are not operational.*

1.3.2. CHC Performance Measurement

All CHCs provide longitudinal care and offer attachment. According to CHC self-reported data, 10 Strategy-Funded CHCs have attached 14,319 patients as of January 2, 2025 .[3,10] There are 10 CHCs who have been onboarded to the reporting process and therefore are included in this attachment figure; the remaining Strategy-Funded CHCs will be included in future attachment data. Work is underway to support CHCs and to address existing challenges in increasing attachment and to continue building their patient panels.

From April 1, 2024, to March 31, 2025, 10 Strategy-Funded CHCs provided 124,454 patient visits for patients from priority populations.[4] Table 5 includes a breakdown of the total CHC patient attachment and visits by health authority.

Table 5 CHC Patient Visits and Attachment by Health Authority (From April 1, 2024, to March 31, 2025)

Health Authority	Number of CHCs	Total Visits	Total Attachment*
Vancouver Island	3	46,038	5,569
Fraser	3	24,294	3,091
Vancouver Coastal	2	23,771	3,567
Interior	1	5,361	823
Northern	1	24,990	1,269
Total	**10**	**124,454**	**14,319**

**Note: Attachment figures are current as of January 2, 2025.*

CHCs provided 138,351 direct patient-provider encounters from April 1, 2024, to March 31, 2025. Of these encounters, over half (75k) were provided by either a registered nurse, allied health professional, or other team-based care provider.[4]

Additional metrics are also being explored for CHCs, in partnership with the BC Association of Community Health Centres (BCACHC) and Strategy-Funded CHCs, to expand current performance metrics beyond patient care volumes. For example, an evidenced-based measure of sociodemographic characteristics[12] is being explored to determine how effectively CHCs are reaching their target populations, to better tailor Quality Improvement activities, and to understand the overall community impact of provided services. The implementation of this tool is being led by BCACHC, with Ministry support. Several CHCs have been selected to trial this new data measure to determine the feasibility of its use and the ability to integrate into Electronic Medical Records (EMRs). This collaboration will lead to better reflection of the full scope of CHCs' contributions to patient and community health.

While CHCs are attaching patients to longitudinal primary care and serving populations that have historically faced barriers to care,[13] they continue to face persistent challenges in meeting patient attachment expectations. As of January 2, 2025, CHCs had achieved an average of 38 percent of their attachment targets; after adjusting for providers hired, progress increases to an estimated 50-60 percent of established targets[14]. There are several contributing factors: most CHCs are not yet fully staffed, some are still in the early stages of operation, and many report caring for highly complex patient panels that require more provider time to meet care needs effectively. This increase in complexity may be due to a higher rate of chronic medical conditions or comorbidities, non-medical factors that impact the patient's health status, or a significant history of unmet care needs. The Ministry is working collaboratively with Strategy-Funded CHCs and BCACHC to better understand these barriers and identify appropriate supports, and attachment rates are expected to increase going forward.

As part of routine performance oversight, the Ministry has engaged with CHCs through the CHC Provincial Reference Group (January 2024 – present) as well as through one-on-one meetings with

[12] Itunuoluwa Adekoya et al., "Screening for poverty and related social determinants to improve knowledge of and links to resources (SPARK): development and cognitive testing of a tool for primary care," *BMC Primary Care* 24 (2023), https://doi.org/10.1186/s12875-023-02173-8

[13] Additional indicators to better understand panel composition are in development

[14] Derived from self-reported CHC Patient Services Period Report FY 2024/25 – Period 10 (Dec 6 – Jan 2), funding targets established in corresponding funding agreements, and the Primary Care Workforce Report FY 2024/25 – Period 10 (Dec 6 – Jan 2)

Strategy-Funded CHCs (May – June 2025). Ongoing input has also been provided by the BC Association of CHCs (BCACHC). More targeted engagement sessions will occur in advance of Report 2 to explore both attachment-related challenges as well as broader operational barriers, and to help inform corresponding investment opportunities under CARGA 1c.

Issues that will be explored further in upcoming engagement sessions include:

- Challenges in meeting the attachment targets outlined in funding agreements
- Opportunities to implement "global" or integrated funding models for CHCs (e.g., providing dedicated funding for social services in addition to existing primary care funding, as CHCs currently lack stable and reliable access to social services funding)
- Health human resource recruitment and retention challenges
- Improved administrative coordination (e.g., through the development of a Shared Services Strategy)
- The role and voice of CHCs within PCNs
- Financial stability for non-Strategy-Funded CHCs

While the initiation of the Primary Care Strategy has brought or expanded team-based care to many communities across BC, there remain barriers that prevent the further implementation of team-based care models and high quality, effective primary care more broadly. Report 2 will delve into these topics in depth, however examples of these obstacles are outlined in Appendix B.

Part 1: Team-Based Care Models Summary

The investment in team-based care is transforming how British Columbians access comprehensive, culturally safe, interdisciplinary primary care services across the province. Implementation targets for PCNs and UPCCs are nearing completion, and other models such as CHCs and FNPCCs are helping to address key system-level gaps.

