Conceptions, conflicts and contradictions

at the introduction of a Swedish Health Call Centre

BY MONICA ANDERSSON BÄCK

GÖTEBORGS UNIVERSITET

SKRIFTER FRÅN INSTITUTIONEN FÖR ARBETSVETENSKAP # 4

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ABSTRACT

Call centres have been called the industrialisation of the service sector, characterised by monotonous, highly controlled work and standardised procedures performed in an old-fashioned, Tayloristic spirit. Stress and work intensification are known implications of such work. Healthcare on the other hand, is based on bureaucracy, but has professional staff. Nurses describe their occupation in terms of caring, cherishing, educating the sick, being dedicated and genuinely concerned for the patient, while assessing and treating individual reactions to health problems. But what happens in an health call centre (HCC)? The call centre is aimed at mass-production, the monitoring of work, performance targets and control. The overall aim of the thesis to elicit and analyse how this can be combined with the nursing profession and the consciousness of taking care of people in vulnerable states of pain and anxiety.

The thesis draws on a study of an HCC in western Sweden, covering the period from 2002 to 2006, based on more than 80 semi-structured interviews with key actors, 400 structured interviews with care-seekers, repeated observations, written documents and other sources. The results show how the HCC's work and work organisation are conceived based on social relations which are shaped and influenced by institutions and social actors. In a Swedish context, HCCs have been introduced on a broad scale since the late 1990s, and it catches the characteristics of the Swedish healthcare system in the horns of a dilemma, i.e. the ambition to address simultanously (1) equality (2) high quality (3) efficiency and cost control and (4) freedom of choice. Designed to solve healthcare problems, HCCs imply new ways to organise work within healthcare, based on new technology, a Swedish variant of New Public Management practices and rhetoric, control mechanisms and new work relations. Yet the HCCs strongly emphasis the continuity of Swedish healthcare connected to overall institutional features in political, economic, regulatory and cultural terms. Accordlingly, the case-study also shows a process of tensions, conflicts and resistance. Visualised as operating in a battlefield, the actors expressed strong and divergent conceptions towards the HCC. The tensions include a focus on primary care versus resources to secondary care, meeting demands for access and immediate care versus steering healthcare, adapting versus changing demands, the responsible care-seeker versus the exigent healthcare consumer, rationalising human service versus more calls on the phone, control versus coordination. For the telenurses, the contradictions also entail fulfilling both quantity and quality imperatives and working in line with ethics and socialised convictions, while wanting care-seekers as well as physicians to be satisfied.

The HCC confirms both a positive and negative picture of call centres embracing contradictions such as control versus autonomy, participation versus exclusion, professional responsibility versus professional vulnerability, upskilling versus deskilling, younger versus older nursing generations, work intensification versus less physical work, isolation versus freedom and different aspects of emotional labour. The concept of HCC might be interpreted as a movement in the direction of a more liberal, Anglo-Saxion model of organising the economy, but with a distinct tendency towards divergency characterised by Swedish industrial relations and work organisation in the healthcare sector and related to the ongoing professionalisation of nursing.

Key words Sweden, healthcare, health call centre, telephone advice nursing, New Public Management, institutions, conceptions, work organisation, labour process, professionals, care-seekers.

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Like all journeys this project of studying health call centres has been brought to a conclusion. Having reached the end of the road, it is with nostalgia that I leave the text to the reader, knowing that the words no longer belong to me.

At this stage I want to express my warm and sincere gratitude to all who have supported me and in different ways contributed to this thesis:

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This thesis is a study of working life, which most simply can be defined as a study of human beings at work and different forms of work. It is a great pleasure to be a part of an established area such as this Swedish multidisciplinary field as well as the burgeoning academic organisation of Work Science (in Swedish *Institutionen för Arbetsvetenskap*) at University of Gothenburg. A great part of my studies have been based here, and I am very happy to benefit from a good and creative work environment. Thanks to Arne Kristoffersson and Bernt Schiller for first introducing me to work life studies. I would also like to express my thanks to many colleagues and friends at University of Gothenburg and collaborating universities. Ahmad Ahmadi, Anders Edvik, Anna-Karin Waldemarsson, Carina Sparud Lundin, Ewa Fredriksdotter Larsson, Frida Wikstrand, Gun-Britt Wärvik, Gunnar Gillberg, Hannes Kantelius, Henrietta Huzell, Jennie Haraldsson, Jesper Hamark, Johan Wass, Kems Adu-Gyan, Lina Burström, Margaretha Mellberg, Marie Hjalmarsson, P-O Börnfelt and Tomas Andrén have encouraged me and brightened my days with their company and discussions. In particular, Curt Andersson deserves extra thanks for his untiring reading and comment on most of

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It is difficult to find an experienced researcher familiar with both working life studies and healthcare for a proficient language check: however this work has benefited from hours of intensive consideration and skilled comments given by Tony Huzzard, who made my findings available for an English speaking audience. All remaining errors are of course my own. Moreover, the cover of this book is a result of Jonas Blomster's and Marcus Lindh's creative work.

As a last reflection I realise how important the development of welfare has been this last century. In the 1920s, when my grand-mother at the age of 25 gave birth to her fifth child, there was no parental (or maternity) insurance, no universal healthcare insurance and very limited possibilities for care, even less an organisation of nurses to phone for information, referral, advice and support. For my grand-mother and later my mother, pursuing higher level studies remained an attractive, but unattainable goal impossible to materialise due to time, financial and overall societal obstacles. Therefore I am grateful for living in a society like Sweden with the opportunity of access to healthcare and education, although contradictory and conflicting as it might be. I am also very grateful for having a wonderful family by my side. Among all strong persons I have met, I am grateful to my mother, who has taught me the power of boundless love, fighting for one's beliefs and goals, and never leaving home without warm socks. My father as well as my aunt and uncle, their children and grand-children are also important to the person I have become. Furthermore, I own many thanks to the children close to me Alex, Emelie, Louise, Ellinore and Christoffer from whom we borrow this world, hoping that we will give them sustainable welfare and a good working life to take care of in their turn. Finally and with all my love, I want to thank my husband and partner in life, Mats Bäck, who has supported me and coached me on this sometimes bumpy, but stimulating and very exciting journey.

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En sista reflektion handlar om hur betydelsefull utvecklingen av välfärd har varit under det gångna seklet. På 1920-talet när min mormor födde sitt femte barn vid 25 års ålder, så fanns det ingen försäkring för föräldra- (eller mamma-) ledighet, ingen allmän sjukvårdförsäkring och begränsade mjöligheter att få vård. Än mindre fanns det en separat organisation med sjuksköterskor att ringa för information, hänvisning, råd och hjälp. För min mormor och sedan min mamma förblev högre studier en attraktiv, men ouppnåelig dröm, omöjlig att förverkliga pga. av tid, pengar och allmänna, samhälleliga hinder. Det får mig att inse vikten av tillgång till såväl skola som utbildning – hur fyllda av motsägelser och konflikter de än må vara. Jag är också tacksam för min underbara familj som står vid min sida. Bland starka personer som jag har mött, uppskattar jag särskilt min mamma som lärt mig styrkan av gränslös kärlek, att stå upp för sin övertygelse och mål samt att aldrig gå hemifrån utan varma strumpor. Min pappa såväl som min moster och morbror och deras barn och barnbarn är andra viktiga personer, bakom den som jag är idag. Jag är också ett stort tack skyldig de barn som står mig nära Alex, Emelie, Louise, Ellinore och Christoffer från vilka vi lånar den här världen, i förhoppning att vi kan överlämna en välfungerande sjukvård och ett gott arbetsliv för dem att förvalta i sin tur. Till sist och med all min kärlek, vill jag tacka min man och livskamrat, Mats Bäck, som har gett mig stöd och 'coachat' mig på den här ibland skakiga och ojämna, men stimulerande och spännande resan.

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TABLES

GLOSSARY – ABBREVIATIONS AND SWEDISH TRANSLATION

ACDs	Automatic Call Distribution switch – a telephone board and part of the call centre technology
A&E hospital/ department	Accident and Emergency (*akutsjukhus*) /(akutmottagning)
Area of responsibility	kind of job-enlargement (*eget ansvarsområde*)
Assistant nurse	(*undersköterska*)
CTI	Computer Telephony Integration
E(M)D centre	Emergency (Medical) Dispatch centre (for example *SOS-Alarm*)
FCC	The Federation of Swedish County Councils (*Landstingsförbundet**)
Documentation	(*Dokumentation* see also the English word *record*)
FASS	the annually updated Swedish book of medication
General practitioner	General physician specialised in general medicine (*allmänläkare*)
HCC	Health Call Centre (*Sjukvårdsrådgivningen*)
Healthcare council	(*Hälso- och sjukvårdnämnd*) e.g. the Västra Götaland region has 12 such councils
The Health and Medical Services Act of 1982	(Hälso- och sjukvårdslagen 1982:763)
HRM	Human Resource Management
HSO	Human Service Organisation (*Människovårdande organisation*)
Hospital clinic	(*klinik/sjukhusavdelning*)
Head of hospital ward	(*avdelningsföreståndare för en avdelning på sjukhus*)
ICT	Information and Communications Technology (*IT*)
IVR	Interactive Voice Response
The Medical Responsibility Board	(Hälso- och sjukvårdens Ansvarsnämnd HSAN)
The Ministry of Health and Social Affairs	(*Socialdepartementet*)
The National Agency for Higher Education	(*Högskoleverket*)
The National Board of Health and Welfare	(*Socialstyrelsen*)
NPM	New Public Management
Patient Advisory Committee	(*Patientnämnd*)
Physician	(*läkare*)
PHC	Primary Healthcare (*primärvården*)

Primary care centre	(*vårdcentral*)
Primary emergency care	(*jourcentral)* for A&E cases treated by the primary care out-of centre hour
Public Employment Services office	(*Arbetsförmedlingen*)
Record	(*patientjournal*)
RN	Registered nurse (*sjuksköterska*)
SAHP	Swedish Association of Health Professionals trade union (*Vårdförbundet*)
SALAR	The Swedish Association of Local Authorities and Regions (*SKL Sveriges Kommuner och Landsting**)[1]
SBU	Council of Technology Assessment in Health Care(*Statens beredning för medicinsk utvärdering*)
SVR AB	(*Sjukvårdsrådgivningen AB*)
The Swedish Social Insurance Agency	(*Försäkringskassan*)
SWENURSE	the Swedish Association of Registered Nurses (*SSF Svensk sjuksköterskeförening*)
TAN	Telephone Advice Nursing - the function (*sjukvårdsrådgivning*)
(Telephone) Triage	medical assessment of a healthcare situation and or symptom
TRIHS	The Swedish association of telephone advice nursing within health- and sickness care (*Föreningen för telefonrådgivning inom hälso- och sjukvården*)
VGR	The Västra Götaland Region
VPT /1177	The name of the nationally organised net of local HCCs and Iits telephone number (*Vårdråd Per Telefon*)

*) From 1 January 2005, The Swedish Association of Local Authorities (SALA) and the Federation of Swedish County Councils (FCC) formed a new headquarter with joint administrative units. In 2007 the two organisations (SALA and FCC) merged and formed the new, joint federation, SALAR

PART I INTRODUCTION TO THE STUDY

CHAPTER 1
INTRODUCTION

This thesis is about work and work organisation in a Swedish health call centre, HCC (in Swedish called *sjukvårdsrådgivning*). The focus is on the work carried out by a relatively new occupational group called telephone nurses or telenurses. These are all registered nurses most of whom have long experience of nursing in clinical settings (see also Wahlberg 2004).

The HCC constitutes a part of a conventional public organisation within a healthcare area. Yet, the HCCs are either located in their own premises or hosted in a variety of healthcare organisations, such as emergency medical dispatch (EMD) centres (mainly *SOS-Alarm*), primary care centres or accident and emergency (A&E) departments (*SVR AB homepage* 2007). The main preoccupations of these telenurses are to take care of people (citizens), on the phone, who are sick, hurt, feeling bad or just worried, or all these at the same time. The telenurses are then supposed to make a first assessment of the callers' problems and advise them on what to do: whether they should to go immediately to the hospital; whether they should call for an appointment at the primary care centre at once or later; or whether their reasons for calling might be best responded to by advising cure at home (see also Wahlberg 2004).

More and more Swedish healthcare areas are tending to state officially the HCC as the first level of care and the institution to call in case of healthcare problem out-of-hours, to avoid citizens 'rushing without forethought' to an A&E department. The HCC should be a complement to primary care during the day-time for those not having a permanent health provider. It also means that the HCC on the one hand deals with healthcare matters and provides a medical service with nursing in focus, and on the other hand the HCC is organised as a call centre and uses the same technology, perhaps also similar practices and rhetoric, as any other call centre.

On a basic level there are two main functions of a call centre – namely a more efficient provision of services and the use of telephones and technology in order to handle the patient/customer contact in a flexible way (e.g. Korczynski 2002). This organisation of work within the public sector could, furthermore, be compared to call centres used within commercial business for several years, and telenurses can be seen as similar to CSRs (Customer Service Representatives), i.e. like employees in commercial call centre work.[1] Yet, this comparison to CSRs may be just one of several ways to conceive the front-line work such as it

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1 Within E-business, CSR or Customer Service Management (CSM) has been described as a system for enabling businesses to actively manage customer relations in an organised and strategic manner. In practice this means developing a company's methodologies, internal operations, software and Internet capabilities to be able to better address customer needs and, as a result, make customer relationships more profitable (Salomonson 2005).

is constructed for telenurses in an HCC (cf. Frenkel et al. 1999; Valsecchi et al. 2007).

The predominant studies and research on work and work organisation origin from manufacturing and industrial employment, although there seems today to be a growing interest in the organising of white-collar service work. The rise of call centres is claimed to be a phenomenon following the network society (Castells 2000), individualism and flexibilisation, consumerism, managerialism as well as new perspectives on time and space (Bauman 1992; du Gay and Salaman 1992; Sennett 1998; Allvin et al. 1999; Beck and Beck-Gernsheim 2005), but also the Bravermanain prediction of the increased importance of service occupations (1985/1974). The call centres are 'only a call away', although they sometimes are very remote both from the actual users and from the organisation they represent.

Call centres have been associated with control systems based on panoptical principles, i.e. 'invisible control through direct supervision and accumulation of information with resulting compliance' (Fernie and Metcalf 1998), virtual conveyor belts as well as an 'assembly line in the head' (Taylor and Bain 1999), 'sweatshops and dark satanic mills' (Taylor and Bain 1999), electronic assembly lines in the new economy (UNI Mitchell 2001) and the 'bright satanic offices' (Sturdy et al. 2001). Are these illustrations also appropriate for describing the merger of nursing and call centre practice?

Concentrating on the issue what a call centre for healthcare is, many questions do inevitably emerge. What kind of phenomenon is it? Is it new – how far does it reflect contemporary working life more generally as well public organisations within Swedish healthcare more specifically? Is the phenomenon differently perceived among major groups of actors such as healthcare management – the politicians and the administrators – as well as the employees themselves and important surrounding colleagues? – not to mention the care-seekers, i.e. people feeling sick, worried about their own or others' health or just having a simple health question. How do they perceive the service? And how might we understand the consequences for the telenurses in terms of employment and working conditions in this new kind of organisation? Before further defining the purpose of the study and the research questions, the following sections (1.1 - 1.1.5) discuss the field of research from a general point of view, in order to form a background for the analysis.

1.1 CALL CENTRES - THE UBIQUITOUS SOLUTION OF SERVICE

Call centres are examples of the 'new' service work, and during the 1990s they were in fact the most striking phenomenon in service work internationally (Frenkel et al. 1999). The transformative technology used in call centres has been considered as revolutionising the relationship between clients/customers and 'front line workers' of services. Considered as one of the fast growing work occupations in the early 2000 century (Paul and Huws 2002; Toomingas 2003: 326; *UNI homepage* 2008), almost every area of economic activity has been influenced by its development (Tengblad et al. 2002).

> No area of economic activity where customer servicing takes place – from telecommunications and financial services to holidays and shopping, or indeed, government services – has, it seems, remained impervious to the call centre's onward march (Taylor and Bain 2004a: 1632).

The call centre is a phenomenon that has been omnipresent in almost all Western societies, and within all sectors of working life since the 1990s. However, there is no universal definition of the concept (e.g. Norrman 2005: 1). I define a call centre as a 'new' type of organisational form, where the organising of actions and the use of technological tools are underpinned by the logics of cost-effectiveness and customer-focus. Call centres in general require their employees to be skilled at interacting directly with customers while simultaneously working with integrated telephone and computer-systems. This is in line with other researchers' understanding of the concept (Taylor and Bain 1999: 102; Deery and Kinnie 2004: 2; Lindgren and Sederblad 2005: 189). Although there are differences among them, they all describe call centres as systems to dictate (control) the pace of work performance and monitor its quality.

Other researchers recognise less the Tayloristic methods and instead emphasise the knowledge side. From such a perspective the call centre system provides the employees with relevant information and/or systematically ordered knowledge in order to support the service interaction between front-line staff and customers (Frenkel et al. 1999: 103).

1.1.1 The characteristics of call centre work and work organisation

Collin-Jacques (2003: 12) gives a thorough description of the characteristics that typically form the usual layout and technological environment of a call centre. A call centre is a workplace in dedicated premises housing a large number of staff sitting next to each other, 'anchored' to their workstation, wearing headphones and manipulating data into a computer. By use of a particular technology, the Automatic Call Distribution system (ACDs), the calls to a centre are automatically routed to available and logged-in operators. The ACD system enables supervisors to track down time until the operators answer a customer, to log the time of a call, and assess the time when the operator is not working or disconnected etc. Furthermore, there are a range of databases for Computer Telephony Integration (CTI), which allow customer records to be transmitted to the call centre worker's computer screen along with the call. In addition, many ACD systems have Interactive Voice Response (IVR) mechanisms that are used to obtain basic information from the caller before they speak to an operator. In external companies, Predictive Dialling technology might display large pre-programmed lists of customers and computerised record of the customer's details (Norman 2005: 3-4).

Call centre work and work organisation have been explored through research, mainly by scholars in the UK, but also by practitioners and researchers in the US, as well as in many other countries around the globe including Sweden (Holman et al. 2007). Besides research on economic and technological matters (outside the scope of the thesis), important theoretical contributions originate from diverse streams of labour process theory, industrial and organisational studies, management regimes and software engineering and computer science

perspective on working life in call centres and interrelated aspects (for an extended overview see chapter 4).

Call centres have been associated with increased automation, close monitoring, tight control, high routinisation, labour division, and strict quality adherence to office work through the integration of telephone and computer technologies – a kind of industrialisation of the service sector, due to its organisation, managerial principles, mass-production and customer orientation (Taylor and Bain 2001; Korczynski 2002; Deery and Kinnie 2004). There is an underlying assumption that call centres are an extension of 'Taylorist' work organisation (Taylor and Bain 1999). Research on call centre has, furthermore, raised issues of de-skilling, the curtailment of employee autonomy, routinisation and the standardisation of encounters between employees and clients, stress and work intensification (Bain and Taylor 2000; Taylor et al. 2002). By entailing highly scripted and closely monitored work, call centres are compared with forms of organisation that were previously preserved for manual labour, but have now been diffused to white collar workers and the exercise of mental labour.

Both in Sweden and internationally, the work in call centres is carried out to a high degree by women, young people (students), part-time workers (Holtgrewe et al. 2002; Deery and Kinnie 2004), immigrants and groups given relatively poor remuneration (HTF 2000) and much of the work in call centres is linked to limited career promotion for women (Durbin 2006). The new organisational form of the call centre has increased both in importance and in size from the end of the 1990s. In 2006 it embraced about 2.5 per cent of the total Swedish labour force (Strandberg, Sandberg and Norman 2005).

However, the majority of call centres are so called in-house operations, i.e. a unit or department within an organisation (having another core activity than that of the parent organisation), contrary to outsourced call centres. Because some call centres are integrated in organisations with other core-activities and some call centre workers belong to existing occupations, it is hard to get exact data about the numbers of Swedish call centres (confirmed in an interview with a trade unionist from HTF in 2005).[2] While Statistics Sweden identify 289 workplaces and 8,000 employees in 2002, the specialised organisation for call centres *Invest in Sweden Agency* specify 192 external call centres and about 14,000 employees for the same year (Toomingas 2003: 325). Most of the external Swedish call centres are small (less then ten employees) and the average size is claimed to be around 46 work stations (ibid.). Such data is, however, not easy to verify.

Moreover, within the public sector, call centres are to be found for various Swedish organisations such the Police, the Swedish Social Insurance Agency, the Public Employment Services Office, the Postal Service (Tengblad et al. 2002; Strandberg et al. 2006) and the Corporation of Swedish Pharmacies (Brandt and Wennberg 2004). Another area is healthcare, the actual theme of this thesis.

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2 In 2002, Statistics Sweden created a proper work category NACE 74860 for telephone service operations (call centre activities) including customer service associated with technical services on behalf of another (Statistics Sweden 2007). Another category is devoted for work 'with treatment within call centres' NACE 74130.

1.1.2 The need to revisit an old dilemma leads to new practices

The aim of Swedish healthcare is described in the following terms: to protect the patient's best, support the personnel's endeavour to do a good job and provide possibilities for quality, access and cost efficiency (FCCa 2004). Healthcare is organised to provide human service on a universal and public basis. However, the goals of healthcare as a human service organisation are multiple and often conflicting and the objectives of healthcare might stand in sharp contrast to its results (Hasenfeld 1983).

Like most European healthcare systems, that in Sweden shares the problems of lacking resources, high total costs, questionable efficiency and an ageing population. Rapid medical-technical developments are helping the sector tackle these problems, but with increased possibilities people's expectations grow. Demography is changing as are health conditions: an older population with multiple diagnoses is posing increasing problems. At the same time as we are physically 'healthier', we feel psychologically poorer. Within society, different generations carry different values. Commercialisation, the possibilities of information technology and other forms of advanced technology have meant that people, particularly younger people have become used to rapid communication, autonomy and individual treatment (Saltman et al. 1998; Hallin and Siverbo 2002).

1.1.3 New Public Management and Swedish healthcare

The introduction of call centres within the public sector can also be seen in the context of contemporary problems and the new doctrine of organising public services, called by some New Public Management (NPM). NPM is defined as bringing the practice of private management tools and rhetoric into public organisations (Hood 1995; Lane 2000). Although, NPM is a theme with many variants, because of national and regional resistance, arrangements, divisions of labour and welfare regimes (Dent 2003: 3), it nevertheless seems that there are some common features.

Hoods (1995) summarised seven characteristic features of New Public Management which stresses: (1) separate cost units for different public products, where single departmental managers are given decentralised responsibility of staff planning, other resources and the overall budget; (2) competition between public sector organisations and between public and private organisations; (3) a greater use of private sector management practices regarding pay and conditions, of employment and more individualised employment contracts and individualised pay; (4) hands on-management and Human Resource Management strategies in order to ensure more active control of public organisations; (5) explicit and measurable (checkable) standards of performance in terms of the range, level and content of service provision; (6) output measures e.g. for healthcare production or pay based on job performance rather than rank or educational attainment; and finally it could be (7) expressed as a massive isomorphic process of copying and imitating from private business (Hood 1995).

The legitimacy of decision-makers (Carter and Mueller 2002) and the financial crises of the welfare state in times of recession, for example, have been stated as major reasons for the focus on cost containment, efficiency and new

practice (Brorström 1994: 7). The emergence of NPM took place at times of new ways to organise production, work and the development of production concepts, for instance Just-in-time and Lean Production. Such delivery is based on customised production and flexible specialisation and related to capital rationalisation performance, with a focus on specific delivery times and management by objectives (Drucker 1954; Peters and Waterman 1982; Womack et al. 1990). Furthermore, a consequence seems to be the hegemony of the customer, who in the name of consumer sovereignty is increasingly colonizing every nook and cranny of contemporary organisations as well as discourses about organisations (du Gay and Salaman 1992; Sturdy et al. 2001, Korczynski 2002).

Since the introduction of NPM in the 1980s, healthcare staff have experienced a range of different methods and principles, alternated with political majorities, economic conjunctures and organisational fashions particularly focusing on cost containment, rationalisation and the prioritisation of resources (Dahlgren 1994; Anell 1996; Harrison and Calltorp 2000).

Call centres are one example of the New Public Management and new ways to provide the service, aiming for mass-production or mass-customisation (Korczynski 2002). However, the arguments against NPM are basically twofold: First, the necessity to sharply distinguish the public sector from the private sector in terms of continuity, ethos, methods of working, organisational design, people, rewards and career structures, as all these factors have different characteristics within a public organisation. Second, it is important to have elaborate structures, procedural rules in order to prevent favouratism, corruption and avoiding public service 'trusts' regarding collective goods (e.g. Hood 1995).

Some scholars argue that there are areas in our societies where services do not have the character of a commodity. Healthcare is one of the most obvious symbol of a collective good, and health or ill-health is closely linked to the human conditions of vulnerability and insecurity. Consequently, researchers have argued that the public sector still differs from business organisations (Steijn and Leisink 2007) and healthcare is one particular area that is hard to commercialise (Deppe 2003: 3).

1.1.3 Previous research on health call centres

A review of the call centre literature shows that its focus has remained on white-collar routine work and workers mostly associated with low-skilled labour. It also includes work in finance, telecommunications and the retail trade (Frenkel et al. 1998; 1999; Taylor and Bain 1999; Batt 2000; Kinnie et al. 2000; Callaghan and Thompson 2001; Bain et al. 2002; Taylor et al. 2002; Holman 2004). On the other hand, service work ranges from a continuum of relatively low skilled to highly skilled jobs, where the type of call centre is internal (in-house) or subcontracted (out-sourced) (Norman 2005; Holman et al. 2007) and the sector appear to be of major importance in terms of employment (Bain et al. 2005; Holtgrewe et al. 2002).

With some exceptions, e.g. Frenkel et al. (1999) and Batt and Moynihan (2002), few call centre studies have covered professional or semi-professional workers. The merger of healthcare and call centres is, however, materialised through HCCs and the functions carried out are also mentioned as including

telephone advice nursing, abbreviated as TAN within Swedish healthcare (Wahlberg 2004).

1.1.4 The characteristic of a health call centre for telephone advice nursing

The telephone has been an important channel to healthcare for as long as it has existed. It has been a means to get information, advice and support. Antecedents of today's HCCs within the guise of special organisations have existed since the 1930s (Wahlberg and Wredling 1999) and telephone advice nursing has been an extensive service within Swedish primary care centres, clinics and the EMD centre (mainly *SOS-Alarm*) for quite some time. Telephone advice nursing within HCCs can be distinguished from the 'traditional' healthcare institutions with respect to work tasks and working conditions, and sometimes in terms of working times (Wahlberg 2004: 15).

Telenurses are in charge of 'telephone advice nursing', which is defined by Wahlberg (2004: 11) as a separate service carrying out the following tasks: (1) triage – assessing the urgency of care needed; (2) giving advice, support and education; (3) referral to an adequate level within the healthcare service; (4) providing healthcare information; and (5) coordinating healthcare resources. HCCs are accessible 24 hours a day, seven days a week, weekdays as well as Saturdays, Sundays and holidays, days as well as nights. HCCs are distinguishable from traditional primary healthcare units (expect acute care) which are only accessible in daytime, but as with most hospital care, this is given directly at the point-of-need and often round the clock (Wise et al. 2007). However, HCCs just receive care-seekers on the phone and have no access to health records from other healthcare providers (Wahlberg 2004: 15).

People phone an HCC because they need advice and help on widely diverse states of ill-health and inconvenience. Telephone advice nursing embraces the whole field of healthcare from urgent and life-threatening conditions to small symptoms that are more adequately described as banal. The aim of HCCs, according to the national guidelines (e.g. the FCC 2004a), is to improve accessibility and security by offering the public a consistent source of professional advice on healthcare, 24 hours a day, so the citizens can manage their problems at home or get referral to an appropriate level of care (ibid.). At the same time, the service is considered to steer flows of patients, which involves a coordination of healthcare resources in order to improve efficiency for healthcare in general (FCC 2004a). This kind of mass-production of service is rendered possible with the help of call centre technology, based on ACDs (FCC 2004b).

In April 1997 all calls during one week to an HCC in Stockholm, the Swedish capital, were recorded and analysed (Wahlberg and Wredling 1999). The study was a first attempt to give an overall picture of the callers and their symptoms. It showed that female callers were more common than male callers (60 per cent versus 40 per cent). A half of the callers telephoned in connection with their own symptoms and the other half on behalf of others – mainly their children or other juveniles in their care. The most common reason for consulting a telenurse was symptoms of infections such as colds, influenza, fever or diarrhoea (31 per cent). The second largest reason was chest abdominal pain (9

per cent). These two kinds of enquiries tended to increase during the evenings and nights (Wahlberg and Wredling 1999). The same study showed that in half of the consultations, the patient received self-care advice, a quarter resulted in information (i.e. phone-numbers and addresses for various parts of the healthcare system) and about 18 per cent of the callers were advised to see a physician immediately. The rest of the callers were advised either to attend an A&E department (6 per cent) or see a district nurse (1 per cent). For one per cent of the calls an ambulance was dispatched (Wahlberg and Wedling 1999).

The requirement of competence for telephone advice nursing is a nursing licence combined with adequate education and long experience of clinical work.[3] Many of the employees in HCCs have extensive experience, documented from primary care, as district nurseries or in home care or alternatively from special clinics. The work is particular in the sense that the telenurses have to rely on aural, second-hand information and sometimes even third-hand information (Wahlberg 2004: 15). As the nurse neither meets the care-seeker personally nor has the possibility to observe his/her symptoms, which is considered as a major problem in telephone advice nursing, she has to base her assessments on verbal and non-verbal communication, such as the sound of a symptom and background sounds like children laughing or coughing (Pettinari and Jessopp 2001).

Different expert systems (decision-support system) have come into use, facilitating and guiding/controlling the telenurses' work (Tjora 2000; May et al. 2003a). In Sweden, the systems basically constitute a technical frame to be filled in with questions, symptoms and advice. Expert systems are yet not a standard or mandatory in Swedish healthcare call centres, although it is argued that they are very important by the national project group for telephone advice nursing (FCC 2003). Like other nurses, the telenurses are obliged to document all interventions they process according to Swedish healthcare regulations,[4] and in some centres this is done in combination with help from a tape/CD recorder (FCC 2002a).

1.1.5 The puzzle of how to combine nursing and call centre

There is still a lack of knowledge about the merger of nursing and call centres in Sweden. Given the particularities of professional employees, public organisation, the characteristics of human services as well as the various institutional features, it might be argued that an HCC is dominated by other mechanisms than its counterparts on the commercial market driven by profit. The relationship between the front-line worker and the customer is central for all kinds of service work (Sturdy et al. 2001; Gabriel 2002; Sturdy and Fleming 2003). The concept of emotional labour (Hochschild 1983) is accordingly central in the study of telenurses. In line with Hochschild's reasoning, emotional labour relates to the

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3 Nurses belong to the occupations that are known as the regulated professions. The Swedish education for nurses lasts three years. In addition there are specialist formations such as district/paediatrics for one year, which is equivalent to a master education. All registrations are made at the National Board of Health and Welfare (National Agency for Higher Education 2005). See more about the formation of Swedish nursing in section 4.4.3.

4 SOSFA 1993:20 about the nurse's obligation to document all interventions, including telephone advice.

management of feeling and trained behaviour, while emotion work is more about the genuine relation between individuals (also Lindgren and Sederblad 2004: 173). My thesis is thus a response to the call for more research not only on the nurse–caller relationship, but also on the social relations of the workplace (e.g. Collin-Jacques 2003), while paying attention to its contextual situation (e.g. Glucksmann 2004; Bain et al. 2005; Jewson et al. 2007) interpreted by me as this particular healthcare organisation perceived by the actors involved.

The institutional context constitutes an important frame for both work and organisation (Johansson 1992; Leppänen 2002). In particular, healthcare is characterised by strong institutional features and is an arena for three main groups of actors: namely, the politicians, the administrators and the professionals. Together, these constitute the basis of healthcare organisations (Human Service Organisations) (cf. Kouzes and Mico 1979; Hasenfeld 1983; Östergren and Sahlin-Andersson 1998). Hogg (2000) depicts an organisation as consisting of internally structured groups connected in a complex network of subgroups, or inter-group relations, relations that are in turn characterised by differences in power, status and prestige.

The actors all have different and particular relations to the care-seekers. For the care-seekers, healthcare is, however, not a part of their working life. For them, health is what they hope to maintain or gain through the help of healthcare actors and the healthcare system. In another sense, as with other kinds of service provision, healthcare production is inseparable from its consumption, as well as the consumer (Korczynski 2002: 4-7). Furthermore, according to the rhetoric of New Public Management, the patient/care-seeker should be the focus of healthcare activities. The different groups of actors, however, conceive and act according to different logics: bureaucratism, professionalism and marketism (market/networks) (Freidson 2001).

When the call centre concept emerged as a new technology and a new way of organising work, it quickly gained huge attention from scholars applying labour process theory. The reason for this was that call centres provided new and vital reasons to revisit Braverman's thesis of de-skilling and the routinisation of white-collar work. The phenomenon also provoked new questions in relation to skills, autonomy and control in the work of the network society.[5] Recent studies of call centres have, however, been criticised for their narrow focus on workplace practice and accordingly an ignorance of the wider context in which call centres are located (Glucksmann 2004; Bain et al. 2005). The salient institutionalism within healthcare motivates a theoretical framework focusing on institutional factors. The development of healthcare systems is dependent on historical, cultural and socio-economic aspects as well as political debates and legal regulations. Furthermore, Saltman et al. (1998) as well as Dent (2003) highlight the importance of financial/payment systems and the different actors in healthcare and their autonomy in terms of information as well as the power asymmetry of medical care.

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5 Furthermore, in terms of the organisation of work and call centres, labour process theory provides an interesting perspective on skills, autonomy and control. These are also highly relevant, when trying to understand the organisation of work in HCCs and the occupational group in focus, telenurses.

1.2 AIMS OF THE STUDY AND RESEARCH QUESTIONS

In sum, a Swedish health call centre is a merger of nursing and the call centre concept. How might we understand the work and work organisation of this particular kind of call centre and what the consequences are for work and work organisation at an HCC? The HCC seems to be a phenomenon that is merging mass-production/mass-customised services and a publicly financed professional human service, healthcare. Yet, it tends to be equally important to consider the service of social goods provided by HCCs based on the contemporary ideas of the healthcare sector, i.e. the predominant context of New Public Management and from the conceptions of the main stakeholders. It is, however, known both among practitioners and scholars that the merger of all these features into a well functioning unit is still far from perfect and several conflicts and contradictions seem to be associated with an HCC.

The overall aim of this thesis is to elicit and analyse the merger of health and call centres with a focus on nursing. In order to explore and analyse the research problem in focus I tackle the following research questions:

1. What are the driving forces behind the formation and development of HCCs?

2. What were the conceptions of the main actors connected with an HCC – politicians, administrators, professionals and care-seekers?

3. What impacts do the different conceptions, interests and actions have and what are the contradictions and tensions?

4. How is the HCC's work organised and what are its consequences in terms of employment relations and the working conditions of the telenurses?

5. How can this study of an HCC contribute to our overall understanding of call centres?

1.2.1 Why is a Swedish health call centre interesting to study?

Employment in call centres generally constitutes a large part of contemporary service work. It is a growing sector of employment, spread among many industries and developed in a large number of countries (Holman et al. 2007). A literature review gives several following reasons for studying health call centres. This is confirmed and developed in chapter 4 on previous research which, together with chapters 6 and 12, sets out my theoretical framework:

First, applying the call centre methodology to a public service like healthcare is a rather recent practice. It implies a new kind of rationalisation of work and service.

Secondly, it is a part of the new public market for healthcare and embraces an adaptation of medical service to new patterns of consumption marked by individualism and the avoidance of risk.

Thirdly, healthcare is one of the major employers in Sweden and the nurses are the largest occupational group within healthcare (96,400 registered nurses in

Sweden, SAHP 2006). It is also a segregated labour market were the all nursing categories are predominantly women, while the majority of physicians are men. Thus HCCs involve many different people and there are complex work relations within healthcare.

Fourthly, nursing is an occupation highly affected by long term sickness and problems related to the work environment, but the issues of control and autonomy as well as other consequences of HCCs are still poorly understood.

Fifthly, HCCs are a unique combination of healthcare and call centre, where the strong occupational identity of nursing gives the call centre separate and distinctive features compared to call centres in general. For all these reasons, the organisation of work in a health call centre seems to be an interesting issue relevant for deeper analysis.

1.2.2 The empirical part of the thesis

The background to this study derives from an evaluation of a pilot project embracing a new organisational model, namely a call centre organised around telephone advice nursing, in one Swedish healthcare area.[6] The local HCC Fyrbodal is situated in the south-west of Sweden, i.e. Västra Götaland Region. The project developed later into a case-study composed of six sub-studies. Three sub-studies considered the telenurses, two sub-studies focused on the users of HCC Fyrbodal and finally one sub-study focused on all actors. The case-study has a longitudinal dimension of five years, starting from the service's introduction 2002, and proceeding until 2006. The empirical findings originate from more than 80 semi-structured interviews with actors at central and local levels: politicians, administrators, managers, trade unionists and telenurses as well as 400 users of the HCC's service. The thesis draws also on documentation, aggregate statistics, data and accounts from the press.

1.2.3 Demarcation of the research

The object studied is the call centre and therefore I will exclude overall telemedicine, telehealth and telenursing, which are large domains that also deal with ICT (Information and Communications Technology) and telephone technology but for larger and other purposes than my focus. *Triage* is a specific term for the medical assessment of a healthcare situation/symptom, and is considered here as one aspect of telephone advice nursing, simply defined as assessing the urgency of care needed (Wahlberg 2004: 11). Göransson et al. (2005) define triage as a process of sorting and prioritising patients based on their acuity of illness and not on their time of arrival for medical care (p. 432).[7] It

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6 Consequently, the call centre in question is an in-sourced one, in opposite to out-sourced call centres. Although extended discussions about outsourcing and privatisation of public functions within Swedish healthcare, most of the activities are still carried out by public actors. See more about the organising of Swedish healthcare chapter 2 below.

7 Göransson et al (2005) differ between emergency department triage, where each patient is assessed and prioritised according to the individuals' needs, and disaster triage, where the allocation is also dependent on the limited resources as a consequence of the disaster or other casualties. Historically, the term triage arose in the 18th century in connection with military settings (p. 432). Within A&E care, many Swedish hospitals have triage nurses in order to make a first assessment of care-seekers (Göransson 2006).

is applied accordingly in the British NHS Direct (Valsecchi et al. 2007), yet not at the HCC Fyrbodal nor in the national net of HCCs, where triage is considered as one aspect of telephone advice nursing. In Swedish HCCs, the callers are taken care of in chronological order.

I will not deal with the reorganisation of healthcare *per se* or the effects or output of the HCC case in terms of numbers, productivity or explicit satisfaction/dissatisfaction for the telenurses or other groups of actors.

When I refer to decision-makers, I normally mean politicians and administrators, although some of these might also belong to the group of professionals, and professionals have great influence over decisions, implicitly or explicitly. Those using the healthcare provision I interchangeably describe as users or care-seekers. Callers are also a possible term, for a deeper discussion see chapter 10.

In Sweden, in contrast to HCC practice in other countries for instance the British NHS Direct, there is only one occupational group: the telenurses. Accordingly, the only group of actors working within the HCC and in focus for this thesis is the telenurses, also called nurse advisers.

The range of different occupations within healthcare is considerable. This is why I had to limit my scope to the group of actors who are most involved in HCCs. Moreover, there is a debate on whether nurses are professionals or not (cf. Witz 1992). When I write about healthcare professionals, I embrace the physicians as well as the nurses and for me both groups are considered within the category of professionals. I am, however, aware of different views on professionals: either as a monopolised and privileged category within an enclosed domain of knowledge in the Weberian sense (Freidson 2001) or as employees carrying out advanced work tasks and/or work in a professional way (Fournier 1999; Evett 2003; Macdonald 2006). The latter is, according to a Foucauldian analysis, about the self-disciplined worker with internalised responsibility (Foucault 1986; du Gay and Salaman 1992). In chapter 4 on previous research, I conduct a line of reasoning about different ways to conceive professionals.

As with nursing in general, most telenurses are women and consequently they will here be addressed in the feminine form (she, her, herself). The other groups of actors are not dominated by one gender in the same way and will therefore be mentioned in both a feminine and a masculine form.

1.3 THE STRUCTURE OF THE THESIS

The following chapters move from an overall macro-perspective on Swedish healthcare to a narrow focus on the work of the telenurses at HCC Fyrbodal. The book is accordingly divided into four parts: part I introduction to the study; part II conceptions of an HCC and its related institutions, part III employment relations and working conditions in a HCC; and part IV concluding discussion. The account is introduced in chapter (2) by outlining some institutional effects, neo-liberal influence, harsh international competition and advanced technological innovations in the Swedish welfare state and its development of the healthcare sector. The context embraces the development of Swedish healthcare in general and of Swedish telephone advice nursing in particular. *HCCs embedded in Swedish healthcare* gives a background picture for the empirical studies of formation and development, from 2002 to 2006 of *a HCC in the area of Fyrbodal* in the south-west of Sweden (chapter 3). Chapter 4 presents *previous research* on call centres and the service debate as well as telephone advice nursing (TAN). The chapter explores, moreover, issues related to Human Service Organisations (HSO), including relevant aspects of professionalism and nursing. Chapter 5 describes the *research methodology and process* used. The first section addresses characteristics of the pilot project evaluation related to this study and the development of my research questions. The other sections describe and explain the three stages of the research process: data collection, processing and data analysis. Therein, the approach of using multiple methods is reflected upon and the overall case-study and its six part-studies is described. The methodological aspects are synthesised into a model framing my empirical findings and the analysis of my data.

PART II starts with a chapter (6) illustrating conceptions of institutions, including a model for analysing the empirical material. Here the important institutions for healthcare and the HCC are illustrated, with a discussion of their possible implications for the study. The following chapters (7-10) contain presentations of *the results* analysing the conceptions of the actors involved. The first chapter takes up the *conceptions of the politicians*, followed by the *administrators, the professionals* (nurses and physicians), and *finally the care-seekers*. The conceptions of these groups of actors provide an overall picture for the subsequent descriptions and analyses of the HCC and its work organisation. All conceptions are also compared and contrasted in chapter 11 pointing out a range of contradictions and tensions.

In part III, chapter 12, I demonstrate *the importance of focusing on employment and working conditions*, when analysing an occupational group and a certain workplace, and how this is done within the thesis. Chapter 13 discusses the characteristics of work organisation at the HCC, where telenurses are monitored, evaluated and rewarded according to both hard and soft criteria. It embraces the structural relations and how *employment relations* are organised and conceived by the telenurses, and adopts a managerial perspective, that of Human Resource Management. Chapter 14 considers *the working conditions* at the HCC and pays special attention to the division of labour, the technological

outline of the HCC and the HCC's work practices. This includes the relationships between colleagues and care-seekers in order to embrace the implications of conceptions, interests and actions in terms of contradictions and tensions. These tensions, furthermore, shape the telenurses' work in terms of control, autonomy and up-skilling or de-skilling tendencies. Chapter 15 has a *focus on the HCC from a healthcare perspective and a call centre perspective.*

Finally, chapter 16, in part IV, readdresses the research questions and draws the conclusions about the merger of the call centre concept and healthcare, with a focus on nursing. The empirical findings are presented in terms of conceptions, practices and tensions and include a discussion of how the findings might be interpreted.

