British Columbia Ministry of Health Services and the General Practice Services Committee

Evaluation of the Full Service Family Practice Incentive Program and the Practice Support Program

Final Report on the Uptake of Incentive Payments for the Full Service Family Practice Incentive Program

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1. INTRODUCTION

The General Practice Services Committee (GPSC) has contracted with Hollander Analytical Services Ltd. to conduct an evaluation of incentive payments instituted under the Full Service Family Practice Incentive Program (FSFPIP). One of the key elements of the evaluation is to address the extent to which General Practitioners (GPs) use the incentives, that is, the level of uptake of the incentives by GPs. Given that there are payments attached to the incentives which were introduced as fee items in the fee schedule, one would expect a reasonable uptake simply for financial reasons. However, it is not a given that all incentives will be automatically used by GPs. The possible reasons why incentives may not be used include: the level of knowledge by GPs of a given incentive; the burdens of additional paperwork; the possible complexity of the rules around billing and audit; and the timing of payments. In addition, there may be different levels of uptake for the different types of incentives. Finally, it should also be noted that, as a counter to the above points, the incentive payments do allow GPs to provide better care to their patients. This can serve as a strong inducement to use the incentive payments. The impacts on costs and service utilization in regard to the incentives will be addressed in other reports prepared for this project. This report focuses primarily on the uptake by GPs of the incentive payments.

2. STRUCTURING THE ANALYSIS

2.1 Introduction

There is no generally agreed upon indicator or formula in British Columbia to determine who is a full service family physician. Considerable effort was expended by our team in trying to determine such a formula but no completely satisfactory approach was found. Currently, GPs can have complex working lives. While some GPs work full-time and have a full service practice, others also provide a full service practice but work part-time. In addition, it appears that it is now relatively common for GPs to work in multiple settings. For example, a full service GP may be located with a group of other GPs, and a drop in clinic may be attached to their practices. Thus, GPs may have their own practice but may also work in their own, or another, drop in clinic. Complexity is further compounded as GPs may have their own practice, may work part-time in a drop in clinic, may work as a hospitalist, and/or may work in an emergency department. Thus, given what is now a complex web of working relationships, it is difficult to determine who is a full service GP.

Given the complexity noted above, it was determined that a multi-part approach would be used. It turned out that when this was done, the number of GPs who were seen to be “regular” GPs was fairly similar. This was encouraging as obtaining similar results using different methods provides greater validity to, and confidence in, the findings. It should also be noted that one can obtain a range of uptake ratios using different approaches. As will be seen later in this report, the ratios of uptake are quite similar for the different approaches used. This again provides greater confidence that one has a reasonable estimate, compared to a situation in which different approaches lead to different results.

2.2 Our Proposed Approaches

In thinking about how to determine who is a full service GP we initially determined an overall approach, and a set of variables which we believed reflected the type of work, and relationships with patients, found in a full service family practice.

Given that one has to be a GP to bill for an incentive payment, we took as our starting point data about GPs who billed for the incentives. For each selected variable, we considered a range of values. It was evident that certain values, or categories, within a variable accounted for a large number of GPs. Thus, the challenge was to determine a parsimonious set of variables, which minimized overlap, and cut points to determine who would be considered to be a regular full service GP, and who would not. Many different combinations were analyzed. We finally developed a set of rules to determine who would be in the "regular" GP group and who would not. In general, for most of the variables we used, we excluded GPs who were in the bottom 5%, or lower, of the distribution for each variable used. Thus, we took as our starting point GPs who were by definition "regular" GPs, because they had billed an incentive, and developed an approach to estimate who was a "regular" GP, and who was not (to simply use the group of GPs who billed for an incentive as the group of "regular" GPs would have resulted in 100% uptake, thus, we did not use this approach).

Two other approaches were also used. The first was an adaptation of the BCMA approach to determining who would be a regular GP. The BCMA rule is a financial rule where, for the past five years, physicians who billed for $70,900 or more per year were deemed to be "regular" physicians. However, given that this is a strictly financial based rule, which could apply to hospitalists and emergency room physicians, we also applied our set of practice based rules to the selected GPs.

