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Are rural health professionals also social entrepreneurs?

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ABSTRACT

Social entrepreneurs formally or informally generate community associations and networking that produces social outcomes. Social entrepreneurship is a relatively new and poorly understood concept. Policy promotes generating community activity, particularly in rural areas, for health and social benefits and 'community resilience'. Rural health professionals might be well placed to generate community activity due to their status and networks. This exploratory study, conducted in rural Tasmania and the Highlands and Islands of Scotland considered whether rural health professionals act as social entrepreneurs. We investigated activities generated and processes of production. Thirty-eight interviews were conducted with general practitioners, community nurses, primary healthcare managers and allied health professionals living and working rurally. Interviewees were self-selecting responders to an invitation for rural health professionals who were 'formally or informally generating community associations or networking that produced social outcomes'. We found that rural health professionals initiated many community activities with social outcomes, most related to health. Their identification of opportunities related to knowledge of health needs and examples of initiatives seen elsewhere. Health professionals described ready access to useful people and financial resources. In building activities, health professionals could simultaneously utilise skills and knowledge from professional, community member and personal dimensions. Outcomes included social and health benefits, personal 'buzz' and community capacity. Health professionals' actions could be described as social entrepreneurship: identifying opportunities, utilising resources and making 'deals'. They also align with community development. Health professionals use contextual knowledge to envisage and grow activities, indicating that, as social entrepreneurs, they do not explicitly choose a social mission, rather they act within their known worldview. Policymakers could consider ways to engage rural health professionals as social entrepreneurs, in helping to produce resilient communities.

Introduction

Primary health care is the range of activities that keep people healthy, happy and maintained in their own communities (World Health Organization, 2008). This acknowledges evidence that health is a product of individual, community and contextual factors (Beard, Earnest, Morgan, & Tomaska, 2008). The New Public Health movement emphasises the role of communities in co-constructing health and the interplay between health, sustainability and the environment (Baum, 1998). Health policy suggests that individuals and communities have a responsibility for maintaining health by adopting healthy lifestyles and self-managing conditions (Department of Health & Human Services Tasmania, 2006; Scottish Government, 2007). Citizens are urged to participate in social actions, such as group activities or volunteering, in their communities (Scottish Executive, 2004), because this produces individual and community benefits (Borgonovi, 2008). These, in turn, contribute to social capital, or resources generated by people working together, that can be applied to community capacity generation (Bridger & Luloff, 2001; Kawachi & Berkman, 1998). A societal return to participation is urged, but is signalled as particularly pertinent to sustaining rural communities (Scottish Government, 2008). This is perhaps because of challenges faced by governments in providing rural services, because rural areas are traditionally richer in social capital or because threats to the viability of rural settlements make action imperative (OECD, 2008). Health and economic policy suggests the generation of social activities will contribute to community 'resilience', a concept that implies individual and community wellbeing (Scottish Executive, 2003; Scottish Government, 2008). A movement, linked to

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communities 'doing it for themselves' that has emerged in the UK is the development of social enterprise (Department of Trade & Industry UK Government, 2002; Scottish Executive, 2007). This encompasses a range of activity from voluntary organisations to not-for-profit business (Dees, 1998). Associated, is the concept of social entrepreneurship. A social entrepreneur is someone who formally or informally generates community associations and networking that produces social outcomes (Austin, Stevenson, & Wei-Skillern, 2006; Dees, 2001).

Evidence suggests that rural health professionals often have extended roles in their communities beyond solely the provision of health services (Iversen, Farmer, & Hannaford, 2002; West, Farmer, & Whyte, 2004). They may provide social care, be involved in or have leadership roles in community social activities (Johns, Kilpatrick, & Whelan, 2007; Kilpatrick, Cheers, Gillies, & Taylor, 2009). This may be linked to their status as one of the few professional roles left in rural communities or to their embedding at the nexus of networks. Building community resilience and developing social enterprise requires appropriate people resources. We sought to establish whether rural health professionals were acting like social entrepreneurs when they initiate or participate in social activities and, therefore, whether there is potential for policymakers to actively nurture rural health professionals in social entrepreneurial roles. This could engender community resilience, and potentially increase job satisfaction and retention of rural health professionals. To do this we explored the experiences of health professionals living and working in rural areas in Tasmania and Scotland in relation to building community social outcomes. We were interested in whether their behaviour could be described and analysed using the concept of social entrepreneurship. We compared the countries because of differences in the roles of community health care personnel. The study involved 38 exploratory qualitative interviews conducted between August 2007 and June 2008. This paper considers the extent to which health professionals and the systems they work within can produce social outcomes, whether this might be characterised as social entrepreneurship, what studying rural health professionals might tell us about social entrepreneurship and what policymakers should do about that.

