

**OurCare | NosSoins**

# **British Columbia Priorities Panel on Primary Care:**

**New perspectives  
and possibilities for  
primary care in Canada**

***A report written by  
members of the public***

**September 2023**

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# Chair's Note



**Richard Johnson**  
OurCare BC Panel Chair

**This report is the outcome of a dedicated and collaborative process involving 31 British Columbians who collectively invested almost 1000 hours of their time and energy over three months towards addressing the critical challenges facing our province's primary care system. The results of their hard work include 25 clear, actionable recommendations that will transform the way we think about and deliver primary care in BC and beyond.**

The OurCare British Columbia Priorities Panel on Primary Care brought together people and perspectives that represent our great province at large, from rural regions to big cities, from all ages and backgrounds, and from a wide range of experiences with respect to primary care.

A Priorities Panel fosters an environment where meaningful dialogue can take place among citizens. Working together, they can make sense of complex issues and find common ground on issues of public concern. This inclusive method of learning and deliberation not only enriches the quality of the panel's

recommendations but also fosters a sense of shared responsibility for change and empowers citizens to become more involved in shaping the policies that affect their lives.

Policy makers, health care leaders, and the public will find in this report a blueprint for making primary care more accessible, equitable, and sustainable; for leveraging innovations like team-based care, virtual care, and new technologies; and for overcoming the inefficiencies, biases, and entrenched practices that are standing in the way of achieving a truly world-class public health care system.

I appreciate and applaud the 31 British Columbians who lent their time and their passion to this work; the entire team of facilitators, guest speakers and other partners who supported the panelists along the way; and our funders and stakeholders for their critical contributions to the success of the OurCare initiative.

Sincerely,

A handwritten signature in black ink, appearing to read 'Richard Johnson'.

Richard Johnson  
OurCare BC Panel Chair

# What Policy Makers Should Know



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**Primary care is the bedrock of our health care system: the solid foundation that everything else needs to hold it up. Yet that bedrock has been eroded over many years, culminating in the health care crisis we all know to be true today: 6.5 million Canadians lack access to a family physician or nurse practitioner, the clinicians who provide comprehensive and coordinated care to patients over the course of their lives. The erosion of family medicine has been fuelled by a lack of thoughtful investment in both the family physician workforce and their workplaces, including crucial infrastructure and the teams needed to support high quality care.**

Without access to a primary care practitioner, patients struggle to address their new health problems, manage chronic conditions, and access other doctors and health services. They also don't get the benefits of preventative care that could keep them healthy long-term.

We need to change how we structure and support our primary care system. But how?

In the course of our work as physicians and researchers in primary care transformation and reform, we often work closely with other physicians, policy makers, administrators, and researchers to make changes to the system so we can better care for patients. But it's rare that we get the opportunity to hear directly from patients about how to design these changes.

Over the last 12 months, OurCare has sought out the voices of the public to better understand their needs and perspectives around health care. This report summarizes the recommendations from 31 members of the public who live in British Columbia — people from across the province, with diverse demographics, life experiences, and interactions with our existing health care system. These panelists spent nearly 30 hours together learning about



primary care from some of the top experts in the field and deliberating with each other to come to consensus around recommendations for a better system. They have identified a set of values that they feel should be our “North Star” in primary care, and their recommendations chart a path that, if followed, will serve British Columbians well into the future.

### **What do BC citizens value most?**

In a province where nearly 30 percent of patients don’t have access to a family physician or nurse practitioner, the citizen panelists feel that accessibility is the most important issue to address. Every British Columbian needs a family physician or care team, and this should be a key priority.

The panelists identified that the care a person receives in BC should not differ depending on where they live, their income, what language they speak, and other factors. They feel that steps to address equity in care go hand-in-hand with access.

There is also a focus on preventative health. This includes targeted investments in social determinants of health, mental health care, social services, and housing, since these are important foundations of a healthy population. It also means prioritizing wellness care — not just sickness care — to prevent problems before they occur.

Finally, the citizen panelists feel that clear and transparent accountability structures are required to ensure that health care investments have their intended effects.

### **How should the system adapt?**

One of the most important ways in which BC citizens believe that primary care can be improved is through the reorganization of how care is provided. Citizens feel that a transition toward health care teams will be the key to improving access to primary care across urban and rural communities. They feel that primary care should be organized similarly to the public school system, with catchment areas that guarantee access to care.

They specifically recommend investing in Community Health Centres (CHCs), which are community-governed, multidisciplinary teams of practitioners that include family doctors, nurses, social workers, and other health professionals who work together in a coordinated fashion to provide care to patients in a model consistent with the “Patient Medical Home.”

To promote equity, they feel that CHC development should be prioritized in remote, Indigenous, and low-income communities. Other recommendations to improve equity include expanding medicare coverage to include, for example, pharmaceuticals, dentistry,

and physiotherapy, as well as introducing patient advocates who can assist vulnerable patients in navigating the health care system and ensure that no one “falls through the cracks.”

To further support the patient journey, citizen panelists advocate for improved access to electronic medical records (EMRs) to facilitate improved continuity and efficiency of patient care. They feel this could be done most logically through the establishment of a central medical data platform for clinicians and patients that would provide province-wide access to records regardless of the database software used in any given location.

The citizen panelists strongly believe that patients want to better understand health care issues and provide ongoing feedback. They feel that targeted education for the public around health care issues will support the development of an informed citizenry, and that there will be value in the establishment of a provincial patient advisory group that can provide feedback to policy makers in a structured and consistent way.

Finally, there are two strong overarching policy recommendations. The first is the recommendation that national and local governments adopt the World Health Organization’s “Health in all Policies” approach to shape public policy initiatives across all sectors. There is also a call for greater transparency in how health care dollars are spent, coupled

with careful evaluation of primary care initiatives to measure their impact and outcomes. They feel that evaluation should be independent, and that efforts should be made to quickly spread and scale effective programs and community-level interventions.

On June 25, 2023, the OurCare British Columbia panelists presented their recommendations for a better system to Ted Patterson, Assistant Deputy Minister of Primary Care for the Ministry of Health, Bonita Zarrillo, MP for Port Moody-Coquitlam, and other key system leaders. The values and recommendations they articulated were inspiring for all of those in the room.

As physicians, health system administrators, and policy makers, it is rare to have the opportunity to hear from people who come from all walks of life and all corners of our province about some of the most important questions in health care. When we do have that opportunity, it behooves us to listen and work to thoughtfully implement their insights.



**Dr. Goldis Mitra**  
*OurCare British Columbia Lead*



**Dr. Tara Kiran**  
*OurCare Principal Investigator*



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# British Columbia Priorities Panel

## At-a-Glance

The OurCare British Columbia Priorities Panel brought together 31 BC residents, randomly selected to roughly match the province's demographics with emphasis on underserved communities. They spent approximately 30 hours learning from experts and deliberating together before making recommendations on what a better primary care system should look like. OurCare is also conducting Priorities Panels in Ontario, Quebec, Nova Scotia, and Manitoba. Reports are written by members of the public. For more information, visit [OurCare.ca/PrioritiesPanels](https://OurCare.ca/PrioritiesPanels).

### Recommendation Highlights:

31 members  
19 speakers  
29 program hours  
25 recommendations

#### Members' Values

- Accessible
- Equitable
- Prevention-focused
- Accountable
- Sustainable
- Person-centred
- Universal

#### Accessible primary care for all British Columbians

- Foster, set-up, and fund Community Health Centres (CHCs) in every community to support timely access to primary care, including physicians and team-based care
- Ensure more CHCs in rural, remote, Indigenous and low-income communities
- Legislate zero out-of-pocket costs on expenses such as transport and meals when accessing primary care
- Fund and implement infrastructure in rural communities to support access to virtual care

#### Primary care system infrastructure

- Assign each resident to a catchment area from where they can select their primary care practitioner or care team similar to how the public school system works
- Refocus the health system to prioritize relational continuity through all stages of life
- Expand primary care coverage, subsidization, and teams to include holistic care, including but not limited to pharmaceuticals, dentistry, physical therapy and mental health services

#### Technology and information system infrastructure

- Establish a central medical data platform for clinicians and patients to access electronic medical records
- Train and support patients in the technological aspects of accessing primary care, including virtual care
- Offer flexible modes of care including, at minimum, in-clinic, video, phone, and secure messaging. Virtual care should complement, not replace, in-person care

## The problems we want solved

Human resource strain • Archaic and fragmented information systems • Lack of equitable access • Continuity of care deprioritized • Absence of systemic patient power • Politics and bureaucracy prevent transformation

# Recommendation Highlights (cont'd):

## Funding and resource allocation

- Adopt the World Health Organization's "Health in all Policies" to shape policy and disbursement of resources
- Ensure more resources go to communities in higher need
- Increase the number of primary care clinicians, for example, by reducing licensing barriers for clinicians trained out-of-province and expanding the use of professionals under physician supervision
- Commission independent, third-party monitoring and evaluation of resources expended on primary care initiatives to measure impacts and outcomes

## Political will and patient advocacy

- Establish a Patient Advocacy Organization (PAO) that supports consultation on provincial legislation, champions transparency, and ensures accountability
- Implement a comprehensive Primary Health Care Charter to define and clarify the rights and expectations of patients
- Implement and fully fund the Patient Medical Home (2019) and establish Goals and Standards for Primary Care

## Public education and mobilization

- Create an independent, publicly funded education campaign about primary care



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British Columbia Association  
of Registered Nurses  
THUY-NGA  
(TIA) PHAM



# Understanding the Panel Process

A Priorities Panel is a long-form deliberative process that typically involves 30 to 48 randomly selected residents. These residents are chosen using a process called a civic lottery, a random selection method that prioritizes fairness and wide representation. The individuals selected for a priorities panel come together to learn about, and then advise public authorities on, divisive and complex issues that typically involve trade-offs or compromises. The panel members' objective is to reach a consensus on a series of recommendations that can be directed to government, professional associations, and society at large.

## What is a Civic Lottery?

A civic lottery is a balanced way of selecting the members of a priorities panel. It is based on a form of sortition that uses a randomized selection process to recruit panelists from a pool of volunteers that have indicated their interest in serving on the panel. The result is a group of volunteers that broadly matches the demographics of the jurisdiction it represents.

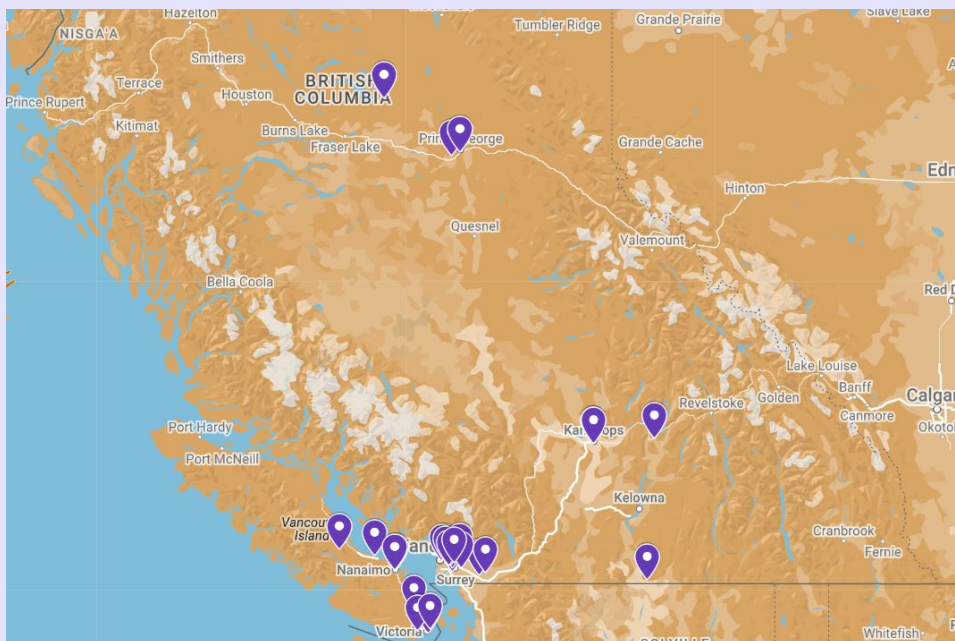
More than a hundred people volunteered for the British Columbia Priorities Panel. Many of these volunteers had completed the OurCare National Survey and indicated their interest in the panel by answering demographic questions in a separate questionnaire. The stratified civic lottery process ensured that members of the panel were fairly selected and broadly representative of the demographic makeup of British Columbia.

