

ORIGINAL RESEARCH

The role of the public health nurse in a changing society

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Abstract

Title. The role of the public health nurse in a changing society.

Aim. This study is a report of a study to clarify the role of the public health nurse in one Irish community care area in the light of acknowledged problems in defining boundaries of the role.

Background. Demographic developments and planned reorientation towards primary care of the health service in Ireland have changed the workload of public health nurses, which is unique compared with other countries. However, there is a lack of clarity and consequent problems in defining the role of the Irish public health nurse.

Method. A descriptive qualitative study was conducted with 25 representatives of community nursing from one county in Ireland with a population of 209,077 and a complement of 65 full-time equivalent public health nurses. Purposive sampling was used and 21 public health nurses, two registered general nurses, one assistant director and one school nurse participated. Tape-recorded, individual semi-structured interviews were conducted over a 15-month period from 2002 to 2004. The constant comparative method was used for analysis.

Findings. Four themes emerged: 'Jack of all trades: the role of the public health nurse defined and described', 'the essence of the role', 'challenges to the role of the public health nurse' and 'communication'. The first theme is discussed in this paper.

Conclusion. Public health nurses need to define and redesign their role so that they no longer think that they are the catch-all service in the community. This will enable them to deal with the rapid demographic, sociological and cultural changes in the population, a change that has international resonance.

Keywords: community nursing, generalist nurse, public health nursing, qualitative research

Background

The public health nurse (PHN) was first included by An Bord Altranais (the Irish Nursing Board) on the register of Irish nurses in 1960 (Commission on Nursing, 1998). This resulted

from the merger of midwifery services, voluntary district nursing services and nurses employed by local authorities (Leahy-Warren 1998). There were 2291 active PHN on the live register in Ireland in 2007 (An Bord Altranais, 2008), the most recent year for which statistics are available. The

current public health nursing service is based on population size, where ideally 2500 people are served by one PHN.

In common with PHNs in many other countries (Clancy 2007, Hansen *et al.* 2007), the workload of nurses working in the community in Ireland has changed over the past decade (Northern Area Health Board, 2002) in two main ways. First, the socio-demographical profile of the Irish population is changing, manifested mostly in an unprecedented increase in asylum seekers coming to Ireland. This number has increased from 39 in 1992 to 4766 in 2004 (Migration Policy Institute 2009). There has also been an increase in the age profile of the population, those over 45 having increased by 30% between 1986 and the latest census in 2006 (Government of Ireland 2007). The increase in immigrants, the majority of whom are of childbearing age, has had an effect on the number of births in Ireland, which increased from 48,255 in 1994 to 70,620 in 2007 [Central Statistics Office (CSO) 2009], an increase that is forecast to continue. Second, shorter hospital stays and earlier discharge from hospitals have resulted in increasingly dependent clients being discharged to the community. This overall increase in caseloads, together with the increased complexity of care for some and the greater communication difficulties experienced when caring for recently arrived people from different cultures (Romeo 2007), has resulted in an increase in workload for PHN.

As a result of difficulty in evaluating the role and work of Irish PHN compared with community nurses with similar roles internationally, there are few comparable studies available. In the international setting, there is a variety of community nursing models from acute to primary clinical care. The World Health Organization commissioned a review of the literature on community nursing (Edgecombe 2001), which showed that internationally there is no shared terminology to identify the role; titles vary from PHN to Community Health Nurse, Health Visitor and Community Nurse, which has led to role confusion. A previous postal survey, with responses from 31 countries, also identified two main models of community nursing practice – a generalist model and a specialist community model, which was described by no < 23 different titles (Whyte 2000).

The research that has been carried out (which is now quite outdated) suggests that Irish PHN are 'generic' (Denyer *et al.* 1999, p. 21) or 'all-purpose' nurses caring for people of all ages 'from (the) cradle to the grave' (O'Sullivan 1995, p. 18). This situation is quite different from that in the United Kingdom (UK), where three groups (district nurses, health visitors and midwives) are acknowledged as playing a main role in achieving the primary care public health agenda (Murray & Cheater 2004). Public health nursing in the United States of America (USA) struggles to maintain a public

health focus, with PHNs filling gaps by taking on a hands-on clinical role to the detriment of their public health role (Grumbach *et al.* 2004). The Canadian Nurses Association designated community health nursing as a specialty practice in 2004 (Community Health Nurses Association of Canada 2009).

