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A FRAMEWORK FOR THE STUDY OF ACCESS TO PEOPLE'S HEALTH CARE SERVICES

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ABSTRACT
Ensuring access to healthcare services for all citizens is a crucial goal within any country's healthcare system. However, analyzing access comprehensively and accurately remains a challenge. This paper introduces various frameworks for measuring access to healthcare services, encompassing key concepts and common measurement frameworks. By applying appropriate measurement frameworks, researchers, policymakers, and non-governmental organizations can gather accurate and valuable information on the public's access to healthcare services. This enables them to identify the most vulnerable population groups, analyze specific barriers, and propose effective solutions to improve healthcare access for everyone.

Keywords: Access, healthcare, framework, ...

1. INTRODUCTION
Perspectives on frameworks for measuring access to healthcare services have gained global attention since the late 1960s. These perspectives delve into theoretical frameworks used to support research (measurement) on healthcare access. Over the years, numerous access frameworks have emerged, prominently including those focusing on behavioral access, barrier-focused access, and individual healthcare service access.

2. METHODOLOGY
This article utilizes a synthesis method of literature review, analysis, and critique of major works by leading theorists in the field of healthcare access research.

3. CONCEPT OF ACCESS
Access is a critical concept in the study of organizational, financial, and delivery aspects of healthcare services. Current perspectives on access view it from two dimensions: potential access and realized access.

Potential access refers to the ability of individuals to access services. It involves the actual and potential ability of individuals to access services, related to their needs, desires, and the barriers they face. This capability falls under individual factors, including facilitators (socio-demographic

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factors and trust) and motivators (family and community factors), as well as the severity of illness (perception of health status and assessment, diagnosis) (Andersen, 1995).

Realized access, on the other hand, entails utilization and effective utilization of services to achieve optimal outcomes (Owen O'Donnell, 2007). This form of access stems from the supply side - whether services are available and the quality of those services influencing individuals' service uptake.

Many perspectives argue that access can be viewed in both aforementioned dimensions: first, in terms of opportunities for healthcare when desired or needed, and second, as the initiation of service use (Millman M, 1993; Andersen, 1995; Owen O'Donnell, 2007; ...). Authors emphasize that both access to services and outcomes of the access process can be used to measure access. Thus, Roy Penchansky and William Thomas explain access as a set of specific dimensions describing the match between consumers and healthcare systems. These dimensions include service availability, accessibility, convenience, affordability, and acceptability. Acceptability involves the relationship between consumer attitudes toward providers and vice versa (Roy Penchansky and William Thomas, 1981). Authors highlight that user satisfaction is a key factor in access structure for measuring outcomes. The access structure includes health policies, characteristics of healthcare delivery systems, characteristics of at-risk populations, user satisfaction, and usage (Andersen, 1974).

4. SOME STUDIES ON ACCESS FRAMEWORKS IN HEALTHCARE SERVICES

4.1. Behavioral Model (since 1986)

The most commonly used framework for measuring individual access to healthcare services is the behavioral model or Andersen model (Kathryn P. D, Carol R. G add Jeane S. R, 2011). This model, also known as the social behavioral model, was developed by Andersen in 1968. It originated from his thesis and was later published with John F. Newman in the study "Determinants of Individual Utilization of Health Services in the United States," aimed at understanding the factors influencing access to healthcare services and providing a measurement framework to support the development of social policies for equitable access to healthcare (Andersen, 1995). According to this model, healthcare access is simply measured by three types of factors: (1) predisposing factors, (2) enabling factors, and (3) need factors for service utilization.

Predisposing factors related to service utilization tendencies include demographic factors such as age, gender, which may lead to varying healthcare service needs; social status factors (traditionally measured through education level, occupation); health belief factors, such as

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attitudes, value norms, and understanding of health and healthcare services, which can affect perceptions of needs and service utilization.