OurCare deliberately sought to overrepresent residents known to be underserved by the primary health care system: racialized, lower income, newcomer, and gender non-conforming residents, and those who live in rural, remote, or northern regions of the province. In short, the panel was composed in such a way as to deliver demographic diversity and to ensure we heard from residents who are most disadvantaged by the current system.



# Panel Snapshot

31 members



## Gender\*:

18 - Women

12 - Men

1 - Non-binary person

## Age:

3 - 18-29 years old

12 - 45-64 years old

9 - 30-44 years old

7 - 65+ years old

**Members who identify as Indigenous: 1**

## Health:

24 - Good, Very Good, or Excellent

7 - Fair or Poor

**Members who have been in Canada less than 10 years: 3**

## Geography:

11 - Southwest

8 - Island

6 - Interior

5 - Vancouver

1 - North

**Members who identify as part of a racialized group: 12**

\* - "Women" refers to cisgender and transgender women. "Men" refers to cisgender and transgender men.



**The Members'  
Report of the  
OurCare **British  
Columbia**  
Priorities Panel  
on Primary Care**





## Who we are and why we volunteered

We are 31 residents of British Columbia who represent a cross-section of our diverse, culturally rich province. We represent a broad spectrum of ages, abilities, experiences, and health throughout the province. Together, we respectfully acknowledge that all of us live, work, and play on the traditional, ancestral, and unceded territories of the Indigenous peoples of British Columbia.

We are gravely concerned with the state of our primary care system. We are troubled by the inequities, deficiencies, and various forms of discrimination within it.

We are frustrated by the systemic lack of progress from those in government at every level, be they federal or provincial; medical agencies and health authorities; and clinicians themselves. This inaction has resulted in an ever-increasing deficit in providing suitable and sustainable health care for all. There is a drastic shortfall in primary care services as well as inadequate support systems for physicians and their patients. There is also inadequate focus on preventative

care, which evidence suggests improves overall patient health and reduces the risk of long-term illness.

We seek to partner with those in governance and our health care professionals to achieve more equitable, accessible, cost-efficient, and reliable health care not only for ourselves, but for all British Columbians both present and future.

We volunteered because we believe all residents of British Columbia have a right to access primary care regardless of where they live, work, and play.

## What we see and what we learned

We see that British Columbians are struggling every day to access adequate health care. We see the incredible strain on our health care workers as they struggled before, during, and since the COVID-19 pandemic. We see a primary care system that is archaic and fragmented, and that does not serve the health care needs of our growing, aging, and culturally diverse population.

We have learned the drastic importance of primary and

preventative care services for health outcomes. We have learned that there are dedicated health care workers, researchers, policy experts, advocacy groups, communities, and individuals who have solutions, yet we largely fail to implement those solutions.

We have learned that there are major barriers with the interoperability of information systems as well as redundancies and bureaucratic burdens that contribute to inequalities of primary care service and delivery. We have learned that there are a multitude of citizens who are engaged, optimistic, and committed to revolutionary change in primary care in British Columbia. We have also learned that we must drive this change.

We believe that by providing a patient perspective, while also recognizing the needs of our medical professionals, we can create a better system for everyone's benefit.

For these reasons, we have joined together to champion this much-needed transformation.

## The Challenges We Want Solved

Our primary care system in British Columbia is in crisis. We have identified the following major challenges that must be addressed:

### **There are enormous strains on human resources in primary care.**

More than a quarter of British Columbians lack access to a primary care physician or team, and countless more suffer from a lack of quality care. Physicians and other health care professionals are overworked, experiencing burnout, and struggling to manage work/life balance – and the problem is greater in rural and remote areas. There are significant barriers to entering the field including high education costs, slow and expensive licensing processes for health care professionals both national and international, and systemic biases. Outdated payment models, administrative burdens in family practices, and the limited number of community health centres are also obstacles to systemic transformation and solving the “attachment crisis.”

All of these issues foster compassion fatigue in primary care all around. Everyone's health suffers when patients cannot be heard and acknowledged because doctors and health care professionals are overloaded with administrative tasks which rely on archaic systems and regulations. Primary care providers are also chronically short staffed and taking on more work than is feasible or safe. Such work continually strains and demoralizes health care professionals to the point that many leave the field altogether, leaving the system with even less support. We must prioritize their mental health to lower the current levels of burnout and frustration and create a supportive system that enables high quality care.

Another issue related to human resources in the primary health care system is the onerous process required to hire new health care professionals, whether these new professionals are recent graduates or new arrivals to the province or to Canada. The current on-boarding process hinders the achievement of desirable goals such as providing new doctors timely, real-world experience interacting and treating patients; alleviating the strain and burnout of current clinicians; offering more options for patients when selecting their primary health care

clinician; decreasing wait times; and creating a network of clinicians available to a patient at any given time.

### **Our primary care information systems are archaic and fragmented.**

British Columbia's primary care system is burdened with information systems and practices that cannot or do not speak with each other, are frequently siloed, and are often founded on outdated technologies (not least of which is the fax machine). Users of these systems, both health care professionals and patients, are frustrated by the lack of coordination and accountability among digital systems. Referrals and electronic medical records are often stuck or lost, for example. The downstream effects of fragmented information systems include limiting the development and deployment of more effective technological solutions and embedded mechanisms to safeguard the accuracy and privacy of patient information, especially for virtual care in rural and remote regions.

The proverb "too many cooks in the kitchen spoil the stew" reflects the frustrations felt by both health care professionals and patients, in that there are too many systems and no



set standards in place, preventing effective access to urgently needed information. This challenge is preventing us from having a world-class, high-tech primary care system here in British Columbia.

**There is a clear lack of equitable access to primary care among different communities.**

Not all British Columbians have equal access to primary care. Residents of rural and remote regions of the province, those struggling with mental health issues or addictions, newcomers with cultural and language barriers, vulnerable low-income populations who face high costs of access, those with physical disabilities, and Indigenous people all face various barriers and biases when accessing primary care. Those without reliable internet access or who are unfamiliar with technology are increasingly left behind. Family doctors are not compelled to change practices that would help overcome issues of access, such as adopting payment models that encourage doctors to take on more patients or practicing different models of care that facilitate access, including team-based care.

Too many family doctors have refused to take on patients who have

complex health issues, which further hinders individuals' ability to access health care. A primary care system that cannot overcome this lack of equity does not work for the majority of British Columbians.

**Continuity of care has been deprioritized**

Primary care in British Columbia has become more episodic, less holistic, and overly focused on treating patients swiftly rather than comprehensively. First points of contact in the primary care system are overwhelmed, while the demand only grows for more access to primary care physicians and teams. Health care professionals and primary care services are increasingly fragmented rather than housed under one (actual or virtual) roof, and there is an absence of a holistic, preventative, and team-based approach to primary care at a system level. Relying on emergency rooms and urgent care clinics for treatment after a patient becomes ill or injured is not a proactive solution for long-term patient care. We must have a primary care system that enables patients and clinicians the ability to stop, reverse or mitigate illness and injury before they happen in order to reduce the adverse effects on our own health and on the system as a

whole. Patients expect comprehensive, longitudinal care, regardless of where they live or move – care that emphasizes relational continuity between patients and the doctors and teams who care for them – and these expectations are not being met.


**There is an absence of patient power in the system.**

The crisis in primary care cannot be overcome without acknowledging that patients lack mechanisms to advocate for their own care and systemic change. Patients currently do not have the means to securely access and verify the accuracy of their electronic medical records. There is currently no comprehensive system encompassing a patient's medical information and no method of responsible data-sharing to ensure those records are accessible and portable. Patients do not have enough knowledge and education on how the primary care system works and how to advocate for themselves within it. Patients frequently feel more like clients than people. There is a lack of trust in the system and its clinicians. Patients expect more accountability and quality assurance than they currently have. They expect more choice in the care they receive, including options in their own communities. They expect clinicians

to take into account the patient's desires to maintain overall good health, especially if the journey to attain that good health will take time, various types of treatments, and input from other health care professionals. Yet there is no central patient advocacy organization or institution that can address this challenge on a system level, such as an ombudsperson.

**Politics and bureaucracy are standing in the way of transformation**

Like other areas of public policy, primary care policy is at the mercy of election cycles, partisanship, and the direction the political winds are blowing. The funding and resource allocation of primary care systems and services is often politically motivated or based on outdated priorities, and needs more transparency and less redundancy. There is political apathy for real, transformational change instead of a "band-aid" approach, which applies only short-term solutions. Bureaucratically, there are too many players with varying priorities, practices, and directives – health authorities, colleges and associations, regulatory bodies, advocacy groups, government departments – and not enough coordination and collaboration.



Innovative pilot projects are common and often successful in British Columbia, but suffer from a systemic lack of will or ability to implement them at greater scales. Though success has been proven in these pilot programs, determined adherence to a broken system by various players has meant that the system has stayed broken for too long, with each leader passing the buck to the next person to fix things, an approach that has only frustrated patients and clinicians alike.

Issues such as the opioid crisis and mental health care are not hot-button fodder for politicians to toss around like a game of hot potato. These are substantial issues that primary caregivers do not have enough resources to address. Politicians must not make political hay out of primary care issues but instead must properly fund programs that have been proven effective. The bureaucracy of politics has left our health care system in peril of being totally ineffectual, while real change and implementation of programs that will work collaboratively and sustainably are left sitting in drawers never to be used wholesale.

Under the UN Charter of Human Rights, recognized again under the

1966 International Covenant on Economic, Social and Cultural Rights, all human beings have the right to access medical care, including primary care. Yet the governments of Canada and British Columbia are falling woefully short in providing sustainable, equitable, and reliable medical care to all Canadians. We want to see this changed.

We, as Canadians, have come together to see such real change be implemented and are tendering this report to reflect a serious desire for the future collective good of this nation and all those who call it home.







# Our Values

When it comes to envisioning an ideal primary care system that acknowledges and serves the needs of all residents of British Columbia, we affirm that system must be:

## Accessible

Accessibility in primary care means the right of access to a space where primary care is provided. It means that there is a physician or care team for every person, when and where they need them, and that there are alternatives to meeting in person, including virtual care, phone, mobile clinics, safe and private spaces to access care virtually. Accessibility in primary care further entails providing assistance to accessing care.

Accessible care also means inclusive care: a primary care system that is available and welcoming to everyone regardless of their location, ability, language, or identity. It also means overcoming barriers to learning and using technology in health care for patients and professionals, as well as ensuring interconnectivity and reliability of information among patients and providers.

## Equitable

Equitable primary care meets the differing needs of everyone who accesses it. It means ensuring that

that the primary care system addresses the many barriers to accessing care, such as financial or geographic barriers, and that everyone – regardless of age, gender, identity, background, or language – receives the same quality of care. Equitable care also means addressing social determinants of health, such as by expanding mental health support and investing in social services and housing. It allows primary care to meet people where they are rather than applying a set standard. Equitable primary care is also destigmatized, anti-oppressive, and culturally responsive.

## Sustainable

Sustainable primary care means taking a long-term outlook towards providing services and devoting the necessary resources to ensure care systems can grow alongside us. Sustainability encapsulates funding and implementing high-quality primary care across all service levels, as well as training current and future medical professionals. Without a sustainable approach to planning and implementation, our primary care system will continue to fail us as we continue to apply a "band-aid" approach.



