

Characteristics and outcomes of patients seeking care at a new “co-pay” convenience clinic established to explore sustainable funding models in Uganda

Rosalind Parkes-Ratanshi¹; Andrew Kambugu¹; Gerald Mukisa¹; Tom Kakaire¹; Faridah Mayanja¹; Adelline Tumikye¹; Brenda Mitchell¹; Shadia Nakalema¹; Walter Schlech²
¹Infectious Diseases Institute, Kampala, Uganda ; ²Dalhousie University, Nova Scotia

Introduction

Across sub-Saharan Africa up to 20% of health spending is used to support HIV care (1). 85% of this is from international donors (2,3). International funding for HIV services has plateaued, but under the 2013 WHO treatment guidelines only 34% (32-37%) of the 28.3 million people eligible for HIV treatment are receiving it (4). This represents a substantial funding gap.

In Uganda the major sources of HIV funding are the Government of Uganda, the Presidents Emergency Fund for AIDS relief (PEPFAR) and the Global Fund. Individual out of pocket expenses account for 42% of spending across the health spectrum (5). Corporate health insurance is limited to the highest earners, and a National Health Insurance scheme has not yet been implemented (6,7). If international funding was to substantially reduce the options for funding would include; National government funding, private, community or a national insurance scheme and full out of pocket costs at point of care.

At the Infectious Diseases Institute we provide free of charge HIV care for 8000 patients (called “friends”). We are exploring novel models of care to provide HIV services with a focus on long term sustainability. HIV prevalence in Uganda increases with socio-economic status. We are interested in whether HIV patients would be interested in paying for services which are more convenient, if they were willing to pay a premium to support poorer patients, and if their HIV outcomes could be improved with a service convenient to their needs.



Figure 1; Photo of the co-pay clinic waiting area

Methods

The Infectious Diseases Institute (IDI) clinic has 8,000 HIV positive friends who have always received HIV services free of charge. A survey of 400 of the patients suggested that 70% would be willing to pay a fee for clinic visits with an enhanced level of service (“co-pay” services). Therefore, we decided to pilot a “fee for service” clinic with opening ours convenient for our patients

We consulted our friends, our Friends Council chairperson (our clinic patient advocacy group) and the head of our Greater Involvement of People Living with HIV/AIDS (GIPA) team as well as clinic staff to determine best communication strategies. We decided that a soft opening of the clinic with direct invitation to clinic patients who had expressed to staff an interest in greater privacy or out of hours service. One of the clinic counsellors rang these patients individually to invite them to join the clinic, but impressed on them the voluntary nature of the clinic. A brochure was developed to advertise the clinic. The “VIP” Friendship clinic, was opened on early November 2013. This is a physician led clinic providing an evening service with increased privacy. The charge is around US\$16 for consultation, with routine drugs and tests provided for free.

In January 2014 we started to communicate the service to all patients in the general clinic through health talks in the waiting area, posters and direct communication from staff during consultations. A second clinic model “convenience clinic” commenced in February 2014. This is a junior doctor (medical officer) led out of hours clinic (consultation charge = UD\$8). Chronic disease care for hypertension and diabetes is offered in both of these clinics.

