demographic changes are also remarkable with the proportion of the elderly increased from 4.8 percent in 1937 to 9.5 percent in 2000 [3].

(2) Health Service Systems in Thailand

The Thai health service systems are pluralistic and dominated more by the public sector. It has evolved from a system of self-reliance based on local wisdom, to the system of modern professional services. Thai people more and more depend on health facility based services. The proportion of using facility based health services has increased from 38.5 percent in 1970 to 77.5 percent in 2004 , while those of self medication decreased from 51.4 percent to 20.9 percent in the same period [3].

Table 1 : Life expectancy , infant mortality rate and maternal mortality ratio 1964 , 1996, 2000.

	Life expectancy at birth (1) (years)		Infant mortality rate (1) (per 1,000 live births)	Maternal mortality ratio (2) (per 100,000 live births)
	Male	Female		
1964	55.90	62.00	84.3	317.3
1996	69.97	74.99	26.1	15.6
2000	69.4	74.9	27.)	13.2

Source: (1) The Survey of Population Change, National statistical Office

(2) Bureau of Health Policy and Plan , Ministry of Public Health

Structurally, the Ministry of Public Health is the main national health agency. It owns the majority of health resources, particularly in the rural areas. (table 2) The private health facilities are operated under supervision of the Medical Registration Division, Department of Health Service Support, Ministry of Public Health. The private hospital has grown rapidly from around 10 percent of total beds in 1985 to 21 percent in 2002 [3]. This was in response to the rapid double digit economic growth, and the influx of low interest foreign loans. After the 1997 economic crisis, many private hospitals were closed down or reduced in size. Recently some started the campaign to attract more foreign patients into the country. They have been so successful that in 2004, it was estimated that there were 1 million foreign patients in Thailand, increasing at the rate of 13-15 percent per year [4].

For health care financing , during the last 2 decades (1983 – 2002) Thailand's annual health expenditure has risen from 4.47 percent of GPD to 6.12 percent. The per capita health spending has risen 6.41 fold from 20 USD to 134 USD. There was also a trend of increase in the proportion of public spending from 31.5 percent in 1983 to 34.09 percent in 2002 [3]. The Ministry of Public Health shares more than two thirds of the public spending on health.

Before October 2001, 75 percent of Thai people were insured under important health insurance schemes, including the Civil Servant Medical Benefit

Scheme, the Social Security Scheme, and the scheme for the poor, the children, the elderly and the disabled. In October 2001, the government started to implement the universal coverage of health care (30 Baht scheme), which covers the population who were previously uninsured. The health insurance coverage was raised up to 95 percent in 2004. Besides, since October 2003, the Antiretroviral therapy program are included in the core benefit package with the target to cover 50,000 people living with HIV/AIDS in the first year and 120,000 people in 3 years. As of March 2005, there were almost 60,000 patient recipients.

All these changes greatly affected the health systems and human resources for health. This paper aims at briefly discussing the human resources for health development in Thailand. It also highlights one of the most important concerns, i.e., the severe shortage of doctors in the rural areas. It also proposes further actions for better management.

(3) Situation and trend of Human resource for health in Thailand

Multiple cadres of HRH are produced in Thailand. As the country develops , more professionals and less paramedics are produced. In addition, village health volunteers have been extensively trained since the primary health care's era in the 1980s' (Table 3)

Table 2 : Health care infrastructures in 2003 : Pleuralistic nature

	Bangkok	Provinces (urban)	Districts (rural)	Tambons (rural)	Villages (rural)
Medical schools					
Public	6	5	-	-	-
Private	1	-	-	-	-
Specialized Hospitals	19	40	-	-	-
Regional Hospitals	-	25			
General Hospitals					
Public	29	70	-	-	-
Private	100	246	-	-	-
Community Hospitals	5	-	725	-	-
Private Clinics	3,100	11,853	-	-	-
Health Centers	61/82	-	214	9,765	-
PHC Centers	-	-	-	-	66,223
1st class drug stores	3,393	4,832	NA and include in province	-	-
2nd class drug stores	985	5,774	NA and include in province	-	-
Groceries that sell medicines	-	-	-	-	400,000

Source : Thailand Health Profile 2001-2004.

Table 3 : Distribution of main cadres of HRH by region , 2000

	Doctors		Dentists		Pharmacists		Nurses		Health Center Staff *	
	Number	Pop ratio	Number	Pop ratio	Number	Pop ratio	Number	Pop ratio	Number	Pop ratio
Bangkok	9,504	668	2,720	2,336	2,764	2,299	17,389	365	-	-
Central	4,973	2,850	1,481	9,598	2,464	5,769	33,474	424	8,769	1,059
North	2,774	4,121	956	11,959	1,864	6,133	23,034	496	7,068	1,292
Northeast	3,294	6,322	1,136	18,332	1,916	10,869	28,887	720	10,248	1,666
South	1,890	4,279	673	12,017	1,346	6,008	16,867	479	5,146	1,141
Whole country	22,435	2,758	6,966	8,882	10,354	5,976	119,651	517	31,231	1,324
Discrepancy ratio between Northeast : Bangkok		**9.46**		**7.84**		**4.72**		**1.97**		-

Source : The Population and Housing Census 2000 , National Statistical Office
* Rural Health Division ,Office of Permanent Secretary , MoPH

1) HRH requirement and supply

From the past projection, it is quite clear that although there will still be some shortage (Table 4, 5), the shortage is not that severe. However, the number will not be enough to alleviate the problem of maldistribution, according to the "trigger down" theory. Furthermore, these attempts of projection were carried out before the intensive movement on the trade in health services and the universal coverage of heath insurance and ARVs. These movements greatly increase the requirement for HRH. Thus there has been evidence of some increasing shortages in the HRH in the past few years [5].

