Medicines Access Coalition - B.C.
2026 Forum

What We Heard Report

Challenges and Solutions in the Drug Access Landscape in B.C.

Medicines Access Coalition - BC

April 7, 2026 · Vancouver, B.C.

Table of Contents

1. Executive Summary

On April 7, 2026, the Medicines Access Coalition – BC (MedAccessBC) hosted its inaugural Forum, bringing together close to 100 participants in Vancouver for a dialogue on medication access in B.C.

The day delivered a clear, consistent message: B.C. patients are being left behind. British Columbia spends less per capita on public prescription medication than most other provinces in Canada, covers fewer innovative therapies, and restricts physician access to therapies through a rigid Special Authority process. A nearly $200 million reduction in planned PharmaCare spending this fiscal year, alongside a flat three-year budget outlook, means this gap is likely to grow.

B.C.'s Ministry of Health is making initial steps toward a more efficient drug review process, including eliminating redundant reassessments for medications already reviewed by Canada's Drug Agency (CDA) and by undertaking a review of the Expensive Drugs for Rare Diseases program. They have also stated a desire to widen their decision-making lens to consider the broader benefits and impacts of changes to the drug formulary.

While stakeholders welcome these initial actions and commitments, they are still **urging greater clarity on timelines and inclusion to ensure patients have improved access to life-changing therapies**.

Six cross-cutting themes emerged from presentations and discussions:

01	**The System is Focusing on Savings over Value** The evaluation and decision-making lens on medications is still too narrow. Drug coverage decisions are overly focused on budget impact and don't place enough value on broader value of medications such as reduced hospitalizations, prevented specialist visits, the ability to remain part of the workforce, and other factors
02	**Special Authority: B.C.'s Biggest Barrier to Timely Access** The Special Authority process is overly rigid and creates unnecessary barriers to patient access to timely, effective therapies. It also contributes to the administrative burden on physicians, removing valuable time better spent delivering direct patient care.
03	**Drug Innovation is Outpacing the B.C. System** B.C. patients face some of the longest waits in Canada to access new, innovative therapies. For patients with progressive or rare diseases, that delay often negatively impacts their health. Recognizing this, the Ministry of Health is streamlining processes, but more will be needed to ensure timely access to care.
04	**The Patient Voice: A Catalyst for Change** The patient voice is a powerful resource. While BC has a patient input step as part of the drug review process, more needs to be done to ensure patient voices are fully embedded in the overall decision-making lens.
05	**Equity Gaps are System Failures** Where you live, your disease, age, and income all determine what medications patients in B.C. can access. Geographic barriers, diagnostic inequity, age-based

	undervaluation, and income-related gaps in vaccine access all received sustained attention.
06	**AI: Opportunities in Drug Access** AI is already running in B.C.'s health system. The opportunity now is to use it deliberately to drive more effective and timely decision making and access.

B.C. has a strong health care foundation. What it needs now is the will and momentum to continue modernizing — including aligning policy, processes, and investments to make it happen. This report includes specific and achievable calls to action to help us get there.

1.2 Overview of Calls to Action

For the BC Ministry of Health	For Patient Advocacy Organizations	For National Systems
• Measure value, not just cost. • Reform Special Authority and include prescribers and patient advocates. • Stop duplicating national reviews. • Set a deadline for the EDRD review and include patient advocates. • Expand vaccination coverage. • Plan for system readiness before coverage decisions, not after. • Increase the PharmaCare budget.	• Use the collective voice. • Demand structural seats at the table. • Make patient stories impossible to ignore.	• Modernize the HTA framework for rare diseases. • Align internationally on pricing and assessment. • Reduce duplication across the review pipeline.

For more details on the calls to action, please refer to section 5 of this report.

2. About This Report

Stakeholders representing government, health policy leaders, patients, patient advocacy organizations, and industry gathered **to explore challenges and solutions in British Columbia's medication access landscape.**

The Forum brought together people who rarely sit at the same table. This report captures the key themes and calls to action that emerged from those discussions.

