



A study of the primary health care identity work of Australian rural nurses in a context of national health reforms

by

Ree Van Galen RN BN (Hons)

Submitted in fulfilment of the requirements for the degree of

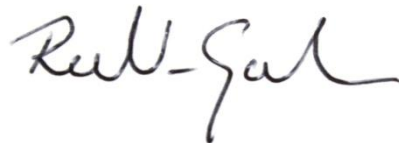
Doctor of Philosophy

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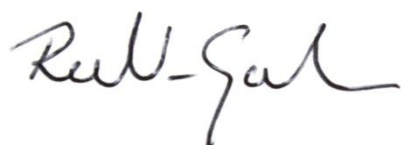
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Abstract

This thesis is an investigation into primary health care (PHC) nursing in Australia, focused on the interface between nurses, their health organisations and the local community. It is set during a period of significant cultural and structural change informed by the move towards a National Primary Health Strategy within health reform. Nurses, as the predominant health workforce in community settings, are pivotal to governments' health reform agenda; however there are tensions evident with different groups, with different expectations and interests, positioning nurses as providers of PHC. The aim of this study is to *explore nurses' agency through identity work to inform an understanding of contemporary rural PHC nursing in Australia* with a focus on how control and agency are evident in PHC nurse identity work. Using a Critical Realist theoretical perspective, an explanation of PHC nursing identity, as a social structure, is presented through analysis of the interactions between structure and agency within a social, cultural and historical context.

Expansion of the role of General Practice is an integral component of the PHC reforms. Historically, Federal Government incentives to increase the number of nurses in these settings were provided to rural General Practice settings. Rural communities experience significantly higher burdens of disease in comparison to urban settings coupled with difficulties in recruitment and retention of health professionals. Therefore, PHC nursing within small outer regional communities provides a distinct and relevant context for this study, given these changing health service environments.

Two forms of empirical data were gathered which reflected PHC nurse identity work at different levels. The first data source consisted of 265 publicly available documents submitted to the National Health and Hospital Reform Commission to inform the draft National PHC Strategy. These documents, as texts, reflected PHC nurse identity work at a broad national level by key groups with an interest in positioning nursing within PHC. Transcripts of interviews with 21 rural nurses working in various PHC settings in two Australian States provided the second source

of data, reflecting identity work at the level of individual PHC nurses. Content analysis of the public submissions and thematic analysis of the interview transcripts provided evidence of PHC nurse identity work.

Nurses' individual interests were predominantly focused on the local context of their clients/community and their local health team through a broad range of nursing roles. Organisations representing government and medical interests emphasised particular nursing roles, and focused on the allocation of funding resources, structuring of medical leadership and support for those roles. There was evidence of nursing's attempts at developing collective agency as PHC nurses. However, resource allocations for and managerial control of particular nursing roles in PHC evidenced ambiguity regarding PHC nurses' collective agency in being able to effectively meet the interests of rural nurses in providing PHC for their clients/communities as autonomous health care providers.

Synthesis of the evidence derived from analyses of the two data sources revealed four main identities for PHC nursing in use within rural health services; The Doctor's Nurse, the Local Community's Nurse, The Organisation's Nurse and the Boundary Spanning Nurse. Diverse interests, including those of individual nurses, broad community groups, health organisations (including nursing and medical groups) and various levels of government in Australian society, were reflected in these identities.

Based on the findings and using Critical Realist theory to underpin the exploration of the empirical data, an explanatory framework is presented incorporating the four main identities. Agency and identity allow the complexity of the nurse/health service/community interface in a cultural and structural context to be incorporated into this qualitative empirical study. Ambivalent representations of nurses' autonomy as providers of PHC within the primary and community care framework have implications for nursing practice, the provision of PHC nursing for rural health services and sustainable PHC reform. Ongoing tensions and difficulties are likely to continue without structural health service changes which enable nurses to provide client/community focused care as autonomous health care providers.

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List of Acronyms

AGPN – Australian General Practice Network
APN – Advanced Practice Nurse
APNA – Australian Practice Nurses Association
CHN – Community Health Nurse
CNM – Clinical Nurse Manager
CHC – Community Health Centre
CN – Community Nurse
CR – Critical Realism
CRANA – Council of Remote Area Nurses of Australia
DVA – Department of Veteran Affairs
EN – Enrolled Nurse
GP – general practitioner
HACC – Home and Community Care
MPS – Multi Purpose Service
NHHRC – National Health and Hospital Reform Commission
NiGP – Nursing in General Practice
NP – Nurse Practitioner
PHC – Primary Health Care
PN – Practice Nurse
RN – Registered Nurse

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Chapter One: Nursing – the ‘powerhouse’ for change in primary health care?

‘If the millions of nurses in a thousand different places articulate the same ideas and convictions about primary health care, and come together as one force, then they could act as a powerhouse for change. I believe that such a change is coming, and that nurses around the globe, whose work touches each of us intimately, will greatly help to bring it about’ (Mahler 1985:10)

Health care reform has become a global, social and economic imperative. Factors including an increasing aged population, rising incidence of chronic disease and inequities in access to health care for marginalised groups such as rural communities, are providing significant impetus for changes in traditional health system structure. Government responses have focused on strategies for increased coordination of health services in community settings with key debate centred on Primary Health Care (PHC), collaboration between primary care, public health and community care, and ways of addressing the social determinants of health (Naccarella, Southern et al. 2008). In Australia, nurses represent the predominant health workforce in community settings (Australian Institute of Health and Welfare 2009), and nurses are seen as pivotal to the Australian PHC reform agenda.

Nursing has been promoted as the backbone to PHC services in progressing strategies for PHC reform (World Health Organisation 2008; World Health Organisation 2009). In 1985, the Director General of the WHO, as quoted above, highlighted the integral role nursing could perform in realising PHC as central to health care reform. More than two decades later, and despite the renewal of focus on PHC strategies, this vision has not been realised. Proposing the idea of nurses as a ‘powerhouse for change’ (Mahler 1985:10) in PHC is based on assumptions of nursing’s collective agency, a uniform understanding of PHC and a consistent underpinning ontology for PHC nursing.

This thesis argues that assumptions of nursing identity and professional collective agency during Australia’s health care reform process have led to a lack of clarity

regarding both the models of care underpinning the PHC practice of nurses in community settings and factors influencing nurses' professional autonomy in advancing PHC. The focus of policies, with significant funding to support the expansion of nurses' roles in community based settings, have inadequately taken account of the complexity of nurses' practice reality, that is the cultural and structural factors informing nursing's professional identity and power. This not only has implications for nurses' job satisfaction but broader implications for nurses' recruitment and retention with consequent impact on sustainable PHC reform. Further understanding is needed about how nurses' agency as PHC providers can be effectively mobilised at both the service and policy level to ensure nurses are able to provide care most effectively for their clients. An explanatory framework that contributes an understanding of the complexity of factors impacting on nurses' professional practice as PHC providers will assist in doing this. The incorporation of cultural and structural factors within an explanatory framework will ensure that power relations are taken into account when promoting PHC nursing as 'the powerhouse for change'.

There is a long tradition within nursing in community settings of providing PHC services for vulnerable and marginalised groups, including rural communities (Hegney 1996a; Blue 2002; Bardenhagen 2004; Grehan 2008). Rural health issues are distinct, with the health status of people living in rural communities in Australia being comparatively worse than urban dwelling populations (Wakerman and Humphreys 2002; Smith 2005; Beard, Tomaska et al. 2009; National Rural Health Alliance 2009). Locational disadvantage in terms of access to services and other social determinants of health such as socioeconomic disadvantage are intricately entwined with aspects of rural living (Humphreys 1998; Australian Institute of Health and Welfare 2003). Workforce shortages, particularly of medical professionals, have provided impetus for significant government funding to support an increase in rural nurses working in primary care settings (Jolly 2007; Pearce, Hall et al. 2010).

As such, rural nurses working in community settings provide a suitable and relevant study group for exploring the factors impacting on PHC nurse identity work. The aim of this study is to *explore nurses' agency through identity work to inform an*

understanding of contemporary rural PHC nursing in Australia. This aim will be achieved through analysis of documents submitted to government to inform the development of Australia's draft PHC Strategy as well as individual interviews with rural nurses to address the research questions.

Defining Primary Health Care

Australia is developing its first National PHC Strategy (Australian Government Department of Health and Ageing 2009a). Sustainable health care reform on such a large scale will, of necessity, need to be underpinned by some common understandings of what PHC is. For most Australians, PHC is not a familiar term, health care is thought about in terms of being provided either in the hospital or in the community setting (Australian Government Department of Health and Ageing 2009b). Definitions of PHC, as socially constructed concepts, are open to interpretation thereby impacting on its potential as a new health paradigm in health care reform (Nesbitt and Hanna 2008; Felix-Bortolotti 2009).

Definitions and descriptions of PHC tend to stress the importance of addressing people's immediate health symptoms (primary medical care) as well as looking to address longer term solutions requiring involvement with the causes of health problems including the social determinants of health. This includes preventative health measures, health promotion and, for some, community development (Keleher 2007e; Nesbitt and Hanna 2008; World Health Organisation 2008). PHC is also viewed in terms of being the first level of care or entry point to the health care system for people (Macdonald 2007). In some descriptions, PHC is taken to mean a particular approach to care, incorporating such aspects as continuity of care, community involvement, person centeredness, accessibility and partnership models (Glasgow, Sibthorpe et al. 2006). Theoretical perspectives describe PHC along a continuum ranging from comprehensive PHC to selective PHC to primary medical care (Baum 2008; Felix-Bortolotti 2009). These various aspects of PHC as a strategy, a model and an approach to practice will be discussed in more detail in the following chapter; however they are mentioned here to highlight the various possible practice and ideological positionings which can be taken in approaching the concept of PHC.

In 1978 the World Health Organisation (WHO) hosted the International Conference on Primary Health Care at Alma-Ata, USSR. The delegates to this conference were responsible for the Declaration of Alma-Ata, in which primary health care was defined as:

‘Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process’ (World Health Organisation 1978).

The aim of developing this definition was not only to foster more equitable and effective basic health care needs but also to provide a guide for participating countries in addressing the social, economic and political determinants of health (Felix-Bortolotti 2009). Implementing PHC within the principles of this definition would entail major transformation of not only the health systems of countries but also their social and economic structures. Operationalizing the Alma Ata definition to inform health system reform has varied with each of the participating countries (Rogers and Veale 2003).

The Australian Primary Health Care Research Institute (APHCRI) developed a definition of PHC for the Australian Division of General Practice (Australian Division of General Practice 2005) which is commonly used in Australian literature and provides an Australian context. Its focus is on PHC as a level of care within the health system and omits aspects of the role of PHC as integral to the overall social and economic development of a community. This is the definition adopted by the Australian government in the draft PHC Strategy and also reflects the government’s decision to limit consideration of the broad social determinants of health in scoping PHC for the report and the draft strategy (Australian Government Department of

Health and Ageing 2009b:24). However, the definition does include health promotion, illness prevention, treatment and care of the sick, community development and rehabilitation as integral to PHC provision (Australian Division of General Practice 2005). This definition reflects the approach to PHC taken by many developed countries, being described as a more acceptable, affordable and realistically demonstrable approach (Cueto 2005; Nesbitt and Hanna 2008).

The principles of PHC, as defined by the Declaration of Alma Ata (World Health Organisation 1978), which are informed by a social model of health to incorporate the social determinants of health, are argued as underpinning PHC nursing, they are the “plinth of community nursing practice” (International Council of Nurses 2007a; Grehan 2008:12; Nesbitt and Hanna 2008). As such, the exclusion of broad social determinants of health from Australia’s PHC strategy has significant implications for nurses’ professional identity and role as PHC providers in Australia.

The research problem

Australia is undergoing historical reform of its entire health system. Recent health policy changes to support sustainable health care reform recognise the reliance on nursing involvement to support a PHC agenda. However, expectations of nursing’s involvement are based on various assumptions about nurses’ collective agency as PHC providers and a congruent understanding of PHC. The problem is that very different conceptualisations and social expectations are held regarding the position of nursing and its PHC mandate as a strategy for health care reform.

Compared to other branches of nursing, there is a dearth of community nursing research in Australia (Brookes, Daly et al. 2004). Health care reform in Australia is providing unprecedented change to the roles of nurses working in community settings (Brookes, Daly et al. 2004; Kemp, Harris et al. 2005; Keleher, Parker et al. 2007g; Phillips, Pearce et al. 2008; Parker, Forrest et al. 2011). While all community nursing roles are changing there has been significant focus on the role of community based nurses providing care for individuals and their families with the notable promotion of expanded roles for nurses in general practice settings (Watts, Foley et al. 2004; Keleher, Parker et al. 2007g; Parker and Keleher 2008).

Role changes for nurses working in community settings towards PHC models of practice will be influenced by the way nursing is characterised, positioned and represented, that is, PHC nurse identity work. This will impact on and reflect PHC nurse identity. PHC nurse identity is critical to how nurses are incorporated into changing PHC settings during significant health reforms. Given that the current PHC nurse workforce is nearing retirement and new graduate nurses are ‘shunning’ primary care (Eccles 2012), PHC nurse identity is central to understanding nurses’ interactions with PHC services (Charles-Jones, Latimer et al. 2003) as well as how nurses and health services negotiate the process of new role developments (Sveningsson and Alvesson 2003)

Whilst the increasing focus on nursing in general practice is relatively new in Australia, there is a long and substantial history of nursing within community settings (Francis 1998; Keleher 2000b; Keleher 2007f; Kralik and Van Loon 2008). Significant policy and funding measures have supported the expansion of nurses working in general practice settings with numbers of nurses increasing from approximately 5,000 at the end of 2005 to 10,693 in 2012 (Australian Divisions of General Practice 2006; Jolly 2007; Eccles 2012), however nurses working in community settings are predominantly situated outside the general practice setting (Australian Institute of Health and Welfare 2009) and there is a lack of information regarding nurses working across these settings. Australia lacks national competency standards or career framework for all nurses as PHC providers in community settings (Brookes, Daly et al. 2004; Keleher, Parker et al. 2007g; Parker, Keleher et al. 2009). While the competency standards for nurses working in general practice settings stipulate that nurses will integrate the principles of PHC into practice (Australian Nursing Federation 2006), undergraduate education does not adequately prepare nurses for work as PHC providers in community settings and post registration education is described as being ‘ad hoc’ (Keleher, Parker et al. 2007g:5; Parker, Keleher et al. 2009; Keleher, Parker et al. 2010). Australian nursing competencies for registered nurses do not specify any particular competencies for PHC and are general in relation to the requisite skills and knowledge for registered nurses (Keleher, Parker et al. 2010).

The medical control of the scope of nursing practice in general practice has been frequently cited as one of the constraining factors to Australian Practice Nurse role development (Patterson 2000; Halcomb, Davidson et al. 2005b; Mills and Hallinan 2009). While nursing's relationship with medicine has been extensively researched, nursing's history of working in general practice in Australia is quite new. A recent and extensive study by Phillips et al. (2008) into nursing roles in Australian general practice describes the role of 'agent of connectivity' as being integral to enhancing the capacity for comprehensive PHC in general practice. However, statistics/data currently available depicting the work of nurses in general practice does not include this role or related practices, while it is described by individual nurses as an important aspect of their practice (Pearce, Hall et al. 2010) and is well researched as an aspect of comprehensive PHC practice (Keller, Strohschein et al. 2004; Keller, Strohschein et al. 2004; Sheridan 2005; Woods 2010). There is scant research in Australia outlining the way in which nursing practice in community settings is identified with this 'connectivity' aspect of PHC within current health reforms.

The way in which collaboration is represented as an aspect of rural nurses' PHC identity varies with different representations of agency. Coordination, collaboration and the development of partnerships with the community and between primary, public and community care are integral to effective PHC reform. Historically, different interests have informed the way collaboration between health services has been operationalized on the ground for rural communities including different funding policies, organisational structures and professional interests. Tensions, barriers and constraints to effective collaborative service provision have been well documented (D'Amour, Ferrada-Videla et al. 2005; Currie, Finn et al. 2007; Anderson, Bonner et al. 2011; Lovett 2011).

Health care funding involving the provision of nursing care in primary and community care settings promotes an individual client partnership focus. Current funding streams do not take into account the organisation's business model which has implications for the way in which the funding devolves at the practice level (Finlayson, Sheridan et al. 2012). Data detailing the actual nursing practice carried out in the primary and community care sector, particularly in regard to practice

which is not directly individually client focused, is inadequately recorded both in general practice and in community nursing (Joyce and Piterman 2010).

Successful interprofessional work and sharing of professional skills in the provision of health care arguably requires confidence about professional identity (Colyer 2004). What is known is that ambivalent mandates for nursing are known to negatively affect retention rates and professional identity with these tensions leaving nursing's position in PHC reform more susceptible to control by powerful groups in the health reform agenda (Kelly and Symonds 2003; Allen 2004; Carryer 2004; Aranda and Jones 2008). Critical awareness and understanding of mechanisms forming, influencing and maintaining PHC nurse identity is needed. These different expectations and conceptualisations of nursing's position will influence the shaping of PHC nurse identity in Australia's current health reform, but how this might impact on the introduction and sustainability of new and advanced roles and ways of working is not yet known.

Individual nurses' internal responses to work place changes during health reforms, including feelings of ambiguity and uncertainty, are well documented as impacting on job satisfaction, retention and perceptions of professional identity (Williams and Sibbald 1999; Hegney and McCarthy 2000; Cowin 2002; Noblet, Cooper et al. 2007; Letvak and Buck 2008). Few studies approach these aspects of nurses' inner lives during health reform whilst also exploring the external structured/structuring influences on collective PHC nurse identity. Studies exploring nurses' collective responses to health reforms, the way in which they are knowledge makers who shape and are shaped by their healthcare situations are less evident (Lindsay 2004).

Approaching PHC nurse identity as work

The previous outline of the research problem highlights the relationship between social structures and nurses' agency for PHC nurse identity. It is important at this stage to clarify the way in which PHC nurse identity is viewed as work, and its significance to the thesis argument.

The concept of identity work connects with the underpinning ontological approach of critical realism. Critical realism offers a scientific philosophy for theorising the social world and provides a way of conceptualising the relationship between agency and structure (Archer 2003). While this will be expanded in Chapter Three, a brief outline of the major tenets of critical realism is necessary to allow the reader, at the outset, to appreciate the logics of this thesis. Within critical realism, the world is stratified and distinguished by three domains (the real, the actual and the empirical) (Archer 2003). The empirical domain consists of all that is observed and experienced; however, not all events that exist are directly observed or experienced. Depending on the position of the observer, events can be partially or differently perceived (this is the domain of the actual). PHC nurse identity work occurs within the actual domain. The forces that tend to produce events are called ‘generative mechanisms’ and they exist in the real domain. Nurses’ agency, social structures and PHC nurse identity exist in the real world and while they have causal powers, the events that are observed, as PHC nurse identity work, are triggered by underlying generative mechanisms which are often difficult to directly observe.

Nurses’ agency, in terms of PHC nurse identity, is the capacity to produce an effect or outcome (Nash 1999). So nurses’ agency can have causal powers to effect changes to PHC nurse identity. However, nurses enter a pre-existing social structure, for example roles within an organisation, which also has causal powers which can constrain or facilitate PHC nurse identity (Archer 1995).

The significance of identity

This chapter has so far highlighted a diversity of factors impacting on and influencing nurses, their changing roles and positioning as PHC providers. Nurses choose to take on the roles available to them. How they respond to the different expectations, positionings, characterisations and representations of their PHC role and PHC identity during health system restructuring necessitates understanding the interplay between the sociocultural structural roles and observable role behaviours. The mechanisms impacting on the space between the actor and the action requires incorporating an exploration of nurse agency (Archer 2000; Phillips, Kelk et al. 2007). PHC nurse positioning and representation through the negotiation of, and

navigation through, this interplay between the structuring roles and nurse agency can be defined as identity work (Sveningsson and Alvesson 2003).

A number of studies have focussed on the changing roles for nursing in PHC by employing aspects of role theory (Brookes, Davidson et al. 2007; Holt 2008). Although there is interplay between the concepts of roles and identity, they are distinct entities. Whilst organisational roles prescribed for nurses in primary and community care provide a lens on some of the sociocultural forces impacting on PHC nurse collective identity, role theory does not provide an authentic account of human agency in the development of collective PHC nurse identity (Jackson 1998; Jackson 1998; Phillips, Kelk et al. 2007). This lack of an ability to deal with agency means that role theory is unable to provide an understanding of the process occurring between the actor and the action, that is, how nurses negotiate/navigate their PHC practice, their agency and in turn their identity as a PHC provider through the reforms, especially given the different constructions/conceptualisations of PHC and the nursing mandate (Phillips, Kelk et al. 2007). If we think of the process of navigation and negotiation as 'work' then a focus on identity as a work in progress allows for an analysis of the interplay between the sociocultural structuring nature of roles/positionings with nurses' subjectivity, how they relate to their practice, how they embrace, negotiate or reject roles. PHC nurse identity is a work in progress.

Identity theory

'Identity is viewed as central for issues of meaning and motivation, commitment, loyalty, logics of action and decision making, stability and change, leadership, group and intergroup relations, organizational collaborations' (Sveningsson and Alvesson 2003:1163).

Exploring the causal powers informing nurses' positionings, which impact on PHC nurse identity, requires the exploration of the interplay between the power of nurses' agency and the controlling structural properties/contexts. Within a CR framework, it is possible to encompass the complexity of the emergence of PHC nurse identity within a realistic account of causation. To reflect the process of identity as 'becoming rather than being' (Sveningsson and Alvesson 2003:1164) requires incorporating an understanding of identity as informed by the interplay between both

agency and the controlling/constraining structures. With a brief outline of the developments in identity theory, this section will focus on situating identity as work. This will then support understanding how exploring the interplay between the causal powers of agency and socio/cultural structures revealed by PHC nurse identity work will allow for greater insight into the mechanisms generating PHC nurse identities in the change process of health care reform in Australia.

The term 'identity' is difficult to define because its meaning is intertwined with the different theoretical philosophies that exist to assist us in understanding who we are to each other (Brewer 2001; Benwell and Stokoe 2006). Historically, early approaches to understanding identity during the Enlightenment placed a strong emphasis on identity being fixed and focussed on the personal identity as an internal conception of agency and reflexion (Benwell and Stokoe 2006:4). Following this period of thinking, theorisation supported the inclusion of social constraints upon the rational human being, whilst still upholding the central notion of identity as being essentialist and driven by the 'rational' being inside us (Archer 2000). These approaches, accentuating agency in the development of identity, are described as upward conflation by Archer (2000), positioning the rational human being as central to identity formation rather than the social construction of identity by cultural, society and structure. More recently, post structuralist approaches to identity have reversed this approach, suggesting that the self is a result solely of social structural construction and that social and discourse practices frame and define identity (Jenkins 1996; Archer 2000; De Fina, Schiffrin et al. 2006). Archer (2000) defines this primacy of the social construction of identity as downward conflation. Archer (2000) posits that both approaches, an analysis of agency and of structure, are needed in the understanding of identity and that neither the sociocultural context nor the 'reality' of the reflexive self should be foregrounded, and nor should they be conflated with each other. An exploration of identity requires both agency and structure to be analysed separately (Archer 2000).

Up to this point, the term 'identity' has been used in a general and undefined fashion. It is necessary to clarify both the term and related concepts before proceeding further. Identity themes are addressed on a multitude of levels, organisational, professional, social and individual. There are three conceptually distinct types of

identity – person based/personal identity, social/relational/group identity and collective identity (Brewer 2001; Snow 2001).

Personal identity is determined by the balance struck between human concerns in the natural, practical and social world and what we determine to be our ultimate concerns. Personal identity is the individual's concept of the self that is derived from interaction with the stratified real world (Archer 2000:257). It can be lost and re-established. Personal identity for social agents is generated by 'inner conversations', reflexivity, which allows 'a liveable degree of solidarity for the self in its commitments' (Archer 2000:10-11).

Social identity is part of the individual's self-concept which derives from a knowledge of membership of a social group (or groups) in conjunction with the value and emotional significance attached to that membership (Tajfel 1981:251). As such, social identity is where the 'full brunt' of the interplay between agency and structure/culture is encountered (Archer 2000:313). An ongoing struggle between an individual's personal identity and his or her various social identities can exist, as the demands of the social identities infringe upon the uniqueness of the personal identity (Brewer 2001). Social identity is a subset of personal identity (Archer 2000).

Social identity as identification with a group differs to collective identity which is the norms, values and ideologies that such an identification entails (Brewer 2001). Although the three types of identity (personal, social and collective) overlap and interact, collective identity is analytically distinguished by the essence of its shared and interactive sense of 'we-ness' and is seen in action as collective agency (Snow 2001:3). The concept of *collective identity* involves the shared representations of the group based on common interests, experiences and a sense of solidarity (Brewer 2001). As such, while professional identity as a PHC nurse may be a collective identity, the dynamics of professional identity involve overlapping and interacting between personal, social and collective identity.

The different theoretical perspectives conceptualise identity in almost a binary fashion, with emphasis on cognitive processes versus group processes, on the role of social contexts versus internal structures as determinants of identity (Brewer 2001).

With the more recent theoretical perspectives focusing on the need to theorise what people do as something more than either an individual lifestyle choice or the one way outcome of structural determinants, the trend is to move away from theories of fixed identities to more discursive or constructed approaches incorporating multiple identities. Identities are forged through shifting relationships which might give rise to ambivalent, partial and sometimes contradictory effects. This approach to identity supports an argument for viewing identity as a fluid process, in terms of becoming rather than being (Sveningsson and Alvesson 2003).

Identity as work – the interplay between agents and the ‘real’ world

The constitution of PHC nurse identity is informed by organisational structures within the health system, the sociocultural history of both the health system and the nurses working within it, as well as the private lives of the nurses. Structural controls including organisational roles, registration licences and sociocultural/historical understandings of nursing impose certain categorisations, classifications and positionings for nurses. Individual nurses and professional nursing groups will insist on asserting their own sense of who and what they are even if they are not successful and it is the interplay between these that is constitutive of identity (Jenkins 1996). In this sense, identity can be viewed as work, as the active process of *being engaged in forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness* (Sveningsson and Alvesson 2003:1165).

During this time of significant health care reform with subsequent changes in both the roles and expectations of the health workforce, PHC nurse identity work can reveal how groups navigate through the change process and any renegotiation of PHC nurse identity. The imperative for research exploring the identity work of nurses working in PHC settings during health care reform is highlighted by a recent and extensive Australian study of nurses in general practice (Pearce, Hall et al. 2010). The authors contend that, whilst policy levers effect a certain amount of change in the organisation, interpersonal relationships and intersubjective dimensions of care are highly influential in the shaping of both nursing behaviours and roles taken up, and these aspects of identity work influence nurses’ satisfaction,

perceptions of quality, patient care and management of nursing time. They state that both policy development and funding structures in health reform would benefit from further understanding and research in this area (Pearce, Hall et al. 2010).

Nurses are constrained by the socially constructed identity choices available to them however, as social actors, they are also actively involved in (re)negotiating, constituting and navigating their PHC identity. Nurses engage in identity work in order to negotiate and optimize the boundaries between their personal and social identities and collective identity representations. The influences of nurses' personal and social identity in relation to practice issues such as job satisfaction and retention are well researched (Cowin 2002; McGrath 2006). Personal identity is not directly the focus of this research, however, its influence on rural nurses' reasons for being in practice, and way of practicing, indicates a definite interrelationship between personal identity and practice, job satisfaction, retention and collective identity (Hegney, McCarthy et al. 2002b; Mills, Francis et al. 2007). The influence of personal identity will need to be kept in mind while exploring nurses' agency in negotiating/ navigating PHC nurse identity.

And so it can be seen that there are many interrelated factors which inform/impact the process of identity work in negotiating/navigating PHC nurse identities. Looking at identity as work, within a CR framework, acknowledges the interplay between pre-existing structures such as nursing roles and the ability for nurses as social actors to intentionally bring about change. It allows for the study of structure, culture and agency in providing depth for understanding PHC nurse identity (Archer 2000). Even though these factors are interrelated it is important to not conflate these concepts but to analyse them separately. This way of defining identity as work allows for discussion of the relationship between agency (the ability for people to deploy a range of causal powers) and social structure (the rules and resources in society) without conflating them (Williams 2003).

Identity - agency and power

Archer (2000:284-285) provides a way of approaching the development of identity that supports an understanding of the factors influencing the way in which individual

agents take up social identities and collective identities. She describes identity as a developing process from birth, where the sociocultural and structural situations (life chances) influence the developing self. This in turn influences their interests and the subsequent choices and constraints for agents in terms of the social identity/ies they form and, as such, the collective identities individual agents are able to take up.

Archer (1995:187) describes how nurses, as agents, occupy a role in order to meet their interests. By taking on a role they procure the vested interests of the particular role. These vested interests can be both constraining and enabling in terms of meeting their own interests. By examining the interplay between a role and its occupants, which is identity work, it is possible to theorize the mechanisms influencing the routine personification of some roles whilst other roles are augmented and transformed by their incumbent. Nurses come into prior roles. And while these roles have certain constraints (legal, contractual etc.); nurses have some leeway in how they 'inhabit' their roles. As Archer (1995:303; 1996:187) explains, variations and discrepancies at the sociocultural level, where nurses as cultural agents negotiate/navigate their PHC identities and practice, do not necessarily reflect cultural system discrepancy in PHC nurse identity. However, the degree of orderliness or discrepancy between identities (as cultural elements) and the relations between agents as components of culture are crucial to accounting for/understanding future stability or change in PHC nurse identity.

An individual chooses to take up nursing; they then position themselves within this social identity as social agents to meet certain interests which are broader than merely role related (Archer 2000). Through interacting with other nurses in the same collectivity, they become more articulate about their interests and thus better able to reflect upon their role positions which will further the realisation of the identity (Archer 2000:284). For nurses this describes how, in taking up the social identity of nurse to meet their broad interests and becoming part of a social collective as social agents, they then influence this collective identity by either working with it to take on life's challenges or else use it to change their life chances.

The concept of collective identity involves shared representations of the group based on common interests and experiences but also refers to an active process of shaping

and forging an image of what the group stands for and how it wishes to be viewed by others (Brewer 2001). Thus, collective identities represent an achievement of collective efforts, above and beyond what the members have in common to begin with. The existence of collective identities can outlast the individual membership and can become directive of the future actors in the group. As such collective identities can have causal properties.

If the actions taken by nurses as part of the social collective are significant and strong enough then the collective identity can actually change. This collective effort or action in pursuit of common interests corresponds to collective agency (Snow 2001), which Archer terms 'Corporate Agency' (2000:260). The description of agency as given earlier in this discussion does little to exemplify its complexity and emphasise the integral position of temporality. Human agency is

'a temporally embedded process of social engagement, informed by the past (in its habitual aspect), but also oriented towards the future (as a capacity to imagine alternative possibilities) and towards the present (as a capacity to contextualise past habits and future projects within the contingencies of the moment)' (Emirbayer and Mische 1998:963).

Collective identity is both a site of connection and of differentiation. For nurses, collective agency can support the progression of their own broader interests as well as maintaining or changing the collective identity. Tensions regarding different interests for nurses in PHC have been discussed. Different corporate agents, as powerful interest groups, are able to bring about a change in collective identity through a process which Archer (1995; 2000) calls morphogenesis. Archer (1995:258) describes corporate agents as organised and articulate interest groups who 'pack a very special punch as far as systemic stability and change are concerned'. Morphogenesis is the reshaping of society; social, cultural and/or structural transformation (Archer 1995:258).

Whilst powerful groups are able to bring about a reshaping of social, cultural and structural aspects of society, less powerful corporate agents who are not as actively organised and articulate collectively can also have effect and bring about change (Archer 1995:260). From a realist perspective, less powerful groups, even without being active or mobilised, can influence collective identity in two ways; firstly their

mere existence means that more powerful groups are obliged to consider them and take them into account, and secondly they provide glimpses of possible identity positions and as such, how nurses behave in their roles informs peoples' concept of the collective identity (Snow and Anderson 1987; Vandenberghe 2007).

Identity - constraint and control

Nurses as agents reproduce and transform the structuring roles and identities they work in/with as well as being formed by them. At the same time, the social structures both shape and place constraints on nurses but are also the result of continuous activity by these individuals as well as being formed by them. This critical realist view of social reality will be further explained in Chapter 3 and is summarised in Bhaskar's (1998) words 'society must be regarded as an ensemble of structures, practices and conventions which individuals reproduce or transform, but which would not exist unless they did so' (:36).

The previous discussion on the different definitions of PHC, nursing's social and PHC mandate and the governance of nursing roles emphasises the potential influence of both cultural and structural properties in shaping and categorising the PHC identity of nurses as well as constraining it. This next section will look at the potential constraints on identity by these structures, practices and conventions through organisational roles, the power of dominant groups and traditional conventions/knowledge/discourse.

Evaluation of nursing roles in community settings, whilst providing valuable knowledge has tended towards being descriptive rather than exploring or theorizing their relationships with broader social and cultural processes (Aranda and Jones 2008). Health reform impacts nursing roles. Ambiguous, unclear and changing roles impact nursing identity. With the promotion of a primary care agenda in health system reform, ambiguity regarding the direction of nursing practice will impact nursing's identity in primary care. Issues such as the need for increasing generalist skills coupled with the support for increased specialisation as well as determining models of care for practice require negotiation.

Social and cultural processes informing nursing roles can be controlled and constrained by dominant groups. The power of dominant groups as corporate agents is relational to their access to the resources of wealth/assets, political sanction and expertise. The greater their access to these resources, the more power they have to define and affect cultural elements. Identity is one of these cultural elements and constraints over the way roles are classified and represented can inform identity and be mechanisms of control.

What this means for PHC nursing identity is that nurses take on PHC nurse identity to meet their interests, however powerful groups have potential to define the cultural elements of PHC nurse identity and as such constrain it. Corporate agents as dominant groups are able to deploy various forms of cultural and structural powers to ensure social developments such as PHC nurse identity are congruent with their defined objectives (Archer 1995:303). One of the ways this is achieved is by using containment strategies as mechanisms through which cultural power is exerted (Archer 1996:189-197).

Collective identity is central to this study as a way of exploring the power of group actions and the constraints of social structures in influencing PHC nurse identity. Collective identity is an emergent process in which the causal powers of both the controlling structures and agents can have impact/influence. The resulting generative mechanisms of the interplay between these two influences on PHC nurse identity in turn have their own causal powers.

Nursing in a 'global village' – expectations and assumptions of PHC nursing

Governments' health policies and nurses' PHC practice at the local level are interrelated; however, they also exist in a reciprocal relationship with the complexity of global historical, political and cultural contexts. In 1978, through the Alma Ata declaration and the WHO (1978), PHC was agreed as a means for the participating world governments to achieve the goal of 'Health for All'. Recognition that biomedical health care systems were inadequate in meeting health care needs,

particularly in underdeveloped countries, provided the impetus for this initiative with the ambition of attaining 'health for all' by the turn of the century (Djukanovic and Mach 1975).

Much of the literature strongly positions nursing as integral to the implementation of these initiatives in addressing the social determinants of health within a social model of health care provision (Besner 2004; International Council of Nurses 2007a; World Health Organisation 2009; Chiarella, Salvage et al. 2010). However, many scholars have highlighted the ambiguous tensions for nurses with the implementation of these initiatives, influenced by factors including the rise of globalisation and health policies dominated by Western biomedicine and market oriented politics (Gott 2000; Davidson, Meleis et al. 2003; Kelly and Symonds 2003; Baum 2008; Keleher 2009b).

Nursing in community settings has a unique history in Australia. Australian PHC nurse identity work has been strongly influenced historically by social, cultural, economic and political contexts (Grehan 2008; Kralik and Van Loon 2008; Taylor 2008). The potential for nurses to 'come together as one force', to have a common conviction about PHC, to have collective agency, as called for by many since Mahler (1985:10), is influenced by this history.

The Alma Ata declaration (World Health Organisation 1978) was signed by delegates at the same time as the world was beginning to experience the increasing impact of international economic expansion and interdependent political, social, cultural and environmental transformation, generally referred to as globalisation (Navarro 1999; Messias 2001). PHC policies and the delivery of PHC nursing services, both globally and nationally, have been influenced by economic rationalism/neoliberalism, marketization and the dominance of Western biomedicine as the framework for social decision making on health and illness (Mahnken 2001; Stanton 2001; Kelly and Symonds 2003; Abrams 2005; Kemp, Harris et al. 2005; Baum 2008). This has specifically influenced nursing in community settings and the delivery of PHC services in Australia (Kemp, Harris et al. 2005).

Economic rationalism/neo-liberalism was strongly evident in government policies of the UK, Australia and New Zealand through the 1980s and 1990s with subsequent moves by governments towards privatisation of health and social services, the use of corporate sector management models and/or the contracting out of public services to the private sector (Alford and O'Neill 1994; Gardner 1997; Stanton 2001; Kelly and Symonds 2003; White 2004). Market driven policies and outcome based funding were foregrounded with resources allocated according to client numbers and type of client (Alford and O'Neill 1994; Kelly and Symonds 2003). In Australia, the right wing Howard Coalition Government held power from 1995-2007 maintaining the ideological direction of marketization and privatisation of public services to meet people's needs and health policy focus on individual responsibility for health (Baum 2008).

Policy based on these ideologies emphasised the role of individuals as consumers of health services, with resultant commodification of the body and of care (Kelly and Symonds 2003:74; Lupton 2003:39; White 2004). As a consumer good, health could be gained by individuals through medical intervention and personal responsibility and endeavour which supported policy focus on measurable targets/outcomes for health gain and emphasised individual self-management/healthy behaviour (Kelly and Symonds 2003).

Market driven managerial discourses of cost effectiveness and efficiency in primary care and community care were argued to be changing the identity of health care providers, including nurses, and clients towards an increasingly biomedical model of care and hierarchy of expertise (Charles-Jones, Latimer et al. 2003; Kemp, Harris et al. 2005; McDonald, Checkland et al. 2008; McDonald, Campbell et al. 2009; Gray, Hogg et al. 2011).

Debate is intense concerning the benefits and disadvantages of globalisation (Meyer and Geschiere 1999; Navarro 1999; Chinn 2000; Davidson, Meleis et al. 2003; Baum 2008; Labonte, Sanders et al. 2008). While discussion of the advantages of a 'global village' include expanded methods for communication, increased forms of trade in technology, goods and services, these benefits are not equally distributed (Messias 2001). The effects of an economic ideology of market forces have resulted in

inequality both globally and locally. The means by which the direction of globalisation is influenced by the political economy underpinning world trade and commerce has been argued as being detrimental to health (Baum 2008). Disparities in the allocation of resources, with resultant disparities in health and access to primary health care services, have widened the gap between rich and poor, both within and between countries (Messias 2001; Labonte, Blouin et al. 2007).

In response to the growing health disparities the Ottawa Charter on health promotion (World Health Organisation 1986), which led to the development of 'the new public health' movement, provided a shift in thinking about public health and health promotion to incorporate the social determinants of health through a social model of care. The International Council of Nurses (ICN) (2008a), representing nurses globally, strongly confirmed its commitment to progressing the 'Health for All' goal (Krebs 1982) and the subsequent Ottawa Charter for health promotion (World Health Organisation 1986). However, despite extensive strategic work by international and national nursing organisations, with the support of WHO, mobilising the nursing profession towards meeting the HFA goals highlighted consistent themes of constraint. These included the lack of nursing representation in health policy making, low status of a female dominated workforce and the dominance of a medical model for nursing practice, with nursing positioned as assisting medicine (Salvage 1993). During the 1990s nursing continued to maintain its commitment globally. However, despite the WHO (1999) mandate for nursing as having a key role in PHC, the way in which nursing and nurses were positioned and represented in different countries was described as 'ad hoc' and reactive to containing health care costs and meeting the needs of varying ascribed populations of need. Nursing's impact on the existing culture and structure of health service frameworks was described as being 'patchy and piecemeal' (World Health Organisation 1999; Patterson 2000:16).

By the turn of the century the HFA goal proved difficult to realise with the WHO (2008) contending that health systems did not flow naturally towards the goals of 'health for all' through PHC approaches and were developing in ways that contributed little to equity and social justice. The initial Alma Ata vision for PHC had been reinterpreted in some developed countries to resemble primary medical care, first line contact provided by general practitioners (Tarimo and Webster 1994;

Labonte, Sanders et al. 2008). However, a changing world with economic imperatives to address the inability for health systems to maintain their tertiary hospital focus as priority, as well as the changes in population demographics with an ageing population and increasing chronic illness, compelled governments to renew their focus on PHC (Atun 2004).

In Australia, the significant increase in the numbers of Practice Nurses working in general practice, following government funding initiatives which commenced in 2001 (Jolly 2007), has seen a powerfully visible and tangible promotion of the benefits of their role to general practices (Keleher, Parker et al. 2009c). This has been especially noted in terms of accessibility for patients and financial benefits for the organisation, with general practices being able to markedly increase the number of clients seen annually (Joyce and Piterman 2011). Reimbursement, through Medicare Item numbers, enabled nurses to provide selected services ‘for and on behalf of’ the GP for individual clients with significant implications for PHC nurse identity and social expectations about PHC nurses (Price, Patterson et al. 2006; Keleher, Parker et al. 2007g).

General practice is promoted as the ‘coalface of primary health care’ with the proposal that ‘ideally every Australian practice will have at least one practice nurse’ (Australian General Practice Network 2009:8,22). The General Practice model of primary care delivery in Australia has been positioned to take a lead role in the PHC reform agenda, with an expanded scope of service delivery (Australian Institute of Health and Welfare 2008). The Australian Primary Health Care Research Institute (APHCRI) provided funding for a review of primary and community care nursing in 2006 which primarily reviewed the role of the Practice Nurse in the general practice setting (Keleher, Parker et al. 2007g). This meant that the evidence for assessing the primary health care workforce primarily focussed on the general practice setting as this was where most of the published evidence existed. Consequently, evidence on nursing’s role in PHC focused on the role of the nurse in general practice. As such, policy recommendations informed by the evidence reviewed by APHCRI regarding nursing as part of the PHC workforce align and conflate the terms General Practice Nurse and PHC nurse (Douglas, Rayner et al. 2009) evidencing the social construction of PHC nurse identity within the health reform agenda.

Within Australia, nurses working within the general practice setting have been urged to incorporate the principles of PHC and a social model of care within their practice (Australian Nursing Federation 2006; Annells 2007). However, questions are raised about the degree of autonomy nurses have within this setting to orientate their practice towards a social model of health (Kelly and Symonds 2003:188). While policy makers have argued that nurses are able to expand their practice to meet increasing health care needs (Australian Government Department of Health and Ageing 2009b), there is scant research in Australia which critically analyses nurses' agency in PHC settings in determining which practices are expanded and whether this meets their interests and/or the needs of the local community (Mills and Fitzgerald 2008).

Recent Australian studies into the role of nursing in primary care suggest that practicing and realising comprehensive PHC, as incorporating a social model of health, may have shifted to being seen as 'hidden' as administration tasks and an 'intangible added benefit' partially due to lack of relevance to current funding and reporting mechanisms (Phillips, Pearce et al. 2008:10; Joyce and Piterman 2011:77). How or whether nurses in Australia incorporate a social model of health in this setting is unknown. There has been very little critical analysis of Australian nurses in general practice settings since the commencement of the NiGP initiative (Jolly 2007; Mills and Hallinan 2009).

While nursing has a long history of providing care and population health measures in community settings in Australia (Francis 1998; Keleher 2007f; Grehan 2008), much of this role and diversity of practice has remained largely invisible within nursing history and policy (Koch 2000; Keleher 2003; Brookes, Daly et al. 2004). There have also been marked historical fluctuations in the extent to which nursing has been funded to embrace PHC measures (Koch 2000). The way in which nursing is positioned to incorporate a social model of health is informed by cultural and structural influences including the philosophies, approaches and practices of different health services and individual nurses (St John 2007b) and the multiplicity of policy driven funded roles in community nursing (Brookes, Davidson et al. 2007).

The recent resurgence of attention on PHC (World Health Organisation 2008), and Australian Government's policy focus on increasing the role of nursing in PHC (Jolly 2007; Australian Government Department of Health and Ageing 2009a), necessitated clarity for nurses in the theoretical frameworks underpinning PHC practice. Nursing practice is conducted within the social cultural and structural world and nursing theory is informed by this, and as such is changing over time.

Theoretical models for nurses working in community settings which incorporate a social model of health are relatively recent, reflecting the dominance of 'hospital nursing' within nursing's history (St John 1991; Kulig 2000; Munro, Gallant et al. 2000; Keleher 2000b; Brookes, Daly et al. 2004; Keller, Strohschein et al. 2004; Sheridan 2005; St John 2007b).

In the first decade of the 21st Century, comprehensive texts for nurses in community settings in Australia were published detailing the theoretical and practical integration of a social model of care and PHC principles into practice (McMurray 2007; St John and Keleher 2007a; Francis, Chapman et al. 2008a). Despite this, an Australian national audit of all undergraduate nursing curricula in 2010 found that Australian nursing competencies (Australian Nursing and Midwifery Council 2006) did not specify any particular competencies for primary health care and described undergraduate student preparation for practice in community settings as 'patchy and not keeping pace with reform agendas' (Keleher, Parker et al. 2010:211).

The proposed health care reforms involve change, restructure and reform to the practice and place of practice of many health care providers (Health Workforce Australia 2011a). Although the term 'community nurse' is used internationally to describe nurses working outside hospital and institutional settings (Kelly and Symonds 2003; St John 2007b), variations in the terminology of titles for nurses working in community settings in Australia leads to confusion regarding role delineation. This has implications for nurses' collective agency and identity as providers of PHC (Brookes, Daly et al. 2004; Kemp, Harris et al. 2005).

Whilst some authors argue nurses are professionally socially mandated to improve population health, thus connecting the principles of PHC with nursing's core values

(Nesbitt and Hanna 2008), the historical invisibility of nursing's role in this area creates ambivalence with this mandate.

A health profession's social mandate is underpinned by the society's expectations of the profession as a provider of health care as well as their expectations of the individual health professional (Lyon 1996; Allen 2007). Society's view of health is not static. It is influenced by changing ideologies including consumerism, individualism, communitarianism and public health surveillance as well as a health system dominated by a biomedical model of health care provision (Lupton 2003). This has, in turn, influenced society's expectations of health professionals' role in health care provision and PHC. The different definitions and uses of the term PHC contribute to the ambiguity of nursing's social mandate to practice and provide PHC. However, while nursing's social mandate is informed by society, the way in which nurses negotiate this reflects an interplay of multiple agendas (Novak 1988), that is, the interplay between structure, culture and agency.

Australia's health system reforms, aimed at shifting health care towards increased care within community settings, require coordination between primary care, public health and community care. Innovations in the drive towards models of integration are reflected internationally (Jackson, Nicholson et al. 2006; McDonald, Cumming et al. 2006; Tieman, Mitchell et al. 2006; Jackson, Nicholson et al. 2008; Anderson, Bonner et al. 2011; Valaitis, MacDonald et al. 2011; Australian Healthcare and Hospitals Association 2012). Critical analysis of the power differences between all the different players, including policy makers, health professionals and the communities they provide care, for is lacking. For nurses working in community settings in Australia, there is significant attention given to developing structured collaboration with hospital services. However, collaboration by nurses between social services and health services receives less focus, raising questions about nurses' abilities to expand practice beyond individual patient centred care (Jarvis 2005; Kemp, Harris et al. 2005).

Nurses have been traditionally weak participants in informing health reform policy (Gott 2000; Rafferty 2000). The drivers for change have come largely from funding for high-level policy initiatives, and this has left many nurses feeling a sense of loss

of control over their practice and of frustration about constantly responding reactively to situations rather than proactively developing the community nursing service (Jarvis 2005; Kemp, Harris et al. 2005)

The reform of health systems towards PHC models are being met with expectant enthusiasm by nurses internationally as an opportunity to acknowledge PHC nurses' historical presence as PHC providers and the incorporation of a social model of health in practice to address the social determinants of health (Gott 2000; Kelly and Symonds 2003; Primary Health Care Working Group 2009; World Health Organisation 2009). However, this is based on assumptions of nurses' collective agency to inform policy direction through clear theoretical frameworks to effect identity change.

Many factors impact nursing's mandate to practice PHC. Nursing in community settings in Australia is based on an historically complex foundation of changing mandates and licence. A lack of definitional clarity, different models of practice and the introduction of new roles and management structures all influence nursing's social mandate for PHC provision with resultant impact on PHC nursing identity. These mandates will be defined and redefined throughout the health reform process and will inform nurses' PHC identity. How nurses negotiate/navigate their practice through this will reveal any epistemological tensions. Conceptual dissonance leaves the construction of nurses' role in PHC open to influence and manipulation by other groups.

Research approach

Whilst nursing has a long history of working in community settings in Australia, there is much less research exploring the PHC practices across a diversity of community nurses. There is a dearth of data that adequately portrays the models of care used in practice across these roles and within rural settings. Explorations of the causal powers of identity on social expectations and also on structures are historically recent (Archer 2000; Stirling 2007). Within a critical realist (CR) perspective, PHC identity has causal powers. Identity work reveals the interplay between agents and the 'real' world. It is a process, the outcomes of which

themselves have causal powers, retroductively informing the reality of PHC nurse identity. Through a critical lens, power relationships evident in the way in which nurses navigate and negotiate their PHC practice and also how PHC identity is used to position nurses as PHC providers in health services, as evidenced by identity work, are explored in this study providing understanding of PHC nurse agency.

The aim of this study is: *to explore nurses' agency through identity work to inform an understanding of contemporary rural PHC nursing in Australia*. It will examine the interplay between nurses' agency and the sociocultural and structural forces influencing PHC nurse identity through PHC nurse identity work. The causal powers of different representations of nursing's position and role/s in the provision of PHC and the impact of these in generating PHC nursing identity will be explored. This will then assist in developing an explanatory framework for PHC nursing identity.

This requires an exploration of both individual community based rural nurses' views as well as cultural structural influences in order to explore/explain the underlying causal powers informing PHC nursing identity.

The research questions are:

- What are the key collective PHC identities that apply to Australian nurses in community settings?
- What key characteristics delineate these identities?
- What does identity work reveal about PHC nurses' agency?
- How do cultural/historical/structural contexts impact on PHC nurses' agency?

Acknowledging identity work within the context of identity as a process of 'becoming rather than being' supports Sveningsson's (2003:1164) assertion that identity lacks sufficient substance and discreteness to be easily measured by single interviews or questionnaires. Exploring the causal powers generating rural PHC nurse identity will necessitate developing an understanding of both PHC nurse agency as well as the controlling sociocultural/institutional historical influencing factors using analytical dualism to avoid conflating the two aspects (Archer 2000). With a CR perspective on the world, human agency and social/cultural structures

(such as PHC nurse identity) are seen as interdependent but essentially distinct. Thematic analysis of semi structured interviews with rural PHC nurses in two States of Australia as well as content analysis of the 265 publicly available submissions used to inform the new Draft PHC Strategy (Australian Government Department of Health and Ageing 2009a) assist in providing empirical data to progress this understanding. Analysis of the identity work revealed by the data provides the basis for an explanatory framework of the causal powers generating changes to PHC nurse identity and shed light on rural PHC nurse agency within the context of National health care reform.

Thesis structure

This chapter has presented expectations and assumptions about nurses as providers of PHC within policy, nursing and more broadly. Long standing tensions for nurses regarding ambivalent representations of nursing's mandate to provide PHC as incorporating a social model of care require further attention to support sustainable PHC reform. Within an identity framework, PHC nurse identity work provides a lens for examining different representations and negotiation of changes to PHC nurse identity by incorporating agency and structural/cultural constraints.

The following chapter presents the case of rural PHC nursing and the historical, social and cultural context of outer regional rural nursing in Australia as an exemplar of PHC nurse practice for a vulnerable population. The available theoretical and empirical literature serves to highlight the various 'connectivity positionings' nurses negotiate within this context. The discussion then progresses to review the relevant literature which positions nurses as providers of PHC, ensuring equitable access and participation for people through collaboration within the PHC team in community settings and rural communities. This provides an understanding of the key factors influencing PHC nurse identity situated within the context of PHC reform in Australia in addition to bringing attention to assumptions and gaps in the current understandings of PHC nurse identity in Australia.

Chapter Three provides further explanation of the critical realist ontology underpinning this study and discusses the methods used for data acquisition and

analysis. The research process is clearly outlined with detail provided regarding the way in which ethical considerations are addressed to ensure rigour and validity. Following this, the findings emerging from content analysis of PHC nurse identity work within documents submitted as texts to the National Health and Hospital Reform Commission (NHHRC) (Chapter Four) and thematic analysis of interviews with rural PHC nurses (Chapter Five) are presented.

Synthesis of the study findings are presented in Chapter Six. Characteristics of four key rural PHC nurse identities emerging from the findings are presented and assist in developing an explanatory framework for rural PHC nurse identity work within the context of National health reform. The concluding chapter, Chapter Seven, summarises the way in which the findings have answered the research questions and met the aim of the study. Implications for rural PHC nursing, particularly in small rural regional communities in Australia are discussed and recommendations are presented.

Conclusion

Assumptions and expectations of nurses as providers of PHC have led to a lack of clarity regarding nurses' professional autonomy to provide connectivity between services in community settings, particularly for vulnerable communities. Within Australia's current health reforms, focused on increasing health care within community settings, ambiguous representations of the extent to which nurses' PHC practice incorporates a social model of care are evident. These issues concern identity work and, given the evidence of tensions for nurses within community settings regarding these factors, necessitate further attention. Identity work provides a useful lens for looking at how nurses' positioning as PHC providers in community settings is negotiated. Incorporating agency and factors controlling identity work necessitates a broad historical, socio cultural and structural focus. Critical realism offers an approach to addressing these factors and allows for close examination within a defined context. The next chapter will draw upon the body of literature, both contextualised and broad, which reveals the way in which the concerns of this study have largely been uncritically addressed for vulnerable communities in Australia.

Chapter Two: Positioning and representing PHC nursing – the case of rural nurses

‘Nurses are the principal group of health personnel providing primary health care. They foster and maintain links between individuals, families, communities and the rest of the health care system, working both autonomously and collaboratively to prevent disease and disability, and to promote, improve, maintain and restore health. Their work encompasses population health, health promotion, disease prevention, wellness care, first point of contact care and disease management across the lifespan’ (International Council of Nurses 2008b:15).

The International Council of Nurses (ICN) claims that nurses are leading the way in PHC (2008b:5). As providers of PHC services, ICN represents nurses as having both a mandate and collective nursing agency to maintain the links between individuals, families and communities and the health system. This connectivity positioning of nurses underpins much of the nursing literature concerned with the provision of PHC both nationally and internationally (Bushy 2002; Kenney 2002; Porritt 2007; Fyers 2008; Phillips, Pearce et al. 2008; Chiarella, Salvage et al. 2010; Australian Nursing Federation 2011).

