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THREE ESSAYS ON POWER DYNAMICS WITHIN CHINA'S COMMUNITY NURSING SYSTEM

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The Hong Kong Polytechnic University

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Three Essays On Power Dynamics Within China's Community Nursing System

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A thesis submitted in partial fulfilment of the

requirements for the degree of Doctor of Philosophy

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CERTIFICATE OF ORIGINALITY

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Abstract

This doctoral thesis investigates the power dynamics within China's community nursing system through three interpretative case studies. Grounded in French and Raven's typology of social power, the initial study categorises the diverse manifestations of power and elucidates the contextual constraints of power faced by community nurses. This analysis highlights the need for initiatives aimed at empowering nurses, thus harnessing untapped power reserves to more effectively meet the needs of patients. The second study employs Rosabeth Kanter's theory of organisational power to explore how community nurses, acting as street-level bureaucrats, manage and utilise power resources within their professional environments. This inquiry exposes significant disparities in access to power and underscores the role of interpersonal relationships in shaping the structures of organisational power. It also provides a framework for understanding the dynamics of power among grassroots policy implementers who operate within both formal and informal job structures, with a particular focus on equity considerations. The third study, informed by Michel Foucault's concept of biopower, examines the profound influence of community nursing on health promotion at both the individual and population levels. It identifies three specific community nursing services that epitomise biopower approaches to health promotion, characterised by their persuasive, constructive, and evidence-based methods. These services align with the core principles of biopower. This study offers a conceptual framework that underscores the significant impacts of community nursing services on health promotion at the primary care level. The integration of French and Raven's typology of social power, Kanter's theory of organisational power, and Foucault's concept of

biopower enables a comprehensive examination of the structural, interpersonal, and ideological forces shaping community nursing in a Chinese context. This tripartite approach provides a layered understanding of how power operates within the community healthcare system and offers a pathway towards reforms that enhance both nurse empowerment and patient care. This thesis asserts that understanding and restructuring power dynamics are essential steps towards not only enhancing the professional stature and effectiveness of community nurses but also improving the overall primary healthcare infrastructure.

Publications arising from the thesis

1. **Li, B**., Chen, J., & Howard, N. (under review). Organizational position and structural empowerment in Chinese community nursing: an interpretive case study. *Journal of Nursing Management.*
2. **Li, B**., & Chen, J. (under review). Reciprocity and power: nurse-patient interactions in primary healthcare. *Health & Social Care in the Community.*
3. **Li, B**. (under review, 1st revision). Uncovering the impact of community nursing on health promotion in China: a biopower analysis. *Social Science & Medicine*.
4. **Li, B**., & Chen, J. (2023). Barriers to community healthcare delivery in urban China: a nurse perspective. *International Journal of Qualitative Studies on Health and Well-being, 18*(1), 2220524. https://doi.org/10.1080/17482631.2023.2220524
5. **Li, B**., Chen, J., & Howard, N. (2023). Community nursing delivery in urban China: a social power perspective. *Social Science & Medicine, 326*, 115923. https://doi.org/10.1016/j.socscimed.2023.115923
6. **Li, B**., & Chen, J. (2022). Barriers to community-based primary health care delivery in urban China: a systematic mapping review. *International Journal of Environmental Research and Public Health, 19*(19), 12701. https://doi.org/10.3390/ijerph191912701

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Chapter 1: General Introduction

This chapter functions as a comprehensive introduction to the thesis, organised into six sections to elucidate the following key areas: 1) the role of primary care in realising Universal Health Coverage (UHC), underscoring its fundamental importance in ensuring equitable and accessible health services for all; 2) a review of the healthcare reforms in China, examining the strategies implemented to enhance the efficiency, accessibility, and quality of healthcare services across the nation; 3) a description of the nursing workforce in China, providing context for understanding the overall nursing practice system; 4) an exploration of the evolution of community nursing practices within China, tracing their development and examining their impact on the broader healthcare landscape; 5) an examination of selected social theories of power that are relevant to the study of healthcare and nursing, framing the discourse within the context of power dynamics that influence healthcare delivery and nursing practices; and 6) an overview of the three case studies that form the core of the thesis, setting the stage for the systematic presentation of each.

1.1 Universal Health Coverage and primary care

Universal Health Coverage (UHC) is pivotal in advancing the Sustainable Development Goals, epitomising a commitment to health equity and social justice (World Health Organization [WHO], n.d.). UHC stands as a cornerstone objective in health policy, encapsulating a comprehensive strategy to ensure equitable access to health services for all individuals and communities, irrespective of socioeconomic status, gender, age, or geographic location (WHO, n.d.). Table 1 presents the foundational pillars of the UHC framework, which serve as guiding principles in the

pursuit of this ambitious goal.

Table 1. Universal Health Coverage (UHC)

Components	Connotations
Coverage for all	UHC aims to extend healthcare access universally, encompassing even the most marginalised and vulnerable segments of society, thus dismantling barriers hindering healthcare access.
Comprehensive services	Encompassing a broad spectrum of healthcare interventions, UHC spans preventive, promotive, curative, rehabilitative, and palliative care. It extends its purview to include mental health services, sexual and reproductive health, as well as the management of non-communicable diseases, recognising the holistic nature of healthcare needs.
Financial protection	At the heart of UHC lies the imperative to shield individuals and households from the economic burdens associated with healthcare costs. This entails the deployment of diverse mechanisms, such as health insurance schemes, tax-funded healthcare systems, or hybrid models, to mitigate the risk of catastrophic health expenditure.
Equity	UHC is anchored in the principle of equitable healthcare access, striving to mitigate disparities in health outcomes across diverse population groups. Addressing social determinants of health, such as poverty, education, and employment, is integral to its mission of fostering equitable healthcare provision.
Quality of care	Central to the ethos of UHC is the delivery of high-quality, evidence-based health services tailored to meet the diverse needs and preferences of individuals and communities. Ensuring the availability of proficient healthcare providers, essential medications, and appropriate medical technologies is imperative within this framework.
Strong health systems	Achieving UHC necessitates the fortification of health systems to render them resilient, responsive, and capable of delivering a comprehensive array of health services with efficiency and efficacy. This entails strategic investments in healthcare infrastructure, workforce development,

	information systems, and governance mechanisms.
Community engagement	Recognising the pivotal role of communities in shaping health outcomes, UHC advocates for meaningful community engagement in decision-making processes pertaining to health. It emphasises the promotion of health literacy and the empowerment of individuals to actively participate in managing their health and well-being.

Sources: Garrett et al. (2009), Reich et al. (2016), World Health Organization (n.d.).

Primary care is instrumental in the attainment of UHC, serving as a fundamental component of accessible, comprehensive, and equitable health systems (De Maeseneer et al., 2020; Sanders et al., 2019). It primarily functions as the initial point of contact for individuals seeking health services, thereby facilitating easy access to healthcare irrespective of socioeconomic status, geographic location, or other demographic variables (Kluge et al., 2018). This accessibility is vital for ensuring that essential health services are inclusive, aligning with the core principles of UHC that advocate for healthcare availability to all, without discrimination.

Meanwhile, primary care adopts a holistic approach that extends beyond addressing immediate health needs, encompassing overall health and well-being within the broader contexts of family, community, and environment (Bodenheimer, 2006; Starfield et al., 2005). Providers of primary care deliver personalised care tailored to the unique needs of each individual and effectively coordinate transitions across different healthcare settings (Gene-Badia et al., 2007). This comprehensive management reduces fragmentation, optimises resource utilisation, and enhances patient satisfaction. These attributes are essential to the successful implementation of UHC, as they ensure a continuum of care that is both efficient and patient centred.

Additionally, primary care emphasises preventive healthcare and health promotion, aiming to pre-empt illness, facilitate early disease detection, and encourage healthy behaviours and lifestyles (Starfield et al., 2005). By prioritising prevention and early intervention, primary care contributes to reducing the burden of disease, minimising healthcare costs, and improving population health outcomes. These factors are crucial for the successful achievement of UHC.

Primary care also functions as a gatekeeper within the broader health system, facilitating access to specialised services as necessary (Li & Chen, 2022; Starfield et al., 2005). Primary care providers effectively triage patients, diagnose common health conditions, manage chronic illnesses, and deliver initial treatment and follow-up care. This role is critical in optimising healthcare resource utilisation and ensuring that care is appropriate and timely, tailored to the clinical needs of patients.

Furthermore, primary care is rooted in patient-centredness and cultural competence, recognising the critical role of engaging patients as active partners in their healthcare journey (Paez et al., 2008). By providing respectful, responsive, and culturally sensitive services, primary care enhances health equity, diminishes disparities in healthcare access and outcomes, and ensures dignified and compassionate care for all individuals. This approach not only promotes patient empowerment but also supports the holistic well-being of diverse populations.

Last but not least, as a fundamental element of health system strengthening initiatives, primary care promotes collaboration and integration across various healthcare sectors and social support systems (Valaitis et al., 2017). By addressing the underlying determinants of health and leveraging intersectoral partnerships, primary care plays a

pivotal role in developing resilient, responsive, and sustainable health systems. These systems are better equipped to meet the diverse needs of populations, thereby advancing the objective of equitable access to quality care for all under UHC.

1.2 Healthcare reforms in China

China's healthcare system has experienced profound transformations, influenced by an array of socioeconomic factors and government policy interventions. Prior to the establishment of the People's Republic of China (PRC) in 1949, healthcare provision was characterised by fragmentation and inadequacy (Lin, 2012). Traditional Chinese Medicine (TCM) was the predominant form of healthcare, with modern medical services being limited, especially in rural areas (Hsu, 2008). Following the inception of the PRC, the government launched significant initiatives aimed at achieving UHC, including the establishment of an extensive network of rural health clinics and urban medical facilities designed to provide basic health services to all citizens (X. Li et al., 2017).

The Cultural Revolution (1966–76) precipitated significant turmoil within China's healthcare infrastructure (H. Li et al., 2017). However, efforts to reconstruct the healthcare system in subsequent years focused on modernisation, expanding access to healthcare services, and incorporating health education and preventive measures (Bu, 2017; Smith, 1998). The economic reforms of the 1980s introduced substantial changes to the healthcare landscape (Smith, 1998; Yip & Hsiao, 2009). A governmental reduction in healthcare funding led to increased out-of-pocket expenses for patients, compelling public hospitals to depend more heavily on revenue from drug sales and medical services (Ramesh et al., 2014). By the early 2000s, China

faced escalating disparities in healthcare between urban and rural areas, alongside rising healthcare costs (Liu et al., 2021; Ramesh et al., 2014). In response, the government implemented a series of reforms, including the introduction of the New Rural Cooperative Medical Scheme and the Urban Employee Basic Medical Insurance. These initiatives aimed to broaden insurance coverage, enhance access to essential medicines, and strengthen primary care services (He et al., 2021).

Under the leadership of President Xi Jinping, China has embarked on ambitious healthcare reforms as outlined in the 'Healthy China' blueprint (Zhu et al., 2024). This landmark initiative aims to achieve UHC by expanding insurance coverage, bolstering primary care, controlling healthcare expenditures, and fostering innovations in healthcare delivery (Zhu et al., 2024). Additionally, the plan prioritises enhancing the quality and efficiency of health services, reducing disparities, and reinforcing disease prevention and control measures (Wang & Gu, 2022). Continued efforts to address ongoing challenges, such as an ageing population, an increasing burden of chronic diseases, and emerging public health threats such as COVID-19, have underscored the need for further healthcare reforms in China (Xing & Zhang, 2021). These endeavours focus on strengthening primary care, enhancing standards in public hospital care, upgrading healthcare infrastructure, and advancing healthcare technology innovations.

Overall, China's healthcare reforms demonstrate a comprehensive approach, addressing multiple facets of the health system. Central to these efforts is the enhancement of primary care, which is identified as a crucial objective in the nation's pursuit of a healthier population under the framework of UHC (Cai et al., 2023; Wu et al., 2017). Key components of China's primary care-focused reforms include:

1) *Infrastructure development*: The government has prioritised the establishment and renovation of community health centres (CHCs) and township hospitals (H. Li et al., 2017). These frontline facilities are critical in providing essential medical services, preventive care, and health education to local communities, thereby enhancing the accessibility and quality of healthcare at the grassroots level.
2) *Workforce capacity*: Initiatives are in place to enhance the capacity and capability of primary care providers, including general practitioners and community health workers (Li et al., 2020). These measures include the recruitment and training of additional professionals, coupled with the provision of ongoing education and professional development programmes (Li & Chen, 2022). This strategic approach is designed to fortify the primary care workforce and ensure a high standard of care delivery.
3) *Accessibility*: Reforms are directed towards ensuring that essential healthcare services are accessible and affordable, especially in rural and underserved areas. Measures to achieve this include reducing out-of-pocket expenses for primary care services and essential medicines, thereby alleviating financial barriers to healthcare access (Su et al., 2017). This strategy is pivotal in extending equitable health coverage to all segments of the population.
4) *Comprehensive services*: Under the framework of the National Basic Public Health Services (NBPHS), primary care facilities have expanded their range of services. These now encompass preventive care, health screenings, chronic disease management, maternal and child health services, and mental health support (Li et al., 2023; Yuan et al., 2019). This enhancement of service provision ensures a holistic approach to

healthcare, addressing a broad spectrum of patient needs within the community.

5) *Integration*: The coordination between primary care providers and higher-level hospitals has been strengthened through the implementation of refined referral systems. This enhancement ensures seamless continuity of care and optimises resource allocation across the healthcare system, thereby improving both the efficiency and effectiveness of patient management (X. Li et al., 2017).
6) *Patient-centredness*: The reforms underscore the importance of patient empowerment and community engagement (Lin et al., 2020). Patients are encouraged to actively participate in healthcare decision-making processes, and communities are engaged in health promotion and disease prevention initiatives (Yuan et al., 2021). This approach fosters a more inclusive healthcare system that prioritises the needs and input of individuals and their communities.
7) *Technological advancements*: Embracing cutting-edge technology, China has implemented electronic health records, telemedicine platforms, and mobile health applications to enhance the delivery of primary care (Li et al., 2020). These technological innovations facilitate improved access to healthcare services, enable remote consultations, and bolster data-driven decision-making, significantly enhancing the efficiency and reach of healthcare provision.

In summary, China's healthcare reforms are designed to establish a robust and responsive primary care system, which is foundational to the country's healthcare delivery system (H. Li et al., 2017; X. Li et al., 2017). By fortifying primary care

infrastructure, enhancing the workforce, and expanding services, China aims to improve health outcomes, elevate patient experiences, and achieve sustainable healthcare development.

1.3 Nursing workforce in China

China's nursing workforce system is multifaceted, encompassing various types of nursing services tailored to the diverse needs of its population.

Hospital nurses in China form the backbone of the healthcare system, working in settings ranging from large urban hospitals to smaller local facilities. These nurses are involved in acute care, providing immediate and intensive care to patients with serious health conditions (Ying et al., 2021). They also work in specialised departments such as cardiology, oncology, paediatrics, and surgery. Additionally, nurse practitioners, who are advanced practice nurses with the authority to diagnose and treat patients often in collaboration with physicians (Wang et al., 2018), play a critical role in hospital settings.

Rural nurses serve in less densely populated areas where access to healthcare is often limited (Bao et al., 2023). Their roles include offering primary care services, preventive care, and education to rural populations. They also engage in community health initiatives, such as immunisation programmes and maternal and child health services. Mobile clinics are another crucial component of rural nursing, providing healthcare through mobile units to reach remote areas (Bao & Huang, 2021).

Rehabilitative nurses focus on helping patients recover from injuries, surgeries, and

chronic illnesses (Zhou et al., 2022). Their responsibilities involve assisting patients in regaining mobility and independence after hospitalisation, managing long-term conditions such as stroke and spinal cord injuries, and coordinating therapy with physical therapists, occupational therapists, and other specialists to develop comprehensive rehabilitation plans.

China's nursing workforce also includes various other specialised areas, each addressing specific health needs. Geriatric nurses cater to the elderly population, focusing on age-related health issues and promoting healthy ageing (Dai et al., 2021). Paediatric nurses provide care for infants, children, and adolescents, including preventive care and treatment of childhood illnesses (Liu & Ge, 2019). Public health nurses work on health promotion, disease prevention, and health education at the community level (Li et al., 2021). Mental health nurses support patients with mental health issues, providing counselling, therapy, and medication management (Zeng et al., 2020).

Overall, China's nursing workforce system is evolving to meet the changing healthcare needs of its population, with ongoing efforts to improve the quality and accessibility of nursing services across the country.

1.4 Community nursing in China

Community nursing is an integral component of China's primary care framework, playing a crucial role in the pursuit of sustainable UHC (Yuan et al., 2012). Historically, prior to the establishment of the PRC, TCM and community-based health practices were predominant, with nursing care primarily provided by family members

and local healers within communities (Smith & Tang, 2004). Following the founding of the PRC, significant efforts were made to enhance nursing education and training, focusing on delivering basic healthcare services across both urban and rural areas (Wang et al., 2019; You et al., 2015). Nevertheless, the recognition of community nursing as a distinct discipline only emerged in the 1980s, marking a pivotal development in the structuring of health services (Ye et al., 2016; Yuan et al., 2012).

During the period of economic reforms, there was a gradual recognition of the pivotal role that community nursing plays in delivering primary healthcare services. Township health facilities and CHCs began to provide essential nursing services, with a particular emphasis on maternal and child health, immunisation, and health education (Yuan et al., 2012). In response to increasing healthcare demands and an ageing society, China significantly increased investments in community nursing training and development in the early 2000s. Consequently, the scope of responsibilities for community nurses expanded to include chronic disease management, health advocacy, and home care services (Li & Chen, 2023).

The watershed moment for community nursing in China came with the sweeping healthcare reforms of 2009, when the Chinese government embarked on an ambitious agenda to strengthen primary care services, including community nursing (Li & Chen, 2022, 2023). These reforms involved the implementation of standardised training regimens for community nurses, an expansion of nursing roles within CHCs, and the integration of community nursing into the broader healthcare infrastructure (Cao et al., 2016). Recent reforms have focused on further elevating the stature of community nursing by advocating for holistic, patient-centric care, particularly targeting vulnerable demographics such as the elderly and those grappling with chronic

disorders. These initiatives include efforts to improve the quality of nursing services, foster interdisciplinary collaboration, and promote community-oriented nursing paradigms (National Health Commission, 2022).

The increasing significance of community nursing in China underscores the need for comprehensive investigations into its multifaceted dynamics. China's rapidly shifting demographics, characterised by an ageing population and an escalation in chronic health conditions, amplify the demand for accessible and comprehensive healthcare services at the community level (Li & Chen, 2023; Li et al., 2023). Positioned as the frontline of primary care delivery, community nursing assumes paramount importance in addressing these evolving healthcare demands. However, within the intricate tapestry of China's healthcare landscape—characterised by regional disparities, urban-rural dichotomies, and evolving policy frameworks (Li & Fu, 2017)—a nuanced understanding of community nursing becomes indispensable. Rigorous investigations into the efficacy, accessibility, and integration of community nursing services are imperative to inform evidence-based policies and interventions tailored to meet the diverse healthcare needs of China's populace. Such inquiries are crucial for elucidating best practices, identifying impediments to effective care delivery, and ultimately strengthening the resilience and responsiveness of China's healthcare system to adapt to the evolving healthcare landscape.

This thesis employs a power perspective to elucidate the complexities inherent in community nursing in China. Recognising that power operates as a pervasive force shaping social structures and interactions (Raven, 2008), especially within healthcare systems (Stevens et al., 2021), this analytical lens reveals the intricate power dynamics embedded in community nursing practices. By centring the experiences and

voices of frontline community nursing practitioners, this power perspective facilitates a comprehensive examination of how power functions across various levels—from the macro-level influences of policy and organisational behaviours to the micro-level nuances of interpersonal interactions. Through this analytical framework, the thesis aims to contribute a novel interpretation of community nursing in China and provide insights for advancing more empowering primary healthcare practices.

It is worth noting that this thesis focuses on urban community nursing practices in China. Studying urban community nursing rather than rural nursing is essential due to the distinct challenges and dynamics present in urban settings. Urban areas in China experience rapid population growth, greater socioeconomic diversity, and a higher prevalence of chronic diseases and lifestyle-related health issues. These factors create unique healthcare demands that differ significantly from those in rural regions. Additionally, urban community nursing practices often involve more complex healthcare delivery systems and a greater integration of advanced medical technologies and services. By focusing on urban community nursing, this thesis aims to inform the development of effective community nursing strategies for managing urban healthcare needs and ultimately enhance the overall quality and accessibility of primary care in China's rapidly urbanising society.

1.5 Power in healthcare and nursing

Power is central to understanding healthcare and nursing due to its pervasive influence across various domains, including medical hierarchical structures, policy formation, interprofessional relationships, patient advocacy, education, and ethical considerations (Bochatay et al., 2021; Kalocsai et al., 2024; Li et al., 2023; Stevens et

al., 2021). Several prominent social theories of power provide insights into both the micro-level relationships and macro-level structures within healthcare and nursing. These theories not only facilitate a comprehensive analysis of how power dynamics shape interactions and operations within healthcare settings but also guide the analysis of phenomena ranging from daily interpersonal interactions to broad organisational and systemic structures.

1.5.1 Foucauldian power

Michel Foucault (re-)conceptualised the notion of power, framing it not as an asset or possession but as a dynamic enacted through institutional practices, discourses, and relationships (Smart, 2002). Within the realm of healthcare and nursing, Foucault's theoretical framework offers a valuable lens for examining the circulation of power in the following aspects:

1) *Control over medical knowledge*: Foucault posited that knowledge and power are intrinsically interwoven, suggesting that those who command knowledge also wield power (Foucault, 2007). In the healthcare sector, this dynamic is manifest in the way medical professionals and institutions maintain authority over medical knowledge and practices. Such control critically influences the shaping of treatment protocols, determines research priorities, and establishes the criteria for what is recognised as legitimate medical knowledge (Cheek & Porter, 1997). This authority over medical knowledge not only dictates clinical practices but also significantly impacts the configuration of power within the healthcare system.

2) *Regulation of bodies*: Foucault introduced the concept of 'biopower' to describe the practices through which modern states exert regulatory control over citizens' bodies (Smart, 2002). Within the healthcare domain, the manifestation of biopower is evident in public health initiatives, such as vaccination programmes, public health campaigns, and screening efforts, which are designed to regulate, monitor, and control the health of individuals and populations (Hsu & Lincoln, 2007). This form of power extends into the operational practices of hospitals and clinics, where medical professionals exercise substantial authority over patients' bodies through a range of treatments, procedures, and methods of medical surveillance. These practices underscore the pervasive influence of biopower in structuring the relationship between healthcare systems and individual bodily autonomy.
3) *Surveillance of health behaviours*: Healthcare institutions employ a variety of surveillance mechanisms aimed at monitoring and modifying patient behaviour, a practice that Foucault would categorise as part of disciplinary mechanisms (Foucault, 2007). These include the implementation of electronic health records, patient monitoring systems, and wellness programmes that monitor lifestyle behaviours such as diet and physical activity (Hsu & Lincoln, 2007). Such surveillance systems are not solely designed to observe patient behaviour but also to align it with health norms that have been established by medical authorities. This alignment illustrates Foucault's theory of how disciplinary power is exercised within healthcare settings to shape and control individual behaviours in accordance with predetermined medical standards.
4) *Power relations between providers and patients*: Foucault's theoretical

framework sheds light on the dynamic power relations existing between healthcare providers and patients, particularly focusing on how power manifests within interactions that encompass consent, patient education, and treatment decisions (Gastaldo & Holmes, 1999). These interactions constitute complex relationships often marked by power asymmetries, where the medical professional generally possesses greater knowledge and, consequently, greater power. This imbalance significantly influences the processes through which decisions about health and treatments are made, underscoring the influence of power structures within the healthcare context.

5) *Governance of healthcare institutions*: The governance of healthcare settings can be effectively analysed through Foucault's theoretical lens, which views administrative power as a determinant that dictates operational protocols and practices. This influence permeates all aspects of healthcare, from patient care standards to staff behaviours (van Rensburg et al., 2016). These governance structures are not only reflective of broader societal norms and power structures but also serve as pivotal arenas where institutional power is both reproduced and contested.

In short, Foucault's analysis of power relations provides a sophisticated framework for examining the complex and often subtle ways in which power is exercised within the healthcare sector. Understanding these dynamics is essential for anyone aiming to effectively navigate, reform, or advocate within the healthcare system.

1.5.2 Weber's bureaucratic authority

Max Weber's theory of bureaucratic authority provides a vital theoretical framework for understanding the structuring of power and control within formal organisations. This theory is especially pertinent for analysing the governance and administrative mechanisms within healthcare organisations, which are typically marked by hierarchical and bureaucratic processes (Hillier, 2022).

Weber identifies three distinct types of authority: traditional, charismatic, and legal-rational (legitimate), of which the legal-rational form is most relevant to modern healthcare organisations (Cockerham, 2015). Legal-rational authority is anchored in established laws and regulations and is expressed through formalised rules and structured hierarchies. In healthcare settings, authority and responsibility are clearly delineated by organisational policies and job descriptions. This precise definition ensures that each role within the hierarchy, from senior administrators to support staff, is specialised and endowed with specific duties that enhance the overall efficiency of the organisation (Ritzer, 1975).

