

Quality of care in Japan: an additional strategy

Hashimoto et al. have suggested that a lack of a production system for primary care physicians in Japan harmed the quality of outpatient care in communities, and proposed the increase in primary care generalists, and strengthening of each prefecture's discretion over healthcare provision.¹

Even though the increase in primary care physicians redresses the current maldistribution of physicians among specialties, equitable access to healthcare among the population cannot be achieved without geographically equitable distribution of physicians, particularly that of primary care physicians. Thus a strategy for better placement is required.

Simple increase of physicians has not improved urban-rural gap of physician concentration.² Thus in 1972, the government and all 47 prefectures of Japan created a medical school, Jichi Medical University (JMU), for producing rural physicians. All JMU graduates have a contract with their home prefectures to work in rural areas of the prefectures for about six years, in exchange for having their undergraduate tuition waived.³ Since 2005, the JMU system has rapidly been adopted as *chiikiwaku*, a sub-quota, by most Japanese medical schools. The number of entrants of these sub-quotas has now reached 1,064 per year (13% of all entrants).⁴

The sub-quota and JMU physicians can potentially connect the two seemingly separate proposals of Hashimoto: specialty balance, and a prefecture's increased discretion. We propose these physicians be trained as primary care physicians, and placed in underserved areas under the discretion of each prefectural government. This strategy would improve the equity of access while strengthening discretion and clarifying responsibility of each prefecture.

References

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