Out-of-Pocket Payments in Accessing Antiretroviral Treatment among People Living with HIV (PLHIV) in Indonesia

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Introduction

Within Indonesia's National Health Insurance (NHI) Program, the package for HIV services is limited in achieving the 95-95-95 targets set by the Ministry of Health's (MoH) National HIV Program. Despite comprehensive coverage, out-of-pocket (OOP) payments remain high when accessing care. While the National Health Account reported a decrease in OOP from 32.2% in 2019 (pre-pandemic) to 25.1% in 2021 (during the pandemic), the National Socioeconomic Survey 2018-2022 revealed an increase of 10% in OOP. However, data on OOP paid by Persons Living with HIV (PLHIV) when accessing antiretroviral (ARV) treatment is limited. This study aims to identify factors associated with OOP when obtaining ARV via health care providers to inform MoH on the achievement of the triple 95 targets of HIV intervention.

Methodology

Between April-August 2022, we surveyed 561 PLHIV in 16 municipalities in Indonesia. The sampling was drawn by a convenient sample undertaken by HIV volunteers in each municipality. Participants filled out a Google Form-based questionnaire. The sampling employed Lemeshow and proportional stratified cluster random sampling techniques. We applied multivariate logistic regression to identify the factors associated with OOP payments in accessing ARV treatment.

Results: OOP Costs

Figure 1. Paying OOP when PLHIV accessed health care providers to get ARV treatment (n=561)

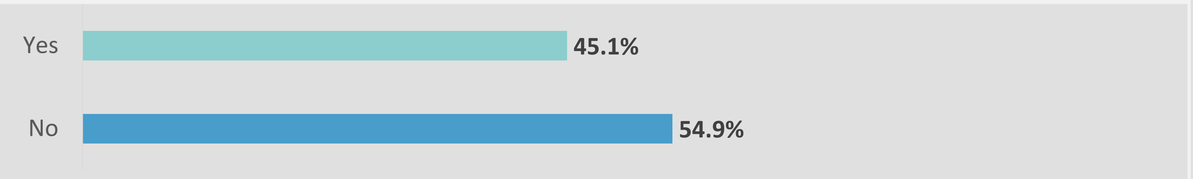
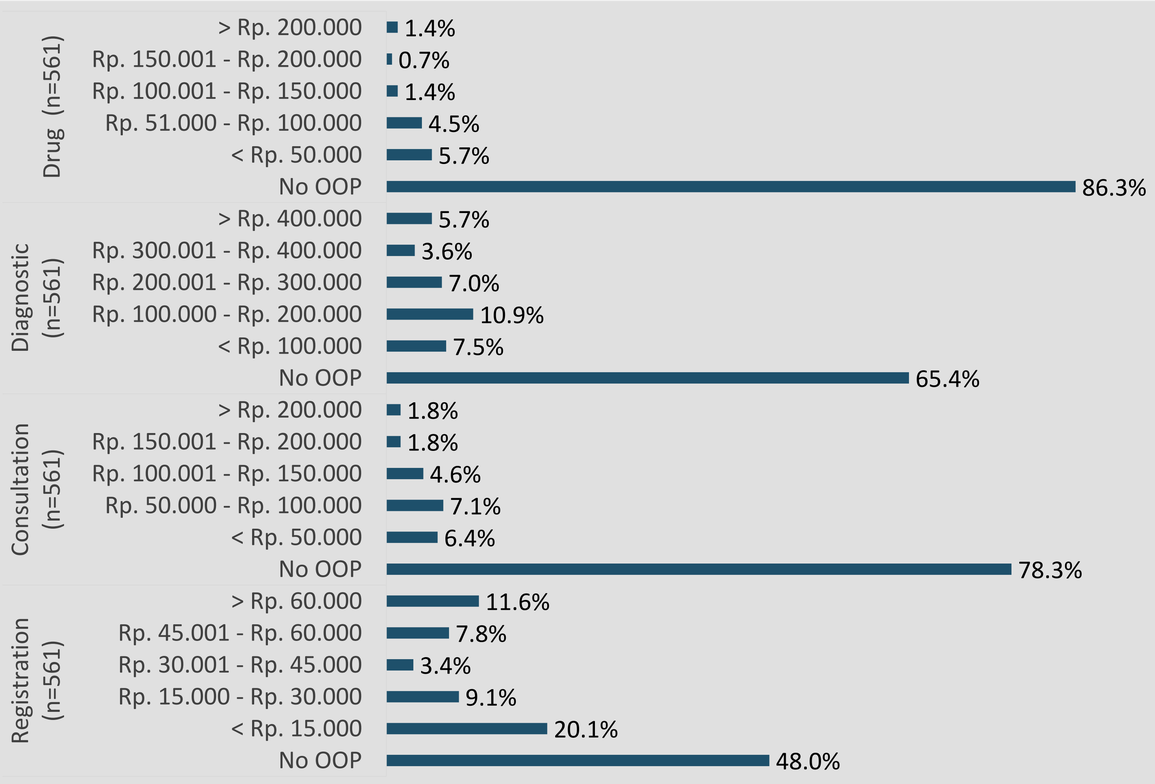


Figure 2. Amount of OOP in obtaining ARV by level of services



Results: Factors Affecting OOP Costs

Figure 3. Percent of PLHIV facing Internalized stigma (n=561)

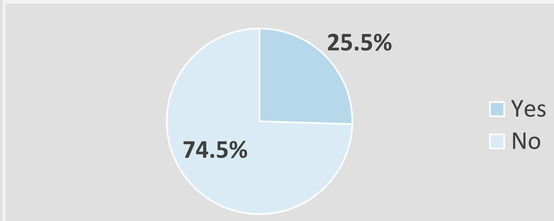


Figure 4. Location of health providers providing ARV treatment (n=561)