Table 4 : Projection of supply and requirement of main cadres in 2015

	Doctors [6]	Dentists [7]	Pharmacists [8]	Nurses [9]
Supply	38,217 – 41,282	10,323	25,124	120,197-173,321
Requirement	40,633 – 46,015	8,924 – 9,768	32,761 – 33,698	137,997-142,366
Shortage	2,416 – 4,733	(537 - 1,399)*	7,637 - 8,574	(30,955)* - 17,800

Source : (1) Nichakorn Sirikanokwilai , 1998 What are [6] [7] [8] [9]?
(2) Duangjai Lexoomboon , 2000
(3) Nipa Panyanantana , 1998
(4) Dr.Vijit Srisuwan, 1998
( ) * : Oversupply

Table 5 : Annual production capacity of main cadre (public and private) , 1997 – 2015

Table 5 : Annual production capacity of main cadre (public and private) , 1997 – 2015

	Doctors (1)	Dentists (2)	Pharmacists (3)	Nurses (4)
1997	914	318	763	4,200
1998	1,178	358	876	4,740
1999	1,235	332	947	6,458
2000	1,262	349	1,027	6,741
2001	1,338	383	1,221	5,902
2002	1,583	420	1,164	4,319
2003	1,478	423	960	4,730
2004	1,407	437	1,412	4,207
2005	1,471	479	1,434	4,161
2006	1,515	462	1,499	4,180
2007	1,499	462	1,498	4,180
2008	1,346	477	1,607	4,279
2009	1,305	501	1,711	5,590
2010	1,919	501	1,711	5,590
2011	2,032	677	1,711	5,590
2014	2,070	677	1,711	5,619
2015	2,134	677	1,711	5,619

Source : (1) , (2) , (3) , (4) from each professional councils
Data 1997 – 2003 : new graduates register at each professional councils
Data 2004 – 2015 : estimated graduates from 95 % of the enrolment annually

2) Major HRH Problems in Thailand

i) Maldistribution

HRH concentrate mainly in the capital and the big cities .(Table 3) The situation of maldistribution is much more severe in the medical profession than in nurses. Furthermore there is a trend towards more specializations and increasing proportion of HRH in the private sectors

ii) Shortages

The increasing demand of health care due to high economic growth, higher education, more urbanization, more elderly people, more chronic diseases, universal coverage of access to essential health care and higher consumption of services by foreign patients has resulted in the increasing demand and the shortage of HRH, particularly in the rural public health facilities.

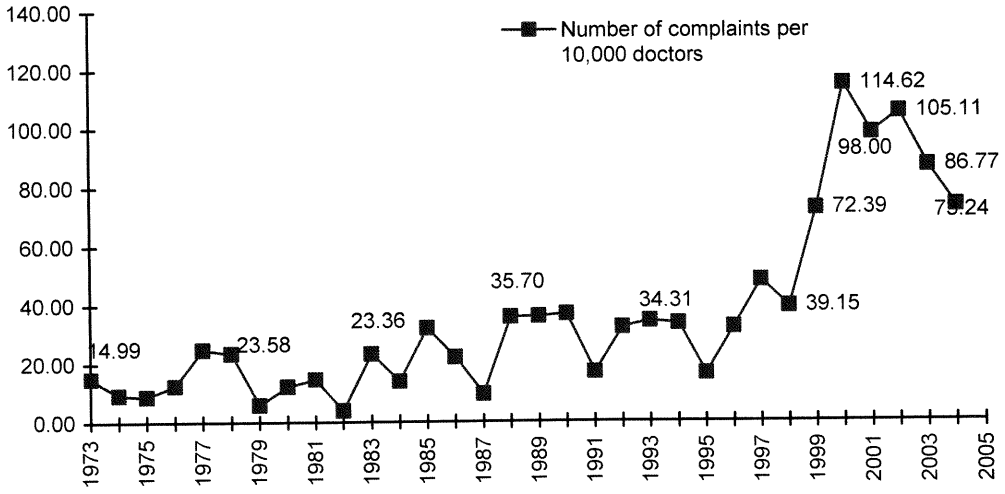
This problem of selective increase in shortages, often co-exists with high workload and wastage resulting from low motivation, ineffective utilization and hence low productivity. The rapid development of the private sector and international trade add more complexity to the situation.

iii) Providers and patients relationship

In the past, HRH were accepted with high respect from the society. This kind of patron-client relationship has been changing to more of a contractual based relationship, since around two decades ago. This is due to the rapid economic growth, the increasing coverage of health insurance, and the changing social and political environment. This changing relationship has resulted in the increasing

rate of malpractice complaints as shown in Figure 1 for the case of medical doctors [11]. The malpractice law suits in the court also increased and there has been some insurance companies that sell "malpractice insurance" particularly to doctors in the private sector.

Figure 1 : Rate of medical malpractice filled at medical council , 1973 – 2004



Source : Thai Medical Council

iv) Moral and productivity

The main causes of low productivity are ineffective use of staff , centralization , bureaucratization , low salaries , inadequate logistic support and low motivation. A study in 1987 revealed that nurses and midwives in the health center used only 33 % of total working time on the direct health services [5].

Dual practice also has many effects in productivity in public work. Its implications range from public time corruption , neglecting patients in public service and poor performance from exhaustion [12].

Several health sector reform strategies have been implemented to increase productivity , solve the shortage problem, contain costs and increase efficiency.

(4) Inequitable distribution of doctors in Thailand

1) Situation of geographical distribution of doctors

The analysis of the Population and Household Census in 2000 indicated that there were geographical maldistribution of all major cadres of HRH [10]. (Table 3) It is clear that the maldistribution is highest for doctors , followed by dentists , pharmacists and nurses , respectively.