Despite these assertions by nursing, the previous chapter revealed different social expectations regarding nursing’s involvement in PHC reform and assumptions about nurses’ positioning as PHC providers. Examination of the literature shows that, globally, varied conceptualisations of PHC and PC have informed health reform and health care policy positioning nurses as PHC providers. Within Australia, there is limited and ambiguous empirical evidence to support the assumption of nurses’ broad connectivity positioning within the current health care reforms. These reforms centre the provision of PHC nursing services within a primary and community care framework with a significant focus on nursing in general practice for primary care services (Australian Government Department of Health and Ageing 2009b).

Research which critically explores how nurses negotiate/navigate these expectations is scant and there are assumptions and gaps in the research on this topic. This review of the literature highlights the need for a critical research perspective to explore

nurses' agency through identity work to inform an understanding of contemporary PHC nursing in Australia.

National and international literature using a combination of the search terms PHC, primary and community care, general practice, community (health) nursing, practice nursing, rural nursing, PHC nursing, PHC reform and policy were accessed for this review. The search engines Google Scholar, Medline, PubMed and CINAHL were used and only English language publications were included. Publications, where the major focus was the provision of specific physical or illness focused care, were excluded from this review. The macro level social, political and theoretical frameworks used to represent PHC nursing in the provision of health care both internationally and in Australia within the accessed literature are presented. Historical developments in PHC nursing in Australia are reviewed. Within the literature the term PHC nurse is ambiguous and in Australia there is scant literature on the topic of PHC nurse identity or nurses' agency in providing PHC. However, combinations of the terms community (health) nursing, practice nursing, rural, PHC and health reform enabled the identification of relevant material and a detailed discussion of seminal works is provided.

This chapter begins by presenting rural PHC nursing as a case for looking at nurses' PHC positioning within a specific context of vulnerable populations with changing health needs. Nursing has a distinct history of approaching these concerns in providing PHC in community settings (International Council of Nurses 2008a). Rural nurses comprise the predominant workforce in rural PHC services providing a suitably large study group (Australian Institute of Health and Welfare 2009). The literature discussing rurality, as it is measured, and its critical influence at the micro level of rural nurses' experiences within this context is reviewed. Providing a detailed discussion of the factors affecting the different interests of those involved in providing rural/regional PHC services is necessary in a critical realist case study (Easton 2010:123).

There is a significant history of rural community nurses providing first line PHC within their community (Hegney 1996a; Francis and Chapman 2008d; Mills, Birks et al. 2010) One of the major policy changes affecting PHC services and involving

nurses has been the Government's NiGP incentives which were originally introduced in rural settings, this provides a bounded temporal context to the study (Jolly 2007). Therefore rural/regional PHC services offer a focussed example of the changes and influences affecting the phenomena of interest, that is, PHC nurse identity work. For these reasons, a case study approach is most suited to offering insights into the nature of the phenomena (Easton 2010:118).

This then provides a platform for reviewing the broad theoretical, academic and empirical literature outlining the influence of policy and funding mechanisms and ideological positions informing nurses' identity as providers of PHC over time. The way in which PHC nurses are positioned within the literature as providers within the 'three pillars' of the movement towards PHC: equitable access, participation and intersectoral collaboration (Macdonald 2004:287) is presented. Evidence in the literature of tension for nursing and nurses in developing/maintaining a collective identity of PHC underpinning practice through these historical changes is provided. Academic literature detailing nursing theory and models for practice in PHC are reviewed to provide clarity regarding the ambivalent development of PHC nurse identity within these contextual forces and constraints. The available theoretical and empirical literature serves to highlight the various 'connectivity positionings' nurses negotiate within this context whilst also bringing attention to both assumptions and gaps in the current understandings of PHC nurse identity.

Historical, cultural and structural factors have shaped the context of nurses' practice in community settings and will influence the way in which nursing and nurses negotiate/navigate their engagement with the health reforms proposed by Australia's first draft PHC Strategy. As such, this review situates this study of rural PHC nurses in the context of nurses and nursing's varied positioning within PHC through a time of transition towards national health care reform.

PHC nursing in regional/rural Australia

Rural health services are very different to their urban counterparts. They are generally smaller and are more dependent on PHC services including general practice and community and aged care (Australian Government Department of

Health and Ageing 2012). Additionally, these services have less infrastructure and provide support to a more dispersed population.

One of the contextual factors impacting on rural PHC nursing practice is the model of health care service in which they work (Mahnken 2001; Birks, Mills et al. 2010). Concerns are raised regarding the directions health reforms have taken to date with the health service models to develop rural health services based on models for urban settings (Gaetani-Black, Stoker et al. 2002; Australian Government Department of Health and Ageing 2012) resulting in a focus for PHC nursing on providing medical support and care for chronic and elderly clients (Wakerman and Humphreys 2008). This is important for this study of rural PHC nursing identity as government policy and funding have a significant impact on behaviour and practice within health services (Pearce, Phillips et al. 2011).

Reforms to rural health care are an integral part of the Australian government's health reform agenda (Australian Government Department of Health and Ageing 2012). Since 2000 the focus of key rural health issues driving reform have been on unmet rural health needs requiring new models of service delivery, rural health workforce supply issues and escalating health costs (Wakerman and Humphreys 2008). Difficulties in recruiting and retaining health professionals to rural areas (Australian Government Department of Health and Ageing 2012), coupled with the pressure to provide equity of access to available resources, pose significant challenges in providing adequate health care for rural communities (Wilkinson and Blue 2002; Smith 2005; Gurran, Squires et al. 2006; Quine and Stacy 2006).

The closing of hospitals in small rural towns and the increased support for PHC services including general practice and multipurpose services as part of rural health care reform significantly influences the context of nursing practice. Wakerman et al.'s (2006) systematic review of PHC delivery models in rural and remote Australia concluded that increased remoteness and decreased population size provided the impetus for more comprehensive PHC service models, while less remote communities were more likely to have a variety of local discrete services focused on sustaining a general practitioner service. While the use of a PHC approach is described as being integral to effective rural nursing practice within rural nursing

theory (Lee and Winters 2006; Long and Weinert 2006; Francis and Chapman 2008d), the way in which Australian rural community nurses in less remote communities identify with a PHC and lifespan approach to practice within these different models for rural health care service delivery has not been well researched. There is a need for studies exploring the impacts of these changes on PHC nurse identity work in rural areas.

With the closure of hospitals in small rural communities, the role and functions of rural nurses have significantly changed (Francis, Bowman et al. 2002). Rural nursing has historically been defined in relation to hospital nursing and community nursing in rural settings (Siegloff 1997), however, health reforms have shifted the focus on rural nursing in small communities to working in community based services providing care for individuals and their families. A national review of nursing education (Heath 2002) suggested that these changes had resulted in nurses providing primary health care, population health and collaborative practice with other health professionals in partnership with communities. However, Birks et al.'s (2010) multiple case study found that the extent to which a PHC approach was implemented varied and was dependant on the model of community based health service delivery nurses were funded and supported to provide. This influenced the degree to which partnership with community was incorporated as part of PHC nurse practice.

The historical, cultural and structural factors informing rural nursing influence the context within which health reforms are introduced to rural health services. The recently published National Strategic Framework for Rural and Remote Health (Australian Government Department of Health and Ageing 2012) provides Australia with its first national approach to policy, planning, design and delivery of health services in rural and remote communities. This framework operates within the overarching context of national health reforms, supporting and supported by the National PHC Strategy (Australian Government Department of Health and Ageing 2009b; Australian Government Department of Health and Ageing 2012). Prior to the development of this framework, rural health service planning and delivery in Australia have been traditionally developed in the context of urban/metropolitan settings limiting the evaluation of health system effectiveness in service models and

models of care to an urban lens (Australian Government Department of Health and Ageing 2012:21).

Population needs within changing rural communities

Rural populations are not homogenous and this influences the practice context for rural PHC nursing. While reports indicate the health status of rural residents being much poorer than urban counterparts, including higher mortality, lower life expectancy, higher rates of chronic diseases, mental health problems, smoking and alcohol abuse and poorer dental health, these factors become more noticeable with increasing remoteness (Australian Institute of Health and Welfare 2010b).

Images of rural Australia are influenced by a history of farming/ agriculture, the 'bush' and neglect of Aboriginal populations (Larson 2002), however, changing rural demographics in Australia are having marked impact on social and economic conditions experienced by rural communities (Burnley and Murphy 2004). Within the literature, differences between aspects of urban and rural populations are used as a means for attempting to gain more understanding of the meaning and impact of rurality within a rural-urban dichotomy (Bourke and Sheridan 2008). While 'common traits' of being rough, resilient, self-reliant and holding traditional and conventional beliefs (Francis and Chapman 2008d) and gender differences which portray rural men as stoic, traditional, heavy drinkers and hard workers and women as strong, resilient and family centred are evident in the literature (Francis and Chapman 2008d), the differences between country and city are often blurred and referring to this dichotomy rather than a continuum has been argued to negate the evolving complexity of both urban and rural living (Bushy 2002; Howie 2008).

The changing population demographics of rural communities in Australia are influencing these generalisations of key characteristics of rural populations which in turn inform responsive PHC nursing practice. Rural health issues are distinct, and while rurality does provide a locational disadvantage in terms of access to health services/care, other social determinants of health such as socioeconomic disadvantage are also intricately entwined with aspects of rural living (Humphreys 1998; Australian Institute of Health and Welfare 2003).

The number of people living in the ‘bush’ is decreasing, however, the more accessible outer regional population areas of the eastern and lower western seaboard are growing (Australian Institute of Health and Welfare 2002; Larson 2002; Wilkinson and Blue 2002; Burnley and Murphy 2004; Smith 2005; Gurran, Squires et al. 2006; Australian Government Department of Health and Ageing 2012). Several factors are contributing to this shift, including the ‘Seachange/Tree Change’ phenomenon (Hugo 2002; Burnley and Murphy 2004). This phenomenon has captured many people’s imaginations, and the influx to these communities is predicted to continue into the foreseeable future (Gurran, Squires et al. 2006). The current climatic drought as well as the imminent retirement of the ‘baby boomer’ generation has been implicated. Burnley & Murphy (2004) provide insight into the myth of escaping the city and creating a new and simple life contrasted with the far more diverse realities of this demographic change. Many of these communities are also experiencing an increase in lower income groups often reliant on welfare benefits and unable to afford to remain living in the cities given the rising housing, rental and living costs (Hugo 2002; Gurran, Squires et al. 2006).

A recent report by the National Sea Change Taskforce (Gurran, Squires et al. 2006) suggests that more detailed research within these specific communities is now needed, including the impact of these demographic changes on smaller ‘hamlets’ whose populations are increasing with people who cannot afford to stay in ‘key coastal settlements’. They conclude that strengthening and supporting community wellbeing and social cohesion during the process of rapid change is a critical factor, echoing the suggestions made by an English study into ageing in coastal communities (Atterton 2006; Gurran, Squires et al. 2006). With ageing and socioeconomic status being high indicators of health status, changing needs in these outer regional communities herald the urgency for innovative and responsive health service provision and are an important context for this study of rural/regional PHC nursing.

Defining rurality – the hidden context of nursing practice

Defining rurality poses problems for understanding rural PHC nurse identity. This is important for this study because health service planning and the allocation of affordable resources for rural PHC services, and as such nursing services, are influenced by measurements of rurality (Wakerman 2004; Smith 2005). Rural PHC nursing is informed by the context of living in a small community and nurses understanding of rurality. While there are nursing models for rural PHC practice (Lee and Winters 2006; Howie 2008), the way in which they inform service delivery by Australian rural nurses is unclear and this has implications for rural PHC nurse identity.

Measuring rurality

Classifying communities' 'rurality' status informs to some extent the context of rural nursing work, however, the complexity of 'rurality' and a lack of conceptual clarity present challenges for developing a single classification strategy (Hugo 2002; Smith 2005; Howie 2008). Measures of rurality and remoteness have been developed by the Australian Institute of Health and Welfare for Government (2004). The three major classifications which describe areas in terms of relative remoteness enable comparison between a range of health and welfare indicators across geographical classifications for metropolitan and non-metropolitan Australia. The main classifications used are the RRMA (Rural, Remote and Metropolitan Areas) classification, the ARIA (Accessibility/Remoteness Index of Australia) classification and the ASGC (Australian Standard Geographical Classification) Remoteness Areas classification (Australian Institute of Health and Welfare 2004). The ASGC classification, using the ARIA+ methodology, is used in the production of the AIHW 'Nursing and Midwifery Labour Force' statistics (Australian Institute of Health and Welfare 2010a). This methodology measures and scores accessibility/remoteness based on the physical road distance to the nearest service centre, with the service centre defined by the population size. There are five categories of service centres.

- A. equal to or more than 250,000 people
- B. 48,000 to 249,999 people
- C. 18,000 to 47,999 people
- D. 5,000 to 17,999 people

E. 1,000 to 4,999 people

While this study is situated in categories D and E, these classifications do little to inform the context of nursing work. Smith (2005) argues that classification systems which primarily focus on geographical distance, population size and access to services are inadequate; they provide little understanding of sociocultural factors for particular communities such as socioeconomic status, cultural factors and morbidity/mortality rates which are integral to the equitable allocation of resources to rural PHC services and also inform rural PHC nursing practice. And indeed the Australian Institute of Health and Welfare (2004), in their guide to remoteness classifications, call for caution in the use of these classifications in determining levels of rural health funding and addressing policy issues, recognising the multifactorial influences impacting on rural health. Whilst rural classification systems provide a necessary basis for defining rurality they are insufficient and require augmentation with additional ‘filters or lenses’ to provide fuller understanding (National Rural Health Alliance 2012). Defining rurality as a critical aspect of the context of rural nursing work is further influenced by the ever evolving nature of rural communities.

Defining rural nursing

Without national consensus for how rurality is defined, a consistent understanding of rural nursing is problematic. Hegney’s (1996b) seminal review of the literature on the status of rural nursing highlighted the limitations evident in the literature which defined rural nursing by the size of the geographic population and the presence or absence of a medical practitioner. More recently, extensive literature reviews by Francis et al. (2002) and Mills, Birks & Hegney (2010) have evidenced a broadened rural nursing definition to include all nurses working outside major metropolitan areas and with populations with compromised access to health services.

Mills et al. (2010:31), in their integrative review of the literature on the status of rural nursing in Australia, suggest that the ACGS’s measure of rurality “provide a framework for clarifying the context of nursing in rural or remote areas” and is the most appropriate system by which a rural nurse can be designated. The Australian Institute of Health and Welfare (2010a), in developing the statistics for the Nursing

and Midwifery labour force, define rural nursing using the ACGS scale as any nurse working in outer regional, rural and remote areas. While these measures provide a geographical framework, the adequacy of this classification for understanding the context of rural nursing work is questioned within the literature (Smith 2005; Howie 2008; Kulig, Andrews et al. 2008).

The potential for rural indexes to ‘average out’ health differences between communities is argued by Kulig et al. (2008:29) as leading to inappropriate standardisation. Their Canadian study highlights limitations for the relevance of the rurality indexes in describing the context for rural nursing work. They contend that:

- i. most indexes have a medical care and medical infrastructure focus,
- ii. their applicability for understanding health status or health human resources needs lack formal testing,
- iii. most rurality indexes do not include social characteristics which include community descriptions or the attributes of the populations in that community, and
- iv. the rurality index score suggests that a community’s degree of rurality exists at a point on a continuum which implies that rurality is a static entity rather than a dynamic evolving construct.

These difficulties are important within a rural local context in understanding how PHC nursing is envisioned and in turn influences rural PHC nurse identity work.

Nurses’ understanding of rurality

Rural nurses’ practices are shaped by their understanding of rurality and the rural community context in which they work. Although rural nursing in Australia has a long and rich history, recognition of the unique contribution of the work of rural nurses within the literature is a fairly recent phenomenon (Siegloff 1997; Hegney 1997a; Francis, Bowman et al. 2002; Mills, Birks et al. 2010). There is a distinctly Australian history of bush nursing in rural areas which has traditionally supported an expanded and integrative model of care influenced by the small isolated nature of geographic populations served and the ‘shortage’ of doctors (Mills 1998; Bardenhagen 2004). Mills (1998:76) describes these nurses as ‘the stuff of legends’

acknowledging the impact of these pioneers on the identity of rural community nurses today.

The differences between rural nursing and urban nursing are often the most valued aspect of practice for rural nurses (Hegney 1997b). Studies exploring the context of rural nurses work internationally have highlighted similarities in practice which include understanding the features of their community is integral and central to nurses definitions of rurality informing their practice (Kulig, Andrews et al. 2008). As part of large multi-method Canadian research project, Kulig conducted a national survey which focused on the meaning of rurality for rural nurses. The 3933 nurses in this extensive survey responded to the question of defining rurality with a multidimensional view which strongly emphasised the importance of community characteristics and the availability of human and technical resources.

Howie (2008) proposes 'The Rural Framework Wheel' for nurses as a method to categorize rural contextual definitions. Whilst incorporating the geographical and conceptual rural classifications, this model clarifies rurality further by incorporating the sociocultural, occupational, ecological and health aspects of the rural context. This model provides a framework for analysing the factors shaping the continually evolving construct that is rurality and fits well with the incorporation of a social model of health informing practice.

The common themes of nursing in small rural communities

Recognition of the common themes of nursing in small rural communities and their impact on nurses' practice and positioning as PHC providers is difficult to quantify and is therefore consistently overlooked in policy as an integral aspect of rural PHC nursing practice (Vukic and Keddy 2002; Crooks 2004). Despite the contextual diversity of nursing in small rural communities in Australia and the varied organisational, political, cultural and social positionings informing nurses' positioning in these setting, there are aspects of rural nursing in small communities which are common themes in the literature across these different contexts of practice (Howie 2008). Their potential to influence PHC nurse identity work is an important factor for this study.

There have been numerous research studies, both nationally and internationally, which have explored and identified aspects of living and working in rural communities for nurses, with the following attributes highlighted as characterising rural nursing practice: knowing the community, caring for relatives and friends, living with a lack of anonymity, isolation from support services, and requiring a broad range of skills and knowledge. (Rosenthal 1996; Hegney 1996a; Keyzer 1997; Siegloff 1997; Mills 1998; Ross 1999; Blue and Fitzgerald 2002; Burley, Duffy et al. 2002; Beatson 2005; Greene and Burley 2006; Scharff 2006; Thompson 2006; Troyer and Lee 2006; Hegney 2007; Mills, Francis et al. 2007; Fitzgerald 2008; Howie 2008; Nursing in Primary Health Care Organising Committee 2008; Bigbee, Gehrke et al. 2009).

The implications of living and working in the same community and being visible and known as a nurse within the community are discussed internationally as distinct aspects of rural nursing (Lauder, Reel et al. 2006; Mills, Francis et al. 2007; Wood 2010). While the lack of anonymity experienced by rural nurses in small communities necessitates recognition of the 'high degree of sensitivity to potential professional compromises that may occur in the course of daily living, where interactions often become everybody's knowledge' (Mills, Francis et al. 2007:586), the dual role of health professional and community member is an important aspect of rural nursing identity (Kulig, Andrews et al. 2008). McConnell-Henry's (2010:15) research, exploring rural nurses caring for people they know, found that for rural nurses this aspect was described as 'the bread and butter side of rural nursing practice'. Many rural nurses live in the community they are employed in, they are known and know the community which assists in providing care which is culturally appropriate (Hegney and McCarthy 2002a) and also means they will re-encounter the person they care for (Allan, Ball et al. 2008).

The longer lengths of employment for rural nurses can result in the provision of care for more than one generation of the same family (Martin in (Hegney and McCarthy 2002a:242) and allows nurses as PHC providers to incorporate their knowledge of factors influencing health across the broader community, social and individual levels. This includes factors such as socioeconomic status and cultural factors, informal

networks and supports including the way in which individual community member's health behaviours are uniquely realised in the rural context.

Being known by the community is linked to knowing the community, the formal and informal networks, and maintaining a responsive relationship with the community (Hegney 1996a:243; Bushy 2002; Tarlier, Johnson et al. 2003; Mills, Francis et al. 2007). Lauder et al. (2006:73) state that rural community nurses have an interrelational role and status in their communities and are often "immersed or embedded in the social networks that make up the fabric of rural life". This understanding of the community provides nurses with a baseline from which to begin engagement in supporting healthy community behaviours (Francis, Chapman et al. 2008a). The PHC role of these nurses is acknowledged as building community capacity (McMurray 2007) and community resilience (Kulig 2000) and there is a strong historical identity of nursing in rural areas for both the nurses and their community (Mills 1998; Francis, Bowman et al. 2002; Lauder, Reel et al. 2006; Thompson 2006). These common characteristics assist in the development and maintenance of the community connectedness which small outer regional communities have expressed a need for (Atterton 2006; Gurran, Squires et al. 2006).

While much of the literature focuses on working with a lifespan approach, the different specialties of community nursing do this differently with some focussing on generalist practice within an organisation such as general practice and others focussing on a specific population group. Often rural nurses will have a generalist advanced scope of practice within the specialty of rural nursing and provide care within a number nursing roles including community nursing, palliative and emergency nursing and it appears that "floating among units" within the one service supports an increase in rural nurses job satisfaction (Hegney 1997a; Hegney and McCarthy 2000; Mahnken 2003; Brookes, Daly et al. 2004; Crooks 2004; Wakerman, Humphreys et al. 2006).

The context of rurality presents limitations to the availability of human and technical resources which significantly influences rural nurses' practice as PHC providers. For many rural nurses, as the most prevalent health care providers for these communities, their role is described as being extended, expanded or multiskilled practice,

dependant on the type and number of other health professionals, the context of practice (Hegney 1997a; Hegney, McCarthy et al. 1999; Kulig, Andrews et al. 2008). Pearson et al. (2000:149) contend that role extension, and the blurring of boundaries within a culture of ‘filling the gap’, has existed for rural nurses since they first practiced in underserved areas, with nurses incorporating a broad approach to PHC including health promotion to serve the community. However, the legitimisation of this specialist generalist role is acknowledged as being contentious. Much of the literature discusses the extended role of rural nurses in relation to addressing medical workforce shortages and ensuring access to medical services (which will be further presented in the subsequent section). Nurses’ agency to practice within an ‘extended’ PHC role in rural communities is influenced by the identity work of groups with different interests in PHC nursing.

There is limited research exploring factors influencing the negotiation of changes to rural PHC nurses’ practice during health reform transition (Banner, MacLeod et al. 2010). Just how the common characteristics of nurses’ lives as rural community members inform their rural PHC nurse identity work and how they negotiate changes to their structured roles within health reforms requires further research. Rurality and rural nurses’ lived understanding provide a context with which to explore the way in which nurses are positioned and represented as PHC providers within the broader academic, empirical and theoretical literature during this period of significant health reform. The next three sections will present this literature within a framework of nurses’ positioning to enable equitable access, partnership with clients and collaborative practice as part of ‘the PHC team’.

Equitable access – nurses as a workforce solution to shortages and increased needs

Representing nurses as a solution to perceived ‘gaps’ in medical services and a way of fiscally meeting changing health needs is not new (Pearson, Hegney et al. 2000) however the way in which identity work positions nurses as having agency to expand health services beyond medical model care towards PHC varies within the literature. The influence of government funding and the dominance of a focus on medicine in health care highlight the way in which identity work has informed PHC nurse

identity over this time. This section presents a review of the broad literature discussing the historical changes in PHC nurse identity work positioning nurses as a solution to workforce shortages and increasing health needs of an ageing western society.

Workforce shortages, economic rationalism and medical dominance

The way that the Australian primary and community care sector has worked historically has been fragmented, uncoordinated and complex (Duckett 2008). The Federal government has had responsibility for funding the services of general practice/GP, medical specialists and aged care, with the States and territories having responsibility for hospitals, community care and public health programs (immunisation, prevention, drug and alcohol etc.). Overlap has been evident in areas such as home and community care services, with both levels of governments funding different programs. The primary care services have tended to operate as disparate sets of services rather than an integrated system delivering services that meet the needs of most people requiring treatment for isolated episodes of ill-health. The State funded services have had no national strategy for community health and there has been considerable variation in the services provided (Steering Committee for the Review of Government Service Provision 2009).

A systematic review of the delivery models for primary health care in rural Australia revealed that much of the national funding for rural and remote health care has been directed towards workforce issues with a particular focus on medical workforce shortages (Wakerman, Humphreys et al. 2006). The cultural, political and social power of medicine within rural health care and its influence on the scope of practice of other health professionals has been well documented within the literature (Hegney 1997a; Hanna 2001; Blue and Fitzgerald 2002; Kenny 2004; Fitzpatrick 2006; Duckett 2008; Harvey 2011).

Wakerman and Humphreys (2008:25) argue that there is a real danger of rural health care being subsumed within PHC programs with their focus on the management and prevention of chronic conditions and the economic management of the broader health care system. Nurses are the most predominant group of health professionals in rural

Australia and, in contrast to medical practitioners, they are relatively evenly distributed across metropolitan, inner and outer regional and remote areas (Blue 2002; Australian Institute of Health and Welfare 2010a). Acknowledgement of the differences between regional and urban community nursing models for the provision of nursing care are less evident (Rural Health Unit & Senior Nursing Advisor of Community & Rural Health Division 1998; Blackmore and Farrell 2001; Gaetani-Black, Stoker et al. 2002; Madsen and Bradshaw 2008).

The impact of policy changes to community nursing

Marketization and economic rationalism/neoliberalism as the framework for social decision making on health and illness have influenced PHC policies and the delivery of nursing services both globally and nationally (Mahnken 2001; Stanton 2001; Kelly and Symonds 2003; Abrams 2005; Kemp, Harris et al. 2005; Baum 2008).

Throughout the 1980s until mid-2000 in Australia, government funding mechanisms and policy changes reflected this ideology, driving changes to the delivery of community nursing services (Kermode, Emmanuel et al. 1994; Smith 2000; Baum 2008).

Federal government responsibility for aged care services and primary care/general practice and the imperative to manage the costs of a rapidly increasing number of residential aged care clients saw the introduction of funding for Home and Community Care (HACC) services in the late 1980s (Keleher 2003). Through shared funding arrangements with State governments, these programs redirected community nursing to increased care for frail aged and disabled people, reducing admission to residential care and the use of hospital emergency departments (Duckett 2008). In addition, these changes resulted in an increase in the acuity of clients receiving nursing care in the community, with shorter more intensive services and a focus on medical care and treatment rather than the historically broader PHC roles which community nurses had provided (Kemp, Harris et al. 2005).

Rural community nurses recognition of constraints to their PHC practice and the tension of competing agendas resulting from these changes is abundantly evident in the literature throughout this period both nationally and internationally (Dowling,

Rotem et al. 1983; Bell, Daly et al. 1997; Gott 2000; Smith 2000; Cashman, Bushnell et al. 2001; Kelly and Symonds 2003; Kemp, Harris et al. 2005).

There is evidence of a 'hidden' resistance at a local level by community nurses in an effort to overcome dominant discourses and control by medicine, employers and State/Federal funding policies to enable them to continue to practice with a PHC approach (Hegney 1996a; Davis 1998). Davis's (1998) research exploring the role of rural community nurses in less remote communities suggests that the narrowing of nurses' practice by funding models such as HACC was covertly expanded on by nurses attempting to provide comprehensive PHC. Davis describes this as an expression of nurses' agency/resistance and working with 'fractured identities' (1998:276).

The key themes emerging from a critical literature review concerning community health nurses conducted by Brookes et al. (2004) highlighted the impact of these changes for nurses' identification as PHC providers, and the diminished power of nurses in policy decision making. More recently, the impact of funding constraints to community nursing practice and the resultant diminishing of a PHC approach is evidenced with nurses' practice focussing on medical and technical intervention in the community care setting (Robinson, Courtney-Pratt et al. 2008). With structured and supported encouragement to implement self-management techniques for COPD clients, Robinson et al.'s (2008) study highlighted nurses' attachment to incorporating 'holistic' care as part of PHC approach. The conflation of 'holistic' care with a PHC approach will be discussed further in a subsequent section of this review.

Nursing in general practice

Changes to the general practice setting have markedly influenced the position of nursing in this sector. In the late 1990s the Australian Division of General Practice received significant federal government funding to assist in its development and role of coordinating Divisions of General Practice and their general practice membership of predominantly GP owned 'fee-for-service' businesses (Keleher 2003). Incentive payments were introduced to general practices to encourage the amalgamation of

smaller practices and the increased employment of practice managers (O'Conner and Peterson 2002). Resultant increased economies of scale facilitated the employment of Practice Nurses (O'Conner and Peterson 2002; Keleher 2003) and in 2001 the Nurse in General Practice Initiative (NiGP) commenced, initially in rural areas, to encourage employment of Practice Nurses (Jolly 2007).

Prior to the NiGP initiatives of 2001, rural general practice was generally characterised by having a single or small number of GPs within a practice. Few practices employed a nurse. Nurses who were employed in general practice predominantly provided services to support the GP rather than clients (Patterson 2000). Historically, general practice has been medically dominated, functioning almost exclusively a private professional industry with self-employed medical practitioners (Keleher, Parker et al. 2007g; Phillips, Pearce et al. 2008).

The dominant focus on rural medicine within rural health care reform and the medico-centric concentration of policy and funding on addressing doctor shortages and ensuring access to medical care has neglected the contribution made by nurses in rural health care (Hanna 2001). The maldistribution of doctors in rural areas is well recognised (Health Workforce Australia 2012; National Rural Health Alliance 2012). Policy reform at the beginning of the 2000s focused on the positioning of nurses as a means for substituting for shortfalls in medical care as well as providing a supplement to existing medical services in rural areas either as specialist nurse practitioners or through medical delegation to Practice Nurses (Duckett 2005; McDonald, Cumming et al. 2006; Murray and Wronski 2006; Porritt 2007; Phillips, Pearce et al. 2008; Australian Government Department of Health and Ageing 2009b; Australian Government Department of Health and Ageing 2012).

The Federal Government conceived nurses in general practice as being an economic solution to the workforce shortages of doctors and addressing the increased care requirements of an ageing population and people with chronic conditions (Porritt 2007). Government funding mechanisms to support the expansion of nurses' roles in general practice were represented as an economic benefit to doctors in assisting with clinical workloads and to the doctor's practice in assuring safety and quality aspects of general practice (Australian General Practice Network 2007). Evaluation of the

initial government funded 'Nursing in General Practice Initiative' which commenced in 2001 (Healthcare Management Advisers 2005) confirms these interests. The evaluation concluded that in addition to successfully increasing the number of Practice Nurses employed in general practices, the employment of nurses had reduced patient waiting time, increased the throughput of patients in the practice, reduced work pressures for GPs and increased the GP's opportunities to liaise more effectively with other health professionals about the care of their patients. Whilst this study did not expand an understanding of nurses' roles in general practice beyond supporting the GP and the practice business, the authors concluded that Practice Nurses were seen to have provided a significant contribution to the quality, accessibility and affordability of PHC in Australia and the recommendations were to promote further incentives to encourage Practice Nurse employment (Jolly 2007).

In 2004 The Royal College of Nursing Australia in conjunction with the Royal College of General Practitioners produced a detailed examination of general practice nursing in Australia (Watts, Foley et al. 2004). Employing an action research methodology, incorporating triangulation of both quantitative and qualitative data collection activities, they found that general practice had the potential to contribute to PHC and that nurses in general practice also had an opportunity to enhance the delivery of PHC through general practice. However, access to education for Practice Nurses was found to be primarily ad hoc and informal. Watts et al.'s (2004) findings describe the model of practice characterising the nurses' role in the general practice setting as defined by flexibility and adaptability with multiple factors informing nurses' roles. These factors include:

- The professional characteristics of the nurse
- The business orientation of the practice
- The practice's patient population
- Local practice and community resources
- Federal funding and policy initiatives (Watts, Foley et al. 2004:4)

The study did not expand on how nurses' flexibility and adaptability in the provision of PHC is 'shaped, moulded and impacted upon' by the range of influencing factors

(Watts, Foley et al. 2004:4). The views expressed by the nurses participating in this study concurred with Patterson's (2000) observations in that they envisaged their future role and role dimensions as similar to their current role, however they did foresee less time spent on practice administration. The GPs participating expressed similar views.

While incorporating the expansion of nurses' roles to encompass tasks previously perceived as confined to medical practitioners was widely proposed as a means by which workforce shortages in rural areas could be addressed (Duckett 2005; Productivity Commission 2005), there is considerable debate in the literature regarding the efficacy and impact and the overall goals for health service delivery of nurses performing 'medical' tasks within their provision of PHC services (Yong 2006; Pearce, Phillips et al. 2011). The National Rural Health Alliance (2005:5), in outlining the scope of practice for rural nurses, discusses the need for expanding the role of rural nurses working collaboratively within a GP led primary care team. However, the Australian Medical Association's position is clear that in order to ensure that the provision of primary care in rural areas is safe and of high quality, the doctor is central to health care provision and substitution of tasks by non-medical personnel must be carried out within a delegated model (Yong 2006).

The nursing profession promoted the potential of nurses in general practice as being in the best position to provide an effective PHC model (Council of Deans of Nursing and Midwifery (Australia and New Zealand) 2004) with a subsequent increase in descriptive research outlining the roles of Practice Nurses (Patterson 2000; Patterson and McMurray 2003; Halcomb 2005a; Keleher, Parker et al. 2007g; Mills and Fitzgerald 2008; Phillips, Pearce et al. 2008; Senior 2008; Pearce, Phillips et al. 2009).

Government policy and funding influenced the unprecedented increase in Practice Nurse numbers and represented nurses as powerful in supporting the expansion of primary health care services through general practice to include prevention and health promotion (Porritt 2007). However, there is conflicting evidence within the literature of these expectations given the assumption of nurses' agency to expand

practice and lack of clarity regarding the models of care used by nurses to provide PHC (Annells 2007; Mills and Fitzgerald 2008; Mills and Hallinan 2009).

Australian Government policy has been a significant driver for the employment of more nurses in general practice and for the development of the clinical role for the nurse, particularly in the management of chronic disease and the establishment of nurse-led clinics. Following the presentation to the Federal Government in 2004 of the RCNA and RACGP study into general practice nursing in Australia (Watts, Foley et al. 2004), a number of funding initiatives were implemented to commence the expansion of nurses' roles in general practice. Funding was provided for practices to support their employment of nurses, expanding the funding already in place for rural practices implemented in 2001. Under the Enhanced Primary Care Program, new MBS item numbers for the provision of wound care management and immunisation by nurses were also instigated with further item numbers for Pap smear screening and a preventative health check the following year (Keleher, Parker et al. 2007g). In addition, a Practice Nurse Scholarship Scheme, to support the education of practice nurses in providing the tasks covered by the MBS item numbers, was provided and administered by APNA in partnership with the Australian Divisions of General Practice (Australian Government Department of Health and Ageing 2005).

Nursing in general practice is currently funded through a blended payment system. However, the funding stream most recognised and preferred by GPs within their business model is fee-for-service (Phillips, Pearce et al. 2008). The introduction of MBS item numbers allowed nurses to perform funded clinical tasks 'for and on behalf of' the GP, with a steady increase in the use of these item numbers after their introduction (Keleher, Parker et al. 2007g). Keleher et al. (2007g) note that the GP retains responsibility for all item numbers used by Practice Nurses. While GPs must see a patient prior to wound management by the nurse, it is left to their discretion to see patients for other item number usage. However, GPs can claim separately for their professional services for all item numbers used by Practice Nurses.

The introduction of Practice Nurse item numbers was promoted as a means for easing some of the GP's workload, however, it could be argued as setting the precedence for nurses' roles to be perceived as task delegation within the general

practice setting and maintaining medical control over nursing practice. Studies informing policy development for expanding practice nursing roles have also focused on overseas models, particularly England (Keleher, Parker et al. 2007g; Parker and Keleher 2008). While international developments in practice nursing reflect similar barriers to expansion of PHC provision, including constraint by factors such as funding arrangements and the GP's control of the practice setting (Atkin and Lunt 1996; Docherty 1996; Williams and Sibbald 1999), the historical cultural and structural factors influencing and informing nurses' PHC practice in Australia are unique.

The relationship between doctors and nurses, working in the general practice setting, significantly impacts on nurses' role development and expansion (Halcomb 2005a; Phillips, Pearce et al. 2008; Mills and Hallinan 2009). The historical hierarchical relationship regarding the balance of power between doctors and nurses has been extensively noted in the literature (Witz 1992; Yerrell and Reed 1997; Willis, Condon et al. 2000; Keleher 2000b; Leonard 2003; Wearing 2004; Apker, Propp et al. 2005; Salhani and Coulter 2009; Chesluk and Holmboe 2010). Traditionally, the image of nurses employed in general practice has been as a 'handmaiden' to the doctor (Pascoe, Hutchinson et al. 2006; Jolly 2007). Funding incentives for general practice in employing nurses and funding nurses' practice have reinforced medicine's assertion that primary care be GP-led (Australian Medical Association 2007). During the course of this study, funding mechanisms have represented nurses' practice as being provided 'for and on behalf of' the doctor.

The economic power of the general practitioner and issues of clinical governance within the general practice team impact nursing practice and the expansion of nursing roles in this setting (Atkin and Lunt 1996; Halcomb, Davidson et al. 2005b; Annells 2007; Halcomb, Meadley et al. 2009; Pearce, Phillips et al. 2011). Nursing in general practice, working in a small business environment with a GP who is both employer and colleague, presents unique challenges to nurses (Halcomb, Meadley et al. 2009). This relationship not only affects operational behaviours such as decision making, task delegation and the degree of nurses' autonomy but is also critical to collaboration and team culture (Phillips, Pearce et al. 2008).

Evidence of expansion of nurses' practice through funding mechanisms is ambiguous. Empirical studies reveal that overlapping, and in some cases conflicting, interests of government and medicine/GPs influence nurses' role expansion (McDonald, Checkland et al. 2008; Mills and Fitzgerald 2008; Pearce, Phillips et al. 2011). However, the extent to which this impacts nurses' agency in providing PHC is unclear. The literature offers underdeveloped descriptions of individual nurse characteristics as influencing the extent to which nurses take on expanded roles including 'passive', 'traditional', 'individualistic', 'a function of personality and drive' (Patterson 2000; Phillips, Pearce et al. 2008).

Patterson's (2000:ii) seminal work in presenting a case study of Practice Nurses, exploring their contribution to PHC, concluded that there was a 'passive acceptance' by the nurses of their circumstances and that many nurses in general practice were happy in what they were doing and felt valued by both the practice clients and their employing GP. Despite a potential for expanded roles in PHC within general practice Patterson (2000) states 'the reality of nursing practice does not always match the aspirations of those who attempt to define or direct it' (:205).

More recently most participants in Halcomb's (2005a) study, exploring the role of the Practice Nurse in chronic heart failure management in Australia, expressed optimism regarding the potential for expanding their role. However 29.7% of the participants in this study believed their current role to be appropriate and were less enthusiastic about role expansion. They cited a range of barriers to expansion including lack of time, hesitancy to expand into perceived medical domains and that their role as a nurse 'extended only to carrying out the doctors direct instructions regarding patient management' (Halcomb 2005a:218). However, there were ambiguities regarding which funded initiatives nurses preferred to undertake, preferring some and not others. Halcomb's study did not expand on reasons for this, reinforcing the imperative for further exploration of nurses' identity work within their roles as PHC providers.

The significant increase in the number of nurses working in general practice settings reflects the interests of government in expanding nursing presence in this sector. However, funding measures which inform PHC nurse identity work have been

ambiguous in regards to whether nurses' increased presence is focused on support for workforce shortages of doctors within a substitution model or to enhance the clinical roles of nurses in expanding PHC services (Pearce, Phillips et al. 2011).

Funding measures, as enablers or barriers to nursing work in general practice were a key analytical theme emerging from a large cross sectional study conducted by Phillips et al. (2008) as part of the Australian General Practice Nurse Study. Pearce et al.'s (2011) published findings of this study, focused on this theme, noted that funding measures clearly influence the role structure and task performance of nurses. They found that hierarchical organisational structures with nurses' practice overseen and constrained by the GP, and practice financing focused on revenue generation, were significant barriers for the expansion of nurses' practice in this setting providing little opportunity for nurses' autonomy within the team to expand their PHC practice. Expanding services to incorporate nurse-led care are informed by a diverse range of interests. There is a lack of clarity and consistency in regards to definitions of 'nurse-led' care adding to the ambiguity of nurses' agency as providers of PHC (Richardson and Cunliffe 2003). There has been little critical analysis of nurses' agency within nurse-led PHC service provision.

The Practice Nurse as the PHC nurse

Within the literature, terminology used to describe nurses providing PHC services working in community settings is inconsistent (Annells 2007; Jolly 2007; Douglas, Rayner et al. 2009; Batt 2011). This is important because language informs understandings of identity and is used in identity work to represent nurses as PHC providers.

Within Australia, the literature regarding the varying job titles and roles of nurses working in the primary and community care sector, including Community Health Nurse, Community Based Nurse, Practice Nurse, District Nurse, PHC Nurse and Domiciliary Nurse, reflects the interrelated influences of social, historical, cultural and political contexts (St John 2007b). Community nursing has a different history and titling of roles in each of the States and Territories in Australia.

Nursing literature in Australia and internationally states that community nursing is underpinned by principles of PHC (Kelly and Symonds 2003; St John and Keleher 2007a; Kralik and Van Loon 2008; Francis, Chapman et al. 2008a) however, the varying titles, roles, client types, community settings and philosophical underpinnings of health agencies influence how PHC principles are enacted (St John 2007b). The division between population focused organisations and individual client focused organisations is variably reflected in the terms Community Health Nursing and Community Based Nursing. However, St John (2007b) describes this differentiation as an arbitrary descriptor, which says more about the underpinning philosophy and focus of the health service than about how nurses working in these settings implement a PHC approach to practice.

Despite the recent increase in numbers of Practice Nurses, most nurses working in community settings are not employed in general practice but have historically worked in NGO and State government funded community health services (Australian Institute of Health and Welfare 2009). The available data depicting where community nurses are employed reveals the way in which nursing in general practice is foregrounded within Government data (Australian Institute of Health and Welfare 2009). With 23,800 nurses working in community settings, comprising 11% of the total nursing workforce, 5,700 were identified as being employed in general practice medical services. The remaining community nurses were identified as working in 'other medical and health care services' (13,100) or in allied health services (5,000) (Australian Institute of Health and Welfare 2009).

McDonald et al.'s (2006) systematic review of comprehensive PHC models in Australia, England, Scotland and New Zealand incorporated extensive annual data collated by AGPN depicting general practice activity. Practice Nurse activity was equated to MBS item usage in this review. Pearce et al. (2011) noted that only 6% of nurses' work in general practice related to the use of Practice Nurse item numbers highlighting the limitations of a lens focused on the economic benefit to practice to depict Practice Nurse activity. McDonald et al.'s (2006) review noted a striking lack of publications reporting on the implementation and impact of community health services and nurses' activity which were predominantly State funded. In developing

health funding policies which inform PHC nurse identity work, Government is reliant on data and systematic reviews such as this are influential.

With health reform changes, increasing interest in the role of nurses in primary and community care as a means for increasing the availability and accessibility of PHC services was coupled with significant funding measures to assess the viability of Practice Nurses to meet these needs. The Australian Primary Health Care Research Institute (APHCRI) provided funding for a review of primary and community care nursing in 2006 which primarily reviewed the role of the Practice Nurse in the general practice setting (Keleher, Parker et al. 2007g).

Policy recommendations for the PHC workforce submitted to government, informed by the evidence reviewed by APHCRI, primarily focussed on the general practice setting (as this was stated to be where most of the evidence existed) and as such, evidence on nursing's role in PHC emphasised the role of the nurse in general practice (Douglas, Rayner et al. 2009). Within these recommendations the terms General Practice Nurse and PHC Nurse are conflated (Douglas, Rayner et al. 2009). This also reflects the Australian Practice Nurse Association's (APNA) claim to represent all PHC nurses (Hille 2011). Identity work which conflates the Practice Nurse as the PHC Nurse has significant implications for PHC nurse identity and leaves questions regarding the framing of other community nurses within PHC nurse identity work.

Historical, cultural and structural influences positioning nurses as enhancing equitable PHC access for people and communities have emphasised nursing as a solution to medical and allied health workforce shortages in rural communities. Economic rationalist funding mechanisms and medical dominance of health services have informed PHC nurse identity work with changes to nursing practice within the primary and community care sector. The literature review has highlighted ambiguous expectations and assumptions of nurses' agency to expand PHC provision within this sector to ensure equitable access. The next section outlines the political, academic and theoretical literature positioning PHC nurses as partners in health within different models of care.

Participation – framing nurses as partners in health

‘...nursing is leading the way in ensuring the active participation of citizens and communities in addressing health issues and accessing appropriate health services’ (International Council of Nurses 2008b:i)

As the above quote suggests, the ICN characterises nursing as able to ensure the active involvement by people and communities towards positive health outcomes. This assumes nurses, as PHC providers, have agency to ensure equitable participation for health care recipients through supporting their rational individual choice to take up opportunities for health benefits and their active action to meet collective concerns.

Participation and patient centred care are central concerns for both the WHO (2008) and the Australian Government’s PHC reform agenda (Australian Government Department of Health and Ageing 2009b; Australian Commission on Safety and Quality in Health Care 2011a). The positioning of nurses as supporting the move towards patient centred PHC and the idea of partnership between people and health providers/services to enhance participation is increasingly noted in both political and theoretical literature.

The literature positioning nurses within different client partnership approaches taken by government, nursing theorists, health services and nurses themselves will be outlined. This review serves to highlight different expectations of nurses’ approach to professional partnering with clients and assumptions made of nurses’ agency to provide PHC within these approaches.

Partnering through relationship

Patient centred care is a broad concept with several terms used interchangeably. Within the Government’s PHC strategy, the provision of patient centred care by nurses within community based primary and community care settings is predominantly focused on individuals, families and their carers (Australian Government Department of Health and Ageing 2009b:42). The emphasis is on developing relationships and plans of care collaboratively between staff and

patients/clients and values the needs of the person and their carers and staff in a reciprocal relationship (Hughes, Bamford et al. 2008). Individuals are conceived as rational decision makers and equitable health care provision is delivered through empowering partnerships which value the person's individuality and decisions (Slater 2006).

There is recognition within the Government's policy framework of the different types of 'centred' care (Australian Commission on Safety and Quality in Health Care 2011a), however 'patient centred' or 'person centred' care is the main approach used within the primary care setting and incorporated into government policy.

Relationship centred care, as another type of partnering, emphasises the formation and maintenance of a genuine relationship within which the social context and interconnected network of relationships of relevance to the person are acknowledged (Australian Commission on Safety and Quality in Health Care 2011a).

While the different types of centeredness for partnering are important for ethical and professional reasons they also inform PHC nurse identity work through underpinning ideological ideas and structural contexts for health care provision (Hughes, Bamford et al. 2008). What they all have in common is the aim to move away from paternalistic, 'expert' biomedical models of care towards unifying common themes of increasing the social, psychological, cultural and ethical sensitivities within partnership encounters for health care provision. (Downie 2007; Hughes, Bamford et al. 2008).

Two main underpinning ideologies informing understandings of the way in which people participate as partners in health are neoliberalism and communitarianism and while both are aimed at promoting equity and self-determination, they do so quite differently. Groups using either of these ideologies characterise nurses as having agency as PHC providers however, the models of care preferred and the positioning of nurses as PHC providers within these differ.

Patient centred care within neoliberal/economic rationalist ideologies promotes the individual client (and the nurse as health care provider) as a rational decision maker in a free market. Community based nursing focused on individuals, their families and

carers is emphasised with technical/medical intervention and behaviour modification as the predominant models of care (Baum 2008:472). The care recipient is regarded as being autonomous, individually responsible and rational (Giddens 1998), with partnership approaches encouraging improved health literacy and self-management. Equity in health care provision is promoted by providing a space of opportunity for people to reach their best potential through their individual participation.

For people with chronic illnesses, this approach is promoted as a way of developing the 'expert patient', empowered to manage their health and minimise acute exacerbation of symptoms and possible hospitalisation (Greener 2008). Decentralised local level health care for individuals is promoted as cost effective, with central Primary Health Organisations (which are termed Medicare Locals in Australia) coordinating population focused health care needs. This approach supports nurses to move away from the 'expert' biomedical approach and towards patient centred care. Robinson et al. (2008), in their study of community nurses' incorporation of self-management techniques for people with COPD, described this as a PHC approach characterised by empathy, consultation, facilitation and a holistic focus.

However, within the literature there are concerns raised about patient-centred care within this framework. The effectiveness of behaviour modification models for health improvement has been questioned (Greener 2008) and Baum (2008) contends that effectiveness has not been established where the person's social context is not taken into account. Competing agendas within health services raise concern regarding the patient centred care approach within neoliberal services models. The incorporation of a person's social context within patient centred care takes more time and a study exploring Practice Nurse attitudes towards providing patient centred preventative health measures by Robinson et al. (2011) found that while this work was satisfying for nurses, it was not prioritised during busy periods within the practice. This concurred with findings by Mills (2008) questioning the extent to which the introduction of new practices within the general practice setting were viewed as 'patient centred care' or an economic incentive for the practice.

The interests of general practitioners, as employers of nurses in rural general practice, inform rural PHC nurse identity. GPs have been shown to question the

value of health promotion beyond individual behaviour management in the practice setting, they have difficulty adopting a social model of health and are cautious in adopting new health promotion models (Sims, James et al. 2002; Raupach, Rogers et al. 2008; Achhra 2009).

The incorporation of a social model of health aligns more closely with relationship centred care and the 'new public health' which began with the signing of the Ottawa Charter (Baum 2008). This instigated a renewal of attention on the social determinants of health as underpinning health inequity and necessitating incorporation of a social model of health into PHC practice (Germov 2009).

Communitarians argue that autonomous individuals do not exist in isolation and that they are shaped by the values and cultures of their social networks/communities (Baum 2008). Active participation through shared goals for the common good aids cohesive societies and vice versa, strong healthy vibrant communities are the prerequisite for strong healthy vibrant individuals (Etzioni 2003). Communitarians place value on community and tradition and place emphasis on the centrality of contextual influences on the individual. This is important for this study of rural PHC nursing where, as stated previously, embeddedness within community is a common theme of nursing in small rural communities (Bushy 2002; Lauder, Reel et al. 2006).

Successful 'patient centred care' for vulnerable and underserved communities is argued within the literature as requiring the combination of community connectedness/social model of health with patient centred care (Silow-Carroll, Alteras et al. 2006) While nurses are discussed within both neoliberal and communitarian ideologies as having agency to provide patient centred care, identity work characterises their practice within different models of care. Within the nursing literature there are claims that nurses can and should work across all three models of care in their provision of PHC, (technical intervention, behavioural modification and social model of care) (Annells 2007; St John 2007b) however there is a lack of research which explores nurses' agency in doing this.

Nursing's theoretical base for working in community

Given the different broader ideological frameworks influencing PHC nurse identity work, the way in which nursing theory informs practice within community settings will be reviewed within nurses' historical and cultural positioning in community.

There has been notable development in nursing's theoretical base towards patient centred care, incorporating a social model of health in partnership with community, which has coincided with the changes towards an increased policy focus on patient centred care (Kulig 2000; Munro, Gallant et al. 2000; Keleher and St John 2007; Francis, Chapman et al. 2008a).

Nursing practice has historically been based on an 'expert' model of helping and 'doing for' (McWilliam, Coleman et al. 2003) with nursing theories guiding practice aligned to care provided to individuals within a hospital nursing context. The global changes towards providing health care in partnership with people are a comparatively new development and have resulted in examination of the implicit and explicit assumptions of the historical 'nurse-patient relationship' (Hagerty and Patusky 2003; Brown, McWilliams et al. 2006).

Historically, community nurses in Australia have had extensive and effective presence in the community especially for underserved and vulnerable populations, providing individual and public health care as well as being politically active advocates (Francis, Chapman et al. 2008a). However, this aspect of nursing has been argued to have been historically marginalised from mainstream nursing interests (Keleher 2000a). The move towards community based nursing services in the latter part of the 20th Century, as discussed previously, led to a change in the 'community' for the community nurse moving from a population focus to a specific client group with higher acuity and shorter more intensive interaction (Kemp, Harris et al. 2005). Brookes et al. (2004) contend that the trend for more community based care through the primary and community care framework challenges the traditionally broader PHC positioning of community nurses. Within the theoretical literature there is suggestion that the lack of philosophical discussion regarding the incorporation of a social model of health in community nursing has contributed to conflicting role expectations and ambiguity in community nursing terminology (Koch 2000; Brookes, Daly et al. 2004). There is a lack of clarity regarding nurses' agency as

PHC providers within different underpinning ideologies which position nurses as providing PHC within different models of care.

Identity work which positions nurses as providers of 'holistic' care creates ambiguous and undifferentiated notions of partnership. Review of the nursing literature highlights the way in which the term holistic care is used interchangeably and in conjunction with patient centred care. Differentiation between the models of care employed in holistic practice is less evident. The extent to which a social model of health underpins understandings of holistic care varies greatly however there appears to be an agreed understanding of holistic care, similar to patient centred care, of moving away from paternalistic, expert biomedical models of care.

Nursing theorists have called for a critical re-examination of the notion of holism in addressing the domain of 'person' in nursing. Drevdahl (2001) suggests that the concept of holism raises concerns in that it appeals to the generic person whilst disregarding interactions with the person's race, socioeconomic status and gender and therefore can leave larger institutional and societal issues unacknowledged, unexplored and unchallenged.

The incorporation of community as partner

Theory development within community nursing that addresses the community as a collective and not simply as groupings of aggregates has been argued as being deficient (Kulig 2000). However, more recently in Australia there have been two influential texts by St John and Keleher (2007a) and Francis et al. (2008a) which provide a solid theoretical foundation for nurses working with communities within a PHC approach.

The emphasis for health care provision in community based health services within Australia's primary and community care framework has markedly influenced the practice setting of community nurses and their client population. These changes are coupled with societal changes to communities including in an increasingly mobile population and unprecedented technological advances enabling social networks and virtual communities which transcend traditional geographic notions of community

(St John 1998). These factors highlight the imperative for clarity regarding who the community is for the community nurse, whether they are a group of people who have some form of interrelatedness and shared historico-cultural factors or whether they are externally defined as a group for example by illness or attendance at a health service (St John 2007b).

For nurses working with a community using a partnership model, some level of interrelatedness and recognition of shared knowledge between the members of the community is required (St John 2007b). This model of care is underpinned by a PHC approach incorporating the principles of health promotion, community development and community capacity building. Resilience and cohesion are strengthened within this approach with resultant health benefits for individuals within the community (Hegney, Ross et al. 2008). Nurses working with this model incorporate a social model of health with a focus on the social determinants of health which the community members identify as important to address. There is extensive literature both within nursing and more broadly recognising nurses' contribution to this approach for PHC provision (Kulig 2000; Earvolino-Ramirez 2007; Galbally 2007; Hegney, Ross et al. 2008; Caldwell and Boyd 2009).