Enabling factors are necessary conditions for accessing healthcare services. These include the availability of healthcare facilities, healthcare personnel where individuals live and work. Additionally, people must have economic resources and know how to access and use these services. Therefore, factors such as income, health insurance, healthcare facilities, distance, travel time, and waiting times are important measures of healthcare access and can also become barriers to service use.

Meanwhile, the need for service utilization may arise from health awareness, health knowledge, or actual health status (See Figure 1).

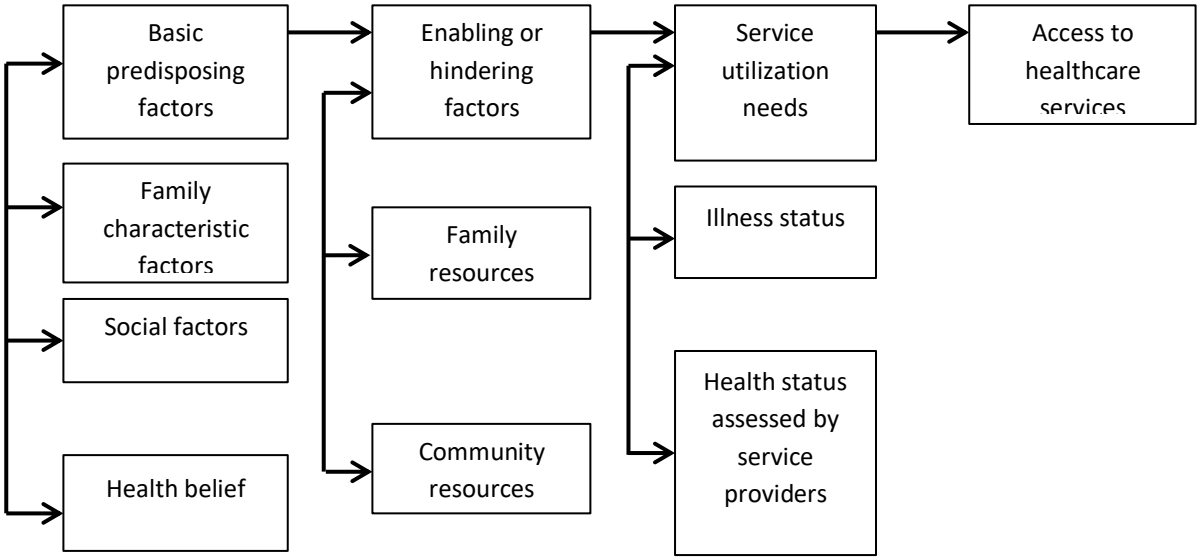

Figure 1: Andersen's Healthcare Service Utilization Framework (Source: Andersen RM, Newman JF, 1973).

Andersen and his colleagues emphasized the importance of healthcare service access and the outcomes of this access process, which are used to measure accessibility. Therefore, twenty years later, in the 1995 version, Andersen proposed his revised healthcare service utilization model, which identified five components: (1) health policies, (2) characteristics of healthcare provider systems, (3) characteristics of populations at risk, (4) healthcare utilization, and (5) consumer satisfaction. These components were categorized as "predisposing" (individual characteristics) or "enabling" (system or structural features). "Need" was considered a crucial component of the model. The overarching framework includes causal links and pathways between factors leading to the outcome of "healthcare service access"

