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イギリスの医療制度 - 医療の「公共性」・「公益性」

国京則幸 (静岡大学・社会保障法)

- 1. イギリスの医療制度概観 【後掲資料 参照】
 - (1) 概念。構造

イギリスの"医療" → NHS[*1]制度

→医療制度、医療保障制度について

・イギリスの医療制度 - 質的確保の責任 GMC[*2]の構造(医師集団=専門職) (医育、医師資格の管理) アングロサクソン的意味合いでの、"Profession"=自律

、イギリスの医療保障制度 – 量的確保の責任 NHSの構造(議会=大臣) (病院の管理、医療費支出の中央政府統制)

(2)制度・しくみ

内部市場 (internal market) NHSトラスト

内部市場 ─廃止→ partnership and "performance"

2. 検討

イギリス医療の公共性・公益性

医療における医師と病院の区別

→医療は、主として「医師」とともに展開されてくる 医療の公共性・公益性 医師の社会的位置付けに由来する →病院の役割とは?

医師の働く場としての病院? cf. 医療法§1の5

「良き医療」の基準 医療成績、患者の満足度 患者憲章 (Patients Charter) 苦情処理制度、オンブズマン

cf. 日本の病院における患者の位置付け

⁻⁻⁻⁻ note

^{*1} National Health Service=国民保健サービス

^{*2} General Medical Council=中央医師評議会

《資料》

1. 現在のGMCの構成。委員会と構成員数、手続

Total 104 members:

54 doctors elected by the doctors on the register

25 members of the public nominated by the Privy Council

25 doctors appointed by educational bodies - the universities, medical royal colleges and faculties

*President's Advisory Committee

18

(Leads the GMC in addressing questions of central policy and external affairs)

*Education Committee

21

(Defines and monitors standards of undergraduate medical education and promotes good practice in postgraduate training)

*Standards Committee

17

(Promotes good practice in professional conduct and medical ethics)

*Fitness to Practise Policy Committee

10

(Co-ordinates and monitors the operation of the fitness to practise procedures)

*Interim Orders Committee

15

(Considers interim suspension or conditions on doctors where necessary for protecting the public)

*Preliminary Proceedings Committee

7

(Screens convictions and allegations of serious professional misconduct and decides which should be heard by the Professional Conduct Committee)

*Professional Conduct Committee

31

(Hears (in panels of between five and eight) cases of doctors charged with serious professional misconduct)

*Assessment Referral Committee

18

(Hears appeals by doctors against a decision to assess their performance)

*Committee on Professional Performance

23

(Considers doctors whose performance is seriously deficient or who fail to comply with remedial action)

*Health Committee

9

(Considers doctors whose health is seriously impaired or who fail to comply with remedial action)

*Registration Committee

9

(Oversees the policies and procedures for registering doctors)

*Review Board

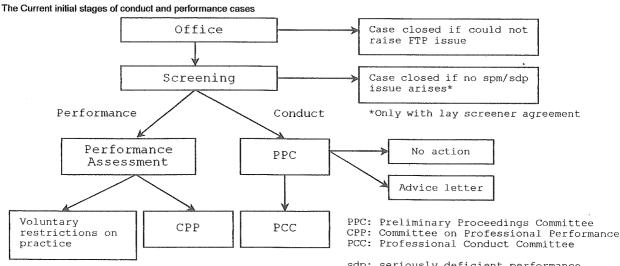
8+2

(Hears appeals against refusals to grant full registration to overseas qualified doctors)

*Finance and Establishment Committee

11

(Oversees the GMC's finances and staffing arrangements)



2. NHSの

 造造

Government department responsible for delivering a fast, fair, convenient and high quality health and social care service to the people of England. It is responsible for giving NHS organisations, such as hospital trusts and GPs, the information, guidance and support they need to deliver the Government's policies and meet its standards of patient care. It supports Government ministers in developing the standards and broad working practices of the NHS and local social services. It monitors standards and takes steps to deal with services that are poor or failing. It also works on ways to prevent disease and help people live longer, healthier and more independent

Government

Department of Health

Primary care

groups/trusts

Primary

care

Primary

care

aroups/

Trusts

GPc

Pharmacists

Dentists

Dental

Access

Centres

Optometrists/

opticians

NH S

walk-in

centres

Special health

authorities

NHS

Direct

Planning

Health

authorities

Secondary

care

NHS trusts

Acute

Community.

Ambulance

A health authority that provides health services to the whole population of England not just to a local community, ie. the National Blood Authority.