The functioning of healthcare organisations is regulated by an extensive system of rules, which encompass clinical procedures, patient care protocols, administrative tasks, and employee conduct. These rules are strategically crafted to promote consistency, predictability, and fairness in the treatment of both patients and staff. Weber's analysis of bureaucratic organisations highlights the principle of impersonality, where decisions are made based on objective criteria rather than personal relationships or emotional considerations (Ritzer, 1975). In the healthcare context, this principle of impersonality is crucial, ensuring that patient care decisions are grounded in medical evidence and standardised procedures, thereby minimising

the impact of personal biases or subjective judgements (Hillier, 2022).

Additionally, career advancement within healthcare organisations is theoretically grounded in a merit-based system, which is determined by qualifications, performance, and adherence to institutional rules. This system is designed to regulate the professional progression of nurses, doctors, and administrative staff, creating an environment where advancements are earned through demonstrated competency and adherence to professional standards (Ritzer, 1975).

Applying Weber’s theory elucidates the dual nature of bureaucratic organisation in healthcare. On one hand, the establishment of clear hierarchies and structured roles facilitates the efficient management of complex operations. On the other hand, this structured approach can engender rigidity (Burger, 2013; Hillier, 2022). Such rigidity may impede responsiveness and adaptability, which are crucial in patient care settings where individual needs may necessitate deviations from standardised guidelines.

Furthermore, Weber’s concept of legitimate authority is instrumental in analysing the distribution of power within healthcare settings and its impact on decision-making and organisational effectiveness. This theoretical framework sheds light on the power dynamics between various groups, including administrators, clinicians, and other healthcare providers, offering insights into how authority is exercised and contested within these environments (Hillier, 2022).

In summary, Weber’s theory provides a critical lens for analysing the structured, rule-bound, and hierarchical nature of healthcare institutions. It illuminates both the operational strengths and the potential areas for improvement, offering insights into

the mechanisms of governance and administration within these settings. This theoretical approach proves invaluable for understanding the complexities of power and authority in healthcare, and for identifying opportunities to enhance organisational effectiveness and patient care. Through this framework, stakeholders can better comprehend how bureaucratic structures impact both efficiency and adaptability in the delivery of healthcare services.

1.5.3 Emerson's power-dependence relations

Richard Emerson's power-dependence relations theory, developed in the 1960s, offers a robust framework for exploring power dynamics within organisational contexts, such as healthcare settings characterised by complex interdependencies among actors. This theory asserts that the power of one party (A) over another (B) is directly proportional to B's dependence on A for resources or outcomes controlled by A (Emerson, 2019). Consequently, power is not an intrinsic characteristic of either party but is instead a product of their relational dynamics, defined by their respective dependencies. This perspective provides a nuanced understanding of how power operates and fluctuates based on the context of interpersonal and intergroup relationships within organisations.

In healthcare settings, power dynamics are displayed across various stakeholder interactions. For example, the relationship between administrators and medical staff is marked by mutual dependency. Administrators wield significant power over medical staff by controlling essential resources such as funding and infrastructure (de Jong & Benton, 2019). Conversely, the quality of healthcare delivery, which is the primary service of the institution, relies heavily on the expertise and performance of medical

professionals. This interdependence grants medical staff a substantial degree of influence over administrative decisions, thereby balancing the power equation between these groups (de Jong & Benton, 2019). This dynamic interplay highlights the complex nature of power relations within healthcare organisations, where power is not static but fluid, contingent upon the ongoing interactions and dependencies among different stakeholders.

Similarly, the doctor–nurse dynamic effectively illustrates Emerson's power-dependence theory (Grembowski et al., 2002). Nurses frequently depend on doctors for medical directives, positioning doctors in a role of authority. Conversely, doctors also rely on nurses to execute care plans and manage patient information, thereby conferring a measure of power upon nurses within this interdependent relationship. Additionally, specialists who possess unique skills or control over scarce resources, such as surgical teams or intensive care units, exemplify significant authority within healthcare organisations due to the high dependence on their expertise (Fewster-Thuente & Velsor-Friedrich, 2008). This dynamic underscores the complexity of power structures in healthcare, where power is distributed across various levels based on specific skills, knowledge, and resource control.

Patients and healthcare providers are also engaged in a power-dependent relationship, wherein patients typically rely on providers for medical care and expertise. Nevertheless, this power balance can shift depending on various factors, such as the patient's access to alternative care options or their level of medical knowledge (Allande-Cussó et al., 2022). These dynamics illustrate how the distribution of power within healthcare relationships can be fluid and contingent upon the specific circumstances and resources available to each party.

Understanding and adeptly managing power-dependence relations is crucial for healthcare administrators and policymakers in creating more effective organisational structures and processes. By acknowledging and balancing the interdependencies among various groups, healthcare leaders can mitigate conflicts and cultivate a cooperative environment (Baker et al., 2011). For example, enhancing the autonomy and resources available to nurses can reduce their dependence on doctors, thereby redistributing power more equitably within the healthcare team. This strategic reallocation of power can lead to improvements in both the quality of care and job satisfaction among healthcare professionals.

Moreover, strategic management of dependencies—through measures such as diversifying control over resources and enhancing collaboration across functional teams—can facilitate a more balanced power structure. This equilibrium promotes collaborative decision-making and enhances organisational efficiency (Ruigrok & Van Tulder, 2013).

Overall, Emerson's power-dependence relations theory provides insights into the dynamics of power in healthcare and nursing settings by illustrating how power is a dynamic entity, contingent upon shifting dependencies within an organisation. This theoretical lens is particularly useful for navigating changes and resolving conflicts within healthcare institutions, where a deep understanding of power dynamics is crucial for enhancing both operational efficiency and patient outcomes.

1.5.4 Kanter's structural empowerment

Rosabeth Kanter's (1993) theory of structural empowerment provides a framework for understanding organisational power dynamics, emphasising the significance of individuals' structural positions over merely personal attributes or political manoeuvring. This perspective is especially relevant in healthcare and nursing settings, where empowerment profoundly affects professional performance and patient outcomes. According to Kanter (1993), the essential elements of structural empowerment encompass access to information, resources, and opportunities.

Access to information encompasses not only the essential data required for task performance but also insider knowledge about organisational decisions and strategic directions (Pirnejad et al., 2008; Yang et al., 2013). For example, a nurse manager with access to high-level clinical and administrative information is better positioned to influence decisions and advocate for critical resources. Access to resources refers to the tangible assets and personnel necessary to fulfil job responsibilities. In healthcare, this may include access to state-of-the-art medical technology, adequate staffing, and financial support—all of which are pivotal for delivering high-quality care but are typically under the control of upper management. Access to opportunities pertains to the chances to acquire new skills, participate in important projects, or advance professionally. Healthcare organisations that provide ongoing education, career development pathways, and leadership roles enable nurses to assume greater responsibilities and enhance their professional standing, thus fostering an environment of empowerment and growth.

Kanter's theory proves instrumental in analysing how the distribution of power impacts staff morale, job satisfaction, and patient care within healthcare settings

(Miller et al., 2001). Empowered nurse managers, who often act as intermediaries between administrative leadership and bedside nurses, play a crucial role in disseminating information, allocating resources, and facilitating opportunities (Laschinger et al., 1997). When these managers are empowered, they are better equipped to support their teams effectively, which can lead to improved patient care and increased operational efficiency. Similarly, when bedside nurses have improved access to essential information, necessary resources, and opportunities for professional growth, they are more likely to be engaged, committed, and satisfied with their work. This increased job satisfaction can subsequently lead to enhanced patient outcomes.

Understanding the dynamics of structural empowerment enables healthcare leaders to formulate strategies that enhance employee empowerment, thereby improving organisational performance (Haugh et al., 1996; Laschinger et al., 1997). Strategic measures could include decentralising decision-making to allow for greater autonomy across different levels of the nursing hierarchy, thereby enhancing motivation and expediting decision-making processes. Furthermore, improving resource allocation ensures that staff at all levels possess the necessary resources to perform effectively, which helps alleviate stress and prevent burnout. Facilitating professional development by offering opportunities for growth not only boosts workforce competence but also aids in retaining talent.

In conclusion, Kanter’s theory of structural empowerment offers insights into how power structures within healthcare organisations influence both individual and organisational performance. By prioritising the empowerment of nurses through enhanced access to information, resources, and opportunities, healthcare leaders can

significantly improve staff well-being and the quality of patient care. This focus not only boosts individual job satisfaction but also drives overall institutional success.

1.5.5 French and Raven's bases of social power

French and Raven's (1959) bases of social power theory provides a seminal framework for understanding the various sources of influence within organisational contexts. This model is particularly valuable in healthcare settings, where complex power dynamics significantly influence interactions among stakeholders. The theory delineates power into five distinct bases: legitimate, expert, referent, coercive, and reward. Each type of power plays a unique role in healthcare environments, shaping how decisions are made and how relationships are managed within the organisational structure.

Legitimate power stems from an individual's formal position within an organisational hierarchy, granting them the authority to exert control over others (French & Raven, 1959). In the healthcare sector, this type of power is manifest in the roles occupied by administrators, hospital managers, and senior medical staff (Braynion, 2004). The authority inherent in these positions is recognised and respected by other staff members and patients, who adhere to this structured authority in accordance with established societal and organisational norms.

Expert power is derived from possessing specialised knowledge or skills that are highly valued. Within healthcare, doctors, specialists, and other medical professionals possess expert power, as their extensive medical training and expertise empower them to diagnose and treat patients, thereby exerting significant influence within the clinical

setting (Salem et al., 2000).

Referent power originates from personal attributes such as charisma or likability (French & Raven, 1959). In healthcare settings, many providers, including family physicians and nurses known for their compassion, exhibit this form of power. Referent power is crucial in patient care as it significantly enhances patient satisfaction and compliance with treatment protocols. This effect is largely due to the emotional bonds that develop between the provider and the patient, underscoring the importance of interpersonal relationships in the healthcare environment (Salem et al., 2000).

Coercive power, though less desirable, involves the capability to enforce compliance through threats or punitive measures (French & Raven, 1959). This type of power is evident in healthcare settings when providers must ensure adherence to treatment protocols or when management imposes strict regulations on staff behaviour (Li et al., 2023). While sometimes necessary in specific contexts, the application of coercive power can negatively impact morale and trust, making its use in healthcare a sensitive and complex issue that requires careful consideration and management.

Reward power involves the ability to offer incentives that are valued by others (Raven, 2008). In healthcare management, this form of power is utilised to motivate staff through mechanisms such as bonuses, promotions, or other forms of recognition (Siegrist, 1996). Similarly, clinicians may employ reward power by providing preferred treatment options or expedited appointments to patients who demonstrate compliance.

Understanding and strategically applying the bases of power can enhance the management of interpersonal dynamics and organisational structures within healthcare facilities (Li et al., 2023). For instance, bolstering expert power through ongoing professional development can elevate the authority and effectiveness of medical staff. Additionally, nurturing referent power by enhancing patient–provider relationships can significantly improve patient outcomes. Carefully managing the delicate balance between coercive and reward power is crucial for maintaining discipline while also fostering a positive staff morale.

1.5.6 Giddens' theory of structuration

Anthony Giddens' theory of structuration provides a framework for examining the interplay between human agency and social structures within organisational contexts, including healthcare and nursing (Greener, 2008). At the core of Giddens' theory is the concept of the 'duality of structure', which argues that structures are not simply external frameworks that govern human activity; rather, they are both created and modified by the actions they regulate (Cohen, 1989). This notion implies that structures and the activities within them recursively shape one another, emphasising the fluid and evolving nature of organisational dynamics.

The concept of the duality of structure is particularly relevant in healthcare settings, where the interplay between nursing practices and hospital policies illustrates a continuous cycle of influence and adaptation. For instance, although hospital policies might dictate specific protocols for patient care, the practical insights and daily experiences of nursing staff can lead to modifications of these protocols, in turn reshaping the organisational structure (Hardcastle et al., 2005). This cyclical process

ensures that the structures within healthcare organisations remain perpetually responsive to the actual conditions and challenges faced by healthcare professionals.

Furthermore, Giddens emphasises the intertwined relationship between agency (individual actions) and structure (rules and resources), asserting that neither operates independently (Cohen, 1989). This perspective is critical in healthcare, where the agency of nurses is simultaneously enabled and constrained by institutional structures. However, it is through their collective actions that nurses can initiate changes, influencing administrative decisions and potentially reforming organisational norms and policies (Coventry et al., 2015).

Giddens' theory provides a framework for analysing the evolution of healthcare practices and the implementation of new policies (Greener, 2008). Recognising that healthcare professionals frequently operate under stringent protocols, Giddens' approach acknowledges that their professional insights and innovative practices play a crucial role in the ongoing development of these standards (Hardcastle et al., 2005). For example, innovative clinical practices developed by nurses can lead to the formulation of updated guidelines that more effectively meet patient needs and enhance care outcomes.

Furthermore, the theory encourages healthcare leaders to view structure not as a static barrier but as a facilitator of innovation (Bodolica et al., 2016). Understanding the dynamic interplay between agency and structure enables healthcare administrators to create environments that are adaptable and responsive to feedback from frontline staff. This adaptability can be promoted through the development of more flexible policy frameworks that allow for modifications based on real-time inputs from staff or

shifts in patient care demands.

1.5.7 Lukes' three dimensions of power

Steven Lukes' three dimensions of power provide a comprehensive framework for analysing power within healthcare and nursing. This model builds upon earlier theories by introducing three distinct levels at which power operates, offering a more nuanced understanding of how power can influence decisions and behaviours, often in subtle and less visible ways (Dowding, 2006).

The first dimension of power is the most visible, involving direct and observable decision-making where individuals or groups exercise authority through formal (political) mechanisms (Dowding, 2006). This dimension is clearly evident in healthcare settings, particularly in decisions regarding policy and resource allocation. For example, hospital administrators and senior medical staff exercise this form of power when making executive decisions about the adoption of new technologies or treatment protocols.

The second dimension of power extends into the subtler realm of non-decision-making, which involves the ability to control the agenda and prevent certain topics from being discussed, thus effectively shaping organisational focus and priorities behind the scenes (Morriss, 2006). In healthcare settings, this might manifest as leadership deliberately avoiding discussions on potentially contentious yet crucial issues, such as improvements in mental health services. By excluding these topics from the agenda, those in power can significantly influence the direction and priorities of healthcare services without engaging in overt conflict or debate (Donovan & Blake,

1992).

The third dimension of power, termed ideological power, is perhaps the most insidious as it involves shaping or manipulating the desires and perceptions of others to secure acceptance of the status quo (Dowding, 2006). In healthcare, this form of power can be exercised through the promotion of specific treatments or health services that align more closely with institutional interests than with optimal patient care (Reynolds, 2019). This not only influences the direct outcomes of healthcare delivery but also affects how healthcare issues are perceived by both professionals and patients. By subtly guiding their preferences and decisions, ideological power ensures that institutional goals are prioritised, often under the guise of standard practice.

Understanding these dimensions of power enables healthcare professionals and administrators to recognise not only the explicit exertion of power but also its more covert forms (Reynolds, 2019). Awareness of non-decision-making processes, for instance, can help stakeholders comprehend why certain critical issues are overlooked or do not receive the attention they deserve. Additionally, recognising the influence of ideological power aids in identifying underlying motives that may subtly shape healthcare practices and policy directions.

Applying Lukes' framework can significantly enhance efforts to foster more transparent and equitable power dynamics within healthcare organisations. By acknowledging all three dimensions, stakeholders are better positioned to ensure that decision-making processes are not disproportionately favourable to those at the top but instead reflect the genuine needs and interests of all parties involved, including

patients and frontline workers. This approach promotes a more democratic and inclusive environment, ultimately improving the quality and fairness of both patient care and organisational governance within the healthcare sector.

The aforementioned power theories can serve as the basis for empirical research into community nursing practices from various perspectives. Since the primary intention of this thesis is not to perform a theoretical analysis of different forms of power, further comparison between these power theories is not included here. However, justifications for using particular theories in the studies of this thesis will be provided in the corresponding chapters.

1.6 The studies

This thesis examines the intricate power dynamics within China's community nursing system through three interpretative case studies, each informed by distinct theories to address the following questions:

1) What types of power do community nurses wield?
2) What factors may inhibit nurses from exercising their powers?
3) How does the power environment influence healthcare delivery outcomes?
4) What are the formal and informal positions occupied by community nurses within their respective organisational structures?
5) How do these positions influence community nurses' ability to access power within their professional environments?
6) How does community nursing impact health promotion?

Specifically, grounded in French and Raven's typology of social power, the initial investigation categorises the diverse manifestations of power and sheds light on the contextual power constraints faced by community nurses. This analysis underscores the need for initiatives geared towards empowering nurses, thereby leveraging latent power reservoirs to more effectively address the multifaceted needs of patients. Subsequently, drawing upon Kanter's theory of organisational power, the second study examines the ways in which community nurses, functioning as street-level bureaucrats, navigate power resources within their professional milieu. This inquiry reveals glaring asymmetries in power access and emphasises the pivotal role of interpersonal relationships in shaping organisational power structures. Furthermore, it furnishes a conceptual framework for deciphering the interplay of power dynamics among grassroots policy implementers, operating within both formal and informal job structures, with a particular emphasis on equity considerations. The third study, informed by Michel Foucault's concept of biopower, elucidates the profound impact of community nursing on health promotion at both individual and population levels. Three distinct community nursing services are identified as exemplifying biopower approaches to advancing health promotion, which are characterised by their persuasive, constructive, and evidence-based nature, aligning with the quintessence of biopower. This study presents a conceptual framework rooted in the notion of biopower, offering insights into the significant impacts of community nursing services on health promotion at the primary care level.

The integration of French and Raven's typology of social power, Kanter's theory of organisational power, and Foucault's concept of biopower enables a comprehensive examination of the structural, interpersonal, and ideological forces shaping community nursing in a Chinese context. This tripartite approach provides a layered

understanding of how power operates within the community healthcare system and offers a pathway towards reforms that enhance both nurse empowerment and patient care. This thesis contends that understanding and restructuring power dynamics are essential steps towards not only enhancing the professional stature and effectiveness of community nurses but also improving the overall primary healthcare infrastructure.

1.7 Chapter conclusion

This chapter begins by underscoring the pivotal role of primary care as an essential component in achieving UHC, highlighting its critical function in delivering equitable health services. It then progresses to a detailed review of China's healthcare reform efforts, outlining the transformative strategies implemented to enhance healthcare delivery across the nation. Subsequent discussions focus on the nursing workforce and the evolution of community nursing practices, illustrating how these have adapted in response to both healthcare reforms and the changing needs of the population. Additionally, a section introducing foundational social theories of power is presented, setting the stage for future studies to critically examine interactions and dynamics within healthcare and nursing settings. Finally, an overview of the three case studies that form the basis of the thesis is provided, along with the research questions. Collectively, this chapter establishes a solid foundation for an in-depth exploration of the power dynamics within China's community nursing system, emphasising the significance and relevance of this research inquiry.

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Chapter 2: Community Nursing Delivery in Urban China: A Social Power Perspective[1]

This chapter represents the inaugural study of this thesis, which is anchored in the theoretical framework of French & Raven's bases of social power. It explores the dynamics of power as exercised by community nurses within the urban context of Shenzhen, China. Employing thematic analysis of textual data derived from 26 semi-structured interviews and two focus group discussions with community nurses, the study identifies six forms of power: indirect reward, indirect coercion, legitimate position, peer reference, field expertise, and caring information.

The study categorises these forms of power into three relational dynamics: nurse-to-doctor, nurse-to-nurse, and nurse-to-patient, thereby illuminating the potential influences nurses exert within healthcare relationships. The analysis reveals that the exercise of certain powers by nurses is often constrained by two predominant factors: the entrenched power disparity between doctors and nurses, and prevailing patient prejudices against nursing. These constraints contribute to a significant loss of power for nurses, adversely impacting the community health environment. Such power adversities hinder nurses' self-improvement, self-assurance, enthusiasm, and cooperation in care.

By applying the insights of social power theory, this study offers a novel

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[1] This chapter is based on the work published as 'Community nursing delivery in urban China: a social power perspective' in *Social Science & Medicine*, available online at https://doi.org/10.1016/j.socscimed.2023.115923. However, the content of this chapter is not lifted verbatim from the article.

interpretation of community nursing delivery in urban China. It argues that empowering nurses could significantly enhance community healthcare delivery. Enhancing the roles of nurses and developing supportive nursing policies could mitigate negative power dynamics, allowing nurses to more effectively convert their potential power resources into active support for meeting patient needs. This approach suggests a promising direction for policy and practice, aiming to elevate the status and impact of community nursing in urban healthcare settings.

2.1 Introduction

Social science disciplines identify various forms of power, consistently emphasising its essence within the dyadic interactions between two agents (French & Raven, 1959). Such interactions invariably influence behaviour, a phenomenon widely acknowledged in societal contexts (Dahl, 1957). Literature on clinical services delivery explores the dynamics of power among participants engaged in interactive caring processes (De Swaan, 1989). However, public health scholarship has not thoroughly investigated the multifaceted impacts of power within community healthcare settings, where interpersonal relationships are notably intricate (Lehmann & Gilson, 2013). Consequently, community nurses and their professional interactions remain relatively neglected in studies of power dynamics, in contrast to their hospital-based counterparts. This study addresses this gap by examining the social power dynamics experienced by community nurses in urban China, a region where community healthcare is rapidly developing. This investigation highlights critical areas previously overlooked in the discourse on power in healthcare delivery.

Community healthcare serves as a foundational platform for primary care and public

health services, playing a pivotal role in engaging communities in health initiatives (WHO & UNICEF, 2020). It is integral to health systems and is essential for achieving UHC (WHO, 2016). As a populous nation with a rapidly expanding global influence, China is critically positioned in the global health landscape (Li & Chen, 2022). The market-oriented reforms initiated in the late 1970s led to an unprecedented increase in China's urban population, which escalated from less than 20% to over 60%, currently surpassing 900 million (National Bureau of Statistics, 2022). This demographic shift, coupled with public health challenges such as societal ageing, chronic diseases, multimorbidity, and epidemics, has strained the hospital-centric health system in Chinese cities. This strain has culminated in a healthcare crisis characterised by difficulties in accessing and affording medical care (Hu et al., 2008).

The economic liberalisation in China triggered a significant shift towards the privatisation of healthcare, which in turn exacerbated health impoverishment and widened health disparities (Ramesh et al., 2014). In response to public dissatisfaction with the healthcare system and to optimise the alignment of resources with clinical demands, the Chinese government initiated a comprehensive restructuring of its formerly lauded primary care system in the late 1990s. This reform positioned community health services as the primary entry point for healthcare access in urban areas (Bhattacharyya et al., 2011). Consequently, a three-tier health system evolved (see Figure 1), wherein community health service agencies are responsible for delivering primary care and public health services, while secondary and tertiary hospitals offer more comprehensive and specialised care (Jiang et al., 2020).

Figure 1. Three-tier health system in urban China

Tertiary hospitals

Tier 3

Serving as medical hubs for multiple regions, providing specialty care and high-end medical services, and playing a key role in teaching and research.

Two-way referral mechanism

District/secondary hospitals

Tier 2

Serving as health centres for several local communities, providing comprehensive health services, and undertaking medical education and research on a regional basis.

Community health service centres & subordinate stations

Tier 1

Grassroots healthcare institutions, providing primary care and public health services to residents of designated communities.

Source: Synthesised from Jiang et al. (2020).

Note: The three-tier health system is derived from the 'Hospital Accreditation and Management Measures' instituted in 1989. This framework establishes grading indicators for medical institutions, which include overall scale, technical capabilities, equipment, management capabilities, and comprehensive service quality. The concept of two-way referrals serves as a mechanism to facilitate the integration and coordination between different levels of healthcare institutions.

The 2009 health reforms in China, which emphasised enhancing health performance at the grassroots level, significantly accelerated the development of the nation's community healthcare system. Initially, approximately 250,000 practitioners were employed across 27,000 community health service agencies nationwide. By 2020, these numbers had increased to 520,000 practitioners and 35,000 agencies respectively (National Health Commission, 2020). This marked expansion underscores significant advancements in the provision of community healthcare. However, despite these gains, substantial barriers continue to impede the evolution of a system capable of delivering high-quality community health services to urban populations (Li & Chen, 2022).

Although there is an extensive body of literature on the delivery of community health services in urban China, much of this research adopts a macro-observational approach, concentrating on aspects such as health insurance, medical information management, professional training and staffing, and equipment and facilities (e.g., Li et al., 2019; Xia et al., 2020; Yin et al., 2015). While these studies offer valuable insights, they often lack a robust theoretical framework, rendering their contributions theoretically insufficient for a deeper understanding of the service delivery processes. Furthermore, despite the recognised importance of community nurses in advancing health care at the forefront of practice (WHO, 2017), their role remains underexplored in the scholarly discourse. This gap in theoretically informed research on community nursing diminishes the potential for advancing knowledge in nursing practice, constraining our ability to develop effective strategies for improving the caring environment. Additionally, this lack of focused, theoretical exploration contributes to negative and overly cautious public perceptions of community healthcare (Yue et al., 2020).