With these initiatives now largely implemented, the focus continues to shift toward performance measurement and optimization – ensuring that all British Columbians receive high-quality, cost-effective primary care when they need it, close to home.

Part 2: Health Human Resources and Attachment

Part 2 presents broader health human resources and attachment data – covering both team-based care models and the wider family practice landscape. As such, it provides a provincial snapshot of the increase in capacity, access, and attachment to primary care for British Columbians since the launch of the Primary Care Strategy in 2018.

Note: Some data are presented by calendar year while others are presented by fiscal year; this reflects the way that the data is collected and reported in respective provincial databases.

2.1. Primary Care Providers

A wide range of health care professionals work to deliver primary care in British Columbia. Longitudinal primary care is provided by family physicians and nurse practitioners. However, team-

based care comprises many other types of providers, including registered nurses, allied health professionals, pharmacists and Indigenous healers and traditional wellness providers.

This shift toward team-based care is a foundational element of the province's Primary Care Strategy. It is designed to improve access and attachment by enabling multidisciplinary providers to work to their full scope of practice. In turn, this approach helps distribute the workload across the care team, allowing family physicians and nurse practitioners to care for more patients and enhancing the overall comprehensiveness of care.

Family physicians form the backbone of primary care, with over 5,200 working in a longitudinal capacity[7] and nearly 4,300 registered for the LFP payment model.[6] Nurse practitioners have increasingly played a role in primary care, evidenced by a more than doubling in the number since 2017/18.[7]

The number of family physicians and nurse practitioners directly engaged in primary care services are provided by rurality region (Table 6) and health authority (Table 7). These are providers who are considered to be longitudinal primary care providers – those who hold patient panels and provide attachment. Most longitudinal providers – sometimes referred to as the Most Responsible Provider (MRP) – are family physicians, representing almost 90% of providers. Reflecting population trends, the majority of longitudinal providers work in metropolitan or large urban centres.

Table 6 Longitudinal Primary Care Provider Count by Rurality Region (2024/25)

Region[15,16]	Family Physician	Nurse Practitioner
Total Count	**5,292**	**636**
Metropolitan	2,389	283
Large Urban	1,024	117
Medium Urban	685	77
Small Urban	543	80
Rural Hub	319	26
Rural	292	47
Remote	40	6

Table 7 Longitudinal Primary Care Provider Count by Health Authority (2024/25)

Region	Family Physician	Nurse Practitioner
Total Count	**5,292**	**636**

[15] Regions are defined by the following characteristics: metropolitan (pop. centre 500,000+), large urban (pop. centre 100,000 – 499,999), medium urban (pop. centre 30,000 – 99,999), small urban (pop. centre 10,000 – 29,999), rural hub (pop. centre 1,000 – 9,999), rural (Index of remoteness <0.5), remote (Index of remoteness ≥0.5).

[16] Urban-rural classification leverages Statistics Canada geography classifications. The Ministry divides the province into 231 Community Health Service Areas (CHSAs). A CHSA's population dispersion is analyzed; the size of its dominant population centre and the index of remoteness (from Statistics Canada data) are used to classify a CHSA. When the majority of the population lives within a population centre(s), the size of the largest population centre in the CHSA is considered. When the majority of the population does not live within a population centre(s), the index of remoteness is considered. Note that large population centres typically span multiple CHSAs.

Fraser	1,554	161
Interior	963	106
Northern	303	48
Vancouver Coastal	1,478	180
Vancouver Island	994	141

As previously discussed in this Report, the Primary Care Strategy has also targeted recruitment of team-based care resources. These resources are largely employed in Primary Care Initiative sites, including UPCCs, CHCs, NPPCCs, and FNPCCs. Recruitment of other primary care providers funded through the Primary Care Strategy, including nurses, allied health professionals, pharmacists, and Indigenous health resources, are detailed in Table 8.[17] The data in Table 8 is likely an underestimate the total number of nurses and allied health professionals working in primary care settings as the numbers do not include those working in family practice offices via other mechanisms.

Table 8 Recruited Primary Care Staff Funded Through the Primary Care Strategy by Health Authority (as of March 31, 2025)

Region	Nursing*	Allied Health	Pharmacist	Indigenous Health	Administrative Staff
Total FTE**	**693.98**	**533.70**	**58.27**	**79.72**	**324.41**
Fraser	171.92	151.74	20.07	5.00	127.34
Interior	164.48	129.34	7.20	24.24	27.20
Northern	46.57	41.90	4.00	7.23	22.80
Vancouver Coastal	138.03	101.16	14.00	20.35	93.36
Vancouver Island	172.98	109.56	13.00	22.90	53.71

**Nursing includes licensed practical nurses and registered nurses.*

*** FTE = Full Time Equivalent.*

Alongside their clinical teams, administrative staff represent the non-clinical roles within PCNs, UPCCs and other models of care, (e.g., PCN and UPCC Directors and/or Managers, Office managers and Medical Office Assistants, Attachment Coordinators, Project and Change Management staff, etc.). This administrative workforce has been essential for the implementation of the Primary Care Strategy across BC and continues to support the sustainability of ongoing clinical operations.

