An Independent Review of British Columbia's Urgent and Primary Care Centres (UPCCs)

Analysis of data obtained via freedom of information requests (2022-2025).

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Jun/2026

What hope is there of improving our health system if we refuse to look at its actual performance?

Effective oversight is challenging when the same organization funds, manages, staffs, operates, investigates, disciplines, reports, promotes, audits, budgets, prioritizes, and controls all messaging.

The challenge is heightened when that same organization depends on public opinion for its survival.

True independent oversight is critical.

UPCCs were supposed to provide rapid access to urgent care while increasing attachment to primary care.

They've done neither and were a significant factor in the closure of many independent family practice clinics.

And they've cost a fortune that could have been used more effectively for better care.

The government pledged regular reports on UPCC performance to the public, but this hasn't happened.

Detailed cost or performance measures for UPCCs have been hard to come by. Instead, we're fed "positive" statistics on total visits that don't tell the whole story.

UPCCs continue to open—there are now 48 in the province. Given the amount of money and scarce human resources devoted to them—and away from more effective ways to deliver health care—the public needs a full accounting of their performance.

Why does this failed experiment continue?

UPCCs provide poor value.

They offer less care for more money, struggle with recruitment, and many are poorly managed.

They don't deliver nearly enough of the care patients need, or the care that was promised.

They divert scarce human and financial resources away from more effective ways to deliver health care.

And that's even before looking at the longitudinal care they promised to provide—but don't.

This report was prepared by Mark Roseman, an independent advocate for transparent, accountable and effective public healthcare.
This report has been placed in the public domain. No funding or other consideration was received for its preparation.
If you notice errors or have questions, please contact me via email: mark@markroseman.com.

Backgrounder: The Wide Gap Between Promise and Reality

UPCCs have been used effectively for political purposes. In particular, announcements of new locations being opened, with grand promises of potential benefits, are used as evidence of the government "taking action" on healthcare. Five new UPCCs were announced in the six months leading up to the 2024 BC election.

Unfortunately, these announcements overshadow the reality of what happens after their openings. And the actual results—often disappointing—are rarely reported by the government. With little data available to the media or others, the initial announcement is often the end of the story.

At right are excerpts from the BC government's media release on the opening of Nanaimo's second UPCC. Consider the impression the media release gives alongside the information it fails to mention.

https://news.gov.bc.ca/32270

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More money spent does not mean more health care delivered.

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Second urgent and primary care centre opening in Nanaimo

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People living in and around Nanaimo will have more access to team-based primary care as a second urgent and primary care centre (UPCC) opens on Thursday, May 1, 2025.

The Central Nanaimo UPCC is at 3260 Norwell Dr.

"This new UPCC is great news for people in the vibrant and fast-growing Nanaimo region," said Josie Osborne, Minister of Health. "Access to primary care is so important to maintaining a good quality of life, and this second UPCC will facilitate more than 86,000 patient visits each year and builds on the success of the first Nanaimo UPCC, opened in 2018. This is one more action we are taking to ensure that people get the health care they need when and where they need it."

This second UPCC in Nanaimo is expected to connect 4,770 people to primary-care providers in the region. The Central Nanaimo UPCC will provide same-day access for people who need support for their primary health-care needs within 12 to 24 hours, but do not require an emergency department. Conditions such as sprains, cuts, high fevers and minor infections are appropriate for care at the UPCC.

"The development of this new UPCC in Nanaimo is the result of extensive collaboration between our partners, including the Snuneymuxw First Nation and the Nanaimo Division of Family Practice," said Leah Hollins, board chair, Island Health. "Nanaimo residents will receive patient-centred, culturally safe care delivered by a compassionate and dedicated team of health-care professionals within a

86,000 visits? Not until staffed up. The current one gets <30,000 per year, and it's declining due to a lack of staff.

UPCCs average ~24k visits/year. And the most ANY of them had in 2023 was 54k. 86k? Never going to happen.

And remember, these are not visits with family doctors. It includes ALL visits—with doctors, nurse practitioners, nurses, mental health, ...

It may be expected, but it isn't going to happen, certainly not without full staffing... and the government has made no information available as to how many patients UPCCs have attached, despite that being one of their main goals. They haven't come close to hitting their targets.

"Once fully operational"... in other words, when fully staffed. The existing Nanaimo UPCC has less than half the doctors, nurse practitioners, and nurses it needs. Where are all the staff for a second one going to come from?

criteria, can be referred to the program. The UPCC will attach people to a family physician or nurse practitioner via the provincial attachment system, pending ongoing recruitment efforts.

The UPCC will be open seven days a week for urgent primary-care needs from 8 a.m. to 8 p.m. Access to the UPCC will be through appointments booked in advance by calling 1 833 688-8722, and up to 20% of services may be offered through virtual care.

Once fully operational, the UPCC will have a clinical staffing complement of approximately 35.71 full-time equivalent (FTE) health-care workers, including 9.80 FTE of family physicians and 2.32 FTE of nurse practitioners, 14.86 FTEs of registered nurses, 6.98 FTEs comprised of social workers and mental-health and substance-use clinicians, and 1.75 FTE of community health worker. This clinical team is supported by several non-clinical roles, including a clinic manager and medical office assistants.

As of April 2025, the ministry has committed $8.8 million in annual operating costs and a one-time amount of $200,000 for Central Nanaimo UPCC.

Additionally, the total capital cost for the Central Nanaimo UPCC is estimated to be approximately $8.2 million.

$8.2 million in capital costs... before you start looking at operating costs. Independent clinics do not receive dedicated capital funding. And because it comes out of their ownERs revenues, they spend a tiny fraction of that amount.

Remember that $8.8 million per year would pay for 153,000 15-min LFP visits per year with a family doctor at an independent clinic.

of Nanaimo have access to safe, comprehensive and timely urgent and primary care."

Quick Facts:

- Including the new Central Nanaimo UPCC, there are 43 announced UPCCs in B.C., with 41 delivering services and nine operating in the Island Health region.
- The Medical Arts UPCC at 103-650 South Terminal Ave. was the first UPCC established in Nanaimo.
- The Medical Arts UPCC is open seven days a week, Monday to Friday from 8 a.m. to 9 p.m., and Saturday and Sunday from 9 a.m. to 6 p.m., and provides same-day treatment for non-emergency injuries and illnesses when people are unable to see a family doctor or care provider at a regular clinic.
- The Medical Arts UPCC was established in September 2019 and has provided more than 150,245 patient visits to date.

Learn More:

Provides same-day treatment only if you can get one of the few appointments available right when they open. Otherwise, you're out of luck.

And there's that "patient visits" again. And 150,245 visits sure sounds impressive. But why are they boasting about 150k visits over SIX years?

Source of Data

Comprehensive performance metrics for UPCCs are not proactively disclosed publicly by the government. Instead, what little we hear is often "cherry-picked" snippets of data, or optimistic forecasts, such as found in government media releases coinciding with each new UPCC.

The data in this report was obtained through a series of freedom of information (FOI) requests. They included data on operating costs, staffing, services provided, and more.

The source data, i.e., original FOI response reports, as well as a spreadsheet collating the data into a more usable form, is available from:

https://healthdatabc.ca/upcc/

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fraserhealth

North Surrey	2018-11-08	✓	Note 1
Edmonds	2019-09-23		
Ridge Meadows	2019-10-01		
Abbotsford	2020-04-17	✓	
Surrey Newton	2020-05-25	✓	
Port Moody	2021-02-22	✓	
Metrotown	2022-11-01	✓	
Langley	2024-03-20		
Chilliwack	2024-04-19		
Mission	2024–05-10	✓	

Interior Health

Kamloops	2018-06-12	✓	
Vernon	2019-10-01	✓	
Kelowna	2019-12-30	✓	
Castlegar**	2020-04-06		Note 2
West Kelowna	2020-10-05	✓	
Penticton	2021-03-31	✓	
Cranbrook	2021-12-12		
Ashcroft	2022-09-27		
Rutland	2023-11-21	✓	
Kamloops North	2024-11-26		
Williams Lake	2025-02-25		Note 3

northern health
the northern way of caring

Quesnel	2018-10-31		
Prince George**	2019-06-05		Note 2

Vancouver CoastalHealth

Vancouver CC	2018-11-26		
North Shore	2019-11-04		
REACH	2019-11-04		Note 4
Northeast	2021-02-16		
Richmond	2021-04-01		
Southeast	2022-03-29		
Richmond East	2024-04-02	✓	

Island Health

Westshore	2018-11-05	✓	Note 5
Nanaimo**	2019-06-03		Note 2
James Bay	2020-04-28	✓	
Downtown	2021-07-19	✓	
North Quadra	2021-11-30	✓	
Esquimalt	2021-12-06	✓	
Gorge	2022-09-21	✓	
Comox Valley	2023-04-03		
Peninsula	2024-08-24		
Campbell River	2024-05-04		
Central Nanaimo	2024-07-24		Note 3
Cowichan	2025-10-20		Note 3

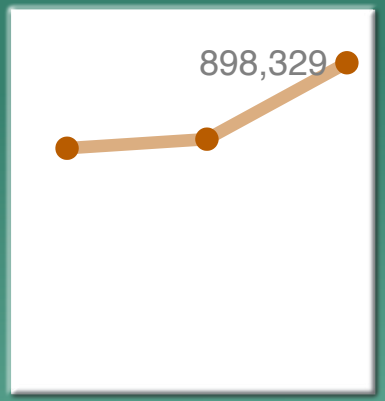
List of UPCCs , opening dates and whether the UPCC "attaches" patients, based on patient visit data. (FY2024–2025)

Notes

1. Actual overhead costs for Surrey North (Whatley) were omitted from the FOI response report. Budgeted overhead of exactly $600,000 is included in the data. Of note, the previous year, overhead was $1,753,230 (budgeted $1,376,686).
2. While at most UPCCs, physicians are paid on salary, at Nanaimo (Medical Arts), Castlegar, and Prince George, most or all physicians are instead paid by billing MSP on a fee-for-service basis. Those costs are not reflected in UPCC physician cost data, so it looks like payments to physicians are much lower than they actually are.
3. Williams Lake, Central Nanaimo, and Cowichan were just launching as of the time period covered by the FOI request, so their patient volumes for that time are very low. As that greatly skews many derived metrics, e.g., overhead cost per visit, they are not displayed in the charts in this report, though their data factors into overall totals.
4. No cost data for REACH UPCC was included in the FOI response report. Of note, it was included in the FOI response reports for the previous two years.
5. The budgeted overhead costs for Westshore in the FOI response report appear to be incorrect (budgeted $356,656 vs. actual $1,846,759), making a disproportionately high actual vs. budgeted ratio (5.18). Of note, in the previous year, overhead costs were budgeted at $1,344,533, actual $1,607,256, ratio 1.20. In the year before that, overhead costs were budgeted at $924,533, actual $1,854,355, ratio 2.01.

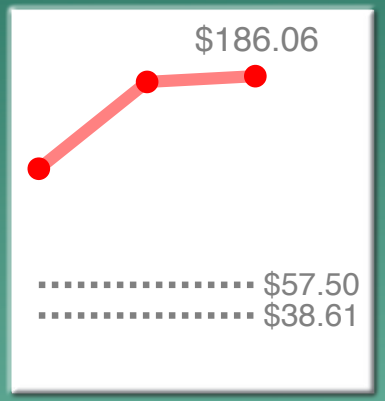
The Big Picture

Visits

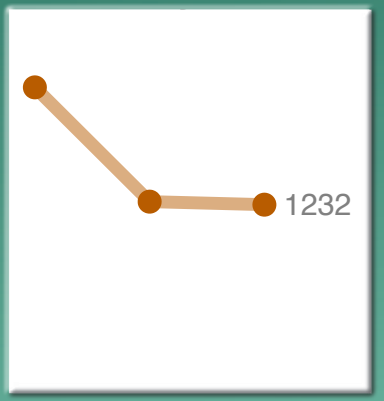


Costs

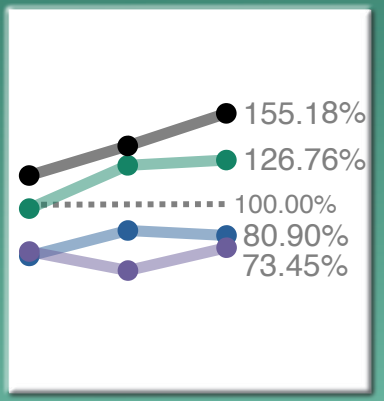
Cost / Visit



Productivity



Efficiency



Good

Patient visits are up.

Bad

Operating costs are way up.

Terrible

Cost per visit is much higher than in independent clinics.

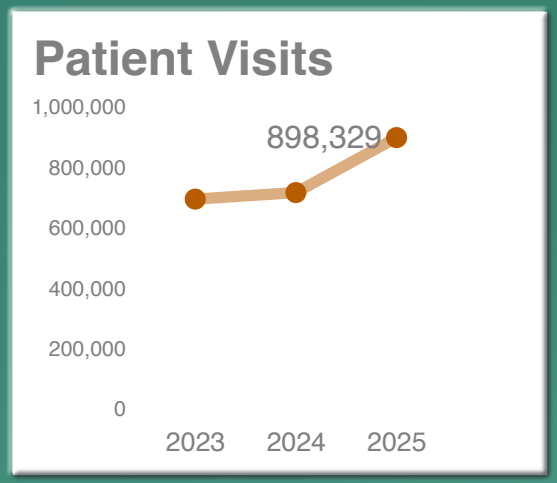
Uh oh

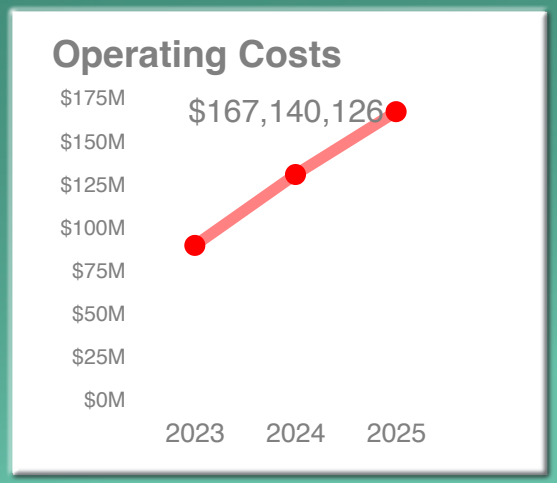
The number of patients seen per year by each family physician, nurse practitioner, or nurse is very low.

Yikes!

Overhead costs are out of control, 55% over budget. Far more nurses were hired than needed. Yet there aren't nearly enough family physicians, nurse practitioners, or allied health.