NHS Direct opened in March 1998 and

In England and Wales, health authorities identify the health needs of local people and make arrangements for services to be provided by NHS trusts, primary care and other agencies, using funding provided by the Government. A board of executive and non-executive directors runs each health authority. The non-executive directors are appointed by the Government. The executive directors are appointed by the chairperson of the authority, who is a non-executive member. Health authorities are monitored by the regional offices of the NHS Executive which manages the NHS for the Government.

offers fast and free 24-hour advice about personal health care. NHS Direct nurses aim to provide callers with the advice and reassurance they need to care for themselves at home — or, if they need further help, to direct them quickly to the right service at the right time. If a condition is more serious, and in the case of emergencies, nurses can give quick advice on what action the caller should take and if

appropriate will call an ambulance.

Specialised treatment usually provided by an hospital.

The first port of call for many people when they develop a health problem is their local doctor, also known as a general practitioner (GP). These doctors usually form a small practice or surgery to serve a particular neighbourhood. GPs are on the frontline of the NHS - the part officially called 'primary care'. Many other health professionals work as part of this frontline team - nurses, health visitors, dentists, opticians, pharmacists and a range of specialist therapists. Every UK citizen has a right to be registered with a local GP and visits to the surgery are free. NHS Direct and NHS walk-in centres are also part of primary care.

Hospital trusts are found in most large towns and cities, and usually offer a general range of services to meet most people's needs. Some trusts also act as regional or national centres of expertise for more specialised care, while some are attached to universities and help to train health professionals. Trusts can also provide services in the community for example through health centres, clinics or in people's homes. Except in the case of emergencies, hospital treatment is arranged through your GP. This is called a referral. Appointments and treatment are free. Together, NHS trusts employ the majority of the NHS workforce including nurses, doctors, dentists, pharmacists, midwives, health visitors and staff from the professions allied to medicine, such as physiotherapists, radiographers, podiatrists, speech and language therapists, counsellors, occupational therapists and psychologists. Their many other staff include receptionists, porters, cleaners, IT specialists, managers, engineers, caterers, and domestic and security staff.

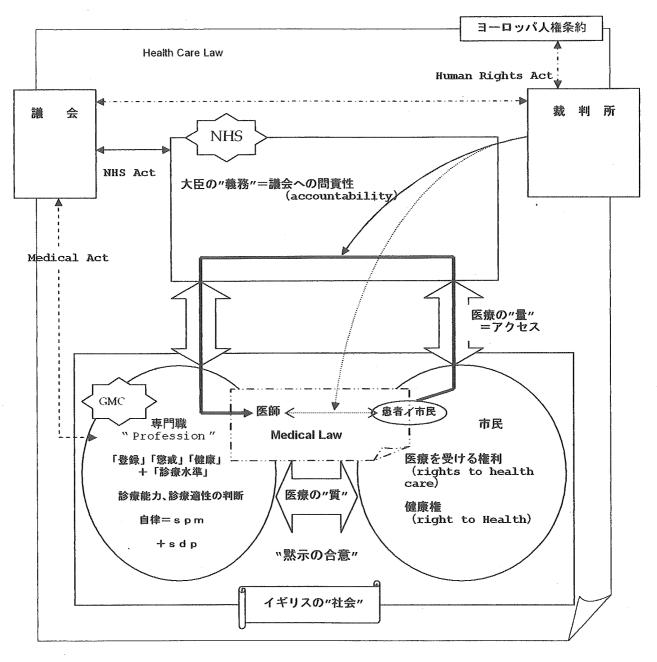
Since 1999, GPs have been able to join together to form 'primary care groups' or 'primary care trusts' along with other health professionals. This means they are given the funding to work together to plan and commission health services for their local communities - a role previously carried out by health authorities. It also means that decisions about local services are made at a local level, by those best placed to make them.

NHS walk-in centres offer fast access to health advice and treatment. They are open and available to anyone and provide:

- *a seven days a week service
- *assessment by an experienced NHS nurse
- *treatment for minor injuries and illnesses
- $\mbox{\ensuremath{^{\star}}}\xspace$ instant access to health advice and information on other local services
- *advice on how to stay healthy
- *information on local out-of-hours GP and dental services
- *information on local pharmacy services.

The first NHS walk-in centres opened in January 2000 and there are now $40\,$

3. イギリスの医療保障法 (Health Care Law) の概念図 (試)



厚生労働科学研究費補助金(政策推進研究事業) 分担研究報告書

「保健・医療・福祉サービスの政策評価手法の開発に関する理論的・実証的研究」

「保健サービスの経済評価にかかわる保健統計データの研究」 分担研究者 藤岡光夫 静岡大学 教授

研究要旨 保健サービスの経済評価を行う上で、利用できる保健統計データの利用可能性ならびに社会科学的な視点からのアプローチは重要な問題である。そこで、イギリスの衛生統計の経緯を明らかにすることにより、健康の社会的不平等・格差の解決のための統計学的視点を明らかにした。