To address these two significant gaps in the research, this study examines Chinese community nurses through the lens of social power, elucidating how the delivery of community nursing is shaped by specific types of interactional power. Employing a power-centric analytical framework is crucial not only because the concept of power has received limited scholarly attention in community health nursing (Lehmann & Gilson, 2013)—thereby allowing this study to contribute valuable insights to the literature—but also because understanding power dynamics is fundamental to any analysis of human behaviour and societal structures (Haugaard & Clegg, 2009). Furthermore, given that social power fundamentally involves influencing and being influenced within interpersonal relationships—and since such relationships are vital to

effective caregiving and patient outcomes (Budge et al., 2003)—a detailed exploration of power dynamics can enhance our comprehension of care relationships and, consequently, improve nursing practice.

The study pursues three distinct objectives aimed at deepening the understanding of social power within the context of community nursing in urban China. First, recognising the absence of prior studies in this area, it aims to develop an initial conceptualisation of power specific to community nursing. This endeavour is intended to establish a theoretical framework that could stimulate further discussion and debate regarding the role of power dynamics in community nursing. Second, the research seeks to explore the experiences of nurses regarding the use of power, with the objective of differentiating between theoretical power resources and actual power exercises, as well as identifying constraints on power. Third, it analyses the effects of the identified forms of power on healthcare delivery, providing insights that support the promotion of nursing from an empowerment perspective.

To achieve these objectives, this study employs French & Raven's typology of social power as a foundational theoretical tool to delineate power dynamics within community nursing. This approach aids in the identification of specific power constraints and enables a thorough assessment of their implications for healthcare delivery.

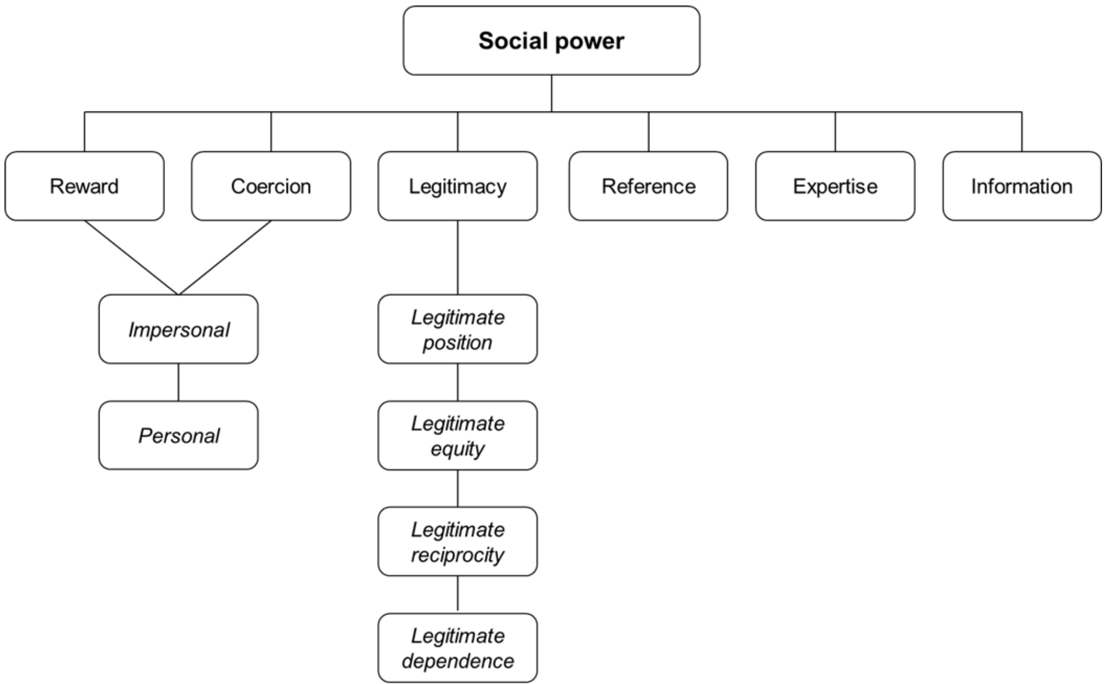
2.2 Theoretical framework

French & Raven's typology of social power commences with foundational concepts such as 'change', defined as the 'alternation of the state of some system over time'

(French & Raven, 1959, p. 151), and ‘social influence’, described as the ‘change in the belief, attitude, and behaviour of a person resulting from the action of another person’ (Raven, 2008, p. 1). French and Raven conceptualised power as ‘the potential for such influence, the ability of the influencing agent or power figure to bring about such change, utilising the resources available to him/her’ (Raven, 2008, p. 1). They interpreted these ‘resources’ as bases of power within the dyadic relationship between the influencing agent and the target of influence. Initially, they identified five principal bases of power: reward, coercion, legitimacy, referent, and expertise (French & Raven, 1959).

Expanding upon this framework to encompass a broader range of dimensions that determine the forms of influence and compliance, Raven (2008) later introduced a sixth category, termed ‘informational’, and further differentiated certain bases, thereby conceptualising a total of 11 forms of social power (see Figure 2). This expanded typology allows for a more nuanced understanding of how power operates within and impacts social interactions.

Figure 2. Typology of social power



Sources: Synthesised from French & Raven (1959) and Raven (2008).

Reward power is rooted in the agent's capacity to offer positive incentives or withhold them, as well as the ability to reduce or remove negative consequences. Coercive power, conversely, arises from the agent's ability to impose undesirable outcomes, functioning primarily as a punitive threat. These two forms of power can be dichotomised into impersonal (or formal) and personal (or informal) categories. Impersonal forms are tangible, such as pay raises, promotions, demotions, or dismissals, while personal forms depend on the target's personal attitudes towards the power wielder, such as the influence derived from liking or admiring someone.

Legitimate power is based on the target's internalised belief in the right of the agent to exert influence and the corresponding obligation of the target to comply. This form of power can be further subdivided into several categories: legitimate position (e.g. subordinates obeying supervisors), legitimate equity (which invokes a compensatory

norm where individuals feel they have the right to request compensation for hard work or suffering), legitimate reciprocity (where individuals feel obliged to reciprocate beneficial actions), and legitimate dependence (where an obligation is felt to assist others who are in need).

Referent power stems from the target's identification with the agent, where the agent is seen as a role model who has earned the target's admiration and likeability. Expert power derives from the target's belief that the agent possesses superior knowledge, skills, or insights within a specific domain. Lastly, informational power involves the agent's ability to persuade the target through the presentation of logical arguments and rational discourse.

French & Raven's typology of power continues to hold significant prominence within scholarly literature (Kovach, 2020) and is particularly well-suited to the micro-level analysis of social interactions that this study requires. Unlike approaches that primarily focus on the power held by dominant individuals or groups, French & Raven's framework offers a versatile tool for examining power dynamics among those who may possess comparatively less power. This aspect of the typology is especially pertinent to the study, given that nursing staff often occupy less empowered positions within the healthcare hierarchy (Radcliffe, 2000). Consequently, employing this typology allows for an examination of the dynamics of power among community nurses from multiple perspectives, thereby providing a richer understanding of their experiences and interactions within the healthcare environment.

2.3 Methodology

2.3.1 Study design

The research adopted a case study methodology, adhering to established normative frameworks as outlined by Crowe et al. (2011). This qualitative research approach allowed for an in-depth understanding of the particular phenomenon under study: the dynamics of power use in nursing practice. Case studies are especially suited for examining complex phenomena within their natural contexts, thus facilitating a comprehensive exploration of both descriptive and explanatory dimensions of the research questions: 1) What types of power do community nurses wield?; 1) What factors may inhibit nurses from exercising their powers?; and 3) How does the power environment influence healthcare delivery outcomes?

I selected qualitative research methods, guided by my epistemological stance and considerations of research feasibility. As Erasmus and Gilson (2008) contend, 'generating information that reveals the influence of power is not very straightforward' (p. 364). This acknowledgement underscores the complexity of capturing the nuances of power dynamics. Qualitative methodologies prove advantageous in observing and interpreting both overt and covert, as well as direct and indirect, manifestations of power phenomena.

2.3.2 Study case

The research questions shape the characteristics of the case study, leading to the identification of the research topic, target social group, and geographical location as critical elements for case definition (Crowe et al. 2011). Consequently, the research topic is defined as the exercise of social power within community nursing delivery.

The target social group is specified as community nurses in non-managerial roles. The geographical focus of the study is Shenzhen—a fully urbanised city in China with a population approaching 18 million (Shenzhen Municipality Bureau of Statistics, 2023).

Nurses occupying managerial roles (such as head nurses), who do not engage in direct patient care, are excluded from the study as they do not align with the research focus on care delivery. The vastness and diversity of urban China precluded its selection as a case site. Given the primary study aim to construct a detailed description of power phenomena, a single case study approach is deemed more suitable than a multiple case approach (Stake, 1995). This study selects Shenzhen as the case site for several reasons.

Firstly, Shenzhen, often referred to as China's Silicon Valley, has undergone a significant economic transformation over the past four decades. Its Gross Domestic Product exceeded RMB three trillion (approximately US$ 430 billion) in 2021, ranking it as the third-largest city economically in China, following Shanghai and Beijing (Upton & Huld, 2022). Leveraging this economic prosperity, Shenzhen has developed an expansive community health network, comprising over 12,000 practitioners across more than 750 community health service agencies (Shenzhen Municipal Health Commission, 2022). According to Stake's (1995) criteria, this robust healthcare infrastructure makes Shenzhen an optimal site for the case study, enhancing the feasibility of data collection.

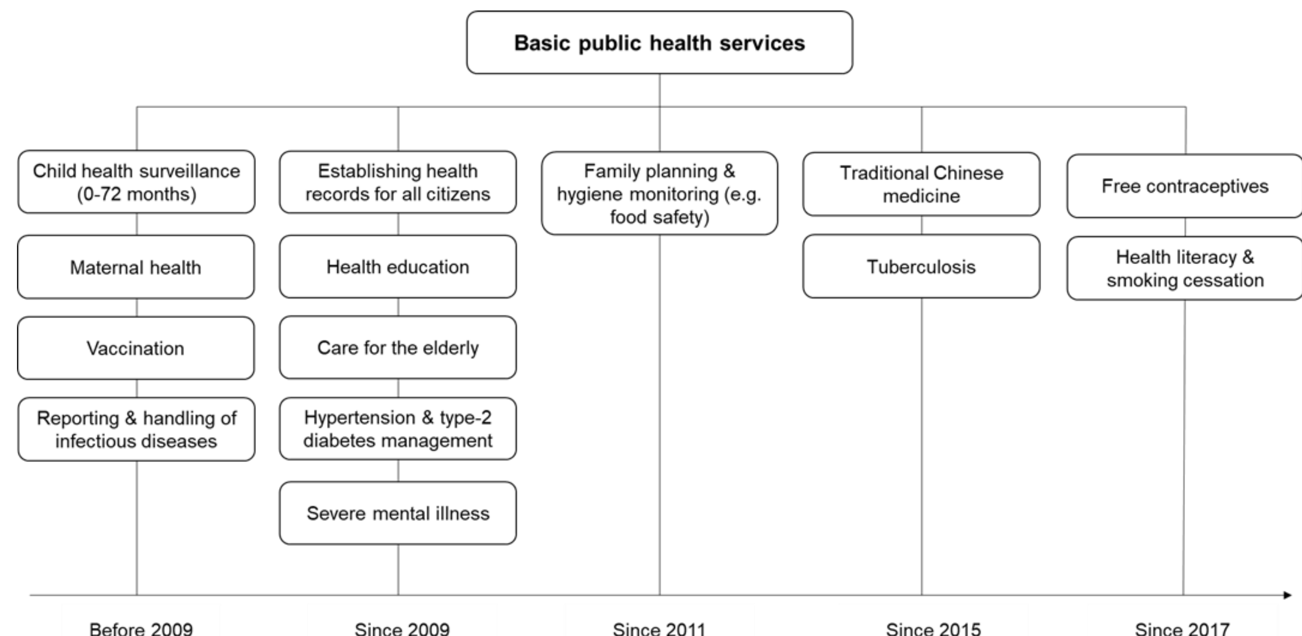
Moreover, as the designated Demonstration Zone of Socialism with Chinese Characteristics, Shenzhen is at the forefront of national experiments and reforms in

various sectors, including primary care and public health services (Wu et al., 2016). This pioneering role facilitates the dissemination of experiences and policies from Shenzhen to other cities across China through mechanisms of learning, diffusion, and replication.

It contends that selecting Shenzhen as the representative city renders the case study particularly instrumental (Stake, 1995), thereby enhancing the conceptual transferability of the findings (Crowe et al., 2011). This strategic choice supports the generation of insights that are not only relevant locally but potentially applicable in broader contexts.

Shenzhen's community health service agencies serve as the primary point of contact for most residents seeking healthcare, and their role has been progressively expanding (Wu et al., 2016). These agencies have traditionally focused on delivering primary care and basic clinical services. However, public health services now constitute a significant component of the routine activities of community health practitioners (Ke et al., 2020), as depicted in Figure 3. Additionally, national policies, such as the Chinese Medicine Health Services Development Plan, prioritise the integration of TCM within community healthcare settings (Meng et al., 2020). This policy direction has catalysed a transformative shift in Shenzhen's community health service agencies. Once primarily providers of basic and primary care, these agencies are evolving into multifaceted platforms that amalgamate primary care, clinical care, public health services, and complementary and alternative medicine.

Figure 3. Basic public health services in urban China



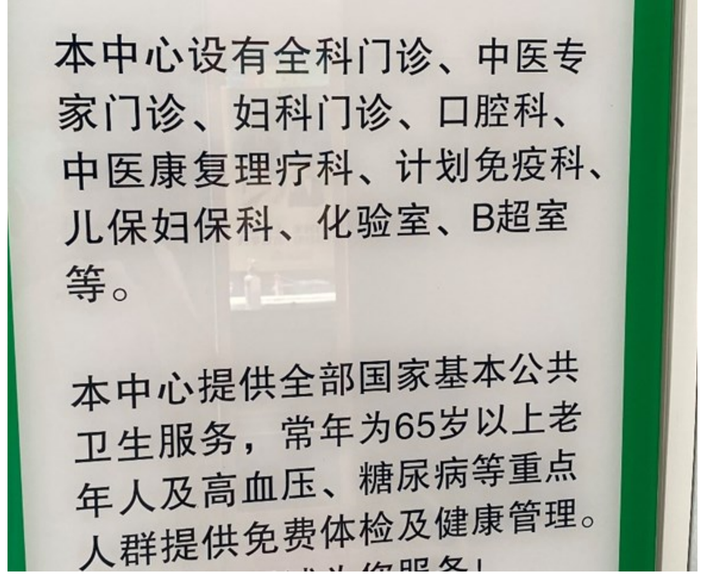
Source: Synthesised from Yuan et al. (2019).
Note: The timeline illustrates the integration of specific services into the basic public health services package.

Accordingly, community health services in Shenzhen are designed to cater to a diverse array of residents, each with distinct backgrounds and specific health needs. These services comprehensively address the requirements of various demographic groups, including women and children in need of vaccinations, elderly individuals seeking physical examinations, patients with chronic illnesses requiring ongoing medication management, and those in need of physiotherapy interventions.

Figure 4 illustrates the various departments within CHCs in Shenzhen. The diverse range of service users ensures a variety of interactions between community health practitioners and clients, including roadshows, home visits, and telephone follow-ups (Wang et al., 2019). The majority of these interactions take place within community health service agencies for several reasons. First, many services necessitate a professional setting for delivery, such as vaccinations and blood tests, which cannot

be adequately administered outside of these controlled environments. Also, encounters between doctors or nurses and patients primarily involve basic health services that require minimal specialised care arrangements, such as family beds (Zhou et al., 2013). Additionally, staff shortages, which are a common issue within these agencies (Li & Chen, 2022), further constrain the ability to offer a broader range of care interactions, limiting the variety of patient–practitioner engagements.

Figure 4. Departmental setting of a community health service centre in Shenzhen



Source: Photograph by author.

Note: Paragraph one: The centre features an array of service and functional departments, such as general practice, traditional Chinese medicine, gynaecology, stomatology, rehabilitation and physiotherapy, immunology, childcare and women's health, laboratory services, and type-B ultrasound. Paragraph two: The centre provides all basic public health services. Individuals over the age of 65, as well as those with hypertension and diabetes, are entitled to complimentary physical examinations and health management services.

2.3.3 Participant recruitment

Purposive sampling was used to select the research participants (Palinkas et al. 2015). To capture a broad spectrum of opinions, restrictive eligibility criteria were intentionally minimised. Community nurses with at least one year of full-time work

experience were deemed eligible. The sampling strategy was iterative, designed to ensure representation of key differences and allow flexibility in the composition of the final sample (Robinson, 2014). The sample was continually refined, and new participants were recruited during the provisional stages of data analysis to achieve informational saturation (Bernard, 2011). This approach enhanced the efficiency of the recruitment process, mitigated selection bias by preventing premature closure of selection, and maintained a reflective stance to maximise the neutrality of the selection results (Francis et al., 2010).

Eligible potential participants were invited from a list of WeChat contacts with community health practitioners, established during previous research (Li & Chen, 2023). Individual electronic informed consent was obtained via WeChat prior to any interview or group discussion. To prevent inadvertent disclosure of identities, all participants remained anonymous throughout the research process.

2.3.4 Data collection and analysis

Data were collected through semi-structured individual interviews and group discussions, providing participants with the freedom to express their ideas and enabling the modification of questions as needed. Interview guides were designed to explore: 1) experiences of interacting with care participants; 2) understandings of influencing and being influenced by others involved in care; and 3) attitudes towards care delivery under circumstances of interpersonal influence. Core questions were included to elicit participant views regarding specific types of power (e.g. ‘How do you positively or negatively influence doctors?’—addressing reward or coercion; ‘How do older nurses influence you?’—considering legitimacy; ‘How do model

nurses influence you?'—referring to referent power; 'How do patients respond to your care?'—focusing on expertise or information).

Interviewees' vocabulary, concepts, and ideas contributed to these modifications (Britten, 1995). For instance, the initial interview began with a general question about influencing co-workers, using the phrase, 'How do you influence your co-workers?' It soon became apparent that the term 'co-worker' was too ambiguous, as the interviewee had distinct perceptions of influence on doctors compared to nurses. Therefore, in subsequent interviews, the question was refined to: 'How can you influence doctors and other nurses?' followed by, 'How does your influence on doctors and nurses differ, and why?' This refinement facilitated a deeper understanding of participant perspectives, which informed the construction of profession-based power dynamics.

Twenty-six nurses from 14 CHCs (see Table 2) were interviewed remotely via WeChat between July and September 2022 (Douedari et al., 2021). Ten of these nurses were randomly selected to participate in two group discussions, consisting of five nurses each, in October 2022, to clarify and expand initial findings (Krueger, 2014). A café in the city centre was chosen for the discussions to create a comfortable environment and minimise distractions. Each participant received a hotpot dining voucher worth 200 *yuan*, and those who attended the group discussions received an additional 100 *yuan* in cash. Interviews and group discussions, which lasted between 40 to 120 minutes, were conducted in Mandarin and digitally audio recorded.

Table 2. Research participants

Code	Age	Sex †	Educational level	Code	Age	Sex †	Educational level

IW1 *	23	Male	SV diploma	IW14	26	Female	Bachelor’s degree
IW2 *	25	Female	PSV diploma	IW15 **	25	Female	PSV diploma
IW3	24	Female	PSV diploma	IW16	26	Female	SV diploma
IW4 *	31	Female	PSV diploma	IW17 **	29	Female	SV diploma
IW5	42	Female	SV diploma	IW18	34	Female	PSV diploma
IW6	29	Female	PSV diploma	IW19	25	Male	PSV diploma
IW7	27	Female	PSV diploma	IW20	37	Female	PSV diploma
IW8	24	Female	Bachelor’s degree	IW21	41	Female	SV diploma
IW9	29	Female	SV diploma	IW22 **	25	Female	PSV diploma
IW10 *	30	Female	PSV diploma	IW23	43	Female	SV diploma
IW11 *	35	Female	SV diploma	IW24	34	Female	PSV diploma
IW12	40	Female	SV diploma	IW25 **	24	Female	SV diploma
IW13	45	Female	SV diploma	IW26 **	27	Female	PSV diploma

Note: * First focus group discussants (G1); ** Second focus group discussants (G2). † Attempts were made to diversify the sample by including more male participants; however, the scarcity of male nurses in the study areas hindered this effort. SV denotes secondary vocational; PSV refers to post-secondary vocational.

Audio recordings were transcribed verbatim, and transcripts underwent quality checks to confirm their exact correspondence with the digital files. Thematic analysis was conducted using ATLAS.ti software (Braun & Clarke, 2006). The process began with a detailed reading of the transcripts to achieve familiarity with the textual data. Open coding was then applied to generate descriptive and interpretive codes. These codes were collapsed and clustered to outline potential themes, which were subsequently reviewed to ensure consistency of interpretation. Axial coding was used to link categorised themes.

To enhance the trustworthiness of the coding process, member checking was performed with three randomly selected participants (Morse, 2015). Data saturation was determined to have been reached when further analysis revealed no new themes (Guest et al., 2020).

2.3.5 Ethics

The study was ethically approved by the Institutional Review Board of The Hong Kong Polytechnic University (reference number: HSEARS20210417003).

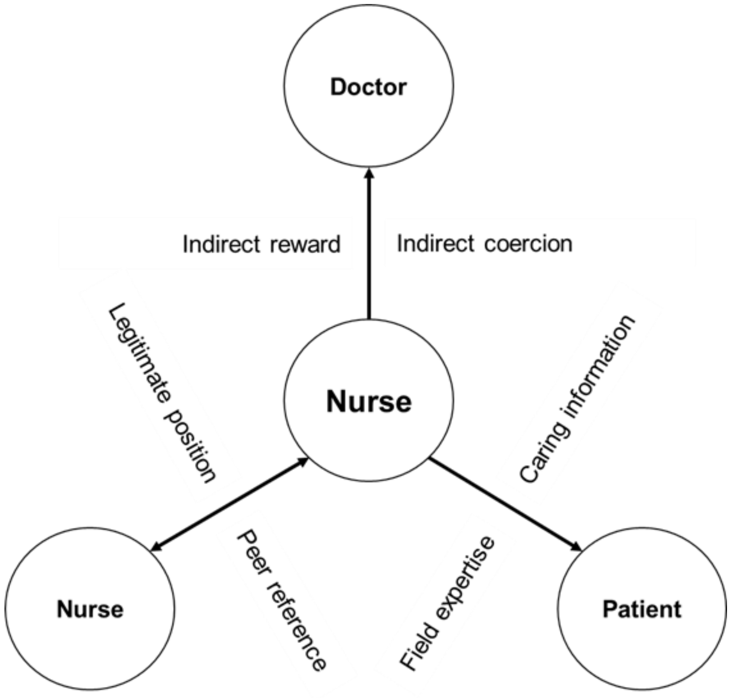
2.4 Findings

The analysis reveals three overarching themes, which are delineated below: 1) trichotomous power dynamic; 2) power constraints; and 3) care delivery under conditions of power adversity.

2.4.1 Trichotomous power dynamic

Following French & Raven's typology, this study identifies and conceptualises powers around the six core bases of power: reward, coercion, legitimacy, reference, expertise, and information. To align with different targets over whom power is exercised, these powers are categorised into three clusters: nurse-to-doctor, nurse-to-nurse, and nurse-to-patient. This tripartite categorisation delineates the potential influences of community nurses in relation to major healthcare actors, as illustrated in Figure 5.

Figure 5. Trichotomous power within community nursing



Source: Author's work.

Note: Arrows indicate the direction of power flow.

2.4.1.1 Nurse-to-doctor: indirect reward and indirect coercion

Reward and coercion in this context relate specifically to the dynamics between nurses and doctors, demonstrating the stimulus-led (positive or negative) influence of the former on the latter. Within community health service agencies, there is a clear division of stewardship: doctors are responsible for diagnosing patients, while nurses manage treatment. This delineation underscores the necessity for cooperative interactions between these two clinical roles. The efficacy of doctors' job performance is significantly dependent on the dedication of nurses to collaborative practices. For instance, should nurses exhibit a lack of commitment to teamwork, the burden on doctors would increase, potentially leading to diminished outputs and negative evaluations by directors overseeing their performance. In this way, community nurses indirectly wield (un)desirable outcomes for doctors by modulating their level of care. Although reward and coercion do not originate directly from nurses, these forces are

mediated by the—relatively predictable—actions of directors. Therefore, this study characterises the influence exerted by nurses on doctors through the agency of a third-party director as indirect reward and indirect coercion (Raven, 2008).

