



HIV FUTURES 8

**Financial security among people
living with HIV in Australia**

Australian Research Centre in Sex, Health and Society
2018

INTRODUCTION

HIV Futures 8 is a survey about the health and wellbeing of people living with HIV (PLHIV) in Australia. The study forms part of a series of cross-sectional surveys that have been run every two to three years since 1997. Funded by the Australian Government Department of Health, the aims of the study are to provide information about factors that support physical and emotional wellbeing among PLHIV. The study is designed to inform the Australian National HIV Strategy and guide community and clinical service provision for PLHIV.

In order to explore the complexity of factors that support health and wellbeing among PLHIV, HIV Futures 8 is a broad survey covering issues such as financial security, housing status, anti-retroviral treatment use, general health issues, stigma and discrimination, clinical and support service use, aging, drug and alcohol use, sexual health, relationships, and social connectedness.

HIV Futures is run by the Australian Research Centre in Sex, Health and Society (ARCSHS) at LaTrobe University. Findings from HIV Futures 8 are presented as a series of short reports. These, along with more information about the study and copies of reports from previous HIV Futures surveys, can be found on the ARCSHS website: latrobe.edu.au/arcshs

METHODS

HIV Futures 8 is a cross-sectional survey of PLHIV. The survey was open to people aged 18 years or older who were currently living in Australia. Data were collected using a self-complete survey that could be filled in online or using a booklet that was supplied to prospective participants with a reply-paid envelope. Participants were recruited through electronic advertising in a range of forums including: advertisements sent through the email lists of HIV community organisations; advertising on relevant websites; social media advertising, particularly Facebook including targeted posts to Facebook groups for PLHIV; advertisements on 'dating apps' used by gay men and other men who have sex with men and; flyers and posters displayed in HIV clinics. Hard copies of the survey were distributed through the mailing lists of HIV community organisations and made available in the waiting rooms of HIV clinics and community services. Data were collected between July 2015 and June 2016.

Full details of the study protocol and method have been published elsewhere and are available on the ARCSHS website: latrobe.edu.au/arcshs/projects/hiv-futures

ARTICLE FREELY AVAILABLE ONLINE:

Power J, Brown G, Lyons A, Thorpe R, Dowsett GW, Lucke J. HIV Futures 8: Protocol for a Repeated Cross-sectional and Longitudinal Survey of People Living with HIV in Australia. *Frontiers in Public Health*. 2017; 5:50. <https://www.frontiersin.org/articles/10.3389/fpubh.2017.00050/full>

BACKGROUND

Financial security is key to people's wellbeing. It enables access to safe housing and other basics – food and clothing – necessary for survival. It also allows people greater choice with respect to how they live their lives, which in turn supports psychological and social wellbeing. By contrast, poverty can be intensely stressful and isolating. It can also be disempowering, limiting people's capacity to demand quality in services and care. All of this can have a negative effect on people's health and wellbeing.

For people living with HIV in Australia, access to an adequate and secure income supports quality of life by facilitating greater security and choice in the places people live, services they utilise, and healthcare providers with whom they interact. Capacity to choose and demand quality of services is important for good healthcare. It may also reduce the experience of HIV-related stigma.

Some people living with HIV may be vulnerable to poverty due to a combination of poor physical or mental health and stigma. In particular, people who have been living with HIV for a long time are likely to have experienced side effects from early (pre 1996) treatment and/or ill-health from AIDS-related symptoms. This may have affected people's capacity to work, having long-term consequences for their financial security as they move into older age.

In this broadsheet we explore the relationship between income, financial stress, and wellbeing among people living with HIV in Australia. This broadsheet is one of a series of short reports on findings from HIV Futures 8. All of these are available to download from the ARCSHS website: latrobe.edu.au/arcshs

SAMPLE

HIV Futures 8 was completed by 895 people living with HIV in Australia. Of these, 90.5% (n=804) were men and 8.3% (n=74) were women, while four participants described their gender in other terms. Six participants identified as transgender.

The majority of the sample comprised men who identified as gay (78.7%, n=697), 5.6% (n=50) as bisexual and 4.3% (n=38) as heterosexual.

There were 21 participants (2.3%) who identified as Aboriginal or Torres Strait Islander.

The age of participants ranged from 19 to 86 years. The average age was 51 years. Over half (56.3%, n=485) were aged 50 years or older.

The majority of participants were born in Australia (74.7%, n=649) and spoke English as their first language (91.2%, n=792).

