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We say we are doing primary health care but we're not: Remote area nurses' perspectives on the challenges of providing primary health care services

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ABSTRACT

Background: Nurses are essential in global strategies to improve population health. However, there is a paucity of research that describes the application of primary health care from a nursing perspective. Australian remote area nurses work in primary health care clinics which are often the only health care service within the community. Services include acute care response as well as health promotion and public health activities.

Question, Hypothesis or Aim: To explore the meaning and application of primary health care principles from the perspective of nurses in Australian remote settings.

Methods: Telephone interviews were conducted with registered nurses and nurse practitioners working in Australian remote settings using constructivist grounded theory methods during 2014 and 2015.

Findings: Nurses in remote settings considered primary health care to be an holistic social model of care that included caring for the community as well as the individual. However, they were unable to provide care consistent with their intention due to the resource-poor nature of the remote setting. Inadequate physical resources, limited specialist health services, and a lack of time were found to impact on remote area nurses' abilities to provide primary health care.

Discussion: This study is unique in its description of a cause of remote area nurse stress as being the inability to provide primary health care in line with their expectations.

Conclusion: Appropriate resourcing is essential for nurses to be able to provide a comprehensive array of holistic services in line with community-identified need that also reflect their own definitions of primary health care.

Summary of relevance

Problem or issue

Expectations that nurses will provide comprehensive primary health care in remote communities are unrealistic given the current availability of resources and clinician availability.

What is already known

Inadequate resources and a lack of time has been described by others as causing stress and contributing to the high rate of staff turnover in remote primary health services in Australia.

What this paper adds

This study is unique in its description of the inability to provide primary health care as a cause of stress among remote area nurses. Understanding the application of primary health care principles to practice requires additional support and further research.

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1. Introduction

Australia has vast areas which are sparsely populated by small remote communities of around 150–2000 people. These communities are great distances from tertiary hospitals and although the health clinics provide a 24 hour nursing response to emergencies, their main function is to provide primary health care services that include health promotion, management of chronic disease, palliative care, antenatal care, child health and public health services. Nurses provide most of these services in collaboration with Aboriginal Health Practitioners, General Practitioners and visiting allied health services. In many instances the only access to medical advice is via telehealth, and admission to tertiary services can only be facilitated by aero-medical and/or road transfer (Lenthall, Byers, & Stothers, 2020).

Primary health care services in remote areas (particularly in discrete Aboriginal and Torres Strait Islander communities) are often provided by Aboriginal Community-Controlled health services, which are governed by a board of directors and independently manage health resources to meet the health needs of the community. Primary health care services or health clinics in other remote communities are provided by local State Governments or private organisations such as Silver Chain (www.silverchain.org.au). Funding is generally sourced from Federal and State government with costs increasing with remoteness but service utilisation decreasing (Thomas, Wakerman, & Humphreys, 2017).

This paper elaborates on one of the key findings from a study that resulted in a substantive theory of primary health care nursing within a remote setting (McCullough, Whitehead, Bayes, Williams, & Cope, 2020). Specifically, we focus in depth on our core finding of how our participants characterised 'providing primary health care' in the context of remote area nursing and why it was difficult for nurses to attain their goal of primary health care as they understood it in a resource limited environment.

2. Background

Nurses are essential in global efforts to improve population health with primary health care principles (World Health Organisation, 2020). Of importance is the health of marginalised communities, including rural and remote communities. Remote and very remote areas (Australian Bureau of Statistics, 2016) were the focus of this study and whilst only 3% of Australian residents live in these areas, the land mass covered is estimated at 85% of the Australian continent (Commonwealth of Australia, 2013). In Australia, the mortality rate of people living in remote Australia was 1.4 times that of major city residents (Australian Institute of Health and Welfare, 2017). Residents are more likely to identify as Aboriginal and/or Torres Strait Islander and have poorer access to specialist and medical health services with generalist registered nurses, Aboriginal health practitioners and nurse practitioners providing most health services (Lenthall et al., 2020).