CHAPTER 2
HEALTH CALL CENTRES EMBEDDED IN SWEDISH HEALTHCARE

This chapter aims to give an overview of Swedish healthcare and its cornerstones. It covers the main reforms since the 1970s that might be of importance in order to understand the drivers of health call centres (HCCs). It covers institutional factors, i.e. political, economic, cultural and legal forces, which according to Saltman et al. (1998; 2006), are factors of significance in understanding the rules of the game and the actions of the different stakeholders. Additionally, information about governmental healthcare reforms and their purposes are explored. Consequently, the rise of HCCs seems closely connected to the overall development of the Swedish healthcare sector, including the more recent practices and rhetoric of New Public Management (see also Pollitts and Bouckaert 2004).

The chapter also gives a background picture to the formation of HCCs, in terms of time and configuration on a national level. The national context serves as a backdrop to reflect on the development of the case-studies of HCC Fyrbodal. Moreover, the chapter offers an introduction to the analysis presented in the following chapters.

2.1 THE OVERALL ORGANISATION OF SWEDISH HEALTHCARE

2.1.1 Different kinds of national healthcare systems

Healthcare is a significant part of a country's welfare regime and highly interwoven with the entrance of Swedish women onto the labour market (e.g. Esping-Andersen 1990: 149).[8] A proper understanding of the work and work organisation of HCCs has to be considered within the context of Swedish healthcare at large.

In Western Europe there are mainly two kinds of healthcare systems reflecting different solutions to the provision of medical services and aspects of a welfare regime. *The Beveridge-model* is predominant in tax-funded health systems such as the Nordic countries including Sweden, as well as Ireland and the UK. The model is equally common in Southern Europe (Greece, Italy, Portugal and Spain). A key element of this approach is universal /near universal access to healthcare (Dent 2003: 11). The public sector is the main provider of funding in order to obtain universal access and equitable distribution of resources accepted by the whole population.

The Beveridge-model stands in contrast to *the Bismarck-model*. The latter is based on funding from public sickness benefit funds and national health insurance legislation for all citizens, and exists in Austria, Belgium, France, Germany, Luxemburg, the Netherlands and Switzerland.[9] Accordingly, the fundamental aim of the Swedish health

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8 Sweden has one of the most gender divided labour markets of all industrialised countries due to the strong predominance of male employees in manufacturing and females in services. Overall, two thirds of the Swedish workforce are employed in the private sector where women comprise 50 per cent of the workforce. By comparison, 79 per cent of all employees in the public sector are women (Statistics Sweden 2004: 15-16). The division of labour between men and women across the Swedish labour market varies greatly, however, for different occupational groups (National Mediation Office 2006: 7-10). For the gender division in healthcare see table 2.1 in section 2.3.

9 The statutory insurance-based systems in these countries are however subject to close regulation by the government.

and medical service emphasises equal access as opposed to, for instance, freedom of choice as in the Netherlands (Dent 2003: 10, 58).[10]

A third type outside Western Europe is a non-universal healthcare like the American model of liberal/residual healthcare, which perhaps cannot even be called a system. Only 25 per cent of American citizens are covered by public healthcare, but most of the population has private health insurance, while 14 per cent have no access to either (Palier 2006: 21 and 51-52). Important national differences imply, among other things, that healthcare staff with different educational backgrounds and specialisations are found at various levels within the particular national system. Organisationally, general practice as the core of primary care can for example cover a large spectrum from being configured in some countries as a for-profit business in the private sector to being structured as in Sweden and some other countries as a public service delivered by civil servants (Saltman 2006: 68).

2.1.2 The political and legal framework

Among the Beveridge-countries, Sweden has gone farthest having a national health service that provides medical treatment directly to its citizens through publicly employed healthcare staff, including physicians working in and salaried by public hospitals and healthcare organisations (Immergut 1992: 6). In most other Beveridge-countries, with the exception of Finland and Iceland, general practitioners are self-employed physicians (Johnsson et al. 2006: 45).

In Sweden, healthcare is planned, provided, financed, regulated and followed up within the framework of political decisions. This includes the ownership of facilities, setting up the system for financing and control as well as the employment of physicians and other professionals. It is therefore highly relevant to consider the Swedish political system and political context, when describing and analysing the healthcare system. This entails Sweden as a whole (the national political majority) as well as the political parties in leading positions in regional and local authorities. The Social Democrats have been in power since 1932 with the exception of two periods with centre-right governments in 1976-1982 and 1991-1994 and the recent shift in government starting from October 2006.[11] Thus Sweden has been described as a configuration shaped by a broad social democratic ethos (Dent 2003: 43).

Furthermore, it is a welfare regime that to a high extent has relied on the capacity of incorporating the middle class and providing benefits for their tastes and expectations, but nonetheless has retained universalism of rights and equality of the highest standard (Esping-Andersen 1990: 27). (For an overview of parties forming governments, major socio-economic events and important reforms see appendix 1).

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10 The Dutch healthcare system also has universal coverage for all citizens, but in contrast to Sweden it has been combined with a variety of social experiments with the freedom of choice. A part of this 'freedom' is however enforced freedom of choice, for example the obligatory choice of one's health insurer.

11 Between the left and right wings there are many ideological disagreements over healthcare, such as centralisation versus decentralisation and privatisation, the role of the state professionals and the market, etc. While centralisation is at the centre of the social democratic vision, the centre-right parties argue for a decentralisation of responsibility and for privatisation. The Social Democratic Party had, however, an influential role in preparing for the introduction of competition and the quasi-market of healthcare before 1991 (Antman 1994).

First of all, the government is responsible for guarding the public interest. Healthcare should be universal offering equal access for all citizens (Dent 2003: 50). Second, the government should act as a policymaker towards this sector, being involved in planning and processing. Third, the government should supervise the sector. The main role for the *central government* is to establish basic principles for the health service through laws and ordinances, mainly the Health and Medical Services Act from 1982 (*Hälso- och sjukvårdslagen 1982: 763*), through the Ministry of Health and Social Affairs (*Socialdepartementet*), and through the central advisory and supervisory agency, the National Board of Health and Welfare (*Socialstyrelsen*) together with a state agency for evaluation of technological research and development, the Council of Technology Assessment in Health Care (*Statens beredning för medicinsk utvärdering*) (WHO 2005: 35). According to the Swedish Law on Professional Activities (*Lagen om yrkesverksamhet på hälso- och sjukvårdens område 1998: 531*), healthcare has to be accountable to the National Board of Health and Welfare. The Board is also the licensing authority for healthcare staff. The licences are granted for an unlimited period of time once the professional has acquired the right to practise. Yet the Board can in cases of malpractice withdraw a single licence (WHO 2005: 71). Furthermore, healthcare providers are obliged to have a system in place in order to report incidents connected to medical treatments and interventions (WHO 2005: 102).

However, the Swedish government has no direct imperatives to steer healthcare. Instead, the self-regulated counties are the principals and the owners of healthcare assets, according to a process of transformation of governmental responsibility undertaken in several steps, also mentioned below in the phases of Swedish healthcare section 2.2.

The healthcare sector is one of the major employers in Sweden. Today, about 230,000 people are employed in the counties' human services, mainly healthcare, equivalent to seven per cent of the entire Swedish workforce, which makes the sector one of the major Swedish employers of large organisations (>500 employees) (Statistics Sweden 2006). In fact, although Sweden is considered as a country with a relatively high proportion of large firms, nine out of the 15 biggest employers in the country are in fact public organisations (Statistic Sweden 2005).[12]

Since the early 1990s an internal market in healthcare has developed in most Swedish counties in order to stimulate competition between public and private actors. However, the majority of Swedish healthcare is still publicly provided (85%) (WHO 2005: 79; Andersson 2007: 67).[13] Private companies that carry out medical and care

12 The 15 biggest organisations are: 1 Stockholm City Council; 2 Västra Götaland Region; 3 Gothenburg City Council; 4 Posten AB; 5 The County of Stockholm; 6 Skåne Region; 7 Volvo AB; 8 Malmö City Council; 9 LM Ericsson; 10 Samhall AB; 11 Ford Motor Company; 12 Praktikertjänst AB; 13 Astra Zeneca Plc; 14 Örebro City Council; and 15 Scania (Statistics Sweden 2004). Of these numbers 1, 2, 3, 4, 5, 6, 8, 10, and 14 are public organisations.

13 Most private entrepreneurs are found within primary care and only four out of 91 hospitals are private. In 2002, 27% of all physician consultations in outpatient care with public funding were conducted at private facilities (FCC 2004c). Doctors practising 'privately' do so mostly through public funding and are closely monitored by the national government and local health authorities. The majority of private physicians and physiotherapists are to be found in the County of Stockholm. Furthermore, the market for voluntary health insurance is growing in Sweden. However, it is still small in comparison with those in other European countries. In 2003, about 200,000 people (2% of the Swedish population) had some kind of supplementary insurance (Swedish Insurance Federation 2004).

activities on behalf of the local authority, the county or the region are financed though public funds. Using tax revenues, the private actors have to provide services equal to the public sector in terms and conditions, i.e. the citizen should pay the same for a service irrespective of whether it is provided by the public sector or by a private company (SALAR 2005b: 7).

2.1.3 A decentralised system based on local self-government

Contrary to a national and centralised healthcare system as for example the British NHS, Sweden has a decentralised healthcare system, placing decision-making as close to the activity as possible. The health services rest largely in the hands of 49,000 regional and local politicians, directly elected to sit on 21 county councils[14] and out of these 97 per cent carry out their official duties in their spare-time (SALAR *homepage* 2008). Hence, it is the interests of national and local politicians and healthcare administrators that predominantly determine the agenda for healthcare provision and to a considerable extent that of the medical profession (Dent 2003: 43-75).

Around half the Swedish population are located in the county/regions that cover the three largest cities, and the other half are found within counties providing medical services to between 200,000 and 400,000 people. A smaller county contains two to four small general hospitals, and one main hospital with most medical specialties. In addition, there are six medical areas that coordinate and deliver tertiary care through ten regional hospitals. Since the beginning of the 1990s, the responsibility for long-term care for the elderly, the disabled, and long-term psychiatric care has been transferred to the 290 local municipalities in Sweden. The counties enjoy a high degree of self-government originating from a 150 year old structure, and their own possibility to levy taxes directly from the population. This makes them stronger than their counterparts in other countries, e.g. the local trusts in Britain.

Furthermore, it means that the public sector is represented by politicians at three levels, i.e. the state, the county and the municipality. The Swedish system of self-governance contributes to the construction of local provision of public service and opens up for large geographical variations within the country (Dent 2003: 54; WHO 2005: 49).

The Swedish healthcare system is best described as being governed by framework laws and general principles provided at national level, and only in very few instances do detailed directives exist. Swedish healthcare reforms have had a more incremental approach than in countries with more centralised government regimes. Because of regional and local self-regulation, the county councils enjoy a high degree of freedom to develop the pattern of health service within their own jurisdictions (Calltorp 1999) and several Swedish reforms are essentially county specific, i.e. developed in one county/region. The County of Stockholm, for instance, decided early to establish an internal market for its medical service. The internal market was based on tendering processes open to all interested actors. Accordingly, providers (hospitals, primary care centres, GPs and other occupational groups) were paid for the service they carried out, i.e. in line with performance (Dahlgren 1994: 30). This kind of self-government has been characterised as a 'bottom-up' strategy within the decentralised Swedish system.

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14 Of the 21 counties/regions, 18 are counties, two are regions and one a local authority.

The result is a variety of municipality/county initiated changes with no overall structure or model being imposed nationally (Calltorp 1996: 587).

2.1.4 The demand for Swedish healthcare

The Swedish population reached 9 million in 2004, a figure equivalent to 2.3 per cent of the citizens within the EU. Yet Sweden's broad territorial expanse of 410,900 km^2 covers 15 per cent of the EU area (Sverigeguiden *homepage* 2007). With a length of 7,300 km, the Swedish coastline is the longest in Europe. However, more than 57 per cent of the country is covered by forest, and mountains dominate the north-western part. The majority of the citizens live in the coastal regions and in the southern part of the country. Eighty three per cent of citizens are concentrated in the urban areas (Statistics Sweden 2007a). In 2006, Stockholm had 793,000 inhabitants, the second biggest city was Gothenburg with 493,000 inhabitants, followed by Malmö with 280,000 inhabitants (Statistics Sweden 2007a).

In comparison with, for example, the UK, the Swedish nation is considered to be homogenous, with the Lapp community in northern Sweden as the only territorial minority culture (Crouch 1999: 297). From the Second World War to the mid-1970s, immigration was welcomed and encouraged by governments and employers as a means of alleviating labour shortages. From the mid-1970s, immigration consisted of refugees compelled to emigrate due to political problems in South America during the 1970s, conflicts in the Middle East, in the Balkans from the end of the 1980s and in particular from the former Yugoslavia during the 1990s (Höglund 2002: 401). About every fifth Swede, equal to 1.7 million of the Swedish population, is of foreign extraction, mainly from the Nordic countries, the former Yugoslavia and the Middle East (Blomsterberg 2004: 14).[15]

Life expectancy in Sweden is among the longest in the world: in 2006, it was 83 years for women and 79 years for men. During the past 30 years, the average life expectancy has risen by about 5.5 years both sex considered (Statistics Sweden 2007b). Furthermore, Sweden currently has one of the world's oldest populations. Infant mortality decreased substantially during the same period from 11 to 3 deaths per 1000 live births in 1970 and 2002 respectively (WHO 2005: 9). The natural population growth was, however, negative. Being one of the world's oldest populations implies that more than 17 per cent of the Swedish population is at least 65 years of age and 5.2 per cent are older than 85 years. The ageing of the Swedish population has important social and political implications (WHO 2005: 3 and 110).

15 A little more than hundred years ago, 72 per cent of Sweden's population worked in agriculture and the country was so poor that 750,000 Swedes or 20 per cent of its population emigrated (Esping-Andersen 1985: 48). After the Second World War, Sweden changed from being a country of net emigration to one of net immigration. The Swedish citizenship legislation is based on the origin principle. This means it is the parents' nationality that determines the child's nationality. The alternative route is to become a Swedish citizen by application (naturalisation).

2.2 THE PHASES OF THE SWEDISH HEALTH SYSTEM

Four phases of Swedish healthcare can be distinguished: (1) the development of Swedish healthcare: pre-1950; (2) the expansion of healthcare: 1950 to the mid-1970s; (3) the financial crisis and cost-containment: mid-1970s to 1990; and (4) New Public Management: from the 1990s.

2.2.1 The development of Swedish healthcare: pre-1950

The first Swedish medical faculties were established early at the end of the 17th century, both as a university and an apprenticeship route. The division between different types of physicians was erased early, when surgeons subsumed themselves to physicians and unlicensed practitioners were outlawed (Immergut 1999: 188). Following this, Swedish physicians are often seen as being highly successful in limiting their numbers (ibid.). From 1860 the ownership of Swedish hospitals was transferred from the state to the counties. However, most hospitals were very small and the real expansion in Swedish hospitals started after the Second World War (Hallin 2000: 8).

From the mid-1950s, the Swedish health system largely expanded and went from first giving aid to the sick on low incomes to guarantee a substitute income for salaried workers suffering from illness with the implementation of a health insurance in 1955 (Immergut 1999: 208).

2.2.2 The expansion of healthcare: 1950 to the mid-1970s

The second phase lasted from the mid-1950s until the 1970s. Post-war healthcare development in Sweden followed the general enlargement of the Swedish welfare state. This period was characterised by a rapid expansion of somatic hospitals and primary healthcare. The peak of the wave of nationalisation took place at the end of the 1960s.

In combination with a compulsory national health insurance for all citizens, the 'Seven Crowns' reform (1969) almost eliminated the private physicians/general practitioners, as the private alternative became too expensive for patients. By charging the patient a fee of seven crowns to be paid to the healthcare organisation (hospital or primary care centre), the patients no longer had to pay directly to the physician. The aim was to ensure equal access for all citizens to primary care centres and hospitals. Consequently, private practice was no longer carried out within the walls of public hospitals (Immergut 1999: 213-214). In order to become publicly employed, the physicians won a generous deal in terms of working time, which made it possible for physicians to carry out their medical service outside public healthcare and in their spare time (Palier 2006: 16). Thus, universal access to a national health system was implemented by a progress strategy, in contrast to the British National Health Service that came into being all at once in July 1948 (Pond 2007: 49).

The medical profession's acceptance of becoming civil servants is explained by the increasing number of young physicians, and that the majority of the physicians sought a secure income, good employment conditions and less variety of income than they received under the payment per intervention system (Immergut 1999: 220-221; Palier 2006: 16). The Swedish Medical Association never took part in the preparation for the reform, but when it became a fact, its representatives conducted tough negotiations regarding working conditions. The result was high salary differentials between physicians working within different medical specialities. Hence they had a

fixed gross salary and workinghours as high salaried employees (Interview Calltorp 2007). Thus with the exceptional reform of 1969 the Swedish civil servants (administrators) secured an ample domain to exercise their administrative power over Swedish healthcare (Immergut 1999: 1).

During the 1960s and the 1970s, the expansion in Swedish healthcare was based on a strong belief in the treatment of patients at large hospitals.[16] Healthcare was driven through long-term plans of principles gradually implemented in annual budgets. Healthcare was, furthermore, a separate system embracing many different, isolated budgets for different specialities and intense internal power battles (Dahlgren 1994: 22). With a stronger focus on a public primary care,[17] telephone lines were also set up and motivated by the growing number of one-generation households and an overall reduction in knowledge about simple illnesses (Wahlberg 2004: 16). Telephone lines were also established in order to increase efficiency and compensate for the shortage of physicians in primary care (Marklund and Bengtsson 1989a).[18]

A great divide in public administration, however, occurred in the mid-1970s, because of the recession, which subsequently led to the first crisis of the welfare state. An ambitious programme of expansionary fiscal policies was undertaken at national level in order to improve the economic situation (Lindvall 2004). At the same time, different levels of care were introduced in order to keep up with the pace of technological developments and attempts were made to eliminate increasing health costs.

From the mid-1970s, attempts were made to modernise the public administration by changing a rigid Swedish bureaucracy into an organisation providing a public service, where consideration was paid to the citizens' personality and individual case needs. Consequently, a new law for public administration came into effect in 1987 including an obligation to provide public/human service. The law stated the necessity for public staff to be flexible, to provide help and meet the demands of the citizen (Johansson 1992: 17).

2.2.3 The financial crisis and cost-containment: the mid-1970s to 1990

A halt in a long phase of economic growth, with the oil crisis in 1973 as the turning-point, paved the way for a neo-liberalist approach in the 1980s. The Swedish economy suffered from problems of low productivity and the remedy according to the increasingly influential group of economists in the public services was to introduce management principles in the public sector from commercial industry (Lindvall 2004).

The period from 1976 to 1982 saw the first term of office of a centre-right government after forty years of social democratic rule in Sweden. This 'bourgeois' government started to introduce new practices in order to improve management recruitment and efficiency. More differentiated and flexible pay policies for the

16 The supply of medical service ranged from primary healthcare with general practitioners and district nurses to the highly specialist hospitals in the Swedish counties, see also section 2.4.

17 The Primary Health Care Act adopted in 1973 required preventive as well as curative primary service for the inhabitants (Saltman 2006: 74).

18 According to Marklund and Bengtsson (1989), telephone advice nursing in Sweden started because the demand for appointments with general practitioners at primary care centres was much greater than the resources available. At the time, general practitioners were in short supply, comprising only 10 per cent of the total number of physicians in Sweden (p. 49).

healthcare sector were thereafter presented by the Social Democrats from 1986 (Elvander 2006: 199).

From 1985, the so-called Dagmar-Reforms came into force whereby the State started to collect contributions for the counties. This implied a shift from a system based on reimbursement for performance (payment per visit, per care day) to a system based on fixed yearly amount related to the demographic structure of the county and its needs criteria. But this new system also had problems in overcoming imbalances between, for example, primary and secondary care (Dahlgren 1994: 30).

One revolutionary decision was that of assigning accrediting private practitioners to be reimbursed by public means in the counties. Contrary to the perceived threat, the number of private practitioners increased. The physicians found it hard, however, to work extra hours as private practitioners in their free time, because the employment responsibility was transferred to the county council (Blomqvist and Rothstein 2000 referred to in Lofgren 2002: 9). From the 1980s onwards, primary healthcare was formally considered the foundation of Swedish healthcare. However, after the peak year of 1982, when Swedish healthcare attained its greatest size – 9.7% of GDP – Sweden became one of the OECD countries with the most vigorous cost-containment programmes built on cost-saving campaigns, wage freezes and cuts in budgets for equipment and buildings (Harrison and Calltorp 2000: 222). The long tradition of an active labour market policy aimed at full employment was the main motive, when the government from the mid-1980s chose a new direction for the economy by undertaking major currency devaluations. The policy, called the third way (*Den tredje vägen*), aimed to avoid a rise in unemployment (Lindvall 2004).

In 1982 the current Health and Medical Services Act (SFS 1982: 763) was introduced. This drew an important demarcation line between care and health, and as a result healthcare would carry out preventive action as a complement to its curing and caring role (WHO 2005: 9).

2.2.4 New Public Management: from the 1990s

In 1991, Sweden faced its deepest recession for 50 years and the central government imposed constraints on the fee per patient and restricted growth in healthcare expenditure. It also froze the county councils' tax levels, and blocked the revenue flow into healthcare (Harrison and Calltorp 2000: 222). Moreover, deflation occurred, but this time the policymakers did not use macroeconomic instruments in order to prevent increasing unemployment (Lindvall 2004).

Between 1992 and 1995, three major reforms took place in healthcare, namely the *Ädel Reform* (focusing on long-term elderly care), the handicap reform and the psychiatry reform, all having the common aim of changing the structure of the overall healthcare organisation. As a result, the accountability for patients with high caring needs (such as the elderly, the handicapped and people suffering from long-term mental illness) was transferred from the hospitals to the county councils and the municipalities. Consequently, the municipalities became responsible for the living arrangements, employment and support services of the nursing homes, the sheltered housing and for people suffering from long-term mental illness. As pointed out by Wärvik (2005: 49), the reforms concerned people with a strong need for nursing care and/or rehabilitation, and who of course demanded supplementary medical treatments, but whose medical

treatment was of secondary importance. It implied the need to guarantee access to nursing services 24 hours a day within the municipalities.

From 1991 to 1994, with a centre-right coalition again in the majority in the Swedish parliament and in many county councils (after a Social Democrat government from 1982 to 1991), a range of reforms were introduced on new payment schemes, internal markets, etc. The focus here was on decentralisation, efficiency, transparency and freedom of choice.

In the shadow of repeated problems (deflation, unemployment, loss of credit) caused by the major recession of the early 1990s, a harsh political debate was held about the necessary pressure for reform in healthcare. The conclusion arrived at, by the so called Commission of Productivity (*Produktivitetsutredningen*), was that healthcare was facing problems because of a lack of incentives for productivity and financial growth. The administration was claimed to be old-fashioned and health expenditure overall accounted for a far too high proportion of tax revenues (Gustafsson 1994: 8). A political change from a Social Democrat to a right-wing majority government (1991-1994) led to a major shift in ideology. Yet Social Democrats previously had investigated the possibilities of moving towards introducing competition and greater freedom of choice during their term of office prior to 1991. Thus the systemic shift within the healthcare sector was a result of 20 years of debate within the Swedish left (Antman 1994: 19).

The debate at the time concerned two main problems which were merged into a common solution based on markets and management. The first problem was the size of healthcare, the second the administration of healthcare. The former was expressed as caused by an inefficient healthcare apparatus and the negative effects of the politics of equality (e.g. the solidaristic pay model). The latter was related to democratic and bureaucratic aspects (Antman 1994: 20). Political economists, with an increasing influence on the political agenda, had argued since the 1980s that resources were not deployed in an optimal fashion. In Sweden this debate became linked to discussions about enhancing patient choice and making providers more responsive to patients as 'consumers'.

Hence, from the end of the 1980s the Swedish healthcare system – as were the public services in general – was touched by the wave of private business concepts and marketisation in order to enhance the importance of the free market and competition – both between different public providers and between public and private providers. This fourth phase was strongly influenced by the American rhetoric and practice widely known as New Public Management (NPM) and spread during the era of Thatcher and Reagan. NPM is usually considered as being adapted to national institutional characteristics (Hood 1995; Pollitt and Bouchaert 2004), although there are some common traits (see also chapter 1 above). In sum, it covers governance focusing on competition, contracting, and control (Almqvist 2006). It is also expressed as processes, goal-setting, and managerialism including decentralised responsibility for staff and separate cost units, consumer choice and empowerment, evaluation and control of performance and costs through measurable output and standards as well as individualised pay and employment agreements (see also Dent 2003: 57-58). New incentives were equally demanded for ensuring efficient healthcare staff, as well as avoiding the abuse of power and resources by professionals (Antman 1994: 23).

Central components of the new management dogma were efficiency and effectiveness with a strong emphasis on flexibility and customer orientation. NPM stresses accountability in the name of cost-efficiency, flexible production and individualised employment relations. Quasi-markets were created for both public and private actors. In the 1990s, Sweden as well as the UK and the Netherlands were pioneers at introducing an internal market purchaser–provider model separating providers and purchasers of health services into different roles, i.e. distinguishing politicians from public administrators in order to create competition, mainly between different care-givers (Dent 2003: 43). Sweden opted for rapid and extended market-orientation (Harrison and Calltorp 2000: 220).

However, because of the counties' self-governance of healthcare, different models of financing were developed in Sweden – mainly the Dala,[19] the Bohus and the Stockholm models (SOU 1993:38: 243), all aiming at performance and cost control. The Bohus variant was, however, primarily a model based on investigations into better information (transparency of costs) focussing on competition based on quality, whereas the Stockholm model was seen as extreme in terms of rapid marketisation and privatisation aimed at both price and quality competition (Dahlgren 1994: 33-34). In the sections to follow, further reforms are discussed as is the tendency to aim for more rational healthcare practices such as mergers, prioritisations, strengthened patient rights, attempts to improve access, and strategies to put primary care in the driving seat.

Mergers of hospitals and healthcare areas

From 1994, hospital mergers and restructuring dominated the county councils.[20] These efforts aimed to better monitor and steer clinical activities and to rationalise services by structural changes (Leffler and Mühlenbock 1999; Brorström 2004). In 1999, several county councils merged into two bigger regions, the Västra Götaland Region in the west and Skåne Region in the south. This development created a new situation regarding the pattern of centre-periphery power relations within the Swedish system (Calltorp 1999: 4). Between 1999 and 2003, the number of hospital beds was reduced by more than 40 per cent and the number of beds per day has decreased by 30 per cent. This has meant a reduction in the average length of hospital stays and a higher rate of patient flow through chains of care,[21] advances in medical technology, better methods with better results, a greater proportion of specialist staff, higher level of training as well as more specialised skills, and different types of structural changes (WHO 2005: 66).[22]

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19 The Dala-model was built on a shared responsibility for all healthcare financing between a local healthcare committee and the primary care organisation in the county. One aim was thus to strengthen the gate-keeper role of primary care.

20 Thirteen mergers of hospitals throughout Sweden had been undertaken in 1999 (Harrison and Calltorp 2000: 228).

21 See explanatory footnote 3.2.5

22 In the EU in 2001, Sweden and Finland had the lowest proportion of beds per inhabitant. The shortest lengths of stay were in Denmark and Finland. Next came Sweden with a 45% shorter average length of stay than in France and Germany (FCC 2004c: 6).

An ethical platform for priority setting

In 1992 along with this development, a Priority Setting Commission was appointed in order to investigate during a 3-year working period the complex issue of priority setting and how to deal with healthcare needs, demands, resources and allocations (Calltorp 1999: 5). In 1997, the Parliament decided to adopt the general principles of the report, creating an 'ethical platform' as the basis for concrete priority setting for all actors in the healthcare system. Generally the comments were positive and the critical remarks were mainly related to the lack of concrete advice on how to prioritise in practice (Calltorp 1999: 8).[23] Furthermore, the principle of prioritisation was included in the fundamental law, the Swedish Health and Medical Services Act of 1997.

The three basic principles for public health and medical care are: the principle of *human dignity*, the principle of *need and solidarity* and the principle of *cost-efficiency*. These are also the terms for prioritisation of healthcare, meaning first that all individuals must be treated with dignity and have the same rights, regardless of their status in the community. Second, those in greatest need should take precedence. Third, if a choice has to be made on different healthcare options, 'there should be a reasonable relationship between the costs and the effects, measured in terms of improved health and improved quality of life' (WHO 2005: 1).[24]

Strengthened patient rights and improved access

Other reforms took place in order to strengthen the position of the patient. In 1992, a 'maximum waiting-time guarantee' was introduced in terms of a joint agreement between the Swedish Government and the Federation of County Councils (FCC). The guarantee covered 12 of the most common surgical procedures, for which the patients were promised a first intervention within three months.

Yet when it turned out to be difficult to fulfil such a promise, the time was expanded to six months. The intention behind the reform was to create incentives for increased productivity and efficiency and to attract patients outside the catchment area while avoiding the loss of local patients to competing hospitals (Harrison and Calltorp 2000). The competitive mechanism focused on access and quality, but not on price (ibid.). However, in most counties, health allocations followed the inhabitants and not the hospital. That is, if a citizen chose to obtain healthcare in another county, the county council/hospital where the citizen resides would have to pay for the treatment.

Access is still one of the major problems of Swedish healthcare, and a reviewed and strengthened version of the Guarantee Act came into practice in 2005 (WHO 2005: 99). The guarantee is based on the '0-7-90-90' rule, i.e. instant contact with the healthcare system implied zero days of delay, seeing a general practitioner within seven

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23 The answer to the question to whether the publication of the Commission's priority groups produced any effects in practice is principally no. According to Calltorp (1999), more management and implementation mechanisms were needed, several areas such as psychiatry have been considered as under-funded and nobody has come up with a good solution on how to create a decent dividing line between an ordinary, established health service and research activities (Calltorp 1999: 18).

24 These guiding principles have since been converted into four priority groups: The first group includes patients with life-threatening diseases, palliative care and care for chronic diseases. The second group concerns prevention and rehabilitation. The third group comprises care of patients with non-acute and non-chronic diseases. Finally, care for reasons other than illness and injury forms a fourth group, e.g. cosmetic surgery, which is not financed by public means (WHO 2005: 101).

days and consulting a specialist within 90 days. To conclude, there should be no more than 90 days before the patient is informed of a proposed treatment.

Primary care in the driver's seat

Other ways to approach the unsatisfactory levels of access to healthcare has been discussed in terms of enlarged responsibility either for the primary care centres or family doctors/general practitioners acting as self-employed (WHO 2005: 99-100). During the period 1991-94, new reforms were introduced emphasising the role of Family Doctors (with the ambition of approaching the practice of having general practitioners as in, for instance, the UK and Denmark). The costs of healthcare rose rapidly in Stockholm following the Family Doctors Reform (see Whitehead et al. 1997). According to Harrison and Calltorp (2000: 6), the reform constituted a watershed for the political parties and when the Social Democrats were back in power in 1994, the role of Family Doctors was weakened. In general the system intended to generate competition among general physicians for public funds and required citizens to enlist at one general physician. The system however threatened to undermine the longstanding Swedish primary care centre system, where physicians were publicly salaried employees (Harrison and Calltorp 2000: 227), and to challenge the nursing profession, whose members' increased duties and responsibilities were questioned (Westander and Lappalainen 1994: 232). The official discourse in healthcare was thus to prioritise primary care, but no important actions were undertaken in this direction (interview Calltorp 2007).[25]

This reform was followed by the Patients' Rights Reform with the aim of pushing citizens to select a primary care centre, wherever they preferred in order to get their own care-provider. The choice was no longer restricted to the local catchment area. Furthermore, a common trend in Nordic healthcare has been that several assignments previously carried out within special care have been transferred to primary care, such as different kinds of post-surgical controls of patients, cytostatics and opiate treatments as well as drug detoxification (Svenska Distriktsläkarföreningen *homepage* 2004). Yet, the allocation of public net costs of healthcare has implied that 71 per cent of Swedish resources are provided to highly specialised healthcare and hospital care, while only 19 per cent are given to primary care. The remaining 10 per cent are allocated for all other care (WHO 2005: 16).

2.3 HEALTHCARE EMPLOYEES

In Sweden, the numbers of physicians and nurses have increased slightly since cost reductions in the mid-1990s, but the overall amount of healthcare staff expressed per 1000 people, has decreased from 47 in 1992 to 32 in 2002. The reason for this is structural change with a shift of resources from hospital to municipality care since the beginning of the 1990s (WHO 2005: 66). In figure 2.1 below the curve depicts the trend in the numbers of employees in the sector from 1965, with a peak in 1990 and a new, more stable level of employees from 1995. The bars present the share of working time for those employed. A high level of full-time (black bar) appeared in the 1960s of 73 per cent, but with more employment within healthcare, the share of part-time staff

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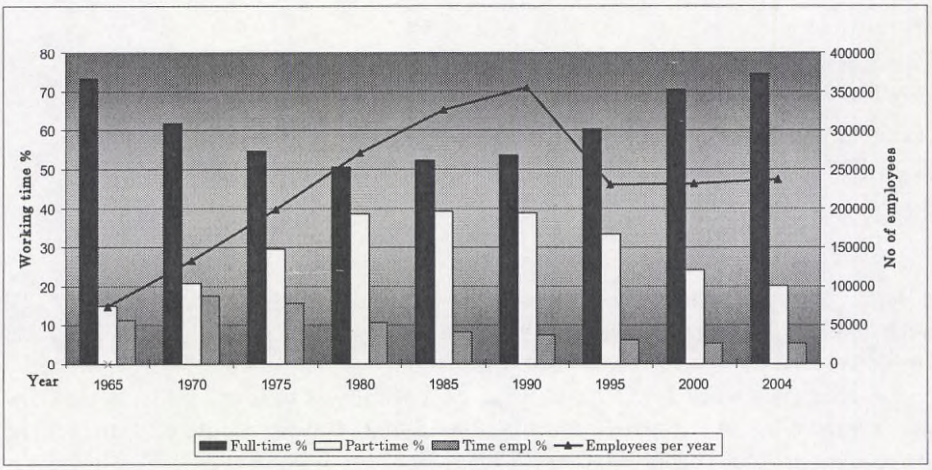
increased to around 39 per cent by 1990 (white bar), but the proportion of part-time employees thereafter declined.

Figure 2.1 Numbers of employees in healthcare, 1965-2004



Source: SALAR (2006a) table 1.1 Anställda fördelat efter löneform.

The trend, furthermore, is a consequence of a strategy from the 1990s to replace assistant nurses by (fewer) registered nurses in order to obtain higher efficiency (Lundgren 2002). This was a completely opposite strategy to that of the 1970s, when the focus was on more assistant nurses in order to increase efficiency. Yet, 60 per cent of physicians are still specialists found in hospital care (WHO 2005: 66). This means that there is a shortage of physicians, in particular general practitioners.[26] Many physicians work on a temporary basis on behalf of an employment agency as 'relay physicians' (*stafettläkare*), some are employed at several workplaces and a few have a private practice. Fifteen per cent of the primary care centres are provided by private not-for profit actors (SALAR *homepage* 2007). Physician density varies among counties.

Table 2.1 gives an overview of the numbers of employees divided by different areas of healthcare as well as the gender allocation, with an obvious domination of women, who comprise around 85 per cent of the workforce in both hospital and primary care. With approximately 3.3 physicians per 1,000 inhabitants, Sweden has relatively fewer registered physicians than its Nordic neighbours and compared to the EU average. In an international perspective Sweden has also relatively few physician contacts per person – 2.8 – a number that has remained stable since 1997 (WHO 2005: 80).

26 The actual number of general physicians is 1/6 less than the goal set for 2008, i.e. 5,000 out of a figure of 6,000 needed (SALAR *homepage* 2007). It seems that a great number of vacancies are not filled (e.g. in Jönköping county between 45 and 30 per cent of the estimated staffing need was not covered). Many GP positions are held by physicians undertaking their mandatory practice, substitutes and physicians from manpower agencies (Lindström and Järhult 2007).

Table 2.1 Numbers of employees within different areas of healthcare in 2006

Area of activity	Women	Men	Total	Per cent
Hospital care	108 237	19 015	127 252	60%
Primary care	33 841	5 699	39 540	19%
Specialised psychiatric care	19 069	8 264	27 334	13%
Other healthcare	12 720	5 521	18241	9%
Total	173 867	38 499	212 367	100%

Source: SALAR (2006b) table 3A Personalen uppdelad på verksamhetsområde.

In terms of the number of registered nurses, Sweden with 10.2 nurses per 1,000 inhabitants, is above the EU average and at the same level as Denmark, but below other Nordic countries (WHO 2005: 66-68). Estimations for the future foresee, however, a huge shortage of nurses. By 2020, forty per cent of today's staff will retire, at the same time as there is an estimated demand for 35-40,000 new registered nurses (The National Agency for Higher Education 2006: 123).

The need for experienced nurses with specialist competencies is equally estimated to increase by virtue of an anticipated need for an accumulated demand for advanced knowledge for handling medical technology (ibid.). A severe shortage is also foreseen for physicians with a specialisation, which is why attractive offers have been made to foreign physicians to work in Sweden. Most specialist physicians are to be found in Stockholm, Gothenburg and Malmö, while the North of Sweden has far fewer specialists (The National Agency for Higher Education 2006: 114).

2.4 HEALTHCARE AT FOUR LEVELS

As stated previously, a salient feature of the Swedish healthcare system is the interlinked relations between the state, more precisely the counties, and the Swedish healthcare professionals. These relations were strengthened during the Social Democratic government's expansion of medical posts in the 1970s (Dent 2003: 55) in parallel with an increased nationalisation of Swedish healthcare and the nationalisation of pharmacies. Primary care has a gate-keeper function and a letter of referral is required from a general practitioner in order to get specialist care. Another measure in terms of gate-keeping is the patient-fee. There are direct, small (although slightly increasing) fees for medical attention to be paid by patients, but these are combined with a price-ceiling. The fees are in the form of flat-rate payments. In 2004, the fee for consulting a physician in primary healthcare varied from SEK 100 to SEK 150 (approximately Euro 11-17) between county councils. In the same year, the fee for consulting a specialist at a hospital varied between SEK 200 and SEK 300 (approximately Euro 22-34) (FCC 2004c).

The formal organisation of Swedish healthcare is conducted at four different levels:

1. Primary care, including primary health centres, dental services, ambulance care (EMD), district nurse surgeries, clinics for children and maternity health

physiotherapists. At this level the HCCs are also to be found. Together these institutions supposedly share the overall responsibility for Swedish healthcare.

2. At next level there are 79 *hospitals for special care* embracing local, central county and regional hospitals (which undertake planned surgery and internal medicine). In addition there are 20 central county hospitals in Sweden, i.e. one hospital for each county council area. In these hospitals, there are about 5-20 specialties.

3. *Accident and emergency (A&E) hospitals,* providing immediate care day and night. Many of the hospitals for special care also provide A&E care.

4. *Nine regional hospitals* (eight of which are affiliated to university medical schools and provide highly specialised care and constitute the engine of research and development within six geographical areas (WHO 2005: 23).

2.5 THE OUTCOME OF SWEDISH HEALTHCARE

In 2007 Sweden was rated the sixth EU country, based on the Euro Health Consumer Index originally devised by Health Consumer Powerhouse.[27] This position is primarily explained by very good health outcomes, i.e. low mortality in relation to myocardial infarctions (heart infarcts), breast- and colorectal cancer, comparatively few infant deaths, few MRSA infections[28] together with a satisfactory level of 'avoidable' deaths. The Swedish system is also considered to be quite 'generous', in terms of the range of services provided by public healthcare.

Although the overwhelming majority of Swedes enjoy good health, there are some worrying tendencies, including self-reported mental illness, anxiety, alcohol-related problems and overweight. Excess weight and obesity, for instance, are nowadays common in all socioeconomic groups (National Board of Health and Welfare 2004). Furthermore, patient rights and information did not score well in Sweden, and waiting times were rated among the worst in Europe.

Top positions in this survey were taken by countries with many general practitioners such as Austria, the Netherlands, France, Germany, and Switzerland. This description of Swedish healthcare thus suggests a system of high quality once the patient has gained access, at the same time as it is hard to secure such access.

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27 A *Consumer Index* has been developed as an answer to demands of performance indicators for Swedish healthcare. The need is described as that of considering national, authorised, regular repetitive, multi-dimensional *evaluations on healthcare quality and efficiency* with the possibility for comparing healthcare nationally between different counties, and internationally with other European and international performance indicators. The EuroHealth Consumer Index is a tool for ranking and comparing national healthcare systems across the EU from the consumer/patient's viewpoint. The key areas are patient rights and information, waiting times for common treatments, care outcomes, provision levels (called the 'generosity of public healthcare systems') and access to pharmaceuticals. It takes a consumer-centred position, excluding from its perspective conventional public health indicators such as the number of hospital beds and life-span expectancy. The Index is compiled from a combination of public statistics and independent research. Since 2006, the Index has covered all 29 EU member nations.

28 Methicillin-resistant Staphylococcus aureus infections. Staphylococcus aureus is a species of bacterium commonly found on the skin and/or in the noses of healthy people. Although it is usually harmless at these sites, it may occasionally get into the body (e.g. through breaks in the skin such as abrasions, cuts, wounds, surgical incisions or indwelling catheters) and cause infections. These infections may be mild (e.g. pimples or boils) or serious (e.g. infection of the bloodstream, bones or joints). MRSA infections are a particular problem in hospitals. For more information see Netdoctor *homepage* (2007).

Furthermore, it is a fragmentised system comprising actors on different levels and a notable division of labour between the county councils and municipalities. Yet Sweden is considered a country with better cost controls compared to the Bismarck-countries and the US in particular (Palier 2006: 76).

2.5.1 The dilemma of Swedish healthcare

Healthcare is neither an isolated part of the world nor of society. Instead, it is highly dependent on global trends in economics, politics, culture, law and regulation. The development of information technology, telecommunications and their diffusion in the world market has had a huge impact on the healthcare sector in terms of new technical solutions. Other aspects of high relevance are the EU criteria for convergence contained in the Maastricht Treaty in 1993, which have influenced the Swedish economy as well as the levels of public spending. National policies for the elimination of unnecessary actions, long waiting times, poor coordination between healthcare actors and interventions and professional profligacy all connected to form a conception of slack within healthcare organisations.

Accordingly, demands for cost containment and lower taxes, were seriously strengthened. These demands were also combined with the requirements of the EU in the mid-1990s.[29] In this context NPM emerged as a movement towards market-orientation as well as a change in the style of governance (Gustafsson 1994: 8; Brorström 1995: 7). It has been argued that marketisation and decentralisation requires a new role for government in terms of steering, and not an abdication by government. It means that, despite market forces, the state should have a responsibility for ensuring that reforms are properly planned and evaluated (Rathwell 1998). It seems equally the case that increased centralisation is a paradoxical outcome when there is a focus on decentralisation (cf. Jonsson et al. 2006).