Historically, Community Health Nurses provided PHC services for a self-defined community within a partnership model (Baldwin, Conger et al. 1998) and rural nurses partnered with a geographically defined community (Hegney 1996a). Rural nurses partnered and collaborated with individual clients, peers, community organisations, other health professionals and across different professional disciplines and outside the health system with social services (Bushy 2002). These networks were both informal and formal. Bushy (2002) states that little is known about the structure and effectiveness of nursing partnership models in rural areas and how this impacts community capacity suggesting this as an area requiring further research.

There appears to be some division in the nursing literature regarding the most effective means for the incorporation of a social model of health in practice. Some academics suggest that the incorporation of a social model of health necessitates a broader approach to PHC provision than centre based or community based care (Baldwin, Conger et al. 1998; Francis, Chapman et al. 2008a) while others contend

that PHC nursing requires the incorporation of a social model into community based practice (Annells 2007).

There is a strong theoretical base developing for nurses engaging with community as partner. However, there is a dearth of critical discussion about the power and impact of funding and organisational influences on models of care (Phillips, Pearce et al. 2008). The ICN (2008a) claims that, with nurses working closely with communities, their role in community participation and community action for health are crucial for healthy communities and sustainable development. Rural community nursing literature emphasises nurses' skills of working with a PHC approach and working with community (Kulig 2000; McMurray 2007; Francis, Chapman et al. 2008a; Francis and Chapman 2008d). Effective nursing work in rural environments is described as being dependent on nurses' capacity to work in partnership with individuals, groups and the community (Francis, Chapman et al. 2008a).

However, many nursing theories make the assumption that nurses can control the context of their practice (St John 2007b). While Francis and Chapman (2008b) emphasise nurses' agency in embracing a community partnership model stating *'the community nurse can close the gaps in service provision, change the focus of care if necessary, from the medical model to a more inclusive community model, and facilitate communication to include non-government and government organisations'* (:150), there is recognition that this is dependent on the employer and the community.

Empowerment and advocacy

Neoliberal and communitarian ideologies informing partnership relationships between nurses and clients represent nurses having agency to support empowerment and provide advocacy for clients. Within the draft PHC Strategy (Australian Government Department of Health and Ageing 2009b), empowerment for people working in partnerships with nurses is predominantly focused on the individual client relationship with nurses supporting individual behaviour change to promote self-management and wellbeing. Within this individualised model of partnership, moving from a professional 'expert' biomedical model to a partnership model is seen as

equality through respect for patient autonomy as a moral and ethical obligation of the nurse. However, there is recognition within the literature of the concept of partnership as an immature concept which, although it has relevance, lacks consensus and consistency of use within political, theoretical and social arenas resulting in tension (Gallant, Beaulieu et al. 2002).

Empowerment and advocacy form part of the foundation for ethical provision of PHC in community settings (Racher 2007). While traditionally nursing theory has guided nurses' individualised practice, there is growing recognition in nursing theory development of the importance in considering the individual, their family and their community/social networks as interrelated aspects influencing their wellbeing (Annells 2007; Keleher 2007c; Nesbitt and Hanna 2008; Francis and Chapman 2008d).

Partnership models which incorporate a social model of health enable recognition and acknowledgement of the interconnection between individual health and the social determinants of health. It is argued that for nurses to provide empowering advocacy for clients at this level, professional autonomy to act broadly on perceived ethical challenges is required (Brown, McWilliams et al. 2006; Racher 2007). This will also require nurses to have developed collaborative networks across health and social services and have the autonomy to instigate action as needed.

While Phillips et al.'s (2008) extensive study provided valuable insight into the roles of nurses in general practice, how nurses identified and were identified with aspects of PHC provision such as health promotion (as distinct from health education), partnership with clients and incorporation of a social model of health were left unanswered. Although nurses described working with a 'holistic' approach with their clients, empowering and enabling them, this was not expanded on. The 'agent of connectivity role' was described as providing an 'intangible added benefit' to general practices, with the focus on supporting the practice to function 'holistically' and 'operating as "boundary spanners" by bridging the interface between different realms of practice life' (Phillips, Pearce et al. 2008:19). Whilst the potential role for nurses in general practice to establish affiliations with local community groups that would support general practice in being more accessible and acceptable has been previously

suggested (Halcomb, Davidson et al. 2005b), partnership in this study was discussed primarily in terms of nurses' relationships within the practice, and primarily with GPs (Phillips, Pearce et al. 2008).

Further understanding is required regarding the way in which nurses are positioned to work in partnership with people as PHC providers and their autonomy to incorporate the models of care required. Developments in nursing theory supporting a clear theoretical underpinning for PHC practice are relatively recent and there is little critical social analysis of the power of groups within community based services in determining preferred models of care.

While nursing claims a social model as underpinning nursing in the community there is ambiguity in nurses' positioning along the continuum between individual, social and political levels of advocacy. Falk-Rafael (2005) links working with a social model of health and the imperative to incorporate political advocacy and influence health policy. Theoretical models have been proposed for nurses community practice which incorporate a social model of health in conjunction with behavioural modification and medical intervention (Munro, Gallant et al. 2000; Brookes, Daly et al. 2004; Keller, Strohschein et al. 2004; Sheridan 2005; Woods 2010). Advocacy and empowerment underpin these partnership models and embody the principles of PHC (Downie 2007; Chiarella, Salvage et al. 2010).

Within the literature the way in which nurses are characterised as providing PHC in partnership with people varies. Neoliberal and communitarian frameworks inform nurses' positioning with an emphasis on ensuring equity. However, while both approaches position nurses as having agency to provide PHC, nurses' autonomy to incorporate a social model of care in practice is ambiguous within community based settings.

This review of the literature has highlighted the way in which the distinction between community based nursing and community health nursing may be changing within Australia's health reform process, informing understandings and representations of the PHC nurse. A critical perspective will benefit this study of nurses' agency within contemporary health reform through acknowledging the effects of identity work and

different power relations impacting PHC nurses within a specific context of rurality and across different structural contexts of health service provision.

Collaboration – positioning nurses within ‘The PHC Team’

Interprofessional collaboration extends the idea of patient centred care and partnership with an emphasis on the collaboration between different providers of care with the care recipient as the central focus. Effective PHC provision necessitates collaboration as a key strategy and is particularly focused on ensuring effective quality care for people requiring multiple services as well as coordinating care across the acute and primary health care interface.

Coordination, collaboration and the development of partnerships between primary, public and community health care is integral to effective PHC reform (Valaitis, MacDonald et al. 2011). A systematic review of integration models confirmed this to be an area which requires considerable development (Jackson, Nicholson et al. 2006; Jackson, Nicholson et al. 2008). Historically, different interests have informed the way collaboration between health services has been operationalized on the ground for rural communities including different funding policies, organisational structures and professional interests. Tensions, barriers and constraints to effective collaborative service provision have been well documented (D'Amour, Ferrada-Videla et al. 2005; Currie, Finn et al. 2007; Anderson, Bonner et al. 2011; Lovett 2011). The way in which collaboration is represented as an aspect of rural nurses' PHC identity differs and this difference is based on different representations of agency.

Within Australia, much of the literature concerning nurses within collaborative PHC emphasises collaboration between providers within the general practice setting, foregrounding the collaborative relationship with the GP, as well as between PHC providers and the acute care interface (Watts, Foley et al. 2004; Australian Government Department of Health and Ageing 2009b). There is scant literature which expands an understanding of collaboration between nurses in different community settings as PHC team members which is a significant area for rural PHC nurses.

The way in which collaboration develops and is consolidated within health care teams is informed by interpersonal relationships within the team, the organisational context and broader systemic societal influences (San Martin-Rodriguez, Beaulieu et al. 2005). Using this framework, literature which deals with nurses' positioning across these three categories of determinants will be presented. This enables a review of the cultural, broad structural, organisational and interpersonal influences and highlights the need for critical analysis of the power differentials within the PHC team and PHC nurse identity work. Notable within the review of the literature is the scant reference to nurses' collaborative relationship with social services. The final part of this section will review literature discussing nurses' agency within this bridging positioning.

There is no clear definition of 'primary health care team' within the Australian health care system (Mills, Francis et al. 2010). The team of health care professionals in a general practice setting is referred to as a primary health care team (Australian Medical Association 2008). Within the Australian PHC Strategy draft document (Australian Government Department of Health and Ageing 2009b) the nurses mentioned as part of the PHC team are Practice Nurses and Nurse Practitioners. Nurses providing PHC services are also described as being members of the community health team (Ryan, Shaban et al. 2007). The way in which collaboration develops and is consolidated within health care teams is informed by interpersonal relationships within the team, the organisational context and broader systemic societal influences (San Martin-Rodriguez, Beaulieu et al. 2005).

Interactional determinants

The interpersonal relationships between nurses and other members of the PHC team influence the way in which collaboration develops and is consolidated. The relationship between GPs and nurses within the general practice setting dominate the literature concerning nurses' interpersonal relationships within the PHC team and the way in which this influences collaborative practices was discussed in detail earlier in the review.

Effective collaboration within health care teams at the interpersonal level is influenced by team members' understandings of each other's roles. For PNs, working closely with the GP increases the opportunity for mutual understanding of each other's roles and increased opportunities for communication in comparison to other nurses in community settings. Pearce et al.'s (2012) spatial analysis of nurses mobility within the general practice setting highlighted the fluid and interconnected nature of nurses' interactions across all of the zones within the practice describing this as an 'access all areas' pass. This mobility enhances communication across people working in different areas of the service and was described as being an aspect of nurses' professional culture and an important contribution to organisational life within the general practice setting.

Organisational determinants

The main organisational factors influencing nurses positioning as collaborative PHC team members include: access to resources to which promote the development of collaborative practice; having collaboration as an underpinning philosophy for the organisation; and the structure of the organisation (San Martin-Rodriguez, Beaulieu et al. 2005).

Increasing Federal Government funding to support Practice Nurse's education through AGPN and APNA (Australian General Practice Network 2007) has provided resources for improving Practice Nurses effectiveness in funding directed collaboration with GPs. Hall (2007:37) provides an understanding of the way in which AGPN (which has now re-established as the Australian Medicare Local Alliance) is the 'face of organised general practice'. AGPN positioned itself as a 'broker' between government funding and policy, the structure and culture of general practice with GPs as business owners and the emerging interests of Practice Nurses. This influences the framing of nurses as part of the collaborative PHC team. Nurses are described as core members of the PHC team and integral to general practice (Jolly 2007; Australian General Practice Network 2009).

Government is the largest funder of general practice and therefore, it has been suggested that general practice behaviour can be influenced by both funding streams

and funding focus (Pearce, Phillips et al. 2011). The provision of funding to general practices and the AGPN by the Federal Government to support both an increase in practices employing nurses as well as support the expansion of their roles within the primary care setting has had and continues to have a significant influence on the shaping of PHC nurse identity.

Keleher et al. (2007g) state that the nurse's role in the general practice setting is envisaged as a complement to the GP and describe the role as having a dual focus of extending the activities of general practice via nurse led services as well as providing a supplement service with nurses substituting for the general practitioner. However, they describe considerable variation in the tasks undertaken, the level of responsibility and the models of practice for Practice Nurses as well as 'the extent to which the Practice Nurse is a true "partner in care" or more of an assistant to the general practitioner/general practice' (Keleher, Parker et al. 2007g:8). While a broad range of roles are envisaged for nurses working in the general practice setting, this study concluded that what nurses actually do in practice is influenced by funding mechanisms.

The ability for practices and nurses in general practice to respond to and use funding incentives to further collaborative PHC provision is influenced by the team work model employed by the practice and in particular the GP. Hierarchical workplace structures with the GP as team leader can result in GPs supervising and directing nurses which limits the ability for the practice to benefit from funding incentives directed at collaborative practice or from block funding initiatives (Mills and Fitzgerald 2008; Pearce, Phillips et al. 2011).

Nurses' allocated work space impacts their positioning as equal members of the collaborative PHC team. Structurally, nurses have a less defined space which aids their connectivity but also limits their expanded roles to take on structured client contact. Without a defined consulting area they are less able to access funding incentives which places them as less important in the team than the doctor in terms of accessing revenue (Pearce, Hall et al. 2012).

While there is debate regarding the future development and direction of nurse led care there is a lack of critical analysis of this positioning for nurses. The lack of clear and consistent definitions for 'first contact', nurse-led and frontline care, with different interests positioning nurses as providers of nurse-led care, markedly influences the way in which nurses are represented as PHC providers and nurses' autonomy in expanding PHC provision (Richardson and Cunliffe 2003).

Keleher et al.'s (2007g:30) review discusses the need for reforming the method of payment of nurses in general practice suggesting salaried positions in preference to the fee-for-service model. The authors contend that this would enable nurses to focus on models of prevention and support nurses in responding to community needs. While funding reform to distance nurses from providing PHC services 'for and on behalf of' GPs may well support nurses' expanded practice, whether this translates to professional autonomy within the collaborative PHC team to incorporate a social model of care is unclear.

Despite the numbers of Practice Nurses employed in general practice significantly increasing through the NiGP initiatives (Australian Institute of Health and Welfare 2009), significant barriers to the sustainability of this growth and future developments in expanding nurses' roles to increase governments' preventative and health promotion agendas were evidenced in a report by Jolly (2007:23-33). Concurring with Keleher et al.'s (2007g) recommendations, Jolly (2007) also noted that lack of clarity regarding the Practice Nurse role and identity and the impact of the employer/employee relationship with GPs on nurses professional autonomy were problematic for future expansion of nurses PHC practice.

Systemic determinants

Broad sociocultural and political factors outside the PHC organisation including medical hegemony, neoliberal economic rationalism and the education system impact on the development of nurses' interprofessional collaborative practice. Power differences between professionals in a team impede effective interprofessional collaborative practices (Lockhart-Wood 2000) and raises questions regarding nurses

agency within PHC teams to practice collaboratively. These factors have been presented throughout this literature review. The influence of the education system in preparing nurses and other members of the PHC team for collaborative practice requires further discussion.

Historically, nurses in Australia have been educated within the hospital setting. During the 1980s, nurse education was progressively transferred to the higher education system within universities with all pre-registration nursing programs transferred into the tertiary sector by 1993 (Russell, 2005).

Interdisciplinary collaboration requires an understanding of each other's roles and scope of practice (San Martin-Rodriguez, Beaulieu et al. 2005). Health professionals have predominantly been educated separately and only recently have they started to be educated together. What is not clear is an understanding of how nurses' education in incorporating a social model of health into PHC practice connects with the education of other members of the health care team. While there is a significant emphasis on increasing effective interprofessional education at the undergraduate level (Parker and Keleher 2008; Primary Health Care Working Group 2009), most of the nurses working in community settings are in their late 40's, increasing the likelihood that their pre-registration education was attained within a hospital setting (Australian Institute of Health and Welfare 2010a) and young nurses are shunning the primary and community care setting (Eccles 2012).

Whilst the increasing focus on nursing in general practice is relatively new in Australia, there is a long and substantial history of nursing within community settings (Francis 1998; Keleher 2000b; Keleher 2007f; Kralik and Van Loon 2008). Despite this, Australia lacks national policy for all nurses working in primary and community health care (Brookes, Daly et al. 2004; Keleher, Parker et al. 2007g; Parker, Keleher et al. 2009). Undergraduate education does not adequately prepare nurses for work in either primary or community health care and post registration education is ad hoc (Keleher, Parker et al. 2007g; Parker, Keleher et al. 2009; Keleher, Parker et al. 2010). Australian nursing competencies for registered nurses do not specify any particular competencies for primary health care and are general in

relation to the requisite skills and knowledge for registered nurses (Keleher, Parker et al. 2010).

While the competency standards for nurses working in general practice settings stipulate that nurses will integrate the principles of PHC into practice (Australian Nursing Federation 2006), the education of nurses in PHC and its theoretical constructs has historically been inadequate for primary and community care needs (Wright 1994; Keleher, Parker et al. 2010; Parker, Keleher et al. 2011).

The ‘ad hoc’ development of nurse led care coupled with a lack of coordinated education for nurses in primary and community care is argued as limiting the future potential of this role due to uncertainty regarding nurses’ scope of practice within advanced practice roles (Richardson and Cunliffe 2003).

The elements influencing the determination of nurses’ collaborative positioning as members of the PHC team highlight the influences of funding mechanisms and medicine’s power to inform PHC nurse identity work. Nurses are predominantly visible as collaborative PHC team members within the general practice setting, however identity work highlights the ambiguous agency of nurses within this setting.

Connectivity – bridging formal and informal networks

D ’Amour et al. (D’Amour, Ferrada-Videla et al. 2005) contend that there is a lack of serious attempt within the literature to determine how clients are integrated into the PHC team despite being recognised as the ultimate justification for the provision of collaborative PHC (D’Amour, Ferrada-Videla et al. 2005). However, references to nurses bridging between the health care team and formal and informal social networks in rural communities are evident with nurses described as being ‘resource brokers’ for their communities (Bushy 2002; Lauder, Reel et al. 2006). Lauder et al. (2006) state that *‘Nurses have traditionally been at the interface between groups within healthcare systems, between healthcare and social care systems, between healthcare professions and patients and, finally, between patients and their families. In this sense, the nurse is a classic example of a broker who facilitates the flow of information between groups’* (:75). While the positioning of nurses as ‘agents of

connectivity' within general practice, as a recognised role, is discussed by Phillips et al. (2008) in terms of the benefits for the practice and the GP, further understanding of the full extent of nurses' ability to enhance connectivity within collaborative PHC provision is needed.

Recognition within the Australian literature of the impact of rural context on the Practice Nurse role varies. Earlier research suggests that while Practice Nurses in rural practices perform a wider range of activities, the role of nurses working in general practice throughout Australia does not differ greatly (Condon, Willis et al. 2000; Watts, Foley et al. 2004). More recently, Phillips et al. (Phillips, Pearce et al. 2008) found rural Practice Nurses were more likely to function as educators within their own practices and their communities as well as having slightly more extended patient care roles – increased technical skills. However, while rural nurses had more control over their activities, they found no difference between rural and urban Practice Nurses in their role as 'agents of connectivity'. This seems at odds with the earlier discussion of the importance of rural context and the influence of 'knowing and being known by the community' for the provision of PHC by rural nurses in the literature highlighting the need for this study.

Historical funding mechanisms for nurses in general practice have influenced both their role structure as well as the tasks performed (Pearce, Phillips et al. 2011), however the extent to which they have influenced nurses is uncertain as is the impact on PHC nurse identity. In January 2012, funding changes were implemented which removed Practice Nurse item numbers from the MBS with the introduction of practice incentive payments for the employment of nurses. As Pearce et al. (2011) note, the climate of the general practice will moderate the capacity for these changes to affect nurses' clinical roles. Practices working within more hierarchical structures limit nurses' autonomy and as such are less able to capitalise on the full skillset nurses bring to a practice setting. The impact this will have on nurses' role expansion and the enhancement of PHC provision will be influenced by the many factors shaping PHC nurse identity.

There is scant empirical literature which examines collaborative practices between nurses working in community settings, other than general practice, and the rest of the

PHC team. The way in which these nurses are positioned as part of the PHC team for clients requires further study.

In summary, one of the key conclusions of the Nursing in General Practice Report (Watts, Foley et al. 2004) was the need for adequate explanation of nursing's contribution to primary health care delivery within a collaborative model with medicine. Recent descriptive research (Halcomb 2005a; Keleher, Parker et al. 2007g; Phillips, Pearce et al. 2008) exploring the practice of nurses in general practice has provided insight into their expanded roles, the impact of funding mechanisms on the restriction of expanding roles and the need for further understanding of nurses' collaborative practice with GPs. However, there has been little critical analysis of how nurse identity work informs the mechanisms impacting on nurses' PHC identity, particularly in the general practice setting, that is, the way in which different interests, including nurses' interests, shape PHC nurse identity and how (or whether) this is informed by a social model of health.

Conclusion

Within this chapter questions have been raised about whether nurses have the agency to expand their practice to provide the benefits of a comprehensive PHC approach to health service delivery through equitable access, partnerships and collaborative team practice. Within these three pillars of PHC, nurses are positioned within the literature as a means for addressing workforce shortages and increased needs, promoting a patient centred care approach and practising within an interprofessional collaborative PHC team. By forwarding the case of rural PHC nurses, the review of the literature highlighted the underdeveloped representation of the PHC nurse as providing connectivity between health services and their community within the current health reforms in Australia.

Historical, cultural and structural influences positioning nurses as enhancing equitable PHC access for people and communities have emphasised nursing as a solution to medical and allied health workforce shortages in rural communities. Economic rationalist funding mechanisms and medical dominance of health services have informed PHC nurse identity work with changes to nursing practice within the

primary and community care sector. The literature review has highlighted ambiguous expectations and assumptions of nurses' agency to expand PHC provision within this sector to ensure equitable access.

Further understanding is required regarding the way in which nurses are positioned to work in partnership with people as PHC providers and their autonomy to incorporate the models of care required. Developments in nursing theory supporting a clear theoretical underpinning for PHC practice are relatively recent and there is little critical social analysis of the power of groups within community based services in determining preferred models of care.

Different nursing groups working within community settings in Australia are variously aligned with the government's policies for PHC. The dominant focus within the literature on nursing in general practice for the provision of PHC in Australia reflects government policy to foreground general practice as critical to the shift in focus of health care provision to primary care. Structural and cultural influences on role development for nurses in general practice are evidenced within recent literature, however there is a dearth of literature that critically studies nurses' agency to expand practice, particularly in regards to incorporating a social model of health.

With contemporary nursing's theoretical commitment to a social model of health and the provision of comprehensive PHC, there is little critical analysis of nursing's social mandate to provide PHC for Australian society. Whilst the literature provides some evidence of collision between cultural and theoretical paradigms for nurses with the expansion of community based roles in primary and community care settings for individuals and their families there is little social level analysis of the nursing role in providing PHC for the community.

The review of the literature has revealed broad uncritical assumptions of nursing's role and capabilities in fostering and maintaining collaboration and partnership with individuals, families, communities and the health system. There has been little social analysis of the position within 'community' for nurses working in community settings. Examination of the broader structural and cultural conditions informing

PHC nurse identity work will expand knowledge of nurses' positioning as providing 'connectivity' within current health reforms.

Broad assumptions and social understandings of nurses' positioning in PHC have been highlighted by this review of the literature. Organisational and professional, hierarchical structures and approaches influencing PHC nurse identity work are evident and also influence the models of care for PHC nurse services. All of these factors interplay with PHC nurse agency in the community setting. There is a gap in the literature in critically analysing the interplay between PHC nurse agency and identity work within the current health reforms and evidence of a need for an explanatory framework to inform this process.

Examining and understanding developments in PHC nurse identity, and nurses' agency in this, requires an approach which can look beyond empirical descriptions and understandings of expanded nursing roles by locating them within broader political, social and cultural processes whilst incorporating the way in which nurses themselves are taking on these roles and shaping them. This will then provide understanding for how PHC nurse identity work is actively involved in shaping PHC nurse identity within current health care reform.

Chapter Three: Methodology and methods

This qualitative study explores nurses' agency in negotiating/navigating changing PHC practices during health care reform in Australia by investigating PHC nurse identity work within rural health services. The argument for using a critical research approach in this exploration will be furthered in this chapter. The conceptual framework involves the notions of PHC nursing, identity, agency and cultural/structural influences and has provided the grounding from which the research questions guiding this study were developed. Using a critical realist ontology to underpin this investigation allows for the understanding that while agency, culture and structure are mutually influential they must be analysed separately to support theorisation from empirical data (Bhaskar 1975; Archer 1996; Archer 2000; Sayer 2000).

Capturing the complexity of PHC nurse identity work requires 'rich' and 'thick' empirical data to support the scope of the aim of this study of identity (Sveningsson and Alvesson 2003:1165). Two distinct data sources were employed to meet this need. In-depth semi-structured interviews with twenty one rural nurses practicing within PHC settings provided the first source of data which, through the interview transcripts, granted access to nurse's individual identity work within their rural context. The second source of data consisted of the extensive public submissions (as texts) made to the National Health and Hospital Reform Commission, and provided access to the characterisations and representations of PHC nursing by a broad range of key groups with different interests in the positioning of PHC nursing in the development of the draft National Primary Health Care Strategy.

Integration and synthesis/recontextualisation of the emergent themes (retroductive analysis) from the two data sources allowed for the development of an explanatory framework for PHC nurse identity and agency and was informed by the works of Archer (1995; 1998; 2000), Bhaskar (1989), Danermark et al. (2002), Clarke (2003) and Crinson (2007).

This chapter begins by revisiting the research questions and moves on to outline the way in which a critical realist ontology has underpinned this study. The research design is outlined providing rationale for the methods and procedures undertaken within the conceptual framework of the thesis to enable answering the research questions. The research process is described clearly and in detail. Ethical considerations arising, including the position of researcher in the research process are explored and detailed.

Research questions

The aim of this study is to explore rural nurses' agency in negotiating/navigating changing PHC practices through analysis of identity work to inform contemporary understandings of PHC nursing. The previous chapters provided an understanding of some of the cultural and structural factors informing PHC nurse identity work in rural health services. There are tensions evident with different expectations and interests positioning nurses as providers of PHC within Australia's PHC reforms. Whilst support for and promotion of PHC nurse agency was noted (International Council of Nurses 2008b; Primary Health Care Working Group 2009), evidence of this in practice varied. Ambiguous representations of nurses' autonomy as PHC providers were evidenced. The predominant focus on general practice as the organisation central to Australia's PHC health reforms, coupled with the historical dominance of medicine and medical care in general practice, has seen nursing practice being provided 'for and on behalf of' the GP. There is also limited visibility of nursing's broader role in PHC within the primary and community care framework of the PHC reform agenda, especially for marginalised and hard to reach groups. As such, interplay between rural nurses' agency as providers of PHC and the power of cultural and structural social factors informing PHC nurse identity will be likely.

To address this study's aim, the questions guiding this research have been developed from both the literature review and the contextual chapter on rural PHC nursing, with the conceptual framework for the thesis providing the substrate for their development. The research questions are:

- What are the key collective PHC identities that apply to Australian nurses in community settings?
- What key characteristics delineate these identities?
- What does identity work reveal about PHC nurses' agency?
- How do cultural/historical/structural contexts impact on PHC nurses' agency?

This study required a methodology which enabled analysis of the interactions between structure and agency within a social, cultural and historical context.

Archer's (1995) critical realist (CR) approach to explaining social structures such as PHC nurse identity supported this by allowing the incorporation of the evaluation of nurse's individual beliefs and experiences within their structural, sociocultural context. As such, a qualitative approach informed by a CR ontology provided the research approach to address the aims of this research.

Using a critical realist ontology

Identity work provides demonstration of the interplay between nurse agency, structural and cultural influences and the 'real' world. The previous chapters have assisted in beginning to address the aim of this study by presenting an analysis of aspects influencing the context of the 'practice world' of rural nurses in providing primary health care.

Answering the research questions requires an approach that will support a study of the interplay between actors, primary agents, collective agents, structural and cultural influences, role positioning and collaborative practices between different professions/institutions – that is, the interplay between agency and structure, in order to gain/increase an understanding of the causal powers generating PHC nurse identity. A critical realist ontology supported an explanatory potential as part of the research strategy and offered a means of focusing on the contrasts, continuities and differences between 'agency' and 'structure' (Clark and Blundel 2007; Crinson 2007; Reed 2009). To explain this further it is necessary to outline how the world is viewed in a CR ontology.

A critical realist ‘world view’

Critical realism, as a structured ontology, perceives the social and natural world as consisting of three different (differentiated) domains. These are the **real** (or deep), the **actual** and the **empirical** (Bhaskar 1989; Ackroyd and Fleetwood 2000; Sayer 2000; Danermark, Ekstrom et al. 2002). These three domains will be briefly outlined, within the context of this study, providing an understanding of how mechanisms (causal powers), events and experiences are represented and overlap via these domains.

The **real** – is all that exists, whether we experience it or have knowledge of it or not (Bergin, Wells et al. 2008). It is the realm of objects, mechanisms, relations, structures and powers that can produce events in the world. The structures in the real are connected and have their own causal powers, they are called generative mechanisms and the real is constituted by the relations among these generative mechanisms (Bhaskar 1975; Bhaskar 1989; Archer 2000; Sayer 2000; Danermark, Ekstrom et al. 2002; Callinicos 2006). Generative mechanisms belong solely to the real and they are distinct from the events that their interactions produce. These events belong to the actual (Callinicos 2006:163). Rural nurses providing PHC services are real, the organisations they work in are real and the communities they work in are real. They all have causal powers. The interactions and the interplay between them all is the subject of this study.

The **actual** –Arising from the real world is the ‘actual’ and this encompasses all the behaviours, events and phenomena generated from the interactions with the ‘real’ (Callinicos 2006). This domain refers to what actually happens when the mechanisms and powers of the real are activated and events and experiences are produced. The actual which is of interest in this study is the identity work that occurs in small rural communities at the interface between PHC nurses, health organisations and the community. As presented in the previous chapters, there can be many proposed and interlinked causes for the behaviours of nurses, the positions taken by health organisations etc. The generative mechanisms of the real and the events that their interactions produce (actual) are also distinct from the experiences through which humans register the occurrence of some of the events (empirical).

The empirical – this domain comprises only what we experience, directly or indirectly. (Since not all events/phenomena are experienced or observed then the domain of the real is distinct from and greater than the domain of the empirical). The empirical domain is in a ‘contingent relation’ to the domains of the actual and the real. The Empirical consists of the subjective experiences and observations of the actual. The interviews with rural PHC nurses and the observations of their identity work along with the observations of PHC nurse identity work within the submissions to the NHHRC comprise the empirical domain for this study. Analysis of the empirical informs an understanding of nurses’ identity work in PHC and PHC nurse agency within the current health care reforms.

Within CR ontology the world is both socially constructed and real which means there can be things that exist in the real which aren’t experienced empirically. As such, causal powers may exist which are not yet exercised. Danermark et al. (2002:39) state that there is an ontological gap between what we experience, understand and perceive as happening and the deep dimension where the mechanisms are (the real domain) which produce the events. This ontological gap has the potential to allow us to understand how we could be from that which we currently are not (Sayer 2000).

It is in distinguishing these three domains that CR proposes a stratified ontology, that is the real world is greater than the actual (the results of activation of the structures and powers of objects) and the empirical (the observations and experiences which result from the application of a socially-influenced conceptual framework to the interpretation of sense-data). This allows for the understanding of emergence. Emergence results from a conjunction between two or more features of the actual or empirical domain giving rise to new phenomena. While a new phenomenon is dependant for its existence on the actual and/or empirical features, it has properties which are irreducible to the individual constituents of those domains. In this study the structure of PHC nurse identity may well be informed by nurse’s beliefs and interests and characteristic representations of PHC nursing evidenced as PHC nurse identity work, however PHC nurse identity is not reducible to these factors. This study uncovers some of the causal mechanisms of PHC nurse identity however, as a

necessarily ongoing process, the explanatory frameworks constitute part of a developing understanding PHC nurse identity.

The benefits of using a critical realist ontology

A CR ontology enables assessment of the interplay between nurse agency and social structures rather than favouring one or the other. The causal power of structures/social forms is mediated through social agency and informed by the social, cultural and historical context (Bhaskar 1989). The introduction of a draft National PHC Strategy for Australia (Australian Government Department of Health and Ageing 2009a) necessitates concomitant changes in nurse's work structures, roles and practices in providing PHC services and many different groups have an interest in how nurses will be positioned. As such, a research approach that can appraise the interplay between agency and structure within temporal and sociocultural contexts is required for this study.

Nursing practice depends on nurses' agency and studying nurses' opinions, interests and beliefs about their positioning as PHC providers incorporating how they 'personify' roles/ positions was required for this study (Archer 1995:187). However, while individual's beliefs and opinions will provide some understanding of nurses' agency and PHC nurse identity, it will be a subjective and incomplete understanding of the reality of PHC nurse identity as a social structure (Archer 1995). Archer (1995:11) describes the privileging of individual's views, through intepreivist approaches, as upward conflation which ignores the influence of the emergent properties of society.

Moving towards an understanding of social structures, such as PHC nurse identity, requires more than just the individual's account of their experiences. However, taking a constructionist or postmodern approach, which present human properties and powers (apart from biology) as derivative from society, will underplay the influence of the individual in producing and reproducing PHC nursing identity within health services (Archer 1995; Ackroyd and Fleetwood 2000:12-13; Archer 2000:86). Viewing the social world as entirely socially constructed is described as downward conflation by Archer (2000:87). A CR ontology enables a depth of exploration and

explanation which goes beyond this ‘methodological cul-de-sac’ of having to choose between structural determinism and individualism (Bhaskar 1989; Archer 1995; Archer 2000; Sayer 2000; Crinson 2007).

Analytical dualism (Archer 1995:15-16) offers an approach within CR which not only recognises the interdependence of structure and agency, the ‘parts’ and the ‘people’, but also that they operate on different timescales. It is this morphogenetic approach to CR which provides the ability to explain ‘different performances of the same role’ (Archer 1995:186). The term morphogenesis acknowledges that society has no pre-set form (morpho) and that it is formed by agents (genesis) (Archer 1995:5). Nursing roles and PHC identity, as structures, exist prior to nurses taking them on, constraining and/or enabling nurses as agents. The way in which nurses interact with these pre-existing structures differs depending on their interests and their aggregate power and this interaction leads to ‘structural elaboration’, transforming or reproducing the initial structure/s. The resulting structures then provide the pre-existing context for future agents (Archer 1995:167-168).

The continuity of a structure such as PHC nurse identity (morphostasis) depends on whether the combinations of events and experiences in the Actual and Empirical have the power to cause change (Elder-Vass 2004). Explaining structures like PHC identity as an emergence of the combinations of factors arising from the actual and empirical is supported by an understanding of morphogenesis and morphostasis (Archer 1995; Elder-Vass 2004). Whether, and how, a structure changes over a period of time is dependent on the aggregate power and structural continuity of the large number of causal influences informing the process. The previous chapters presented evidence of ongoing tension between different types of causal powers informing PHC nurse identity. Therefore, underpinning the conceptual framework of this study with a CR ontology allowed for an exploration of nurses’ agency to provide explanatory frameworks for the morphogenesis/morphostasis of PHC nurse identity as a structure.

Archer (1995:167) argues that even though structure and agency are interdependent it is possible to analyse structural/cultural powers and agents’ interactions separately. By isolating the structural/cultural factors which provide the context for nurses’

actions and exploring the subsequent interaction with these factors by nurses, it is possible to investigate how nurses' interactions may result in redefining the roles/structures as well as reforming individual nurse's beliefs/interests. This supports investigation of PHC nurse identity and recognises that it is not static. The morphogenetic approach allows *'a tool for examining the dynamics by which the "parts" and the "people" shape and reshape one another through their reciprocal interactions over time'* (Archer 1995:194).

Finally, a CR ontology allows for a connection between the empirical data gathered and an explanatory framework which is the aim of this study. Critical realism provides a methodological means of looking beyond the empirical (that is, the practices, observations, experiences and representations of PHC nursing and nurses) as real, to allow for the underlying causal mechanisms (powers) to be theorised (Sayer 2000; Danermark, Ekstrom et al. 2002). Identity work in this study is the outcome of mechanism interplay, which allowed for the development of explanatory frameworks about PHC nursing identity.

Despite the growing recognition of CR ontology within social science, there is an absence of guidance and advice regarding research design or specific types of analysis for approaching research questions (Ackroyd 2009). CR supports a wide range of research designs with the particular choice of methods determined by the nature of the object of the study including what one wants to learn about it (Sayer 2000:19). As such, the deliberate choice of research methods for this study supported analysis of empirical data in order to connect to an explanatory ability.

From the previous chapters, the conceptual framework for this thesis highlighted the importance of rural PHC nurse identity, agency and factors constraining and enabling (controlling) their PHC practices as the significant theoretical constructs of this study. The questions guiding this research process and supporting the studies aim were developed within this theoretical framework. Two data sources were each purposively chosen as having the potential to contribute to answering the research questions by revealing different aspects of these constructs (Neuman 2003:215). Interviews with rural nurses and publicly available submissions informing the NHHRC's development of the draft PHC Strategy provided the empirical data which

through thematic and content analysis evidenced PHC nurse identity work (the actual). This then provided the basis for further analysis which enabled examination of nurses' agency within identity work and social and structural controls. The emergence of causal mechanisms (the real) for nurses' agency as PHC providers and the structural/cultural powers within rural health services were uncovered.

This qualitative research design fits within CR descriptions of an 'intensive' study (Sayer 2000; Danermark, Ekstrom et al. 2002; Reed 2009). As such, in identifying generative mechanisms and causal explanations for nurse's agency as PHC providers in rural health services as a particular case, the explanatory framework is generalizable as a theoretical conceptualisation however it is not representative or generalizable to rural nursing populations (Sayer 2000).

The diagrammatic representation on the following page (Figure 1) depicts the interrelationships between 1. The critical realist ontology of empirical/actual/real. 2. The research project's conceptual framework of representations in texts/identity work/identity and agency with 3. The research strategies employed to answer the research questions - interviews and submission documents/content & thematic analysis/ data synthesis and an explanatory framework. This representation is informed by the works of Stirling (2007), Crinson (2007), Sayer (2000) and Lupele (2007).

Figure 1: Diagrammatic representation of interrelationships between critical realist ontology, the conceptual framework and research strategy employed by this study of PHC nurse agency and identity

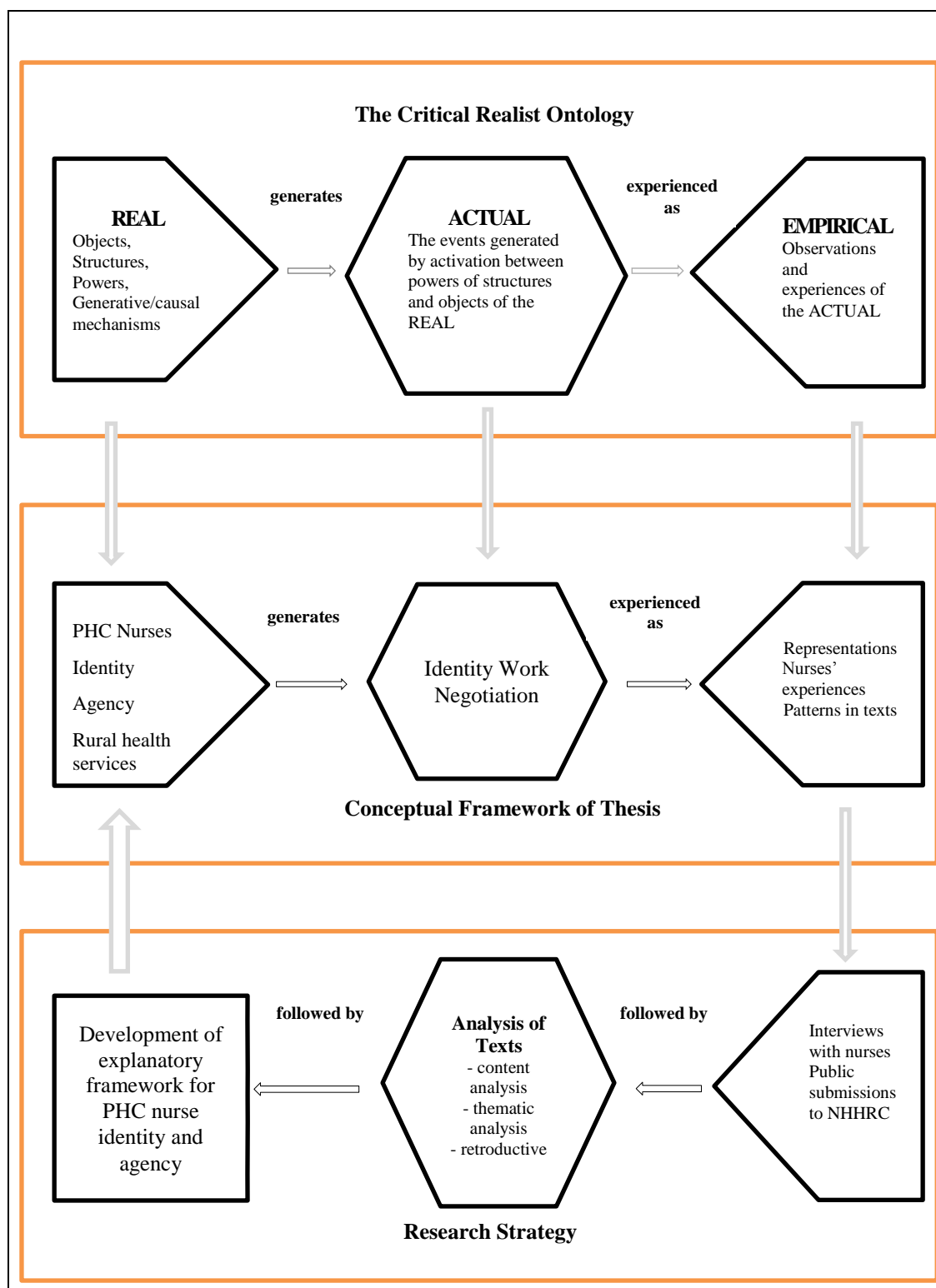


Figure 1: Informed by the works of Stirling (2007:113), Crinson (2007), Lupele (2007) and Sayer (2000:11-15).

Ethical considerations

There is substantial literature on ethical considerations in social sciences (Polit and Beck 2004:144; Punch 2004) and these are largely aimed at ensuring research participants are protected from any potential harm associated with their involvement in the research (Hansen 2006). As this study involved interaction with nurses, the formal application process required for approval of the research project demanded that ethical considerations, as espoused by the NHMRC for research involving human participants, were met. Researching within the ethical codes of conduct, including obtaining ethics approval, are a legal requirement and some of the key concerns involve ensuring informed consent is obtained, participant confidentiality, and in this project anonymity, is maintained and that participation is voluntary (Punch 2004). These requirements were fully met and using the National Ethics Application Format (NEAF), approval for the project was granted by the University of Tasmania Social Sciences Human Research Ethics Committee (Ethics Reference: H10387).

However, on commencing the initial contacts with NSW State Government nursing managers, to enable contact with potential participants and inclusion of NSW data, I was made aware of the need to submit an additional ethics application to the NSW Greater Southern Area Health Service (GSAHS). In order for approval to be granted, GSAHS requested the insertion of an amendment to the Participant Information Sheet. (See Appendix 1&2). This required submission of a formal ethics amendment to the UTas Social Sciences Human Research Ethics Committee, which was subsequently approved. All of the reporting obligations including annual and final reporting for this study were met.

Self-reflection is central to understanding the nature of critically grounded qualitative research (Kincheloe and McLaren 1994:147). Recognising that conducting ethical research requires continual reflexivity regarding ethical behaviour (Creswell 2003; Hesse-Biber and Leavy 2006), I initially found the requirement to amend the Participant Information Sheet to specifically include an ethical obligation within my Nursing Code of Ethics and Professional Conduct confusing (Australian Nursing and Midwifery Council 2008; Australian Nursing and Midwifery Council 2008). I had

been under the assumption that the ethical obligations stipulated by the approval process would sufficiently govern researcher behaviour. However, as well as meeting the legal requirements of gaining ethics approval to ensure adherence to ethical standards, this amendment reinforced for me the understanding that the standards for ethical behaviour within the approval process are less clear regarding moral obligations to act ethically. The need to be reflexive about underlying ethical values contained in the codes reinforced the imperative that research integrity demands moral obligations and as such I was obligated to disclose any information which would signify a participant's breach of the Nursing Code of Ethics and Professional Conduct. To ensure the rigour of this qualitative research, its trustworthiness, validity and reliability required 'moral integrity' (Kvale 1996:241; Hansen 2006).

Methods to enhance the quality of the research design and interpretations

Validity in qualitative research requires that interpretations of results are consistent with the data. The integrity and credibility of the researcher and the research is built up through the researcher's perceived actions in checking, questioning and theorizing the claims as well as not suppressing negative findings. In this study, CR as a strategy requires that in observing behaviours, any deviations from expected or sanctioned beliefs and actions are noted to enable recognition, understanding and confirmation of the causal powers underlying them (Ackroyd 2009). So in some ways continual negative case analysis underpins the analysis process, thus ensuring interpretation of the results maintains consistency with the data. Consistent and extensive discussion with my supervisory team throughout the analysis process contributed to ensuring the validity of interpretation of the data.

Hesse and Leavy (2006) provide a reliability checklist for qualitative studies derived from Gay and Airasian (2003). With a particular focus on interviewing, the checklist includes the importance of providing full description of the sampling methods, the participants, interview methods and transcription documentation. The structured process of coding and refinement within the thematic analysis of the interviews and the content analysis of the NHHRC documents are outlined later in this chapter within the relevant methods sections. The emergence of themes following this

process is clearly explained to ensure rigour. Hesse and Leavy (2006) also stress the importance of fully describing the researcher's relationship with the group and setting. This aspect of reliability will require further explication of my positioning as researcher within the research process.

Positioning myself in the research

My positioning as the researcher for this study incorporated my professional history as a rural nurse living in a rural town. As a product of the social world in which this research is based, I bring my own subjective meanings to the field. Entering a familiar care setting to undertake research required continual acute awareness of the influence of my own experiences in collection and analysis of the data including how my reality may alter the responses elicited from participants. Within this study, my role as researcher is subject to the same scrutiny and critical analysis as the research itself (Liamputtong and Ezzy 1999). As a rural nurse, and having been employed in many of the PHC roles available to nurses in small rural towns, to some extent I share a common culture with both the nurses interviewed and many of the organisations providing submissions to the NHHRC. Acknowledging this position and providing the reader with the measures taken to address issues arising within the complexity of this research relationship is essential. These are issues having potential impact on the validity and trustworthiness of the findings of this study. Outlining how I have addressed the issue of 'insider research' plays a critical role in ensuring integrity and credibility of the study's findings (Liamputtong and Ezzy 1999; Mullings 1999; Corbin Dwyer and Buckle 2009).

The issue of 'insider research', that of sharing the characteristic, role or experience under study with the research participants, has generated much discussion in the literature (Corbin Dwyer and Buckle 2009). Primarily these discussions are situated within the epistemological positioning of each research study and subsequently promote the advantages or disadvantages of either the insider or outsider position. Issues about which characteristics are shared and 'what' the researcher is in or outside of are often either not detailed or left unanswered (McGrath 2006). Moving beyond these binary positions, the complexity of the relationship between the researcher and the research study (including the participants) can be perceived as a

dynamic process which some authors suggest is more accurately conceived as a 'space between' allowing for the researcher positionality of both insider and outsider rather than accepting a dichotomous perspective (Mullings 1999; McGrath 2006; Allen, Chapman et al. 2007; Corbin Dwyer and Buckle 2009).

Whether occupying a position of insider or outsider or a 'space between', Corbin Dwyer and Buckle (2009) posit that *'the core ingredient is not insider or outsider status but an ability to be open, authentic, honest, deeply interested in the experience of one's research participants, and committed to accurately and adequately representing their experience'* (:59).

One critique of my positioning as a nurse within this study in regards to research credibility is that the researcher's familiarity with the characteristics under study may result in taking some knowledge in common for granted. With this in mind, supervision of the project by a non-nursing member was secured and from the outset of the study I maintained a detailed reflective journal about the research process, noting thoughts, feelings and decisions made throughout the entire project. Reflective journaling, whilst still based within my subjective reality, reinforced the imperative of awareness of my biases.

Critical theorists, in addressing the issue of researcher relationship with people/groups being studied, argue that representation of the participants position, particularly those of groups perceived to be marginalised, demands both the researchers engagement and active avoidance of distancing (Kincheloe and McLaren 2000). Being recognised as a member of the group one is studying provides an understanding of commonality which supports a level of trust and openness within the research relationship. Engaging in this process created a need for some reciprocity of disclosure of some pertinent personal details which enhanced rapport and was evident in comments such as 'you would know having done community nursing' or 'you know what it's like'. It is this commonality of understanding within which the researcher must remain mindful to take these points further rather than assume an understanding and this was undertaken.

Maintaining participant's anonymity was a critical factor for this study. Health services in small rural communities in Australia have distinct individuating characteristics and, coupled with the low number of health professionals working in them and the significantly low number of male nurses, it was possible both for the nurses participating in this study as well as their health services to be readily identified. There was only one male participant in the interview component of this study. To ensure this participant's anonymity, gender was not ascribed to the individual nurse's quotes. Assurance of confidentiality was paramount to many, although not all, of the nurses. Most of the nurses asked for assurance of de-identification of the data and anonymity for their responses, and some asked for this to include which State they practiced in.

Transcription of the interviews and review of my journal entries highlighted how the understanding of commonality between me as researcher and the participants supported the potential to promote an ease of conversation whilst also necessitating vigilance regarding confidentiality and anonymity. My ethical obligation as a researcher, to avoid potential harm, demanded recognition of information provided by the participants which had the potential to adversely affect either the nurse's employment position or the organisation/s within which they worked. The often frank and open manner in which participants engaged in discussion necessitated data de-identification which included the removal of any distinguishing features including idiosyncratic speech patterns or naming of health services to ensure anonymity and did not adversely limit the study.

Within this discussion of my positioning within the research process, and mindful of my position as a product of the social world in which this study is based, I have entered the project with a priori understandings of the research interests including power, identity and agency. While I have addressed efforts taken to acknowledge potential bias, critique of the adoption of a critical realist approach as implying determinism requires further discussion.

A CR ontology acknowledges the existence of a predetermined nature of what some objects can and cannot do (Sayer 2000). The domain of the real includes many potential causal mechanisms including the categories such as nature, social, human,

physical and chemical. Theorists argue that some aspects of these essences can be predetermined while others are socially constructed (Bhaskar 1975; Collier 1994; Archer 2000). The influence of causal mechanisms is not in a linear or predictable fashion because they can act concurrently, simultaneously and within and across different domains. Therefore, rather than being able to predict outcomes of the influence of causal powers, CR provides a way of uncovering what might need to exist in order to explain something which is experienced or observed to happen. This allows for providing explanatory frameworks for deep causal mechanisms (Cruickshank 2003; O'Mahoney 2011). Determinism is also reduced through clearly explicating the particular context within which this study is situated as well as acknowledging the agency of nurses which incorporates their reflexive potential to inform their practice. The acknowledgement that the explanatory frameworks emerge as part of an ongoing process in developing understanding of PHC nurse identity and nurses' agency as PHC providers assisted in minimising determinism within this study.

Although the previous chapters have outlined power dynamics as a central concern within this study, the study's aim and design was not to observe power dynamics directly. Employing a critical paradigm provides a focus for the way in which the power dynamics of the underlying causal mechanisms can generate a given set of meanings (ideologies) about nurses' social reality (Hesse-Biber and Leavy 2006). As such, this realist study developed an explanatory framework for nurse's agency within PHC nurse identity to validate the empirical findings.

Selecting the data, methods of collection and analysis

This section will detail the approaches taken for data selection and collection, the data analysis methods and the rationale for the research methods used to address the aims of this study and contribute to answering the research questions. Two empirical data sources were purposively selected which had the potential to contribute to answering the research questions through data which would uncover PHC nurse agency and socio/cultural structural factors in PHC nurse identity work. These two data sources were: (a) Semi-structured interviews with 21 rural PHC nurses and (b) Submissions presented to the NHHRC.

The first data source involved conducting in-depth interviews with 21 nurses working in primary health care settings in rural outer regional Australian towns in the States of NSW and Tasmania. The rationale for selecting this data source included its potential to access the identity work of PHC nurses at an individual level and within their rural context. Further detail is provided regarding the rationale for using this specific data source within the section detailing the selection of participants.

The second data source consisted of 265 publicly available submissions from interested individuals and organisations provided to the NHHRC. The submissions were made in response to a nationally advertised request for input, over two weekends in early April 2008, as part of a wider program of engagement and consultation to inform Australia's primary health care reform. The commission drew on these submissions to inform the development of their report to the Minister for Health (National Health and Hospitals Reform Commission 2009). This report provided the essential basis for the development of Australia's first Draft National PHC strategy (Australian Government Department of Health and Ageing 2009a). This extensive data source was selected due to its representation of the many groups with a significant interest in Australian PHC reform. The review of the literature highlighted the integral position of nursing within PHC reform, and as such, the submissions provided access to the representations, positionings and characterisations of PHC nursing by key groups including the health care professions and policy makers as well as at an organisational level and a broad public level.

The two sources of data were analysed separately with detailed methods provided further in this chapter on pages 101-116. Thematic analysis of the interview transcriptions, using the qualitative data analysis software program NVivo 8 to manage the data (QSR International Pty Ltd 2008), followed a structured process of coding and refinement to support the identification of emergent themes. Similarly, patterns and trends in the NHHRC texts were identified through Content Analysis of the submission data with the use of the Adobe Acrobat Document function of Edit/Advanced Search (Adobe Systems Inc. 2010). The use of multiple methods and materials is advocated as one of the means by which a researcher can support the production of a valid research analysis (Lincoln and Guba 2000).

Immersion in the literature revealed a multiplicity of influences potentially impacting PHC nurse identity. Employing a tool developed by Clarke (2003), within grounded theory analysis, I placed all of these potential impacts on a 'situational messy map' (See Appendix 3). This mapping process highlighted the confluence of influences (potentially) exerting different kinds of causal powers on PHC nurse identity but it did not provide any information on how the 'structures' impinge on 'agency' or about how the powers of 'agents' affect its reception (Archer 2003:15). With the understanding that these powers of structures and agents are distinctively different and irreducible, Archer (2003) contends that the reflexive deliberation of agents provides a mediatory process to link them. It was with this in mind that I decided to allow the voices/reflections of the individual PHC nurses, via a semi structured interview process, to dominate my consciousness initially before approaching the content analysis of the submission documents.

In-depth interviews

In-depth semi structured interviews provided a means of accessing the way in which nurses working in PHC understand their positioning and also how they negotiate and navigate the changes happening both locally and nationally in PHC which affect their professional roles. In-depth interviews are particularly appropriate within context specific situations in gaining issue orientated information (Hesse-Biber and Leavy 2006). This fits well with the research design for this study of an intensive case study of rural PHC nursing. The interviews provided some access to the reflexive deliberations of PHC nurse agents and the way in which they supported or resisted changes to PHC nurse identity work in their local setting. As such, the task at hand was to engage with and to try to understand individual and/or group constructions relevant to the enquiry. By interpreting this material, through thematic analysis, emergent themes were generated.

Selection of participants

The geographic locations chosen for providing potential participants for the interviews incorporated towns in the Australian States of New South Wales and

Tasmania which fitted the demographic of: rural towns with a population under 10,000 permanent residents. The towns considered were outer regional (not remote) with a large hospital within 2 -3 hours' drive. The actual towns will not be identified to ensure the anonymity of the participants.