> *"The interdependence of doctors and nurses is fundamental to our roles. ... My duty is to treat patients according to the assessments of doctors. ... When collaborating with a doctor I dislike, my engagement may wane, potentially compromising patient care. Consequently, both the doctor and I could face repercussions from our director. Conversely, when I work with a doctor whom I respect and like, I commit fully, enhancing our performance and increasing the likelihood that both of us will be recognised [by the director] for our superior achievements."* (IW7)

A nurse shared her interaction with a doctor, illuminating the coercive power she exerted:

> *"One day, we were administering influenza vaccinations to children. The doctor on duty for immunisation handled billing, while I was responsible for giving the injections. As the crowd increased, her demeanour deteriorated, and she began yelling at me in a commanding tone. I thought to myself, 'You're tired, and so am I! It's not like I'm resting on the couch! You're not my boss, so why are you yelling at me?' In response, I became less active and slowed down the injections, thereby exerting a negative influence on our workflow. As a result, we ended up working overtime that day and still failed to complete our tasks, which led to a reprimand [soft punishment] from our director."* (IW8)

Not every nurse is 'unforgiving'. Whether or not to use coercion depends on both

situation and personalities, as another commented:

> *"Coercion leads to conflicts. ... I prefer to avoid conflicts with anyone, doctors included. ... I am not an aggressive person."* (IW20)

2.4.1.2 Nurse-to-nurse: legitimate position and peer reference

The study observes patterns of influence and compliance among nurses, particularly from older to younger nurses, which can be attributed to the age advantage entrenched within societal norms (Raven, 2008). This age-based influence is generally accepted within the nursing community, granting older nurses the authority to dictate behaviours for their younger counterparts. Such acceptance elevates the position of older nurses, legitimising their dominant role within the power hierarchy (French & Raven, 1959). This study identifies age-based influence as an embodiment of legitimate positional power. As highlighted by a group discussant:

> *"Older nurses tend to take charge, and younger nurses often comply simply due to the seniority of their colleagues. This age advantage confers special rights upon older nurses. ... The compliance of the younger nurses reflects their acceptance of the influence exerted by their older counterparts."* (G2)

Secondly, the analysis reveals that certain nurses exhibit charisma and gradually earn the admiration of their peers. For instance, nurses who demonstrate energy, stamina, and diligence often ascend to the status of informal role models. These role models possess significant power to influence others, with peers frequently adopting the advice, instructions, and values of such model nurses to strengthen their connections with these 'idols'. This type of influence exerted by model nurses over their peers is

identified as peer referent power, exemplified by one interviewee's description of a colleague:

> *"Chen [26 years old] is someone I deeply admire for her diligence. ... Chen had only recently joined the centre when COVID-19 began to affect the city. Since then, she has not only been involved in health education but also took charge of conducting nucleic acid tests on community residents in residential quarantine. Nearly every working day, she visited numerous households, tirelessly navigating multiple floors, often emerging drenched in sweat. ... Despite the stressful nature of her duties, she seldom complained. ... Chen's dedication and attitude towards her work profoundly influence me, energising me. ... Chen truly exemplifies a model community nurse, and I am inspired to emulate her approach in my professional endeavours."* (IW9)

2.4.1.3 Nurse-to-patient: field expertise and caring information

Community nurses wield considerable influence over their patients. The majority of nursing behaviours during care are perceived by patients as rational and essential, largely due to the patients' confidence in the nurses' clinical expertise and skills. This dependence on nurses is pervasive throughout the care process. Particularly noticeable within community health service agencies, patient dependence manifests as obedience, thereby enabling nurses to exert significant influence, and at times, control over their patients. Drawing on French & Raven's concept of expert power, the term 'field expertise' is adopted to conceptualise the influence that community nurses exert on patients, an influence compounded by the patients' trust in the nurses' competencies. A group discussant noted the following about this expression of expert power:

> *"As registered nurses, our specialisation in care is pivotal. Patients, often unfamiliar with professional healthcare, must depend on us for their treatment and medication; indeed, who else can they turn to?"* (G1)

This power facilitates nurses in persuading patients, evident both through smoother communication when delivering services and increased patient receptiveness to nurses' advice on health promotion. Although additional effort is occasionally necessary to convince patients, this does not suggest a waning in patient compliance with nurses or the healthcare information provided. Community nurses, endowed with the aura of health professionalism, are generally perceived by patients as authoritative and knowledgeable, thereby enhancing their persuasive capacity. This capacity is particularly influential in inducing behavioural changes, especially during the provision of follow-up services for chronic conditions. Drawing upon Raven's conceptualisation of informational power, this persuasive ability is characterised as 'caring information'. An interviewee highlighted this dynamic as follows:

> *"I conduct follow-ups with hypertensive patients, monitoring not only their physical condition and medication adherence but also providing advice on lifestyle improvements. Convincing patients to alter their lifestyles could be challenging, requiring me to repeat explanations frequently. However, reassuringly, most patients adhere to my guidance. Given my role as a nurse, the information I provide on care is considered dependable."* (IW3)

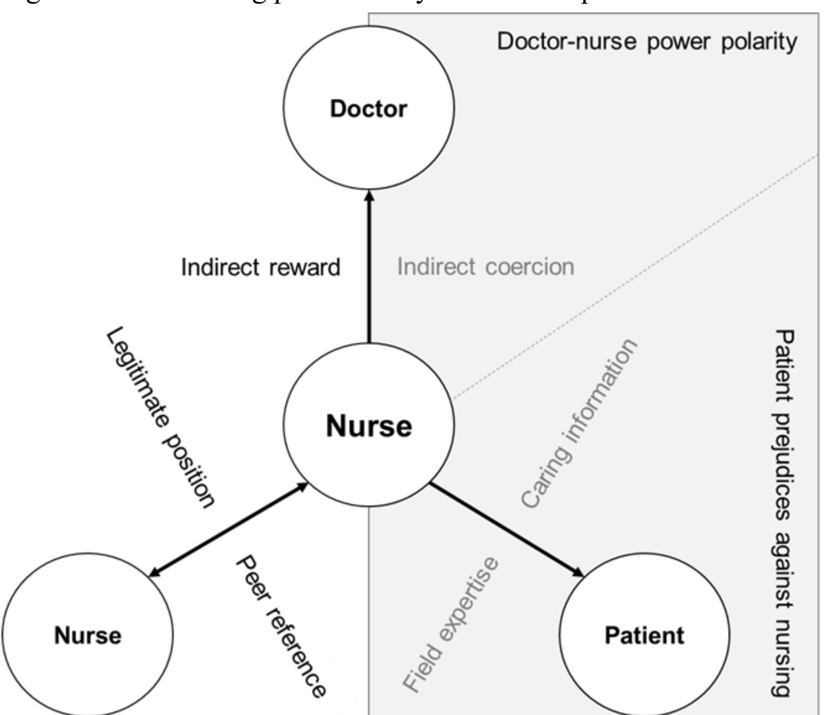
Frequent interactions enhance patients' trust in community nurses, solidifying the basis for nurses to utilise informational power effectively. As one interviewee shared:

“There is a patient suffering from chronic disorders. Initially, she visited me once a month for check-ups. As our interactions increased, she began to see me more regularly. ... I could sense her growing trust in me, as she frequently sought my advice [advantage to using informational power] regarding her health.” (IW11)

2.4.2 Power constraints

Despite possessing power bases to influence other care actors, community nurses often face challenges in exercising social power within an unequal power system. The three identified powers—indirect coercion, field expertise, and caring information—are constrained by two seemingly immutable factors: the doctor-nurse power polarity and patient prejudices against nursing. These factors negatively impact the use of nurses’ power. Doctors hold the majority of power in community health services, a dynamic that is reflected in the tripartite power model as a constraining influence on nurses’ experiences of their own social power (see Figure 6).

Figure 6. Constraining power use by doctors and patients



Source: Author's work.
Note: The shaded areas highlight three community nurse powers that are negatively impacted by two contextual factors: the doctor-nurse power polarity and patient prejudices against nursing. These influences are dichotomised based on two power relations: nurse–doctor and nurse–patient.

2.4.2.1 Doctor–nurse power polarity

Community doctors wield significant power due to their dual roles as clinicians and managers. In China, community health services are typically delivered by family-doctor teams, consisting of one doctor and several nurses. As team leaders, doctors are tasked with patient care and also hold managerial responsibilities, including supervising team members and managing team affairs. This combination of clinical and administrative duties endows community doctors with authority that is unlikely to be significantly challenged by nurses' actions. Consequently, nurses rarely employ coercive power, recognising the limited likelihood of success in power struggles with doctors and the potentially severe consequences of engaging in power antagonisms. Instead, nurses most often utilise reward power, aiming to align with doctors' preferences and avoid potential severe reprisals. A group discussant elaborated on this dynamic:

> *"Indeed, our actions can significantly influence doctors' job performance. If we perform poorly, it reflects directly on the doctors, who may then face repercussions [from directors]. However, very few nurses choose to compromise their performance as a means of penalising doctors. To avoid discomfort and conflict, we generally refrain from antagonising doctors. Instead, almost all of us strive to maintain their satisfaction [e.g. by adhering to their directives]. After all, our professional advancement is largely dependent on those in positions of power, such as doctors."*

(G1)

However, it is observed that some nurses are undaunted by doctors' 'repressive' authority. This trait is attributed to personality characteristics, as described by an interviewee:

> *"Whenever someone deliberately undermines my interests, I will retaliate, regardless of whether they are a doctor or a nurse. ... I admit that I tend to be somewhat vengeful."* (IW7)

Nevertheless, the overt power of doctors tends to diminish the influence of nurses and exacerbate the power disparity. At the community level, most nurses lack professional titles or specialisations, functioning primarily as general nurses. Moreover, unlike hospitals, the organisational structure of community health service agencies is predominantly horizontal, which limited significant promotional opportunities. A lack of advanced education further hinders nurses' prospects for career advancement, positioning them lower in the hierarchy. This situation fosters a perceived sense of powerlessness among nurses, especially among younger ones who are frequently deemed inexperienced. One interviewee expressed this frustration:

> *"The key to gaining power is through promotion. ... Promotion relies on educational background or work experience. Unfortunately, I possess neither an outstanding diploma nor sufficient work experience. Thus, for me, this state of powerlessness appears interminable."* (IW22)

The perceived inferiority of nurses relative to the supremacy of doctors creates a

polarised power structure, serving as an internal contextual constraint on nurses' ability to exercise coercive power. This polarisation results in pronounced power differentials and asymmetries within the community health system. As observed by a group discussant:

> *"Power inequality between doctors and nurses is pervasive and has become a traditional aspect of the system. ... Nurses and the nursing profession are consistently viewed as inferior, ... a situation that is unlikely to change in the foreseeable future."* (G2)

2.4.2.2 Patient prejudices against nursing

This power differential is also evident in patient attitudes, where prejudice against nursing emerges as a significant barrier to community nurses' ability to exercise power. Specifically, some patients regard nurses as subordinate to doctors and consider their services less crucial. This perception adversely affects patients' trust in nurses, diminishing their perceived reliance on nursing care and complicating communication between the two parties. Moreover, it can heighten patients' resistance to healthcare information provided by nurses. Consequently, community nurses note that their efforts to influence patients are not always successful. As one interviewee remarked:

> *"Some patients are hesitant to engage with me, displaying impatience and even hostility. From their reactions, it is evident they lack trust in me. ... They regard doctors as far more significant and treat them with marked deference, which leaves me feeling marginalised and diminishes the effectiveness of the care I provide."* (IW2)

Another interviewee poignantly illustrated this prejudice in a nurse-patient interaction:

> *"A hypertensive patient once came for a consultation and initially approached me to inquire about medications. Shortly after, he noticed a doctor passing by, promptly stood up, interrupted the doctor, and posed the same questions! This experience was quite disrespectful to me. ... Knowledge of hypertension medication is fundamental for nearly all healthcare professionals in our centre. Doctors are aware of it, and so are we, the nurses! ... In fact, he received the same answers from the doctor as he had from me [I overheard this because I was sitting right next to them]. Perhaps he wanted to confirm my information with the doctor? Regardless of his reason, it was evident that he trusted the doctor more [sigh]."* (IW24)

This prejudice not only diminishes the professional stature of community nurses in the eyes of their patients but also weakens their persuasive capabilities. As an external contextual factor, patient biases impede nurses' application of expert and informational powers. This effect is particularly pronounced among younger nurses, who are often perceived by patients as less competent. A younger interviewee observed:

> *"Some patients perceive me as not only subordinate to doctors but also to older nurses, whom they trust more due to their more experienced appearance. This perception significantly undermines my authority in providing care."* (IW16)

2.4.3 Care delivery under conditions of power adversity

Power adversities stemming from contextual constraints significantly impact care delivery. This study examines these impacts through four critical dimensions identified in the analysis: self-improvement, self-assurance, enthusiasm, and cooperation. These elements are essential from a provider perspective for maintaining a robust care delivery system.

First, the challenging power dynamics hinder nurses' self-improvement. In healthcare, the quality of medical staff is crucial, and self-improvement—representing a proactive approach to learning—is vital for enhancing caregiving capabilities. As nurses advance their skills and knowledge, their influence within the healthcare setting tends to increase. Typically, nurses who are perceived as more capable are more likely to be trusted and relied upon. However, the polarised power structure dampens nurses' motivation to enhance their skills, as many believe that self-improvement will not substantially change their relative powerlessness compared to doctors and can, in fact, add further pressure. Consequently, it is unlikely that quality of care will improve through training initiatives. As one interviewee expressed:

> *"Training might enhance my technical skills, but it does not elevate my status within the organisation. ... The idea of gaining more power by improving skills seems like a pipe dream. I would prefer to avoid the trainings, as they only result in fatigue without offering any real benefits."* (IW1)

Secondly, the challenging power dynamics diminish nurses' self-assurance. Prejudices held by patients against nursing, coupled with a consequent erosion of trust, lead nurses to doubt their own abilities and act with increased indecision. This further

weakens patients' confidence in the nurses' expertise and the healthcare information provided, potentially creating a vicious cycle of distrust, indecision, and perceived inadequacy in care. An interviewee observed:

> *"My confidence in my abilities wanes, especially under the scrutinising gaze of patients. Even when I subconsciously know I am correct, I find myself compelled to double-check with colleagues. Although this does not significantly impact the care provided, it has created a communication and trust gap between the patients and myself, leaving them with the impression of my incapacity."* (IW26)

Thirdly, the challenging power dynamics dampen nurses' enthusiasm. For many participants, feeling relatively powerless translates into being at the mercy of more powerful individuals, or even facing bullying. When their hard work does not alter this disadvantaged status, many opt not to invest their full energy into caregiving but instead treat their work as merely a job requiring minimal effort. Consequently, inertia and thoughts of resignation are not uncommon among nurses. Once the passion for care diminishes, how can the strength and sustainability of nursing be maintained? A group discussant remarked:

> *"We perform our duties not out of passion, but because we need to earn a living. ... Many of us aspire to work in hospitals where there are more opportunities for promotion, better welfare, and higher pay, all of which confer a sense of power. The situation where we currently work is quite the opposite. ... We feel a lack of hope and find it difficult to remain energetic or positive at work. ... Many simply go through the motions, handling their tasks mechanically."* (G2)

Lastly, power adversities compromise the effectiveness of teamwork, creating an invisible barrier that hinders cooperation among community healthcare professionals. Power disparities between doctors and nurses, as well as between senior and junior nurses, impede the development of professional relationships characterised by rapport, trust, solidarity, and mutual respect. In the absence of high-quality cooperation, the care process remains disjointed. An interviewee shared:

> *"I have difficulties with some co-workers, particularly the older ones who exert their power in a domineering manner. ... At times, I chose to ignore their directives. ... Once, our director requested that I conduct a free medical consultation alongside such a colleague. I refused because I simply did not want to collaborate with her [consequently, the activity was not carried out]."* (IW14)

2.5 Discussion

2.5.1 Key findings

This study investigates the influence of community nurses on healthcare delivery in urban China through the lens of French & Raven's typology. It outlines a trichotomous power dynamic across three interfaces within community health settings: nurse-to-doctor, nurse-to-nurse, and nurse-to-patient. This dynamic is characterised by a predominance of doctors' power, which shapes the analysis of two contextual constraints on nurses' exercise of social power: the doctor-nurse power polarity and associated patient prejudices. These factors, in turn, affect nurses' initiatives towards self-improvement, their self-assurance, enthusiasm, and cooperation, and indirectly influence the overall delivery of clinical care.

2.5.1.1 Nurse–doctor power dynamic

Stein (1967) introduced the term 'doctor–nurse game' to describe the interprofessional dynamics between doctors and nurses, suggesting that nurses' passivity reinforces a professional hierarchy dominated by doctors. Over time, significant social changes and redefinitions of nursing roles have ostensibly shifted this dynamic, with nurses increasingly seeking expertise, discretion, respectability, and equality, as noted by Stein et al. (1990). Brown (2019) posits that such role enhancements potentially expand the power of nurses, flatten hierarchical structures, and eventually dissolve the traditional 'game'. This evolution might be particularly evident in hospital settings where the complexities of emergency, specialty, and intensive care demand assertive nursing roles (Phillips & Norman, 2020).

Contrary to these predictions of empowered nursing roles championed by Stein and many feminists, the findings align more closely with Radcliffe's (2000) assertion of 'new game, same result'. Focused on general practice, community healthcare is less complex than hospital care and does not necessitate advanced nursing skills. This inherent simplicity restricts community nurses from augmenting their power through specialised training, as suggested by Brown (2019). The lack of specialisation, coupled with mediocre educational standards, perpetuates a sense of professional powerlessness among community nurses. Nickelsen (2019) discusses how the relatively flat organisational structures of community health services and the scarcity of promotional opportunities further impair nurse empowerment, perpetuating feelings of oppression and inferiority.

James and Bennett (2022) identify clinical leaders as potential agents of change in transforming the doctor–nurse dynamic by addressing nurse disempowerment. This

notion supports Raven's (2008) third-party perspective and the study's observations of indirect reward and indirect coercion. However, clinical leaders do not consistently mediate power disparities, particularly in community health settings where leadership norms traditionally favour doctors (Nickelsen, 2019). The dual role of doctors in China's family-doctor system reinforces their dominant position and exacerbates power challenges for nurses. Consequently, nurses' motivation for self-improvement remains subdued, their enthusiasm for caregiving wanes, and adversities in power discourage cooperative efforts, leading to a lack of mutual support in care delivery (Daiski, 2004).

2.5.1.2 Nurse–nurse power dynamic.

Considerable discussion exists regarding the interprofessional relationships between doctors and nurses, yet relatively little focus has been placed on intra-professional interactions among nurses. The study explores influences among community nurses in terms of legitimate position power and peer referent power. Legitimate position power is particularly pronounced due to age advantages and is grounded in social norms. Older nurses, especially in traditional societies such as China where Confucianism advocates 'respecting the older' as a moral norm, often wield this form of power. This cultural value fosters age-based power differentials (Raven, 2008), which can dampen younger nurses' enthusiasm for caregiving.

In contrast, peer referent power, deriving from appealing personal qualities (Vecchio, 2007), transcends age distinctions and is oriented towards individual characteristics (Kovach, 2020). Those who possess this type of power do not necessarily occupy formal or managerial positions; however, they exert leadership influence within the workplace through peer recognition (Kovach, 2020). The findings suggest that, with

its positive attributes, peer referent power may bolster cohesion among nurses. This contrasts with how age-based influence tends to alienate younger nurses and hinder care delivery by disrupting cooperation and collective commitment (Kunze et al., 2010).

2.5.1.3 Nurse–patient power dynamic.

The nurse–patient power dynamic is scrutinised, revealing two principal forms of influence exercised by community nurses in front of patients: field expertise and caring information. Both forms are closely linked to patients' perceptions of nurses' clinical knowledge and skills (Kettunen et al., 2002). Power imbalances between nurses and patients are well-documented, particularly in hospital settings where patient empowerment is often hindered by nurses' reluctance to share power (Henderson, 2003). However, in the context of Chinese community health, it appears that nurses' influence over patients may be diminished due to rising patient resistance against nursing. This resistance stems from societal stereotypes portraying nurses merely as 'ancillaries' to doctors, which erodes patient trust in community nurses and disrupts communication between the two parties.

In hospital environments, effective communication is recognised as a key strategy to balance power among care participants (Tan et al., 2017). Conversely, open communication between nurses and patients often falls short in these settings (Hewison, 1995). In the community context, nurses show a readiness to engage patients in communication; however, efforts are frequently rebuffed due to patients' low trust in nursing professionals. This trust deficit is particularly challenging for younger community nurses, who are often viewed as inexperienced by patients, reinforcing social norms that prioritise age-based experience. The findings indicate

that unlike the nurse–patient power asymmetry typically seen in hospitals, characterised by nurses' dominance (Henderson, 2003), the prejudice and resulting low trust in the community setting create a detrimental power dynamic for nurses. This adverse environment undermines community nurses' confidence and effectiveness in care delivery.

2.5.2 Nurse empowerment

Community nurses play a pivotal role on the front lines of healthcare, possessing the potential to significantly influence the broader community healthcare landscape. As such, empowering these professionals is crucial for enhancing healthcare delivery in Chinese cities and potentially other regions. The case study conducted in Shenzhen has identified two key implications for empowering community nurses.

First, there is a need to redefine the roles of healthcare professionals within China's family-doctor system. To foster equity in doctor–nurse power relations, it is essential to eliminate the dual role of doctors and to augment the roles of nurses. Nene et al. (2020) propose a framework to enhance nursing in the context of primary care, providing potential guidance for role enhancement of community nurses in China. Moreover, the role of clinical leaders should be strengthened as they play a crucial role in mediating power confrontations and achieving balance in power relations among healthcare professionals (James & Bennett, 2022).

Secondly, empowering nurses necessitates policy support. Although there has been commendable progress in China's community healthcare over the past decade, policies specifically aimed at community nursing have not seen equivalent

development. Using Shenzhen—a city at the forefront of China's policy reforms—as an example, while policies on community healthcare have been enacted, few specifically cater to the needs of community nursing. Some recognition of community nursing development exists within broader public health policies, such as the Shenzhen Special Economic Zone Medical Ordinance (Health Commission of Shenzhen Municipality, 2022). However, these measures are insufficient to bring about the substantial changes needed to address the professional vulnerabilities of community nurses.

While advocating for nurse empowerment, it is also crucial to implement checks and balances. Over-empowerment carries risks as it could lead to 'metamorphic effects of power' (Raven, 2008). Therefore, achieving genuine power equality requires a mechanism that not only empowers but also oversees the empowerment process to prevent the emergence of 'unrivalled' nurse figures, thereby maximising the benefits of power interactions in care delivery.

2.5.3 Limitations

Theoretically, this study's elaboration on six social powers expands upon French & Raven's typology, enhancing the understanding of this seminal power theory within the context of community health nursing. Nonetheless, two limitations merit attention. First, although it is posited that community nurses are well-suited to articulate their experiences of social power, the exclusion of other care participants' perspectives, such as those of doctors and patients, may have limited the comprehensiveness of the analysis regarding power interactions. Second, field observations were not conducted, primarily due to restrictions imposed by the zero-COVID policy. Considering the

nuanced and complex nature of interpersonal interactions and influences, observational methods could enrich the exploration and interpretation of power dynamics. Therefore, incorporating the viewpoints of other care participants and employing field research methodologies are recommended for future studies.

2.6 Conclusion

In the nursing literature, power is a prevalent topic, often explored within the dynamics of nurse–doctor and nurse–patient interactions. These relationships can display markedly different power landscapes for nurses, ranging from relative powerlessness in interactions with doctors to a position of authority when dealing with patients (Henderson, 2003; Svensson, 1996). Consequently, the power dynamic for nurses varies significantly depending on the relationship context. Moving beyond these traditional dichotomies, this study introduces a novel approach by differentiating between theoretical power bases and practical power use, thus providing fresh insights into the interpretation of power dynamics in nursing practice.

In China, the conditions for nurses to gain and exercise power remain challenging. The nursing profession is characterised by heavy workloads, low wages, and poor working conditions, which collectively diminish the appeal of nursing as a career choice and contribute to a shortage of professionals in the field (Yang & Hao, 2018). Furthermore, societal stereotypes that elevate doctors above nurses undermine the relative standing of nurses (Yang & Hao, 2018).

Distinct from studies that offer a macro-level description of Chinese nurses' powerlessness and its correlation with organisational issues such as job satisfaction

and burnout (Cai & Zhou, 2009), this study takes a micro-level approach. It examines nurses' power through the lens of interpersonal relationships and identifies potential power bases that nurses can leverage during caregiving. This approach lays a theoretical groundwork for investigating interactional power in nursing, offering a nuanced understanding of how nurses can assert influence within their professional interactions.

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Chapter 3: Power in Policy Implementation: An Organisational Perspective[2]

This chapter reports on the second study, which draws on Rosabeth Kanter's theory of organisational power to examine how policy implementers' positions shape their power access in the workplace.