2.1.1. Growth in Providers Since 2017

Since 2017, all categories of providers have experienced considerable growth, with most notably the number of nurse practitioners more than doubling between fiscal years 2017/18 and 2023/24. Initiatives such as the Longitudinal Family Physician (LFP) payment model and new-to-practice contracts and incentives have contributed to the growth in primary care family physicians in British Columbia. A comprehensive list of recruitment and retention incentives is provided in Appendix C. Additionally, Appendix D highlights the substantial expansion of residency positions at the University of British Columbia's medical school, which has further bolstered the province's primary care workforce. The cumulative effect of these initiatives has been provider growth exceeding

[17] Primary Care Workforce Report. FY 2024/25 – Period 13 (Feb 28, 2025 – Mar 31,2025), retrieved from Ministry of Health, validated Primary Care database

population growth; while BC's population grew by 12% between 2017 and 2023, the number of longitudinal family physicians grew by 18%, nurse practitioners by 120%, registered nurses by 15%, and allied health by 22%.

Total workforce numbers have been presented in this section to facilitate comparisons across years as well as against other provinces. However, some considerations must be made before the discussion of provider growth data. These include:

- Not all providers represented in the following tables are necessarily engaged with primary care; rather, these numbers should be interpreted as the size and growth of the overall workforce. For example:
    - Not all family physicians provide longitudinal care and may provide episodic care or practice in other settings (e.g., as hospitalists, in emergency medicine, etc.).
    - Most registered nurses and allied health professionals are employed in non-primary care settings such as acute care and long-term care.
- Detailed breakdowns of time spent providing primary care in contrast to other services is not operationally feasible to collect from health care providers and thus is not available.
- Provider's capacity to attach and provide additional access to the system by way of patient visits is dependent on individual providers' practice patterns. The complexity of a provider's patients and individual and/or clinic choices on hours of work will vary from provider to provider.
- Pharmacist involvement in primary care began primarily with the Minor Ailments and Contraceptive Services (MACS) initiative, launched in July 2023, whereby pharmacists who have completed the necessary educational requirements can directly diagnose and prescribe medication for 21 eligible conditions and dispense contraceptives.
- Headcount data for physicians and midwives are reported on a fiscal year basis, while nursing and allied health professional data are reported on a calendar year basis. The following tables are segregated for accuracy.

Table 9 Active Headcount of Providers Since 2017

Provider Type (Fiscal Year)	**2017/18**	**2023/24**	**% growth since 2017/18**
Family Physician - Longitudinal + Other Settings[18]	6,384	7,555	18%
Family Physician - Longitudinal Only[19]	4,283	5,050	18%
Nurse Practitioner - Longitudinal Only[19]	189	575	204%
Midwife[18]	312	397	27%

Provider Type (Calendar Year)	**2017**	**2023**	**% growth since 2017**
Nurse Practitioner - Longitudinal + Other Settings[20]	522	1,151	120%

[18] Ministry of Health. Report ID: 2857 Version: V10. Health Human Resources, Physicians and Midwives. Last accessed on 2025-06-25
[19] Ministry of Health. Retrieved from Medical Services Plan, 2022/23 and Provincial Health System, 2023/24
[20] Ministry of Health. Report ID: 3850 Version: V2. Health Human Resources, Nurse Practitioners. Last accessed on 6/25/2025

Registered Nurse* [21]	36,220	41,634	15%
Allied Health* [21]	25,080	30,588	22%
Pharmacist*** [21]	-	4,259	N/A

Registered nurse data also includes licensed practical nurses.

***Allied health professionals do not include pharmacists.*

****Pharmacist data only includes pharmacists participating in the MACS program.*

Using publicly available population data from BC Stats PEOPLE population estimates, per capita calculations of provider headcount can be derived. These statistics place provider growth in the context of population growth. Across all categories of providers, the growth in providers has exceeded population growth.

Table 10 Provider Headcount per 100,000 Population Since 2017/18

Provider Type	2017/18	2023/24	% growth since 2017/18
Family Physician – Longitudinal + Other Settings	129.4	136.9	5.8%
Family Physician - Longitudinal Only	86.8	91.5	5.4%
Nurse Practitioner – Longitudinal + Other Settings	10.6	20.9	97.1%
Nurse Practitioner – Longitudinal Only	3.8	10.4	172.0%
Registered Nurse	734.1	754.4	2.8%
Midwife	6.3	7.2	13.8%
Allied Health	508.3	554.2	9.0%
Pharmacist	-	77.2	N/A

2.1.2. Comparative Data from Other Provinces

Understanding how British Columbia compares to other provinces is an important aspect of assessing primary care in a national context. Interprovincial migration of medical professionals is a key aspect of not only health human resource strategies but also understanding what is – and isn't – working in other provinces. BC's implementation of the LFP payment model, for example, can be viewed in the context of attractiveness of practicing family medicine in BC, which has historically been a net importer of family physicians from the rest of Canada. Compared to other provinces, BC has a higher per-capita complement of family physicians.