We also thought about whether or not a simpler, practice based, rule could be developed. It turned out that we obtained similar results with a single rule in which "regular" GPs were defined as those who had a minimum of 50 patients for whom they were the majority source of care (MSOC) physician (this rule worked quite well and could be considered for broader application by the Ministry of Health Services). In determining the cut off for the number of MSOC patients, we looked at cut offs of 25, 50 and 100 MSOC patients per GP. The best fit which seemed to minimize both possible false positives and false negatives appeared to be the rule of at least 50 MSOC patients per GP. Data from these four approaches are presented in this report. The approaches will be referred to as the practice based approach, the BCMA financial approach, the modified BCMA approach, and the MSOC approach.

In addition to the different approaches for estimating "regular" GPs, we also looked at uptake at three levels. The first was uptake based on all GPs. The second was uptake based on the "regular" GPs. The third approach initially used the same rule for determining "regular" GPs (i.e., the MSOC approach) but used this approach only with people who had a given condition for which uptake could be looked at over a multi-year period, i.e., diabetes and CHF. The cut-off for a regular GP for these special groups was that a GP had to have at least 10 MSOC patients who had the particular condition (e.g., diabetes) for which an incentive was paid.

3. METHODS

The following outlines, in greater detail, the methods that were used to obtain information on the three approaches we selected for this analysis. It should be noted that for each type of category of incentive, all of the different incentive codes were used, for the respective type or category of incentive.

All physicians with both a specialty and a functional specialty of GP and an FTE factor greater than zero were included for each year. The PRACDS file was used as the source of physician data.

An attempt was made to determine which GPs might be considered to be "regular" or full service physicians. A number of characteristics were considered. These characteristics were derived from submitted claims for patients with diabetes, congestive heart failure, and complex care needs[1]. A patient was considered to have a disease in any given year if they were on the registry for that disease or there was a claim submitted for the patient for an incentive payment related to that condition. The registries reviewed for complex care included only those diseases for which a complex care incentive could be claimed. A patient had to be on at least two of these registries to be considered a complex care patient.

Using the claims of the above patients, a physician's main practice was determined. This was defined as the practice where the highest number of services was performed. The percentage of services performed at diagnostic facilities and the number of payees a physician used were also calculated. Other characteristics derived from these claims were the percentage of services performed at the main practice, the average number of services per selected patient at the main practice, the number and percentage of selected patients seen at the main practice with more than three services, and the total services for selected patients at the main practice. The number of selected patients for whom each practitioner was the majority source of care was also determined. To be considered the majority source of care a physician must provide more than fifty percent of a patient's services and the patient must have at least three services in the year.

All GPs who billed for an incentive or who claimed for more than one of the obstetrics fee items related to delivery were assumed to constitute the base for selecting 'full service' physicians. These GPs were reviewed according to the above characteristics. The characteristics of the majority of this group of physicians were then used to determine which physicians might then be classified as full service physicians. This represents the practice based approach to determining "regular" GPs.

The characteristics that applied to majority of this group of physicians were:

1. They provided the majority source of care for at least one patient, or,
2. At least 40% of their services were performed at the main practice, or,

[1] The analysis to determine "regular" GPs was based on this sub-set of the BC population, plus GPs who had billed for at least two deliveries. This is a large sub-set and seemed to provide reasonable estimates. It was not deemed to be reasonable to try to look at all claims for all patients, for all GPs, over a 4-5 year period in order to derive the estimate for a "regular" GP, due to the computing resources it would entail for the Ministry.

3. They provided 100 or more services to the selected patients at their main practice, or,
4. They saw 25 or more selected patients at their main practice, or,
5. They provided more than three services to at least 7.5 percent of these patients at their main practice, or,
6. Less than 50% of their services were for diagnostic services, or,
7. They had an FTE factor greater than .2, or,
8. They had at least two services related to delivery.

The practice based rules were also applied to the BCMA financial rule for determining a "regular" GP to derive the modified BCMA approach. Finally, a third approach was also developed with only one rule, i.e., the GP must have a minimum of 50 MSOC patients for whom they are the majority source of care.

4. ESTIMATES OF UPTAKE

4.1 Overall Uptake

Table 1 presents data on uptake for all GPs, the overall uptake for "regular" GPs (i.e., those with 50 or more MSOC patients), and the uptake for the "other" or remaining GPs. Uptake is defined as having billed for at least one incentive in a given time period such as a fiscal year. We also examined the distributions of the number of incentives to see if some refinement was required in the analysis due to skewed distributions (e.g., analyze uptake for GPs who billed at least 5 or 10 incentives). However, the distribution was relatively flat so it was decided to keep the definition of uptake as billing one or more incentives.