In Sweden there are some initiatives where the state is trying to impose itself. The introduction of a national organisation of HCCs is one example that will be described below. Another is the attempt to create a common platform uniting all the counties within a common ICT strategy. However, the Swedish government has few opportunities for steering neither being owners, nor being in a position to undertake important evaluations.

Given recent developments and reforms within healthcare, Swedish decision-makers are caught in the horns of a dilemma: how to retain public accountability for healthcare services, while delegating direct involvement in strategic and operational matters. Solving the dilemma, moreover, seems ever more complicated. The healthcare actors are charged with dealing with at least four dimensions of healthcare: (1) equality (equal access and universal use); (2) good quality of healthcare (good results); (3) costs (controls); and (4) freedom of choice (satisfied users and care-givers). These seem to be of equally significance at the core of the healthcare dilemma and recurrently in focus for the different reforms during recent years. The fulfilment of all four dimensions simultaneously seems to be an impossible equation, a point also raised by other researchers, for example Palier (2006: 76).

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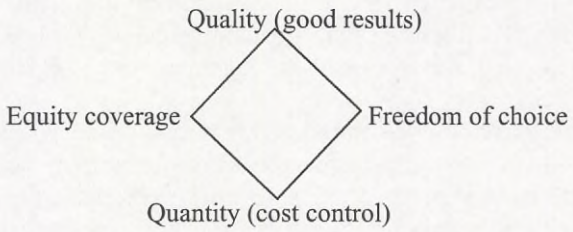
29 The public sector at large, like the healthcare sector, is strongly influenced by EU requirement for convergence: public sector borrowing should not be above 3 per cent of GNP, the national deficits should be not more 60 per cent of GNP. National economies should have a stable exchange rate and low national interest rates.

Figure 2.2 The fundamental dilemma of healthcare



I will return to the task of resolving this fundamental problem later in the thesis, as it seems to be a leitmotiv for the HCC and its organisation, employment relations as well as its working conditions. The next section, however, will focus particularly one response to the dilemma, the setting up of HCCs. After all, at the end of the 20th century the telephone advice nursing was presented as one possible way to meet the challenge of the time (FCC 1998).

2.5 THE NATIONAL DEVELOPMENT OF TELEPHONE ADVICE NURSING

2.5.1 The early use of the telephone

Wahlberg (2004: 15) describes the very first Swedish telephone centre for healthcare purposes (*Sjukvårdcentralen*) that had already opened up in the 1930s in Stockholm. Its primary aim was to coordinate patients at hospitals within the capital. It was later on developed to enable patients to make appointments with physicians and nurses and to dispatch ambulances. From 1986, Stockholm had an HCC co-located with the EMD centre (Swedish *SOS-Alarm*). In 2000 it secured its own premises and was out-sourced to the private sector *Telefonakuten AB* (Wahlberg 2004: 15).

As in Stockholm, separate organisations for healthcare advice opened up in the county of Jämtland in the 1960s, in Gothenburg in the 1970s, and in Malmö in the 1980s (FCC 1998: 29-31; FCC 2002a: 20).[30] A review of the past shows, furthermore, that the telephone has been in the focus of debates several times over the years (e.g. Spri 1973). The telephone has played an important role in the continuous planning of care, which is one of the functions prioritised within nursing. The telephone is also a significant channel for contact between healthcare staff and patients.

2.5.2 Methodology for telephone advice nursing

During the 1980s, the general physician Bertil Marklund, employed at the primary care centre of Torpa (within the area of Fyrbodal) became highly interested in the way nurses handled patients over the phone. Consequently, he elaborated checklists containing questions connected to different symptoms and advice, measures to undertake and ratings of urgency of various sickness and health problems. The methodology for front-line contact with callers and patients (including checklists covering the ten most frequently observed symptoms in general medicine) was soon

30 These early precedents were, however, not linked to the modern idea of a call centre, with Automatic Call Distribution Switches (ACDs) technology at its heart.

spread to primary care and pharmacists all over Sweden. In 1990, Marklund submitted a doctoral thesis regarding nurses' advisory and information activities within primary care centres and pharmacies. The thesis included general guidelines on how to carry out the service and training and also presented results from studies evaluating the function (Marklund 1990).

However, in 1991, a new reform was introduced emphasising the role of family doctors instead of nurses on the phone and the focus was transferred from the nurses in the primary care centres as the first point of reference to free access for the public to family doctors. In particular, it meant a backlash against the burgeoning telephone nursing advice, as physicians and the general practitioners in primary care were expressed as the first and natural contact persons for people in need of care and advice, both face-to-face and over the phone (interview Marklund 2006).

At this time, Marklund continued his work, but on a limited scale. He adjusted and fine-tuned the first version for primary care, at the same time as he started to elaborate questionnaires and guidelines for employees in pharmacies (ibid.). The questionnaires and guidelines were then developed into software (abbreviated SRÅ) for computerised decision-support with the aim of supporting telephone advice in healthcare centres and pharmacies (Marklund 1990, see also chapter 14 below).

2.5.3 The origin of telephone advice nursing

The origins of telephone advice nursing and HCC can also be traced from the EMD centres. Several HCCs have a background in, or are still co-located at an EMD centre. At the EMD centre no. 112, emergency calls are received by the operators (in general, assistant nurses or paramedics), who also connect care-seekers to fire departments, police and poison-information centres (Wahlberg 2004: 14). The operators are the least formally trained within pre-hospital care (Wahlberg 2004: 14), but when needed, they are supposed to seek assistance from physicians and registered nurses. However, the County of Stockholm has recently started to require competency as a registered nurse for the assessment and prioritisation of ambulance delivery.[31]

2.5.4 TAN as a political instrument for improving national healthcare

In Europe, HCCs are only the predominant advice format in Sweden and the UK (perhaps marginally, too, in Finland). The arguments in favour of healthcare call centres were seriously put forth in the late 1990s. The Swedish and the British introduction of telephone advice nursing as a politically attractive instrument for improving national healthcare, was extended approximately at the same time around 1997 (DoH 1997; FCC 1998). But since, separate trajectories have been discernible. The British development has been explosive.

After the policy decision in 1997, a pilot project with three British telenursing call centres was established (compiled under the umbrella of the public NHS Direct). These expanded quickly to a net of activities, which from 2001 extended across England and Wales (Munro et al. 2003). However, the initial service provision in the 22 NHS Direct call centres has recently, 2006, been rationalised and concentrated (Valsecchi et al.

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31 The HCCs in Gothenburg, Malmö and Stockholm all have a background in EMD centres. If the telenurses are not located at the EMD, they give assistance on the phone. For more information on EMD centre see Wahlberg et al (2003b), Forslund et al. (2004) or Forslund et al. (2006).

2007: 3) at the same time as the number of patient contacts rose.[32] In Scotland a more concentrated service (NHS24) offers TAN provision across the whole of Scotland.[33]

In Sweden it was not until the late 1990s that the national arguments in favour of HCCs were seriously put forth. In 1997, a national project was set up by the FCC (*Landstingsförbundet*) to evaluate the potential of a common telephone advice nursing for the Swedish counties.[34] At that time, only five Swedish counties had a separate call centre (Wahlberg 2004: 15). The FCC's final report in 1998 was entitled *Security, access and efficiency: Healthcare advisory activity over the phone*.[35] The report was very optimistic and concluded that telephone advice nursing could be an important way to improve efficiency and access in Swedish healthcare, two serious problems which healthcare had to overcome. However, the conclusion of the investigation was that a national service was not yet possible or desirable. In the same way, a second project concluded in the report *Everybody can win! E-relations open up healthcare!* (FCC 2001)[36] ascertained that the conditions and possibilities for telephone advice nursing largely varied between different Swedish counties. Hence, a central implementation of telephone advice nursing, i.e. a so called top-down-model, was not recommendable. Instead, the investigation emphasised the need to follow the overall structure of Swedish healthcare based on the local independence of counties/regions. A sub-report was presented in (2002a) *One number for telephone advice nursing. A sub-report from the investigation into national coordinated telephone advice nursing*[37] and finally, in line with a national project report (2003a), given the name *Healthcare Direct. Telephone advice nursing in collaboration,*[38] the FCC took the decision to create a nationally coordinated service for locally based HCCs.

From 2004, the planning for implementation of the service was initiated and *A prospectus for 1177* (1177 is the name of both the project and of the future national telephone number) was sent out to all the counties/regions in Sweden. In November 2004, an agreement was settled between the State and the newly merged organisation of Swedish Association of Local Authorities and Regions (SALAR 2005). Thus, in contrast to the, more centralised model of HCCs in Britain, the Swedish project planned a model of separate HCCs in different counties/regions linked together in a network.

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32 In Britain between March 2005 and March 2006 the total number of patient contacts rose from 1.65 million to 2.14 million per month and according to the planned expansions of the service, this number will rise again during 2006-2007 *NHS Direct Annual Report and Accounts* 2005-2006 (2006: 6).

33 Both the Welsh and Scottish government have rejected important elements of the recent health re-organisations in England. Subsequently, the private sector has a much greater role in public English healthcare than its counterparts in the rest of the UK.

34 The state provides supplementary grants, so-called *Dagmar-means,* for different kinds of general and special targets. The investigation of telephone advice nursing was one such particular target (SALAR 2005.)

35 The author's translation of the Swedish title Trygghet, tillgänglighet och effektivitet. Sjukvårdsupplysningen per telefon.

36 In Swedish Alla kan vinna! –e-relationer öppnar vården!

37 In Swedish Ett nummer till sjukvårdsupplysningen. Delrapport från utredningen om nationellt samordnad sjukvårdsupplysning.

38 The Swedish title Vårdråd direkt. Sjukvårdsrådgivningar i samverkan. Slutrapport från utredningen om nationellt samordnad sjukvårdsrådgivning.

In parallel with the development of the national service, a study was undertaken in order to investigate the inhabitants' attitudes charging 5 or 6 SEK per call (0.55-0.66 Euro) for using the national TAN the national TAN (5-6 SEK per call). However, the economic motivation behind its implementation was limited. Instead, accessibility, safety and reference to an adequate level of care were expressed as the prioritised objectives. The first national initiative of telephone advice nursing embraced four, soon to become six, pilot HCCs in selected counties (e.g. SALAR 2005). The national project team stated that it had been inspired by other public organisations; e.g. the call centre for the Swedish public company for pharmacy (*Apoteksbolaget AB*) which provided information and advice on medical issues; the Swedish Police which had around twenty local call centres that were about to be linked together; and overall investments in call centres made by The Ministry of Health and Social Affairs.

2.5.5 The Swedish network of local health call centres

As with the British system, the Swedish concept of HCC is based on a combination of the telephone, specially designed computerised decision-support, website information and a healthcare book. The Swedish website also aims at virtual information to youngsters on sexual and reproductive health, relationships and mental well-being (SVR AB *homepage* 2007).

As no available decision-support system, either British, Canadian or American corresponded to the needs defined by the National Project, a specialised system designated only for telephone advice nursing in Swedish HCCs was constructed (*Project presentation of National Project Team* February 2006). An editorial committee with responsibility for the decision-support system was given the mission to construct the system and compile the content including medical texts, which were to be subsequently updated. The texts arose from frequent reasons cited by callers for contacting local HCCs, and were to be composed of evidence-based research and experience.[39] The language and structure of the texts should continuously be tested by telenurses (*Newsletter 1177* 2005), and should only contain evidence-based medical advice.

The vision of the National Project Team 'Health Advice over the Phone' (*Vårdråd Per Telefon, VPT*) was that these local centres should be linked together, so that 85 per cent of the Swedish population would have access to the service from 2008 (national officials 2007). The cost of a future system is estimated at SEK 4.25 per inhabitant, i.e. about SEK 38.25 million (4.25 million Euro) as in a first step equal to and SEK 60.88 million (6.76 million Euro) as a final step (SALAR 2005: 47).[40] The future requirement in order to cover the Swedish population of 9 million inhabitants is assessed as being approximately 1,200 telephone telenurses in a fully expanded national system of HCCs (SVR AB *homepage* 2007).

In 2003, some 500 Swedish telenurses were employed at primary health centres or in HCCs (Dagens Medicin 17 November 2003). The figure of 1,200 Swedish telenurses

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39 This implies that one or two experts assure that the factual content is correct, evidence-based, according to national guidelines or Swedish medical praxis – national or regional. The expert should be highly proficient within his/her domain and has good relations with his/her profession (Policy for editorial principles SVR AB 2007).

40 where 1 Euro = 9.06 SEK as at 1 January, 2005 (Oanda trader *homepage)*

covering a population of 9 million inhabitants can be compared with the figure of around 2,000 telenurses for the HCC in England (NHS Direct) covering a population of almost 50 million people.

In line with the Swedish more decentralised model for healthcare, the focus has been on encouraging local development of HCCs within the counties. In June 2006 the national service VPT was launched and embraced county councils within the five previous pilot HCCs sharing the same technical system, including the same software for decision-support and a common database with health information. The interlinked HCCs are organised in a kind of matrix organisation, where the national organisation VPT is responsible for certified guidelines for Swedish HCCs and provides overall induction, authorised training and meetings for telenurses, (including technical solutions as well as medical information) and a system of authorised auditors to guarantee the quality of the system. Along with the local formation of HCCs, around 10 universities and university colleges have started to offer specialised courses in telephone advice nursing at the 15 or 30 ects credit level (see for example Karolinska Institute *homepage* 2007 and SVR AB *homepage* 2007).

Whereas the overall framework of the HCC network was created by the national VPT, the operations in each HCC should be financed and shaped by the distinctive forms of healthcare in each county. An additional ambition of VPT was to follow-up the pace and extent of changed patient behaviour, such as the pressure on the telephones in primary care and the numbers of spontaneous visits to the A&E departments (FCC 2003a: 74-75). The reasons for single counties connecting their HCCs to the national net 1177 are threefold and concern: (1) cost-efficiency, as development costs as well as maintenance costs are shared; (2) high medical security-based accreditations of procedures; and (3) the national accountability for technical problems such as stoppages (interviews with administrators 2006). In January 2007, the project team VTP was merged with a former company for healthcare information (*Infomedica*) and together they constitute today a publicly financed, but independent company *Sjukvårdsrådgivningen* AB (abbreviated SVR AB).

2.5.6 The situation in 2007: for a national network of health call centres

Today, besides conventional healthcare, the public's telephone calls are answered by local HCCs, available in 25 locations in Sweden and more than seven million Swedish inhabitants can reach the service either within the public organisation or the out-sourced services (SVR AB *homepage* 2007). Fifty one per cent of the population is covered by the national public provider SVR AB, which regulates six interrelated local HCCs, which in late 2007 were soon to become ten. Another 27 per cent of the Swedish population is served by private HCCs (calculation *SVR AB* 2007). The major private actor is called MedHelp. MedHelp provides HCC in outsourced, previously public services and serves about 2.5 million Swedes. Certain patterns of establishment are concentrated in sparsely populated areas, where experience suggests the need to maintain workplaces and avoid staff turnover (Bain and Taylor 2002). Within this segment, the only spatial distribution of HCC concerns the private HCC's localisation of its major HCC in northern Sweden. All other HCCs by late 2007 were situated in the region/area which they mainly serve (SVR AB *homepage* 2007). However, in different areas and at various times, telephone advice nursing has been outsourced to private

manning agencies such as Manpower (2000-2004) in Skåne Region (Sederblad et al. 2005; Sederblad and Andersson 2006).

To sum up, some kind of HCC does exist in almost every Swedish county/region and is either run by publicly employed nurses within conventional care or outsourced. The development of HCC is integrated and a part of a national ICT-strategy for healthcare, where strategic actors[41] and all the Swedish counties finally agreed to collaborate in order to create a common platform harmonising rules and regulations, ICT-structures and use within the decentralised Swedish counties (SVR AB 2007).

During the entire case study, the local HCC Fyrbodal in focus for this thesis was situated outside the national network of HCCs, VPT and then SVR AB. However, at the same time as the case-study was concluded in 2006, the owner, the Västra Götaland Region, decided that the four HCCs in its catchment area should be attached to the national activity, including the HCC in Fyrbodal.

2.6 THE PROCESS OF HCCs IN AN INTERNATIONAL PERSPECTIVE

2.6.1 An institutional isomorphic process?

The Finnish researchers Suomi and Tähkäpää express the isomorphic process accordingly 'the good news is that health-oriented contact centres can to a great extent use the same tools and concepts that call centres do' (2003: 4). Gradually, the organisation of telephone advice nursing within EMDs and primary care has merged with the call centre concept from the commercial sector, a development that took off in the early 1990s. It is not rare that private sector changes are transferred to the public sector by a process of institutional isomorphism, that is, the diffusion of ideas (Czarniawska and Sevón 1996, Björkman 2003) – either by regulative, mimetic or normative means or as a combination of these (DiMaggio and Powell 1991/1983: 67-74).

However, according to DiMaggio and Powell, the driving forces behind such a development towards convergence are powerful actors belonging to the state, bodies of professionals and successful consultancy firms. Without underestimating their importance, the stance in this thesis is that capital accumulation and the striving for profit and its equivalence in healthcare – cost containment and the optimal use of scare public resources/tax money – are much stronger development forces than the actors highlighted by DiMaggio and Powell. Weber's iron cage formed by the ongoing process of rationality is still valid in the 21st century. However, concepts, practice and organisational models from the private sector do not yield the same results when implemented in the public sector (Pollitts and Bouckaert 2004; Stein and Leisink 2007).

The features of call centre become subsequently shaped by its sectoral context, in this instance public healthcare. In the case of HCC, history shows that the function of TAN existed before the actual introduction of the call centre concept and its technology. The actual call centre organisation, as we encounter it today, was not

41 The group for development of national ICT strategy consists of representatives from The Ministry of Health and Social Affairs, SALAR, the Medical Products Agency and Carelink (SVR AB *homepage* 2007).

introduced until in the 1990s. Hence it is more accurate to talk about a parallel and mutual process of adaptation between the call centre concept and telephone advice nursing, and as a result Swedish health call centres with a distinct national and sector character. In terms of salient Swedish features, Marklund and Bengtsson already argued in their article from (1989) that

> it may be stated that the telephone advisory system is a typical Swedish phenomenon. Great interest in it, however, has been shown by colleagues in many other countries. We therefore think that our results are of interest to general practitioners in other countries (1989: 50).

The integrated telephony and computer system of telephone triage service exists in the US, Canada, Denmark and Sweden, according to Goode et al. (2004a: 214) and these systems have been argued as the inspiration behind the development of NHS Direct (see also Lattimer et al. 1998: 1055; Richards et al. 2002; Greatbatch et al. 2005: 803). Greatbatch et al. also considered the UK GP out-of-hours services and A&E departments as another source of inspiration for the British NHS Direct. However, whereas the services in Denmark and the US were based on the general practitioner, the concept in other countries focused on the nurse (cf. Marklund and Bengtsson 1989; Christensen and Olesen 1998). The Finnish HCC MediNeuvo started in 2002 in Helsinki, but with national ambitions of covering the Finland in its entirety. The service is based on the Swedish concept and is a part of the Swedish HCC company, Medhelp (Suomi and Tähkäpää 2003: 4; MedHelp *homepage* 2008).

2.6.2 The Swedish versus the British formation of HCCs

In comparison with the British formation process, the Swedish health call centres first emerged on a broad scale at the beginning of the 2000s, that is, some years after NHS Direct. The former took a different format and developed in a different way (Valsecchi et al. 2007). First, the Swedish HCCs are less centralised and, crucially, combine both public and private delivery. Swedish healthcare is decentralised with the power mainly located at county council /regional level.

Accordingly, instead of a centralisation strategy as in the British case, the need to follow the overall structure of Swedish healthcare was emphasised based on the local independence of counties and regions. This means that different forms of telephone advice nursing and HCCs emerged at the local and regional levels, due to various organisational and funding practices as well as different conditions based on the geographical area concerned and its population density. According to FCC (2002a: 54), while the NHS has stimulated vertical integration, the Swedish focus was to stimulate horizontal integration within the country. Second, the average size of Swedish centres is smaller than their British equivalents (both NHS Direct and NHS24) but Sweden has a higher number of telenurses per inhabitant. The Swedish HCCs are situated in the counties or parts of regions, and provide medical services to populations ranging from around 200,000 to 400,000 people. In the UK, each site covers a catchment area of between 1.3 and 4 million people (Valsecchi et al. 2007: 5).

The express aim of HCC is to improve accessibility and security by providing the public with a consistent source of professional advice on healthcare, 24 hours a day, so citizens can manage their problems at home or get rapid referral to an appropriate level of care. This embraces, furthermore, an ambition to strengthen Swedes' general level of health and to empower the Swedish public in the area of healthcare. The service is also

considered by healthcare politicians and management to be a good tool for steering flows of patients. This process involves the coordination of healthcare resources in order to improve efficiency for healthcare in general. Thus, the main priority of the HCCs is to provide better access to high quality healthcare, in combination with deliberate actions to transfer the flow of patients from expensive A&E care out-of-hours to more cost-efficient planned day care in primary care centres. By following the principles of Swedish healthcare, both the safety of the service and guaranteed access to medical services (efficiency) are considered as main pillars of the development strategy (FCC 1998; FCC 2002a; FCC 2003a). The positive tone of the Swedish investigations has silenced potentially critical voices and the possibility that any risks might be connected to the new service. Furthermore, like most other healthcare solutions, the reform of HCC foregrounds either the advantages to users or those of the healthcare organisation; on the other hand, it disregards the perspective of the employees whose voice is not appreciably heard in public debate.

2.7 SUMMARY

The Swedish medical service is publicly planned, provided, financed, regulated and followed up, within a democratic process, in other words it is governed by political decisions. Furthermore, the health service is considered to be organised according to strong institutional features. The chapter has outlined Swedish healthcare economic, political, cultural and legal institutions together with the roles of key actors. First, the development of healthcare was briefly described on the national level. Second, changes and reforms were described from the 1970s onwards, as were events related to New Public Management practice and rhetoric. This embraced the crux of the Swedish dilemma: that between quality, quantity, freedom of choice and equity. These factors have also paved the way for telephone advice nursing within Sweden. Third, telephone advice nursing on the national level has been discussed analysing the national strategies compared to developments outside Sweden, notably in the UK. The development of telephone advice nursing within an HCC is about the Swedish evolution of a new organisational form as well as being an attempt to improve healthcare efficiency and being a service to citizens. The call centre conception including technology and organisational matters might be related to a more general isomorphism or diffusion of ideas from the commercial sectors, but it is mainly about cost containment, service imperatives and the striving for efficiency. In this specific case, that of health call centres, telephone advice nursing existed beforehand and was a precondition of the formation of HCCs. Accordingly, it is argued that the HCCs contain particular features related to the public sector context in general and Swedish healthcare in particular. The next chapter will approach the formation and development of HCC Fyrbodal from 2002 to 2006, the central empirical focus of the thesis.

CHAPTER 3
HCC FYRBODAL FORMATION AND DEVELOPMENT 2002 - 2006

The HCC Fyrbodal followed a process from firstly being unknown, to secondly being vaguely known and unaccepted, then thirdly being rather well-known and finally to becoming both well-known and accepted by users and the majority of healthcare actors such as politicians, health administrators/management and regular healthcare staff. Besides the action of significant actors, the findings point at HCC's embeddedness in a healthcare area and the importance of political, economic, legal and cultural institutions. With the overall healthcare dilemma in mind, as discussed in the previous chapter 2, this chapter aims to describe the healthcare area of Fyrbodal and the organisation that HCC is a part of. The next section covers the formation and development of HCC Fyrbodal in general over the years.

3.1 THE HEALTHCARE AREA

3.1.1 Fyrbodal, a part of the Västra Götaland Region

In 2006, approximately 50,400 people out of the 1.5 million inhabitants of Västra Götaland were employed by the regional government, which makes it the second largest employer in Sweden.[42] Some 45,900 members of staff were employed by the hospitals and primary healthcare in the same year equal to 90 per cent of the staff employed by the region. Within the sector the registered nurses formed the largest occupational group (15,400) followed by assistant nurses (9,800), physicians (4,800) and administrative personnel (4,200) (*Annual Report Västra Götaland Region 2006*).

This case-study focuses on an HCC in Fyrbodal, which is one of five administrative areas within the region. The distance from Gothenburg to the very south of Fyrbodal is about 60 kilometres, equivalent to about an hour by car if taking the motorway. The infrastructure in terms of roads is, however, underdeveloped caused by a lack of investment and large rural areas characterised by small roads.[43] The area is a broad expanse of 7,657 square kilometres, which corresponds to 30 per cent of the entire region. Fyrbodal embraces three out of twelve local healthcare councils (*hälso- och sjukvårdsnämnder*) namely Dalsland, Norra Bohuslän and Trestad. With its 258,000 inhabitants, Fyrbodal corresponds to 17 per cent of the population in the region and is the size of the average Swedish county[44] (Västra Götaland Region *homepage* 2007). During the period of time covered by the case-study the population decreased slightly (by about 13,000 people) because of declining opportunities on the labour market and less immigration. The unemployment rate is slightly higher than that

42 In 2005 the largest employer was Stockholm City Council (Statistics Sweden).

43 Although the main road connects Gothenburg with Oslo in Norway it is hilly, narrow and winding causing many traffic accidents. It is equally considered as a threat to production industry in the area (e.g. Government bill 2005/06:T396 *The Swedish Parliament homepage*).

44 The average size is estimated at 200,000 to 400,000 inhabitants.

for the overall region as well as that for Sweden in total. The gender distribution of Fyrbodal's population is 49.9 per cent women and 50.1 per cent men, which means that there are slightly fewer women in Fyrbodal compared to the national average (50.4 women) (Statistics Sweden 2004). Half of the population in Fyrbodal lives in the urban areas, where Trollhättan, Uddevalla and Vänersborg are the biggest towns with (53,000, 50,000 and 37,000 inhabitants respectively). These areas are the most expansive parts of the region, each with a population increase of 3.5 per cent during the last ten years. Fyrbodal covers both urban and rural areas, where the rural area Dalsland is characterised by a decreasing population rate (between 4 and 9 per cent in each municipality during the last ten years). Moreover, Dalsland includes Dals-Ed, defined as Sweden's smallest municipality with 4,900 residents (Statistics Sweden 2004).

One demographic pattern of Fyrbodal is that a high share of people aged 65 years and above live within the rural areas (Dalsland 22.3 per cent and Norra Bohuslän 21.3 per cent) compared with the urban areas (the figure for Trestad as well as the region being 18.2 per cent) and the Swedish average (17.1 per cent) (Statistics Sweden 2004).

In Fyrbodal as in the rest of Sweden, female inhabitants represent the majority of those on long term sick leave (more than 60 days). Of these, 63 per cent are women and 37 per cent are men and many of whom are found within healthcare.

In the Västra Götaland Region about 12 per cent of inhabitants are of foreign extraction most of whom live in the city of Gothenburg or, for example, in Trestad within Fyrbodal. The immigrants constitute very heterogeneous groups, several of whom experience states of vulnerability, whereupon healthcare becomes very important at the same time as conceptions of ill-health are highly correlated with culture and basic cultural values (Blomsterberg 2004: 16).

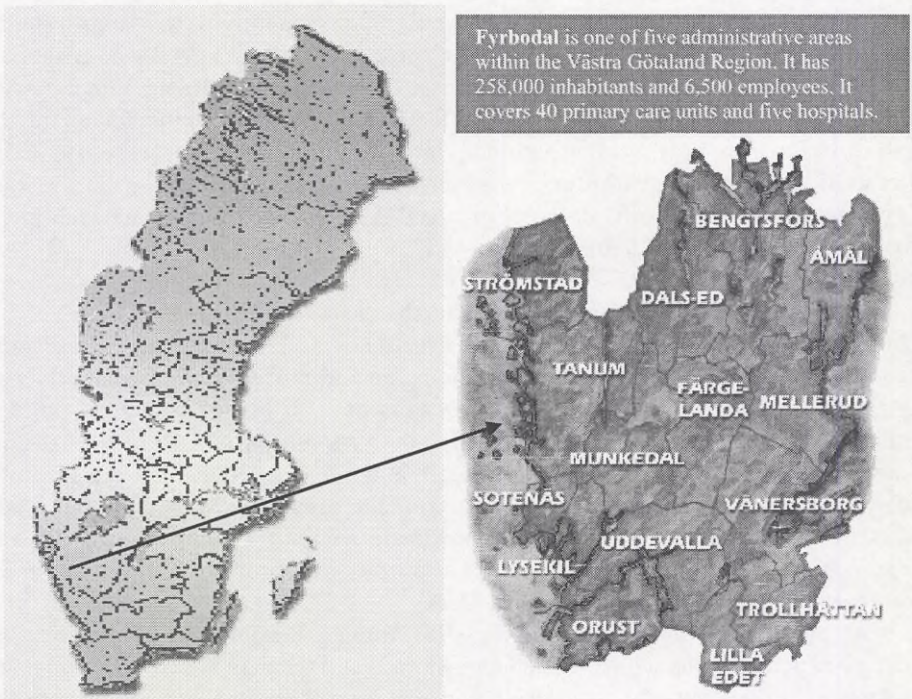
The catchment area of Fyrbodal covers the coastline from Strömstad in the north bordering Norway and the island of Orust in the south. Fyrbodal is considered to be a very attractive area in Sweden for tourism and during the summer the number of dwellers almost triples because of the flow of both national and international tourists, coming to sail and visit resorts on the coast and in the archipelago located to the west of Fyrbodal. Other tourists are attracted by the forests and the canals incorporating the inland areas of Dalsland in the eastern part of Fyrbodal. Tourists amount to some 2.5 million overnight guests per year (SALA Kommunförbundet Fyrbodal 2004: 4).

3.1.2 Early implementation of New Public Management

As described earlier (chapter 2), new ways of thinking about healthcare in terms of competition, contract, performance, and control in the area materialised in the so-called Bohus-model (Dahlgren 1993: 32) from 1992 to 1998. Its implementation meant an early split from a Swedish perspective, between the roles of politicians and administrators and between the local and the county level. In each municipality, a local healthcare council was established with decentralised responsibility to buy healthcare for the inhabitants in the area from internal as well as external care-providers (historical presentation Region- & Stadsarkivet Göteborg *homepage*). The Bohus-model was exceptional in comparison with other models, with its emphases on collecting and comparing financial and medical information. Extended analyses and surveys were carried out in order to calculate local norms for performance and pricing (resource

allocation according to needs) instead of directly adopting foreign models (e.g. American or Norwegian Diagnosis-Related-Groups models) as was the case in the Stockholm-model. Within Bohuslän (sooner to become a part of Fyrbodal) the local politicians purchased both primary and secondary care. Therefore they had a good view of the overall healthcare provisions. The price for different kinds of care was settled centrally by the county council board, giving a fixed price per patient and care episode. Accordingly, revenues were based on performance (Bergman and Dahlbäck 2001: 6). This meant that competition was based on quality and not quantity as in the Stockholm-model. The Bohus-model was intended to focus on methodological and system factors with service to the citizen being at stake (Dalhgren 1993: 33-34).

Figure 3.1 The healthcare area of Fyrbodal



Fyrbodal was created by the merger of two counties Bohuslän and Norra Älvsborg[45] within the formation of the Västra Götaland Region from 1999. The merger meant, however, a clash between different traditions. Whereas the politicians in Bohuslän have applied the above mentioned purchaser–provider model for a longer period, the representatives in Norra Älvsborg had, until the merger, worked with granting appropriation. This implied decision-making at different levels. In Bohuslän decision-making occurred on an overall level as opposed to more detailed regulation in Norra Älvsborg (Leffler and Mühlenbock 1999: 12).

45 Embracing Dalsland and Trestad

3.1.3 The healthcare providers

Healthcare in Fyrbodal is mainly provided by five hospitals (*NU-sjukvården*)[46] and the organisation of Primary care Fyrbodal. The hospitals have 995 care places and 5,500 employees, of whom the 1,000 employees within primary care are spread throughout 40 primary care organisations, comprising some 70 workplaces (Västra Götaland Region *homepage 2006*). The actual organisation of primary care was created in 2001 on the merger of two counties and the overall intention was described as creating a strong organisation based on 'independent health centres' (interview health administrators 2004). It means that the political and organisational aims are that public and private actors should have the same prerequisites and conditions to carry out healthcare. This objective is materialised through decentralised responsibility given to the principal (*verksamhetschef*) in each part of the entire primary care organisation (including primary care and primary emergency care). Consequently, after a process of public tendering, it is the responsibility of the executive managers/head managers for public as well as private organisations to conclude separate agreements with the politicians for each service (cf. Panfilova 2004). Although the fusion of the five hospitals in area was abandoned in 2002, the hospitals were far more hierarchically managed through the hospital board than the primary care organisation. At the hospitals, the clinics and their single departments each had a strict individual budget to manage.

3.1.4 The roles of the decision-makers in the case-study

The health administrators' job is to investigate and estimate the needs and demands of healthcare based on previous performance (healthcare delivery), demographic figures and statistics. The results of their estimations are compiled annually in a purchaser's balance sheet for the year (*Beställarbokslut*). Then, the factual allocation of resources and overall planning is decided by the political healthcare councils for the three geographical areas of Fyrbodal – Trestad, Dalsland and Norra Bohuslän. These healthcare councils cover both primary and hospital care. Thus the politicians in the role of purchasers buy care from different 'medical and healthcare providers'.

Although there are various region-wide Human Resource (HR) policies and management, each area within the region also runs and maintains its own HR practice as long as it does not obviously clash with the overall regional outline or with the institutional structure of Swedish working life and medical service provision (interviews with health administrators 2004). Healthcare as a professional bureaucracy responsible for public service is highly regulated and routinised. This often stands in contrast to the professionals' knowledge and efforts to strive for autonomy.

46 The actual formation of hospital care took place in 1996, when two bigger and three minor hospitals merged into a common organisation under the same management. The fusion of hospitals concurred with a fusion of the two counties in the area, the county of Bohus and the county of Norra Älvsborg (Leffler and Mühlenbock 1999: 1). From 2002 the joint management was dissolved and each hospital secured its own management. One hospital manager was succeeded by four, one for Uddevalla, one for NÄL and one for the three minor hospitals, each being responsible for resources, staff and overall performance. A fourth hospital manager was given the mission of strategic coordination, i.e. medical and structure issues (*Västra Götaland Region* 14 June 2001 presentation of suggestion for project).

Consequently, the long tradition and strong institutional foundations create a situation where the new reforms and models have been mixed with old models, routines and habits. The result is often a form of loose coupling between healthcare words and deeds as well as between intended reforms and actual practice (cf. Mintzberg 1983; Alvesson 1992; Östergren and Sahlin-Andersson 1998; Blomgren and Sahlin-Andersson 2003).

3.2 THE PROCESS

3.2.1 Before the implementation of a separate health call centre

Before the implementation of a separate HCC in Fyrbodal, telephone advice nursing was provided partly within the primary care centres during the daytime and by the primary emergency care centres during evenings, nights and weekends, and partly by the accident and emergency (A&E) departments at the five hospitals, Uddevalla, NÄL, Lysekil, Strömstad and Bäckefors. A number of telephone calls were addressed to the different specialist clinics (e.g. paediatrics, gynaecology or ear, nose and throat clinics). Whereas the major hospitals in the urban areas of Uddevalla and Trollhättan included A&E departments and primary emergency out-of-hours care centres, the service within the rural areas was delivered within the frame of primary emergency care. When the HCC was introduced, 80 per cent of healthcare in the area consisted of acute care and the main flow of patients came predominantly from areas in the proximity of the major hospitals (*Beställarbokslut 2001*). This implied high uncertainty for those who estimated, allocated and planned healthcare resources, both on a long term as well as on daily basis. Furthermore, about 67 per cent of the total costs in 2002 comprised of personnel costs. Of these, costs for manning agencies, irregular working hours and supplementary hours were significant elements (auditor's report by Ernst and Young 2003).[47] Manning agencies were mostly used to recruit physicians to primary care and secondly to recruit physicians to specialist care. Nurses were also employed from the manning agencies especially during 2001-2003. It was particularly hard to recruit physicians for primary care and geriatric care with the result that the patients experienced lacking continuity in their care (*Annual Report Västra Götaland Region* 2006: 23).

3.2.2 Discussions about forming an HCC

The introduction of HCC Fyrbodal in 2002 was a matter for the customary process of change, including an investigation which ended up in a political decision. Yet it was a rather drawn out process, characterised by different conceptions from the urban and rural representatives in the area. The change took place because the new service was supported by the majority of the politicians and some health administrators. But at the time of the introduction, many health administrators and representatives of the medical and nursing professionals

47 The cost of manning agencies to recruit physicians for primary and secondary care reached its peak in 2002 (SEK 140 billion), although their use has decreased considerably for hospital care and also for primary care: SEK 90 billion was still spent in 2005. From 2001 to 2003 many nurses originated from the manning agencies.

within hospitals and primary centres in Fyrbodal were sceptical towards the new organisation and the changed distribution of responsibility and tasks within the area. A more thorough description of the implementation process will follow below.

3.2.3 The HCC initiative and decision preparation

The point of departure was a decision taken in 1998 by the regional government to investigate possible solutions for the organisation of telephone advice nursing within the different healthcare areas. The initiative originated from the Department of The Ministry of Health and Social Affairs via the regional employer,[48] which provided special grants in order to investigate and improve telephone advice nursing throughout Sweden. In 1998, to prepare the issue, Fyrbodal formed a project group for evaluating the future provision of healthcare advice and referrals. The project included representatives from the major healthcare providers in the area, embracing both the hospitals and the primary care providers. The aim was primarily to investigate the actual practice, needs and prerequisites of the healthcare area. According to the assignment given to the project group, the project should elaborate a 'specification of demand'. When the actors had finally concluded the specification it would become a guiding document, which emphasised the perspective of the citizens. This meant that requirements specified for the future organisation of telephone advice focused on the need of *the citizens in general*, and not only the patients, i.e. those who already had established a contact with a local caregiver. The 'specification of demand' for Fyrbodal brought out *access* and *quality* as the overall goals stated as:

> The telephone advice nursing should form a telephone service aimed at giving citizens access to advice and information by specialised registered nurses. Thereby, the service should be a complement to existing primary care and other departments within the area. Through good access and high quality, the telephone advice nursing presumes to provide security and trust to the inhabitants (the author's translation of *Hälso- och sjukvårdskansliet* 2001).

Based on their investigation the project group presented two alternatives for the local politicians to decide upon. The main suggestion was to create a new organisation focusing on central telephone advice nursing for the entire healthcare area. The second suggestion was to divide the allocated resources among five healthcare units in order to strengthen their individual telephone advice nursing. These propositions led to a vivid and at times animated debate among all actors. Major opposition, however, was evident among the professionals, and particularly the professionals in primary care within the rural areas (Dalsland and Norra Bohuslän), who opposed a central HCC and wished instead the resources to be allocated to their own organisations. Furthermore, the professionals within hospital care expressed great scepticism towards a change in the existing division of labour. They feared increased pressure on acute care and consequently an increased number of visits to the A&E departments.

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48 More precisely, the initiative came through the regional body of the Swedish Association of Local Authorities (SALA), in Swedish, *Kommunförbundet*.

In my interviews with the politicians and health administrators about the process of HCC Fyrbodal, the politicians mentioned how they first found out about the concept of call centres for healthcare purposes from a presentation. These presentations, given by officials, described – among other things – an HCC in the rural areas of northern Sweden:

> Personally, I was aware of the HCC in Gothenburg ... That I know... but for my political mission, it was the official level that first started to work on it... we got presentations ... in different steps... and there was this idea... I have not looked at the material.., but there were examples given from telephone advice nursing in other geographical areas and how the manning needed to be constructed...it was in northern Sweden somewhere... Östersund or something like that[49]... which was equally sparsely populated, I remember... and then we discussed it for quite some time ...before something happened, partly because of the financial aspects and partly because we needed to agree within the healthcare councils. In my area it created terrible opposition from primary care and from the emergency primary care people at the hospital... it was ....totally mad I would say. (politician 4 Centre Party 2004).

Accordingly, the decisive power about the future provision of telephone advice belonged to the healthcare councils. In April 2001, the final decision to start an HCC was taken in Fyrbodal. All the three healthcare councils voted for the main suggestion – to establish a central telephone advice nursing service separated from other healthcare organisations in the area. When the question of reasons behind the decision was brought up, the politicians presented arguments based on financial and quality matters. In the press release about the HCC, the chairman of the rural area council highlighted the importance of common actions for the entire Fyrbodal. As the healthcare council was divided into two opposing camps opinions about HCC the chairman's vote was determinant for the outcome.

> Dalsland is a small part of Fyrbodal and consequently dependent on the strength found in common solutions for healthcare (press release April 2000).

The politicians had high expectations about the organisation of a separate but common service to all citizens in Fyrbodal.[50] In a newspaper the chairman of another of the three healthcare councils highlighted the importance of HCC for reducing the pressure on other caregivers:

> This is an important organisation that will release pressure on the A&E departments in Uddevalla and the primary care centres (the regional newspaper *Göteborgs Posten* 7 March 2002).

The political decision was to establish a separate HCC for a trial period of three years. After this time, the trials should be evaluated. Consequently, the HCC Fyrbodal was originally financed by temporary resources, separated from the ordinary healthcare budget. The politicians and responsible health administrators motivated the introduction of a separate HCC by the result of a pre-project study. Accordingly, they argued that no existing healthcare units would have the

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49 When the discussion of national HCCs started, Östersund and more precisely the county of Jämtland, was frequently stated as a model for other counties (FCC 1998: 10).

50 The protocols from healthcare councils in Trestad, Dalsland and Norra Bohuslän 2001; documents from the Hälso- och sjukvårdskansliet 2001 and 2000; Reference group meeting in October 2002.

possibility to shoulder the prerequisites and the mission given. The mission was to carry out telephone advice nursing during evenings, nights and weekends, when the primary care centres were closed and at the same time guarantee the competence requirements of the new service within the existing budget (healthcare administrator 2002). Furthermore, it was not considered possible to obtain and maintain high competence, if telephone advice nursing were to spread to several locations and the phone handling remained only a small share of the working time of the nursing role in general. Instead, the project group claimed specialisation, concentration and identification within a separate place, group and duties.

In line with the decentralised Swedish healthcare structure, the formation shows the particular conditions and structure of a healthcare area. Before decisions are made, an issue is prepared and examined by administrators. The allocation of finances for individual departments/units within the healthcare area is carried out through the purchaser-provider model. The initiative to invest and improve the function of telephone advice nursing came from the regional government, but was supported by state grants from 1998. The decision to introduce HCC Fyrbodal was first prepared by a project group. The project group, who represented the major organisations in the area, carried out a local investigation in favour of a central HCC. In April 2001, after considering different propositions, the politicians decided unanimously in favour of the main suggestion to create a new, common organisation taking care of advice and information to the citizens in Fyrbodal.