In the Australian context, there is no specialist nursing qualification for public health community nurses, and community nursing includes primary health care and community-based clinical care. Primary care includes health promotion, health education, community development and disease prevention with a framework that encompasses economic, environmental and social determinants of health. Kemp *et al.* (2005) suggest that community nursing in Australia continues to fill the gap by being reactive to the needs of the community and to be a 'catch all' service because of the lack of leadership and strategic planning of the service.

A recent review of community nursing in Scotland (Scottish Executive 2006) showed that, in common with international trends, there were too many titles and the roles overlapped, leading to confusion; there was a need for healthcare professionals, carers and individuals to have a single point of access to the nursing service. The review identified positive aspects in community nursing, with nurses seen as being accessible; families valued relationships with identified nurses that were based on mutual respect, trust and rapport (Scottish Executive 2006). This type of individually focused care approach promotes a holistic assessment that encourages self-care and assists people to reach their maximum levels of health and well-being, in contrast to the community-focused model of care based on population-centred objectives and focused on disease prevention and health promotion (Edgecombe 2005). The two models are used simultaneously across Europe (Edgecombe 2001), with governments generally supporting the population-centred model and expecting PHNs to manage the resulting conflict (Edgecombe 2005).

Public health nurses in Ireland interface with a multitude of client groups in the community and their range of activities and responsibilities is extensive, leading to lack of clarity and problems in articulating the boundaries of the PHN role (Chavasse 1995, Hanafin 1997). A qualitative study of Irish public health nursing showed that PHNs have a dual role, which is both preventive and therapeutic (O'Sullivan 1995); however, questions remained as to whether or not such a comprehensive role is feasible in the future. The key theme to emerge from the literature is the capacity of the PHN to see the 'big picture' regarding the needs of clients in the community (Reutter & Ford 1996). In Ireland, 44% of people over 65 years of age live in rural areas (Government of Ireland 2007). These older clients are supported primarily by

PHNs, who are consequently the main providers of care in the community, according to O'Neill and O'Keefe (2003). These authors also identify that community occupational therapists and physiotherapists have long waiting lists and are few in number. The result is that PHNs are left to fill the gap when adequate provision of facilities and services are lacking. Finally, the Republic of Ireland continues to under-fund the healthcare system compared with other countries, the latest figures for 2005 suggesting that only 8.2% of gross national product (GNP) is spent on health compared with 10.7% in Germany and 11.4% in Switzerland (World Health Organisation 2009).

The origin of the research reported in this study was that a group of PHN from a county in Ireland wished to define and describe the role to plan for the future in which the Irish Primary Care Strategy (Department of Health and Children 2001b) is driving change. A project steering group was set up, consisting of PHNs, a PHN Director and representatives from the Nursing and Midwifery Planning and Development Unit from the local Health Service Executive. This group worked in partnership with the research team throughout the project.

The study

Aim

The aim of the study was to clarify the role of the PHN in one Irish community care area in the light of acknowledged problems in defining boundaries of the role.

Methods

A descriptive, qualitative design was employed, using semi-structured interviews with 25 community nurses to gather data.

Setting

The study was carried out in one county of Ireland with a population of 209,077 (Government of Ireland 2007). There were 65 full-time equivalent PHN positions in the county, a small and fluctuating number of registered general nurses (RGN) providing nursing care in the community, and a number of directors and assistant directors of public health nursing.

Participants

Community nurses with an expert knowledge of the topic were selected for the interviews. Purposive sampling was used

to identify 25 volunteers from urban, rural and island areas in one county. The sample consisted of 21 PHN, two RGN, one assistant director and one school nurse. These were deemed by the steering group to be representative of the differing roles of community nurses across the various geographical areas of the county. All those who were contacted agreed to participate.

Design of interview guideline

A consultative meeting with the steering group of PHN took place in October 2002. Views obtained at the meeting were combined with a synthesis of topics from the literature reviewed, and a semi-structured interview guide was constructed. Twelve questions were included in the semi-structured interview schedule, they were designed to explore different aspects of the role of the PHN, the configuration of community nursing services, team working and communication issues as well as the views of nurses on the future of services and how they should develop see Table 1.

