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表1. 文献の種類の内訳

		論 説	研 究	報 告	計
活動	母子保健	4	6	2	12
	予防接種	1	1	1	3
	健康教育	2			2
	精神保健	5			5
小 計		12	7	3	22
概 念		2			2
看護提供者		4	12	7	23
教 育		3	5	10	18
推進への方略		1	1		2
総 計		22	25	20	67

表2. WHOが提唱するPHCと米国でのprimary careの比較 (Eribes et al.1995による)

論点	WHOの提唱するPHC	米国でのPrimary Care
起 源	HFAの戦略の一つとして考え出された。	プライマリー医の不足、医療資源の不均衡な分布、貧困層・地方住民の利用可能なサービスの減少、医療費の増加に対応するため。
定 義	PHCは实际的、科学的、社会的に受け入れられる方法による基本的なヘルスケアであり、住民の参加を通じて広く利用でき、地域や国の費用で賄うものである。	初回の接触から維持的ケアまでを含む複合的サービスの提供である。利用者のニーズと文化的価値観に応じて特定のサービスを照会する責任を持つ。
原則・本質	<ul style="list-style-type: none"> ・PHCはすべての人が健康になるために必須なもので、社会経済開発も含む。 ・公的に推進される。 ・ケアの最小レベルは住民によって決められる。 ・予防に重点を置いた保健サービスを大多数に提供する。 ・支払能力に関係なく、広くサービスが可能。 	<ul style="list-style-type: none"> ・身体/精神的ヘルスサービスの臨床的分配は必要なものである。 ・プラーベートで商業セクターが推進 ・身体的健康と機能の治療と回復に焦点を当てる。 ・必要ならば二次、三次ケアへの照会 ・かぎられた予防的ケアを行なう。 ・高度のケアの分配を焦点にする。
住民参加	<ul style="list-style-type: none"> ・人々のヘルスケアへの参加は、権利であり務めである。 ・利用者主導 ・草の根協力において利用者はパートナーとして参加 ・専門職の役割：ファシリテーター、コンサルタント、促進者、資源 	<ul style="list-style-type: none"> ・サービスの再構築には住民の参加は考えられていない。 ・提供者主導 ・コミュニティは権力ブローカーによって規定される ・専門職の役割：エキスパート、提供者、権威者、チーフリーダー
多領域の協力	<ul style="list-style-type: none"> ・ヘルスセクターの範囲を超えて、保健、雇用者、教育対象者、他のセクターを含む協力 ・コミュニティ/集合体を対象 ・資源の割り当てでの協力 	<ul style="list-style-type: none"> ・保健専門職、ヘルスケアチームメンバー間で行なわれる。 ・個人/家族を対象 ・資源に対する競争
アクセス	<ul style="list-style-type: none"> ・ヘルスケアサービスと資源は、広く入手可能であり適正がある ・住民の優先度、必要性に応じて、どこに何を求めるかが決まる 	<ul style="list-style-type: none"> ・医療職が、個々の疾患の予防と治療に必要なニーズをもとに決める ・医療職主導の市場原理によって、どこに何を求めうるかが決まるため、ヘルスケアサービスの入手に制限がある。
エンパワメント	<ul style="list-style-type: none"> ・集団的意思決定と行動 ・権力の再配分 ・共同して働く、機能の付与；過程と結果 	<ul style="list-style-type: none"> ・個人の意思決定と行動＝ノンコンプライアンスはエンパワメントの現われ ・相互作用はパートナーリスティック ・供給者—支援過程

