BACKGROUND

As people with HIV live longer due to effective treatment, increasing numbers may experience co-morbidity, impacting upon HIV service use, as well as quality of life. Using national cohort and patient survey data we examine the impact of co-morbidity on HIV service attendance patterns.

METHODS

A representative sample of 3,861 people attending HIV clinics in England & Wales with linked clinical data in 2017

RESULTS

Multivariable regression for consultation frequency

In multivariable regression controlling for age, gender, ethnicity, VL suppression and HIV risk group, there was a significant positive association between consultation frequency and the number of co-morbidities reported by a patient (β=0.16 (0.12-0.20), p<0.001).†

Dementia was most strongly associated with consultation alongside psychosis/schizophrenia, neuropathy/peripheral neuropathy, cancer, and anxiety (Figure 5).

Figure 5. Results of multivariable regression model for consultation frequency adjusted for age, gender, ethnicity and HIV risk group

Additional HIV clinic attendance costs of co-morbidity

It was estimated 12,602 HIV clinic visits cost £5.67M per annum (12,602 visits at £450 per visit). The incremental cost per patient (per annum) of additional HIV clinic visits incurred due to presence of co-morbidities with significant effect was calculated using estimates from the multivariable regression model (Table 1).

Table 1. Incremental costs of five co-morbidities associated with increased HIV clinic visits

LIMITATIONS

• These data, whilst covering a wide variety of complex health conditions, represent patient-reported conditions at any time within the past 10 years. It was not possible to determine recency or severity of any co-morbidity.

• Data are limited to respondents to the Positive Voices survey and people who were able to be linked to HIV specialist care attendance records. Whilst this survey was broadly representative of the population of people living with HIV, results may not be generalisable to the overall population.

• This analysis was not able to provide an insight into the time and resources spent on an individual patient, or resource utilisation outside of the HIV clinic, which may be greater for people with complex needs. These data items are not currently collected through the national HIV surveillance cohort dataset (HARS).

CONCLUSIONS

• In this engaged cohort of people living with HIV, almost three-quarters were diagnosed with a non-HIV co-morbidity.

• Our results show a significant association between co-morbidity burden and increased clinic attendance, with neurological and mental health conditions associated with the most extra HIV clinic attendances, alongside cancers.

• Monitoring the increasing burden of co-morbidities, and resulting financial and resource impact, is needed to plan the future of HIV services and the need for integrated health services.

• The definition of a ‘complex’ patient †should continue to be refined to include information about attendance frequency, which may indicate presence of co-morbidity not currently collected through HARS.

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REFERENCES

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HIV co-morbidities and their impact on attendance frequency at HIV clinics in England & Wales

Findings from the Positive Voices Survey 2017 linked to national cohort data

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PARTICIPANT CHARACTERISTICS (n=3,861)

72% Men 28% Women (including 13 Transwomen)
98% on ART
52% Live in London
97% suppressed viral load (of those on ART)