Patient Visits and Operating Costs





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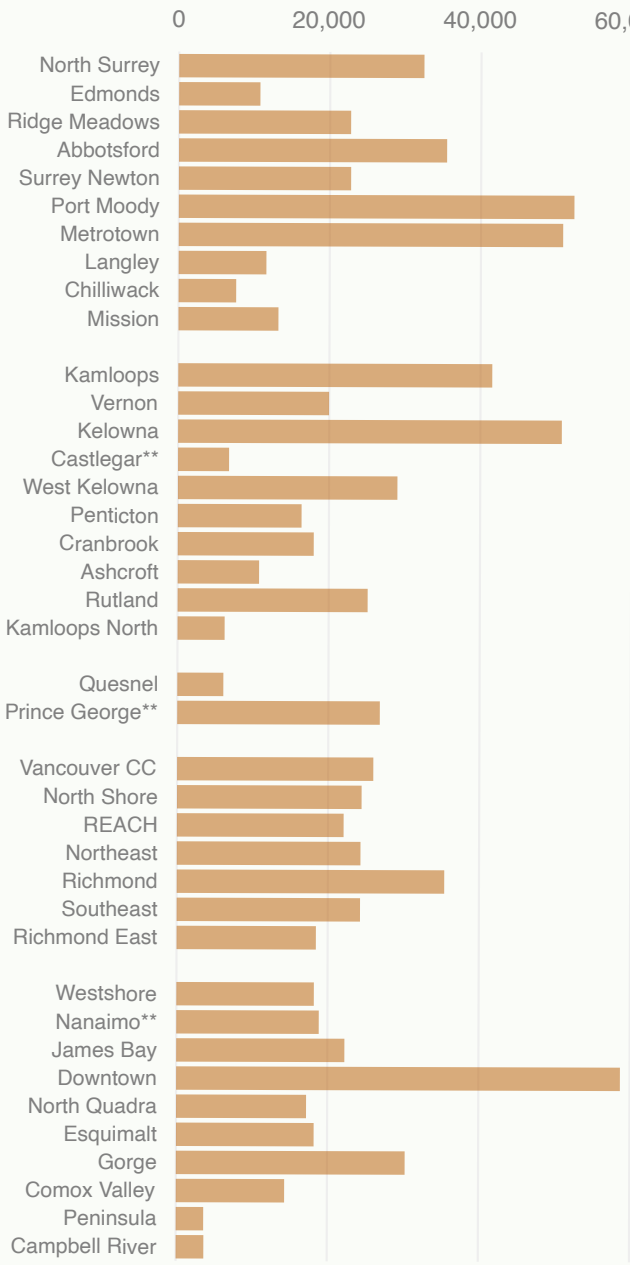
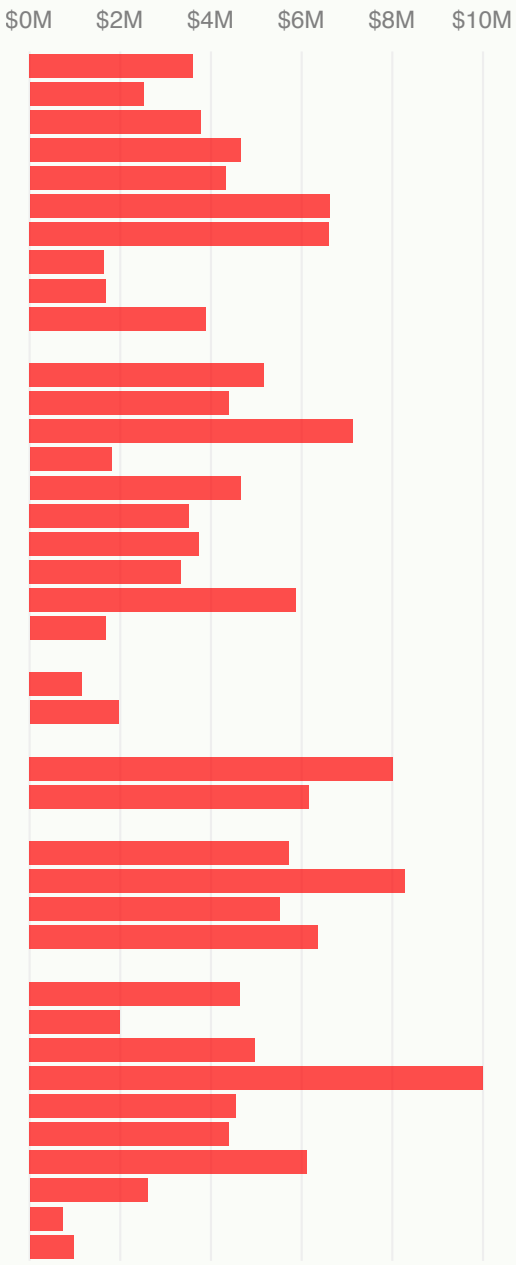
Some UPCCs are larger or busier than others and see more patients. Naturally, their costs are higher as well. But even a casual look at the charts below shows that there isn't a 1:1 correlation—some UPCCs with a similar number of visits have vastly different costs. To understand why, the following pages will dig into the details.



Number of patient visits (FY2024–2025).



Total operating costs (FY2024–2025).

Measuring Value: Cost per Visit

While all patient visits aren't identical, the main performance metric we use to account for differences in patient volumes across UPCCs is the cost per patient visit.

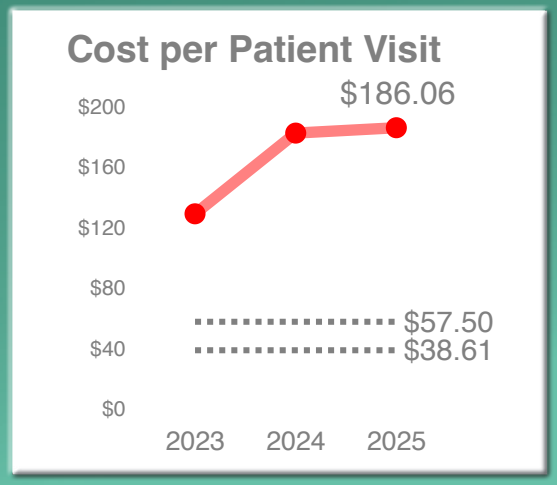
Cost per visit is also extremely useful for comparing with other clinics that provide overlapping services.

As UPCCs opened, many walk-in and other primary care clinics operated by independent family physicians (i.e., not the government health authorities that operate UPCCs) closed.

Those clinics billed MSP for their services. How much?

Physicians working under the classic fee-for-service (FFS) model could bill $38.61 for a "standard" patient visit (billing code 00100).

Under the longitudinal family physician model (LFP), they could bill $57.50 for a 15-minute visit (codes 98010, 98031).



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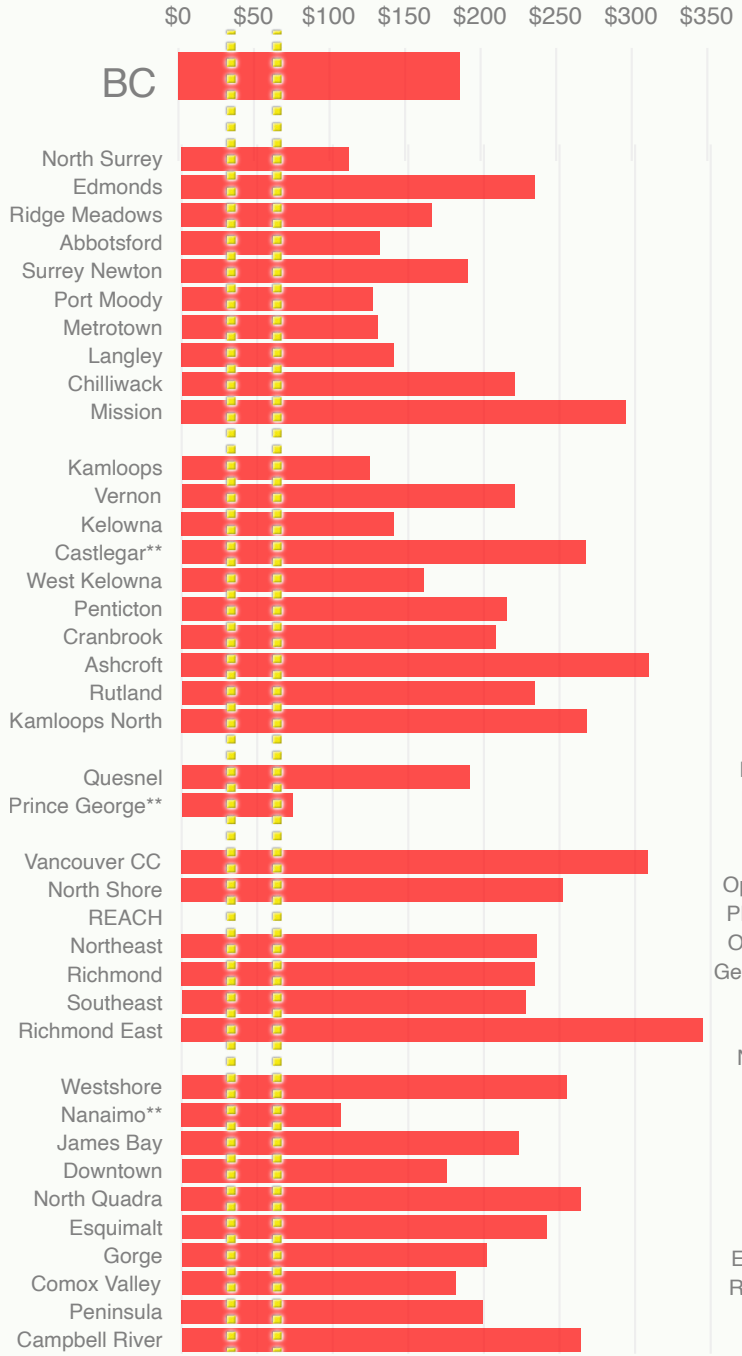
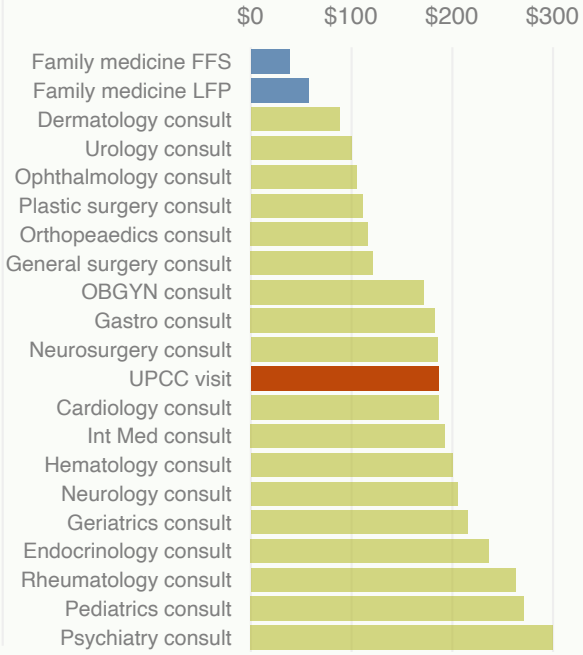


Total operating cost per patient visit (FY2024–2025).

Is $186[06] for an *average* UPCC visit good value?

The chart below puts that amount in the middle of the pack for what many specialist physicians bill MSP for a full consultation (exam, history, review of tests, report). And well above what family physicians bill MSP for a full visit.

What would justify this disproportionately high cost for UPCC visits?



For comparison, average cost of UPCC visit vs. common MSP fees billable for family medicine and specialist physician visits at independent clinics.

Backgrounder: Attachment, Access & Services

The consistent story about UPCCs from the beginning was that they would be a better solution for primary care and also address urgent care needs, diverting patients from emergency rooms. The reality is different.

They're still promoted as providing rapid access to care for patients who need it. Yet they've moved to a model where you need to book an appointment (if you're lucky) when they first open to be seen. Which really defeats the purpose.

Emergency physicians have repeatedly told us that low-acuity patients—those that UPCCs could help—are not the cause of ER overcrowding or waits. Instead, it's the higher-acuity patients admitted but "boarded" in the ER waiting for a bed to open upstairs. UPCCs will never solve the real problems in ERs.

UPCCs also promised to "attach" patients (i.e., connect them with a regular primary care provider). That has not happened.

In effect, UPCCs have become very expensive appointment-based walk-in clinics.

Except that they actually have fewer responsibilities to patients than independent walk-in clinics do.

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UPCCs were originally first-come, first-served, with lineups often starting at 6am for 8am openings; arrive later, and they were already at capacity for the day. Those lineups became embarrassing.

To hide the problem, lineups were replaced by requiring patients to schedule appointments by phone when the clinic first opened. So medical care became like a radio contest.

More recently, people have been calling and leaving messages. A nurse calls back to triage and better prioritize appointments.

Except that often people are waiting all day and not getting callbacks if their problem isn't deemed sufficiently urgent.

This is not access to health care.

Unfortunately, no data is available regarding people who try to access a UPCC but fail.

Patients needing to be seen quickly often can't access care. Capacity is reached minutes after first opening–or before, if family physicians and nurse practitioners are not available that day.

Do UPCCs attach patients?

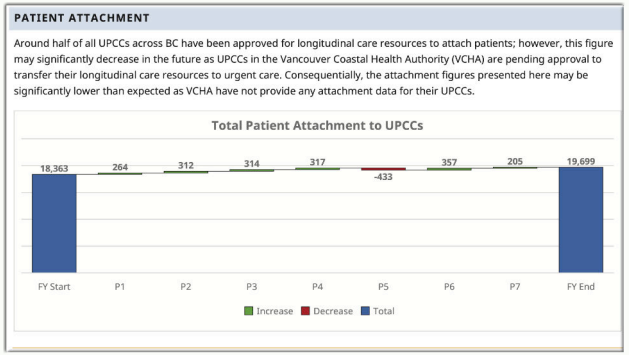
They were supposed to. And announcements continue to emphasize the number of patients UPCCs will eventually attach to primary care.

But over half don't attach patients to primary care providers at all (21 vs. 19).

For those that do, it's not many (<20k total, or 0.35% of BC's population).

And those in VCH are getting out of it entirely.

In reality, attachment at UPCCs plays a diminished role compared to both original expectations and ongoing promises.

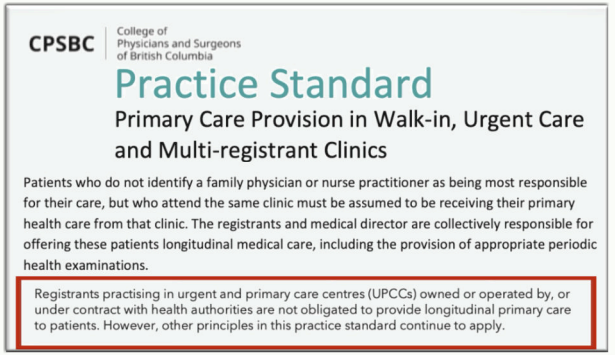


Data on attachment (FY2023-2024).

Responsibilities to unattached patients

We know that episodic care is no substitute for longitudinal care. With so many patients in BC lacking access to a regular primary care provider, physicians at walk-in clinics and other venues offering mostly episodic care have been obligated to provide longitudinal care to patients who regularly attend the same clinic.

UPCCs, however, despite receiving massive amounts of government funding, are exempt from that requirement. They may have forced the closure of many walk-in clinics in their communities, but they don't have to provide the same service to patients.


CPSBC College of Physicians and Surgeons of British Columbia

Practice Standard

Primary Care Provision in Walk-in, Urgent Care and Multi-registrant Clinics

Patients who do not identify a family physician or nurse practitioner as being most responsible for their care, but who attend the same clinic must be assumed to be receiving their primary health care from that clinic. The registrants and medical director are collectively responsible for offering these patients longitudinal medical care, including the provision of appropriate periodic health examinations.

Registrants practising in urgent and primary care centres (UPCCs) owned or operated by, or under contract with health authorities are not obligated to provide longitudinal primary care to patients. However, other principles in this practice standard continue to apply.

Excerpt from CPSBC Practice Standard.

Who Uses UPCCs?

This year's UPCC data now includes information on whether patients who visit a UPCC are attached to a primary care provider.

The idea of being attached to a designated primary care provider (their "medical home") has been an increasing focus in recent years. We see this in other initiatives such as the Health Connect Registry, which facilitates these connections.

Attachment also plays a significant role in payment models for family physicians, including the Longitudinal Family Physician plan that launched in 2023.

The UPCC patient visit data is broken down into patients who are attached to the UPCC, patients attached to another clinic or provider, and those not attached to primary care at all.