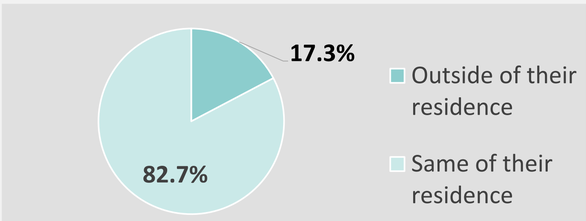


Figure 5. Travel time to health care providers (n=561)

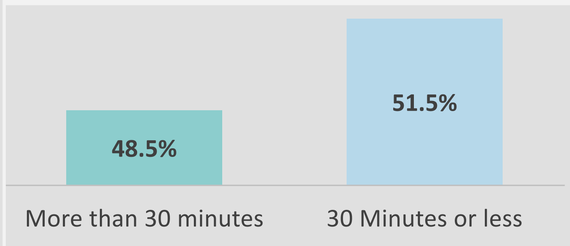


Figure 6. Type of health facility used to access ARV treatment (n=561)

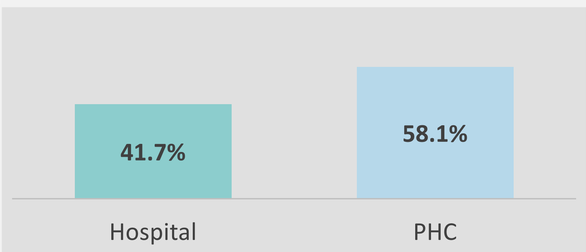
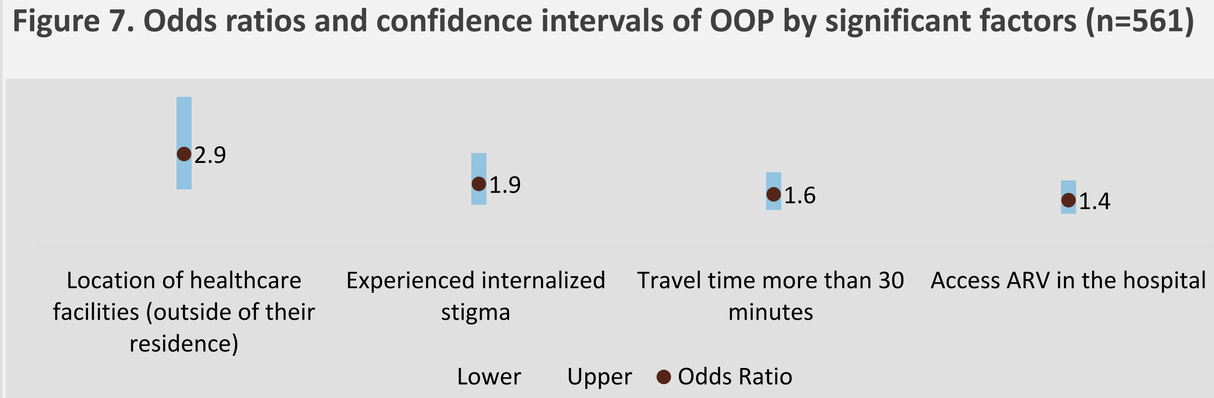


Figure 7. Odds ratios and confidence intervals of OOP by significant factors (n=561)



Key Findings

1. 45% of PLHIV reported paying additional costs (OOP) when accessing ARV at healthcare providers. These included registration, consultation, diagnostic, and drug fees as demonstrated in Figure 3.
2. More than a quarter of the respondents experienced internalized stigma (25.5%)
3. About 17% of respondents obtained ARV outside of their residential area and more than half of the respondents reported traveling over 30 minutes to reach their health care providers.
4. While most respondents received ARV treatments in primary health facilities, more than 40% of respondents visited hospitals to access ARV treatments.
5. PLHIV who obtained ARV medication outside their residential area were almost three times more likely to pay OOP as compared to those who obtained ARV within their residential area (OR=2.9; 95% CI= 1.8-4.6).
6. PLHIV who reported travelling over 30 minutes to reach their healthcare providers were more likely to pay OOP than those who travelled less (OR=1.6; 95% CI = 1.1-2.3).
7. Individuals who felt stigma in accessing ARV treatment were twice as likely to pay OOP as those who did not (OR=1.9; 95% CI = 1.3-2.9).
8. Patients visiting hospitals were 1.4 times more likely to pay OOP compared to those visiting primary health care providers (OR=1.4; 95% CI = 1.0-2.1)

Conclusion

Nearly half of the surveyed PLHIV reported OOP expenses when visiting health care providers. These included registration, consultation, diagnostic, and drug fees. Factors associated with these payments include location, travel time, experiencing internalized stigma (self-stigma, and type of health care provider (p-value < 0.05).

Recommendations

To address the incidence of OOP payments, the MoH might consider implementing back referral policies that encourage PLHIV to access ARV treatments at primary health care (PHC) facilities and refer those who regularly receive ARVs at hospitals back to these facilities. In addition, different payment mechanisms should also be considered, such as non-capitation and performance-based capitation for HIV services. Health care providers could also adopt multi-month dispensing of ARVs to reduce the frequency of travel for PLHIV to healthcare providers. Furthermore, health care providers should offer counselling services to address feelings of powerlessness, guilt, anger, and reactions from others when PLHIV access HIV care. This support is especially crucial for those newly diagnosed and initiating HIV.

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