- **The patients who spoke at the Forum put a human face on a system in crisis.** One woman had exhausted every avenue to access the medication that makes her disease livable without debilitating side effects. Another was spending 30% of her monthly income on a vaccine her doctor deemed essential — and one the public plan won't cover. A third patient, a man who believes a cure for his disease may exist within three years, fears it won't be approved in time to help him.
- **A former provincial health minister reflected that Canada *"doesn't have the greatest health care system anymore"*.** A psychiatrist described receiving zero drug approvals for her patients through B.C.'s Special Authority process.
- Government representatives were also in the room. **The Ministry of Health's most senior official for the pharmacare portfolio acknowledged that drug coverage decisions have not always accounted for the full benefits to the health care system**. He also noted that the Ministry is currently conducting a thorough review of the Expensive Drugs for Rare Diseases with extensive consultations, signalling recognition that existing processes may not be meeting patient needs. Two MLAs from opposite sides of the legislature both agreed that patients should be put at the center of decision-making and the system should work to ensure no one is left behind.

> *"Behind every decision, there is a patient waiting. Forums like this move the needle forward."*
>
> **— MLA Sunita Dhir, Vancouver-Langara**

3. About the Forum

3.1 The Purpose

The mandate of the inaugural MedAccessBC Forum was simple: **get the right people in the same room, hear what is happening to patients, and leave with a shared idea of what needs to change**. The goal was to foster honest dialogue among the key stakeholders in B.C.'s therapeutics sector. Please refer to Appendix A for the full Agenda.

3.2 The Organizer

The Medicines Access Coalition — BC (MedAccessBC) has been advocating for timely and equitable access to medications since 1997. Today, the Coalition represents more than 30 chronic disease-specific patient organizations — a unified voice for over two million British Columbians living with chronic disease.

> *"To achieve fair, equitable, and timely access to medicines for the people of BC."*
> **— MedAccessBC Vision Statement**

3.3 The Sponsors

This Forum was sponsored by the industry partners outlined below, whose support enabled a day of open dialogue.

PLATINUM	Alexion · GSK · Johnson & Johnson · Merck
SILVER	Pfizer
BRONZE	Boehringer Ingelheim · LEO Pharma

3.4 The Author of this Report

The Nordic Consultant

This *What We Heard* report was authored by The Nordic Consultant, a boutique health care consulting practice. The Nordic Consultant was engaged to capture the key themes, insights, and priorities that emerged from the Forum's discussions, translating a day of candid dialogue into a structured, actionable summary for all stakeholders.

Please refer to Appendix B for more details on and contact information for The Nordic Consultant.

3.5 The Participants

The Forum was deliberately cross-sectoral and included participation from the following groups:

Government & Policy	A Senior Ministry of Health official offered the government’s perspective on drug coverage and ongoing reforms. Representatives from both the governing party and the Official Opposition participated and offered remarks.
Patients & Caregivers	People with lived experiences of diseases like multiple sclerosis, multiple myeloma, rare heart disease, Alzheimer’s disease, irritable bowel disease, lymphedema, arthritis, and rare hereditary conditions shared their insights as panelists and at the microphone. Their voices anchored every discussion.
Clinicians	Psychiatrists, endocrinologists, and physicians brought frontline evidence — speaking to the challenges of securing the most appropriate medicines for their patients.
Patient Organizations	Leaders from national and B.C.-based advocacy organizations participated across all four panels and in the audience, bringing decades of health policy experience and deep familiarity with the access challenges their communities face.
Industry	Pharmaceutical and industry association representatives contributed perspectives on pricing, managed entry agreements (MEA), and the domestic and international pressures reshaping the drug access landscape.

Please refer to Appendix C for a full list of speakers, moderators, and panelists.

4. What We Heard

4.1 Key Challenges

The discussions at the Forum **surfaced ten interconnected challenges that, together, explain why B.C. patients continue to face access barriers to appropriate therapeutics**. They are not new — but they were named with unusual clarity and consistency across every panel.

1. Lowest drug spending in Canada

B.C. has the lowest per capita spending on drugs at $257 per capita vs. $442 nationally (2022).

2. $200 million budget reduction

The recent PharmaCare budget's $200 million reduction in planned spending comes alongside a flat three-year funding outlook.

3. 31 innovative medications not covered

31 innovative therapies that are approved and covered in other provinces are unavailable to B.C. residents (2018 - 2023).

4. Special Authority overuse

The Special Authority to gain access to specialty drugs is a tool that has become administratively unmanageable and limiting timely patient access.

5. Most complex approval pathway

Canada has more gatekeeping levels than any comparable country. A new drug passes through 5+ national stages before provincial listing even begins - delaying patient access.