Provincial mapping indicated that high density of doctors were in the capital and periphery , the central region and the big cities particularly those with medical schools and regional hospitals. In remote provinces , particularly in northeastern region and small cities and the newly established provinces , the

density was low. (Figure2) . The difference of population to doctors ratio between Bangkok to the less dense province was 23.0 fold.

The distribution of doctors was influenced by multiple factors. The democracy movement with a strong social call for high public spirit among university graduates in early 1970s , the worldwide movement of primary health care and the rural health development policy during 1977 –1987 were the positive factors toward more equitable distribution. The improved distribution of doctors during that period was quite evident. (Figure 3)

On the other hand , the rapid economic growth in 1987 – 1997 and increase of the international health service trade in late 1990s, resulted in increased private hospital demand , which were negative factors contributing to the increasing maldistribution

The 1997 economic crisis resulted in a decline in private hospital demand. The distribution of doctors became more equitable. (Figure 3)

Overspecializations also contributed to the maldistribution (Figure 4) The most important factor of the resigned general practitioners of MoPH in 2003 was the opportunity for further training [13]. After the training they tended to stay in the provincial hospital and the big cities.

2) Strategies used in solving inequitable distribution of doctors in Thailand

i) Supply side strategies

Educational strategies

• Local recruitment strategy

Rural recruitment , training in rural health facilities and hometown placement after graduation were factors of the successful distribution of nurses and other paramedics in Thailand [14]. In 1974, These strategies started to be applied in some medical schools. The students were recruited from rural areas by provincial committee and sent back to their provinces after graduation. Evidence suggested that they had higher continuity in working in rural areas after the compulsory 3 years public work

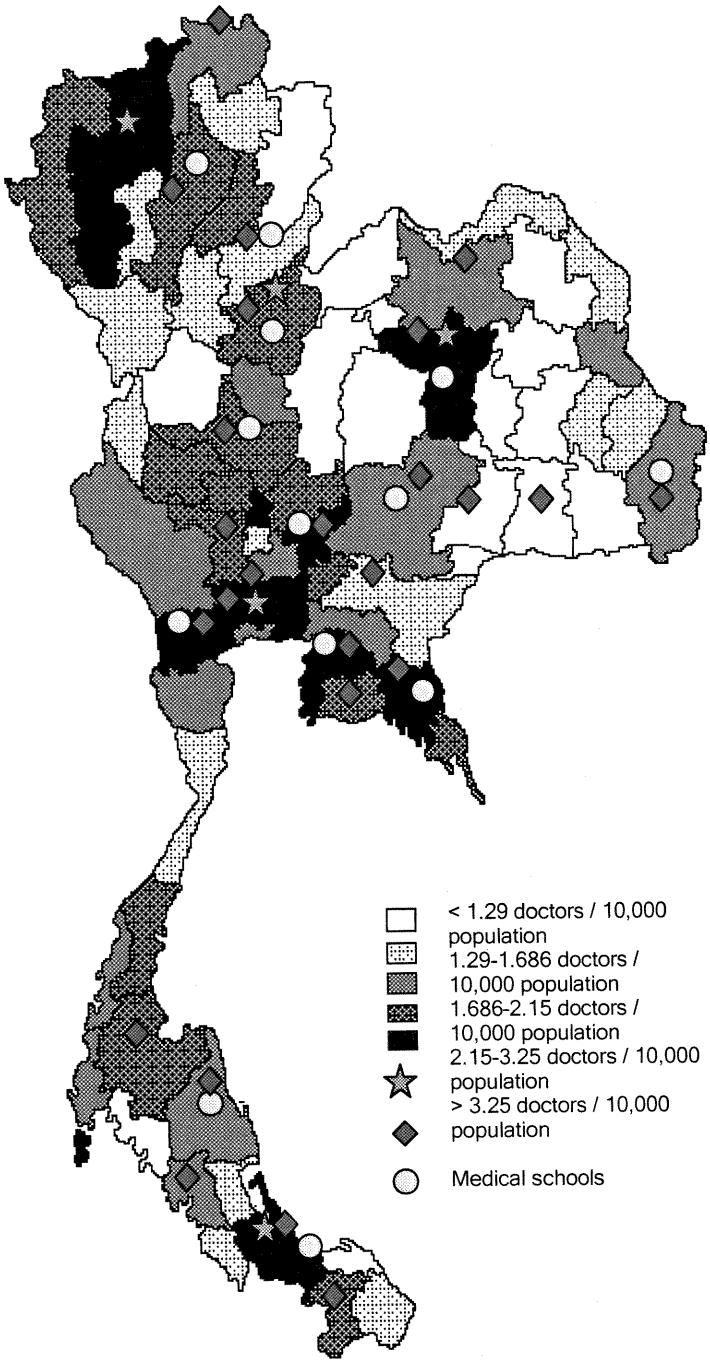
In 1995, in respond to the severe shortage of medical doctors in the rural areas, a " Collaborative Project for the Production of Rural Doctors (CPIRD)" was started based on this strategy. This CPIRD increased the proportion of rural medical students. (Figure 5). It is producing 300 graduates now and is increasing to 500 in the next few years. Since 2004, the government move further to establish a "One rural district one doctor" project, aims at recruiting from the rural districts, not only from the provincial level. The application of this concept has proved quite effective in distributing HRH to the rural areas [10]. (Table 3)

• Increase production

There were four major increases in the production of doctors in Thailand [4]. The first was in 1979 , with an increase of 200 enrolled medical students. The second was in 1993 , the additional production were 340 enrolled medical students