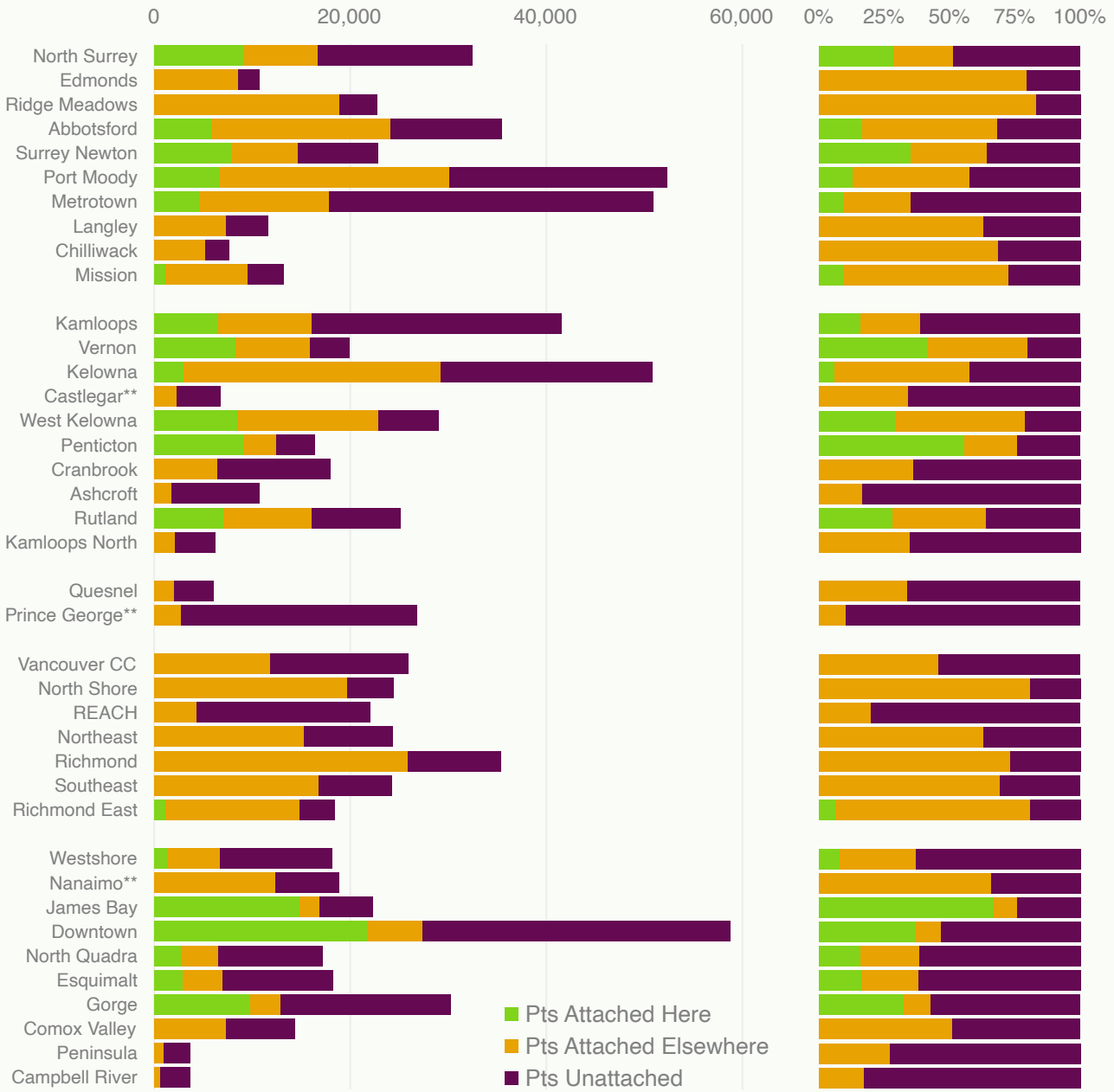
Looking at the charts, you'll notice first that just under half of UPCCs see any patients attached there (in green)–a reflection that many don't attach anyone.

Second, most see a substantial number of patients not attached anywhere (dark purple), as you'd expect (~45% overall).

The orange, patients attached elsewhere (~40% overall), is interesting. It seems high. Why are so many attached elsewhere going to a UPCC?

At least two possible reasons. First, they can't get in to see their own provider promptly, which is a problem.

Alternatively, while they may be officially attached, in practice, they aren't. They may have moved (or their doctor did), or they've stopped seeing them, but the attachment status hasn't been updated to reflect that. How common are such "zombie attachments?"



Number of patient visits for each UPCC broken down by patient attachment. "Attached here" are patients attached to that UPCC, "attached elsewhere" are patients attached to a different clinic or healthcare provider, and "unattached" are not attached to anyone.

Same data shown as percentage of total visits for each UPCC.

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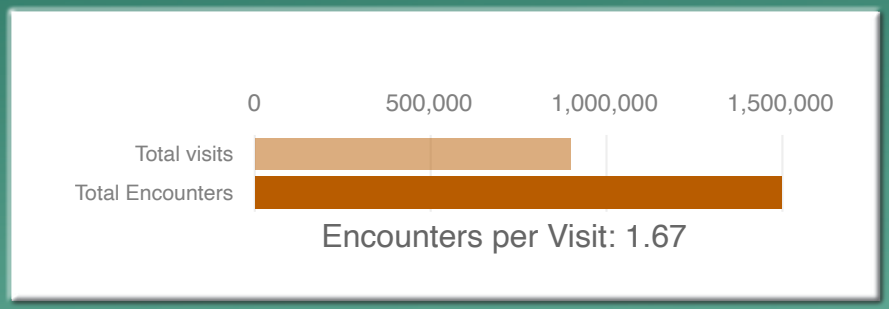
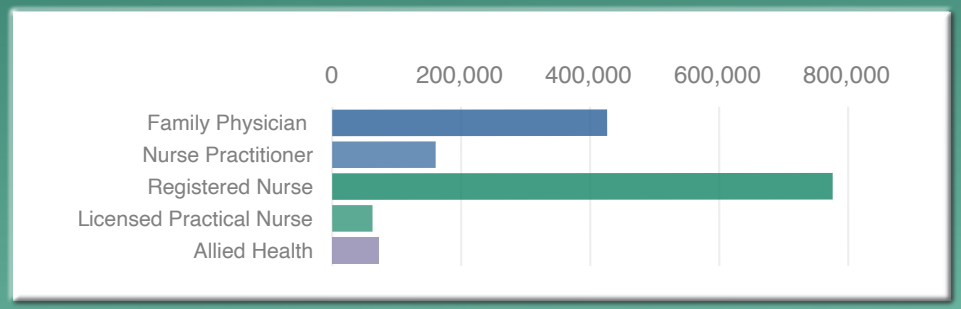
Who do you see at a UPCC?

Patient Visits and Encounters





In previous years, UPCC data only reported total patient visits. Many of us have been demanding data on what those visits entail for years, such as whether patients saw a physician, a nurse, both, etc. So we're grateful that the most recent year's data now includes patient *encounters* as well as *visits*.

We now know who a patient saw during their visit (family physician, nurse practitioner, registered nurse, licensed practical nurse, or allied health, which may include a mental health clinician, pharmacist, etc.). And a single visit may now include multiple encounters, e.g., seeing a nurse and then a physician.

This is a step forward, though we still don't know the *scope* of those encounters, e.g., was a visit with a nurse a 5min blood pressure check, or 45min to provide detailed education around managing their diabetes?

Still, this allows for new insights that we did not have previously. Which often raises more questions.

As you'll see from the data, UPCCs have different mixes of encounters, and there's likely some discrepancies in terms of recording—what one site counts as an encounter, another may not.

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Visits and Encounters

Each *patient visit* may consist of one or more *clinical encounters* with different healthcare staff, including family physicians, nurse practitioners, nurses, and allied health.

As you'd expect in team-based care, seeing multiple providers in a visit isn't unusual, but how many varies by site. Some of this is likely differences in how encounters are recorded. Unfortunately, we have no information on the scope of those encounters (superficial or in-depth) is. More details, e.g., time, activity, would make it easier to determine how effectively this team-based care model is working at UPCCs.

Patient visits and clinical encounters. Each patient visit includes one or more clinical encounters. (FY2024–2025)

Ratio of clinical encounters to patient visits. Provincial average is 1.67. (FY2024–2025)

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Encounters

This chart breaks down the number of clinical encounters at each UPCC by profession.

Even factoring in differences in patient volume, you can see differences in the relative patterns of those encounters.

For example, some UPCCs have a much higher proportion of primary care (family physician and/or nurse practitioner) encounters than others.

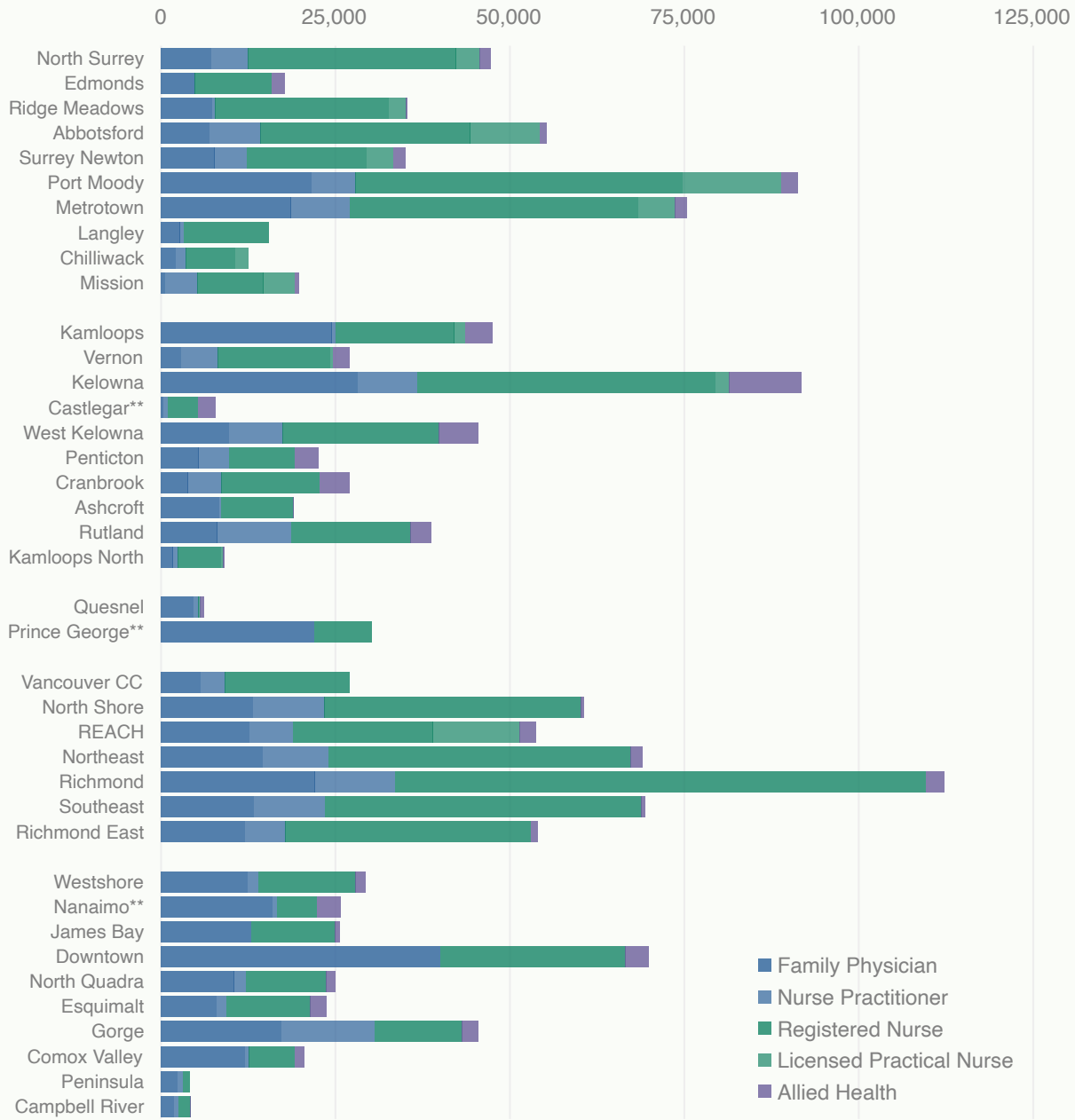
Even the relative proportion of family physicians vs. nurse practitioners varies quite a bit.

Some UPCCs have a much higher proportion of visits with nurses than other sites. And some have a fair number of allied health encounters, while others have few or none.

Who you see (and the services you can expect) at each UPCC varies. For patients, that matters.

In the coming pages, we'll look more closely at this data, focusing on what it says about primary care, nursing, and allied health encounters.

Every UPCC manages care a bit differently, and so you find a different mix of encounters. How much of the mix is explicitly driven by community need?



Number of clinical encounters by profession. (FY2024–2025)

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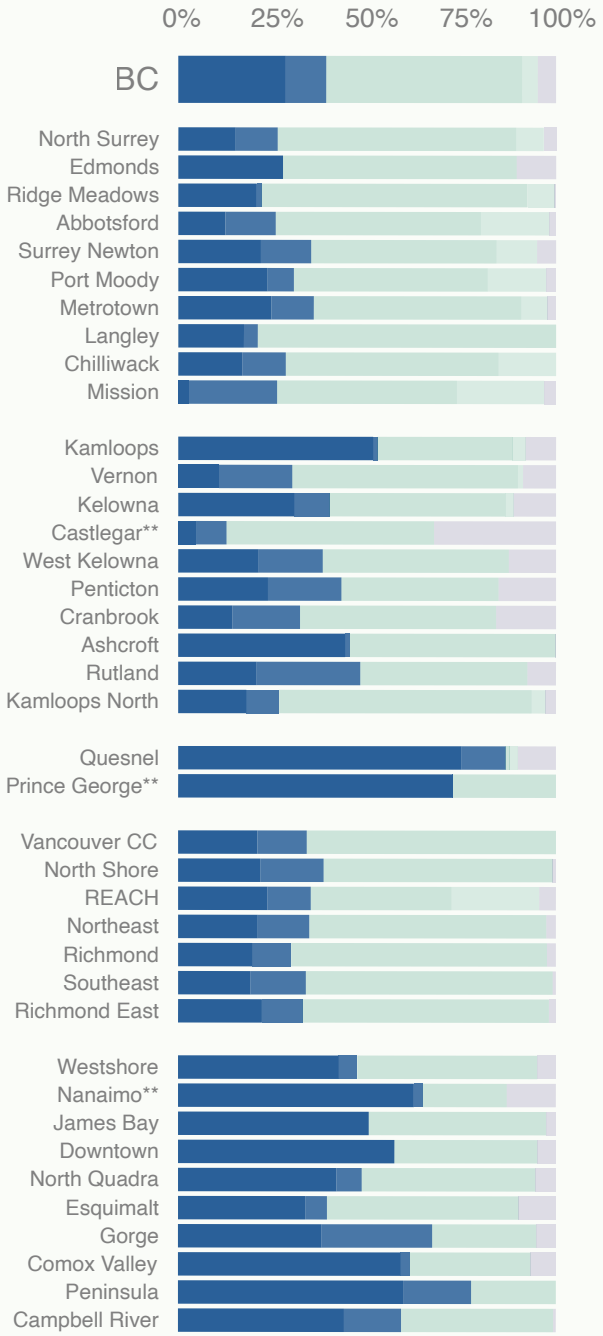
Visits and Encounters: Primary Care

ENCOUNTERS: 39% (13%–87%)
- Family Physicians: 28% (3%–75%)
- Nurse Practitioners: 11% (0%–27%)

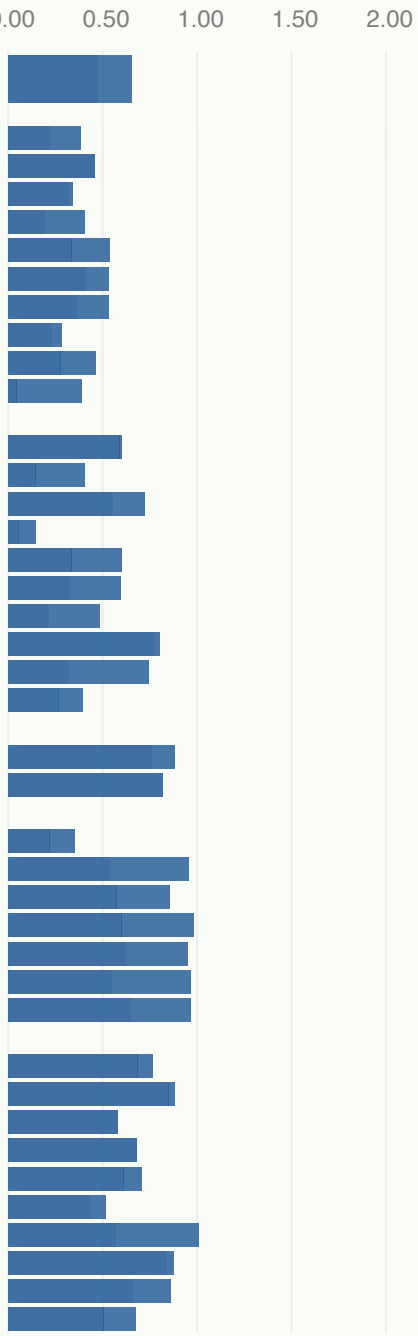
ENCOUNTERS/VISIT: 0.65 (0.15–1.01)
- Family Physicians: 0.47 (0.04–0.85)
- Nurse Practitioners: 0.18 (0-0.44)

On average, about two of every three visits to a UPCC include seeing a family physician or nurse practitioner, potentially along with nursing or allied health.