6. Vaccine access inequity

B.C. does not publicly cover adult vaccinations like shingles; many other provinces do. 75% of eligible adults are unvaccinated, costing an estimated $73M in avoidable care costs annually.

7. System readiness gaps

Positive coverage decisions routinely arrive without the infrastructure to deliver the therapy. The CAR-T rollout in Alberta — where patients had to be sent to Ontario — is a cautionary case.

8. Postal code lottery

Geography determines access. Rural patients face specialist shortages and travel burdens. 25% of Canadians seeking care abroad come from B.C.

9. Rare disease program at a cross-road

While the Expensive Drugs for Rare Diseases review is a positive development, it currently has no confirmed timeline and has not formally included patient organizations.

10. Global drug pricing shifts put Canada at risk

Canada's 2% global market share leaves it vulnerable. The recent US Most Favoured Nation (MFN) pricing policy adds further uncertainty — when prices shift, the ripple effects reach Canada. Manufacturers may deprioritize Canadian entry when the process is too costly and unpredictable.

4.2 Key Themes

Six key themes emerged across presentations, panel discussions, and audience comments — cutting across the challenges described above and, in some cases, giving them sharper definition. Each theme is presented here because it surfaced repeatedly and with force across every panel and discussion, regardless of the speaker's role in the system.

While these themes are not new — patients and advocates have raised them for years — what was notable was the degree to which people with very different roles in the system surfaced them in the same way.

01

B.C.’s Health System is Focusing on Savings over Value

Budget savings takes priority over system-wide value

02

Special Authority: B.C.'s Biggest Barrier to Timely Access

Physicians and specialists struggle getting access to the right medications for their patients

03

Drug Innovation is Outpacing the B.C. System

The system is challenged by approval delays, access gaps, and system readiness

04

The Patient Voice: A Catalyst for Change

Patients and advocates are more powerful when united

05

Equity Gaps are System Failures

Geography, diagnosis, age, and income all contribute to access gaps

06

AI: Opportunities in Drug Access

Untapped opportunities exist, from imaging to prescribing to paperwork

01. The System is Focusing on Savings over Value

We heard that B.C.'s drug coverage decisions prioritize bottom-line savings over therapeutic value and patient outcomes.

A recurring theme across panels was that **the health system is asking the wrong question. The question should not be whether a drug saves money — it should be what value it adds**. Conflating them has led to budget-driven rather than outcomes-based decisions.

The Ministry of Health's Assistant Deputy Minister (ADM) of Health System Policy & Oversight, Ian Rongve, was direct on this point: **drugs are a net new cost**. He argued that the health system faces a capacity crisis across primary, emergency, and acute care, and that the crisis will not be resolved by keeping patients out of care through increased drug funding. Even when a drug prevents an ER visit, ER wait times remain long. Ministry finance officials currently remain unconvinced by the argument that pharmaceutical investments lead to broad long-term cost savings.

Not everyone in the room agreed with this perception. Patients, clinicians, and patient advocates argued that the **right medications have the power to change lives and relieve the system** of further spending — through preventing disease progression, reducing hospitalizations, keeping people in the workforce, and allowing caregivers to stay fully employed. The vaccine panel made a strong case: investing in shingles vaccination alone could prevent an estimated 42,000 physician visits and save $73 million in senior care costs in B.C.

These effects are real and measurable — but to patients, they seem to land in different budget columns. **The Ministry representative acknowledged that drugs *can* solve problems in emergency departments and primary care, but the system isn't always capturing that**. Spending is not as siloed as it looks in the budget: it doesn't mean that value generated in one part of the system never flows back to the drug budget that produced it.

> *"It's not about savings — it's about the value being added back into the system. If you keep someone out of hospital and in the workforce, you're making money."*
> **— Forum participant**

02. Special Authority: B.C.'s Biggest Barrier to Timely Access

We heard that Special Authority is causing real harm — to patients, to clinicians, and to the system.

No issue surfaced more consistently. The government's position is that **Special Authority is a necessary guardrail: without it, prescriptions could be written outside clinical guidelines**. Participants listened to this rationale. The problem is what the current system has become in practice; clinicians and patients told a different story — one of denials, delays, and patients unable to access the medications their doctors believe they need. **One psychiatrist reflected that she has received zero approvals for her patients since the online Special Authority process was initiated.** Physicians across specialties described that Special Authority criteria were developed without input from the prescribers who use them, with requirements to fail on decades-old medications before newer options can even be considered.

