CEIS Tor Vergata
Centre for International Studies on Economic Growth

CEIS Tor Vergata
RESEARCH PAPER SERIES

Working Paper No. 1 January 2003

"Cost to the patient or cost to the healthcare system?
Which one matters the most for GP prescribing decisions?
A UK-Italy comparison"

ATELLA V., HASSELL K., SCHAFHEUTLE E., NOYCE P., WEISS M.

CEIS Tor Vergata - Research Paper Series, Vol. 2003, No. 1, January 2003

Cost to the patient or cost to the healthcare system? Which one matters the most for GP prescribing decisions? A UK-Italy comparison.

Karen Hassell (PhD)[1], Senior Research Fellow
Vincenzo Atella (PhD)[2], Associate Professor
Ellen I Schafheutle (PhD, MRPharmS)[1], Research Associate
Marjorie C Weiss (DPhil, MRPharmS)[1], Lecturer in Primary Care*
Peter R Noyce (PhD, FRPharmS)[1], Professor of Pharmacy Practice

Abstract

Charges for health services help contain healthcare costs. Despite showing that medicine consumption decreases when charges are increased research has not yet identified how doctors 'manage' the charge system to help patients who cannot afford treatment. This paper describes how the charge system influences the prescribing decisions of Italian and UK physicians. The data are from the qualitative stage of a multi-stage study exploring cost related influences on GP and patient decision-making regarding medicine use. The analysis presented is based on transcripts of focus groups conducted with general practitioners. To help patients who have difficulties affording their medication Italian GPs rely on a smaller number of cost reduction strategies compared to their UK counterparts. They use 'samples' left by pharmaceutical companies, or diagnose patients with pathologies that allow exemption. Occasionally they recommend some delay or change therapy to a cheaper but less effective alternative. Italian and UK GPs have firm views about patients abusing the NHS and believe costs to the system are as important as costs to the individual patient. Prescribing budgets were not viewed in a positive light by Italian GPs. Due to the nature of the charge system in Italy GPs there are able to choose a reimbursable product for patients, so have less need than UK doctors to look for other means of reducing costs. Conversely, the UK GPs have developed a large number of cost reduction strategies, probably because of the charge system itself and the relatively high charges incurred by patients.

KEY WORDS/PHRASES: patient charges, health care system, decision-making, prescribing.

Acknowledgement: This work forms part of the Italian and United Kingdom contributions to an international study being undertaken by ENDEP. The project is funded by the European Union under Framework IV of the BIOMED program. Contract number BMH4-98-3576. Special thanks are due to Roberto Chiaverini who helped to organize and run the Italian focus groups, and to all GPs who participated in the study: without their help this study would not have been possible. Corresponding author: Dr Karen Hassell - e-mail: Karen.Hassell@man.ac.uk Tel: 0161-2752422 Fax: 0161-275 2416.

[1] School of Pharmacy and Pharmaceutical Sciences - University of Manchester - Oxford Road Manchester M13 9PL
[2] CEIS Tor Vergata - University of Rome Tor Vergata - Via Columbia n. 2 - 00133 Roma – Italy
*Now at: Division of Primary Care - University of Bristol - Canynge Hall - Whiteladies Road, Bristol BS8 2PR UK

Introduction

Various reimbursement schemes exist and different types of charges for health care and pharmaceuticals are encountered across the European Union (EU). Two main types prevail: the fixed charge system and the graduated charge system. In most healthcare systems charges for services or products are a means of containing healthcare cost, and findings showing the negative correlation between utilisation of medicines and increases in patient charges from several economic studies demonstrate the extent to which such policies are effective at this level[1-3]. However, health care expenditure continues to rise, and governments are putting pressure on health care professionals and patients to become more cost aware in the matter of health care expenditure. In the UK moves towards 'rational prescribing' embody this.

Despite the link between reduced drug consumption and higher patient contribution to costs, the consequences of reimbursement and other cost related policies on the health of individual patients and their impact on GP prescribing, are less clear. Research is beginning to emerge which shows that non-exempt people on low income are the most likely to decrease consumption[4,5]. The influences leading to this behaviour are likely to be multi-faceted however, and are likely to include among them characteristics of the reimbursement system as well as characteristics relating to the health care system in general.

A three-year study was carried out in six European countries to explore the complex effects of prescription charge arrangements on the decision-making process of physicians and patients in relation to the costs incurred by patients within different systems. The study incorporated a number of stages including a macro-economic study[6]; exploratory qualitative research to identify *how and whether* physicians consider cost when prescribing for patients[7-9] and how patients are affected by cost issues; and finally, a quantitative stage to describe the *extent* to which patients are affected by cost and the extent to which physician prescribing takes account of patients' economic background.