## **Accountable**

Accountability within the health care system is built through both transparency and trustworthiness. Transparency allows for better understanding of how the health care system functions and is funded. The health care system must embody honesty and integrity to build trust on a broad scale. Individual trust is built through relationships wherein health care professionals communicate with and are accountable to patients, including through listening and taking concerns seriously, ensuring that patients feel heard and informed, and following up with patients regarding test results and referrals. Recognizing that health records belong to the patient is essential in ensuring accountability. Accountability within the health care system must further ensure that standards of care are met and shortcomings addressed. Together, accountability, transparency and trustworthiness allow for better care and empowerment of patients.

## **Person-Centred**

Person-centred care aims to empower patients by equalizing the power dynamic between patients and health care professionals, focusing on a mutually respectful and collaborative relationship. This begins by addressing systemic

discrimination in the context of language, culture, and socio-economic status so that patients can feel safe, comfortable, and empowered within the health care system. Person-centred care empowers all patients to know their rights, their care options, and how to access services. Person-centred care focuses on all of a patient's concerns and gives ample time for health care professionals to understand and address multiple and overlapping issues, especially life-long disabilities or diseases, in order to facilitate a good quality of life for the patient.

## **Universal**

Universal primary care encompasses equity in the extent, quality, and accessibility of medical services and coverage. Universal primary care keeps the patient at its centre. This does not equate to a homogenous or singular approach to primary care; rather it allows for a diversity of approaches considering individual, cultural, regional, and socio-economic factors. As such, a universal health care system is inclusive, impartial, and conscientious. This value is a crucial cornerstone of a social contract that upholds citizens' rights to well-being, equality, and agency.



## **Prevention-Focused**

Prevention-focused primary care is proactive in nature, aiming to prevent health problems before they occur rather than waiting to address them when they happen. It means educating children and youth to set a strong foundation in their lives for the basis of healthy living, and continuing to support lifelong learning as health needs continue to evolve. It means taking a comprehensive view of patient well-being and investing in the right infrastructure to support a strong and supportive level of care from day one. Prevention-focused care aims to mitigate the burden on the entire health care system and enhance quality of life for all British Columbians. Without a fundamental government commitment to preventative care, there will be no real improvement to our daily health or to the health care system.





# Our Recommendations

## A. Accessible Primary Care for all British Columbians

In order to ensure universal and equitable access to primary care for all residents, we recommend:

1. The Provincial Ministry of Health establish and fund community health centres in every community with the goal that everyone has timely and reasonable access to primary health care, including physicians and team-based care. The following mandates of the plan would fall under the purview of the Ministry of Health.
  - a. Take an active role in supporting the development of community health care services in any community with unmet needs;
  - b. Take responsibility for funding and reducing implementation time to one year or less for the installation of community health centres;
  - c. Develop a framework, with input from appropriate stakeholders, by which to evaluate the performance of, and ensure adherence to, defined, measurable targets to improve primary health care services;
  - d. Create a panel – which should include health care professionals, patients, community health care centre operators, emergency room staff and directors, technicians, and paramedics – to give regular updates as to the status of implementation of these new practices, as well as reporting on those areas that are not performing to standard and that require more input, attention or financing to meet the targets required.
2. The Provincial Government pass legislation for zero out-of-pocket costs (for example, transportation or meals) so that people can access primary care at no personal cost.
3. The Provincial and Federal governments review and provide a plan within 1 year, and fully fund and implement within 5 years, for an internet/satellite-based infrastructure such that rural communities can access virtual care.



4. The Federal Government perform a systematic review of policies to ensure that they do not marginalize vulnerable groups in such a way that causes barriers to accessing primary care. Policy areas for review include, but are not limited to, education, infrastructure, and health care accessibility.
5. The Provincial and Federal governments devote funding, spaces, and initiatives to train people within their own communities to access quality health care services in those communities. Ideally, this means that local residents are given the opportunity to study, live, and work within those communities.

## **B. Primary Care System Infrastructure**

In order to guarantee primary care attachment, quality, and comprehensive coverage throughout the health care system, we recommend:

6. The Provincial Government assign each resident to a catchment area within which they are guaranteed access to a primary care provider or team, ideally of their choice.
  - a. Create catchment areas throughout British Columbia in the same manner as public school districts, for example, ensuring primary care attachment, especially for children;
  - b. Create an easy-to-use directory of practitioners accepting patients within a reasonable radius of each resident;
  - c. Build in flexibility when accommodating new patients, according to availability within and across catchments;
  - d. Accommodate those patients who have moved to another catchment but wish to continue with their clinician or team of clinicians because they have developed a strong connection or attachment. The patient should not be automatically cycled out of their clinician's office if they do not wish.
7. The Provincial Government prioritize relational continuity of care in all aspects of primary care transformation, in order to enable a primary health care model that best serves the changing needs and preferences of patients, care practitioners and communities.


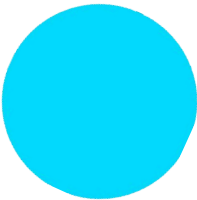



- a. The expansion of team-based primary care throughout the province will greatly enhance attachment, continuity and overall patient care. There is ample evidence that team-based care reduces burdens on both family doctors and patients while fostering more comprehensive care.
- 8. The Provincial Government re-evaluate the efficacy of services within the multiple health jurisdictions to streamline administrative processes within health authorities.
- 9. Regions across the province work collaboratively to pilot, evaluate, and scale up projects and new research with a clear timeline to drive innovation in primary care service delivery.
- 10. Primary care service coverage and teams be expanded to include holistic care, including but not limited to pharmaceuticals, dentistry, physical therapy, and mental health services, to ensure comprehensive and preventative care for all residents of the province.
  - a. These services should be covered at the point of service or highly subsidized for those who cannot afford to pay.

### **C. Technology and Information Systems Infrastructure**

In order to advance information system interoperability that facilitates the exchange of patient and primary care information, access to medical records, and other elements of in-person and virtual care, we recommend:

- 11. Provincial health care authorities establish a central medical data platform for clinicians and patients that provides province-wide access to electronic medical records (EMRs) regardless of the database software used in any given location. The goal is to facilitate continuity, portability, comprehensiveness, and efficiency of patient care.
  - a. This platform should include all patient notes, test results, prescriptions, and referrals. This platform should provide clinicians and patients with comprehensive, easy, and free access to their medical records. The goal is to ensure portability, continuity, accessibility, and agency for patients;

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- b. In addition, the platform must include adequate accessibility features. This includes, at minimum, support for screen readers, automated translation, enlarged and simplified text, closed-captioning, responsive design and mobile compatibility, and color-contrast;
  - c. The platform should allow for patients to input information to make sure records are up-to-date for both the clinician and patient's benefit;
  - d. The platform should have a singular, easy point of access, such as your BC Services/CareCard, which works like a library card; inputting your individual card number allows you access to your information.
12. Government funds be allocated to support community-based initiatives that raise awareness of and provide training and support for patients in the technological aspects of accessing primary care, including virtual care. This should be implemented based on community resources and needs and may include, for example, classes at community and senior centres, mobile outreach to rural and home-bound patients, and training for health care and support workers.
13. Clinicians and agencies commit to adopting a standard for electronic medical records (EMRs) that is mutually agreed upon by public officials, patient representatives, and industry experts. These EMRs must be inter-operable with the aforementioned patient and practitioner medical data platforms. They must also have robust security and data encryption in place to protect patients' privacy. Clinicians should receive sufficient, high-quality, professional training and support to ensure timely and seamless adoption of these systems.
14. Primary care practitioners offer flexible modes of care including, at minimum, in-clinic, video, phone, and secure messaging to ensure accessible, inclusive health care for all patients.
- a. Patients should have agency in choosing their mode of care, thus honouring the values of accessibility and safety;
  - b. Virtual care should complement, not replace, in-person care if it is requested and feasible;

- c. Provincial authorities should fund virtual services to such a complete extent that they fully complement in-person care. They should also fund and support communities to develop public and mobile infrastructure that allows patients to access telehealth appointments. For example, funding could be allocated to expand call booths in public libraries or purchase mobile call booths. Implementation should again be based on community resources, needs, and preferences;
- d. Patients should have the ability to authorize a family member or friend to access their medical file in case of emergency.

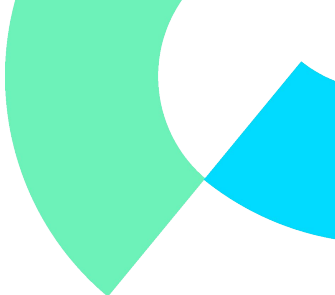
#### **D. Funding and Resource Allocation**

In order to maximize innovation, primary care quality, and health care management costs, we recommend:

- 15. Federal and Provincial governments commit to adopting the World Health Organization's "Health in all Policies" approach to shape public policy initiatives across all sectors/ministries and the disbursement of funding and resources. This is in recognition that health is a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity.
- 16. The Provincial Government engage with partners in the private sector to find innovations and technological solutions that can streamline administrative processes and procedures, reduce duplication, enhance primary care initiatives, and maximize clinicians' time with patients.
- 17. The Provincial Government reallocate and increase funding to expand patient and population health initiatives that address social determinants of health (e.g. housing, food security, etc.) with an equity lens and attention to rural and remote communities.
- 18. The Provincial Government commit to the expansion of Community Health Centres (CHC) to ensure that all British Columbians have access to primary care via CHCs. At a minimum, there should be at least one CHC in each community, and ideally more in rural, remote, Indigenous and low-income communities. These CHCs must also be funded to provide







expanded resources to these patients, who are more likely to face greater barriers to care than those in more affluent communities.

19. The Provincial Government, the Federal Government, and regulatory bodies work collaboratively to expand the number of health care clinicians via:
  - a. Expanding access and reducing systemic barriers to health care education for potential primary care clinicians;
  - b. Reducing barriers for internationally trained and out-of-province professionals (i.e., pan-Canadian licensing). This includes streamlining the process of certifying immigrant primary care clinicians;
  - c. Integrating and expanding the use of physician assistants and other health care professionals to provide care under physician supervision;
  - d. Medical schools and regulatory bodies expanding family medicine residents' training to emphasize values such as continuity of care, long-term illness support, and chronic pain management. This training should also focus on the stability required of a clinician/patient relationship, which fosters a beneficial partnership in long-term care.
20. Federal and Provincial governments commit to independent, third-party monitoring, evaluation, and research of resources expended on primary care initiatives to measure impacts and outcomes, financial or otherwise (i.e., to scale up effective pilot projects in an expedited manner).