These geographic locations were purposively chosen. Considerable academic, research and policy emphasis has focussed on the provision and accessibility of health care in outer regional communities in Australia experiencing significant migration of aged and lower socioeconomic populations to these areas (the 'seachange/treechange' phenomena) as discussed in Chapter 3 (Hugo 2002; Murphy 2002; Abernathy 2004; Burnley and Murphy 2004; House of Representatives: Standing Committee on Health and Ageing 2005; Gurran, Squires et al. 2006). Tasmania is particularly affected by these changes, having the oldest demographic in Australia and many outer regional NSW towns have experienced significant increases in their aged populations. Both these areas have also experienced an increase in migration of people taking financial advantage of lower house prices than in urban/metropolitan cities. Participants in these communities were purposively sought because of their involvement in rural health services specifically impacted upon by these changing demographics and the health reform changes directed towards increased coordination and provision of primary care services particularly for aged and marginalised groups. As such, data from these settings allowed a contextual focus on rural PHC nurse identity work during significant health reform change processes which is of central concern in this study.

Having chosen specific geographic areas meeting these criteria, contact was made in the following manner:

- For State Government run and NGO services, initial telephone contact was made with the sites Nursing Manager, outlining the project. The Managers who verbally agreed to be involved were sent, via email, an invitation to participate with an attached information sheet (Appendix 1&2). They were requested to forward the email on to their nursing staff as potential participants as well as placing a downloaded hardcopy on their staff notice boards (Appendix 4).

- For Practice Nurses, initial telephone contact was made with the Practice Nurse support officers employed by the General Practice Network (AGPN) covering the geographic area. On agreeing to participate, they were also sent the invitation with an attached information sheet which they subsequently forwarded to Practice Nurses in general practices.
- Individual face to face meetings were requested by some of the nursing managers and a Practice Nurse support officer prior to their forwarding of the introductory emails to potential participants; this had a positive effect on the participant response rate from the sites they managed.
- On receiving the ‘invitation to participate’ email, potential participants self-selected to participate by self-identifying as PHC nurses. The participants then made initial contact with me via email and following this we set up a mutually suitable time and meeting place. Prior to meeting, they were sent an email with an outline of the interview questions and a consent form.

Interview questions

The participants received a copy of the interview questions prior to interview, noting that these questions would be used as a flexible interview guide (Minichiello, Madison et al. 2004; Hesse-Biber and Leavy 2006). The question guide used in the semi-structured interviews is given in Appendix 5. The questions acted as a basic guide for the progress of the interview ensuring that each interview addressed the enquiry topics of the study. The four key areas of inquiry were based on the literature review with the sub topics covering the main points relating to rural PHC nursing identity and the change processes within health care reform.

The four key themes addressed in the semi-structured interviews were:

- a) The participant’s PHC positioning in terms of their current professional nursing role(s)
- b) The participant’s identification with their professional nursing role and PHC.

- c) Collaborative practices with other nurses, health care providers and community.
- d) Rural PHC nursing as a distinct professional positioning.

The interview guide serves as an aide, prompt and checklist within semi structured interviews and may require modification early in the data collection process to ensure all key areas are addressed (Weiss 1994; Hesse-Biber and Leavy 2006). Following the initial interview, the question guide was reassessed for its effectiveness in being able to cover all the topics of interest to the study. This highlighted the importance of including an extra sub topic regarding nurse's perceptions of their PHC role as being an advanced practice role and the way in which this influenced/informed the participants PHC practice.

Interview procedures

The in-depth interviews were carried out between May 2009 and February 2010 with a total of 21 nurses participating. Of these, 19 were Registered Nurses and two were Medication Endorsed Enrolled Nurses. The participants were employed by a wide range of rural PHC services including non-government organisations (NGO's), State Government health organisations, federally funded organisations and private provider organisations. Their professional role titles included those of Practice Nurse (PN), Community Nurse (CN), Community Health Nurse, Clinical Nurse Manager (CNM), Clinical Nurse Specialist (CNS) and Rural Nurse. Two nurses were undertaking study to qualify as Nurse Practitioners; one was employed as a Practice Nurse whilst the other nurse worked as a Community Health Nurse and also a Practice Nurse with different employers. While most of the nurses described their scope of practice as rural generalist, some were working as nurse specialists.

The following table (Table 1) depicts the range of the participants PHC roles as well as the number of participants employed within these roles. The table also provides delineation of the nurses who were concurrently employed in more than one PHC role within their community which predominantly entailed more than one employer.

Table 1: Interview Participants and Their PHC Roles.

	PHC nurse roles	Number of participants
Employed in single PHC nurse role	Community Nurse (CN)	1
	Community Health Nurse (CHN)	5
	Nurse Manager (CNM)	2
	Rural Nurse (RN)	1
	Nurse specialist (CNS)	1
	Practice Nurse (PN)	3
Employed in more than one PHC nurse role	CHN:PN:RN	3
	Rural Enrolled Nurse: PN	2
	CHN:PN	1
	CHN:RN	1
	CNM:PN	1

Face to face interviews were conducted with 20 of the 21 participants. With the nurses choosing the interview place and time, half of the nurses (12) chose a private room at their workplace, agreed to by their manager. Four of the interviews were held at the nurse's own home, two interviews were held in Cafés near the nurse's work and during work time, two were at my private office and one interview was via phone after the nurse was unable to make the interview date due to illness. Using the telephone is not a preferred means for conducting in-depth interviews (Rubin and Rubin 2005) and for this reason was avoided in the study despite the extensive travel required to meet with regional nurses. Having said this, however, the one interview which unavoidably required using the phone went very well, lasting nearly two hours. This may well have been assisted by the multiple contacts via email prior to the interview as well as the participants eagerness to 'put her point across' and also the deliberate timing of the phone call later in the day on a weekend and ensuring no interruption. This interview was also the last interview conducted.

At the commencement of the interview all of the participants were given a Demographic Questionnaire (See Appendix 6). Whilst the demographic data collected was not aimed at building a representative picture of the participants, the

results for both age and gender do correlate closely with the national demographic data for nurses (Australian Institute of Health and Welfare 2010a). The majority of the interviewees were working part time as nurses and all of the nurses lived in the community they worked in. The participants' demographic details assisted in ascertaining key themes influencing rural nurses PHC positioning and their identity work in this process and are tabled below (Table 2).

Table 2: Interview Participants Demographics

	Demographic data of participants
Gender:	20 Females (95.2%): 1 Male (4.8%)
Age:	Range: 27 – 61 years old. Average age: 50.4 years old
Length of nursing practice (years)	Range: 4 – 40 years Average length of nursing practice: 28 years
Length of rural practice (years)	Range: 1 – 40 years Average length of rural practice: 14.7 years

During the interviews, at differing stages, all of the nurses questioned me about my clinical background as well as my positioning as a nurse researcher and my personal reasons for undertaking this study, as discussed previously. Expressing my familiarity with the interviewees practice world was supportive in encouraging the participants to share depth and detail in the responsive interview as an extended conversation (Rubin and Rubin 2005).

Each interview commenced with signing the consent form and completing the Demographic Questionnaire. With the consent of the participants, all of the interviews were recorded using a digital voice recorder. The telephone interview was similarly recorded by placing the caller on speaker phone, with her consent. The interviews lasted between 60 and 120 minutes, with most interviews requiring the full 2 hours.

Whilst the interviews did not follow the sequence of questions as outlined in the Interview Questions guide (Appendix 5), I ensured that through the course of the interview the topics were addressed. However, the semi structured nature of the interviews allowed participants to focus more fully on topics and areas significant to them (Minichiello, Madison et al. 2004). This form of interviewing also provided me, as the researcher, with the opportunity to probe responses to questions more fully to ensure clarity of meaning (Rubin and Rubin 2005). This allowed for a degree of continuity between interviews. Towards the conclusion of the interviews, the participants were again shown the question outlines and asked if there was anything else they wanted to add or felt had been missed.

Interview data collection, recording, transcribing, member checking

All interviews were transcribed verbatim by the researcher as soon as possible after the interview, this allowed for reflective critical assessment of my interview techniques as well as highlighting emergent topics for subsequent interviews. Included in the transcriptions were behaviours such as laughter and pauses as well as points which the interviewee stressed by raising their voice or repeating a phrase. Interruptions were also recorded. These aspects proved to be very beneficial promoting insight during the analysis process. These transcriptions were checked for accuracy and then sent to the participant via email (after ensuring their preferred email address for confidentiality). Each interviewee then reviewed the transcript for accuracy and returned it to me. None of the participants chose to adjust or alter the original transcripts. Once the transcripts were returned to me via email they were finalised. The transcripts were confidential, and with this understanding they were only seen by me and the participant to ensure candour. Each participant was assigned a unique identification code which was then used in the thematic analysis.

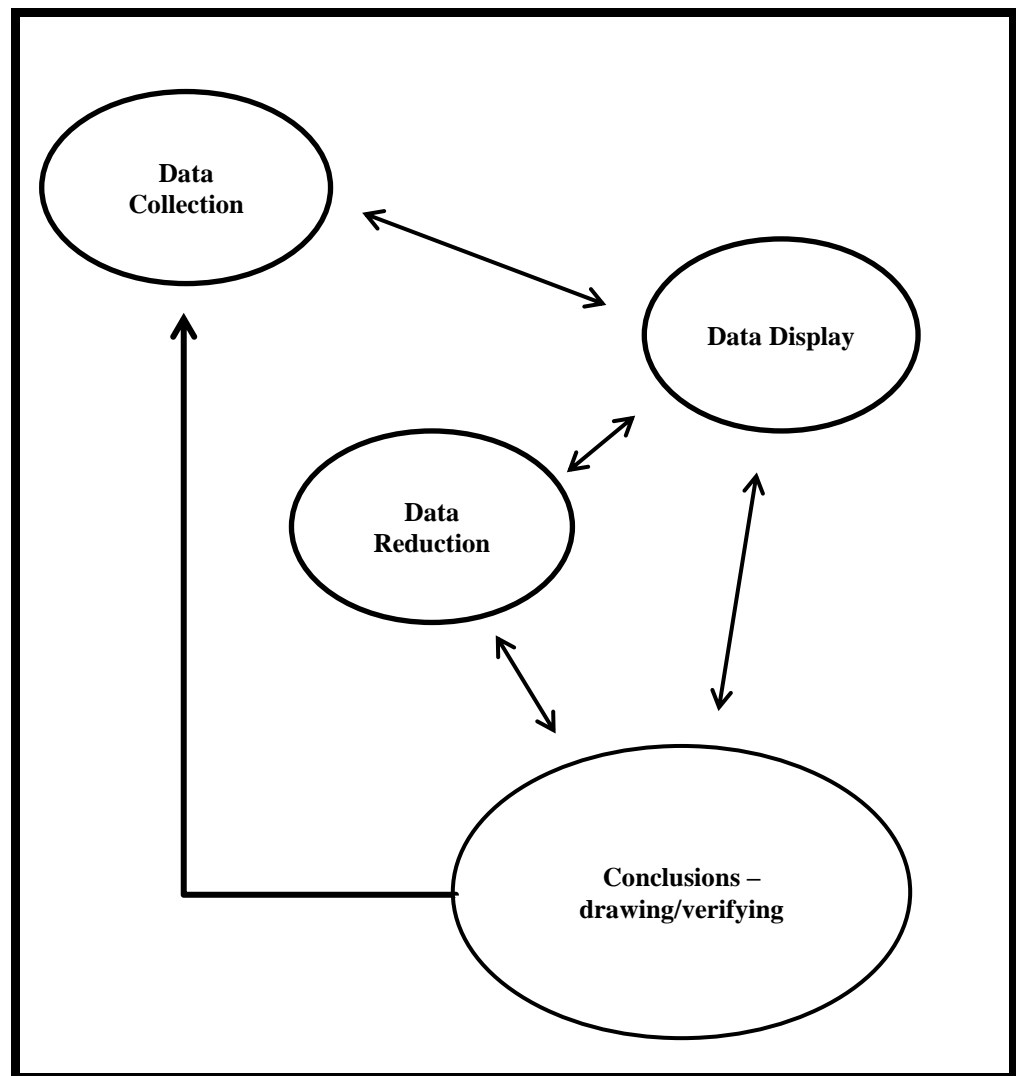
Interview data analysis – Thematic analysis

Thematic analysis was used to identify emergent categories, themes and relationships in the interview data. The interviews yielded over 168,000 words of transcript and the computer software program NVivo8 (QSR International Pty Ltd 2008) was used to assist in data reduction and data display. Interviews were thematically analysed and codes were assigned to each theme (both those which were previously identified

(in the semi structured interview guide) and those which emerged during the interviews). These themes were based on similar phrases, relationships between variables, patterns, themes. A deep level of familiarity with the data was achieved during the process of organising and conducting the interviews, personally transcribing them and then printing them out, reading and rereading them followed by importing and coding them in NVivo. This level of familiarity supported the process of thematic analysis.

The process of analysis was informed by The Miles and Huberman Framework (1994) which supports ‘tracing out lawful and stable relationships among social phenomena, based on the regularities and sequences that link these phenomena’(p4). This interactive model for analysis integrates well with the conceptual framework of the study and has three main components which are concurrent and interacting throughout the analysis process.

Figure 2: Model depicting Miles and Huberman framework (1994)



Data display initially involved transcribing and printing out the interview transcripts. These were imported into NVivo. Coding allowed for the emergence of conceptual structures. Data reduction occurred iteratively with data display, involving coding, memoing, discerning themes, clusters and patterns. Mapping techniques as developed within Situational Analysis (Clarke 2003) were used to support relational analysis within the process of coding and development of emergent themes. These mapping techniques were also employed in the synthesis of data from both the interviews and the NHHRC submissions and will be more fully detailed within that section.

The interviews and the interview analysis process occurred simultaneously over approximately a ten month period. Attempting to present the process in a sequential

manner is not possible, the process is iterative and Miles and Huberman (1994) outline tactics for transforming and interpreting qualitative data within this iterative process. Employing these tactics assisted in both generating meaning from data and testing/confirming findings.

The tactics used iteratively for generating meaning included:

- Noting patterns and themes, seeing plausibility and clustering, this assisted in developing 'connections' between data.
- Making metaphors, which assisted in developing further integration between diverse pieces of data
- Making comparisons, counting and partitioning the variables supported sharpening understanding as well as differentiating between codes.
- Subsuming specific codes into more general codes and noting relationships between the variables supported further abstraction of patterns of meaning.

Testing and confirming these patterns of meaning/findings was also informed by tactics outlined by Miles and Huberman (1994), including checking for representativeness, checking for outliers, looking for negative evidence and checking out rival explanations. The main themes emerging from analysis of the interview transcripts are depicted in the following table (Table 3). Elaboration of these themes is presented in Chapter Five.

Table 3: The Main Themes Emerging from the Interview Data:

Connecting with PHC concepts	Rural PHC as Advanced Practice	Structured & Structuring Roles	Collaboration & Integration	Living & working Rural
A sense of enthusiasm for 'holistic nursing'	Specialist vs. Generalist practice	Funding for PHC nursing	Fragmented funding mechanisms	Aligning PHC concepts with regional nursing
Connecting with the language of 'PHC'	The concept of 'community' in advanced practice	Health promotion & community development	Between Nurses and GP's	Rural nursing in regional Australia
	Attachment to titles	First contact roles	Collaboration between nurses: hierarchies & networks	Health agencies perceived 'connection' to the community
	Access to PHC education as advanced practice	Availability to clients	Transboundary work to provide integrated care	

NHHRC submission documents

The interviews go some way in understanding the everyday social world of the PHC nurse however, as Reed (2009) contends, understanding the social worlds as 'members understand it' is merely the starting point within a critical realist study of PHC nurse identity and agency within the domain of the 'real' world – it is necessary to go beyond this to consider the adequacy of their understanding of the world to produce a combination of generative mechanisms. Moving beyond the actor's level of understanding (Archer's (2000) 'internal conversation') and embedding it within an appropriate sociocultural context is a necessary precondition for developing possible explanations for the actor's understandings and actions in relation to the structural mechanisms that generated them. Analysing both these aspects of identity work separately and then synthesising this understanding allows for theorising of explanatory causal mechanisms of PHC nursing identity. The public submissions made to the National Health and Hospital Reform Commission (NHHRC) offer a unique opportunity to gauge the positioning, representation and characterisation of

nursing in regards to identification with primary health care in Australia and provided the second data source with which to analyse PHC nurse identity work.

Selection & collection of documents

In 2008, the Australian Government's Department of Health and Ageing released their document 'Towards a National Primary Health Care Strategy' (Australian Government Department of Health and Ageing 2008), which was aimed at providing a broad framework of key issues impacting on PHC. They invited submissions commenting on the discussion paper to be submitted to an external reference group, the NHHRC. The NHHRC called for submissions to provide comment on the 10 proposed elements which could underpin a future PHC system. The submissions were made publicly available via their website

www.nhhrc.org.au/internet/nhhrc/publishing.nsf/content/submissions-table-aug-2008

in August 2008. The NHHRC published their final report in June 2009 (National Health and Hospitals Reform Commission 2009) which provided key direction for the development of the Australian Government's first Draft National Primary Health Care Strategy (Australian Government Department of Health and Ageing 2009a).

The report was informed by extensive consultation which included the 522 submissions received from the Australian public, frontline health workers, professional and consumer groups and other interested people and organisations as well as submissions from invited key 'thinkers'. These submissions were received in response to a nationally and widely circulated Federal Government discussion paper (Australian Government Department of Health and Ageing 2008) which detailed ten key elements which could underpin Australia's PHC system and called for broad public response.

The diverse range of contributors submitting comment to the NHHRC, and the broad platform of PHC principles they had opportunity to comment on, offers significant data for analysing the sociocultural positioning of nurses within PHC. Within critical realist theory, these texts offer a means of investigating the sociocultural powers and control of this positioning through insights into identity work and the underlying real structures (Sayer 2000; Hesse-Biber and Leavy 2006). While the focus of the submissions was not PHC nursing, nurses are integral to the context of health service

delivery and as such the submissions provided access to broad social representations of PHC nurse identity work within this context.

Submissions analysis - Content analysis

With such large volumes of qualitative material/texts, Content Analysis offered a means of data reduction and ‘sense making’ in attempting to identify and present ‘core consistencies and meanings’ (Patton 2002:453). Content analysis can be defined as ‘a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use’ (Krippendorff 2004:18). Conceptualisation of content and the process of analysis is strongly influenced by the underlying ontology within which it is used (Beckwith, Dickinson et al. 2008) and also the clarity with which explication of the context is made. Using a critical realist ontology to underpin the conceptual framework of this study, the documents were searched for evidence of representations of identity work and these findings were then further analysed through retroductive analysis to develop an explanatory framework for nurses’ agency as providers of PHC through identity work.

Of the 522 submissions, commissioned opinions and discussion papers submitted to the NHHRC, 265 were made publicly available on their website as ‘pdf’ files (Adobe Systems Inc. 2010). Nursing was not the central focus of these documents, however, as a critical component of the conceptual framework for this study and contextually present in many of the submissions, these files were then searched for the terms ‘Nurse’ and ‘Nursing’ with the use of the Adobe Acrobat Document function Edit/Search for searching terms in pdf files (Adobe Systems Inc. 2010). A small number of the documents did not allow for this search process and so they were searched by hand and marked up.

Nursing (or nurse) is mentioned in 146 of the submissions. Thirty two of these were individual submissions, many of them from nurses and not representing the views of organisations/groups or commissioned submissions. Given the fact that in-depth interviews had been conducted with nurses to gain their understandings of their positioning in PHC and that there were a large number of submissions, these

individual submissions were not included. In reading the 114 remaining submissions which contained the term Nurse or Nursing, 25 of the submissions only give nursing a cursory mention, either within referenced literature or in discussing health professionals/professions generically (doctors, nurses and allied health). These were excluded. The resultant 89 submissions from organisations containing the terms 'nurse' and/or 'nursing' were printed out as well as being uploaded into NVivo8 (QSR International Pty Ltd 2008) as 'internals' and read thoroughly. These 89 submissions formed the data source for analysis.

The initial choice of search term changed at the commencement of analysis. I had initially decided upon using the term 'PHC nurse', however on starting this search, the results were very limited, with the term only used four times. Three of these instances were within one document submitted by a medical organisation and the one other instance was within a document submitted by Australian Capital Territory (ACT) Health, a government organisation. I concluded that, with the Federal Government calling for comment on the reorientation of the health care system towards a greater focus on primary health care and primary care, the focus of the submissions would be on this aspect (PHC) and would include a focus on population health, a wider range of services and a move away from hospital centric modelling. As such, searching the term 'nurse' and 'nursing' within the documents would provide insight into the representations of nurses within the theoretical concepts of PHC nurse identity, agency and identity work for nursing thus addressing the aim of this study.

The coding framework

The paragraphs within the documents which contained the terms Nurse or Nursing were tabled to enable detailed examination of the way in which nurses were represented and positioned as PHC providers within the text. Aspects of the textual material which were then taken into account included evidence of nurse identity work within PHC and were based on criterion derived from the conceptual framework and the development of the research questions specific to this study within a critical realist ontology. The emergent process required constant re-examination of the data to allow for the appearance of new meaning units and the use

of memoing provided a means of iterative reflection and interpretation throughout the process (Hesse-Biber and Leavy 2006).

Analysis of the submissions involved classifying each use of the term nurse or nursing into specific meaning units. Developing the framework for this was informed by the work of Beattie et al. (2004) using the coding method of ‘topic’ and ‘type’. Four main topics provide the first dimension in this framework. These topics (broad themes and categories) emerged from the literature review and the context of the case of rural nursing and were also influenced by iterative immersion in reading the submissions. The four topics are:

1. Nursing for ‘and on behalf of’ who?
2. Roles and care focus in Primary and Community Care
3. Providing connectivity & linking medical & social care
4. Advanced nursing practice

Codes were then developed which depicted the different ‘information items’ nested within each of these four broad topic themes (Beattie, McInnes et al. 2004:10). The process of coding for the meaning of the use of the word Nurse or Nursing ensuring that codes/meaning units are conceptually and logically distinct (Krippendorff 2004) can be distinguished by three steps Mayring (1983), Flick (1998) in (Gray 2004).

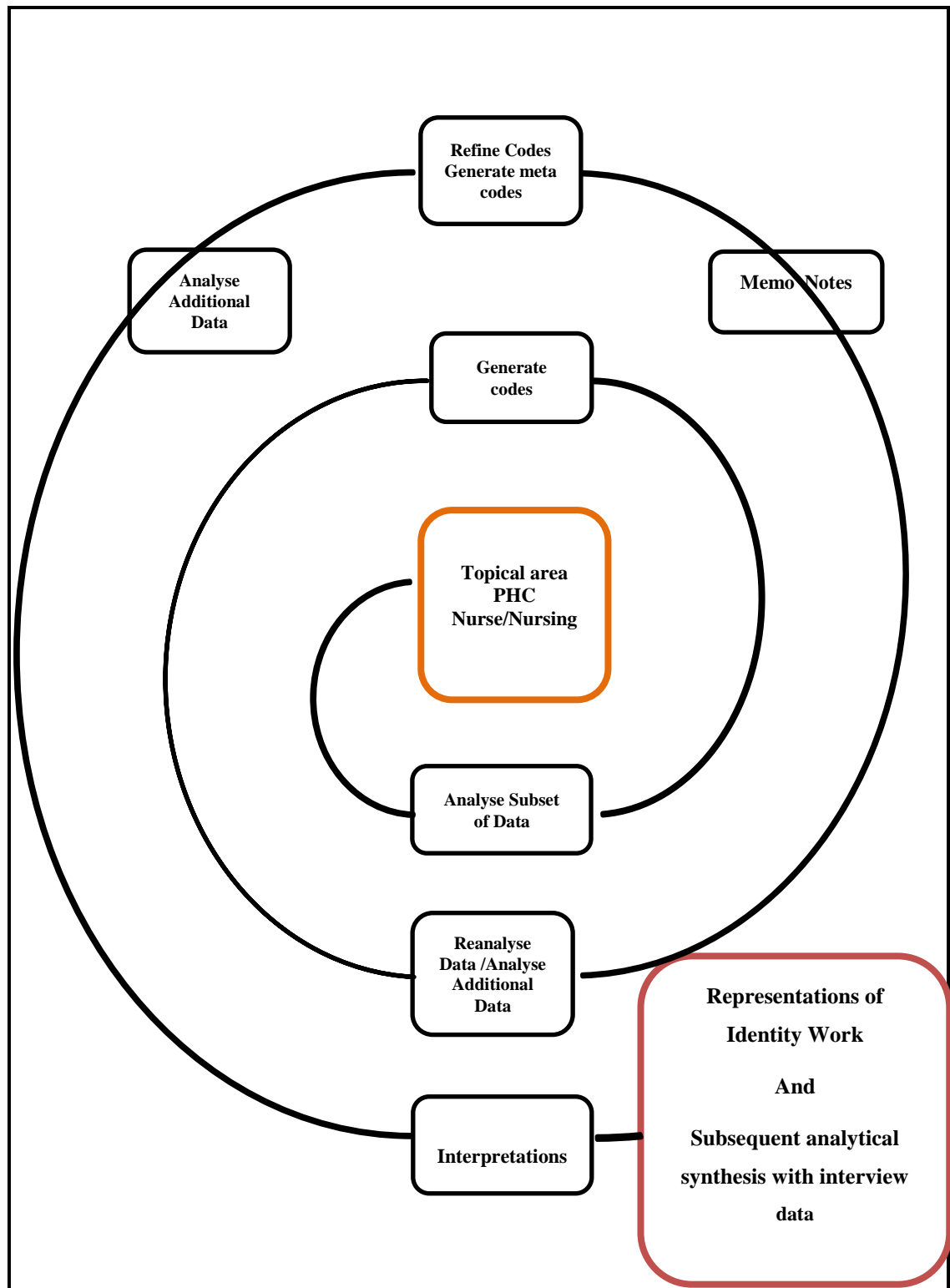
- Summarizing - the paragraphs containing the word/s Nurse or Nursing were paraphrased. Similar paraphrases were coded together.
- Explicating - these paraphrases were then clarified, defining terms, exploring any ambiguity or contradiction
- Structuring – the meaning units were formalised using key features.

With the meaning units within the texts identified, commencing analysis allowed for an organisation and reduction of the volume of textual material (Gray 2004:328-329). It provided a means of making inferences about the conceptualisations of the writers from the proximity of particular words within the texts (Krippendorff 2004:36). To exemplify, within this study, the proximity of the word Nurse or Nursing and the phrase ‘task delegation/delegated tasks’ allows for inferences across

‘logically distinct domains’ and the frequency with which this occurs within a document and across the volume of documents presents the possibility of inferences of the prevailing conceptualisations of nurse identity work.

Historically, Content Analysis has been conducted quantitatively and presented in a linear model. The iterative and inductive process of conducting a qualitative content analysis is best described visually using a spiral model of research design (Neuendorf 2001; Hesse-Biber and Leavy 2006). The following flow chart, adapted from Neuendorf (2001) and Hesse-Biber & Leavy (2006) provides a visual depiction of this process for this study.

Figure 3: Content analysis flow chart – adapted from Neuendorf (2001)



This process of summarising, explicating and structuring provided insight into the similarity of positioning of the different groups providing submissions. The groups were then coded into six categories:

- a) Nursing
- b) Medicine
- c) Other Health Organisations
- d) Government Organisations
- e) Education Institutions
- f) Non-Government/Community Organisations

This allowed for the recognition of the existence of similarities within particular groups' submissions as well as assisting the categorisation of such a large number of submissions. The decision to group submissions in particular primary interest groupings was based on the dominant constituency of the group – for example the National Rural Health Alliance was placed in 'Other Health Organisations' rather than in 'NGO/Community Organisation' because of the predominance of health organisation representatives within their constituency. Likewise, the Australian General Practice Network was placed in 'Medicine' rather than 'Other Health Organisations' because at the time of providing the submission, 2008, despite increasing moves towards multidisciplinary care, doctors represent the dominant constituency and the focus is on care provided by them or 'for and on behalf of' them (Britt, Miller et al. 2009). For example, medical organisations had a general convergence of agreement on their positioning of nurses in PHC with a focus on nurse's professional role in terms of medical leadership.

Twenty seven different meaning units with thematic distinction were identified and each mention of nurse/nursing in each submission was coded to these meaning units (See Appendix 7). With all the submissions coded I then tabulated the data to enhance comprehension. Tabulation refers to collating similar meaning units in categories and presenting counts of how many instances are found in each (Krippendorff 2004:192). Tabulation revealed variations in relative frequencies of meaning units within the four categories of group submissions. Consistent, extensive and detailed discussion with my supervisory team throughout the analysis process, including the development of categories and themes, supported the validity of the findings.

Each of the different ‘information items’ was also coded for their use by the six different types of primary interest groups. For each different information item/meaning unit both the number of submissions mentioning a meaning unit and the number of times it was mentioned were counted and are presented in Table 3.

While the complete coding list is provided in Appendix 7, Table 4 presents only the meaning units/codes for the six submission respondents’ categories which provided either the highest number of responses or else the greatest degrees of divergence between responses. Divergence was evidenced by the extent of response between different group categories (either strongly supportive or oppositional). The extent of response across ‘meaning sub units’ also evidenced divergence within each group category.

Table 4: Meaning Units and Their Frequency within Different Interest Groups

Meaning Unit	Meaning Sub Units		Nursing (16)	Medicine (20)	Health Orgs(20)	Govt Orgs(5)	Ed. Orgs(10)	NGO & Comm(18)
Nursing for 'on behalf of' who?	Task delegation by GP	No. (%)	0 (0%)	9 (45%)	1 (5%)	0 (0%)	2 (20%)	0 (0%)
		Times mentioned	0	24	1	0	6	0
	Task Substitution	No. (%)	0 (0%)	8 (40%)	7 (35%)	2 (40%)	1 (10%)	4 (22%)
		Times mentioned	0	13	3	2	1	6
	Task transfer or Supplement GP medical care	No. (%)	5 (31%)	1 (5%)	2 (10%)	1 (20%)	2 (20%)	5 (28%)
		Times mentioned	9	2	3	1	3	6
	Autonomous Practitioner	No. (%)	10(62.5%)	3 (15%)	0 (0%)	2 (40%)	2 (20%)	6 (33%)
		Times mentioned	56	3	0	11	8	14
Primary & community care	Practice Nurse	No. (%)	6 (37.5%)	13 (65%)	2 (10%)	1 (20%)	2 (20%)	7 (39%)
		Times mentioned	38	43	5	1	11	9
	Community Nurse	No. (%)	3 (19%)	2 (10%)	5 (25%)	0 (0%)	1 (10%)	5 (28%)
		Times mentioned	28	3	8	0	7	6
	Chronic Conditions	No. (%)	7 (44%)	6 (30%)	3 (15%)	2 (40%)	2 (20%)	4 (22%)
		Times mentioned	29	9	4	2	11	9
	Care Coordination	No. (%)	10(62.5%)	7 (35%)	4 (20%)	2 (40%)	3 (30%)	7 (39%)
		Times mentioned	50	15	10	5	19	16
Providing connectivity & a link b/n medical & social care	Gap Filling	No. (%)	6 (37.5%)	0 (0%)	1 (5%)	1 (20%)	0 (0%)	6 (33%)
		Times mentioned	21	0	1	1	0	8
	Holistic Care	No. (%)	7 (44%)	0 (0%)	1 (5%)	0 (0%)	1 (10%)	2 (11%)
		Times mentioned	20	0	1	0	1	3
	Identifying with community	No. (%)	9 (56%)	4 (20%)	2 (10%)	1 (20%)	2 (20%)	5 (28%)
		Times mentioned	56	4	5	6	5	9
Advanced Practice	Advanced Nursing Practice	No. (%)	11 (69%)	3 (15%)	4 (20%)	2 (40%)	1 (10%)	8 (44%)
		Times mentioned	59	4	5	8	7	13
	Nurse Practitioner	No. (%)	10(62.5%)	5 (25%)	5 (25%)	3 (60%)	4 (40%)	10 (55.5%)
		Times mentioned	98	8	8	7	12	23
	Specialist vs. Generalist	No. (%)	10(62.5%)	2 (10%)	4 (20%)	1 (20%)	1 (10%)	1 (5.5%)
		Times mentioned	46	3	5	1	2	1
	Rural Nursing	No. (%)	8 (50%)	5 (25%)	3 (15%)	2 (40%)	2 (20%)	4 (22%)
		Times mentioned	39	9	14	2	5	8
	PHC Nursing	No. (%)	2 (12.5%)	1 (5%)	1 (5%)	1 (20%)	0 (0%)	0 (0%)
		Times mentioned	20	3	1	1	0	0

Synthesis of Data

Thematic analysis of the interviews and content analysis of the NHHRC documents provided two sets of emergent themes. While evidence of PHC nurse identity work emerged within the analysis process for both the interviews and the NHHRC documents, the concept was most relevant in the retroductive stages of analysis.

Denzin (cited in Patton (2002:247)) states '*Because each method reveals different aspects of empirical reality, multiple methods of observation must be employed. This is termed triangulation*'. As discussed in Chapter One, events can be partially or differently perceived depending on the position of the observer. Further analysis of the broad themes and features of identity work from the interview and submission findings, using mapping tools developed within situational analysis (Clarke 2003), supported the delineation of four main PHC nurse identities. These four identities and their key characteristics are presented in Chapter Six.

The situational analysis mapping techniques, as well as aiding in the delineation of the four main identities, were also used with retroductive analysis methods to further explore PHC nurse identity work in terms of how these identities are used to negotiate/navigate different interests at the interface between rural PHC nurses and rural health organisations, communities and government funding policies. This further analysis of identity work allowed for the postulation of concrete conceptualisations and explanations of the causative mechanisms underlying PHC nurse identity work (Danermark, Ekstrom et al. 2002; Clark and Blundel 2007; Crinson 2007; Reed 2009). Retroductive analysis allowed for the development of explanatory frameworks for how rural PHC nurse agency interplays with rural health services and broader social, cultural and structural conditions.

The next section will provide technical detail of the situational analysis mapping techniques employed in the synthesis of the emergent themes from the two data sets and their assistance in applying retroductive analysis techniques which contributed to the development of an explanatory framework for nurse's agency in rural PHC nursing.

Retroductive analysis

Retroduction, as a thought operation, allows the researcher to explain actual events (identity work) by postulating and identifying structures and causal powers which are capable of generating them (Sayer 2000; O'Mahoney 2011). For this study, retroductive analysis as a methodological tool supported the progression from the empirical observations and experiences within the nurse's interviews and the

NHHRC submissions texts towards postulating reasons for why these might have occurred and obtains knowledge of the properties that are necessary for a phenomenon such as PHC identity work to exist (Danermark, Ekstrom et al. 2002; Clark and Blundel 2007).

Retroductive analysis was aided by using the integrative and comparative mapping techniques of situational analysis as proposed by Clarke (2003). Identity work is realised primarily through discourse and the positional and relational maps and discourse/social maps provided a visual tool for a way of reconceptualising the identity themes emergent from the two data sources.

The three main mapping techniques, as outlined by Clarke (2003), provided visual tools which assisted in synthesis and integration of the emergent themes and informed the process of retroductive analysis. These mapping techniques are:

1. Relational analysis mapping which delineates the relationships between actors, discourses, themes.
2. Social worlds/arenas (discourses) mapping depicts the interrelationships between different discourses evident within the research data and includes how actors position themselves in relation to these discourses/themes.
3. Positional mapping – positional maps lay out most of the major positions taken in the data on major discursive issues – topics of focus, concern and/or contention. In this study the representations of autonomous practice of PHC nurses provided such a position. Positions on positional maps are positions in discourses and are not associated with individuals or groups.

The situational mapping techniques employed within the data synthesis process provided a visual framework which fitted well with the concepts of CR and with the analytical methods for retroductive analysis as outlined by Danermark et al. (2002:96-106). These methods for retroductive analysis will be further explicated.

The first method involved scanning the data for the patterns supporting social order and then reconceptualising them by ‘tracing the conditions for the social interaction to be what it is’ (Danermark, Ekstrom et al. 2002:101). This also involved assessing

for how any breach of this order was repaired in conversation. An example within this research was the labelling of PHC nurses as ‘supplements’ rather than ‘assistants’ to the GP. This example is an attempt at repairing social order to avoid the ‘handmaiden’ inference of assistant however reconceptualization allows access to the view that identifying nurses either as supplement or as assistant maintain social order by supporting the notion of PHC as centred on the GP/doctor. Relational mapping (Clarke 2003) was a supportive visual technique for this aspect of retroductive analysis.

The second method involved ‘counterfactual thinking’ (Danermark, Ekstrom et al. 2002) which required the delineation of all the different representations/major positions taken in the data. This correlates well with the use of Clarkes (2003:128) positional maps in which positions on the map are positions in discourse.

Another tool for supporting retroduction involves investigating ‘extreme cases’ or where the precondition for a structure appears more clearly (Danermark, Ekstrom et al. 2002). In this case study of rural PHC nursing, the PHC nurse identity of nurses working in rural settings provided an intensive focus for the study of PHC nurse identity work. Chapter Two highlighted the aspects of PHC in a rural setting which brought the context to the fore such as the notion of community having some clear geographical distinctions, the increased relational nature between people within smaller populations, and the impact of fewer staff on workplace collaboration. Social world mapping techniques of both the individual’s responses and the structural/cultural representations/positionings supported the visualisation and recontextualisation of these ‘universes of discourse’ (Clarke 2003).

This synthesis of the findings/identity themes from the two data sets via retroduction resulted in developing explanations of the causal structures generating PHC nurse identity work.

Conclusion

This chapter has outlined the way in which a critical realist ontology supported the explanatory potential of this study informing the methods used in collecting and

analysing the empirical data. The chapter clearly outlines the research process and provides detail of the ethical considerations addressed. The pursuit of a rigorous approach to the research design is detailed through efforts to ensure valid, reliable and trustworthy collection and analysis of data.

To approach the aim of this study, the research design as outlined provided a coherent and consistent approach. The theoretical framework allows for an approach to answering the research questions which acknowledges the power relations/control of social structures and culture while also incorporating the effect of reflexive 'human being'. In this way it provides a means for exploring agency, structure and culture without conflating them.

The two data sources purposively chosen to uncover PHC nurse agency and socio/cultural structural factors in PHC nurse identity work provided a specific rural context for the study of PHC nurse identity. The methods for analysis; thematic, content and retroductive, fitted well with a critical realist ontology.

The critical realist process of inquiry goes beyond the observation of empirical experiences and observations of PHC nursing to support explanatory frameworks about the structures of PHC nurse identity in the real world and assists in informing nurses about how their collective identities impact on their agency (Neuman 2003:81).

The following chapters present the findings which emerged from the NHHRC submission texts (Chapter Four) and the rural nurses' interviews (Chapter Five). Chapter Six presents the synthesis of these findings and the emergent explanatory framework.

Chapter Four: Positioning and representing the nurse in PHC

This first findings chapter presents analysis of 89 purposefully selected submissions made to the NHHRC to inform the development of Australia's first draft PHC Strategy. The submissions were categorised into six primary interests groups reflecting their priority interests. The identity work of these diverse interest groups reveals the disparate positionings and representations of PHC nursing within varied roles across State, Federal and Non-Government funding mechanisms.

Within the submissions, PHC nursing in community settings is predominantly discussed in terms of the coordination of care for clients and the models of collaboration between different health professionals. However the different representations of nursing roles in these settings are underpinned by various understandings of PHC and the scope of autonomous nursing practice. While there are gains in attaching to particular nursing roles, it is not the roles themselves but the identity work attached to the roles which reveal the way in which representations of PHC nursing are used to meet/negotiate different interests at the interface between health professionals, health services, clients and communities.

The chapter presents the PHC nurse identity work of the primary interest group submissions within four main conceptual constructs based on the prioritised interests within the groups. Nurses are variously characterised as:

- Providing pragmatic workforce substitution
- Assisting the doctor through GP task delegation
- Expanding general practice through complementing and supplementing the GP role
- Expanding PHC roles within and beyond general practice

The historically recent and increasing focus on the positioning of the nurse in general practice settings within policy is reflected within the representation of PHC nursing

across the submissions. The positioning of PHC nursing within these four themes provides insight into both the possible gains and losses with each position taken and furthers the understanding of the power of the different interest groups to meet their interests. Issues raised by primary interest groups regarding the impact of different funding models on nurses role expansion in PHC and the ambiguous representations of nurses autonomy as PHC providers are presented highlighting the interplay between structural/ cultural mechanisms and collective agency.

Nursing “for and on behalf of” who?

Characterising nursing within PHC in community settings raises the question of ‘who is nursing providing PHC for?’ The way in which different groups position and represent nurses as PHC providers (PHC nurse identity work) not only reflects the different interests and priorities of those groups but also provides a lens for understanding the cultural and structural mechanisms influencing the power of groups to meet their interests including access to and control of resources and funding.

The six primary interest groupings are organisations representing:

1. Nursing
2. Medicine
3. Government
4. Other Health Organisations
5. Community/Non-Government Organisations
6. Education Providers

In discussing nurses’ roles and positions in PHC in relation to other health care providers and within collaborative care, various terms are used by the primary interest groups, which further an understanding of their prioritised interests. Some of the groups use descriptors such as ‘task delegation’, ‘substitution’, ‘complementing and supplementing’ in extending the role of nurses in PHC, focusing on nursing’s collaborative relationship with medicine. Most submissions from nursing groups used the terms ‘task transfer’ and ‘holistic care’ to represent nurses’ position as expanding the collaborative provision of PHC within nursing models of care to

incorporate social care. Analysis of the use of these different terms, and the groups using them begins to provide an understanding of the ambiguity of nursing's identity as an autonomous provider of 'client centred' PHC.

A significant trend emerged from the content analysis of the submissions with a noticeable variance between medicine and nursing in a number of key meaning units. Most notable was the omission of the meaning unit "Task Delegation" from nursing's identification with PHC provision coupled with medicine's strong support for this positioning (see Table 4). The power of this difference is evidenced by the number of submissions by medicine (9/20) and the number of times the meaning unit was mentioned within those submissions (24). Nursing group submissions strongly refute the medical delegation model, foregrounding the broader scope of the role in PHC, providing services through nursing models of care as autonomous health professionals.

Presenting the different positions for PHC nursing proposed by the primary interest groups and the tensions voiced in this begins to lay the groundwork for understanding the gains and losses attached to various PHC nurse identities.

Providing pragmatic workforce substitution

Workforce substitution of aspects of GP's roles by nurses is foregrounded by some primary interest groups as providing cost benefits for health care organisations and is pragmatically promoted as a means of sharing the 'burden of service delivery' (Submission 446:28) whilst also addressing workforce shortages of GPs. With economic necessity as a strong motivator for change, coupled with the impending costs of the 'ageing population' including an ageing workforce, the focus on workforce substitution within the submissions is on ensuring tasks are done and needs are met.

Health organisations, such as the National Rural Health Alliance (Submission 333:10), contend that while 'the ideal health workforce' requires GP/medical presence, shortfalls in numbers, especially in rural areas demands a need to be

pragmatic and find a way to let others do the tasks, allowing for service substitution of mundane or repetitive tasks by ‘middle level’ providers such as nurses.

Submissions representing the primary interests of Government, other health organisations, Education and NGOs discuss the potential for role substitution by nurses of some tasks currently undertaken by doctors.

‘In the absence of adequate numbers of GPs, ACT Health supports the utilisation of other health professionals such as practice nurses and allied health professionals to enhance the provision of primary care’. Submission 005:2 (Govt)

This allows the development of nurse led clinics for ‘minor problems’ (Submission: Dunn (Educ.)) broadening the role of nurses as first contact for patients, including those who ‘inappropriately’ see the GP (Submission 138:2).

Representations of workforce substitution contain the role of nurses in PHC within a medical model focus, capable of substituting tasks done by the doctor when a doctor is unavailable or otherwise occupied. Choice (Submission 063:11) proposes that Nurse Practitioners could potentially ‘fulfil the role of doctor’ in areas of workforce shortages, particularly in rural and regional areas while other submissions suggest more limited substitution of GP services by nurses.

‘Increased flexibility in the provision of care would help address the maldistribution of health professionals by enabling some service substitution, where clinically appropriate. For example, routine immunisations could be provided by nurses instead of GPs’. Submission 060:22 (NGO)

‘Many services performed by general practitioners are routine. In many GP practices, a nurse has been engaged to undertake some of these tasks (although not prescription). This is good because it frees up the GP’s time to see patients and manage more complex conditions’. Submission 063:11 (NGO)

While the pragmatic approach to substitution foregrounds approaches to address workforce shortages, a number of the submissions supporting this positioning also recognised cultural and structural factors constraining the viability of direct role substitution. Given the complexities of historical relationships, particularly between medicine and nursing, General Practice Victoria (Submission 084) noted that workforce shortages across all health professions made the suggestions of ‘simple solutions of workforce substitution’ a less viable option.

‘Nurse practitioner programs have been in Australia for over a decade and yet very few are actually working - one has to ask why and note the very significant opposition from other health professionals’. Submission 412:3 (Ed)

In discussing the transfer of some tasks currently undertaken by doctors, to nurses, the nursing submissions contend that this is carried out within a nursing model of care, preferring the terms ‘task transfer’ and ‘supplement’ rather than substitution. The nursing submissions do not engage with the discussion of workforce substitution and this will be further expanded in the subsequent section.

In many of the submissions representing medicine, discussions regarding any substitution by non-medical personnel of tasks perceived to belong to medicine are described as second rate, ‘brave experiments’ (Submission 445:17) providing inequitable models of health care. This positioning is highlighted by the following quotes

‘The substitution of medical practitioners with other classes of health practitioner for workforce reasons or cost saving cannot be supported. The compromise of patient care is at stake, and increased costs will be incurred with loss of cost effectiveness’. Submission 445:29 (Med)

‘We highlight the need for rural Australians to receive direct equity in health service provision and decry any tendency to suggest these Australians should receive a second tier medical access through a “task substitution model”’. Submission 499:3 (Med)

GP delegation of roles/tasks rather than substitution of the GP by other health professionals is seen as paramount. Within many submissions representing medicines interests, the contention is that coordination, direction and delegation of primary care must be GP-led.

Assisting the doctor through GP task delegation

The provision of PHC by nurses within a task delegation model is predominantly foregrounded by the submissions representing the primary interest group of medicine. There appears to be a general consensus in these submissions that general practice is the preferred setting, by consumers, of primary care provision (and as such PHC) and should be led by the medical profession and in particular GPs.

‘General practice is central to the provision of primary health care in Australia and its improvement and has a strong and respected tradition in Australia...There is high value placed on the GP as a guide to ongoing, coordinated clinical management, the use of medication and referral to consultant specialists’. Submission 511:3 (Med)

‘In Australia the GP is at the heart of primary care’. Submission 333:14 (HOrg)

Medicines submissions are predominantly focussed on primary care and general practice, with the GP positioned as the central and key player (Submission 034). The core practice of GPs, historically, has involved the provision of primary medical care through general practice. The submissions in this category are in general agreement that a medical practitioner should lead the primary care team. The assumption is made that the provision of quality health care equates with the provision of quality medical care and as such requires coordination and direction by a medical practitioner.

‘Quality health care for patients depends on a well-trained workforce providing coordinated care under the direction of fully educated, trained and accredited medical practitioners’. Submission 445:29(Med)

Positioning nurses in the provision of collaborative PHC, within these submissions, involves the delegation of less complex tasks by the GP, as team leader. Framing PHC nurses as working within the GP-led team in a delegated role also positions nurses as core and critical members of the team. A task delegation model with respect to nursing in PHC involves the GP as team leader delegating tasks and care being provided to clients ‘for and on behalf of’ the GP.

‘Doctors however need to concentrate on what they are good at - diagnosis and complex management - the uncertainty of illness - and be able to pass on more mundane or repetitive tasks to other well trained providers. Repeat prescriptions, review of medication charts, vaccinations, management of chronic disease, assistance with surgical procedures, routine anaesthetic delivery and delivery of primary care are but a few of the tasks that could be carried out by middle level providers working closely with more senior health professionals (a delegated model)’. Submission 412:3(Ed)

‘GPs will work more centrally at the primary health care / hospital interface and at the more complex end of care, delegating less complex and more routine matters to others in the team such as practice nurses’. Submission 34:32 (Med)

Analysis of the position taken by the submissions using a task delegation model for nursing in PHC reform reveals a focus on coordinating and extending primary care services through general practice based team care.

Extending the role of the practice’s nurse through delegation

The Practice Nurse role in general practice is a primary focus of the submissions in this category in terms of a nursing role in PHC. While collaboration and team work

are discussed in terms of delegation to the team, the added proviso for nurses is of tasks being done ‘for and on behalf of’ the doctor and ‘under medical supervision’.

‘Belonging’ to the GP’s team

As part of the ‘general practice team’ Practice Nurses are viewed differently to other health care providers such as allied health professionals and externally funded nurses. Within the submissions in this category, they are discussed ‘in the same breath’ as GP, as central components to the team. The submissions point to the relationship between the GP and Practice Nurse in general practice as being essentially different to other team members. The lingering historical relationship between medicine and nursing, as outlined earlier in the literature review (Jolly 2007), appears to have a marked influence on the collaborative model of general practice teams and of nursing in primary care. Nurses are referred to in submissions in terms of ‘our nurses’, and there is a sense of ‘belonging’ to medicine/general practice.

‘Task referral or delegation and doctor led patient care is not new to the medical profession. We do it every day when we work with our nurses, refer to allied health providers, discuss with the pharmacist and consult our colleagues. The “team” is a reality, and it works efficiently without compromising care’. Submission 445:29 (Med)

Practice Nurses are characterised as being core members of the general practice team consisting of the GP, the Practice Manager and the Practice Nurse (Submission Young: 12). The Practice Nurse is positioned as central to supporting the GP’s provision of care. The core team works for the general practice however, as previously discussed, the power base is with medicine and doctors and the roles are delegated to the nurses.

Providing nursing care ‘under medical supervision’ and ‘for and on behalf of the GP

The Practice Nurse is portrayed within many of these submissions as not only a valuable assistant to the GP led general practice provision of care but, as stated by

the Australian Medical Association, they are most effective when under medical supervision.

‘Nurses and other health providers are skilled and respected in their role in assisting patient care but in terms of comprehensive primary care, they are most effective for patients while under medical supervision’. Submission 445:15-17 (Med)

Within submissions presented by medicine, nursing is represented as having a key role in supporting the provision of fiscally responsible primary care by general practice. The Royal Australian College of General Practitioner’s submission (511:22) promotes the benefits of ‘supervised’ Practice Nurse care being provided ‘for and on behalf of’ the GP within general practice as being able to improve efficiencies in the primary care setting. These benefits are described as the provision of clinical care, clinical organisation and practice administration as well as supporting communication within the practice and between the practice and outside organisations and individuals.

Funding made available to general practices for nursing care provided ‘for and on behalf of’ the GP supports primary care funding to follow the presence of a doctor, whether collocated or remote. In representing nurses within a remote supervision model, the Rural Doctors Association of Australia submits:

‘Providers in the rural generalist team may provide services for and on behalf of the rural doctor... including Aboriginal Health workers, practice nurses, remote area nurses and AHPs working in teams with general practitioners either collocated or in remote locations from the practice’ Submission 154:14 (Med)

With adequate and specific funding, the delegated expansion of the nursing role in general practice is envisaged as incorporating roles of other community nurses under the Practice Nurse umbrella.

The expansion of a delegation model to include other community nursing roles which have traditionally had more autonomy such as community health and child

health nursing reinforces the notion that the GP coordinates and delegates tasks/care provision to all nurses in PHC and the roles of community nurses are delegated and supervised by medicine.

‘Medicare rebates should be expanded to provide for services delivered by nurses and allied health professionals for and on behalf of GPs, including evidence based preventive medicine, domiciliary care and aged care’. Submission 511:5 (Med)

The dependency of the relationship between nurses working in general practice and GPs has been historically enmeshed within the funding mechanisms for general practice and health care provision as discussed in Chapter Two. Maintaining the position of the dependence of nursing practice on medical delegation is reinforced throughout the submissions in this category and exemplified by the Rural Doctors Association of Queensland.

‘We believe that any expansion of current nursing roles should be limited and through task delegation rather than task substitution. We further endorse the viewpoint that any access to MBS funding for nurse activities be through a designated medical practitioner’s provider number’. Submission 499:2 (Med)

Access to other services within the health system has often required the GP’s sanctioning and a number of the submissions in this category state that medicine should maintain its position as ‘gatekeeper’ to the health system citing benefits including cost effectiveness. The Rural Doctors Association of Queensland submitted that:

‘We acknowledge local Medical Officer’s role as gate keepers to the health system and also the cost and outcome efficiencies this promotes’. Submission 499:2 (Med)

The impact of ‘cost efficiencies’ on the gate keeping role of the GP for nurses in general practice is also further evidenced by the submission from the Australian Institute of Primary Care Latrobe (Submission 038) which discusses funding

mechanisms for chronic conditions management where funding is linked to the GP providing a service. The GP can then decide whether to delegate tasks to be carried out for them by a nurse. The representation of nursing as part of the core team but in a delegated role maintains the positioning of medicine as leading the collaborative PHC team. By positioning Nurse Practitioners as supporting the provision of appropriate medical care and primary health care within a delegated model, medicine is able to support the increasing size of the ‘medical’ workforce while also maintaining the centrality of primary medical care within the provision of PHC.

‘An adequate supply of appropriately trained medical practitioners is fundamental to the health of rural Australians. A greater commitment to increasing the size of the medical workforce is needed... (and) a more flexible and innovative approach is needed including task delegation. This includes the need for specific funding systems to support and reward task delegation so as to enhance primary health care through the use of physician assistants, nurse practitioners and medical technicians’. Submission 137:7 (Med)

Most of the medicine submissions discussing the expansion of general practice for the provision of PHC incorporate the use of Nurse Practitioners as core team members to enhance care and collaboration between the three areas of acute/hospital care, primary care/general practice and community care/aged care. However, collaboration with Nurse Practitioners, as with Practice Nurses, is conducted through the use of the delegation model, maintaining medical control over Nurse Practitioners practice.

‘GPs will routinely delegate less complex and more routine matters to others in the team such as...nurse practitioners with limited prescribing rights who will complement and support the role of the GP and assist to enhance existing service provision and improve access’. Submission 034:32 (Med)

Whilst the delegation model is maintained, the use of the terms ‘complement and support’ by medicine positions Advanced Practice Nurses in a different relationship with GPs compared to Practice Nurses who are characterised as providing care

‘under supervision’ and ‘for and on behalf of’ the GP. The implications of this will be furthered in the next section.

Expanding general practice through complementing and supplementing the GP role.

Government policy promotes general practice as central to the provision of PHC whilst also recognising the need to expand the role of general practice beyond its traditional focus of the provision of primary medical care. Positioning nurses as complementing, supplementing and extending the reach of the GP allows for extended nursing roles in general practice and is foregrounded within many of the submissions as enabling the potential expansion of the provision of PHC through general practice. Within many of the submissions, extending nurses’ primary care role in general practice is seen as one of the means of improving general practices’ capacity to perform, however, how this meets the prioritised interests of nurses as providers of PHC varies.