It appears from data arising from the qualitative arm of the study[7-9] that doctors working in these different countries are affected by patient costs in different ways. This paper attempts to draw attention to differences and similarities between GPs working within the Italian and UK systems to help inform how and why prescribing strategies vary across different reimbursement systems when patient cost issues are considered. Some data from UK GPs have been reported in detail elsewhere[9]. New data are presented here about Italian and UK doctors' views on how their prescribing is influenced by 'cost to the system'.

Italy and UK both have a taxation-funded National Health Service, but differences exist regarding the scale of patient co-payment for pharmaceuticals. In addition, there are other fundamental differences in the way GP services are organised and delivered. These are described briefly before presenting the results.

The healthcare system and patient cost-sharing in the UK

A National Health Service (NHS) was introduced in the UK in 1948. Its aim was to provide health services to all in need, free at the point of delivery. Although increasing numbers of people are taking up private health insurance, compared to other countries it still plays only a minor role[10]. Funds for the NHS come from three main sources, the largest being general taxation. National insurance contributions and funds raised through prescription charges form only a small part (less than 6% in 1998)[11].

User charges on prescriptions were first introduced in 1952, and other than for a short period in the mid-1960s NHS patients have always incurred a charge for their medicines. The charge began as a per *prescription form* charge aimed mostly at reducing demand and costs by deterring 'unnecessary' utilisation of services and drugs[1], but to further contain costs a fee *per item* charge was introduced in 1956[12].

Exemption categories and pre-payment certificates were introduced in 1968. (See Box 1). Approximately 85% of prescription items are now exempt from charges[13], covering approximately 50% of the adult population[14].

The present UK prescription charge remains at a fixed rate, flat fee, payable for each item prescribed, irrespective of the actual drug cost, the amount prescribed, or the type of pharmaceutical preparation. In 1998 when these focus groups were conducted non-exempt patients incurred a prescription charge of £5.80 (9.6 Euros) per item.This cost is relatively high in comparison to many other countries in the EU[6].

The healthcare system and patient cost-sharing in Italy

Prior to 1978 when a National Health Service was introduced, Italy's health care system was based on compulsory social insurance. As in the UK, the principle of access based on need underlies the relatively newer Italian NHS. In contrast to the UK system however, the majority of funds for the Italian NHS are generated through payroll taxes rather than through general taxation[15].

Cost-containment measures for pharmaceuticals were introduced with the inception of the NHS. Compared to the UK these measures are a little more complicated and have altered considerably between 1978 and the present. For ease of reference these changes are presented in tabular form (Table 1). A description of the system as it was in 1998 when the study was conducted follows.

In 1998 products were classified according to three groups of reimbursement. For class “A” drugs, medicines considered “essential”, the patient paid a prescription charge of 3000 liras (1.7 Euros). For drugs in class “B” the patient paid 50% of the retail price, and for Class “C” drugs the patient paid the whole price. Disabled persons were exempted from paying the fixed charge on both class “A” and class “B” drugs.

At the time of the study drug co-payment in Italy was based on a rather complex structure where the cost to the patient depended on drug efficacy, age, income, clinical conditions, professional status, and family size. It is worth noting however, that given the reduced importance of the class “B” category of drugs, (8.2% of total specialties reimbursed by the Italian NHS), the Italian system is not dissimilar to the UK system. However, with a 3000 lira flat rate charge for Class "A" drugs, the Italian prescription charge was considerably lower than the one incurred by almost 50% of patients in the UK. Even if the data are adjusted for ‘Purchasing Power Parity’ the amount paid by Italian patients remains lower.

Method: UK and Italy

Qualitative focus groups were undertaken to provide detailed information on the influence of cost on doctors’ prescribing behaviour in this stage of the European study. Focus groups are useful for encouraging discussion on topics to which participants may not previously have given much thought. They allow exploration of poorly understood issues, and their interactive nature can encourage discovery of insights not considered by the researchers[16]. This methodology has yielded important revelations that merit early discussion, while also helping to inform the development of subsequent stages of the work that has sought to test out the extent to which the findings are generalisable and how they compare across EU member states.