## **E. Political Will & Patient Advocacy**

In order to guarantee the rights of patients in the health care system, we recommend:

21. The Provincial Government legislate the creation of a Patient Advocacy Organization (PAO) – which shall be publicly funded, independent, and non-partisan – in order to provide equitable representation of the diverse needs and perspectives of British Columbians. This PAO should consist of publicly elected board members and its mandate should include, but is not limited to:

- a. Training and supporting Individual Patient Advocates who will learn about and implement the required knowledge to assist vulnerable patients in navigating the primary health care system. This would include assistance in filling out forms, making and following up on appointments, explaining medical jargon, and asking appropriate questions on behalf of the patient;
  - b. Supporting local, community-based primary care champions and chapters that engage with the PAO in community initiatives;
  - c. Consulting on provincial legislation related to primary health care before it is voted on and with the option of carrying out referendums;
  - d. Championing transparency throughout the primary health care system, including but not limited to:
    - i. Publicizing information on:
      - 1. Provincial health care legislation and policies;
      - 2. The internal processes of the various professional colleges that oversee health care workers;
    - ii. Providing patients' access to their personal medical records;
    - iii. Acting as an independent body separate from the College of Physicians and Surgeons, that can review medical professionals ethics and conduct, and ensure that, when a complaint has been lodged, the patients' concerns are being addressed adequately.
  - e. Defending and upholding the Primary Health Care Charter (see Recommendation 22) on behalf and in the best interest of the patients in British Columbia.
22. The Provincial Government and the PAO draft and implement by 2025 a comprehensive Primary Health Care Charter to define and clarify the rights and expectations of patients that includes but is not limited to:
- a. A discussion of socio-economic determinants of health;
  - b. Recommendations for ensuring transparency, accountability, and equitable and timely access to medical services for all British Columbians;
  - c. Provisions for publicly funded (free or subsidized) education for all medical professionals in exchange for a period of public service in BC;

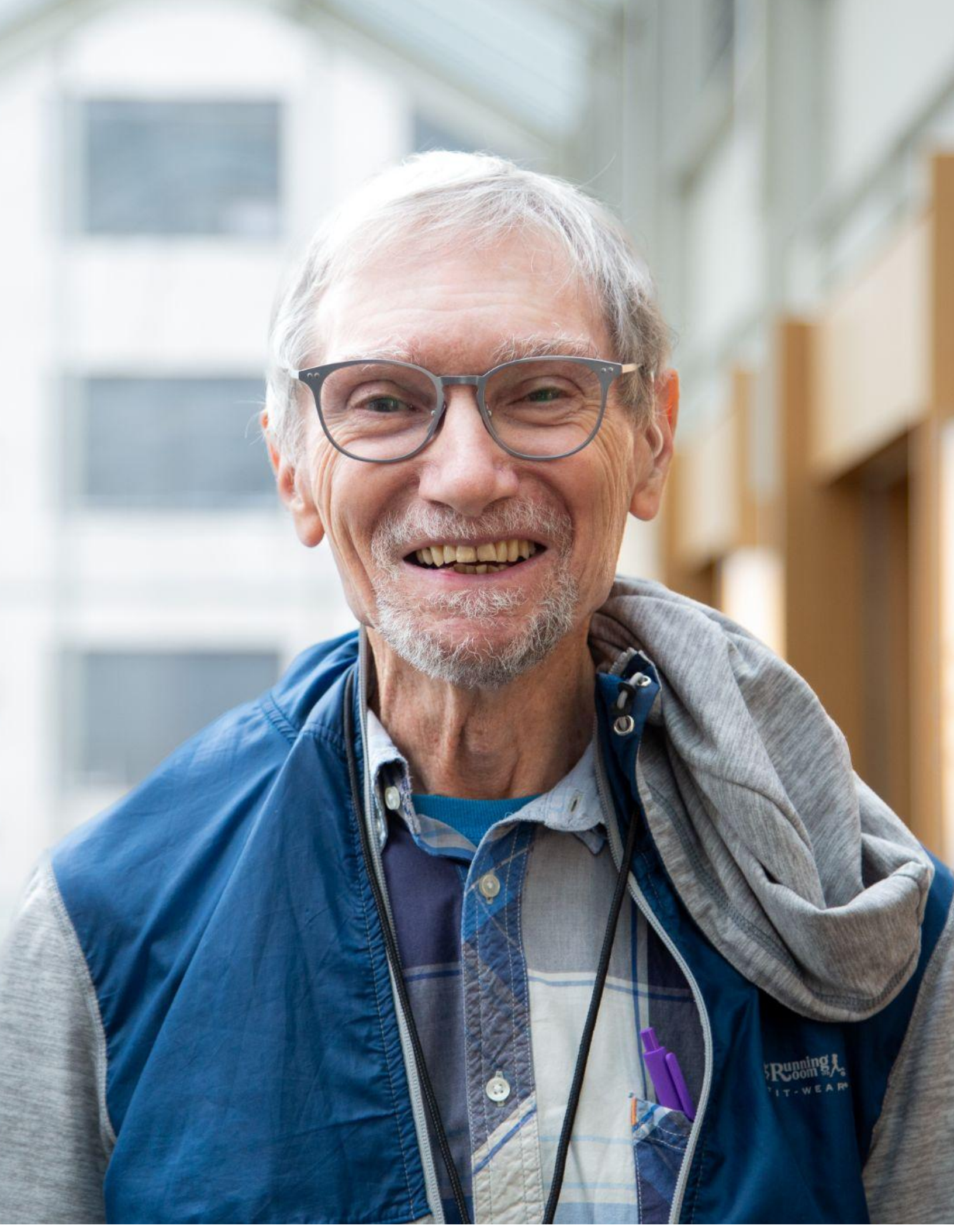
- a. A framework to enhance work-life balance for medical professionals;
  - b. Guidelines on continuity of care.
23. The Federal Government, in consultation with other regional and provincial health organizations, implement and fully fund the Patient Medical Home (2019)<sup>1</sup> as well as establish Goals and Standards for Primary Care by 2025 in order to provide timely, consistent, quality primary care to every British Columbian, regardless of:
- a. geographical location;
  - b. socio-economic level;
  - c. race;
  - d. colour;
  - e. national or ethnic origin;
  - f. Indigeneity;
  - g. age;
  - h. gender identity and expression;
  - i. sex;
  - j. sexual orientation;
  - k. size;
  - l. diverse physical and mental abilities;
  - m. pre-existing conditions;
  - n. substance use.
24. The Provincial Government create regional primary care health boards, consisting of publicly elected members, working in a transparent and accountable manner, to provide oversight on medical services.
- a. Each primary care board should have no more than one politician while also including at least: a medical clinician, an outreach/social worker, a community health center administrator, and a patient with multiple health barriers or issues, as well as various additional stakeholders to reflect the diverse backgrounds of all British Columbians.

## F. Public Education & Mobilization

In order to increase public awareness of primary care issues and empower British Columbians to shape health care public policy, we recommend:

25. Patient Advocates (see Recommendation 21a) create an independent, publicly funded education campaign that includes the following actions:
  - a. Supporting grassroots storytellers through broad media reach to highlight “cracks” in the current system;
  - b. Educating the public on their rights in primary health care including access to their own information through a “Health Care Basics in BC” campaign;
  - c. Highlighting success stories of change on a community level to motivate and educate the public on the benefits of participating in efforts to transform the primary care system;
  - d. Inviting the public to large venue areas to have a meet-and-greet with clinicians, offering incentives like free food, so the public can be asked questions like, “Do you know what happens when you don’t have primary care?” or have clinicians acknowledge the short-falls of the system and let the public inform clinicians of their needs and fears;
  - e. Inviting independent filmmakers who reflect the diverse background of British Columbians to make short films and other interactive media from their perspective on how best to interact with clinicians and patients. The wider the spectrum of public engagement and information communications, the greater knowledge base you are providing to the public.





Running Room  
FIT-WEAR

## OurCare Priorities Panel Program

The British Columbia Priorities Panel, consisting of 31\* members from across the province, met online twice (in April and May 2023) and then in-person over three days in Vancouver (in June 2023). During their nearly 30 hours together, panel members learned about primary care in British Columbia and other jurisdictions; they heard from and engaged with 19 subject matter experts in presentations or moderated discussions. The members also spent a significant amount of time in conversation with each other as they engaged in a series of facilitated discussions and deliberations that culminated in the consensus recommendations put forward in this report. Videos of session presentations and related materials are available to the public at [ourcare.ca/prioritiespanels](https://ourcare.ca/prioritiespanels).

\*Owing to personal and health-related circumstances, two members were unable to travel to Vancouver for the final sessions, though their perspectives were still a part of the process.

## Session 1: Saturday, April 29, 2023 Virtual

The opening session of OurCare BC began with a formal welcome from the Panel Chair, **Richard Johnson**, as well as OurCare's Principal Investigator, **Dr. Tara Kiran**. Richard talked about the panel's mandate and tasks, and ensured members understood how a deliberative process like a priorities panel is unique in how it asks its members to think about the broader public and to consider the interests of those they represent. Members then had the opportunity to meet one another in small breakout groups.

After a brief presentation from Richard on the history and evolution of Canada's health care system, including the Canada Health Act, the panel welcomed **Dr. Christie Newton**, President of the College of Family Physicians of Canada and Associate Head, Education and Engagement, at the University of British Columbia's Department of Family Practice, who delivered a presentation giving an extensive overview of primary care in BC. Members learned about various facets of population health and the roles that primary care systems play





OurCare  
British Columbia Premier's Office  
Policy Day

in ensuring individual and community health. The presentation also covered the principles and values of primary health care, the evolution of primary care delivery in BC, the various ways primary care is organized and funded in the province, and how a stronger primary care system may help overcome broader crises and challenges facing health care in the province.

Members had the opportunity to ask questions of Dr. Newton before heading into small group discussion about the values that should guide a renewed primary care system.


Later in the opening session, members heard from **Dr. Goldis Mitra**, a family physician in North Vancouver and the BC Project Lead for OurCare. Dr. Mitra presented the findings from the OurCare National Survey, which, between September and October 2022, gathered insights from more than 9,000 Canadians about their experiences with primary care and their preferences and priorities for the future. The full results of the survey are available to the public at [data.ourcare.ca](https://data.ourcare.ca). Dr. Mitra took questions from members about the survey data and how it may guide their work as a panel.

## **Session 2:** **Saturday, May 27, 2023** **Virtual**

The second session of the OurCare BC Priorities Panel began with a welcome and recap from Panel Chair Richard Johnson, followed by a presentation from Dr. Tara Kiran on models and features of primary care systems in OECD comparator countries (including Finland, the United Kingdom, Norway, and the Netherlands) and other Canadian provinces, highlighting how these differ from the current structure and delivery of primary care in BC and offer potential ideas for this province to consider. She discussed various features of primary care systems such as practice and rostering models, funding and payment models, use of information systems and data sharing, after hours and urgent care, and accountability measures. After a lively Q&A period, members broke into small groups to discuss the pros and cons of the different features, and to identify which features should be available to all British Columbians.

Later in the session, members listened to a moderated discussion about access to primary care for equity-deserving communities in





which Panel Chair Richard Johnson engaged with three guest speakers: **Dr. Evan Tesla Adams**, Deputy Chief Medical Officer of the First Nations Health Authority; **Dr. Lindsay Mackay**, UBC clinician and Medical Coordinator of Downtown Eastside Connections, a substance care clinic in Vancouver; and **Dr. Alan Ruddiman**, a family physician in rural BC and former President of Doctors of BC. The speakers discussed the importance of considering equity in delivering quality primary care to all British Columbians, focusing on social determinants of health and underscoring the social and economic disadvantages many people face accessing the health care services they need. The speakers described some of the challenges of delivering primary care in rural and remote regions of the province, among Indigenous populations, and in the context of mental health and substance-use care. Each speaker also gave examples of interventions that could help improve access and lead to better health outcomes for these equity-deserving populations. The moderated discussion was then followed by a robust Q&A with members.

### **Session 3: Friday, June 23, 2023 Vancouver**

After two months of virtual work, the members of the OurCare BC Priorities Panel gathered together at the brightly lit Morris J. Wosk Centre for Dialogue at Simon Fraser University in the heart of downtown Vancouver, located within the shared, unceded, ancestral territories of the *xʷməθkʷəy̓əm* (Musqueam), *Sk̓wx̓wú7mesh* (Squamish), and *səlilwətał* (Tsleil-Waututh) Nations.

Following a round of introductions as members met each other in person for the first time and shared why they volunteered and what they learned so far, they broke into six small working groups to define the values previously identified in Session 1, which they believe should guide any and all efforts to improve British Columbia's primary care systems. Members moved between tables to assist one another and shared their results in plenary.

Later that evening, the members welcomed four speakers in a moderated discussion with Panel Chair Richard Johnson about virtual care and its role in delivering high-quality, accessible care within primary care systems. Addressing





the panel were: **Dr. Lindsay Hedden**, Assistant Professor of Health Services Research at Simon Fraser University and co-Principal Investigator of the Health Systems Research Lab; **Dr. Birinder Narang**, Clinical Assistant Professor in the Department of Family Practice at UBC and a family physician for the REACH Community Health Centre; **Dr. Keir Peterson**, Chief Medical Officer of Telus Health; and **Gladys Selkin**, a member of the Saik'uz First Nation residing with the Stellat'en First Nation, who presented a patient perspective on how virtual care is working with the Carrier-Sekani Family Services.