Consequently, the HCC case explores the institutions' cultural characteristics and how they have defined the framework and procedures for policy-making. These include the selection of actors/groups whose opinions will be represented and the opinions that will shape the choice of demands for goal-setting. The project group, led by various health administrators, together with the executive politicians formed the strategic environment in which the agenda for telephone advice nursing was formulated. Consequently, the structure has formed the way in which interest groups are brought into the policy process and has provided incentives for some actors to act and others to remain on the periphery. In other words, it has been possible for the politicians to decide on a reform of telephone advice nursing without vetoes from critical administrators, professionals and citizens opposed to such a decision. Of particular importance was the idea of consensus, which did not provide opportunities for minority interests to override the agreed view within the executive.

3.2.4 The organisation of an HCC in Fyrbodal

When the decision was taken to introduce an HCC, the former project-leader was recruited for the position as head of the HCC Fyrbodal. She was a nurse with long experience from healthcare organisations in the area and from acute care in particular. The aspirations of the project group were

> to provide the citizens with telephone advice of high quality. The organisation should have a high level of specialist competence and a clear identity, achieved through twenty nurses located in suitable premises outside the clinics and A&E departments. (HCC manager 2002)

The decision to house the service separately from both other healthcare premises and the emergency medical dispatch centre (EMD) was quite radical at the time.

Most HCCs were either located in existing healthcare premises or co-located at EMD centres. However, the ambition was to create an HCC in Fyrbodal, where the telenurses had the opportunity to develop high competence and a sense of their own identity. The HCC manager's vision was that the nurses should not be employees at hospital X or primary care centre Y.

Moreover, the idea of having some nurses among the many 'operators' at an EMD department was not considered optimal. Instead, the aim was that the staff at HCC Fyrbodal should form an individual group of telenurses in their own premises with their own duties and responsibilities. Exceptionally, in comparison to other HCCs, 20-25 per cent of the telenurse's working time in HCC Fyrbodal was dedicated for individual work within 'areas of responsibility' as a form of job-enlargement (in Swedish *eget ansvarsområde*). The areas of responsibility were presented as the HCC manager's ambition to create continuous learning and variations in the work of handling healthcare matters on the phone. Furthermore, the ambition was to create a feeling amongst the telenurses of participation and acting on their own discretion.

Two months before the service was launched, an introduction phase took place. During this time, the recruited telenurses were asked to be involved in the planning of their induction as well as the creation of routines for continuous training and development. The newly employed telenurses also participated in the planning of the workplace and its design, including ergonomics, decoration, routines and timetabling. The premises of the HCC workplace were arranged in order to house several telenurses sitting together in the same room, able to 'anchor' to an individual workstation, using headphones and computerised decision-support. The calls to the centre were automatically routed and controlled by use of an ACDs system (Automatic Call Distribution switch) connected to the overall telephone switchboard of the nearby hospital. The newly employed telenurses were, however, not introduced to the computer system until one week before the opening of the HCC. It was not until that last week that they got an opportunity to practise how to use the software.

During this introduction phase, the telenurses were also given opportunities to exchange experiences with other HCCs in Sweden. This gave rise to the telenurses discussing all kinds of problems, solutions and worries... The aim of the HCC manager was to obtain a better understanding of the features connected to a separated HCC, something unfamiliar to most of the nurses, of whom only two had previously worked in a separate HCC. It should also be underlined that the service was rather small compared to HCCs in the larger cities of Sweden. On average, three or four nurses occupied the telephone lines at a time during the starting phase.

With the launching of the HCC, special advisory lines at A&E departments, hospitals and primary care centres (out-of-hours) were cut off in order to concentrate the service at one location. An information campaign in the daily press, at pharmacies and clinics had preceded the event encouraging local inhabitants to contact the HCC in question 'for advice, help and referral'. Small brochures and written presentations about the service were handed out for marketing the HCC, for example a magnet to attach to the refrigerator with the name HCC *(sjukvårdsupplysningen)* and its telephone number. Within the healthcare organisations, internal information was passed on to staff via the different management groups.

3.2.5 The first year of service: turbulence, mistrust and turn-over

At the start, the expectations of the HCC seemed to be high, but of a differing nature between professionals, politicians and officials. The telenurses sought stimulating work with their own responsibilities and opportunities to handle the population's access needs, referring them to appropriate healthcare providers and passing on advice for self-care (health prevention and promotion), whereas the politicians and the officials also wanted the HCC to steer the patient flow in order to relieve the workload from the A&E departments and the primary health care centres. The professionals of other healthcare units wished to be able to take care of 'their' patients on the phone as well as through face-to-face appointments. However, the introduction of HCC Fyrbodal initially reflected turbulence and mistrust from professionals and some officials from the healthcare organisations concerned. Particularly critical voices from professionals and citizens strongly expressed their dissatisfaction and complained that the access to the centre was poor, occasionally very poor. This evoked, furthermore, a general offensive supported by the media.

In my interviews with the telenurses during the first year, they said they were experiencing high levels of stress. The telenurses found themselves at a new place in a new role, where contact between the HCC and other caregivers had not yet been established. One reason for the stress experienced, they argued, was the newspapers' lead stories. At the time, the newspapers wrote that 'the telephone lines to the HCC were constantly occupied and long queues faced the care-seekers trying to get medical assistance and help' (e.g. the regional newspaper *Göteborgs Posten* 18 June 2002). When telephone lines to A&E departments at the hospitals and at primary care centres were cut off, HCC Fyrbodal was claimed to be the single actor for out-of-hours calls. The pressure to get through on the telephone lines to HCC Fyrbodal was particularly severe during evenings and weekends. The newspaper wrote several articles exploring the histories of citizens, who stated that it was almost impossible to get through to healthcare in Fyrbodal (see also *Göteborgs Posten* 28 August 2002).

In September 2002, in order to adapt to the level of public demand, HCC established a new time-table with more staff employed during evenings, nights and weekends (four telenurses out-of-hours and two telenurses during the day). A consequence was changed employment contracts for some telenurses as the HCC could not afford to have more than a third of the staff working full-time. The changed time-table with more work out-of-hours and less full-time work was badly received by the telenurses in terms of expectations, work satisfaction and work-life balance. Hence, in its first year, HCC Fyrbodal experienced considerable turbulence due to high labour turn-over, as a third of its staff left the service, and the HCC manager went on long term sick leave being totally absent for about half a year. Moreover, HCC experienced severe financial pressure because the hospitals were not willing to pay their share of the pilot project costs so HCC was missing essential revenues. During this time, the HCC organisation had passed the phase of being unknown to the phase of being vaguely known and unaccepted, towards entering the phase of becoming rather well-known.

3.2.6 The overall restructuring of healthcare

It seemed that national as well as regional and local politicians (mainly in the larger cites Stockholm, Gothenburg and Malmö) were very positive towards

telephone advice nursing carried out within separate HCCs.[51] HCC attracted politicians, irrespective of the political colour (Västra Götaland *Region* 2004a; the County of Stockholm 2005).

In Fyrbodal an HCC was introduced in order to improve access to healthcare in combination with major restructuring in the overall provision of healthcare – such as efforts to prioritise and to divide work and responsibility among actors within the 'chain of care'(cf. SALAR 2004). The central focus of the new structure was the chain of care.[52] The links within the chains of care varied from the most elementary and less expensive to the most advanced and most cost-demanding unit of care (*Västra Götaland Region* 2004b).

Moreover, in Fyrbodal the decision-makers explicitly announced that HCC should constitute *the first level* of care and the initial choice for inhabitants seeking healthcare. In this sense Fyrbodal went further in its ambitions with HCC than most other Swedish healthcare areas at the time. The cornerstones of the new structure were defined accordingly: (1) healthcare in a proximal (local) environment, i.e. more obligations for primary care and fewer for the county hospitals, as well as an enlarged ambulatory service for transporting patients over more extensive areas; (2) planned care, instead of *ad hoc* treatments; and (3) reduced patient flow to acute and emergency care departments, through strict prioritising of urgent care and a general focus on common resources and collaboration among health providers (*Västra Götaland Region* 2004b).

In Fyrbodal, the restructuring of healthcare implied a change in acute care, as the A&E departments moved to other premises outside the hospitals and being located in the primary healthcare centres out-of-hours. This was a way to draw the public attention away from the hospital and foster a better attitude towards primary care as the first and obvious place to turn for healthcare (cf. conceptions of the politicians and the health administrators in chapter 8 and 9 below). Other reorganisations entailed changing and splitting the locations of different specialities between the hospitals and/or departments at various geographical locations.

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51 In Gothenburg an HCC has existed for more than 30 years, co-located with the EMD centre, outside the hospital areas. Soon after the inception of HCC Fyrbodal an HCC at Södra Älvsborg was developed in October 2002, on similar lines and based on the same principles. In the healthcare area of the neighbouring district of Skaraborg, telephone advice nursing took place at several centres within the primary and emergency care centre. Discussions in the area had already started in 2004 about establishing a separate HCC in connection to the main hospital in the area (*Kärnsjukhuset* in Skövde). However, all the HCCs in the four different healthcare areas were organised within primary care. In 2002, a private HCC was set up in the neighbourhood area of Karlstad. The service was outsourced but related to the hospital. Some of the inhabitants of the north of Fyrbodal used to visit the hospital at Karlstad. Consequently, they had been informed and were using HCC Karlstad.

52 There are several different approaches, scopes and terms to signify integrative efforts between healthcare organisations, for example the patient's pathway (Ekman Philips et al. 2004), care pathway (Dent 2003: 44) or chains of care (Åhgren 2007: 26). One objective of integration might be to eliminate professional and departmental boundaries and develop multiprofessional teams. Another aims at integrating different levels of care, i.e. linking primary, secondary and tertiary care (Åhgren 2007). The latter definition correlates best with my use of the term.

The result was that citizens thought it hard to know where to find the appropriate care. The options were either to go to an A&E department no matter where and presume long waiting time, to call an ambulance, or to call the HCC.[53]

During its first years of service, HCC entered the phase of being accepted. In 2005 the majority of care actors in the area had accepted HCC as a complement to the ordinary healthcare organisation, and the health administrators calculated that one call to HCC could replace four visits to a primary care unit (*Västra Götaland Region* 2004: 24). Yet some professionals, especially in the rural areas, still expressed difficulties in taking care of 'the needs of their inhabitants' (health administrator and professional 2005). The desire to relieve the workload of the A&E departments was not fully achieved, but the number of visits out-of-office hours fell especially in the cities from 2004. According to calculations, the patient flows to the emergency primary centres (including those that had moved from the hospitals) had experienced fewer visits (see also Andersson 2005: 46). The result was expressed in positive terms as a reduced level of ineffective activity of 5.7 per cent! (*Västra Götaland Region* 2004: 17). This development was seen both as a result of HCC and an effect of the overall structural changes of healthcare in the area.

Other activities that probably contributed to the reduced patient flow were projects undertaken in Fyrbodal. Actors from both primary and hospital care agreed on a united policy for giving advice within a project called 'Advice: Once is Enough' (*Ett rätt råd räcker*). The purpose of the project was to create commonly shared guidelines for urgent and primary care, and in this way avoid care-seekers being called around to attend different care-givers in the area to check whether they were given the same (the right) answer or whether another care provider would answer differently. The project was initiated after several crisis meetings between HCC and an A&E department, where the parties discussed how to improve their communication. In connection with the project, 400 nurses were trained in conversation methodology and how to use the computerised decision-support applied in HCC Fyrbodal. By the same token, HCC had many professionals (mainly nurses) in the area, who came for educational visits. The project 'Advice: Once is Enough' and the subsequent training were seen as means to stimulate collaboration between different care-givers and arrive at a first line (front-line) of healthcare that was more unified and efficient. The initiators were the HCC manager and some health administrators. 'Efficient' should be understood in the sense of meeting the needs of citizens at the first telephone call and reducing the general workload of healthcare in the area, as only one care-giver took care of/encountered the care-seeker. In the rural areas HCC was first marketed after several years of service and the information campaign (posters and flyers) did correspond to a growth of callers from these areas. Other initiatives, such as the creation of basic values and the use of a Balanced Scorecard methodology for the entire primary healthcare organisation, also aimed to stimulate the overall collaboration effort. The main problem was, however,

53 The HCC at Gothenburg was very hard to access for the citizens. On the debate around enlarging the extent and responsibility of HCC Gothenburg, the media discussed the danger that nobody was responsible for the calls concerning children below two years in Gothenburg (3 May 2007). However, from 2008 there would be permanently employed specialised physicians with competencies on general medicine/primary care at the emergency departments (Göteborgs Posten 9 January 2006). In Stockholm City, the media debated that families with small children went to A&E departments for minor and banal ailments (3 February and 6 October).

not only that behaviour of 'rushing' into A&Es, but also that the primary centres had insufficient appointments to offer to meet the public need to visit a physician within a shorter waiting time (the same day or the same week). Consequently, the care-seekers were advised by their primary care centre to make an acute call in order to arrange an appointment at the emergency primary care centres out-of-hours, hopefully the same evening (telenurse 2005). However, during 2005 there was an attempt to let HCC Fyrbodal make some early appointments (in the morning) at six primary care centres. In line with the mission to be 'the first alternative and level for healthcare', HCC Fyrbodal was granted the responsibility to book appointments at A&E departments and emergency primary care centres out-of-hours from November 2005.

3.2.7 The development process expressed in numbers

Statistics are presented below regarding the total number of calls based on HCC's own data from the annual reports from 2002 to 2006.

Table 3.1 The total number of calls per year, month and day

	2002*)	2003	2004	2005	2006
Total number					
of calls per year	61,022	99,104	105,548	114,505	142,204
No calls per month	6,423	8,259	8,796	9,542	11,850
Increase in calls from					
one year to the next		1,835	537	746	2,308
No calls per day	207	272	288	314	390
Increase in calls per day					
From one year to the next		65	17	26	76
Increase (per cent)		29%	7%	8%	24%

*) 2002 only had 295 days as HCC only started in March 2002

An important increase in the number of calls took place between the first and the second year (1,800 calls more per month that is +29 per cent) and between the fourth and the fifth year (2,300 calls more per month that is +24 per cent). The increase of the first period was explained, by the HCC manager and the staff, in terms of experience gained and better routines. Discussions regarding potential reasons for the chaotic situation will be included in the following chapters. Reflecting back, it might, however be concluded that the initial service was undersized, or the capacity of three telephone lines was overestimated. The centre was based on an estimate of handling more than 10,000 calls/month – in the first year it managed about 6,400 calls/month and in the two following years 8,200 and 8,800 calls/month were managed respectively (also in Andersson 2005: 29).[54] The same goal was estimated for the other HCC in the region. However, it took more than four years to obtain this goal. An additional increase in the number of calls took place between 2005 and 2006, when the HCC was recruiting more staff. During these years several initiatives were taken by the decision-makers in order to inform citizens about the service obtainable from HCC. From

54 The planning of HCC Fyrbodal and its activity was based on a goal of 122,500 calls per year equivalent to 330 calls per day and 0.45 calls per inhabitant. The calculations were based on the national investigation from 1998 considering recommendations for HCC capacity (FCC 1998:7).

the 1st November 2005, HCC Fyrbodal was officially expressed as the first level of healthcare and the first contact point for citizens when they needed care out-of-hours. Instead of going directly to an emergency ward, the citizens were required to phone HCC.

3.3 SUMMARY

In line with the decentralised Swedish healthcare structure, the development process at HCC shows the particular conditions and structure of a healthcare area. The decision to introduce HCC Fyrbodal was first prepared by a project group. Their propositions made it possible for the politicians to decide on a reform of telephone advice nursing without vetoes from critical administrators, professionals and citizens opposed to such a decision. Of particular importance was the idea of consensus, which prevented opportunities for minority interests to override the executive.

During its first year of service, the HCC experienced turbulence, mistrust and high labour turn-over. But gradually and with support from the politicians and some health administrators, the HCC became accepted in the eyes of the general public as well as the majority of healthcare staff. One aspect which probably contributed to as well as counteracted the HCC was a simultaneous restructuring of the overall healthcare organisation. Consequently, the healthcare administrators undertook several measures to steer 'the patient flows' from the emergency departments, out-of-hours, to other healthcare organisations, i.e. primary care, HCC Fyrbodal and self-care at home. These were argued as being primary levels of care, less expensive and defined as more appropriate in most cases. Moreover, the access to HCC was improved by several actions such as internal projects aimed at normative control[55] and overall targets to transform into operational actions to improve the understanding of each others' work and move towards better collaborative forms among healthcare providers.

55 Kaplan and Norton (1992) would not describe their method the Balanced Scorecard in terms of normative control. Instead they considered it a concept for measuring a company's activities translated into visions and strategies, which in turn would give managers, co-workers, stake- and shareholders a comprehensive view of the performance of a business.

CHAPTER 4
PREVIOUS RESEARCH

This chapter reviews previous research, which reveals a blind spot – two topical and important fields that are not yet explored. One is the particular type of HCC from the perspective of service work in *call centres,* and the other is the organisation of HCCs from the perspective of *healthcare/human service organisations focusing on nursing.*

The chapter starts by exploring call centres and different kinds of service work, which shows that call centre studies range from all sectors in society, but there is a predominance of organisations other than professional ones. In this sense, human service organisations are still insufficiently represented in empirical studies of call centres.

The research on the HCC covers telephone advice nursing, which takes up the perspective of certain actors, but not all the conceptions that are important for a healthcare organisation: it misses the administrators' and politicians' perspectives. Other studies, still in their infancy, consider the work organisation that the professional employees, telenurses, experience in this particular kind of call centre within the Swedish public sector of healthcare.

4.1 THE CALL CENTRE AND THE SERVICE DEBATE

4.1.1 The call centre concept

In call centres, cost-efficiency is aimed at through expansion of the service provision with the mass-market automatic distribution of calls (ACDs) to employees located in remote work settings. First, a call centre enables providers to meet greater demand with less capital resources. *Economies of scale* are obtained as the numbers of customer transactions reduces the costs per customer compared to face-to-face transactions (e.g. Taylor and Bain 1999: 105). Secondly, in some firms the call centre organisation materialises a centralisation of back office and administrative functions (Jewson et al. 2007). Thirdly, the call centre concept reduces the need for premises at expensive addresses in the inner city (e.g. Collin-Jacques 2003: 9). The financial benefits include the *ability to locate* the call centre wherever land, infrastructure and labour are available and are most cost-advantageous (Bain and Taylor 2002). Fourthly, the call centre is given an important position strategically at the interface between the organisation and its clients, providing *client focused service* or building *a loyal customer base* (Batt 2000: 54). The estimated advantages for customers are described as price competitive products and service, more convenient access including personal assistance and service round-the-clock (Collin-Jacques 2003: 9).

4.1.2 Two main perspectives

In recent years, the establishment of call centres has led to an increasing amount of research, especially in the Anglo-Saxon parts of the world. Call centres have been researched from two contrasting perspectives. On the one hand, by those who consider call centres as being characterised by monotonous, highly

controlled work with standardised procedures in a Tayloristic spirit, which will complete or even reinforce society's traditional structures of inequality (Arkin 1996; Taylor and Bain 1999; Callaghan and Thompson 2001; Bain and Taylor 2000; Taylor et al. 2002; Bain et al. 2002). This low-discretion call centre work has been described as carried out by women, young people, immigrants, part-time workers with low-trust roles, where management holds a high level of technical, detailed and bureaucratic control (HTF 2000; Taylor and Bain 2001; Tengblad et al. 2002; Belt 2004; Mulholland 2004).

Notwithstanding the organisation, the functions or knowledge of the employee, call centre work contains a great deal of stress, tension and little autonomy (Taylor and Bain 1997; Bain and Taylor 2000; Callaghan and Thompson 2001; Bain et al. 2002). For Bain and Taylor (2000), call centres give rise to a new kind of structural control, a finding also confirmed by several scholars, for instance, Callaghan and Thompson (2001). Other comparisons of call centres have been made with Bentham's vision of a prison fulfilling panoptical control of its prisoners. Call centres and panoptical control have, thus, been described as a metaphor for disciplinary power in a Foucauldian sense (Fernie and Metcalf 1998). According to Thompson and Warhurst (1998), the service requires all kinds of control, i.e. direct and technical, administrative/ bureaucratic as well as normative control (see also van den Broek 2004). However, the presence of worker resistance has also been argued (Knights and McCabe 1998; Mulholland 2004) and in some cases, it has been recognised by the use of humour and different collective actions. Examples are given as subversive satires in the form of photos, poems and notes as well as jokes or practical jokes seeking humiliation of managers and drawing attention to the call centre workers' dubious work conditions (Knight and McCabe 1998; Bain and Taylor 2000; Taylor and Bain 2003).

On the other hand, other researchers highlight the organisation in call centres as being based on technology and creative intelligence with the possibility to obtain competence development and autonomy, if managed in a productive way (Frenkel et al. 1999; Frenkel 2000; Korczynski 2002; May et al. 2002; Lindgren and Sederblad 2004; Korczynski 2005). The more enthusiastic scholars emphasise a large part of call centre as empowered work (Frenkel et al. 1999) with highly committed and skilled employees delivering customised quality service (also Schneider and Bowen cited in Thompson 2007: 105). From this more positive perspective, management control can never be total in service work, because of the specific characteristics of service. Service is an intangible, perishable product, inseparable from consumption as well as from the consumer (Korczynski 2002: 4-7), as well as the interactive form of service work based on emotions (Hochschild 1983; Frenkel 2000; Korczynski 2002; May et al. 2002; Korczynski 2005).

Different mixtures of negative versus the positive stances are, however, also argued as being possible. This is also how I interpret the research of Korczynski (2002) as well as Lindgren and Sederblad (2004). They recognise the control aspects of call centres at the same time as they highlight the autonomy connected to interactive service relations. Such a middle category highlights a rather fierce striving for efficiency, but this is some way from cost minimisation and low road work organisation. Instead, it is relatively serious in its consideration of service quality (Korczynski 2002).

4.1.3 Workers and work in call centres aiming at different kinds of service

For Batt (2000), the customer interface is a significant factor in determining competing models of work. Where customers require a homogenous service, for example, in the mass and residential markets of US telecommunications firms, the work organisation is comparable to a mass-production model. Whereas the interaction with customers is less amenable to rationalisation and provides opportunities for discretion, electronic monitoring is more difficult. Furthermore, employees servicing higher value-added customers are '. . . at least twice as likely to have control over their daily tasks, work methods, pace of work, schedules and use of technology' (Batt 2000: 552). Moreover, research on call centres in the UK has generated conclusions similar to those of Batt (2000).

Taylor et al. (2002) argue that the diversity in call centre work is best understood in terms of the dichotomy between 'quantity' and 'quality' (mass-production versus flexible specialisation). At the 'quantity' extreme the work system is volume-driven, repetitive and routinised, with standardised procedures and tight monitoring. By contrast, the work design at the 'quality' end offers task discretion and more relaxed targets. Deery et al. (2004: 208) also show that call centres emphasising the quality of customer interaction operated a work system in which employees enjoyed fewer standardised procedures than those privileging a 'mass-production approach to service delivery'.

4.1.4 Three kinds of work

According Korczynski (2002) the quantity and quality logics underpin most call centres simultaneously, and these are also contradictory. The two logics are equally expressed as the logic to improve cost-efficiency and the logic of customer-orientation, which enable organisations to deliver at a higher and more consistent level, for example outside normal business hours (Korczynski 2002: 91). In the words of Korczynski (2002), three different kinds of service are distinguishable, i.e. there are three ideals types: the mass-production, the mass customisation and the professional service model (see also Batt and Moynihan 2004).

In similar ways and regarding the productivity or the added-value that the different jobs are providing, Reich (1991) divides jobs into three main categories: *routine jobs* in services (and production), *in-person service jobs*, and jobs for *symbolic analysts*. *Routine jobs* involve mostly relatively low skills both for operators and their supervisors. Call centre work is usually considered as routine, and it involves jobs in focus for delocation (off-shoring) as well as sub-contracting to a large extent (e.g. Holman et al. 2007). One way to facilitate 24 hour service provision is, namely, delocation to other countries, so that employers begin their working day when people in the country of use normally get off work or into bed. Call centre work might also belong to the second type of job, the *in-person service jobs*. Some in-person services might be delocated such as distance learning replacing direct teaching, while others like hairdressing and cleaning cannot be performed at distance (Reich 1991). The third type of job is *the symbolic analyst job* based on the so-called knowledge economy and is involved with advanced problem solving. Such jobs are demanded for innovations, when non-standardised, complex issues are involved, and might also entail creating and generating new markets (Reich 1991; Korczynski 2002). In line with the arguments

above, Frenkel et al. (1998; 1999) and (Korczynski 2002) distinguish a hybrid model of *mass-customised service*, which is the most common form of front-line service work, called the *customer bureaucracy*. Furthermore, Korczynski states that it is highly possible that some call centre relations intertwine with the enduring myth of service-work rooted in the Fordist notion of quantity rather than quality, and as a result, labour-intensive work is claimed to give low productivity (2002: 169). When analysing mass-customer service work, Korczynski uses empirical evidence from hospitality, call centres and healthcare work. However, this excludes professional service work, and the combination of healthcare work and call centre work is not considered as a distinct category.

4.1.5 Knowledge, employment relations and working conditions

The contrasting images of work organisation – the negative and the positive – serve as a basis for the study of front-line workers by Frenkel et al. (1999). The aim of their research was to understand the nature of work from the front-line workers' perspective, i.e. to explore whether empirical evidence confirmed whether one of the images was dominant – that is the regimented or the empowered organisation (p. 13). Frenkel et al. (1999) describe and analyse various forms of work organisations undertaken in different kinds of service work, i.e. related to service, sales and knowledge (p. 265).

According to Frenkel et al.'s (1999) classification, the service worker rarely uses theoretical or higher-order contextual knowledge, whereas sales workers and knowledge workers do so in order to identify, diagnose and resolve problems. But all three types use social and analytical skills (1999: 39, 65). In conclusion, they argue that over time, service and sales work will resemble knowledge work. Knowledge work is a hybrid organisational form that combines weak hierarchical relations with strong lateral relations within the organisation. Yet Frenkel et al. issue a warning note: management's way of taking care of future employment relations and technological strategies are of decisive importance (1999: 265-78). As to front-line workers' job satisfaction, Frenkel et al. (1998) have earlier shown that this varies with factors in the overall work situation and the level of discretionary work effort. The only things that might alleviate the negative effects of call centres were job security and co-worker relations. Human resource management is otherwise a frequently applied strategy to compensate for poor working conditions (see Kinnie et al. 2000; Kågström and Rubing 2002; Bolton and Houlihan 2007).

Tengblad et al. (2002) show variations in call centres deriving from their typology of customer relations. Customer relations might be mainly qualitative or quantitative, and the work might be of different degrees of control and intensity (Tengblad et al. 2002: 13). In their Swedish study comparing two call centres within governmental authorities with two within private companies, Tengblad et al. (2002) observe how the assignment and the users/ customers influence the call centres. At the Public Employment Services Office and the Police – two governmental call centres – the assignment was to give information and deal with reports for citizens, i.e. people in vulnerable situations exposed to unemployment or crime. Meanwhile, the call centres within the Postal Services and the aviation company SAS operated in an open market with paying customers, where the assignment was to sell and give service (Tengblad et al. 2002). Accordingly, they differed between supporting and serving versus selling and

serving (see also Glucksmann 2004). The way that service is carried out, and is perceived by the customer, varies greatly depending on the producer, the consumer of the service and their relationship (Korczynski 2002: 4-7). Likewise, the practices of Human Resource Management and call centre work are dependent on the segmentation of customers and the target of the call centre (Batt 2000; Tengblad et al. 2002).

Call centres in general as well as in Sweden are associated with a young workforce with a relatively limited formal education or academics being at the beginning of their working life. They are also dominated by women carrying out more simplistic and standardised tasks and work routines (Tengblad et al. 2002). A study by the main Swedish white-collar retail union, HTF, shows that most employees are women (approx. eighty per cent), and almost half the employees are younger than 25 years of age. For the younger workers, the job is usually a first step in the labour market; for their older counterparts, it might be the only possibility to get a job – especially in geographical regions with high unemployment (HTF 2000: 4; Toomingas and Bengtsson 2007: 8-9).[56] This could be compared with Belt's view of call centres as a feminised sector (Belt 2004) (see also Durbin 2006). These groups constitute less expensive manpower on the labour market. Furthermore, HTF also showed that only 71 per cent of their members working in call centres had a permanent employment contract. The rest had fixed time contracts, quite equally spread over contracts based on needs, time, trial periods of employment and projects (HTF 2000: 4).

Several scholars have intensively discussed the importance of the overall working conditions including relations at the workplace (Korczynski 2002; Fernie 2004; Houlihan 2004; Kinne and Deery 2004). Some researchers have studied job satisfaction and emotional exhaustion in call centres, for example Deery et al. (2004) and Holman (2004), on the well-being, and the effects of management practices on employees. Swedish research carried out by The National Institute for Working Life (*Arbetslivsinstitutet*) has demonstrated that call centre workers experienced their work as stressful, which in combination with strict control, sedentary and monotonous movements tends to be the reason why six out of ten complained about physical pain (Wigeaus Tornqvist et al. 2001, see also Norman 2005; Toomingas and Bengtsson 2007).

Thus, few studies reveal beneficial effects of call centre work, although employment relations and working conditions seem to vary according to sector and by occupational group. This is also contrasting picture of call centres to that frequently presented and related to globalisation, the network society, individualism, consumerism and managerialism. The consequences of call centres described here make up the less glamorous reverse side of work, which has been less frequently highlighted in the Swedish public debate in recent years.

4.1.6 National and industry-wide contexts

Another source of differentiation is the national or societal effects. However, there are still few studies outside the Anglo-Saxon world. Frenkel et al. (1999) employ a cross-national design including two types of emerging industrial and occupational structures. The 'service industry model' fits American and

56 Many of the call centres have received Swedish state development grants in order to establish in regions with a relatively higher unemployment rate or in order to stimulate employment in the area (Toomingas and Bengtsson 2007: 8-9).

Australian call centres, while 'the industrial production model' describes Japanese call centres (p. 37). Frenkel et al. show that the national context plays a central role for the nature of work in call centres, for instance the Anglo-Saxon structure differs from the Japanese, as Japanese service work is more bureaucratic, routinised and managers tend to rely more on direct, personal rather than info-normative, control and supervision (Frenkel et al.1999: 270).

The Collin-Jacques's study showed major differences in the formation of services and their development depending on whether the health call centres were situated in English speaking areas or in the French speaking Quebec (2003; Collin-Jacques and Smith 2005). Holtgrewe et al. (2002) compared British and German call centres in the book *Re-organising Service Work: Call Centres in Germany and Britain.* The evidence from the German case studies shows tendencies towards both de-regulation and re-regulation in terms of institutional resources. The conclusion drawn by Holtgrewe et al. (2002) was that German call centre work is disembedded from the traditional regulatory constraints moving in the direction of a more liberal, Anglo-Saxon model of the economy, characterised by work intensification and stress. However, the dual-system of training in Germany,[57] means that German call centre workers get more vocational training than their counterparts in Britain (Arzbächer et al. 2002).

Additionally, the repetitive nature of the work seems to be a problem in both countries, but while British call centres emphasise performance evaluation and pervasive control, the German ones focus to a greater extent on work design (e.g. job enlargement), training and employee development (Arzbächer et al. 2002; Bittner et al. 2002). A comparison between call centre work in Sweden and the UK has shown that work in both countries was characterised by performance measurement, rules and supervision. However, British employees were more often and strictly measured and had more difficult targets to achieve compared to their Swedish counterparts (Kågström and Rubing 2002).

Koskina (2005 and 2006) concludes that research on call centres of different origins clearly indicates that the overall labour process in these occupations appears to be a divergent phenomenon, which is likely to be influenced by institutional characteristics such as national workplace (industrial) relations rather than just the technological design as driving forces (Koskina 2005: 13). Her case-study of Greek call centres is markedly distinguished from the omniscient, control-framed Taylorist accounts and they confirm that the host-country's national context exerts a much stronger influence on the work organisation than technology. Koskina, thus, highlights the importance of developing flexible relations between the employees and management in order meet the distinctive cultural traits of Greek workers used to individualistic encounters and entrepreneurial freedom (2006: 184-185).

57 The dual-system is known as a special feature of the German training system combining off-site general schooling with competence-based apprenticeships, on-the-job-training at workplaces. The financing of the training costs are split across the tripartite structure: the Government funds the schools, the employers fund the workplace training and workers fund their training indirectly by accepting a lower trainee rate of pay (Rubery and Grimshaw 2003: 120-121).

4.2 CONCLUSIONS ABOUT THE CALL CENTRE AND THE SERVICE DEBATE

In sum, the literature review indicates that work organisation in call centres differs according to *the national context* (cf. Holtgrewe et al. 2002; Collin-Jacques 2003; Koskina 2005; 2006). UK research has focused on the tight labour process and elements such as routinisation, repetition, employee control with an emphasis on the technological control of workers, while studies outside the UK have taken a broader work organisation perspective embracing Human Resource Management and arguing for diversification according to a *model of different service provision* such as mass-production, mass-customisation and professionalism (Batt 2000; Korczynski 2002; Collin-Jacques 2003).

With some exceptions, e.g. Frenkel et al. (1999) and Batt and Moynihan (2002), few call centre studies have covered professional or semi-professional workers. The kind of work has been shown to be another filter for analysing call centre and service work. *Occupational identity* (see also the next section) makes the nurses who staff healthcare telephone call centres different from their counterparts in the commercial call centre field. They are highly qualified and competent workers with a strong occupational consciousness (Collin-Jacques and Smith 2005).

4.3 PREVIOUS RESEARCH ABOUT TELEPHONE ADVICE NURSING

Several Swedish studies have addressed the function of telephone advice nursing (TAN) within traditional healthcare, but only to a very limited extent from a call centre perspective. Most analysis of health call centres originates from studies of the British NHS Direct. In focus of the above-mentioned studies are the nurses', the callers' and the managers' conceptions. The issues from other professionals within healthcare and the decision-makers' point of view are only briefly and more implicitly mentioned.

4.3.1 HCCs in other national contexts

The research on call centres within healthcare and on professions or semi-professions such as nursing is so far limited. Exceptions are the comparative studies of Collin-Jacques, Smith and their followers focusing on HCCs in the UK, the NHS Direct (e.g. 2005), and highlighting the impact of a strong occupational conscience on work methods and the design and use of call centre technology. Accordingly, the health call centre is considered a unique kind of call centre, where occupational identity and consciousness are important factors for shaping both work and work organisation (Collin-Jacques and Smith 2005).

Studies of health call centres in England and Quebec have been carried out by Collin-Jacques (2003; 2004; 2005) and more recently by Collin-Jacques and Smith (2005) and the research group around Smith together with Mueller, Valsecchi, Elston and Gabe. Some studies of work and work organisation in HCCs have been carried out in the UK (Munro et al. 2000a; 2000b; 2003; O'Cathain et al. 2001; 2004; Smith et al 2004; Mueller et al. 2004; forthcoming 2008; Smith et al. forthcoming) covering the British system of NHS Direct. Work has also been conducted by the group based on Hanlon, Strangleman, Goode, Luff, O'Cathain and Greatbatch (2005) studying the technology and effects on nursing autonomy. Goode et al. (2004) and Goode and

Greatbatch (2005) have also studied the issue related to the callers of the service within the project 'NHS Direct: Patient Empowerment or Dependency?'. Other researchers of HCCs belong to the University of Sheffield (Munro et al. 2000; Knowles et al. 2002; Munro et al. 2003). They also comprised the group evaluating NHS Direct at national level, including studies of the effects on healthcare in total. Studies have also been published from research on telephone advice nursing in the USA (Chang et al. 2001; May et al. 2003), , M;in Australia (Larsen 2005) and in Finland (Suomi and Tähkäpää 2003). Thus, the merger of healthcare and call centres has been materialised through health call centres and the functions carried out are also labelled as telephone advice nursing, abbreviated TAN within Swedish healthcare (Wahlberg 2004).

4.3.2 The emergence and efficiency of TAN

Sweden's interest in health call centres has grown apace with the Swedish Federation of County Council's (FCC) increased attention to telephone advice (e.g. FCC 1998; 2001, 2002a; 2003, 2004a; 2004b; SALAR 2005). However, most of the studies originating from the disciplines of general medicine or nursing primarily focus on the medical and caring aspects of telephone advice nursing.

In Sweden, the first structured research including a doctoral thesis of nurses' advisory and information activities concerned work in primary care centres and in pharmacies (Marklund 1990). These studies were carried out within the discipline of general medicine by a research group led by Bertil Marklund. During a three year period, 1989 to 1991, Bertil Marklund and associated researchers carried out a number of studies of telephone advice nursing activities. These issues covered the function of TAN (Marklund and Bengtsson 1989;), its service and contribution to more adequate visits to healthcare (Marklund et al. 1991), how to carry out and stimulate advisory practices at pharmacies and its relation to primary healthcare (Marklund et al. 1990b), the nurses' consultations (Marklund et al. 1990a, Marklund et al. 1991), and the preparation of general guidelines on how to carry out the service and training (Marklund et al. 1998; Marklund et al. 1990a).

Marklund et al. (1990a) described the Swedish delivery of healthcare as under continuous structural change, and in their perspective the district nurse was in special focus for TAN. A district nurse in the area of Fyrbodal was pictured by Marklund et al. (1990a), as a person responsible for a defined geographical area, including child welfare and home sickness care of disabled people, but not responsible for school or maternity healthcare. All district nurses worked with preventive healthcare to a limited extent. Yet, the district nurses had limited time devoted to telephone calls. For example in the study of Marklund et al. (1990a) the district nurses had only one hour per day specified for telephone contact. They stated that the old role of the district nurses as a link between the healthcare system and the population ought to be taken over by the reception nurses at the primary care centres (p. 62). The district nurse at the end of the 1980s devoted most of her time to preventive and social work, while the time for exclusive medical care was diminishing. Marklund et al. advocated a combination of the roles of reception nurse and district nurse, which they argued would mean a more rational way of working. Consequently, with TAN, the primary care providers might be responsible for fewer individuals, but would have increasing knowledge about each of

them and as a result the work for both categories of nurses would be more rewarding (1990a: 62).

4.3.3 The telenurses and the callers

Researchers in the fields of nursing, public health and caring have also studied the implications of telephone advice services for nurses and patients/users. The major foci have concerned TAN from the nurses' experiences of problems and bases for assessments. The first extended study exclusively dealing with telephone advice nursing in a call centre environment was a doctoral thesis presented by Anna Carin Wahlberg in 2004.[58] Other studies in the field deal with the nurses' understanding of their role in TAN and the patient encounter (Holmström 2002), and telephone nurses' experiences of their work in EMD centres (Forslund et al. 2006). Holmström and Dall'Alba (2002) state that conflicting demands in telephone advice nursing create dilemmas for the telenurse, as she takes on the role of both a gatekeeper and a carer. They label this problem in terms of contrasting roles (Holmström and Dall'Alba 2002).

Forslund et al. (2004) find the most striking problems in TAN in EMD centres to be uncertainty, communication patterns and insufficient resources. Consequently, Forslund et al. (2004) argue that the employees' skills, knowledge and experience as well as personal qualities, such as sensitivity, insight, emphasis and intuition are very important. The employees themselves demanded guidance, feedback and training in order to perform a good job (2004).

Other issues taken up are the callers' conceptions of TAN (Wahlberg et al. 2003). Forslund et al. (2005) strive to illuminate how callers with acute chest pain experience their emergency calls, which involves feelings of disturbance, vulnerability, calling in vain and the long waiting times. The study shows also that the callers, who experienced their lives to be in danger, felt that it took too long for the emergency operators to answer and to understand the urgency. In such life-threatening situations the feelings of vulnerability and dependence are matters of great concern. The care-seekers were aware of the emergency number, but felt uncertain about their condition warranted calling for acute help.

Furthermore, the circumstances related to complaints have been explored, highlighting the risk of second-hand consultations (Wahlberg et al. 2003), and nurses' decisions-making in terms of feedback on assessments, an important task required of and feared by the nurses (Wahlberg 2004).

Other relevant studies are Kvilén Eriksson's investigations (2000a and 200b) showing the shortcomings and lack of up-to-date documentation and decision-support systems for telephone advice nursing within primary care, and Wannberg's study (1997) of the telephone nurses' educational and advisory functions. Wannberg stresses that the telenurse and the caller might perceive the context and conditions differently. Consequently, the telenurse has to be sensitive to communications matters in order to understand and make herself understood, when she encounters the caller and conveys advice or a referral to him or her (1997). From a sociological perspective, studies have analysed the conversation and social interaction between nurses and callers (Leppänen and Sellberg 2001) and how nurses assess the reasons for visiting a physician and the

58 Here Wahlberg also suggested the systematic use of the term TAN from the American use.

plausibility's of these reasons, based on institutional factors within healthcare (Leppänen and Thelander 2001; Leppänen 2002).

On behalf of the Swedish project team for national HCCs 'Healthcare Advice over the Phone' (*Vårdråd Per Telefon*), a healthcare economic evaluation compared telephone advice nursing in a city (Malmö) versus a rural area (Jämtland) (Norling 2001) on the effects of HCCs in terms of access and security. The report concludes that the most efficient use of HCCs occurred, when they predominantly steered patient flows in the city areas, from A&E departments to emergency care centres in combination with telenurses who were making appointments for different healthcare providers. In the rural areas, the HCC was best adapted for providing self-care advice, so that citizens avoided long distance travel to make personal visits to healthcare (Norling 2001). The report drew great attention in the media claiming that telephone advice nursing eliminates many unnecessary visits to healthcare providers and steers patient flows (the regional newspaper *Göteborgs Posten* 31 Aug 2001). 'It is an efficient way to use the healthcare resources and that will save several millions for the counties' (*Göteborgs Posten* 9 Sept 2001).

The reports from the Swedish project team for national telephone advice nursing (the FCC 1998; 2002a; 2003a) also include studies, discussions and analyses of existing HCCs in Sweden arguing that the purpose, demands and utilisation of HCCs differ from county to county (Marklund 1990; Swedin and Norberg 2002). The FCC also pointed out the Swedish choice to take another path compared with the national service in the UK, the NHS Direct (FCC 2002a: 54-58). Additional studies of health call centres were carried out by the national group for coordination of TAN within Sweden.

A pilot group of four counties, later to become six, in various parts of the South and Middle regions of Sweden[59] was established in order to examine different kinds of arrangements and to elaborate quality parameters to guarantee patient security (prospectus for 1177 dated 2004). In these areas, several surveys regarding users' satisfaction have been carried out (by Ipsos-Eureka since 2004) and regarding the planning and development of TAN for single counties (for instance Analysis for 1177, 2004). With the purpose of gathering telenurses and others interested in the issue of TAN, the occupational association of TRIHS (TRIHS *homepage*) was founded in 1998. TRIHS later became a section within SWENURSE (*SSF*).[60] Meetings and the setting up of the homepage of TRIHS have been actions taken by devoted telenurses in order to collect and promulgate experience and research about TAN activities in Sweden (Wahlberg 2007: 86).

4.3.4 The telenurses' work and working conditions

According to Leppänen (2002), the nurses in primary care centres are well aware of the situation of a limited numbers of appointments to physicians being available, and that they have to prioritise these meetings 'to the most needed'.

59 To be precise the counties of Östergötland, Kronoberg, Gävleborg, Jämtland, Skåne and Uppsala.

60 SSF is the occupational association for nurses established in 1910. In 2007, SSF included about 90,000 members, all registered nurses and student nurses (SSF *homepage*).