The focus group methodology was standardised as far as possible across each of the six countries. Training in organising, conducting and analysing focus groups was provided to all researchers prior to the study. Agreement was reached on recommendations regarding recruitment of physicians, use of incentives, location of focus groups, moderation of the groups, and data recording and analysis. A topic guide (box 2) was formulated and refined through mutual

discussion between team members, and then piloted in each country. Detailed information on the focus groups conducted in Italy and the UK is provided in Table 2.

In both countries the groups were tape-recorded and transcribed. Using the 'framework' method of analysis[17] the UK team developed and applied a thematic framework and index categories on each of the transcripts. The coding frame was refined through independent coding with any discrepancies resolved through discussion and agreement. This was then applied to the Italian transcripts by the Italian researcher.

Results

Factors which influence GP prescribing

While clinical factors were given, not surprisingly, as the most important influence for GPs in both Italy and the UK, patient demand was also a major influence on doctors in both countries. This phenomenon is already well recognized in the UK[18], but less so in Italy. Acquiescence by physicians to patient demand is driven by their desire not to lose patients to other GPs. GPs in Italy are paid on a capitation basis and since there is a large number of GPs who do not reach the maximum number of patients allowed this competition works as an incentive to prescribe. In their view if a prescription is refused there is a high probability that patients will change GP. Moreover, since national prescribing budgets do not exist for physicians in Italy there is no limitation on physicians to prescribe.

While the researchers' agenda in these groups was to gather information on the effect patient costs had on the prescribing decisions of the doctors, cost to the patient was mentioned rarely by Italian or UK physicians as an overriding influence on their prescribing. Neveretheless, when physicians were aware that patients anticipated problems paying for their medicines, certain strategies were employed by GPs in both countries to help reduce the cost to patients for whom they considered treatment was vital, or for patients they perceived as 'demanding'.

Strategies employed by Italian GPs to reduce the cost to the patient

We have already reported these findings from the UK[9]. In this section we discuss the Italian results, but for comparative purposes list the different strategies identified by GPs in Italy and the UK in Table 3.

Italian GPs in this study appeared to have recourse to fewer cost reduction strategies overall, and what strategies are available were used differentially according to their judgement or knowledge of the patients' personal circumstances:

> *'It is very difficult to face situations where pensioners with a minimum pension have to start a treatment for osteoporosis or for depression. In these cases they have to pay the full cost. In many cases it is a question of "buy the food or buy the drugs". For these situations I use the samples left in my office by the pharmaceutical representatives' (Italy: FG 3, GP1).*

Compared to the doctors in the UK arm of the research, the strategy mentioned in the above comment appears to be utilised more frequently by Italian doctors. Particularly for patients they perceived or knew to be below the poverty line, or for patients who may have financial difficulties if they require certain treatments, the option of offering samples seems to be their most often used cost-reduction strategy. It is not however, an ideal solution for all 'deserving' cases:

> *'I also use samples to help patients with financial problems. However, I am not able to manage all the cases with this strategy, because these samples*

have a limited amount of product inside. Sometimes I have expressly requested some particular drug from the pharmaceutical representative' (Italy: FG 3, GP2).

A second strategy employed by the Italian doctors was to diagnose the patient with a pathology that allows exemption:

'I give drugs under class "A" (100% reimbursed) by classifying the patient as affected by a certain pathology for which the drug can be given for free. Of course, in these situations the patient's financial situation really matters' (Italy: FG 3, GP1).

Finally, a third strategy was mentioned, although it did not meet with universal agreement among the doctors. This was to recommend some delay or to change the therapy to something less effective but cheaper:

'I had a case of an old woman who needed HRT therapy for osteoporosis. The treatment costs about (40 Euro) per month, for a period of 6 months. She could not afford it, nor had I a real solution to the financial problem. In this case I had to change the prescription and give her some less effective but also less expensive drugs' (Italy: FG1, GP 3).

'I really disagree with those specialists who impose their choices. I refer to those specialists who prescribe aerosol therapy, but do not recognise if the patient can afford the purchase of the aerosol equipment. ... in cases where they impose injections, but the patient can't afford to pay a nurse to have them, in all these cases patients come back to us and ask what we can do' (Italy: FG3, GP 5).

This strategy of the Italian GPs is similar to one used by the UK GPs, who talked about not prescribing at all, or limiting the number of prescription items when more than one item would have been the most effective clinical option. Like the Italian GPs, GPs in the UK arm of the study expressed dissatisfaction with this course of action, and would really only agree to it if patients experienced financial problems.