Conducted as a case study on community nurses in China—acknowledged as street-level bureaucrats capable of determining the final shape of public health policy implementation, the research engaged twenty-four purposefully selected participants from Shenzhen in semi-structured online interviews. Non-verbal cues from video recordings augmented the self-reported dataset. Thematic data analysis unveiled four explanatory themes: 1) dual-function policy implementers; 2) entitlement to formal power access; 3) diverse informal positions; and 4) disparities in informal power access.

This study contributes to policy implementation scholarship by furnishing a framework to understand policy implementers' powers within a nested dual-position system. The findings indicate that while the formal roles of community nurses theoretically provide transparent and equitable access to organisational power resources, in practice, access varies due to differing informal positions shaped by workplace interpersonal relationships. These insights ignite discussions on power dynamics in organisational settings of policy implementation, notably through the

[2] This chapter is based on a manuscript submitted to the journal *Social Policy & Administration* for consideration of publication.

lens of equity.

3.1 Introduction

Lasswell (1956) introduces the concept of policy sciences, emphasising the significance of implementation as a pivotal stage within the policy process. Subsequently, policy implementation has become entrenched within the discourse of public policy (deLeon & deLeon, 2002), evolving into a burgeoning field of scholarly and practical inquiry, notably catalysed by the seminal work of Pressman and Wildavsky (1973). Defined as 'the process by which policies enacted by the government are put into effect by the relevant agencies' (Birkland, 2011, p. 263), policy implementation represents the phase in the policy cycle where tangible action intersects with governmental intentions—a critical juncture often characterised as where 'the rubber meets the road' (Rinfret & Pautz, 2019, p. 91).

To enhance comprehension of the policy implementation process, Smith (1973) introduces a transactional model comprising four key components: idealised policy, implementing organisation, target group, and environmental factors, which together engender 'tensions' influencing policy outcomes. Smith (1973) thus conceptualises policy implementation as a 'tension-generating force' within society (p. 197). This framework underscores the pervasive influence of social power—mutual influences embedded within societal dyads (Raven, 2008)—in policy implementation, a revelation pivotal for subsequent policy theorists who explicitly or implicitly anchor the discourse of policy implementation on the notion of power.

Proponents of the top-down approach (e.g. Hogwood & Gunn, 1984; Mazmanian &

Sabatier, 1989; Van Meter & Van Horn, 1975) contend that policy implementation commences with authoritative decisions by higher-level bureaucrats, which lower-level implementers must adhere to for desired policy effects (Howlett et al., 2020). This command-compliance schema typifies the conventional sovereign power as delineated by Smart (2002), characterised by coercion, arbitrariness, and a somewhat foreboding presence within the policy process hierarchy.

Conversely, proponents of the bottom-up approach (e.g. Hjern, 1982; Hull & Hjern, 1987; Lipsky, 2010) adopt a pragmatic perspective on policy implementation by scrutinising the roles and behaviours of micro-level agents in policy processes. They contend that individuals at lower implementation levels can directly influence policy delivery in specific local contexts (Hupe & Buffat, 2014). Thus, the bottom-up approach elucidates power distribution in a decentralised or democratic manner, aligning with Foucault's (1990) assertion that power is a mundane and ubiquitous product of social environments.

Numerous scholarly inquiries have delved into the intricate interplay of power dynamics within the policy implementation process. For instance, Erasmus and Gilson (2008) have conducted an analysis on the utilisation of power in policy implementation, elucidating methodological challenges inherent in observing power dynamics within the realm of health policy enactment. Marquardt (2017) has examined the ramifications of central-local power relations on the implementation of environmental policies, focusing on the Philippine Renewable Energy Act as a case study. Nunes and Lotta (2019) have researched the mobilisation of power by community health workers and its implications for perpetuating health disparities during policy implementation. Additionally, Balane et al. (2020) have proposed a

stakeholder analysis framework aimed at assessing the power of policy actors throughout the implementation phase. In a recent contribution, Topp et al. (2021) have furnished a comprehensive guide elucidating the intricacies of conducting power analyses in the field of health policies, with a specific emphasis on power dynamics manifesting during the policy implementation stage.

Despite the richness of insights garnered from these endeavours, the extant literature falls short in explicating how grassroots policy implementers accrue power, particularly within the organisational milieu where policies begin to concretise. This lacuna not only constrains our comprehension of power dynamics within organisational policy implementation contexts but also renders power a somewhat elusive variable, thereby dissuading researchers from fully unpacking the multifaceted nature of policy implementation processes at large.

This study seeks to fill this gap by applying Rosabeth Kanter's (1993) theory of organisational power to scrutinise the impact of policy implementers' positions on their access to power within their professional roles. Specifically, the research focuses on community nurses in China. Community nurses represent a substantial segment of the healthcare workforce across various nations and play an active role in the formulation and execution of health policies, thereby aiding governments in fulfilling public health mandates (Li et al., 2023; WHO, 2017). As delineated subsequently, this study contributes to the discourse on policy implementation by: 1) introducing a novel organisational perspective—namely, position—as a lens through which to examine power dynamics within policy implementation contexts; and 2) stimulating discussions regarding the distribution of power among policy implementers from an equity-oriented standpoint. The following section delineates Kanter's (1993) theory,

which underpins the formulation of the research questions: 1) What are the formal and informal positions occupied by community nurses within their respective organisational structures? 2) How do these positions influence community nurses' ability to access power within their professional environments?

3.2 Theoretical framework

This study adopts an organisational perspective, framing the analysis within Kanter's (1993) theoretical framework. Kanter's model has served as a cornerstone in the examination of nurse power (Bradbury-Jones et al., 2008), demonstrating its utility and comprehensive nature in elucidating power dynamics within health organisational contexts.

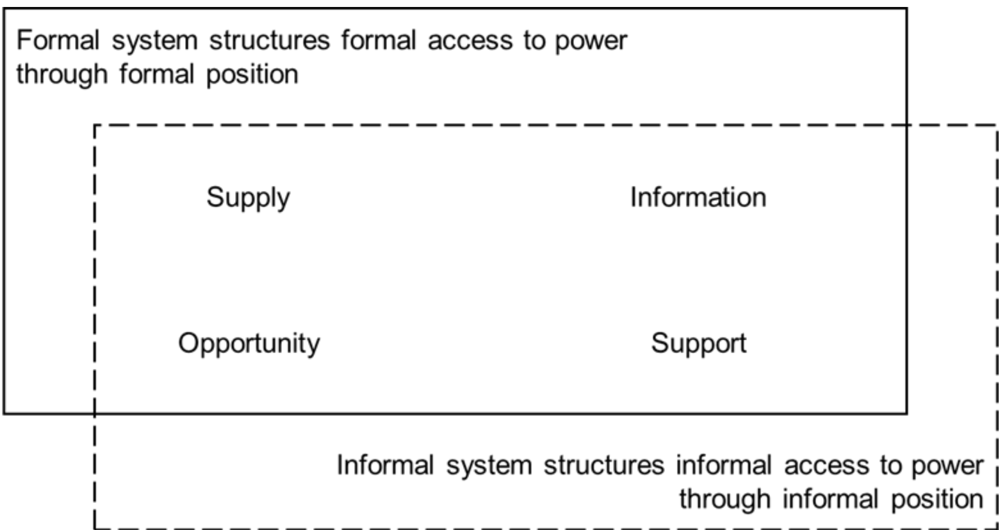
Kanter's (1993) theory has originated from her fieldwork in a prominent American corporation, wherein power is succinctly characterised as 'the ability to mobilise human and material resources to get things done' (p. 66). Contrary to traditional perceptions of power as control, dominance, or coercion, Kanter (1993) emphasises that true organisational (or job-related) power manifests positively, signifying efficacy, capacity, and fulfilment. This conceptual shift lays the foundation for Kanter's argument in favour of empowerment, rather than power containment, in organisational settings.

Kanter (1993) posits that an individual's power is primarily derived from their organisational roles, rather than solely from personal attributes. This power can be categorised into formal and informal positions within the organisational structure. The formal position encompasses the duties and attributes of the job, including discretion

in decision-making, recognition of performance, and alignment with organisational objectives. Conversely, the informal position is intertwined with relationships within the organisational hierarchy, including interactions with superiors (who confer approval, support, and top–down delegations), peers (who constitute circles of acquaintanceship and provide support for the use of additional resources), and subordinates (who act as a proxy for the leader, helping relieve superiors of burdens and representing their viewpoints).

Kanter (1993) underscores the significance of both formal and informal roles in accessing organisational power resources, as depicted in Figure 7. These resources encompass various facets: 1) supply—the capacity to procure materials, financial resources, rewards, or prestige necessary to fulfil job and organisational demands; 2) information—the access to pertinent knowledge and insights through both formal and informal channels; 3) support—endorsement from key organisational figures that facilitates discretion, innovation, and effectiveness; and 4) opportunity—favourable working conditions conducive to professional development, fostering the acquisition of knowledge and skills. In essence, individuals occupying high formal or informal positions tend to enjoy greater access to organisational resources, thus augmenting their power. Conversely, those positioned lower within the organisational hierarchy are more prone to feelings of powerlessness and even disempowerment.

Figure 7. Access to power in organisational settings



Source: Synthesised from Kanter (1993).

Drawing upon Kanter's (1993) theory, this study offers a nuanced examination of community nurses' access to both formal and informal organisational power. By scrutinising nurses' power dynamics within the dual job position systems, the research uncovers inherent contradictions and sheds light on de facto power opportunities faced by community nurses. In doing so, the analysis provides a more sophisticated portrayal of power in organisational settings of policy implementation.

3.3 Methodology

3.3.1 Study design

Given the cryptic complexities of social power (Erasmus & Gilson, 2008; Li et al., 2023), the study uses an interpretivist qualitative approach (Lin, 2005). This methodological choice is operationalised through an interpretative case study involving a sample of community nurses from Shenzhen, China. Distinguished from other case study methodologies, the interpretative case study prioritises case explanations grounded in existing theories, thus facilitating the generation of detailed,

realistic, and theoretically informed accounts of the 'what-how' research questions (George & Bennett, 2005).

3.3.2 Study case

This study was conducted in Shenzhen, a pivotal site amidst China's community health reforms and policy experimentation (Li et al., 2023). Over nearly three decades, Shenzhen has developed a robust community health system comprising community hospitals, CHCs (*zhongxin*), and community health service stations (*zhan*). Community hospitals are relatively new, first appearing at the end of 2022 as part of an initiative aimed at 'capacity expansion and quality improvement' (Baoan Central Hospital of Shenzhen, 2022). These hospitals are distinct from other community health facilities in that they are equipped to handle emergency and inpatient cases, while CHCs focus on primary care and general practice. By 2022, Shenzhen accommodated nearly 5,000 nurses across more than 750 CHCs (Health Commission of Shenzhen Municipality, 2023). This abundance makes Shenzhen a 'hospitable' research site for the case study, allowing for easier field access and data collection (Stake, 1995).

This study uses a sample of community nurses from Shenzhen to investigate policy implementers' access to power in organisational settings. According to Lipsky (2010), community nurses (also known as public health nurses) are classified as street-level bureaucrats, characterised by their frequent interactions with citizens, a considerable degree of autonomy in their professional activities, and significant influence over the lives of those they serve. Hence, community nurses are pivotal in shaping the implementation of public health policies through their discretion and direct

engagement with the community during service provision.

In China, community nurses play crucial roles in a range of public health policy initiatives, including NBPHS, Family-Doctor Signing Service, Patriotic Public Health Campaign, Healthy Cells, and notably, the Dynamic Zero-COVID strategy of 2021-22. The involvement of community nurses in these significant public health efforts renders the case study both 'typical' and 'instrumental' (Stake, 1995), enhancing the generalisability of findings.

3.3.3 Participant recruitment

Participants for this study were selected using purposive sampling. Eligibility required at least one year of full-time experience: a criterion met by a significant portion of the local nursing workforce (Li & Chen, 2023). This selection aimed to capture a comprehensive and representative array of perspectives within the community health setting. To avoid the confounding influence of administrative power, the study excluded head nurses from the sample, recognising their distinct role as higher-level policy implementers and nursing managers. No further eligibility criteria were established, permitting a broader diversity of opinions and enhancing the depth of analysis.

Participants were recruited through a WeChat group consisting of approximately 40 nurses who had engaged with the previous research (Li & Chen, 2022; Li et al., 2023). A recruitment message was disseminated, outlining the study's objectives, procedures, incentives, and confidentiality protocols. During the two-week recruitment period in January 2023, it received 26 expressions of interest, two of

which were excluded based on the inclusion criteria (i.e. not currently in service). Subsequently, between March and December 2023, 24 community nurses (see Table 3) participated in semi-structured, open-ended interviews conducted via WeChat (Salmons, 2015). Each participant was compensated RMB 100 (approximately US$15) through WeChat as a token of appreciation for their time and contribution to the study.

Table 3. Research participants

Interviewee code [a, b]	Age	Sex	Years of service [c]	Interviewee code [a, b]	Age	Sex	Years of service [c]
IW1	25	Female	3	IW13	27	Male	3
IW2	29	Female	3	IW14	25	Male	3
IW3	24	Female	2	IW15	41	Female	14
IW4	31	Female	5	IW16	37	Female	9
IW5	25	Female	2	IW17	42	Female	12
IW6	32	Female	5	IW18	37	Female	10
IW7	25	Female	1	IW19	36	Female	8
IW8	26	Female	3	IW20	40	Female	7
IW9	28	Female	4	IW21	38	Female	13
IW10	26	Male	2	IW22	26	Male	2
IW11	23	Male	1	IW23	25	Male	3
IW12	23	Male	2	IW24	27	Female	5

Note: [a] The participants were assigned codes in chronological order based on the sequence of interviews conducted. [b] The study did not investigate educational backgrounds, as existing research suggests that most community nurses possess a post-secondary vocational diploma obtained through full-time study. Although some older nurses may only have a secondary vocational diploma, their extensive work experience is considered to mitigate any educational disadvantages (Li & Chen, 2023; Li et al., 2023). Consequently, it hypothesises that educational background has a minimal impact on power differentials among nurses within the context of this study. [c] This variable represents the number of years each participant has worked within Shenzhen's community health system.

3.3.4 Data collection and analysis

The interview guide was informed by existing literature and the previous research (Li & Chen, 2022; Li et al., 2023), incorporating essential questions designed to explore the roles of the participants and their influence within their organisations. Sample questions included inquiries into job characteristics from a formal position perspective (e.g. 'How would you describe your job characteristics?'), relational dynamics with colleagues (e.g. 'How do you get along with your colleagues?'), and access to organisational resources as a means to gauge opportunities for gaining power (e.g. 'How do you access organisational resources?'). The guide was structured to allow for modifications to questions and the exploration of emergent topics as the research progressed. The interviews, conducted in Mandarin, ranged from 70 to 90 minutes in duration and were digitally recorded with the consent of the participants.

During the interviews, I not only documented participants' language usage and descriptions of their experiences but also their non-verbal responses (Navarro, 2018). Observations included noting facial expressions indicating frustration, anger, fear, discomfort, happiness, or satisfaction, particularly when participants discussed interpersonal influence in informal positions. These non-verbal cues offered critical nuances that shaped the formulation of follow-up questions and enhanced the understanding of the participants' lived realities. The analysis of non-verbal behaviours from video recordings, alongside detailed participant narratives, enriched the dataset. This approach facilitated both semantic and latent coding of the interview corpus, providing a robust foundation for subsequent qualitative analysis.

Adhering to established normative procedures (Braun & Clarke, 2006), I first auto-transcribed the Mandarin audio files and then engaged in an iterative-reflexive

thematic analysis of the transcribed data. Initially, I thoroughly read through multiple copies of the transcripts to gain a comprehensive understanding of the participants' narratives. Subsequently, I identified central concerns, paradigmatic cases, and atypical instances by examining each interview, at which point data saturation was assessed. As central concerns became apparent, I focused on distilling common meanings and emergent themes by condensing and categorising codes. This involved organising notes and excerpts, which facilitated the synthesis of interpretations aligned with the identified themes.

In the coding process, the study employed a structured approach that incorporated open coding to generate descriptive and interpretive codes, axial coding to integrate these codes into cohesive themes, and selective coding to derive deeper theoretical insights (Gibbs, 2018).

3.3.5 Ethics

Prior to data collection, I secured ethical clearance from the Institutional Review Board of The Hong Kong Polytechnic University (reference number: HSEARS20210417003). Participants provided their informed consent orally, in accordance with the details outlined in the study information sheet and as discussed by the researcher. To maintain confidentiality, the study adhered strictly to institutional data security protocols for the proper storage, transfer, and disposal of audio files and transcripts. This included redacting or deleting personal identifiers from the transcripts and employing anonymous identifiers in quotations to ensure participant anonymity throughout the study's documentation and reporting processes.

3.4 Findings

The analysis identifies four explanatory themes: 1) dual-function policy implementers; 2) entitlement to formal power access; 3) diverse informal positions; and 4) disparities in informal power access, which together contribute to a framework to comprehend and conceptualise policy implementers' power dynamics within formal and informal job structures (see Figure 8).

Figure 8. Access to organisational power in two job position systems

Formal position system
Formal position
Entitles
Formal access to power
Supply
Information
Support
Opportunities for professional development
Informal access to power
Differentiates
Informal position
Informal position system

Source: Author's work.

Note: This framework is designed to facilitate the investigation of power dynamics among policy implementers within a nested dual-position system. It offers an approach to analyse how roles and relationships intersect and influence the distribution and exercise of power in organisational settings.

3.4.1 Dual-function policy implementers

This study delineates the formal roles of community nurses as dual-function public health policy implementers, underscoring their multifaceted job activities and characteristics while highlighting their pivotal role in executing various health policies, such as the Family-Doctor Signing Service and NBPHS. Specifically, within the statutory framework of China's community health services—which encompasses 'both primary care and public health' (IW20)—community nurses are tasked with delivering essential non-clinical public health services alongside their clinical patient

care duties. Consequently, the integration of both clinical and non-clinical responsibilities defines the formal positions of nurses within their organisations, shaping their professional identity and function. An interviewee elucidated this dual role by stating:

> *"This is a healthcare organisation where patient care is my foremost priority. My daily routine primarily involves vaccinating, administering injections, and assisting physicians with dressing changes. Additionally, as this is a community healthcare organisation, I also engage with residents in the catchment area through outreach initiatives aimed at promoting health literacy, smoking cessation, and food safety, among others. These non-clinical services are just as crucial to my role."* (IW6)

Regarding this theme, the analysis reveals a notable consistency across participants' narratives, with no anomalous cases detected. This uniformity likely stems from the fact that the formal positions of community nurses are clearly delineated in accordance with organisational norms and objectives (Kanter, 1993). However, it is important to note that these dual functions can sometimes become unbalanced, particularly among male nurses, as one interviewee elaborated:

> *"In theory, my responsibilities encompass both clinical and non-clinical services. However, in practice, I rarely engage in clinical tasks beyond performing dressing changes for male patients with special conditions. This distribution of duties often reflects the perceived suitability of female nurses for general patient care, due to certain nursing-specific factors. Consequently, my primary role involves non-clinical services like health education, which are deemed to require more physical strength and thus typically involve more male participation."* (IW10)

3.4.2 Entitlement to formal power access

The formal position held by community nurses provides them with official access to organisational power resources, recognising their crucial role as street-level policy implementers in enhancing organisational performance and effectiveness. This study elucidates this relationship using Kanter's (1993) four theoretical dimensions.

First, the formal role of community nurses entails duties that are essential for 'achieving organisational goals' (IW17). In response, organisations acknowledge nurses when their 'work meets high standards of quality and timeliness' (IW23). This recognition often manifests as '(non-)material organisational rewards' (IW2), which Kanter (1993) identifies as critical sources of power. According to the findings, the practice of rewarding by the organisation not only motivates nurses to enhance their contributions to the workforce but also significantly boosts their sense of self-worth and professional status. The impact of this dynamic is aptly captured in the following statement:

> *"During the COVID-19 crisis, I served on the front lines. My salary increased significantly during this period, which motivated me to persevere through the challenging work. Additionally, I was recognised as an 'excellent community health worker,' which affirmed my ability to make a meaningful impact. This accolade, along with the trust and respect I gained from my colleagues, greatly enhanced my reputation within the organisation. Without my role as a community nurse, I would not have had the opportunity to contribute significantly or receive such recognition and rewards."* (IW7)

Secondly, the dual roles of community nurses not only compel them to excel in clinical areas but also to effectively implement the latest knowledge in non-clinical practices. Their skills are considered ‘an invaluable collective asset’ (IW20), essential for achieving organisational objectives. In recognition of this value, local authorities and community healthcare organisations provide training to community nurses, enhancing both policy implementation and service quality. This approach aligns with Kanter’s (1993) assertion that opportunities for career progression can significantly empower nurses. As highlighted by one interviewee:

> *“Indeed, I have access to numerous training opportunities, which I regard as a privileged aspect of my job. Recently, I participated in specialised trainings focused on specimen collection and palliative care, specifically tailored for community nurses. These sessions have been instrumental in enhancing my professional expertise.”* (IW16)

Thirdly, the formal role of community nurses requires them to engage in interdepartmental collaboration to effectively manage their dual functions. Clinically, nurses collaborate with a range of healthcare professionals, such as ‘general practitioners, dispensers, acupuncturists, and laboratory technicians’ (IW19), to deliver outpatient services. Conversely, in their public health role, ‘nurses act as community health cadres, addressing non-clinical responsibilities’ (IW4). These interpersonal interactions facilitate the emergence of ‘information sharing’ (IW19), providing community nurses with access to a variety of work-related information through multiple cooperative care opportunities. The frequency and quality of these interactions contribute to the accumulation of professional knowledge and enhance

the potential for nurses to increase their influence within the organisation. As one interviewee noted:

> *"Unlike hospital nurses, who are typically assigned to a specific service unit, we [community nurses] operate across multiple departments and manage a diverse array of medical conditions. For instance, while my primary responsibility may be immunisations, I also assist in changing dressings, drawing blood, providing health consultations, and occasionally dispensing medications at the pharmacy. This multidisciplinary approach not only enhances my skill set but also increases my interactions with a broader range of colleagues. These interactions enrich my understanding of my role and the organisation as a whole."* (IW1)

Finally, the formal position of community nurses is integral to organisational performance and effectiveness, necessitating professional supervision to support their functions. Practically, 'knowledge from trainings and textbooks is found to be inadequate' (IW22) for preparing nurses to deliver efficient and consistent services. Consequently, the expertise and guidance of seasoned professionals are essential for ensuring high-quality care. The research identifies that 'family-doctor teams led by attending physicians or general practitioners who are experts in community healthcare' (IW24) are the prevalent method of providing nurses with supervision and professional support. This structure not only facilitates the practical application of their skills but also promotes the growth of their influence within the organisation through enhanced confidence and encouragement. As one interviewee expressed:

> *"Our role is crucial to the organisation because we provide direct patient care. However, the job can be particularly challenging for those of us who are new to the*

field. It is standard practice for novices like myself to receive supervision from experienced colleagues to minimise errors and maintain high-quality service. Their mentorship not only enhances my confidence in patient care but also instils trust, as their insights and proven strategies can guide our daily practices." (IW3)

Overall, the participants' narratives within this theme are coherent, as they all recognise the importance of their formal roles and the corresponding entitlement to access organisational power resources. However, the 'age advantage' (IW1) uniquely positions older nurses as veterans, especially those with extensive experience and qualifications. Consequently, these seasoned professionals infrequently require supervisory oversight. This dynamic alters the distribution of supervisory power within the organisation, as elucidated by one interviewee:

"Supervision serves as a form of professional support primarily targeted at less experienced nurses to facilitate their rapid acclimation to the practical demands of the job. For more seasoned nurses like myself, such oversight is rare, as we possess the expertise to manage challenges that arise during patient care effectively." (IW15)

Meanwhile, reduced involvement in clinical care may undermine male community nurses' entitlement, particularly by restricting their access to informational power derived from cross-departmental interactions. This observation is particularly noteworthy as it highlights a critical aspect of professional dynamics within healthcare settings.

"My role frequently confines me to the public health office for paperwork and telephone follow-ups, or takes me outside the centre for outreach activities.

Consequently, I have limited opportunities to interact with colleagues from other departments, who primarily engage with patients onsite and seldom participate in my activities. This isolation not only reduces my ability to communicate with peers but also occasionally contributes to a sense of loneliness by separating me from the broader team dynamics." (IW13)

3.4.3 Various informal positions

According to Kanter (1993), informal positions within an organisation are defined by interpersonal relationships and are gauged by the level of colleague support, which in turn reflects the extent of access to organisational power resources. Utilising Kanter's concept of alliances, this study analyses the informal positions of community nurses. In this context, alliances refer to cliques or networks within the organisation, indicating nurses' associations with specific superiors or peers. The findings indicate that all participants are integral to their respective alliances, having cultivated relationships and a degree of intimacy with their colleagues. The study categorises these alliances into two distinct groups based on the level of support they offer their members, thereby illustrating their varying impact on the informal positions of community nurses.