Furthermore, they have to answer to physicians for the appointments made. Therefore the nurses carry out complicated organisational assessments to decide whether a patient needs to see a physician or not (p. 13). Hence, regardless of where the telephone advice takes place, the nurses have a role of gate-keeper to the public medical system (Leppänen 2002). To be a gate-keeper is only one role, in the words of Holmström and Dall'Alba 2002). A non-optimal match between the care-seekers' needs, other professionals' different conceptions of 'appropriate practice' together with managements' emphasis on the budget frame, might cause problems and frustrations for the telenurses (Holmström and Dall'Alba 2002).

Telephone advice nursing implies reading between the lines in order to assess the needs, symptoms and problems of the care-seeker, which might be a time consuming task. The caller shall be given the time needed, but the nurses are expected to make the calls as short as possible. Educating and self-care advice to people, especially to parents (one third of the all the calls to telephone nurses concern children younger than ten years) stands in contrast to the fear of misinterpreting the situation. Moreover, the role of telephone advice nursing includes encountering callers' satisfaction and dissatisfaction (Holmström and Dall'Alba 2002). Many difficulties are also connected to communication with immigrants, for reasons of language and culture, and to calls with angry and aggressive people (FCC 2003a). Wahlberg (2004) highlights the lack of healthcare resources as a major problem, which sometimes makes it impossible for the telenurse to refer to accessible healthcare. In the worst case, a misjudgement can endanger the care-seeker and jeopardise the career of the nurse or even her licence to work as a nurse (Holmström and Dall'Alba 2002).[61]

Studies before introducing the HCC in Fyrbodal were carried out in 40 primary care centres (Kvilén Eriksson 2000a and 2000b). These studies indicate low access to healthcare by phone which might be one reason why the nurses did not document their advice according to the regulations. Further, the nurses did not have a common policy for TAN and they expressed the need for training and decision-support. The observations revealed that the nurses only used decision-support in exceptional cases (no computerised solution was applied). 'The support mainly used was FASS [the Swedish medical encyclopaedia] and consultation with colleagues and physicians.' (Kvilén Eriksson 2000a: 11).[62] Competencies and the use of a computerised decision-support system have been studied by several British researchers. O'Cathain et al. (2001) show that the advice given by the telenurses varies with different kinds of computerised support systems, i.e. software. Accordingly, the software was shown to be an important variable for decision-making. However, nurses with less then ten years of experience were less apt to give self-care advice compared to nurses with more than 20 years of experience, regardless of the software applied. The nurses also claim that the software is important, but not *the* single tool for decision-making. Consequently, critical reasoning is very important, as the computer cannot cover all possible problems or circumstances. Furthermore, O'Cathain et al. state that the nurses' special

61 Complaints presented by personnel or clients, for example a Lex Maria, which is a case or report to the Medical Responsibility Board.

62 Also note the distinction made between the two groups consulted. Colleagues comprised the nurses among them and physicians did not belong to this group.

knowledge is reflected in their advice and that district nurses, for instance, are the most apt to let the caller's social situation influence the given advice (2001). Leppänen (2002) and Wahlberg (2004) argue that telephone advice nursing includes decision-making not only on medical grounds, but also related to different kinds of social resources to reveal the nature of the problem. Wahlberg (2001) argues that nurses develop skills to manage the interaction with callers in order to compensate for the absence of visibility. Their skills are based on their professional backgrounds and experiences, and are often developed in an ad hoc way. The FCC notes (1998: 19) that

> When a physician or a nurse who temporary and without any particular training tries out the role of telephone advisor, they have the tendency to recommend more often than experienced telephone advisor that the patient visit a healthcare provider as a precautionary measure (the author's translation).

4.4. CONCLUSIONS ABOUT TELEPHONE ADVICE NURSING

To conclude, few Swedish studies of call centres within the healthcare sector have been carried out from a perspective of work and organisation. Focusing on technological ICT and gender, Andersson (2004) investigated TAN in respect of the nurses' work and organisation in a customer service for healthcare (issues also discussed by Sederblad et al. 2005). Lindgren and Sederblad (2005) further explore the call centre worker's use of different strategies in order to create a feeling of autonomy within 'the electronic birdcage of a call centre' by finding reasons to temporarily leave their work-stations and to cut the work on the line. The particular setting of HCC work was, however, not focused. Fältholm and Jansson (2007) identify the different and contradictory discourses of New Public Management and nursing, within a primary care centre occupied with telephone advice nursing.

Some studies of HCCs have been carried out in the UK. However, separate trajectories have been discernible for the Swedish and the British HCCs (see also chapter 2). One major difference is that in the British NHS Direct, the telenurses are obliged to use a decision-support system, called the Clinical Assessment System (CAS) when responding to caller enquiries. Studies discussing CAS have addressed the issue of whether software restricts or facilitates the acquisition of knowledge by nurses within a call centre setting: the answer seems so far to be discouraging with de-skilling effects as a result (Mueller et al. 2004; Smith et al. 2004). The conclusions for NHS Direct point, furthermore, towards a tension between occupational autonomy and organisational control within a new service that has not yet finalised its design for the job of a telenurse. Yet technology is only one factor that characterises health call centres. According to Collin-Jacques and Smith's (2005) argument; neither the occupation nor the technology is a constant mediator, instead, it is the extent to which nurses are able to shape their call centre work that differs cross-nationally. Based on comparisons between Canada and England, they stress the simultaneous interplay of different social constructions of nursing and the national–historical development of health call centres (ibid.).

4.5 HUMAN SERVICE ORGANISATION AND (SEMI) PROFESSIONALS

It is argued that issues of organisation of work have particular salient features in healthcare organisations and other kinds of Human Service Organisations (HSO), because of their strong institutional character (Lipsky 1980; Hasenfeld 1983; Johansson 2002; Leppänen 2002). This is further defined in the section to follow. The influence of institutional factors on conversations and relations in particular between the employees in HSO, called street-level bureaucrats or (semi) professionals, and their clients, have been shown in recent studies for example by Mäkitalo and Säljö (2002); Leppänen (2002; 2005) and Taylor and Kelly (2006). Accordingly, the employees who meet the users of the service have a high degree of influence on how clients are to be considered within the organisation (e.g. Dunér and Nordström 2006). This has also ample significance for the work in such organisations.

4.5.1 The characteristics of Human Service Organisations

Two classic books about welfare organisations are *Street-Level Bureaucrats* by Michael Lipsky (1980) and *Human Service Organisations* (HSOs) by Yeheskel Hasenfeld (1983). Human Service Organisations are, according to Hasenfeld, 'organisations whose primary function is to define or alter a client's behaviour, attributes, and social status in order to maintain or enhance his well-being' (p. 1). These organisations differ from other bureaucracies in two ways

> (a) their input of raw material are human beings with specific attributes, and their production output are persons processed or changed in a predetermined manner and (b) their general mandate is that of 'service' that is to maintain and improve the general well-being and functioning of people. (Hasenfeld 1983: 1)

Somewhat pessimistically, Hasenfeld (1983) argues that on the one hand HSOs are based on the image that welfare organisations will solve many of our social and individual problems, while on the other hand there is a lack of efficient service technologies and methods to deal with the complex problems in focus for the organisation. Therefore the Human Service Organisations are somehow condemned to fail already from the start. The expectations of society are very, very high (unlimited needs and wishes) at the same time as the resources and competences are limited. Moreover, HSOs as well as other public welfare organisations have vague and ambiguous objectives. By the same token, the service technology is indeterminate, and therefore the HSOs lack reliable and valid measures of effectiveness. Finally, the staff-client relations are the core activity of the HSOs and they rely highly on professional discretion and knowledge.

4.5.2 The political and administrative side of healthcare organisations

The Swedish providers of healthcare are politically controlled as healthcare is a part of public sector practice and regulation in Sweden. The relation between the State and its citizens is a classical topic within political science. Following the original path of Weber, who discussed the authority of the state and its legal grounds, two sides of the welfare state can be distinguished. On the one hand

there are the politicians – the input side embracing the right to form public opinion, to vote and to run for public elections – and on the other there are the administrators – the output side covering the administrative relations with the public. Thus, the politicians and the administrators constitute two sides of the welfare state, where the first has the right and obligation to take political decisions, whereas the second is in the position of executing the decisions taken. The output side's importance in upholding the legitimacy of the State must not be neglected. It has the direct contact with the citizens, and reflects the citizens' dependency on the State (Rothstein 1991: 42-43).

4.5.3 A battlefield of interests

The major activities in a HSO are based on the relations between the staff and the clients/patients/users. Through these relations, the HSO defines the needs of the client, the work (treatment) required and how the client may obtain desirable results.

> The professional has two basic tasks: (1) to categorize the client's needs in terms of contingency, which indicates which standard program to use, a task known as diagnosis; and (2) to apply, or execute, that program. (Mintzberg 1983: 192)

As these relations are highly individually determined (in the guise of professionalism), it is difficult for the organisation to secure internal quality through bureaucratic control (Hasenfeld 1983: 10). In a democracy, decisions are generally legitimatised through the process of its establishment. However, in a public welfare organisation, the decisions are many and cover single cases and specific circumstances. The decision-making is constantly on-going and usually requires particular knowledge related to the case in question. In other words, the successful treatment of a healthcare case is claimed to be dependent on the professional's knowledge and creativity, which also demands his/her discretion to act (Lipsky 1980; Freidson 2001). The discretion to act also implies that it is difficult to guarantee the precise delivery of healthcare objectives and clinical practices from a bureaucratic/managerial point of view. Control remains in the hands of the professionals and their control mechanism of peer reviews.

Moreover, treatments require judgements carried out by subjects, no matter whether they are professionals or not. Treatments are furthermore applied to various individuals, whose needs and conditions are widely diverse. The relation between the professional and the client is asymmetric, as the professional is in possession of the knowledge, the organisational resources and has the power to decide whether a care-seeker should get access or not. The client on the other hand is dependent. She or he needs to trust the organisation, whereas he or she can only superficially influence the policies or the functioning of the HSO (Hasenfeld 1983).

The dilemma of professional discretion and bureaucratic/political control has been called the black box of democracy (Rothstein 1991) or the blind spot of professional bureaucracy (Lipsky 1980). Kouzes and Mico (1979) argue that the field of the healthcare organisations, consists of three different domains: the policy domain, the management domain and the service domain (see table 4:1 below). The domains operate by different and contrasting principles, structural arrangements and work mode. Accordingly, the interaction between these three areas creates conditions of disjunction

and discordance. Not only is healthcare characterised by competing norms- and value systems, but power is also unequally distributed between the actors – mainly the professionals, the administrators and the politicians. Theoretical analyses and empirical descriptions of Human Service Organisations have been made by several scholars (cf. Hasenfeld 1983; Kouzes and Mico 1979; Östergren and Sahlin-Andersson 1998; Hallin 2000; Henriksen and Rosenqvist 2003). The domains are occupied by people of similar backgrounds, education and experience, whose professional identity has been created through long socialisation. Socialisation is considered the foundation of society and a process for production and reproduction of societal life. Socialisation takes place primarily at home and within the family, secondarily through schools, formal education and contact with significant institutions, and finally through the workplace and work life experience (Castells 2000). Accordingly, and sharpened by similar socialisation processes, a group of actors might be a constellation of people with similar formal responsibilities/ assignments representing similar interests (e.g. an occupational group). A result of a socialisation process is for example bonds of loyalty within and between different professions on various levels, expressed in relationships and by communication patterns within the healthcare organisation (cf. Hallin 2000).

Table 4.1 The three domains of Human Service Organisations

	POLITICAL DOMAIN	**ADMINISTRATIVE DOMAIN**	**PROFESSIONAL DOMAINS**
Guiding principle	Consent of the governed Democratic representation system	Hierarchy Control and coordination	Network peer-review Autonomy Self-regulation
Aims	Equity	Cost-efficiency/ effectiveness	Quality of service Good standard of practice
Structure	Representative Participative	Bureaucratic	Collegial
Working mode	Voting Bargaining Negotiating	Use of linear techniques and tools (eg. HRM, Balanced Scorecard, Core values)	Client-specific Problem-solving

Source: inspired by Kouzes and Mico 1979: 458.

4.6 THE PROFESSIONALS

4.6.1 Different perspectives on professionals

Professio in Latin is 'a publicly notified occupation' also from the word *profiteor* meaning 'to openly confirm' (National Encyclopedia *homepage* 2007), related to who knows best and who requires consent and trust. The studies of professionals originate from the time after the Second World War in USA, when Talcott Parsons, inspired by Weber's texts, led the way in the research of self-employed people such as physicians and lawyers in the area of organisational sociology. The trend over time has shifted from considering the profession as a value system, to that of being an ideology, and finally ending in today's consideration as a value *and* an ideology (Evett 2003; see also Macdonald 2006).

According to early studies of professionals, for instance those by Talcott Parsons, the trait of professionalism such as special training, code of ethics and peer supervision arouse out of social necessity. Consequently, medical autonomy required a relation of trust. It was argued that patients trust the physicians if they feel that the physicians are loyal and qualified but free from outside pressure (Immergut 1999: 13). Later views have criticized the notion of social necessity. The critical aspect of professionals and their autonomy is that only fellow members of the profession are capable of judging the quality of the technical evidence (Freidson 2001).

A profession could be described an occupation based on scientific knowledge that has certain control over its own practice. The professions are institutions, reproduced over time and space (countries), which delineate for example its role, its function, power and status (cf. Abbott 1988). Freidson's book The third logic from 2001 considers professionalism as an alternative logic compared to two others – the market and the bureaucracy. According to Freidson, there are different aspects of professionalism: its full time occupation, its jurisdiction, its educational system, its professional self-governing association, code of ethics and its relation to the state. The issue is framed as how to define a profession, who belongs to one, to what degree professions are constant over time and to what degree they can simply be seen as societies dedicated to 'closure' (Freidson 2001). The boundaries of different types of work are connected to a process of legitimating and its consequences, where the professionals have achieved a unique status from their exclusive routes for training and licensing (Freidson 2001). An offshoot of this view focuses squarely on technical expertise and licensing. Studying the evolution of the medical profession, Magali Sarfatti Larson, for example, regards the medical organisation as a kind of modern guild. Instead, autonomy is defined by the market monopoly and the professionals' subsequent position, which results in high social status and economic advantage (Immergut 1999: 13-14). The concept of closure, originally from Weber, might then be related to as the monopolising group defining other groups as subordinated and unqualified (see also Abbott 1988; Fredson 2001).

Another way to consider professionalism is as advanced and complex work that is carried out with high quality, in order words professionally (Evett 2003). This reasoning is in line with du Gay and Salaman's Foucauldian analysis of the self-disciplined worker who has internalised his or her responsibility vis-à-vis qualitative customer relations (1992), and with Fournier's (1999) conception of professionalism as a collective identity mediating and disciplining the action of occupational groups. More post-structuralist researchers critical towards theories that focus on control (e.g. labour process theory), discuss accordingly the internalised norms in the name of subjectivity that have made management control superficial as control already exists within the worker him-/herself (Knights and McCabe 1998):

> Subjectivity, then, is not something that is done to individuals; they participate in the constitution of their own subjectivity as they reflect on, and reproduce the social world. (Knights and McCabe 1998: 424)

Professional autonomy reflects an occupational group's strategies to gain control over their own labour process and their power to remain qualified to possess this control (Dent 1998: 207). Physicians, lawyers and priests are presented as the classical types of professions with a pervasive discretion to make decisions of

their own education, socialisation and experience ensuring that they are adequately trained and monitored. Moreover, these groups are self-regulated as they have a relatively high degree of freedom from external scrutiny. The (professional) control of a group of employees might be widened or limited by actions from the state or other occupational groups. It is argued that large social, cultural and political actions have been carried through in order for the medical profession to achieve cultural authority. The authority encompasses the status, the specific use of language and gives the right to define medical issues (Immergut 1999: 14). However, related to professionalisation and the professionals within healthcare, there are continuous negotiations between the groups of actors involved about the right to definition and control (Freidson 2001). The process of professionalisation is structured by interprofessional competition and conflict (Abbott 1988).

4.6.2 Swedish nursing from a calling to a profession

The development of nursing has long been dominated by the conception of nursing as a calling. Professional factors and professionalising strategies have also been important and the case of HCCs and telephone nurses could not be explored without discussing the development over time from nursing as a calling to nursing as a profession.

Describing nursing from its historical development, Bevis (1982) mentions four different philosophical directions which equally reflect society and its prevailing values during different epochs: the ascetic, the romantic, the pragmatic and the humanistic-existentialistic eras (Bevis 1982). From 1850 to 1920 in the *ascetic era*, healthcare was more about carrying out an act of charity (Bevis 1982). Tuberculosis and other infectious diseases were life-threatening, and even if the physicians could give the patient a diagnosis, there was no treatment. The function of a nurse during this period could be characterised as a calling in the Christian sense. Society was structured according to God's will and the human being was an indispensable cog in the big saint wheel. Nursing was based on a hierarchical and patriarchal order related to the church. A good nurse provided care and love to her neighbour (Bevis 1982). Education was provided by hospital management in the counties and the municipalities. The purpose of this education was to satisfy the needs of the sick, which did not require any theoretical knowledge, but hard military and practical training in order to learn discipline, patience and sacrifice (Dahlborg-Lyckhage 2003: 29).

During the *romantic era* (until the end of the Second World War), the image of the nurse was romantic and more objectified as a caring soldier (Bevis 1982). Nursing became based on the medical model and new theoretical knowledge (e.g. psychology) was integrated into the education. The growing conception of the nurse was the little physician. This means that the calling of nursing was no longer connected to the church, but to the work. As an authority the priest was replaced by the physician (Bevis 1982). One example is the fact that the Swedish restriction of the Working Time Act, adopted in 1920, did not cover nurses and auxiliary nurses before 1971 (Elvander 2006). The leader of the nursing association in the 1920s, insisted strongly on the helping and self-sacrificing side of nursing. However, the religious sister of charity was transformed into a bourgeois occupation 'open for all scrupulous cleanliness people and an honest and sacrificial occupation for devoted women'

(Dahlborg-Lyckhage 2003: 29). The process also implied the nurses' adaptation to the physicians (Dalhborg-Lyckhage 2003). But the nurses paid great attention to distinguishing themselves from the auxiliary nurses and other kinds of nurses. Thus, healthcare was strictly segregated by gender between physicians and nurses, and hierarchically divided into groups of registered nurses and subordinated nurses (Emanuelsson 1990).

In *the pragmatic era,* also called *the medical-technical era* (1950-1970), nursing focused on logical thinking and intellectual capacity. A lack of nurses led to the introduction of other occupational groups, and instead, the nurse became a supervisor and a teacher. Care was to be provided by other groups. A good nurse was apt to learn and had a capacity of breadth of view and organisation. She was a trustful woman of good judgement with an extensive sense of responsibility. The needs of the physicians were in focus for the nurses' work, not the needs of the patient (Dahlborg-Lyckhage 2003: 32). The occupation of nursing was officially a female occupation until 1965, and religious values remained implicitly until the 1960s in education as well as in practice (ibid.).

4.6.3 The modern nursing formation

At the beginning of the 1950s, the nursing education was extended to three years. In order to assist the physicians, the nurses' formation and training took on an advanced technical content. Until the end of the 1970s, nursing was, however, dominated by medical science and it was taught as a practical apprenticeship by observing and imitating (Benner 1984; Dent 2003: 70). Its implications were made visual through the fact that nursing remained for a long time an oral culture. This means that oral communication dominated the nursing culture in Europe, a culture that can be traced back to the craft traditions of Nightingale nursing: a 'mystery' learnt by watching and assisting (Lindgren 1992; Östergren and Sahlin-Andersson 1998).

From the 1960s in the USA and the 1970s in Sweden nursing entered an era with a *humanistic-existentialistic approach.* Consequently, the patient and a holistic view were again to be prioritised by the nurses. The theory of nursing aimed to make the nurse more autonomous and responsible for the care of patients in line with the physician's confirmation (Bevis 1982). In 1977 the reform of university colleges arrived (SOU 1973: 3) and as a result of a continuous professionalisation project among European nurses, nurse training was from 1981 carried out on university education programmes and claimed to rest on a scientific base (Dahlborg-Lyckhage 2003). The Swedish nursing programme constitutes three years' full-time study divided between theoretical studies and clinical training, in order to become a RN (Registered Nurse).[63]

63 Comparably, to become a registered physician in Sweden, the person must successfully complete seven years of education and training in total, i.e. a five and a half year training course and an 18-month pre-registration-period as a house officer (National Agency for Higher Education 2005).

The registration is certified by the Swedish authority the National Board of Health and Wealth (*Socialstyrelsen*) and given on a life-time basis.[64] The main object is nursing. However, the discipline does still lack a united definition. This means there is no standardised syllabus or curriculum, except the need to comply with EU regulations. The nursing programmes are locally designed and the content varies between the individual universities and university colleges, in Sweden as well as globally (Dahlborg-Lyckhage 2003). Today, most Swedish nurses have, undertaken an additional education of one year for becoming specialist in some field (the Swedish Institute 2004).[65] This tendency has accentuated over the last decade

4.6.4 Contradictory images of nursing and professional ambitions

The Swedish education is based on North American 'nursing theory', which is characterised by a holistic approach to patient care and capacity of feeling, empathy as well as to be able to document, develop and evaluate one's work (Benner 1984). Benner's view emphases the difference between theory and practice, and the nurse's need to build on past experience. She conceptualises nursing in seven domains in which expert clinical competence is required. The domains include such things as: (1) the helping role; (2) the teaching-coaching function; (3) the diagnostic and surveillance function; (4) the function of effective management of rapidly changing situations; (5) the role to implement and monitor treatments; (6) to monitor and guarantee the quality of practical nursing (evaluation); and (7) to plan and organise staff and nursing. The domains, like the roles, can be divided into tasks and sub-tasks.

However, Dahlborg-Lyckhage (2003) found that certain of Benner's domains are less articulated by nurses in Swedish practice such as prevention, the responsibility of caring and the participation in research and development. Thus, the message of the caring practice is partly contradictory to Swedish laws and status in education. In practice the concept of 'working skills' is used instead of the concept of 'competence', which gives nursing a focus on manual and contextual knowledge in the actual clinical setting. Furthermore, this contributes to the image of nursing assistants rather than the independent professional (2003: 161). The nursing education has, however, been criticised for being too theoretical, e.g. by the Minister of Education, who argued that it

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64 This is the case in most European countries except in the UK. Since 2002, the British independent charity the General Medical Council (consisting of elected physicians, public appointed members and representatives of the educational bodies) has gained strengthened powers to supervise medical practice and standards and to revalue the physicians' registration every five years.

65 In 1997 higher demands of qualifications were required for entering nursing school, which meant the applicants had to follow courses in English and Swedish, supplementary to Secondary School. Supplementary courses for nurses available according to the 1982 Study Regulation, were: Anaesthetic Nursing Intensive Care Nursing, Paediatric Care Nursing and Orthoptics (40 points equivalent to one year of university study), Obstetrics and Gynaecology (Midwifery 50 points) and Oncological Healthcare (20 points). The new study regulation from 1 July 1993 deregulated specialist nursing courses and consequently the universities were allowed to start specialist courses in new areas. In 2002 a number of specialist nursing exams were introduced in the degree system (SAHP 2005). The most attractive specialisation by numbers was Primary healthcare nursing, but since 2002 this has had competition from other specialisms. Primarily, there is a proportionally increasing share of nurses specialised in Emergency care/Anaesthetic Nursing and Intensive Care Nursing and Paediatrics (SAHP 2005).

was not rational in a social sense to make an academisation of an occupation based on working skills (*Dagens Medicin* 2007 no 7: 7).

The formal requirement of nursing in Swedish law and education policies consider their preventive work, their responsibility of caring and participation in research and development. But in practice certain factors tend to conserve the conceptions of the nurse as an assistant with knowledge based on medical science. Furthermore, there is a discrepancy in views of nursing, as a great deal of the nurse's work in clinical settings requires technical-practical competence (Dahlborg-Lyckhage 2003: 161). Contrary to these already divergent images of nursing (from society via laws and statutes and the historical image on the one hand; and the image of caring practice on the other), stand further images of nurses from soap operas in TV and the students' conceptions of nursing (Dahlborg-Lyckhage 2003).

4.7 CONCLUSIONS ABOUT HUMAN SERVICE ORGANISATIONS AND PROFESSIONALS

In sum, a healthcare organisation is a result of the amalgamation of bureaucracy and professionalism, also described as a professional bureaucracy to use the terms of Mintzberg (1983). The focus on staff competence distinguishes the professional organisation from other organisations. The professionalism is needed for deep and precise problem-solving and the practices are claimed as hard to standardise. These kinds of organisations could be described as strongly individual-oriented with great demands on autonomy, special knowledge and high professionalism. The staff, the professionals, are expected to take personal responsibility for their work. They are accountable for their actions. This implies a form of control that is based on professional knowledge, rules, regulations and licences for the professional occupations. The professional side stands, however, in contrast to the bureaucratic side and the new public market logic. Healthcare has changed from a charity organisation to a public organisation, to an organisation on the new public market in the 1980s.

Over the last twenty years, there has been a tendency in Europe as well as in Sweden to a healthcare service that is more equivalent to other kinds of commercial services (WHO 2005; Wärvik 2005: 50). The use of NPM practices (see chapter 1 and 2), that in this case is exemplified by the call centre organisation and technique, is, subsequently, claimed to reduce the professionals' capacity to exercise discretion (cf. Carter and Mueller 2002; Bolton 2002; Taylor and Kelly 2006). The growing field of HCCs and their work organisation is interesting to explore in order to know more about the particular type of health call centres from the perspective of service work in *call centres* in combination with the perspective of *healthcare/human service organisation focusing on nursing.*

CHAPTER 5
RESEARCH METHODOLOGY AND PROCESS

This chapter is about the research methodology and process of studying the blind spot of two topical, but not yet explored fields related to HCCs. The fields were revealed in the review of previous research leading to the puzzle at stake, namely the combination of nursing and call centres. The overall aim of this thesis is to elicit and analyse the merger of health and call centres that focus on nursing.

I will here explore the development of the research design and research questions, pretty much in a chronological order. First, the chapter explains the basic methodological approach used in this thesis. In the following section, I consider the data collection and processing. Furthermore, I describe how the sample was determined and outline the entire fieldwork within the case-study and its sub-studies. The final section reflects on the procedure of analysing and writing up the study.

5.1 THE PILOT PROJECT

The background to this study derives from a three year evaluation of a pilot project embracing a new organisational model, the HCC Fyrbodal. The initial study focused on what happens in healthcare when a separate service for telephone advice nursing is introduced. The project was undertaken at the request of the three healthcare councils in Norra Bohuslän, Dalsland and Trestad (see also the map in chapter 3 above) and was carried out in collaboration with stakeholders from the Primary Care Organisation in Fyrbodal, the (NU)-hospitals[66] and Göteborg University. The assignment was to follow the service's formation during the first years of practice and consequently to evaluate the pilot project.

The evaluation report intended to cover four items: the HCC as a workplace, the profession of telenurses, the significance and use of the HCC Fyrbodal for healthcare and finally, the users/citizens' use of the service (Andersson 2005). However, I had considerable freedom to follow the HCC on my own initiative, conducting interviews, attending meetings and having discussions with the actors involved as well as gathering data that I found necessary.[67] I realised that the first of the four items constituted my main interest, whereas the decision-makers were eager to know more about the consequences and preferably the efficiency of the HCC in terms of workload (for example measured by the citizens' visits to the A&E departments) as well as the citizens' conceptions and satisfaction.

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66 The first letter of the two hospitals NÄL (Trollhättan) and Uddevalla give the abbreviation NU.

67 Sweden has an overall principle of public access to official records instituted in the Act 1976:954, which is also a part of a fundamental law of the Swedish constitution (Tryckfrihetsförordningen). The Act gives everybody, Swedish as well as foreign citizens, the right to access to general, public documents issued by Swedish public authorities and organisations. It may be the case that this Swedish institution has made access to public material somewhat easier, compared to what would have occurred had the study been undertaken in other countries without this right. One general criticism is, however, that because of this Act, public authorities and decision-makers sometimes avoid putting things in writing.

In connection to the evaluation project I published four reports (see Andersson 2002a; 2002b; 2003 and 2005). When the evaluation period was concluded, I had however, compiled a great deal of material on this HCC. My ambition then was to conduct a larger study based on these findings.

5.2 A QUALITATIVE APPROACH BASED ON CASE-STUDY METHODOLOGY

5.2.1 The exploration of a new field and a new concept

The HCC was a new way of organising healthcare and at the time I found little written about the phenomenon and very few research studies. As it was originally a Swedish study, I did not even employ the term call centre; instead, like others in Fyrbodal, I used the Swedish word *sjukvårdsupplysningen* (literally sickness care[68] *information*), where the last part of the word can also can signify enlightenment or illumination). As it is a rather new phenomenon, the discussion of its name has become important and there have been several debates on how to conceptualise the service (see chapter 2 and 3).

In 2003, at the national level the official term was set as *sjukvårdsrådgivning* (literally sickness care *advising* in the sense of guidance, counselling or orientation). At the international level, many different concepts flourished, such as telephone advice, advisory service, telenursing, telephone triage and so forth (see also the discussion in chapter 1 above). Different terms give a preconception about how the service is seen and constructed in different contexts. It was only after some years that I began to analyse the service based on its call centre organisation, practice and technology, when I started to take part in the call centre debate.

The introduction of an HCC – a new organisational form, new tasks and new technical practices – gave a preconception of developments in the Swedish healthcare sector in particular and the transformation of working life in general. The insight I got from the evaluation of the pilot project and the review of previous research led to the development of the specific research questions for this thesis. During the study I became increasingly aware of the contemporary and growing importance of call centres in general and the 'telephone advice nursing' call centres in particular. The merger of two contradictory phenomena, nursing and call centres, was new and puzzling. I discovered that the work and work organisation revealed conflicting conceptions and structural tensions. Consequently, the aim and research questions were elaborated little by little until they were finally specified in the way they are presented in the introduction, section 1.2 above.

The three year evaluation of the pilot project as well as the aim to describe and analyse the research object made my choice to initiate a case-study rather self-evident (Danermark et al. 2003). In order to explore and further understand the phenomenon, I considered an overall qualitative approach based on multiple methods to be the most advantageous.

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68 Healthcare in Swedish is called (conceptualised) sickness care although the term health and sickness care (*hälso-och sjukvård*) is also frequently used.

5.2.2 Implicit and explicit comparisons

Conducting studies is about making comparisons, implicitly or explicitly of very different degrees (e.g. Mörner 1980). Qualitative analyses focus on characters and features of a phenonenon /research objective, while quantitative analyses tell us about the degree of co-variance between certain characters (e.g. Danermark et al. 1997: 224-233). Yet comparisons are essential during the research process. In this case it was a question of comparisons over time and between different groups of actors. Particular experiences, behaviours or events might be interpreted in terms of implications related to the context. Furthermore, comparisons between words and deeds are possible. I have observed such kinds of deviations, when analysing my material, although my explicit purpose was not to elicit difference structurally, for example loose couplings between written and oral statements and actions in Weick's (1979) terminology. Comparisons to theories and written sources are of course other self-evident methodological choices.

I could also have compared different HCCs from different geographical areas. However reflecting on that option, I ended up by considering the value of the case-study material and decided to concentrate on one main case instead of blurring my focus. I saw a risk of only getting several, but superficial views of different HCCs, some without the connection to the healthcare area that I had in Fyrbodal. Because of the self-governance of Swedish counties, there are sometimes large deviations between areas within Sweden (Calltorp 1999) and as a consequence, deviations exist between HCCs, which are structured in line with local decisions and healthcare organisation (Marklund and Bengtsson 1999; FCC 2003a). Apparently, my conviction was that the concentration on one centre gave deeper knowledge and made it possible to study the function embedded in its context (Yin 2004). Furthermore, during the case-study I have encountered and discussed with other relevant groups of actors who have all contributed to broadening my perspective and opening up possibilities for comparisons of certain aspects.[69]

5.2.3 Multiple methods and triangulation

The qualitative methods that I have applied covered mainly interviews of various degrees of structure collected during six periods. For three of the studies I, III and IV (see the sections below) I carried out more than 80 semi-structured interviews with telenurses, professionals, politicians, administrators and trade union representatives. Study II and VI were based on structured telephone interviews with 400 care-seekers, using primarily questions with predefined alternatives, to which I added some open-ended questions.[70] Besides the interviews, I drew upon written documents and different kinds of secondary sources. I also carried out observations at the workplace of the work processes, at meetings and training sessions. A combination of different data, such as these, is

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69 These are mainly the decision-makers and telenurses related to the HCCs in the Västra Götaland Region, persons from HCCs within the Swedish net of HCCs (*VPT*), telenurses from other HCCs connected to lecturing and the presentation of results (at Karolinska Institutionen) and from the private HCC (MedHelp).

70 The questionnaires are available in Swedish from the author.

claimed to offer a more thorough understanding of a phenomenon. (Danermark et al. 1997: 222-224).[71]

It was, furthermore, my aim that data triangulation should enrich such understanding, and offer a broader and more stable empirical foundation than the use of a single data form (Djurfeldt et al. 2003: 19). By using a design based on multiple methods, the empirical material can combine the advantages of qualitative methods, in order to capture specificity and uniqueness – with those of quantitative methods that elucidate diversity and effects (Scandura and William 2000). The critique of this, however, is triangulation cannot guarantee that the multiple methods are complementary (ibid).

5.2.4 The longitudinal dimension

The longitudinal dimension of five years gave me the opportunity to closely and intensively investigate this HCC and the actors. It made it possible for me to scrutinise different aspects during a longer period in order to develop a grounded feeling for how stable the results are over time. Thus another advantage with the case-study method besides the possibilities of multiple research methods was the depth that I might obtain from both narrow and persistent observations (see for instance Yin 2004; Norén 1990). One problem, however, was maintaining an adequate balance between the whole and its subunits. Like other studies, the HCC case included both elements of particularisation (states and dynamics that are particular for this research) and elements of empirical generalisations (in line with existing theories). The long-term observation made it a bit easier to distinguish such variations (cf. Yin 2004: 113-124).

Good access to an organisation and the openness of its actors should not be underestimated (cf. Tillmar 2002; Reis 2004: 48-51), as it may very helpful, and sometimes even essential for getting a discerning answer to the actual questions one poses. I had the support of a dedicated reference group who consisted of representatives from the politicians, the administrators and the professionals within primary health care and the county organisation of hospitals. It was they who introduced me to the field in January 2002 and our official meetings ended with the closing of the evaluation in May 2005. The reference group consistent of four persons, besides myself, and supported the different studies giving me formal access to the research field.

5.3 DATA COLLECTION AND PROCESSING

After exploring how I justified my choice of methods I will, in the following sections, step by step illustrate how I have conducted the different case-studies, their different parts and the strategic choices I have made during the work.

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71 Triangulation is an old method, used for instance by navigators to find their position and course at sea based on a cut-off point from the angle between the horizon and the sun. Similar surveying practices have been applied by combining measures of churches and other high standing objects in order to determine the height of a mountain.

5.3.1 The telenurses and the introduction of HCC Fyrbodal

Initially, for Study I, I carried out interviews with all the staff recruited to the HCC before the service had started. The majority of the interviews took place after the telenurses had had their introduction period (duration about two months). At the time, the telephone lines were about to be introduced to the public, only some weeks after our interviews in March 2002. Some nurses were employed after the introduction, and therefore I interviewed them in connection with their entering into their new employment (May-August 2002). I interviewed the entire workgroup consisting of 20 telenurses, covering all telenurses on permanent or long-term contracts, including several discussions with the HCC manager. The interviews lasted about 30-45 minutes, like most of the interviews carried out within these case-studies.[72] In this initial phase I also conducted non-participatory observations including meetings and two sessions aimed at formulating an ethical and value basis for the HCC.

5.3.2 The care-seekers – the users of the service

In 2003, for Study II, I focused on the users of the HCC in question. This study, with the same structure and content, was then repeated three years later in 2006 (Study VI). For the data collection in both user studies, I was helped by undergraduate students, first from Mina Imsirovic and then from Susanne Stegeland, who also wrote undergraduate theses based on the material (Imsirovic 2003 and Stegeland 2007).

As to the users, the data was primarily based on telephone interviews with defined alternatives for each question. The questionnaire was constructed with inspiration from the few existing quantitative studies in the field (Wahlberg and Wredling 1999; Norling 2001) and later from the national study of HCCs conducted by Ipsos-Eureka (2004). In total, 400 users answered 34 structured questions about the HCC Fyrbodal. The questions covered knowledge about the HCC, its access, the encounter given, the service provided, the users' total assessment of the HCC and of the primary care centre. Besides the structured questions, the respondents were given the possibility to comment freely and give their points of view in open-ended questions at the end of the telephone interviews. In all, I collected 997 comments about the centre in the first round, and then 112 comments in the second round in 2006. The point of departure for calculating a suitable sample was the total number of calls to the HCC in 2002. Based on the estimated number of 61,000 calls, a representative sample of 300 interviews was considered to be equivalent to a satisfactory statistical significance at 95 per cent (Holmberg and Petersson 1980).[73] For the second occasion the sample was set at 100 users.

The collection of data proceeded in two steps. The first took place at one of the workplaces from 7 am. to 11 pm. The time of the investigation was carefully selected in order guarantee that the interviews were built on calls from different times of the day, weekdays and months. The selected weeks did not embrace any national holidays, only traditional weekends. A spread over different months of the year was undertaken

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72 Some interviews lasted up to one hour, sometimes even more, especially with politicians and health administrators.

73 The population in Fyrbodal was 270,000 inhabitants in 2002 and 258,000 inhabitants in 2006.

in order to capture both times of high and low demand for the HCC. The study was also arranged in order to facilitate for telenurses, as they were to inform about the study at the same time as they carried out their ordinary work. In the best of worlds I would have preferred to undertake the study without the telenurses' involvement, but for ethical reasons and as many calls were on strictly personal and delicate issues, it was necessary that the telenurses asked the callers' permission before I included them in the sample.[74] It was obvious that it was ethically justified to exclude some callers from the study. The exclusion criteria were set to cover people under 18 years old, people who were neither ethically nor morally justified for the study, e.g. if the nurses expected the caller to be too sick or confused to participate, people who were translating errands for someone else and colleagues of the telenurses. Accordingly, the telenurses informed every caller about the study, its purpose and the necessity to alert on whether they desired to be excluded from the overall research population. All reasons for declining to participate were documented and analysed.[75] The most common reasons to decline are summarised in table 5.1.

Table 5.1 The non-response analysis 2006

	Reasons for not answering	Women	Men	No data	Total
1	The caller did not want to participate	16	13	3	32
2	Not ethically justified because of the nature of the case	15	7	8	30
3	Not ethically justified because of the nature of the case (e.g. an emergency)	15	11	0	26
4	The telenurse forgot to ask	13	9	3	25
5	Calls for others without their knowledge	6	15	3	24
6	Calls on behalf of another person	11	4	3	18
7	Difficulty to communicate	6	8	3	17
8	Not ethically justified because the caller was confused	2	3	1	6
9	The caller had no time	3	2	3	8
10	Technical problems	3	0	0	3
		90	**72**	**27**	**189**
	Per cent of total	(48 %)	(38 %)	(14 %)	

n = 189

74 By classifying the study as a performance evaluation related to the on-going activity, I avoided the rather complicated and time-consuming procedure related to the appliance of an ethical admission for carrying out studies on human beings. According to the Act for Ethical Assessment, all persons involved in clinical studies should be informed beforehand in order to make an individual choice to participate or not. Because of the nature and issues involved in healthcare, the Act is more rigidly applied than in most other sectors of society (see for example the homepage of *Vetenskapsrådet*).

75 For 2006 illustrated here, 698 care-seekers called HCC Fyrbodal during the two relevant weeks. Considering the exclusion criteria 509 calls remained. Correspondingly, for 2003 during the three weeks of the first study 1433 calls occurred in total, of which 371 calls were excluded because of the predefined criteria and 138 calls were excluded because the care-seekers refused to participate.

In the next step, we conducted a controlled, randomised sample, with the result that every third name on the list of the remaining 924 callers was selected and contacted by phone one week after their calls to HCC Fyrbodal. In 2006, every fifth person was selected in order to obtain a sample of 100 calls. Additionally, some people were, however, not possible to reach because they had called several times to the HCC, they did not want to participate after all, the caller was not available or the telephone number was not correct. The non-response analysis, however, showed no sign of biases that would have affected the general pattern presented in this study. Furthermore, in comparison to postal surveys, on average there was a very good response rate (Patel and Davidsson 2003).

5.3.3 The telenurses after two years of work

Study III started when the HCC had been operating for two years, in 2004, and I chose to follow up the first interviews. It then became obvious to me that major changes within the personnel group had taken place – certain persons had left or chosen not to continue their employment after a trial-period, and new persons had been recruited to the HCC. I thus decided to interview the two groups, both those who remained in the organisation and those who had left. I was aware that people who intend to leave an organisation or who already have left are more willing to talk more freely, as their loyalty to the organisation is much weaker. Findings from interviews connected to the employees' own resignations supported this view. This I considered as an advantage. Most studies of call centres have excluded employees who have left their positions. One example is that by Knowles et al. (2002), who stated that they had no opportunities to include the nurses who had left NHS Direct.

However, my encounters with former HCC personnel were shorter than the interviews with employees still working at the HCC. In total, the interviews covered 23 persons. I missed two interviews with employees who were on sick leave due to the fact that I did not find any ethical arguments to insist on their participation in this study. As time went by I realised that I had not addressed a group of nurses employed on temporary contracts and some were even employed on an hour-by-hour basis in order to cover for at short notice. Consequently, and regrettably, I have no insight about the conceptions of this peripheral group: it might differ from other perspectives (cf. Håkansson and Isidorsson 2003).

5.3.4 The actors involved: professionals, politicians and administrators

Study IV focused on actors in other care organisations who are supposed to have close contacts with the HCC. They were selected on a basis of their occupational, organisational and geographical positions, for instance politicians on important seats, administrators, professionals (including managers) within primary care, heads of wards and healthcare centres as well as professionals assigned to have a certain contact with the HCC. Accordingly, I asked key-persons involved and affected by the introduction of HCC Fyrbodal to meet for an interview.

Those interviewed were from strategic positions in the political, administrative and professional domains. The number of interviews here was 21 in total.[76]

Furthermore, during the period of the study I gained access on repeated occasions to the politician's and the health administrators' conceptions in connection with meetings of the political healthcare councils, the management groups and the reference group. The group who was most difficult to interview was the professionals. It was difficult to get an appointment with the nurses and head nurses in primary care centres and A&E departments because they were dispersed over the whole healthcare area and their time was limited. But the most difficult to interview were the physicians: first they were hard to reach by phone, e-mail and letters and then it was problematic to argue for their participation in the study and ask for dedicated time for an interview. All the interviews (phase I, III and IV) were carried out either in the respondent's workplace or at a quiet place, for example a conference room or a seclusion room for the staff.