Cost to the health care system

While cost to the patient was the main focus of the study many of the GPs, from both countries, appeared more pre-occupied with how their prescribing was influenced by cost to the health care system. In the face of considerable patient demand and expectation the Italian GPs rarely refuse treatment, but some stressed how they try to discourage patients from asking for medicines the GP considers they do not really need:

"In my experience, when I have a patient that claims a prescription that I judge unnecessary, I prescribe something that is very expensive and needs to be fully paid by the patient. Usually this discourages patients to claim for further unnecessary drugs. Another possibility to help reduce unnecessary claims by patients is to force them to have costly diagnostic tests" (FG3, GP1).

This view appears to be a commonly held one, at least among the Italian GPs in this study, and seems to be driven by their views for reducing public drug expenditure:

> "*It is difficult to spend time to convince patients that drugs are not always necessary. I believe that patient education about drug use is extremely important in terms of overall drug expenditure" (FG1, GP2).*

GPs in the UK study were also adamant that patients should not abuse the NHS and were equally aware that costs to the system should be considered when prescribing:

> *"They don't have the right to abuse the service. On the one hand they have a right to a prescription, but on the other they don't have the right to abuse the NHS. You can't go to the doctor for all these things you can get over the counter, all the time. I'm not saying once, all the time. They're abusing the service" (FG2, GP1).*
> *"I would try to use the cheaper ones first… whether they're paying for it or not, because I think in terms of cost to the country, cost to the NHS" (FG1, GP7).*
>
> *"…I am talking about clinical necessity... once you're satisfied, you do it at the cheapest cost to the patient or to the State, if it's clinically necessary" (FG1,GP8).*

While the majority of the Italian GPs manifested a keen interest in any policy that would help reduce public drug expenditure, few had thoughts about how best this could be achieved. Even though a pilot service introduced in March 1998 in which GPs receive a note of their prescribing activity was recognised as a useful tool "for reducing drug expenditure and for correcting poor prescribing behaviour", as a cost containment strategy, they believed it would have little impact if it remains simply a 'memo'. When asked about prescribing budgets specifically, the Italian GPs held generally negative views on their usefulness as a cost containment strategy:

> *"I do not see a budget for physicians as a good policy to contain drug expenditure. We are not accountants. We must be able to practise our profession. With a budget we will end up being more influenced in our prescribing activity" (FG2; GP4).*
>
> *"I prefer a system where, instead of budgets we have an auditing process. Something similar, may be more elaborate to what we have received in the last few months. This can help me understand the situations in which I am under or over-prescribing. It will never prevent me though from giving the right drug just because I am over budget" (FG4; GP1).*
>
> *"In theory a budget should serve to attain more responsible prescribing behaviour. In practice…I imagine myself losing days trying to explain to some special committee why I over prescribed. This activity will just detract time from my main profession. In any case I will never refuse a drug to a patient if he/she really needs it. This means that I may incur a lot of bureaucratic activity". (FG1; GP4).*

Conclusions

Like the GPs in the UK study[9], using strategies to make spend on medicines lower for patients did not appear to be a major concern of Italian GPs. Most of the GPs rarely thought about this problem and did not see this issue as important. However, compared to Italian GPs, doctors in the UK have developed a much wider range of strategies with which to address patient cost-related problems if and when they arise.

In both the UK and Italy the existence or use of particular cost-reduction strategies may be partly explained by the structure of the regulatory systems in place in the two countries. The use of a limited number of strategies in Italy may be a result of GPs being able to choose a mostly reimbursable product in place of a product not reimbursable, given that the majority of active ingredients are also available on the NHS system. In this way GPs, with a few exceptions, have an obvious and simple solution to cost problems should they exist for their patients. GPs working within the UK reimbursement system, however, have had to find other ways to manipulate the charge system to reduce the cost to their patients. It is also possible that the variety of strategies is so extensive because of the relatively high prescription charge.

That GPs in both countries preferred to focus on public expenditure issues rather than individual patient cost issues is perhaps not too surprising. In Italy GPs have recently been put under a lot of 'informal' pressure to help reduce health care costs, in fact they have been highly criticized for being partly responsible for the increase in drug expenditure which has occurred over recent years. Recent experiments to introduce prescribing budgets were not met with a great deal of approval by most of the Italian GPs in these focus groups because of the more formalized and bureaucratic constraints they felt it would impose on their prescribing and professional behaviour. While they appear concerned with helping to reduce public expenditure many clearly have concerns about the State imposing formal procedures upon them to do so.