Members had the opportunity to engage with these speakers on issues of virtual care and digital information system infrastructure before retiring for the evening.

#### **Session 4: Saturday, June 24, 2023 Vancouver**

On Saturday morning, members gathered once again at the Wosk Centre for breakfast and a recap of the previous day's work, led by panel chair Richard Johnson. The members then heard and interacted with two panels of guest speakers. The first was an interactive presentation on

team-based care, led by **Dr. Thuy-Nga (Tia) Pham**, family physician and Co-Medical Director of the South Island Urgent and Primary Care Centres in Victoria, and her team, including: **Estephanie Acebedo**, a nurse lead; **Hayley Diakiw**, a nurse practitioner; and **Davana Harlow**, a registered social worker. Joining them virtually via Zoom was **Valerie St. John**, Executive Director of the British Columbia Association of Community Health Centres (BCACHC). Members had the opportunity to learn about the roles and opportunities of team-based care and the potential of models like CHCs to be scaled across the province, and to engage in a lively Q&A with the guests.

In the day's second presentation, members participated in a moderated discussion on tradeoffs between timeliness, continuity, and community-based care, welcoming three guest speakers: **Dr. Rita McCracken**, a family doctor and Assistant Professor in the Department of Family Practice at UBC; **Dr. Tracy Monk**, a family doctor and the Faculty Lead for the UBC Centre for Relationship Based Care; and **Andre Picard**, an award-winning Globe and Mail health reporter and columnist. Members had the opportunity to learn and ask questions about the

tradeoffs in primary care delivery with the aim of understanding how best to prioritize and balance elements of primary care that work for all British Columbians.

Following each of the morning presentations, members broke into small working groups to identify the issues and challenges facing our primary care system and begin to prioritize them and identify potential solutions. After lunch, members worked collaboratively to group their lists of issues into six themes, which became the working groups in which they spent the bulk of the afternoon developing their consensus recommendations.

After an hour's break, members reconvened in the lovely Mount Pleasant conference room next door at the Delta Vancouver Hotel for a sumptuous dinner, followed by a moderated discussion with Dr.

**Kathleen Ross**, President-Elect of the Canadian Medical Association and a family physician in Coquitlam and New Westminster, who shared her perspective on primary care system transformation and engaged members in an "Ask Me Anything" session, in which they raised any lingering concerns and questions regarding their recommendations in progress.

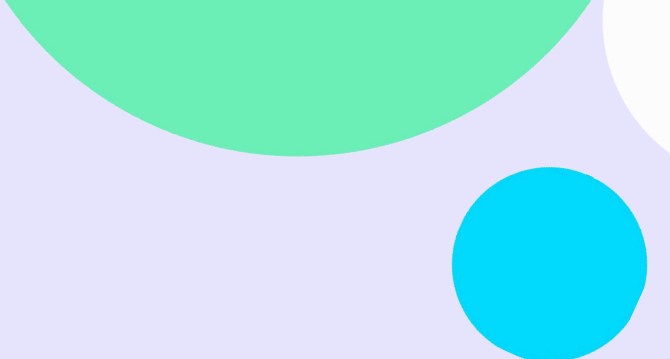
## **Session 5: Sunday, June 25, 2023 Vancouver**

On the morning of their final day, following a plenary reflection led by Panel Chair Richard Johnson on the work achieved to this point, members of the OurCare BC Priorities Panel spent time in small facilitated working groups finalizing their recommendations, drafting other parts of their final report, and reporting back to each other in plenary as they worked towards consensus. After lunch, invited guests – including leaders in British Columbia's health care sectors – joined to listen as members presented their draft final report, including 25 recommendations for strengthening primary care in the province.

Panel Chair Richard Johnson welcomed guests joining in person and online, and gave an overview of the OurCare process, acknowledging the financial support of the Max Bell Foundation, the Staples Even the Odds Campaign, and Health Canada. Next, individual members of the Priorities Panel came to the podium in turn to deliver the various sections of the draft report. Following the presentation, members







welcomed to the podium two very special guests who delivered their reflections on the report and committed to taking up the final report when it is published in September: **Ted Patterson**, Assistant Deputy Minister for Primary Care at the British Columbia Ministry of Health; and the Honourable **Bonita Zarrillo**, Member of Parliament representing Port Moody-Coquitlam, NDP Critic for Infrastructure, Communities, and Disability Inclusion, and Deputy Health Critic.

Panel Chair Richard Johnson then invited panel members and invited guests to share their reflections on the panel process and its outcomes. Finally, **Dr. Goldis Mitra**, the BC Project Lead for OurCare, and **Dr. Tara Kiran**, the OurCare Principal Investigator, gave words of thanks and distributed Certificates of Public Service to each panel member, acknowledging and documenting their contribution to the conversation about the future of primary care in this province. They thanked each panel member for their time and work on behalf of all British Columbians towards strengthening primary care as outlined in their recommendations.











# Meet the Members

## REBECCA AUSTIN

Except for the first year in Alberta, I have lived my whole life in BC, growing up in beautiful North Burnaby. I moved from the Lower Mainland to Prince George where I started a family and raised my two boys. Now retired six years from a career with the provincial public service in which I assisted residents with accessing multiple government programs, I am taking college classes, learning to play the flute, and making soaps and fermented foods. My husband and I enjoy our rural acreage and our dogs, chickens, and bees. It is a privilege to be on a panel contributing to a discussion on crucial health care decisions.

## CORRIE BELTRAME

Hi, I'm Corrie, originally from Didsbury, AB, but I've had the opportunity to live in several countries, which include Scotland, England, Australia, South Africa, and now back in Canada. I currently reside in Osoyoos, BC, and have been here since October 2020. My experience has been primarily in administration roles, including general admin and office management positions. Having a keen eye for detail and a procedural mindset have proven to be valuable assets in my career. For the first time in my life, I have not had access to health care for 2.5 years, and this is one of the reasons why I wanted to participate on the panel, for myself and countless others who have suffered due to our lack of health care. I enjoy solving problems and finding creative solutions to challenging situations, and I am excited to work with you all to help make a positive change in our health care system.

## JANE BOCKMAN

I am originally from the USA, New York in particular. The 1960's was a fantastic time to be living in NYC; a time of exploration, expression, activism and music. In the 1970's I traveled the world, settling in the Middle East where I founded a kibbutz. After years I returned to North America, settling at first in Montreal, then Toronto, Calgary and Vancouver. Five years ago I moved to Vancouver Island. I studied Dental Technology in Toronto and Vancouver, and had a long, successful career. I was elected to sit on my regulatory board and eventually became a college instructor in my profession. I have practiced yoga my entire life. I became a registered yoga instructor as well as a certified Pilates instructor and have taught classes in many studios and recreation centres. Currently I teach yoga and Pilates for the Parks Board in Nanaimo. I hope I help people find some balance in our challenging world. I love animals and am currently a slave to two demanding rescue cats. Community and world involvement are responsibilities that I take seriously.

## DANA BOSCHMAN

*No biography available.*



## SABRINA BROSNAN

I was born and raised in North Delta, BC, identify as She/Her and am an active member in my communities. I have had a chronic illness for more than 30 years, am the primary caregiver for my disabled, senior mother, and I had been for my grandmother at one time as well. I have a great many friends that are members of the BIPOC, LGBTQ2+, single/married/ committed communities as well as those who are able in different ways; their perspectives and needs are of the utmost importance to me. I have worked in a large variety of fields, from administration to construction, manufacturing to landscaping, charity fundraising and public engagement. I have volunteered for many panels, surveys, and groups to try and help bring awareness to issues that are important to people, many of whom feel they do not have a voice, except with me. As someone who has seen the very worst in the public medical services of Canada, as well as too many good doctors burning out or throwing in the towel because the system itself was against the needs of the doctors and patients, I'd like to see these issues come forward and have them discussed seriously. I have a great love of reading, writing, gardening, sports, dancing, and other physical activities, when not working.

## DEBBIE CHOW

I was born and raised in Vancouver. I was pleased and excited to be chosen for this panel. I have a long complex history that began over 30 years ago. More importantly, I have heard many stories mainly from stroke survivors. We began "Building Life After Stroke Together" with an Easter weekend BLAST. This led to a monthly dinner. That runs itself every 15th at Trocadero's. When local stroke recovery branches were shut down, we created SOCIALS "Survivors Offer Camaraderie In Active Life Style." It is peer-led by stroke survivors. We choose to be autonomous and not apply for grants. We have no lead person and only ask \$5 per session which includes lunch.

## ELLY GRABNER

My name is Elly and I am a 41-year-old mother of 3. I was born and raised in Kamloops, where I currently live, work, create, learn, and raise my family, on the traditional territory of the Tk'emlúps te Secwépemc nation. My family is diverse, and includes women, 2SLGBTQIA+, Metis and indigenous backgrounds. I have worked in public service for almost 2 decades and am passionate about women's rights and social equity. I joined this panel to help form a recommendation for our primary health care system that is rooted in real, attainable goals, based on the experiences of the average British Columbian.







## MICHA HOGG

I have lived on Vancouver Island for over three decades, having moved here with my mom when my parents divorced. I obtained a Diploma of Arts and Science through Vancouver Island University and am currently enrolled in a Bachelor of Arts, majoring in psychology. My work life has been varied, running the gamut from cleaning homes and offices, working in manufacturing, working within the hospital system in Medical Imaging, to my current employment with the BC provincial government working with marginalized individuals and seniors. I have two amazing sons and am currently living with my partner in Mill Bay on the island to be closer to family. Enjoying the outdoors, whether hiking, camping, boating, gardening, walking the dog, or taking photos, is my passion. There is nothing better in life than being a steward of the land, a trait I inherited from my grandfather. I volunteered for the OurCare Priorities Panel because health care is important to communities and individuals throughout life. I support the provision of well-rounded preventative, accessible primary care which includes dental, optometry, and mental health coverage, and remains provincially covered under increasingly diverse needs, avoiding two-tiered models supporting access according to wealth.

## BENSON IZUNWANNE

I was born in Port Harcourt, Nigeria. I immigrated with my family to Winnipeg in 2011. I am an accountant and work in the public sector. I am married with four children, but only the youngest lives with us now. We moved to Kelowna, BC in 2014 and Victoria in 2017. I enjoy soccer and am a fan of the Arsenal Football Club of London. I love hiking and enjoying the beautiful natural environment of Vancouver Island. I volunteer as Treasurer for some Charities, Tax Clinics, and my professional organization. I volunteered for the panel as a way of giving back to the community that has been good to me and my family and contributing to building a better Canada.

## RUBY JAGGERNATH

I moved to BC's Lower Mainland with my family when I was 13 and have lived here ever since. I firmly believe in the value of talking to front line "workers" or "clients" so I felt this panel is important to maintaining a healthy community, and a great way to contribute to our community. I've volunteered for the past few years by picking up garbage along our streets. I'm also president of the Fraser Valley Rock and Gem Club and past secretary of the Bradner Community Association, as well as a member and former active member of the Abbotsford Photo Arts Club and a member of CAPA. I've been a teacher, day care worker, news reporter on a small local paper, independent technical writer, and done some freelance writing, as well as raising three boys who are now raising their own families.



## JASMINE JAVILLO

I was born in Surrey, British Columbia, and have lived in various areas in Metro Vancouver. I am now living in East Vancouver with my partner and my little Corgi named Monai. I studied Dental Hygiene at Vancouver Community College and went on to complete my bachelor's degree at the University of British Columbia. In my spare time, I enjoy reading and volunteering for various events throughout the city. As a Dental Hygienist, I can see how limited access to care affects my clients, and the need for improvement within our health care systems. I volunteered for this panel to provide my individual perspective on our primary care system, as well as learn about the experiences of others.