As can be seen in Table 1, the overall uptake for all GPs ranged from 33.6% in fiscal 2003/04 to 71.7% in fiscal 2007/08. This represents a reasonable uptake and a significant year to year increase in uptake. For the "regular" GPs, using the MSOC rule, uptake ranged from 45.6% to 92.2% from fiscal 2003/04 to fiscal 2007/08. This is quite a high uptake ratio. It is interesting to note that the uptake for the "Other" group ranged from 4.1% to 27.4% over the same time period. It is hypothesized that this level of uptake is due to locums or GPs with a very low FTE factor. While it is not possible to conclusively determine what percentage of GPs who are eligible to bill for incentives actually do so, it appears, particularly from the uptake by the "Other" group, that most of the GPs who can bill for incentives do so. Finally, it must be remembered that for fiscal 2003/04 and 2004/05, the main incentives for which GPs could bill was limited to diabetes and CHF.

Table 2 presents data on the uptake of "regular" GPs using our other approaches. As can be seen, the overall percentage of uptake is quite similar. For fiscal 2007/08, the overall uptake was 89.1% for the practice based approach, 90.7% for the modified BCMA approach and 84.1% for the BCMA financial approach.

Table 3 presents data for the number of incentives billed by GPs. As can be seen, the "regular" GPs accounted for over 99% of total billings for incentives in fiscal 2007/08 and had an average of at least 330 billing for incentives per GP in fiscal 2007/08, except when using the BCMA Financial rule.

Table 4 presents financial data for the different approaches used to estimate 'regular' GPs. As can be seen, some 98%, or more, of incentive amounts were billed by regular GPs (for all definitions of regular GPs). Using the three approaches, the total amount billed in fiscal 2007/08 by the "regular' GPs amounted to some $110 to $111 million dollars, out of total billings of some $112 million.

The various incentives instituted by GPSC have been implemented at different points in time. Table 5 presents data on the uptake, by the number of GPs, for each type of incentive payment, by year, using the MSOC approach. Table 6 presents the same data in terms of percentages. As can be seen in Tables 5 and 6, there has been a reasonable uptake for many of the incentives. The uptake for obstetrics, however, has remained quite low as only a moderate number of GPs do deliveries. It should, however, be noted that incentives are billed for almost all deliveries.

It was somewhat surprising to see a relatively modest uptake of 57.9% by "regular" GPs for CHF incentives. Given that the CHF incentive has been in place for some time, the GPSC may wish to investigate this matter further. While the conferencing incentives and the mental health incentives are relatively new, their uptake ratios (56.1% and 32.7%) are relatively modest compared to other new incentives such as complex care and the cardiac prevention incentive.

Table 7 presents data on uptake, by type of incentive, for "regular" GPs using the other definitions. The results are, again, quite similar to the MSOC approach.

Table 1: Uptake of Incentives Using the MSOC Rule

	All # of GPs					% in each Group Year					% Using Incentives Based Care Year				
	2003/04	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**
Group															
Full Service (MSOC Rule)	3,218	3,204	3,235	3,263	3,291	71.1	70.0	69.3	68.6	68.4	45.6	63.3	80.1	87.5	92.2
Other	1,306	1,375	1,434	1,497	1,521	28.9	30.0	30.7	31.4	31.6	4.1	8.1	13.6	21.6	27.4
Total (All GPs)	4,524	4,579	4,669	4,760	4,812	100.0	100.0	100.0	100.0	100.0	33.6	46.7	59.7	66.8	71.7

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

Table 2: Uptake of Other Approaches to Estimating "Regular" GPs

	All					% Using Incentives Based Care				
	# of GPs					Year				
	2003/04	2004/05	2005/06	2006/07	2007/08	2003/04	2004/05	2005/06	2006/07	2007/08
Group										
Practice Based Approach	3,308	3,335	3,392	3,428	3,487	44.3	61.9	77.4	85.3	89.1
Modified BCMA Approach	3,097	3,120	3,156	3,167	3,236	45.9	63.4	79.4	87.3	90.7
BCMA Financial Approach	3,577	3,600	3,612	3,645	3,676	40.5	56.0	70.9	78.9	84.1

