

LETTERS

The authors respond to: letters by Catherine Clelland and Shelley Ross

Dr. Ross¹ writes that, overall, the Full-Service Family Practice Incentive Program (FSFPIP) has resulted in substantial cost avoidance and reductions in hospital admissions. This is based on cross-sectional comparisons of patients with diabetes, congestive heart failure, chronic obstructive pulmonary disease and hypertension who did and did not receive incentive-based care. The article she cites found that, after adjusting for measurable confounders, patients who had incentives had lower costs for three of the four conditions and had fewer admissions to hospital for all four.²

Interpreting differences in costs and admissions to hospital as evidence of cost avoidance and reductions in hospital admissions confuses correlation with causation. We observed that patients with incentives had lower costs and hospital admissions on average, as well as higher continuity or “stickiness,”³ but this was true even before incentives were billed, so this difference cannot be causally attributed to the incentive payments. We previously examined changes in primary care over the full period of investment in the FSFPIP and observed sustained decreases in continuity, although this was across the whole population and not just among patients targeted by FSFPIP.⁴

Our article³ focused on the complex care incentive because management of complex disease is a critical challenge facing our system,⁵ and most existing research focuses on incentive payments for individual diseases. Given a much higher value (\$315 v. \$50–\$125 for chronic disease management), this program costs more than all of the other chronic disease management incentives combined,⁶ and a larger impact was plausible.

Dr. Clelland⁷ suggests that we do not observe effects because earlier chronic disease management incentives had already improved continuity of care. Given methodological limitations of the analyses she cites, we are not convinced this is the case. Even if continuity had increased previously for some patients, it does not alter our conclusion that the more expensive complex care payments did not yield measurable improvements in the outcomes examined.

It was not our objective to examine the impact of the FSFPIP on physician supply, but as both Dr. Ross¹ and Dr. Clelland⁷ write that the program attracted medical students to family medicine, we wish to offer some additional data relevant to this point. Similar to what was observed in British Columbia, the percentage of Canadian medical graduates choosing family medicine as their first choice for residency climbed from 25.0% in 2003 to 38.5% in 2015 across Canada.⁸ Since 2003, the number of family medicine physicians per capita increased by 11% in BC and by 19% across Canada.⁹ Over this period, the University of British Columbia’s Faculty of Medicine dramatically expanded training capacity, and, between 2003 and 2008, the number of graduates entering family practice more than doubled.¹⁰ Growth in family medicine is not unique to BC, and FSFPIP is not the only policy that might plausibly have shaped observed changes.

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■ Cite as: *CMAJ* 2017 February 13;189:E251. doi: 10.1503/cmaj.732524

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Competing interests: None declared.