The Canadian Institute for Health Information (CIHI) is the only source of pan-Canadian comparative numbers. The methodology used by CIHI, including population counts and provider counts, may differ from other data presented elsewhere in this report, which is sourced from internal Ministry data systems. CIHI provider counts are available on a calendar year basis, as opposed to fiscal year reporting periods for information presented above.

Presented below are BC numbers alongside Alberta, Manitoba, and Saskatchewan, as well as Canada's two largest provinces, Quebec and Ontario. Note that Manitoba has not reported nursing data to CIHI since 2018.

[21] Ministry of Health. Report ID: 3455. Health Human Resources, Allied Health and Nursing. Last accessed on 6/25/2025

Table 11 Providers per 100,000 Population (BC, Alberta, Manitoba, and Ontario)

Province	2017	2018	2019	2020	2021	2022	2023
Family Physicians[22]							
BC	129.1	133.9	130.8	133.0	136.2	140.5	138.0
Alberta	130.4	127.9	128.6	124.7	122.4	120.1	116.1
Sask.	115.0	114.1	117.1	120.5	116.5	119.3	118.4
Manitoba	111.0	110.0	108.8	108.3	108.1	111.1	107.4
Ontario	114.3	117.4	115.7	115.1	116.0	115.0	110.1
Quebec	123.0	122.7	127.1	129.8	132.2	132.0	130.1
Nurse Practitioners[23]							
BC	6.3	6.8	8.2	9.4	11.1	12.5	14.4
Alberta	10.0	11.1	12.1	12.4	12.9	12.8	14.1
Sask.	16.4	16.7	19.2	16.6	17.7	19.8	20.4
Manitoba	11.5	12.3	-	-	-	-	-
Ontario	19.8	20.6	21.9	22.6	23.9	25.1	26.9
Quebec	5.1	5.7	6.1	7.6	10.6	13.0	15.4
Registered Nurses[23]							
BC	645.5	645.1	615.8	639.7	670.9	665.3	674.0
Alberta	738.6	734.8	735.9	731.4	722.3	706.8	694.1
Sask.	812.8	814.1	833.3	822.1	835.4	844.9	858.0
Manitoba	804.1	752.0	-	-	-	-	-
Ontario	613.0	605.5	607.6	602.7	607.2	600.2	610.5
Quebec	728.0	733.1	724.2	720.7	744.9	743.3	759.2

2.2. Attachment Progress Since 2023

Since the launch of the Primary Care Strategy in 2018, over 750,000 British Columbians have become newly attached to a primary care provider.[9] Of note, the pace of attachment has significantly increased beginning in fiscal year 2023/24, when the LFP payment model was implemented and the Provincial Attachment System was launched. In July of 2023, the Health Connect Registry was rolled out as a province-wide program (previously, it was available in a limited number of PCNs).

Over 70 provincial attachment coordinators, working directly within PCNs, utilize the Health Connect Registry with oversight from HealthLink BC to connect British Columbians to a family physician or nurse practitioner. Attachment coordinators prioritize attachment based on a patient's complexity, recent health changes and status, and time waiting on the Health Connect Registry (or waitlists that were previously held in community or clinic and have been transitioned to the Registry). Primary care providers who indicate capacity to attach new patients through the Provincial Attachment System are digitally provided with a combination of high to low complexity Health Connect Registry registrants to ensure a balanced panel.

[22] Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2023 — Historical Data. Ottawa, ON: CIHI; 2024

[23] Canadian Institute for Health Information. Nursing in Canada, 2023 — Data Tables. Ottawa, ON: CIHI; 2024

Along with initiatives, such as the New to Practice contracts for new family physicians and nurse practitioners, these efforts have led to 229,876 people becoming newly attached in fiscal year 2024/25. Currently, an average of around 4,400 new attachments are occurring on a weekly basis.

Table 12 Total Volume of Attachments (Fiscal year 2022/23 to 2025/26)

Fiscal year	2022/23	2023/24	2024/25	2025/26*	All Years
Attachments	148,363	218,679	229,876	50,719	**783,580**

*Note: 2025/26 includes data from April 2025 to June 2025. All years includes data from 2018/19 to 2025/26.

2.2.1. Attachment Rates Throughout BC

The Provincial Attachment System allows the Ministry to, for the first time ever, understand who is attached to which provider, and where. Previous measures of attachment that were available could only measure *new* attachments, but did not allow for a system-wide view of existing attachment relationships.

Table 13 breaks out attachment statistics at a PCN community level across the province. The percentages often total more than 100% as some patients are attached *and* seeking a new provider through the Health Connect Registry.