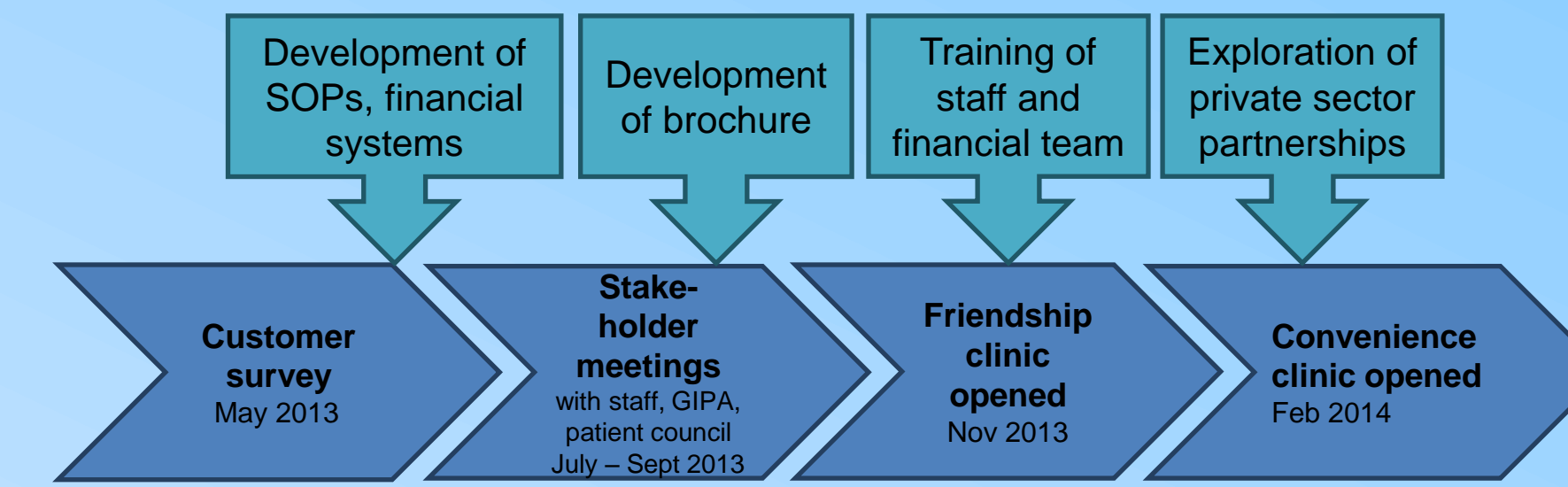


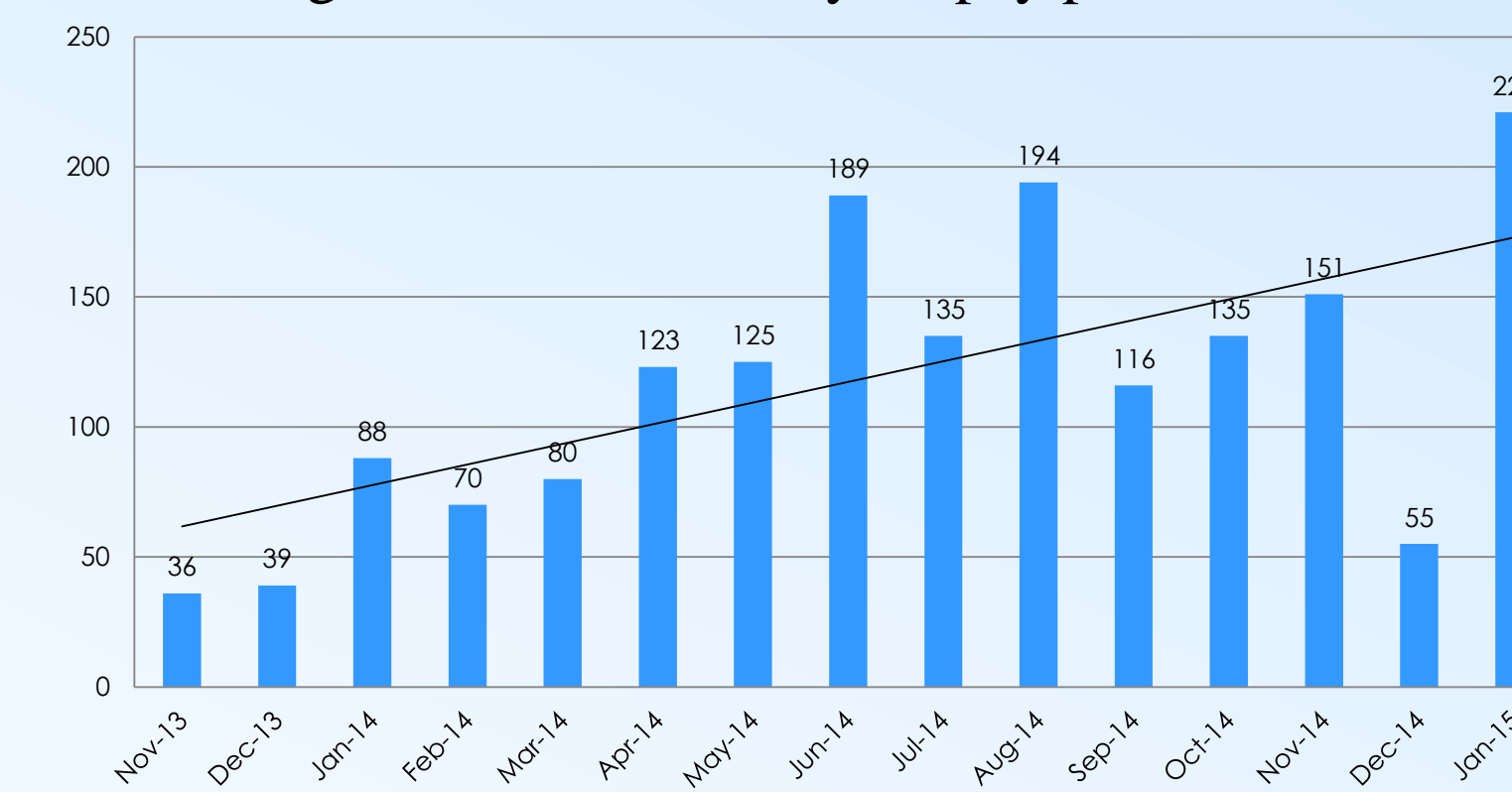
Figure 2: Flow diagram showing steps undertaken in establishment of the co-pay clinics at IDI