The Australian Government's 'Closing the Gap' program aims to eliminate inequalities in life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2031 (Council of Australian Governments, 2008). This program requires a re-orientation of the health system away from the 'medical' model to an approach that consistently includes the social and psychological aspects of a health problem. Primary health care incorporates primary care (traditionally general practitioner and first level services) with health promotion and population health in a way that emphasises community participation and empowerment, social justice and equity, cultural safety, trust and accountability and results in self-reliance and more effective health care (Talbot & Verrinder, 2018).

In 2009, The Australian Nursing Federation released a report supporting the philosophy and implementation of primary health care in Australia (Australian Nursing Federation, 2009). The report outlined several areas where nurses and midwives can make a significant contribution to primary health care objectives such as in health promotion, management of chronic disease, aged care, child and family care and mental health. Explicitly mentioned is the generalist role of nurses in underserved areas, such as with Indigenous and Culturally and Linguistically Diverse (CALD) communities and in rural and remote areas.

The importance of a primary health care approach to health service delivery is also evident in the Australian codes of conduct for nurses; where principle seven states, "Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequality"(Nursing and Midwifery Board of Australia, 2018 p.14). Primary health care is a model of health service delivery that is expected to curb the spiralling costs of chronic disease and with its focus on preventative care, bring about significant health improvements in communities by reducing health inequalities (Talbot & Verrinder, 2018). Whilst primary health care is included in the scope of practice of registered nurses, there is a need for more education and training (World Health Organisation, 2020) as well as support for the transition from acute to primary health care settings (Ashley, Halcomb, & Brown, 2016).

Remote area nurses are primary health care nurses with a particular focus on providing culturally safe care to Aboriginal and Torres Strait Islander communities. They provide acute and preventative health services across the lifespan in an advanced practice role (Lenthall et al., 2020) . The remote area nursing role differs from many other primary health care nursing roles in its need for broad generalist knowledge, living and working within a small community and working in isolation, particularly outside of normal business hours (McCullough et al., 2020; Smith, 2016). This paper contributes to primary health care aims by reporting on nurses' perspectives of the reality of providing primary health care in the remote community setting.

3. Methods

This article reports on descriptive data which was generated during the development of a grounded theory. Constructivist grounded theory methods were used to develop a substantive theory of primary health care nursing in a remote setting (McCullough et al., 2020). Grounded theory methods such as constant comparison, theoretical sampling, and focused, axial and theoretical coding (Charmaz, 2014), guided data collection and analysis. In constructivist grounded theory, the researcher draws on their own experience, and to that end, the theory is co-constructed but grounded in the participants' data (Charmaz, 2014). The chief investigator worked as a remote area nurse from 2000-2004 and reflexivity during data analysis was enhanced throughout by discussion with the research team as well as the use of memos, journaling and diagrams to illuminate the researcher's tacit knowledge (Birks & Mills, 2015).

Thirteen nurse practitioners and 11 registered nurses working in 'remote' and 'very remote' according to ARIA+ methodology (Australian Bureau of Statistics, 2003) areas across the Northern Territory, Western Australia, Queensland and the Indian Ocean Territories, participated in the study. Eleven participants were also registered midwives. Participants had a wide range of experience within the remote setting from 3 months through to more than 20 years.

Ethical approval to conduct the study was granted by the university human research ethics committee (Approval Number 10810). Data were generated via telephone interviews lasting be-

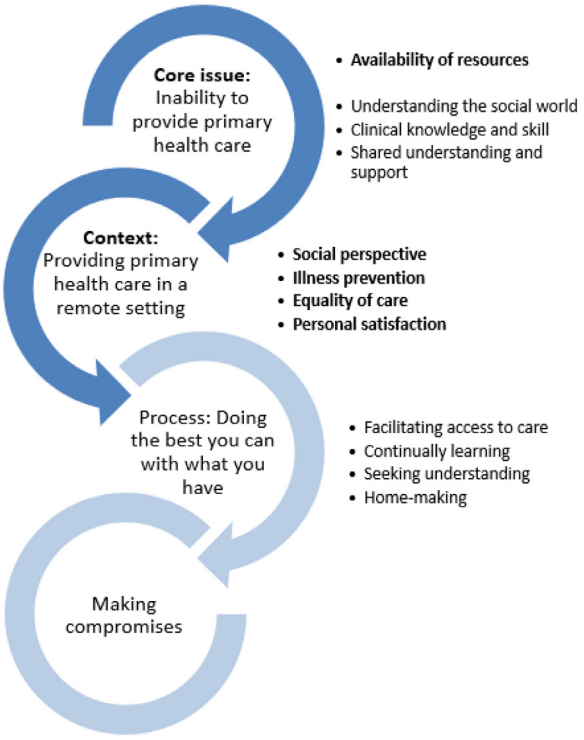

Fig. 1. Overview of the theory "making compromises to provide primary health care" adapted from McCullough et.al. (2020).

