Financing of HCV Treatment – Cameroon

Table Ronde – Lutte Contre les Hépatites au Sénégal
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PharmAccess FOUNDATION

PHARMACCESSGROUP

Project Summary – HCV Treatment Cameroon

- Original Objective: facilitation of the establishment of a medical and logistical protocol, along with a financing structure, for the broad treatment of HCV in Cameroon, with a longer-term goal of eradication.
- Project sponsored by the PharmAccess Foundation and the Joep Lange Institute and the support of the Ministry of Public Health.
- Early efforts to develop a sustainable financial model were also partially funded by the Achmea Foundation.
- Principal stages:
    - First Pilot Treatment Project – 150 Patients at 6 Treatment Centers in Yaoundé
        - Traditional donor funding
        - On-site environmental validation, with follow-on financial modeling and high-level financing and protocol discussions with MPH and other stakeholders
    - Second Pilot Treatment Project planned (2019)
        - To incorporate ”mini Performance Based Financing”
        - Patient sourcing initially from blood donor screening in Yaoundé and Douala.
        - Will use same Cameroonian medical management team.

Status – First Demonstration Treatment Pilot

- Project parameters agreed in the fourth quarter, 2017
- Pilot includes patients at 6 treatment centers in Yaoundé, supervised by gastroenterologists. Overall study led by Pr. Oudou Njoya, at the Centre Hospitalier Universitaire de Yaoundé
- Pilot patient in-take commenced in November, 2017.
- Status as of May, 2018:
  - Total target patient cohort 150
  - Patients pre-enrolled 161
  - Patients under treatment, 122
    of which, treatment competed 90
  - Observed cure rate for patients fully treated 96%
  - Target for completion of treatment November, 2018
  - Interim Analysis Completed August, 2018
  - Final Analysis to be Completed Feb/March, 2019
  - So far, very few patients have abandoned treatment (0.5%). Currently examining implications and causes of 5.7% who have missed some required doses.

Initial Observations – First Demonstration Pilot

- Consistently high cure rates of about 95%, analogous to those obtained in clinical trials in Europe and North America.
- Successful logistical and medical management by Cameroonian team, led by gastroenterologists. Slightly heavy ongoing diagnostic measurements, driven by the desire to generate clinical data.
- High levels of adhesion, close to 100% for patients that began treatment.
- Relatively large drop (about 13%) from initially diagnosed patients to those who enrolled in the treatment program. Reasons are unclear but are currently being examined as part of the program's final analysis.

Second Pilot Treatment/Financing Project – Overview

- Project is in the planning stage and is subject to multiple levels of approvals. We have applied for funding for the first half of the target patient cohort – 250 treated patients.
- Patient acquisition can be from any one of several potential new pilot projects, but probably through blood donors screened at selected hospital blood banks in Yaoundé and Douala.
- Target patient cohort of 250 – 550 patients, with enrollment periods of between six and twelve months, driven by available funding. Project management to use the same medical team from the Centre Hospitalier Universitaire de Yaoundé that managed the first pilot treatment project.
- Funding to be structured as a mini "Performance Based Financing" (PBF).
- Medical and local logistical coordination will be overseen by the same team that managed the first demonstration project.
- The project will be subject to the usual ethical and regulatory approvals.

Financing Alternatives

Financing Options	Pros	Cons	Comments
1. Patient Pays – no financing	Simple. No administration needed.	Relatively high cost, combined with low perception of disease, creates barrier to treatment.	Current government program cost levels seem to be principal constraint to growth of treatment, per participants in existing program.
2. Government Pays – no financing	Simple.	Limited government resources to achieve scale.	No leverage of government resources.
3. Patient Pays – loan financing provided to individuals	Simple at a national level; spreads patient payment obligation over longer period.	Requires very strong (probably govt.) credit guarantee.	Likely low-quality repayment performance, given underdeveloped credit culture and misaligned incentives. Very high recourse to guarantee. Limited leveraging of government resources.
4. Employer-provided Health Insurance Pays	Leverages existing health insurance schemes.	Coverage severely limited; international and large national companies.	Demographics do not seem to be aligned with HCV population. Thus, limited impact.
5. Universal Health Coverage Pays	Simple.	UHC program is only in the planning stage.	Expected only to cover basic needs, not more complicated treatment like HCV.
6. Classical Partial Donor Funded Program	Leverages patient/govt. resources.	Complicated and costly pre-disbursement auditing and control mechanisms.	Large donor requirement, will require “wastage” protection.
7. Pay-for-Performance, with Partial Donor Funding	Leverages patient/govt. resources. Simpler outcome payor verification process. Easy to measure results.	More complex financing structure. Stricter governance requirements. Need to align government interests with other participants.	Large donor requirement, “wastage” protection automatic through outcome verification.

Second Pilot Project – PBF Summary

- Classic development impact facility structure, but as a revolving impact facility, much like an overdraft line of credit.
- Impact investors finance defined costs: medical consumables (commodity costs) and direct project operational expenses. Organizational overhead expenses for this specific pilot demonstration effort will be borne as a separate grant expense, outside of the PBF structure.
- Impact investors underwrite project performance. They will potentially be at risk if aggregate fixed outcome payments per cured patients fall below forecast levels. Base investment return to impact investors will be increased if cure rates exceed an agreed threshold level.
- Outcome Payors (fixed amount per cured patient) will pay into an account that will ultimately reimburse the Impact Investors if the minimum cure rate is achieved. The amount per cured patient will be calculated as an amount necessary to fully repay investors if minimum performance results are achieved.
- Any remaining funds will be applied to future HCV control efforts.

Expected Outcomes

- Positive direct medical and financial experience, to support fundraising efforts for national program:
  - Successful treatment using newly available pangenotypic medication and a more diverse patient cohort.
  - Validation of coordination and medical management capabilities of the Cameroonian team that was locally responsible for the first pilot demonstration project.
  - Successful implementation of a PBF structure, incorporating governmental and medical-community priorities.
- Establishment of a clearer sense of current prevalence levels, which will allow better planning for future PBF structures.
- Heightened insight on many key variables:
  - Appropriate levels to set minimum cure rates and thresholds above which bonus interest will be payable.
  - Patient payment levels which will ensure appropriate adherence levels, but will not meaningfully deter participation.
  - Best ways to manage procurement and to forecast future needs.
  - Optimal structure to manage and control cash flows.