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

Table 3: Number, and Average Number, of Incentives Billed by "Regular" GPs

	Total Incentives					Average # of Incentives				
	2003/04	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**
Group										
MSOC Rule	52,908	74,684	101,989	335,142	1148157	16.4	23.3	31.5	102.7	348.9
Other	368	838	1,589	4,408	10,868	0.3	0.6	1.1	2.9	7.1
Total (All GPs)	53,276	75,522	103,578	339,550	1159025	11.8	16.5	22.2	71.3	240.9
Practice Based Rule	52,603	74,229	101,155	335,315	1150599	15.9	22.3	29.8	97.8	330.0
Modified BCMA Approach	52,024	72,663	99,204	330,012	1141507	16.8	23.3	31.4	104.2	352.8
BCMA Financial Approach	52,284	73,270	99,657	331,980	1145330	14.6	20.4	27.6	91.1	311.6

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

Table 4: Cost, and Average Cost, for Incentives for "Regular" GPs

	Total Incentive Amount in Thousands $					Average $ for Incentives				
	2003/04	2004/05	2005/06	2006/07	2007/08	2003/04	2004/05	2005/06	2006/07	2007/08
Group										
MSOC Rule	3,968	6,915	8,843	31,219	110,432	1,233	2,158	2,733	9,568	33,556
Other	28	146	203	714	1,504	21	106	142	477	989
Total (All GPs)	3,996	7,061	9,046	31,934	111,936	883	1,542	1,937	6,709	23,262
Practice Based Rule	3,945	6,960	8,857	31,559	111,159	1,193	2,087	2,611	9,206	31,878
Modified BCMA Approach	3,902	6,794	8,673	30,981	110,250	1,260	2,178	2,748	9,782	34,070
BCMA Financial Approach	3,921	6,842	8,707	31,127	110,592	1,096	1,901	2,411	8,540	30,085

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

Table 5: Numbers of Incentives Billed by Year for "Regular" GPs Using the MSOC Rule

		Number Using Incentives										
		All	Any Incentive	Diabetes	Heart Disease	Hypertension	Chronic Disease	Obstetrics	Complex Care	Cardiac	Conference	Mental Health
All	**Year**											
	2003/04	4,524	1,522	1,510	818	0	1,522	0	0	0	0	0
	2004/05	4,579	2,139	1,954	948	0	1,963	637	0	0	0	0
	2005/06	4,669	2,787	2,595	1,268	0	2,608	721	0	0	0	0
	2006/07	4,760	3,179	2,826	1,584	2,235	2,929	814	0	0	1,454	0
	2007/08	4,812	3,450	3,009	1,963	2,763	3,107	809	2,544	2,527	2,003	1,122
Group	**Year**											
Full Service	**2003/04**	3,218	1,469	1,457	809	0	1,469	0	0	0	0	0
	2004/05	3,204	2,028	1,877	930	0	1,883	596	0	0	0	0
	2005/06	3,235	2,592	2,457	1,230	0	2,465	655	0	0	0	0
	2006/07	3,263	2,856	2,675	1,548	2,130	2,736	706	0	0	1,352	0
	2007/08	3,291	3,033	2,828	1,906	2,596	2,881	698	2,414	2,369	1,847	1,077
Other	**2003/04**	1,306	53	53	9	0	53	0	0	0	0	0
	2004/05	1,375	111	77	18	0	80	41	0	0	0	0
	2005/06	1,434	195	138	38	0	143	66	0	0	0	0
	2006/07	1,497	323	151	36	105	193	108	0	0	102	0
	2007/08	1,521	417	181	57	167	226	111	130	158	156	45

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

Table 6: Percentage of Incentives Billed by Year for "Regular" GPs Using the MSOC Rule