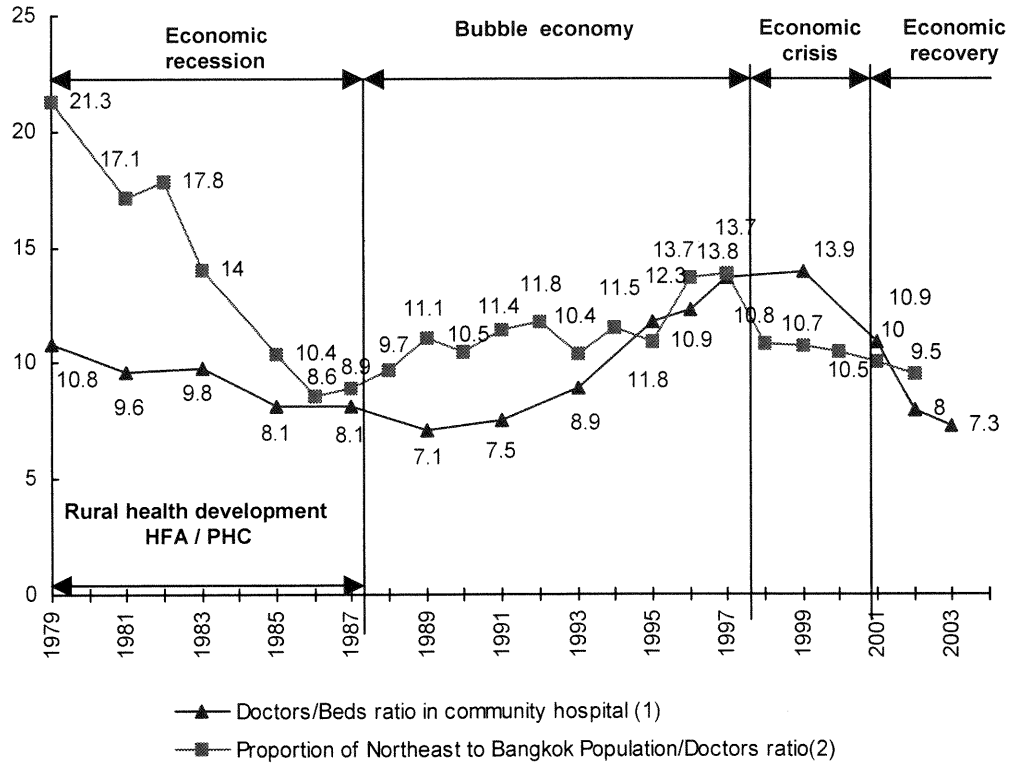
annually. In 1995 , the collaborative Project to Increase Production of Rural Doctors (CPIRD) was proposed to enroll 300 medical students annually to respond to the shortage of doctors in rural areas. It is now accepting 500 students annually. The last big increase was in 2004, in respond to severe shortage in the rural areas, the government decided to support the production of an additional 10,000 medical doctors in the next 15 years.

Figure 2 : Density of physicians by province in 2000



Source : : The Population and Housing Census 2000 , National Statistical Office
As quoted in Thaksapholn Thamarangsi , Analysis of Human Resource for Health based on Population and Housing Census 1990 and 2000

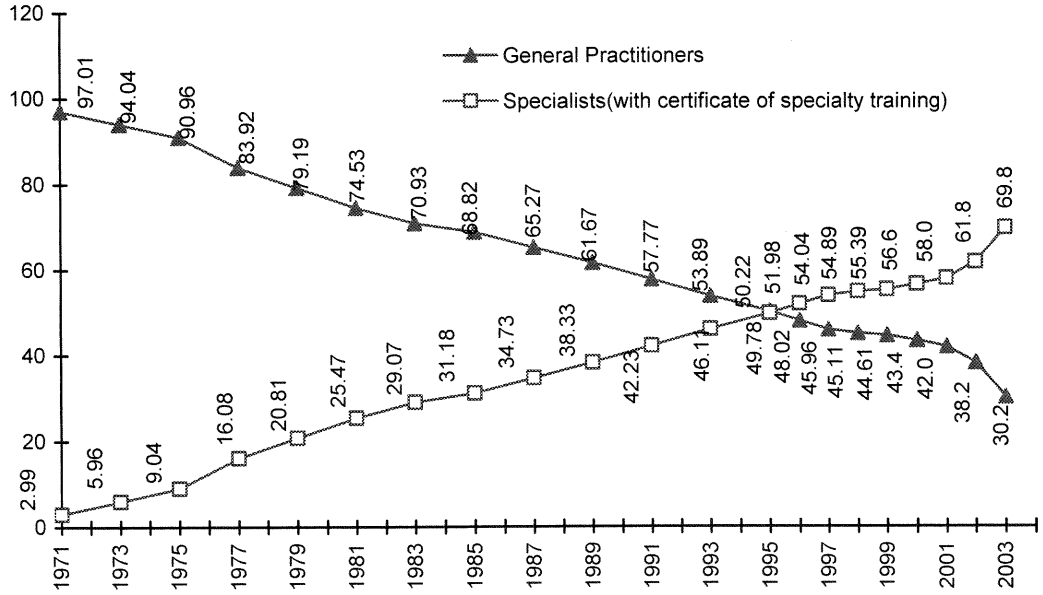
Figure 3 : Doctor to Beds ratio at Community Hospitals and Proportion of Northeast's to Bangkok's Population/Doctor Ratios in 1979-2003



Source : (1) Rural Health Division, MOPH.