tween 45 minutes to 2 hours duration using an interview schedule which evolved in line with the emerging concepts and theory. An expert reference group was convened mid-way through data collection to help focus the interview questions and discuss the emerging theory. Interviews were transcribed verbatim and deidentified by the first author. The emerging theory was presented at an industry conference in 2017 and feedback in the form of field notes recorded from the remote area nurses' input at this event. This opportunity enhanced the methodological rigour of this study (Charmaz, 2014)

4. Findings

This paper reports on two important elements of McCullough et al.'s (2020) theory; the context of providing primary health care in a remote setting and the condition of availability of resources (or lack thereof) that impacts on the nurses ability to provide primary health care. Figure one Figure 1 positions these elements within the complete theory with the darker text and image indicating the focus of this paper.

Participants in this study were asked to describe what primary health care meant to them and how they applied their understanding of this philosophy of care into their nursing practice. Interview questions were very broad and included: "What does primary health care mean to you?" and "How do you contribute to the health of people living in remote areas?" Four themes emerged: a social perspective on health, an emphasis on illness prevention, providing equality of care, and feelings of personal satisfaction that came from the opportunity to "make a difference."

4.1. A social perspective on health

Nurses referred to providing care from a social perspective as 'holistic care' (NP3) 'complete care' (NP3) and looking at 'the whole picture' (NP1). NP3 explained, "**...** we're looking at the psychosocial needs of the patient, [as well as] the physical needs of the patient." For NP2, nursing care included:

> ... saying: "What about their social stuff?" People didn't automatically think of that. Have they got money? Have they got transport? Where are they living?... have they got someone to live with? Is their Centrelink [welfare payments] sorted out?

Primary health care also included understanding the person within their family and community:

> You won't get to treat somebody unless you engage with them in the context of their family. You have to find out who's responsible for them [where], they sit with a family; so, the family as a whole has to have trust in the medicine you are giving (NP4).

Furthermore, encouraging community participation in health services was considered part of the nurses' role, and participation was considered to be an indicator of credibility: "... we want to involve the patients in their care and offer a service to them so that ... it is an authentic and credible service" (NP3). Nurses described this service thus:

> This is my community of people, ... and this is me providing whatever support it is that that community needs. So I might use different things in a toolkit which might be clinical focus, or it might be relationship or it might be my brain or it might be my knowledge of systems or relationships with other people in the system to help this community to get to whatever their needs may be (RG4).

4.2. Illness prevention

Providing primary health care was also described as having a focus on wellness rather than illness with an emphasis on the prevention of ill health, often in terms of managing chronic disease and health promotion: "[primary health care is] ... providing care prior to somebody being sick. It's about opportunistic healthcare and screening and to educate ... before the problem turns into a chronic problem" (NP1). This perspective was considered different to other acute care nursing roles: "... changing your focus of health care instead of just looking at the acute presentation and putting the band-aid on to fix that and it's about taking a step back and trying to prevent stuff from happening" (NP1). The use of the term 'band-aid' was a colloquialism that indicated a temporary or basic solution to a more complex problem.

Health promotion and management of chronic disease were considered a core element of quality primary health care: "... when a clinic is run right, the majority of our work is chronic disease related ... out in Aboriginal communities "(RAN2). NP9 agreed "it was probably 80% chronic disease management and 20% acute" (NP9).

These opportunities to work with people to prevent illness were considered satisfying and worthwhile:

> I'd rather sit down with a diabetic patient and really sit there and talk and set some plans and help people work through those challenges of a diagnosis like diabetes or heart disease ... It's that sort of helping people through ... the emotional side of it as well, you know dealing with a diagnosis and then the second plan is to improve health (RAN6).

