CHAPTER 3

The Eight Factor Model for Evaluating True Access

Getting your needs met, once in the system, is a must.

—Lovett-Scott & Prather

Behavioral Objectives

At the end of this chapter the students will be able to:

1. Discuss the Eight Factor Model as a framework in determining true access.
2. Determine whether true access exists in selective healthcare systems.
3. Identify ways in which they might utilize the Eight Factor Model in their practices.

Key Concepts

Primary care
True access
Restorative
Third party payer
Primary health care
Disparity
Social determinants

ch03.indd 31 9/4/2012 6:33:18 PM

INTRODUCTION

When the health community makes reference to patients having access to care, the reference is generally limited. The concept of access is too often described as individuals getting to and from health services and having the ability to pay for the services either by virtue of a third party or out-of-pocket. We believe access to be much more than this and suggest that a redefinition of access is long overdue. *True access* means being able to get to and from health services, having the ability to pay for the services needed, and getting your needs met once you enter the health system. This text introduces a framework for assessing the strengths and weaknesses of selective healthcare systems, and determining if the system is providing true access to health care. The framework is called "The Eight Factor Model."

The comparison of health systems is made by utilizing The Eight Factor Model, which was developed by the authors, and has "true access" as the driving value. As illustrated in **Figure 3-1**, the model has true access at its core, and eight surrounding factors that are important for health systems to demonstrate in order to provide that true access. A solid directional arrow from the factor to the core depicts a system that has demonstrated evidence to support that it is providing true access. A broken directional arrow from the core to the factor suggests the system is not providing true access, and much work must be done to achieve it. **Table 3-1** (a format for assessing true access) provides a template for learners to formulate their own opinions about the extent to which countries discussed in this text provide true access. **Table 7** in Chapter 16, The Eight Factor Model for True Access, summarizes author observations regarding the extent to which each of the 11 countries discussed in the "Health Care in Industrialized (Developed) Countries and "Health Care in Developing Countries" sections of this text have addressed true access. This will hopefully enable the learner to briefly review it against the Eight Factor Model illustrated in Figure 3-1. Table 7, The Eight Factor Model for True Access, which appears at the end of Chapter 16 (Comparative health perspectives) should be fully reviewed as the learner approaches the end of the text.

In describing comparatively what systems are doing globally, we apply this model which allows for a thorough and critical analysis of each healthcare system solely for the purpose of promoting what the users of one system might learn from the users of another rather than focusing on a system's shortcomings. The eight factors depicted by the model are: 1) historical 2) structure, 3) financing, 4) interventional, 5) preventive, 6) resources, 7) major health issues, and 8) health disparities.

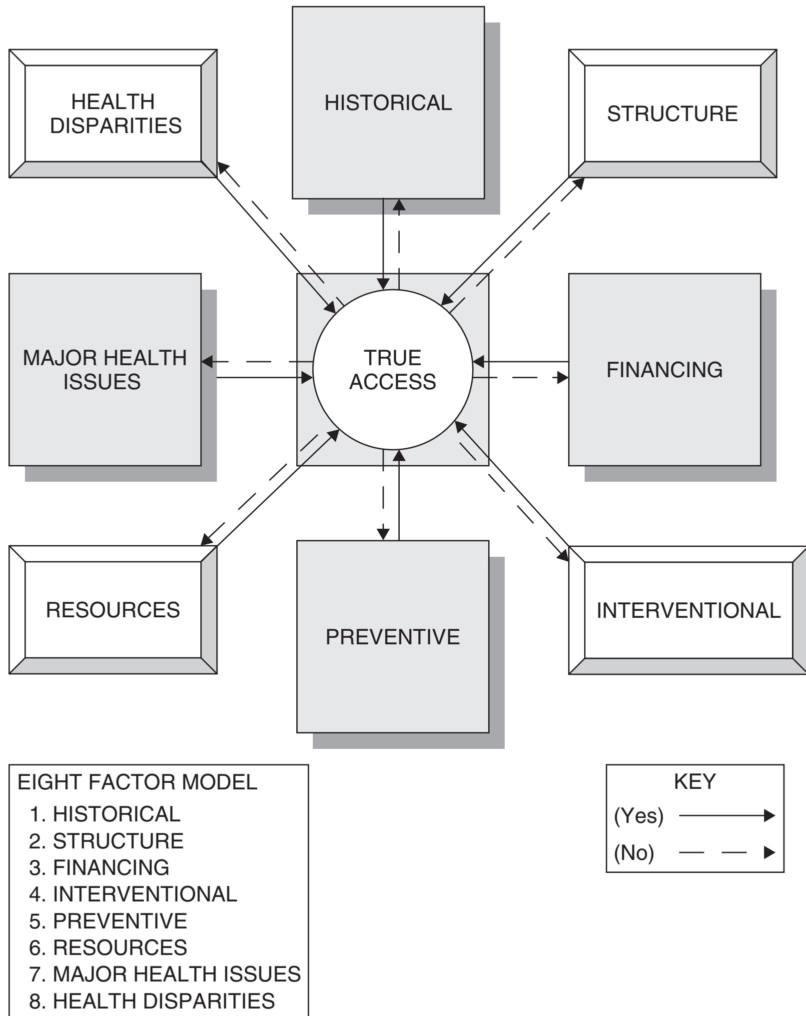

Figure 3-1 The Eight Factor Model

HISTORICAL

The first factor, historical, describes the health of each nation and explores how health and access to health services have been historically defined by the nation discussed. This includes how the health system emerged, and the role of emergency departments, community-based health centers, and clinics in providing health care.