5.3.5 The telenurses' work practices and training in a four year perspective

The third study of the telenurses, Study V, took place at the workplace of HCC Fyrbodal during May 2006, two years after the second interview round and four years after the first interviews were held. The study consisted of non-participative observations partly based on my sitting next to telenurses, listening, observing and documenting the calls during one week. Additionally, I also took part in HCC Fyrbodal's workplace meetings as well as training sessions including both HCC Fyrbodal and the neighbouring HCC.[77] For training occasions, half of the HCC workgroup attended at the time while the other half were on duty.

5.3.6 Written documents and different kinds of secondary sources

To gain a more thorough understanding of the HCC in terms of its work organisation and its consequences within the healthcare area, I also studied statistics and different official material issued by officials at regional and national levels. I followed, for instance, the measuring of access to healthcare by telephone and other data from the *Providers Yearly Report* (*beställarbokslut*) as well as the results issued from national statistics (e.g. *Vårdbarometern*). Collecting valid statistics relating to HCC Fyrbodal on the numbers of calls received, the overall number of callers and patients' visits to different healthcare organisations obviously entailed many difficulties, because of technical problems and issues related to definition and measurement. The HCC manager described, for instance, in the annual reports of the HCC covering all years in the period 2002-2006, that it was not possible to measure the care-seekers' waiting-times on the phone before getting access to a telenurse.[78]

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76 17 politicians are found in each of the three health councils. Among the interviewed health administrators, 13 persons were situated in Fyrbodal, two persons at a regional level and three persons at a national level. The professionals consisted of three nurses at A&E departments, four physicians at A&E departments and hospital clinics, as well as five nurses and two physicians at primary care centres.

77 Along the years the two HCCs tried to co-organise their training in order handle the fact that one of the two HCCs always should be open.

78 Verksamhetsberättelse för SVU Fyrbodal 2004; 2003; 2002

5.3.7 Observations, interactions during the case-studies and additional interviews

Hence, in order to complement the interviews, I conducted observations at the workplace during meetings and of the proceedings of telephone advice nursing, i.e. when the telenurses worked. The latter was a necessary exercise to understand the nature of HCC work. The former made it possible to gain an impression of the HCC staff as a group and its internal interactions. In relation to the workplace visits, meetings, presentations and observations, I had the opportunity to acquaint myself with the field. Informal small talk over a cup of coffee or when passing through was both highly agreeable and a very valuable way to get to know the respondents and the case-study better. The observations also covered the work processes (in particular Study V). The opportunity to listen to calls while sitting alongside the nurses and discussing their task performance formed important sources of my understanding. The picture of professionals' conceptions (which was the hardest to detect) was completed with discussions from general meetings and meetings in connection with national teams for TAN (*VPT*),[79] leading articles and letters to the editor in the specialist press, for example the healthcare daily *Dagens Medicin* (September to November 2003).

In contrast to the experience of Collin-Jacques, who was obliged to carry out her interviews with English and Canadian telenurses when demand or the call volume was slack,[80] I had no difficulties getting the time or people willing to answer my questions. For interviews with the telenurses, I selected, together with the HCC manager, several days off when the staff could choose a time for talking to me. Thus, the interviews were conducted during paid working time and in connection with the ordinary work shift. The only individuals who had difficulties prioritising the interviews were some professionals, physicians as well as nurses occupied as ward managers/head nurses. One politician, for instance, I interviewed sitting in his car as he was driving from one meeting to another.[81] In sum, I would say that I had good access to the daily and particular work activities and that I, through sustained contact, gained the confidence of key respondents.

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79 Several times on such occasions I obtained minutes in order to individually collect the professionals' views on the matter of HCC Fyrbodal.

80 Collin-Jacques described her data collection as follows: 'most of the time, the interviews with nurse advisors had to be conducted late at night, generally between 10.30 pm. and midnight, when the service was generally not too busy.../...in one site...it was difficult to release a nurse advisor of her duty to answer my questions. To counter that problem, some interviews were conducted as early as 7 am..../...other interviews were conducted when the nurse advisor was off duty, while they were on a break, or after they had finished their shift (Collin-Jacques 2003: 61).

81 Västra Götaland region is a vast geographical area for the politicians to commute within and their daily car trip equals several tours around the year all put together for one year.

Table 5.2 Overview of the respondents

Study	Group of actor	Year of intervention	Sample included in the study	Main focus
I III V	Telenurses	2002 2004 2006	Interviews and observations 20 telenurses 23 telenurses Mainly observations	Conceptions on HCC Employment relations Working Conditions
II VI	Care-seekers	2003 2006	Telephone interviews to 300 users/care-seekers 100 users/care-seekers	Conceptions on HCC
IV	Politicians	2004 2005	Interviews and meetings 4 politicians in 3 healthcare councils	Conceptions on HCC
IV	Administrators	2002-2006 2004 2005	Interviews and reference group meetings 18 health administrators	Conceptions on HCC Employment relations Working Conditions
IV	Professionals	2004-2005	14 professionals (6 physicians – 8 nurses)	Conceptions on HCC
	Other stakeholders	2004-2006	4 trade unionists, incl. 1 chairman of a professional association for telenurses, Telenurses in private HCC and Training sessions[82]	Conceptions on HCC
			More than 480 persons	

5.4 CRITICAL PERSPECTIVES

Certain aspects of the research process deserve particular attention (Alvesson and Sköldberg 1994). To choose an independent researcher, i.e. someone from the university and someone who was not employed in the healthcare area, was an advantage from the point of view of the reference group. The evaluation of the pilot project aimed to create a basis for the future use and organising of the HCC in the area. Worth reflecting here is first, the possible effect from just observing a phenomenon (initially confirmed by the Hawthorne-study, see Roethlisberger and Dickson 1964/1939). And second, a study based on an evaluation project like this, has an obvious taskmaster, who might have different purposes. According to my understanding, all the actors were to some extent driven by interests: their own, collective, obvious and sometimes hidden as well as subconscious motives. In other words, the organisation of a separate HCC in Fyrbodal did indeed affect many people involved in the healthcare area. It was confirmed by the interviews and the observations that actors were guided by strong interests in expression of their views and conceptions, as far as these were known to them (consciously).

In the case of the HCC staff, the fact that they had chosen rather recently the job at the call centre (or to leave the job at the call centre in some cases), it is far from possible that they more than other actors tried to find reasons ex post to motivate their

82 This included the trade union SAHP and the professional association TRIHS. Several discussions also took place with students at Karolinska Institutionen, with health administrators at national HCCs (VPT) and with management at the private HCC.

choices and to defend their reasoning and actions as being rational. However, using the approach of Weick (1976; 1979), I pay attention to the importance of sense-making at a phase of *fait accompli*. In the words of Weick, it is first after an action has taken place that we are able to explain what we have done and why.

Meetings and discussions gave very valuable comments and feedback that I carefully noted. In particular, comments and arguments that contrasted with mine were valuable. The fact that the group consisted of different actors soon made it obvious that the conceptions varied from one group of actors to another. Of course, individual actors had different connections to the HCC (how deeply they were involved and how deeply their work situation was affected), which also might affect their conceptions of how important the HCC really was. The table found in appendix 2 intends to give an idea of the case-study in total and how the data collection proceeded over the years.

5.5 ANALYSING AND WRITING UP THE DATA

In the following section, I will explain how I have analysed and organised the writing up of the raw material by taking into account three essential aspects: how I made sense of the raw material, how I selected extracts from the case-study and how I argued in terms of my writing style.

5.5.1 Transcribing the respondents' accounts

All the interviews during phases I, II and IV were tape-recorded. I then transcribed the entire material. I paid no particular attention to dialectal characteristics, but I have included grammatical, lexical and sentence mistakes made currently in the spoken language. I also considered pauses and non verbal reactions such as laughing, deep sighs, particular ways of speaking, e.g. *chopping manner of speaking*. This was only used for the analysis of the material, but not in the final writing. My ambition was to capture the essential aspects in the conversion, in line with the purpose of the study and major recommendations made by Linell (1994), letting the depth and content of a transcription be guided by the overall purpose of the study.

5.5.2 Organising and describing the material after the data processing

Interpreting starts, of course, with the researcher's first encounter in the field, but the first systematic way of understanding the fieldwork begins with writing up a text. The fundamental and common unit in all the interviews was my main interest 'how do *you* conceive the health call centre in Fyrbodal?' In this way I tried to implement the advice of Glaser (1978), who recommends that researchers start by a applying an open and general question to the empirical material in order to capture the main concerns of the actors. During the process, the issues of making sense of how to select extract from the material and the style of writing then took form. Miles and Huberman (1994) suggest that writing a text or even a less organised display is a question of recurring patterns, themes or 'gestalts' which join many divergent pieces of data. The analysis of the material was accomplished in several steps.

Initially, I read the transcripts, my notes, fieldwork reports, and the memos carefully. The interview transcripts were first read in their entirety in order to obtain a

general sense of the respondents' concepts and understanding of the HCC, i.e. kind of wholeness. Hence, the interviews were analysed to identify and categorise dimensions and inter-relationships (cf. Kvale 1997). My overall lens regarded the different conceptions on work, organisation and the consequences of the HCC especially in terms of employment relations and working conditions.

The transcripts were then re-read, I went though the material – underlined, marked, commented and noted concepts in the margin. Some data I organised in diagrams in order to get a new structure and understanding of the material (cf. Miles and Huberman 1994) and significant statements or words and descriptions were extracted and organised in common and new units of meaning. Accordingly, I organised the data in different combinations embracing codes and categories in order to make sense of the material. Each 'meaning unit' was then transformed into to steps (transformations); in each transformation the text was condensed further inspired by the Grounded Theory method (Glaser and Strauss 1967; Starrin et al. 1997).

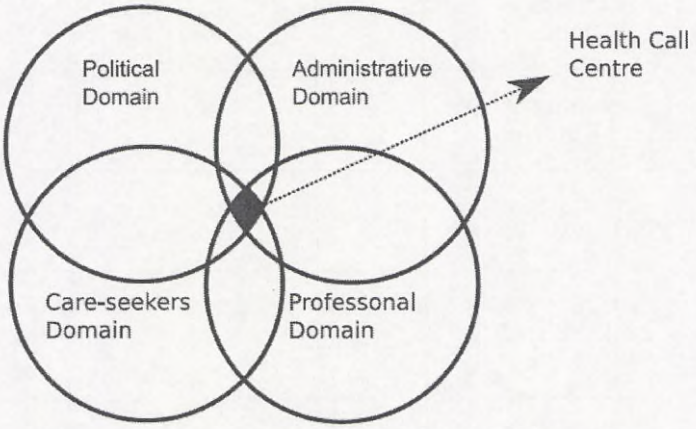
The comments from the telephone interviews were analysed in the same way as the other data, i.e. in codes and categories in order to let patterns related the conceptions of care-seekers emerge. As to the structured questions, these were transferred into a statistical format for a closer examination. The data is presented as descriptive statistics in terms of distributions in percentages for the two years respectively. The validity of data was confirmed by chi-square tests, where such a test was appropriate.

5.5.3 Patterns in the material

On becoming more familiar with my material, I started to compare it with a kaleidoscope – reflecting several aspects of today's society, healthcare and a kind of constructed, artificial 'healthcare market', the workplace and one's individual position as an employee. Inspired by theories on human service organisation, different actors within healthcare and institutional theory (Kouzes and Mico 1979; Douglas 1986; Blomgren and Sahlin-Andersson 2003), I considered healthcare as a kind of battlefield. The HCC was found at the intersection of a myriad of conceptions. The conceptions seemed influenced by the actors involved, some less and others more, and the conceptions formed various understandings of the HCC connected to the healthcare area, connected to market arguments as well as connected to healthcare and Swedish working life, in general. I found it more and more appealing to describe these conceptions, their internal clashes and existence side by side, while I wondered about the implications of such variations. One focus for studying the HCC was how the actors conceived the phenomenon, its organisation of work as well as the implications of different conceptions, interests and actions, in terms of contradictions and tensions. From such a perspective, I understand that the social relations were more complex than I had realised at the being (also emphasised by Holmström and Dall'Alba (2002). The goals and arguments of different groups were put in relation to the HCC, as shown in figure 5.1 and with help from the model in figure 5.2 below. At the intersection between the different healthcare domains and based on the interrelated connection, the HCC was conceived, constructed and reconstructed. Accordingly, the codes and categories revealed a

pattern of conceptions of the HCC (cf. Denzin 1994: 507) that I have tried to interpret.

Figure 5.1 Model of the social relations in an HCC



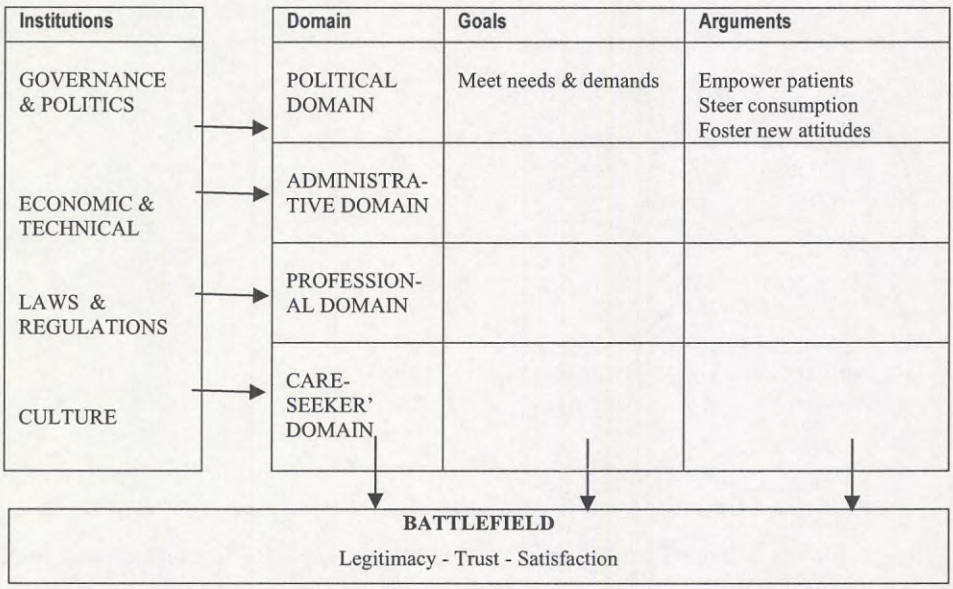
In line with the advice from Smith (2005), I also carried out the analysis by letting the group of actors 'speak to each other'. This was managed through a design where I put a specific conception of, for example, the politicians in relation to what the professionals had expressed. Afterwards, I took the same conceptions and contrasted these with conceptions from other actors, by asking myself what might have been the result of actors if they had interacted in reality.

3.5.4 A model for analysing the empirical material

In the following chapters (7 - 10) I analyse the conceptions of the actors involved. The first chapter deals with the conceptions of the politicians, followed by the administrators, the professionals (nurses and physicians), and finally the care-seekers. In chapter (11), the conceptions of these groups of actors are then compared and contrasted. The analysis is carried out with help from a theoretical model (figure 5.2) taking into consideration the institutional setting as well as the conceptions, expressions of interest and actions carried out by the actors significant for the service. 'The meaning groups' for each domain are grouped into a number of themes related to how the actors perceived the goals of the HCC and the arguments they expressed. These conceptions were then narrowed down into some main topics – core aspects connected to contradictions and tensions, providing us with the theme of their mutual battlefield.

In figure 5.2 the political domain is set out as an example to illustrate the process. One of the main goals expressed by the politicians in relation to the HCC considered the importance of meeting the citizens' needs. Their arguments supporting this major objective were to empower the patients by steering the consumption of healthcare and foster new attitudes. Implicitly, the politicians strive to obtain legitimacy for their action, trust in their way of taking care of strategical planning and customer (patient) satisfaction. All the stakeholders were important, but in focus for the politicians' words and actions were the citizens and the patients (here the care-seekers), who were also the object of action to gain legitimacy, trust and satisfaction.

*Figure 5.2*A model for analysing conceptions, tensions and contradictions



5.5.5 Employment relations and working conditions

From the initial inductive approach in the first phases of both the research process and this thesis, in the later stages I turned towards a deductive research perspective. Inspired by the model of front-line work in call centres used by Frenkel et al. (1999), I decided also to organise the analysis in accordance with different relations at the HCC, namely the hierarchical employment relations, as well as the telenurses' lateral relations to colleagues, care-seekers and to their own workgroup (see the model in chapter 12).

Besides employment relations, I found different forms of control of major interest: direct control, technical control as well as administrative/bureaucratic and normative control (Edwards 1979; Thompson 1990; van den Broek 2004). From the shareholders' conceptions and overall analyses, I identified several forms and expressions of control which stood in contrast to the telenurses' professional autonomy. These created tensions, contradictions and conflict for the telenurses and their work (see more in part III: 'Employment relations and working conditions in an HCC'). From comparative analysis with other kinds of call centres both within Sweden and outside its borders, I understood that the phenomenon of an HCC was quite unique, but also tightly connected to Swedish institutional factors.

5.6 SUMMARY

The most adequate approach to gain understanding about the HCC seemed to be from the perspective of those involved, and from their conceptions, interests and actions analysing the HCC's impact, for example in terms of work organisation. Conducting an initial evaluation of the pilot project, I later got the unique opportunity to study the HCC from its start in January 2002 until the end of

2006. The empirical part of the study consists of a long-term case-study following the service from a macro and meso level during a five year period. In total, the case-study came to embrace six sub-studies covering more than 80 interviews with politicians, administrators, professionals and trade unionists. The interviews focused especially on the telenurses and were complemented by repeated observations at the workplace level and interviews with telenurses and stakeholders at regional as well as national levels. Furthermore, two telephone interviews were made, the first time to 300 users of the service provided by the HCC and the second time to 100 users. These multiple methods enabled triangulations, and the empirical findings were analysed with help from a grounded theory approach, more hypothetical questions and comparative studies. The next chapter introduces part II with a chapter on the conceptions of institutions, including a discussion of the model for analysing the main actors' conceptions and its impact.

PART II CONCEPTIONS OF AN HCC AND ITS RELATED INSTITUTIONS

CHAPTER 6
CONCEPTIONS OF INSTITUTIONS

This chapter forms a framework for the analysis of conceptions and institutions, and how I make sense of my empirical material. Before approaching the institutions, the chapter outlines briefly some core themes for work and organisation. Of particular interest for HCCs, based on a combination of call centre and healthcare/human service, is the endeavour for efficiency, the division of labour and mass-production, as well as its foundation on bureaucracy and professional practioners. While some researchers argue that Taylorism, Fordism and bureaucracy are still significant principles of modern organisation, others argue that flexible specialisation, and in healthcare, New Public Management practice based on market imperatives, as more important concepts in today's society. Such debates touch upon different opinions on whether institutions diverge and are path-dependent for a country and a country's public sector, or whether institutions have become global forces converging on a world wide level.

The empirical material implies an intensive attention to the group of actors, their descriptions, statements, comments and writings in terms of conceptions, expressed interests and actions and social relations. The different actors connected to the HCC are driven by different interests, at the same time as their conceptions reflect characteristics of the overall society and the sector in question, in other words its attendant political, economic, legal and cultural institutions.

6.1 EFFICIENCY, THE DIVISION OF LABOUR AND MASS-PRODUCTION

A central thought both in the early period of industrialisation and today is (cost-) efficiency. One important landmark for the efficiency of organisations was Frederick Taylor's today well-known book *Principles of Scientific Management* (1911). According to a Taylorististic organisation, efficiency is to be obtained through management's responsibility for work and a scrupulous formation of the work process. The scientific principles for an efficient organisation were compiled at the end of the 19th century constructed in order to obtain maximum productivity and maximum profit for all involved with a focus on the development of mass-markets for relatively standardised consumer goods (Taylor 1911).

However, already by the second half of the 18th century, Adam Smith had argued that efficient production depended on the way work was organised, and therefore work should be divided into individual tasks among many workers with varying levels of skills (Braverman 1985/1974). However, it was Taylor who introduced the concept of the division of labour for efficient industrial

production, within his then new philosophy of management and its related work relations (Edwards 1979: 98).

6.1.1 'Scientific' principles and the division of labour

'Scientific management' is meant to be applied to all kinds of work regardless of technology. The technology per se is of minor importance (Braverman 1985/1974: 81-5). The principles for efficient production are based on a strict division of labour, separation of planning from execution (the hand from the mind). Taylorised work implies few opportunities to work across regulated boundaries and limited autonomy or little discretion enjoyed by workers (e.g. Rubery and Grimshaw 2003: 177). Based on an assembly line for mass-production and comparatively high wages in order to stimulate mass-consumption, Henry Ford's factory for car production embodied Tayloristic principles under the name of Fordism (Sandkull and Johansson 2000).

The scientific system aimed at strict demarcations of job task and tight managerial (supervisory) control through the assembly line, which maximised work intensively and reduced unit costs. The basic assumption of Taylorism is that all work can be simplified, specified, standardised and grounded in routines. By acquiring skills about labour from the workers, management use its knowledge monopoly to monitor and control the labour process, sometimes in detail. With a simplified work process and increased control, fewer qualifications are needed from each employee and it becomes less expensive to recruit. However, more planning is needed for a fragmentised work. Thus these factors are described as creating space for both higher surplus for management and improved standards and general conditions for the worker outside the workplace (Taylor 1998/1911).

Taylorism has had an enormous influence on the organising of work. 'Scientific management' was implemented in Sweden at an early stage known as the rationalisation movement (*Rationaliseringsrörelsen* described by for example Björkman and Lundqvist 1981) and in Swedish healthcare (Gardell and Gustafsson 1979).[83] Karlsson and Eriksson (2000) belong to the scholars who argue that working life today is still highly influenced by Taylor's principles of scientific management of work organisation. In the same way, several researchers of call centres (Arkin 1997; Taylor and Bain 1999; 2001; Bain et al. 2002) have claimed signs of Tayloristic impact on companies as well as on work organisation in general (cf. chapter 4).

6.2 BUREAUCRACY

As Taylor's scientific principles are fundamental in order to understand the organisation of work, the ideal-type of bureaucracy elaborated by Weber is also

83 Taylor's book from 1911 was relatively quickly translated into Swedish as early as 1920 compared to the relatively late introduction of Taylorism in for instance Germany. Braverman (1985/ 1974: 173) explored how the couple Frank B. and Lilian Gilbreth added to time study the concept of motion study for an efficient method for the division of labour. The so-called MTM approach (Method-Time-Measurement) was rapidly diffused to Swedish production industry through studies of time and movements.

of major importance. Like the ideas of mass-production, standardisation and assembly lines, bureaucracy has been applied throughout society for public as well as commercial organisations in all kinds of sectors. Weber's notion of bureaucracy was formed around three principles – specialisation, centralisation and formalisation. *Specialisation* (or the division of labour) implied that the overall organisation was divided into smaller and definite units, where the staff carried out tasks according to their formation and training. Well-defined areas of competence aimed to distinguish an employee's duties and power to command as well exercise control over staff, who were defined as sub-ordinated to a competence area. *Centralisation* referred to the hierarchical construction of command and control, converging in one position at the top. All positions are based on legitimate authority. *Formalisation* means that all authority and control, as well as official actions are regulated through formal rules and directives (Weber 1987/1924: 58-60).

Human service organisations are founded on bureaucratic principles in combination with characteristics of its professional practioners (eg. Mintzberg 1983; Johansson 1992). The advantages of bureaucracy are described in terms of its possibility to divide power and positions according to competence and thereby avoid nepotistic means. Abuses of power, sub-optimisation based on power interests, favouritism and injustice treatment arising from an official's pure arbitrariness are also circumscribed by the objectivity, prediction and expertise of the bureaucratic organisation (Weber 1987/1924: 76). In later years the disadvantages of bureaucracy have been pinpointed as a basis for arguing the merits of New Public Management as an alternative set of practices (cf. Hood 1995).

6.3 INDUSTRIAL RELATIONS AND FLEXIBLE SPECIALISATION

Like bureaucracy, the logic of Taylorised work organisation is, however, countered by many scholars, for instance by Braverman and his formulation of Labour Process Theory. This argues that Taylorism leads to the de-skilling of workers and the degradation of work towards alienation, but also recognises the likelihood of worker resistance (see also Lysgaard 2001/1961). In contrast to Taylorism, the Human Relations school and the subsequent adherents of Human Resource Management were founded on the basis of mutual goals and understanding of management and employees. Somewhat later, the socio-technical school emphasised the balanced design and joint optimality between technical and social systems, and the encouragement of autonomous work groups in order to alleviate negative effects of Tayloristic and Fordist production systems (Trist and Bamforth 1951; Thorsrud and Emery 1969) (see also chapter 12).

Inspired by the Althusser-school and Gramscis' conception of hegemony, Burawoy (1985: 87) propagated conscious politics driven by the state and at the point of production, and their interrelation as well as supplementary regulations for protecting and supporting workers. Accordingly, and with help from changed and regulated factory regimes, the workers should be more independent with enhanced power resources to oppose management. Sweden was, according to Burawoy, considered as one model for such a production regime (Sederblad

1993: 33; Fleming and Thörnqvist 2003). Regulation theorists conceptualise work arrangements from tight relationships within the entire production organisation, including suppliers and employment relations (work execution, work organisation and management-employee relations) (e.g. Frenkel et al. 1999: 15-16). According to Aglietta (1979), crises in profit accumulation had lead to a demise of the necessary conditions for Fordism – mass-production and mass-consumption. As a result, employers constructed new production systems based on flexible specialisation, replacing the old ideas of Taylorism and Fordism. Flexible specialisation indicates a production system, declining markets for standardised commodities coupled with a growth of international trade. This system is completed on the basis of product differentiation, fashion, quality, service and novelty rather than price. Consequently, a sophisticated market relies to a greater extent on the capacity of an organisation to produce rapidly changing products in small volumes, at high quality (Rubery and Grimshaw 2003: 53-54). However, these ways of organising work do not adapt freely from a 'path dependency' given by historical and institutional influences (Piore and Sabel 1984). Flexible specialisation, another production system than mass-production, existed in artisanal business e.g. construction, fashion and the printing industry. It emerged among the small entrepreneurs in parts of Italy, Germany and Austria in the late 1970s, as one of the first major examples given of this kind of production identified in smaller social entites (Piore and Sabel 1984).

Cross-border comparative studies have, however, debated the significant influence of nations and institutions upon work arrangements (Lane 1989; Maurice et al. 1986; Mueller 1994; Smith and Meiksins 1995; Isidorsson 2001; Rubery and Grimshaw 2003; Holman et al. 2007).

6.3.1 Convergence of systems

The convergence of systems is often argued in relation to transnational financial markets, flexible specialisation and flexible production systems, intangible products that can be transferred instantaneously, ICT systems and new considerations of (separation in) time and space. Such arguments are based on research that labour markets, work organisation and industrial relations are converging around the globe as a result of the transformation of the political and cultural framework. The driving forces, in the words of Traxler (1995), are global market competition and the global division of labour, which stress higher flexibility and efficiency. As a consequence, 'productivity coalitions' within MNCs are claimed as replacing macro- and meso-corporatist arrangements. Another result is that of the single market within the European Union which is having indirect and converging effects on national systems.

One theory in support of convergency is the SSD model claiming system, societal and dominance effect with a focus on cross-national organisational theory (Smith and Meiksins 1995; Smith 2006). Accordingly, global systems imperatives dominated by capitalism are influencing employment, work and organisation related to the changing nature of technology and world-wide competition, at the same time as state socialism has reduced its influence. *System effects* are the results of the political economy's impact on social formations and their economic mode of production such as capitalism and state-socialism; such

effects exist on a global macro level across national borders. The second influence embraces the *societal effects*. However, these effects are neither necessarily related to a particular society nor have any national status, according to Smith and Meiksins (1995), because political-economic conditions are repeated across borders, creating macro rules for organisations, the *dominance effects*. However, Smith and Meiksins (1995) state that the pressure from global factors (general technology and global market competition) might by mitigated by national as well as international societal systems. Thus their suggestion is that divergent phenomena should not be studied only with respect to their internal logic, but also analysed within a world system of international politics and power relations, with attention paid to inter-country relations, new pan-national organisations and arrangements such as the European Union (Rubery and Grimshaw 2003).

The novelty of the SSD model of Smith and Meiksins (1995) is the way it adds the concept of dominance effects to theories about convergence and global forces embedded in the emulation and borrowing of 'dominant recipes' constructed by different nations in different periods of time (Collin-Jacques 2003). The traded sector, primarily manufacturing, has a particular significance for the global market as well as for the creation of best practice techniques/systems of work organisation within traded sectors as well as within domestic industry (Rubery and Grimshaw 2003: 51).

6.3.2 Divergence of national systems, work organisation and industrial relations

The opposite argument is that of arguing for the specific character of national institutions. The guiding hypothesis here is that changes in national industrial relations mainly make patterns attributable to path dependency. Traxler et al. (2001) argue that institutions predetermine their own alternation (2001: 18-19).

The Swedish Industrial Relations (IR) system differs from other IR-systems. Swedish industrial relations are characterised by free collective bargaining between centralised nationwide, high-density confederations covering all sectors of the economy, for both employers and employees. Sweden, together with Finland, Denmark and Belgium, belongs to a small group of countries with high union densities. This is often explained by the so-called Ghent system, which implies union-led unemployment insurance schemes funded by state subsidies, which facilitate the unions' contact with employees looking for jobs or receiving unemployment benefit (Traxler et al. 2001: 80–92). However, according to Kjellberg (2003), the Ghent system is no doubt very important, but there is another variable of similar importance: the combination of strong central and local levels. Centralisation prevents fragmentary union coverage and promotes bargaining, while decentralisation (i.e. an extensive network of local union branches well integrated into the unions) brings the trade unions closer to their members (ibid.) Furthermore, it should be emphasized that the collective agreement is by far the most important means of regulation in the Swedish labour market. A most salient feature is that Swedish law does not regulate minimum wages; it is, instead, the collective agreements that hold such clauses. The labour legislation largely consists of framework laws and most clauses are semi-

dispositive, i.e. they can be modified by collective agreements (Fransson and Thörnqvist 2003).

By the same token, Frank Dobbin and Terry Boyschuk (1999) have drawn on neo-insititutional theory (mentioning e.g. Fligstein and Byrkejflot 1996: Scott 1994) to emphasise the importance of divergent employment systems. According to their studies, major institutions in the US, Canada and Australia are oriented towards government by rules, whereas in the Nordic countries practices are oriented towards the governance of skilled work and this has had a determinant influence on control and autonomy in work organisations (Dobbin and Boyschuk 1999).

New Public Management has been diffused around the world. The Norwegian researchers Christensen et al. (2001) question, however, the idea of NPM having a convergence effect on civil systems. A substantial transfer of private sector models and concepts into public sector organisations is an attempt to make them more like commercial firms, but according to Ferlie et al. (1996), there are both similarities and differences between the public and the private sector. Definitions and boundaries within Swedish healthcare are set by government in the counties through a political process. For instance, NPM ideas are argued as being easier to implement in countries with a unitary and centralised state and a dominant political party in governance like the UK, compared to more federal and fragmented structures such as the Netherlands. Moreover, concepts, practices and organisational models from the private sector do not give the same result, when implemented in the public sector (Pollitts and Bouckaert 2004; Stein and Leisink 2007).

6.4 INSTITUTIONS

6.4.1 The definition of institutions

Institutions can be defined as 'a set of rules that define and limit the set of choices for the actors' (Traxler et al. 2001: 11). They concern the conceptions about norms, rules, prescriptions and routines that embrace the taken-for-grantedness of daily life. The institutional perspective implies that the collective norms and conceptions steering people's thoughts and actions are well anchored in the institutional field, the organisations and their different sub-cultures/groups (Hedlund 2007). Consequently, real changes in things and people do not happen easily, and neither does the institutionalised course of action need any confirmation to be reproduced.

In line with such reasoning, North's (1990) description of institutions considers them both constraints and possibilities for action (agency). Institutions provide a framework for human acting, which include both formal rules and regulations and informal conventions and codes for 'accepted behaviour' in a specific society (North 1990: 36). Yet, institutions are not solely determinant, as they imply a voluntaristic component, where institutions are created and change through actions of individuals. Institutions emerge, for instance in order to reduce insecurity, both as social order and social control (see also Hedlund 2007). Thus, institutions are taken for granted by the actors involved and transmitted from one generation to the next (e.g Johansson 2002).

6.4.2 Systems and actors

A work organisation might be considered by its social relations (Schulz 1970), and be defined as well as constructed by a system within an institutional field (Johansson 1992). One specific feature of organisations is that they dichotomise social identities and relations. For many cases, one is either included or excluded in an organisation. Accordingly, Ahrne states (1993) that people do not have as much freedom as they think to choose their organisational affiliation/identity. Some affiliations are decided by birth, such as citizenship and family bonds, while others are carried out by choice or by elections such as what workplace, school, hospital, area of a housing estate, or region to call one's own.

This reflects the classical dilemma of the system versus the individual. The system is the supra-individual setting the frame and the borders for individual actions, but the system cannot steer completely, as there are also individuals with their own will to make personal choices. Another ontological difference between them is that individuals do not remain stuck in time, whereas structures persist (Danermark et al. 1997). The mutual dependency of structure and agency has been discussed by many researchers. Social structures influence human action, at the same time as actions construct and reconstruct structure, both intentionally and unintentionally (Berger and Luckmann 1967). Such a position holds that social reality is a human construction created through interaction. The process by which actions are repeated and given similar meaning by the self and others is defined as institutionalisation related to sedimented traditions, socialisation and behaviour according to different roles (Berger and Luckmann 1967: 65-110). Human action is therefore both enabled and constrained by individuals' embedded structures (Granovetter 1985).

6.4.3 Institutional approaches: far from a united theory

However, the institutional perspective per se is far from a united and coherent school. As a multi-disciniplinary approach, institutions have a tradition in political economy, and are discussed in sociology, industrial psychology, organisational theory, organisational behavior as well as studies related to public management. The core of institutionalism and the objectives to be studied are defined differently related to the discipline of the scholar and his or her country of origin (Johansson 2002). An older approach focuses on power, affections and values, whereas neo-institutionalism embraces the cognitive aspects of interaction. Moreover, the neo or new institutionalism includes, for example, the family in its analyses, while another branch is more interested in loosely coupled organisations within different kinds of arenas and the metaphorical approach to organisational studies (Johansson 2002).

Douglass North is one prominent figure within neo-institutionalism. North's theories have been applied by Björn Brorström and associated researchers interested in healthcare development in Sweden. In their studies, institutions and their actors are of major significance in order to understand the effects of New Public Management practice in healthcare (Brorström 1994; 1995; Leffler and Mühlenbock 1999; Hallin 2000; Brorström 2004).

Other research on structure and behavior in European healthcare systems are built on instutional analyses (e.g. Rathwell 1998; Saltman and Joseph Figueras

1988; Saltman et al. 1998; Saltman et al. 2006).[84] Saltman et al. (1998; 2006) claim political, economic-technical, legal and cultural institutions as being significant in order to understand the rules of the game and the actions among the different healthcare actors. Accordingly, a reform within healthcare is embedded in a complex context shaped by the interchange between actors, content and process. This means that the results of a reform vary according to the settings, the period of time, different stages of monitoring and execution and the actions of different stakeholders (cf. Walt 1998).

6.5 IMPLICATIONS FOR THIS STUDY

A focus on institutions, i.e. both structures and actors' possibilities and choices (to initiate change) is of major importance for understanding the HCC. However, most call centre studies consider the social embedding of call centre work or HCCs as unimportant, and thus ignore its context (except Leppänen 2002; Glucksmann 2005; Taylor and Bain 2006; Jewson et al. 2007 amongst others). Like Pollitt and Bouckeart (2000), whose main conclusions are that models of reforms such as NPM differ substantially between countries, I will draw attention to four main institutional forces for studying the formation and growth of an HCC in a Swedish context.

6.5.1 Conceptions related to institutions within an HCC

Four institutional factors seem to be particularly important for studies of HCCs. First, *governance and politics*, whose character and importance for Swedish healthcare was highlighted in chapter 2. Governance and political institutions also embrace the specific industrial relations tradition in Sweden based on tripartism and collective agreements.

Second, *economic and techical institutions* embrace the overall economic situation in local society, but it is undeniable that local economies are also dependent on both national and international markets. Economic and techical institutions affect local economies such public healthcare through competition influenced by technological developments as well as enhanced possibilities for treating and alleviating disease and human pain.

Third, *laws and regulations* are, moreover, of major importance in the case of HCCs, and are related to the work environment, labour law regulation and healthcare provision, embracing the legal frameworks and regulations for healthcare professionals, employers and patients.

Fourth, *cultural institutions* have a distinct character within the healthcare sector and are influenced by different groups of actors and their sub-cultures. Cultural aspects are included within each of the other institutions, and culture is

84 Richard Saltman's research focuses on the behaviour of European healthcare systems, particularly in the Nordic Region. Together with Josep Figueras, he is a member of the European Observatory on Health Systems and Policies. Their publications focus on analysis as well as support to health European policy-making, and are the outcome of a collaboration between WHO in Europe, representatives of several European goverments as banks and research institutes.

spread and applied through beliefs about best practice, HRM strategies, ideologies, tastes and fashion forming, for example, consumption patterns. These four parameters exert influence on a societal system, at the same time as they seem to be mediated by the social actors. This means that the social actors shape the evolution of the societal system, but are themselves conditioned and shaped by the society in which they reside.

Accordingly, the main actors related to the HCC, i.e. politicians, administrators, professionals, care-seekers, are all embedded in the system of Swedish healthcare and the local healthcare area in Fybodal. They are explicitly addressed in my study. I recognise that other important actors are trade unionists, the media and institutes of higher education, which have an influence on the HCCs. However, for the case-study of HCC Fyrbodal their impact is more indirect, which is why I have chosen to present them as institutional factors instead. This kind of approach takes seriously the influence of institutional factors at the same time as it highlights the role of human agency in responding and acting, considered from a dialectical approach (cf. Rubery and Grimshaw 2003: 43-50). Such reasoning suggests that important actions are made by relevant actors which can have independent effects on different outcomes at the same time as institutional forces have a huge impact on the actors and their actions. My heuristic framework for the analysis emphasises the dynamic and man-made nature of external factors that impact on the ongoing process of decisions carried out by relevant actors. These theoretical implications are summarised in the analytical model already presented in chapter 5, figure 5.2 . The model will hereafter be used in order to organise and analyse empirical findings related to the major actors' conceptions of the HCC Fyrbodal in the subsequent chapters.

CHAPTER 7
THE POLITICAL DOMAIN

A HCC for prioritisation and strict control in order to avoid waste and carrying out the right actions from the beginning, seemed to be the issues that motivated the politicians, irrespective of their political colour. Politicians claim to ensure value for tax money. Actually, the politicians were unified in their ideas. However, they did not agree with the citiziens and professionals on several points. The politicians complained about the resistance, dissatisfaction, improvidence and lack of overview/collaboration from other groups of actors – at the same time as they stressed their own limited responsibility and that they were not in charge of operational matters. The focus of their efforts was to create an HCC, which draws public attention away from the hospitals and fostered a better attitude towards primary care as the first and obvious place to turn for healthcare. Telenurses would thus contribute to a more rational and efficient use of time and labour in the entire healthcare area. The politicians' demands for more generalists made telenurses very attractive as they had an overall view of healthcare.

Figure 7.1 Politicians' conceptions of the HCC – goals and arguments.

Institutions	Domain	Goals	Arguments	Battlefield
GOVERNANCE POLITICS ECONOMIC & TECHNICAL LAWS & REGULATIONS CULTURE	POLITICAL DOMAIN	Strategic planning Allocation of resources Equity and justice Meet needs & demands Value for tax money	Prioritise & control Rationalise Divide work/specialise Coordinate resources Improve/restructure Halt conservatism Empower patients Steer consumption Foster new attitudes	Legitimacy Trust Costs Satisfaction

7.1 THE POLITICIANS AND THEIR WORK

Views were ascertained from politicians via reference group meetings and meetings with the three health councils based on 17 politicians from each, and from interviews with four local politicians, two women and two men. The respondents had been active representatives for between 15 and 25 years, and were well familiar with the structure of the healthcare area. Three of the politicians chaired healthcare councils in the geographical areas. Two of the politicians belonged to the Social Democratic Party and two belonged to the right-wing bloc, the Centre Party and the Liberal party. The left-wing bloc was in charge from 1998 to 2002, when the decision to start an HCC was made. However, the political landscape represented in Fyrbodal shifted in the period 2002-2006. Accordingly, the healthcare councils had a new composition of members and a centre-right majority in September 2002. Like most local politicians in Sweden,

those presented here carried out their official duties in their spare-time.[85] Two of the politicians worked within healthcare, one shared duties between political and administrative service, and one was self-employed.

7.1.1 The arena

The politicians work through regular internal meetings within their councils as well as meetings with different groups of citizens and health administrators. As political representatives, they should present their political missions and achievements in different fora in order to keep and renew mandates for terms of office of four years. The main interface between the politicians and the telenurses is implicit and without face-to-face meetings in connection to budget work. Here the politicians consider the investigations made by the health administrators regarding future needs (and demands) of HCC work, based on evaluations from the past year's performance. The politicians then define the external frames of the HCC by allocating resources to it. Finally, healthcare staff are, of course, also tax-payers and vote for different political representatives.

7.1.2 Formal responsibility for resource allocation and strategic planning

What did the conceptions of the politicians' express? Their duties were to plan and allocate financial resources in order to create an 'optimal basis' for strategic management, balancing demands and needs. Their utmost goals concerned user satisfaction, accessibility, healthcare services together with rationalisation for better usage, coordinate and control scare resources.

The politicians had long experience of political work and representation, and they said that they were familiar with the changing fashions of management models for healthcare (cf. Björkman 2003). During the last decade, a tendency of centralisation of healthcare and mergers has taken place in parallel with an ambition to decentralise the work and responsibility (cf. Ohlson and Rombach 2000). A purchaser–provider model had been applied since the mid-1990s.[86] However, as different areas introduced the model at different times, some of the politicians had more experience of a role strictly as a purchaser than others. The major aim of the purchaser-provider model was to separate and clarify the different roles within healthcare, between politicians and health administrators. Previously, the politicians had also been working with execution. According to the new practice, the politicians were responsible for overall planning and resource allocation, while the health administrators were responsible for operational issues and that goals were implemented in practice.

> ...it is very hard to explain to people in the streets when there are no physicians that it is not we in the healthcare councils who recruit physicians. It isn't logical to people in general, but as a politician, I consider it very good to be a representative of the citizens and not have to deal with human resource related issues. (politician 4 Centre Party 2004)

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85 In the Västra Götaland Region, for example, only 17 out of 1700 politicians work full-time as political representatives. Only the politicians elected for the regional board are full-time employees (Västra Götaland Region homepage 2007).

86 The introduction of the purchaser–provider model in the Swedish counties started in the 1980s, but the speed of dissemination was initially low. The two areas forming Fyrbodal (Bohuslän and Norra Södra Älvsborg) had different experiences of the model.

7.2 PRIORITISATION AND CONTROL

7.2.1 Needs and demands

Irrespective of the politicians political colours, all politicians interviewed claimed the importance that less powerful groups, those that have the greatest needs, have a voice and that their needs are taken into consideration – not just those who have the strongest voice.[87] The politicians found it, however, to be a great challenge to obtain as much care as possible from the allocated funding and still guarantee that patient needs steered the flow of resources into healthcare.