- Patients Attached is the proportion of a region's population that is reported as being on a provider's panel in the Provincial Attachment System. In a small number of cases, a patient is reported on more than one provider's panel; these patients are only counted once.
- Patients Seeking Provider is the proportion of a region's population that is currently on the Health Connect Registry. A patient may be on the waitlist while already being on a panel; this patient is counted in the Patients Attached column *and* the Patients Seeking Provider column,
- Population Remaining is the proportion of a region's population that is neither on a panel nor on the Health Connect Registry.

Many primary care investments are still in the process of reaching their full staffing levels and attachment targets (e.g., newly implemented initiatives that are actively building their care teams and patient panels). Further, adoption of the Provincial Attachment System as the centralized attachment mechanism and the system's role in panel management and health capacity planning continues. The shift from individual practice or provider attachment solutions to a centralized, equitable approach for all patients no matter where in British Columbia is a substantial shift and work continues to support providers, clinics and staff to fully realize the Provincial Attachment System. This includes down tooling pre-existing and local administrative processes that have now been streamlined into the provincial solution and supported by HealthLink BC and local PCN attachment coordinators. As a result, patient attachment is expected to continue growing as these initiatives reach full staffing and operational capacity. Additionally, as the Provincial Attachment System matures, these data will continue to increase in accuracy.

The Health Connect Registry provides information about which people are explicitly seeking attachment. Not all patients who are unattached to a provider are seeking an attachment relationship with a provider. However, relative differences in regional representation on the Registry demonstrate that further work may be needed to establish awareness of and trust in the solution as the mechanism for attachment in BC. Additionally, ongoing human health resource (HHR)

shortages continue to impact the province's ability to expand longitudinal care to more individuals. To address this, the Ministry is prioritizing its HHR Workforce Strategy – working in close coordination to recruit and retain more primary care providers and staff across BC.

. Table 13 Attachment by PCN Community within the Provincial Attachment System (as of June 2025)[9]

PCN Community*	% of patients attached	% of patients seeking provider	% of population remaining
Interior	**76.5%**	**8.3%**	**18.2%**
Central Interior Rural Division	67.5%	9.9%	25.6%
Central Okanagan	78.9%	5.3%	17.9%
East Kootenay	79.3%	7.2%	15.8%
Interior Rural and Remote	70.3%	4.2%	28.3%
Kootenay Boundary	78.1%	8.5%	16.0%
Revelstoke	80.5%	0.0%	19.4%
Shuswap North Okanagan	81.0%	4.1%	16.6%
South Okanagan Similkameen	81.8%	8.3%	13.4%
Thompson	64.6%	20.0%	22.6%
Fraser	**77.0%**	**5.0%**	**20.1%**
Abbotsford	78.5%	5.5%	18.6%
Burnaby	74.0%	6.2%	21.9%
Chilliwack and Fraser Health Rural	81.7%	5.7%	15.6%
Fraser Northwest	79.3%	6.2%	17.4%
Langley	81.8%	2.8%	16.9%
Mission	85.0%	2.3%	14.1%
Ridge Meadows	85.7%	2.9%	13.3%
South Delta	84.8%	5.0%	13.2%
Surrey-North Delta	70.3%	5.4%	26.2%
White Rock South Surrey	82.2%	3.3%	16.1%
Vancouver Coastal	**76.0%**	**4.2%**	**21.4%**
Bella Bella	77.1%	0.0%	22.9%
Bella Coola	78.6%	0.2%	21.3%
North Shore	82.6%	1.7%	16.7%
Pemberton	88.7%	0.1%	11.3%
qathet	83.4%	2.3%	15.5%
Richmond	80.3%	3.6%	17.7%
Sea to Sky	76.4%	1.4%	22.8%
Sunshine Coast	75.5%	11.6%	17.0%
Vancouver	72.4%	5.1%	24.3%
Vancouver Island	**73.8%**	**13.3%**	**17.2%**
Campbell River	79.1%	6.8%	17.5%
Comox Valley	85.9%	8.4%	11.3%
Cowichan	83.1%	7.3%	12.7%
Gabriola	80.6%	17.7%	9.8%
Long Beach	54.1%	0.9%	45.3%
Nanaimo	76.5%	11.3%	16.2%
North Island	72.0%	0.3%	27.9%

PCN Community*	% of patients attached	% of patients seeking provider	% of population remaining
Oceanside	78.8%	16.8%	12.3%
Outer Southern Gulf Islands	78.9%	7.7%	16.5%
Port Alberni	77.7%	6.0%	18.3%
Saanich Peninsula	78.5%	12.0%	13.2%
Salt Spring Island	73.0%	9.4%	20.0%
Victoria	62.5%	20.1%	22.3%
Western Communities	69.0%	17.3%	17.8%
Northern	**73.1%**	**6.5%**	**22.9%**
Bulkley Valley Witset	82.9%	5.5%	13.8%
Coast Mountain	69.9%	8.4%	24.0%
Fort Nelson	62.4%	0.1%	37.5%
Haida Gwaii	56.9%	0.4%	42.9%
Hazelton	67.7%	1.7%	31.1%
Kitimat-Haisla	75.7%	4.4%	21.2%
Nisga'a	44.2%	0.3%	55.6%
North Peace	80.7%	2.6%	17.6%
Northern Interior Rural	77.1%	5.3%	21.0%
Prince George	74.4%	7.3%	20.6%
Prince Rupert-Coast Ts'msyen	62.7%	14.6%	27.0%
South Peace	58.5%	10.3%	35.6%
British Columbia	**76.0%**	**6.8%**	**19.8%**