> *"Our providers want to improve our lives, but they're handcuffed by the government. It is punitive for both patients and physicians."*
> **— Forum participant**

03. Drug Innovation is Outpacing the B.C. System

We heard that by the time a new therapy reaches a B.C. patient, it may have been available elsewhere for years.

Participants reflected that Canada has one of the world's most complex drug approval pathways: Health Canada safety review, CDA health technology assessment (HTA), pan-Canadian pricing negotiations, and then each province's own listing process. Each stage has its own process, its own timeline — and its own potential for delay. **For patients with progressive or rare diseases, the years it takes have an immense impact on patients.**

Recognizing the impact of delays on patients, the Ministry of Health has announced that, **beginning this year, medications reviewed through the CDA will no longer require routine reassessment by B.C.'s Drug Benefit Council**. This is a welcome step toward reducing the administrative burden that has historically delayed patient access.

The Forum also identified a systems-readiness challenge: even after a therapy is approved and covered, the system must be able to deliver it. An early CAR-T rollout in Alberta illustrated the gap — patients approved and funded for the therapy had to travel to Ontario because Alberta lacked the infrastructure to administer it. Addressing this requires earlier conversations — before funding decisions are made — and practical tools like the I2U System Readiness Tool could be an enabler, as they help assess the system's readiness.

A further challenge is that Canada's 2% share of the global drug market means **manufacturers can and do deprioritize Canadian market entry when the process becomes too uncertain**. The US Most Favoured Nation pricing policy increases this risk — as **American prices shift, countries like Canada face new pressure, and the calculus for market entry becomes harder to justify.**

> *"In three years, this disease may be curable. But I won't make it in time before Canada approves the drug for me. Health Canada should stop reinventing the rules — if the EU and like-minded countries have done the studies, we don't need to repeat them."*
> **— Forum participant living with a rare disease**

04. The Patient Voice: A Catalyst for Change

We heard that patients are not receiving timely access to therapeutics and that they need to unite to bring attention to decision-makers.

Every panel featured a patient with a story of barriers to timely access to therapeutics: a woman with multiple sclerosis who lost access to her stabilizing medication and spent months in correspondence with the Ministry without resolution; a patient spending nearly a third of her monthly income on a recommended vaccine because the public plan didn't cover it; a man whose Canadian physician referred him to the Mayo Clinic for urgent testing — because there was no capacity in the Canadian health care system to assess him promptly.

Participants reiterated that the gap is structural. Clinicians, patient advocates, and not-for-profits emphasized that **patient voices are crucial to moving the needle forward and that this is the most underrated tool for shaping decision-making.** A former health minister reflected that to drive change, patient groups should *"push for reviews, lobby opposition for changes - and make their voices heard as much as possible".*

Historically, B.C. patients have had limited involvement in therapeutic decision-making — but the Ministry of Health is signalling change. It is increasingly finding opportunities to incorporate the patient voice, marking a meaningful shift from past practices.

A notable example is the ongoing review of the Expensive Drugs for Rare Diseases (EDRD) program, undertaken in recognition that existing processes may not adequately meet patient needs. This review is a welcome step forward. However, **stakeholders are looking for greater clarity on timelines and structured mechanisms to ensure the patient voice is meaningfully embedded throughout the process.**

> *"When patients bring their voices together, policy makers want to listen."*
> **— Theresa Tang, CEO, Praxus Health**

05. Equity Gaps are System Failures

We heard that where you live, what disease you have, your income, and your age all determine access to therapeutics.

Health equity surfaced in almost every conversation — but not always in the same form, because inequity in medication access takes many shapes.

The most direct form of inequity is geographic: patients residing in rural and remote communities do not have the same access to care as those in urban settings. For example, B.C.'s only stem cell transplant centre is Vancouver General Hospital. Coverage on paper is not the same as access in practice for patients in Prince George, Haida Gwaii, or the Interior. Not surprisingly, 25% of Canadians seeking care outside Canada came from B.C.

Income is also a barrier. **When vaccines are not covered by a public plan, patients pay out of pocket — and for many, that is not a viable option**. One patient described spending 30% of her monthly income on a vaccine her doctor deemed essential. Another noted that a shingles vaccine, at $150 a dose with two doses required, was out of reach on a fixed income.