The first category, strong alliances, exhibits two defining characteristics. First, these alliances are spearheaded by influential superiors who effectively exert power both upwards—by securing greater stake and recognition for alliance members from higher management—and downwards—by decentralising authority to enable autonomously functioning subordinates. Influential leaders within these alliances are not only adept at delegating critical tasks but are also capable of allocating additional resources to

their members (Kanter, 1993). Consequently, forming alliances with such superiors equips nurses with robust 'top–down support' (IW19), which not only elevates their informal positions within the organisation but also enhances their access to vital organisational power resources. As highlighted by one interviewee:

> *"I have developed a close relationship with our head nurse, which has led to a high level of trust between us. Consequently, she assigns me significant tasks and coordinates resources to support my work. Additionally, our relationship extends beyond professional boundaries as we are also acquaintances in our personal lives, often meeting after work. During these gatherings, she shares insider knowledge and the latest information about the organisation with me."* (IW17)

Membership in strong alliances is characterised not only by influential leadership but also by professional diversity. As noted earlier, cross-departmental collaboration is a hallmark of Chinese community health services. Therefore, alliances that include healthcare professionals from various specialty backgrounds afford community nurses access to 'a broader spectrum of peer support during cooperative care' (IW2). This dynamic aligns with Kanter's (1993) concept of acquaintanceship, which she describes as a form of social capital that fosters support among members through affection, moral obligation, or reciprocity (Liang et al., 2018). This concept is further elucidated by an interviewee who described their experience within such a network:

> *"As the adage goes, 'One more friend, one more path.' Cultivating relationships across diverse groups can expand one's network of acquaintances, proving invaluable when assistance is needed. While it may seem utilitarian, this approach is pragmatic in professional settings. In my experience, although I am not friends with everyone, I*

maintain strong relationships with several colleagues from different departments. The mutual trust established within these relationships enhances our communication and cooperation and, crucially, grants me easier access to the resources they control." (IW5)

However, not all community nurses are fortunate enough to be part of strong alliances. Instead, some find themselves entrenched in weaker alliances, primarily due to two factors: insufficient bonding with superiors and professional homogeneity. First, inadequate connections with higher-ups can significantly diminish the advantages of being in an alliance. While not all superiors are as influential as others, they typically possess unique benefits due to their elevated status in the organisational hierarchy. These superiors often 'represent management and have the authority to regulate, mobilise, and (re-)allocate resources' (IW7), enhancing the strategic positioning of their alliances. In the absence of such pivotal figures, alliances may 'lack the necessary top–down support for nurse members' (IW19), impeding their ascent to higher informal positions and restricting their access to vital organisational power resources. As highlighted by one interviewee:

"I have several close colleagues at the centre, but none of us hold managerial positions. While we support each other at work, our capacity to assist is somewhat limited. Despite managers appearing to treat everyone equally, in practice, they exhibit favouritism, showing greater concern for colleagues with whom they share a personal rapport. For instance, when training opportunities arise, managers often prioritise those they are privately close to [the interviewee demonstrated this point by curling lip and shrugging shoulders, showing frustration and helplessness]. If one of us [the interviewee and her close colleagues] were in a managerial role, the situation

would likely be quite different." (IW8)

Secondly, the professional homogeneity of membership often leads to weaker alliances. Community nurses, who typically provide public health services in teams, are prone to forming tightly knit circles composed exclusively of fellow nurses. While these community nurse-only alliances can foster a strong sense of belonging and cohesion within the group ('nourishing belongingness and cohesion among alliance members' [IW5]), they frequently suffer from 'lack of external influence' (IW22). This limitation arises due to the absence of diverse healthcare professionals within these alliances, which is crucial for forming robust support networks during cross-departmental collaboration. Consequently, community nurses in such homogeneous alliances encounter difficulties in securing higher-level informal positions that offer access to broader and more varied peer support. As one interviewee noted:

> *"Although the relationships among us [community nurses] are generally positive, our capacity to assist each other beyond the confines of nursing practice is limited. This limitation stems from the fact that none of us hold influential 'bigwig' positions within the organisation that control significant resources. Consequently, friendships with fellow nurse peers do not facilitate access to additional organisational resources, nor do they simplify my job responsibilities [the interviewee expressed this sentiment by sighing and shaking head, looking disappointed]."* (IW2)

It is noteworthy that older community nurses are more likely to form strong alliances, thereby achieving higher informal positions and enhanced access to organisational power. This propensity is largely attributed to their age advantage. In Chinese society, where the ethos of 'seniority rules' predominates (Fischer, 2008), many organisational

leaders are older. Consequently, age similarity facilitates easier connections between older community nurses and their powerful or influential superiors. Additionally, the 'legitimate power' (Li et al., 2023) derived from their age and accumulated service experience 'not only heightens their esteem among peers but also enhances their professional allure' (IW4). This respect and professional magnetism enable older nurses to forge broader networks and foster connections within a larger circle of acquaintances.

3.4.4 Disparities in informal power access

As previously discussed, the formal position of community nurses grants them formal access to organisational power resources. However, this entitlement can differ significantly based on their informal positions, thereby creating a hierarchy of access to informal power through interpersonal relationships. Nurses who establish strong alliances often experience increased entitlement, which translates to greater informal access to power resources, including supplies, information, support, and opportunities for professional advancement, as exemplified by statements from IW5 and IW17. Consequently, nurses in higher informal positions can be viewed as having vested personal interests within the organisational structure, maintaining their influence by exploiting the less visible aspects of organisational power dynamics to accumulate power informally. One interviewee critically noted:

> *"One of my colleagues has a close relationship with the head of our centre, which gives her early access to information and insights that are not available to the rest of us. While this arrangement benefits her, it undoubtedly creates an imbalance and is perceived as unfair by others [the speaker expressed this sentiment with a frown and a look of displeasure]."* (IW1)

Conversely, community nurses whose informal positions are linked with less influential individuals within the organisation consequently experience restricted access to power. As one participant noted, ‘it is seldom achievable to join strong alliances by rapidly building trust and intimacy with powerful organisational figures’ (IW20). Therefore, nurses occupying lower informal positions often find themselves compelled to accept the existing hierarchical structures. Rather than democratising access to organisational power resources, this acceptance perpetuates and reinforces the established hierarchy, limiting opportunities for equitable power distribution and advancement. As one interviewee remarked:

> *“Despite all of us being community nurses and performing the same job, there is no absolute equity in access to organisational resources. Priority access often gravitates towards those who have close relationships with the management board, particularly when resources are scarce. As a staff nurse without any influence, I am left with little choice but to accept this discriminatory treatment.”* (IW4)

In contrast to earlier themes, participants express divergent views regarding informal access to power and its disparities. Specifically, younger nurses frequently perceive a hierarchical structure in power opportunities, highlighting their susceptibility to what they view as ‘oppression’ within the system. In contrast, older nurses do not report similar perceptions, likely due to their enhanced access to power attributable to seniority and a possible intentional overlooking of established ‘pecking orders’ in power acquisition. Given their status as ‘beneficiaries’ with vested interests in the existing organisational power structures, older community nurses are less inclined to advocate for systemic changes. An older interviewee noted:

"I do not perceive any disparities in access to organisational resources; in my view, they are equally available to everyone. The issue is not about who can or cannot access these resources, as we are all nurses and should be treated as equals." (IW21)

3.5 Discussion

Drawing on Kanter's (1993) theory, this study explores positions and access to power within policy implementation organisations, with a specific focus on Chinese community nurses. The research illustrates how the positions of street-level policy implementers influence their access to organisational power resources such as supplies, information, support, and professional advancement opportunities. The four themes emerging from the analysis not only illuminate the formal and informal roles nurses occupy in their respective workplaces but also detail the avenues through which they can acquire power across different job position systems.

The findings suggest that while the formal positions of community nurses provide a framework for accessing power that appears transparent and equitable, the reality of this access can vary significantly due to the diverse informal relationships that nurses navigate in the workplace. Over time, perceived disparities in access to power can detrimentally impact organisations by fostering tension, animosity, and even conflict among community nurses, thereby undermining the effectiveness and efficiency of public health policy implementation. This study contributes to the policy implementation literature by introducing a novel organisational perspective—namely, position—to analyse power dynamics in policy implementation and by initiating debates on the equity of power distribution among policy implementers.

3.5.1 Key findings

Previous research on power in policy implementation has predominantly adopted a theoretical approach centred on street-level bureaucracy (Lipsky, 2010), emphasising the discretionary power of street-level bureaucrats to influence policy delivery behaviour within specific local contexts (Loyens & Maesschalck, 2010; May & Winter, 2009; Taylor & Kelly, 2006). This body of work highlights how policy implementers utilise discretion—a form of social power—to enact policies, raising the critical question of how they acquire and sustain such power. Recent advances in organisational theory have begun to address this query (Andreotti et al., 2023; Hupe et al., 2015; Paraciani & Rizza, 2021; Rice, 2013; Sager & Gofen, 2022). However, these studies typically focus either on the influence of structured individual factors (e.g. education, gender) on power at the micro-level, or explore the dynamics of power acquisition or loss by street-level bureaucrats at the macro-organisational or state level.

Kanter (1993) suggests that such analyses overlook a critical 'meso-level'—the organisational position—which plays a pivotal role in an individual's acquisition of power in the context of policy implementation. This study introduces a novel perspective by examining this meso-level, offering a fresh vantage point for interrogating the dynamics of power among policy implementers in their professional environments. This approach not only bridges the gap between micro and macro analyses but also enriches the understanding of the complex interplay between individual agency and institutional structures in shaping power dynamics within organisations.

The research employs the concept of entitlement—defined as the inherent right to access—to elucidate how the formal role of public health policy implementers with dual functions grants them formal access to organisational power. This underscores the critical role that community nurses play in the effectiveness of an organisation's policy implementation and highlights organisational recognition of this significance. Such recognition inherently embeds power within the community nurse profession, which naturally manifests as they execute public health policies and services. This organic process of power realisation challenges the perspective held by some critical social theorists that power is purely a manipulative construct, only existing when explicitly conferred by those in control to less empowered groups (e.g. nurses within the medical hierarchy) (Bradbury-Jones et al., 2008; Fulton, 1997). Moreover, The findings concerning community nurses' formal access to power lend support to the argument from advocates of a bottom-up approach that street-level bureaucrats can significantly influence policy implementation, despite their lower position in the policy apparatus (Lipsky, 2010; Hull & Hjern, 1987; Hupe et al., 2015). This insight provides a nuanced understanding of power dynamics within hierarchical structures, emphasising the potential of lower-tier professionals to effect change.

Nevertheless, as the analysis also reveals, the access of nurses to power is complicated by their informal positions, which emerge from organisational interpersonal relationships. The study interprets this as unequal informal access to power. Drawing on Kanter's (1993) concept of alliances, it identifies cliques among community nurses to explore psychological factors influencing organisational interpersonal dynamics, such as the need to belong, attach, and affiliate (Jackson-Dwyer, 2014). This analysis enhances the understanding of how policy implementers'

networking behaviours shape their informal positions and, consequently, their access to organisational power.

Specifically, this reveals how interventions by individuals in power foster a covert environment of competition and continual differentiation among policy implementers, manifesting in a greater likelihood of power accumulation for nurses in strong alliances—with robust vertical (superior) and horizontal (peer) support—and power diminishment for those in weaker alliances. Given the scant attention to the impact of interpersonal relationships on the power dynamics of policy actors in organisational settings, the findings prompt new discussions on this issue, especially concerning equity. This fresh perspective invites a broader debate on the relational underpinnings of power within policy implementation frameworks.

This study further identifies gender and age as significant factors affecting equity in access to power within community health organisations. Notably, an age advantage informally boosts the status of older nurses, facilitating their power accumulation and consequently intensifying power disparities. This phenomenon aligns with existing research that documents age-based power hierarchies in public and social service organisations (Kollmann et al., 2019; Li et al., 2023). Additionally, the findings challenge conventional perceptions of gender roles within power structures, revealing that male nurses often struggle to gain power in community health settings, which predominantly focus on primary care and general practice. This observation contradicts the common stereotype that men generally occupy higher ranks and wield more power within organisations (Nicolson, 2015; Tabassum & Nayak, 2021). Such insights underscore the necessity of considering the specific operational contexts of policies and services when analysing gender-related dynamics in organisational

power.

It argues that achieving equitable access to power within organisational settings, especially for policy implementation, is challenging due to the influence of various factors, including organisational structures, customs, and practices. Nevertheless, the role of leadership is paramount in addressing these challenges. Organisational policymakers, vested with managerial authority, should be compelled to institute rules that promote equitable distribution of power. A fundamental requirement for such leadership is the avoidance of behaviours such as patriarchal or dictatorial practices that impede fair access to power. Leaders who embody equity, adhere to ethical standards, and uphold egalitarian values play a critical role in curbing alliance-building practices that can fracture organisational unity. By ensuring that the access to power for policy implementers is not only transparent but also systematically monitored and institutionalised, such leaders can foster a more cohesive and equitable organisational environment.

3.5.2 Limitations

This study is subject to two limitations that warrant consideration. First, there is the potential impact of gender bias. Although male nurses are under-represented in the study areas (Li et al., 2023), there is a possibility that eligible male participants experienced delayed access to study information due to the recruitment strategy, which focused on participants from previous research. Given the noted differences in interpersonal and behavioural styles between genders (Smith & Johnson, 2020), the under-representation of older male participants limited my ability to conduct a thorough gender analysis and to interpret the nuances of informal positions and access

to power.

Secondly, while online interviews are instrumental in facilitating the collection of participant insights, particularly given the geographical distances involved during data collection (Salmons, 2015), they also present challenges. Specifically, the absence of in-person interaction restricted my ability to observe workplace dynamics and the subtle manifestations of power phenomena influenced by interpersonal relationships. These methodological limitations should be carefully addressed in future research to enhance the depth of findings.

3.6 Conclusion

Grounded in Kanter's (1993) theory, this study offers a critical analysis of power dynamics within organisational settings of policy implementation. It illuminates how positional roles influence street-level policy implementers' access to organisational power and underscores the imperative of ensuring equitable power opportunities within community health service environments. The research enriches policy implementation scholarship by establishing a theoretical framework that elucidates and conceptualises the power opportunities available to policy implementers within both formal and informal job position systems.

While this study is centred on China, the issue of power distribution is a universal concern in public policy implementation, making the findings potentially applicable across diverse international contexts. Moreover, the exploration of how interpersonal relationships affect policy actors' positions and their consequent power within organisational hierarchies has broader implications. These insights are relevant not

only for community nurses but also for a wide array of professions at the street level.

While it may seem self-evident that policy implementers require empowerment for both their personal well-being and the efficacy of policy and service delivery, this assumption should not be taken for granted. Indeed, caution must be exercised regarding individuals in higher informal positions, where there is a risk of over-empowerment leading to a potentially 'unrivalled' level of street-level bureaucracy. Thus, this study advocates for a critical examination of power dynamics within specific policy contexts.

This study serves as a valuable addition to both practical and theoretical perspectives on policy implementation, offering insights into the dynamics of power within public health policies and services in China. By advocating for equitable power opportunities, the research contributes to the advancement of policy implementation practices in this domain. It encourages other scholars to apply the findings and conceptual framework as tools to deepen their exploration of power dynamics in organisational settings of policy implementation, thereby fostering further advancements in this critical area of study.

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Chapter 4: Uncovering the Impact of Community Nursing on Health Promotion in China: A Biopower Analysis[3]

This chapter presents findings from another study, which examines the intersection of community nursing and health promotion through the lens of power within the context of China. Despite the central role of power dynamics in health promotion, there is a paucity of research on the influence of community nursing in this domain. Drawing upon Michel Foucault's concept of biopower, a case study on hypertension control was conducted. Twenty-two community nurses from Shenzhen participated in online semi-structured interviews, followed by a face-to-face group discussion with seven nurses and a four-month nonparticipant observation at a prominent community health facility.

Thematic data analysis reveals that community nursing serves as a pivotal biopower mechanism for advancing health promotion at both individual and population levels. Through regular follow-ups facilitated by the dual referral system, nurses engage in disciplinary training tailored to individual patients. Additionally, nurses disseminate health knowledge through lectures and engage in governmental policy advocacy and statistical endeavours to regulate the health behaviours of the patient population. These power techniques for hypertension control are executed in a persuasive, constructive, and evidence-based manner, aligning with the characteristics of biopower.

[3] This chapter is based on a manuscript submitted to the journal *Social Science & Medicine* for consideration of publication.

Building upon these findings, this study presents a robust framework rooted in the concept of biopower, offering insights into the significant public health impacts of community nursing services in the context of Shenzhen. Furthermore, it provides valuable insights crucial for informing policy development and guiding practices within the primary healthcare sector, not only in Shenzhen but also across the diverse regions of China.

4.1 Introduction

Health promotion, as 'the process of enabling people to increase control over, and to improve their health' (WHO, 1998, p. 1), is a holistic healthcare approach to safeguarding and enhancing individual and societal well-being. Nursing emerges as a cornerstone in the realm of health promotion. Drawing from Pender's model, nurses leverage their nuanced grasp of patient characteristics, experiences, and cognitions to facilitate the identification of health risk factors and develop salubrious behaviours among patients (Pender et al., 2010). Meanwhile, Orem's care deficit theory contends that nurses play a pivotal role in conferring tangible health benefits by assisting individuals in circumventing or compensating for impediments to self-care (Orem, 2001). Moreover, within Neuman's systems framework, nursing assumes an indispensable role as an interventionist force capable of alleviating environmental stressors and fortifying individuals' defensive capacities (Hayden, 2012). These multifaceted roles underscore nursing's profound impact on health promotion, yielding a wealth of findings that resonate across medical and social scientific domains (Melariri et al., 2022).

From a medical sociological standpoint, notwithstanding the diversity in theoretical and practical approaches, existing research on health promotion vis-à-vis nursing consistently converges on a pivotal theme: human interaction within the healthcare process. This thematic emphasis typically manifests in two patterns of engagement. First, a majority of studies attempt to elucidate how nurses, through their practice, effect changes in patient behaviour (i.e. direct nurse-patient engagement) (Melariri et al., 2022). Second, analyses exist that probe into how nurses' interactions with other healthcare professionals, notably physicians, shape patient behaviour and outcomes (i.e. indirect nurse-patient engagement) (Staples, 2016). These two patterns of engagement underscore a fundamental tenet in medical sociology—power, as the fulcrum of social power resides within the dyadic relationships and interpersonal influences (Li et al., 2023; Raven, 2008). However, scant attention has been directed towards explicitly examining the influence of nursing on health promotion through the power lens, especially within primary healthcare milieu.

Primary care assumes a pivotal role in the promotion of health, exerting a profound impact on the holistic well-being of individuals and communities alike. Serving as the initial point of contact within the health system, primary care offers a diverse spectrum of preventive and remedial interventions across all stages of life. Its fundamental tenet lies in universal accessibility, ensuring that individuals and families within the community can fully engage with healthcare services at a manageable cost (WHO, 2017). Within primary care, community nursing emerges as a vital constituent, prioritising the prevention of ailments, enhancement of health outcomes, and management of health issues within specific demographic cohorts or societal clusters, employing approaches that are comprehensive and culturally sensitive (WHO, 2017). Noteworthy is the collaborative ethos inherent in community nursing,

wherein nurses partner with various stakeholders to bolster health literacy, foster health management, and cultivate conducive health behaviours (WHO, 2017).

The burgeoning significance of community nursing in health promotion has catalysed a corpus of research across diverse contexts (Kulbok et al., 2012). Nonetheless, with few exceptions (e.g. Li et al., 2023), there exists a conspicuous dearth of power-centric analyses of community nursing within the framework of health promotion, particularly within the evolving landscape of Chinese healthcare where community nursing represents an emerging domain. This deficiency not only encumbers the comprehension of the interplay between nursing interventions and health promotion at the primary care nexus but also detracts from the sociological robustness of interpretations concerning this interpersonal modality.

In response to the identified research lacuna, this study focuses on community nursing services for hypertension control in China, employing Michel Foucault's concept of biopower to explore how community nursing impacts health promotion. It contributes to the scholarly discourse in several significant ways. First, it introduces a power-centric perspective to conceptualise the role of nursing within the realm of health promotion at the primary care level, thereby facilitating a sociologically nuanced depiction of the mechanisms through which community health interventions influence patient behaviour and promote health. Second, the study identifies three core community nursing services—namely follow-ups, health lectures, and health statistics—as integral components of governmental strategies aimed at enhancing public health, shedding light on the pivotal role of community nurses as 'agents of the state' (Perron et al., 2005) in regulatory endeavours pertaining to public health management. Third, the study underscores the paramount importance of these

community health services in effecting behavioural changes among patients and managing chronic diseases, thereby furnishing insights for advocating the expansion of such services through targeted nurse training initiatives and optimisation of the nursing workforce at the grassroots level. This holds particular significance within the context of China's evolving healthcare landscape, characterised by a transition from secondary to primary care paradigms.

4.2 Theoretical framework

4.2.1 Power in nursing

Within nursing discourse, three primary theoretical paradigms offer insight into power dynamics (Bradbury-Jones, 2008). The first, critical social theory (Freire, 1996), portrays nurses as an oppressed group subjected to various forms of subjugation. However, this framework fails to fully capture the nuances of power dynamics, particularly in instances where nurses wield authority in patient interactions, challenging its applicability in healthcare contexts (Bradbury-Jones, 2008). The second paradigm, organisational theory (Kanter, 1993), centres on the hierarchical distribution of power within institutions. Yet, as this study does not delve into organisational power structures, this perspective proves tangential. Lastly, social psychological theory (Bradbury-Jones, 2008) examines power through the prism of individual experiences, such as self-esteem and self-efficacy. However, this perspective has been criticised for its narrow concentration on individualistic factors, often at the expense of overlooking broader sociocultural influences (Bradbury-Jones, 2008). Furthermore, akin to organisational theory, social psychological theory is deemed incongruent with the thematic concerns of this study, leading to its dismissal from consideration.

4.2.2 Biopower

This study adopts a poststructuralist power perspective, employing Foucault's concept of biopower to elucidate how community nursing impacts health promotion. Two primary justifications underscore this theoretical choice. First, at the micro level, nurses are not uniformly powerless; indeed, even within the doctor–nurse dynamic, instances of nurse agency and influence are well-documented (Li et al., 2023). Biopower, as a nuanced theoretical framework, aligns with the recognition of nurses' inherent power (Bradbury-Jones, 2008). It posits power as a pervasive societal construct rather than a scarce commodity (Smart, 2002), acknowledging the potential for power dynamics within nursing practice. This acknowledgement is both theoretically sound and practically consequential, as nurses wield tangible influence over health promotion paradigms, as previously elucidated. Second, in alignment with the WHO's definition of health promotion as a communal endeavour, a theoretical framework capable of illustrating nurses' power at the macro level is imperative. Biopower offers a nuanced lens in this regard, conceptualising power as a multifaceted social and political strategy that extends beyond individual agency (Smart, 2002). Consequently, biopower not only elucidates the micro-level power dynamics within nursing practice but also offers insights into the broader societal implications of nursing influence on health promotion efforts.

Biopower (or 'power over life') represents a subtle and ubiquitous form of authority that emerged alongside the demographic explosion of 18th-century Western societies (Smart, 2002). Confronted with the perceived threat posed by burgeoning populations to social stability, authorities of the time devised meticulous strategies aimed at

managing the populace and ensuring societal well-being (Perron et al., 2005). Consequently, Foucault contended that biopower was not an external imposition upon society but rather a construct fabricated by society itself to interrogate the social at a political level (Smart, 2002). In Foucault's articulation, biopower encompasses 'the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power' (Foucault, 2007, p. 16).

In contrast to conventional sovereign power, which often operates in arbitrary and clandestine manners, biopower manifests as a force that permeates every aspect of life in a more persuasive and efficacious manner, exerting its influence through the dual poles of anatomo-politics and biopolitics (Foucault, 2007).

The primary objective of anatomo-politics resides in the management of individual bodies through mechanisms of disciplinary power, thereby enhancing their efficiency within the broader social system (Smart, 2002). Within this framework, disciplines denote methods facilitating meticulous control over bodily operations, ensuring the constant subjugation of bodily forces and their alignment with notions of docility and utility (Foucault, 2007). Essentially, disciplines encompass the comprehensive management of an individual's existence to foster their compliance and utility.

Biopolitics, intertwined with the concept of anatomo-politics, shifts focus towards the regulation of the human body as a holistic entity (Smart, 2002). Herein, the body is perceived as subjected to both biological and social conditions of existence, notably including health status. Biopolitics further enables the governance of entire populations as social and political entities. Contrary to connotations of repressive

coercion, control in this context entails liberal governance strategies revolving around governmentality, which concerns the administration of individuals' conduct (Foucault, 2007).

In a seminal work, Perron et al. (2005) delineate a comprehensive array of 44 biopower indicators, spanning domains ranging from health to non-health sectors such as architecture, philosophy, education, environment, and the military, thus underscoring the omnipresence of biopower. However, attempting to encompass the entirety of these indicators, each with its distinct connotations, within a single study is both practically unfeasible and theoretically untenable, especially considering that some are unrelated to health or nursing. Drawing from existing literature and empirical findings, Perron et al. (2005) establish a nexus between biopower and nursing, elucidating its theoretical relevance to nursing practice. Accordingly, this study narrows its focus to three salient biopower techniques—training, knowledge, and social policy—that are deemed most pertinent and pervasive within nursing services (Holmes & Gastaldo, 2002; Perron et al., 2005).