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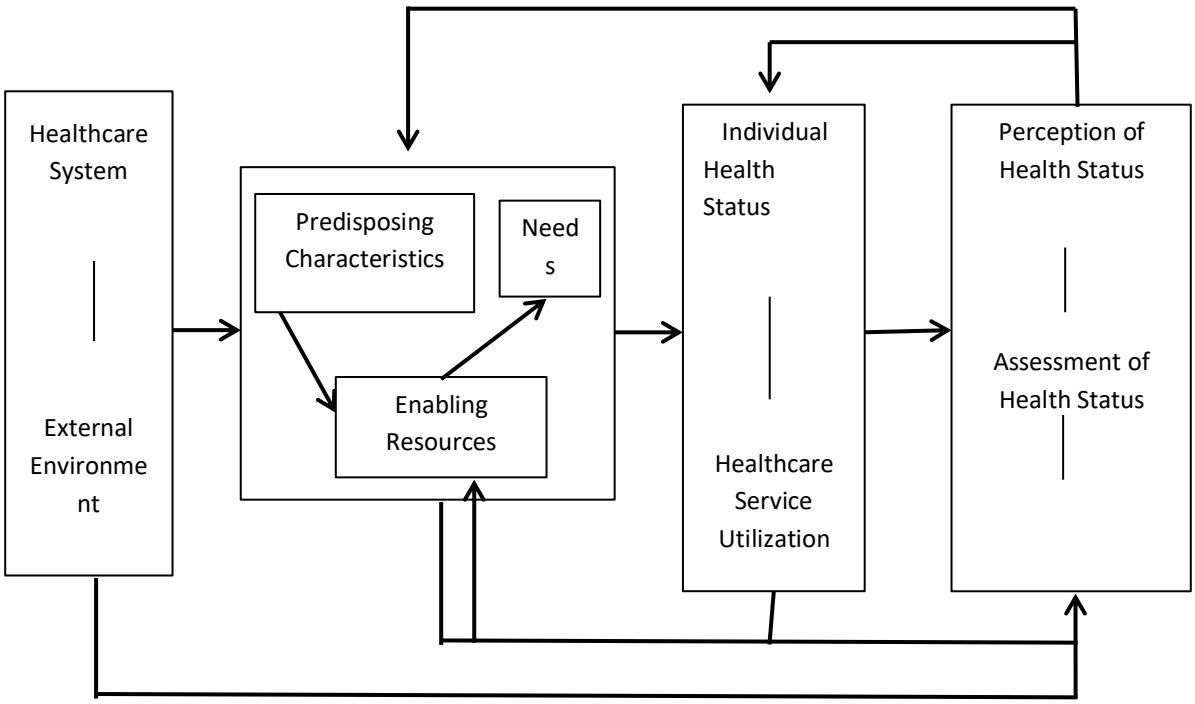

Figure 2: Andersen's Healthcare Service Utilization Model (1995 version) (Source: Thomas C. Ricketts, Laurie J Goldsmith, 2005)

The refined Andersen Model has distinguished between potential access factors (e.g., whether an individual has stable care from family) and actual access factors (e.g., patient satisfaction with the quality of healthcare services). Furthermore, it has been adjusted to include environmental factors, health behaviors, and health outcomes.

The behavioral model has evolved over time to include factors beyond the individual level, such as changes in healthcare policies and factors like the environment and healthcare system characteristics. However, most practical applications of the behavioral model continue to focus on individual-level factors influencing healthcare-seeking behaviors.

4.2. Barrier-focused Model (since 1981)

Building on applications from Andersen's Service Utilization Model, subsequent studies suggest that access is a concept often linked to the ability and willingness of service users to engage with the healthcare system, and cannot be fully explained solely through health status analysis or public concerns or perceptions. Any significant phenomenon affecting the use of healthcare services must be identified and measured to identify effective interventions that can impact the

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system in ways that achieve desired outcomes (Nguyen Minh Chau, 2019). Therefore, new research directions have focused on barriers to accessing healthcare services. This access model recognizes that individual-level factors such as income, health insurance, stable care sources, etc., can facilitate or hinder people's access to healthcare services.

However, access to services largely depends on the concept of "appropriateness". This concept is proposed to emphasize the reciprocal relationship between key determinants of healthcare service utilization (Roy Penchansky, 1977). It involves five dimensions: (1) availability, which includes the number of physicians and other healthcare services; (2) accessibility, the spatial or geographic relationship between healthcare providers and service users; (3) accommodation, the organization and content of the healthcare system as it relates to convenience for service users (e.g., clinic hours, waiting times); (4) affordability, the financial ability of the population to use healthcare services provided by the system and perceptions of the value by a segment of patients; and (5) acceptability, reflecting the attitude of service users toward healthcare providers, and vice versa (Roy Penchansky, 1977). This is the "appropriateness" between the elements: resources, needs, and demands; these factors interact and mutually determine each other (see Figure 3).