4.3. Equality of care

A social justice perspective was evident when nurses talked about why they chose to work in primary health care within the remote setting:

> ... I'm not a smarmy do-goodery type person ... but I like that ... as an organisation we have a social conscience and we are

doing something to help marginalised people ... I come from a very disadvantaged family and ... I feel lucky that it's something that I can do that's a little bit benevolent ... I'm doing a good job and I'm helping people (NP3).

Furthermore, nurses described wanting to provide quality care as benchmarked against the care provided in metropolitan areas: "... these people deserve just a good quality care as the person presenting in a big city like Melbourne" (NP1). Quality care was also described as relating to nurses' skill and knowledge: "... I think that [physical and cultural safety] is the beginning and then from there they [nurses] need to have the skill and the knowledge to provide safe and quality care" (NP1). Quality care was also assessed in terms of avoidance of hospitalisation and medical evacuations:

But as I got control of the chronic disease patterns and the more I knew about community and the more we worked together to actually get the right medication to the right patient, and they were actually doing what they could for their health there was less and less of that transfer stuff (NP8).

In this study, quality care was described as equality in access and standards of care as compared to that provided to Australians in larger centres.

4.4. Job satisfaction

When nurses described providing primary health care, they described wanting to make a difference in the lives of people in their community: " I think it's just those connections with people ... you see what happens in the long journey that they are experiencing. Hopefully you can be part of some positive effects that come out of it" (RAN6).

5. Inadequate resources to provide primary health care

It was apparent that in the remote nursing setting, the level of resources available was not comparable to urban areas. A lack of resources included the availability of physical resources and nursing staff, as well as the nurses' access to specialist practitioners. Nurses described experiencing distress and fatigue in situations where they did not have the time or resources to provide primary health care. Nurses in this study described being unable to provide primary health care in line with their definitions due to inadequate resources. One nurse stated: "we say we are doing primary health care but we're not" (RAN4) and this led to feelings of frustration and dissatisfaction and a focus on the provision of acute care: "... once primary health stops happening you become an ambulance service" (RAN2).

5.1. Lack of physical resources

Some clinics appeared to only have access to basic equipment: "... what's available for you there on the ground? Even if you wanted to deliver the best possible care ... but you are in a situation where you don't have access to that sort of machinery [drugs or equipment] then you may feel that you can't give the best care" (NP14). Similarly, a lack of access to diagnostic resources impacted on patient care as nurses had limited information about their patient's condition: "... if they walked into ... Emergency Department [after an accident] we would put them through the [CT] scanner and then decide everything else. Well it doesn't quite happen like that down here. So that took a bit of adapting" (NP13).

Furthermore, lack of information technology infrastructure in some areas - such as electronic patient records - were thought to inhibit the provision of quality care: "... they didn't have a shared clinical ... record so ... it was so unsafe in terms of really looking after the patient well, because you never knew where bits and pieces of information about that patient might be" (NP8).

5.2. Limited availability of specialist health services

Distance from tertiary services also meant difficulty accessing specialist health services. Nurses identified that as individuals, they were not able to provide specialist care in addition to their generalist role: "I personally think it's unrealistic for nurses to be specialists in everything" (NP4). NP14 agreed, "Nobody can do everything". As nurses were the primary caregivers in remote health services, there was a need for specialist health services to supplement the nursing service. To improve the lack of resident health resources, many specialist services visited communities on a periodic basis. Larger communities also employed nurses in specialist roles for example as child and maternal health or chronic disease management specialists.

However, sometimes certain specialist services simply were not available. For example, "... there's no permanent mental health worker aside from the Aboriginal Health Worker so the services are less than the need is" (NP4). In many Indigenous communities, there was perceived to be a gap in culturally appropriate services, usually provided by Aboriginal Health Workers. A recent title change from Aboriginal Health Worker to Aboriginal Health Practitioner recognises a specific, regulated professional role in Australia for Aboriginal and Torres Strait Islander people. However, nurses also worked with other types of indigenous health and community workers as well. In the case of the Cocos-Keeling Islands, the health workers were not registered Aboriginal Health Workers as they are not considered as Aboriginal Australians. This created a unique situation where they did not have access to the same education and support as Aboriginal Health Workers and yet some of the health workers have spent more than 40 years providing care on the islands. NP1 stated: "... Yeah, unfortunately they [Aboriginal Health Workers] are rare and we could definitely do with an Aboriginal Health Worker here. Especially a female Aboriginal Health Worker" (NP1). The lack of Aboriginal Health Workers was considered to impact on the quality of care because of their role in communication and cultural understanding: "Indigenous counsellors or health workers are usually better skilled at providing counselling ... within culture. That's my observation" (NP4).