At some UPCCs, it's close to one of every three visits; at others, most visits on average include seeing a FP/NP.



Primary care clinical encounters (both family physicians and nurse practitioners) relative to all clinical encounters. (FY2024–2025)



Number of primary care clinical encounters relative to patient visits. For example, a value of 0.5 suggests that (on average) every second patient visit included a primary care clinical encounter. (FY2024–2025)

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Visits and Encounters: Nursing

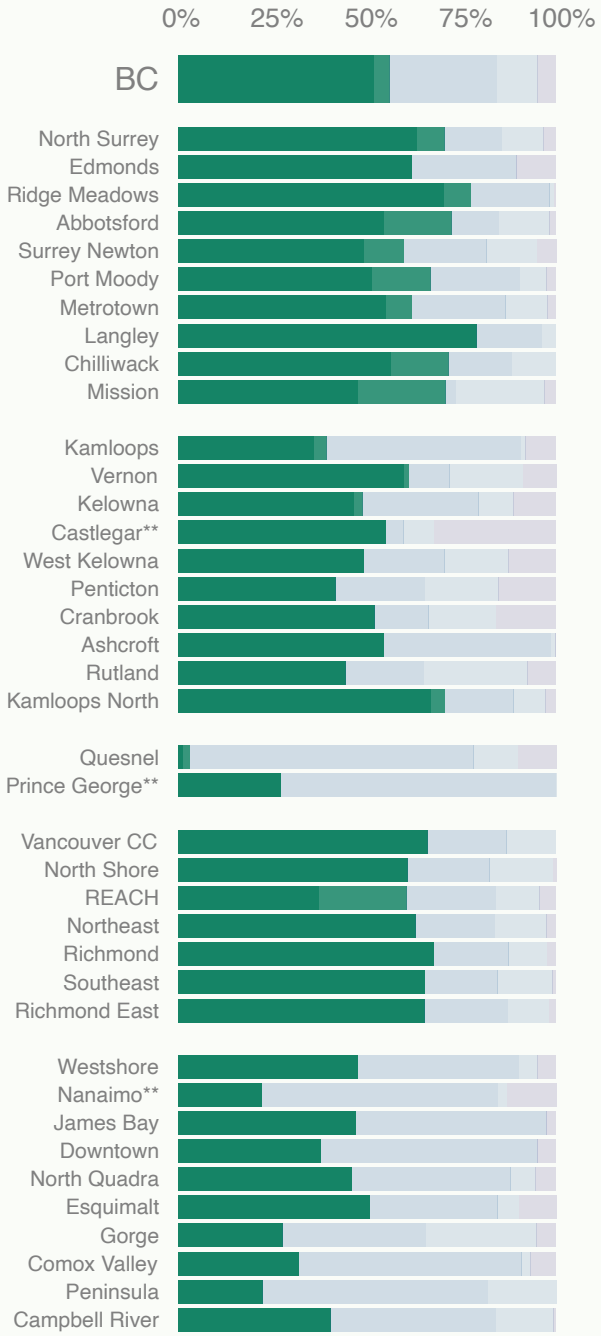
ENCOUNTERS: 56% (3%–77%)
Registered Nurses: 52% (1%–79%)
Licensed Practical Nurses: 4% (0%–23%)

ENCOUNTERS/VISIT: 0.93 (0.03-2.15)
Registered Nurses: 0.86 (0.01–2.15)
Licensed Practical Nurses: 0.07 (0-0.57)

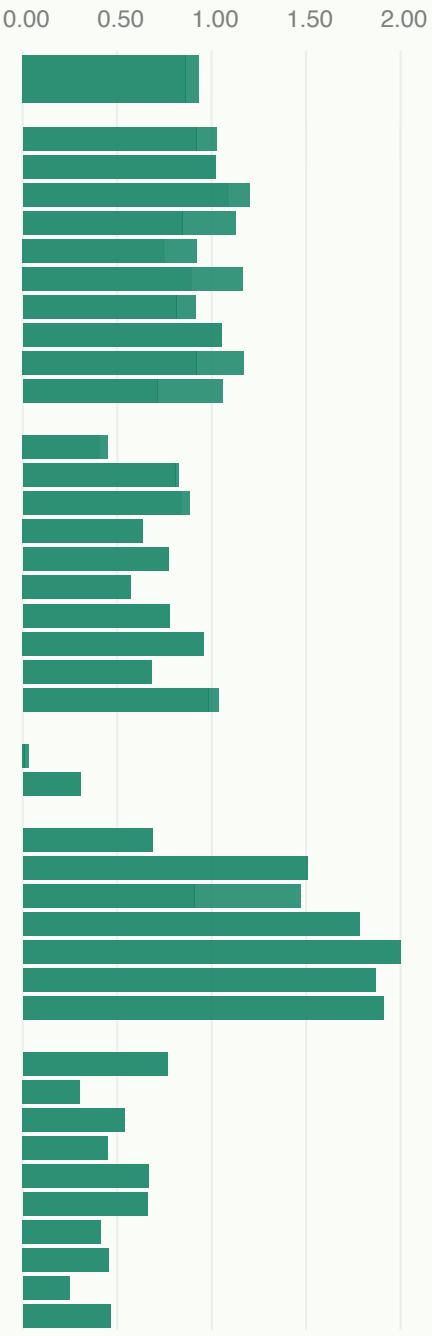
On average, nearly every visit to a UPCC includes seeing a nurse, potentially along with a family physician, nurse practitioner, or allied health.

At some UPCCs, it's less than half of visits, while at others, an average patient visit averages close to *two* clinical encounters with a nurse.

More details on the role of nursing, particularly multiple encounters with nurses during a single visit, would be useful to obtain.



Nursing clinical encounters relative to all clinical encounters. (FY2024–2025)



Number of nursing clinical encounters relative to patient visits. Values > 1 suggest that (on average) more than one nursing encounter is involved per patient visit. (FY2024–2025)

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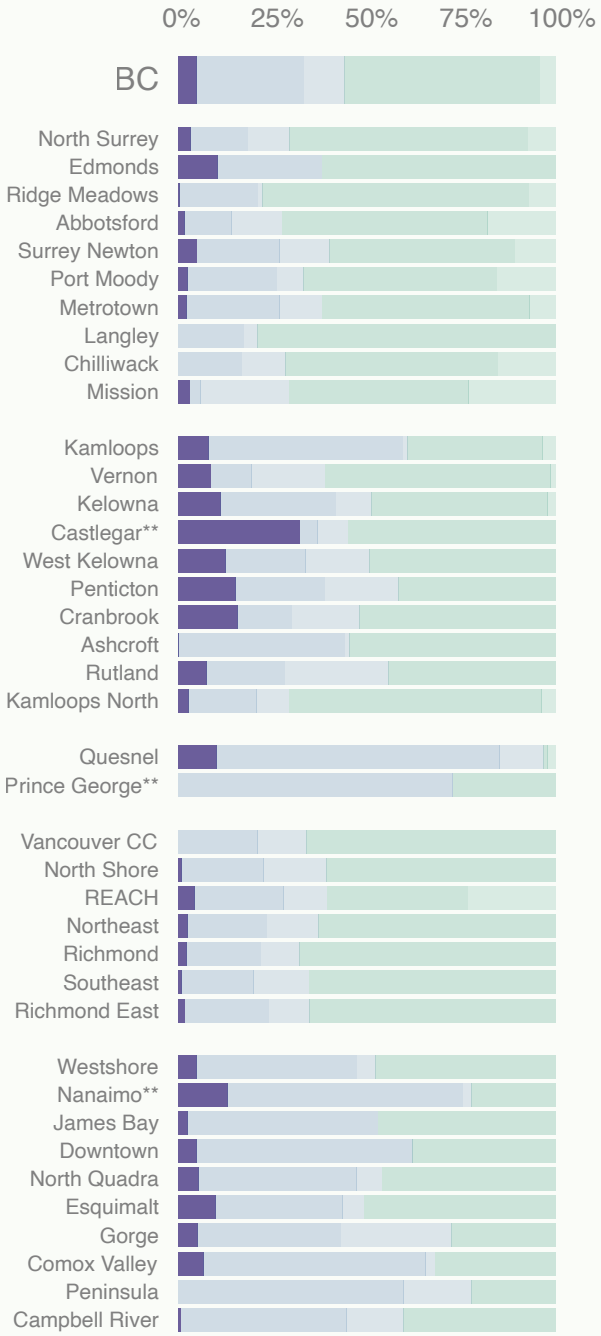
Visits and Encounters: Allied Health

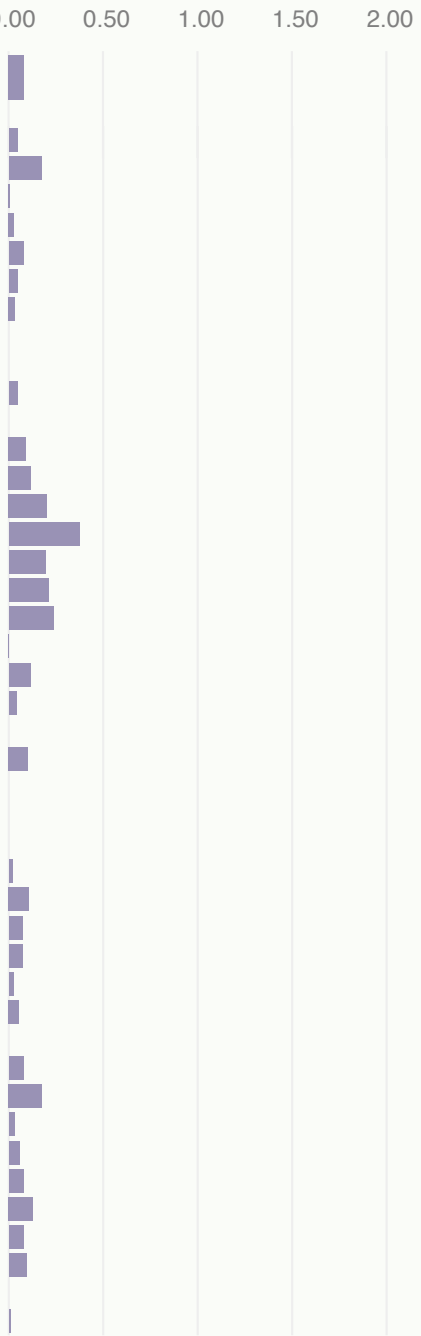
ENCOUNTERS: 5% (0%–32%)
ENCOUNTERS/VISIT: 0.08 (0–0.37)

Visits with allied health (primarily mental health and substance use clinicians) make up a fairly small percentage of encounters at most UPCCs. Some offer more availability of these services; others, less or none at all.

While the availability of government-funded outpatient mental health services of any kind is very limited, in many regions, there are more dedicated mental health centres or PCN-based services available than in others. A look at the overall availability of such services in a given region is beyond the scope of this report.



Allied health (primarily mental health) clinical encounters relative to all clinical encounters. (FY2024–2025)



Number of allied health clinical encounters relative to patient visits. (FY2024–2025)

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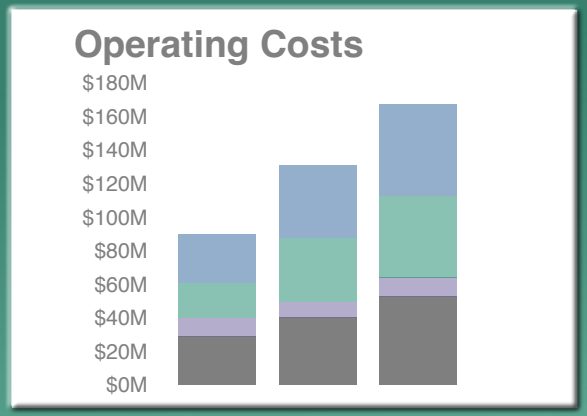
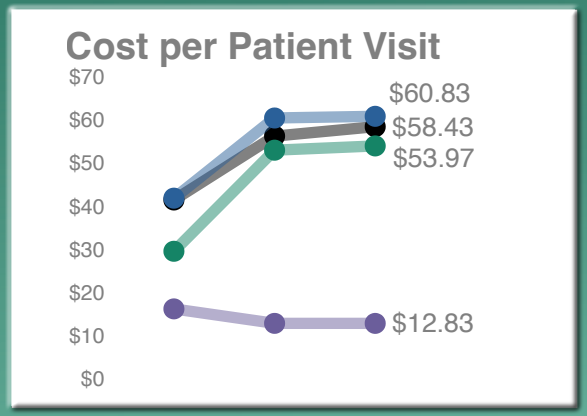
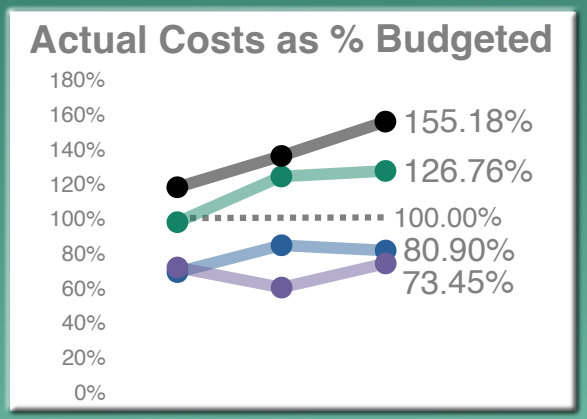
Operating Costs

What are UPCCs spending, and how well do they manage that spending?







How much does it cost to deliver all the patient visits and clinical encounters we just examined? That's the question this section addresses.

We previously looked at total costs and the relatively high average cost per visit ($185.74). We noted that it more closely resembled visits with specialists than traditional primary care clinics.

Keep in mind, too, that nurses play a much larger role in UPCCs than FPs/NPs. That suggests the high costs at UPCCs may be even further out of line.

Here, we're going to explore exactly how those costs break down–what it is UPCCs are spending on.

We'll also examine how closely they keep to their budget in different categories.

While every UPCC is different, you'll see that, on average, they're underspending on family physicians, nurse practitioners, and allied health.

In contrast, they're greatly overspending on nursing (and it's not clear from the data exactly why that many nurses are needed. The other major concern is overhead.

Bottom line: containing costs doesn't seem to be a priority.