## DAMAN KANDOLA

I am a settler and second-generation Canadian of Sikh Punjabi heritage. I currently work as an Evaluation Specialist with Northern Health and as an Adjunct Professor with the Faculty of Medicine at the University of British Columbia. A trained research scientist, my interests include health services and policy, rural health, knowledge translation, patient-oriented research, and cardiovascular health. Outside of work, I am active in my community and enjoy exploring the outdoors. I'm an avid reader and curious traveller who is always looking forward to my next big adventure. I volunteered to participate in the OurCare Priorities Panel because I am passionate about ensuring healthy and sustainable primary care with equitable access for all.

## COLE KEITAMO

I was born and raised in a small town in Northern Finland and immigrated to Burnaby, British Columbia, 27 years ago. My career as a sales manager in the travel industry gives me opportunities to explore the world and marine life which I am passionate about. I also enjoy the community I live in, the stunning views, the closeness to nature, and the hiking opportunities. A couple of years ago, I saw the effects of climate change: the extreme heat wave that caused many people to lose their lives; this is one of the reasons I volunteered for the Panel. I want to contribute my ideas and thoughts and be part of positive changes in Canada.

## JEANETTE LIM

I have lived in Metro Vancouver since my family emigrated from Singapore 30+ years ago. When I am not working as an accounting temp, I am a caregiver to my aging parents and grandaunt. John F. Kennedy's words, "Ask not what your country can do for you, ask what you can do for your country" have always challenged me to contribute in some way to the public good. I excitedly volunteered for this Panel as it gives me the opportunity to shape our primary care system. In my spare time, I love to do different kinds of walking – power walking, Nordic walking and racewalking. I also love to read non-fiction, watch documentaries, and volunteer with charities.

## MALIKA LIM

I was born in Vancouver and have lived in most areas of Greater Vancouver. I work full-time within the tech industry and have for the last near-decade now. In 2019 I got married and was also diagnosed with Multiple Sclerosis. It took over 9 months to be diagnosed. My first noticeable onset symptoms included half my body going numb. I live with constant levels of chronic pain and fatigue as a result. One of the main reasons I volunteered for the OurCare Panel is because I am hoping to see real positive actions and impacts come out of this. I have not had access to a family doctor in over ten years and the shortage of health care resources is only rising. As someone with severe health issues, I don't want anyone else to go through what I experienced in my diagnosis process.

## JESSE MacGREGOR

Born and raised in Vancouver, I now reside in Mission following several relocations around the province over my working years. Much of that work has been concentrated in seeking social change, whether in working for neuro-diverse populations, low income groups, or persons with HIV/AIDS. More recently I spent 8 years volunteering in my local hospice facility, where, among the many life lessons I gleaned, I had the rare privilege of spending many hours with individuals on their final transition. Finally, as a transman and a now elder, I have a keen interest in how health care/policies are or are not meeting the needs of this demographic. For fun I am a home renovation junkie and watch far too many home renovation TV shows, much to the consternation of my partner.

## DONALD WESLEY MARCH

I was born in Nanaimo BC and raised in Ladysmith. I currently work in telecommunications. In addition to my interest in all things technological, I also enjoy reading, writing, and walking. I have ADHD, and I am a passionate advocate for the neurodiverse community. I am honored to have been selected to participate in the OurCare panel. Everyone will interact with our health care system in many ways over the course of a lifetime, and while I believe we have a good system, I also believe we can make it better via active participation.

## AMY MASON

I was born in Vancouver, went to school in Montreal, lived in the southern US as a young adult, and returned to the Vancouver area when I could. Unable to afford living downtown, for the last several years I've been in a remote suburban area. Online role-playing games are the main way I spend my time. I'd work in the creative sector as a writer if I could afford to live where such jobs are available. As a transgender woman living below the BC poverty line for the past decade, I volunteered for the panel to provide my perspective on health care in BC.



## RAY McDONALD

I have lived in South Burnaby since retiring as a food plant manager following a stroke in 2011. I'm active in local stewardship groups and an avid walker and transit rider. I've participated in many five and 10K walks. I volunteered for the Panel to help shape our health system for my children and grandchildren. I am active in the stroke recovery community. I am concerned about health care for my daughter suffering from long COVID. I look forward to exchanging our varied lived experiences and viewpoints.

## MARK NEATH

Originally from the Maritimes, I have lived in Northern Alberta and Central Ontario in my journey across Canada. I have, though, spent the last forty years in BC working in telecom (project management) and raising my two boys. I was attracted to Vancouver primarily for the work but also the community as I enjoy both the mountains and sea. When not working, I usually find time for photography and hiking. Though I am trained as a glass artisan I haven't invested too much time in it lately, something I hope to remedy at retirement in the not-too-distant future. I put my hand up this panel for two reasons: I think it is important to do more to make our voices heard and hear the voices of others on topics important to Canadians in a structured manner; and I would like to return a bit to the community which has given me and my family so much.

## HENDRIK DE PAGTER

I was born in the Netherlands, grew up in Montreal, and have spent most of the last four decades on the West Coast. I graduated from Concordia University in Montreal and UBC, where I studied social work, followed by a decade in child protection and sixteen years in mostly psychiatric hospital social work, with an eight-year stint as a Canada Immigration Officer, posted in Pretoria and Paris, in between. Now retired, I'm keen to distill my experiences as a hospital social worker, as a caregiver for fifteen years to a parent, and as an engaged citizen, to help Canada realize the full intent of comprehensive and equal health care for all.

## JENNIFER RAMESCH

I am an Indian, Panamanian, and North American female geological engineer. I have lived experience with primary care in Panama (Panama City, Colon City), the United States (Eugene OR, New Haven CT [both in and outside of university], and Boston MA), and in Canada (Vancouver [both inside and outside of university], Burnaby, and now Nanaimo.) My interests are in everything, except hockey (please don't hold it against me) and spreadsheets. My interests involving health care include:

- Different cultural norms around health and wellness;
- What we know about preventative medicine, including oral and gut health;
- Private vs public health care, hybrids, and gaining knowledge from health care policies in Europe and Scandinavia;

- Alternative medicine, such as acupuncture, naturopathic, TCM and other modalities;
- Pharmaceutical medicine versus nutrition, stress-management, and other whole-body approaches in primary care;
- Similarly, the connection between mind and body and how many diseases and conditions may be related to psychological “dis-ease”;
- Mental health and the best approach to treat and support individuals struggling with mental health issues.

In essence, I want to look at how primary care practitioners can expand their “toolbox” to make our health care system more efficient and equitable for Canadians.

## KEN RAYNOR

My wife and I currently live in the Shuswap, which we picked to be our retirement home. We were both born in Vancouver but have lived most of our lives in smaller towns all over BC. My last four years of work had us living in the US, which gave us direct exposure to private insurance and for-profit medicine. I hope to be able to express the views of small town residents, where your care is often provided by recent graduates trying to get established and not intending to stay, and where anything beyond basic care requires the time and expense of traveling to a regional centre.

## CHRISTINE SORENSEN

I am a registered nurse from Kamloops BC. I have worked in community public health as well as senior health care leadership for the past 33 years. I spent the last 15 years of my career advocating for changes to health policy that would provide for safe patient care. In 2022, I completed a Master of Health Leadership and Policy from UBC, and I am currently teaching health policy to nursing students. I am the mother of two amazing young men, daughter of a retired nurse, and I identify as Metis. I love to travel and I am an avid walker and reader. I am keenly interested in health care reform as I see the gaps in care related to seniors, mental health and addictions, accessibility, racism, and health prevention and promotion.

## BOBBI TATOOSH

I was born and raised in Port Alberni and have lived everywhere between Campbell River and Victoria in a span of 20 years (with a short stint in Calgary somewhere along my gypsy travels). I currently reside in Fanny Bay with my husband (married last year) and my 13-year-old daughter and commute to Nanaimo daily for work as the Training and Development Lead for a scaffold company. I have a Bachelor of Business Administration with majors in Accounting and Human Resource Management. I used to volunteer with Nanaimo Search and Rescue, and now volunteer my time to the Port Alberni Shelter Society. My current hobbies are lifting weights and beading earrings. I have volunteered because of my own issues with our failing health care system.





## JOEL THERRIEN

I was born in Kelowna BC but moved to the Vancouver area in my early 20s. I studied my master's in statistics at SFU and currently work as a Data Scientist, where I use machine learning to automatically appraise homes. I like to stay up to date with the news and the economy and have followed some of Canada's health care challenges. A few years ago I needed a family doctor for care and was affected by BC's family doctor shortage. I was very lucky in that a new clinic opened up near my home, but it bothers me that others aren't so lucky. I volunteered so that I can lend my perspective and advocate for a better system.

## HANNAH WILSON

I am a dedicated and experienced social service worker and community activist based in Burnaby, British Columbia. With over 7 years of experience in social work and non-profits, and a diploma in Social Work from Humber College, I have developed a wide range of skills and expertise in various advocacy-based settings. Currently, I work at a large animal welfare non-profit organization and as a private disability advocate for community members. I am an avid reader, knitter, and artist, and enjoy spending time in nature as a way to recharge and stay connected to the Earth. Driven by my personal experiences as a chronically ill and disabled woman, I am deeply committed to addressing medical misogyny and systemic medical oppression. I recently volunteered for the OurCare Priorities Panel to contribute my expertise, experience, and passion for social change. Through this Panel, I look forward to engaging with other individuals, learning from their insights and experiences, and exploring opportunities for collaboration and impact.

## SANDI WILSON

Hello, my name is Sandra Wilson, but please call me Sandi. I moved to Vancouver Island 30 years ago. I was born in Vancouver but moved to Medicine Hat Alberta in the early 1980's. I am self employed as a housekeeper, working to help seniors to stay in their homes for longer. I also work for a few young families. My husband is disabled, but the government will not pay him anything, making us a low-income household. I volunteered for this panel because I feel I can reflect the needs of seniors and families who are both struggling with our health care system.

## ERIC WINTER

I have lived in the Duncan area for the last three years. I lived in Victoria for the prior year and a half. I currently work in a quick service restaurant. I am divorced and have one child. I am a homebody, and I mainly spend my free time reading, watching TV, and playing video games. I volunteered for the panel as I believe in giving back to the community.

## **MATTHEW ZHISS**

I was born and raised in the Chicago area before immigrating to Vancouver in recent years. At my core, I'm a clinical social worker with a major interest in health care equity and accessibility. Every day, as both a health care clinician and a patient myself with ulcerative colitis, I see firsthand how Canada can improve in supporting the health of all. Volunteering for this panel was thus an obvious opportunity which aligned with my goals and, in my time so far in BC, I've built a strong faith in this province's potential to re-envision an amazing health care system. When not advocating for this change, I'm otherwise an avid swimmer, cyclist, and amateur photographer.





# Guest Speakers

*Nineteen experts generously gave their time and shared their knowledge with the British Columbia Priorities Panel on Primary Care. The Panel extends its sincerest thanks to each of them.*

**Estephania Acebedo** is a Clinical Nurse Leader for the Urgent and Primary Care Centre for Island Health in Victoria, responsible for three of the six urgent and primary care centres in the South Island—Gorge, North Quadra, and Downtown Victoria. She has a B.Sc. in Nursing and has worked in specialized care areas including Operating Room (OR), Pediatric Intensive Care Unit (PICU), and Orthopedics and Rehabilitation Unit. Over a twenty-year career in patient care, she has held other leadership roles including Clinical Nurse Leader and Clinical Nurse Educator.

**Dr. Evan Tesla Adams** is a Coast Salish physician from Tla'amin First Nation near Powell River, BC. Dr. Adams completed his Medical Doctorate at the University of Calgary, a residency in the Aboriginal Family Practice program at UBC in Vancouver, and has a Master of Public Health from Johns Hopkins University in Baltimore, Maryland. He was the Deputy Provincial Health Officer for BC (2012 to 2014), the Chief Medical Officer of the First Nations Health Authority (2014-2020), and then the Deputy Chief Medical Officer of First Nations & Inuit Health Branch, Indigenous Services Canada (2020-2023). He has recently returned to the First Nations Health Authority as their Deputy Chief Medical Officer.