Data collection

Tape-recorded, individual semi-structured interviews took place in the clinics in which the nurses were based between December 2002 and February 2004. Participants were asked to complete a demographical data collection form, giving their qualifications, age, length of experience as a PHN and place of work.

Table 1 Semi-structured interview guide

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1. Could you tell me about what the role of the PHN involves?
 2. Can you identify what aspects of community care do not constitute your role?
 3. Can you tell me about the ideal configuration of the community nursing service?
 4. What would facilitate your role?
 5. Can you tell me about how you manage your caseload of clients/patients?
 6. What are the problems you experience in your job as a PHN?
 7. Can you tell me about your role in health promotion?
 8. What does team working involve for you?
 9. What helps communication within the team?
 10. What hinders communication within the team?
 11. What developments do you foresee in the future regarding the role of the PHN?
 12. Do you have any other points that you would like to make?
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PHN, public health nurse.

Ethical considerations

The appropriate ethics committee granted approval for the study.

Data analysis

All data were transcribed and loaded into NUDIST version 6 (QSR International, Southport, UK). Data analysis was carried out using the constant comparative method (Strauss & Corbin 1998) and was concurrent with data collection. This method is integral to and derived from the grounded theory methodology which was the framework for the data analysis. The initial step involved examining the data line by line and identifying segments that were then given labels in the process termed ‘open coding’ (Strauss & Corbin 1998). These codes were reviewed and renamed in an ongoing, fluid manner by constantly comparing newly generated labels with previous data. Lines with similar labels were then grouped under higher-order headings known as concepts (Strauss & Corbin 1998), and concepts were grouped into categories from which four broad themes emerged: ‘Jack of all trades: the role of the PHN defined and described’, ‘the essence of the role’, ‘challenges to the role of the PHN’ and ‘communication’. Data saturation (Streubert Speziale and Carpenter (2007) was achieved as no new codes emerged during the latter phase of the analysis. The first category, relating to the clinical and practical aspects of the PHN’s role is presented here (see Table 2).

Rigour

Three approaches were used to ensure credibility and robustness of the analysis. First, two researchers coded the transcripts independently and then discussed the resulting analysis to increase dependability or consistency (Appleton 1995). A third researcher acted as an auditor before the final results were written up. An audit trail was maintained (Koch 1994) and peer debriefing carried out (Mariano 1995), where the two researchers conducting the analysis

Table 2 Theme 1. Jack of all trades: the role of the public health nurse defined and described – categories

Clinical care
Hidden role
Public health nurse as ‘Jack of all trades’
Work overload
Care priorities
Scope of practice
Job satisfaction

were questioned by other members of the research team to explore for potential bias and to check their interpretations of the data. This process resulted in minor changes that were incorporated into the findings.

Findings

Demographics

Twenty-two of the 25 participants (88%), all women, completed the demographical form and three (12%) did not. The minimum age groups was 25–30 years ($n = 8$) and the largest group of participants ($n = 14$, 48%) was aged between 46 and 55 years; there was a mean experience level as a PHN of 15 years, reflecting national statistics on the age profile of PHNs (Department of Health and Children Nursing Policy Division 2002). Over half of the interviewees ($n = 13$, 52%) came from rural areas, eight (32%) from urban areas and one (4%) from an offshore island. Nineteen (76%) held a nursing diploma, two (8%) a first degree and one (4%) a certificate.

Jack of all trades: the role of the public health nurse defined and described

The theme ‘Jack of all trades: the role of the PHN defined and described’ encompasses the holistic clinical care given by PHNs; their scope of practice is varied, and that of the island PHN is particularly vast. These diverse responsibilities often lead to work overload and, despite prioritizing care, preventing PHNs from carrying out their health promotion function.

Clinical care

The clinical role of the PHN involves the provision of direct care to diverse service users:

The PHN is a very general family nurse, as it were, covering...the frail to the baby.

My main job is the nursing care of everyone in the area.

Care was seen as curative and restorative and crossed the social divide. One nurse described aspects of total care:

In relation to clients, we see all categories. Nobody is refused a service, so in relation to the clients it’s difficult -, there is nobody we don’t see...(sigh) and we do provide a service, we do and try (to) facilitate clients. I find it difficult to see what we don’t do.

The role includes many practical tasks such as ‘dressing bedsores (sic), giving injections, monitoring blood pressures’. Monitoring those at risk, such as older or isolated individuals,

was also an essential component to keeping people in the community rather than them going into residential care:

It could be something as simple as somebody who lives on their own, (a) home help might make the difference of keeping them at home rather than needing residential care.