Further, **age shapes access in ways that rarely get named directly**. The Alzheimer Society of BC and Yukon pointed out that dementia is often treated as a senior's problem — and that this perception affects how treatments are valued. **When HTAs weigh the economic contribution of a patient, older adults come up short. But this framing misses the full picture:** 90% of family caregivers supporting someone with dementia are of working age, carrying enormous personal and economic burden. The societal cost of under-treating dementia affects families, workplaces, and the broader economy. Valuing a treatment only by what it does for the individual patient is, as the Alzheimer Society of BC and Yukon puts it, a mistake.

Participants also highlighted diagnostic inequity: **when B.C. lists only one drug in a therapeutic class, patients who experience severe side effects have no easy path to an alternative** — they must go through Special Authority to access what should be a routine clinical option. Requiring a patient to switch from a medication that works to one the system prefers on cost grounds is not a clinically neutral decision.

> *“Ageism is a barrier. If we assess the value of treatment only by the individual patient’s economic contribution, we’re making a mistake. The family lives with the diagnosis. 90% of dementia caregivers are of working age.”*
> **— Jennifer Lyle, CEO, Alzheimer Society of BC and Yukon**

06. AI: Opportunities in Drug Access

AI is here – the question is how we best use it. We heard both real optimism and measured caution about AI in health care.

The representative from the Ministry of Health noted that **AI is an important element of health care and that it is already in use in B.C.'s health system** — in imaging analysis, post-market drug surveillance, and drug discovery — with more on the way. He also noted that generative AI and machine learning are distinct tools with different applications, and both have a role to play in the health care system.

Participants welcomed these initiatives, and there was excitement in the room about the potential positive impact of AI. For example, one participant described optimism in using AI tools for his own health research and bringing AI-generated analysis to his physician. Another participant highlighted a physician who has built a model that predicts which drug is most likely to work for an individual patient — precisely the kind of innovation the system needs more of. A clinician expressed caution: systems trained on population averages may not guide decisions well in fields where individual variation is the norm and the evidence base is thinner.

AI can reduce burdens in administrative workflows, Special Authority processing, and pharmacogenomic decisions — without replacing clinical judgment. The message across participants was consistent: **use AI purposefully, with clinicians in the loop, and start now**. The 20 million physician hours spent annually in B.C. on medication-related paperwork is a problem AI can measurably reduce.

> *"A physician has built a model that can predict which drug will work for an individual patient. That is exactly the kind of innovation we need to build a better health care system."*
> **— Terry Lake, former BC Minister of Health**

5. Calls to Action

From the discussions, the message was clear: **British Columbia has a strong health care foundation and a clear opportunity to modernize its drug coverage approach.**

Ensuring timely access to appropriate medications will not only improve patient outcomes, but also reduce pressure on other parts of the health system — including hospitalizations, physician visits, emergency care, and surgical interventions. By aligning policy direction, processes, and investment, B.C. can reinforce its leadership in delivering high-quality, patient-centred care while ensuring more equitable access to therapies across the province.

The inaugural MedAccessBC Forum ended with clarity, not just about the challenges, but about what can — and needs to — be done. There are achievable changes that would meaningfully improve the lives of British Columbians needing access to innovative therapeutics.

Several calls to action surfaced through presentations, questions, discussions, and debates:

5.1 For the BC Ministry of Health

- **Measure value, not just cost.** Adopt a societal value framework that counts what medications prevent — hospitalizations, caregiver burden, lost employment — not only what they cost in a single budget line.

- **Reform Special Authority and include prescribers and patient advocates.** Special Authority criteria must be developed in collaboration with the clinicians who use them, grounded in evidence and lived experience.

- **Stop duplicating national reviews**. Where Health Canada has approved a drug, CDA has recommended it, and pCPA pricing is complete, a B.C. listing should follow without a full parallel assessment.

- **Set a deadline for the EDRD review and include patient advocates.** A review without a timeline, conducted without patient organizations, will not produce the changes B.C.'s rare disease community needs. This must change, and fast.

- **Expand vaccination coverage.** The evidence is clear. 42,000 physician visits and $73 million in avoidable care costs are waiting to be prevented through one vaccination alone.

- **Plan for system readiness before coverage decisions, not after.** Implementation tools (like the I2U Systems Readiness Tool) help prepare for implementation.

