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Increases in general practice workload in England

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Primary care services form the backbone of health care in most high-income countries. Yet, there are growing concerns about the effects that numerous changes in the content and delivery of primary care have had on the workload of primary care practitioners. In a retrospective analysis in *The Lancet*, F D Richard Hobbs and colleagues[1] investigated the direct clinical workload of general practitioners (GPs) and practice nurses in primary care in the UK, and present data from consultations of patients registered at 398 English general practices between April, 2007, and March, 2014.

Hobbs and colleagues[1] used data from electronic health records in the Clinical Practice Research Datalink, and linked these data to national datasets that included more than 100 million consultations and 20 626 297 person-years of observation. The study findings show that the overall workload of GPs in England rose by 16% in the 7 years up to 2014, with more frequent and longer GP consultations. Rates of GP consultations rose by 12·36% per 10 000 person-years, compared with 0·9% for practice nurses. Moderate rises in rates of GP face-to-face consultations (5·2%) were overshadowed by an almost 100% increase in the rate of GP telephone consultations. Additionally, the mean duration of GP face-to-face consultations rose by about half a minute, from 8·65 min (95% CI 8·64–8·65) in 2007–08 to 9·22 min (9·22–9·23) in 2013–14. This rising tide of workload is probably an underestimate, since an additional 40% of GP time is spent on tasks not measured in this study, such as arrangement of referrals or admissions, renewal of prescriptions, administrative and clinical meetings, and teaching.[2] Moreover, although the dataset does not provide data about the number of GPs (which could account for the increase in consultations), the investigators point out that other data show there has been a 1% decline in full-time equivalent GPs over this time period.

These startling results reflect what we and many of our GP colleagues have experienced—a seemingly endless demand for consultations, coupled with more complex patient care, escalating administrative tasks, pressures to meet quality performance targets, and rising documentation requirements. A worrying amount of this work happens not just within consultations, but also afterwards, which can account for an estimated additional 8 h of work per week or more for an average GP.[2] This struggle to provide the quality of care GPs would like to offer in the face of competing demands on time, is contributing to alarming rates of burnout. 54% of UK GPs older than 50 years report a considerable or high likelihood of quitting direct patient care within 5 years, with 82% intending to leave or reduce their clinical work within the next 5 years.[3,4] When GPs who have left the UK's National Health Service (NHS) are asked why, they cite the negative impacts of administrative tasks and overall workload, and limited ability to provide patient-centred care.[5] The lowest level of job satisfaction among GPs since 2001 is deeply concerning, and presumably reflects, among other things, the various changes to organisation of general practice in England under successive governments.[2]

Are GPs unique in the NHS in terms of their rising workload? Hobbs and colleagues focus on general practice, but rising workload has been documented in other areas of the NHS. For example, emergency admissions of children to hospital have risen by 28% in the past decade, with similar experiences in other parts of the health service.[6,7] To some extent, the rise in GP workload parallels similar increases in overall health-care workload in the UK.

Is rising GP workload an English NHS problem, or is it common to primary care in other countries? Surprisingly little information exists about consultation numbers and duration internationally, but other data suggest that English GPs are not alone. A 2008 survey of family doctors in 12 European countries found burnout was a common issue, with 43% of family doctors experiencing burnout from emotional exhaustion.[8] In the USA, almost half of primary care physicians have symptoms of burnout.[9] The reasons for this unhappiness internationally mirror those of English GPs—increasing administrative burdens, greater expectations placed on primary care, time pressures, longer working days, and fewer rewards. Even in countries with greater investment in health care, such as the USA, as Sinsky and colleagues have remarked, "joy is in short demand".[10]