**Note: A PCN Community sometimes includes multiple smaller PCNs within it (for regions that cover larger geographic areas). As such, there are 54 PCN Communities, comprising of a total of 104 PCNs within various stages of implementation.*

Part 2: Health Human Resources and Attachment Summary

Since the launch of the Primary Care Strategy in 2018, there has been significant progress in expanding both health human resources and patient attachment. While there is more work to do, particularly in rural/remote and underserved areas, the progress to date is encouraging. Additionally, many primary care investments are still in the process of reaching their full staffing levels and attachment targets (e.g., newly implemented initiatives that are actively building their care teams and patient panels). As such, attachment and access are expected to continue to increase in 2025/26 and beyond.

Part 3: Next Steps and a Path Forward

Report 1 provides a foundational, data-driven overview of system-level investments in BC's primary care system since the launch of the Primary Care Strategy. It reflects the system's shift toward team-based care, including models specifically designed to address key system-level gaps. It also demonstrates significant actions taken to expand primary care capacity, access, and attachment for British Columbians.

Importantly, Report 1 represents an initial step and is not intended to be a comprehensive assessment of the entire primary care system. Rather, it sets the stage for more in-depth analysis and continued system-wide dialogue.

Significant investments have underpinned this work, with the Ministry allocating more than $579M to support Primary Care Strategy implementation in 2024/25 and committing over $672M for 2025/26.

Looking ahead, Report 2 will build on the foundation established in this report. It will include expanded engagement with system leaders, health organizations, and partners; deeper performance analysis; and the identification of specific actionable commitments to advance the broader goals of CARGA. Particular attention will be given to the CHC sector, including better defining existing and emerging challenges as well as proposing a path forward for the CHC model of care and corresponding CARGA commitments, with the goal of better supporting both Strategy- and non-Strategy-Funded CHCs.

Finally, Report 2 will explore indirect and systemic barriers affecting the expansion and effectiveness of team-based care models more broadly (e.g., beyond CHCs). These insights will help to shape future policy and funding approaches to further strengthen team-based care as a cornerstone of BC's primary care system.

Appendix

Appendix A Funding Parameters for Strategy-Funded CHCs

Funding parameters were developed to standardize the CHC model across the province, while allowing for flexibility in the model design to accommodate the unique needs of the population and community served.

- **Attachment:** All Strategy-Funded CHCs are expected to prioritize the attachment of populations who have historically experienced barriers to accessing high quality primary care. CHC attachment targets are adjusted lower to account for the assumed patient complexity. For example, due to increased rate of chronic medical conditions or comorbidities, non-medical factors that impact health status, or a significant history of unmet care needs.

- **Team Based Care Resources:** Strategy-Funded CHCs employ an interdisciplinary team of primary care providers to co-locate services, thus increasing access and reducing barriers to comprehensive care.

- **Overhead Funding**: Strategy-Funded CHCs are provided with overhead funding as part of their service model to provide for non-medical costs and ensure that CHCs can focus on providing high quality of care. Overhead funding is proportional to the complement of primary care providers within a team. Additional considerations include whether the clinic is operating in a metropolitan or urban/rural location.

- **Governance:** Strategy-Funded CHCs are operated by registered not-for-profit or co-operative societies as per the Society Act. CHCs are community governed and must have a representative community-elected board of directors or an equivalent governance system, to ensure they are responsive to the health needs of their community. This governance structure must invite First Nations and Indigenous community members to join in the decision-making process.

- **Change Management and Start-Up Costs:** The Ministry of Health and Regional Health Authorities support not-for-profit/co-operative societies in the implementation of CHCs by providing operational expertise, change management funding, and one-time start-up tenant improvement and equipment funding (determined on a case-by-case basis).

Appendix B Indirect Obstacles Impacting Expansion of Primary Care Delivery Models

- Lack of Electronic Medical Record (EMR) standardization and integration.
- Cost of living and housing availability.
- Inflationary pressures on residential and commercial real estate impacts where primary care providers open and sustain practices.
- Lack of job opportunities for spouses or partners of health care providers and access to daycare spaces or schooling for children in rural areas.
- Scope of practice complexity making it difficult for medical professional associations to address and endorse primary care reform.
- Competing work environments with differing employers can result in unclear overall governance.
- Gaps in technology and infrastructure in rural and remote areas.
- Demand for services outpacing health human resourcing, driven by an aging population, a growing population, and concurrent public health emergencies of COVID-19 and the toxic drug crisis.[24]
- The availability of other health services in rural and remote areas to ensure coordination of care.