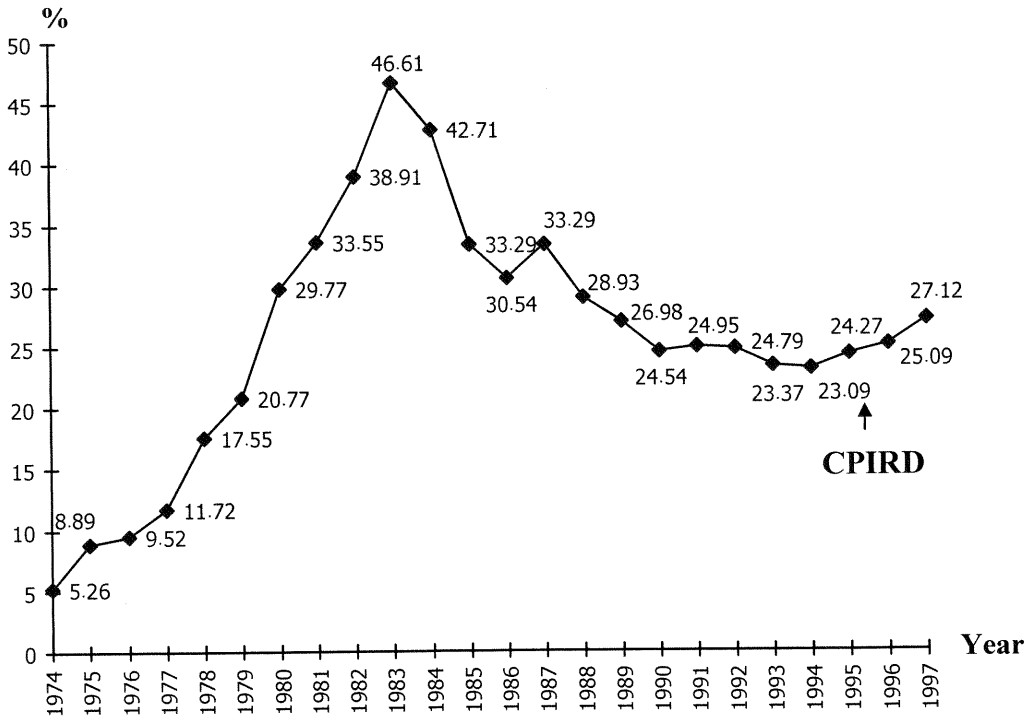
(2) Report on Health Resources Survey, Bureau of Health Policy and Plan, MOPH.

Figure 4 : Proportion of Medical Specialists and General Practitioners, 1971-2003



Source : The Medical Council. (Medical specialists include only those certified by the Medical Council).

Figure 5 : Proportion of rural medical students



CPIRD = Collaborative Project to Increase Production of Rural Doctors.
Source : Faculty of Medicine of all universities.

- Medical education reform

The reform of medical education resulted in suitable graduated doctors to work in rural areas [15]. In 1979 the resolution of the forth national medical conference stated that all medical schools will reform their curriculum to produce medical graduates suitable for working in district hospitals. All medical schools sent their medical students to be trained at district and provincial hospitals for at least 3 – 6 months to allow the students to familiarize themselves with the rural life and change their attitude toward rural working.

- Appropriate skill mix

Production of lower level professionals and strengthening their capacity were very important strategies to improve services in rural areas particularly at health center levels. Patients with simple problems should be cared for by the health centers. The intensive investment in the development of rural paramedical personnel since early 1980's has resulted in greatly reducing the proportions of outpatient visits in the hospitals and reduced the demand for doctors' services. (Figure 6)

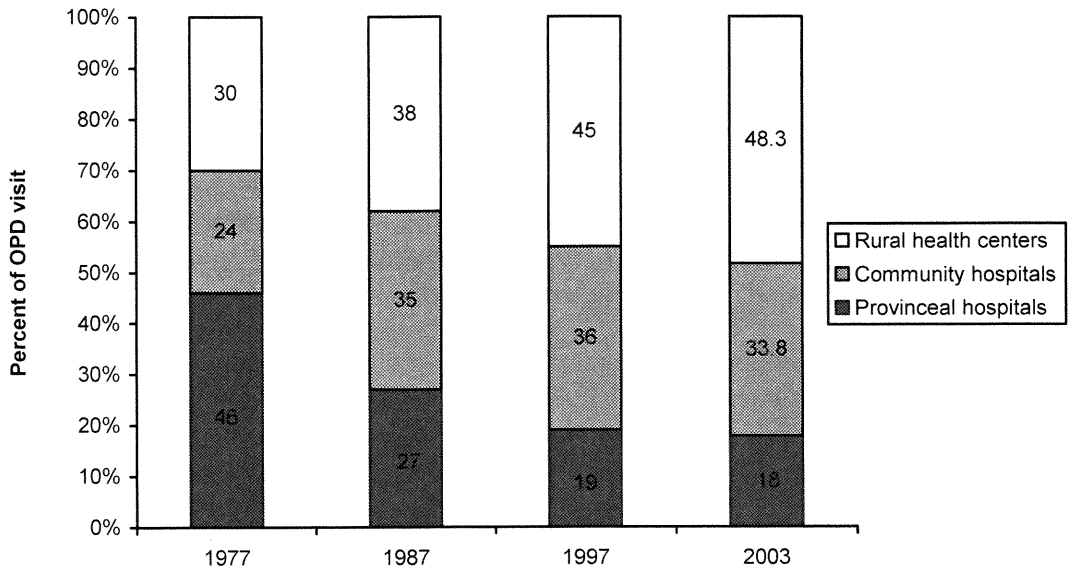
ii) Demand side strategies

Financial strategies :

- Development of rural health infrastructure

In 1979 the Thai government initiated rural development policy. This policy strongly supports the development of rural health facilities with an excellent supporting system , including personnel , equipment , transportation , housing and incentives.

Figure 6 : Proportion of OPD visit at public health facilities



Source : Rural health division , MoPH

- Compulsory public services

The compulsory 3 years of public work contract was started at 1972 , in response to severe external brain drain to the USA. All new graduated doctors must work in public hospitals , particularly in rural district hospitals , for the first 3 years. If they breach the contract, they would have to pay a fine of 10,000 USD .

- Increase financial incentive

Special hardship allowances , non – private practice allowances , workload related payment for non-official hour services were paid , in addition to the basic salary , to attract doctors to rural work.