(Regarding the) elderly at risk...particularly (in) bad weather, you know (there is) a lot of flooding so they'd actually be cut off from maybe other households and I would go visit them on a regular basis to make sure they are OK.

Public health nurse's role in home screening of babies was noted to have increased because of the early discharge from hospital of mothers and infants and the increased number of births in the catchment areas. Such visits were time-consuming:

(We) have to visit the babies five days post-delivery, so that includes examining the mums and the babies and giving health promotion education and talking them through any problems (such as) feeding.

Public health nurses believed that they provided holistic care to everyone, where clients were placed at the centre of care, and were respected:

I do think public health nurses are very client-focused.

You are a guest when you visit the home, and one has to be accepted first...It's a process of arriving and being received and finding our way through to the family.

The advantage of the current PHN role, based in one area for a prolonged period of time, was that they knew the families well:

So you have the one person going in...for 20–30 years, so they are seeing generation after generation, and they have the history of that and that is unique...So they almost become like a mother to the family...a surrogate.

Because of this, PHNs were able to develop a relationship of trust with their clients/patients, a fundamental element of all nursing processes.

Hidden role

In addition to the more obvious clinical care, PHNs also reported a hidden role, one stating 'I spend an awful lot of time doing invisible nursing', by which she meant counselling and spending time with people. Time was also spent on supporting care with phone calls and clerical work and other processes such as decision-making and accountability:

If you had a problem family there would be a lot (of) ringing, a lot of phone calls and that would be just one case.

Public health nurse as 'Jack of all trades'

Participants described how they 'filled the gaps' in the community when other professionals were either not involved or were not in post:

An awful lot of nurses allow themselves to be the pick-up person.

The occupational therapist has such a long waiting list at the moment, that we end up ordering equipment so we can say at least that our client has got their bed or whatever, and wait for the OT to see them at a later stage.

In addition to providing some occupational or physiotherapy services, PHNs were often involved in advocating for clients with social problems, which was fraught with difficulties and very time-consuming:

Report writing on social issues, as in housing issues, as in over crowding, as in poor housing, doing battle with environmental health officers, doing battle with the housing section, trying to get extensions for disabled people.

Travellers have specific needs...you are advising them where to get extra services, writing to the urban council to get them housing, to get them housed.

Work overload

Perhaps because of acting as 'Jack of all trades', PHNs were seen by many service users as providing services at any time and any place, which put an extra burden on PHNs:

People might stop you in the street (to consult you).

PHNs bring home their records and do all their paperwork in the evening.

In addition to their clinical care, they had responsibilities for educating PHN students, nursing students, and sometimes medical students, and this took up time.

The need for clerical support and information technology to assist with workload was noted. Another solution to the increased workload was suggested by one participant:

I think it is incredibly simple, I think we just need more PHNs.

Care priorities

As a result of the heavy demand placed on the service, PHNs had to prioritize their workload:

I would prioritise by our daily diary...there are certain calls that could be maybe withheld for a day if the next day was going to be very busy.

The acuity of need determined client priority. Older people at risk, people discharged from hospital needing dressings,

terminally ill people and bed-bound patients received priority attention, along with neonates and their mothers:

The ideal is health promotion and health education and it's done in a very ad hoc way, but...it's of secondary importance, primary importance is home nursing, terminally ill patients, bed bound patients, Alzheimer's and the numerous leg ulcers.

As a result of work overload, PHNs thought that their role in health promotion was reduced, and this led to opportunistic health promotion rather than planned formal activities, despite their wishes:

You could say that every single day that every house you go into you're promoting health.

Stop smoking and healthy eating, and positive parenting have long term implications but...the facilities aren't there to deliver them.

Scope of practice

The category 'scope of practice' only concerned PHNs working on the islands, because of the fact that they are the only healthcare professional living and working there. This participant's words demonstrate the scope of her role:

I'm at the coalface for every single problem that comes, be it a social problem, be it a medical problem, be it a nursing problem, either curative or prevention, be it physiotherapy, speech therapy, dental referrals, people coming looking for suturing, people having accidents, people having drowning incidents, people looking for transport to get onto the helicopter after they've had an accident, calling the lifeboat, escorting people to the mainland that are too sick to go on their own or go with a carer.