**Hayley Diakiw** is a Nurse Practitioner at the Gorge Urgent and Primary Care Centre in Victoria, where she provides primary care for patients of all ages. She completed her Master in Nursing in 2020 at the University of Victoria and currently has a locum for her patient panel and works part time in urgent care. She and her spouse recently welcomed a baby girl in February. When not working, she loves being active outside and spending time with her friends and family.

**Davana Harlow** is a Registered Social Worker with the Downtown Victoria Urgent and Primary Care Centre, with a special interest in supporting individuals with concurrent disorders, complex health care needs, and those facing barriers in accessing care. A systemic thinker, she looks for ways that we can catalyze improvement in our service delivery to best meet the needs of our patients. She loves learning and is supported by her team and leadership to continue to improve on her own practice and to identify ways to improve access and continuity of care within our broader system.

**Dr. Lindsay Hedden** is an Assistant Professor of Health Services Research working in the Faculty of Health Sciences at Simon Fraser University, a Michael Smith Foundation for Health Research Scholar, and the co-Principal Investigator of the Health Systems

Research Lab. Dr. Hedden's current projects address the rapid shift to the use of virtual care; measuring current and predicting future health system capacity and demand; and examining the effects of the increasing corporatization and privatization of primary care on equity, accessibility, and quality of care.

**Dr. Tara Kiran** is the Fidani Chair in Improvement and Innovation at the University of Toronto and Vice-Chair of Quality and Innovation at the Department of Family and Community Medicine. She practices family medicine at the St. Michael's Hospital Academic Family Health Team (SMHAFHT). Dr. Kiran completed her family medicine residency at McMaster University in 2004 and spent her first couple of years in practice as a locum in Indigenous communities in northern Ontario and in Community Health Centres in urban Toronto. She practiced at the Regent Park Community Health Centre from 2006 to 2010 before joining St. Michael's in 2011.

**Dr. Lindsay Mackay** is a family physician and clinician-scientist in the Department of Family Medicine at UBC. She provides primary care and addiction medicine at PHS Community Services Society and Vancouver Coastal Health in Vancouver's Downtown Eastside. Dr. Mackay is the Medical Coordinator for Downtown Eastside Connections, a Vancouver Coastal Health low-barrier, rapid-access substance-use care clinic. She is also Chair of the Vancouver Division of Family Practice Mental Health and Addictions Committee and a member of the Vancouver Community Action Team on overdose response in the Downtown Eastside.

**Dr. Rita McCracken** is a full-service family doctor and an Assistant Professor in the Department of Family Practice at UBC, where she studies primary health care workforce issues and reliable ways to measure changes in primary care access. Her other research work includes assessing the effects of medications prescribed by family doctors and how to alter those prescribing patterns. She chose medicine as a second career after almost 10 years working in Human Resources for high tech companies. She lives in East Vancouver with her family.

**Gladys Mitchell** is from the Saik'uz First Nation located near Vanderhoof, BC, but has resided on the Stellat'en First Nation for 33 years. She is the granddaughter of the late Dr. Mary John Sr, also known as "Stoney Creek Woman." She and her husband owned and operated a logging company for 30 years, during which time he earned a law degree. Together they won the BC Aboriginal Award and a Canada Wide Award for outstanding business. They employed 95 percent

Indigenous people from 10 different First Nation communities. After selling the business, Gladys now works from home with a very successful sewing business, creating custom handbags and working with Indigenous artists to create one-of-a-kind pieces. "I do what I love every day."

**Dr. Goldis Mitra** is a family physician based out of North Vancouver, British Columbia, and practices as a Hospitalist at Surrey Memorial Hospital. Her interests include both practice- and system-level innovation in primary care. She works with BC Family Doctors and Doctors of BC negotiating provincial primary care compensation and primary care reform. She is a Clinical Assistant Professor in the Department of Family Practice at the University of British Columbia, and teaches both medical students and residents.

**Dr. Tracy Monk** is a family doctor in Burnaby / Coquitlam. She graduated from McGill medical school in 1987. She is the Faculty Lead for the UBC Centre for Relationship Based Care and Clinical Assistant Professor in the UBC Department of Family Practice. She is the Physician Lead for the Provincial Pathways website and sits on the Family Practice Services Committee (FPSC).

**Dr. Birinder Narang** is a Clinical Assistant Professor with the Department of Family Practice at the University of British Columbia, a Medical Contributor for Global BC and CKNW 980, and a Family Physician for the REACH Community Health Centre. He is currently in the role of Chair for the Board of Directors at Burnaby Divisions of Family Practice, as well as the Board of Governors for the South Asian Community Health Task Force, where he also co-founded the 'This Is Our Shot' Vaccine Confidence Campaign across Canada.

**Dr. Christie Newton** is Associate Head, Education and Engagement, at UBC's Department of Family Practice and Medical Director of UBC Health Clinic, where her time is dedicated to building capacity for community-based clinical education within team-based care models to enhance primary care in BC. She is a former President of the British Columbia College of Family Physicians (2015-2017), has been a member of numerous CFPC committees, and now is President of the College of Family Physicians of Canada.

**Dr. Keir Peterson** is the Chief Medical Officer at TELUS Health, a global health care leader delivering digital innovation and clinical services to improve total physical, mental, and financial health and wellbeing. He supports a team of more than 1,000 clinicians, covering over 50 million people with in-person and virtual patient care solutions. Keir combines a background in health technology with two decades of clinical experience. He has been an emergency physician in BC and Alberta, and is a former Associate Clinical Professor and Program Director at the University of Alberta.

**Dr. Thuy-Nga (Tia) Pham** is a family physician who trained, worked and taught within a University of Toronto affiliated Family Health Team for close to 20 years when primary care teams were first introduced in Ontario. She has lectured and published internationally on primary care teams in her role as an Associate Professor at the University of Toronto, and brings this passion to Victoria where she currently is the co-Medical Director of the six South Island Urgent and Primary Care Centres, seeing patients and families daily who struggle because they do not have a family doctor.

**Andre Picard** is a health reporter and columnist at the Globe and Mail, where he has been working as a journalist since 1987. He's the author of six bestselling books, most recently *Neglected No More: The Urgent Need to Improve the Lives of Canada's Elders in the Wake of the Pandemic*. He was named Canada's first "Public Health Hero" by the Canadian Public Health Association, as a "Champion of Mental Health" by the Canadian Alliance on Mental Illness and Mental Health, and received the Queen Elizabeth II Diamond Jubilee Medal, for his dedication to improving health care.

**Dr. Kathleen Ross** is a family physician in Coquitlam and New Westminster, BC and President-Elect of the Canadian Medical Association. She does clinical work in community primary care and obstetrics and surgical assist work, including cardiovascular surgery, at Royal Columbian Hospital (RCH). Dr. Ross is past president of Doctors of BC; founding member and chair of the Fraser Northwest Division of Family Practice (FNDFFP), RCH's Collaborative Services Council and FNWDFFP's Shared Care Committee; and president of the RCH medical staff. She has served as the physician lead and chair of the Pathways Patient Referral Association.

**Dr. Alan Ruddiman** is an internationally trained rural generalist physician living and working in Oliver, British Columbia, for the past twenty-seven years. He served as president of Doctors of BC from 2016-2017, and from 2014-2023 he co-chaired BC's Joint Standing Committee on Rural Issues. Alan holds an appointment to the board of BC's Institute for Health System Transformation and Sustainability (IHSTS), and currently serves as one of nine commissioners on British Columbia's Medical Services Commission (MSC). He remains connected to UBC Faculty of Medicine holding a longstanding Clinical Teacher appointment.

**Valerie St. John** has served as the Executive Director of the BC Association of Community Health Centres (BCACHC) since July 2020. She has worked in a number of capacities in BC's health sector for 15 years prior to joining BCACHC holding roles such as Assistant Deputy Minister, Health HR Planning; Managing Consultant, EnVision Business Solutions; and Chief Executive Officer, Nurses and Nurse Practitioners Association of BC. Val's passion is a focus on system level change in support of health service excellence and thriving communities. She lives in Victoria and enjoys island life to the fullest, hiking and boating with family and friends.





## Appendix

# Minority Reports

Members were encouraged to share all points of view throughout the panel process. Discussion remained lively and respectful throughout the proceedings and, while some minor differences in opinion remained, every member of the panel endorsed the recommendations in this final report. However, members also were given the opportunity to write a minority report if they wished to highlight any points of agreement or disagreement, or to include their own commentary.

### Matthew Zhiss

We have known for decades that health is more than our physical, anatomical, and pathological wellness. Health is social, spiritual, psychological, financial, nutritional, legal, cultural, educational, and, most importantly of all, tied closely to housing. Yet we rarely so much as whisper these words during health care discussions. We shout about hospitals, more physicians, more nurses, more MRI machines, and never truly broaden our view to the social determinants of health. As a clinical social worker, I see every day the importance of securing basic shelter, food, cleanliness, and belonging towards the health of those whom I serve.

While the work that myself and my fellow panelists recommended in this report are a vital beginning for re-imagining the primary care system, I implore us to think macroscopically and ingrain health into the very fabric of society. Give me a system which genuinely addresses the social determinants of health. A system where I can offer incredible social services such as comprehensive housing supports, mental health services, and sufficient income supplements. A system where I never again need to tell a person, "I'm sorry, but the system does not have any resources which I can offer you."

This is the deadly failing of our system. It remains centred around hospitals and clinics, set locations for advanced clinical medicine, and fails to address the broader aspects that truly encompass our health.

### Ruby Jaggernath

Doctors can't do it alone. The patient needs to be part of the primary care team. Person-centred care supports people to develop the knowledge, skills, and confidence they need to more effectively manage and make informed decisions about their own health and health care. Doctors try to encourage patients to do better self-care, but altogether too many people are apathetic about health care until they are in an emergency situation themselves. Then they want the doctor to fix it. There needs to be a lot more work on public awareness, especially of personal responsibility

On the other hand: Why doesn't everyone access their medical data?

I got my sixth COVID vaccination recently. I then received an email suggesting I could download information about what to expect over the next few days, depending on which vaccine you received. If you have a BC Services card, they told me, you can view your immunization record online after 24 hours at [healthgateway.gov.bc.ca](https://healthgateway.gov.bc.ca). OK, great idea! I would like to track my health reports. I clicked on their link. OOPS! have to set up a BC Services Card account. I clicked on the new link. There are 2 options: mobile device or password. Okay, I don't have a mobile device. Now I need to go to a Service BC location. Another link, another click. In order to find the service BC location, I have to enter a keyword? What keyword, eh? "Service BC, Abbotsford" gives me a list of 66 locations, in groups of 5. What a waste of my time! It took a while, but I finally found the nearest Service BC location, in Chilliwack. I can even book an appointment, but I have to have my BC Services card or my BCeID ready when I book. The idea is that I am trying to get a BC services card! And what is a BCeID? I am thunderstruck. Again!

People with a low income are even less comfortable using technology. A lot needs to be done to help people achieve personal responsibility for their care, something that will reach the public. Video games about health or the health system? Support from popular singers? Movies? Cartoons for school kids? Let's think outside the box more.

## Joel Therrien

There's one recommendation that I feel that, even on its own, could make a substantial improvement to primary health care if implemented properly: Recommendation 19.c: Integrating and expanding the use of physician assistants and other health care professionals to provide care under physician supervision.

The basic idea here is to reuse the same model already used in other highly regulated professions.

Consider dentists: Dentists employ dental hygienists to take care of simpler tasks such as cleaning teeth while the dentists can focus on the tasks that really require their expertise. This keeps the costs of the system manageable without sacrificing safety as the dentist is still handling complications and determining treatment plans. There would be waitlists if we required dentists to perform all aspects of dental care. The lack of these waitlists is a meaningful clue as to what a successful model might look like.