- **Increase the budget**. A flat pharmacare budget applied to a growing and aging population, rising drug costs, and an expanding pipeline of innovative therapies is a budget cut in real terms. Sustainable investment in medications reduces pressure on acute care, emergency departments, and specialist services across the system.

5.2 For Patient Advocacy Organizations

- **Use the collective voice.** Disease communities speaking together are far more powerful than these communities speaking alone.

- **Demand structural seats at the table.** Patient organizations should have formal roles in the EDRD process, Special Authority reform, and every major drug coverage review — not invitations at the final stage or updates after decisions are made.

- **Make patient stories impossible to ignore.** Every patient advocacy organization has members whose experiences need to be in front of decision-makers persistently — through MLAs, ministers, and media.

5.3 For National Systems (Health Canada, CDA, pCPA)

- **Modernize the HTA framework for rare diseases**. Managed entry agreements, outcome-based contracts, and real-world evidence pathways should be the standard for rare disease assessment.

- **Align internationally on pricing and assessment.** Canada is 2% of the global drug market. The UK has already negotiated preferential pharmaceutical terms with the US by committing to increasing drug investment. Canada should pursue comparable alignment.

- **Reduce duplication across the review pipeline.** The years between approval and patient access are failures. The direction of pCPA process improvements is a step in the right direction — the pace needs to match the urgency of the disease.

6. Next Steps

This was MedAccessBC's first Forum. The conversations that took place must, and will, continue — in the minister's office, in legislative committees, in clinical practices, and among patient advocacy organizations representing the two million British Columbians who depend on someone in the system to act on their behalf.

Change will not happen automatically. The system will not reform itself. The budget will not grow to meet patient needs without a sustained case being made for why it must and why it benefits the health system.

6.1 MedAccessBC's Recommended Steps to Improve Access to Innovative Therapeutics

There is a clear opportunity to build on the momentum at the Forum through targeted, practical improvements. As such, MedAccessBC continues to advocate for the following actions to improve access to innovative medicines in B.C.:

1. **Accelerate approval timelines** so patients can access innovative therapies sooner.
2. **Commit to timely funding for therapies** that receive a positive CDA recommendation and a completed pCPA pricing agreement, building on recent steps to streamline and align provincial decision-making.
3. **Limit Special Authority requirements** to cases where they are clinically necessary and expand regular benefit coverage where appropriate.
4. **Strengthen collaboration with stakeholders,** including patients, providers, and industry, to support informed and sustainable decision-making.

> *"We're leaving today with a clear opportunity to build on this momentum through targeted, practical improvements."*
>
> **— Alanah Duffy, MedAccessBC Board Director, closing remarks**

7. Appendices

Appendix A — Forum Agenda

Agenda Item	Topic
1	Opening Remarks & Land Acknowledgement — MedAccessBC Co-Chairs
2	Keynote Address — BC Ministry of Health — Ian Rongve, Assistant Deputy Minister, Health System Policy and Oversight Division
3	Panel 1 — Breaking Barriers: Improving Patient Access to New Medications in BC
4	Panel 2 — Rare Disease Realities: Challenges and Opportunities for Patients and Families
5	Brief Remarks — MLA Sunita Dhir (Government)
6	Panel 3 — Maximizing Impact: Vaccines as a Cornerstone for Public Health and Fiscal Sustainability
7	Brief Remarks — MLA Brennan Day (Official Opposition)
8	Panel 4 — Strengthening Resilience: Overcoming Implementation Barriers for Innovative Therapies
9	Closing Reflections — Patient Panelists
10	Closing Remarks — MedAccessBC Board Director

Appendix B — The Author: The Nordic Consultant

About The Nordic Consultant

The Nordic Consultant is a boutique advisory firm based in New Westminster, B.C., offering a wide range of consulting services to organizations in the health, non-profit, and public sectors.

Pia Kristensen is the founder and principal consultant of The Nordic Consultant. With extensive experience across strategy, governance, policy, and research, Pia partners with national and provincial organizations, health systems, professional associations, and multidisciplinary societies to deliver practical, evidence-informed solutions tailored to each client's needs and context.

Pia's work spans the full consulting spectrum — from strategy development and organizational governance to policy analysis, program evaluation, research, and the development of white papers and reports. She brings the same rigour and attention to stakeholder engagement, environmental scanning, and event planning and outcomes reporting, ensuring that every deliverable is grounded in diverse perspectives and sector-wide insight.