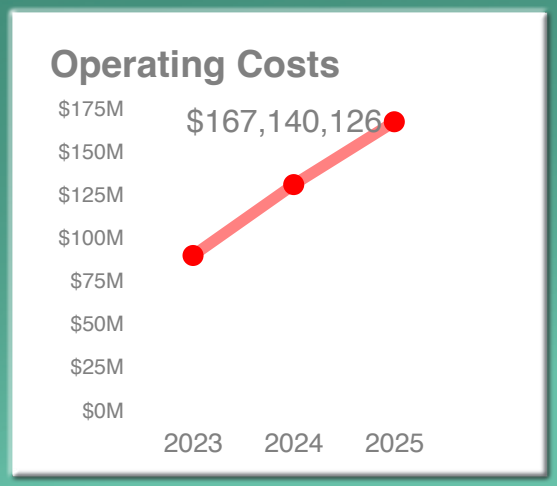
Actual Costs

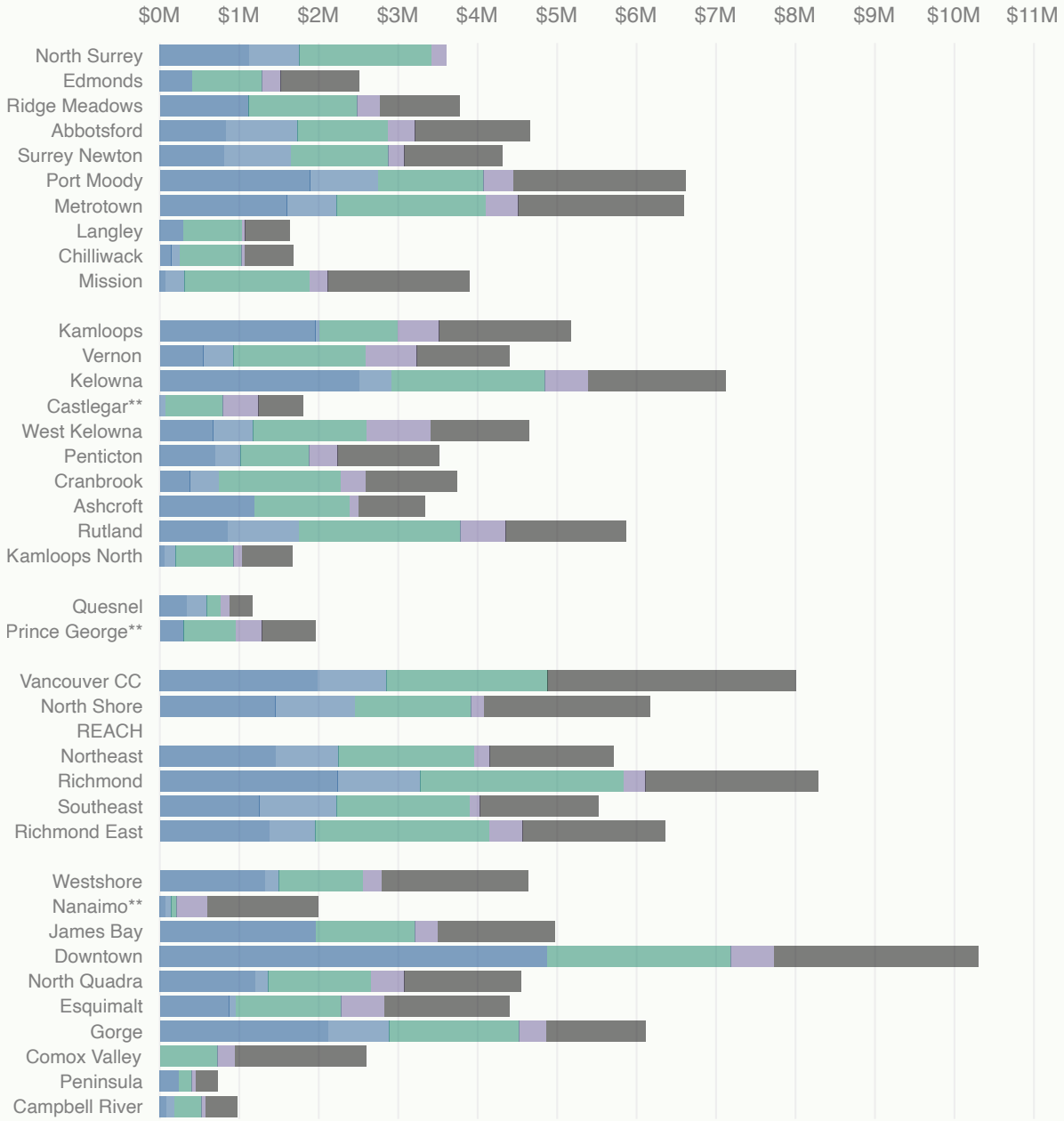
You'd expect costs to increase with higher patient volumes, so looking only at the total raw cost numbers in isolation doesn't tell us a lot.

However, once you break them down into spending categories, you can already see patterns emerge across different UPCCs.

Focus on the relative portion of spending at each for a given category (e.g., family physicians, overhead). Relatively speaking, you can see some spend a far higher portion of their budget in certain areas than others.

Not included are the initial startup capital costs, which can run into several million dollars per UPCC.





Operating costs at each UPCC broken down by category: family physicians, nurse practitioners, nursing, allied health, overhead. (FY2024–2025)

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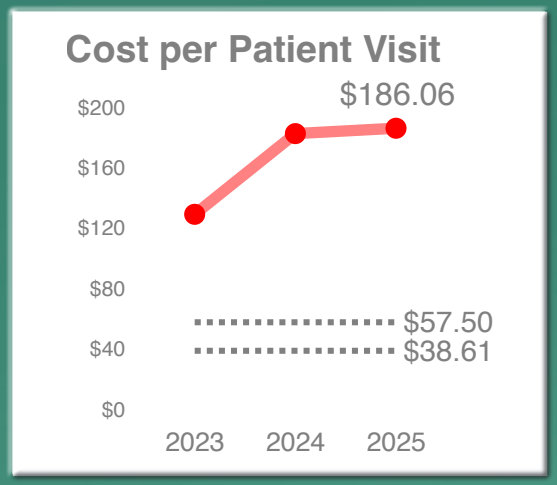
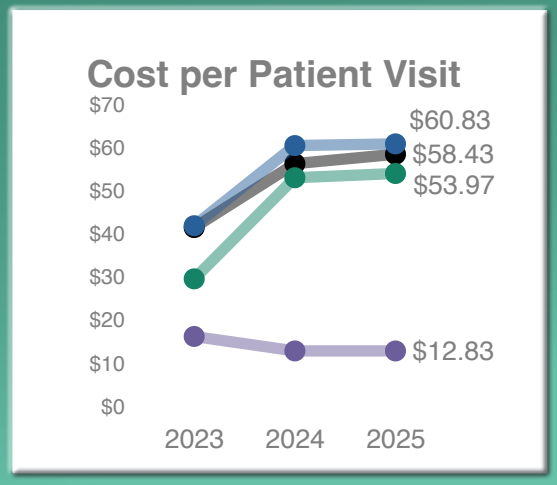
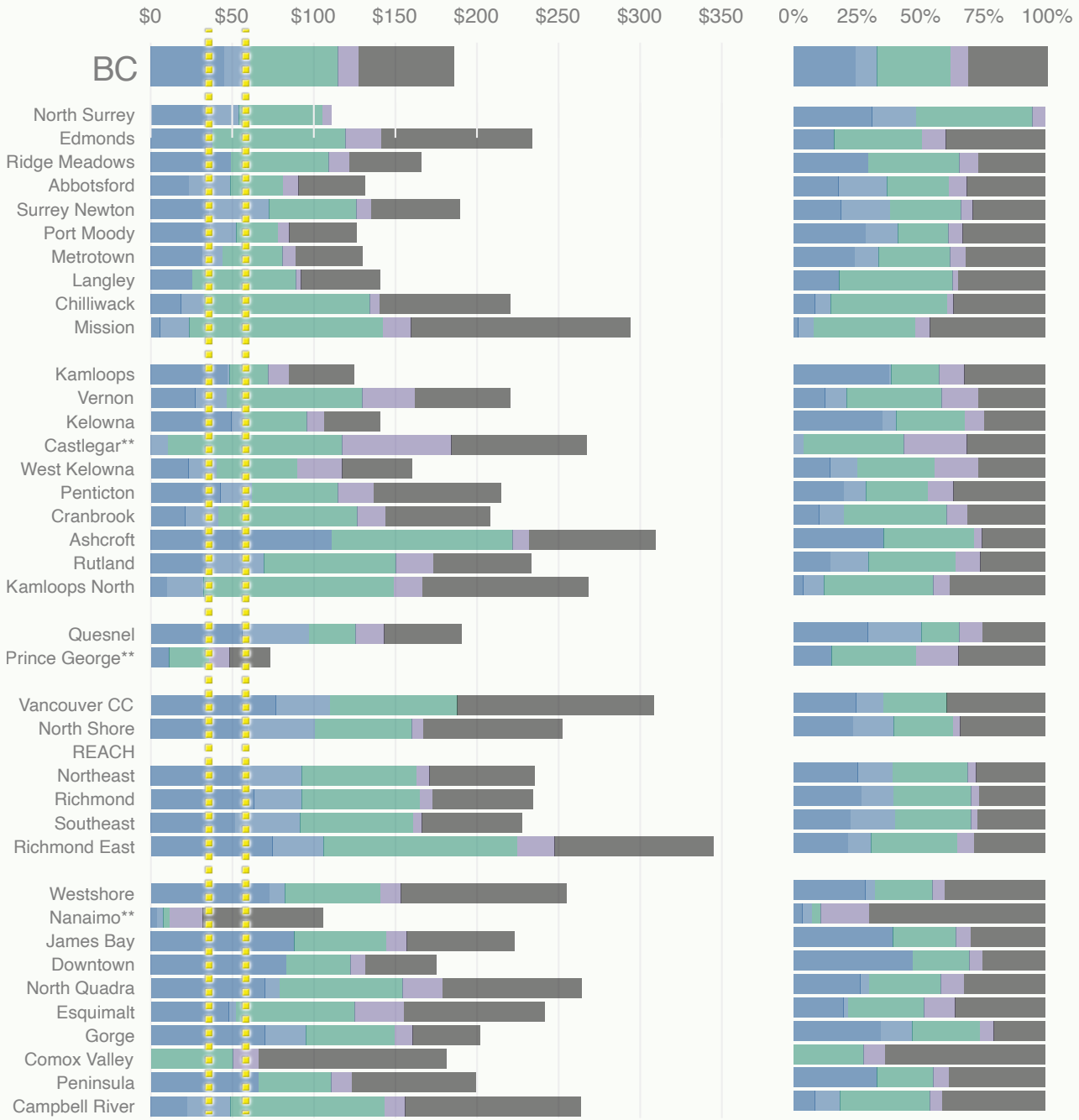
Cost per Visit

As before, looking at costs per patient visit helps compare across UPCCs having very different patient volumes. Cost per visit is therefore a core efficiency metric.







Effective cost per visit for each UPCC, broken down by family physicians, nurse practitioners, nursing, allied health, and overhead. For comparison, MSP billing rates for FFS visit and 15min LFP visit. (FY2024–2025)

Same data shown as percentage of costs for each UPCC.

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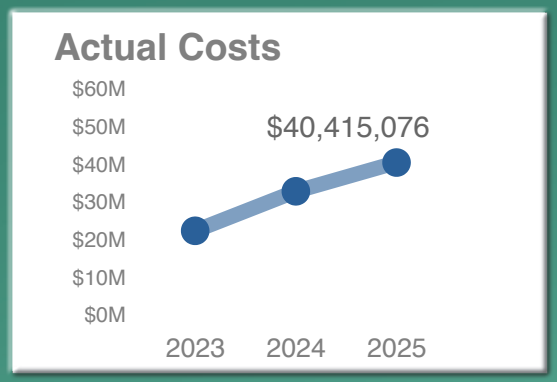
Family Physicians

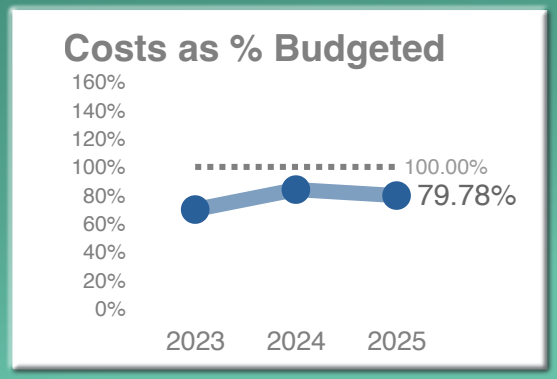
24.18% of total UPCC costs

Here and on the next few pages, we'll compare actual costs with budgeted costs in different categories.

Shortfalls in actual spending generally represent recruitment challenges.

Overspending may indicate excess recruitment (e.g., hiring more physicians to handle higher patient volumes) but could also indicate problems with fiscal responsibility. Is there a genuine need for the excess spending?





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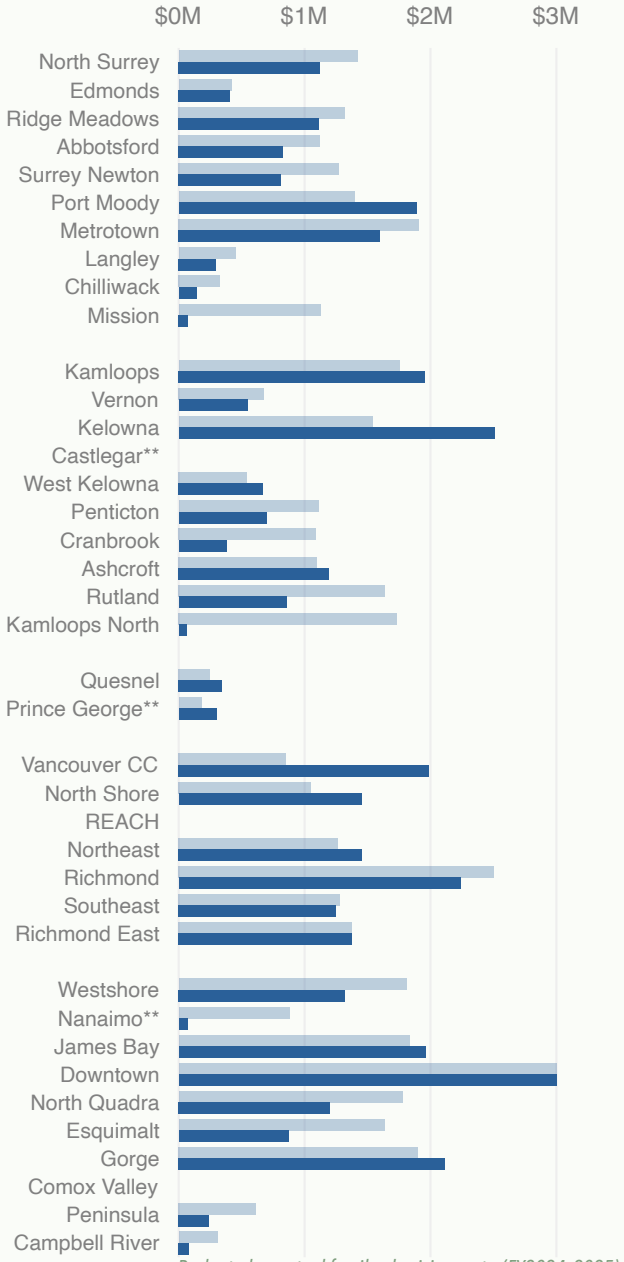
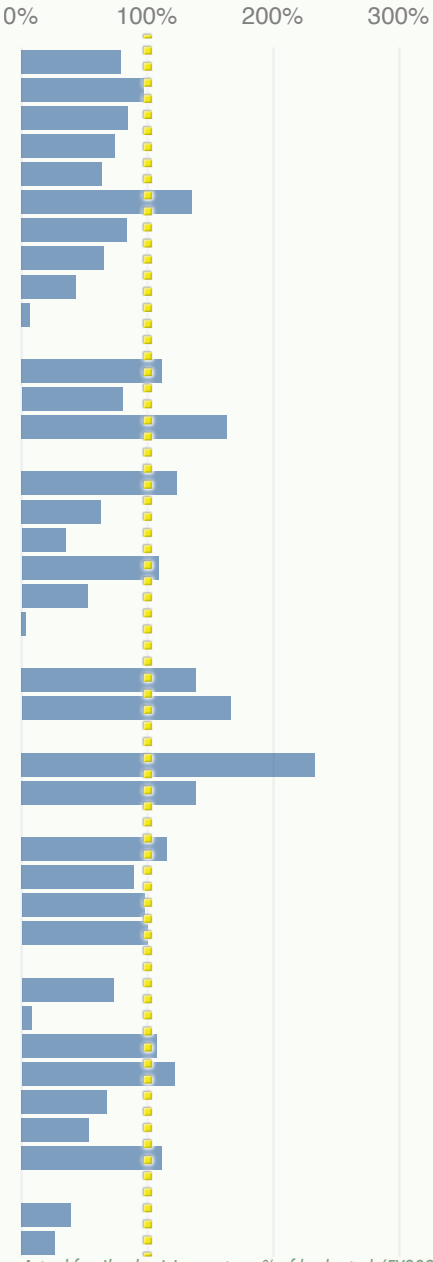
UPCCs underspend by 20% on physicians.