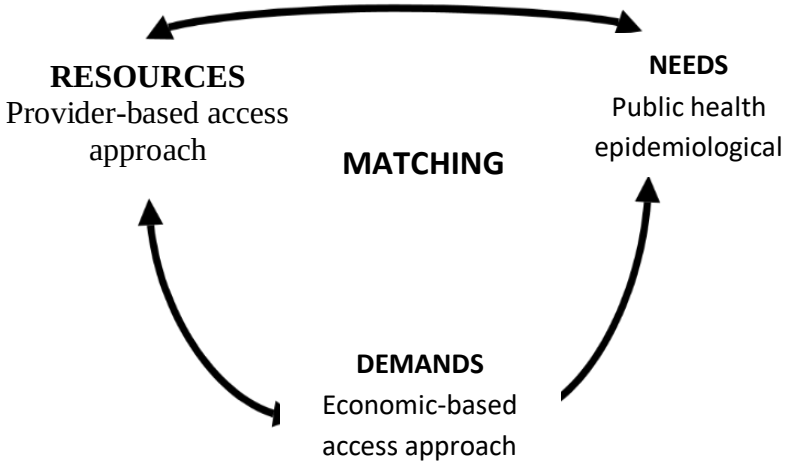

Figure 3: Julio Frenk's Service Access Model

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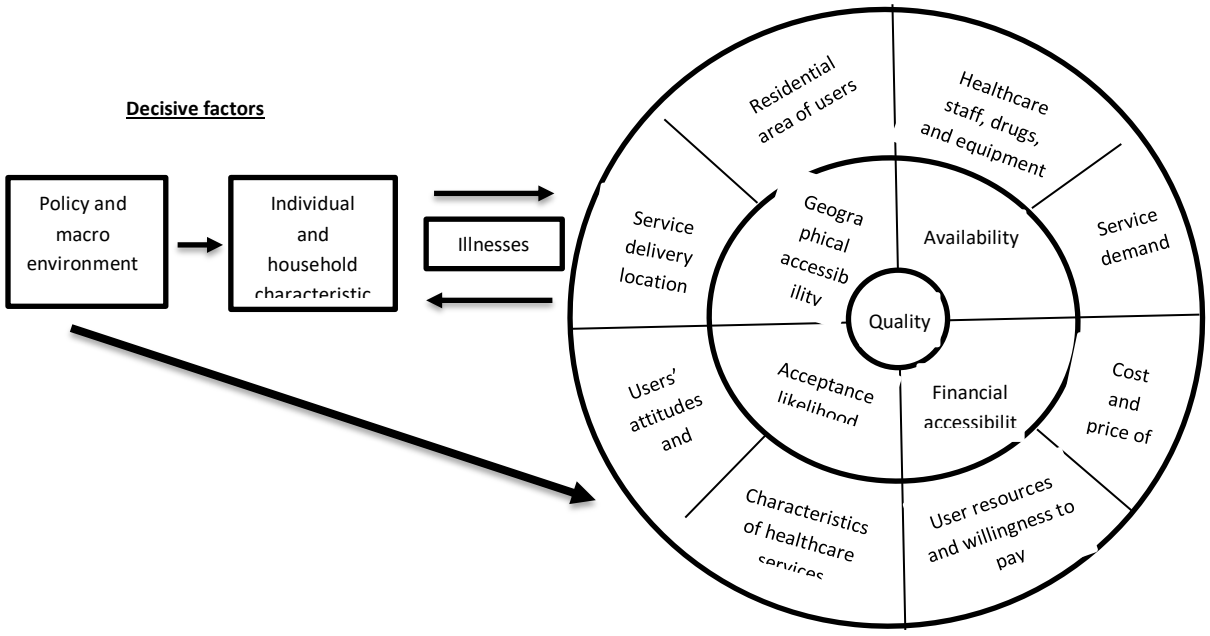
Following this, a new research direction on the healthcare service access model considers the perspectives of supply, demand, and barriers to access. Accordingly, a framework analyzing barriers is presented across four dimensions of access, considering both supply-side and demand-side aspects. The four primary dimensions of access are: (1) Geographic accessibility - the location of service providers and the location of clients; (2) Availability of services - the types of available care, appropriate healthcare personnel, and necessary equipment and medications to serve patients when needed; (3) Financial accessibility - the relationship between service costs, pricing, willingness to pay, and financial ability of patients to afford services; (4) Acceptability - the alignment between service providers' cultural and social expectations and those of service users and the community. Importantly, the quality of care is a crucial component across all four dimensions and directly relates to the professional capacity through which healthcare services can impact human health (David H. Peters et al., 2008 - cited in Nguyen Minh Chau, 2019) (see Figure 4).