The terms ‘complementing’ and ‘supplementing’, in representing nurses as PHC providers for expanded general practice, are variously used across submissions representing most of the primary interest groups. Analysis of the submissions furthered the understanding of the context within which these terms are used providing evidence of the identity work of the different groups.

As presented in the previous section, most of the submissions representing the interests of medicine position all nurses’ provision of PHC within general practice via a delegation model with the GP as team leader. While the Practice Nurse role is characterised as providing care ‘for and on behalf of’ the GP, nursing roles discussed in terms of complementing the GP in general practice are predominantly applied to Nurse Practitioners and Advanced Practice Nurses. The overarching delegation model coupled with the absence of definition of the use of the term ‘complementing’ maintains ambiguity regarding nurses’ autonomy as providers of PHC in general practice.

Analysis of submissions from some community groups/NGOs characterising the nurses' role in the primary care setting also reflect the theme of nurses 'complementing', supporting, assisting and 'freeing up' the GP by taking on less complex, routine services. These interest groups do not overtly position nursing within a delegation model and there is recognition of nurses' roles being greater than only assisting the GP, incorporating a focus on the client's pathway through the health care system as exemplified by the following quote:

'Practice nurses are effective in assisting general practitioners to provide care and help consumers navigate the health system, for example, linking the patient with the illness-based support group they may need, local counselling and other allied health services or community support networks'. Submission 509:10 (NGO)

However, in representing nurses as assisting the GP, the inference could be made that nurses provide care within a GP led team, maintaining the traditional culture of general practice as medically dominated.

Content analysis of the submissions highlighted nursing organisations as rejecting both the task delegation and substitution models (see Table 4). Many of the nursing submission use the term 'task transfer' in preference to describe nurses taking on expanded roles which included tasks previously perceived as GP tasks, maintaining nurses' work within a nursing model of care.

One nursing submission, forwarded by the Australian Practice Nurse Association (APNA) which represents nurses working in general practice settings (Submission 042), positions nurses as able to 'supplement' doctors in the provision of PHC.

'Extending nurses' roles can relieve the GP workforce shortage... Supplementing doctors with practice nurses, if carefully managed, promotes the use of effective chronic disease control and preventative health functions'. Submission 042:7 (Nurs)

‘General practice nurses (GPN) can support and relieve the General Practitioner (GP) workforce shortages in rural areas by functioning as a doctor supplement’. Submission 042:10 (Nurs)

Positioning nurses as functioning as a ‘doctor supplement’ avoids the use of the term ‘substitution’ however clarity regarding the term is not offered. Despite the issue of a GP led delegation model for nursing having distinct significance for Practice Nurses and being raised as contentious within many of the nursing submissions, the APNA submission does not engage with the issue, focussing primarily on changes to funding mechanisms to support extending the Practice Nurse role. The historical, cultural and structural precedence of general practice as a medical hierarchical organisation influences the current climate of individual organisations and the level of autonomy and support for expansion of nursing’s PHC role in general practice (Pearce, Phillips et al. 2011). These factors mediate the impact of any funding mechanism changes.

Consolidating aspects of community nursing roles into general practice

As a consequence of role expansion for nurses in general practice, both within policy and within some of the submissions, the boundaries of practice/roles in other areas of community nursing are also experiencing flux. Within some submissions, extending the role of practice nursing within general practice is discussed as including the specialties of child health, community health, aged care and rural nursing as a further specialisation in their specialist generalist approach. In a number of the submissions, the care coordination role of nurses is discussed as a speciality within the speciality of NiGP

‘Using recent UK reforms as a guide, it is possible to construct a more defined role for practice nurses akin to the NHS “community matron” program in which responsibility is taken to ensure that health and social care needs are met (Murphy, 2004; UK Department of Health, 2007). Such a role could be created within the current Medicare programs for patients with TCAs in place, where, in addition to the allied health items available, extra services are available from practice nurses to assist with the coordination of

health and social services for the patient under the TCA where it is necessary'. Submission 038: (Ed)

Nursing roles, in terms of providing care for people with chronic health issues, are characterised as being positioned either in primary care (as Practice Nurse or Nurse Practitioner specialist) or community care (as Community Nurse or Nurse Practitioner specialist) however, how the 'team' collaborates in care provision is left unanswered.

'Consumers need health professionals to work together, and with the consumer, to get the best health outcome. CHF values team-based care; for example, the team for a person with rheumatoid arthritis may include their GP, the practice nurse, specialist, physiotherapist, dietician, community care nurse and pharmacist'. Submission 509:9 (NGO)

While co location of services is suggested (for example Submission:067), submissions by some of the groups representing medicine suggest integrating the community health roles of nurses working in community health services, including health promotion and preventative health care, into the general practice/primary care setting to be provided 'for and on behalf of' the GP. Incorporating the funding and the practice of these aspects of the Community Nurses' role into general practice via Practice Nurses is promoted as enhancing 'continuity of care'. With Government policy and many of the submissions asserting general practice as the first point of contact with the health system for many Australians and the acknowledgment of nurses' relational connectivity with their community, integrating these aspects of Community Nurse practice and calling for increased funding to support this role is argued to promote increased access to health promotion measures.

Whilst a number of submissions forwarded by groups representing medicine discuss the opportunity of Practice Nurses taking on the 'community health' nursing role, arguing that this would be 'better aligned to the catchments of general practice', they are less enthusiastic about the tasks of community care/domiciliary services, viewing these roles as distinct from community health. This positioning promotes distinction between the health promotion/preventative health roles of nurses in community

settings, based on funding structures, leaving ‘community care’ tasks to ‘outside’ organisations such as State and NGOs.

This furthers the delineation of PHC nursing roles between primary and community care by extending health promotion funding for NiGP. Centralising nurses’ health promotion role to general practice is described by one submission as relieving nurses’ difficulty in ‘working for two masters’, that is, general practice and community health services (Submission Wenck: 11).

In discussing the role of nurses providing health promotion in general practice, many of the submissions focus on the primary care/medical model of early intervention, surveillance, illness prevention, and opportunistic education when people attend the practice. Workforce shortages and time based remuneration for services through Medicare are proposed as limiting factors for the potential expansion beyond this opportunistic role in general practice for nurses (Submission 154). Submissions from primary interest groups positioning nurses as extending the reach of the GP call for changes to current MBS remuneration mechanisms.

‘...changes to the Medicare Benefits Schedule to provide incentives for GPs and practice nurses to undertake preventative health care as a routine part of their work. The present time-based remuneration of the MBS does not encourage practitioners to take the time with patients in this area’.
Submission 034:24 (Med)

Many of the nursing and community/NGO submissions describe the potential for providing more extensive health promotion if nurses are able to work to the full scope of their practice whether within or beyond general practice settings.

Providing nurse-led, ‘first contact’ PHC

Within the nursing submissions, nurses are described as providing PHC through ‘first contact’, frontline and ‘nurse-led’ care. Within all of the primary interest groups, including nursing, the way in which these initiatives are used to position nurses as expanding the provision of PHC in general practice reflects their prioritised interests.

It also serves to reflect the debate within the literature regarding the future development and direction of nurse led care and the lack of clear and consistent definitions for ‘first contact’, nurse led and frontline (Richardson and Cunliffe 2003). These different positionings markedly influence the way in which nurses are represented as PHC providers and nursing autonomy in expanding health care provision in general practice.

The activities which can be undertaken by nurses in nurse-led/first contact care include assessment, referral, diagnosis, prescription, decision making and discharge. The following table, adapted from Richardson (2003:82), provides a classification of the different positions taken within the submissions and provides a lens for the ways in which nurses are positioned as ‘first contact’ PHC providers within the different activities.

Table 5: Classification of Nurse-led Practice within Submissions

Activity	Level 1	Level 2	Level 3
Assessment	Site/type specific	Speciality specific	Broad and first line
Referral method	To GP within general practice	To GP and/or other health professionals within general practice/community care	External/internal sources – any types
Diagnostic tests/consultation	Medically initiated	Joint discussion between GP & nurse	Independent decision/order
Prescription	Not undertaken	Clear protocols	Independent interpretation of tests/drug prescriptions
Decision making	With permission from GP	In discussion with GP	Autonomous and collaborative
Discharge	Refers back to GP/medical staff	Discharge from nurse led service	Discharge from service/hospital and /or into the community

Informed by Richardson (2003:82)

Within the submissions by medicine, there is no reference to nurse-led or front line care however; representations of nurses PHC activities are within Level 1 and 2, with

Level 2 primarily referring to Nurse Practitioners/Advanced Practice Nurses. Some of the groups specifically maintain the GP-led position for all nurses' activities within primary care (AGPN and AMA). While others do not overtly use the term 'GP- led', their focus is on the general practice team with Practice Nurses as integral team members, however, examples provided within their submissions position the GP as team leader (Submission Harris (Med)).

Submissions representing the interests of education and government predominantly focused on activities within Level 2. They suggest service and care arrangement through MBS funded team care arrangements, particularly for chronic conditions management, coordinated by Practice Nurses or other nurse coordinators noting that this is the major work of Practice Nurses at the moment but unrecognised. Within this, Medicare funding for the general practice still comes through the GP (Submission 38). The focus on chronic disease management and the need for fully functioning coordinated teams means the focus of PHC delivery by nurses, and nurse-led initiatives, are on populations of disease and disease specific assessment/triage as well as incentive payments for information management. The payments to practices for nurses care provision are provided via the GP, for Practice Nurses assisting the GP, with the focus on measurable quality outcomes.

While submissions from community/NGO groups predominantly represent nurses' PHC activities within Levels 2 and 3 there is concern raised, particularly for rural areas with smaller health teams, with funding aligned to the presence of a GP, and the predominance of focus on chronic conditions protocols. Some of the submissions state that areas with fewer doctors will have inequitable access to health funding. There is a call for broadened access to health care providers, in particular nurses, with role expansion to recognise multiple entry 'first contact' for primary care.

Many of the submissions from groups representing other health organisations represent nurses within a dependant role on the doctor, in comparison to other health professionals within the PHC team. The representation of nurses' 'first contact' role aligns nurse-led activities within Levels 1 and 2.

'The threshold political decision, however, will be to extend Medicare cover to selected interventions of professionals who, unlike the practice nurses, are independent of the doctor – such as the physiotherapist who is the first contact practitioner'. Submission 333:11 (HOrg)

While the number of Practice Nurses represents the fastest growing area of nursing in Australia, and is strongly supported by medicine and Government policy/funding, the submissions evidence ambiguity regarding nurses' autonomy within the provision of PHC.

All of the nursing submissions which discuss nurses' first contact role forward the potential of nursing in providing front line, first point of contact and nurse-led care. However, within these submissions descriptions vary. Most of the nursing submissions discuss nurse-led activities within the Level 2 and 3 classifications. Many discuss the potential for the Nurse Practitioner/Advanced Practice Nurse position in nurse-led care, whilst some also position nurses as providing front line care from prevention to chronic conditions management. Overt distinction between nurse-led and GP-led is forwarded within many nursing submissions.

'This paper does....seek to challenge...that an acceptable model for future PHC is the current system of GP led services based on a model where the individual takes the initiative to see a GP or GP employee, usually for advice about illness. The nurse-led models...are often not only community-based services, they are home-or school-based services, whereby the nurse seeks out those hard-to-reach people who are rarely the recipients of GP care in Australia today. Furthermore although some of the models are based on the management of chronic disease, these nurse-led models are not concerned with disease treatment per se but with healthy living and self-management. All of these nurse-led models are free at the point of service and all focus strongly on coproductive models of community participation, where the recipients of care and their carers and families are viewed as integral component of the health workforce'. Submission Chiarella: 4 (Nurs)

The nursing submission by APNA, (Submission 42), details the potential for nurse-led care, first point of contact care and front line care within the general practice setting. However, without engaging with the model of leadership within which these activities are provided, ambiguity remains regarding the classification of the Level within which these activities are conducted with implications for PHC nurse identity.

While using the terms complement, supplement and support to represent the positioning of nurses as expanding general practice allows some distancing from the implications of GP-led task delegation, it does not address the cultural, structural and historical precedence of medical ownership, control of staffing and control of resources within general practice and the influence of this power to represent extended roles of nurses within this setting. Outcome measurements of nurses PHC provision performance, and the way in which these are determined remain unaddressed within the submissions positioning the nurses' role in expanding general practice through complementing and supplementing the GP.

Submissions by medicine use the terms to represent nurses' roles within the GP-led task delegation model, however, the main group claiming to represent nurses in general practice (APNA) uses these terms to represent their role as providers of PHC without engaging with the issue of delegation by medicine. This evidences a division within the submissions by nursing groups, with most nursing submissions preferring terms such as 'task transfer' to actively acknowledge their distancing from the GP-led delegation model.

Within the submissions there was evidence of recognition of the potential for nursing's broader roles within general practice beyond GP-led 'primary and community care'. The ability to cross service boundaries in collaborative practice, as well as reach people hesitant in accessing general practice services, will be furthered in the following section on expanding nurses' roles in PHC within and beyond general practice.

Expanding nurses' PHC roles within and beyond general practice

Tensions are evident in the submissions regarding the constraints on nursing roles and practice in working within the GP-led primary and community care framework and the recognition of the potential of expanded nursing roles in PHC provision.

'The health reform agenda offers an opportunity to consider an alternative model of primary health care that extends beyond the services of a general practitioner to a multidisciplinary model to offer comprehensive primary health care services. The current system of primary health care in Australia is not so much "primary health care" as "primary care"'. Submission 313:12(Nurs)

In coding the submissions for the meaning units encompassing role expansion, Halcomb et al.'s (2006) description of role expansion for nurses within primary care was used as it fitted well with the characterisations as provided by the submissions.

'Role expansion is generally regarded as more far-reaching than role extension, encompassing a holistic rather than task-oriented approach to nursing interventions. Role expansion entails nurses taking their own initiatives and making independent decisions based on experience and education rather than relying on medical delegation of tasks, which occurs with role extension' (Halcomb, Patterson et al. 2006:378).

Positioning nurses as autonomous health care providers in community settings is foregrounded as supporting the role of PHC nurses as 'first contact' practitioners for people in connecting with the health system. Many of the submissions, in highlighting the limitations of current GP-led primary and community care funding on nurses' autonomy, provide alternative funding mechanisms which support nurses autonomous positioning, as exemplified by the following quote:

'Access to a recurrent source of funding based on a capitation model would help address the anomaly that exists with the current MBS items numbers which ignored the autonomous nature of nursing practice in reimbursing

*general practitioners for services provided by a nurse'. Submission 313:14
(Nurs)*

Within the coding framework, see Table 4, representations of the expansion of nurses roles as autonomous practitioners within and beyond the general practice setting are tabled within the sub meaning units 'autonomous practitioner', 'gap filling', 'providing holistic care' and 'identification with community' evidencing nursing's significant identification with these aspects of PHC nursing in comparison to other primary interest groups.

While medicine and government support the centrality of general practice in the provision of PHC there is discussion within nursing and community/NGOs' submissions about the need to recognise a broader community base for PHC provision to move beyond a focus on illness and the historical and cultural understanding of the general practice setting as being for primary medical care. This would also support consideration for people who do not readily access general practice.

The expansion of general practice incorporating the delegated extension of nursing roles is central to PHC reform for many of the submissions by primary interest groups representing medicine. However, submissions by the other primary interest groups reveal enthusiasm for the potential of expanded nursing roles in PHC, with general practice discussed as one area of primary care within the primary and community care framework. Recognition of broad positionings and expanded roles of nursing in the community beyond the GP-led primary and community care framework is evident in submissions representing nursing, State Government and community/NGO groups. The tension between the positioning by medicine and these other primary interest groups for nursing in PHC is evidenced by the following quote:

'As regulated health professionals, nurses work collaboratively with other health professionals, not under the 'supervision' or 'for and on behalf of' the GP. Recognising this for what it is: the efforts of the medical profession to

control the flow of funds under the guise of directing the practice of others’.
Submission 313:14(Nurs)

While there are nurses practicing community health and primary health care outside the GP-led primary and community care umbrella, as the invited submission by Chiarella points out, comparatively less research has focussed on these nurses, research funding more recently has centred on practice nursing and community care nursing. One example given in the submission by Chiarella is the role of the school nurse:

‘Overall little is known about the role of the school nurse in Australia. Preliminary research indicates that school nurses engage in clinical care, health counselling, health promotion, school community development activities, networking/resource and referral, and general clinic management. However, it is unclear whether these accurately reflect the roles of school nurses, what proportion of time nurses spend on these various activities and what are the common health concerns of students presenting to school nurses. Part of this uncertainty appears to stem from the lack of standardised data collection methods for school nurses. Notwithstanding this uncertainty it seems that most undertake PHC work’. Submission Chiarella:7 (Nurs)

In recognising nurses’ potential as autonomous health care professionals providing PHC, the identity work of some of the primary interest groups highlighted an expanded nursing identity in PHC and raised issues of concern regarding constraints to this expansion.

Addressing gaps in service provision

Recognition of the importance of a broad understanding of community health beyond the GP and general practice and the necessary expansion of the nurses’ role in these areas is voiced by many of the Community/NGO submissions. The Consumers Health Forum submits:

‘Currently, the Australian Government invests in primary health care, including through Divisions of General Practice. However, involvement of a wider range of health services is essential to a healthy community. Nurses, allied health services and community health educators have an important role to play’. Submission 509:5 (Com/NGO)

The contention by many of the submissions that extending the reach of general practice provides an inadequate framework with which to provide comprehensive PHC is exemplified in the following quote (with particular focus on rural settings)

‘The current ‘one size fits all’ model of Medicare funded general practice has proven particularly inadequate in addressing the complex primary care needs of remote and rural communities’ Submission Dunn:3(Ed)

In response to this recognition of the inadequacies of the current system nurses are characterised as ‘filling the gaps’ and ‘holding the fort’ (Submission 313). This gap filling role is discussed in these submissions in areas such as rural and remote PHC, aged care and health care provision for vulnerable and marginalised client groups. Nurses’ role expansion in these areas is described in terms of meeting the discrepancy between perceived needs and health care availability. The gap filling role is discussed as being broader than merely a substitution for the absence of a GP. It is variously described as including filling in for a GP, filling the gap that isn’t filled by general practice and primary medical care, filling a gap in addressing the needs of people who do not use general practice services, filling a gap in collaborative care between medical and social care and filling a gap between health care outside ‘primary and community care’ services. All of these gap filling roles are attributed as expanded nursing roles by submissions in this category.

Submissions by medicine groups do not address this nursing role of gap filling. General practice within these submissions, as the site for primary health care service delivery and coordination, is seen as expanding to meet the unfilled needs as identified. The issue of nurses filling gaps in the provision of primary health care not met by GP-led primary or community care services is not raised.

While nurses are discussed as ‘holding the fort’ in service provision, their contribution in this is acknowledged as being unrecognised within the development of health policy. This is attributed to factors such as professional boundaries and legislative barriers (Submission 313). There is also evidence of nurses working in expanded roles in voluntary capacities due to funding limitations, further silencing the recognition of this gap filling role.

Within the nursing submissions, it is the Nurse Practitioner role which is discussed as a viable means of addressing gaps in service provision primarily in the integration of care between primary care services and hospital and community care services (Submission 14). However, the limitations placed on the expanded role of the Nurse Practitioner, beyond GP-led general practice, in addressing gaps in service provision is recognised by NGO/Community groups, as exemplified by this quote:

‘If nurse practitioners were permitted to work separately to a GP practice, it would provide an opportunity to improve the provision of primary health services in areas where there may be no doctor (e.g. in rural and remote Australia or even parts of metropolitan Australia)’. Submission 063:11(Com/NGO)

The gap filling role, as part of nurses’ role expansion beyond GP-led primary and community care, is also discussed as addressing the need for better integration of the provision of PHC between individuals and their community. Nurses working in advanced practice roles are identified as having a long term commitment to their local communities, areas of specialty and their work units, providing a means for strengthening local care and coordinating care across relevant services. They are described as providing connectivity and linking primary and social care, increasing access to services for hard to reach client groups.

The expansion of nursing roles in rural settings beyond the confines of general practice and HACC funded community care services is discussed not only as a means of addressing rural GP shortages but also as an opportunity to enhance the provision of PHC.

'This problem presents an opportunity to utilise the skills mix of nurses... and encourage broader roles for nurses in a range of settings including workplaces, schools, working with General Practitioners, in Community Health services and in rural and remote areas. Their role should also incorporate case management of people with chronic conditions or complex needs'. Submission 194:4 (Com/NGO)

Role expansion for providing holistic care

There is a high correlation within the nursing submissions for the meaning units related to the provision of holistic care. Nurses are characterised as having a holistic view of health and wellbeing. The importance given to the incorporation of community as well as the individual client into the provision of 'holistic' care suggests this has particular significance for their identification as PHC providers. These meaning units are not recognised as being as significant for the other primary interest groups. Although the following quote represents the view of one submission for a specific client group, it is broadly representative of many of the other submissions in their representation of nursing's relationship with the provision of holistic health care.

'Nurses have a holistic view of health and wellbeing and ...nursing still provides for the day to day health and care needs of individuals and communities....CRANA members are in remote communities; they battle the daily problems with communities, they are part of the community. CRANA is an organization that fights for social justice and works towards improving the health outcomes for those most in need in our society. We urge the Commission to take a broad view of health when determining the future of the health system. It is the health of the whole community that matters and by that we mean the whole Australian community including those who live and work in rural and remote areas'. Submission 073:1 (Nurs)

Holism encompasses the broad identity of nursing in community, expanding the boundaries of primary and community care to encompass holistic care. Being able to work across perceived 'boundaries' of care to facilitate the connection between

organisations/services/people and in doing so enhance the professional capacity of other providers is an aspect of nursing's positioning in PHC present in some of the nursing submissions.

'Nurse practitioners represent value for money; they are able to cross boundaries in the health workforce and, through collaborative practice, can facilitate the capacity of each health care practitioner, including medical staff, to focus on their area of clinical practice expertise'. Submission 164:2 (Nurs)

In some submissions the representation of nurse as provider of holistic care incorporates the health of the whole community. Some nursing groups, such as CRANA (Submission 073), suggest that the full potential of nurses' community connectedness as part of the expanded PHC nurse role is not recognised. In urging the NHHRC to broaden their view of health in their deliberations for preparing input to the draft PHC Strategy, CRANA incorporates the broad social determinants of health within its representation of the expanded role of nursing in PHC, recognising nurses as members of their community, working broadly towards improving the health of community members most in need. The connectedness to community and the recognition of this relational connection as integral to effective expanded nursing is reinforced by the following quote from a submission from the Faith Community Nursing group.

'The FCN seeks to create and strengthen individual and community capacity, facilitate resilience and nurture the relationships that keep people connected in community. Programs focus on relationship building, health promotion, illness management, disease prevention, nurturing holistic well-being, aiming to empower active participation in the management of personal and community health'. Submission 033:13 (Nurs)

Whilst not specifically using the term holistic care as a nursing position, Community groups including Women's Health Vic (Submission 194) and the Consumer Health Forum (Submission 509) suggest expanded roles for nurses outside the current primary (general practice) and community care framework which takes on the

broader aspects of PHC in strengthening community health. These include practices such as harnessing community support and involvement, ensuring a well organised coordinated network of services and delivering care via a multidisciplinary team with a model based on population health.

However, there are inconsistencies in the use of the term ‘holistic’ in the nursing submissions in regards to the role of the community. Within some of the submissions, holistic care refers to care provided for individuals and their community whereas other nursing submissions focus on patient centred care provided for individuals and their families.

Ambiguous representations of nurses’ autonomy

Many of the submissions discussed the need for nurses, as integral to PHC reform in moving from an illness model of care to include health promotion practices and a social model of care, to be recognised as autonomous health professionals. This recognition extended to all community nurses including Practice Nurses in general practice and Nurse Practitioners. Nursing in Australia has a history of being ‘under’ medical supervision (Keleher 2000b). Despite this, the nursing profession, similar to other regulated health professions, affirms its position in providing autonomous practice.

‘Professional codes of ethics, codes of conduct, professional practice standards and employer policy and practice standards all influence nursing and midwifery practice. All these provide support for nurses and midwives, as autonomous regulated professionals, to determine their own scope of practice’.(Nursing in Primary Health Care Organising Committee 2008)

In Australia, Community Health Nurses and other nurses working in the community have a history of practice and community recognition of less direct ‘supervision’ (Keleher 2007f). Most of the primary interest groups, except for medicine, foreground the potential benefits of nurses’ role expansion through recognition of autonomous nursing practice. Recognition of factors limiting the autonomous

practice of nurses including entrenched hierarchies and funding control is evidenced within the submissions

‘The Productivity Commission’s enquiry into Australia’s Health Workforce (2006), reports that nurses, as professional practitioners are under-utilised in terms of their capacity. It was suggested that this was due to entrenched hierarchies and traditional roles’. Submission 014:7 (Nurs)

‘Current funding of nurses in general practice significantly limits their contribution to general practice as an accessible, affordable health service’. Submission 042:8 (Nurs)

State funded health services in Australia have had a longer history of working with community nurses who have not worked directly under a delegation model. Some of the nursing submissions discuss broader community nursing roles including School Health Nurses, Faith Community Nurses and Child Health Nurses as autonomous health professionals working outside the general practice setting. Acknowledging the professional autonomy of nurses as health care providers and the significance this has on effective and sustainable collaborative care is highlighted by this State Government submission.

‘There is direct correlation between those organisations that create a quality work environment, where nurses’ and midwives’ autonomy, education and pursuit of excellence is valued and reflected by increased patient satisfaction and quality patient outcomes’. Submission 458:18 (Govt)

Many of the submissions describe and discuss the nurses’ role in terms of coordination of care. Whilst positioning nurses in a broad range of community settings including general practice, community health services and community care services, nursing’s focus of care is recognised as placing clients at ‘the centre of care’. This influences the way in which the submissions view collaboration within multidisciplinary teams. Limitations to nurses’ autonomous practice is recognised as impacting on the PHC Strategy aim of fostering a health system focused on ‘patient centred care’ as well as limiting nurses’ role expansion.

'Breaking down the legislative and professional barriers to enhance the professional role of nurses, nurse practitioners and other allied health workers, is an important issue and one that needs addressing...making the patient 'the centre of care' needs more than rhetoric and access to professional health care by the community is a basic right, not something that is to be restricted due to territorial disputes, or a view that the patient belongs to any particular primary health carer'. Submission 481:1(NGO)

Whilst the recognition of nurses as autonomous health professionals is evidenced in some of the submissions, it is the Advanced Practice Nurse and Nurse Practitioner roles which are foregrounded as providing opportunities for autonomous nursing roles. Primary interest groups describe the Nurse Practitioner role as complementing GPs and other health professionals in a general practice. However, restrictions and limitations to the role of the Nurse Practitioner providing broader access to primary health care Nurse Practitioner services are noted by groups including nursing and community/NGOs.

'Nurse practitioners... could provide services in smaller towns. However, nurse practitioners are not as widely used...In many cases nurse practitioners would be able to work in practices with GPs, providing a complement to the GP and other health professionals in the practice'. Submission 063:11 (NGO)

Some of the nursing submissions use the term 'task transfer' attempting to distance the discussion from the delegation/substitution debate whilst maintaining clarity regarding practicing from a distinctly autonomous nursing perspective. The submission by the Royal College of Nursing (Submission 164) places a strong focus on the Nurse Practitioner role and describes the Nurse Practitioner's ability to cross boundaries of services to provide coordinated care in terms of shared tasks as 'task transfer'.

Within nursing groups contradictions appear evident in their positioning regarding autonomous nursing practice. On the one hand the cost effective 'supplement'

extending the GP's role in primary care is foregrounded, especially in areas of workforce shortage. This representation of the nurse in PHC does not address the issue of autonomous practice. Whilst in other nursing submissions, autonomous nursing care expands the delivery of PHC service beyond the focus on the GP-led delegation model providing nurses with leadership opportunities within multidisciplinary teams.

'Nurse have developed expertise in offering holistic aged care and nurses have the systems and clinical knowledge to lead multi-disciplinary and cross-sectoral teams to provide world class aged care services'. Submission 164:10 (Nurs)

Despite the focus by some primary interest groups on advanced practice and specialisation as an avenue for recognition of nurses' autonomous practice, medicine groups maintain a delegation model for all nurses. This is recognised as having significance for the positioning of all nursing within PHC reform with the framework for autonomous practice remaining a contentious issue.

The number of submissions specifically discussing the PHC nurse as a distinct role was very low, with some evidence of the nurse in general practice/primary care being referred to as the PHC nurse (Submission 457) and one Government submission (005) referring to a nurse member of the community mental health team as a primary health care nurse. Likewise, the absence of a generic term for nursing in the community was noted throughout the submissions. Despite the term 'community nurse' having wide acceptance in the literature for nurses working in community settings, this was not evidenced in the submissions.

Although many of the submissions identify nursing in PHC as providing a link between individuals, their communities and the health care system, nurses' role in PHO's, who are charged with coordinating care within and between primary and community care and overseeing PHC provision, is not discussed at all in the submissions.

Within many of the submissions, representing nurses as having expanded PHC roles both within and beyond the general practice setting was foregrounded as a means of progressing an increased ‘client centred’ focus for PHC provision. The concerns and issues raised regarding the historical, cultural and structural positioning of GP-led primary care highlighted the constraints to expanded PHC roles for nurses.

The PHC nurse identity themes of the structured groups

There are four themes, as cultural emergent elements, revealed through analysis of the submissions. These themes evidence the way in which nurses’ PHC identity is represented through the identity work of corporate agents to meet their interests in addressing PHC reforms for the Australian health system. The structured groups/corporate agents using these representation themes include nursing organisations, medical organisations, other health organisations/providers, government bodies, education institutions and community/NGO groups.

Table 6: Representations of PHC Nursing by the Six Primary Interest Groups.

The groups	1. Providing pragmatic workforce substitution	2.Nursing ‘for and on behalf of’ the GP	3. Expanding general practice through complementing the GP role	4. Expanding nurse’s PHC roles within & beyond general practice
Medicine		X	X	
Nursing			X	X
Government	X		X	X
Community/NGO	X		X	X
Other health organisations	X	X	X	
Education		X	X	X

The identity work of these groups/corporate agents provide ‘pregiven’ positionings for PHC nurse identity. Nurses, as primary agents, in their identity work, encounter and use these positionings to meet the interests, both social and practical, which they have prioritised.

Conclusion

This chapter has highlighted the various positionings for nurses within PHC reform by different primary interest groups. The tensions between the groups in their support for the GP-led primary and community care framework as a model for PHC reform is exemplified in their characterisation of the role of nursing in PHC.

Medicine strongly supports the GP-led primary and community care framework with nurses providing care ‘for and on behalf of’ the doctor or complementing the GP within a delegated model. Some of the other primary interest groups also positioned nurses within this representation. However, whilst rejecting the delegated model of care, some nursing submissions characterised their position within this framework as means of supplementing and extending the reach of the GP.

Presenting nurses’ role expansion, beyond the boundaries of GP-led ‘primary and community care’, provided primary interest groups with a means for addressing some of the issues of concern regarding this framework. It also highlighted contradictions in the representations of nursing as an autonomous health profession providing holistic health care.

Analysis of the PHC nurse identity work of primary interest groups providing submissions to the NHHRC to inform the first draft PHC Strategy for Australia provides some understanding of contemporary PHC nurse identity. However, a more complete understanding requires evidence of how nurses, as agents, negotiate and navigate these representations and positionings to meet their prioritised interests. The following chapter presents findings of the identity work of individual rural nurses through analysis of interview transcripts.

Chapter Five: Rural nurses as providers of PHC.

This chapter is the second of the two findings chapters presenting analysis of empirical data depicting PHC nurse identity work. Transcripts of in-depth semi-structured interviews with 21 outer regional rural nurses in New South Wales and Tasmania provided access to nurse's individual PHC identity work within their rural context. The Interview Schedule (Appendix 5) provided a guide during the interview process, ensuring that each interview addressed the enquiry topics of the study.

The findings reveal nurse's perceptions of their role/s as providers of primary health care within a rural context and the way in which they negotiate/navigate these roles within the context of their health service positioning in an attempt to meet their different interests. In exploring the factors influencing the construction of PHC identity for regional rural nurses, their interview responses reveal aspects of a shared philosophy of the concepts of a PHC approach. However, marked variations in the nurses actual practice of these concepts is also evident.

Four themes emerged from the analysis of the transcripts and provide the structure for the presentation of the findings in this chapter (See Table 3). Discussion within these four themes provides a lens not only for the nurse's individual choices and prioritised interests through identity work but also the structural/cultural and historical factors impacting on nurses' agency. The themes are:

- Nurse's understandings of PHC and the influences of living and working in a rural context
- Aligning PHC provision with the concept of 'client'
- Developing a PHC scope of practice within a rural/outer regional context
- Nurse's perceptions of enablers and barriers to their provision of PHC

Nurses' understandings of PHC in a rural context

While all of the nurses interviewed thought of themselves as rural primary health care nurses, the interviews reveal that the way in which they understand and action the concepts of PHC vary. Inconsistencies in the use of terms, frameworks and models for PHC practice contribute to their problematic identification with the conceptual theory of PHC. In defining the concept of PHC, the nurses employed their understanding of providing holistic care. However, despite the shared notion of holistic health care as integral to their nursing practice, descriptions of its meaning also vacillated.

The overarching context of living in a small rural community had a significant impact on the way nurses discussed the provision of holistic health care and as such their PHC practice. The interconnectedness and interrelationships with individuals and their families and, for many nurses with the community as a whole, was foregrounded in their understandings of providing PHC within this context.

Connecting with the language of primary health care

Inconsistencies in the meanings ascribed to the language and terms used in PHC and primary care, as well as the differences nurses noted between their ideal PHC practice and the reality of practice, resulted in feelings of confusion, alienation from the language and a reluctance to engage with the terminology. While shared language facilitates communicating understanding and meaning for nurses (Allen, Chapman et al. 2007), the lack of commonality in nurse's PHC language impacted on their practice/praxis, influencing their degree of 'attachment' to the concept and practice of primary health care.

Undergraduate and/or post graduate university nurse education provided nurses with increased familiarity with the concepts of primary health care compared with nurses with hospital training and limited university education. Most of the nurses interviewed were hospital trained. They discussed how primary health care, as a named concept, was not covered in their training and for many it was seen to be a relatively new and academic concept.

'I assume there are a lot of Community Health Nurses who are my age, and there would be quite a few nurses who haven't done university degrees and so therefore they are virtually behind in being educated about this'. (Interview 1)

A number of the nurses spoke about the difficulty in accessing education to assist in developing their conceptual understandings of primary health care.

'Well, with primary health care does epidemiology come in to that? It does, doesn't it? And also public health – they used to be the older type of focus weren't they and now we've moved on to primary health – epidemiology and public health – that's right isn't it? I don't know of any available education other than the two day taster course that was run by CRANA...and I haven't seen anything else available and considering that this is the direction that everything is taking, the amount of education that is available is really poor'. (Interview 21)

Four of the nurses discussed Alma Ata, the Ottawa Charter or spoke about the definition of primary health care using terms such as access, affordability and appropriateness.

'We do primary health care, it's making health care affordable and accessible to people. Being able to, as a service, meet the needs of a client, consulting with the client about their care, it's a joint consultation between the nurse and the client, to meet the goals that you want to achieve, treating people with respect and dignity no matter what their race or culture is, being respectful. As I said, health promotion, on a one to one as well as group stuff, we mainly do the one to one a lot more. Involving people in their health care'. (Interview 7)

Most of the nurses spoke almost apologetically about not being 'completely up to speed with it all'; of being able to 'drag out the theory' when needed with an awareness of a disconnection between the theory of the concept of a primary health care approach to practice and the actual practice of primary health care 'on the

ground'. This disconnection between the conceptual theory of primary health care and its practice was much discussed and promoted a reluctance to engage with PHC terminology.

'I suppose I feel uncomfortable about using the terminology because it has connotations of health promotion which we don't do enough of. I've done some reading but that is uncomfortable because it just serves to highlight that you aren't doing it enough or you're not... there are ways this could be done better but you find that in your actual job you are curtailed'. (Interview 1)

For a number of the interviewees the inconsistent use of terms and frameworks/models for PHC exacerbated their detachment from it and they described the language around primary health care as "jargon".

'a lot of it is jargon and if its jargon to me I'm not sure how much the community is going to understand of it and I think the biggest challenge is going to be changing the community views and concepts of primary health which in its bones means you don't wait for a disease to happen you try to stop it from occurring'. (Interview 5)

'It's all the jargon...I have trouble with all the jargon stuff, that's one of the biggest differences I see with the young ones to us'. (Interview 14)

While most of the nurses used the terms 'primary care' and 'primary health care' interchangeably, for a few there was recognition regarding the lack of clarity between the terms and related practice.

'Primary care is part of primary health care. Primary health care covers the whole lot...they always get mixed up'. (Interview 10)

In describing their PHC practice, the terminology used by all of the nurses incorporated the notion of holistic health care.

Holistic health care – shared concepts, varied meanings

The concept of primary health care connects with the nurses shared philosophy of holistic care. The nurses interviewed described their rural PHC practice as being ‘holistic’, enabling people and providing care for the whole person. They discussed it in terms of being the frontline, drawing together the services that a person needs for their health, outside a hospital setting, highlighting the importance of interrelationships. In defining the concept of primary health care, the incorporation of the language of holistic nursing care was used by most of the nurses.

‘It’s holistic, and it’s about the whole person....It’s the whole holistic health care, it’s not just providing nursing care, it’s to do with community development, it’s to do with advocacy, it’s to do with finding out about people in their own environments and making the best of the resources we’ve got and the resources they’ve got’. (Interview 10)

For many of the nurses, their understanding of PHC as being more than just the clinical care of individual clients was evident. This reflects nursing ontology which incorporates primary health care as a framework for combining social care with illness management and health maintenance (Keleher 2007f:72) and to support their clients to maintain/regain/develop wellbeing (Meleis 2002; McMurray 2007). Linking the notions of providing holistic care and PHC with their specific rural context of practice was evident for most of the nurses.

Common understanding of living and working rurally

Prompted by questions from the interview guide which queried whether their role differed to urban practice or other more remote settings, the nurses described their rural/outer regional context as being ‘in between’. Rural practice in their small communities was described as being neither remote and nor urban, but having a distinct identity.

‘Our population can go from 2,000 in winter to 10,000 in the summertime, during the Christmas holidays. In this job you have to be able to cope with

*the winters with your regulars and then all the 'blow ins' in the summertime'.
(Interview 1)*

Nurses living in small rural communities understand and work with the interrelationship between 'nurse as worker' and 'nurse as community member' in different ways and this influences their approach to PHC practice. Varied instigators for being a nurse in their community influenced the nurse's approach to working with/in the community. Many of the nurses described how living in and knowing the community in an ongoing way over time, building an ongoing picture of the community, influenced and supported them to practice holistically. This supported the incorporation of their knowledge of people's interconnections and interrelationships in providing PHC for the community as 'client'. They discussed how their nursing practice involved working within a dynamic process with people within their community, with their changes over time and changing relationships including ageing in place.

The change in the focus of their rural nursing practice over the years, from beginner to expert in practice, was discussed. The initial focus in the early years of practice was primarily on gaining skills and focussing on professional development however with increasing confidence and expertise as well as time in community their focus broadened to encompass 'community interrelationship' as being fundamental to the role. There was a sense of becoming more 'connected' with increasing length of time spent in the community. They described this connectivity using words like 'commonality', 'common ground' and 'belonging', 'becoming a local'. One of the nurses, in describing what they found most enjoyable about being a nurse in their community, stated:

'I suppose being accepted by the community, being a part of the community...25 years, I might be a local soon. I've had 2 children in the area. So they will be local. I'm going to stay here and die here'. (Interview 5)

Staying in the community until they die was a common refrain from a number of the nurses. The nurses who discussed community with this sense of connectedness and commonality had all been actively involved in seeing/being with their community

through different traumatic community events, for example major changes/loss in health services, traumatic deaths and industry closures. They discussed these events as engendering connectedness and ‘community spirit’, resulting in their concept of community, and their role within in it, changing as the community needs changed and also as people in the community recognised the different roles these nurses took on. These interconnections influenced some of the nurses to expand their notions of ‘client’ to include their work colleagues, their scheduled clients and also all the people living within or travelling through the geographic region.

‘The job, from then, has really changed heaps to what it is now and you find yourself now being coordinator of everything...I think that with being Dom, [Domiciliary Nurse] what really made us change and focus much more on the community was the (community) tragedy, and since then, it seems to me that there has been an extra responsibility, maybe even an increase in the connectedness to the community that comes with time spent here and therefore a change in thinking’. (Interview 1)

There is a dual aspect to living and working in a small community; that of the nurse knowing the community members and their interrelationships and also the residents responding and connecting to the nurse. For some nurses, living in the intimacy of a small community was part of what attracted them to the work. They also recognised the potential benefits for their approach to PHC service provision.

‘Yeah, it’s the best thing about it, you have to be content with everyone knowing your business, but if you don’t mind about that it’s good. It’s really good management for the patients’. (Interview 17)

However, living with a lack of anonymity was also described by most of the interviewees as one of the challenges of living and working in a small outer regional community. For some of the rural nurses experiencing role change during health service restructuring, with moving from a small rural hospital to having an increased primary health care focus, the criticism from members of the community, who were struggling with the change in their health care facility, were felt personally and professionally.

‘Everybody calls it the hospital. (The manager) actually had somebody come to her at a meeting and, it was one of the...umm...hospital perpetrators I guess, ‘So, I heard that your staff are walking around with folders under their arms, so nothing to do all day’. (Interview 9)

The lack of anonymity also reinforced the added need for awareness regarding ‘potential professional compromise’ including issues of confidentiality and the difficulties of this in a small community where the nurses and /or their work colleagues know the clients, reflecting previous research findings (Mills, Francis et al. 2007).

‘You feel some pressure to get on with everybody. When there are strong divisions in the community there can be tension between expressing your opinion and having to take the line of least resistance to ensure you can work with them professionally if needed’. (Interview 1)

Tensions in the workplace posed particular difficulties socially. A number of the nurses discussed tensions between workers in differently funded colocated services. The lack of clarity regarding boundaries/professional roles, particularly in regards to Community Health Nurses and general practitioners, resulted in professional dilemmas socially outside their working role. They described the importance of keeping these tensions ‘in house’, ensuring any difficulties were dealt with ‘professionally’.

For most of the rural nurses interviewed, the issues of living rurally, with the inherent interrelationships of community members, are intricately linked with their concept of providing holistic health care. For many of them, developing an understanding and practice of primary health care builds on this foundation. The context of living and working in these communities contributes to shaping nurses’ practice identity. They are not only influenced by the rural community context of practice but are part of that context and therefore changes to health services, especially if they are not readily understood or supported by the community, can be more difficult and very personal indeed for rural nurses.

Aligning PHC provision with the concept of ‘client’

The way in which nurses perceived who their practice was directed towards varied. While they all perceived the individuals they were providing clinical care for as ‘clients’ and most included the individual’s family/significant people as clients, there was less clarity regarding the incorporation of the concept of ‘community as client’. For these nurses, in their professional role, there is both an overt and covertly prescribed connectivity with community. Factors influencing the way this was then enacted in their practice included their length of practice and education in nursing/health, their sense of connection with their geographic community and their incumbent health service role.

Most of the nurses interviewed had hospital training as their nursing qualification, and for many of them, their early career trajectory focused on hospital or acute nursing. Consequently, the individual client and the culture of the organisation have featured strongly within their professional identity. For some community nurses the change in their role identity over time with changing health policy directives, discussed in the literature review, influenced their notion of client to incorporate ‘individual/family/community’ as client.

More recently, education in some of the chronic conditions self-management programs have also included aspects of working with a broader focus on community development. However, many of the nurses commented on the disparate focus of the chronic conditions programs. With some programs providing nurses with ‘tools’ for supporting individual client self-responsibility and other programs including community development as a focus, there was notable variance in their preference for the different programs.

‘No, I wished I had done Flinders because I’m very much the bedside nurse, I did Stanford and it’s taken me out of my comfort zone doing the Stanford...doing group work and facilitating that group work. (Interview 9)

The variety of factors influencing the development of nurse’s understandings of the ‘client’ for the PHC service provision, within a rural context, included conflicting

role expectations, ambiguity in PHC nursing terminology and the influence of health service funding. Within the literature review (Chapter Two) the historical development of nursing education and community health nursing theory within Australia regarding the concept of community as a unit of practice was outlined (Francis 1998; Keleher 2000a; Keleher 2007f; Francis, Chapman et al. 2008a). Community based nursing, with a focus on individual clients, has received significantly greater policy focus within the current health reforms than community health nursing which includes provision of care for individuals and their families as well as communities, groups and populations. These factors, combined with the lack of philosophical discussion regarding the incorporation of a social model of health in community nursing (Koch 2000; Brookes, Daly et al. 2004) informed the way in which nurses conceptualised the ‘client’ they were providing care for in three different ways; providing PHC services for the whole community, for the clients of the health service or assisting in providing PHC services for the GP’s clients.

Providing health care for the whole community

For most of the nurses their professional identification with ‘community as client’ has been a developing concept over time. For many of the nurses this led to perceiving their professional role as including the promotion of community wellness.

‘Ok, so how I see primary health care, well, I suppose the first definition that springs to mind in a rural area is that you’re sort of the front line of helping the community move into wellness I suppose, and part of that is health promotion and primary prevention’. (Interview 19)

The way in which nurses identified who they were providing PHC services for highlighted the interrelationships between their identification with their ‘community’, their health organisation’s conceptualisation of ‘client’ as well as their nursing education/socialisation.

‘The community can be ‘blow ins’, the scheduled clients, through casualty and the doctors surgery, the people you work with (colleagues), the people you know in the community because you live here – so even when you aren’t

*working, when you are not on duty, you are still known as the Community Nurse or the Community Health Nurse or whatever they perceive your role to be. So, when you have links with other organisations within the community then because it's innate in you to take a caring, minding, nursing role then that also comes out with your input into that organisation. So it's not just the scheduled clients or the people who are officially referred to you'.
(Interview 1)*

For these nurses, their client focus is influenced by living in the community, sharing relationships and history. Their work has become an extension of living in community, with particular skills aimed at that community. These nurses used their community knowledge to enhance their organisational role. Nursing in a community which has experienced significant adverse community events such as fire/drought/flood or major accidents/trauma had a particular impact for nurses' sense of 'connectivity' and identification with a geographic community. For some of the nurses this made it even more likely that, in their professional role, they would perceive all the inhabitants of the geographical region as 'clients'.

Formally and informally available

Many of the nurses understood their role, as defined by their organisation's policies and funding, as being the provision of care for individual and their families. However, for these nurses their focus included the health of the community as well as the individual clients of their health services. Their knowledge of the interrelationships and interconnectedness of community members informed their practice. Despite the broader geographic population focus being perceived as outside the scope of their organisational role, nurses found ways to encompass this broader role, expanding their 'first contact' capabilities.

'I've got an elderly lady at the moment who's grandson fell off his skateboard so he's in (city hospital) at the moment in a coma, so we've done things about accommodation for his mother and getting somebody to stay with her because the daughter used to pop in for her all the time and she's a bit isolated and

all those kinds of things, and in a small community they come to you because they trust you and they know you'. (Interview 16)

The title and role of nurse in a small outer regional community was acknowledged by many of the nurses as a privileged and respected role. All the nurses agreed that there was a general belief that holding the position of nurse in their community came with a community acceptance as a respected person and 'opens doors for you'.

'Being a Community Nurse...or a Community Health Nurse is a very...it's a title, it's a position you hold in the community that opens doors for you sometimes...I mean it's a position that has with it mostly a general acceptance and it encourages communication...it's like your accepted for both who you are and the job you are doing straight up, before you even start doing your work'. (Interview 1)

This then further impressed on them a duty to provide care, with an overall concern for the welfare of the community and was described in various ways and termed 'minding the community'. It included the notion of 'keeping an eye' on community members in a non-official support way.

For some of these nurses the provision of PHC in their professional role was confined to clients of the service, however, this did not preclude them from providing 'care' outside their professional role. The interviews provided evidence of nurses being involved in health promotion as an adjunct to their employed work role, for example joining other community groups such as the Lions club, or helping with establishing a skate park for the younger people. Some of the nurses incorporated the physical geography of their community in their understanding of community development, recognising physical space as having an impact on the health of people within their community. For these nurses, promoting a healthy and connected community included 'out of hours' support for projects such as footpath access, community gardens and coast care projects as well as support for other community groups such as the local neighbourhood house. However, despite thinking of these activities as part of PHC, these nurses did not regard these activities as recognised within their role as proscribed by their health service.

By positioning themselves as providing PHC for the whole community, there was a distinct disconnection for some nurses between their identification with their professional nursing job and their identity as a community member who happens to be a nurse.

'I have done some talks with the little kiddies. I sort of volunteered to do one at the kids school...They were doing the circulation system. And I think I must have sounded nosey and said I'm happy to do a little bit on blood and bleeding

R. So, did you do that as your role as a nurse from here or did you do that just on your own?

No, I just did that as a parent of the school I guess you'd say'. (Interview 8)

One Community Nurse described attending the local carnival to assist with health checks on her day off after having her request for paid attendance declined by her organisation. While their professional PHC practice includes the provision of care for individuals and their families, these nurses also position themselves to include the wellness and resilience of the whole community as part of their PHC identity whether this is part of their employed professional role or not.

A few of the nurses had negotiated broader community development health promotion activities within their work role. This was primarily achieved by applying for small one off funding for specific group work which had been recognised as a community need. These nurses occasionally witnessed some consistent change within their role in the health promotion activities of their organisations aimed at the broader community. One of these nurses positioned herself within her employed role as a Practice Nurse to be able to take on some expansion of her health promotion role for her community by regularly writing an article for the local gazette.

Nurses who identified with providing care for the whole community maintained diverse links with services throughout the community as part of their networking for PHC provision. Some of the nurses also expanded their PHC role in the community by taking on positions with a range of health employers in the community, which

was particularly noted if each different health organisation provided services for distinct client groups. They viewed this as assisting in them accessing a broader range of geographical community members and ensuring networking between services. Collaboration with other health professionals and integration of care between different agencies, including health organisations, revealed the complexity and diversity of nurses PHC positioning in their rural communities.

The health service clients and their specific needs as the focus of care

For some of the nurses interviewed, their employing health organisation, which included the clients of the service, was the focus of their PHC practice. This was most evident for nurses who described the organisation as integral and connected to their community. However, this was also evident for other nurses who, despite the length of time living in their community and their community 'connectedness', described their preferred positioning in their professional role as doing 'one on one' clinical care with individuals who were health agency clients.

There was general agreement amongst the nurses that their employing health organisation's funding models favoured an individual/family focus for health care provision. Some nurses perceived all the clients attending or being seen by their health service as the 'community'. The workplace had become their community in their professional role. Working with collegial interconnections and then taking on the clients as 'part of the family' was discussed as familiar and within the 'known role' of the nurse.

'You see the same people... you get to know the reception staff, and they're all local, and you sort of build up a relationship with them and I'm very fortunate because our practice is like a family. It really is like a family. And then the patients that come in, and they see the rapport between the members and they know it's a family'. (Interview 11)

'They feel as if they are coming into their family and that what we do for them in here is going to be the best thing for them'. (Interview 17)

Connectivity within the workplace has always been a nursing skill. It was discussed by a number of the nurses interviewed as ‘minding everything’ and being ‘a linchpin’ with recent research into the role of the practice nurse confirming this and describing the nurses role as being an ‘agent of connectivity’ (Phillips, Pearce et al. 2008). The nurses described their role as connecting the practice clients and the rest of the organisation.

‘...some days it’s just flat out triaging calls, I do the triage of the walk-in patients as well as the phone calls. And pretty much liaise between reception and the doctors, so you’re pretty much a linchpin, sort of the go between, between them all’. (Interview 12)

With a sense of being already far too busy with their current role to take on anything extra ‘outside the organisation’, this notion of the community being defined as the workplace and including the clients of the health service was, for some of the nurses, a means of managing their workload.

‘Yes, we still nurse the community, like I said we are the biggest practice in this community and I mean there are things that I would love to do from within here to out in the community but I just haven’t got time to do it...Well, hopefully what we are doing is we promote a lot of this through the surgery, and so I do a lot of one on one education’. (Interview 14)

Some of the Practice Nurses were also able to structure appointment/consultation times for clients accessing the organisation, for example when doing ‘Well Woman Clinics’ and, given the extra time during these consultations, they described the importance of establishing a strong connection with their clients which then carried forward to subsequent visits and, they believed, promoted a sense of their availability to their clients.

Assisting the GP to provide care for the doctor’s clients.

People accessing general practice settings for PHC were understood, by some of the nurses, to be the GP’s clients. These nurses positioned themselves as providing PHC

services for the GP's clients and extending the GP's practice. Their role was primarily perceived to be that of assistant to the GP and therefore their time and availability was strongly influenced by the GP's time structuring and needs. This reflects the cultural, structural and historical dominance of medicine within the general practice setting.

One nurse described her 20 years of practice together with her GP resulting in a strong understanding of each other's professional identity which allowed for 'a good working relationship'. In describing her collaborative PHC role she considered herself and her role to be that of 'the right hand to my doctor'.

'Generally speaking, I suppose I have always seen my role, and that's how I define my role myself, as the right hand to my doctor. That I will try to support what he has to do by doing as much as I can to make that possible. Be that in taking history from patients, preparing to do things with patients, looking for things that he may have missed, simply because he's been busy and the patients forgotten to say something, things like that. So, yes, that's where I see my role, I see my role as pivotally as his right hand, not as an independent individual' (Interview 13)

The collaborative positioning between nurses and GPs is influenced by the perceived 'value' of the nursing role to the GP. As one of the Practice Nurses stated:

'Well, actually he came to me and he was saying how long it took him to do the care planning and so I had a bit of time and I got it all ready and he came in and I said "Well, let me show you something here, let's have a look at this care plan, this is what I could do in half an hour" and he looked at it, and after that he referred me about five patients a day, and I would get it prepared and he would go off and do it, you know, and he's making all the lovely big money and doing bugger all and I'm doing all the work'. (Interview 12)

This Practice Nurse was completing her qualifications as Nurse Practitioner in general practice and was very aware of the necessity of ensuring her position was useful to the GP's practice.

'the only reason my room hasn't been taken over is because it's too small to put an examination bed in here, it makes it quite small, and so in that way I'm really lucky, I'll keep my room, but if push came to shove, then I'd be out in the treatment room like a lot of other Practice Nurses with no privacy to see my patients and no computer, you know, I don't think that I would have any push, the doctors are always more important than the nurses in general practice, they make the money'. (Interview 12)

Despite the fact that this nurse perceived the clients she provided PHC services for as being 'my patients', there was also the recognition of not having equivalence with the GP as a health professional within general practice, particularly in terms of financial reimbursement for the organisation.