Roland and Everington have warned that "If general practice fails, the whole NHS fails".[11] With the NHS's budget under increasing financial pressure, what are practical solutions for achievement of a fully functioning and modern general practice? Increasing the supply of GP workforce is one solution, with 5000 more GPs cited as being needed in the UK by 2020.[12] However, with "GP training, recruitment, and retention in the UK fast approaching crisis point",[5] recruitment of more GPs is unlikely to fix the problem in time. So, what are other solutions? Roland and Everington gave sensible suggestions about what is needed to revive general practice, including substantial financial investment in general practice and in the NHS overall, novel ways of improving communication between GPs and specialists, and improving recruitment and retention of GPs.[11] We believe that a major shift is also needed in general practice, away from a doctor-centric model to one that is truly a shared care model, in which more and varied types of clinical support staff (eg, nurses, pharmacists, physician assistants) work in collaboration with GPs. However, Hobbs and colleagues' data show that English general practice is currently top heavy, with about three times more GP than nurse consultations.[1] Expansion of the roles of different types of clinical support staff, rather than simply employing more GPs, is an underused approach in the UK, leaving GPs to bear the burden.

Finally, what can be done to reduce demand for general practice consultations? Many GPs believe that

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however much capacity is provided (supply), whether by telephone, in person, and in some settings over the internet, this capacity is rapidly filled. Perhaps health-care services might never be able to fully match demand. For example, a random survey of 49 706 individuals, representative of the Danish adult population, found that some symptoms such as tiredness were reported in 49·4% of individuals.[13] GPs usually only see the tip of this so-called symptom iceberg, and might never be able to see (or should see) everyone with every symptom.[13] If general practice in England is to survive, new approaches are needed to address the expectations of patients and to provide advice and health care that does not always have to involve GP consultations, and with no additional health-care costs.

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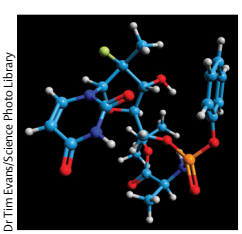
Indian hepatitis C drug patent decision shakes public health community



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Sofosbuvir

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On May 9, 2016, the Indian Patent Office granted the US pharmaceutical company Gilead a patent for sofosbuvir, a direct-acting antiviral for the treatment of hepatitis C virus (HCV).[1] The decision to grant the patent reversed an earlier decision by the Indian Patent Office to reject the application after civil society organisations and generic manufacturers had filed a formal opposition to the patent application.[2]

The new sofosbuvir patent decision is again raising concerns among public health advocates. HCV infection can lead to lethal liver disease if left untreated. WHO estimates that 130–150 million people worldwide have chronic HCV infection, although recent estimates suggest this figure could be lower, at around 80 million.[3,4] WHO has laid out a global strategy for the treatment and elimination of HCV and has added sofosbuvir and other HCV medicines to the WHO Model List of Essential Medicines.[5,6] The implementation of such an ambitious strategy will depend on the availability of affordable medicines.[7]

Affordability is central to the HCV issue. The price of a 12-week sofosbuvir treatment course of up to US$84 000 in the USA and €48 000 ($54 400) in the Netherlands,[8] for example, is prohibitive for most health systems. In high-income and middle-income countries where generic HCV medicines are not accessible, the high price of HCV medication has led to the rationing of the treatment.[8] The production cost of sofosbuvir is estimated to be $68–136 for a 12-week treatment course[9] and is for sale in India for $500.[10]

India's generics industry flourished during the country's decades-long ban on medicines product patents, and was able to produce generic copies of new medicines and offer them at much lower price. Indian generic antiretroviral medicines, for example, have been essential in the scale-up of HIV treatment.[7] This situation ended in 2005 when India amended its Patents Act to introduce medicines product patents to become compliant with the intellectual property rules of the World Trade Organization.[11] As a result, since 2005 pharmaceutical companies apply for medicines patents in India, which means that all new medicines can be subject to 20-year patents there. When a patent is granted, other manufacturers cannot produce a generic version of the medicine until the expiry of the patent.

The grant of the sofosbuvir patent to Gilead does not mean that generic production and supply are impossible because of agreements between certain producers and Gilead that allow for generic production. In 2014, 11 Indian generic companies signed a voluntary licence agreement with Gilead for the production of the HCV medicines sofosbuvir, ledipasvir/sofosbuvir combination tablet, and the investigational combination tablet sofosbuvir/velpatasvir.[12] The Indian companies can supply in India and export to 100 low-income and middle-income countries, potentially providing access to the products for about 100 million people living with HCV. The agreement also prohibits the generic companies from supplying these