Access to specialist health services, such as general pharmacy services, also impacted on the quality of care provided in remote communities where residents were seen to 'miss out': "Why should our community miss out on access to pharmacy advice?" (NP5). However, even when specialists were available, it was apparent that providing primary health care was sometimes impeded by a lack of knowledge and skill: "... that was luck of the draw as to who was in those teams." (NP8), and the narrow perspective of specialist practitioners:

... a lot of patients have complex health needs ... so they may come in with one problem but they've got a lot of comorbidities so I find that even your specialists can be very isolating in what they look at and no one's really looking at the whole person (NP9).

Similarly, poor communication and lack of continuity that impacted on patient care because the nurse was not able to incorporate the specialist's assessment or treatment into the patient's care:

... you have a parade of doctors of all different sorts and doctors basically run their clinics without any input from the nurses ... nobody has looked up the history to see why do they want to

see the doctor? Do they need to? Is there something that needs to be followed up? (NP14).

Patient care was also impacted by the availability of retrieval services, meaning that nurses had to monitor and provide care for extended periods (sometimes overnight), and rely on untrained volunteers for ambulance transfer: "At night there's only one aeroplane so there isn't a lot of resources to get people out" (NP14).

5.3. Lack of time

Nurses frequently described not having enough time to give adequate primary health care. The lack of time related to the busyness of the clinic and simply not having enough staff to complete the work: "I think we are demanding more and more from clinic staff ... they struggle to keep on top of what's already on there … a lot of things aren't done" (RAN4). When staffing resources were needed for urgent care, formal health promotion activities such as 'chronic disease care plans' or screening programs were deprioritised and at times were not done. In addition, the following participant was concerned about the lack of knowledge around how to use health promotion tools properly, and the lack of time needed to perform health promotion activities: "... managers need to allow staff the time to sit with somebody like me to get the education around it and there is a lot of staff resistance because all they see is more work for them" (RAN4). Similarly, providing care in the patient's home or outside of the clinic environment was seen to be desirable but unachievable because of time constraints: "... we don't have the capacity to really do home visits" (NP5).

When nurses described not having enough time, this was interpreted as a result of not having enough staffing resources to provide the care needed. The lack of time meant that nurses prioritised their care activities and attended to presenting complaints rather than health promotion or education activities. The time demands on nurses were not just for clinical reasons, but also contained an element of non-clinical tasks.

5.3.1. Nonclinical workload

Nurses described clinical care as the most important aspect of their work in providing primary health care. In contrast nonclinical tasks such as paperwork, ordering, administration and clerical tasks as well as vehicle and equipment maintenance, were unsatisfying and time-consuming. The following participant described a range of nonclinical activities including management of property, data systems, documentation and education, which they saw as barriers to providing primary health care:

> ... you can't provide the care you want because of the care the system needs ... the basic logistical stuff like you order your stores and your vehicles are operating and that sort of stuff and you've got to do that as well as filling out things for Key Performance Indicator's and quality improvement checks (NP14)

However, completing administration and other non-clinical tasks was also part of providing quality care: "... you could 'not care' but you try to maintain a standard" (NP5). However, the burden of non-clinical work was considered to contribute to burnout: "... I can see why people would burn out and why they wouldn't want to come back" (NP14).

Nurses were unable to provide primary health care in the way they aspired to because the resources (both physical and human) were insufficient and this disparity lead to feelings of frustration and distress. The properties of this condition include physical resources such as medications and equipment, diagnostic resources such as radiology scans, as well as a lack of human resources in terms of specialist staff, Aboriginal and Torres Strait Islander and other indigenous health workers and nurses. The availability of resources was found to vary, in that some nurses had access to more resources than others, and this was interpreted as influencing the ability for nurses to provide primary health care.