Integrated collaboration between GPs and Community Health Nurses is also dependant on perceived value to the GP. The blurred boundaries for collocated services were highlighted in a number of interviews. With the introduction of the rural Practice Nurse incentive payments to general practices in 2001 (Jolly 2007), some of the GPs had an expectation that the Community Health Nurses would also act as their assistants. One collocated Community Health Nurse described a feeling of caution about doing things which the GP asked for and which stepped over the centre based CHN role boundary.

'He would like us to be his right hand, handmaiden'. (Interview 9)

She discussed the funding boundaries between a collocated private general practice and the State funded CHC as also blurred, adding to the tension.

'...the State supplies dressings and financial support to have the GP stay and so the nurses are required to 'assist' him'. (Interview 9)

This nurse described 'feeling like a pawn'. With collocation of general practice and community health services, this Community Nurses expressed difficulty with there being no structured agreement or understanding about which clients should see the GP or Practice Nurse and which should see the Community Nurse for example for wound care, and collaborative practice remained 'ad hoc'. The Community Nurses discussed collaborating with GPs regarding client care for issues ranging from suggestions for wound care changes, antibiotic needs, syringe driver changes and access to specialists, for example palliative care specialists. The collaborative role between nurses and GPs was strongly influenced by the nurse's personal relationship with the GP and the length of time in practice together rather than reliance predominantly on the relationship of professional roles. This lack of clarity resulted in a tension between Community Health Nurses and GPs in a number of these communities with significant and lasting effects for the whole community.

Most of the nurses discussed their perception of the promotion of general practice and the GP (the doctor's surgery or the medical centre) as a central focus of primary health care provision in a rural area. In the interviews conducted in NSW there was much discussion amongst all of the nurses interviewed about the marked decline in funding towards community health centres and nursing services within them and an equally marked increase in general practice funding. Some of the nurses attributed this redirection in funding towards nursing in general practice being due to the doctors feeling more comfortable with 'their own nurses' and wary of the autonomy of Community Nurses.

In some general practices, all of the clients attending were designated, through Medicare, as having seen the GP. Some of these practices did not use Medicare Item reimbursements for tasks carried out by Practice Nurses without concurrently assigning a GP consultation with the visit. The low reimbursement payment, in comparison to the same task being undertaken by a GP, was discussed as 'insulting' and not appropriately valuing the nursing role. These practices were reimbursed for clients visiting the Practice Nurse by also recording them as a doctor's visit, with the GP 'overseeing' each client. In effect, technically all the Practice Nurse clients are seen by the GP and all of the clients are the GP's clients.

Nurses working in general practice also perceived their community as misunderstanding their role and seeing their role as an assistant to the GP.

‘But you still talk to people and they say “what do you do”, and you say “Practice Nurse” and they say “oh, so your sort of look after the GPs”, “Ah, yes....plus...” so they’ve still got this sort of thing about the sort of, you know, the receptionist is also the Practice Nurse’. (Interview 10)

Nurses’ provision of PHC services within outer regional communities was strongly influenced by both their own and their employing health organisation’s concept of who the ‘client’ was, with the predominance of policy and funding focus for nursing care supporting organisations to centre their client focus on individuals within the community. With limited financial resources directed towards nursing’s broader role of working with ‘community as client’, nurses’ sense of connection with the geographic community informed the variety of ways in which they incorporated this concept into their PHC practice within their identity work as PHC providers.

Developing a PHC scope of practice within a rural/outer regional context

A complex range of factors inform a rural nurse’s PHC scope of practice (Boase and Pedron 2011), including the rural context, the nurse’s education and authorised competencies as a clinician, the perceived needs of the client base/community and the employing health organisation and its priorities which are significantly informed by funding mechanisms. The way in which the rural nurses interviewed developed their scope of practice within these constraints/controls to meet their interests as providers of PHC is revealed.

Generalists, specialist generalists or specialists?

Most of the nurses described their role as providers of PHC within their rural context as requiring a generalist approach to rural nursing practice requiring advanced generalist skills and knowledge. Not having the staffing or service access of urban communities necessitates a broad range of skills with nurses describing their role as

either broadly generalist at an advanced level or as generalist but with advanced skills in a specialty. In viewing themselves as ‘specialist generalists’, the nurses described themselves as the ‘coordinators’, the ‘minders’ and the ‘fixers’, requiring a ‘good handle’ on emergency care but without the extreme isolation of remote areas.

‘...you find yourself now being coordinator of everything...’. (Interview 1)

‘...you get to have a little dibble in everything, be a Jack of all trades and master of none; you do have to be versatile’. (Interview 6)

One nurse, working as both a Practice Nurse and a rural nurse in a multipurpose service discussed the difficulties in attracting new staff to her rural facility. In describing the type of nurse needed she expanded on the ‘specialist generalist’ practice.

‘I know that even the nurses, especially nurses when you get Aged Care Nurses or they’ve been Community Nurses, they say, oh yeah I’m ok doing this but I don’t want to know about that ...so you’re stuck because you’ve got Aged Care Nurses who don’t want to know about the acute and you’ve got acute nurses, and there is not enough of it to keep them interested, they don’t want to know about aged care, so we are sort of stuck in a thing in the middle, for the type of nurse you want. You know, in your training as a nurse, whether it be an EN or an RN, the broad thing of being a rural nurse isn’t really pushed....it’s the common sense factor I think. It’s not just training in a whole lot of areas, you have to be able to be really flexible, and we nurse [see] so many different people on the one day’. (Interview 6)

Nurses developed their PHC scope of practice as ‘specialist generalist’ in different ways and their formal qualifications as Advanced Practice Nurses varied greatly. For most nurses, the development of their advanced rural generalist skills was in response to the perceived needs of their clients including their broader community. This also included developing skills in areas of unmet needs, for example podiatry. For some of the nurses, their practice, as advanced practice, was discussed within a task focus on technical clinical skills such as cannulation, suturing, emergency

triaging and physical health assessments. For others, the interpersonal aspects of advanced practice in rural areas such as working with known clients and thinking of the community as client, meant that population and community health management skills were included in their description of their advanced practice role.

For other nurses, their 'specialist generalist' practice was focussed on their defined role within their employing organisation, such as Community Nursing or Practice Nursing. Within this they developed advanced skills in areas such as palliative care, chronic conditions management or immunisation. Some of the nurses were supported and encouraged by their organisations to access education for advanced skills to address the needs of the organisation's client base, with specialist skills focused on priority themes including chronic conditions and hospital avoidance and directed towards individuals/families.

'we're actually going towards the focus of chronic conditions self-management...that's one part of it, another part is I think that because of the stretch on the hospitals and hospital beds, especially with the pandemic ramping up, I see that people will be discharged earlier, so we'll be getting people in the community in the more acute phase, needing earlier intervention and it might be more acute intervention, I mean we're already doing the IV antibiotics via the PIC line but we might be doing more central lines or there might be other clinical things that we're not doing currently that we may be doing in the future'. (Interview 7)

The development of generalist advanced skills was both socially and practically informed, for some nurses, by their perceptions of community (client's) needs as well as their own preferences and interests in advanced practice. This resulted in a number of nurses working across different organisations to enable access to a broad range of education and experience opportunities to develop their own career pathways and maintain specialist generalist skills within their own perception of rural PHC nursing. For example, one of the nurses was employed by a number of service providers in a community as a Practice Nurse, Community Nurse, Nurse Immuniser and rural MPS nurse, ensuring access to a range of professional development, clinical skills and community members. For these nurses, maintaining a broad skill

base and not attaching to a single health care provider was discussed as enabling their increased perception of autonomy as generalist rural PHC Advanced Practice Nurses, allowing access to a range of people living within a community.

Two of the nurses were studying for their Masters in Nursing (Nurse Practitioner), one in general practice and one in community nursing with chronic conditions focus. Whilst a number of the other nurses were contemplating undertaking Nurse Practitioner studies, there was ambivalence in undertaking this given their perceptions that the advanced practice education for Nurse Practitioners was seen as focussing on individual/family care and not on the community as client. They also discussed their perceptions that the focus for Nurse Practitioners in regional areas was on specialising and prescribing rather than generalist primary health care with a community development focus (as seen in remote or isolated rural nursing).

'but the thing is that the Masters that they offer, the Nurse Practitioners they offer is either community health nursing, general practice nursing, rural and remote nursing. They don't actually do a primary health care nurse one, so I was thinking whether to go to community nursing and then do extras in rural and remote. Or focus on rural and remote and do the extras for the community'. (Interview 10)

A number of the Community Health Nurses discussed the changes in their role as becoming more community aged care specialists and coordinators rather than the previous generalist role they perceived they had had. They saw that the rural generalist specialist role was moving, over time, to the Practice Nurse role in the last 10 years. Some of the nurses discussed the Practice Nurse role as not recognising, or having the structure to recognise, autonomous advanced practice, which influenced their decision to stay with community nursing despite their dissatisfaction with the perceived narrowing of the role.

And finally, some nurses preferred to focus on a specialist area of nursing practice, for example diabetes or breast care. Specialisation was recognised by most of the nurses as having both higher status and a recognised career pathway as opposed to generalist rural nursing. The provision of specialist services by nurses invariably

involved a client base defined by individuals with specific conditions within a large geographical area. Most of these nurses were based either in the area's major town or came into the area periodically from the nearest major city, reflecting the previously outlined transience of staff in rural settings. Involvement with the broader community was less common and involved sporadic health promotion opportunities focused on the specific health conditions. For these nurses, providing this specialisation within a rural setting also required a strong generalist knowledge base. The specialist nurses interviewed discussed the flexibility of their role as enabling them to be both centre based and able to visit clients in the community, which improved client access to the service by providing client appropriate contact. However, despite specialisation offering clarity of career pathway for rural nurses, many of the nurses interviewed were hesitant to move towards a specialisation which removed them from the centrality of their local community context.

First contact

In defining PHC, the Alma Ata definition states 'It is the first level of contact with individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process' (World Health Organisation 1978). With the introduction of the Practice Nurse incentive payments for rural general practice, the resultant changing roles for nurses as providers of 'first contact' PHC are ambiguous for nurses working in different nursing roles within the same community. While the Practice Nurses discussed having a role as the first contact for people coming into the general practice, the Community Nurses first contact role has become unclear for the Community Nurses interviewed.

The nurses discussed the influence of a history of bush nursing and the early public health nurse role in their communities, with many of these small outer regional communities regarding their local nurse as readily available and the first point of contact for broad health information. With changes in funding of nursing in primary and community care, Community Nurses expressed concern at the loss of their general first contact role. They described their first contact role as 'opportunistic' and holistic whereby, for example, a Community Nurse visiting an elderly woman would

take a family members BP if they were concerned about it. It is this role which Community Nurses believe is being curtailed through their health organisations.

All the nurses described the ‘first contact’ role as being transitioned to nurses working in general practice.. Some of the nurses suggested that this role was now more primary care/illness focussed stating that ‘if there is something wrong you go to the doctor’ with the perception that the role was being promoted to ease the load on the GPs.

The variety of physical practice options available to nurses in outer regional communities includes being centre based at a general practice, community health centre or multipurpose service/small rural hospital or else being able to move around the community as a Community Nurse, Community Health Nurse or Clinical Nurse Consultant. The physical positioning/mobility of their role was determined by their employing health agency, and while the physical positioning was not the determinant of a primary health care approach to their practice, the nurses discussed the varied ways this influenced their work within their community and their ability to implement primary health care practice. The varied roles afforded different opportunities for access and availability of the nurse to clients and the community generally. The way in which nurses positioned themselves as ‘first contact’ PHC professionals furthers an understanding of how they align their PHC approach with their concept of ‘client’, that is, who they are providing ‘first contact’ for.

Available and accessible

The ‘availability’ of rural nurses to their community is changing. The nurse’s availability to clients/community is related to how they structure their role and how their role is structured by the organisation. For some centre based nurses, they are the first contact within the service and triage clients coming in. Within other centre based agencies, the receptionist is the first contact and decides who/which health professional will address the client’s needs. For most of the Community Nurses, their care is made available to clients who are on their schedule via external referral from a central metropolitan agency. The way in which their work time was structured by the organisation influenced this. Some of the Community Nurses discussed their

perceptions of the 'ad hoc' nature determining which health professional addressed a client's needs. This was seen as having some positive aspects in that this allowed/supported community members to decide who they chose to access as their first contact, and had the effect of improving accessibility of health service utilisation for some community members.

'it's changed for the community because by word of mouth people know there is a Community Nurse here all the time, so people drop in and they'll ask for their blood pressure or they'll want to talk about something or they'll ask some questions, yeah, so I think it's been really good for everybody really...we have a drop in service... and anybody is welcome to come for any reason'. (Interview 16)

Many of the nurses equated their availability with being accessible. For some of the nurses, the fact that they were working for an agency in a rural community meant that their skills were available, people were referred or invited to attend and therefore they perceived the health care they provided as accessible. Addressing the need to support and promote the accessibility and affordability of health services included the bulkbilling of their service and awareness of their own physical positioning within the practice, however access still relies on the client coming in to service.

However, there was also evidence of nurses consciously working to increase their availability in a range of ways to broaden their client base within their community and increase access, appropriateness and equity of health care for their community, ensuring contact with community members who were considered 'hard to reach'. For some, this involved working across a number of agencies, for others it meant going into people's homes to provide care, and while there, assessing the needs of the whole family, and for others it included being involved in events outside their professional role which they then linked back into the health service. It included the notion of advocacy, as discussed by Keleher (2007c), for community members.

Consciously structuring 'free time' into the schedule/appointment timetable, to support the opportunity for broader availability to community, was evidenced within the interviews. Nurses discussed ensuring that they are seen as available/accessible

(perceived availability) and that this supported the opportunity for more reticent community members to ask for appointment/time. Some of the nurses ensured that they were perceived as able to go out to people if needed, and that they could make time around the client. Being seen to be available was an important aspect of the provision of accessible health care for many of the nurses. Some of the Community Nurses acknowledged that they would accept 'first contact' with clients by word of mouth, and would initially bypass the external referral mechanisms; they would see the client anyway and then 'fill in the paper work later', especially for known community members who were otherwise 'hard to reach'.

Other methods used to support their availability to community members included ensuring time for other family members to ask questions when the nurse was in their environment/home. Some of the centre based nurses discussed having structured client time but also ensuring time to be seen to be more 'floating' and therefore more available and less structured. They described this as allowing for any other relevant information to be received, less formally.

The way in which the 'first contact' role is provided by PHC nurses in rural communities varies. This is influenced by a complexity of factors including the rural context and the structured rural health service roles. However, while the way in which nurses position themselves, in attaching to different PHC nurse roles, reveals their attempts to meet their interests as 'first contact' PHC providers, it is not the structured role itself which provides the gains but their identity work attached to the different roles. With policy focus and funding aimed at increasing the Practice Nurse role as 'first contact' provider, many of the nurses interviewed recognised the potential for gaps in PHC service provision for particular members of their community and the community as a whole. Attempts to address these perceived gaps in service provide further understanding of nurse's interests and also their agency as PHC providers within their community.

The 'gap filler' role

Nurses invariably expanded their roles when they perceived gaps in the provision of PHC for their clients/community out of a sense of duty to provide care. In describing

their practice, many of the nurses discussed the ‘doer’ approach; the sense of duty connected to their role and that:

‘if something needs doing then you do it ...cos there’s no one else to do it and you can’t just leave it for someone else to pick up’. (Interview 1)

This ‘gap filler’ role, so frequently acknowledged in rural nursing literature (Keyzer 1997; Ross 1999; Mills, Birks et al. 2010), was discussed by the nurses as necessary to ensure holistic care and for some it encompassed more than taking on extra tasks, it was part of the recognition of developing and sustaining an intimate and interconnected knowledge of and relationship with clients and community.

‘But that’s rural medicine and when I say my role has expanded, my role has expanded by choice, ummm because the longer I have lived in this community and the more I have got to know it, I have chosen to actively say to the boys (the employing GPs), alright I am doing audiometry, I am doing cardiographs, I am doing pathology, I am doing dressings, I am doing Well Women’s, I’m doing immunisation clinics, I’m doing diabetes, I’m doing foot care...they are the needs that we have and I pick up. And I am here’. (Interview 13)

Where nurses believed their organisations did not condone their practice of expanding their roles to meet the perceived gaps in PHC provision, some of the nurses spoke about surreptitiously providing this care. Confirming previous research findings, as discussed in Chapter Two, the Community Nurses interviewed in this study described the constraints to their PHC practice. The increased rationalisation of their role to providing care for individual clients of the service through specific funding resources such as HACC and DVA, significantly curtailed their ability to maintain the broader community access to their services.

‘It’s changed, there’s not that caring for the community...if they’ve got a problem you go and see them...but if they are just an elderly person who is isolated with early stages of dementia...you can’t go and check how they

are... (but) you do...and you work your numbers out at the end of the day'.(Interview 3)

However, not all the nurses attached to this role, with one nurse strongly refuting the gap filler role believing that by nurse's gap filling, they were in effect hiding a need and therefore further disadvantaging their communities.

'You won't ever demonstrate a need for another service if we keep picking up all the other service needs. Look I am not a nail cutter. All our clients are compromised in some way, they are either palliative care or frail aged or have some cardiac problems, circulation, they are diabetic, and there is some reason for them to be our clients, so why would you be mucking around with toenails'. (Interview 2)

This quote provides further understanding of the different ways in which nurses construct the identity of 'client' and how this impacts on their perceived role in the provision of PHC.

Nurse's satisfaction in PHC practice

This next section reveals the factors nurses perceive as informing their levels of satisfaction with being able to provide PHC services within their roles in rural communities. There were four main areas nurses discussed which impacted on enabling or posed barriers to their effectiveness as PHC providers and therefore impacted on their levels of satisfaction within their role/s. These were:

- the health service's perceived 'connection' with the geographical community,
- the models of PHC used by health services,
- the level of nurses' autonomy within collaborative practice,
- nurse's feelings of appreciation and recognition for their service provision.

Health service's perceived 'connection' to the rural community

Satisfaction with providing PHC services was enhanced by a belief that the employing organisation was intricately connected to the community. This was reinforced, for nurses, by a perception that their role in supporting this connectivity, including collaborating with other health services and other agencies within the community, was appreciated and utilised by their employer.

Some nurses identified with their health agency, including clients, as 'their community'. This was more likely if their health agency was perceived as 'being part of the whole community'. One of the nurses working in a general practice discussed her drive to 'give 110% effort' in her work. The importance of having a supportive general practitioner (GP) employer with 30 years of practice in the community, who provided obvious support for all the practice staff as well as for local community groups, was seen as being instrumental in this.

'Local community groups, they love us, we donate, (the GP) is very close with everybody, most of them are our patients, but aside from that, (the GP) gives a scholarship to a Year 12 leaving student each year....preferably if they are going to study medicine.... we've always got our photo in the paper supporting this, supporting that, yeah, if the RSL want us to go and give a talk on health we'll go and do that'. (Interview 17)

For nurses who positioned themselves as members of their community, tensions were evident if they perceived their health agency as not prioritising PHC provision for their community. Some of the nurses discussed the 'external' management of their services as lacking responsiveness to the rural context of their practice which impacted on their PHC provision. In describing her difficulties in progressing the repair of essential equipment, one nurse expressed her frustration with the management of her service stating 'they couldn't care less' (Interview 15). The negative impact of this sense of disconnection from PHC provision for the community as the organisation's priority was reiterated by a number of the Practice Nurses who perceived their Practice Nursing role to be primarily supporting primary medical care and a market driven model.

'It's medical services basically ... look I'm a bit cynical on this... a lot of these packages are put together through drug companies who offer incentives and so I'm not really impressed with that... they come and do the health assessments and pay (the practice) to come and do them and then you have everyone being put on Vitamin D and on Caltrate. So you know the drug companies have got a lot they are after but really I mean the medical practice, being a small company... they are always chasing the dollar'. (Interview 5)

While most of the Practice Nurses discussed an awareness of the importance of their role being seen as economically beneficial for the practice as a business, the way in which this met their own interests varied. Some of the nurses discussed the importance of ensuring and maintaining a GP service within their small communities. Through assisting the practice/business to survive and thrive they perceived their role as supporting the GP to stay in their community. For one enterprising nurse, her recognition of the practice receiving incentive payments for meeting a target of blood sugar readings for the practice's diabetic clients also enabled her to claim this target as her area of clinical responsibility, ensuring clients were up to date with having blood taken and encouraging them to 'stick to the diet'.

Following the instigation of an external base, situated in the major city, as a central referral point for accessing community nursing, barriers to communication between nurses working for different services within the same town concerning a client in common were discussed. One of the Practice Nurses, in describing her connection with the local Community Nurses stated:

'Don't have a lot to do with them, with referrals its now sort of we fax it through to one number, at (Central Referral Point), and then they sort of send it on and sometimes if I miss something out or they want more information, then they'll ring, or they're checking on somebody's INR or with their next blood form, could I organise the doctor to get their blood form for so and so, so not a lot to do with them'. (Interview 12)

The impact of models of PHC for nursing practice

Nurses described working within models of health care delivery they believed reflected an urban bias and did not adequately encompass their prioritised interests as PHC providers within a rural setting. Ambiguity in the focus of their role in health promotion activities within their organisation added to the sense of dissatisfaction for some nurses in being able to provide PHC services. The perceived powerlessness of some of the nurses to influence the frameworks within which they worked to provide PHC services further promoted a sense of despondency.

Many of the nurses interviewed described the way in which the frameworks used by their employing health agency did not differ markedly to their urban counterparts except for allowing for travel time for community nursing. They discussed their perception that the funding was directed from 'town' with a lack of understanding of the full extent of their role in their rural community.

Primary health care, as a strategy in these rural regional areas varies in its full development, in terms of nurses being able to provide wellness, prevention, early intervention and illness support in partnership with individuals/families and their community as a whole to maintain resilience. For many of the nurses, their overt practice focus was on the individual clients they were working with, with some of them voicing their belief that this narrowed practice reflected both the political and fiscal decision making of their organisation as well as the culture of their nursing practice.

'I have to say that the majority of the time I'm just concentrating on what I'm there for...I think it is what community nursing is at the moment...and it will probably be even more so with us going back under the hospital...it's scary...I'm hoping that it's changing but I think that we are of a generation which is very bogged down in our what we've been doing for years and how we feel we should still be doing it.' (Interview 4)

The aspects of ‘nonquantifiable & hidden’ practice

The general practices employing all of the nurses in this study received Practice Incentive Payments as a subsidy for employing a rural Practice Nurse. They also were able to claim for some of the nurse’s work through Medicare Item numbers. However, while the use of Item numbers provided data depicting some of the nurses’ work, all of the nurses discussed the way in which this failed to reflect the extent of their actual practice. They described being ‘run off my feet’ all day, with most of their time being focused on ‘keeping everything ticking over’ (Interview 12).

Community Nurses working for State run health facilities or NGO’s had differing ‘time structured contact’ with health service clients. For many, their role was delineated into time structured episodes of care for specific clients. This provided the service with information for funding and billing purposes and statistics on service provision. However, some of the nurses felt their PHC role within their community was not truly reflected by this information.

‘We are trying to develop stats that reflect our role but it’s really difficult to reflect what we do do... I rang various sites to get a hint at what they were doing to try and develop our stats so they would reflect our work. And I realised it is the same as the town stats for them...And it only very basically reflects what I do....I don’t know how to categorise the rest of what you do...you find yourself in support roles all thru the day....whether it be a staff member in tears or casualty or your role as minding the carers of your clients’. (Interview 1)

The time structured contact with health service clients also influenced, and for some nurses curtailed, their perception of being more broadly available as PHC nurses for their community.

The Community Nurses interviewed discussed how the influence of HACC eligibility and a task focus of care provision, for example wound care, has meant that statistics are kept for certain criteria and community nursing is viewed as more task focussed. However, a number of the Community Nurses suggested that, in reality, the statistics kept did not adequately reflect their role and time spent on different

practices. With data is not kept on these broader PHC practices, the practice itself is not clearly overt and remains silenced.

While the flexible availability of nurses to community members was considered important for nurse's PHC practice, they suggested that the statistics they kept depicting the work they undertook failed to highlight this positioning and the opportunity to provide this flexible first contact delivery of care varied at different sites.

The complexity of the reality of rural community living incorporates the ongoing nature of peoples' relationships. Belonging and being included in the community's culture promotes reciprocity of interconnection and interrelationship. This mutual exchange of relationship was described as adding depth and meaning to practice but also adding to the emotional cost of practice. This reflects Clarkes (2004) description of the nonquantifiable aspects of public health nursing which allow for nurses 'embeddedness and situatedness' within their community.

Barriers to incorporating health promotion and community development models of practice

The scope of practice for rural nurses providing PHC, as defined by their health agencies/funding bodies, has changed with increasing acuity of care and concomitant technical/clinical skills and a focus on individual chronic conditions self-management support for clients. The impact of these funding changes and concomitant role changes for nurses has included ambiguity in the understanding of the practice of 'health promotion', the provision of 'first contact' care for members of the geographic community and the perceived availability of, and access to nursing care in the community. Nurses who positioned themselves as providing health promotion/PHC for their whole community discussed their perception that these 'narrowed' funding models resulted in a silenced gap in the provision of PHC for their community.

'...well see it feels like it's gone off in two areas already...so the people that you see who need the day to day support, maintenance, dressings or pall care...that's one area...then the other area is where, if we were resourced for

it properly, would be with health promotion and that is a much wider group... ' (Interview 1)

Health promotion was discussed as a recognised component of PHC. Community development is one of the major underpinnings of health promotion. Within nursing, community development is defined as the process of involving a community in the identification and reinforcement of those aspects of everyday life, culture and political activity which are conducive to health (Chalmers and Bramadat 1996). There were varied understandings and practice of health promotion, health education and community development amongst the nurses with evident tension between having a population focus of practice and providing individual/family care within the context of health services for outer regional communities.

With the specialist generalist role of rural nursing practice, the nurses work within multiple mandates. Working with a tension between prioritising care/practice and managing time, one on one client care was perceived as having more authority and support as a focus for care. The perceived support by the organisation for the type of health promotion taken on was strongly influential; however the health promotion models supported were seen as constantly changing without a consistent theoretical base, going from community development to evidence based behaviour modification, to public health education training. Some Community Nurses had a working history that included a time when they felt that a broader focus for health promotion and community development was acknowledged and promoted and supported as aspects of their role. One nurse also discussed the more recent prioritisation of individual clinical care:

'We've recently been told by management that with budget cutbacks we will have to give up the new health promotion work we've been doing'. (Interview 1)

In some communities, nurses noted that PHC roles such as community development and health promotion were no longer core nursing business but had become health promotion worker roles within local councils or had been designated as core social work roles. They described how their organisations were employing other non-nurse

workers to provide health promotion services in response to changes in funding allocations.

Nurses discussed the State funded community nursing service as being viewed predominantly as funded for individual/family focussed community care with some attempts at broader community health nursing. Community Health Nurses were described as becoming more 'aged and community care' focussed. Some of the Community Nurses were making time to do health promotion and wellness programs with a community development approach whilst aware that their organisations focus for practice appeared to be directed more towards rehabilitation, client coordination, individual lifestyle and chronic conditions management.

There was a sense of frustration at not feeling supported by their organisation to incorporate a more extensive health promotion role within their position. Some of the nurses interviewed believed that group or community development work was perceived as an 'extra' to their sanctioned role. And that health promotion was often undertaken 'off the side of the desk'.

'It's an area I get so passionate about really, the role lifestyle changes can play in preventing a reoccurrence say in someone with breast cancer. You know, like she might have a grade I, II or III breast cancer and you know, just by making comprehensive lifestyle changes, the evidence now says that you can reduce your risk of reoccurrence by up to 60%'.

R. So, do you get involved with things like breast cancer support groups?

'No, no I don't umm...I...I ummm...I don't tend to do anything outside my clinical work because we are not funded for it. At one stage I was getting involved in extra things and it was taking away a lot of my family time and I just thought 'oh no' like I really just have to stick to my 8 hours...you want to get stuff like that started but no I don't have any actual involvement in that. It's a self-preservation thing really'. (Interview 19)

In discussing the funding influences for these changes in their practice, some nurses suggested that the structural change in their management ,with community health being managed again by the hospital system, would mean an increase in focus on

avoidance of acute admission, further focus on ‘hospital in the home’, and an increase in ‘step downs’ from the acute sector.

‘I’ve seen a lot of changes from in the earlier times when you were a lot more directly involved with health promotion activities and working very much as part of a team, planning health promotion days, the intervention stuff; to it now gradually going around more post- acute care, supporting the acute care system’. (Interview 15)

Some nurses doing one-on-one individual health education, primarily focussed on management of illness, as supported by their organisation, did not express the same levels of frustration about not being able to expand their roles. This was despite recognition of possibilities for broader health promotion activities such as continence education sessions for the community. They were aware of dissonance between the individual health education they were able to achieve in their role and possible expansion of health promotion activities, however they discussed being extremely busy with the workload they were currently managing.

Nurses who positioned themselves as providing PHC encompassing the ‘community as client’ discussed barriers related to their nursing colleagues’ recognition of this role in instigating PHC community development work. One nurse, in discussing the outcomes of a community driven ‘Girls Surf Day’ for local teenagers described the necessary juggling of her workload to enable her attendance as a team leader and the resultant cynicism of her work colleagues:

‘The comments going around after the ‘Girls surf day’ were things like “what’s that got to do with nursing?”’ (Interview 1)

There was a sense of a constraining self-surveillance in regards to the extent of the generalist nature of rural advanced practice. The nurses described accessing regular professional development to ensure the adequacy of their generalist skills however, with some of these skills only employed/practiced irregularly these nurses, some with many years of experience, still spoke about an underlying hesitancy in practice. This hesitancy was most notable with skills that were perceived as less favoured, not

fully supported or not seen as the highest value/core nursing business by the health agency. Community development approaches, counselling skills and broader health promotion skills outside the one-on-one individual client approach were the practice areas nurses were more hesitant in undertaking.

'It's like "this is what primary health care really is and you aren't any good at it" You don't get a chance here to do it properly and we don't liaise as a team and we work in isolation...' (Interview 1)

Alienation from the construction of the PHC nursing role

Some of the nurses discussed feeling alienated from the construction of their rural PHC roles by their employing health services despite avenues for input such as strategic plans. They described a need for stronger nursing leadership in the direction primary health care was taking, however, there was a sense of feeling separated from the decision making process of role development and funding for rural nursing, and for many a sense of cynicism about their ideas being listened to. There was strong evidence among many of the nurses interviewed of a general cynicism and despondency about the future direction for nurses in PHC and the lack of nursing leadership in this. Some of the nurses spoke with resignation and negativity about the 'taking over' of community health by medicine.

Many of the nurses interviewed discussed their perception that nursing leadership in PHC was predominantly influenced by medicine through general practice and practice nursing organisations. While there was discussion about these avenues being supportive and useful for gaining some clinical skills and networking, nearly all of the nurses spoke of a lack of definitive nursing leadership for PHC nursing. Despite nursing leadership in PHC through RCNA, especially with the consensus document (Primary Health Care Working Group 2009), surprisingly most of the nurses interviewed were unaware of RCNA's role in PHC and were not members.

Working collaboratively as an autonomous health care provider

While recognition as being an autonomous health professional was important for most of the nurses, attaining this was less evident and nurse's identification of autonomous practice varied. Some of the Practice Nurses, who had been working with their employing GP for extended periods of time, discussed their collaborative working environment as being supportive and satisfying. Trust, which developed over time between the GP and Practice Nurse, supported an increase in their perception of the level of autonomous practice they achieved whilst still working within a GP-led team. Community Nurses working in small teams also described the benefits of working collaboratively with each other to provide care for their clients however the recognition by GPs of their autonomy was less evident and a source of tension.

The GP as leader and gatekeeper

In describing their PHC practice, many of the nurses discussed enjoying a degree of autonomy as a health professional in both practice and regulation, however, the perceived surveillance of nursing practice by medicine was an underlying concern. The tensions related to the GP being seen as the 'gatekeeper' to health care access were discussed by most of the nurses. For some of the nurses the gatekeeper role was seen to be related to funding policies such as Medicare funding as discussed previously, however, for other nurses it was related to their perceptions of the control of PHC by general practice/medicine.

'The traditional roots of community nursing as illness prevention and health promotion, have really been lost and it is really that direct patient care, immunisation, is the primary intervention, but again that's medical model based and the pharmaceutical companies, and they are very narrow in their focus, around their criteria of who they can support...I certainly have some grave reservations if the GP is the gateway to community support services because of how they function as a private business and how their vision of health is pretty much based on the treatment model'.(Interview 15)

Some Practice Nurses discussed working within the culture of ‘general practice land’ and described a ‘separateness’ between the GPs and the rest of the staff/clients which reflected previous findings in the literature (Chesluk and Holmboe 2010).

‘It’s interesting working with doctors in general practice land because they’re used to working autonomously, they’re not used to being in a team, the patient comes to them and they’re their patients. And it’s really hard’.
(Interview 12)

Some of the Community Nurses expressed a belief that the GPs have always been a bit suspicious of Community Nurses and, as such, preferred “their own nurse”; this has been discussed in the Australian literature for many years (Montalto and Dunt 1992).

‘When you’ve been working in a different way, and particularly when you’ve been working in the community, you do have that autonomy and that’s why the doctors traditionally, and I’ve had a doctor say that to me, why they do find, or become challenged, or don’t like Community Nurses is because they feel that they are making decisions without the doctors authority and that didn’t sit comfortable with them’. (Interview 15)

Community Health Nurses within the different communities discussed their awareness of the high social standing of the GP in the community. This created tension for nurses if they perceived a need to clarify the professional collaborative relationship between General Practice and State Government funded nursing services. Experiences of ‘community backlash’, both socially and professionally, were discussed as resulting from GP dissatisfaction with Community Health Nurses who placed limitations on the requested ‘assistant’ role.. The impact socially for nurses of workplace tensions and the power difference between nurses and doctors is exemplified by this quote.

‘It will never be clear, I have very good working relationships with them but at times you feel like, because you have that working relationship, and he is our family doctor, so it’s on two levels, and away from it all I consider them

lovely people who I would like to call my friends, but sometimes you feel like you're a bit of a pawn, like he's pulling you or using you'. (Interview 9)

The GP team leader model was described as resulting in some people in the community having decreased health care access. With changing demographic profiles, the nurses discussed how some community residents accessed less formal health care support. They described how not all of the new residents, for various reasons, will go to the local GP, and for some practices the GP's books are closed while others find the local GP inappropriate for their health care needs. This included some people with 'alternate lifestyles', women (if the practice only has male GPs) and workers or carers who have difficulty accessing the practice during work hours. The changes to practice, in terms of being able to provide 'first contact' service, especially for Community Nurses, and the way this impacted on nurses' perceptions of their scope of practice, have been previously outlined.

Working in general practice, with the GP as team leader, some of the Practice Nurses described their collaborative roles in general practice as that of task delegation. One Practice Nurse described it as:

'What would you say? Handmaiden role or something. You get all the ear syringes and all the dressings and the bloods. They see them and then they flick them to you for any treatment'. (Interview 5)

Describing her previous general practice employment, one Practice Nurse reiterated the task delegation role, which she felt undermined her professional identity.

'I was taking blood, sterilizing, actually cleaning, cleaning! Not very exciting. Cleaning the equipment. It's just such a waste of nursing, such a waste, and then the practice manager wanted me to do more hours, she wanted me to do more reception work and that's when I sort of said to her "I don't want to do that, I'm not trained as a nurse to do that". (Interview 12)

Community Health Nurses discussed their difficulty with accessing information on clients from the GP. The term integration is used to describe working between

different services and in some cases, especially for State funded Community Health Nurses, this is the difficulty when trying to work across services with no integrated governance model – there is no agreement on information sharing and collaboration (Jackson, Nicholson et al. 2006). They suggested that access depended on developing a personal relationship with the GP rather than a structured process and this became more difficult with irregularity of GPs. One Community Health Nurse, when asked about the structure for collaboration with the GP stated:

*'Is there one! No! You write him a letter, and he doesn't get back to you and that's the end of the story unless you have a chance to ... there's a whole lot of things that have to be changed...obviously...and sometimes there is this assumption that all of this is in place and we just need to shift our focus'.
(Interview 1)*

Collaboration between nurses

Whilst all of the nurses agreed that they were rural PHC nurses they did not use this title in describing/discussing their provision of PHC. Most of the nurses expressed strong attachment to the titles of their structured roles, for example when asked how they described themselves as nurses they discussed thinking of themselves as Community Health Nurses, Community Nurses, Practice Nurses or Rural Nurses. This reflects the previously discussed literature around the historical development of nursing and nursing titles/roles outside hospital settings in Australia (St John 1996; Francis 1998; Keleher 2000b; Keleher 2007f). There was recognition of the lack of understanding of the different roles, their responsibilities and boundaries. Their identification with and attachment to the historical and current structured roles/titles highlights the tension regarding the lack of a generic PHC identity/framework.

One nurse who worked as both a Practice Nurse and Community Health Nurse for different organisations, and was studying for her Nurse Practitioner qualification as a PHC nurse, identified the lack of understanding of each other's roles:

'The Practice Nurses don't know what the Community Nurses role is and responsibilities are, the Community Health Nurses don't know what the

Practice Nurse's role is, I think I'm in an ideal position because I see both sides of it, and they're both right in a limited way but they're both wrong.... And that is the key...collaboration between primary health care nurses'. (Interview 10)

Despite suggestions in the literature of 'community nursing' as the overarching descriptor for nurses working outside hospital settings (Kelly and Symonds 2003; St John and Keleher 2007a), the Practice Nurses interviewed spoke strongly about not being called community nurses and expressed negative responses to the Community Nurse role, describing it as distinctly task focussed, perceiving their role as Practice Nurses as supporting a more holistic approach.

'Well the way I see it is probably a bit different but I see it more as, I know they (Community Nurses) probably do a lot more than I think, like a lot of people don't know what Practice Nurses do, but I see it as being more sort of task orientated, like going and doing a dressing, or doing a shower or whatever, I like to have my finger in the pie, I like to sort of see the big picture and I like to see people in the whole thing and make sure that this persons got that right and that right'. (Interview 12)

The titles used to designate the roles these nurses held reflected both the health agency employing the nurse, as well as the diversity of positioning for rural nurses in small communities. Within current Australian literature the term 'Community Health Nurse' is also used to encompass the collective profession of nurses caring for populations in primary care settings and outside hospital and institutional settings, (Brookes, Davidson et al. 2007; McMurray 2007; St John and Keleher 2007a; Woods 2010) however, there was a lack of agreement amongst the nurses in this study on the use of the generic term 'Community Nurse' or 'Community Health Nurse' for their practice in primary care settings in regional rural towns.

However, one nurse who worked in her community as a Practice Nurse, a Community Health Nurse and a Rural Nurse, reflected on her role after being asked whether, as a Practice Nurse, was she a community nurse:

'(long pause)...Interlaced, but not as such...ummm...that's a good question...if you thought about it I suppose you would have to say yes because...yes, you are a practising community nurse...I was thinking of referrals and so forth but I mean it works both ways and ummm...a lot of what you do...yes it is, its community nursing, although I hadn't seen that before'. (Interview 5)

Community Health Nurses were also hesitant to be identified with Practice Nursing. In terms of Community Health Nurses maintaining their sense of autonomy in practice, some State funded Community Health Nurses working in general practice settings were clear about not being Practice Nurses.

'They never call themselves Practice Nurses; they've always called themselves Community Health Nurses working in the general practice because they've got a wider focus. But they do do a lot of Practice Nurse stuff like immunisations and things like that, a lot of procedures.' (Interview 7)

The terms Community Nurse and Community Health Nurse were used interchangeably. In Tasmania the State employed nurses were employed as Community Health Nurses and in NSW they were employed as generalist Community Nurses. All the interviewees attached differently to thinking of themselves as primary health care nurses. While some nurses preferred to maintain their particular role titles such as Practice Nurse or Rural Nurse or Community Nurse, others were more attracted to using the term rural primary health care nurse to portray their practice identity. This was particularly so for nurses working across a range of roles in different health services. For the nurses interviewed, a positive attachment to the overarching title of rural primary health care nurse was seen across all the roles, including Practice Nursing, Community Nursing/ Community Health Nursing and Rural Nursing.

Feeling appreciated and recognised for their role

There is disparity between nurses' sense of appreciation and recognition afforded by different structured PHC nurse roles. This informs their identity work in attaching to

different roles. There were two aspects to nurses' sense of appreciation and recognition for their role. One aspect was the respect and appreciation they perceived from their employer/GP and the other was the appreciation received by their community. While their status and recognition within the community as a nurse was acknowledged, it was the employer/GP's appreciative behaviour which dominated their discussions as impacting on their sense of satisfaction in their workplace.

Practice Nurses discussed the increasing level of support and respect they felt in their practice both from the AGPN and within their team. They also spoke enthusiastically about the future possibilities for PHC nursing practice in general practice. With increased levels of support and encouragement, especially since the introduction of the rural Practice Nurse subsidy, these nurses highlighted the benefits of being so appreciated in their work place. As one Practice Nurse stated:

'That's why we give 110%. Because we get 110%'. (Interview 17)

This Practice Nurse spoke enthusiastically about seeing herself as a team member; she described how her employing GP encourages a team approach in the practice, with all colleagues having a voice at regular team meetings. It is a GP led team and the GP is a long term committed and respected community member.

'Oh yeah, we all sit around in (the GP's) office and she gets sandwiches and everything and we've got the board and we write all our issues on it, and you can say anything you want in there, from (GP) down to me, I think I'm the lowest in the pecking order, or the medical students, they're below me, but everybody is there and everybody's got something to say and everybody gets to have their turn'. (Interview 17)

The above quote exemplifies the hierarchical GP led team described in all of the Practice Nurse interviews. Some of the nurses described an added sense of security derived from working with this model.

'I like the security of having other people around me, I like the security of having another pair of eyes to look at it, I like the security of having another

thought into whatever is going on, which you always have here'. (Interview 14)

The importance given to having the respect and trust of 'their GPs' regarding their competence, reflects previous research findings (Pullon 2008). As one Practice Nurse revealed, both length of time working together and focused effort at 'connecting' with the GP also influenced this level of respect and trust and consequently enhanced the Practice Nurse's PHC role:

'Yes, it takes a while for them to get to know and get to trust you, and the good thing that we have here, that the other surgery didn't have, is a tea room, so we actually have morning tea, and we have lunch, and that's where you get to know new people, and get to chat, and that really enhances relationships, and you can get to talk and get to know people... what does this person know? How much can I trust this person, cos that's how they're looking at me, and it's taken five years now but my boss now will call me in and say "What do you think I should put on this wound?" and I go YES! And that's taken five years'. (Interview 12)

Organisational support for continuing education, skill acquisition and practice in clinical primary care skills was perceived as encouraging for nurses. For some nurses this fitted well with their rural specialist generalist professional agenda and offered clear career pathway opportunities.

'...the Practice Nurse's role is going to take off and they are going to become more specialist generalists rather than just generalists'. (Interview 10)

However other nurses discussed being either unable to access education opportunities which they believed to be important to their PHC position or else offered/encouraged to develop skills which they perceived as beneficial to their organisation but less beneficial to their PHC role. The interviews revealed that primarily Practice Nurses expressed satisfaction with their ability to provide PHC services for their clients. Recognition of constraints to providing PHC was predominantly voiced by nurses working in roles outside general practice.

Conclusion

This chapter has provided a lens for PHC nurse identity work through analysis of interviews with rural nurses as empirical data. The themes emerging from these interviews assist in understanding nurse's interests as well as their agency as providers of PHC for their communities.

Living/ working rurally impacts on regional nurses' professional identity. The positive aspects and the more difficult facets of living and being known as a nurse in a small community play a role in shaping nurses prioritised interests as PHC providers. However, PHC as both a familiar yet problematic concept for these nurses hints at a disconnect between the theory of PHC as an approach to practice and nurses perceptions of their practice of PHC.

Nurse's identity work highlights similarities in the way in which nurses see their role as PHC providers in rural settings, however there are distinct differences in the ways nurses align their PHC provision with the concept of 'client'. While there are health service controls and constraints for nursing roles which influence these constructions of who the client for the rural PHC nurse is, their identity work reveals prioritised practical and social interests in attaching to PHC nurse identities. This resulted in their practice being focused on the 'client' in three different interrelated ways as:

- a) providing PHC nursing services for the whole geographic community as client.
- b) providing PHC for the clients of their employer health agency.
- c) supporting the doctor/GP to provide PHC services for the GP's clients.

While the health services employing nurses strongly influenced the development of their scope of practice, nurses modified their practice to meet their prioritised interests. Some nurses actively shaped their own career pathways, which included working across a range of health organisations, to develop a professional practice which matched their interests as rural PHC providers.

Perceived enablers and barriers impacting on nurses levels of satisfaction and ability to provide PHC services in their rural settings were described. While the perceived connection between the health service and the whole geographic community was important, many of the nurses felt their PHC practice was constrained by the proscribed models of care supported by their health services resulting in a strong voicing of despondency and cynicism for the future of PHC nursing.

While the views of nurses as agents and how they negotiate go a long way in understanding contemporary PHC nurse identity in rural areas they are an incomplete understanding. There is a need to incorporate the identity work of not only nurses but the identity work which reflects the broad range of other agents with interests in PHC nurse identity. As such the following chapter will provide the synthesis of these two findings chapters

Chapter Six: Four emergent rural PHC nurse identities

This chapter presents a synthesis of rural PHC nurse identity work evidenced by the previous findings chapters. Four key identities that were used to characterise rural PHC nurses are outlined in this chapter. Chapter Four provided analysis of the submissions made to the NHHRC and representations of PHC and PHC nurses. Analysis outlining the sociocultural properties of the identity work of nurses as primary agents as they negotiate and navigate between these structural cultural elements in their PHC identity work was presented in Chapter Five.

The analysis is integrated with the literature presented in Chapter Two, detailing rural nurses' positioning as PHC providers and the historical context and forces informing the current situation. The four identities show how nurses variously position themselves and are positioned as providers of PHC for rural areas in meeting different interests, including how structural positioning represents nurses as providing PHC.

The analysis of each identity is progressed through retroduction (Sayer 2000; Danermark, Ekstrom et al. 2002; Clark and Blundel 2007; Reed 2009) and provides depth of understanding of rural nurses' agency as PHC providers. This enables the discussion to proceed towards an explanation of some of the generative mechanisms affecting rural nurses' PHC service provision and how rural PHC nurse agency interplays with rural health services. This contributes to meeting the research aim: *to explore nurses' agency through identity work to inform an understanding of contemporary rural PHC nursing in Australia.*

The Four Identities

The four key identities used to characterise rural PHC nurses and outlined in this chapter are: The Local Community's Nurse, The Doctor's Nurse, The Boundary Spanning Nurse and The Organisation's Nurse. While these identities are not used

exclusively by any one group and there is overlap in some of their interests, the key characteristics of each identity delineating them from each other will be presented. The discussion foregrounds the dynamics and struggles rural PHC nurses as primary agents encounter in using identities to support their interests, however it also reveals how these identities are used to position nurses as PHC providers within the complexity of rural health services and the exchange transactions and power relations involved.

The following table (Table 7) outlines the key features of the four rural PHC nurse identities including: the key characteristics, who uses the identity, its strength and implications, the predominant model of care and overarching identification and commitment summarising the major theoretical contributions of the thesis.

While the themes emerging from analysis of empirical data in the previous two chapters presented evidence of PHC nurse identity work, it is in this chapter, presenting the retroductive analysis of identity work, that the link between the four PHC nurse identities and identity work become evident. The key characteristics and overarching identification and commitment of the four typologies highlight the way in which nurses take on a PHC nurse identity to meet their interests. Corporate agents, as dominant groups, are able to deploy various forms of cultural and structural powers to ensure social developments such as PHC nurse identity are congruent with their defined objectives (Archer 1995:303). This is highlighted by the different groups who use each of the four identities, and the subsequent strength of each identity.

Collective identity is central to this study as a way of exploring the power of group actions and the constraints of social structures in influencing PHC nurse identity. Collective identity is an emergent process in which the causal powers of both the controlling structures and agents can have impact/influence. The resulting generative mechanisms of the interplay between these two influences on PHC nurse identity in turn have their own causal powers and this is reflected in the table as ‘implications’.

Table 7: The Key Features of each of the Four Rural PHC Nurse Identities

Identity	Local Community's Nurse Identity	Doctor's Nurse Identity	Boundary Spanning Nurse Identity	Organisation's Nurse Identity
Key Characteristics	- 'Belonging' to the community - practising in relationship with community – 'filling in the gaps' and 'holding the fort'	- assisting the doctor to provide primary care services - exchanging autonomy for access to resources, status, trust and respect	- developing networks of collaboration spanning health sector and social services - maintaining an autonomous identity	- expanded practice for addressing organisational priorities. - 'belonging' to the organisation
Used by	- individual nurses as primary agents - community groups	- Medicine - individual nurses as primary agents - policy makers	- individual nurses as primary agents - some nursing organisations - Community groups	- policy makers - medicine - some nursing organisations - individual nurses
Strength	Traditional and weak	Traditionally dominant but weakening	New (with elements of traditional) Weak	New and strengthening
Implications	- Hidden practice. - Distanced from organisational accountability	Not used by nursing organisations	Not visible in health reform. No clear career pathway, specific education requirements or leadership support to develop the positioning	Lack of clarity re social model of health for nursing practice Ambiguous autonomy for nurses
PHC Model	Social model for defined community. Incorporating nursing/medical intervention and behavioural modification	Medical intervention and some behavioural modification	Social model for defined community. Incorporating nursing/medical intervention and behaviour modification models with social model.	Medical intervention & behaviour modification – some opportunity for incorporation of social model for individuals & aggregates of individuals
Identification and commitment	Identify and committed to the local community as the overarching determinant of practice	Identify with the GP and GP clients as the overarching determinant of PHC practice	Dual identification – overarching commitment to the local community with concomitant identification with the range of 'working groups' providing services.	Identify with and committed to the health organisation and its clients as the overarching determinant of practice

The Local Community's Nurse – individually responsible

The Local Community's Nurse Identity reflects the traditional positioning of nurses within rural communities and the tension between serving the community and working for the interests of a health service. This section outlines the key characteristics of this identity as used by individual nurses, community groups and some nursing groups which foreground the cultural significance of community attachment for nurses living and working in a small community.

Key characteristics

The key characteristics of the Local Community's Nurse Identity are:

- Belonging to the community
- Practising in relationship with community
- 'filling in the gaps' and 'holding the fort'

This identity foregrounds the importance of nurses being recognised as trusted and responsible members of their community, both personally and professionally. The findings of this study show that it is the blurring of the boundaries between their public and private selves that enables the use of the Local Community's Nurse Identity to meet the interests of rural nurses, community groups and some nursing groups. Being connected to their community as both a community member and a provider of health care underpins the rationale for nurses PHC practice within the Local Community's Nurse Identity.

'Belonging' to community

An integral feature of the Local Community's Nurse Identity is that, in attaching to 'belonging', nurses as community members are immersed in the informal networks of support that underpin rural living and are characteristic of the 'ethic of self-reliance' that geographic isolation can generate (Simmons, Huddleston-Casas et al. 2012). These social relationships confer a level of reciprocal trust and strengthen feelings of community attachment and satisfaction for community members (Toth, Brown et al. 2002; Kulig, Stewart et al. 2009).

The Local Community's Nurse Identity aligns rural nurses personal interests in community attachment and belonging with their position as PHC providers. As such the reciprocal trust relationships which develop as a community member are interconnected with their position as health care provider. Using this identity to meet their prioritised community attachment interests commits nurses to a sense of responsibility within their PHC role for upholding the trust placed in them. An example of this from the individual nurse interviews was the way in which one nurse using this identity described her PHC role as 'minding the community'(Interview1).

The finding of the importance of community attachment for many rural nurses is supported by other studies. As outlined in Chapter Three, this attachment is described as a sense of belonging and is ranked as one of the main reasons nurses cite for choosing to work in a rural setting (Hegney, McCarthy et al. 2002b; Mills, Francis et al. 2007; Mills, Birks et al. 2010). This connectedness runs across both their personal lives and professional life with community members and work colleagues (Lauder, Reel et al. 2006; Sedgwick and Yonge 2008) and has been shown to be strongly correlated with job satisfaction and supporting nurse retention in rural settings (Hegney, McCarthy et al. 2002b; Kulig, Stewart et al. 2009; Roberge 2009).

Practising in relationship with community

The importance of connectedness and the imperative of reciprocity of relationship means that in using this identity the concept of 'partnership with clients' promoted by the health reform agenda (Australian Government Department of Health and Ageing 2009b) is inclusive of advocacy with individuals, their families and their interconnected relationships as a small community. Nursing's historical traditions and image in advocating for the needs of marginalised groups and providing 'holistic' care for people 'where they live and work' (Kelly and Symonds 2003; Mills, Francis et al. 2007) is well documented. However, advocacy, as a component of the Local Community's Nurse Identity, expands the traditional 'patient centred' care approach ascribed to nursing towards a relational model of care as discussed in Chapter Two. As such, advocacy as an aspect of the Local Community's Nurse Identity necessitates working with a social model of health to incorporate factors

such as socioeconomic and cultural determinants impacting on the community as a whole and community members' health status and utilisation of health services (Beard, Tomaska et al. 2009).

A sense of belonging is further enhanced by experiences of significant trauma and crises within small rural communities which align nurses with the Local Community's Nurse Identity. This was acknowledged in submissions to the NHHRC by community groups using this identity, as well as individual nurses who lived and worked in their community and had experienced being personally affected and those working closely with the community and its members through periods of adversity. The findings of this study show that, within the Local Community's Nurse Identity, community partnership and community development models of 'recovery' focused on resilience are emphasised as aspects of PHC provision using a social model of health.

In taking on the Local Community's Nurse Identity, nurses not only meet their prioritised commitments to community attachment and belonging but are also rewarded by the status and high regard afforded to health professionals in rural communities. However, it is through this identity that they are also positioned as responsible for ensuring service provision.

'Filling in the gaps'

The third key characteristic of the Local Community's Nurse Identity involves positioning nurses as having agency in providing PHC services for their community despite funding shortfalls and/or workforce shortages – that is, 'gap filling'. Nurses in this study identified 'gap filling' as part of their practice not only to address workforce shortages but also as a means for addressing constraints to expanded practice through funding mechanisms which focused their care provision on individual client's needs. The traditional culture of 'gap filling' by rural nurses for doctor and allied health shortages is internationally recognised (Pearson, Hegney et al. 2000; Connor, Nelson et al. 2009), with statements including 'if nurses did not fill the gap the service would not be provided' (Pearson, Hegney et al. 2000). However,

representations of nurse's agency in providing a 'gap filling' role varies greatly both in the findings of this study and in the literature, reflecting different interests.

