

CEDS-GDN Policy Brief



Is community clinic the way forward?

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Background

The number of HIV cases in Indonesia has been rising rapidly, increasing the need for antiretroviral treatment (ART). However, the public health expenditure on HIV/AIDS is relatively low; ART in West Java is undersupplied and has limited funding, resulting in only less than 50% of those eligible actually receive the treatment. New strategies are urgently required to increase the uptake of ART within the limited resource setting. The questions are how and where?

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What is ART?

Anti Retroviral Treatment (ART) is an HIV treatment program that uniquely acts as both prevention and treatment. It reduces both the amount of virus in People Living with HIV (PLHIV) and their probability of infecting others. Its effectiveness in combating HIV has been shown in many studies.

In Bandung, West Java, ART is mainly conducted in an HIV/AIDS clinic in a largest public referral and teaching hospital in West Java, called Hasan Sadikin. The clinic is visited by high at-risk groups and the general population (mainly from West Java), and delivers HIV-related services such as VCT, ART, and sexually transmitted infections (STI) services. The hospital also coordinates the provision of ART in other 26 satellite hospitals across West Java, which is believed to be underutilized.

Is community clinic the way forward?

As the treatment in Bandung is focused mainly in Hasan Sadikin hospital, it results in a high load of patients. This lead to disadvantages such as very long waiting time and high transport cost for patients who need to travel long distance: these may reduce patients adherence. There is a need to scale up the service to other sites, or to strengthen the already established but underutilized sites. Among these sites, the community based clinics are viewed as having a very important role.

Why community clinics?

Utilizing primary healthcare supported by adequate fiscal, infrastructural and human resources may increase the access of PLHIV and other risk groups to HIV care. Indeed the scale-up of HIV testing and treatment is primarily related to improving access as well as integrating HIV services and adherence programs with primary healthcare. From the patients' point of view, a survey among 57 HIV patients has revealed that most of them (74 percent) feel the need for ART at the primary/community healthcare centers (*puskesmas*). Community-based ART may also ensure better adherence, although several conditions such

as the guarantee of confidentiality need to be fulfilled to encourage the patients to take ART in *puskesmas*.

As such, scaling up ART to the community level holds significant potential in that it can, among other things, reduce the load on the hospital, waiting time and transportation cost for patients as well as ensure better adherence. Currently, there are only two *puskesmas* in West Java which provides ART (under the supervision of Hasan Sadikin hospital) which provides the potential to scale up.

Our study

We simulated two scenarios in West Java, namely scaling up ART through community based clinics (in our case, *puskesmas*, which numbers to 854 across West Java, and two of them provide ART) and scaling up ART through hospitals (currently 27 hospitals providing ART). We focus only on the 1st line ART, and we assume the utilization of 2nd line ART to be constant. We then assess the costs and effectiveness of these two scenarios.

Our first step of analysis is that we assume that all *puskesmas* and hospitals provide ART. By assuming this, we found that the yearly costs of providing 1st line ART in 27 hospitals amount to US\$ 17.3 million per year (US\$637,000 per year per hospital), while the cost of providing ART in 854 *puskesmas* amount to US\$ 30.5 million (US\$ 35,629 per year per *puskesmas*).

Second, we utilize an epidemiological modeling to estimate the number of infection averted by up scaling ART, called HIV in Indonesia Model (HIM). We estimated that assuming by 2020 an additional 20,000 PLHIV are treated with 1st line ART, the epidemic would potentially decrease by 1 percent (roughly) in that year, averting approximately 2,100 HIV infections. Again, assuming that around 45,000 additional PLHIV are treated with 1st line ART in 2020 the epidemic will potentially decrease by approximately 4 percent in that year, averting roughly 6,000 HIV infections.

To achieve this coverage, as many as 19 to 43 additional hospitals (total costs amounting to US\$ 12.2 million to US\$ 27.7 million) or around 833 to 11,400 additional *puskesmas* (total costs amounting to US\$ 29.7 million to US\$ 67.4 million), respectively, are required to distribute 1st line ART.

As such, it costs roughly US\$ 4,500 to US\$ 5,800 to avert one infection if we scale up through hospitals, against US\$ 11,000 to US\$ 14,000 per infection averted if we scale up through *puskesmas*. From this results, although community clinics have its potentials for providing ART, optimizing the function of hospitals in providing ART is seems to be more cost effective.

Recommendation

First, we recommend that *puskesmas* should provide ART only if there is a demand and need for the service (this will also depend on the location of the *puskesmas*), and should act as a support to the already established hospital-based ART system. Therefore, the scale-up of ART should combine the efforts of both these service providers, with the main referral hospital taking the lead, supported by the satellite hospitals and *puskesmas*. Keep in mind that, regardless of the cost effectiveness results, patients have express their need for ART in *puskesmas* as they see this as more accessible facilities.

Second, although the scale-up of ART will require substantial funding, it seems that any additional funding will depend largely on the expanding role of the satellite hospital and the number of additional *puskesmas* required to support the main referral hospitals.