Appendix C Current Recruitment and Incentive Programs

- **Indigenous Primary Care Incentives Program pilot:** A new incentive program to increase primary care availability and support equitable access for Indigenous Peoples through recruitment and retention of longitudinal and culturally safe family physicians and nurse practitioners. The program is being proposed as a three-year pilot and is available by invitation to a total of twenty-four clinics. This includes nine First Nation owned and operated clinics across five Nations and up to 15 FNPCCs.

- **New to Practice (NTP) Family Physician Incentives Program:** Introduced in June 2022, this program offers newly graduated and early career family physicians a two-year, hours-based contract to help them establish community based longitudinal primary care practices. This initiative aims to support recruitment by offering a steady income and incentives while physicians onboard patients and grow their patient panel. This program was recently renewed until September 30th, 2025.

- **Practice Ready Assessment – British Columbia (PRA-BC):** PRA-BC is an assessment program for internationally trained family physicians who have completed residencies in Family Medicine outside of Canada. This program has increased seats from 32 to 96 seats as of March 2024 allowing an alternative pathway to licensure in BC.

[24] Ministry of Health. BC's Primary Care System. Retrieved from: https://www2.gov.bc.ca/gov/content/health/accessing-health-care/bcs-primary-care-system. Last accessed on 6/27/2025.

- **Rural Retention Program:** Annual retention benefits are paid to physicians working in eligible communities covered under the Rural Practice Subsidiary Agreement. The goal of the program is to enhance the supply and stability of physicians in isolated communities.

- **Rural Recruitment Incentive Fund:** Under the subsidiary agreement, physicians who are recruited to fill current or pending vacancies in eligible rural communities can receive an incentive from $5,000 - $20,000.

Appendix D Resident Matching for Family Physicians in 2024/25

Between 2017 and 2024, the Ministry directed funding to significantly increase the number of entry-level residency positions at the University of British Columbia (UBC) medical school from 170 to 204 (~20% increase).[8]

As of 2024, the UBC Family Medicine program is the single largest program in Canada offering 204 entry-level positions in the national residency match (CaRMS). The total number of Family Medicine positions is behind only Ontario and Quebec, which have multiple medical schools.[25]

Table 14 Entry-level Family Medicine Residency Positions in Canada (2024)

Province	Number of Medical Schools	Family Medicine Positions
Ontario	6	560
Quebec	4	528
British Columbia	**1**	**204**
Alberta	2	159
Nova Scotia	1	84
Manitoba	1	71
Saskatchewan	1	57
Newfoundland	1	39
Total Family Medicine positions in Canada (2024)	**17**	**1,702**

The UBC Family Medicine program continues to be highly sought after among applicants across Canada. In 2024, all 204 entry-level residency positions were successfully filled after the national residency match. BC will also be opening a second medical school at Simon Fraser University, with a projected opening in 2026.

[25] Canadian Resident Matching Service. (2024, October). Table 8: Number of quota by school of residency https://www.carms.ca/wp-content/uploads/2024/10/2024_r1_tbl8e.pdf. Last accessed June 4, 2025

Appendix E CARGA Report 1 Glossary of Terms

Allied Health: Members of the allied health workforce deliver, support, or inform direct patient care and have completed occupation-specific education or training. For examples of allied health professions, see the Provincial Allied Health Definition (Provincial Allied Health Definition, MOH, 2022).

Attachment: The documented existence of a clear ongoing care relationship between a patient and a most responsible provider, or a team of providers, such as in a family practice or health authority primary care clinic.

Community Health Service Area (CHSA): The CHSA is the smallest geographical area in B.C.'s health boundary classification, covering all land area in the province. CHSAs were developed through extensive consultation and were introduced to provide a means to better understand health needs and service provision at a community level (Health Sector Information, Analysis and Reporting Division, MOH, 2024).

Comprehensive Primary Care: A full-range of primary care services including clinical screening, diagnostic testing and treatment are provided through different clinical settings, such as community-based clinics, virtual care services, mobile outreach, long-term care facilities and in-patient care facilities within the PCN (Comprehensive Primary Care Services, MOH, 2024).

Cultural Humility: A life-long process of self-reflection and self-critique to understand personal and systemic biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience. Undertaking cultural humility ensures Indigenous Peoples are partners in the choices that impact them throughout their care (In Plain Sight: Addressing Indigenous-specific racism and discrimination in BC health care, 2020).

Culturally Safe Care: Providing care based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care (FNHA, Office of Indigenous Health, 2020).

Episodic Primary Care Visit: When a patient presents for a health concern, where neither the provider nor the patient expects attachment.