6. Discussion

In this study, nurses described primary health care as providing holistic care that addressed the physical, social, psychological and emotional needs of the individual and the community. The participants used words such as 'comprehensive', 'holistic', 'complete' and 'whole' to describe quality care within the primary health care context. They also described providing quality care as requiring extensive knowledge of the social world, wide-ranging clinical and health system knowledge and the resources to provide primary health care (McCullough et al., 2020). They measured success in reaching their goal of providing primary health care by feelings of satisfaction that they were making a difference to the health of individuals and the community. This view is consistent with other descriptions of providing primary health care as a strategy to reduce health and social inequalities (Smith, 2016; Talbot & Verrinder, 2018). Furthermore, the emphasis on the health needs of the community rather than just the individual is in line with the principles of community nursing from a primary health care framework (Guzys, Brown, Halcomb, & Whitehead, 2021).

Whilst nurses in this study described a core problem as the inability to provide primary health care, they were still able to provide some care, even if it did not meet their overall expectations. This finding implies that there may be degrees of care perhaps ranging from an acute response to a presenting problem to a full comprehensive service. Nurses stated that at times they provided 'selective primary health care', 'acute care', 'some care' or even 'band-aid' care as opposed to comprehensive primary health care. It may be that some services or clinical situations are managed in line with expectations of primary care (usually General Practice) as "the first point of contact an individual has with the health system" (Guzys et al., 2021 p.275) rather than a service driven by primary health care objectives. If this is indeed the case, then the "Doctor substitute" role (Muirhead & Birks, 2020) of registered nurses in remote areas warrants further attention.

However, this variation in level of care provided also suggests that comprehensive primary health care may be an unrealistic or even undesirable objective in some communities. This notion was suggested by participants when they described differing expectations of health service delivery in some communities where managers expected a focus on acute care. It is not known how the provision of services is determined, although some research has attempted to describe what health services should be available in remote primary health care facilities (Hussain, Robinson, Stebbing, & McGrail, 2014; Thomas, Wakerman, & Humphreys, 2015; Wakerman & Humphreys, 2011).

The term 'comprehensive primary health care' has been used by others (Lawless, Freeman, Bentley, Baum, & Jolley, 2014) which also suggests variation in the definition or understanding of primary health care. Labonté et al. (2008) define comprehensive primary health care as an "... approach aimed at reducing health inequities that is based on meaningful community participation, multidisciplinary teams and action across sectors" (p.58). These authors contrast this with examples of selective primary health care such as "... low cost interventions, mostly directed to child survival" (p.58). Similarly, Talbot and Verrinder (2018) state that primary health care, primary care and comprehensive primary health care are often used interchangeably. They explain that primary care describes a level of care which is often the first point of contact with the health system, usually through contact with GPs, whereas primary health care (or comprehensive primary health care) services are "... guided by the principles of equity, social justice and empowerment" (p.25).

A lack of resources was a common explanation for the inability to provide primary health care. The finding that practical constraints exist on service delivery in remote areas as a result of reduced economy of scale, is consistent with earlier work in the field (Humphreys et al., 2008; Paliadelis, Parmenter, Parker, Giles, & Higgins, 2012). Data regarding a lack of physical resources in this study was only provided by three participants and the reasons behind the lack of resources such as a small population or organisational constraints on purchases were not specifically explored in this study. However, resources such as medical imaging machines and electronic patient information systems are likely to be related to the size of communities or broader organisational resources. This aspect would benefit from further investigation.

Indeed, variation in the ability to provide primary health care services has been described as commensurate with the proportion of staff to population or health need. For example, populations over 100 residents should have access to resident health workers who can provide acute care and mental health, sexual health, child and maternal health and public health/illness prevention services (Thomas et al., 2015). Where it is not possible to provide specialist health services by resident health workers, then remote area nurses must fill those gaps with their generalist scope of practice.