In 2004 , in the response to the increasing resignation of doctors from both rural and urban public hospitals , the MoPH further developed the special incentives based on 2 objectives. One was based on the hardship of professionals and the other was based on the hardship of their workplaces. (Table 6)

Table 6 :Total income of new medical graduate (include average work – related incentive)

	1975	1995	2005
Community hospital			
Non remote	150	735	890
Remote	170	755	1080-1,330
Provincial hospital	90	680	830

The exchange rate is 1 US$ = 40 Baht I hope you can at least estimate the 1985 figures. I think it is around 200, 225, and 150 USD respectively.

Non financial strategies:

- Social strategies

To encourage the doctors who have worked in rural areas for a long time and devoted their life to improve the community health, many public recognition awards were established. These awardees were invited to deliver special addresses in the prestigious medical schools. All the social movements and supports improved the morale of rural doctors and encouraged them to continue their rural working.

- Career development

All doctors in rural district hospitals start their career at PC level 4 (total 11 levels) and after 7-8 years of public work they will be at level 7 and within 12 years they at level 8 , equivalent to the director of division in central MoPH office. Some of them are also promoted to level 9 which is equivalent to the deputy Director General of a Central Department or the deputy governor.

iii) The effects of these strategies

Inspite of all these strategies, there are the problem of inequitable distribution of doctors still exist and some time even become more severe. This is due to the fact that these strategies were implemented as reactionary strategies in respond to immediate serious situation, so they are fragmented, ad hoc, uncoordinated and some time even conflicting. For example the three year compulsory public work with fine when the contract is bleached. There has never been any increase in the amount of fine for more than 25 years. At the same time the increase financial incentive to the new graduates has allowed them to pay the fine easily and leave the rural area earlier.

(5) Conclusion and Recommendations for the future HRH development

Inspite of the fact the the importance of HRH and its problems have been recognized highly in Thailand and several successive and intensive strategies were employed to solve them, there are still some serious issues continue to occur and need to be tackles. Lessons from the previous successes and failures prompted the Health Systems Research Institute to convene several multistakeholder meetings to discuss the issue of sustainable and continuous improvement to replace the ad hoc and fragmented attempts. Through systematic analysis and several

multistakeholders consultations, a package of three components are proposed for the future continuous and sustainable HRH development in Thailand.

1) **Knowledge generation and management**

Knowledge generation: Policy linked research package on priority areas including:

(i) HRH distribution: Situation and trend of HRH distribution, and evaluation of all the supply and demand side measures to achieve more equitable distribution.
(ii) Dynamics of HRH demand: The epidemiological, demographic and socio-economic transition, including the New Public Management and the International Trade on Health Related Services, affecting the demand and distribution of health services and HRH .
(iii) Generation of basic information: Basic researches to generate essential information for HRH planning and projection, including HRH dynamics, skill mix, productivity, and labor economics.
(iv) Research and development on innovative strategies: The research and development for improving the efficiency, quality and morale of HRH as well as the model for the community involvement in the supply and demand side HRH development.

Knowledge management:
Provinces and districts with successful retention and management of HRH will be identified. Active systematic knowledge management and sharing activities will provide necessary wisdom and incentives for changes by the administrators and civil society from different areas of the country. There should also be interaction, networking, sharing and learning with global community as well.

2) **Development of HRH Information system**

Several sources of HRH information in relation to health care systems and geographical areas need to be further developed and continuously verified and updated, e.g., the annual Health Resources Survey, the licensing data bases, the production data bases, and the population census. The national HRH information clearing house is proposed to be the supporters and coordinator for the development and sharing of HRH information. The minimum HRH information set should be developed as a standard tool for the information generation and sharing. .

3) **Development of sustainable capacity for HRH management**

A continuous plan for the institutionalization of an HRH development unit, independent but links to all stakeholders, should be formulated. The initial phase will be exploratory activities and human resource capacity development, including short term and long term trainings, the linkages to the knowledge generation and management and information development activities. This unit can be assigned to be responsible for the management of this HRH development package. The funding may come from several sources, i.e., the Health Systems Research Institute, the

National Health Security Office, the Thai Health Promotion Foundation, the government budget through stakeholders, and international organizations.

Establishment of Multistakeholders mechanism on HRH development at the national level. This will be a forum for knowledge sharing and knowledge-based consensus building for the integrated and comprehensive measures to ensure longer term and sustainable HRH development in relation to the health systems development. This mechanism may be part of the National Health Systems Reform Committee, chaired by the Prime Minister, or may also be part of the National Health Committee, under the new National Health Bill, or under some other multistakeholders national health mechanism. The HRH development unit in 5.3.1 should be assigned to be the secretariat of this multistakeholder mechanism.

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第４部：　国内各団体の動向

A．政府、官庁　　国立保健医療科学院　　井上まり子

B．学会・大学医学部・大学医局　～アンケート調査のまとめ～

国立保健医療科学院　　種田憲一郎　・井上まり子

C．診療科偏在と学会の取組み

山形大学　　船田孝夫

D．都道府県

1．東北地方の医師分布状況

山形大学　　船田孝夫

2．医師不足県における医師需給

国立保健医療科学院　　千種あや

3．茨城県

茨城県保健福祉部　　泉　陽子

E．職能団体・供給側　　国立保健医療科学院　　井上まり子

第４部：国内各団体の動向

第４部では、医師需給に関連する国内の各団体の動向を報告する。国内の各団体とは、A.官公庁、B．医学系の学会と大学医学部などの学術界、C．診療科、D．都道府県、E．日本医師会などの職能団体、である。