		% Using Incentives									
		Any Incentive	Diabetes	Heart Disease	Hypertension	Chronic Disease	Complex Care	Obstetrics	Cardiac	Conference	Mental Health
All	**Year**										
	2003/04	33.6	33.4	18.1	0.0	33.6	0.0	0.0	0.0	0.0	0.0
	2004/05	46.7	42.7	20.7	0.0	42.9	0.0	13.9	0.0	0.0	0.0
	2005/06	59.7	55.6	27.2	0.0	55.9	0.0	15.4	0.0	0.0	0.0
	2006/07	66.8	59.4	33.3	47.0	61.5	0.0	17.1	0.0	30.5	0.0
	2007/08	71.7	62.5	40.8	57.4	64.6	52.9	16.8	52.5	41.6	23.3
Group	**Year**										
Full Service	**2003/04**	45.6	45.3	25.1	0.0	45.6	0.0	0.0	0.0	0.0	0.0
	2004/05	63.3	58.6	29.0	0.0	58.8	0.0	18.6	0.0	0.0	0.0
	2005/06	80.1	76.0	38.0	0.0	76.2	0.0	20.2	0.0	0.0	0.0
	2006/07	87.5	82.0	47.4	65.3	83.8	0.0	21.6	0.0	41.4	0.0
	2007/08	92.2	85.9	57.9	78.9	87.5	73.4	21.2	72.0	56.1	32.7
Other	**2003/04**	4.1	4.1	0.7	0.0	4.1	0.0	0.0	0.0	0.0	0.0
	2004/05	8.1	5.6	1.3	0.0	5.8	0.0	3.0	0.0	0.0	0.0
	2005/06	13.6	9.6	2.6	0.0	10.0	0.0	4.6	0.0	0.0	0.0
	2006/07	21.6	10.1	2.4	7.0	12.9	0.0	7.2	0.0	6.8	0.0
	2007/08	27.4	11.9	3.7	11.0	14.9	8.5	7.3	10.4	10.3	3.0

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

Table 7: Percentage of Incentives Billed by Year for "Regular" GPs Using Other Rules

		% Using Incentives									
		Any Incentive	Diabetes	Heart Disease	Hypertension	Chronic Disease	Complex Care	Obstetrics	Cardiac	Conference	Mental Health
Group	**Year**										
Practice Based Rule	**2003/04**	44.3	44.0	24.2	0.0	44.3	0.0	0.0	0.0	0.0	0.0
	2004/05	61.9	56.4	28.1	0.0	56.7	0.0	19.0	0.0	0.0	0.0
	2005/06	77.4	72.1	36.0	0.0	72.4	0.0	20.9	0.0	0.0	0.0
	2006/07	85.3	77.5	44.7	61.6	79.3	0.0	23.4	0.0	40.5	0.0
	2007/08	89.1	81.2	55.1	74.6	82.6	70.1	22.7	68.9	54.4	31.3
Modified BCMA Approach	**2003/04**	45.9	45.6	25.3	0.0	45.9	0.0	0.0	0.0	0.0	0.0
	2004/05	63.4	57.8	29.0	0.0	58.1	0.0	19.6	0.0	0.0	0.0
	2005/06	79.4	74.1	37.3	0.0	74.4	0.0	21.6	0.0	0.0	0.0
	2006/07	87.3	80.4	46.8	64.2	82.1	0.0	24.0	0.0	42.2	0.0
	2007/08	90.7	83.9	57.9	77.7	85.2	73.3	23.2	72.2	56.6	33.0
BCMA Financial Approach	**2003/04**	40.5	40.2	22.0	0.0	40.5	0.0	0.0	0.0	0.0	0.0
	2004/05	56.0	51.1	25.2	0.0	51.4	0.0	17.1	0.0	0.0	0.0
	2005/06	70.9	66.3	32.9	0.0	66.5	0.0	18.9	0.0	0.0	0.0
	2006/07	78.9	71.8	41.3	57.6	73.9	0.0	20.9	0.0	37.8	0.0
	2007/08	84.1	75.7	51.4	70.3	77.6	66.4	20.4	65.5	51.6	29.5

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

4.2 Uptake for Specific Incentives

As noted previously, we have prepared estimates of uptake at three levels: all GPs; "regular" GPs; and GPs providing care for specific categories of people for whom incentives can be billed. This section deals with this third group. Given that most of the incentives are fairly new and, thus, not amenable to longitudinal analysis we focus on two conditions, diabetes and CHF. As noted previously, the approach we used is to identify people who were on the respective registries for diabetes and CHF, and any patients for whom an incentive was billed who was not on their respective registry. Based on this grouping (e.g., all diabetics). The following rules are applied to determine who is a "regular" GP providing care for a given condition, for example, diabetes. The group of all GPs for purposes of analysis is defined as follows:

- GPs who have least 50 MSOC patients, and
- GPs who have at least 10 MSOC patients who have the condition in question (i.e., diabetes, CHF).