Social entrepreneurship

Entrepreneurship is a term associated with business and often confused with the concept of starting a small business. The term first described entrepreneurs in the 1800s as those who 'shift resources out of an area of lower and into an area of higher productivity and greater yield' (Drucker, 1985: p. 30). With the Thatcherite era in the UK, terms associated with capitalism, like 'enterprise', have increasingly made their way into the tone of society (Williams, 2007). Indeed, Chell (2007) suggests there is almost an association now, in the UK, between being a good citizen and being enterprising. Roper and Cheney (2005) suggest this is not true of other cultures, such as Canada, where linking social and business spheres is less acceptable. Commonly, entrepreneurs are associated with risk-taking and innovation; inherent are ideas of excitement, energy and potential gain (Roper & Cheney, 2005). The concept of 'the opportunity' is contested, with debate as to whether entrepreneurs are those who cleverly 'spot' opportunity (Shane & Venkataraman, 2000) or whether they make opportunity where others do not see (Martin & Sugarman, 1996). Chell (2007) describes opportunities as mental constructs, with entrepreneurs envisioning what might happen and how to realise it. Drucker (1985) suggests there is no set of defining entrepreneurial traits; rather entrepreneurs are hard working, flexible and knowledgeable within their own field of work, but with the capacity to take an external perspective. They tune into contextual changes that represent opportunities: 'successful entrepreneurs do not wait until 'the Muse kisses them' and gives them a 'bright idea'; they go to work (p. 31)…[the] entrepreneur always searches for change, responds to it, and exploits it as an opportunity (p. 25)'.

Entrepreneurship has been embraced by policymakers looking to stimulate the 'third sector' (voluntary or not-for-profit organisations) as a provider of services (Simmons, 2008). Promotion of social enterprise as a way of engaging community members into organising to help themselves has stimulated interest in how to recognise and develop social entrepreneurs. Various explanations and definitions exist; it is generally agreed, social entrepreneurship is difficult to define (Hart & Haughton, 2007). In the USA, a social entrepreneur may have accrued wealth through business and applies it to social causes; for example Bill Gates (Certo & Miller, 2008). In the UK, social enterprise may be defined broadly, as on a spectrum between a voluntary organisation and a not-for-profit business (Dees, 1998), or narrowly as a business with social objectives, that generates a proportion of income from trade activity and whose surpluses are reinvested for social gain (Department of Trade & Industry UK Government, 2002). Those involved all comply with Dees' (2001) definition of social entrepreneurs as change agents who create and sustain social value, look for opportunities, and engage in ongoing innovation, adaptation and learning. There is a gap in knowledge about the relationship between those who work in the public sector and the production of social entrepreneurial activities. Roper and Cheney (2005) suggest it is harder to create innovation within the public sector due to contextual constraints and 'habit'; however, Simmons (2008) notes that employees of public service departments that change into social enterprises are inspired to creativity by the freedom afforded by a business environment. This suggests latent entrepreneurial potential in the public sector, but little attention has been paid to the idea of public sector employees acting as social entrepreneurs within their existing job role. This is possibly related to policy ambiguity around the extent to which public sector employees should engage in community capacity-building activities, such as forming activity groups, voluntary organisations or social enterprises as part of their job. For example, the Scottish review of community nursing suggests that nurses should enable chronically sick people in communities, prevent illness and provide anticipatory care, but does not specify or give examples of activities (Scottish Executive, 2006). Given that rural health professionals are embedded in communities (therefore ideally placed to identify needs and opportunities), that they have skills and networks in an appropriate milieu and have been highlighted as boundary crossers who can link communities with external resources (Kilpatrick et al., 2009), it is pertinent to consider whether they are or could be social entrepreneurs, generating activities that improve community resilience.

Features said to be commonly held by commercial and social entrepreneurs include applying imagination and vision, seeing opportunities, risk-taking, securing resources, persistence and repeated activity (Austin et al., 2006; Mair & Marti, 2006). Austin et al. (2006) suggest that social mission is the social entrepreneur's key driver and the major distinction from commercial entrepreneurship is that social entrepreneurs choose a social orientation (Thomson, 2002). Others suggest that contextual factors (Wong & Tang, 2006) and familiarity with the environment (Chell, 2007) affect the non-commercial direction of social entrepreneurs.