Table 3-1 The Eight Factor Model for true access.

United States	Canada	Japan	United Kingdom	France	Cuba	India	Ghana	Italy	Brazil	Russian Federation
HISTORICAL										
(Determine access & barriers)										
STRUCTURE										
(Infrastructure, policies, staff needs, roles, & responsibilities)										
FINANCING										
(Cost & funding priorities)										
INTERVENTIONAL										
(Care: primary, acute, & restorative)										
PREVENTIVE										
(Success with promoting health, & preventing disease)										
RESOURCES										
(Human & fiscal)										
MAJOR HEALTH ISSUES										
(Top 10 diseases)										
HEALTH DISPARITIES										
(Race/ethnicity, age, & income based)										

STRUCTURE

The second factor in the model examines the structure of healthcare delivery. This structure includes whether it is a national healthcare system, the health system's infrastructure, health policies, interdisciplinary roles and responsibilities, staffing patterns and needs (supply vs. demand), physician providers, nurses, advanced practice nurses, other health professionals, and related outcomes. For example, in regard to interdisciplinary roles, responsibilities, and outcomes, physicians around the globe are proficient at diagnosing and treating illnesses. Some even instruct their patients on how to prevent illness and stay healthy. However, no matter where you are in the world, nurses are generally found in the trenches striving to make the communities in which they work and live more viable and healthy. In many cases advanced practice nurses are bridging the physician gap and are advocating for patients and families to get true access once in the healthcare system. It is very difficult, if not impossible, for any system to provide true access without embracing an interdisciplinary approach to care and services.

This factor also examines the presence of structural barriers that exist that could prevent or impede access to care, or it could identify structures in place to facilitate access to care and services. These include such things as the location of services, government policies and procedures, and various health policies and legislation.

FINANCING

The third factor, financing, is perhaps one of the most difficult factors to address in discussing true access in that much reliance is placed on a nation's ability to fund health care. This factor describes the nation's fiscal responsibilities and financing priorities, and helps to determine where the majority of the healthcare budget goes. Particular attention is given to long-term and older adult care, maternal child care, technology, research, and the emphasis a system places on curative. How health care is funded and where the funds come from (private or public) are important considerations of factor three. The government's role in administering and overseeing health care, and provider compensation is also examined.

INTERVENTIONAL

The importance of service quality is critical, especially in today's healthcare environment, and is the focus of factor four, interventional. This factor

calls attention to whether the delivery focus is on primary care, primary health care, acute care, or restorative care, in relation to outcomes. An important measure of a healthcare system's effort in preserving health and preventing illness is how the system is structured. In the case of a *primary healthcare* system, the majority of its services are community-based rather than hospital-based, making services more accessible to everyone in the system. Examples of primary healthcare systems are Cuba and Brazil. Another measure is whether the system offers primary care, perhaps best exemplified by the healthcare systems in the United States and Canada. *Primary care* focuses on health promotion, disease prevention, early intervention, cure, and care. From the perspective of one notable expert, primary care is:

> . . . care that is coordinated, comprehensive, and personal and available on first encounter and continuous thereafter. It involves such tasks as, medical and psychological diagnosis and treatment; personal support of patients of all backgrounds, in all stages of their illness; communication of information about diagnosis, treatment, prevention, and prognosis; maintenance of patients with chronic illness; and prevention of disability and disease through detection, education, behavioral change and preventive treatment (Stoeckle, 2000, p. 1).

Despite the type of system offered, the focus, or the approach to care, there are often similarities in outcomes. As individuals age, if the healthcare focus is not on maximizing physical, mental, and spiritual function, there will likely be a decline in functioning and in achievement of quality outcomes. In a system such as the United States, achieving desired outcomes may very well determine whether a *third party payer* reimburses a healthcare system for the care provided. For example, if a patient develops a major preventable complications, such as skin ulcerations, while hospitalized, in many cases insurance companies in the United States will refuse to reimburse the hospital for care. In other countries, reimbursement for services may not be an issue.

When care is evaluated in any system it is important to consider care outcomes. Outcomes are typically evidenced by patient and staff satisfaction with the health services provided. The overall patient/family experience since entering the healthcare system is a good measure of service quality. Met and unmet needs of patients and families are very important considerations. For example, part of quality care delivery includes making a determination about whether care received or services provided are congruent with the patient's culture (Leininger, 2004; Purnell & Paulanka, 2008). When care is consistently incongruent with the individual's culture it will be ill-received,

sometimes openly challenged, and might result in individuals separating from a practice without notice.