A. 研究目的

本年度は、利用できる保健統計データの利用可能性ならびに、社会科学的な視点から健康問題を分析するための枠組みを検討するために、イギリスの保健政策を取り上げて、論点を整理することを目的とする。

B. 研究方法

文献研究の方法による。

C. 研究成果

日本では、健康問題は、一般に医学や疫学の問題として、疾病とそれに直接関連する原因に焦点が当てられ、社会科学的な視点からのアプローチは軽視されがちである。しかし、現実社会で生活する住民の健康問題は、労働や所得、家族、生活、地域、環境、等々の社会経済的な要因と切り離して考えることはできない。その一方で、健康問題が社会や経済に与える影響も大きく、社会科学にとっても

重要な関心事である。

現在、世界の保健政策は、WHOの "Health for All"計画を基本としている。WHO 規約 の前文では、「達成可能な最高水準の健康を享 受することは、人種、宗教、政治的信条、経 済的・社会的条件に関わらず、全ての人間が 有する基本的人権のひとつである」と明記さ れている。そして、1977年の WHO 第30回世 界保健会議では、すべての人々に健康を保証 するための"Health for All"の基本方針が打 ち出され、翌年の1978年のアルマ・アタ宣言 において、健康の不平等への取り組みが、保 健分野だけでなく他の多くの社会的・経済的 分野の行動を必要とする最も重要な世界的な 社会目標であることが確認された。さらに、 1998年の世界保健宣言で、健康における社会 経済的な不平等を減少させることの重要性と、 "Health for All"計画実行への各国の責任が 再確認された。

このような国際的な流れを受けて、イギリスでは、"Health for All"計画として、1998

年に"Our Healthier Nation"が発表され、 「すべての人々の健康づくり、とくに最も条 件が不利な人々の健康改善」を目的とする保 健政策が打ち出された。そこでは、「病気の根 源的な原因は非常に多様」であり、「不健康は、 運動や喫煙、食事による影響があるが、それ だけでなく、貧困、低賃金、失業や水準以下 の住宅、不十分な教育、犯罪・混乱・環境汚 染やレクリエーション施設の不足などにも起 因している」とされ、健康を阻害する社会経 済的要因、及び環境要因の重視が明示された。 これを受けたアクション・リポート「健康の 不平等の縮小」(1999年)では、健康政策の主 要な目的のひとつが社会の中で最悪の状況に ある人々の健康を改善し、公平な社会を目指 して健康の不平等を縮小することであるとさ れている。これに対して、日本版の"Health for All"計画である「健康日本21」において は、健康の不平等の改善は明記されておらず、 日本では、社会経済的要因に起因する健康の 不平等は存在しないという考え方が根強い。

イギリスにおける保健政策を推進していく 基本的なシステムとして国民保健サービスが ある。イギリスの保健政策は、戦後、社会保 障の中心的な部分のひとつとして位置づけら れてきた。国民保健サービスは、1948年に始 まるが、その前提には、戦後イギリスの社会 保障政策の基本方向を決めることになった1942 年のベヴァリジ報告があった。それは、国の 制度として国民が生活に必要な基本的な所得 を保障し、国民の最低生活を支える「最低生 活水準の給付」という原則を打ち出したもの であった。所得保障の方法は、社会保険、国 民扶助、任意保険によるが、そのうちで最低 生活を保障するものが社会保険であった。この報告書では、窮乏の防止、疾病の減退が全国民の共通の関心ごとであり、「包括的な保険医療サービス供給体制が生活水準の改善に関わるいかなる計画にも不可欠」であるとされた。その包括的な内容とは、「治療や看護、あるいは手術、リハビリテーションなどのサービスの提供であり、国民全てに最高かつ最新の医療とその補完的なサービスを受ける平等な機会を与え、医療を個人資産と切り離すこと」であった(ジョン・バトラー(中西範幸『イギリスの医療改革―患者・政治・政策』到草書房、1994年)。

国民保健サービスのシステムでは、全ての 国民が、国民保健サービスの無料のサービス を受けることができる一方で、その枠外で私 費診療を受けることもできる。国民は一般開 業医から家庭を選んで登録し、医療サービス を受ける。治療が必要な場合は、一般開業医 の診療を受け、その紹介を得て病院の専門医 の治療を受けることになる。保健サービスは、 一般開業や専門医のほか、予防的取り組みと して訪問看護師やヘルスビジター(保健師) などによっても担われてきている。この国民 保健サービスのシステムは、すべての国民に 健康を保障するという原則に置いて、画期的 な保健政策であった。

しかし、実際の運営においては、政府の医療費負担の増大とともに、サービス供給体制の地域格差、恒常的な病院の入院待機などの問題が生じ、それらの改革が課題となっていた。1974年には、大規模な組織改革によって、病院サービス、一般開業医サービス、地域保険活動等の各部門の連携を軸にした国民保健