It is in linking the first two key characteristics of the Local Community's Nurse Identity, that is, the individual sense of responsibility and trust as both a community member and a nurse combined with an understanding of working with individuals/families within a community partnership model of health care provision that the salient features of this third key characteristic of this identity can be understood. In using the Local Community's Nurse Identity to link an expanded scope of practice with community responsive care, community groups and some nursing groups highlight this through the positioning of rural nurses as locally present, available and able to provide competent, autonomous, advanced nursing practice. The findings of this study show how they connect this with nurses practicing within an expanded scope of practice that is greater than extending services to individuals and incorporates working with the community, using knowledge appropriate to the specific community context. However, funding models largely determine the data collected about rural health services and these do not adequately identify the way in which rural nurses work in partnership with their community.

The Local Community's Nurse Identity positions rural nurses as responsible for 'filling the gap' in service provision resulting from funding mechanisms which focus on individual health service clients to incorporate practicing in relationship with their community. For example, some nurses in this study discussed how they felt personally compelled to provide assistance and support to extended family members and friends of a designated health service client during times of crisis. While the nurse's practice supported community members to respond to the crisis and maintain their support for the health service client, and in turn strengthened the community's self-reliance and resilience, nurses reinforced that documentation of their practice, as required by their health service, needed to relate to the individual health service client. As such, they discussed how much of their work remained undocumented and unacknowledged.

In managing the tension between being a trusted and responsible community member and working within the funding constraints and workforce shortages of rural health services, this study shows that it is through the Local Community's Nurse Identity that rural nurses use individual resistance strategies to maintain their expanded scope of practice to incorporate comprehensive PHC within a social model of health. However, the full extent of their nursing care remains unacknowledged within the health service data requirements as an integral component of PHC nursing practice. This connects with literature, although scant, on rural community nursing alluding to a culture of subversive practice to maintain their PHC identity as incorporating relational care which is community responsive (Davis 1998). It is in this respect that the salient aspects of the gap filling role as integral to the Local Community's Nurse Identity remain invisible to health services, funding bodies and policy makers.

Linking living locally and 'belonging' with the practice of 'filling the gaps' within a social model of health is pivotal to the Local Community's Nurse Identity. It underpins the assumption of nurses as having responsibility for ensuring accessible and appropriate service delivery. In this way nurses as responsible for 'caring' for the community becomes a cultural entity, which has generative effects.

The Local Community's Nurse Identity provides status and rewards for nurses at the community level rather than at the organisational level, which compounds the invisibility and primary agency of nurses as PHC providers. Whilst attaching to the status of being a responsible community member, the feelings of individual responsibility for maintaining services which are community responsive reveals the weakness of this identity for nurses and for rural communities.

The ineffectiveness of the Local Community's Nurse Identity

The lack of recognition of salient aspects of rural nurses' PHC work in using a social model of health in providing care in partnership with individuals, their families and their community underlies much of the disquiet in nursing and community groups within health care reforms in Australia. The Local Community's Nurse Identity has been an ineffective identity for nurses in arguing for the inclusion of the social model of health to support their expanded nursing practice as incorporating this community

relational role. The cultural generative effects of the key characteristics of this identity actually maintain its invisibility and show its weakness in meeting these interests. There are three main reasons for this, and these will now be discussed.

Normalising ‘gap filling’ as rural nursing practice

It is through the Local Community’s Nurse Identity that the traditional culture of ‘gap filling’ by nurses in rural communities to address workforce shortages and unmet needs is not only normalised but works to hide the full extent of nursing’s PHC practice. However, the extent to which ‘gap filling’ incorporates expanded practice varies with nurses’ different prioritised interests. The findings of this study concur with much of the literature in that ‘gap filling’ is mainly discussed in terms of addressing medical and allied health workforce shortages, cost effectiveness and centred on nursing services, as opposed to other health professionals (Pearson, Hegney et al. 2000). In this respect much of the emphasis on ‘gap filling’ within rural health service policy for expanding nursing practice is centred on care to meet the needs of individuals including medication management/prescribing rights, admission and discharge from services, referral capabilities and assisting in minimising GP workload.

The implications of a culture of ‘gap filling’ as normalising rural health service inequity were discussed in Chapter Two (Wakerman, Humphreys et al. 2006; Australian Government Department of Health and Ageing 2012), and reinforced by the findings within this study. Urban models for the provision of rural PHC services in regional communities further disadvantage these rural communities. The lack of critical analysis of the ‘gap filling’ culture maintains the focus on gap filling as addressing workforce shortages however, it is through the Local Community’s Nurse Identity that the full extent of gap filling remains hidden from policy makers and remains the individual responsibility of the nurse.

Funding mechanisms for rural nursing practice constrain nurses’ provision of PHC to individuals and their families. It is through the Local Community’s Nurse Identity that the perceived gap in community responsive service provision is embedded within the ‘gap filling’ culture. Without covert policy and funding mechanisms

which supports the incorporation of a social model of care as integral to expanded nursing practice, it is through this identity that nurses are characterised as responsible for addressing this unacknowledged gap in service provision. However, it is as primary agents that nurses using this identity expand their nursing practice to incorporate relational and social care and as such the adoption of this aspect of the ‘gap filling’ role remains hidden.

Individual resistance and subversion

In using the Local Community’s Nurse Identity to address constraints to their PHC practice, rural nurses use individual resistance strategies which include providing services which blur the boundaries of accountability to their employing health service. Examples of this were presented in Chapter Five and included opportunistic ‘first contact’ practices such as taking a family member’s blood pressure whilst visiting a health service client. In being unable to include these practices in health service data, the full extent of rural nurses’ PHC practices remain hidden.

The Local Community’s Nurse Identity creates an environment of tension for nurses between governance by employer/health services and the nurse’s own personal beliefs/values of what constitutes professional nursing practice and what is supported by their professional nursing codes and standards. The ‘stress of conscience’ created by this conflict of interests (Glasberg, Eriksson et al. 2007) and nurses being positioned as individually responsible for their expanded practice through the Local Community’s Nurse Identity has implications for workforce retention. Chiarella (2007) provides a way of understanding the consequences of this positioning of individual accountability by describing nurse’s behaviour as practicing within a zone of isolation. In using individual resistance strategies to ensure services are provided which meet their local community nurse identity, nurses are not effectively engaged with their employing organisations in informing service policy development. This works to maintain the invisibility of nurses’ PHC practice within the Local Community’s Nurse Identity.

Distanced from organisational accountability

The weakness of the Local Community's Nurse Identity is primarily due to the fact that it is connected to a relationship with community more so than with health services. The inadequacy of service data in relation to the work of nurses using this identity has the effect of isolating this identity from impacting on organisational structures.

The findings of this study show that while aspects of the Local Community's Nurse Identity, such as an intimate knowledge of community connections and needs, are acknowledged as beneficial for the provision of PHC by nurses within health services, they are not incorporated as integral aspects of nursing practice within the organisational structure of health services through service policy development and consistent funding models. Nurses using the Local Community's Nurse Identity locate themselves in 'ambiguous spaces of the local context' (Purkis and Bjornsdottir 2006) as knowledge makers incorporating the context of the client, the organisation they work for (with) and the community they are partnered with.

However, while the nursing literature promotes community development and increasing community capacity as central tenets of nurses' PHC practice (McMurray 2007; Paterson, Duffett-Leger et al. 2009; World Health Organisation 2009) there is a lack of clarity and inconsistency in which models of community development are used (Boutilier, Cleverly et al. 2000) and how they are enacted by either the nurses themselves and their health service. As Bushy (2002) notes, little is known about the structure and effectiveness of community partnership models used by rural nurses. And while the Local Community's Nurse Identity emphasises community partnership, this work remains largely invisible within the health service as either undocumented and 'off the side of the desk' or else contained to direct service provision for individual health service clients.

The Local Community's Nurse Identity is an ineffective identity for arguing for the inclusion of a social model of health as underpinning rural PHC nursing. In using this identity, rural nurses meet their prioritised interests of community attachment and belonging as primary agents however, the full extent of PHC nursing practice using a

social model of health is unacknowledged within health service structure and policy and distanced from organisational accountability.

The Doctor's Nurse – constrained as assistant

The Doctor's Nurse Identity draws on discourses of medical dominance in health care and in nursing history. Within the findings of this study, many of the submissions made to the NHHRC frame PHC nursing practice within a GP led task delegation model. The Doctors Nurse Identity links the interprofessional relationship between nurses and doctors as one based on the practice delegation model controlled by medicine, rather than a collaborative model in which each health professional is licenced to provide a unique yet overlapping scope of practice working within a team (Patterson and McMurray 2003).

Key characteristics

The key characteristics of the Doctor's Nurse Identity are:

- Practice provided 'for and on behalf of' the doctor
- Exchanging autonomy for trust, respect and access to resources

The historical and traditional cultural positioning of the role of nursing as determined and controlled by medicine was outlined in previous chapters. The continuance of this representation of governance is evidenced by the identity work of both groups and individual nurses to meet their interests and prioritise nursing's PHC practice as extending the reach of the GP. While groups representing nursing resist the subjugation of nursing's professional autonomy represented by this identity, the findings from this study evidence individual nurses, although small in numbers, using this identity as primary agents to meet their interests. Equally, a small number of community groups, endeavouring to expand the provision of PHC services by nurses and cognisant of difficulties in attracting doctors to rural areas, used the Doctors Nurse Identity to ensure the viable provision of medical care and PHC to rural communities without challenging the traditional status of the rural doctor.

Structurally embedding a culture of medical dominance and nursing subordination

The Doctor's Nurse Identity is linked to the traditional, strategic positioning of medicine, general practice and the GP as leader in the provision of primary care. The key characteristic of nurses' PHC identity as the Doctor's Nurse reflects this positioning of nurses as economically controlled, delegated by and carried out 'for and on behalf of' the GP. This representation of the PHC nurse reflects medicine's power to access wealth resources such as Federal Medicare funding which maintain the provision of nursing care within general practice as being provided 'for and on behalf of' the GP.

The Doctor's Nurse Identity maintains inequitable health service provision for rural communities by limiting nurses' PHC practice within a medically defined scope of practice. The control of general practice and the AGPN by medicine, as discussed previously in Chapter Two, coupled with funding mechanisms for general practice favouring GP services and the historical positioning of the GP in rural communities (Fitzpatrick 2006) reinforce a medical intervention model of service delivery in rural health services.

As employers of nurses in general practice, it is through the Doctor's Nurse Identity that doctors and medically controlled organisations not only have economic control but their perception of control of nursing includes misconceived beliefs of the doctor being required to maintain professional supervision over nursing practice, thus further enmeshing nurses' practice with the medical dominance of general practice. It is not surprising then that this identity features strongly in the submissions made to the NHHRC by groups representing medicine's interests as shown in Chapter Four.

Submissions from some community groups revealed similar identity work to support the historically/culturally dominant position of the GP as provider of health care in rural communities. The tension for rural people between requiring access to health care, GP shortages in rural areas and the availability of advanced generalist PHC nurses within their community was dealt with by these community groups through the Doctor's Nurse Identity. Using this identity allowed for access to nurses as PHC providers practicing 'for and on behalf of' the doctor without undermining GP

dominance and potentially threatening GP availability. This reflects the findings of earlier rural nursing research (Hegney, Price et al. 2004; Price, Patterson et al. 2006) which found that consumers perceive the role of the nurse working in general practice within a GP led task delegated model.

The Doctor's Nurse Identity is used predominantly to represent the nurse as providing PHC to assist the GP's practice for the GP's clients. This identity variously represents the nurse as providing PHC in a delegated position supporting the GP, as a specialist brought into the organisation to provide specific tasks for the GP's business, or as a Nurse Practitioner working within a collaborative agreement with the GP. It is through aligning with the Doctor's Nurse Identity that medicine maintains its interests as leading the primary care team and determining/defining the roles of other health care providers.

The Doctor's Nurse Identity is used by corporate agents such as policy makers, managers and medicine to support the extension of rural nurses' generalist practice through the delegation of generalist roles. As outlined in Chapter Two, rural nurses value generalist practice, and government workforce policy promotes this as the preferred mode of practice in rural settings (Australian Government Department of Health and Ageing 2012). Although throughout this research GPs and general practices were supported to provide nursing services via PIP and Medicare rebates for some schedule items, this has changed in January 2012 with practices receiving direct funding to employ nurses. Whether this will increase or decrease nurse's ability to define their expanded practice in general practice will require further investigation.

This study has supported the findings of other research which shows that funding measures which support the GP-led delegated model of PHC aid in concealing the full extent of the nurse's role in PHC (Pearce, Hall et al. 2010). This is highlighted by the way in which individual nurses negotiate meeting their interests by using the Doctor's Nurse Identity.

Nurses negotiating interests – exchanging autonomy for access to resources, status, trust and respect

The inherent loss of autonomy contingent to the traditional Doctor's Nurse Identity is the antithesis of much of contemporary nursing voice evidenced by the findings of this study and reflected within the literature presented in Chapter Two. However, Chapter Five, which presented the findings of the nurses interviewed for this study, revealed some nurses using this identity to meet their interests. This section will discuss how these nurses, as primary agents, negotiate their PHC interests within this identity, with the subsequent section outlining the implications of this identity work for rural nurses' agency as providers of PHC and for the equitable provision of PHC for rural communities.

Within this study, nurses using the Doctor's Nurse Identity are older and considering retirement in the near future. They are hospital trained with extensive and varied experience in nursing and limited tertiary education. Nurses personal biographies inform their concerns, interests and motivations which in turn influence how they will relate to sociocultural structures and give meaning to them (Archer 2000). Generational differences in nurses' values and interests have been noted in previous work (George and Davis 1998; Patterson and McMurray 2003) and concur with the findings of this study in which the new 'professionalism' of nursing is not perceived by some older nurses as advantageous in meeting their interests.

While not all of the nurses using this identity within this study were employed by a GP or working in general practice settings, they had worked with the GP within their rural community for extended periods of time. Their relationship was based on trust, respect and recognition of their areas of expertise, with these nurses expressing loyalty to the GP and the GP's practice. This relational positioning supported their accommodation of the positioning of working 'for and on behalf of' the GP in meeting their interests and concurs with previous findings (George and Davis 1998; Patterson 2000; Pullon 2008; Pullon and McKinlay 2009).

Trust and respect – supporting extended practice

Within the Doctor's Nurse Identity the development of trust and respect over time positions the nurse as being able to access their interests in extending their generalist

practice. The relationship between rural nurses and doctors is influenced by their professional isolation, the small size of the community and the likelihood of social interactions, increasing the co-dependent relationship between doctors and nurses in rural communities (Blue and Fitzgerald 2002). Trust and respect within this relationship develops over time with increased recognition of each other's professional competence (Blue and Fitzgerald 2002; Pullon 2008; Pullon and McKinlay 2009).

The findings of this study show that while recognition of nurse's professional competence by the doctor/employer allows for increasingly extended practice, nurses' practice is constrained to tasks the GP/practice deems necessary to meet their interests. Attaching to the Doctor's Nurse Identity requires nurses' extended practice be attained at the expense of autonomous practice within a nursing model of care. While nurses using this identity recognised that this constraint to practice limited their ability to provide quality care, reflecting previous findings by Pearce et al. (2010), they framed funding mechanisms as the external constraints to practice. This enabled them to distance their relationship with the GP/employer as 'team leader' from the constraints of the task delegation model to their extended practice.

Access to resources and status

Nurses' use of the Doctor's Nurse Identity foregrounds their interests in maintaining access to the resources of primary medical care for their community. Nurses, as primary agents, align with this identity to support connecting community members with doctors and primary medical care, whilst also protecting doctors from any 'unnecessary' work. This was predicated on the nurse's knowledge of, and longevity of practice with, their community and reliant on community members being clients of the doctor and the doctor's practice. So while nurses used this identity to support their community connectivity interests, the community's access remained defined by the client base of the doctor/practice and required members of the community to attend the practice for consultation.

Given the tenuous nature of maintaining adequate medical presence in small rural communities, the identity work of these nurses is directed towards their interests in

supporting and protecting ‘their’ GPs from excessive workloads. In using the Doctor’s Nurse Identity, the taking on of delegated and less complex tasks to ‘save the GPs time’ and to avoid their burnout and resignation is framed as ensuring continuity of PHC access for the rural community. This concurred with earlier findings by Blue and Fitzgerald (2002) in their study exploring interprofessional relationships between rural nurses and doctors.

Medicine’s power to attract resources and education opportunities provides nurses working ‘for’ doctors with access to comfortable working environments, access to functioning equipment and opportunity to access educational resources. Within this study, nurses use this identity to link with professional resources whilst also differentiating themselves from other nursing services, in particular State funded services, which are perceived as both underfunded and under resourced.

The culturally embedded characteristics of nurses’ loyalty, respect and trust through the Doctor’s Nurse Identity links nurses with the prestige, power and status of medicine within rural communities. By assuming agency for supporting and protecting a medical presence, nurses distance themselves from any perceived challenges or conflict. Given the small size of rural communities, the likelihood of social interactions and the power of medicine and medical services in rural communities (Kenny 2004), the findings of this study highlighted the strength with which rural communities ostracise nurses who ‘upset’ doctors, having marked social impacts for those nurses who live and work in their community.

The consequences of the Doctor’s Nurse Identity

Nurses’ PHC practice through the Doctor’s Nurse Identity reflects the traditional culture of medical dominance in general practice. The cultural characteristics of nurses’ loyalty, trust and respect for the GP have been structurally embedded through funding mechanisms supporting a GP-led delegation model. Through the Doctor’s Nurse Identity nursing’s PHC practice is aligned with assisting and providing care ‘for and on behalf of’ the GP. This limits the full extent of rural PHC nursing for rural communities by confining it to the GP’s clients. This has implications for equitable access to PHC services for all rural residents within a community. This

identity works against nursing's collective interests in providing autonomous collaborative PHC services for rural communities within a social model of care.

Limited accessibility to PHC for rural communities

The GP-led task delegation model limits nurses' provision of PHC to the doctor's clients thereby constraining broad community engagement. This positioning has equity implications for the provision of rural health care, potentially limiting the nurses' role in reaching the 'hard to reach' (Flanagan and Hancock 2010:92) demographic within rural communities and also in undertaking community development work which is not funded through the doctor.

The Doctor's Nurse Identity has distinct implications for the sustainability of rural health services in providing PHC services. The culturally embedded characteristics of nurses' PHC practice within this identity are structurally maintained by policy and funding mechanisms which frame PHC nursing within general practice and 'for and on behalf of' the GP. The findings of this study showed that the Doctor's Nurse Identity was emphasised in traditional rural health services in which GPs were owners of the service and nurses were older and had developed relationships with the GP over extensive periods of time. The imminent retirement of the primary agents using this identity coupled with the corporatisation of general practice which favours group practices rather than single GP employer businesses signals a possible change in the use of this identity 'on the ground'. However, the way in which this will impact rural general practice requires further investigation given the cultural and structural precedence of medical dominance in rural health services.

Rural communities' access to the full scope and specific expertise and knowledge inherent in nursing practice is constrained through the Doctor's Nurse Identity. Despite extensive literature supporting the need to expand PHC services beyond primary medical care to ensure equitable and socially just access to health care, the Doctor's Nurse Identity confines nurses expanded scope of practice to meet medically defined needs. As such, it is through the Doctor's Nurse Identity that primary medical care becomes further embedded within an understanding of PHC provision. The provision of PHC services by nurses in rural communities outside the

general practice setting are only made visible within this identity through their interaction with the GP for GP clients.

The Doctor's Nurse Identity has implications for future recruitment of nurses in rural health services as evidenced by the strongly voiced disengagement with this identity by individual nurses and nursing groups. Many nurses in this study, while eager to engage with the notion of the expanded role of nurses in primary care settings expressed their reticence in working in health services where the use of the Doctor's Nurse Identity was evident. Nurses using this identity and acting as preceptors for new nurses entering general practice may actually hinder retention and further recruitment by exposing new nurses to a culture of limited autonomy.

Constrained PHC nurse practice

The full scope of nursing practice remains hidden within the Doctor's Nurse Identity. Government reports reviewing and evaluating PHC provision in general practice provide scant data for specific nursing contribution to the health care of clients (Australian Institute of Health and Welfare 2008) with the focus on the activities of the GP being paramount. Economic invisibility is maintained by nursing practice being funded 'for and on behalf of' the doctor to support the services provided by the GP in general practice.

The Doctor's Nurse Identity has implications for collaborative teamwork within rural health services. Nurses' autonomous functioning in providing expanded PHC practice is constrained within this identity. Patterson and McMurray (2003:48) conclude that supporting collaborative practice in the primary care setting will require nurse's 'intrinsic motivation' to change. However, the findings of this study have revealed that nurses' agency in changing interprofessional relationships to support a collaborative teamwork model is constrained to that of primary agency by the Doctor's Nurse Identity, with policy makers, medicine and managers having the control over representations of PHC nursing within this identity. In using this identity, nurses are motivated to meet their local interests of gaining trust, respect and status through their relationships with and loyalty to doctors. Interprofessional relationships based on trust and respect are not sufficient to result in fully effective

teamwork (Pullon 2008; Pullon and McKinlay 2009) and within a culture of medical dominance, the structures of fee-for-service funding attached to GP practice coupled with medical ownership of health services further inhibit fully collaborative teamwork (Pullon 2008; Pullon and McKinlay 2009).

The Doctor's Nurse Identity evidences the cultural, structural and historical precedent for the GP-led task delegation of nurses' PHC practice within rural health care settings. The interests of organisations providing primary care services are met through their engagement and alignment with supporting the extended role of nurses in PHC. However, this does not necessarily equate to supporting the PHC interests of nurses, nursing groups or community groups in expanding the provision of PHC practice to enable an equitable and collaborative team approach for the health of individuals and their community in rural communities.

The Boundary Spanning Nurse – actively maintaining autonomy to integrate public, primary and community health care.

The Boundary Spanning Nurse Identity foregrounds rural PHC nurse's advanced generalist skills and reflects nurses' interests in providing relational care for community members across services and groups within rural communities as autonomous health professionals. This identity appears to be relatively new, emerging in response to changes in policy and health care reforms evident in the last decade affecting the role of nurses working in community settings, as outlined in Chapter Two. While aspects of this identity align with the traditional cultural characteristic of 'gap filling' as outlined in the Local Community's Nurse Identity, the salient features which differentiate these identities will be presented.

Key characteristics

The key characteristics of the Boundary Spanning Nurse Identity are:

- Developing networks of collaboration
- Maintaining an autonomous professional identity

The Boundary Spanning Nurse Identity was prominent within the rural nurse interview findings, with nurses gaining part time employment with general practice through the PIP funding incentives whilst maintaining their employment with other health services in their community. It was also evident in submissions by nursing organisations and community groups. The key characteristics of this identity are also strongly reflected in rural nursing literature as representing the attributes of the rural nurse (Hegney 1997b; Scharff 2006; Troyer and Lee 2006; Howie 2008; Francis and Chapman 2008b). Developing collaborative relationships within and between rural services when providing PHC is a key feature of this identity, and resonates with aspects of health reform policy (Australian Government Department of Health and Ageing 2012), however the following section explains how the Boundary Spanning Nurse Identity might present risks for health services, nurses and rural communities.

Supporting networks of collaboration

In line with the health reform agenda, new models for the integration of health service delivery and integrated governance between different services are being explored by State governments, the private sector and non-government organisations, however significant barriers to such new approaches have been identified (Jackson, Nicholson et al. 2008). It is through the Boundary Spanning Nurse Identity that rural PHC nurses develop informal networks of collaboration between health services and across health and social services to enhance PHC provision.

Enhancing collaboration through 'dual identity'

Rural nurses' connection with their local community is reflected in the way the Boundary Spanning Nurse Identity enhances networks of collaboration. This identity positions nurses as members of the different health and social services they work in. However, the overarching focus is on ensuring collaborative and coordinated care, within and across these services, for individuals/families and the local community. An integral feature of the Boundary Spanning Nurse Identity is that, while nurses might be providing care for individual clients, it is their interrelationship with the geographically defined community population which is the overarching focus of their PHC provision.

Richter et al.'s (2006) study on the role of boundary spanners and intergroup relations in health care provides a means for further understanding the way in which the Boundary Spanning Nurse Identity aligns the overarching focus of nurses' PHC provision with their local community. Using Richter's (2006) model, the whole community can be viewed as the nurses' 'organisation' with health services, social services and community groups representing 'working groups' within the 'organisation'. In this respect, nurses are positioned as members of different 'working groups' in their various employed positions. This allows for understanding how the Boundary Spanning Nurse Identity represents nurses as having a dual identity, that is, strongly identifying with the 'organisation' and also with their different 'working groups'.

Having a dual identity and also consistent and regular intergroup contact has been shown to increase the effectiveness of collaboration and minimise conflict between 'working groups' (Pettigrew 1998; Richter, West et al. 2006). The Boundary Spanning Nurse Identity is used to meet interests in providing relational coordination of care for the whole community through effective networking while minimising the tensions, conflicts and barriers between 'working groups'. Submissions by community groups to the NHHRC used this identity to support the role of nurses as autonomous health professionals for their community whilst working collaboratively within and across health services.

In fact, by shifting the focus of care to the whole community, the Boundary Spanning Nurse Identity acts as a buffer to the tensions inherent in strongly identifying with one particular 'working group' during intergroup collaborative work which can foster hostile attitudes, stereotypes, rivalry and competition (Richter, West et al. 2006). This was exemplified in the interview with one nurse who described a situation where the GP requested that the Practice Nurse attend to the wound care of an aged care resident in the colocated MPS. The Practice Nurse was only employed by the GP. This created tension for the MPS nursing staff, described as 'having their competence questioned'. This tension was eased when the interviewed nurse, who worked across both services, took on the task of attending to the wound care.

The dual identity model of the Boundary Spanning Nurse Identity, with its overarching identification with the whole local community, resonates with aspects of the Local Community's Nurse Identity. However, while both identities are underpinned by a social model of health, the Local Community's Nurse Identity positions nurses as personally responsible for ensuring and maintaining services, while it is through the Boundary Spanning Nurse Identity that the responsibility for services remains with the health and social service organisations with nurses working across services to enable effective networking for collaborative care. It is through the Boundary Spanning Nurse Identity that nurses are positioned as 'health brokers' for the community.

Providing informal leadership

The Boundary Spanning Nurse Identity positions nurses as trusted, informal leaders within and across the services they work. Through this identity nurses are perceived by group members of each service as 'belonging' to each 'working group' with an overarching focus on using their extensive generalist practice and extended networks to support collaborative care for both the service and the geographic community.

The findings of this study reveal systemic and organisational segregation between nurses working in different services as well as within different units of the same organisation. Lack of role clarity, particularly between Practice Nurses and Community Nurses, as well as the positioning of the GP as coordinator of individual clients care, posed challenges to nurses in facilitating collaboration with nurses in other services. Animosity and tension between nurses working in PHC services, particularly between general practice and community nursing services, was highlighted in the findings. As has been outlined, there are tensions, barriers and constraints to intra and inter organisational collaborative practice compounded by the potential of perceived risks to professional and organisational control and power (Blue and Fitzgerald 2002; Currie, Finn et al. 2007).

Informal networking is a significant aspect of the informal leadership role through the Boundary Spanning Nurse Identity. This networking between nurses, through collegial relationships that are separated from the dominant organisational

management aspects of collaboration between different services, links nurse's practice through a sense of 'holistic' care for the community and clients. Positioning nurses as informal leaders, through the Boundary Spanning Nurse Identity, assists intergroup relations and the management of conflict (Gittell and Weiss 2004; Richter, West et al. 2006). It is through the regular contact within and across services, the recognition of their advanced practice and knowledge of their extended networks of collaboration for the local community that trust and respect in nurses as informal leaders is conferred through the Boundary Spanning Nurse Identity.

While working across a range of services, most of the nurses using the Boundary Spanning Nurse Identity incorporated working with/in general practice. Establishing a trusting relationship with the GP was integral to meeting their interests in supporting relational care for community clients. Through working regularly with the GP, their advanced practice skills and extended networks/relationships across local community services were recognised and they were afforded informal leadership positions. Being perceived as 'belonging' to the general practice promoted collegial trust and allowed them to practice with greater autonomy and also provide much needed support for the regularly changing GPs. This enabled them to use their extended networks, through the Boundary Spanning Nurse Identity, to provide suggestions for collaborating with other local services in resolving health care issues thereby extending the traditional referral pathways preferred by general practitioners (Fuller, Edwards et al. 2004).

It is through the informal networking characteristic of small rural communities that nurses using the Boundary Spanning Nurse Identity are known locally as not 'belonging' to one health service but working across services. This affords informal leadership positioning as 'health brokers' enabling increased access to PHC for community members hesitant to use particular health services for a wide variety of reasons.

Maintaining an autonomous identity

The Boundary Spanning Nurse Identity reflects rural nurses' professional interests in maintaining their autonomous identity as frontline PHC providers. It is by linking the

salient features of the first key characteristic of the Boundary Spanning Nurse Identity, which encompasses the development of informal networks of collaboration with concomitant informal leadership positioning, that this second key characteristic, of maintaining an autonomous identity, can be understood. By working across the local health and social services in their community, nurses meet their interests in providing generalist PHC, accessing education and supporting continuity of access to services across the whole geographic population. The Boundary Spanning Nurse Identity 'accommodates' the tensions inherent in structural collaboration between different professional groups and the various funding and policy influences informing organisational hierarchies.

The Boundary Spanning Nurse Identity aligns nurses' interests in maintaining and advancing generalist skills with working across the different health services in a local community. The nature of providing health services in rural settings, with workforce shortages and distance from major services, necessitates both increased autonomy and a generalist and advanced skill base for nurses (Francis, Bowman et al. 2002; Scharff 2006; Canadian Association for Rural and Remote Nursing 2008). Working across different areas of practice in health services meets nurses' interests in ensuring currency of skills and a broad range of skills while also supporting access to professional development/education opportunities.

The findings of this study connected with the literature in confirming a strong correlation between being able to work more autonomously, often on the front line of rural health care provision and across different areas of practice with rural nurses' sense of job satisfaction and retention (Francis, Bowman et al. 2002; Mollinari and Monserud 2008; Roberge 2009). However, despite the understanding of rural nurses as requiring advanced generalist skills and a high degree of autonomy, how this is incorporated as a characteristic of their PHC identity varies with different representations of agency.

Advanced nursing practice

The nursing profession, in Australia and internationally, is developing models to enable a consistent understanding of advanced nursing practice with an

understanding that specialist practice requires the attainment of a professionally approved advanced education program that leads to a recognised qualification (Australian Nursing Federation, Australian Nurse Practitioner Association et al. 2008; International Council of Nurses 2009). The findings of this study have shown that rural nurses align advanced nursing practice with extensive nursing experience, clinical expertise and a broad range of recognised qualifications relevant to the different services within which they are employed. This is coupled with an intimate working knowledge of the range of health and social services in the local community.

Analysis of nurses' interviews presented in Chapter Five highlighted a tension for nurses in using the Boundary Spanning Nurse Identity to access a recognised qualification which fully supported their identification as autonomous advanced practice rural PHC nurses. The uptake of Nurse Practitioner qualifications by nurses in rural communities in Australia has been notably cautious (Harvey 2010; Mills, Birks et al. 2010). While the characteristics of this identity would appear to provide a platform from which nurses would seek to access professionally approved advanced education program such as Nurse Practitioner to legitimise their positioning, it is the salient features of the Boundary Spanning Nurse Identity which provide understanding of nurses' hesitancy and difficulties in doing so.

Structural and cultural constraints to enabling Advanced Practice Nurse/Nurse Practitioners to effectively work to their potential are well documented both internationally and in Australia (De Bois Inglis and Kjervik 1993; Harvey 2010; Fairman, Rowe et al. 2011) with regulatory constraints largely driven by medicine (Harvey 2011). The interdependent relationship between doctors and nurses in rural communities is well documented (Blue and Fitzgerald 2002). Most of the nurses interviewed for this study highlighted the imperative of maintaining good relationships with local GPs. This was not only in relation to ensuring effective collaborative care for clients but also for their own interests as a nurse living in a small community, as previously discussed. Rural nurses' professional identity is influenced by cultural and structural factors which maintain the dominance of medicine and the medical model for rural health services and within rural communities (Hegney and McCarthy 2002a; Kenny 2004; Fitzpatrick 2006).

While Nurse Practitioner opportunities which supported rural PHC generalist advanced practice were available for more remote contexts with limited access to doctors, this did not reflect the practice context of the nurses in this study. The Boundary Spanning Nurse Identity positions nurses' autonomous advanced practice using a social model of care to develop networks of collaboration between services, service providers and clients with the whole local community as a focus. The findings of this study showed that the integration of Nurse Practitioners as generalist PHC providers aligns nurse's practice with the clients of the general practice through the fee-for-service business model. It is through the Boundary Spanning Nurse Identity that hesitancy to strongly align with one 'working group' can be understood.

Underdeveloped relational practices

Recognition of nursing's leading role in using a social model of health to develop collaborative and partnership relationships between rural health professionals, health service organisations and their local community remains underdeveloped through the Boundary Spanning Nurse Identity. The generative effects of the key characteristics of this identity maintain the informality of nurses' leadership role in collaborative PHC provision. Despite nurses being characterised as having agency within this identity, without a defined career pathway or strategic input into policy formation, it is as primary agents that nurses engage with this identity.

Latent collaborative networks

The collaborative practices maintained through the Boundary Spanning Nurse Identity incorporate a social model of health to form extensive and innovative informal network relationships between different agencies, professionals and community members. However, while the networks enhance relational care, and there is recognition of this within the literature (Bushy 2002; Phillips, Pearce et al. 2008), the partnership models used and the determination of inclusion and representativeness remain unevaluated and informal.

The Boundary Spanning Nurse Identity positions nurses as accountable to each of the health services they are employed by for the care provided, however the way in which health services are accountable to the local community in which they are based varies and is less clear. Partnership with community within rural health services is underdeveloped (Jackson, Nicholson et al. 2008) and, within current health reform policy, Medicare Locals (as outlined in Chapter Two) have the responsibility for coordination of services to provide care for populations. While the Boundary Spanning Nurse Identity offers significant potential to inform policy formation for local rural health services and Medicare Locals in developing their coordination of effective and collaborative PHC for rural communities, the key characteristics of the Boundary Spanning Nurse Identity highlight the lack of structured recognition of rural nurses' boundary spanning practices through this identity.

The lack of a defined career pathway for rural nurses through this identity means that the dual identity model which positions the whole local community as the nurse's focus through a social model of care is also unrecognised. In this respect the Boundary Spanning Nurse Identity does not openly challenge the community participation practices of each of the services employing nurses, which are formed and reinforced through funding policies and the interests of corporate agents. Structured collaboration between services, professionals and community members remains reliant on the dominant care models and policies informing each health service. This works to maintain the potential of the Boundary Spanning Nurse Identity to inform policy as latent within health care reform.

Constraints to leadership potential

The generalist rural PHC nurse model for regional areas is underdeveloped in Australia. The Boundary Spanning Nurse Identity positions nurses as providing autonomous generalist PHC in rural communities, transcending interprofessional and health service boundaries through networks of collaboration. However, without a structured career pathway, recognised formal education or clear policy direction that specifically meets their interests, the Boundary Spanning Nurse Identity is used by

nurses as primary agents limiting their ability to collectively influence policy formation.

The leadership potential of nurses working as autonomous generalist PHC professionals in rural regional communities is constrained through the use of the Boundary Spanning Nurse Identity. While local nurses working within a rural community provide a consistent nurse presence, leadership between nurses across different services is underdeveloped. Specialist nurses such as palliative, diabetic, breast care, child and family health nurses attending to the needs of population groups within the community predominantly commute into the community from larger urban sites and are not a daily presence. Hierarchical, professional and managerial interests dominate the structure of collaboration between nurses working within different health services. Structurally, the GP is positioned as clinical coordinator of the local care for many of the individuals receiving care by specialist nurses. Through the Boundary Spanning Nurse identity, collaboration between nurses, with a focus on incorporating the social model of health to address the needs of the whole community, remains informal and structurally underdeveloped.

This section has highlighted the way in which the Boundary Spanning Nurse Identity meets the interests of nurses and community groups in maintaining expanded generalist frontline PHC provision and developing networks of collaboration between health and social services within rural communities. This identity characterises the PHC nurse as a clinical leader with an overarching focus of care for the whole community. However, it is through the Boundary Spanning Nurse Identity that these interests are met by nurses as primary agents. While the Boundary Spanning Nurse Identity provides nurses with a means for maintaining a sense of autonomy in providing PHC practices, the informality of this identity as a newly emerging identity means that it is unrecognised and latent and it remains underdeveloped within policy.

The characteristics of the Boundary Spanning Nurse Identity evidence a lack of collective agency to change PHC nurse identity at a structural policy level. However, as Archer (1995:260) explains, even without being active or collectively mobilised, nurses using the Boundary Spanning Nurse Identity can influence collective PHC

identity in two ways, firstly their very existence means that more powerful groups are obliged to consider them and take them into account and secondly they provide glimpses of possible identity positions and as such, how nurses behave in their roles informs people's concept of the collective identity (Snow and Anderson 1987; Vandenberghe 2007).

The Organisation's Nurse – expanded practice within a changing primary and community care framework

The Organisation's Nurse Identity foregrounds the pragmatic expansion of nursing roles within the primary and community care framework of Australia's health system reforms. This identity positions nurses to support government policy aimed at developing a flexible workforce to meet the growing demands and increasing financial strains on health service provision. As an emerging identity within Australia's developing PHC Strategy it is predominantly reflected in the policy focus on increasing the numbers of nurses working within general practice organisations to support the expansion of primary care beyond primary medical care. Nurses providing community care are aligned through the Organisations Nurse Identity with 'patient centred care' in collaboration with general practice. This focus incorporates coordinating the care of people who are aged, with chronic illnesses or disability as well as providing higher acuity care for people to enable earlier discharge from hospital.

Key characteristics

The key characteristics of the Organisations Nurse Identity are:

- Expanding nursing practice to meet the needs of changing primary and community care organisations
- 'Belonging' to the organisation

The Organisation's Nurse Identity is used by policy makers, medical organisations, managers (including medical and nurse managers) and nursing organisations to meet new and changing policy directions within the primary and community care framework. The Organisation's Nurse Identity emphasises nursing's expanding PHC

role in terms of cost containment, safety and quality assurance, flexible substitution for GP workforce shortages, integrated care, the avoidance of duplicated services and increased patient access to primary care services. This identity characterises nurses as core members of collaborative health teams predominantly through general practice. This connects with rural health care literature highlighting the imperative of teamwork in small rural settings (Blue and Fitzgerald 2002; Bourke, Sheridan et al. 2004). This identity allows the expansion of nurses' practice while avoiding some of the constraints of the Doctor's Nurse Identity and the Local Community's Nurse Identity.

However, while use of the Organisation's Nurse Identity enables support for an increase in the nursing workforce and expansion of the tasks they undertake, how this translates to meeting nurses' interests in increased PHC services is influenced by the models of care used and assumptions of nurses' agency in providing these services. The Organisation's Nurse Identity aligns nurses with their employing organisation and its model of care, funding mechanisms and outcomes focus. For nurses using this identity, the explicit support and encouragement for expanded practice enhanced the sense of attachment and belonging to their employing organisations. Despite assumptions of community nursing practice being underpinned by a social model of health, as discussed in Chapter Two, the Organisation's Nurse Identity evidences inconsistent conceptual clarity regarding the models of care used to provide these expanded practices.

As a newly emerging identity, the implications of this identity for nurses and the provision of PHC for rural communities are revealed by the overlap of interests. Nurses' agency and the interests of corporate agents influence the extent to which expanded practice through the Organisation's Nurse Identity enables nurses to work to their full scope of practice.

Expanded practice for primary and community care priorities

The Organisation's Nurse Identity aligns expanding nursing's generalist roles in PHC with general practice organisations. Within this identity nurses are positioned as members of the collaborative health care team. General practice is positioned as

being central and critical to Australia's primary health care reform agenda. Expanding general practice beyond primary medical care is an integral component of Australia's PHC Strategy with the terms general practice and primary health care used interchangeably (Australian Government Department of Health and Ageing 2009b).

The increasing strength of this identity is reflected by the dominant focus of recent Australian research exploring the role of nurses in primary and community care centred on their relationships within general practice and in particular with GPs (Keleher, Parker et al. 2007g; Parker, Keleher et al. 2008; Douglas, Rayner et al. 2009; Mills and Hallinan 2009; Keleher, Parker et al. 2009c; Merrick, Duffield et al. 2011; Merrick, Duffield et al. 2012).

Pragmatic support by policy makers for the substitution by nurses of tasks traditionally undertaken by doctors reflects Government's interests in providing fiscal transfer of tasks to address GP workforce shortages, particularly in rural areas. Health workforce literature promotes substitution by nurses as an opportunity to provide a substantial increase in service provision (Duckett 2005). While the Organisation's Nurse Identity characterises nurses as providing PHC within the collaborative health care team, there is ambiguity in the Government's focus evidenced by funding for nurses in general practice, through Medicare, being provided 'for and on behalf of' the doctor/GP. Although this funding direction changed in January 2012, as discussed in Chapter Two, it has set a 10 year structural and cultural precedent for nurses' positioning with/in general practice.

The Organisation's Nurse Identity provides a means for coalescing the interests of policy makers and the medical profession in wanting to expand the provision of PHC through general practice. Their interests overlap to position nurses as providers of primary and community care coordinated through the organisation of Medicare Locals (of which many have evolved from AGPNs). However, the findings of this study show medicine's preference for nursing practice within a task delegation model, refuting the notion of substitution by nurses. It is through representing nurses' expanded practice within the Organisation's Nurse Identity as supplementing and

extending the central role of the GP in general practice that some of the tensions inherent in policy support for substitution are avoided.

Despite the suggestion that expanding nurses' roles through substitution of medical tasks meets nursing interests and will therefore support nurse retention (Duckett 2005), evidence within the interviews and submission findings for this study show that nurses strongly refute the substitution model. In stressing the importance of maintaining nursing practice within a nursing model of care, many of the submissions by nursing organisations discussed expanded practice which incorporated traditional medical tasks as 'task transfer'.

One nursing organisation representing the interests of nurses working in general practice settings, the Australian Practice Nurse Association (APNA), uses the term 'supplement' to describe nurses' expanded practice. This provides a means by which the interests of some nurses overlap with those of medicine and policy makers through the Organisation's Nurse Identity to expand the provision of PHC with/in general practice. However, in using the term 'supplement', the model of care used is not stipulated. The increasing presence of nurses with/in general practice is a relatively new area for nursing focus in Australia and, as discussed in Chapter Two, nurses do not share governance or economic power in general practice (which are predominantly GP owned) nor have they shared governance in AGPN (Mills and Hallinan 2009). It is in this respect that nurses engage with the Organisation's Nurse Identity as primary agents. Policy makers and medicine as corporate agents control PHC nurse identity change through the Organisation's Nurse Identity, and as such there is a risk for nurses in that their interests may well be misrepresented.

Aligning nurse's expanded generalist practice with being The PHC Nurse within general practice

The findings of this study (and the wider literature) reflect the fact that expanded generalist nursing practice is a valued positioning for nurses in rural areas (Hegney and McCarthy 2000; Francis 2005). It is through the Organisation's Nurse Identity that the expansion of nurses' generalist PHC practice is aligned with the general practice setting. Nurses providing specialist care and community care, on the other

hand, are represented as supporting the role of the GP and general practice through collaborative care for specific needs of health service clients. These include palliative care clients and people with chronic conditions (predominantly aged or disabled). Nursing support to enable early hospital discharge and hospital avoidance for clients requiring acute care is also emphasised.

In positioning general practice as central within health care reform, the Organisation's Nurse Identity is used to characterise nurses working with/in general practice as being The PHC Nurse. It is through the Organisation's Nurse Identity that APNA's claim to being the peak body representing all PHC nurses can be understood (Hille 2011).

By aligning nurses working with/in general practice with being 'The PHC Nurse', the Organisation's Nurse Identity legitimates the expansion of nurses' generalist practice to incorporate the acquisition of tasks (such as health promotion and child health care) previously undertaken by other community nurses. The findings of this study reflect Hogg & Terry's (2000) propositions regarding organisational 'acquisitions and mergers' in which the recognised higher value of generalist rural nursing practice aligns with being The PHC nurse and assists nurses in adopting these expanded tasks within their enhanced social identity.

While there is overlapping of interests with these initiatives, determining the model of care used in providing the merged tasks remains with the organisation and predominantly within a medical intervention/behavioural management model. The full scope of the role of the nurse providing the same task within a social model of care is not addressed. The interests of policy makers and medicine coalesce in using the Organisation's Nurse Identity to supplement and complement the GP in general practice, aligning nurses' expanded generalist practice with being The PHC nurse. However, as evidenced by this study's findings, nursing's collective interests risk being misrepresented.

‘Belonging’ to the organisation

Nurses align with the Organisation’s Nurse Identity through a sense of attachment and ‘belonging’ to their health organisation. Belonging, attachment and ‘sense of community’ are human needs and it is through the Organisation’s Nurse Identity that this need is met. A sense of belonging is engendered through a common sense of purpose, rewards and recognition. Emotional attachment to the organisation is enhanced through a shared sense of purpose to increase access to services for community members and also to support team cohesiveness in meeting this purpose. Organisational identification connects an individual and an organisation through linking the persons ‘deep, self-defining affective and cognitive bond with the organisation as a social entity’ (Edwards and Peccei 2007).

By engendering feelings of belonging, a ‘sense of community’ is developed (Alvesson and Willmott 2002:630) and it is through the Organisation’s Nurse Identity that the health service population becomes the community for the nurse. While a sense of belonging does not necessarily mean that nurses are connected to organisational goals and values (Alvesson and Willmott 2002), it is through the Organisation’s Nurse Identity that belonging is aligned with shared purpose, rewards and recognition and a sense of the health service population as community and these in turn enhance identification with the organisation (Edwards and Peccei 2007).

Effective clinical governance in primary and community care requires a strong sense of cohesion and organisational belonging by health care clinicians with their health service (Huntington, Gillam et al. 2000). Enhancing organisational identification assists in meeting government and managers interests in supporting expanding primary care and integrating community care with general practice by connecting nurses with the goals and values of the organisation. Strong organisational identification enhances cohesive working teams, cooperation and motivation to meet organisational goals (Edwards and Peccei 2007). The use of the term ‘Practice Nurse’ to depict nurses working in general practice/primary care settings further reinforces organisational citizenship through the Organisation’s Nurse Identity, the nurse belonging to and working for the practice.

Rural health care literature, as discussed in Chapter Two, emphasises the particular complexity of rural collaborative care which closely aligns nurses with doctors based on trust (Blue and Fitzgerald 2002) and this was reinforced by the findings of this study. However, it is through the Organisation's Nurse Identity that collaboration moves beyond the constraints of the Doctor's Nurse Identity to engender a sense of belonging to the health service organisation. Attachment to the organisation is enhanced through rewards and recognition which include the support for expanded practice and increased education to develop skill acquisition.

The Organisation's Nurse Identity further enables abrogation of personal responsibility for community responsive PHC by nurses and a structured way of dealing with the tensions of 'multiple senses of self' that is well described in the rural literature (see Chapter Two). In attaching to 'belonging' to the organisation and the 'sense of community' through the health service population, nurses are able to contain the responsibility of service provision to clients of the health service, and as such provides a way of addressing the constraints of the Local Community's Nurse Identity. Rural nurses' connection to community is acknowledged as assisting continuity of care for individuals, however, responsiveness to and partnership with community is represented as an aspect of organisational quality assurance accountability and therefore a health service responsibility.

This aspect of the Organisation's Nurse Identity was particularly noted in interviews with nurses employed by health services undergoing significant restructure from small rural hospitals into primary health care services. It enabled nurses to disengage from a sense of personal responsibility for perceived service gaps and the resultant animosity from communities divided by the restructure of their health service. Within this study, aligning community responsiveness as an organisational responsibility also met the interests of nurses who did not strongly identify as connected to the geographic community, which included nurses who were new to a community or had been ostracized from the community.

Possibilities and pitfalls

The Organisation's Nurse Identity provides strong possibilities for nurses' expanded practice in meeting Australia's health reform agenda in strengthening the primary and community care framework. Nurses benefit where corporate interests overlap with nurses' interests. However, despite the marked increase in the number of nurses working in general practice, this identity poses risks for nurses' PHC provision through the misrepresentation of nurses' interests. Deeper structural and cultural issues which impact on nurses' autonomy and provision of PHC using a social model of health are not addressed through the Organisation's Nurse Identity. Two main issues highlight the possibilities and potential problems emerging from the cultural and structural generative effects of the key characteristics of the Organisation's Nurse Identity.

Expanded generalist practice – ambiguous autonomy

Expanding tasks and functions and increasing the technological skills of nurses to support expanding primary and community care through collaborative primary health care teams are foregrounded within the Organisation's Nurse Identity. As evidenced by the findings, medical intervention and behavioural modification models of care are emphasised to support this expansion. While this aligns with nurses' clinically-oriented interests and overlaps with government and medicine/managers' interests, the focus on 'pathologised' care risks divorcing nurses' PHC practice from community nursing's ontological foundations of the social model of care (Kelly and Symonds 2003; Colyer 2004).

Rural health care services are affected by broader governance issues such as the influence of medicine in health care and funding mechanisms including Medicare and HACC funding. However, the control of this identity is broadened to include government and academic research institutions so that knowledge and power are linked with the promotion of concepts such as 'patient centred care' and 'self-management' principles promoting the individual and their family as the focus for health care provision within community based services (Australian Commission on Safety and Quality in Health Care 2011a). The findings of this study evidenced tension for nurses' positioning as PHC nurses between the philosophical positioning of care being provided for the client as a self-managing autonomous individual and

relational connected care with clients as members of self-defined communities based on a social model of health.

Nurse-led PHC services are emphasised through the Organisation's Nurse Identity. The findings of this study show that the use of the term 'nurse-led' for the provision of PHC services is ambiguous in terms of nurses' autonomy and this concurs with nursing literature (Richardson and Cunliffe 2003). Within the interview findings of this study, nurses discussing nurse-led services were employed in general practice settings. They variously described their services within this model as requiring the GP to 'pop their head in' to ensure the tasks undertaken could be billed through Medicare (Interview 17), highlighting the lack of clarity between 'GP-led' and 'nurse-led' services. These nurses also discussed the constraints to their 'nurse-led' care provision through time limitations and practice protocols which focused on tasks to be undertaken, resulting in a predominant health service focus on medical intervention and behaviour modification practices.

With general practice funding incentives for targeted outcomes, it is through the Organisation's Nurse Identity that nurse-led clinics provide nurses with the opportunity to define areas of clinical practice as distinctly their responsibility within the practice whilst also attaining the data required to meet funded outcomes. For example, ensuring that all diabetic clients are up to date with records of their HbA1c (blood glucose reading) and within desired perimeters and their blood pressure is recorded. This highlights the degree to which funding mechanisms determine the model of care which is prioritised and also raises questions regarding the extent of nurses' autonomy to practice 'patient-centred' care beyond pathologised care echoing concerns raised within the literature (Rose 1992; McDonald, Checkland et al. 2008).

While nurse-led community care services were evidenced in the submissions, nurses working within community services outside the general practice setting did not use the term 'nurse-led' to describe their practice. Through the Organisation's Nurse Identity, the model of care is dependent on the organisation and while there is potential scope for using the social model of care, medical intervention and

behavioural modification models dominate funding mechanisms influencing nurses' practice.

Medicine's historical and cultural power in controlling the practice of health professionals with/in general practice and nurses' lack of economic power through funding mechanisms within the general practice setting compound the weakness of nurses' negotiation positioning in determining their expanded PHC practice through this identity.

Health service responsibility for community responsiveness

The finding of this study that many rural nurses are strongly connected to their community was also supported throughout the nursing literature (Bushy 2002; Spinaze 2008; Kulig, Stewart et al. 2009; Chiarella, Salvage et al. 2010). The difficulties for nurses in managing the balance between personal and professional lives in small communities have been well researched (Davis 1998; Hegney, McCarthy et al. 2002b; Crooks 2004; Greene and Burley 2006; Mills, Francis et al. 2007; Kulig, Stewart et al. 2009). One of the key characteristics of the Organisation's Nurse Identity, nurses attachment to and sense of 'belonging' to their employing organisation, offers strong possibilities for ensuring not only the ability for this connectedness to be incorporated into providing increased community responsiveness for health services but also a way for nurses to manage the 'multiple perspectives of self' as described by Mills et al. (2007) inherent in working as a health professional in small communities.

The Organisation's Nurse Identity provides possibilities for addressing the invisibility of the Local Community's Nurse Identity, the constraints of the Doctors Nurse Identity and incorporating the leadership and networking characteristics of the Boundary Spanning Nurse Identity. Rural nurses' connection to community is acknowledged as assisting continuity of care for individuals, however, responsiveness to and partnership with community is represented as an aspect of organisational quality assurance and accountability and therefore a health service responsibility. The way in which nurse's connectedness to their health service and to the community translates through the Organisation's Nurse Identity to nurses' PHC

provision is influenced by nurses' agency and the model of care used by the health service to provide community responsive health care.

While health services at the local level in rural communities are accountable for the care provided to their individual clients, the coordination of primary and community care services and community responsiveness is abrogated to Medicare Locals.

Medicare Locals are invested with the role of coordinating the provision of PHC services to meet the health care needs of the whole local community (Australian Government Department of Health and Ageing 2011) by improving integration of primary health care services and improving access to services. However, local health service accountability for community responsive health care delivery lacks clarity. At this time, there is only one Medicare local in Tasmania covering the whole state and, as a newly established Primary Care Organisation developing its role, community responsiveness at the local level is still largely reliant on local health services.

Community partnership models used by health services at the local level vary with the different models of care (Baum, van Eyk et al. 2006; Chiarella, Salvage et al. 2010). The findings of this study show that while the Organisation's Nurse Identity foregrounds nurses expanded practice within the primary and community care framework, the control over which services are accepted for expansion, the role of the nurse in providing these services and the power to determine which clients will have access remains with the local health service and, as has been noted, this remains both medically dominated and funding driven. Nurses' health promotion activities within 'patient centred' medical intervention and behavioural management models have a biomedical focus (Boutilier, Cleverly et al. 2000). The lack of clarity around the incorporation of a social model of care within the Organisation's Nurse Identity means that community development and social care are not prioritised as nursing responsibilities. The Organisation's Nurse Identity therefore potentially risks inequity in rural populations through removing nurses, the most predominant health professional in rural communities, from the role of supporting community resilience.

This section has highlighted the cultural and structural generative effects of key characteristics of the Organisation's Nurse Identity in maintaining nurses' visibility as providers of PHC through the primary and community care framework. Within

this framework the centrality of general practice for the provision of PHC services is foregrounded. The Organisation's Nurse Identity is used by policy makers, managers and medicine as corporate agents to represent the PHC nurse and nurses' expanded practice as supplementing and complementing the role of the GP as a member of the general practice team or providing collaborative care with the GP. Through this identity, the model of health is determined by the health service. While aligning with this identity meets nurse's interests, the historical cultural influences and structural funding mechanisms limit nursing's power to strategically position nurses' expanded practice through the Organisation's Nurse Identity as incorporating a social model of health.

Morphogenesis of rural PHC nursing: the trajectory of change.