Training serves as a quintessential anatomo-political method frequently employed by nurses to regulate individual patients through hierarchical observations, normative judgements, and systematic examinations (Perron et al., 2005). Knowledge embodies the dissemination of perceived 'truth' within specific contexts, thereby transmuting biopolitical management of populations into a mode of social scientific intervention (Smart, 2002). In the realm of nursing services, knowledge, as a form of expert authority, is often leveraged by nurses to advocate for adherence to rational care protocols (Holmes & Gastaldo, 2002). Social policy stands as yet another pervasive biopolitical technique within the nursing domain, functioning to orchestrate social

practices and shape the quality of life for the general populace (Hewitt, 1983). Across societies, health is universally regarded as a collective asset, with health policies primarily geared towards illness recovery and the preservation of public health (Holmes & Gastaldo, 2002). Given their prominent role as the largest cadre within the healthcare workforce in many countries (WHO, 2017), nurses wield substantial influence in health policy formulation and implementation (Perron et al., 2005). Consequently, nursing services are integrated into the state's operational framework, not only meeting its health-related expectations but also re-shaping health as a socially constructed phenomenon (Perron et al., 2005).

As a foundational theoretical framework, biopower has been instrumental in informing numerous health studies. For example, Lorenzini (2024) has applied biopower theory to scrutinise the manifestations of vulnerability engendered by biopolitical mechanisms during the COVID-19 pandemic. Espina and Narruhn (2021) have similarly explored the implications of biopower amidst the COVID-19 crisis, drawing parallels between the pandemic and the enduring crisis of racism. Meanwhile, Mizelle Jr (2022) has offered reflections on the dynamics of power in the context of disease and public health through a biopower lens, elucidating how certain groups are systematically denied access to health protections and subjected to health-related violence. While insightful, with a few notable exceptions (e.g. Thompson, 2008), there remains a paucity of biopower-informed research examining the impact of nursing on health promotion, particularly within primary healthcare settings, in recent years.

4.3 Background

4.3.1 Community nursing in China

China embarked on the development of community-based care in the late 1990s, positioning community health services as an entry point for patient care (Li et al., 2023). Within community healthcare, community nursing has emerged as an increasingly significant component in safeguarding and advancing population health in China (Li & Chen, 2023). Over nearly three decades of development, China has established a comprehensive community nursing system, evidenced by the presence of approximately 250,000 registered community nurses as of 2021 (National Health Commission, 2023). This cadre represents one of the largest segments of the healthcare workforce in China, assuming responsibility for both therapeutic interventions and the delivery of public health services.

4.3.2 Health promotion in China

Since the New Healthcare Reform in 2009, China has witnessed notable advancements in health promotion endeavours, aiming to achieve universal access to affordable and equitable primary healthcare by 2030. This aspiration is underpinned by a series of national public health policies and initiatives, including the NBPHS and the Healthy China 2030 blueprint. Spearheading these efforts is the National Health Commission, entrusted with the formulation of pertinent policy directives and practical guidelines, overseeing their implementation, and coordinating nationwide health promotion initiatives (State Council, 2016).

Given the grassroots orientation of health promotion practices in China (State Council, 2016), community nurses assume a pivotal role in delivering essential public

health services encompassing health education, disease prevention, rehabilitation, chronic disease management, mental health support, and elderly care. To incentivise community nurses, various measures have been instituted by local authorities, including financial incentives such as performance-based pay, comprehensive training programmes, avenues for professional advancement, and enhancements in working conditions (Li & Chen, 2023). Moreover, concerted efforts have been made to enhance the professional status and societal recognition of community nurses through targeted public health campaigns (State Council, 2016).

4.3.3 The prevalence of chronic diseases in China

However, notwithstanding commendable strides in health promotion in China over the past decade, significant challenges persist, notably the pervasive burden of chronic diseases. Among these, hypertension emerges as the most prevalent, afflicting approximately 270 million adults aged 18 to 69, corresponding to a prevalence rate of approximately 25% (Zhang et al., 2023). Diabetes also poses a substantial public health concern, with China reporting the highest number of adult diabetic cases globally, estimated at around 140 million, equating to a prevalence rate of nearly 14% (International Diabetes Federation, n.d.). Chronic obstructive pulmonary disease, attributed largely to elevated smoking rates and exposure to air pollutants, affects over 100 million individuals, with a prevalence exceeding 13% (Fang et al., 2018). Furthermore, heart disease, a leading cause of mortality, exhibits a rising prevalence fuelled by factors such as population ageing, dietary shifts, and escalating smoking rates. Cardiovascular diseases alone accounted for more than 45% of all deaths in 2020 (The Writing Committee of the Report on Cardiovascular Health and Diseases in China, 2023).

Effecting behavioural changes among patients with chronic diseases presents a formidable challenge owing to a myriad of intricate and interconnected factors. For instance, the chronic and protracted nature of these conditions frequently precipitates psychological distress, impeding patients' motivation for adopting behavioural modifications (Mather et al., 2022). Moreover, managing chronic diseases necessitates substantial lifestyle adjustments such as dietary modifications and increased physical activity, which often prove arduous to initiate and sustain (Oh et al., 2023). Socioeconomic determinants, encompassing access to healthcare services, financial constraints, and educational attainment, exert a pivotal influence on patients' capacity to effectively manage their conditions (Wang et al., 2022). Additionally, cultural beliefs and attitudes towards illness can shape patients' perceptions of their health status and impact their willingness to engage in health-promoting behaviours (Daher, 2012). Finally, the fragmented nature of the health system and the absence of patient-centred care pose significant impediments to fostering meaningful behavioural changes (Linden, 2013).

4.3.4 Community nursing and hypertension management in Shenzhen

This study was conducted in Shenzhen, China, focusing on the case of hypertension control due to its high prevalence and significant impacts on the local population. Leveraging its robust fiscal capacity and proactive public health policy agenda, Shenzhen has established a comprehensive community nursing system, boasting approximately 5,000 registered nurses deployed across nearly 800 community health facilities (Health Commission of Shenzhen Municipality, 2023). The ample availability of community nursing resources renders Shenzhen an ideal case study site

(Stake, 1995), facilitating research feasibility by streamlining field access and data collection processes.

Nursing personnel in the community have made significant contributions to the effective management of hypertension in Shenzhen. According to the most recent epidemiological survey on chronic non-communicable diseases conducted in Shenzhen (Health Commission of Shenzhen Municipality, 2021), the prevalence of hypertension among individuals aged 18 and above in the city is 20.74%, which is comparatively lower than both provincial and national averages. Moreover, the rates of awareness, treatment, and control of hypertension among hypertensive patients were reported at 54.34%, 43.48%, and 25.21%, respectively, surpassing the corresponding national averages of 46.9%, 40.7%, and 15.3% (Wang et al., 2023). Consequently, the experience of Shenzhen offers valuable insights into hypertension control and health promotion at the community level nationwide.

4.4 Methodology

4.4.1 Study design

Given the intricate and often elusive nature of power dynamics in real-world contexts, qualitative methods are deemed most suitable for capturing and interpreting social power phenomena (Li et al., 2023). Hence, this study adopts an interpretative case study approach (George & Bennett, 2005), chosen for its emphasis on generating detailed, naturalistic, and theoretically informed depictions of complex issues within specific contexts.

4.4.2 Data collection

Data collection followed a three-phase progressive approach. Initially, semi-structured open-ended interviews were conducted with 22 community nurses (see Table 4), each session lasting between 80 and 110 minutes. These interviews were conducted via WeChat video calls in March 2023. Participants were purposefully selected based on specific inclusion criteria: they were in-service nurses with a minimum of one year of full-time experience at one of Shenzhen's community health centres. This population constituted the majority of the local community nursing workforce (Health Commission of Shenzhen Municipality, 2023), thereby enhancing the instrumental nature of this case study and facilitating the generalisability of findings (Stake, 1995). However, it is pertinent to highlight that head nurses were excluded from the study due to their managerial roles, which often entail less direct involvement in hypertension control practices.

Table 4. Research participants

Interviewee code [a]	Age	Interviewee code [a]	Age
IW1	24	IW12	35
IW2	28	IW13	25
IW3 [b]	25	IW14	33
IW4 [b, c]	29	IW15	34
IW5	27	IW16 [b, c]	27
IW6	26	IW17	25
IW7 [c]	27	IW18	23
IW8 [b]	25	IW19 [b]	24
IW9	25	IW20 [b]	31
IW10 [c]	24	IW21	30
IW11 [b]	31	IW22	29

Note: [a] All participants identified as female and were coded in chronological order based on the sequencing of their interviews. [b] Focus group discussants. [c] Those engaged in member checking.

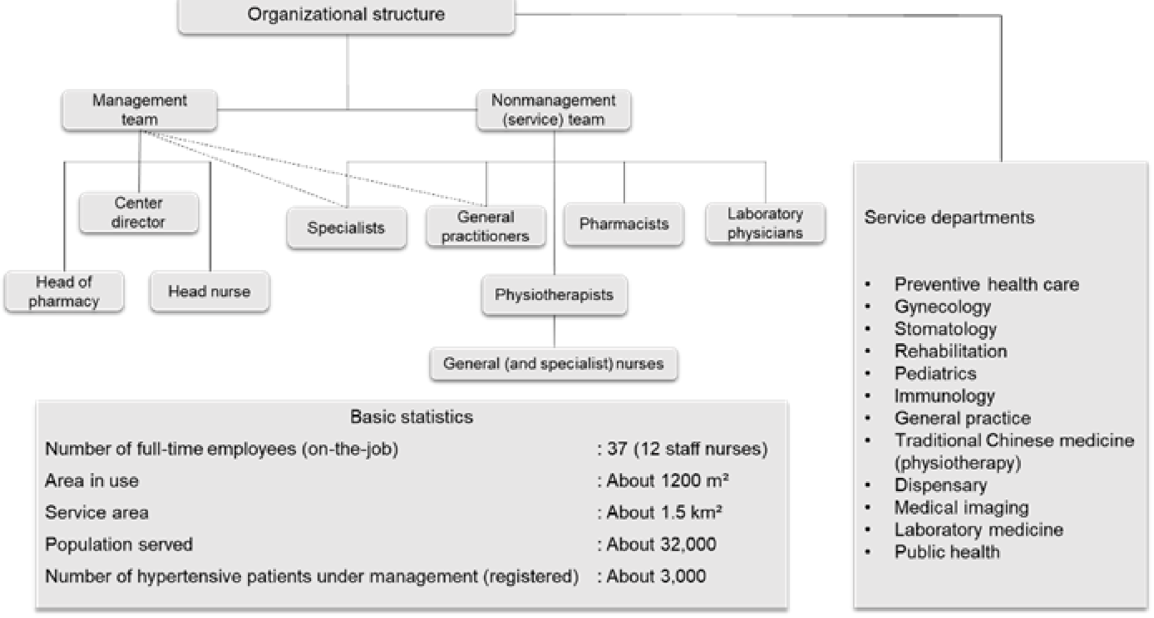
Interview guides, crafted from insights gleaned from existing literature and previous research (Li & Chen, 2023; Li et al., 2023), were structured to encompass key inquiries aimed at eliciting participants' perspectives in a systematic manner. Core questions included queries such as 'How do you ensure effective patient management?' and 'How does patient information inform your approach to hypertension control?' Additionally, participants were prompted to reflect on the influence of their professional expertise and knowledge on their hypertension control practices, as well as their perceptions of their role in relation to relevant government policies and its impact on their work in hypertension control.

To further elucidate and enhance the initial findings, seven nurses engaged in a face-to-face group discussion in July 2023. This facilitated an environment where participants were encouraged to articulate their perspectives and engage in constructive debate under the guidance of the researcher. Individual and group interviews were conducted in Mandarin and were digitally recorded with participants' consent. As an incentive for their participation, each nurse received a dining voucher valued at 200 *yuan*, with an additional 100 *yuan* provided in cash to each group discussant.

Drawing inspiration from the insights garnered during the interviews, non-participant structured observations of nursing services for hypertension control were conducted at a prominent community health center (see Figure 9) between August and November 2023, with explicit permission obtained from the center director. These observational sessions complemented the self-reported dataset, facilitating data triangulation by capturing real-world actions and behaviors of participants within natural contexts (Morgan et al., 2017). Integrating these observational findings with interview data

facilitated a comprehensive understanding of how community nurses wielded their influence in the realm of hypertension control.

Figure 9. Observation site



Source: Compiled from observational data.

4.4.3 Data analysis

Following normative procedures (Braun & Clarke, 2006), the audio-recorded interviews underwent verbatim transcription, while both interview transcripts and handwritten observation notes were subjected to thematic analysis using NVivo software. Initially, data familiarisation was achieved through repeated readings of the transcripts, facilitating a comprehensive understanding of participants' narratives regarding their utilisation of biopower techniques in hypertension control. Open coding was subsequently employed to generate descriptive and interpretive codes, identifying segments of data that encapsulated the essence of the content. Through iterative rounds of open coding, axial coding was then applied to organise coded data into cohesive themes. An iterative-reflexive review of categorised themes ensued to

ensure their alignment with the underlying codes, with data saturation achieved at this stage. Finally, each theme was meticulously named to encapsulate the essence of the corresponding textual content. Additionally, in this study, four randomly selected participants engaged in member checking with original interview transcripts to verify the accuracy and completeness of the interpretations derived from their statements.

4.4.4 Ethics

This study received ethical clearance from the Institutional Review Board of The Hong Kong Polytechnic University before commencing data collection (reference number: HSEARS20210417003). Prior to the interviews, participants provided informed consent orally, as outlined in the study information sheet and discussed by the researcher.

4.5 Findings

In the context of nurses' utilisation of three distinct power techniques in managing hypertension, community nursing arises as a pivotal biopower mechanism for advancing health promotion. This assertion is substantiated through the examination of three thematic constructs.

4.5.1 Patient training through follow-ups

This theme delves into the concept of training, employing an anatomo-political disciplinary framework to elucidate the dynamics of patients' compliance and normalisation at the individual level. Hypertension, characterised by its chronic nature, underscores the imperative of sustained therapeutic interventions and preventative measures. Central to this paradigm is the notion of continuity in

healthcare practices, necessitating the provision of effective and responsive follow-up services subsequent to patients' initial engagement with healthcare professionals.

In Shenzhen, the implementation of a two-way referral mechanism between hospitals and community health sectors positions community nurses as key actors in conducting follow-up consultations with hypertensive patients. This strategic positioning enables them to 'monitor patients' physiological parameters and adherence to prescribed pharmacotherapy' (IW4).

> *"Hypertensive patients are typically re-directed to community health facilities subsequent to their diagnosis at hospitals. So, we assume the role of overseers, engaging in ongoing follow-up assessments to maintain a comprehensive understanding of patients' evolving health statuses."* (group discussants)

The implementation of nurse-led follow-up protocols, integral to the efficiency of the referral system, establishes a recurring engagement framework for a significant proportion of hypertensive patients. This framework operates as a surveillance mechanism, enabling nurses to assess patients' progress continuously. Notably, the utilisation of patient charts (see Table 5) compiled from routine follow-up assessments enhances the visibility of patients, thereby facilitating 'nurses' identification and evaluation of deviations from prescribed behavioural norms' (IW9).

Table 5. Patient charts (examples)

Follow-up record form of hypertensive patients within 14 days (one day)						
Date of follow-up	Patient information			Key information	Remarks	Nurse in charge of the follow-up
	Name	Sex	Age			
7	Redacted	Male	72	The family answered the		

October, 2023	for privacy			phone; Blood pressure: 130/70+; Take medicine regularly (daily); No discomfort		Redacted for privacy
		Male	67	The patient answered the phone; Blood pressure: 160+/90+; Exercise for 40 minutes a day; Light diet; Take medicine regularly (but cannot remember the name)	28-day follow-up	
		Female	77	The patient answered the phone (in Teochew dialect); Blood pressure: 150+/100+; Take medicine regularly (but cannot remember the name); In her hometown (not in Shenzhen); Exercise for an hour every morning; No discomfort		
		Male	69	The patient answered the phone; Blood pressure: 150+/90+; Take medicine regularly; In his hometown in Sichuan (not sure if to return to Shenzhen); 20 cigarettes and 4 taels of liquor (1 day); Exercise for one hour a day; Moderate salt intake	Followed up in person on September 29	
		Female	68	The patient answered the phone; Blood pressure: 116/78; Take medicine once every two days (Irbesartan Capsules); Do housework; Light diet		
		Female	50	The patient answered the phone; Boold pressure: 130/89; Take medicine regularly (prescribed by us [the community health service centre]); No discomfort	Followed up in person on October 5; Accompanied by family member	
		Female	66	The patient answered the phone; Blood pressure: Normal (specific value not disclosed [suspected that she insisted on self-monitoring?]); No medication; Light diet; Not exercising because of leg pain; No discomfort		
		Female	58	The patient answered the phone; Blood pressure: 130–140+/70–80; Exercise for 30 minutes a day; Had stopped taking medicine after only a		

				few days (prescribed by hospital doctor); Light diet		
		Male	64	The patient answered the phone; Blood pressure: 140+/90+; Exercise for 30 minutes a day; 7 cigarettes (1 day); Not drinking; Buying the medicine himself at the pharmacy; Light diet		
		Female	67	The patient answered the phone; Blood pressure: 170/90 (sometimes 140–150/90); Light diet; Daily walk for an hour (taking care of her grandchild); Take two medicines regularly (Nifedipine Sustaimnd Release Tablets & diuretic drug [cannot remember the name]; both prescribed at hospital)	28-day follow-up	

Source: Compiled from observational data.

As reported by study participants, community nurses adhere to hypertension management protocols outlined by both national regulations and those specific to the municipality of Shenzhen. Mandated by established guidelines, ‘in-person follow-up visits are required to occur no less than four times annually’ (IW19). In contrast, the scheduling of telephone follow-up visits offers greater flexibility, ‘with intervals typically ranging from every 2 to 4 weeks, contingent upon factors such as the size of the target population’ (IW19). This scheduling discretion is left to the individual CHC. The regularity and frequency of these follow-up sessions enables nurses to effectively monitor hypertensive patients and manage their medical conditions.

> *“Mr. Wang, formerly residing in his native locality, encountered challenges stemming from limitations within the local healthcare infrastructure, resulting in inadequate management of his hypertension. Moreover, Mr. Wang noted a prevalent disregard for hypertension among the local community, viewing it as asymptomatic and inconsequential to daily life. Following his re-location to Shenzhen two years ago*

and subsequent enrolment in our CHC, I assumed responsibility for his ongoing care. Through consistent monitoring, Mr. Wang's hypertension has been effectively regulated, maintaining his blood pressure within a stable range. Importantly, regular dialogue during follow-up appointments has enhanced Mr. Wang's understanding of hypertension, empowering him to cultivate health through lifestyle modifications. Remarkably, he has refrained from smoking for over a year." (IW7)

While explicit punitive measures are absent within the healthcare context, subsequent interactions serve to enable nurses in exercising their discretion to ensure patient accountability for their care. In instances necessitating corrective action, nurses may employ subtle, normative 'sanctions' aimed at guiding patients, such as cautioning them regarding the irreversible ramifications of inadequately managed hypertension. These verbal interventions, serving as normative corrections, possess the potential to elicit psychological effects on patients, fostering 'internalised adjustments in their behaviours' (IW5).

"Follow-up procedures facilitate the compilation of patient data, enabling the identification of individuals exhibiting adverse behaviours such as smoking. In response to such instances, I typically escalate the frequency of follow-up interactions to reinforce patient adherence to recommended protocols. However, instead of resorting to coercive methods to ensure compliance, I prefer to engage in persuasive strategies, undertaking 'ideological' interventions to raise patients' awareness regarding the perils associated with their condition. Given the nature of hypertension management, it is imperative to instil a sense of self-discipline in patients, motivating them towards proactive health behaviours." (IW1)

Follow-up procedures additionally afford nurses the opportunity to perform assessments on patients throughout the anti-hypertensive treatment regimen. During these assessments, patients and their behaviours undergo 'thorough scrutiny, analysis, and evaluation by nurses, adhering to predefined criteria' (IW7). Notably, through the systematic documentation of ongoing measurements (see Table 5), nurses can identify patients whose progress aligns with established care standards, while employing corrective measures for those falling short of expectations. Consistent with the principles of normative judgement, the disciplinary actions taken during patient assessments are typically conveyed in a euphemistic manner.

> *"Regular follow-up appointments yield a comprehensive patient report, enabling a holistic assessment of their condition over a specified timeframe. Patients demonstrating effective hypertension management are provided with verbal affirmation, fostering optimism and motivation conducive to achieving heightened levels of disease control. Conversely, in instances of suboptimal blood pressure regulation, patients are encouraged to undergo periodic in-person evaluations and are advised on preventive measures to mitigate disease progression. While this approach may elicit some degree of stress in patients, it is recognised as a vital catalyst for enhancing self-motivated competence among individuals grappling with inadequate hypertension management."* (IW7)

The process of patient training facilitated by follow-up protocols encompasses observations, assessments, and evaluations, 'each mutually reinforcing the other' (IW11), thereby constituting an integrated framework for case management. This study underscores how the regular implementation of follow-up procedures interconnects these facets, serving as the modus operandi for nurses to methodically

address the needs of hypertensive patients on an individual basis.

> *"Follow-up procedures facilitate a detailed depiction of each patient's clinical profile, enabling us to discern the appropriate timing and nature of interventions. Therefore, follow-up mechanisms serve as effective tools for the ongoing supervision of hypertensive patients, contributing to the enhancement of health outcomes."* (group discussants)

However, the substantial influx of patients, coupled with the heterogeneity of their conditions and backgrounds, underscores the challenging nature of anatomising and managing hypertension cases through individualised follow-up protocols, thus rendering the process as 'difficult and somewhat inefficient' (IW3). This difficulty and inefficacy underscore two structural constraints inherent in Shenzhen's community nursing system: the inadequate number of community nurses and the expanding scope of responsibilities placed upon nursing staff, both of which exacerbate challenges associated with follow-up practices in certain instances.

> *"In Shenzhen, despite substantial investments in community health initiatives, the prevalence of hypertension has led to a sizable patient population, contributing to feelings of overwhelm in my endeavours. Furthermore, the influx of task directives from authorities to community health institutions exacerbates personnel shortages, thereby constraining my capacity to enhance the frequency and quality of patient follow-up visits."* (IW7)

Moreover, the non-compliance and resistance exhibited by certain patients further complicate the task of achieving favourable follow-up outcomes.

“The majority of patients demonstrate compliance, yet there are also instances of non-compliance. Some patients may fail to respond to my calls, and when they do, they exhibit impatience or even anger towards my inquiries, perceiving them as intrusive or potentially threatening, and even mentioning the possibility of lodging complaints. These individual behaviours pose challenges to my work and diminish my motivation.” (IW19)

4.5.2 Knowledge dissemination through lectures

This theme elucidates the strategic utilisation of knowledge by nurses to attain proficient hypertension management on a population scale. Within this context, knowledge serves as an internalised asset necessitating dissemination to enable nurses to wield an informatively authoritative influence over patients. In this study, lecturing emerged as the principal modality for knowledge dissemination.

Within the study area, health lectures are designed to encompass all inhabitants within the service watershed, with a particular focus on chronic disease patients and the elderly demographic (naturally, lecture topics may vary, attracting different audiences accordingly). Regarding lectures pertaining to hypertension management, they are structured into both online and offline modalities. ‘Online lectures have no participant cap, with a larger attendance being preferable’ (IW7). Conversely, ‘offline lectures typically limit invited attendees to approximately 20 individuals, contingent upon the capacity of the health education venue’ (IW7). Moreover, ‘intermittent community outreach initiatives involve hosting outdoor health lectures’ (IW7), which tend to draw larger audiences due to the open venue setting. Nonetheless, irrespective of

lecture format, 'recruitment primarily relies on an invitation-based approach to attract attendees' (IW5).

Health lectures adhere to a structured process from inception to conclusion, encompassing the 'delineation of the topic, content planning, selection of delivery format (including time and venue considerations), material preparation, audience invitation, promotional activities, lecture delivery, and post-event feedback analysis' (observed).

As healthcare professionals, nurses are often regarded as authorities in their field (Li et al., 2023), with a perceived responsibility to impart information 'truthfully' to patients. Lecturing, unlike individual follow-ups, entails a collective approach (either online or in-person), where patients are organised as the recipients of health-promoting information. 'In accordance with the directives of the head nurse or chief physician' (IW22), nurses specialising in relevant medical fields are empowered to oversee the entire process of lecturing. Unlike clinical services, often shrouded behind privacy curtains, lecturing, as a non-clinical care approach, serves to illuminate community nursing, allowing nurses to 'publicly showcase their expertise on a recurring basis' (IW3). Consequently, nurses' expertise can be effectively disseminated to numerous patients.