A．官公庁では、厚生労働省とともに主にへき地医療に関連して連絡会議を行っている総務省と文部科学省、規制改革に関連して内閣府、医療システムに関連して経済産業省を取り上げる。B．医学系の学会と大学医学部については、平成 17 年 2 月～3 月にかけて厚生労働科学特別研究「医師需給と医学教育に関する研究」で行った、医師需給に係る調査から医学系学会と大学医学部を対象に行ったアンケート調査の結果をまとめる。C．診療科では、不足が指摘される小児科、産婦人科、麻酔科、放射線科についてそれぞれの状況を解説する。D．都道府県では、特に不足が指摘される東北各県と茨城県を取りあげ、現状と対策を報告する。また、本研究の協力研究者らが行った、平成 16 年度地域保健総合推進事業「医師不足地域におけるその実態と対応に関する研究」の報告要約も掲載する。E．職能団体については、日本医師会、日本病院会、全日本病院協会、日本医療法人協会、日本精神科病院協会、全日本自治体病院協議会の 6 団体を対象に、各団体が公表している資料、委員会での討議内容を調べ、動向を探る。

A．政府・官公庁

本章では、医師需給に関わりがあるとされる５つの省の現状を報告する。それぞれ、厚生労働省とともに主にへき地医療に関連して連絡会議を行っている総務省と文部科学省、規制改革に関連している内閣府、医療システムに関連して経済産業省、である。各省の検討会、研究会等の進行状況、医師需給に関する報告などの文書を参考にしてまとめることにする。

１．総務省

平成 16 年度、総務省では「地域医療の確保と自治体病院のあり方等に関する検討会」を開催した。自治財政局地域企業経営企画室が担当したこの検討会の目的は、自治体病院の医師確保システム及び再編・ネットワーク化のあり方等を検討することであった。検討会の主な議題は自治体病院再編とそのための地方からのヒアリングであったが、検討会では医師不足の状況を検討していたため、検討会報告書から内容を要約する。この検討会報告書は、平成 16 年度内に行われた 4 回の会議の後、平成 16 年 11 月に取りまとめられたものである。

医師不足の状況として、医療法に規定する病院の医師の標準数充足状況（平成 14 年度）を各地域で比較した。充足している病院の割合は、全国で 75.0%であるが、北海道・東北地方では 52.0%と大幅に全国平均を下回っており、地域による医師不足の違いが伺える。

表１：医師の地域別充足状況（単位：%）

全国	北海道東北	関東	北陸甲信越	東海	近畿	中国	四国	九州
75.0	52.0	79.1	67.1	79.3	89.5	74.1	74.0	79.0

出典：医療法第２５条に基づく立入検査結果について（平成 14 年度）

地域以外にも、診療科単位での不足、特に小児科、産婦人科、麻酔科等は全国的な問題となっていることが指摘された。

医師の地域・診療科での不足以外には、仮に医師が確保されたとしても、これまで検討されてこなかった、医師に対する待遇、特に医師本人が望む技能向上のための対策や、ライフサイクルを考慮した人事等、医師の生きがいへの配慮が課題となっていることが挙げられた。

こうした医師不足問題の解決策として、自治体病院間、民間医療法人立病院を含め、医師を柔軟に活用することが重要になってきている。検討会では自治体病院間で医師を相互に派遣しあうことを検討会でも議論された。考えうる派遣の形態については様々な形態があるため、労働関係法規にも留意しつつ、派遣類型ごとに必要な手続きを踏むことにより、医師派遣に柔軟に取り組むことが求められる。

今回取り上げた総務省主催の「地域医療の確保と自治体病院のあり方等に関する検討会」は、全国自治体病院開設者協議会と全国自治体病院協議会共催で設置した、「医師確保対策等検討委員会」とも連携を図っていた。この検討委員会については、本章E．職能団体の全日本自治体病院協議会の説明で解説する。

2．文部科学省

文部科学省では現在、平成17年5月から2年間の計画で「医学教育の充実・改善に関する調査研究協力者会議」を実施している。これは平成13年3月の「医学・歯学教育の在り方に関する調査研究協力者会議」* による報告を受けて実施されている調査研究協力者会議である。会議実施の背景には、各大学のカリキュラム改革、参加型臨床実習等の推進、医師免許取得後の臨床研修（2年間）必修化、地域医療を担う医師の確保への課題等がある。平成16年2月、総務省、文部科学省、厚生労働省による、地域医療に関する関係省庁連絡会議において、医師需給見通しの見直しを踏まえた大学における医師養成のあり方を検討することが必要だと判断され、調査研究協力者会議が行われることになった。文部科学省での担当は高等教育局医学教育課である。

「医学教育の充実・改善に関する調査研究協力者会議」における調査研究事項は、1）学部及び大学院における医学教育の改善・充実について、2）地域医療を担う医師養成のあり方について、3）教育研究病院としての大学病院のあり方について、4）教育研究・診療組織のあり方について、である。第1回の調査研究協力者会議においては、21世紀における医学・歯学教育の改善方策、今後の学士を対象とする医学・歯学教育の在り方、中央教育審議会大学分科会大学院部会の審議状況、地域医療に関する取り組み、医学部入学定員の削減等について議論された。

特に、地域医療に関する取り組みについて、地域を指定した入学者選抜の実施状況に関する課題が報告された。文部科学省医学教育課によれば、平成17年3月の時点で地域を指定した医学部入学者選抜の実施状況は以下の通りであった。

	国立	公立	私立	合計
実施している	3	3	1	7
実施を予定している	6	0	1	7
検討中である	4	0	0	4
実施していない	29	5	26	60

出典：文部科学省医学教育課

医学教育の改善・充実に関する調査研究協力者会議（第1回）配布資料

すでに地域を指定した入学者選抜を実施している 7 大学は、信州大学、滋賀医科大学、佐賀大学、札幌医科大学、福島県立医科大学、和歌山県立医科大学、岩手医科大学である。平成 18 年度から実施する 6 大学は弘前大学、秋田大学、島根大学、香川大学、愛媛大学、宮崎大学であった。