Furthermore, a chronic lack of availability of other nurses, meant that those present were required to do more on-call than they would like and were often not able to take leave when required. The resultant stress and fatigue reduced their personal resources and impacted on their ability to provide primary health care. Occupational stress in remote area nurses has been well described as due to a lack of emotional support, high levels of responsibility, high workload, social issues and unrealistic expectations from employers and communities as the major job demands that contributed to stress and high staff turnover (Lenthall et al., 2009; Lenthall et al., 2011; Opie et al., 2010). The nurses in the current study emphasised that it was not just a lack of nursing staff but rather a lack of nurses with the necessary skills and knowledge. The expectation of a generalist scope of practice that met all of the needs of the community has been reported as unrealistic without education and support (Lenthall et al., 2018 p.186).

High staff turnover and difficulty in recruiting staff to remote areas has been well documented (Garnett et al., 2008; Lenthall et al., 2011) and suggested to be the main outcome of stress in various nursing contexts (Baernholdt & Mark, 2009; Delobelle et al., 2011; Hayes et al., 2006). The turnover rate for nurses working in remote clinics in the NT is estimated at 150%, this is in stark contrast to other nursing non-remote contexts where a turnover rate of 40% is considered high (Zhao et al., 2018). Reducing staff turnover by providing additional personal and professional support is proposed as the answer to improving quality of patient care and reducing costs (Zhao et al., 2018). Providing this support would require additional resources but these costs are likely to be offset by savings made from lower staff turnover (Zhao et al., 2018). Lack of time has also been identified as a significant factor leading to feelings of dissatisfaction when providing primary health care by general practice nurses (Halcomb & Ashley, 2016). The impact of frequent staff turnover was described as creating a workforce that often lacked the necessary clinical and community knowledge to provide this care. Difficulty in recruiting and retaining health staff in remote areas is a global phenomenon (MacLeod et al., 2017; Mbemba, Gagnon, & Hamelin-Brabant, 2016).

Findings in the current study suggest that stress and dissatisfaction would be reduced if more nurse staffing resources and education were available, as they would facilitate nurses to be able to better provide primary health care. The 'Back from the Edge' team described interventions aimed at reducing occupational stress in remote area nurses and whilst some of their earlier recommendations had been implemented, many had not. This was due to a lack of financial resources and infrastructure, continued high staff turnover and insurmountable contextual issues (Lenthall et al., 2018). This is certainly borne out by the experience of the participants in the current study.

The lack of nurses with an appropriate generalist scope of practice which is aligned with the community health needs and context, underpins the nurses' aims of equality in the provision of primary health services. They seemed to align their perspective of quality care with the care that would be provided in a metropolitan setting. Buckley (2015) also found that nurses in rural settings also lacked the resources, both physical and human, to implement the expectation of urban-based policy makers. Buckley (2015) recommended encouraging practitioner involvement in policy making, furthering educational opportunities and increasing the scope of nursing practice to meet the community need. Whilst 'rural' and 'remote' have different formal definitions and contexts of practice (Muirhead & Birks, 2020), there is overlap in the scope of practice of rural and remote nurses. Therefore, the results of this study may resonate with nurses in rural settings.

7. Conclusion

This study questions the appropriateness of the expectation that remote area nurses are able to provide comprehensive health services with the current level of resourcing. Participants described wanting to provide comprehensive services that attend to the individual and community's bio-psycho-social-cultural-spiritual needs but were unable to provide that care to their satisfaction due to a lack of staffing and physical resources. The tension between what they want to do and what they are able to do is suggested to be a source of feelings of stress and dissatisfaction. This paper suggests that this tension may be a contributing factor in the challenges associated with recruitment and retention of remote area nurses.

The current study, with its focus on the perspective of nurses, informs the expectation of the crucial role of nurses as providers of primary health care by calling for more nurses and greater education, support and recognition for nurses as a significant community health resource.

Author contributions

Kylie McCullough: Conceptualisation, Data curation and analysis, writing. Sara Bayes: conceptualisation; writing: review and editing. Lisa Whitehead: Conceptualisation, analysis, review and editing. Anne Williams: Conceptualisation, formal analysis, review and editing. Vicki Cope: Conceptualisation, formal analysis, review and editing.

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Ethical statement

Permission to conduct the study was granted by the Edith Cowan University Human Research Ethics committee (Approval Number 10810).

Conflict of interest

None.

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