Rural health professionals

In both Scotland and Tasmania, rural primary health care services tend largely to be provided by general practitioners (GPs) and community nurses. In Scotland, GPs remain accessible for those

living in remote communities with the continued existence of small remote practices (Farmer, Hinds, Richards, & Godden, 2005). Recruitment to rural GP positions was boosted by the salary rises and additional payments if GPs decide to provide out of hours cover introduced in the 2004 UK GP contract. While the high costs of GP services for Scotland's remote areas seem unsustainable, they are the only health professional group able to work outside the constraints of the European Working Time Directive due to their independent contractor status. Thus their presence is generally the only alternative for providing security for remote communities, out of hours. In rural Tasmania, for many years, it has been difficult to recruit GPs and access is sparse, with less than 66 full time equivalent GPs per 100,000 Tasmanians outside the capital city of Hobart, compared to an Australian average of 74.5 per 100,000. Most Tasmanian rural GPs run their own practice and many are also contracted by the Department of Health and Human Services to provide medical services part-time in rural hospitals (Le & Stirling, 2007). Scottish rural GPs remain high status, autonomous practitioners. Depending on individual personalities, they tend to command respect from, and have influence over, the local population (Farmer, Lauder, Richards, & Sharkey, 2003). In comparison, while there are some remaining traditional Scottish community nurses and a small group of experimental 'family health nurses' who operate as holistic community practitioners, other nursing incumbents tend to have strictly defined roles and often work in peripatetic teams. Community health nursing is currently under review in Scotland which may signal a change to a more holistic and extended role with public health and community development components. In rural Tasmania, nurses are based in community health centres and rural hospitals. They occupy a mix of positions from acute in-patient focus through child and family health nurses to community health promotion roles. Most rural hospitals and community health centres are managed by nurses. Community health centre managers act to manage primary care for their wider region.

Health institutions are suggested as important to rural communities as symbols of identity and sustainability (Kearns, 1998). In both Scotland and Australia, rural GPs and nurses have been shown to be embedded in the social fabric of their communities, with remits that extend into counselling, lift-giving, delivering medicines, providing social care and involvement in community facilities and action groups (Greene & Burley, 2006; Johns et al., 2007). Engaged across many community activities, their pivotal position at the heart of rural life and their professional connections outside the community suggest a potential role for health professionals in generating community social capital. Social capital might be conceptualised as an intangible, but applicable social resource that emerges from, and creates, norms, values, attitudes, trust and networks (Falk & Kilpatrick, 2000; Woolcock, 1998). Health professionals' association with social capital might be both bonding (bringing people from the same community to work together) and bridging (bringing in knowledge and assets from outside the community) (Putnam, 2000; Woolcock, 1998). Social capital has been linked to community capacity and readiness to work together (Hunter & Killoran, 2004; Kilpatrick, Auckland, Johns, & Whelan, 2007). Kilpatrick and colleagues (2009) found that health professionals can work across the boundaries of rural communities and the health system to engender health outcomes. Combined with evidence of stronger and richer networks in rural, compared with urban, areas (Granovetter, 1973), rural health professionals should be well-resourced to generate activities with social outcomes, such as voluntary or social enterprise initiatives. In this study we sought to discover if rural health professionals were active in this arena, in what sorts of activities and engaging what sorts of skills and processes. We recognise that other rural professionals such as teachers may act as social entrepreneurs, as might urban professionals, however the evidence cited above suggests that the roles rural health professionals play in their communities warrant further investigation.

Method

The study investigated the actions of rural health professionals working in the Highlands and Islands of Scotland and rural Tasmania. The sites were chosen because of their physical similarities and health system differences. Both have mountainous terrain and remote areas where access can be affected by adverse weather and populations on remote islands (around 100 in Scotland and three inhabited islands in Tasmania). Their populations of some 430,000 (Scotland) and 490,000 (Tasmania) are dispersed and ageing due to out-migration of younger people and in-migration of older people in search of idyllic 'sea change' and 'tree change' lifestyles. Their land areas (40,000 km^2 and 68,000 km^2 respectively) are comparable. While sharing a neo-liberal health policy orientation, the two health systems have differences; for example, GPs and allied health professionals are integrated into public rural health services and facilities in Scotland. Health facilities in Tasmania are operated by the State government and generally managed by nurses. Tasmanian GPs operate from private practices mainly on a fee for service basis and allied health care is delivered by public and private practitioners. In Tasmania, health and social care operate from the same government department, while in Scotland social care is operated through local government.

A qualitative design that collected rich data from a restricted group, rural health professionals, was chosen for the study, consistent with its exploratory nature (Patton, 2002). Ethics approval was obtained from the Tasmanian Human Research Ethics Network and the North of Scotland Ethics Committee.