平成 17 年度の医学教育の充実･改善に関する調査研究協力者会議では、今後 8 回の会議を行い、地域医療を担う医師養成の在り方について、また卒前教育について、関係者からのヒアリング等を含めた検討会を行う予定である。それらを基に平成 18 年 3 月中に中間報告公表される。

* 医学・歯学教育の在り方に関する調査研究協力者会議とは、平成 12 年 3 月 10 日から平成 13 年 1 月 18 日までに行なわれ、平成 13 年 3 月に報告を提出した。

3．内閣府　～規制改革・民間開放推進会議～

平成 9 年 12 月の閣議決定以降､公的部門と民間部門の活動領域の見直しを目的として、規制緩和が議論されるようになった。平成 10～13 年は規制緩和委員会、平成 13～16 年の総合規制改革会議と名称や委員は変えてきたが、平成 16 年度以降も改革をより一層推進するため、内閣府は規制改革・民間開放推進会議を設置している。平成 16 年 3 月の閣議決定では、規制改革・民間開放推進 3 か年計画が定められた。この 3 カ年計画はその後もフォローアップされ､計画達成のために講じられた措置が定期的に報告されている｡現在、医療分野で行われている規制改革の項目は、次の 10 項目である。

1．医療提供者に関する徹底的な情報の公開
2．ＩＴ化の推進による医療事務の効率化と質の向上
3．オンラインによるレセプト請求原則化のための条件整備
4．電子カルテシステムの普及、医療用語・コードの標準化・徹底等
5．ＥＢＭの一層の推進
6．保険者機能の充実・強化
7．診療報酬体系の見直し等
8．我が国における外国人医師・看護師による医療行為等の解禁
9．高齢者介護の新しい仕組みの在り方
10．薬学教育６年制導入に伴う薬剤師国家試験の受験資格見直し

この中で医師需給に関係するのは、特に８．の外国人労働者の問題と、その他の改革分野に属する救急医療、小児医療等の改革である。

労働者としての医師の問題については、次の 5 つの項目について、規制を緩和する方針が立てられた。１）医師の臨床修練制度の充実や医療先進国からの臨床修練医の教授に対する適正な報酬を支給できるようにする。２）国家資格取得者の就労制限の緩和をし、日本で正規教育を受け、かつ日本での就労意欲のある者については、高度な教育を受けた人材として、その有効かつ適切な活用が必要である。３）２）のためには、医療分野の日本

の国家資格を取得した外国人に対しては、就労地域、施設などの制限無く就労期間の延長を認めるなど、就労制限を緩和していく必要がある。４）医師・看護師の国家資格取得要件の緩和、明確化、５）医師などの相互受入協定締結の推進、である。

その他も改革として救急医療、小児医療、医療事故対策等への対策が望まれている。

① 救急医療の再構築

24時間体制で上質な救急医療を提供できる体制を早急に整備する。期待される役割を果たしていない救急医療機関については、他の医療機関と役割を交代させる等、救急医療体制が実際に機能するよう、適正な制度の運用管理を行う。また、総務省、国土交通省、警察庁と合同でドクターヘリを全国的に導入し、救命救急を要する患者が迅速に高度な救急医療を受けられる体制を早急に確立することが挙げられている。

② 小児医療（小児救急）の充実

「健やか親子21」において示されている「小児保健医療水準を維持・向上させるための環境整備」の施策を含め、小児救急・小児医療の充実や小児科医の確保策を積極的に推進する。また、小児救急の逼迫の一因として指摘される小児の健康管理に関する親の知識不足を解消し、適切な小児医療の受診を促すため、「健やか親子21」の施策と併せて、小児の健康管理に関する父母への啓発・情報提供等を実施する。第3に、夜間・休日における救急医療体制、小児科医による対応が可能な救急病院について、インターネットによる情報提供等、地域住民への広報活動を推進する。

③ 医療事故防止システムの確立（厚生労働省、文部科学省） 医療事故防止対策について、医療機関内の安全管理に関するインフラ整備、医療の安全確保に関する社会的なインフラ整備、医療専門職の養成過程の見直し等を含め、有効な対策の在り方について診療報酬上の対応の必要性を含め検討し、医療事故防止システムの確立に向けて総合的な施策を講ずる。

④ 非医師による自動体外式除細動器（ＡＥＤ）の使用の容認

医師以外の者が緊急の場合に医療機器を使用することに許可を与える規制緩和も計画されている。

４．経済産業省

医療に関しては、バイオ産業から特許に関することまで取り扱う部門が多い経済産業省であるが、医師需給に主題を限ると、通商白書で取り上げられた海外の優れた資源の活用と、医療問題研究会による医療費抑制の選択肢としての医師数の問題が説明されたことに絞られてくる。

2003年版通商白書では、「日本経済の活性化に向けて」という特集の中で、海外の優れた人的資源の活用を取り上げ、外国人医師の問題が説明されていた。先進諸国の専門職の外国人労働者について、医師等は免許制度があることから外国人労働者の受入が限られて

いる現状を述べたうえで、外国人が十分な医療サービスを受けられる環境を整えることは、日本の対内直接投資を促進すること、専門的・技術的分野の外国人労働者の受入れへの対応、外国人観光客の増加を促進する上でも重要であると考えられている。

その他、医師需給に関連しては平成 13 年度の医療問題研究会の報告書で論じられており、主に日本の病床規制や医療費抑制の 1 選択肢として医師数の供給規制をしているフランスの例を取り上げて報告した。

まとめ

医療・保健分野とはいえ、政府系の官公庁では、厚生労働省だけではなく、様々な省庁の役割分担とつながりがある。各検討会や研究会の結果の利用や、機能分化した際の省庁間の連携が必要である。

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