Results

Baseline Characteristics

By the end of January, 2015, 600 patients had ever attended co-pay clinic in IDI. Of these, 52.7 % were female, compared to 63.2% in the general clinic. The median age is 36 years (IQR 29, 42). 104 (17.3%) were new to IDI, the remaining were already registered in the general IDI clinics. Median CD4 count at entry was 440 (IQR303-647). Of 104 patients newly registering in clinic 91 were receiving care elsewhere and 10 were returning to care having been lost to follow up at other clinics. 31 reported poor adherence upon joining the clinic

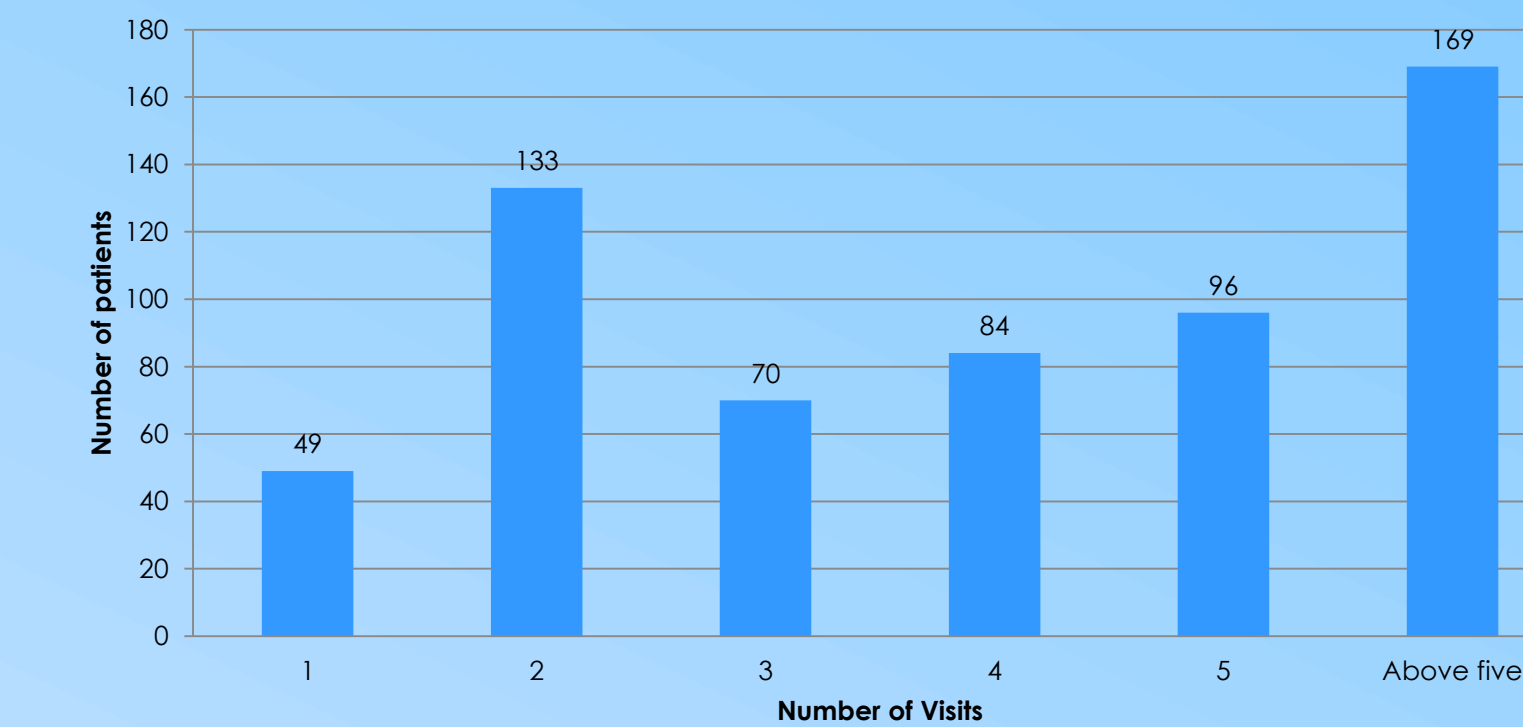
Figure 3: Total monthly co-pay patient visits