Participants were recruited through newsletter and email advertisement within the extensive networks of the researchers' health service contacts in the two locations. Participants were invited to respond if they were 'formally or informally generating community associations or networking that produced social outcomes', which we defined as social entrepreneurship in our project information sheet. Fifteen interviews were conducted in Tasmania and 23 in Scotland. The majority were face to face, with seven telephone interviews when face to face meetings were impossible due to timing or distance. Interviewees comprised 21 nurses, seven GPs, four primary health care managers and six allied health professionals. Thirty were female and eight were male. The Scottish sample contained GPs while the Tasmanian sample did not. Possible reasons for the absence of GPs in the Tasmanian sample are considered in the discussion. Otherwise the makeup of the sample matched the mix of health professions that work in the two rural regions (ISD Scotland, 2009; Productivity Commission, 2005).

The audio-recorded interviews of 20–80 min duration were relatively unstructured. Participants were asked to discuss their roles in their jobs and communities, and to describe the process of initiating and progressing between one and three community initiatives that produced community social outcomes. Some were involved in one initiative, but others in several. The interviews were transcribed and analysed for themes with the assistance of the NVIVO qualitative data management package. Themes induced from the data were compared with the literature reviewed (Patton, 2002). From the cross-interview thematic analysis, some holistic themes, describing a combination of characteristics and actions, which applied across whole interviews, emerged (Creswell, 2005). Examples are the extent to which the health professionals built the capacity of others and cultivated resources, the sophistication of the process by which they built initiatives (the 'deals' as Austin et al.

(2006) describe them) and the degree of freedom to act afforded by the system in which they worked. Some of these themes were found in the literature when it was revisited within an iterative process. As it is a qualitative study, it is inappropriate to generalise the findings beyond the two countries. Participants self-selected and it is not expected that all rural health professionals engage in activities that could be described as social entrepreneurship. However, the design was chosen to illuminate a set of behaviours with potential to improve rural community resilience.

Findings

Activities

The rural health professionals described their engagement in a range of activities that 'formally or informally generate community associations or networking that produce social outcomes'. Thirty-one of the 38 described initiating at least one activity. Some activities were initiatives carried out as part of their work duties; others took place outside of work hours. Most saw their involvement as part of the job of being a health professional (22), giving examples including initiating exercise classes, health clinics, a drop-in centre and woodwork activity at a 'men's shed'; six viewed activity as an extension of their job, but overlapping with their community member role. Examples cited, again, included exercise and outdoor activities, a Gaelic singing group, leading a Girl Guide group and establishing a community shop. Some activity development was discussed as arising from encounters with specific individuals or groups of patients, for example, exercise classes in a residential care home and support for drug addicted new mothers. Most activities were viewed as being for general community wellbeing. Ten others gave a range of similar examples, but viewed generating these activities as distinct from their job, emanating from personal or community-orientated desire for action.

Drivers of activity

Drivers for involvement included wanting to address problems seen through their job. A physiotherapist who established community exercise classes explained '*I look at the world through physio' (Tasmania*: *physiotherapist)*, exemplifying the approach described by others who saw patients or communities with challenges and sought to address these by applying health improvement techniques. Enjoyment from being active in the community was a further driver. A nurse who ran a Girl Guide troop said: *'I'm just that sort of person. I like to be out and I like to be doing things' (Tasmania*: *community nurse)*. Personal or family interests were responsible for sports clubs being established or revitalised. Some discussed feeling obliged to help because alternative leaders were scarce. Three said that community engagement should be integral to being a rural health professional:

> "If they're [rural health professionals] not engaged in their community they're not doing their job properly." (Tasmania: nurse manager, rural hospital)

The process of establishing activities

Twenty participants described habitually producing activities; for example, a Scottish school nurse set up a samba music group, then established a youth café, as a spin-off from that, was involved in a development programme for young people. Sometimes participants talked of their involvement as 'a project', having a set time-frame; for example, a Tasmanian nurse manager was involved in establishing a community bank. He saw himself as moving to another project once the bank was established.

The process of initiating new activities consisted of: recognising an opportunity, mustering people resources and finding funding. Initiators described recognising 'space', within their community, for activities that had worked elsewhere; for example, a GP and a psychologist set up a large and innovative children's playground in one rural setting. A GP explained his initiative to save the local shop:

> The shop was about to be sold and nobody wanted to buy it. There was a real danger that the shop would actually close…and if that happened the village would die. I'd been up in Orkney before I was here and I'd seen a couple of community co-operatives set up and I suggested 'why don't we, you know, consider this?' (Scotland: GP)

Need for action sometimes emerged following a formal community health analysis. Others described situations where communities desired change, but lacked leadership. A Tasmanian nurse established a village fun run and an occupational therapist in Scotland helped to set up an indoor horse-riding arena. Others described a process of actively seeking solutions to address challenges seen through their jobs. A café for troubled teenagers and a mental health referrals programme were developed following a search for evidence of good practice.

