DEFINITION OF ACCESS

Access measures can serve the needs of policy makers for policy formulation. Customarily, access to health care is usually viewed as a one-dimensional issue. In other words, access to health care is viewed simply as possessing any form of health insurance policy without considering the time period or contents of coverage. For instance, almost 43 million Americans (approximately 1 in every 6) are without health insurance,[4] while more than 96% of the population in Taiwan is covered by National Health Insurance. However, access can be viewed as a means for attaining outcomes or as a valued end in itself. In most of the literature related to access to health care studies, utilization of health care is one of the important indicators because of its links to access, outcomes, and quality-of-care.[5,6]

The 1993 US Institute of Medicine report[7] on Access to Health Care in America defined access to health care as "the timely use of personal health services to achieve the best possible health outcomes". An important characteristic of this definition is that it relies on both the use of health services and health outcomes as yardsticks for judging whether access has been achieved, even though this definition stipulates no principles to apply in judging the distribution of health care.[8] In this definition, access is appropriately evaluated by outcome indicators of the rate or quality of passage through the system.

On the other hand, Andersen et al.[6] defined access as, "the actual use of personal health services and everything that facilitates or impedes the use of personal health services". In this definition, access is directed to process-related measurement, through which those factors associated with health service utilization patterns can be examined.

From the preceding depictions, we can see that the concept of access and its measurement are obviously value laden. Therefore, if we build a synthetic framework to link health care systems and the populations they serve by considering the within and between relationships of the characteristics of the population (i.e., demand side), the providers (i.e., supply side), and the organizational resources (i.e., the context), we may refine the definition of access to health care as, "the capacity of individuals or a population to obtain needed health care".

CHANGES OF ACCESS TO HEALTH CARE

There are 3 major issues addressed in the present discussion about necessary changes in the current delivery system: access, cost, and quality. Undoubtedly, the impacts of National Health Insurance (NHI) are profound. The changes are reflected not only on structural and economic levels, but also in the interactions within the triangle of the insured, the providers, and the insurer (i.e., the Bureau of National Health Insurance). In terms of utilization patterns, the high utilization rate of health services, which is around 3 to 5 times those of its counterparts in developed countries, has continued to increase after the implementation of the National Insurance Program under the fee-for-service payment system and with little effects of co-payment. For example, average annual outpatient visits per capita[9] increased from 10.6 visits in 1995 to 15.3 visits in 1999; meanwhile, the average annual number of hospital admissions per 100 insured increased from 10.2 visits in 1995 to 12.3 visits in 1999. In addition, once the insurance barrier was removed, more-equitable access was achieved across income levels regarding the decision to utilize various types of services.[10] We expect that most of the previous vulnerable population no longer is limited to poor access to the acute care services except for unemployed Aboriginals living on the fringes of the metropolitan areas, those living in remote mountains or outlying islands, and those who are chronically ill with higher health needs of long-term care.

Immediately after implementation of the National Health Insurance Program, the government was confronted with several issues that other industrialized countries have addressed in various ways: the equity of health resources distribution and the effectiveness of health resources utilization. In other words, the government tried to readjust the current regressive grading table of insured payroll-related amounts, to balance the geographical vicissitudes of practitioners'