Job satisfaction

Despite all the work pressures and frustrations, PHN participants were mostly positive about their engagement with their clients/patients and felt that working in this role brought fulfilment both personally and professionally:

I love my job and I love the idea that people can see me as a resource.

It's a kind of very fulfilling kind of business, everything you do is of some help to somebody.

Discussion

Study limitations

The sample size in this study was limited and a larger number of respondents might have been preferable, although data saturation was achieved. The study was

limited to one county in Ireland, and a wider geographical spread might have elicited different results. Theory generation might have been attempted; however, it was not our intention to do this as the main aim of this qualitative research was to generate data for the development of an instrument for a subsequent quantitative study to measure the workload of the Irish Public Health Nursing Service (Byrne *et al.* 2006).

Defining the role of the public health nurse

There are difficulties in defining the role of the Irish PHN (Chavasse 1995, Reutter & Ford 1996), many of which arise because community care services in Ireland are changing. Irish PHN, in common with those in Slovenia, Finland, Iceland and Latvia (Scottish Executive 2006), are generalist nurses with responsibility for providing primary, secondary and tertiary care to a variety of groups (Hanafin *et al.* 2002); thus, they must develop a very wide range of skills, which makes it difficult for them to focus on specific areas. Increasing specialization across all disciplines in nursing worldwide, also, this makes it difficult for a generalist to provide care that equates to best practice in each discipline, with many governments moving to increase specialist nurse numbers amid professional and lay fears of resulting confusion (McKenna *et al.* 2003). The Australian government has addressed this issue by rationalizing practice strands into a new framework of nursing specialties, including community health (National Nursing & Nursing Education Taskforce 2006).

The PHN role is both curative and preventive, because of the nature of the work; however, for functional reasons it is the former that predominates in Ireland (O'Sullivan 1995, Western Health Board 2001) as in the UK (Stuart *et al.* 2008). Irish PHNs have a role within every facet of community health and it might be helpful if PHNs were to define and limit their role in this context. International trends are towards more population-focused objectives that concentrate on disease prevention and health promotion (Edgecombe 2005), which requires national funding.

The theme 'Jack of all trades' was a central one in this study and the term has been used previously by O'Sullivan (1995), who refers to the PHN as feeling like a 'Jack of all trades'. This phrase was also used by one respondent while exploring the category the 'generalist role' of the PHN which was seen as both strength and a weakness. Begley *et al.* (2004) build on this category and see the role of the PHN as a holistic one that caters for the community from the cradle to the grave. However, public health nursing ends up being a catch-all service in which PHNs receive little support from

other professional groups; as a result the boundaries of the role need clarifying.

A differing view of the role is that the inherent strength and uniqueness of the service is that PHNs have such diverse clinical skills, and that they can provide holistic care to very different care groups. The disadvantage is that all clients and patients use this service and PHNs tend to pick up the work of other healthcare professionals, with many participants reporting overwork, in common with community nurses in the UK (Rout 2000, Evans 2002, Stuart *et al.* 2008). The PHN role has remained largely unchanged in Ireland since 1966 (Hanafin 1997), which may be because high demand for the curative role of PHNs has impeded the profession from reflecting on what its core aim is and how it should change to meet the changing society in which it is located. In this study, health promotion at a 'micro' level was said to occur frequently, an opportunistic approach that does have a place; more formal health promotion initiatives are still required, as have been implemented in, for example, Australia (Edgecombe 2005). It is interesting that the Scottish Executive has published plans to introduce a new Community Health Nursing role that appears very similar to the overloaded role of the Irish PHN (Scottish Executive 2006).

Participants in our study reported a hidden role involving decision-making, accountability, judgment, assessment of need and counselling of clients. A study of 100 women attending 24 child health clinics in the UK examined the advisory role of the Health Visitor and found that mothers valued the advice received and initiated 59% of the interactions (Plews & Bryer 2002). The consequence of this valuable, but invisible, advisory and support role is that PHNs do not document or quantify it and it may be unaccounted for in workforce planning (Brady *et al.* 2007).