Outcomes in co-pay clinic

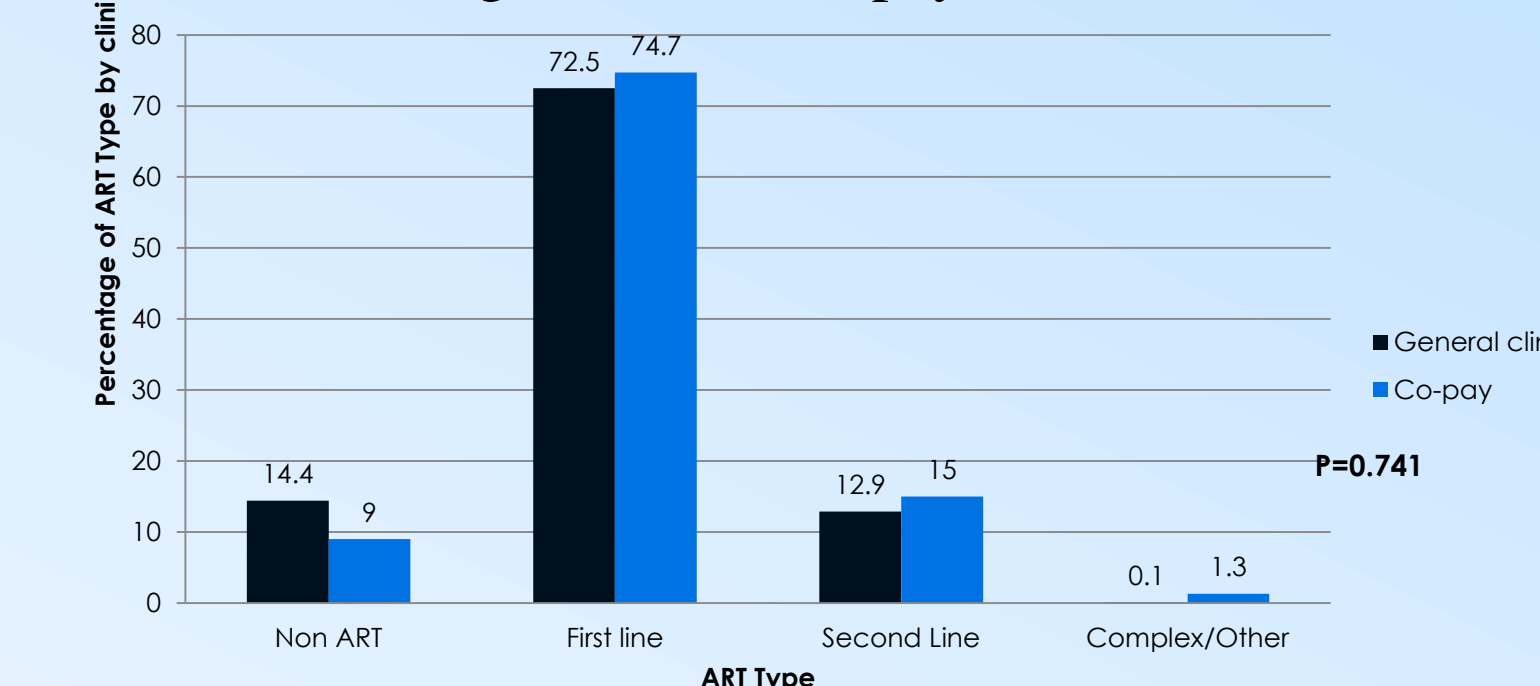
By January 2015, 4 patients had died and 10 (1.7%) were lost to follow up (having not attended clinic for >6 months). 16 patients have switched from first to second line, 2 from second to complex regimen and one from complex to second line.