Figure 4. Evaluation framework of healthcare service access by Peters et al.

[Source: Annals of the New York Academy of Sciences. 1136:167-171 (2008)



(cited in Nguyen Minh Chau, 2019)]

It is argued that accurately identifying the origins of barriers is essential for designing appropriate interventions, and access barriers can arise from the supply side, the demand side, or both. An analytical framework for assessing barriers to healthcare service access, viewed from the perspective of separate supply-side and/or demand-side considerations, has been developed. In this

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framework, determinants of demand are factors influencing individuals', families', and communities' ability to use healthcare services, while determinants of supply reside within the healthcare system itself, hindering individuals', families', and communities' access to healthcare services (Tim E, Stephanie C, 2004). It can be observed that this analytical framework shares many similarities with Peters et al.'s framework. Both frameworks were later combined and further developed into intervention frameworks to address barriers to healthcare service access from both supply and demand perspectives, acknowledging previous studies' view that barriers from both supply and demand sides need simultaneous resolution for effectiveness, and access barriers do not necessarily exclude each other but can interact and influence each other (Bart Jacob et al., 2012 – cited in Nguyen Minh Chau, 2019).

4.3. Other access models

In the early 1990s, individual healthcare service access models were developed to study individuals' access to healthcare services. This model focused on structural, financial, and personal barriers to usage, integrating the "appropriateness" of healthcare services received, such as treatment effectiveness, provider quality, and patient adherence to prescribed treatments and medications (Kathryn P. D., Carol R. G., Jeane S. R., 2011). The individual healthcare service access model has been widely applied to highlight healthcare outcomes as an index of healthcare service access. It is a more focused model compared to earlier access research models, including equity of access — whether differences in usage and outcomes between groups result from financial barriers or other barriers to care. However, it does not specifically identify the role of community health in monitoring and addressing identified inequalities (Michael M, 1993).

Recent economic studies have documented the potential impact of contextual factors on individuals' healthcare service access. For example, Carole Gresenz and colleagues emphasize that social networks can influence the transmission of information among people regarding how and where to use healthcare services. It can also influence individuals' ideas in choosing appropriate healthcare services. Such social networks can have a significant impact on individuals' and groups' access to healthcare services, especially social networks defined by race or ethnicity, language, and geography (Carole Roan Gresenz, Jeannette Rogowski, José J. Escarce, 2007).

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5. CONCLUSION

Thus, from inheriting the Andersen behavioral model's framework for measuring healthcare service access to identifying barrier-focused access frameworks or recent studies on individual healthcare service access, there are many similarities in the analytical frameworks. These models all acknowledge factors influencing public access to healthcare services and the interactions between these factors that can yield different access levels. In reality, issues related to these factors are not easily separated and are directly related to and governed by the policy environment along with the socioeconomic conditions of each specific country, region, and locality.

Currently, the behavioral model remains a widely cited, referenced, utilized, or adjusted model by many healthcare service access researchers.

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