In the UK, recent changes to the organisation and delivery of primary health care have meant that GPs have had to operate within a fixed budget, that includes prescribing, for some years now.[19,20] That some of the GPs demonstrated an awareness of the costs of drugs and talked of prescribing 'cheaper' drugs indicates the extent to which this does influence their prescribing. Managing prescribing is also still very high on the policy agenda[21], so as a driver of GPs' prescribing behaviour, greater concerns about public expenditure rather than cost incurred by patients is also not surprising.

All this has important implications, since it suggests that each time policy makers want to intervene through policy changes, they need to be aware of the direct and indirect consequences of any new policies. This is particularly true in a sector like health care services where principal-agent problems are predominant. Idiosyncratic changes in cost containment rules and on prescribing behaviour incentives may produce disruptive effects on both patient welfare and public accounts.

This study provides some evidence to suggest that the organizational context and structure of the NHS system in both Italy and the UK makes GPs more sensitive to cost to the system rather than to patient cost. However, it is also clear that both issues do have an impact on their prescribing behaviour which impacts on management decisions at the patient level and raises some serious questions about whether patients receive the best treatment on each occasion they visit their doctor. Subsequent stages of the study, including a conjoint analysis of doctors' cost-related prescribing decisions, will ascertain the extent to which these findings are prevalent across a generalisable population.

References

1. O'Brien B. The effects of patient charges on the utilisation of prescription medicines. Journal of Health Economics 1989, 8, (1): 109- 131.
2. Ryan M. & Birch S.Charging for health care: evidence on the utilisation of NHS prescribed drugs. *Social Science and Medicine* 1991, 33, 681-687.
3. Atella V. Drug cost containment policies in Italy: are they really effective in the long-run? The case of minimum reference price. Health Policy, 1999; 50: 197-218.
4. Lundberg L, Johannesson M, Isacson DGL, Borquist L. Effects on user charges on the use of prescription medicines in different socio-economic groups. Health Policy 1998; 44: 123-34.
5. Kidderminster and District Community Health Council. Do prescription charges deter people from having treatment? A study of prescription uptake in the Kidderminster area. Kidderminster and District Community Health Council, April 1995.
6. Noyce PR, Huttin C, Atella V, Brenner G, Haaijer-Ruskamp FM, Hedvall M-B, et al. The cost of prescription medicines to patients. Health Policy 2000; 52: 129-145.
7. Huttin C and Andral J. How the reimbursement system may influence physicians' decisions: results from focus groups interviews in France. Health Policy 2000; 54: 67-86.
8. Atella V. Physicians prescription behavior and cost to the patients in Italy: first evidence based on Focus Group techniques and prescription data, CEIS Working Paper 2000; n. 112.
9. Weiss MC, Hassell K, Schafheutle EI, Noyce PR. Strategies used by General Practitioners to minimise the impact of the prescription charge. European Journal of General Practice 2001; 7: 23-6.
10. Schoen C, Davis K, DesRoches C, Donelan K, Blendon. Health insurance markets and income inequality: findings from an international health policy survey. Health Policy 2000, 51: 67-85.
11. Ham C. Health Policy in Britain. Hampshire: McMillan Press Ltd, 1999.
12. Martin J and Williams S. The effects of imposing prescription charges. Lancet 1959; 1: 36-39.
13. Department of Health. Statistical Bulletin 1999.
14. Bradley CP, Riaz A, Tobias RS, Kenkre JE, Dassu DY. Patient attitudes to over-the-counter drugs and possible professional responses to self-medication. Family Practice 1998; 15: 44-50.
15. Fattore G. Cost containment and reforms in the Italian National Health Service in Mossialos,E; Le Grand,J, editors. Health Care and Cost Containment in the European Union. Aldershot: Ashgate, 1999: 513-546.
16. Morgan DL. Focus Groups as Qualitative Research. London:Sage, 1988.
17. Ritchie J and Spencer L Qualitative data analysis for applied policy research. In: A Bryman and R G Burgess, editors, Analysing Qualitative Data. London: Routledge 1994.
18. Bradley C. Uncomfortable prescribing decisions: a critical incident study. BMJ 1992; 304: 294-6.
19. Department of Health (1990) Improving Prescribing. HMSO, London.
20. Walley T, Ferguson J, Carter Y. Impact of the UK healthcare reforms on prescribing. In: Hobbs and Bradley, editors. Prescribing in Primary Care, Oxford General Practice Series, Oxford University Press, 1998.
21. Department of Health. The NHS Plan. Stationery Office CM4818-1. 2000