> My main priority is to bring as much healthcare as possible to the citizens for their tax money (mmm) and to secure that there is an equal healthcare based on equal conditions and respect for all human beings. It is very important for me as a politician that we prioritise needs. (politician 3 Liberal party 2004)

Such a stance is very difficult to contradict as it correlates with the fundamental beliefs in the equal provision of healthcare, stated in the ethical platform for healthcare and also included in the overall Swedish Healthcare Act. At the same time, the sometimes opposite ideological stance, based on freedom of choice, was also advocated, where the demands of the citizens should guide the provision of healthcare. To steer and prioritise according to needs, means that somebody has the right to decide. This is not the same thing as letting citiziens choose among an innumerable range of available alternatives. For the politicians this was related to one very critical issue: money. Who should pay and what should one recieve for money spent on healthcare?

7.2.2 The lack of money

The great frustration that unified all the politicians was the lack of money. One politician expressed the difficulties concerning the gap between healthcare funding and the needs of the citizens:

> We don't get the care we need from healthcare and ... the money we put into healthcare... and additionally we are supposed to try to govern according to the need and those two things don't harmonise. It is very frustrating. (politician 1 Social Democratic party 2004)

This quote and many others reflected a conception that healthcare was constantly under pressure because of its rapid developments and increased possibilities, which are effects of technological development and medical research. Accordingly, the politicians claimed that we do actually produce more medical service than we have ever done and this is still not enough. From that point of view, the politicians felt it important to consider the gap between divergent wishes in society, but as a matter of not really knowing the consequences of different alternatives. One example given considered the choice between and within a multiple range of technological solutions and medical products. The politicians experienced difficulties because of uncertainty and that the regulations, rules and values differed between the municipality, the healthcare area and

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87 The quote is strongly related to Swedish priority claims, where the three basic principles of public health and medical care are: the principle of human dignity, the principle of needs and solidarity and the principle of cost-efficiency. Yet there are different ways of conceiving priorities – should the government prioritise or should the public's choice govern the care in focus?

the region and they did not harmonise. Furthermore, it was considered problematic that the needs and demands of the local community, especially rural areas, did not necessarily correspond with those of the region. The politicians thus stressed the importance of control systems in order to better use and more efficiently steer healthcare resources. Measurement was considered a way to guarantee that the right actions were undertaken and that improvements really took place. This was thus a way to avoid slack and imprudent and careless use of resources.

7.3 THE RATIONALISATION AND DIVISION OF LABOUR

7.3.1 Steering the patient flow and fostering behaviour

A strong motive for introducing a separate HCC was the pressure on the primary healthcare centres and their telephones. According to all the politicians in the three health councils, the citizens' demands for contact with healthcare staff were extremely high, and therefore a complement to the existing healthcare service was absolutely necessary. One politician expressed this as follows:

> It is an important complement to healthcare in general (mmm), because people have an incredible number of questions and thoughts...and a lot of people are uncertain how to act. They don't have to visit the primary care centre or the hospital with everything … there are other ways to get advice… when the pressure on the healthcare units is so high, I consider the HCC a good complement and … for many people it is totally natural that this is the contact to make,…one should call the HCC… whenever there is a problem. (politician 4 Centre Party 2004)

The politicians' expectations were that the HCC should release some of the pressure from other care providers. The politicians wanted, for example, the HCC to make appointments on behalf of care-seekers with primary healthcare, acute care and hospitals. The politicians reasoned that the public were going to the A&E department because they thought mistakenly it was the best alternative. Yet they believed that if citizens got good advice over the phone and were assured and calmed down by the telenurses, they would not rush to the A&E departments at nights in cases of minor ailments. Furthermore, at the inception of the HCC, people could confide with a telenurse on their problem: she might arrange an appointment at the primary care centre the following morning. Accordingly, people would avoid spending the whole night at the A&E only to get a quick examination to be assured that their symptoms did not pose a danger, and then have to call their primary care centre for an adequate examination. A restructuring of healthcare provision occurred during the case-study.

Consequently, the A&E departments moved to other premises outside the hospitals and were located in the primary healthcare centres out-of-hours. For the politicians, this was a way to draw the public attention from the hospital and to foster a new attitude and behaviour towards primary care as the first and evident point of contact for healthcare. Furthermore, the political ambition was, as a next step, to transfer competencies from the hospitals to other healthcare institutions and to primary care as well as expand the district surgeries as a complement to the appointments with the physicians. Nurses and telenurses were considered important actors for carrying out simple interventions that were previously included in the physicians' work responsibility. The HCC was thus considered to free-up resources for face-to-face appointments without appropriating resources from the production of care. With the

introduction of an HCC, the politicians hoped to reduce the level of duties on the phones so that clinical care would have additional time to take care of more face-to-face appointments:

> I am a bit confused about the poor access to primary care on the phone... but I think that it is also a matter related to the lack of time and physicians available for appointments....There is a lot of pressure on the production [of healthcare] in order to have a couple of nurses at each primary care centre to answer the phones the whole day long.... They might instead produce healthcare... (politician 3 Liberal party 2004)

The politicians expressed great expectations toward the HCC as a means of easing pressure first in terms of acute care and second, in terms of timing, to provide service out-of-hours. The HCC was considered as a spider at the centre of a web maintaining good communication between the patient and all the providers of care. It was also a condition of a well functioning chain of care and of healthcare rationalisation. The HCC was one step towards less expensive care in the daytime within primary care, and towards an extended use of self-care instead of 'unnecessary' and expensive acute care out of hours.

7.3.2 Trust, legitimacy and dissatisfied professionals as well as citizens

The politicians said that they were dependent on the citizens' trust and legitimacy in their actions. When meeting the citizens, the politicians experienced problems explaining why they as representatives were not involved in addressing the lack of doctors, and that a politician should not deal with issues related to the work environment and recruitment. Citizens are frequently displeased and they dumb down the politicians. For the politicians, this is difficult to explain as the political picture is so complex. They feel that the public's expression of dissatisfaction is very tiring. It is also hard to support healthcare staff, who are dissatisfied with their working situation and defend the lack of physicians. The management of human resources issues belong, according to the politicians, to the providers of care, i.e. the officials and the professionals.

> A politician might be a person to whom to lodge complaints, and it is very easy to act in that way. But since I started to be politically active I have realised that it is not easy to be a politician (ah)... because when you get the whole picture everything becomes so complex. (politician 1 Social Democratic party 2004)

As a politician, one should be able to have a holistic perspective. Several politicians expressed their major tasks were to prioritise, govern resources and to defend the weaker groups in society. Furthermore, a politician had to separate questions of fact from questions of people, as conflicting views and attitudes were parts of one's daily work – a politician is the possible target of dissatisfaction from internal groups such as the professionals and from external groups of citizens. The politicians expressed a wish to obtain legitimacy and mobilise opinions to support their actions. Consequently, it was important to show the results of their actions. The politicians bought healthcare and evaluated the costs, the service quality, the access (also over the phone) and they considered it a balancing act to optimise real care versus access by phone. The politicians had to negotiate and were dependent on other healthcare actors; i.e. the administrators and the professionals. But the politicians did not think that healthcare

staff shouldered their responsibility in terms of manning, the prioritisation of needs and good maintenance of resources. Instead, many professionals (physicians?) were improvident and had a poor sense of planning and economising with limited resources. The physicians were self-centred and very solicitous about status and pay without considering healthcare as a precious and solidaristic service (even a calling). The conception of healthcare as a calling and being an unselfish cause (aultruistic) was the prevalent view of the politicians.

7.4 THE COORDINATION OF RESOURCES

7.4.1 The communication and coordination of resources

It seemed as if the politicians had high expectations of the HCC. The politicians emphasised the need for communication between the HCC, primary care and specialist care. Good relations between the call centre and the rest of the healthcare organisation were accordingly a precondition for a well-functioning chain of care. The hospitals within the area were established through a merger in 1996 between hospitals from two different counties and researchers have highlighted the problems of functioning and collaboration (e.g. Leffler and Mühlenbock 1999). However, the politicians saw the potential of HCCs for logistics and better co-ordination between the hospitals.

> ...the relationship between the two major hospitals has not always been very good, but I have heard that now it works much better. The hospitals use the service and it *functions well*. A smooth communication with the HCC is a precondition for the chain of care and it is very important for the future. (politician 2 Social Democratic party 2004)

The internal clashes between different care-providers at different hospitals were seen as being major inconveniences for the whole healthcare area. The politicians were, however, aware of the cold relationship between the HCC and for example the A&E departments when the HCC was introduced. The quote above reflects a conception where the politicians equated the HCC with some kind of liaison centre (*sambandscentral*). The HCC was compared to a spider which should connect all the parts of healthcare to each other. The HCC should be highly significant both for external communication towards the citizens, and for internal communication within the healthcare area. The result was expressed in terms of an optimal coordination of the resources. Moreover, the politicians predicted an extended future role for the HCC, where the telenurses also would make appointments for callers on behalf of general practitioners as well as specialists. This was subsequently materialised in 2005.

7.5 SPECIALISATION AND THE IMPROVEMENT OF WORK

7.5.1 A group specialised on prioritisation

The politicians saw no differences between the work in a separate HCC and the work in an ordinary healthcare unit. The prerequisites, they argued, were that the HCC and the conventional healthcare units had the same medical procedures and attitudes. For the politicians, the same kind of people were employed with the same education; either the nurses were located at the hospitals or at an HCC in order to handle calls. As the nursing profession did not differ from one place to another in the eyes of the

politicians, the medical security was considered as guaranteed. The professionals, however, had their doubts about the level of medical security, an issue of major importance for them. Some politicians even believed that quality levels might be higher in an HCC.

> I believe the HCC is professional as it is based on advice from people who are not distracted by other work tasks … so they can concentrate on the advice part and …become more proficient …. What you're doing a lot you will be good at... In the primary care centre, there are a lot of things that are carried out at the same time... and that might endanger patient safety... as it is now, therefore it would be an advantage if more people called the HCC,... but that is only my speculation... I have no proof of it... but I see how the primary centre is run. It is rare to see someone who remains seated and only handles the telephone calls. (politician 2 Social democrat 2004)

Accordingly, one inconvenience, in the primary care centres was that telephone advice was given alongside many other tasks. In the traditionally clinical settings, the nurses often handled the telephones at the same time as they treating patients, walking in the corridors and discussing with their colleagues. In a HCC, the nurses' main task was to answer the phone. Consequently, the telenurses would be the most appropriate staff to give advice.

7.5.2 A risk of duplicity of work? The HCC eases some of the burden

Discussing the perceived consequences of the call centre, the issues in focus concerned accessibility, cost efficiency, steering patient flows and self-care. Despite the introduction of the HCC, there was still intense pressure on the telephone lines of other healthcare providers. The HCC's lines were also heavily occupied.

> The access on the phone is still a major problem and a balancing act … how much time should be dedicated to telephone advice nursing and how much time should be dedicated to real care?… that is the question. The people that I meet are furious because they don't get through on the line, but they are also angry because they don't get an appointment the same day, at the same time as they are calling, so the demands are not that low. But what would the situation have been if the HCC had not existed? We would certainly have had even greater pressure… but it is complex and hard to measure. (politician 3 Libral Party 2004)

According to the conceptions of the politicians, it was difficult to balance the high demands of the citizens. The politicians, thus, perceived that they had to deal with the dilemma of needs/demands versus limited resources/'real' access, which implied taking decisions that were not comfortable or satisfactory for everybody.

7.5.3 Holistic thinking and general perspective

The HCC was also equally seen as a significant actor, because there are many specialists in the healthcare system, but there is also a great need for more generalists. This reflected a conception in favour of holistic thinking and overall solutions. It is not enough that each specialist (understood as each physician) takes care of a small piece (of the human body), as one politician expressed it, if the overall picture is missing. Accordingly, the politicians focused on the lack of general solutions, which might be related to their view of themselves as generalists with an overall responsibility and not as specialists. The HCC might also be a descent workplace for people with high competence who experienced clinical care work as being too physically arduous. As

the politicians considered themselves generalists, they considered the HCC as a workplace for generalists and people with a holistic view able to capture 'the whole picture'. In that sense the telenurses were similar to the politicians and when the politicians talked about the telenurses, one got the image of the telenurses as the politicians' extended arm in order to carry out their will.

7.6 RESISTANCE FROM THE PROFESSIONALS

7.6.1 Resistance because of the threat of change and of losing resources

When the HCC started in Fyrbodal, the level of discontent was very high among the professionals in almost all other parts of healthcare, i.e. in primary care centres, A&E departments and clinics. One reason for the discontent could be, according to the politicians, that the professionals were too conservative. They resisted all changes that concerned them as they wished to maintain working as they had always worked. The professionals were simply too conservative:

> a hostile atmosphere was created... and I find it fascinating at some distance that it might be like that because of a relatively small change, at the same time as huge changes are accepted without a reaction. I don't know what they are afraid of...if it is not being needed as before. (politician 4 Centre Party 2004)

The politicians did not think that the professionals were acting in a logical way. They claimed that they had too heavy a workload, but when some tasks were simplified, they were still not pleased. And the professionals continued to complain about the amount of telephone calls to their centres. Another aspect, brought up by the politicians, was the highly skilled nurses. Many experienced nurses from the healthcare centres applied for positions within the HCC. Some politicians believed that there was a fear from the primary care centres that the good nurses would leave their jobs and start to work at the HCC instead.

> It is a question of a lot of competent staff, I don't know about the age structure...I think that some of the applicants were relatively young... and others were old servants...connected with the great number of staff who will soon retire... because high qualifications are required... in order to do a good job at the HCC and that was exactly one of... yes... [the reflections] that the primary care centres made...that now all our proficient nurses will apply for these positions, now will we lose them as they hereafter will be seated handling the phone, forever ...(ha-ha). But that was not the outcome... although, it may also be that those who have worked hard within healthcare for many years... and the body is worn, but the mind is as alert as always. For them it could be a good workplace, a place apt for somebody who is on sick leave and doesn't have the strength to do something else: but that is only speculation. (politician 1 Social Democrat party 2004)

It was a problem, the politicians pointed out, that the professionals did not collaborate either with each other or with the politicians. Physicians and nursing staff claimed that the work intensity had increased with the introduction of the HCC. For the politicians it was more a matter of constant dissatisfaction. According to the politicians, the professionals were not aware of the number of enquiries put to the HCC and the professionals did not consider what would have been the consequences without the HCC. The politicians thus found the professionals were very one-eyed focusing on

their own unit, i.e. they were sub-optimising, moaning and groaning about their own situation instead of lifting their eyes. The politicians thought it was an obligation to prioritise, and therefore it was important that the politicians and the professionals agree together and collaborate, as prioritisation was difficult and required considerable courage.

7.7 INFORMATION AND MARKETING

7.7.1 Difficulties for certain groups of users

> It is the major panorama of illness and diseases that burden… or not burden, but are charged to the primary care centres because of their needs… (mmm) and then I think we have to try to explore self-care to a greater extent. But of course, we should not go too far in order not to risk any medical safety. There has to be a balance. (politician 3 Liberal party 2004)

Why do the old people not use the HCC's service as much as the younger generation? That was an issue of primary concern for the politicians, particularly as the older generation is the major consumer of healthcare. The politicians frequently meet together with representatives of citizens and representatives of senior citizens (groups of retired citizens), who give their opinions on all kinds of matters. The politicians' conclusion was that the older people were not used to addressing a HCC, and therefore advertising was extremely important for information about the concept and usage making them try the service. The elderly could also benefit from self-care advice and the feeling of security, if they chose to stay at home. In particular, the self-care advice was an issue repeatedly mentioned by one politician. One person explained the difficulties and resistance to the HCC among senior people because of poor hearing, in combination with an unwillingness to contact a place or nurses unfamiliar to the caller, and the distance caused by the phone.

> I think it [HCC] might have a higher significance for younger people, who are adapting to more modern ways of getting information. However, the elderly, who have called once and had a positive experience, they might call again. (politician 4 Centre party 2004)

However, the politicians consider it takes time to change one's way of acting and seeking for healthcare. Through information and changed routines the citizens should learn new ways to behave:

> It is therefore a question of educating the public. Many people have the habit of seeking for care for very banal things that they ought to take care of themselves. And I think therefore that the HCC has an important role of empowering people on how to treat themselves. The crucial target is to spread the knowledge … about the HCC to the public that there is such a resource for them. (politician 2 Social Democratic party 2004)

The issue of creating new health habits and new patterns of healthcare consumption involves disseminating a great deal of information, something also discussed in terms of marketing the new service. Several politicians also mentioned the possibilities of distributing a handbook for self-care, which would be a good complement, helping citizens to take care of themselves. Moreover, it could be a source to refer to, when the telenurses were advising and educating people over the phone.

7.7.2 Cost-efficient solutions: not always appropriate for rural needs and demands

According to the politicians, the small and rural parts of Fyrbodal neither had the finances nor the inhabitants to motivate major radical innovations and separate solutions. They were dependent on overall solutions in healthcare, and not capable of acting independently. But it might be that the overall solutions did not fit the smaller problems and that other solutions might have been more beneficial for the rural inhabitants. Within Västra Götaland a decision was taken to restructure healthcare throughout the region, and as a result the bigger hospitals become the major actors also with responsibility for the medical service that was previously provided locally, i.e. the duties of local hospitals were moved away to a great extent. This was very negatively conceived by the inhabitants in the rural areas. The politicians on the rural health commission talked about 'great resistance'. Furthermore, the politicians argued that the local inhabitants tended to associate the move of resources from their hospital and primary healthcare to the same source. This resulted in local reductions in healthcare provision and telephone advice nursing, instead of personal meetings and phone calls to local healthcare staff. Both were changes associated with centralisation and delocalisation.

Before contrasting the conceptions of all the groups of actors, let us move to the administrative domain in the following chapter.

CHAPTER 8
THE ADMINISTRATIVE DOMAIN

The administrative domain focused on cost-efficiency, productivity and service delivery – the first two of these in relation to the organisation, and the third in relation to the patients. The HCC Fyrbodal had a strategy for standardising the first healthcare encounter, while arguing that health provision should be more flexible for the public. The administrators' conceptions were, moreover, that as professionals are poor at thinking in financial terms. The introduction of the HCC was characterised by a top-down strategy of change presented as a means to prioritise resources and the needs of care-seekers through a new division of labour, emphasising the role of telenurses in a rational and efficient healthcare organisation.

HCCs also imply a stricter evaluation of which care-seekers should enter the system and of the costs incurred by professionals. In the eyes of the health administrators, the HCC is a customer service function for treating the eternal dilemma of healthcare with its distinct features in the 21st century, such as new patterns of healthcare consumption and the service demands of exigent and insecure citizens. The HCC should improve health provision by promoting new patterns for citiziens to seek healthcare. Being very service-minded, the telenurses would encourage citizens to take care of themselves and their relatives at home with the aid of self-care advice. Service-minded telenurses are therefore urged by the administrators to encourage citizens to assume 'empowered' ways of acting, such as self-care and the rational use of healthcare.

Figure 8.1 Administrators' conceptions of the HCC – goals and arguments.

Institutions	Domain	Goals	Arguments	Battlefield
GOVERN-ANCE & POLITICS	ADMINI-STRATIVE DOMAIN	Cost-efficiency	Divide work/specialise Rationalise	Legitimacy
		Productivity	Evaluate and control Market competition	Trust
ECONOMIC & TECHNICAL		Service delivery	Financial consciousness Coordinate resources Provide service/Empower	Labour Costs
LAWS & REGULA-TIONS		Control of labour & activities	Meet new consumption Foster new attitudes	Satisfaction
CULTURE				

8.1 THE HEALTH ADMINISTRATORS AND THEIR WORK

Conceptions from the administrative domain were obtained from interviews as well as observations and my participation during meetings. Of the 18 health admininstrators interviewed, two were based at the regional level, three at the national level and thirteen at the central level in Fyrbodal.[88] Half were women

88 The central managers could be described as divisional managers within the primary healthcare organisation (*primärvårdsområdeschefer PVO*).

and half were men. They worked either within primary care, A&E departments or in management positions. Moreover, the interviewees all had a role encompassing support and most had a long experience of healthcare management from different positions. The background of the respondents were diverse: general medicine, nursing, midwifery, business administration and the behavioural sciences.

8.1.1 The arena

The health administrators/managers have internal meetings, as well as meetings within management groups and within groups for executive managers. The main interfaces between the health administrators and the HCC (the telenurses) take place implicitly and without face-to-face meetings, in connection to budget work, the allocation of finances and the pay formation process. The HCC manager represents the management perspective at the workplace of HCC Fyrbodal and towards the staff. She also has the main external contact with health administrators/and managers from other healthcare units, politicians and other stakeholders at regional and national levels as well as the media.

8.1.2 Formal responsibility for support and management

The health administrators are in charge of the overall, operational processes of planning, coordination and control of resources. Control is described in terms of performance evaluations, considering how well a healthcare unit has succeeded in balancing its revenues and healthcare delivery during the year. Another kind of evaluation is job evaluation, i.e. the rating of the individual employee in terms of performance and competence forming a basis for his or her pay formation.

8.2 RATIONALISATION AND COST-EFFICIENCY

8.2.1 A top-down strategy for prioritisation and a new division of labour

The administrators described the HCC as a centralised initiative from the regional government and above all from the State based on a belief that the introduction of a HCC would serve healthcare in general. The promised special grants from the State given via the regional organisation in order to develop the telephone advice activities had, however, been drastically reduced:

> As usuall the sum given was a fraction of what had been promised...//...But for us, it is obvious that primary care is the foundation of the health system and that it actually should have the responsibility for the first assessment 24 hours per day seven days a week. But it is not necessary that the most urgent need should be handled by the physicians, it might instead be taken care of by nurses assuring access and monitoring people to the right level of care. (administrator 7 2004)

HCC Fyrbodal was about to render healthcare more effective, but in line with the major work to restructure healthcare it also focused nore explicitly on the primary care centre and on easing the burden on hospital care. According to administrative calculations, one call to a health call centre could replace four visits to primary care (VGR 2004: 24). Thus, the HCC was seen as a means to

deliver the promise to the population as set out in the Guarantee Act.[89] The citizens should have access to healthcare the same day as their initial contact and the HCC was an important tool in this. Access to healthcare did not necessarily mean getting in touch with a physician, it could also be nurse.

Before letting HCCs shoulder a higher responsibility for healthcare, telephone advice nursing needed to improve. Based on studies undertaken at 40 primary care centres and at A& E departments in Fyrbodal, the problems were obvious: the degree of telephone availability was low, the nurses did not document their advice according to the regulations, the nurses did not have a common policy (no conformity) for giving advice and they expressed the need for training and decision-support (Kvilén Eriksson 2000a). Furthermore, the studies emphasised that the existing telephone advice nursing was insufficiently related to the nurses' work environment and technical conditions (Kvilén Eriksson 2000b). According to some health administrators, the iniative of the HCC did not, however, reflect an organisational change based on the needs of those who worked in healthcare or on the local needs of the citizens. In order to implement change successfully, consent from the citizens and staff is a necessary condition:

> A reorganisation is an idea of change that springs from below... which makes people enthusiastic and committed to coordinate and disseminate information in order to convince others about its excellence. And then there is a *massive* requirement on the politicians to be in favour of something that is needed locally. That was *absolutely not* the case for HCC Fyrbodal. (administrators 5 2004)

The administrators also discussed the HCC in relation to necessary, but complex prioritisations due to the following factors. First, thanks to advanced technology and recent innovations, staff at hospitals are able to carry out new and complicated interventions. New techniques require resources; at the same time somebody has to manage and solve more simple healthcare problems. Secondly, all this implies a division of labour, where primary care should focus on simple ailments, but after primary care there are no other organisations to which delegate work tasks. Prioritisation is then necessary as is the prompting of people to take care of themselves with the help of self-care advice. Thirdly, prioritisation on an individual level is very difficult. It is hard to deny somebody care, at the same time as one talks about patient-centred healthcare:

> There are no easy solutions, and it is hard to face the patient eye to eye. But to prioritise among the healthcare activities, that is essential. (administrator 3 2004)

8.2.2 The physicians, the chain of care and the tourists

According to several administrators, the introduction of the HCC was a visual and powerful way to show the politicians' will to improve healthcare finances and to meet the citizens' demands for more and better access to healthcare, in order words to gain and hopefully maintain legitimacy for political agendas. The problem seems to be that less money means less healthcare, but that was something that the politicians tried to ignore. According to the officials, the politicians did not want to officially mention the financial problems. Such problems created conflict, particularly because the recruitment of physicians was

89 See also section 2.2.4

a huge and expensive issue. A lack of physicians, furthermore, led to serious complications in terms of quality and development. The organisation of healthcare is dependent on the physicians and when they are missing, this affects the patients and their medical safety as well as that of the whole staff and the development and competence of a unit. The administrators argued that 'the chain of care' and the whole organisation suffered from a lack of physicians. As a result the internal work of healthcare was not well developed:

> It feels like a cash register with an open hole, the money is eddying down the drain because the physicians are expensive and the lack of them is a great problem, especially in the rural areas. We need to attract physicians, who are enthusiastic about living in the forest near Dalsland or far away on the coast side in Bohuslän during the winter. (health administrator 8 2004)

The situation is aggravated because healthcare is segregated – a large part of the area is sparsely populated. Yet, Fyrbodal is very popular in the summer and the invasion of tourists amounts to about three times the permanent population. From a financial perspective, tourism means many more patients to treat without any additional resources, because the allocation of money is based on the actual number of tax-payers, i.e. the permanently resident citizens.

8.2.3 Market competition and making the professionals think in financial terms

Another problem, according to some health administrators, was that neither the politicians nor the professionals seemed to have understood the meaning of market competition in healthcare. The market argument was further built on a HCC having an overall view of the healthcare area. If so, the HCC might contribute to a situation where citizens start to compare different healthcare providers, for example primary care centres within the healthcare area and specialist care between different Swedish healthcare areas. The result might be that citizens required new treatments and the same quality and access from different healthcare providers. In the long run a positive effect of this could be an improvement in overall quality, whereas the negative effect might risk a rise in costs and dissatisfaction among individual healthcare actors and citizens...However, internal competition would oblige the healthcare staff (mainly the physicians) to keep updated and familiar with new research and technological innovations, new treatments and nursing developments, and therefore it was a very good thing, according to several administrators.

Many scholars and healthcare studies, especially within public organisation and public administration, have analysed the financial situation of healthcare, and according to these one major problem is making the physicians think in financial terms (e.g. Brorström 1994; Targama 2006). Even in different management models aiming to clarify the responsibility of different actors and common values (e.g. Siverbo and Hallin 2003), the issue of financial responsibility has been shown as hard to materialise.

Financial reasoning was, however, combined with discussions about optimal primary care and the extent to which the HCC contributed to improvements in primary care. One health administrator tried to distinguish between the different consumers of

primary care, concluding that for some, a HCC was very beneficial and for others HCCs were not particularly appropriate.

> In my opinion, optimal primary care is built on a feeling of security and health prevention in order to take care of people with diabetes, asthma and other chronic diseases. If the big consumers are well controlled they will not visit healthcare more than necessarily. Good primary care is equally about a psychological understanding of care by elderly people and how they experience their everyday life. Young people with snivelling kids will not care where the nurse is located, while the elderly feel very vulnerable as their social net thins out and they are more and more in need of support and security. Different citizens have different needs and then we have the tourists, representing a fourth group of primary care consumers. (administrator 12 2005)

8.3 EVALUATION AND CONTROL

8.3.1 Responsibility of costs

HRM and the division of labour are tools in the hands of the officials who seek to obtain a combination of cost-efficiency and committed employees (called co-workers). In focus of their efforts is the coordination/communication of work as well as the control of work. A political intention emphasised by the health administrators was the independent primary healthcare centres equivalent to independent results units. By stating that the public and private units should operate under the same conditions, the administrators made internal comparisons possible. Consequently, the users as well as management should be able to compare different units, in the same ways as coercive comparisons take place between plans within multinationals in the private sector. Such attempts at 'best practice' constitutes a means for levering up productivity and financial performance in each of several subsidiaries.

> Each executive manager operates independently...and independency is also required in order to successfully tackle the job...because it is hard work to be a responsible manager...//...the demands originate from the capitation and the performance criteria connected to each organisation. It is hard to guarantee the revenues through appointments or other performance measures and the revenues are supposed to cover the costs... for the staff, the rent, costs of laboratory analyses and X-ray examinations and other costs...so yes, it has become much harder, at the same time as I see it as work with more distinct requirements. (administrator 1 2004)

The condition described above is valid for all the healthcare units in Fyrbodal.[90]

8.3.2 How independent is a primary care centre?

The health administrators' picture of 'the independent' healthcare units was, however, not shared by the executive managers in different clinics or primary care centres. They did not experience them as being independent. Instead, they considered them as strongly monitored by the regulation in the healthcare area and in the region. They estimated the financial pressure on them as being severe and they thought that they had little discretion to decide on the amount of healthcare that they were supposed to deliver during the year. The level of healthcare delivery was estimated through investigations carried out at a central level and based on the numbers and age of the inhabitants (cf. Panfilova 2004).

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90 Except the HCC that during the pilot project secured an annual allowance for its operations.

Managers in primary care centres exemplified the problems in terms of the overall demographic pattern in a catchment area, such as the number of immigrants, the socio-economic level, the unemployment rate and the share of inhabitants on long-term sick leave. This was not really taken into consideration when allocating resources. The individual managers had no say on the 'clients', i.e on. either the inhabitants' perceived health status and problems or on the external circumstances that prevailed in the catchment area. In areas with a relatively higher proportion of immigrants, the primary care centres needed much more manning and resources than what was estimated for primary care centres in general. At the same time, it was harder to recruit and keep healthcare staff: the centres were often dependent on relay physicians (*stafettläkare*) and private physicians (Blomsterberg 2004: 63). Furthermore, 'new Swedes' required healthcare staff with skills related to cultural, language and psychosomatic problems (Blomsterberg 2004).

In commercial organisations, the owner can to a certain degree, choose the kind of target customers for a service, in a healthcare organisation there are no possibilities to choose one's patients. A public health organisation is dependent on the population in the catchment area. For minor ailments, people are less apt to travel to distant areas to get medical service and care. In emergencies there might not even be the time or opportunity to choose a healthcare provider. These were arguments raised related to the difficulties of results units and market imperatives within healthcare.

8.3.3 Financial targets as a basic tool and the political definition of resources

HRM aims at recruiting and retaining committed, motivated and skilled employees who work according to the overall goals of the organisation, while a more critical labour process perceptive would recognise the control aspects of such a practice. For the administrators, the HRM strategies as well as the financial targets were the basic tools, combined with the basic values (including ethical rules) which formed the regulations of the overall organisation of healthcare in the region. In line with NPM, the healthcare organisation applied concepts such as cost units, competition between units, job descriptions with defined responsibilities and a decentralised process for pay formation. The administrators considered the organising of healthcare was difficult and therefore the executive managers needed the regulations and the policies in order to handle a range of difficult situations that they faced in their everyday lives. One crucial issue referred to continuously by the adminstrators concerned how to make their staff aware of the implications of working in a political organisation:

> My most important work task is to inform our staff and our management in a way that creates loyalty and makes them understand the meaning of work within an organisation managed by political decisions. I feel that I have to stress it over and over again, as if staff didn't know it already. Moreover, it involves arousing enthusiasm although it might feel difficult because we have less money and more work tasks, it is important to evoke commitment. We have to develop our organisation in order to work smarter not harder. (administrators 16 2004)

The quote reveals the eternal question among managers regarding the employees' non-logical belief system and their failure to comprehend managerial logic including that of optimising financial and technological performance (e.g. among many others Roethlisberg and Dickson 1964/1939; Burawoy 1979; Wärvik 2005).

8.3.4 Financial resistance

The basic assumption of HCCs was to deliver a common service for all healthcare actors in the area. To secure commitment and support for decisions taken, the representatives of healthcare in the whole area were invited to the pre-project and investigation preceding the inception of the HCC. According to the decisions made, the HCC should be co-financed by both the hospitals and primary care in the area. The hospitals should pay 1.4 million SEK as they were no longer responsible for telephone advice nights and weekends and could release one nurse previously working on the phone. Yet, finance was a way for the professionals to resist the HCC. This meant that the hospitals ignored the payments that they were supposed to make to the HCC and the HCC manager consequently faced cash-flow problems. The argument from the hospitals was their estimation of still having the same number of patients who called the A&E departments. According to the health administrators, it was up to the politicians to fund the co-payment from the hospitals. The effect was, however, that the hospitals never paid for their share of the project. However, the HCC manager drew the politicians' attention to the matter repeatedly in the annual report of the HCC during the first three years when the HCC was run as a pilot project.

Furthermore, the HCC manager was faced with financial problems in that the pressure on the phone was higher than the original calculation. It was hard for the HCC to meet the defined targets for healthcare delivery. The original calculations were based on higher activity during the days, but in practice the demands on the phone were greatest out-of-hours. Accordingly, the HCC manager had to change her time-tabling and was faced with higher labour costs as a result.

8.4 HEALTHCARE SERVICE AND EMPOWERMENT

8.4.1 A customer service function

One way to ameliorate the relations between the HCC and the rest of the professionals was, according to the health administrators, to create meetings and meeting points. Recalcitrant professionals would thus realise that their shared interests lay in a commitment to the patient as well as an efficient chain of care, i.e. patient-centred healthcare. However, the healthcare profession comprised many divergent views at different workplaces and for different kinds of medical specialities. Primary care focuses on minor ailments and general problems that are rather easy to cure, such as common colds, influenza, stomach complaints, ear wax etc., whereas secondary care was pathological by nature and had the course of serious and complicated diseases as its conceptual template. A general physician should refer a patient if he or she felt a sense of danger or did not know how to treat the patient, whereas a physician specialised in a disease or on a part of the human anatomy should find out the cause, often through close examinations, scrutinisations and testing (cf. Eckerlund et al. (1993). The officials perceived specialist physicians as people who could not say no or set borders to their work, and as a result:

> A&E becomes a department with swingdoors as the specialised physicians have to examine all the patients that arrive for acute care out-of-hours in order to have their problems examined, regardless of the cause or the pathological picture. (health administrator 1 2004)

8.4.2 A function in order to meet new pattern of healthcare consumption

According to some officials, a new group of people were calling because of the greater possibility to contact healthcare providers on the introduction of the HCC. This new group of people had not made such contact previously, but now they took the opportunity to call the HCC, for example, when they felt a bit worried. Formerly, they were content to talk to a relative or do nothing.

> ...We now have a new group of people calling primary care. There are people who contact us, because it is possible to call and because they have worries. If this possibility had not existed, this group of citizens would have confined themselves to talking to a friend or a relative or simply doing nothing,... anyhow they would have taken care of themselves. But now when there is the possibility to call the HCC ... the number of entries to the healthcare system is increasing. (administrator 13 2004)

One argument was that with the introduction of the HCC, more and new patient groups have been calling healthcare providers. The interviewees most negative towards the HCC compared it with a fully-open water tap, from which the money was flooding out. They meant that the HCC was impossible to control and it would create new demands and consequently more consumption of healthcare.

> Today a lot of people are seeking medical services out-of-hours... for social reasons, because they have nobody to take care of their children and in the evening partners are at home ....for practical reasons because they have neither the time nor the will to leave work in the middle of the day... I understand all those reasons... and we have not sufficiently considered the consumers, when we have organised healthcare. However, if we are also to satisfy the new demands on healthcare and new consumption patterns, a price has to be paid by the politicians and the tax-payers in the end. (administrator 3 2004)

The organisation of the HCC is also connected to the changed consumption pattern. The health administrators talked about the insecurity and new demands in society today. The younger generation has different demands from the service than their elders. Several health administrators stressed the importance of being service-minded, which according to them was nothing the professionals were taught at school or in their daily practice. Professionals were not that good at providing a service to consumers or at providing a service on an equal basis. This was explained by some as being attributable to their socialised paternalistic behaviour. The administrators wished the physicians and nurses in Fyrbodal to develop another view of the users, as the patient was actually the reason for the professionals carrying out their work and the reason for them to go to work. One administrator said that her vision was that the telenurses should gradually adopt their encounters towards other ideals in non-paternalistic (commercial) services:

> "-Hi! Oh so you are calling from X-town and have not been in touch with healthcare before. How nice that you call us! Let me explain a bit about the healthcare organisation, how we work and what we might offer. If then, you still have some questions, after we have talked you might read our homepage or call me back when ever you need it." –This is how I want it to be within healthcare and when you call the healthcare provider. Service is important! (administrator 18 2006)

8.4.3 The costs of new consumption patterns

A further issue was that of working hours. One administrator talked about how hard it was to find persons who were willing to work evenings, nights, and

weekends. Furthermore, it was expensive and demanding to provide a service '24-7' and most healthcare providers were not interested in that kind of mission.[91]

> The access to care during the day still leaves a lot to be desired; we need more resources in order to enlarge healthcare provision and increase the number of nurses in the primary care centres during the day, at the same time as resources are needed in order to answer the phone after 5 pm. But there are fewer providers and employees who like to shoulder the burden of work out-of-hours. (health administrator 9 2006)

After having considered the conceptions of health administrators it is time to focus on the professional domains and their goals and arguments.

91 HCCs as well as traditional healthcare organisations are labour intensive, where a large part of the total costs derives from personnel costs such as the costs of manning agencies, irregular working hours and supplementary hours (cf. Baumol 1993; Ernst and Young 2003).

CHAPTER 9
THE PROFESSIONAL DOMAIN

The professionals countered against continuous and poorly elaborated changes in healthcare, which had had negative effects on their working situation. The physicians were very upset because the decision-makers neither informed them in advance nor paid attention to their opinions when introducing an HCC. They accordingly conceived that important functions were put out of their hands and, furthermore, rules and regulations had increased the distance between them and the patients. Thus, the physicians experienced a higher degree of control and centralisation of duties, while nurses, if concerned, felt inspired by new ways to consider telephone advice nursing.

At the same time as the physicians emphasised the necessity of closeness to the patients, they claimed that certain bogus patients filled their time to the disadvantage of those who really needed their service. The professionals also conceived that politicians and health administrators were eager to introduce changes in order to divide labour, standardise, measure and control, all in the name of improvement. However, this jeopardised both the proficiency of the professionals and the security of the patients. The rhetoric of the independent healthcare unit was only talk and was not materialised in reality. The healthcare context is too complex, filled with uncertainty and contradictory demands, which is why the professionals' discretion to act within the frame of results units is heavily conditioned.

Figure 9.1 Professionals' conceptions of the HCC – goals and arguments.

Institutions	Domain	Goals	Arguments	Battlefield
GOVERNANCE & POLITICS	PROFESSIONAL DOMAIN	Autonomy of work	Professionalism	Resources
ECONOMIC & TECHNICAL		Self-regulation	Duplicity of work No continuity	Control
LAWS & REGULATIONS		Ethical behaviour	Competence Problem-solving	Information
CULTURE		Consult, alleviate and cure medical problems	TAN of higher quality Medical safety	Knowledge Status, prestige Working Time Workload

9.1 THE PROFESSIONALS AND THEIR WORK

The fourteen interviewed professionals correspond in this case to two physicians and five nurses in primary care centres, four physicians and three nurses at A&E departments and clinics. Five of the six physicians were men and all the nurses were women. Most had various lengths of formal education and long experience from clinical care within Fyrbodal, all at slightly different positions, including supervisory functions. The professionals were usually connected to one healthcare unit, where they worked individually as well as together in teams

performing a particular work practice at the individual workplace. However, the nurses to a significant extent saw themselves as parts of teams (cf. Fältholm and Jansson 2007), while the physicians described their work tasks and the work of the medical profession in more individual terms. Practices differ not only between primary care and hospital care, but also within these two levels, especially within the latter.[92]

9.1.1 The arena between professionals from other healthcare units and the telenurses

The professionals belonged either to one of the 40 primary care centres, small workplaces spread over the whole area with a flat structure, or to the larger hospitals merging 5,500 employees and five hospitals of different sizes within under an integrated, hierarchical management structure. The main interface between the professionals and the telenurses took place implicitly in connection with the daily referral of patients and documentation from the telenurses to the professionals or to the telenurses' demands for support and advice from the professionals (mainly the physicians on duty). Other interfaces occurred in connection with the telenurses' individual work in areas of responsibility in order to update the level of medical decision-support, their auscultations or the physicians' presentations and lectures for the telenurses within the frame of the HCC's internal competence development programme.

9.2 THE ENFORCED DIVISION OF LABOUR

9.2.1 The changes for healthcare staff

Several professionals, especially the paediatricians, felt caught by surprise when the HCC was introduced. They were discontent with its establishment, as they neither felt involved nor able to influence matters.

> I was very upset, I think we got the information at a lunch meeting about the health call centre and that the telephone calls from the A&E department were to be transmitted to a separate function. At this meeting the telenurses informed us how the work was about to change and we did not feel able to counteract or react. (physician 3 in a clinic 2005)

Accordingly, the information about the HCC was not spread to the entire healthcare area through the official channels. Information to the management groups often remains in these fora and is not spread to those concerned in their daily work. Consequently, at several workplaces, the telenurses themselves became brought the news about the start of the HCC and that they would take over the phones from the ordinary nurses. So instead of discussions and planning about the medical system and the telenurses' competence development, the

92 The staff could very simplistic be described: at primary centre with the interaction between general physicians, (assistant and district) nurses, and medical secretaries. At clinics and A&E departments the numbers of employees and the range of different occupations were comparably higher. It involved mainly: medical professors, associated professors, specialised physicians, interns carrying out their training, head nurses, nurses, enrolled nurses and auxiliary nurses. Both workplaces were supplemented by physiotherapists, occupational therapists, social workers etc.

telenurses had to encounter the healthcare staff's anger about not being involved or able to have any influence as well as their doubts regarding medical safety and the risk of increasing workloads at individual units. The professionals were upset as they considered that the introduction of an HCC was a strategic question regarding the overall planning of resources and the organisational structure that greatly demanded their medical involvement. From the administrators' point of view, this kind of complaint was characteristic of the professionals, as they wanted to be involved in everything, irrespective of competency, the relevance to their work and the right to decide.

All the professionals were directly or indirectly influenced by the introduction of the HCC, as their special advisory lines were cut off in order to concentrate the service at one location. Consequently, especially in A&E departments, the nurse's work had changed in some sense, as they no longer automatically received the first call from the care-seekers or made the first assessment of a citizen in need of healthcare information, advice or medical service. Instead, a telenurse at a distant location carried out the first assessment. Her documentation was then sent interactively via the computer or by facsimiles to the care-providers who, based on her notes about the patient and the level of urgency, was supposed to encounter the patient.

For the physicians, it was a question of neither being able to talk directly to the nurse who had answered the phone nor being capable of giving her feedback regarding their work situation, the care-seekers' health status or the physicians' medical point of view. For the primary care centres, the effect of the HCC was not that obvious. As mentioned in chapter 3, the question of resources was vividly debated and the professionals in the primary care centres had hoped to obtain additional resources in order to strengthen their capacity to answer the phones at their workplaces. The professionals' resistance was expressed in that they wanted the money to be allocated among the existing healthcare units so that the professionals close to and familiar with the citizens could take care of their needs. A similar debate was driven by physicians in the daily journal of medical professionals (see *Dagens Medicin* September to November 2003). Consequently, the staff in the primary care centres doubted that the HCC would have any effect on the people in their catchment area.