That reflects challenges in recruiting. However, several of them–especially around Vancouver–have managed to attract and retain many. Is it more than just location? And how can you offer primary care services without enough physicians (or NPs)?



Budgeted vs. actual family physician costs. (FY2024–2025)



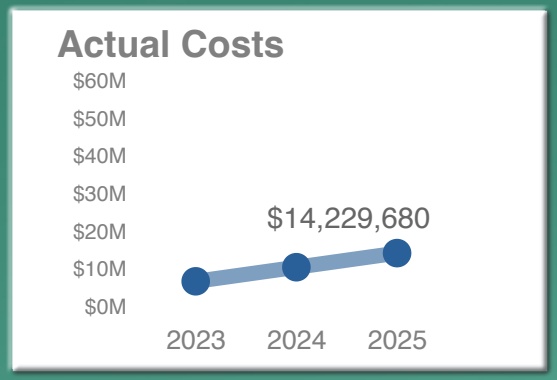
Actual family physician costs as % of budgeted. (FY2024–2025)

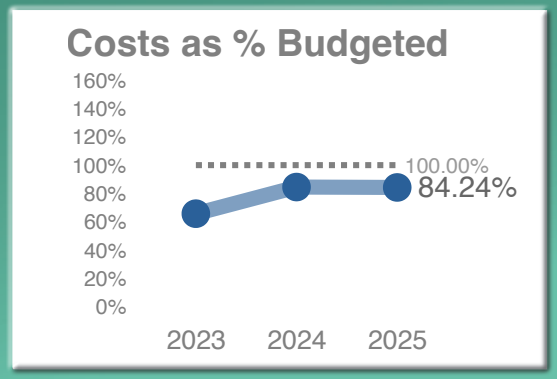
Nurse Practitioners

8.51% of total UPCC costs

As we saw when examining encounters, some UPCCs rely on nurse practitioners (vs. family physicians) far more than others.

Looking more closely at the sites that have recruited larger numbers of NPs to understand the rationale would be helpful; the data we have does not address that.





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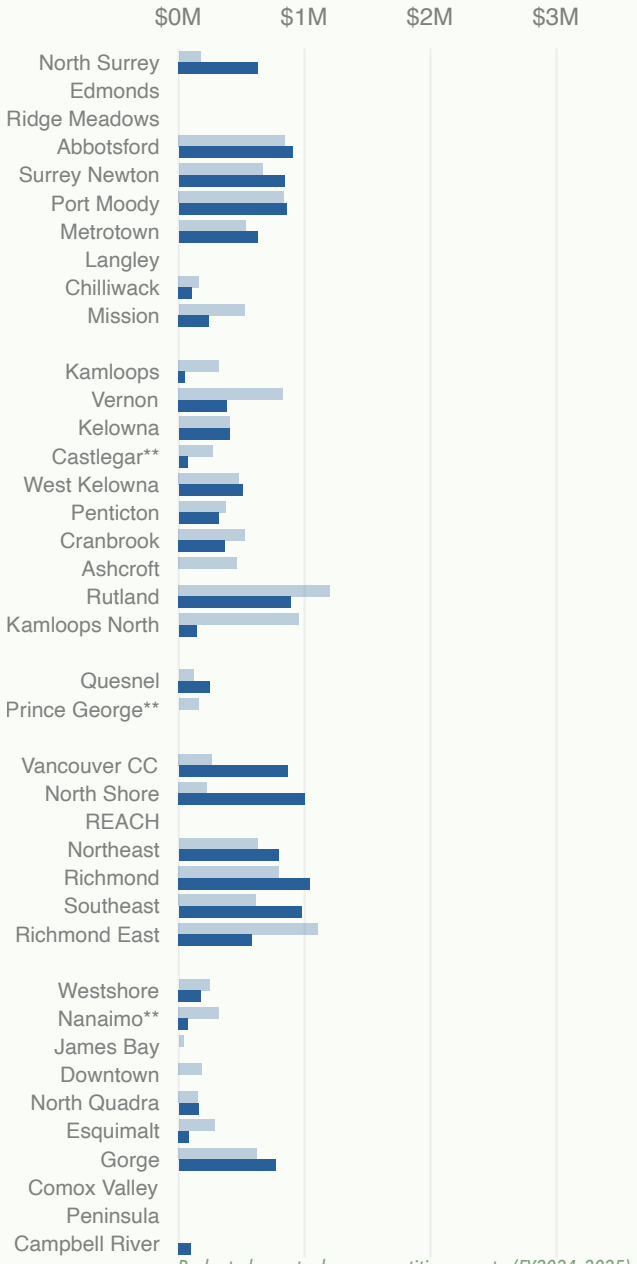
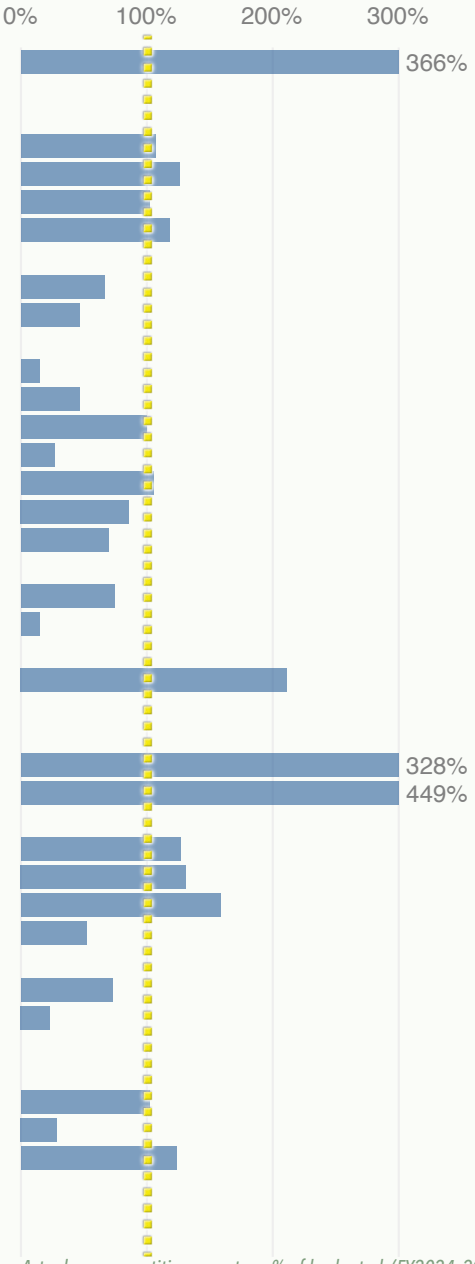
Many UPCCs are also short of nurse practitioners.

Many sites short of FPs are also short of NPs, leaving a gap in primary care services. As NPs can't bill MSP for services, they have fewer options than physicians. So why the challenge for those locations?



Budgeted vs. actual nurse practitioner costs. (FY2024–2025)



Actual nurse practitioner costs as % of budgeted. (FY2024–2025)

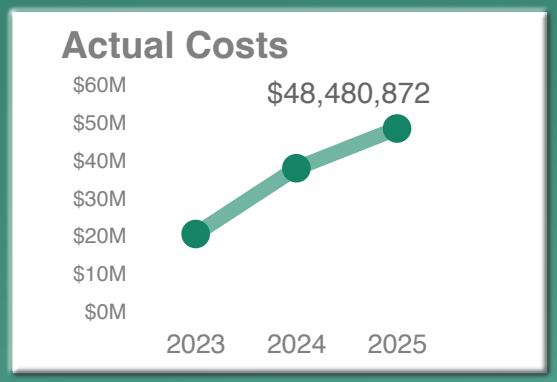
Nursing

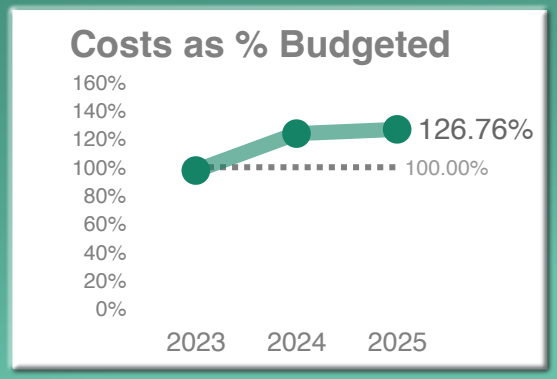
29.01% of total UPCC costs

One of the more striking results of this spending analysis is that most UPCCs are greatly overspending on nurses.

Interestingly, they were close to on budget in 2023 but ramped up hiring substantially afterwards. The reasons for that aren't clear.

We'll return to the issue of potentially excessive nursing resources in the next section on Staffing.





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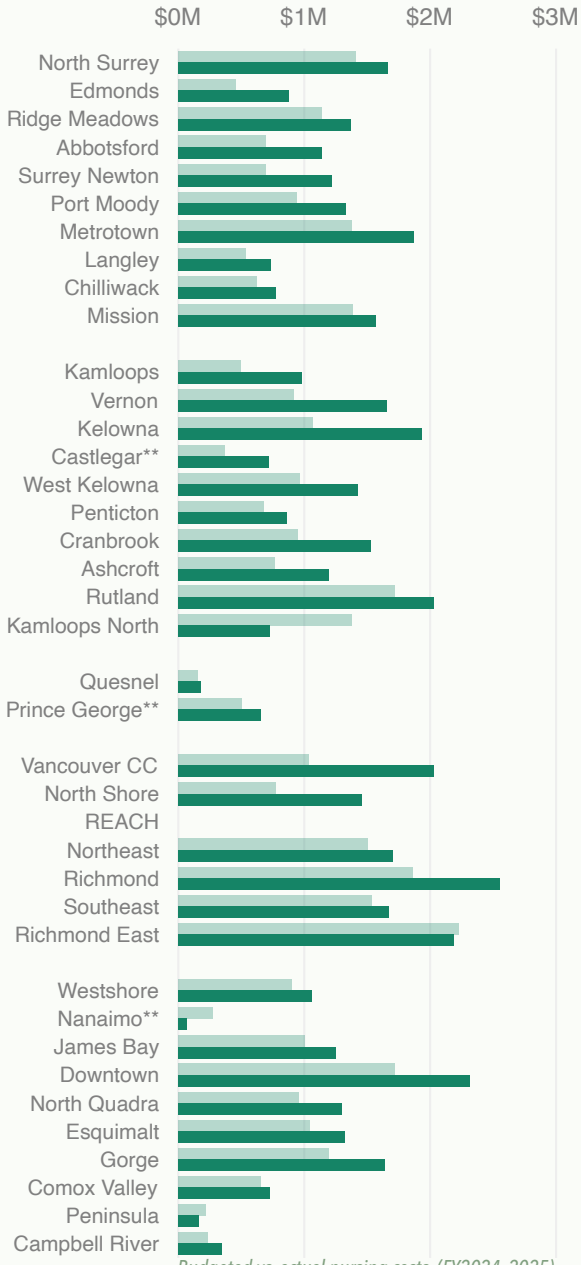
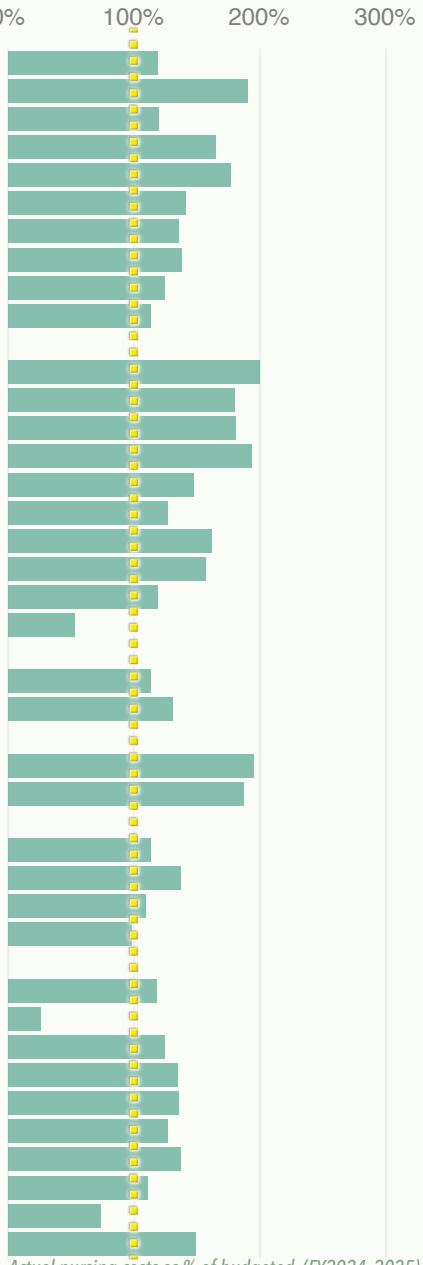
Why are nurses 27% over budget in UPCCs?

Too many nurses, not enough FPs/NPs. Why so many? That's far more than at any other type of primary care clinic (though they can't diagnose, prescribe, refer, etc.). And why did we keep hiring more after we had enough in 2023?



Budgeted vs. actual nursing costs. (FY2024–2025)



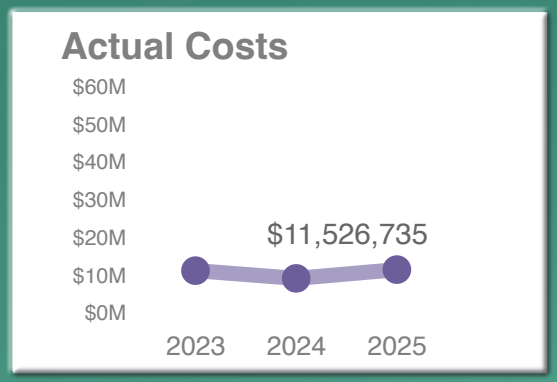
Actual nursing costs as % of budgeted. (FY2024–2025)

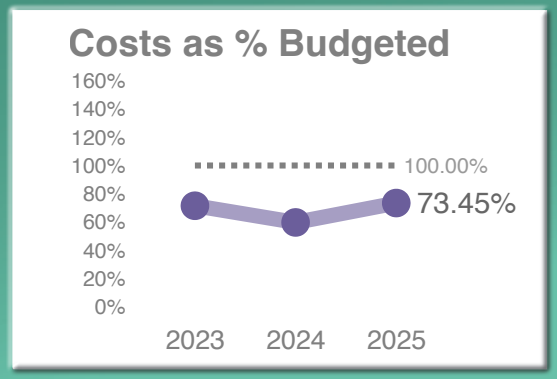
Allied Health

6.90% of total UPCC costs

As noted previously, allied health utilization varies widely across UPCCs.