Figure 4: Number of visits per patient



Median CD4 by January 2015 was 505 (IQR 335,706). 54 patients were ART naïve, 438 on first line, 90 on second line and 4 on complex regimens (Figure 5 shows a comparison with the general clinic). Routine viral load (VL) monitoring was introduced in December 2014; prior to this targeted VL for immunological or clinical failure was done. 260/600 (43.3 %) patients have received a viral load test. Of these, 40 (15%) patients had a detectable viral load on either targeted or routine monitoring. 12/19 patients have so far achieved virological suppression, 21 are awaiting repeat VL.

Figure 5: Comparison of ART regimen between general and co-pay clinics



Conclusion

Around 6.4% of the total IDI clinic population have voluntarily paid for at least one co-pay clinic visit in since its inception 14 months ago. The clinic has also attracted new patients from outside of IDI he clinic is showing consistent growth in numbers by month at present, showing a demand for services.

The clinic is showing a trend towards patients who may be having difficulty in accessing care elsewhere, such as men. In addition many of the new patients have had a poor adherence history or periods of lost to follow up at other clinics. 19 patients have had an intensification of regimen due to attendance in this clinic and so far 12 patients with virological failure have achieved virological suppression. 94.6% patients eligible for ART with a CD4 count <500 (as per 2014 Ugandan guidelines) have started ART.

This suggests that the co-pay clinic may be serving a group who have struggled to find accessible services prior to attending the co-pay clinic, and shows early indications of improved outcomes. Qualitative work is exploring the appetite for these patients to support poorer patients to receive services, and we aim to extend services with the addition of a HIV women's clinic with a focus on sexual and reproductive health in the near future.

References

1. Amico P, Aran C, Avila C. HIV spending as a share of total health expenditure: an analysis of regional variation in a multi-country study. PLoS One. 2010;5(9):0012997.
2. WHO. The World Health Report: health systems financing: the path of universal coverage. Geneva: World Health Organization (2010). 2010.
3. Hecht R, Stover J, Bollinger L, Muhib F, Case K, de Ferranti D. Financing of HIV/AIDS programme scale-up in low-income and middle-income countries, 2009-31. Lancet. 2010;376(9748):1254-60.
4. UNAIDS. Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS). 2013.
5. MOH. National Health Accounts FY 2008/09 and FY 2009/10 : general health accounts, reproductive health sub-accounts, and child health sub-accounts Ministry of Health, Kampala, 2013 2013.
6. Zikusooka CM, Kyomuhang R, Orem JN, Turmwine M. Is health care financing in Uganda equitable? Afr Health Sci. 2009;9(2):S52-8.
7. Basaza RK, O'Connell TS, Chapcakova I. Players and processes behind the national health insurance scheme: a case study of Uganda. BMC Health Serv Res. 2013;13(357):1472-6963.