The PHNs in this study had long employment histories, and the maturity of this workforce has been highlighted (O'Sullivan 1995). PHNs display a loyalty and consistency that allows for the development of strong relationships and deep roots in the communities in which they are located. This suggests that nurses in the community do obtain job satisfaction, and that this is enhanced when the potential for professional development is offered (Jansen *et al.* 1996), which is a largely unrecognized strength of the public health nursing service in this area. Other countries such as Australia (van Loon & Kralik 2006) and Scotland (Scottish Executive 2006) have found similar dedication in their community nurses.

The PHN demographics also highlight the developing problem of an ageing workforce, because the largest cohort of participants was aged between 46 and 55 years.

National statistics on the age profile of nurses employed in the study area indicate that at least 63% of PHNs employed in the service are over 40 years old. The Nursing and Midwifery Resource Final Report (Department of Health and Children Nursing Policy Division 2002) caution that there is potential for shortages in the numbers of PHNs because of this, unless more nurses are recruited into the service. Similar ageing of community nurses is seen in the USA, Australia and Canada (Hatcher *et al.* 2006, Weymouth *et al.* 2007, Montour *et al.* 2009), and some agencies have highlighted the need to make strong efforts to retain community nurses in post (Armstrong-Stassen & Cameron 2005, Hegney *et al.* 2006).

A number of issues were raised during the study regarding the workload of PHNs and its influence on their role. Participants focused on responding to needs as they arose, and did not appear to be proactive regarding the primary aspects of the role. Some debate exists between those who think that Irish PHNs are overstretched and need to relinquish some of their roles (O'Sullivan 1995), and those who consider that the great strength of PHNs is the fact that the whole community is potentially their client (Department of Health 1997). However, there is always a requirement for more PHN time, particularly in care of older people (McKeown 2007), and a need to increase population-focused objectives that will have an impact on the future health of the community (Edgecombe 2005).

In 2001, the Irish government launched its second health strategy, with key goals aimed at ensuring that a better financed, more responsive healthcare system was established. One of the aims of the strategy was that 'primary care services will undergo major development to deliver an integrated community-based service accessible to all on a round the clock basis' (Department of Health and Children 2001a, p. 11). This report ensured that a context of change was established in the Irish healthcare system and it is in such a context that this consideration of core elements of the role of Irish PHNs needs to be framed. Clarke (2004) is concerned about the imposition of the Primary Care Strategy, where the role of the PHN may be diminished; however, the PHNs in our study realized that there was a need to relinquish part of their role in the restructuring process. Similar re-structuring has also been recommended, or is taking place, in other countries (McKenna *et al.* 2003, Edgecombe 2005, National Nursing & Nursing Education Taskforce 2006).

There is evidence that Irish PHNs feel under stress in a period of radical change from both external and internal sources as they, in common with PHNs and health visitors in other countries (Clancy 2007, Winters *et al.* 2007), are unsure how their role will change in the future; however, the

What is already known about this topic

- Demographical developments and planned reorientation towards primary care of the health service in Ireland have changed the workload of public health nurses.
- The role of the Irish public health nurse is unique compared with other countries.
- There is a lack of clarity and consequent problems in defining the role of the Irish public health nurse.

What this paper adds

- The Irish public health nurse is an all-purpose, generalist community nurse who provides holistic care to clients throughout the lifespan.
- Care is prioritized by public health nurses to those with the greatest need.
- Curative care takes priority over the public health nurse's health promotion role, because of work overload.

Implications for practice and/or policy

- Public health nurses should develop a case management system, which includes a referral system for effective and efficient workload and caseload management, and should then monitor admissions to and discharges from their caseloads.
- Exploration of possible career pathways that include clinical nurse specialist and advanced nurse practitioner roles in the community is recommended.
- The valuable essence of the public health nurse's role needs to be preserved and enhanced.

suggestion of PHNs that a redefinition of their role would enhance their effectiveness in the primary care team would seem to be opportune (O'Neill & Cowman 2008).

Conclusion

The development of a model of practice based on case management would serve to address many of the problems that PHN raised in this study. The goal of case management is to provide cost-effective, quality care to meet a continuum of patient needs. Other recommendations are that a re-definition of the role of the PHN in terms of its generalist vs. specialist role components is required and that there is recognition of the valuable role that PHNs play in the evolving community care service.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

CNP, CG, GB, PH, AB and CB were responsible for the study conception and design, and responsible for the drafting of the manuscript. CNP and CG performed the data collection and performed the data analysis. CNP, CG and CB made critical revisions to the study for important intellectual content.

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