Changes to rural PHC nurse identity are influenced by a complexity of interests and occur over time. While the PHC focus of the Government's health reform agenda is a recent influence, changes to funding mechanisms through health policies affecting nursing practice in rural community settings over the past decade were outlined in Chapters Two and evidenced through identity work informing the collective PHC identities.

Within the four collective identities, the Local Community's Nurse Identity and the Doctor's Nurse Identity are more traditional identities. These identities have an historical presence within the structural and cultural context of rural health services and rural communities. The Boundary Spanning Nurse Identity and the Organisation's Nurse Identity are more recent, reflecting the identity work of both corporate and primary agents to meet their interests. The way these new identities will influence structural health reform changes is interrelated with how they are used by corporate agents and primary agents. This can be further understood through Archer's (2000:265) concept of Corporate Agents as having strategic collective capacity to shape resource distribution and change in contrast with Primary Agents who 'lack a say in structural and cultural modelling'.

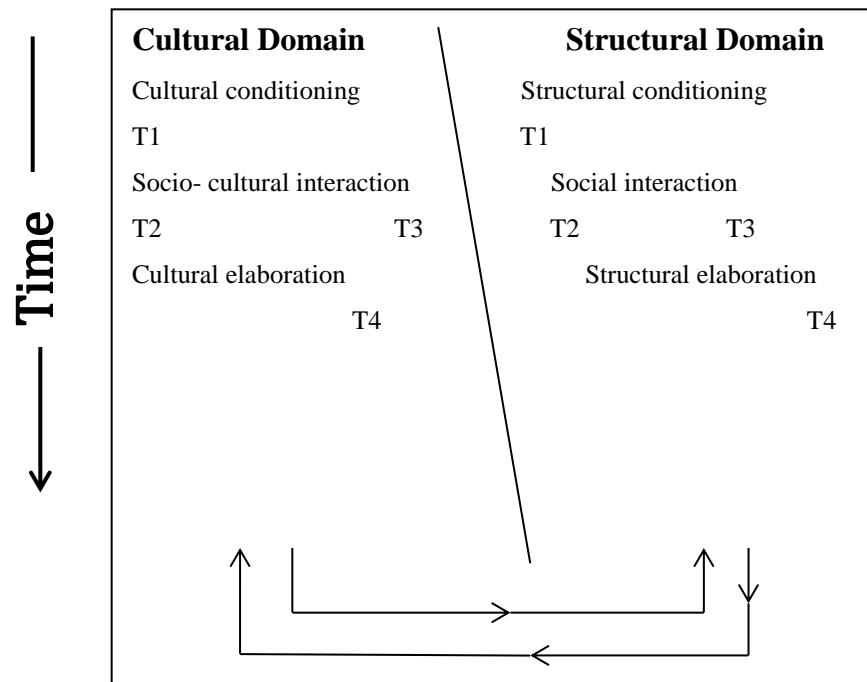
The reality of the social world is produced and reproduced by causal powers such as activities, attitudes or engagement with social structures, these are the mechanisms which generated the observed events within this study (Connelly 2001).

Changes to structural and cultural elements, such as rural PHC nurse identity, not only occur over time but require the combined interaction of agents, through new ideas, responding to needs to address perceived difficulties. The global response of health care systems in moving towards an increased focus on PHC delivery was discussed in Chapters One and Two, outlining the imperative for this change over many decades. Structural and cultural change requires the impetus of a combination of events to trigger morphogenesis (Archer 1995). The proposed introduction of a National PHC Strategy for Australia, together with significant development of a framework for the coordination of primary and community care by AGPN, combined with structured support through policy and government funding for nursing in general practice settings, provided impetus for morphogenesis of rural PHC nursing identity towards the Organisation's Nurse Identity.

Archer's (2000:265) morphogenetic model within a critical realist approach, through its analytical separation of structure, culture and agency, provides a useful means for theorising changes to PHC nurse identities over time. The incorporation of time through this model is pertinent for the explanatory value of this study.

The figure below shows culture and structure as have emergent properties which pre-exist agency (T1). This allows for understanding the potential for agents to influence cultural and structural change through interaction (T2 – T3).

Figure 4: Archer's (2000:323) morphogenetic model



By outlining the way in which funding mechanisms can drive identity change through corporate agents' identity work resulting in the emergence of the Organisation's Nurse Identity, it is possible, through Archer's (1995; 2000) model of morphogenesis/morphostasis, to theorise the conditions pre-existing this study. This allows for analysis of the effect of time on changes to rural PHC nurse identity towards the Organisation's Nurse Identity and the Boundary Spanning Nurse Identity and nurses' agency within this.

The Local Community's Nurse Identity and the Doctor's Nurse Identity, as more traditional and long standing identities, are likely to have been in a state of morphostasis for some time. Medical dominance of rural health services in Australia is well documented (Blue and Fitzgerald 2002; Kenny 2004; Fitzpatrick 2006). Community health nursing and rural nursing have notably lacked visibility in Australia's nursing history and nursing organisations have historically been argued to be hospital centric (Hegney 1996a; Francis 1998; Keleher 2000b). The distinct culture of bush nursing in rural areas, as outlined in Chapter Two, has had a significant impact on the identity of rural community nurses as providing PHC

through expanded and integrative models of care (Mills 1998; Bardenhagen 2004). Through the Local Community's Nurse Identity, these nurses have practiced with relative autonomy largely due to their geographic isolation as well as being distanced from medical dominance at the local level as a result of medical workforce shortages in rural areas (Bardenhagen 2004).

Changes over time to funding mechanisms for community nurses working outside general practice settings were outlined in Chapter Two. These policy and funding changes have variously shifted the focus of community health nursing practice from generalist first contact PHC towards more specialised community care for people who are aged, disabled or with complex needs including increased acute care to enable early hospital discharge (Keleher 2003). This shift was in large part fiscally driven by increasing costs for residential care for aged people during the 1980s and 1990s (Keleher 2003; Duckett 2008). Nurse managers of community nursing services did not see themselves as the 'drivers' of these changes to practice nor a response to changing needs of their communities (Kemp, Harris et al. 2005:312). Despite these Commonwealth Government driven changes in policy directions and funding, nurses as primary agents attempted to maintain broader PHC service provision incorporating a social model of health through the Local Community's Nurse Identity and its key characteristic of 'gap filling' (Davis 1998).

Despite an increasing voice of tension within nursing literature regarding the impact of these changed funding mechanisms on community nursing practice and literature calling for validation of community nurses' practice and perceptions (Keleher 2000a; Mahnken 2001; Brookes, Daly et al. 2004; Kemp, Harris et al. 2005), the lack of visibility of the Local Community's Nurse Identity within policy processes maintained this identity within a state of morphostasis.

The characteristics of the Doctor's Nurse Identity resonate with the medical dominance of health services, with this identity evident throughout nursing history. However, the presence of this identity within community based settings in rural Australia, prior to 2000, was less evident with relatively few nurses working in general practice and a limited medical presence for State funded Community Nurses. As outlined in Chapter Two, the development of GP controlled Divisions of General

Practice and the subsequent significant Commonwealth funding to support the establishment of AGPN occurred through the 1990s. Towards the end of the 1990s, increasing focus on the potential for expanding nurses' generalist practice within this primary care setting within government, nursing and medicine occurred (Patterson 2000; Watts, Foley et al. 2004; Jolly 2007). This was seen to be a way to assist in the workforce challenges and sustainability of general practice as the 'lynchpin of primary health care in Australia' (Watts, Foley et al. 2004:12) with subsequent Commonwealth funding, initially in rural areas, 'to support medical services' and the education of nurses (Jolly 2007). Funding mechanisms were tied to the stipulation of nurses' extended practice being provided 'for and on behalf of' the GP with medicine, managers and policy makers rural PHC nurse identity work sustaining the Doctor's Nurse Identity and increasing its presence in PHC services.

As outlined in Chapter Two, from the late 1990s single GP provider general practices became increasingly corporatized. Significant government funding provided to AGPN to coordinate general practice organisations saw the strengthening of a primary and community care framework and nurses' positioning within this. In combination with health reforms towards a national PHC strategy, which focused on expanding general practice as central to PHC delivery, the funding for new ideas and new structures triggered a morphogenesis of the Doctor's Nurse Identity towards the Organisation's Nurse Identity positioning nurses as organisational workers with GPs as clinical leaders.

Funding mechanisms and policy changes as causal mechanisms, distinctly generating the events which have been revealed, have driven the morphogenesis of nurses' PHC identity towards the Organisation's Nurse Identity. The cultural impact of dominant knowledge has also influenced policies and practices within health services, with patient centred care through medical intervention and behavioural modification the preferred models of care (Australian Commission on Safety and Quality in Health Care 2011a). Policy makers/planners, through funding mechanisms, are able to control cultural and structural phenomena within rural health services which drive identity change or stasis. By interacting with pre-existing cultural and structural conditions, corporate agents' identity work through these funding mechanisms has informed structural elaboration. The 10 year structural precedence of funding nurses

within general practice to provide care ‘for and on behalf of’ the GP has generated a cultural causative mechanism of nurses subordinate to doctors within community settings and nursing care provided within a pathologised model. Funding measures for nurses in community care have also driven this model of pathologised care for individuals.

Evidence within the submission findings of this study has shown the efforts of one nursing group to acquire the characteristics of Corporate Agency to effect PHC nurse identity change through the Organisation’s Nurse Identity. Using the processes of articulation and organisation, as outlined by Archer (2000:276) this group characterises nurses’ expanded PHC practices as supplementing the GP. However, the influence of this group on structural and cultural transformation of PHC nurse identity is contingent on its ability to shape resource distribution and change policy. While this group receives significant funding, as previously discussed, the historical and structural position of nursing as distanced from the modelling of both general practice and AGPNs provides a basis for arguing that the interests of this group may well be met as a collective of primary agents with potential to develop corporate agency. Archer (2000:268-275) argues that this positioning may mean that there is a risk that they are more likely to be mobilised for the convenience of more established Corporate Agents.

Existing Corporate Agents strategically hold their positioning (Currie, Finn et al. 2008). For example, despite the development of competency standards for nurses in general practice funded by government, there are contradictions in the way these standards have been used by policy makers to inform the context and content of nursing practice in general practice settings (Australian Nursing Federation 2006; Mills and Hallinan 2009). With the lack of explicit inclusion of the social model of health as underpinning PHC within the primary and community care framework, and a lack of collective agency to change the Organisation’s Nurse Identity, nursing groups risk misrepresenting the collective interests of nurses through aligning with this identity.

For nurses working in rural health services, the interplay between nurses’ agency and the structural and cultural conditions maintains the ‘invisibility’ of rural PHC nurses’

broader relational care. Through the Organisation's Nurse Identity, nurses' practice incorporating a social model of care is constrained through funding mechanisms to individuals and groups predominantly through individualistic models of care. Nurses' practice which enables people and their communities to manage their own health, improve their quality of life and change factors contributing to their poor health continues to be hidden from policy and health reform discussions and maintained within a local and social field. The responsibility for ensuring relational coordination between social services, public health and services providing care through the primary and community care framework is centralised to the newly established Medicare Locals. Models for relational coordination at a local rural community level remain underdeveloped.

A newly emerging identity was the Boundary Spanning Nurse. However, while the emergence of this identity appeared to be recent in response to the changes in funding to health services within the community, many aspects of this identity resonate with the Local Community's Nurse Identity. The move by nurses, nursing groups and community groups towards the Boundary Spanning Nurse Identity has been influenced by cultural practices of nurses 'gap filling' to incorporate a social model framework of health in combination with individualistic medical intervention and behavioural modification models. This identity also reflects nurses' interests in maintaining autonomous advanced practice as generalist rural PHC nurses (Robertson 2004; Annells 2007; Chiarella 2007; Francis, Chapman et al. 2008a; Carryer, Budge et al. 2010; Australian Nursing Federation 2011).

However, the Boundary Spanning Nurse Identity is not used by policy makers, managers or medicine. As such the PHC practices of nurses using this identity remain hidden from policy makers and from rural health services. While the findings of this study evidence the potential for nurses using the Boundary Spanning Nurse Identity to impact the culture of rural health services, the way in which this identity will impact on structural and cultural transformation is ambiguous and remains to be seen.

Government funding models and policy processes/proposals as structural determinants mean that the resultant ambiguity of nursing's agency to provide PHC

within a social model of health results in new primary agents entering the rural health services within a culture of dissonance. This has implications for nursing retention and recruitment in rural areas.

Using identity work as a lens for exploring PHC nurse agency within rural health services, underpinned by a critical realist ontology, an explanatory framework has been presented which allows for explaining the ‘real’ causative mechanisms/structures which generated the events observed within this study. The interactions between structure, agency and culture at the interface of nurses and rural health services were revealed. This allows understanding how ‘real’, different social processes with structural and cultural effects might inform the transformation of nurse’s PHC identity during health reform. The morphogenesis of rural nurses PHC identities and the link with funding mechanisms shows how the identity work of corporate agents, including policy makers and medicine, through dominant knowledge, control changes to rural PHC nurse identity.

Nursing’s lack of collective agency to incorporate a social model of health within PHC practice leads to the interests and practices of rural PHC nurses being not adequately understood or incorporated into proposed workforce development strategies.

Conclusion

This study has demonstrated the changes to rural PHC nurse identity over time. Nurses’ agency to meet collective interests within contemporary national PHC reforms in Australia has been analysed and an explanatory framework provided. This study has shown that changes to rural PHC nurse identity are controlled by strong corporate agents including medicine, health service managers and policy makers with identity work largely driven by funding mechanisms. Nurses lack collective agency to effect their collective interests as PHC providers. Without collective agency, nurses’ interests are met where they overlap with the interests of more powerful corporate agents through the collective PHC nurse identities. Within the developing primary and community care framework of Australia’s health reforms, rural PHC nurses’ autonomy to incorporate a social model of health in their care provision remains ambiguous and unrealised.

Through a critical realist ontology as the central premise of this thesis ‘real’ structural and cultural social processes have been proposed to explain the observable events evidenced through the nurses interviews and the submissions to the NHHRC. These were the driving force of funding mechanisms and policy processes used by strong groups such as medicine, government policy makers and managers to change rural PHC nurse identity. The other real process was the culture of gap filling which maintained nurses’ broader relational practices with community as ‘hidden’ from health service and policy frameworks. Ambivalent representations of nurses’ autonomy as providers of PHC within the primary and community care framework have implications for nursing practice, the provision of PHC nursing for rural health services and sustainable PHC reform. Ongoing tensions and difficulties are likely to continue without structural health service changes which enable nurses to meet their interests in providing client/community focused relational care as autonomous health care providers.

In using critical realism and identity work as the underpinning frameworks, the findings of this study provide an explanation for some of the difficulties rural nurses have expressed in meeting their interests as PHC providers. With a lack of conceptual clarity regarding the models of care used within the primary and community care framework, the way in which the proposed health reforms will meet the interests of nurses relies on either nurses’ collective agency to influence the change or else meet their interests in the overlap with more powerful corporate agents. Identity work shows there are many interests, and sociocultural conditions influence which of these will be prioritised.

The findings suggest that a lack of nurses’ collective agency within contemporary PHC nursing may risk the social model of health as an underpinning ontology being lost to rural nursing practice. With nurses being the most prevalent health care providers in rural areas the impact of this for nurses’ capacity to advocate on social justice issues evidenced by rural/urban health differentials may well be limited. The following chapter will consider further implications of the findings of this study.

Chapter Seven: Conclusion and recommendations

This study sought to gain depth of understanding of how rural nurses, as reflexive beings with prioritised interests and emotions, position themselves and are positioned as PHC providers within their community.

The investigation was prompted by the imperative for health systems to reorientate towards PHC, both nationally and internationally, which has heralded significant changes to the structured roles of nurses within community settings. In Australia, government policy situates general practice as central to PHC provision through a primary and community care framework, with significant federal funding provided to expand nurses' generalist roles within this setting. Under federal-state agreements within this framework, nurses providing community care are predominantly state government employees. Policy development has seen the establishment of PHO's (Medicare Locals) with responsibility for coordinating collaborative practices within this framework and between public health and social care. However, as detailed in Chapters One and Two, there is no clear definition of the 'primary health care team' within the Australian health care system. Collaborative practices and the incorporation of the principles of PHC lack clarity, with the recently drafted PHC Strategy excluding broader social determinants of health from its scoping.

There are tensions evident with different expectations and interests positioning nurses as providers of PHC within Australia's PHC reforms. Within the literature, support for and promotion of nurses' PHC practices as underpinned by a social model of care was noted (International Council of Nurses 2008b; Primary Health Care Working Group 2009), however evidence of this in practice varied. Ambiguous representations of nurses' autonomy as PHC providers were evidenced. The centrality of general practice within Australia's PHC health reforms, coupled with the historical dominance of medicine and medical care in general practice, has seen nursing practice being provided 'for and on behalf of' the GP and within a pathologised model of medical intervention and behavioural modification. There is

also limited visibility of nursing's broader role in PHC within the primary and community care framework of the PHC reform agenda, especially for marginalised and hard to reach groups.

Within this wider social context, this study sought to explore nurses' agency through identity work to inform an understanding of contemporary rural PHC nursing in Australia. Australia's PHC reforms have seen a shift in nurses' generalist PHC practice to the general practice setting, with rural general practices receiving the initial funding incentives to increase their employment of Practice Nurses. With rural nursing characterised as requiring generalist practice, this thesis uses a rural case study to explore changes to contemporary rural PHC nursing.

The aim was: *to explore nurses' agency through identity work to inform an understanding of contemporary rural PHC nursing in Australia.*

To achieve this aim this study required a methodology which enabled analysis of the interactions between structure and agency within a social, cultural and historical context. Archer's (1995) critical realist approach to explaining social structures such as PHC nurse identity supported this by allowing the incorporation of the analysis of nurses' individual beliefs and experiences within their structural, sociocultural context.

As such, a qualitative approach informed by critical realist ontology provided the research approach to address the aims of this research. Capturing the complexity of PHC nurse identity work requires 'rich' and 'thick' empirical data to support the scope of the aim of this study of identity (Sveningsson and Alvesson 2003:1165). Two distinct data sources were employed to meet this need. Extensive public submissions (as texts) made to the National Health and Hospital Reform Commission provided the first source of data, and provided access to the characterisations and representations of PHC nursing by a broad range of key groups with different interests in the positioning of PHC nursing in the development of the draft National Primary Health Care Strategy. The second source of data consisted of in-depth semi-structured interviews with twenty one rural nurses practicing within PHC settings

which, through the interview transcripts, granted access to nurse's individual identity work within their rural context.

By capitalising on the theoretical strengths of critical realist ontology, the research framework supported the proposal of explanatory mechanisms for the interplay between rural nurses' agency as providers of PHC and the power of cultural and structural social factors informing PHC nurse identity through analysis of identity work.

To address this study's aim, the questions guiding this research were developed from the literature review, incorporating the context rural PHC nursing, with the conceptual framework for the thesis providing the substrate for their development. The research questions were:

- What are the key collective PHC identities that apply to Australian nurses in community settings?
- What key characteristics delineate these identities?
- What does identity work reveal about PHC nurses' agency?
- How do cultural/historical/structural contexts impact on PHC nurses' agency?

This chapter will now summarise the key findings of this study and the way in which they have addressed the research questions. The implications of these findings for future PHC nursing, particularly in small rural regional communities in Australia, assist in setting the scene for recommendations for policy planners, nursing and nurses and health service managers.

Key findings:

The key findings of this study are: the emergence of four different rural PHC nurse collective identities in use in rural health services; nurses' lack of collective agency to change the main identities used within the health reform process; changes to rural PHC nurse identity driven by structural funding mechanisms with morphogenesis towards the Organisation's Nurse Identity; and rural PHC nursing practices incorporating a social model of health remaining largely 'hidden' from influencing

policy planning and health reform. The following section further details these findings.

Four emergent rural PHC nurse identities

Four main rural PHC nurse identities have been identified by this study as demonstrated in Chapter Six: The Local Community's Nurse, the Doctor's Nurse, the Boundary Spanning Nurse and the Organisation's Nurse. While nurses and community groups use all four identities, only the Doctor's Nurse Identity and the Organisation's Nurse Identity are used by health services and policy makers and medicine. The Organisation's Nurse Identity and the Boundary Spanning Nurse Identity are more recent and reflect identity work to meet changes within Australia's PHC reforms.

The delineating features of each of these identities are outlined and discussed in chapter Six. Nurses' interests were reflected in each of the identities, as outlined in Chapter Four, Five and Six. By incorporating the way in which the identities reflected the interests of other key groups concerned with PHC service delivery, the positioning and strength of these identities within rural health services, rural communities and within the health reform processes were demonstrated. The identities also reflect the preferred model/s of care used for the provision of PHC by nurses. These aspects were important for being able to assess nurses' agency as PHC providers to meet their collective interests.

Evidence of nurses' agency through PHC nurse identity work

The findings of this study show nurses' lack of collective agency within current PHC reforms. Nurses' interests are met as collectives of Primary Agents, but they lack Corporate Agency. Identity work shows it is Corporate Agents, (including policy makers, managers and medicine), who are able to make collective identity changes within rural health services and health reforms. These changes to rural PHC nurse identity are driven by funding mechanisms resulting in the increasing strength of the Organisation's Nurse Identity within rural health services. It is where nurses'

interests overlap with those of Corporate Agents that nurse's benefit, however nursing lacks collective agency to change PHC nurse identities.

The finding of nurses' lack of collective agency and lack of power to change the Organisation's Nurse Identity and the Doctor's Nurse Identity as the main identities used by Corporate Agents was based on evidence of nurses' ambiguous autonomy within health services and included the difficulties in incorporating a social model of care into practice. Nurses' social and integrated practices were maintained as 'hidden' through the identity work of Corporate Agents by influencing funding mechanisms and power imbalances. This related to much of the discontent experienced by nurses within this study and noted within the literature (Smith 2000; Stanton 2001; Reiger and Keleher 2004; Kemp, Harris et al. 2005; Condon, Nesbitt et al. 2008).

The emergence of the Boundary Spanning Nurse Identity used by nurses and community groups reflected interests in maintaining nurses' autonomy as generalist PHC providers incorporating a social model of health. Corporate agents did not engage with this identity and as such may have the power to control its visibility within the health reform processes. The use of this identity by nurses as primary agents maintained the full extent of rural PHC nursing practice as 'hidden' from rural health services data collection, policy development and evaluation processes making the negotiation of nurses' interests difficult.

The impact of structural, cultural and historical contexts on nurses' agency

The demonstration of nurses' lack of collective agency within the context of this study is underpinned by cultural, historical and structural factors. These influences maintain nurses as primary agents within the PHC reform process and contribute to the invisibility of aspects of nursing practice such as the inclusion of the social model of care within PHC nursing beyond individualistic practice.

A key finding of this study was the impact of funding models as a main generative mechanism resourcing new rural PHC nurse positions. Funding was a key driver in

assisting Corporate Agent identity work in the proliferation of the Doctor's Nurse Identity and the morphogenesis towards the Organisation's Nurse Identity. The power of funding mechanisms to drive identity change was evidenced by nurses, as individuals and collectives of primary agents, taking on the new identity of the Organisation's Nurse and the strengthening of this identity within rural health services. This study found that nurses perceived the Organisation's Nurse Identity as potentially beneficial in expanding PHC roles beyond being mere 'handmaidens' to the GP. Nurses were motivated to take on this identity where it overlapped with their interests, which included maintaining generalist PHC practice as well as addressing medical workforce shortages and an increased client load within their communities.

Funding measures have also set a cultural and structural precedent for community based nursing care in rural areas being provided for individuals and their families. Within this study, identity work evidenced nurses as providing care for individuals and families 'for and on behalf of' the doctor for the doctor's clients through the Doctor's Nurse Identity, as well as individualised community care for clients via State/HACC funding. The focus on individuals and families is maintained through the more recent Organisation's Nurse Identity, with control of this identity by policy makers extended to academics through promoting 'patient-centred' care within the primary and community care framework (Australian Commission on Safety and Quality in Health Care 2011a). Collaboration between primary & community care services for individuals and public/ population health and social services is centralised to Medicare Locals while collaborative structures at the local community level remain underdeveloped (Jackson, Nicholson et al. 2008).

Funding mechanisms for nursing care within the primary and community care framework maintain pathologised models of care through 'patient-centred' medical intervention and behavioural modification. Through Corporate Agent identity work, morphogenesis towards the Organisation's Nurse Identity supports nurses' expanded practice; however there is a lack of clarity regarding nurses' partnership with the community as client and the inclusion of the social model of care. Nurses' Primary Agency within this identity results in their PHC practice being constrained to models of care controlled by Corporate Agents. As such, the promotion of nurse-led care is

ambiguous in respect to nurses' autonomy to provide care within a social model of health.

Nurses' 'hidden' practices were culturally and structurally embedded in rural health services as shown in Chapters Four and Five. The findings evidenced a culture of 'gap filling' within rural nursing necessitated by historical, structural workforce shortages and reinforced through a culture of community attachment and connectivity. With funding mechanisms driving changes to PHC nurse identity, Corporate Agents' identity work largely influences which practices will remain 'hidden' and which will be recognised.

This section has summarised the way in which the key findings of this study have answered the research questions. The next section of this chapter will summarise the implications of these findings, as discussed in Chapter Six, for nursing practice, rural health services and sustainable PHC reform in Australia.

The future of rural PHC nursing

The findings of this study have broad implications: for policy planners, rural health services, managers, nurses and nursing organisations, and importantly for rural communities. The last decade has seen significant changes to rural PHC nurse identity which have been demonstrated by this study. Two new identities have emerged, the Organisation's Nurse and the Boundary Spanning Nurse. Through the use of an identity work framework as a lens, underpinned by critical realism, explanations for these changes have gone beyond descriptions of structured roles to be able to look at the negotiations occurring between nurses and rural health services and their communities.

Australia, similar to other countries, is facing an imminent crisis with an ageing nursing workforce. Adequate nursing numbers are critical to the sustainability of health system reform towards an increased focus on health care provision within primary and community care settings. Within the context of this study, long standing tensions have been demonstrated for nurses working in community settings, particularly in regard to constraints to nurses' autonomy to expand PHC provision

beyond pathologised care. Analysis of the findings supported the development of an explanatory framework for how morphogenesis of rural PHC nurse identities may influence which nurses are attracted to working in different rural PHC settings in the future. Although the numbers of nurses working in general practice have increased, the nurses taking on these roles are getting older with newly graduated nurses ‘shunning’ the primary care setting (Eccles 2012). The explanatory framework presented in Chapter Six has enabled new ways of looking at the changes to structured positions beyond role incumbency to encompass nurses’ interests, agency and identity as PHC providers. Sustainable PHC reform necessitates a viable and active nursing workforce. With nursing recruitment and retention in rural areas a distinct problem and new generations of nurses shown to change jobs and leave organisations if their prioritised interests are not met (Christmas 2008), this framework provides opportunities for broader understandings of factors influencing nurses’ PHC practice.

The emergence of the Boundary Spanning Nurse Identity highlights sociocultural influences on rural PHC identity work. The way in which nursing’s history of ‘gap filling’ in rural communities to provide unmet services and needs informs rural nurses’ identity work has been demonstrated through the findings of this study. While the Organisation’s Nurse Identity addresses some of these needs through the expansion of nursing roles, the Boundary Spanning Nurse Identity provides opportunity for new ideas to inform policy, particularly in regards to integration of services at the local level, and the incorporation of a social model of health to inform practice beyond a focus on individuals or aggregates of individuals. However, the use of this identity by nurses and community groups as primary agents evidences the weakness of this positioning in the negotiation of identity change within PHC reforms.

Rural communities in Australia, including the nurses working in communities represented in this study, have once again experienced the devastation of bushfires and droughts. The impact of these disasters on rural communities and the importance of developing community resilience for recovery and health through a social model framework have been well researched (Kulig 2000; Rolfe 2006; Allan, Ball et al. 2007; Earvolino-Ramirez 2007; Galbally 2007; Hegney, Ross et al. 2008; Caldwell

and Boyd 2009) These studies highlight the integral aspects of ‘sense of belonging’ to community, broad networking and leadership for enhancing community resilience. These are the key characteristics of the Boundary Spanning Nurse Identity demonstrated by this study and have been recognised, both nationally and internationally, as informing nursing practice in rural community settings. However, the full extent of these practices remains hidden from health services and policy planners through funding mechanisms which assist in maintaining these practices as informally used by nurses. Partnership with community by nurses is ambiguous within the primary and community care framework and governance issues for integrated care between different organisations at the local level are underdeveloped (Jackson, Nicholson et al. 2008).

The explanatory framework developed by this study reveals funding mechanisms as one of the generative mechanisms driving rural PHC nurse identity change. There is a risk that rural PHC nurse identity work which remains ‘hidden’ and un/underfunded, yet meets the interests of nurses and rural communities for including the incorporation of a social model of health, could be lost to rural communities and to nursing practice.

Traditionally, community nursing has been used as the overarching title for nurses working outside the hospital setting however, the findings of this study show this may be changing in Australia. Ambiguous use of the term PHC nurse was evidenced, with the term being used for nurses working in the general practice setting while ‘Community Nurse’ and ‘Community Health Nurse’ were predominantly applied to nurses providing PHC services within the community care sector. This has implications for nurses’ identification with PHC nursing and nurses’ collective voice as providers of PHC. Some nursing groups, such as APNA, are organising to develop corporate agency which will increase their ability to influence changes to PHC nurse identity particularly through the Organisation’s Nurse Identity. However, their claims to being the peak body representing PHC nurses may pose risks for their ability to change the Organisation’s Nurse Identity to meet nurses’ collective interests as PHC providers. Their lack of wider representation of PHC nurses beyond the general practice setting may limit nursing’s collective PHC nurse ‘voice’ through this group.

The development of competency standards for nursing practice by the nursing profession provides legitimising strategies for control over the competence of nurses practicing in different settings. While nurses working in general practice settings are guided by specific competency standards for this setting, there is a lack of overarching competency standards for nurses working in community settings providing PHC services in Australia. The competency standards for nurses in general practice state that nursing is practiced within the principles of PHC (Australian Nursing Federation 2006) however, while this has been argued to require a commitment to incorporating a social model of health in practice (World Health Organisation 1978; Keleher 2007c), evidence within this study has shown ambiguity regarding the extent to which this occurs. While Australian Government funding enabled the development of the nursing in general practice standards (Australian Nursing Federation 2006), the power of identity work of Corporate Agents such as policy planners and managers to influence PHC nurse identity is evidenced within this study and the literature with contradictions in the implementation of these standards for both the content and context of PHC nursing within this setting (Mills and Hallinan 2009).

Rural nurses are recognised as working with, and requiring, advanced nursing practice skills (National Rural Health Alliance 2005). However, this study has reinforced concerns within the literature regarding the lack of consensus of description of the advanced practice nurse (APN) (Hegney and McCarthy 2002a; Chiarella 2006; Duffield, Gardner et al. 2009; Cant, Birks et al. 2012). It is through the Boundary Spanning Nurse Identity that networking and leadership are aligned with advanced nursing practice skills for the residents of the whole community and identify as PHC nurses across services within the primary and community care framework. The findings of this study highlight the implications of a lack of consistency and clarity regarding the inclusion of community as client for advanced practice nurses.

This final section has summarised the main implications of the rural PHC nurse identities emerging from this study for the provision of PHC nursing services in outer regional rural communities. Through answering all of the research questions, this study has met the aim of the research project which was: *to explore nurses' agency*

through identity work to inform an understanding of contemporary rural PHC nursing in Australia by incorporating the interplay between nurses' agency and the sociocultural and structural forces influencing PHC nurse identity through PHC nurse identity work.

Strengths and limitations

The strengths of research approach taken in this study are directly related to the use of identity work as a theoretical lens underpinned by critical realist ontology. Identity work allowed this study to explore the negotiation of interests and the navigation of power dynamics at the interface between rural PHC nurses and rural health services. Examining agency and prioritised interests through identity work enabled the study to explore and provide explanation for the way in which stronger groups can control the visibility of primary agents and their interests, maintaining some practices as 'hidden' from the conversation of PHC reform.

Recent studies have focused on nurses structured roles in primary and community care settings (Patterson 2000; Halcomb 2005a; Keleher, Parker et al. 2007g; Phillips, Pearce et al. 2008). However, by using identity work as a framework underpinned by a critical realist ontology this study goes beyond descriptive and experiential accounts of nurses' PHC practices within structured and developing roles to assess the power dynamics at play and allow for the interrelationship between culture, structure and nurses as actors in health services (Archer 2000).

A strength of using critical realism is that it allowed the development of this thesis through content, thematic and retroductive analysis of evidence (NHHRC submissions and nurses interviews) to actual events, and through an explanatory framework, to propose the 'real' social processes such as a 'gap filling' culture within rural nursing and funding mechanisms generating these events. Critical realism also acknowledges that these real mechanisms also have a causal effect on structure and social expectations (Archer 1995).

By taking this approach, a broader examination of empirical evidence of nurses' 'hidden' practices sheds light on the interaction between nurse agency, culture and

structure influencing the control of models of care within rural health services, particularly within the role of ‘agent of connectivity’ (Phillips, Pearce et al. 2008:9) and the implications for rural health services and rural communities.

This study commenced at a time of significant and unprecedented changes to PHC nursing in Australia. While this research uncovers some of the causal mechanisms for collective PHC nurse identities, as a necessarily ongoing process, the explanatory framework constitutes part of a developing understanding PHC nurse identity. One of the strengths of using retroduction as a mode of inference is that it provides knowledge of conditions, structures and mechanisms that are not directly observed in the empirical domain.

The research approach used in this thesis does have limitations. While it has supported new knowledge and ways for understanding contemporary rural PHC nursing, a number of factors present limitations to the generalizability of these findings. Nursing is a predominantly female occupation; however, the implications of gender as an influencing factor for PHC nurse identity have not been explored in this study. The imperative to maintain confidentiality of research participants and the ease with which male nurses in small rural communities could be identified necessitated the assignment of female gender to the responses of all participants.

The use of a case study method also presents limitations to the generalizability of the findings. The empirical data is context specific to small outer regional communities within two Australian States and the nurses interviewed are not representative of all rural nurses or all PHC nurses. Additionally, the fact that the nurses in this study self-selected to be interviewed presents limitations to representativeness of this sample.

However, studies such as this, within a critical realist perspective, generalise based on causal explanations not representativeness (Easton 2010). Within a critical realist ontology, the ‘real’ world is complex and stratified, and so explanatory frameworks are not fact, there is no fixed criteria from which it would be possible to assess, in a definite way, the validity of a retroductive conclusion (Danermark, Ekstrom et al. 2002:80-81). As such, the findings of this study are fallible. However, while this might be the case the research processes undertaken in this study are well recognised,

tested and robust (Grbich 1999; Neuman 2003; Krippendorff 2004). The causal explanations proposed within this thesis contribute to the knowledge base of PHC nursing and provide a basis for developing theory beyond this case (Easton 2010:127).

Finally, my status as an ‘insider’ researcher introduced the potential for bias and limitations to the validity and trustworthiness of the study’s findings. In ensuring the integrity and credibility of the findings of this study, one of the measures taken was the securing of a non-nursing member within the supervisory team from the outset of the study. Within Chapter 3 a detailed discussion acknowledging my ‘insider’ position, and the efforts undertaken in an attempt to address the complexity of this research relationship, has been clearly outlined.

Recommendations

This study highlights that future and further expansion of nurses PHC provision requires a new framework for thinking about PHC nurses and research studies that focus on the practice reality of nurses providing services underpinned by a PHC approach to practice. Assumptions about nurses, particularly those which lead to policy directions, need to be challenged. Expectations of nurses as providers of PHC and their ability to expand practice which meets community needs within market driven structures need to be examined. This is particularly so in light of the changes to practice incentives and the removal of Practice Nurse Medicare Item numbers for nurses working in general practice settings which occurred after the data collection phase of this study. This study has raised questions about nurses’ collective agency within the general practice setting to expand practice beyond pathologised individualistic care to incorporate a social model of care into practice.

More specifically, the following recommendations are based on the findings and concern nurses’ involvement as PHC providers with rural health services and their communities.

1. For managers of rural health services – This study has evidenced increased job satisfaction for nurses who perceive their organisation as connected to their local

community. This could be enhanced through auditing, identification and recognition of nurse employees with broad networking and leadership skills including competencies to incorporate a social model of health in practice. Utilising these skills to develop and regularly maintain broad community networks to increase the partnership between health service and broader community beyond health service clients. Opportunities could be created for structured networks for nurses that enable collaboration between nurses across local health services with the aim of assisting in continuous community profiling. This would assist in services developing integrated needs based models of service provision beyond market driven forces.

2. For education and policy makers – Funding for the development of national competency standards for nurses which address nurses working in all community settings as providers of PHC is essential. This would ensure a consistent understanding and expression of PHC as underpinning nurses' practice in community settings. This would assist in standardising education underpinned by the competencies framework for both undergraduate and post graduate nurses. The term 'client' requires consistency and clarity within the competency standards to include 'community' in addition to 'individuals and groups' as recognised clients. This also needs to be reflected in the APN competency standards.

3. Development of a nationally coordinated approach to implementing a career framework for nurses as providers of PHC services, which will incorporate nurses working in a range of primary and community care services, based on education levels, competencies and skills. There is currently no career framework for nurses as providers of PHC working in community settings. A career framework would provide a pathway for nurses to achieve the level of skill appropriate to meet their collective interests and the needs of the individuals, populations and the health services they provide care for/with. It may well also help attract younger nurses into the PHC sector and retain the services of nurses who work in the sector, providing professional and financial recognition of their advanced practice nursing skills.

4. There is a need for nursing to advance a collective voice in order to effectively represent nurses' collective interests as providers of nursing care using a PHC approach to practice. All of the nurses in this study identified with being PHC nurses.

While groups representing all nurses providing PHC services collaborated to develop the Consensus Statements (Australian Nursing Federation, Australian Nurse Practitioner Association et al. 2008; Australian Nursing Federation, Australian Nurse Practitioner Association et al. 2008) there is also a need for this to be an ongoing dialogue through an overarching group voice for representation in discussions at the policy level. While the rise of APNA is important for one specialty of PHC nursing there is a risk that the practice reality of all areas of PHC nursing may well continue to be hidden from policy discussions (as discussed within this study). If the principles of PHC, including the social determinants of health through a social model of care, underpin nurses practice in a broad range of community settings then nursing needs to have a discussion about the social construction of PHC nursing as general practice nursing. There is a need to looking beyond the primary and community care framework to recognise all nurses working in community settings providing nursing care using a PHC approach. The risk is that, without strong representation at the policy level to influence funding measures, much of nurses' PHC practice incorporating a social model of health may remain 'hidden' and be lost to nursing and to the communities they work with/in.

5. For policy planners and academics and nurses - further understanding of the models of care most appropriate for rural health services and rural communities and nurses' participation in these is required. The impact of incorporation of all three models of health care in practice on rural/urban health differentials is needed. The inadequacy of the dominance of medical intervention with behavioural modification as models of care for marginalised groups is well researched and evidenced within the literature reviewed for this study. The role of nurses in providing services which incorporate all three models requires critical analysis and further research to understand the ideological and power issues that sustain policy processes. While there are claims that nurses' incorporation of a social model of care improves community resilience, this requires further research within rural health services and rural communities.

In light of the findings of this study, expectations that nurses will continue to be attracted to general practice, particularly in rural health services, need to be questioned. The assumption that the interests of nurses working with/in general

practice are representative of and reflect all PHC nurses interests risks the development of policies for PHC nurses based on assumptions of PHC nurse identity. This may well be ultimately counter-productive to the health reform agenda. This study highlights the incorporation of a social model of health as integral to rural PHC nurse identity for many rural nurses and community groups.

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Appendix 1 Participant Information Sheet

Information Sheet for Study Participants

Primary health care and rural nurses in small Australian coastal communities: a study of identity.

PhD Thesis Research

The national focus on primary health care strategies to address changing demographics has particular importance for nurses providing health care for small rural coastal communities.

Rural communities in Australia are experiencing marked changes in their population demographics. The number of people living in the 'bush' is decreasing, however, many rural coastal population areas are growing. The impact of these demographic changes, coupled with spiralling costs, an ageing population and an increasing number of people living with chronic conditions have provided impetus towards a significant review of the provision of health services.

A vital aspect of this research project is to talk with rural nurses in these small coastal 'hamlets'; to explore their experience of working as a rural nurse in regards to providing primary health care services for their community. The geographic locations for this study will include rural coastal towns in Tasmania and New South Wales. The impacts of organisational reforms regarding primary health care strategies on the professional identity of rural nurses in small communities in terms of enablers and barriers to practice are of particular interest to this study.

My intention is to focus on a group not larger than 50 nurses, who have experience providing nursing support for small rural coastal communities

An Invitation:

You have been identified as a potential participant in this study because of your role as a rural nurse in a small coastal community. You are invited to participate by agreeing to be interviewed by the researcher about your ideas regarding primary health care and your nursing role and practice.

- Your involvement in the research will require a commitment to an hour long interview and will be conducted at a mutually agreeable time and private venue.
- With your permission I would like to audio record the interview. I will personally transcribe the interview and send the transcript back to you for confirmation, or to enable you to make any changes. You have the right to delete any parts of the transcript, and to withdraw from the study at any time until you return the transcript to me for data analysis.
- I will ask that you return the transcript to me within a month of receiving it. The data will be used for my thesis, and for any publication or presentation that may arise in association with this study.

- The deidentified audio recording and transcript will be stored in a locked filing cabinet and kept separate from the consent forms. At completion of the study, I will destroy the recording, transcripts and consent forms after five years. You will be referred to by an agreed pseudonym in the study and you will not be identified by your place of employment.

You have the right

- to decline to participate.
- to refuse to answer any particular questions.
- to withdraw from the study up until the time the transcript is returned to me following the interview.
- to ask any questions about the study at any time during participation.
- to provide information on the understanding that your name will not be used.
- to be given access to the summary of the findings of the study when it is concluded.
- to ask for the audio tape to be turned off at any time during the interview.

Potential risks and benefits from participation

Benefits from your participation are the opportunity to talk about and reflect on your role and identity as a rural nurse in your community and the direction that you see this role taking in the future. You will be contributing to research that will inform future models for rural primary health care nursing. A potential risk of participation is the cost of your valuable time, I will aim to minimise the cost of your time by travelling to meet you.

If, after reading this you are interested in being involved in this study, I look forward to hearing from you – you can send your contact details to me via email at Ree.VanGalen@utas.edu.au or by phone and I will be in touch to organise a time to come and talk with you and I will send you an outline of the questions we will be discussing. Should you wish to ask any questions concerning this research, please do not hesitate to contact me or either of my two supervisors.

Thankyou for taking the time to consider participating,

Researcher

Ree Van Galen, RN

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Christine.Stirling@utas.edu.au

This project has been reviewed and approved by the Tasmania Social Science Human Research Ethics Committee. If you have any concerns about the conduct of this research, please contact the Executive Officer of the HREC (Tasmania) Network on 03 62267479 or email human.ethics@utas.edu.au. You will need to quote [H10387.....]

Appendix 2 Amended Participant Information Sheet



Information Sheet for Study Participants

Primary health care and rural nursing in small Australian communities: A study of identity.

PhD Thesis Research

The national focus on primary health care strategies to address changing demographics has particular importance for nurses providing health care for small rural communities.

Rural communities in Australia are experiencing marked changes in their population demographics. The number of people living in the 'bush' is decreasing, however, many rural coastal population areas are growing. The impact of these demographic changes, coupled with spiralling costs, an ageing population and an increasing number of people living with chronic conditions have provided impetus towards a significant review of the provision of health services.

A vital aspect of this research project is to talk with rural nurses in these small 'hamlets'; to explore their experience of working as a rural nurse in regards to providing primary health care services for their community. The geographic locations for this study will include rural towns in Tasmania and New South Wales. The impacts of organisational reforms regarding primary health care strategies on the professional identity of rural nurses in small communities in terms of enablers and barriers to practice are of particular interest to this study.

My intention is to focus on a group not larger than 50 nurses, who have experience providing nursing support for small rural communities

An Invitation:

You have been identified as a potential participant in this study because of your role as a rural nurse in your community. You are invited to participate by agreeing to be interviewed by the researcher about your ideas regarding primary health care and your nursing role and practice.

- Your involvement in the research will require a commitment to an hour long interview and will be conducted at a mutually agreeable time and private venue in your community.

- With your permission I would like to audio record the interview. I will personally transcribe the interview and send the transcript back to you for confirmation, or to enable you to make any changes. You have the right to delete any parts of the transcript, and to withdraw from the study at any time until you return the transcript to me for data analysis.
- I will ask that you return the transcript to me within a month of receiving it. The data will be used for my thesis, and for any publication or presentation that may arise in association with this study.
- The deidentified audio recording and transcript will be stored in a locked filing cabinet and kept separate from the consent forms. At completion of the study, I will destroy the recording, transcripts and consent forms after five years. You will be referred to by an agreed pseudonym in the study and you will not be identified by your place of employment.

You have the right

- to decline to participate.
- to refuse to answer any particular questions.
- to withdraw from the study up until the time the transcript is returned to me following the interview.
- to ask any questions about the study at any time during participation.
- to provide information on the understanding that your name will not be used.
- to be given access to the summary of the findings of the study when it is concluded.
- to ask for the audio tape to be turned off at any time during the interview.

Potential risks and benefits from participation

Benefits from your participation are the opportunity to talk about and reflect on your role and identity as a rural nurse in your community and the direction that you see this role taking in the future. You will be contributing to research that may inform future models for rural primary health care nursing. A potential risk of participation is the cost of your valuable time, I will aim to minimise the cost of your time by travelling to meet you. As a fellow nurse, bound by the (ANMC) Codes of Professional Conduct and Ethics, you will be aware that in the unlikely event that I encounter conduct clearly constituting a breach of either of these codes I will be under professional obligation to report it to the relevant authority.

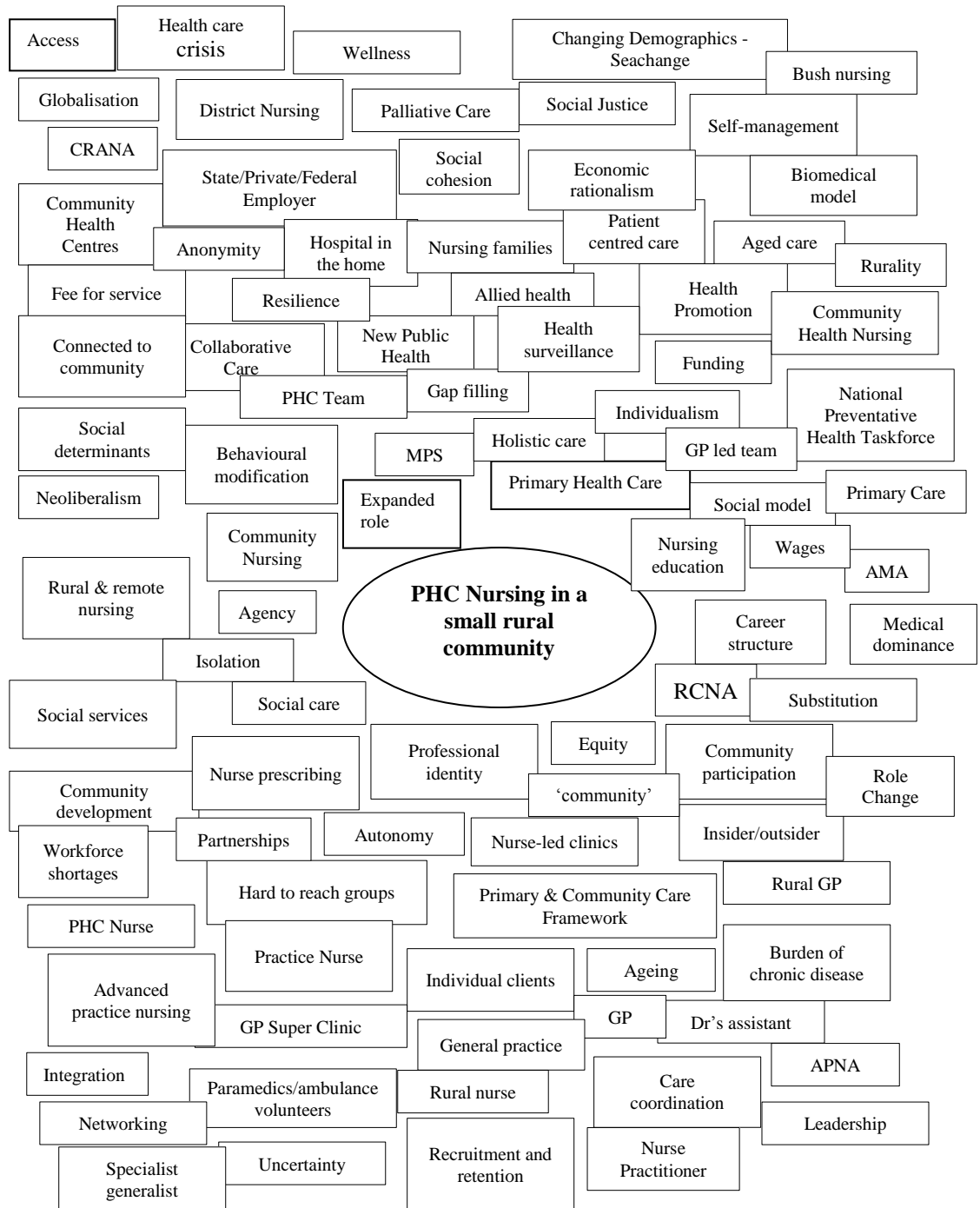
If, after reading this you are interested in being involved in this study, I look forward to hearing from you – you can send your contact details to me via email at Ree.VanGalen@utas.edu.au or by phone and I will be in touch to organise a time to come and talk with you and I will send you an outline of the questions we will be discussing. Should you wish to ask any questions concerning this research, please do not hesitate to contact me or either of my two supervisors.

Thankyou for taking the time to consider participating,

Researcher	Primary Supervisor	Co Supervisor
Ree Van Galen, RN	Dr Clarissa Hughes	Dr Christine Stirling
Phone 03 62503868	University Department of	Menzies Research Institute
Ree.VanGalen@utas.edu.au	Rural Health	University of Tasmania
	University of Tasmania.	Ph. 03 62264766
	Ph. 03 62267797	Christine.Stirling@utas.edu.au
	Clarissa.Hughes@utas.edu.au	

This project has been reviewed and approved by the Tasmania Social Science Human Research Ethics Committee. If you have any concerns about the conduct of this research, please contact the Executive Officer of the HREC (Tasmania) Network on 03 62267479 or email human.ethics@utas.edu.au. You will need to quote [H10387]

Appendix 3 Situational ‘Messy Map’



Appendix 4 Email to managers

Email Subject Heading: An invitation to participate in an important study for rural nurses.

Dear Practice Manager/Director of Nursing/Clinical Nurse Manager (Delete as applicable),
Following our phone conversation I am emailing you with this request of forwarding this email to the nurses working at your facility/practice/centre (delete as applicable). I have also attached the information sheet which can be placed on the staff noticeboard.

Thank you again for your assistance,

Regards

Ree Van Galen

Dear rural nurse, I am emailing you to invite you to be involved in a PhD research study exploring the experience of working as a rural nurse in a small community. You have been identified as a potential participant in this study because of your role as a nurse in this community.

You are invited to participate by agreeing to be interviewed by me, for about an hour, regarding your ideas about primary health care and your nursing role and the direction that you see this role taking in the future. This will provide you with an opportunity to have crucial input into research that may inform future ideas about nursing in small rural communities.

Please find attached an information sheet providing more detail about being involved in the study.

Participation is entirely voluntary. If you would like to be involved or would like more information you can contact me via email at rmvan@utas.edu.au

Thankyou for your time, I look forward to hearing from you,

Regards,

Ree Van Galen, RN

PhD Candidate

University Department of Rural Health

University of Tasmania.

Appendix 5 Interview Question Guide

Interview Schedule

These questions are guidelines, the interview will be semi structured.

Nursing Role and Primary Health Care

- 1) In what role/s are you currently employed/ how long have you been in your current role?
- 2) How would you describe your current practice within your role/ what types of activity does your current role require? (e.g. centre based, home visits, group work and also main tasks eg wound care, chronic disease, bloods, cervical smears, immunisations, assessments)
- 3) Who are your clients? Which groups make up the predominance of your client base?
- 4) Do you see your role changing in the next five years and if so how and what is influencing this?
- 5) How important is a primary health care approach for your current role/practice?
- 6) What changes would you like to see in your current role that would assist you in providing quality primary health care?
- 7) What factors in your work and professional environment support or prevent your primary health care approach to practice? How does your employer/ organisation influence the way you practice or how your practice is defined?
- 8) What professional development/education have you had regarding primary health care and within your role?

Professional Identity

- 1) Nursing career to date (length of time nursing, roles, choices and how you came to be nursing in a small rural coastal community)
- 2) What do you enjoy and value about being a nurse in this community?
- 3) What aspects are less enjoyable?
- 4) Do you think of your nursing role as rural, remote or isolated?
- 5) Do you call yourself or see yourself as a community nurse?

Nursing Role and Collaborative Care

- 1) How do you collaborate/work with other health care professionals involved in health care provision for your clients and community?
 - Discuss general practitioners
 - other nurses – e.g. district nurses, practice nurses, community health nurses
 - allied health incl. social workers, physio etc
- 2) How do you collaborate with local community groups e.g. local school, youth groups, RSL etc.

Rural Nursing

- 1) Do you think your current role differs to urban practice? If so how?
- 2) Can you see any differences in your role in this coastal town to other rural settings?
- 3) Do the residents of your local community have input into determining the types of services you provide?

Appendix 6 Demographics Questionnaire

Participant Demographics

The following demographics will be noted for each participant

- 1) NSW or TASMANIA (Circle applicable state)
- 2) TASMANIA
 - NorthWest
 - South
 - North
- 3) Age
- 4) Gender
- 5) Nursing qualifications
- 6) Years of nursing practice
- 7) Years of nursing practice in a rural setting
- 8) Current hours per week working as rural nurse
- 9) Do you currently live in the rural community you are working in? Yes or No

Appendix 7 Complete Coding List (Content Analysis)

1. Funding
2. PC & PHC Interchange
3. Medical Dominance
4. Identification with community
5. Recruitment & Retention
6. Task delegation
7. Substitution
8. Gap filling
9. Autonomous Practice
10. Advanced Nursing Practice
11. Specialist Generalist
12. Nurse Practitioner
13. Practice Nurse
14. Community Nurse
15. PHC Nurse
16. District Nurse
17. Midwife
18. Child Health Nurse
19. Mental Health Nurse
20. Chronic Conditions Management
21. Decrease Acute/Hospital Needs
22. Coordination of Care -
23. Collaboration – Multidisc. Team
24. Health Promotion/Public Health/prevention/ education
25. Task Transfer or supplement
26. Rural nurse
27. Holism/Holistic Care