Having identified an opportunity, interviewees described mustering people to help. A GP described how he initiated a community alarm scheme for older people:

> …I found a very friendly old lady who needed one of these things and persuaded her that she was going to live safe in her own home and what she should do is get one. We then took that to the local newspaper to show how it worked so that we could then raise funds…as soon as the newspaper published that, the minister from the other side of the island rang up and said, 'that's funny, I was going to do exactly the same thing'. So the two of us got together and set it up from there. (Scotland: GP)

A primary care manager reported how she built activities at her centre:

> It's a long term developmental process. When I started at [X] I spoke to them [the Council] and looked at opportunities for partnerships…we were fairly strategic in that we would bring persons from other areas to talk to them about what their council does and this is their needs programme or their whatever and it works really well. So we were educating them all the time…Whenever we did anything or had any involvement with them …especially where we had good outcomes, we always went back and presented that and provided them with feedback and acknowledged them on everything…so it was just chip, chip, chip… (Tasmania: primary health care manager)

Participants described attracting financial resources. Influential support had to be gained so the activity was legitimised for the community. Tactics were employed such as harnessing politicians and council managers. Useful contacts were sometimes cultivated ahead of a specific purpose. Interviewees described their strategic networking activities and their involvement with key local groups in anticipation of eventual benefit:

> I had already made prior contact, so when I come knocking on the door, they know who I am and what I'm doing. (Tasmania: primary health care manager)
>
> …my involvement with the Rotary Club puts me in a pretty good position… they're a wealthy club…that's my agenda… (Tasmania: nurse manager, rural hospital)

In spite of cultivating contacts, most interviewees still had to apply for grant funding for their activities. The honing of skills over time and enjoying the competitive element of applying for funding were described. The scale and ambition of activities appeared related to the 'degrees of freedom' to operate inherent within interviewees' jobs. Of the Scottish participants, the GPs described introducing the larger scale changes – within the health care system (for example, developing an anticipatory care scheme), and within their community (for example, developing affordable housing). In Tasmania, primary care managers described ambitious programmes of activity such as leading the community in developing a primary care centre when a hospital closed.

Resources drawn upon

The process of establishing activities was fed by knowledge, skills and contacts from being a health professional, being a community member and personal interests and aptitudes. Being a health professional helped with opportunity recognition. Interviewees identified need, knew the potential for outcomes and could draw on examples of good practice; for example, a Scottish midwife developed a support programme for homeless families because she anticipated benefits when she started working with pregnant young women. Status helped to attract people and resources to initiatives:

> …being a GP… people don't say no to you quite as readily as they do [to others]… there needed to be a little bit of bridge building between different people. I was able to do that. (Scotland: GP)

Interviewees were also rural community members, helping them to know who was available in the community, which initiatives might attract interest and how to develop projects sensitively. Personal and family interests led to initiatives, including sports and running groups. Interviewees had or gained non-health qualifications and specialist skills that were applied to activity development; for example, a Scottish GP saw that the local sailing training school was failing due to a lack of skilled instructors in the community so he took the required courses, qualified and revitalised the initiative.

Outcomes of activity

All participants expected physical and/or psychological health impacts to result from their activity; some were directly related to health through exercise groups and classes and, within the health care system, through improvements they had made. Some were indirectly associated. Activities aiming for direct social benefit, like creating new jobs or housing were linked with psychological wellbeing. Sporting clubs and leisure activities were assessed to enhance social interaction which brought psychological benefits in addition to physical health benefits.

Personal outcomes were also expressed, spontaneously, by around half of the interviewees (18), describing either a feeling of excitement (the word 'buzz' recurred) or gaining confidence from activities. Since an interest in social entrepreneurship was stated by the authors in generating the sample, it is perhaps unsurprising that 21 interviewees stated viewing themselves as 'entrepreneurial'. Others did not mention being entrepreneurial or said they did not see themselves as social entrepreneurs.

For some, outcomes extended beyond individual and community health and their own fulfilment. They expressed community empowerment, increasing local social capital, and building capacity resulting from their activity. Restoring or building local identity, mentoring others in aspects of the process of activity development and leadership and developing the skills and confidence of younger local people were all mentioned by interviewees in both Scotland and Tasmania. One said she had helped a group to develop a proposal and funding application for a new initiative and that *'they didn't need me with the next thing they did, which is good' (Tasmania: primary health care manager).* A Scottish participant explained:

> …we've employed some of our young people that used to be in the café as users and we've also supported them into education. One of the main former movers and shakers is now doing a community education degree… (Scotland: social worker)

Thus a range of benefits of activity were expressed within the health and social sphere, but economic impacts for communities were not mentioned at all.