Throughout her career, Pia has worked with community service organizations, hospitals, health associations, and member-based professional organizations. Her practice has included meaningful engagement with patients, caregivers, staff, policy makers, health care leaders, boards, Indigenous peoples, and community members in both virtual and in-person settings — work she approaches with care, humility, and a commitment to inclusive processes.

Across all engagements, Pia's goal is the same: to help organizations navigate complexity, strengthen capacity, and move forward with clarity and confidence.

Contact Details
You can reach Pia at: Pia@TheNordicConsultant.com.

Appendix C — Speakers, Moderators, and Panelists

Name	Role / Organization	Contribution
Dr. Ian Rongve	ADM, Health System Policy & Oversight, BC Ministry of Health	Keynote Address
Jamie Myrah	Executive Director, Pulmonary Hypertension Association of Canada; MedAccessBC Co-Chair	Emcee
Don Bindon	BC Director, Canadian Spondyloarthritis Association; MedAccessBC Co-Chair	Land Acknowledgement & Opening Comments
Gail Attara	CEO, GI Society & President, Canadian Society of Intestinal Research	Panel 1 Moderator
Terry Lake	Former BC Minister of Health	Panel 1 Panelist
Dr. Diane McIntosh	Psychiatrist, Author, and Educator	Panel 1 Panelist
Cassandra Nieman	Patient — Multiple Sclerosis	Panel 1 Panelist & Closing Reflection
John Adams	Co-founder & Past President, Canadian PKU and Allied Disorders	Panel 2 Moderator
Charles Brown	Director, Government Affairs, Innovative Medicines Canada	Panel 2 Panelist
David Fowler	Patient — Transthyretin Amyloidosis	Panel 2 Panelist & Closing Reflection
Dr. David Kendler	Medical Director, Prohealth Clinical Research	Panel 2 Panelist
Antonella Scali	CEO, Psoriasis Canada	Panel 3 Moderator
Dr. Jia Hu	Interim Medical Director, Immunization Programs, BCCDC	Panel 3 Panelist
Theresa Tang	Co-founder & CEO, Praxus Health	Panel 3 Panelist
Alison Pozzobon	VP, Government Affairs, Market Access & Communications, GSK	Panel 3 Panelist

Graham Statt	Senior Associate, Santis Health; former ADM, Pharmaceutical & Supplementary Benefits, Alberta Health	Panel 4 Moderator
Hélène Lalonde	Patient — Multiple Myeloma	Panel 4 Panelist & Closing Reflection
Jennifer Lyle	CEO, Alzheimer Society of BC and Yukon	Panel 4 Panelist
Matthew Sebastiani	Patient — Inflammatory Bowel Disease	Panel 4 Panelist & Closing Reflection
MLA Sunita Dhir	Vancouver-Langara; Parliamentary Secretary for International Credentials	Government Remarks
MLA Brennan Day	Courtenay-Comox; Official Opposition Critic, Rural & Seniors’ Health	Opposition Remarks
Alanah Duffy	Manager, Government Relations, MS Canada; MedAccessBC Board Director	Closing Remarks

Appendix D — Glossary

Term	Definition
BC PharmaCare	BC's provincial public drug insurance program, covering eligible prescription drugs for BC residents.
CAR-T Therapy	Personalized cancer immunotherapy in which a patient's T-cells are modified in a lab and reinfused to fight disease.
CDA	Canada' Drug Agency — conducts national health technology assessments of new medicines for Canadian drug plans.
EDRD	Expensive Drugs for Rare Diseases — BC PharmaCare's program for high-cost rare disease therapies. Currently under review with no confirmed timeline.
HTA	Health Technology Assessment — structured evaluation of the clinical and cost-effectiveness of health technologies, including drugs.
I2U Systems Readiness Tool	Implementation-to-Use system readiness assessment — evaluates whether a health system can deliver a new therapy once funded.
MEA	Managed Entry Agreement — a risk-sharing arrangement tying drug coverage or pricing to real-world patient outcomes.
MFN	Most Favoured Nation pricing — a US framework linking US drug prices to international lows, creating market access pressure for Canada.
NACI	National Advisory Committee on Immunization — issues Canadian immunization recommendations.
pCPA	pan-Canadian Pharmaceutical Alliance — collective drug price negotiations across Canadian provinces and territories.
Special Authority	BC PharmaCare's prior authorization requirement for many covered drugs.