Health Inequities: Unfair differences in health status and health outcomes between population groups due to social factors and structures shaping access to health care and other health-promoting resources. These structures include, but are not limited to, social exclusion based on race, ethnicity, sex, age, sexual orientation, gender identity, language and cultural identity, and other socio-demographic factors; and access to health care barriers informed by preventable social factors.

Longitudinal Primary Care: The relational continuity between patients and their Most Responsible Provider (MRP) or a team regardless of the presence or absence of particular problems or illnesses.

Most Responsible Provider (MRP): Family physicians or nurse practitioners, who attach patients and provide longitudinal care. The MRP has overall responsibility for directing, coordinating care and management of patients.

Optimized Scope of Practice: An approach to team design where the most effective complement of professional roles is determined by the relative competencies of all health care providers on the team.

Person- and Family-Centered Care (Individuals and Families): The practice of partnering with individuals, families, volunteers and caregivers across all levels of the health care system to empower all parties to be genuine partners in their health, wellness, and care, at the level they choose.

Preventive Care: The application of interventions to mitigate health concerns and enhance the health and wellbeing of patients (Comprehensive Primary Care Services, MOH, 2024).

Primary Care Network (PCN): A PCN is a clinical network of local primary care service providers located in a geographical area, with family practice as the foundation. A PCN is enabled by a partnership between a local division of family practice, their regional health authority, local First Nations, and other community partners. In a PCN, physicians, NPs, nurses, allied health professionals, health authority service providers, local First Nations, and community organizations work together to provide all the primary care services a local population.

Primary Care Provider: Primary care providers are family physicians and nurse practitioners, who attach patients and provide longitudinal care in team-based settings that can include nurses, traditional wellness providers, midwives and allied health professionals.

Priority Populations: Those who would benefit most from public health program and services, and in which public interventions may have a significant impact at the population level. These individuals are at a higher risk of adverse health outcomes, may experience an increased burden of disease, or face ongoing health inequalities and access barriers to public health services. These populations may include: Indigenous People; people with perinatal and newborn care needs, children; older adults; people with disabilities; individuals who need chronic care or end-of-life care; 2SLGBTQIA+ communities; people living on low income; racialized communities (such as Black and South Asian); refugees; other newcomers to Canada who face barriers to public health services due to language or socioeconomic status; and other populations disproportionately impacted by social, structural and ecological inequities and injustices.

Provincial Attachment System: A digitally enabled system with a patient portal designed to connect patients to primary care providers in their community in a coordinated and seamless way as well as a provider portal designed to help the Ministry and health-care planners better understand what primary care services are available, attachment progress and capacity throughout B.C. to inform effective planning, and provide better data for primary care provider compensation models that rely on attachment numbers (Provincial Attachment System Resources and Supports for Providers, MOH, 2023).

Relational Care: Referring to holistic, primary health care that uses Indigenous cultural perspectives based on a variety of determinants of health, which may include, trust, wellbeing, kinship, belonging, or acts related to these concepts of wellbeing. This definition may vary amongst cultures.

Scope of Practice: The activities based on professional regulations that a health care provider is educated and authorized by the employer to perform if they have the competence.

Service: A clinical service provided in a patient encounter.

Social Determinants of Health: A specific group of social and economic factors within the broader determinants of health. These relate to an individual's place in society, such as income, education or employment. Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, 2SLGBTQIA+and Black Canadians (Social Determinants of Health and Health Inequalities, Government of Canada, 2024).

Team-based Care: Multiple health care practitioners from different professional backgrounds work together with patients/clients, families, caregivers, and communities to deliver comprehensive health care services as integrated primary care teams across care settings. Effective teamwork is a critical enabler of safe, high-quality care and supports a patient's ongoing relationship with their primary care provider.

Traditional Wellness Provider: Elders, Traditional Healers/Knowledge Keepers, Traditional Food Advisors and others recognized by their community for providing traditional health practices, approaches, knowledge, and beliefs rooted in Indigenous healing and wellness (British Columbia Cultural Safety and Humility Standard, Health Standards Organization, 2022).

Urgent and Primary Care Centres (UPCC): A flexible resource to meet both the urgent unplanned and ongoing planned primary care needs of people in communities across the province. UPCCs fulfill service gaps in select urban and metro communities and are a full-service facility with team-based care to provide urgent, non-emergency primary care to people who need medical attention within 12-24 hours. UPCCs also provide temporary and/or ongoing attachment to patients who do not currently have a regular primary care provider, and then work to attach them to either to the UPCC or to permanent providers as capacity opens within a broader Primary Care Network (Urgent and Primary Care Centres policy, MOH, 2020).

Urgent Primary Care: Primary care for injuries and illnesses that should be seen by a primary health care provider within 12 to 24 hours but do not require the level of service or expertise found in an emergency department (Urgent and Primary Care Centres policy, MOH, 2019).

Virtual Care: Any interaction between patients and registrants, occurring remotely, using any mode of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care.

Visit: An occurrence of a patient visiting a clinic. There may be one or more encounters and services during a single visit. A visit is a measure of patient volumes.