Discussion

Study participants self-selected as those who 'formally or informally generate community associations or networking that produced social outcomes'. Not all rural health professionals could be expected to engage in such activities; the purpose of the study was to explore the capacity of rural health professionals for such actions rather than the extent of such activity. They revealed a range of activities that they initiated or were involved in. Fig. 1 summarises elements of the activity generation process that emerged from this exploratory study. If the activity recorded here is regarded as entrepreneurial, then the figure could be said to be summarising the entrepreneurial process of rural health professionals.

Drivers for activity initiation or involvement included perceiving needs and ways to address these from the perspective of a health professional, enjoying involvement, personal or family

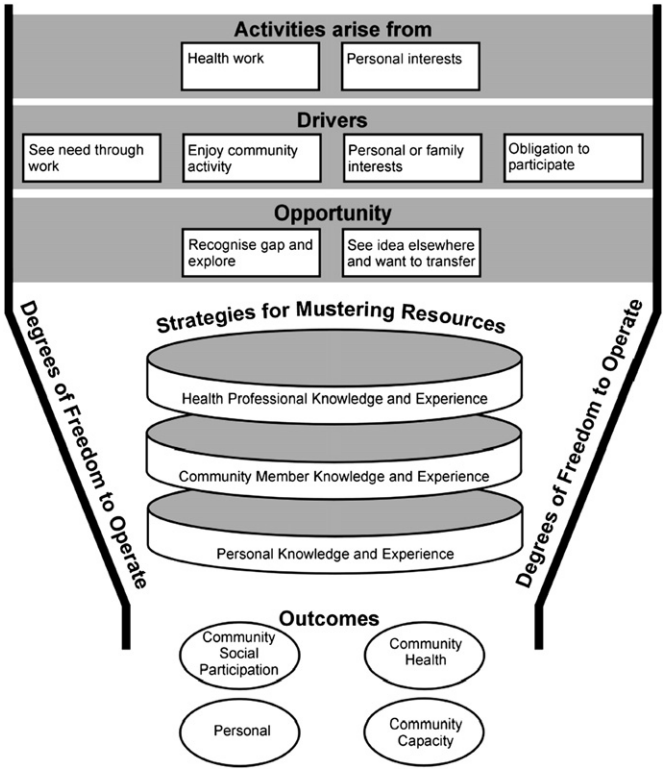

Fig. 1. Rural health professionals' social entrepreneurial process.

interests and feelings of obligation. Identifying opportunities was often related to envisioning solutions to patients' or community challenges or seeing 'spaces' to introduce initiatives seen elsewhere. Strategies for mustering people and financial resources drew on over-layering of skills, knowledge and perceptions coming from being a health professional, being a community member and personal attributes. Degrees of freedom to generate activity appeared associated with role status. Participants recognised beneficial health and social outcomes arising from their activities, many reported a personal 'buzz' from involvement and some described deliberately building community capacity.

Self-selection by participants means that this paper cannot indicate the prevalence of activity generation among rural health professionals and the lack of comparison with urban areas, means we cannot make the case that rural health professionals are different. (Although there is evidence that rural communities have high levels of volunteering and are more conducive to social enterprise development (Williams, 2007)). Rather, the variety and serial production (by some) of activity generation by rural health professionals has been revealed, indicating wider latent potential. Observation of motivations and processes allows understanding of why health professionals produce activity and how they can use their position in society to access assets. The definition of social entrepreneur given to elicit interviewees was broad, potentially exposing an incohesive range of respondents. The alternative was a narrow definition that might restrict participation. The result has been a spectrum of activity, in many respects similarly patterned in both countries, that has provided knowledge about the range of activities and what health professionals understand them to be and to be for. Conducting the study in two countries highlights systemic issues that shape activity production.

Rural health professionals in Scotland and Tasmania are well placed to make activity with intended health and social outcomes happen in their communities. This is because, as has been revealed here, their placing in society allows them to see opportunities from a position over-layering the health work, community and personal dimensions (Kilpatrick et. al, 2007). Simultaneously, rural health workers can deploy their status as *known professionals* to draw on useful *people resources* identified through their interconnections with residents and others outside the community. Status means that health professionals are invited to participate in influential community organisations, such as Rotary, that allow them access to knowledge and contacts for obtaining financial resources.

In terms of the effort involved in networking that is advocated as key to entrepreneurs' attracting resources and support, health professionals are naturally assisted by their place in local communities. That said, different workers appeared to have varying 'degrees of freedom' to achieve activities. In Scotland, greater freedom was associated with GPs' high status, perhaps reflecting the longstanding status and power of medicine within Scottish society (Greer, 2004). In Tasmania, primary healthcare managers had most freedom as their remit, linked with budget and authority, tasks them with working with communities to improve health. The remit of Tasmanian GPs is their individual patients, not a community. Tasmanian GPs operate private sector businesses which charge a fee for service, and so they have no discretionary allocation of time or budget, unlike Scottish GPs whose income is less dependent on the number of patient consultations they conduct each day. The links between freedom and action may explain the absence of GPs electing to participate in the study in Tasmania and the lack of primary healthcare managers electing to participate in Scotland. Nurses had less freedom within the system in both countries and their activities were largely confined to direct health improvement.