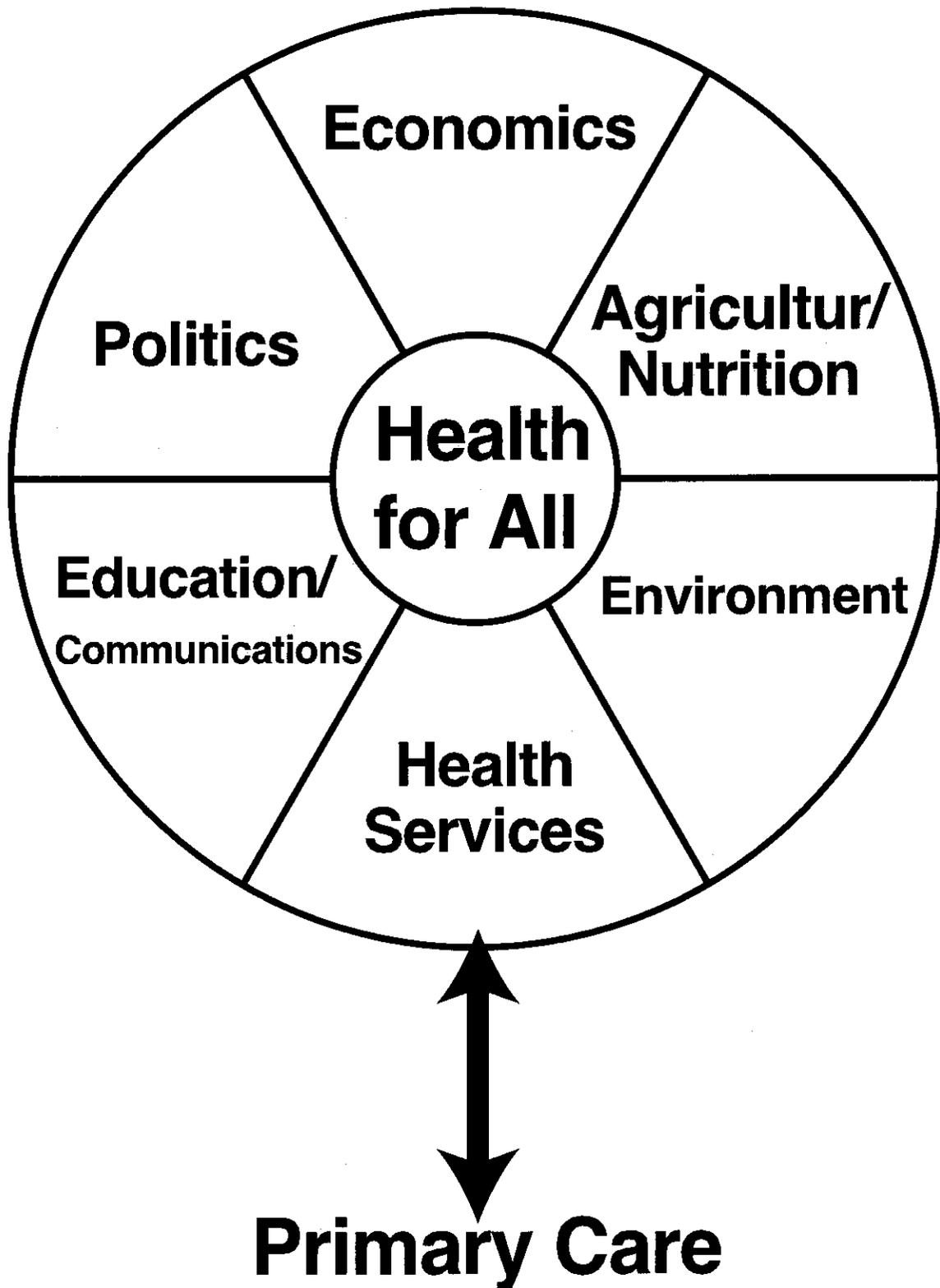


図1.PHCのモデル (Shoultz et al.1997による)

平成10年度厚生省看護対策総合研究事業

研究報告

看護の質の確保に関する研究—

プライマリヘルスケアに基づく看護モデルの開発—

：プライマリヘルスケアと看護実践・教育・研究に関する文献から

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