Note: for consistency with previous years, the FY2024-2025 numbers in this report include the relatively small amount ($541k) separately identified as "Admin" in this category as well as allied health professionals; most admin spending is already included in Overhead.





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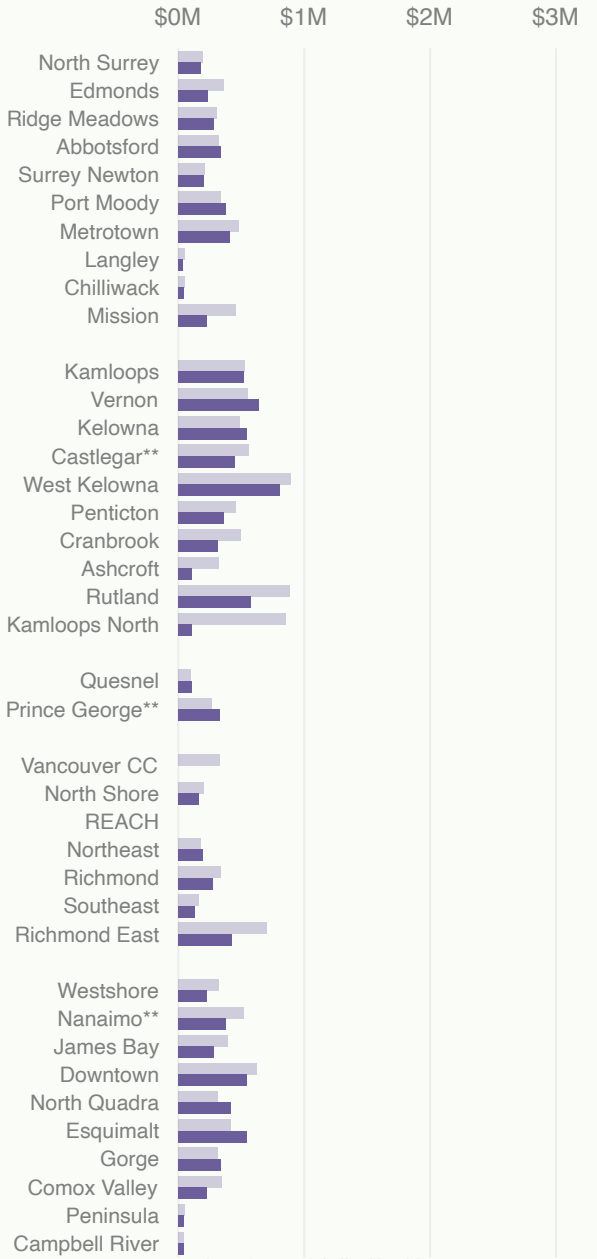
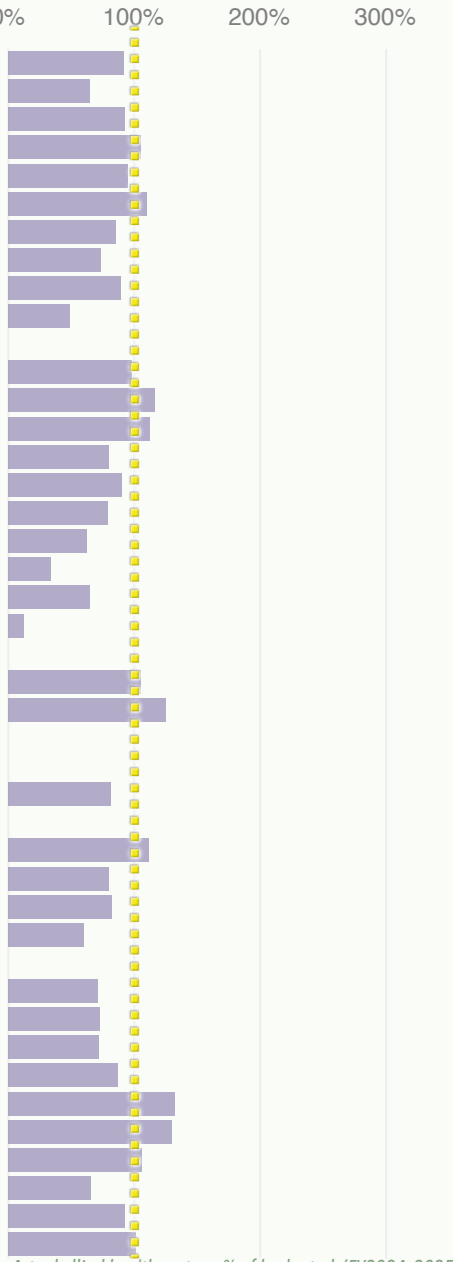
In contrast to spending on family physicians, nurse practitioners, and nursing, no UPCCs have greatly exceeded their budget on allied health. As provision of allied health services is less of a "core" requirement than other clinical areas, budgeted amounts may be more discretionary.



Budgeted vs. actual allied health costs. (FY2024-2025)



Actual allied health costs as % of budgeted. (FY2024-2025)

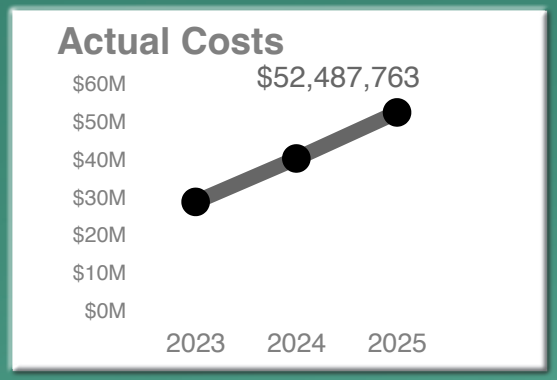
Overhead

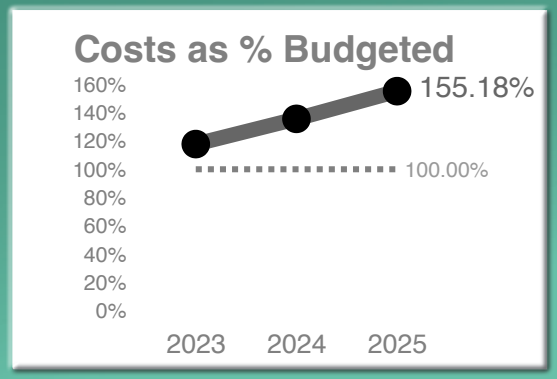
31.40% of total UPCC costs

Consistently high overhead spending (only three UPCCs are within budget) has been a longstanding concern at UPCCs for years.

Factoring in failures to recruit FPs/NPs, the overspending on overhead is even more untenable.

The sharply rising gap between budgeted and actual overhead spending raises important questions about management's fiscal oversight.





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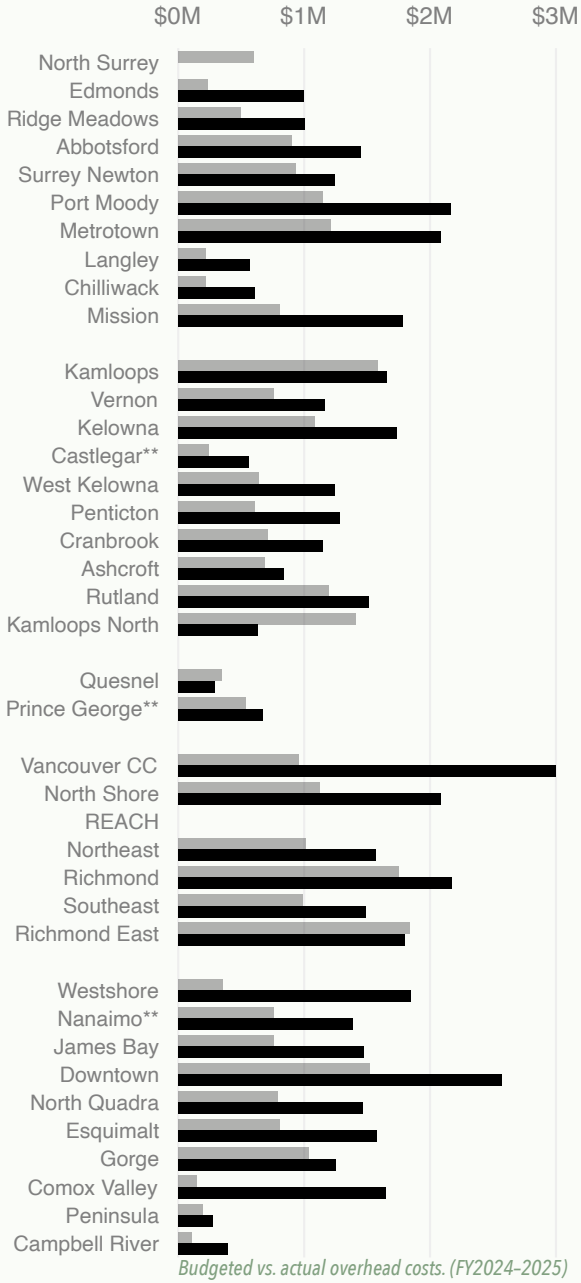
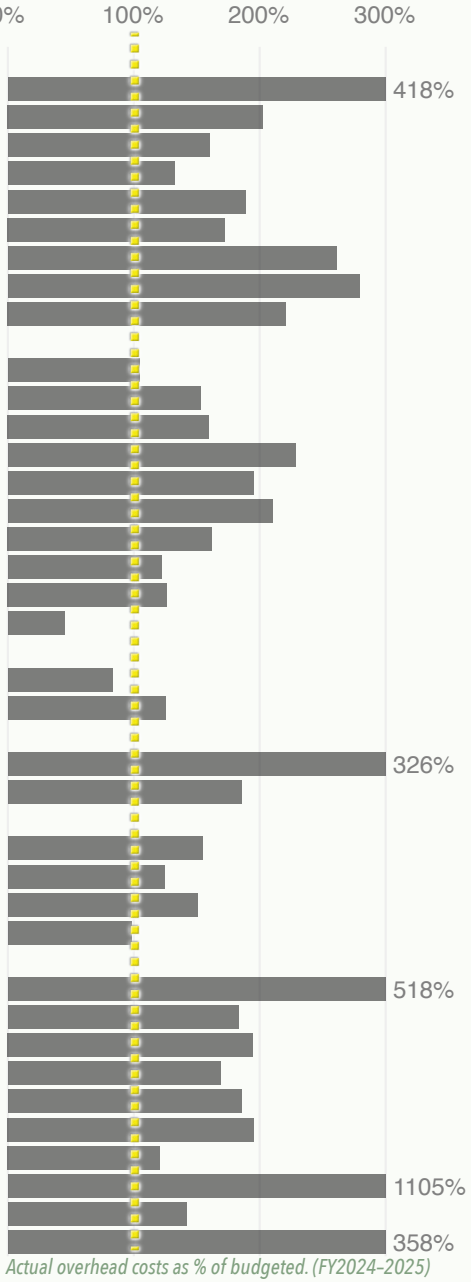
Overhead (31% of total cost) is 55% over budget. 11 UPCCs spend over double their budget.

*At $58.43 per patient visit, UPCCs spend more on overhead alone than independent physicians bill MSP for an **entire 15min visit** under LFP.*



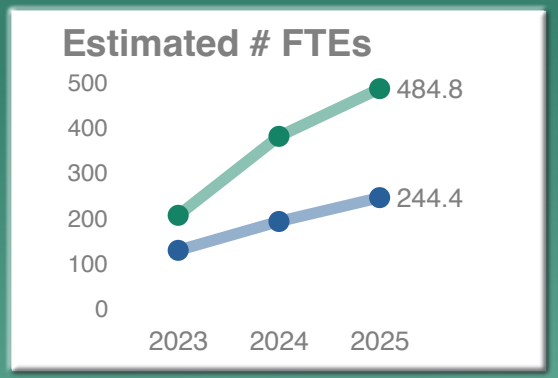
Budgeted vs. actual overhead costs. (FY2024–2025)

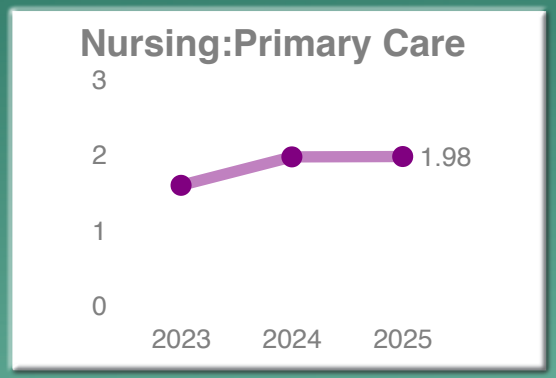


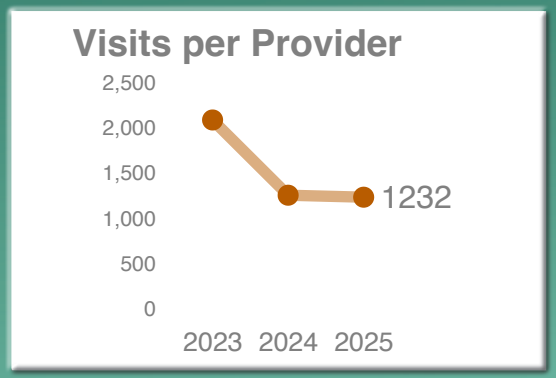
Actual overhead costs as % of budgeted. (FY2024–2025)

Staffing

How many primary care and nursing staff are there at UPCCs?







We've seen that spending on primary care (FP/NP) accounts for 32.69% of UPCC spending, while spending on nurses accounts for 29.01%.

We also know that primary care is about 19% under budget, and nursing is about 27% over budget.

But given that, e.g., doctors cost more than nurses, how many family physicians, nurse practitioners, and nurses are actually working at UPCCs?

And do those staffing numbers make sense?

The internal UPCC dashboards track hiring closely as a key indicator.

The hiring model assumes that most staff are hired for a fixed commitment (e.g., full-time, half-time). So the dashboards track how many "full-time equivalents" (FTEs) have been recruited.

In practice, many UPCC staff don't have such fixed commitments, and so work on a "casual" basis. Internal reports acknowledge that the "recruited FTEs" model doesn't capture this well.

This may have factored into the excess hiring of nurses and the striking imbalance between nursing and primary care.

Comparing Two Staffing Measures

There is substantial internal data in the FOI response report tracking the hiring of UPCC staff. It uses a model of "full-time equivalents" (FTEs). A target "approved" FTEs is set, with "recruited" FTEs measured against that. If recruited = approved, they're at full staffing.

The model works well when virtually all staff are hired, but doesn't reflect casual staff with less formal commitments.

Rather than focusing on recruited FTEs, we prefer instead to estimate actual FTEs based on the cost data. This way, casual staff are fully factored in.

The charts on this page compare the FTE-based recruitment data (recruited as a percentage of approved) in the FOI report with a cost-based staffing model (actual costs as a percentage of budgeted costs). Displayed are the recruitment of both family physicians and nurses using both these models.

Notice how many UPCCs are at or near 100% nursing recruitment using the FTE model. However, when you use the cost-based model, factoring in the large amount of casual staff, you see that most UPCCs are far over budget on nursing. There are far too many nurses, not reflected in the recruited FTE model.

The next page uses estimated FTEs based on costs to compare staffing levels of primary care and nursing.