Box 1 – Prescription exemption categories in the UK

- Exempt on age grounds
  - under 16 years of age
  - 16, 17, or 18 *and* in full-time education
  - 60 years or over
- Holds a Health Authority exemption certificate
  - Maternity exemption (pregnancy & 12 months after giving birth)
  - Medical exemption, for one of a number of specified conditions, such as:
  - Permanent fistula
  - Hormone deficiencies, such as hypoadrenalism (Incl. Addison's disease), diabetes insipidus, diabetes mellitus (unless controlled by diet alone), myastenia gravis, hypothyroidism
  - Epilepsy requiring continuos anti-convulsive therapy
  - A continuing physical disability which prevents the patient leaving his residence
  - War/MoD pensioner exemption
- Receives or the partner of someone receiving:
  - Income support, family credit, disability working allowance, income-based jobseekers allowance, a current HC2 charges certificate
- Pre-payment certificate (FP96) - these allow patients to receive all prescriptions within either a 4 or 12-month period 'free' on payment of a one-off initial sum.
- Free of charge contraceptives

Box 2: Physician Focus Group Topic Guide

1. Very briefly can you brainstorm what factors are involved in your decision to prescribe?
2. Do patient factors ever affect the decision?
3. Thinking about all of those influences, which ones are the most important?
4. Does the cost to the patient ever affect your decision-making?
5. How much do you consider whether the patient can afford it?
6. Are there any other ways it can be made cheaper for the patient?
7. Let's consider the specific area of [dyspepsia/HRT/hay fever/mild hypertension], what would your treatment options be?
8. Would these treatment options change if the patient could not afford the initial option you had in mind?
9. How would you like to see the prescription charge system changed?

Table 1: Patient charges for pharmaceuticals In Italy

1978	A moderate fixed-charge system is introduced on drugs classified as 'not essential'
1983	Drugs are classified into 3 classes: 'A' = no charges; 'B' and 'C' are subject to co-payment (15% + flat rate). Exemption criteria introduced, based on income, age and health status.
1989	Proportional co-payment is increased and differentiated according to two classes of drugs (30% and 40%); a ceiling on the amount due on each prescription (30,000 ITL) is introduced. Exemption criteria are substantially enlarged.
1992	Co-payment percentages and the ceiling per prescription are increased (30% and 50%; ITL 50,000)
1993	Exemption criteria changed: pensioners entitled to a bonus of 16 free prescriptions per year.
1994	Positive list revised. Bonus system introduced in 1993 is abolished; income selectivity replaced by age selectivity
1995	Income criteria added to age selectivity for exemption to co-payment. Positive list radically revised. And drugs re-classified in three classes which incur different charges: Class "A" - patient pays only a prescription charge; Class "B" - patient (if aged 16-65) usually pays 50% of the drug price; Class "C" - the patient pays the whole price.
2001	Prescription charge abolished altogether for class "A" and "B" drugs. So, in the present system Italian patients receive drugs that they either have to pay for in full, or are completely free. The list of drugs reimbursed 100% is extensive.

Source: adapted from Fattore, (1999)

Table 2: Focus Group methodology in Italy and the UK

Details	Italy	UK
How many	5 Focus Groups	5 Focus Groups
Geographical area	4 centres representing 2 diverse geographical regions: Cassino, Venafro, Isernia, Roma	3 Health Authorities: Manchester, Bolton and South Cheshire
Venue	Meeting rooms, hotel	Post-grad meeting rooms and hotels
When	October 1998 and March 1999	August to December 1998
Incentive	Dinner after the discussion	Buffet and £75 (124 Euros)
Contacts	48 invited	856 GPs contacted/103 replied
Attended	28	51
Gender	10 women, 18 men	11 women, 40 men
No. in each group	Btw 4 and 8 in each group	Btw 10 or 11 GPs in each group
Ages	Range: 30 to 66 years	Range: 29 to 70 years
Duration	Average: 1 hour 10 min	Average: 1 hour 15 minutes

Table 3: Cost reduction strategies used by physicians

Strategies	UK	Italy
Recommend purchase of medicines OTC	✔	
Issue a private and an NHS prescription	✔	
Recommend purchase of a pre-payment certificate	✔	
Increase the quantity supplied	✔	
Prescribe for an exempt family member	✔	
Prescribe a product in a cheaper category		✔
Write fewer prescriptions	✔	
Prioritise prescriptions	✔	
Prescribe 'stronger' medication for non-exempt patients	✔	
Offer a free 'sample'	✔	✔
Diagnose a pathology so patient meets exemption criteria	✔	✔