Participants came from all states and territories in Australia as detailed in Table i.

	n	%
ACT	20	2.3
NSW	306	34.5
NT	6	0.7
QLD	136	15.3
SA	65	7.3
TAS	10	1.1
VIC	265	29.9
WA	78	8.8

Table i. States and territories in which participants currently live

*Nine participants did not identify their state/territory

The majority of participants were working (53.8%, n=475), either full time (38.6%, n=341) or part-time (15.2%, n=134). There were 18.1% (n=160) who were retired/no longer working, and a further 7.2% (n=64) were not working or seeking work due to home duties or other reasons.

The length of time since participants had been diagnosed with HIV ranged from one year or less to 34 years with an average of 15 years. There were 234 (26.7%) participants who had tested positive to HIV within the five years before the survey (i.e. from 2010 onward). Of these, the majority (77.0%) were under 50 years of age. However, there were 51 participants (23.0%) aged 50 or older who had been diagnosed in 2010 or more recently.

The great majority of participants were currently using antiretroviral therapy (96.5%, n=844). Of these, 91.0% (n=756) reported they had an undetectable viral load at their most recent tests. (Note, these figures exclude missing data).

Full details of the study sample have been published elsewhere (Power et al. 2017) and are available on the ARCSHS website: latrobe.edu.au/arcshs

HOUSEHOLD INCOME

The 2015/16 average annual income for Australian workers (full-time or part-time) was approximately \$60,320 (ABS, 2016). Among participants in HIV Futures, nearly 50% earned less than \$50,000 per year (pre-tax household income), while 30% lived in households in which the yearly household income was less than \$30,000 (see Table 1).

Income	% (n)
\$0–\$29,999 per year	29.7 (245)
\$30,000–\$49,999	16.0 (132)
\$50,000–\$99,999	31.2 (258)
\$100,000–\$149,999	12.3 (102)
\$150,000+	10.8 (89)
Excluding missing data	

Table 1. Household income

FINANCIAL STRESS

The HIV Futures 8 survey included questions about participants' experience of financial challenges in the past 12 months, such as not being able to pay bills or needing to ask friends/ family for money. These questions are indicators of financial stress. If none or one of these events occurred, this is classified 'as little or no financial stress' and if two or more occurred this is classified as 'significant financial stress' (Wilkins, 2016). The Household, Income and Labour Dynamics in Australia (HILDA) survey findings revealed a relationship between significant financial stress and deprivation (i.e. not being able to afford items that are considered essential) (Wilkins, 2016). In this report, we use financial stress, rather than household income, as an indicator or poor financial means as household income may not always reveal financial means. For example, if people have savings, support from family, or significant assets their financial means may be greater than indicated by income.

Among HIV Futures participants 23% (n=205) had experienced 'significant financial stress' (more than two events) in the past year (see Table 2). Not surprisingly, these participants tended to have lower incomes (50% reported an annual household income of less than \$30,000) and the majority (60%) were reliant on social security as their main source of income.

In the past 12 months did any of the following happen to you because of a shortage of money?	% (n)
Asked for financial help from friends or family	21.2 (190)
Could not pay electricity, gas or telephone bills on time	19.8 (177)
Went without meals	13.7 (123)
Asked for help from welfare or community organisations	12.6 (113)
Pawned or sold something	11.1 (99)
Could not pay the mortgage or rent on time	7.8 (70)
Was unable to heat home	6.8 (61)

Table 2. Indicators of financial stress

Participants aged over 50 years were significantly less likely to report experiencing significant financial stress than those under 50. More women and bisexual men reported experiencing significant financial stress than gay or heterosexual men, although these differences were not statistically significant (see Figure 1).

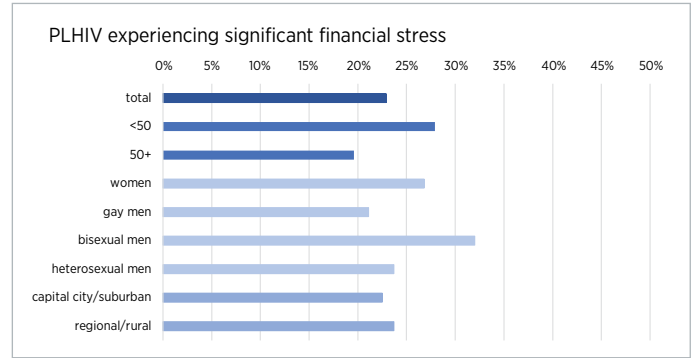


Figure 1. Financial stress among HIV Futures participants

FINANCIAL STRESS AND WELLBEING

People who have limited capacity to work due to ill-health or mobility problems are likely to also live on low incomes. Hence, it is expected that we would find a relationship between financial stress and poorer wellbeing. While financial stress in itself may not cause poor health, it may create added stress in people's lives, reduce their capacity to access health services, and increase social isolation, all of which can further erode health. Either way, there is a clear relationship between poverty and poorer health. Financial stress may be an indicator of people needing support across a range of areas.