In our calculations, we use the following costs as equivalent to 1.0 FTE:

Family physicians	$260,000
Nurse practitioners	$160,000
Nursing	$100,000

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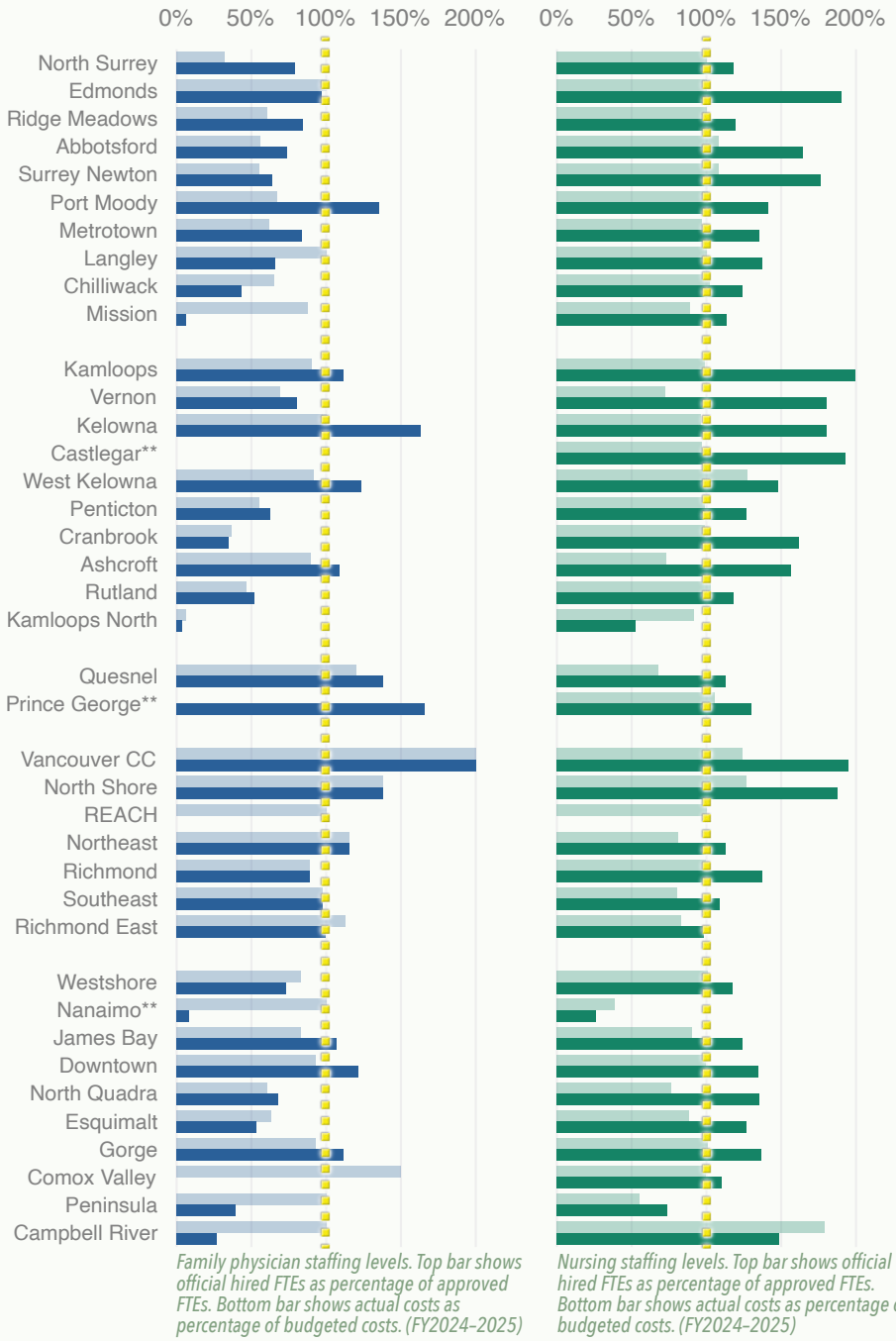
Focusing on recruited FTEs gives the illusion of full nursing staffing, but led to massive overstaffing.



Family physician staffing levels. Top bar shows official hired FTEs as percentage of approved FTEs. Bottom bar shows actual costs as percentage of budgeted costs. (FY2024–2025)

Nursing staffing levels. Top bar shows official hired FTEs as percentage of approved FTEs. Bottom bar shows actual costs as percentage of budgeted costs. (FY2024–2025)

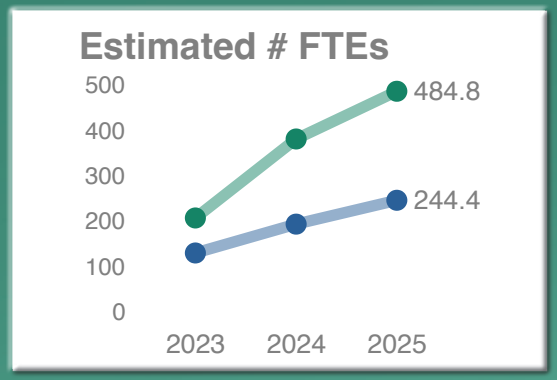
Primary Care vs. Nursing Staff

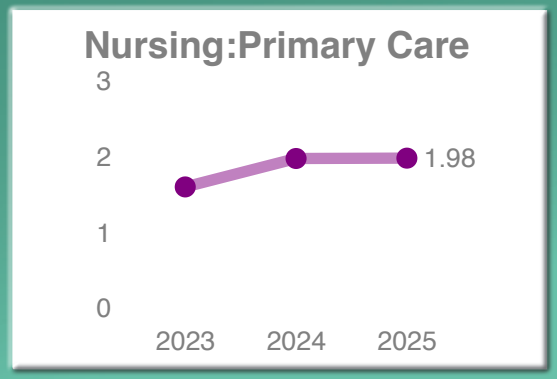
This shows estimated primary care (family physicians and nurse practitioners) and nursing staff using our cost-based FTE model.

It also shows the ratio of nursing to primary care, which averages almost 2:1, with many UPCCs being far higher.

Do these ratios make sense in UPCCs? What are all those nurses doing?

Of note, if calculated using the recruited FTE model, the ratio remains high at 1.52.





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Do we really need 2 nurses for each FP/NP?

This seems excessive in clinics offering mainly primary care, given their scope of practice. Why an excess of nurses at UPCCs but a shortage in ERs?

Estimated family physician, nurse practitioner, and nursing FTEs based on actual costs. (FY2024–2025)

Relative FP/NP/nursing estimated FTEs per site. (FY2024–2025)

Ratio of estimated nursing to primary care FTEs per site. (FY2024–2025)

Backgrounder: Nursing in UPCCs

What happens if people come to a UPCC seeking primary care, but due to the staffing challenges outlined earlier, no physician or nurse practitioner is available to see them?

Do they see a nurse instead? After all, UPCCs have a lot more nurses than most primary care clinics. Make no mistake: nurses are amazing professionals and can do many valuable things.

But nurses can't diagnose, order tests, refer to specialists, prescribe medications, and many other things people need from primary care.

As suggested previously, we have difficulty keeping emergency rooms open, in part due to a shortage of nursing staff. Yet, in UPCCs, we have an excess.

Of course, not every nurse at a UPCC has the qualifications to work in an ER. And there are serious challenges at many ERs that make for a difficult working environment. Most UPCCs would be extremely pleasant in comparison.

Despite that, we need to ask whether we're making the best use of our scarce nursing resources. And if not, what can we do to fix that?

The excerpt at right is from a brochure produced by the South Island UPCCs and speaks about services that nurses can provide.

Clearly, nurses provide many valuable services. Some of which may have traditionally been done by a primary care provider.

For more, see the Island Health news release [1].

Nurse-led appointments often allow nurses to delve deeply into a patient's concerns and collect important information for physicians and nurse practitioners. When the latter are available.

Nursing Scope of Practice

However, nurses cannot:

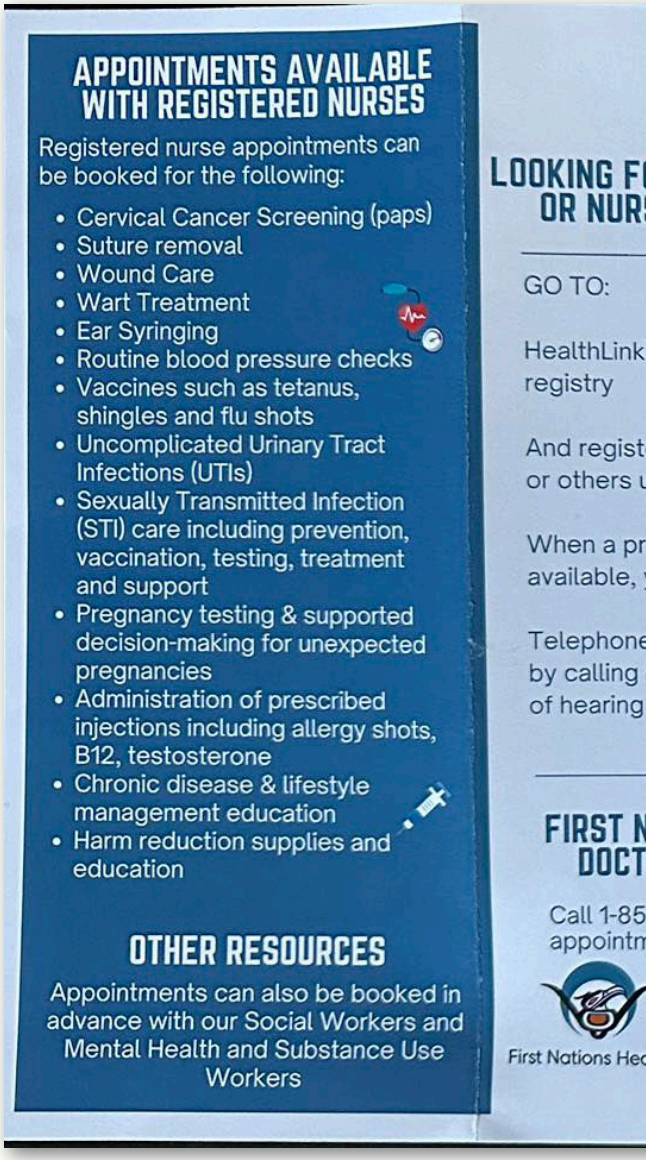
- diagnose a disease or other medical disorder
- order laboratory tests, medical imaging
- refer to specialists or other health services
- prescribe medications or renew prescriptions
- complete disability, insurance, or other forms

These all require a primary care provider (family physician or nurse practitioner).

Too often, because of staffing shortages, patients cannot see a physician or nurse practitioner at a UPCC.

For more on the scope of practice for registered nurses, see [2]. For example, regarding diagnoses:

> *Specifically, registered nurses can make a nursing diagnosis that identifies a condition—not a disease or disorder—as the cause of a client's signs or symptoms.… **it is not, and must not be treated as, a formal diagnosis of any disease or disorder.** Such a formal diagnosis can only be provided by an authorized health professional after they have personally assessed the client.*



[1] https://www.islandhealth.ca/news/news-releases/nurse-led-care-supports-patients-and-health-care-providers-south-island-upccs

[2] https://www.bccnm.ca/RN/ScopePractice/part4/section6/Pages/diagnosis.aspx

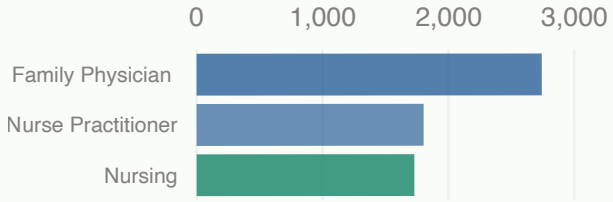
Productivity

We'll wrap up with two more measures related to our estimated staffing numbers (FTEs based on cost).

They try to answer the question: how effective are the clinical staff at UPCCs?

When interpreting these, it may help to know that a 1.0 FTE is generally equivalent to 1,680 hours per year.

Encounters per Estimated FTE



The above chart shows the total number of clinical encounters with each type of provider divided by the number of providers (estimated using our cost-based FTE model).

Family physicians average 2,743 encounters per year (approximately 1.63 per hour), nurse practitioners 1,804 (1.07 per hour), and nurses 1,729 (1.03 per hour). Keep in mind that any clinical position requires significant time spent away from direct patient care.

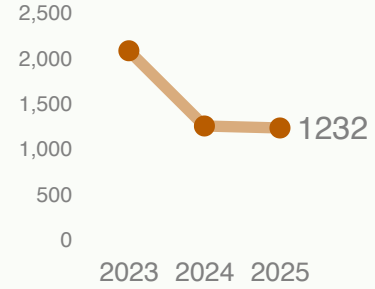
While these numbers sound very low, particularly when compared with patient visits at conventional primary care clinics, caution is warranted in their interpretation.

When we looked at clinical encounters, we found considerable variability in how they were reported, particularly in nursing. Some sites reported very few nursing encounters, while others averaged nearly two nursing encounters per patient visit.

As has often been the case with UPCCs, without considerably more detail on what all these various encounters actually represented, it's difficult to draw any solid conclusions from this data.

Yet, it's unlikely that more detail will be made available.

Visits per Provider



Given that the arrival of UPCCs in many communities led directly to the closure of existing walk-in clinics, it's worth considering how many patients are actually now being seen compared with the number of staff.

The above chart shows the number of patient visits per FTE family physician, nurse practitioner, and nurse.

The number of patient visits per provider is continuing to decline.

When it comes to productivity, that's not a good sign.

Professionals running their own clinics, keeping a careful eye on hiring and the bottom line while striving to provide excellent patient care, are likely to be unimpressed by what appear to be very low productivity numbers.

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Bottom line: we can't keep wasting taxpayer dollars and scarce healthcare worker resources for so little in return.

Health authorities need to get out of delivering primary care.

We need to stop ignoring those with real expertise at running efficient and effective primary care clinics.

UPCCs were a great idea, horribly executed. They should transition to physician-led team-based care clinics, publicly accountable for results.

- average cost per visit $186.06
- 16-27% understaffed on family physicians, nurse practitioners, allied health
- 27% overstaffing on nurses (who are likely needed far more elsewhere)
- 2:1 nursing:primary care ratio
- 55% over budget on overhead
- limited patient attachment
- limited access for urgent care
- very low patient volumes given resources
- excessive performance differences across sites
- administrator-heavy, with limited accountability for results or expenditures

Why does this failed experiment continue?

UPCCs provide poor value.

They offer less care for more money, struggle with recruitment, and many are poorly managed.

They don't deliver nearly enough of the care patients need, or the care that was promised.

They divert scarce human and financial resources away from more effective means of delivering care.

And that's even before looking at the longitudinal care they promised to provide—but don't.

Are things really so bad?

UPCCs were sold as keeping patients out of emergency rooms, attaching them to primary care providers, and providing access to primary care on an urgent basis.

Municipal politicians continue to lobby for their own UPCC for just those reasons.

On those fronts, UPCCs have clearly failed. And done so at an incredibly steep cost.

But is something else going on too?

Maybe we need to unify the UPCC promise with their reality.

The huge differences between individual UPCCs should be a clue.

You can't explain away the magnitude of those differences only by incompetence, waste, and failed or absentee management–though I maintain all are factors to varying degrees.

Similarly, when you talk to patients, they're quick to criticize some UPCCs but heap praise on others.

It's clear that different UPCCs are offering a range of different services, many well beyond the core "urgent and primary care" mandate. Many of those are much needed by their community and led by dedicated health professionals who saw a gap and filled it.

UPCCs could serve as excellent hubs for many services, but it's now far too piecemeal. To say nothing of untraceable and unaccountable. We can't afford to continue like this.

Communities are depending on UPCCs to deliver on their core services, and are being let down. They need primary care and urgent care and aren't getting it. That must change.

Make no mistake. We are here as a result of deliberate policy decisions by a government that created and continued to expand these sites. A government that puts their public relations value and its need for control above all. Those decisions have consequences.

Management needs to focus on real results, value, and productivity, making clear to the public exactly what results are being delivered and how. Both core services and community-driven extras.

BC's political leadership and the health authorities beholden to them have proven they're not up to that job.

UPCCs still have tremendous potential. But that will only be realized if a new sign appears on every UPCC: "under new management."