The extent to which health professionals include patients and families in the health decisions may be evidenced by such questions as, "How would you feel about this procedure or this method of treatment?" "What would you like us to do?" And in deciding about actions to take, raising questions such as, "What makes your problem worse, or better?" "What do you do other than take a prescribed or over-the-counter medicine to feel better, or get better when this problem occurs?" Asking questions of the primary caregiver prior to the patient entering the system should include, "In your opinion, what seems to work best?" Such questions could be a key indicator of the desire to provide quality care and services. Inclusion of essential "others" in the interventional plan, especially when they are close family members, is key to providing service quality.

PREVENTIVE

The fifth factor provides an evaluation of preventive measures. It includes making a determination about the extent to which the system is maintaining and preserving the physical, emotional/mental, and social health of its people. Environmental health and safety (tobacco and substance use and abuse), traditional health practices, religion, family, long-term care, women's health, child and adolescent health, and adult and older adult care and services are important considerations of factor five.

RESOURCES

The sixth factor, resources, does not consider fiscal resources. Rather, it evaluates the availability and adequacy of human resources and social and spiritual resources. These include licensed and unlicensed professional staff, trained and untrained workers, traditional healers, unpaid volunteers, family (extended and nuclear), community, and other support systems. This factor considers the extent to which these types of resources are available in each healthcare system discussed.

MAJOR HEALTH ISSUES

Factor seven, major health issues, describes specific social determinants of health such as illiteracy (generally and as it pertains to health), poverty, culture, race, and gender. It also describes public health challenges and initiatives, the top ten diseases for each nation, the nature of the diseases,

and the similarities and differences among nations in their approaches to treating diseases. These include the incidence rates and prevalence of diseases, chronic illnesses, vulnerable populations, familial and genetic illness tendencies, and how people are coping in regard to their level of independence or dependence in carrying out their daily care activities.

HEALTH DISPARITIES

Factor eight, the final factor for evaluating true access, concentrates on health disparities, or unequal treatment. It reports the top three diseases that disparately affect the particular country's population based on such social determinants as race/ethnicity, age, and income. For example, in some nations heart disease leads the way as the major cause of death, in other nations it is infection. Both are preventable yet deadly, and often the poor outcome is tied to income, age, or race (Long, Chang, Ibrahim, & Asch, 2004; Burroughs et al., 2002; Exner et al., 2001).

SUMMARY

The model introduced in this chapter, if consistently applied, provides a great opportunity for assessing the strengths and weaknesses of a healthcare delivery system. Utilization of the model will be beneficial in identifying countries that not only provide its residents true access to health care, but determine the extent to which access is provided. It could possibly be a catalyst to changing initiatives in countries searching for new directional approaches to addressing gross inequities in their systems.

Discussion Questions

1. Why is it useful to examine the concept of access from the framework of the Eight Factor Model?
2. How does the Eight Factor Model affect your understanding about providing the best possible access to patients? Which factors are familiar to you? What factors are new to you or provide you with a different way of thinking about access?
3. To what extent does your work setting reflect true access as defined by the Eight Factor Model? What factors would you say are effectively addressed? What factors represent ongoing challenges?
4. Do you know of a healthcare setting that practices (demonstrates) true access? Utilizing the Eight Factor Model, describe how this organization

achieves this outcome. What factors stand out? What happens in this healthcare setting that could be replicated in your own workplace?

5. As a health practitioner or administrator, what aspects of the Eight Factor Model do you feel you can manage on your own? What factors require teamwork? In your opinion, are there factors in the model that represent issues outside of your control? If so, explain your point of view.

References

Burroughs, V. J., et al. (2002). Racial and ethnic differences in response to medicines: Towards individualized pharmaceutical treatment. *Journal of the National Medical Association, 94*:10, 1–26.

Exner, D. V., et al. (2001). Lesser response to angiotensin-converting-enzyme inhibitor therapy in black as compared with white patients with left ventricular dysfunction. *New England Journal of Medicine, 344*:18, 1351–1357.

Leininger, M. M. (2004). Culture care diversity and universality. *Nursing Science Quarterly, 1*(4) 152–160. Sage journals online. Retrieved from nursing.jbpub .com. doi:10.117710894198831848800100408.sitzman/ih.15.pdf.pdf

Long, J. A., Chang, V. W., Ibrahim, S. A., & Asch, D. A. (2004). Update on the health disparities literature. *Annals of Internal Medicine, 139*:558–563. [PMID: 14530226]

Purnell, L. & Paulanka, B. (2008). *Transcultural health care: A culturally competent approach* (4th ed.). Philadelphia: F.A. Davis Company.

Stoeckle, J. D. (2000). The tasks of primary care. In Goroll, A. H. & Mulley, A. G. *Primary care medicine: Office evaluation and management of the adult patient* (4th ed., p. 1). Philadelphia: Lippincott Williams & Wilkins.

ch03.indd 40

9/4/2012 6:33:20 PM