In HIV Futures 8, participants who had experienced significant financial stress (vs those with no or low stress, and controlling for differences in age, gender and sexuality), were 'more likely' to:

- report 'poorer mental health' (SF 36 Mental Health Component score, Mean Score =34.34 vs. Mean Score =45.09) (Wu et al., 1997)
- report 'poorer physical health' (SF 36 Physical Health Component score Mean Score = 38.25 vs. Mean Score =46.75)
- have been diagnosed with a 'mental health condition' (74% vs. 45%) and taken medications for a mental health condition in the past six months (53% vs. 26%)
- be diagnosed with an 'ongoing health condition' other than HIV (Mean number of co-morbidities 2.03 vs. 1.73)
- report a lower 'level of resilience' (Connor-Davidson Resilience Scale, Mean Score = 24.72 vs. Mean Score = 28.71) (Connor and Davidson, 2003)
- report 'lower levels of social support' (Social Support Scale; Mean Score = 2.93 vs. Mean Score =11.07) (Baker, 2012)
- report experiencing 'higher levels of HIV-related stigma' (Berger enacted stigma subscale, Mean Score =46.53 vs. Mean Score =38.17; Berger negative self-image scale, Mean Score =31.78 vs. Mean Score =27.32) (Berger et al., 2001).

FINANCIAL STRESS AND ACCESS TO MEDICAL SERVICES

Lack of financial resources may make it difficult for people to access health services. The majority of HIV Futures participants who reported experiencing significant financial stress had a healthcare card (64%) to offset some medical expenses, although only one in five (23%) had private health insurance. Financial stress was associated with a range potential barriers to health service access. Participants who had experienced significant financial stress were 'more likely' than those reporting low or no financial stress to report:

- difficulties 'traveling to places they need to go' (39.6% experience difficulty at least sometimes vs. 14%)
- difficulties 'paying for specialist medical services' (35% vs. 10%)
- having experienced 'long waiting lists' when accessing specialist services (31% vs. 17%)
- having 'experienced discrimination' in a healthcare context (medical services, dentistry, hospital) in the past two years (26% vs. 13%)
- feel 'less capable of engaging actively with healthcare providers' and have lower capacity to navigate the healthcare system (based on the Health Literacy Questionnaire, Osbourne et al 2013).

ACCESS TO HIV SUPPORT SERVICES

A number of support services for PLHIV provide financial assistance and advice. Financial support was one of the services most likely to have been accessed by HIV Futures participants, particularly those experiencing significant financial stress. Among participants in HIV Futures who had experienced significant financial stress, 35% reported having accessed financial assistance provided by HIV related organisations in the past 12 months, 17% had accessed financial advice, while 15% had accessed legal advice.

SUMMARY AND CONCLUSION

HIV Futures 8 findings showed that, of the PLHIV who completed the survey, around half were living on household incomes substantially lower than the average Australian income at the time of the survey, while close to one in four had experienced significant financial stress in the past two years.

People who had experienced financial stress had poorer health, more experiences of HIV-related stigma and lower levels of resilience. This study does not enable us to differentiate between cause and effect when it comes to financial stress and ill-health. But, irrespective of this, we can clearly say from these findings that many Australian PLHIV are living on low incomes and that PLHIV on low incomes are (for whatever reason) likely to face greater challenges when it comes to accessing health services. Barriers to accessing health services may mean PLHIV on low incomes have less choice of healthcare provider, which could explain their greater likelihood of experiencing HIV-related stigma and discrimination in healthcare settings. PLHIV experiencing financial stress may also be socially isolated, which could be a consequence of low income as well as poor health or limited mobility. Services for PLHIV play a vital role in provision of support for people who may be vulnerable because of their financial status. This includes financial advice, financial support, providing access to housing or food, as well as social services aimed at reducing isolation. These services are currently utilised by a number of PLHIV experiencing financial stress, although it may be worth exploring whether there are unmet needs – or unidentified barriers to community service access – for PLHIV experiencing financial stress.

SUGGESTED CITATION

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