In social capital terms, rural health professionals can draw on both bonding (within community) and bridging (extra-community) connections. As 'boundary crossers' (Kilpatrick et al., 2009) they can identify and combine 'external' resources because they link professionally, managerially and through policy structures to the world outside their community. This may be especially important in rural settings because of distance from centres of power, evidence and resources. Distance may foster bonding, and depreciate bridging, contacts. Entrepreneurs may be those that best maintain their bridges and/or those that are legitimised by status to be bridgers (Woodhouse, 2006).

In entrepreneurial terms, rural health professionals meet Sahlman's (1996) criteria for successful entrepreneurs in that they: know the industry sector, are known for their abilities and are, therefore, able to gain trust. But, is it appropriate to regard the rural health professionals in this study as social entrepreneurs? This is somewhat determined by the analytical framework adopted; i.e. if we look through the lens of social entrepreneurship, we find social entrepreneurial behaviours. Findings can be viewed through alternative lenses, including that of community development. What was entrepreneurial was serial initiation among the majority. Within this group, all identified gaps, injected vision, attracted and excited others, secured resources and were persistent. These are entrepreneurial behaviours (Thomson, 2002). Findings can also be aligned with Austin and colleagues' (2006) framework of entrepreneurship as people, context, deals and opportunities. This would suggest the rural health professionals are entrepreneurial because: 1) they use their contextual embedding in the health service policy and public health environments to identify opportunities, use the appropriate discourse to attract support and funds and identify funding streams; 2) They use their connections, accrued through status and community working, to harness influential people as supporters and volunteer workers; 3) Their layered perspective (health/community/personal) allows them to see different aspects of value, thereby enabling them to 'sell' their ideas in ways that are appealing to different stakeholders (enabling sophisticated 'deals').

Alternatively, study participants could be viewed as leading and stimulating community development. Aligned approaches were building community identity, developing local leaders and combining groups for mutual benefit (Taylor, Wilkinson, & Cheers, 2008). Within a community development paradigm, a leader is 'an agent at the local level who can motivate, organise and direct the effort of the social partnership and, at times, give confidence' (Billett, Clemans, & Seddon, 2005; p. 22). A useful characteristic distinguishing entrepreneurship and community development is individual versus collective orientation (Sen, 2007). Parkinson and Howorth (2008) suggest that social enterprise is an evolution of community development that has emerged from market led approaches favoured by neo-liberal and post neo-liberal governments. They say social entrepreneurship is marked by its use of capitalist discourse and highlighting of leaders as charismatic and heroic. Social entrepreneurship highlights community capacity and responsibility, but suggests focus on the individual as leader rather than collective action. The rural health professionals in this study tended to identify themselves as individuals significant in change processes, which is not surprising given that they chose to participate in the study. They were often motivated by personal buzz, seemingly highlighting alignment with individual rather than collective orientation. Another perspective considers the activities produced and their placing along the spectrum of social enterprise through to voluntary organisation activity. Certainly, few engaged in tradeable activity and most would be considered at the voluntary organisation, rather than commercial, boundary of activity. However, some activities were clearly generated as a response to market failure (affordable housing, running a village shop,

establishing a café, running services for homeless people), resonating with reasons for establishing rural social enterprise and most focus on meeting social need and are locally bounded (Clark, Southern, & Beer, 2007). Studies caution of the need to inject an element of reality into considering the possible ambition and scale of rural social enterprise (Clark et al, 2007; Zografos, 2007): there is an inevitable limit to tradeable activity with a tiny marketplace and, to an extent, social enterprise is in the eye of the beholder – there are different ways of interpreting the activity (community development or enterprise), but the important thing is that innovative activity is occurring to address needs. The activities recorded in this study might therefore be viewed as a range of social entrepreneurial activity that is realistic given the limitations of a rural context.