> *"Typically, clinical care is conducted in a private setting, limiting its visibility to the public. Lecturing serves to counteract this by engaging patients in a communal setting. So, lecturing serves as a mechanism to broaden access to my knowledge and services, thereby offering distinct advantages to a larger segment of the community."* (IW15)

Furthermore, akin to anatomo-political training, nurses frequently endeavour to 'persuade patients towards health-promoting behaviours through lecturing' (IW15). This underscores the core tenet of health education, which centres on the internalisation of idealised health behaviours (Holmes & Gastaldo, 2002). Indeed, lecturing serves as a conduit for patient education and health literacy, as it enables nurses to leverage their expert power and informational power to raise patients' awareness regarding the rationality and scientific basis of care, thereby bolstering their authoritative stance in caregiving (Li et al., 2023). For nurses, 'such authority is pivotal in fostering patient trust' (IW13). Elevated levels of trust correlate with increased patient compliance and overall efficacy in patient management.

> *"Lecturing presents an avenue for me to cultivate professional esteem among patients, showcasing my expertise and competence. The trust garnered from patients enhances their receptiveness to my guidance, crucial for the sustained cooperation and commitment required for effective hypertension management."* (IW18)

> *"One of my hypertensive patients, Mrs. Chen, demonstrates keen interest and endorsement of health lectures. Mrs. Chen has communicated to me her substantial learning from our lectures, prompting adjustments in her previous lifestyle practices, notably in reducing her salt and sugar consumption. Furthermore, these modifications have catalysed a corresponding shift in her husband's behaviours and the collective lifestyle of their family unit. These alterations bear considerable significance in augmenting the management and regulation of her medical condition."* (IW5)

Nevertheless, while facilitating the collective management of patients, solely relying on lecturing may not guarantee effective hypertension control, as it heavily depends on individual nurses' qualities, attitudes, and objectives.

> *"The implementation of health lectures presents challenges, particularly evident among young nurses who often lack the requisite experience to effectively engage with their audience. Also, certain individuals may inherently struggle with public speaking due to personality disparities and deficiencies in articulation skills. Moreover, the demanding nature of clinical responsibilities leaves some nurses with insufficient time to adequately prepare for such educational sessions, thereby compromising their commitment to the endeavour. Under these circumstances, the efficacy of health lectures may be significantly constrained."* (IW12)

Consequently, addressing this public health challenge necessitates a more impersonal form of influence. Therefore, the subsequent sub-section delves into social policy, which embodies the state's intentions concerning societal welfare.

4.5.3 Policy advocacy and statistics

This theme explores the utilisation of social policy by community nurses as a biopolitical strategy in addressing hypertension on a population-wide scale. Here, social policy pertains specifically to NBPHS, a comprehensive health promotion framework (Li et al., 2023). The NBPHS framework, operationalised at the governmental level, problematises hypertension as a public health concern and underscores its control as a fundamental objective within the community-based care.

As a biopolitical strategy for managing hypertension, the integration of nurses' roles within the NBPHS framework constitutes a pivotal aspect of bipartite policy practice. Central to this approach is the acknowledgement of patients' engagement with health policies and their subsequent willingness to modify behaviours, 'predicated on their understanding of policy content' (IW19). Achieving this awareness necessitates effective policy advocating strategies aimed at informing the populace about issues beneficial to the broader community (Damewood, 2023). While various avenues exist for advocating public health policies, such as health bulletin boards (observed), WeChat, often referred to as Chinese WhatsApp, emerged as the primary channel for this purpose, owing to its unparalleled ubiquity in China. Consequently, 'the utilisation of WeChat-led advocacy campaigns concerning NBPHS has evolved into a significant community nursing practice' (IW16).

As a result of 'governmental command' (IW22), this online policy advocacy undergoes constant refinement, ensuring a persistent exposure of patients to authoritative messages concerning hypertension. This exposure serves to motivate individuals to discern factors conducive to optimal health outcomes.

> *"Advocating information regarding NBPHS through WeChat proves advantageous for hypertension management due to its widespread accessibility among patients. The majority of patients exhibit a preference for accessing pertinent information via our official WeChat accounts. The 'official' designation of these accounts imbues them with credibility, thereby increasing the likelihood of patients voluntarily engaging with the online information and adhering to the directives embedded within it."*
> (group discussants)

> *"Our official WeChat account not only disseminates health knowledge in alignment with regulatory mandates but also periodically prompts subscribers to schedule medical check-ups. Insights gleaned from regular interactions with a patient underscore the significance of these reminders. They mitigate the inconvenience associated with individual outreach efforts, particularly considering that certain patients are disinclined to respond to direct phone calls. Additionally, these reminders operate under the auspices of a 'collective' entity, leveraging the authority and communal identity associated with our 'Centre' to reinforce the importance of health management through medical check-ups."* (IW19)

Concurrently with policy advocacy, the engagement with hypertension prevalence statistics constitutes a customary community nursing practice within the NBPHS framework. Indeed, hypertension incidence exhibits temporal and demographic variability, necessitating policy adjustments to ensure the ongoing efficacy of the initiative. As primary agents of policy execution, community nurses bear direct responsibility for enacting such adaptations grounded in 'incontrovertible' evidence (Foucault, 2007), and 'executing them promptly' (IW12). To this end, through collaborative efforts in mapping and synthesising health demographics, nurses endeavour to ascertain the veracity of hypertension statistics and discern prevailing trends. This approach not only aligns with governmental imperatives by rationalising policy modifications (thus politicising the matter) but also underpins evidence-based interventions for patients by delineating standards of behavioural normalcy.

> *"Community-based health surveys represent the primary, if not exclusive, mechanism through which the government obtains insight into the health profile of the populace. The resultant data not only inform governmental decision-making processes but also*

afford us a holistic understanding of the hypertension landscape within the community at large. This knowledge empowers us to respond promptly and judiciously to the prevailing health needs." (IW20)

"In Shenzhen, the Centre for Chronic Disease Prevention and Control, in collaboration with tertiary hospitals, oversees the collection and analysis of policy statistics pertaining to hypertension. We serve as the primary agents responsible for distributing and collecting questionnaires, occasionally providing input on questionnaire development as deemed appropriate. Thus, we assume the role of 'policy lieutenants' within this process, contributing to the ongoing implementation of NBPHS. These contributions not only enhance our professional endeavours but also furnish us with empirical data to accurately assess the health status of community residents and identify deviations from the norm within the population. Consequently, we are equipped to implement targeted and precise interventions for patient management." (IW2)

In comparison to patient training and knowledge dissemination, the implementation of this policy-driven approach to hypertension control operates with a relatively indirect influence, owing to the intermediary role of the government as a third-party entity. Nonetheless, this intermediary role can empower nurses to advance the overall health of patients by 'augmenting their caring authority' (IW14). Indeed, to some extent, assuming accountability for policy execution, and in certain instances, the re-configuration of policy parameters, endows community nurses with the mantle of 'agents of the state' (Perron et al., 2005), imbuing them with legitimacy to call the shots.

Nonetheless, not all individuals demonstrate a willingness to engage in activities related to the collection of health information. Several factors contribute to this reluctance. One is the perception that participation in these endeavours entails a squandering of time. Another significant concern revolves around apprehensions regarding the potential compromise of personal privacy.

> *"The majority of patients demonstrate a willingness to participate in health surveys, albeit there exists a subset who are unwilling to engage. I recollect a specific incident during the recent district-wide chronic disease survey wherein a patient vocally expressed discontent, characterising the process as 'an infringement'."* (IW19)

4.6 Discussion

The investigation into hypertension control elucidates the methodologies and processes by which community nurses harness biopower techniques in delivering health services through three themes: 1) patient training through follow-ups; 2) knowledge dissemination through lectures; and 3) policy advocacy and statistics.

4.6.1 Key findings

Through an analysis of individual patient training, this study identifies patient follow-ups as the predominant service mode facilitating the utilisation of disciplinary power techniques. Within this mode, nurses ensure continuous patient engagement through consistent observations, thereby enabling meticulous judgement and normalisation of undesirable patient behaviours over time. This finding aligns partly with prior research on the purpose and function of follow-up practices in ensuring appropriate secondary care and patient compliance (Luciani-McGillivray et al., 2020).

However, what contributes to the existing literature is the revelation that this study uncovered 'convincement' as a subtle mechanism through which nurses exert power over patients during follow-ups. This underscores the intrinsic nature of biopower, which aims to be less coercive and more persuasive (Foucault, 2007). While convincement can serve as a linguistic 'deterrent' to suppress rebelliousness, it also fosters the cultivation of compliant patients who engage in self-policing behaviour (Holmes & Gastaldo, 2002), crucial for effective management of chronic conditions such as hypertension.

Furthermore, this study highlights the pivotal role of health system infrastructure in facilitating the exercise of nursing powers. A supportive nursing framework, exemplified by Shenzhen's dual referral system and ensuing patient follow-up protocols, underscores the central role of nurses in community healthcare practices, thereby fostering their professional empowerment in advancing public health objectives.

In the context of population-level health promotion, this study elucidates the role of lecturing as an empowering tool for nurses to harness their expertise and exert influence over patients at the cognitive level. Indeed, community nurses embody a 'halo of health professionalism' (Li et al., 2023), endowing the health knowledge they disseminate through lectures with a sense of authority and reliability (Perron et al., 2005).

Analogous to the dynamics of training power, such dissemination of knowledge adopts a didactic approach, aligning with the objectives and characteristics inherent in

biopower strategies (Foucault, 2007). Essentially, lecturing functions as a conduit for translating knowledge sharing into a structured form of health education service, serving as a heuristic intervention capable of positively influencing the health outcomes of service recipients (Steckler et al., 1995; Wang et al., 2023).

Meanwhile, echoing the assertions of health communication theorists (Kish-Doto & Poehlman, 2021), this thematic exploration underscores the significance of disseminating health information within the public domain to shape health behaviours. Furthermore, this study contends that knowledge sharing serves as a technology for enhancing the image of nursing and reinforcing nurses' authority. This contention has sparked discussions regarding the impact of health education practices on healthcare professionals, particularly their exercise of expert power over patients, a facet that warrants further elucidation, particularly within primary healthcare settings.

This study further elucidates the integration of community nursing within social policy, representing an additional biopolitical strategy for advancing population health collectively. This integration is evidenced by nurses' involvement in the delivery of NBPHS, notably through policy advocacy and participation in policy statistics. By engaging in these activities, nurses are primarily recognised as key agents in the implementation of health policy, thereby contributing to the governance of health promotion at the population level (Holmes & Gastaldo, 2002).

Meanwhile, nurses' participation in governmental health statistics contributes to their elevation to a more advanced status, transitioning from mere recipients and implementers of health policy to influential 'leaders' with a strong voice in policy reform (Rasheed et al., 2020). This subtle yet significant shift underscores nurses'

evolving role in shaping health policy formulation and implementation, an area ripe for further exploration.

4.6.2 Implications

Shenzhen provides a compelling paradigm for investigating the efficacy of community nursing in advancing health promotion endeavours. Noteworthy for its demonstrating role in pioneering primary healthcare reforms within China, the examination of Shenzhen as a case study offers valuable insights into the development of pertinent policies and practices applicable to diverse contexts.

First, the adequacy and calibre of community nursing personnel must rank as a priority concern in governmental policy-making. As discussed earlier, notwithstanding its relatively adequate community nursing workforce, the rapid evolution of Shenzhen's primary healthcare system and the ensuing surge in nursing responsibilities still unveil deficiencies in community nursing personnel, particularly those of exemplary proficiency. Rectifying this predicament necessitates concerted endeavours, encompassing reforms in nursing educational frameworks, fortification of grassroots-oriented vocational training, and the revision of societal paradigms that undervalue grassroots nursing. While the extant 'strengthening grassroots (*qiang jiceng*) policy framework at the central level signifies a commendable strategic orientation, its realisation mandates proactive alignment with local policies.

Secondly, it is notable that, within China's grassroots healthcare structure, nurses are not solely responsible for health promotion initiatives; rather, various professionals, including public health physicians, general practitioners, and village doctors,

participate in such initiatives. This study's findings shed light on avenues for amplifying the contributions of these non-nursing professionals at the grassroots level to health promotion endeavours. Specifically, given the nature of health promotion, all grassroots healthcare practitioners should fulfil their supportive roles, instilling habits and practices of self-management among patients through interventions such as follow-ups and health education. Moreover, active engagement in public health processes is imperative, as it can augment their societal influence. However, attaining these objectives nationwide in the near term is unfeasible owing to China's extensive diversity. Consequently, local authorities must assume a leadership role, leveraging policy mechanisms to fortify their respective grassroots healthcare sectors. This necessitates additional policy guidance and decentralisation from the central government.

Thirdly, the investigation into the utilisation of WeChat for health management bears implications for the ongoing expansion of eHealth in China. Used for surveillance, assessment, and examination of individual patients, eHealth technologies must also uphold the principle of regularity. Sporadic application not only proves ineffective but also risks eliciting resistance from patients towards such methodologies.

Furthermore, while this study primarily examines non-clinical facets of community nursing services, it is imperative not to disregard the importance of clinical interventions in health promotion. Future research should endeavour to analyse the impact of community nursing on health promotion by integrating or comparing both clinical and non-clinical approaches.

4.6.3 Limitations

Two limitations of this study warrant acknowledgement. First, while community nurses provide valuable insights into their own experiences of power use, the absence of patient perspectives may limit a comprehensive understanding of how nurses employ biopower techniques. This omission can potentially introduce bias regarding the effectiveness of community nursing interventions. Second, the study's participants comprised predominantly younger female nurses (aged ≤ 35), leading to sample homogeneity. This homogeneity may have resulted in a scarcity of notable divergent cases, potentially introducing bias into the findings.

4.7 Conclusion

As a fundamental aspect of public health, health promotion serves not only to enhance individual health but also to assist communities and governments in addressing public health challenges. Employing Foucault's theory of biopower, this study uses three themes elucidating the utilisation of power techniques by community nurses in practice: 1) patient training through follow-ups; 2) knowledge dissemination through lectures; and 3) policy advocacy and statistics. In light of these findings, this study advances a novel framework centred on biopower, highlighting the unique public health contributions of community nursing services in the Shenzhen context. It also offers valuable insights into the development of policies and practices within the primary healthcare sector across diverse regions of China.

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Chapter 5: Conclusions

In concluding this doctoral thesis, I reflect upon the nuanced explorations into the power dynamics within China's community nursing system through the prism of three distinct theoretical frameworks. The integration of French and Raven's typology of social power, Rosabeth Kanter's theory of organisational power, and Michel Foucault's concept of biopower has enabled a comprehensive examination of the structural, interpersonal, and ideological forces shaping community nursing. This tripartite analytical approach not only enriches the understanding of power dynamics but also amplifies the potential for policy reform and enhanced practice in community healthcare systems, both within Shenzhen and potentially across diverse urban regions of China.

This thesis adopts a sociological approach to studying the power dynamics of community nursing in China. Sociology offers valuable insights into the social structures, relationships, and cultural norms that shape healthcare practices and professionals' roles within the community. By applying sociological theories and methods, I can explore how power dynamics operate at various levels—from interpersonal interactions between nurses and doctors/patients to broader institutional and societal influences. This approach allows for a nuanced analysis of how community nurses navigate and exert power within the healthcare system, considering factors such as authority, autonomy, social capital, and professional identity. Ultimately, a sociological perspective provides a robust framework for conceptualising the diverse forms of power that community nurses hold and the implications for community healthcare delivery and policy in China.

The initial study grounded in French and Raven's framework, dissects the power dynamics at play, unveiling the significant constraints community nurses face. The typology provides a robust structure to categorise and understand these dynamics, revealing critical gaps in power sources such as legitimate, expert, and referent power. Importantly, this analysis highlights latent power reservoirs that, if tapped, can empower nurses to address the diverse and complex needs of their patients more effectively. The recommendations for initiatives to enhance nurse empowerment are not just about augmenting their authority but also about improving patient care outcomes.

Moving to the second study, informed by Kanter's theory of organisational power, it gains insights into how community nurses act as street-level bureaucrats, navigating and sometimes circumventing the rigid structures of their work environments to leverage organisational resources. This study provides a portrayal of power asymmetries and the significance of interpersonal relationships in defining access to power. The developed conceptual framework not only aids in understanding the power dynamics at the grassroots level but also suggests mechanisms through which these dynamics can be recalibrated towards greater equity. This recalibration is crucial for fostering environments where nurses can thrive professionally and respond more effectively to healthcare challenges.

The third study, rooted in Foucault's idea of biopower, shifts the lens towards the strategies employed by community nursing to promote health at the individual and population levels. By identifying and categorising community nursing services into three approaches, this study illustrates how community nurses implement biopower. It

underscores the proactive role nurses play in health promotion, influencing patient behaviours and health outcomes through subtle power dynamics that go beyond mere compliance but involve convincing and educating the community about health practices.

Collectively, these studies underscore the critical role of power in shaping the practice and outcomes of community nursing. They provide a layered understanding of how power operates in different contexts within the healthcare system and offer a pathway towards reforms that enhance both nurse empowerment and patient care. This thesis asserts that understanding and restructuring power dynamics are essential steps towards not only enhancing the professional stature and effectiveness of nurses but also improving the overall healthcare infrastructure.

The implications of this research are manifold. For policymakers, the insights into power dynamics offer guidance on structuring policies and systems that support equitable access to power resources for nurses. For nursing professionals and administrators, this work illuminates the importance of fostering empowering environments that enhance job satisfaction, professional development, and effectiveness. Moreover, for the broader field of health services research, this thesis serves as a call to further investigate the intersections of power, practice, and health outcomes in varied contexts.

Looking ahead, the frameworks and findings from this thesis are instrumental in guiding further research into various aspects of community healthcare delivery and public health initiatives. Comparative studies across different cultural or national contexts could particularly enrich the understanding of universal versus context-

specific dynamics. Longitudinal studies could provide deeper insights into how changes in power structures within community nursing impact long-term health outcomes. Additionally, examining the viewpoints and voices of other healthcare participants would enhance the understanding of power dynamics surrounding community nurses.

In conclusion, this doctoral thesis not only contributes significantly to the theoretical understanding of power dynamics in community nursing but also provides practical pathways for empowering nurses and enhancing health services. The research underscores the importance of considering power dynamics as central to the design and implementation of effective community nursing practices and health policies. By addressing these dynamics, we can better equip community nurses to meet the evolving health needs of populations, ultimately leading to more resilient and responsive healthcare systems.

Intellectual Property Rights Statement

This thesis has resulted in several journal publications coauthored with senior scholars, as previously noted. However, the writing of the thesis is solely my own work, as the content is not copied verbatim from the published articles and contains a substantial amount of new information. Additionally, I conducted all data collection and analysis independently, which has been acknowledged in the publications where applicable. Therefore, it is reasonable to assert that the intellectual property rights belong entirely to me.

Appendices

Appendix I: Ethical Approval for the Studies

To	Chen Juan (Department of Applied Social Sciences)		
From	Siu Yu Kwan, Delegate, Departmental Research Committee		
Email	kaxton.siu@	Date	21-Apr-2021

Application for Ethical Review for Teaching/Research Involving Human Subjects

I write to inform you that approval has been given to your application for human subjects ethics review of the following project for a period from 01-Jun-2021 to 01-Jun-2024:

Project Title:	Optimising China's Community Health System through Governance Recalibration
Department:	Department of Applied Social Sciences
Principal Investigator:	Chen Juan
Project Start Date:	01-Jun-2021
Project type:	Human subjects (non-clinical)
Reference Number:	HSEARS20210417003

You will be held responsible for the ethical approval granted for the project and the ethical conduct of the personnel involved in the project. In case the Co-PI, if any, has also obtained ethical approval for the project, the Co-PI will also assume the responsibility in respect of the ethical approval (in relation to the areas of expertise of respective Co-PI in accordance with the stipulations given by the approving authority).

You are responsible for informing the PolyU Institutional Review Board in advance of any changes in the proposal or procedures which may affect the validity of this ethical approval.

Siu Yu Kwan

Delegate

Departmental Research Committee (on behalf of PolyU Institutional Review Board)

Page 1 of 1

Appendix II: Study Information Sheet

Example[1]

INFORMATION SHEET

Community health system in urban China

You are invited to participate in the above project conducted by Prof. Chen Juan, who is a staff member of the Department of Applied Social Sciences in The Hong Kong Polytechnic University (PolyU). The project has been approved by the PolyU Institutional Review Board (PolyU IRB) (or its Delegate) (Reference Number: HSEARS20210417003).

The aim of this project is to examine community health services in urban China.

You are invited to complete an interview and/or focus group, which will take you about one hour.

The interview and/or focus group should not result in any undue discomfort.

The information you provide as part of the project is the research data. Any research data from which you can be identified is known as personal data. Personal data does not include data where the identity has been removed (anonymous data). We will minimise our use of personal data in the study as much as possible. The researcher and her team will have access to personal data and research data for the purposes of the study. Responsible members of PolyU may be given access for monitoring and/or audit of the research.

All information related to you will remain confidential and be identifiable by codes only known to the researcher. The information collected will be kept for five years since the interview date. PolyU takes reasonable precautions to prevent the loss, misappropriation, unauthorised access or destruction of the information you provide.

You have every right to withdraw from the study before or during the measurement without penalty of any kind.

If you have any questions, you may ask our helpers now or later, even after the study has started.

You may contact Prof. Chen Juan (tel. no.: +852-34003689/ email: juan.chen@) or Ms. Cherrie Mok (tel. no.: +852-27666378 / email: cherrie.mok@) or Mr. Li Bo (tel. no.: 1529663 / email: bo-li.li@) of PolyU under the following situations:

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[1] This example is suitable for research project conducted by (a) PolyU only or (b) PolyU together with collaborator(s) but the collaborator(s) are not collecting any research data or personal data.

If the collaborator is also collecting research data or personal data and will allow the PolyU team to access the data, the collaborator shall have its own consent form and Information Sheet and obtain the written consent of the research subjects. The collaborator shall have the research subjects' written consent to allow PolyU access to and use the data collected. The collaborator is responsible to the research subjects from whom the data are collected for the obligations under the Personal Data (Privacy) Ordinance.

a. if you have any other questions in relation to the study;
b. if, under very rare conditions, you become injured as a result of your participation in the study; or
c. if you want to get access to/or change your personal data before (the expiry date).

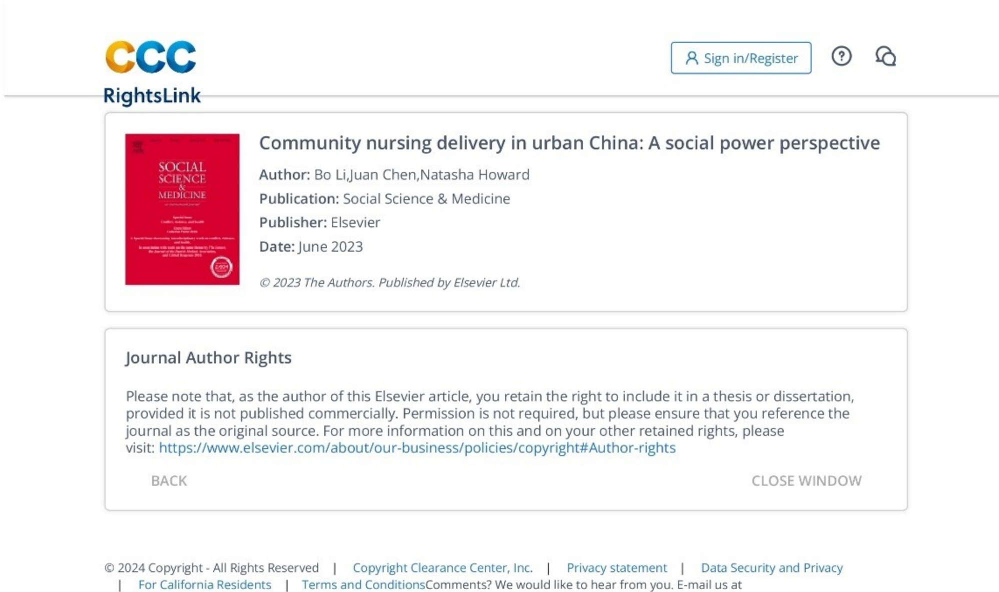
In the event you have any complaints about the conduct of this research study, you may contact Secretary, PolyU IRB in writing (institutional.review.board@polyu.edu.hk) stating clearly the responsible person and department of this study as well as the Reference Number.

Thank you for your interest in participating in this study.

Prof. Chen Juan
Principal Investigator/Chief Investigator

Hung Hom Kowloon Hong Kong 香港 九龍 紅磡
Tel 電話 (852) 2766 5111 Fax 傳真 (852) 2784 3374
Email 電郵 polyu@polyu.edu.hk
Website 網址 www.polyu.edu.hk

Appendix III: Journal's Permission to Reuse Chapter 2 in the Thesis



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Sign in/Register

Community nursing delivery in urban China: A social power perspective

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Publication: Social Science & Medicine
Publisher: Elsevier
Date: June 2023

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