Using this base of GPs, the uptake percentage for the use of incentives was 91.1% for diabetes and 73.9% for CHF patients (see Table 8). This compares to 85.9% and 57.9% for GPs who had 50 or more MSOC patients (i.e., the "regular" GPs).

Table 9 presents data on the number of incentives billed for diabetes and CHF patients. The average number of incentives billed for diabetes for the selected GPs was 47.7 while it was 2.8 for GPs who met the 50 MSOC patients rule but did not meet the 10 diabetics MSOC rule. The corresponding numbers for CHF were 8.2 and 0.8.

Table 10 presents data on costs. The average cost per selected GP for diabetes incentives was $5,958 while it was $349 for the other GPs who were not selected. The corresponding numbers for CHF were $1,024 and $104.

Table 8: Uptake for GPs Specializing in Diabetes and/or CHF

	All					% in each Group					% Using Incentives Based Care				
	# of GPs					Year					Year				
	2003/04	2004/05	2005/06	2006/07	2007/08	2003/04	2004/05	2005/06	2006/07	2007/08	2003/04	2004/05	2005/06	2006/07	2007/08
Group - Diabetes															
10 or More MSOC Patients with Diabetes	2,768	2,799	2,872	2,906	2,930	86.0	87.4	88.8	89.1	89.0	50.2	63.6	81.1	86.9	91.1
Other	450	405	363	357	361	14.0	12.6	11.2	10.9	11.0	15.1	23.7	35.5	42.3	44.3
Total	3,218	3,204	3,235	3,263	3,291	100.0	100.0	100.0	100.0	100.0	45.3	58.6	76.0	82.0	85.9
Group - CHF															
10 or More MSOC Patients with Diabetes	1,861	1,890	1,974	1,985	2,052	57.8	59.0	61.0	60.8	62.4	35.9	40.8	50.2	61.6	73.9
Other	1,357	1,314	1,261	1,278	1,239	42.2	41.0	39.0	39.2	37.6	10.3	12.0	19.0	25.4	31.4
Total	3,218	3,204	3,235	3,263	3,291	100.0	100.0	100.0	100.0	100.0	25.1	29.0	38.0	47.4	57.9

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

Table 9: Number, and Average Number, of Diabetes and CHF Incentives

	Total Incentives					Average # of Incentives per GP				
	2003/04	2004/05	2005/06	2006/07	2007/08	2003/04	2004/05	2005/06	2006/07	2007/08
Group - Diabetes										
10 or More MSOC Patients with Diabetes	46,632	65,513	88,117	113,411	139,651	16.8	23.4	30.7	39.0	47.7
Other	408	810	908	1,019	1,009	0.9	2.0	2.5	2.9	2.8
Total	47,040	66,323	89,025	114,430	140,660	14.6	20.7	27.5	35.1	42.7
Group - CHF										
10 or More MSOC Patients with Diabetes	5,561	6,850	8,668	12,514	16,812	3.0	3.6	4.4	6.3	8.2
Other	307	393	568	786	1,030	0.2	0.3	0.5	0.6	0.8
Total	5,868	7,243	9,236	13,300	17,842	1.8	2.3	2.9	4.1	5.4

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.

Table 10: Cost, and Average Cost, of Diabetes and CHF Incentives

	Total Incentives Amount in Thousands ($)					Average $ for Incentives per GP				
	2003/04	2004/05	2005/06	2006/07	2007/08	2003/04	2004/05	2005/06	2006/07	2007/08
Group - Diabetes										
10 or More MSOC Patients with Diabetes	3,497	4,913	6,609	14,171	17,456	1,264	1,755	2,301	4,877	5,958
Other	31	61	68	127	126	68	150	188	357	349
Total	3,528	4,974	6,677	14,299	17,583	1,096	1,553	2,064	4,382	5,343
Group - CHF										
10 or More MSOC Patients with Diabetes	417	514	650	1,564	2,102	224	272	329	788	1,024
Other	23	29	43	98	129	17	22	34	77	104
Total	440	543	693	1,663	2,230	137	170	214	510	678

Source: British Columbia Ministry of Health Services, Primary Care Data Repository, June 2009.