It is notable that primary healthcare managers in Tasmania were the most systematically engaged in developing activities. Such repeated and programmatic activity was rarely noted in Scotland, except perhaps in the case of one GP and one nurse. The Tasmanian primary healthcare manager role might be viewed as a health system response to market failure in providing health services in rural Tasmania in that recruiting and retaining health professionals is difficult. Part of the solution of service provision for communities is to prevent ill health, maintain wellbeing and foster community participation in health care. The concept of primary healthcare managers with a specific remit to work with communities on health initiatives might also be viewed as enabled by neo-liberal policy, enhancing personal responsibility and rolling back state assistance or as a response to the New Public Health movement, encouraging participation in anticipation of sustainable communities. In any case, primary health care managers' programmatic and repeated initiation of activity shows an organised and systematic model of co-locating health care and community development/ social enterprise compared with Scotland. In Scotland there are public health practitioners who consider healthcare needs over large areas and there is a proposed new role for community nurses that specifically highlights an underpinning of community development principles, but this still does not constitute a clear framework for involving health professionals in community development or associating health activities with capacity building or sustainable community outputs.

Disappointingly, perhaps, given their place at the heart of networks, implying the opportunity to produce diverse social activities and innovations (Uzzi, 1997), health professionals predominantly produced health-related activities. This would tend to place them more within the New Public Health and community development paradigm than the enterprise one. Why was their vision so apparently limited? This may be due to the lens through which health professionals portrayed their activity (describing it as about health when it could be seen to have social and economic implications), or to the lens through which health professionals choose activity (they know about health, therefore they 'do' health). This links with consideration of what this study might add to understanding and clarifying the woolly concept of social entrepreneurship. A striking feature is that rural health professionals did not appear to explicitly choose a social mission over a commercial mission; rather, their development of activities was emergent from the perspective and world view that being a health professional brings. The social entrepreneurship literature often implies choice of social mission as the distinction between social and commercial entrepreneurship (Thomson, 2002). Our findings concur with Drucker's (1985, p. 61) suggestion that the 'sources' of entrepreneurial activity, such as recognising opportunities, are grounded in knowledge of the specific sector of work. Further, while the literature describes social entrepreneurship as business activity with a social mission, the activity we surveyed would be more appropriately termed social activity within a business framework. Thus, if indeed we regard what was found as social entrepreneurship, it seems to support views that social enterprise is an evolution of community development that suits current policy orientation and is a form of community development work that utilises the discourse of enterprise, thereby appealing to those who tune-in to contemporary trends.

There is a final and crucial point: is there value in highlighting rural health professionals as social entrepreneurs, and should policymakers strive to encourage (more) social entrepreneurial behaviour? Health and social policy suggests that the relationship between rural communities and services should change. It asks that communities become 'resilient' within a primary health care paradigm that acknowledges social action contributes to community health more than technical service interventions. This study has shown that rural health professionals are well placed to develop community activities with health and social outcomes. Further research is required to investigate the nature of similar activities among other rural professionals. While the study highlights the convergence of the concepts of social entrepreneurship and community development in rural communities, it also shows that some see personal value in identifying themselves as social entrepreneurs. They associate the buzz and thrill of the chase for funding with business-like activity. This may suggest latent potential in further utilisation of the term for motivating activity with social outcomes. Simultaneously, it highlights that health professionals are engaged in community development activities and would benefit from the capacity development skills that are part of community developers' toolkit.

There is a suggestion in the Scottish review of nursing in the community that health professionals engage in community development for increasing exercise and generating self-care and expert patient schemes, but these are related to health. Some rural health professionals, as we have shown, are already engaging in a range of community capacity generating activities and wider evidence has shown that they work in a way that inter-meshes them with community life (Farmer et al, 2003; Iversen et al, 2002). Rural communities are increasingly revealed as depleted in terms of human capital in both leaders and volunteers to address the neoliberal participative community agenda (Skinner & Joseph, 2007). Adding social entrepreneurship to rural health professionals' training and jobs might serve to: a) let students know of the commitment to community often demanded of a rural health professional; b) attract the right people into rural healthcare jobs; c) make explicit what many workers already do; d) add value to the community orientation by giving commercial knowledge. But is it social entrepreneurs that are needed? If creative change agents are sought (Dees, 2001), then perhaps yes, but if explicitly 'business-developers', then perhaps that would be less appealing both to health professionals and rural communities. The spectrum of activity they might reasonably be expected to engage in would also require some unpicking; activities related explicitly to health or right through to social and economic generation (i.e. less directly health-related)? It is perhaps unreasonable to suggest that all rural health professionals be socially entrepreneurial; this might be to fall into the trap suggested by Chell (2007) of regarding 'enterprise orientation' as part of being a 'good health professional'. If all rural health professionals were social entrepreneurs, then paternalism could result, stifling the emergence of local community leaders. Perhaps a gap for community development or social entrepreneurship skills is best considered in relation to the needs of each different rural community and could be incorporated in job descriptions, and addressed in professional development (and remuneration), for specific jobs by communities themselves, in partnership with health and social care authorities. In this way,

those who are skilled at building capacity might be attracted to key roles in rural communities and help move towards achieving the elusive policy goal of rural community resilience.

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