How can this work in primary care? Allow family physicians to hire nurses to be the first point of contact with patients. Nurses are more than qualified to bandage up a sprained ankle, look at a patient's tonsils, and talk through the patient's symptoms and history. The nurse can report their findings to their supervising physician and the physician can determine the best course of action. With this model one doctor can supervise a team of nurses all simultaneously treating patients. This one recommendation alone could double or triple the capacity of BC's primary health care system.

Will this worsen the nurse staffing shortage? No. Many nurses are leaving the profession because of burnout due to physically exhausting work, long shifts, inconsistent schedules, and an impossible patient load. This opportunity could provide a way for nurses on the verge of burnout to still serve in the medical system in a relaxed manner with consistent hours. Nurses who'd retire may instead opt to work part-time alongside a close physician colleague. Finally, these nurses will absorb some patient load before it reaches hospitals — helping their colleagues there. The end result is that less nurses will leave the profession while still supporting ERs.

## Sabrina Brosnan

An issue I raised during our sessions which did not make it into the consensus recommendations has to do with access to services in a private area of your local library. For many people, accessing any kind of medical care can be a daunting task, due to barriers in a patient's life. These barriers can be due to homelessness; mental health issues; dangers due to physical, sexual or domestic violence; and those that are elderly and not familiar with virtual care technologies among other scenarios. Furthermore, individuals who are in a cohabited living arrangement, such as roommates, do not want to talk to their clinician virtually with the stigma of a roommate hearing private medical information.

Having a private room at the local library to virtually connect with a clinician is a vital way to reach some of the most marginalized members of the public. I recommend that the Federal and Provincial governments fund the addition of these private rooms at libraries, as well as add further funding for staff to be trained to assist those individuals, to train and retain individuals who are social or outreach workers who can better assist those individuals to work in a library, as well as create an awareness campaign to educate individuals as to the availability of these services at libraries.

Another issue I felt needed to be included in this report was to address the opioid crisis that has caused such a strain on the medical system, for clinicians and patients alike. From a patient viewpoint, the crisis began when clinicians stopped prescribing opioid medications for serious illnesses and injuries due to fear of retaliation from medical authorities. This in turn caused patients in extreme pain to look to street dealers with dangerous and deadly variations of opioids.

In order to combat this, I recommend the following:

- a. All clinicians be able to prescribe opioid medications, while under a strict review process by an independent panel made up of fellow clinicians, college administrators, medical authorities and social/outreach workers who interact with opioid users.
- b. Patients receiving opioid medication must be placed on a pain treatment management program where the patient and clinician work to get the patient to a good quality of life status, where an end to opioid use is the target goal. Those with life-long illnesses or injuries who must stay on opioid medication long-term must also be on a treatment plan with a clinician for a minimum monthly review of amounts of opioid medication consumption, with a goal of reducing the need for opioids, as



well as ensuring the patient is not or is not getting addicted to opioids. A plan must be put into place for patients to receive medical treatments such as physical therapy, which must be covered under Fair Pharmacare or BlueCross for those in lower income brackets.

- c. Clinicians who prescribe opioids without proper review of patients' progress to ensure the patient isn't becoming addicted to opioids must be fined and have to work with patients in areas of high drug use for at least one year to mitigate and reduce the number of drug overdoses due to opioids.

In conjunction with the issue of the opioid crisis, there is also the issue of a severe lack of mental health care being provided to those in need. A specific recommendation that I feel is necessary is a dedicated hospital for those with mental health issues. This should be addressed in the reopening of Riverview Hospital, which would require both the Federal and Provincial governments funding for the existing building to be torn down and a new modern hospital to be created, with input from those who deal directly with those with mental health issues, as well as from the patients themselves, as to what would make them feel safe in such a building. In other areas of the province or across the country, other such hospitals must be opened to address the need for a dedicated facility that has the ability to provide in-patient care and that works with organizations such as BC Housing to find permanent, safe housing for individuals. This would assist in getting many homeless individuals with mental health issues off the streets as well. Furthermore, all emergency departments should have a designated area for those suffering either a mental health crisis or an overdose, in which the patient can be quickly assessed and transferred to a more appropriate in-patient care facility, such as a rehab or the mental health hospital for dedicated care, reducing the number of patients in ER's.

An issue that I also felt needed addressing has to do with the continuing climate changes we are all experiencing with greater frequency. There have been reports, from Fraser Health among others, that due to the extreme changes in weather, both in summer and winter, emergency departments are often overburdened with patients suffering from heat/sunstroke, heat exhaustion, or frostbite and hypothermia. Due to the large number of individuals who have been in the emergency departments at the same time, the air control systems have failed, often making the indoor temperature feel the same as the outdoor temperature.

In order to combat this I recommend the following:

- a. Federal and Provincial governments fund the immediate upgrade of air heating and cooling systems to a more efficient system, such as with heat pumps. In conjunction

with BC Hydro, these systems could be implemented and BC Hydro could use the addition of these systems as part of their advertising, in a partnership to raise awareness of the use of systems such as heat pumps.

- b. Install solar and reflective panels to use for energy generation and to reflect heat and sunlight off hospitals and other medical facilities in order to reduce heat in the summer.
- c. Consult blueprints from old buildings (e.g., 100 years and older) and install vents systematically throughout medical buildings to vent heat in summer.
- d. Create mobile outreach units that can provide pop-up cooling or heating areas in public spaces. These units would function like a food-truck-type service where individuals can get water or coffee, thermal blankets in winter, or mini battery fans in summer, as well as medical care for those in need of aid during these seasons with extreme temperature fluctuations.

Finally, as per conversations during the panel meetings, I recommended that for each medical clinic or community health centre, each doctor have one scheduler who inputs specific doctors' appointments into a system that can determine in real time whether the doctor will have enough time in their schedule to cover each aspect of the appointment. I also sought to discuss the need for clinicians to maintain appointments at no less than 20-minute intervals, as less than this amount of time does not allow for clinicians and patients to properly cover medical issues. However, the allotted time for an appointment must be for one patient only.

Patients bringing a number of family members to an appointment and then demanding the clinician take the allotted time from another patient to deal with the family member's health issues is unfair to the clinician and other patients, and it deviates from the set schedule, taking time out of a clinician's personal life as well. Those patients who bring family members for any reason other than for translation or support purposes and then demand the clinician treat the family members as well will be given one warning not to do so again. Should the patient try to do so a second time, they will be removed from that clinician's patient roster for abusing the regulations of that clinic, centre, or office. A clinician's time and attention are too valuable to waste on patients that do not respect the rules of the office or respect the personal time and life of the clinician that gets taken away when they must spend extra time treating patients that are not scheduled for that day.



I also suggest that in order to cut down on the amount of paperwork that clinicians have to fill in daily/weekly, a transcriptionist be employed to take doctors' notes during or after an appointment; fill in medical forms as per clinician's instructions, so a clinician can just review and sign the forms; and provide neatly typed notes with all relevant information before an appointment with a patient to remind the clinician of any pertinent information, prior to the start of the appointment.

As indicated at the outset of this report, I had discussed these issues with various members. However, other members were focused on the core issues set out in the draft report and didn't recognize the importance of adding these issues I have addressed in this minority report, given their correlation to the core issues in the draft report. While many of the issues I have addressed herein can be connected to other sections of the draft report, such as the need for resources at local libraries to aid the most marginalized members of the population, other Panel members felt that these issues shouldn't be included in the draft report for fear that it would be too voluminous or distracting to those who will be reviewing the final report. In addressing the urgent need for these issues to be included in the final report, I feel that those who will be reviewing the final report will not have any difficulty in recognizing the importance of including these issues long-term, as they are issues being dealt with not just in BC, but nationally.



OurCare

# About OurCare

OurCare is a pan-Canadian conversation with everyday people about the future of primary care. It seeks to understand what residents want in a high quality, equitable primary care system and to capture their recommendations for change.

The project is led by Dr. Tara Kiran, a family doctor and renowned primary care researcher based in Toronto. She and the project team are working with Advisory Groups across the country to align with different provincial contexts.

OurCare has three stages:

## **National Research Survey**

The survey was online from September 20 to October 25, 2022. More than 9,200 Canadians completed the survey, sharing their perspectives and experiences. Vox Pop Labs co-designed and executed the survey.

## **Priorities Panels**

Priorities Panels will be held in five regions: Nova Scotia, Quebec, Ontario, British Columbia and Manitoba. MASS LBP is co-designing and executing the panels with OurCare advisors and local delivery partners.

## **Community Roundtables**

Two community roundtables will be hosted in each of the five regions, focusing on equity-deserving groups that we did not hear enough from during stages 1 and 2. MASS LBP is co-designing and executing the community roundtables with OurCare advisors and local community organizations.

# OurCare Project Partners

## OurCare is funded by:

### Health Canada

Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances. Production of this document has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

### Staples Canada – Even the Odds Campaign

Staples and MAP have come together to create Even the Odds: an initiative to raise awareness of inequity in Canada and to help build vibrant, healthy communities. The partnership is based on the shared belief that everyone should have the opportunity to thrive. Even the Odds funds research and solutions to help make the future fair for everyone. Learn more at [staples.ca/eventheodds](https://staples.ca/eventheodds)

### Max Bell Foundation

Max Bell Foundation began making grants to Canadian charities in 1972. Today, the Foundation supports innovative projects that are designed to inform public policy change in four program areas: Education, Environment, Health & Wellness, and Civic Engagement & Democratic Institutions. The Foundation also delivers the Public Policy Training Institute, a professional development program designed to help participants more effectively engage in the public policy process, and PolicyForward, a future-oriented speaker series that brings thought leaders together to discuss the intersections of policy, technology, and innovation.

## OurCare is based at:

### MAP Centre for Urban Health Solutions

MAP Centre for Urban Solutions is a research centre dedicated to creating a healthier future for all. The centre has a focus on scientific excellence, rapid scale-up and long term community partnerships to improve health and lives in Canada. MAP is based at St. Michael's Hospital in Toronto.

### St. Michael's Hospital, Unity Health Toronto

St. Michael's Hospital is a Catholic research and teaching hospital in downtown Toronto. The hospital is part of the Unity Health Toronto network of hospitals that includes Providence Healthcare and St. Joseph's Health Centre.



# OurCare Supporters

## Our Care is also supported by:

### **Department of Family & Community Medicine, University of Toronto**

The University of Toronto's Department of Family & Community Medicine is the largest academic department in the world and home to the World Health Organization Collaborating Centre on Family Medicine and Primary Care.

### **St. Michael's Foundation**

Established in 1992, St. Michael's Foundation mobilizes people, businesses and foundations to support St. Michael's Hospital's world-leading health teams in designing the best care – when, where and how patients need it. Funds support state-of-the-art facilities, equipment needs, and research and education initiatives. Because St. Michael's Foundation stops at nothing to deliver the care experience patients deserve.

## OurCare is working with:

### **British Columbia Advisory Group**

Toby Achtman, **BC College of Family Physicians**

Terri Aldred, **First Nations Health Authority**

Ray Chaboyer, **North Shore Division of Family Practice**

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### **National Collaborating Organizations**

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Vanessa Wright, **Women's College Hospital**  
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### **Patient Advisory Groups**

Canadian Medical Association's Patient Voice Advisory Group  
MAP Centre for Urban Health Solutions' Improving Primary Care Public Advisors Council

*OurCare is engaging with distinct Advisory Groups in each province where it is working.  
Visit [OurCare.ca](https://www.ourcare.ca) for more information about our supporters.*

# Panel Development and Facilitation

The British Columbia Priorities Panel on Primary Care was designed and facilitated by MASS LBP.

Founded by Peter MacLeod in 2008, MASS is Canada's recognized leader in the design of deliberative processes that bridge the distance between citizens, stakeholders, and government. For more than a decade, MASS has been designing and executing innovative deliberative processes that help governments develop more effective policies by working together with their partners and communities.

To learn more about MASS LBP's work, please visit [masslbp.com](http://masslbp.com)

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**Image credits:** Olivia Neale, Department of Family and Community Medicine, University of Toronto

To follow developments on this project, please visit [ourcare.ca](http://ourcare.ca)





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