> We wanted the money allocated to our primary care. It is not a good idea to clump it in one place. We need more resources for primary care ...in order to meet directly the needs of the citizens. We presented a suggestion with a pool of money divided between all primary care centres. The answer we got from the politicians was that the result would be that the work on the phone should constitute a very small part of a nurse's job in each centre ...well...we do not believe that a HCC will reduce the number of calls to us... people are used to calling us, and they feel more secure calling us than a foreign, distant centre for advice. (physician 1 in a primary care centre 2004)

The change was conceived as a kind of loss of control: over the first contact with care-seekers, the nurses working on the phone, over the input to healthcare units and over the function to arrange appointments (i.e. the physicians' time schedule). Furthermore, it represented a centralisation of work duties and control.

9.3 RESISTANCE

The hospitals neglected to pay their share for financing the HCC. Their motivation was that although there had been an introduction of a supplementary organisation for telephone advice nursing, the hospitals (in particular the A&E departments) experienced high demands on the phone and there were still many telephone calls that they were forced to handle. They said that they could not hinder people from calling on critical and urgent matters. One A&E department kept a nurse on duty for answering the phone,[93] the other transferred calls to the receptionists at the hospital who were required to indicate the number to the HCC.

9.3.1 More patients and the difficulties of working on the phone

When the HCC was introduced, the professionals were afraid that it would imply more patients turning to conventional healthcare as well as attracting 'new', inappropriate patients who had not called upon healthcare before, but would do so now because there was a new channel open. Furthermore, most physicians, as well as nurses, mentioned that it was difficult to make assessments over the phone and secure medical safety. Some of the physicians stated that they preferred not to work on the phone and several of the nurses who worked with telephone advice nursing confirmed the difficulties:

> As a nurse... the absolutely most difficult part of the work is making assessments over the phone... and giving advice to somebody who you do not see... it is so much easier to work through direct meetings... when you can observe facial expressions and get signs that the patient has understood what you mean. It is difficult to communicate sustainable advice that makes the care-seekers feel secure. It is hard enough to encounter people face-to-face. (nurse 10 at an A&E department 2004)

9.3.2 Different conceptions of symptoms and diseases

The physicians stressed strongly that the front-line of healthcare and the telephone contact was important both for the patient and the use of relevant healthcare resources. Only the most urgent cases should be treated out-of-hours, other patients should seek care at primary care centres the next day. Of course, a certain safety margin was needed in order not to risk somebody's life or health:

> Assessments over the phone are difficult and critical matters. It is much easier to count in than to count out; there is always a risk that it might be serious. It is also a question of how citizens describe a problem or a symptom, as their language is not the medical language. The citizens interpret medical information in one way and perceive symptoms in other ways than medically trained staff. Citizens read the internet information and make their interpretation of an apathetic child. But citizens reading about the development of a disease, see things differently compared to the medical staff who treat diseases as their profession. (physician 13 at an A&E department 2003)

Different conceptions and interpretations of medical symptoms is an important issue, especially as citizens are recommended to treat themselves by reading about symptoms and so forth before contacting healthcare providers. The

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93 A position, which at the A&E departments, was supposed to have been withdrawn on the introduction of the HCC.

physicians encountered many people who come to A&E departments having called the HCC, and some cases were really banal, i.e. of very little significance for healthcare. The physicians were upset because they did not think that this was the right way to handle scarce collective healthcare resources.

> There are lots of cases that are not meant for healthcare, they ought to be taken care of somewhere else. A lot of people come to A&E departments, who do not belong there. This means that people who really need us will suffer. We should give our time and energy to more important, emergent cases. A physician is expected to be a psychologist, a priest and a buddy by the patients. The conclusion might be that there is a lot of anxiety and worry in society and perhaps that is something that the health call centre might alleviate. (physician at an A&E department 2003)

As long as the HCC does not refer care-seekers with banal symptoms to A&E departments, the physicians conceived the HCC to be positive for society and healthcare. Consequently it was a question of *the wrong patients* being referred to the A&E and the physicians thereat that made the physicians upset.

9.3.3 Duplication of work

Several professionals, and some health administrators and politicians, were critical as they saw the danger in yet another organisation, with a duplication of work, 'several dossiers that would be discussed interminably and other defects because of elephantiasis, i.e. the unreasonable swelling of the bureaucracy' (physician at a hospital clinic 2004). The region, with its considerable numbers of politicians and bureaucrats, was perceived to generate a great deal of unnecessary work and the duplicitation of work in different places. In line with this argument, some professionals considered it hard to abolish a new organisation once it was established. Like other 'inventions', the HCC was seen by some as being hard to remove and something that probably would be institutionalised into the rest of the healthcare structure:

> In the business world, the leaders sometimes clean up and eliminate relics that don't serve their purposes any longer, but within healthcare we are adding and adding all the time without reducing anything. (physician 11 at a hospital clinic 2004)

The conception was that healthcare was adopting some parts of the NPM toolbox, but it was not consequent in its practice. Some areas such as removing obsolete units/departments, non-functioning institutions were not considered. This was counterproductive for healthcare. The primary care centres also claimed that they suffered from poor access during the day, a high workload and lack of structure. Financial means and the lack of physicians were mentioned as two major reasons for the turbulence. During the period of the case-study, the primary care centre seemed to be relieved not to have the responsibility for telephone advice nursing out-of-hours. But at the beginning, the professionals were really angry and thought that it was no more than right to let the telenurses know how they experienced the change:

> The collaboration between us and the HCC was not good at the beginning.... The HCC had a hard time carrying out their responsibilities and the nurses here, they thought that if the HCC was given responsibility for the phones, then they should *assume* it as well...Accordingly, it is difficult to draw up the demarcation line ... and no HCC assures 100 per cent of the telephone

> advice nursing. Many people still do not know about the HCC, they call us and we have to refer them to the HCC. Then of course there are patients who we do not refer but for whom we do an immediate assessment and let them come to us… it is hard to make definite demarcations, when it is a question of human beings – of flesh and blood. (nurse 10 at an A&E department 2004)

For the nurse it was also a question of marketing the service, making citizens aware of the existence of the HCC and that they should not call the A&E department, but first call the HCC. This information was also very important in order to avoid frustration on the part of the citizen:

> Some who called got very angry and upset, when we referred them to call the health call centre. They thought that they had already called a healthcare provider… We have to shoulder a lot of stress and negative feelings…we don't want the patients to be pushed back and forth in the system…(nurse 9 in an A&E department 2004)

For some professionals, the HCC only carried out very preliminary assessments of symptoms and problems, making a decision on whether the caller should visit the healthcare provider or remain at home. It was only when the caller came to the hospital that a real assessment could start: the physician's diagnosis. One thing, however, seemed to unify all the professionals once the HCC started to be accepted and that was a demand for more resources to the HCC so that the service might be able to meet the demands of the citizens that the HCC should be the first line of healthcare. The question of cost-efficiency had several layers and several professionals questioned the basis for calculating the reduction, when the HCC was introduced and supposed to reduce the flow of patients to A&E departments, clinics and primary care centres. Some thought that it required a great deal of manpower to maintain only one line to the public all the day, week and year.

9.3.4 Help and inspiration

The HCC also gave help and inspiration to other nurses not working in it on how it was possible to improve telephone advice nursing. It seemed that the telenurses had another kind of attitude vis-à-vis the other healthcare units and healthcare overall. They considered it their duty not only to provide a service and consultation to the public, but also to coordinate the internal flow of patients and help to the rest of the healthcare actors, for example managing the waiting lists for different diagnoses. The telenurses and some care providers interacted through internally organised courses. Several primary care centres had continuously connected their proper phone to the HCC since 2002, when they were not available to answer themselves because of training, workplace meetings or other events. Otherwise, it was more common that the telenurses and other nurses met for common projects or educational activities within the healthcare area. Some nurses at other workplaces also stated that they had been inspired by the way the telenurses were working, their way of seeking support from the physicians on duty when they did not know how to advise or where to refer a patient. They said that before, they had not thought of the possibility to consult a physician outside their workplace in order to get support. Some physicians, however, expressed their dissatisfaction at being disturbed by nurses in primary care centres, besides their own nurses. But for those nurses the interaction with

the HCC had been refreshing in terms of an alternative way of perceiving telephone advice nursing. For nurses in primary care centres, telephone advice nursing was a marginal and often ignored work duty. It was mandatory duty, but previously it had not received so much positive attention. Higher status and new competences were welcomed.

9.3.5 Continuous structural changes

The hospitals embraced areas with different traditions (cf. Leffler and Mühlenbock 1999: 12). The merger of the hospitals into the NU-healthcare was considered as a 'quick fix' both by the professionals and their trade unions and a fix that ignored the interests of long term development (Leffler and Mühlenbock 1999: 26). The reorganisation and constant structural changes were, furthermore, considered to put heavy demands on the professionals, besides the already too high level of pressure from the patients. The merger of the paediatric clinics in two hospitals meant for instance that the working shifts on duty were heavily reduced and as a result, the physicians experienced more intense work and the shifts became longer. The physicians on duty had to cover an area twice the size compared to how they had previously worked. The gap in terms of culture, routines and practices between the two hospitals were considered to be deep and an attitude of 'us-and-them' had a great impact on the two. For the HCC, it was important to be up-to-date with the allocation of resources between different health providers in order to know where to refer the callers:

> In terms of organisation, we have moved our departments back and forth, we have been merged with the hospital in Uddevalla, and before we came here we provided care together with the hospitals in Trollhättan and Vänersborg, and now the primary care out-of-hours is moving... There has been a lot of different ways and different flows of patients...continuous changes. (nurse 8 at an A&E department 2004).

By the time of the interviews, a new reorganisation was about to take place by moving the primary care centre out-of-hours from the hospitals (the A&E departments). The unforeseen consequences were for the older care-seekers who did not get help from their primary care centre out-of-hours. It was seen as especially difficult to meet the care needs of the elderly and during the night as the gap between primary care and home care had to be filled by someone, in this case the A&E departments:

> In later years, we have had new challenges... that of all the old people who have to visit the A&E department, because they can't get the care they need in the primary care centres or in their home, by home care. We have noticed a distinct increase in patients requiring more care. They could have been helped elsewhere, but it is often so that they are old and live on their own and when the night falls, all of a sudden, they get problems breathing or likewise. (nurse 9 at an A&E department 2004)

The effects were increased health and safety problems for the nurses taking a position between the physicians and the patients. The nurses at the A&E department had to encounter the disputes between the patients out-of-hours and the physicians refusing to make more appointments.

9.4 ENSURING MEDICAL SAFETY AND COMPETENCE

Patient safety and the telenurses' competence were two other factors highlighted in interviews with the physicians. For nurses in conventional healthcare settings, these were traditionally guaranteed by the physicians' presence and their direct feedback from the examination of the patients to the nurses answering the phone.[94]

> The nurses at the A&E department, we are working directly with them and physically we are not more the ten metres from each other, if something is particularly good or bad, then it we only have to approach the nurse saying that this patient does not have to visit the A&E department or for that patient it was good that she had observed certain things; when we work in the same corridor it is easy to comment for a few seconds or half a minute. (physician 12 at a hospital clinic 2005)

However, when I asked the nurses about the close collaboration and direct feedback, their opinion was that the physicians were far too busy to give comments on single patients. It was only in cases when the physicians conceived an assessment as being incorrect that a nurse got some feedback. 'But of course if they want to tell us something we are always here', was one remark.

9.4.1 The computerised system for decision-support and competence development

Since no doctors physically supervised the HCC, the project group behind the introduction of the service HCC Fyrbodal was very concerned that the 'new' telenurses' competence should instead be complemented by a computerised system for decision-support. The importance of the decision-support system was stressed highly by politicians and administrators as a means to guarantee medical safety.[95] However, for the professionals, mainly the physicians, safety based on machines and guidelines could hardly be seen as a complement. In their definition of professionalism, it was not possible to capture professional medical knowledge and empirically based problem-solving within a simple system or software for medical diagnosis and consultation.

One positive aspect of the HCC, in the longer run, was the possible standardisation of the first contact with the healthcare system. According to some professionals, an HCC might facilitate the same encounter and advice given throughout the system, i.e. coherent advice applied for a whole area. They recognised, however, the difficulties of such a mission. The negative side was that the telenurses were not specialised in different areas in contrast to the previous situation, when the nurses at each department only took care of questions within their speciality:

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94 However there are some exceptions such as the district nurses who make up a group working at a distance from the general physicians.

95 Evidence-based health care (medicine) within medical work corresponds to the conscientious and systematic use of scientific facts, i.e. evidence together with clinical experience and the preference of the patient (SBU *homepage* 2007).

> Our nurses who work with the group of children the whole day, they have knowledge about the patients. It is always easier if you know the patient for whom the assessment is made, if they should have an appointment or not, what symptoms to focus on and whether there are any important aspects to consider. (physician 12 in a hospital clinic 2005)

9.4.2 Frosty work relations and controversies

The work relations between telenurses and other healthcare staff varied for different kinds of healthcare providers. Displeased professionals tried to provide direct feedback on incorrect assessments made by the tele-nurses', because they felt that call-seekers were sent to the A&E departments 'in vain'. This was done by hand written-messages sent per fax to the HCC. At times, the personnel from A&E departments called the HCC when they had a busy time, calling into question how the telenurses were actually working. Little by little, the contact physicians decided to collect feedback from their colleagues. The physicians stated, however, that they were overloaded with work and referred to the time. Some of them thus considered it very difficult to prioritise the HCC.

9.4.3 Hard to meet both quantity and quality goals

The professionals tried to prioritise their own work at the healthcare department, but this was constantly a matter of whether they should give some patients more time or if they should try and encounter more patients. The result of examining too many patients at the time was that the quality of the encounter between the patients and the physicians was affected. The physicians felt that it was hard to perform a decent job, i.e. to really listen to and communicate with the patient. The most important aspect of this was expressed as giving professional care within a reasonable time, without waiting too long, at the same time as the professionals had their own ethical considerations on good medical interventions. Consequently, it was extremely hard to fulfil both quantity and quality goals simultaneously.

9.4.4 Market forces and contradictory messages

Some professionals seemed really upset, asking what was happening to healthcare, when the social goods of healthcare were being invaded by market forces? How could one reasonably and decently organise the work of prioritisation and stratification of the consumers' needs? And who should take care of those who required all kinds of care? It was considered contradictory that the politicians purchased a specified number of appointments on the one hand, and promised the citizens a guarantee of unlimited care/service on the other:

> One can read on the same page in newspaper, one article declaring that now the waiting times at the clinics have increased and another article saying that the healthcare guarantee group has decided that everybody should have access to healthcare within the existing frameworks, i.e. within the framework that we have today! Then it is obvious that these two things are not possible to combine.... I don't know how they are thinking, the politicians, they are steering one group, the professionals by their definite purchases, and the other groups, the patients, they are promising rapid and unlimited access. *But it does not fit!* (physician 2 at primary care centre 2005).

The professionals considered the HCC as one attempt to combine two goals that were not compatible – the required limited numbers of physicians and possibilities for appointments with the statement of service and unlimited access to healthcare.

CHAPTER 10
THE CARE-SEEKERS' DOMAIN

Care-seekers want to get in touch with healthcare when they experience a need and when they have the time. They also want rapid access as well as their needs and demands satisfied. During the period of study, care-seekers started to adapt to the new routines to first call the HCC, when they needed healthcare help out-of-hours. Some, however, were upset that they could not get the help of their own free choice. Others were very pleased with the help regardless of time or place, and the encounter with the telenurses. At the HCC, the care-seekers sought a confirming encounter, relevant help and good service. They expect the telenurse to be service-minded and calming, offering security and caring at the same time as they do not feel obliged to behave similarly in return. The telenurse was evaluated in terms of being trusting, and how care-seekers conceived her willingness to help or try to find a solution. Many care-seekers do not want to accept the idea that healthcare is limited and should be prioritised according to needs, urgency and state of vulnerability. When calling the HCC, care-seekers pay most attention to the service given and the encounter. Consequently, despite the poor access, the quality of the advice and needs fulfilled were major sources of satisfaction.

Figure 10.1 Care-seekers' conceptions of HCC – goals and arguments.

Institutions	Domain	Goals	Arguments	Battlefield
GOVERNANCE & POLITICS	CARE-SEEKERS DOMAIN	Needs and demands satisfied	Service The encounter Help + perceived quality	Access
ECONOMIC & TECHNICAL		Freedom of choice Rapid access & help	Access Security, safety, certainty	Credibility
LAWS & REGULATIONS		'Best' help		
CULTURE				

10.1 THE CARE-SEEKERS AND THE HCC

10.1.1 The arena

The interface between the users and the telenurses exclusively took place over the phone. On occasions, a telenurse calls the healthcare provider, if she has referred a caller and does really wish to get feedback on her assessment. In some unique cases, the telenurses stated that they had called back to a care-seeker in order to hear about his or her health status. Otherwise, the telenurses get no information about the adequacy of their help over the phone. The telenurses are the first encounter with healthcare for most citizens, when they experience some kind of healthcare problem, especially if they do not have a permanent contact at a primary care centre and in cases of problems out-of-hours. The care-seekers do not expect to speak to the same person again. The relation is thus characterised by distance in space and is generally described as momentary and temporary. In

some cases, according to the particular practice of HCC Fyrbodal, the nurses call back in order to supervise the health condition over a critical period (usually some hours).

10.1.2 The users' different roles

Care-seekers, callers, citizens and users are terms used to describe those who are in contact with HCCs. There is, however, a slight difference between the terms, *a citizen* is a person with Swedish citizenship, but it is, however, possible that tourists and other people visiting or staying for a longer or shorter period in Sweden calling HCCs. In the same way it is possible to call a HCC from abroad on questions about Swedish healthcare and it is usual that Swedes living or staying outside Sweden call HCCs. A *care-seeker* is, as the word denotes, a person seeking care at a HCC. A care-seeker is the person in focus of the help offered, but is not necessarily a caller. *A caller* might call on behalf of someone else, i.e. a child, another family member or person in need of help. *A user* is the broadest term and it might include all the above mentioned roles and people making use of the HCC service, for example, healthcare staff and others calling for advice related to their work and patients in their care.

10.2 THE DEMAND AND NEED FOR HCC

10.2.1 The users' sex and their age

More women than men called the HCC, although the relative share of men increased from the first to the second study (77 per cent women and 23 per cent men in 2003 versus 70 per cent women and 30 per cent men in 2006). The majority of the callers were found in the age cohort 31-41 years according to table 10.1. In 2003, 22 per cent of the callers were in the age cohort 21-30 years and 14 per cent within that of 41-50 years old. Over the years the share of young people (below 40 years) decreased slightly, whereas the share of older care-seekers increased. This could be compared with the annual reports of HCCs stating that demand from people +70 was pretty stable at around 8-9 per cent.

Table 10.1 Percentage of care-seekers by age group for 2003 and 2006

The care-seeker's age	2003	2006	Difference
< 20	2	1	-1
21-30	22	19	-3
31-40	42	41	-1
41-50	14	19	+5
51-60	9	8	-1
61-70	5	8	+3
> 70	6	4	-2
	100	100	0

n=300 care-seekers in 2003 and 100 care-seekers in 2006

10.2.2 The rise in the use of the HCC

There was a significant increase in use of the HCC from 2003 to 2006 confirmed by the surveys. In 2003, the proportion of first-time-callers was 24 per cent, while the same share was 13 per cent, three years later. A majority of the care-seekers were women both in 2003 and 2006. The women in general had more contacts with the HCC than the men. In 2006, 23 women out of a total of 70 had more than ten contacts with the HCC.

Table 10.2 Percentage of care-seekers by number of contacts with the HCC expressed for 2003 and 2006

No. of previous contacts	2003	2006	Difference
First time	24	13	-11
1 -5	43	34	-10
6 - 10	14	25	+11
> 10	19	28	+9
	100	100	0

n=300 care-seekers in 2003 and 100 care-seekers in 2006

Chi-square; $p \leq 0.002$

Table 10.2 might be interpreted as the HCC having few new users, and in 2006 most of the respondents had used the HCC on several occasions. In 2003, many of the interviewed (38 per cent) said they had been in touch with the HCC because they were referred from the hospital. This answer might be interpreted either in terms the caller being connected by a person at the hospital's telephone exchange within an A&E department, or being connected by the answering machine at a primary (emergency) care centre:

> I called the hospital but nobody answered. Instead there was an answering machine that told me to contact the HCC. (user 231 2003)

A quarter of the respondents said that they had received information messages or magnets marketing HCC and the telephone number. Such information was provided by the hospitals, the primary care centres and the pharmacies in the area. In connection to the introduction of the HCC information and posters were put in the waiting rooms around Fyrbodal. In 2003, none of the respondents mentioned the internet as a channel of information or that they had been connected from the emergency telephone number 112. Some said that they had used the telephone book in order to get the number of the HCC; others had got the information about the HCC from relatives and friends. Some users were of the opinion that they had always known that the HCC existed or that the existence of HCC was general knowledge, which probably meant that they were used to calling an HCC in another part of Sweden. Some of the callers worked within the care sector which was how they knew about the HCC. However, as almost two thirds of the callers (62 per cent) in 2003 had been in touch with HCC Fyrbodal before, it seemed that awareness that the HCC was the first place to call had rapidly spread as early as one year after its introduction:

> Are there other possibilities to get through to a healthcare unit? I thought the HCC was the only option? (user 133 2003)

Some were very critical as they believed that freedom of choice was limited: the HCC had become the point of reference and the gate necessary to pass before getting access to healthcare, more advance healthcare resources, prolonged assessments/diagnoses and treatments.

10.2.3 Time taken to contact the HCC

Most callers made contact with HCC Fyrbodal during the evening between 4 and 11 pm., see table 10.3 below. Slightly more calls were made in the morning (7-12 am.) than during the day.

Table 10.3 Percentage of care-seekers by time of call to the HCC for 2003 and 2006

Time of call	2003	2006	Difference
7 -12 am.	36	33	-3
12 am. - 4 pm.	23	20	-3
4 pm. - 11 pm.	41	47	+6
	100	100	0

n=300 care-seekers in 2003 and 100 care-seekers in 2006

Proportionally the telenurses answered more calls during the weekends than during the week days, although most of the calls in this survey were taken during week days. The surveys followed the HCC's own statistics. The statistics also revealed that the evening calls to the HCC had increased in later years. There seems to be a close relationship between demands on the HCC and opening hours as well as accessibility in general to healthcare in the area. Many people call the HCC on Saturday morning when they are free from work and consider it a good time or inappropriate to wait any longer to deal with the family health. Apparently, having a long weekend breakfast and discussing ailments also leads people to seek advice and care in some sense.

10.2.4 The citizens of Fyrbodal and different users of the HCC's service

Table 10.4 shows how the different areas vary in terms of their utilisation of HCC Fyrbodal. The numbers are expressed as real figures as well as a percentage of the total number of calls per year.

In 2006, the numbers of callers to HCC Fyrbodal corresponded with the population in the different areas of Fyrbodal, with the exception of the rural parts of Dalsland – having fewer calls to the HCC in proportion to their inhabitants and the number of calls three years earlier, between 5 and 6 per cent. The relative increase in the number of calls was, however, most significant for Dalsland. Over the period, in the rural the increase corresponded to 180 per cent in Dalsland and to 166 per cent in N Bohuslän. The increase of calls from urban parts, i.e. Trestad, was about 150 per cent and from 'other areas' 62 per cent. Calls from

'other areas' implied calls mostly from other parts of the region and included calls from mobile phones.[96]

Table 10.4 The distribution of calls among Fyrbodal's three areas

Area	2002	%	2003	%	2004	%	2005	%	2006	%	Increase 02-06 %
Dalsland	3,051	**5**	4,955	**5**	5,277	**5**	6,870	**6**	8,532	**6**	**+180**
N Bohuslän	8,543	**14**	14,866	**15**	18,999	**18**	20,611	**18**	22,753	**16**	**+166**
Trestad	35,393	**58**	66,400	**67**	65,440	**62**	69,848	**61**	88,166	**62**	**+150**
Other areas	14,035	**23**	12,884	**13**	15,832	**15**	17,176	**15**	22,753	**16**	**+62**
Total number of calls per year	**61,022*)**	100	**99,104**	100	**105,548**	100	**114,505**	100	**142,204**	100	

*) In 2002 HCC Fyrbodal was only open for 295 days due to its start in March 2002

Moreover, those between 31 and 40 years old taking care of sick children use the HCC most frequently. Some older people were used to telephone advice, others experienced it as strange and difficult, especially if they had to talk to an automatic voice or press buttons to indicate information. Most of the calls for children (< 18 years) concerned fever, abdominal pain, symptoms of infections (e.g. ear infections), soar throats and coughs. The calls from the elderly (persons > 70 years) were mainly about abdominal or chest pains, urinary infections and difficulties e.g. in breathing, together with questions about medicines (*Annual Report HCC* 2005).

10.2.5 Calls on behalf of somebody else

In 2006, women usually called for themselves as often as they called for children in their care (46 per cent and 48 per cent respectively), while men usually called for matters regarding themselves (60 per cent) and only in 37 per cent of the cases for children in their care. Several telenurses, however, observed that it was frequent that men call when the matter was an emergency for their child:

> ...it is like now it is really important that our sick child got an immediate appointment at the A&E department, and then the men try to summon up all their energy in order to confront me [the telenurse] convincing me of the importance of making an acute appointment. (telenurse 9 2006)

About half of the conversations concerned children below 18 years old in the care of the callers (50 per cent in 2003 versus 44 per cent in 2006). However, from 2003 to 2006 the share of adult cases did increase marginally, but the difference between the two samples is not statistically significant. Of these, the majority of calls concerned people in the age span between 18 and 60 years and only a minority comprised those above 60 years (13 per cent in 2003 versus 12

96 The typical Swedish or Danish call centre serves the overall national market in contrast to call centres within the healthcare sector, which mainly have regional user area (cf. Sørensen and El-Salanti 2005: v; Strandberg et al. 2006).

per cent in 2006) and callers above 70 years old were even fewer (6 per cent in 2003 and 4 per cent in 2006).

Table 10.5 Percentage of care-seekers for whom help was sought for 2003 and 2006

Person in need of help	2003	2006	Difference
Oneself	41	50	+9
Child in one's care	50	44	-6
Wife/husband	5	4	-1
Parent	2	1	-1
Other	2	1	-1
	100	100	0

n=300 care-seekers in 2003 and 100 care-seekers in 2006

However, research on the factors and circumstances that contributed to misjudgements and filed complaints have shown that a major cause of the complaints that were made arising from wrong assessments is second-hand information and that the telenurses did not talk directly to the sick person (Wahlberg et al. 2005).[97] Consequently, the recent training of telenurses has stressed the importance of talking directly to the person being assessed. Also important for the assessments is non-verbal communication and all kinds of sounds (Edwards 1998) such as the ongoing behaviour and preoccupation of the sick together with the sounds of coughing and breathing. This means that changes in the group of callers might either be a result of the telenurses adopting new practices adjusted for telephone mediation or that the patterns of callers has actually changed. There is good reason to assume both that the telenurses have been more proficient in using the phone and call centre technology and at the same time that new groups of care-seekers are calling the HCC.

10.2.6 The callers' language skills

Only 6 per cent of those interviewed had another mother tongue than Swedish, and only in very rare cases did those interviewed have problems in making themselves understood. One reason is connected to the criteria of exclusion in the studies, where those who had difficulty in communicating were excluded (see also chapter 5 on methodology). Other reasons might be that it is more difficult to make assessments when the telenurse does not understand the caller and vice versa. Usually, this leads to a practice, documented by the telenurses as 'hard to assess because I don't understand', 'problems of language' or 'the callers had problems expressing themselves' and the telenurses saw no other choice than to refer the caller to the primary care centre or to the A&E department out-of-hours.

97 Complaints to the Patient Advisory Committees, the Swedish National Board of Health and Welfare and the Medical Responsibility Board

10.3 THE ENCOUNTER

10.3.1 The conceptions of the encounter

The encounter embraced a set of questions regarding the contact with the telenurse. Of the citizens interviewed who had been in contact with HCC Fyrbodal, 85 and 89 per cent stated that they were pleased with the demeanour of the telenurse in 2003 and 2006 respectively. They stated that they had been courteously met by the telenurse, who gave them time to describe their problems, had listened to them and given them help and advice.[98]

Table 10.6 Percentage of care-seekers by satisfaction from encounters for 2003 and 2006

Encounter in total The share that agreed totally	2003	2006	Difference
Well received	95	96	+1
Time given to describe	94	100	+6
Skilled	85	90	+5
Easy to understand	92	97	+5
Satisfied with the answer/ the help	85	89	+4

n=300 care-seekers in 2003 and 100 care-seekers in 2006

In general, the rating of the encounters on all aspects were slightly higher in 2006 compared to the rating three years before. The majority thought that they had been well received by the telenurses. Everybody thought that they were given the time needed to describe their health problems. The majority found the telenurse skilled. The answers were easy to understand and overall 85-89 per cent said that they totally agreed that they were satisfied with the answer/the help that they had got. In total the encounter was conceived very well and on several aspects the rating approached 100 per cent.

The conception of safety was based on that the callers perceiving the telenurse to be a knowledgeable person, who was able to provide help and the time to discuss different possible causes, risks and interventions, swap thoughts irrespective of the time of day and night that they called. Other reasons for satisfaction with the calls to the HCC derived from the conception that the telenurse had helped them take care of their child or themselves at home 'and because of that it was not necessary to go to the hospital' (user 115). It seemed that care-seekers appreciated that they did not have to visit the hospital emergency department and that they received confirmation that they should remain at home. The comments in connection to the encounter evoked feelings of security (*trygghet*) and safety (*säkerhet*), two rather closely related words in both Swedish and English representing two closely related concepts. Security and safety were both factors that contributed to the confidence in the telenurses and the HCC:

98 The alternatives in the questionnaire were agree totally, agree partly, agree rarely and not agree at all. In Swedish Stämmer helt, stämmer delvis, stämmer dåligt, stämmer inte alls.

> *Security (trygghet)* is to be able to talk to a knowledgeable person about your worries and to get support and help, for instance discuss your thoughts, regardless of time – night or day and to get help taking care of your baby at home. (user 253 2003)

> If you leave your personal code number,[99] they have your data in the computer, so the physician also might have a look later on. My grand-mother who is retired has also called..../...One wants to do the right thing and when the HCC exists, one doesn't have to be worried. The HCC is security and one gets good answers. It is particularly important when it is a matter of your first child. (user 33 2003)

> *Safety (säkerhet)* is avoiding going to the hospital in vain. (user 286 2003)

> There is no such thing as sitting and waiting at the A&E department with a sick child. She sent a message to the emergency department that we were on our way so my documentation and everything was prepared when we arrived. (user 143 2003)

Insecurity seems to be related to the fact that many people, especially the elderly, do not understand what the doctor says. The telenurses expressed that it was usual to have older people as well as the young who had been to the doctor's and therefore had many un answered questions: the reasons might be that they thought they were not given the time needed, the doctor talked too fast or in a way that was hard to understand, or that they did not dare to ask the questions they wished. Some wanted to double-check the physician's prescriptions and recommendations; others just wanted to get an additional interpretation regarding the meaning of the doctor's words and deeds.

The quotes also express a widespread misunderstanding that the documentation and the patient's case history is a common and shared object among all the care providers in a healthcare area and even within Swedish healthcare as a whole. The telenurses described encounters with callers who just wanted to have the results of a test taken or callers who referred to 'my last visit to doctor X'. Consequently, some callers did not describe their problem in terms of the telenurse already knowing everything, because the telenurse got all her data from taping the caller's personal number into the computer. However, the telenurse only had access to the documentation provided from contacts with the HCC Fyrbodal and no other documentation was obtained from other healthcare units.[100]

The comments also underlined what the politicians and health administrators stressed, namely that HCCs could be a way to avoid uncomfortably long waiting times within healthcare including time-consuming travel at late hours. Instead, the care-seeker could stay at home and take care of himself or his children and relatives with help from the telenurse. Thus the HCC is considered a solution for those feeling worried. In particular, families with small children and those having

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99 Approximately social security number

100 This is far from panoptical access to patient records. However, recent discussions have concerned how to make records more accessible for different care providers through ICT, among different care providers and different counties. The common databases for Sweden as well as shared within a county/healthcare area are so far a vision which seems to be constrained not only by technical and legal hindrances, but also by problems of acultural nature (see chapter 2).

their first baby needed considerable help from healthcare. The callers stated that they felt confidence in the telenurse based on her commitment and knowledge, but also because the telenurses understood them and confirmed their needs.

> It is easy to talk to them. They talk so that you understand. (user 115 2003)

> We have four children, that is why we use the HCC. It is good as a sparring partner. I am a nurse, myself but for me the HCC fills a good function. One can discuss different problems and solutions. It is one thing to take care of other people, but it is another to care for your own children. One is not always so rational when it is a question about your own kids. (user 196 2003)

It was frequent that healthcare staff and especially those who worked on their own call the HCC in order to get a sparring-partner. But as in the quote above, healthcare staff also called in their spare time on private matters. In the interviews, the callers talked about commitment, which implied that the telenurse showed that she cared, listened and gave the caller time to talk through his problem. She might, furthermore, confirm or reject the caller's own thoughts and in that way she could help them to examine the reason for a problem and its possible solution . Some callers said that the telenurse might not always answer their questions and she might be very unsure about how to address the caller's problem. For some callers this was even acceptable, as they considered that she had really tried to help them by consulting colleagues and books. Some of those interviewed mentioned explicitly the telenurse's knowledge and according to them the nurse had good questions, she quickly got an understanding of the problem and she could give a very detailed or simply a good explanation.

> She gave a very detailed answer. (user 199 2003)

> She really seemed to care and dedicate herself to my problem. (user 212 2003)

> I called because of the problem with my heart and she understood at once what was happening. (user 227 2003)

> She asked really good questions. (user 239 2003)

Still there were also callers who did not experience any confidence in the telenurse. Twelve per cent answered 'partly' to the question about their confidence towards the telenurse. This scepticism seems to be based on the nurse's role as gate-keeper to healthcare and that she was not able to make precise statements/assessments. A few others felt no confidence because they thought that the telenurse was protecting herself and did not give any concrete answers, but very general answers to the question asked:

> They hinder you, you have to threaten them, saying that they will be held *responsible* if something was to happen. (user 150 2003)

> They did not consider that my problems needed urgent care, so they said that I could wait until tomorrow and then visit the primary centre. (user 191 2003)

> I think it is wrong to have people judging others' problems over the phone. It is dangerous. (user 252 2003)

Some callers felt indignant when the telenurse questioned them, some did not understand why she had to ask all these questions and some wondered on what grounds she had the right to hinder them from seeking healthcare. Many callers considered that they had the final decision. But even if the decisive power belonged to the caller, some respondents expressed confidence in the telenurse's commitment and her knowledge:

> They will always protect themselves. It is hard to get a concrete answer and even harder when it has to be made over the phone. At the end of the day it is up to me to decide. [the caller worked as a carer and a medical secretary] (user 221 2003)

10.4 THE HELP AND SERVICE PROVIDED

10.4.1 The kind of help/service provided

More than half of those interviewed considered that they were given an answer to their questions and problems (53 per cent in 2003 and 58 per cent in 2006). Between 36 and 51 per cent stated that they had received self-care advice. The tendency, however, was decreasing, in contrast to the increasing tendency regarding information about medication. The figures of callers immediately referred to A&E departments were very significant for the decision-makers. This category had almost been reduced by half. The figures for immediate referrals to contact primary care were also decreasing, while an increasing number of callers were, instead, advised to contact the primary care later or to call back to the HCC.

Table 10.7 Ten categories of help provided by the HCC and the percentage of all callers to receive help per category for 2003 and 2006

Help provided by HCC Fyrbodal	2003	2006	Difference
Information		6	
Self-care advice	51	36	-15
Information and advice about medication	13,7	27	+13,3
Referral – to contact the primary care centre later	18	28	+10
Referral – to contact the primary care immediately	39	29	-10
Referral – to visit a A&E department immediately	34,3	16	-18,3
Referral – to call back to the HCC later*)		23	
Called by the HCC*)		4	
Referral – to another healthcare provider	7	10	+3
Other help	6	16	+10

**) options not available in 2003*

n=300 care-seekers in 2003 and 100 care-seekers in 2006

The questions used to obtain the data for table 10.7 allowed the respondents to indicate several alternatives. Each alternative is expressed as a percentage of the total number of respondents per year.

In line with the findings from these studies of HCC Fyrbodal, the patient flows to acute care showed a reduction, at the same time as referral to later contact day care and primary care had increased (Andersson 2005: 46). In comparison with Wahlberg and Wedling's study from 1999, where one half of the callers had received self-care advice, the findings at HCC Fyrbodal showed less self-care advice. However, the findings in other studies have pointed out that it is usual that the care-seekers' and the telenurse's views deviate from each other on self-care advice. It might be that this is something taken-for-granted by the call-seeker or that the care-seeker does not perceive it as advice.

> The nurse said good things, but I didn't consider it advice, it was something that I knew already. (user 296)

> The same thing as I have got each time, and I know that it has not helped. How can I proceed, that is what I would like to know. (user 185)

Those who received advice and information about medication expressed themselves as being very satisfied or satisfied (80 per cent). Almost everybody who was consulted about medication thought that the advice was easy to understand (95 per cent). Some respondents thought that the advice was partly easy to understand (three per cent). Some thought that, likewise, the self-care advice, the advice on medication was very simple. One person stated that he was very pleased to be reminded on how to act:

> It is an advantage to be able to call and ask if you have any second thoughts, for example, if I have not understood the doctor. It is very easy and is very good help. (user 189 2003)

> I found the advice very unsatisfactory, saying that tonsilitis can go away by itself. It is only wait and see. I talked to my doctor, who thought it irresponsible of a nurse to give somebody the advice not to see a doctor. I myself had a blood clot [embolism] when I was 23. (user 161 2003)

> The telenurse made an incorrect diagnosis. I had to call back the day after and get help to make an appointment. Consequently, my treatment was delayed. (user 2006)

Most of the callers stated that they followed the advice and referrals given by the telenurse entirely or to a great extent (81 per cent in 2003 and 91 per cent in 2006).

Yet 6 per cent in 2003 and 3 per cent in 2006 had not followed the advice.[101] However, several comments also expressed feelings of dissatisfaction towards the advice, because it did not match expectations or because it was not conceived as being correct.

As time went by, the HCC and the A&E departments developed an improved collaboration. A&E required that all patients had to call the HCC before coming, unless in obvious cases of high urgency, and it was well-grounded for the patient to visit a hospital immediately. If a care-seeker with more banal symptoms came without a referral from HCC Fyrbodal, he or she might get a reprimand, and a notice that it could take a very long time before a physician would be able to examine him or her. At least that was how the telenurses described the situation facing the callers to me.

10.5 ACCESS TO THE HCC

10.5.1 The conceptions of access to HCC

> I will call the HCC again if I have the patience to wait. I was satisfied with the encounter, but incredibly dissatisfied with the system and the extremely long waiting time. (user 214)

As to the time that the callers estimated for waiting on the phone, about two thirds of the callers had access to the HCC within its own time limit of three minutes in 2003, while only a half of the callers in 2006 got through within three minutes. It meant that the waiting time had increased from 2003 to 2006 and the increase was statistically significant. In 2006, thirty nine per cent estimated that their waiting time ranged between 4 and 15 minutes, while 9 per cent estimated it as between 16 and 30 minutes. One person said that he had waited for one hour, two persons for 40 minutes and one person for half an hour. The average waiting time was 7.5 minutes, while the median remained at 4 minutes. Most people had waited in a telephone queue, apart from two persons who had tried to phone repeatedly.[102]

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101 One man motivated this accordingly: 'On the one hand, it concerned referrals to emergency care, but after serious consideration I decided to stay at home mainly because the thought of spending half the night at the A&E department or the emergency primary care centre was not appealing and I did not feel that ill. On the other hand there have been times previously that I felt obliged to go to the emergency department, despite getting the advice that it would be unnecessary. It depends on the evolution of things and if it concerns myself or my children' (user 202 2003)

102 The findings from the survey correspond with HCC Fyrbodal's internal statistics which showed that about 40 per cent, on average, of the callers reached the HCC within the defined waiting time of three minutes during the first six months of 2006 (*Annual Report HCC Fyrbodal 2006*).

Table 10.8 Percentage of care-seekers according to their estimated waiting time for 2003 and 2006

Waiting time	2003	2006	Difference
< 3 min	62	48	-14
4 -15	29	39	+10
16 -30	7	9	+2
31 -60	2	4	+2
	100	100	0

n=300 care-seekers in 2003 and 100 care-seekers in 2006

Chi-square; $p \leq 0.005$

The ambition was that at least 80 per cent of the calls should be taken within three minutes. Yet, the annual report of HCC Fyrbodal (2006) mentions that 42,200 calls were not replied to at all during the first six months, which is equal to 60 per cent of all the calls!!! Some 20,000 callers interrupted the call during the queuing time and about 21,800 did not even get a chance to queue, because of the limited possibilities to register more than a limited number of people at the same time (*Annual Report HCC Fyrbodal* 2006). However, it was hard to measure the calls because of frequent breakdowns of the ICT system. The longest crash lasted from July until November, before the fault was corrected. These two studies of users show that accessibility is also a major problem for the HCCs. This problem has been highlighted in the national investigation (FCC 2005) and is something that the media have stated repeatedly.

The most significant factor affecting caller satisfaction with the HCC was, according to the two surveys in 2003 and 2006, the encounter – how the care-seekers were treated. The encounter brought together the factor of access with that of the provided help including the motivation behind the assessment given by the telenurse. In particular, if the care-seeker gained the conception that the telenurse was trying to do her best to find a solution, it meant that callers in general were pleased with the HCC. Yet the access did not match up to either the callers' expectations or the promises given by decision-makers. Therefore, it is somewhat surprising that the overall satisfaction rate for HCC Fyrbodal was as high as it was, despite the estimation of waiting times. This might be interpreted that access is of lesser importance, and that the encounter and the experience of getting help are more significant. It might also relate to the lack of other options for the care-seekers, which means that if they get help in one way or another they feel pleased. A third way view is that the callers might have a crying need to feel secure:

> It is about security, avoiding going to the hospital, because you don't need that for everything. It is good for me as well as for the children. I always call in beforehand... [I do something else] (user 11)

> To get help... one has to know where to go, for the moment it is not obvious – which of the hospitals to choose. There are different specialists at the two places, and one has to go to different geographical premises for different problems. So I find it very good to get advice, where to go and who to address; the information has been useful. (user 17 2003)

Continuous re-organisation and mergers were also reasons for the public to feel confused about how to act and where to seek help. In the survey of 2003 one question concerned whether those interviewed would call back to the HCC if they encountered a similar problem in the future. The vast majority (90 per cent) replied 'yes, probably', while some (7.3 per cent) hesitated, perhaps because they felt it unnecessary and always felt forced to announce their arrival at an A&E department:

> ...if it was really acute, I would go immediately to the A&E department. If I have a broken leg, then I know that the HCC cannot help me. (user 15 2003)

On the other hand, some persons said it was good to call the HCC before going to an A&E department or an emergency primary care centre. Accordingly, the HCC could take care of the preparations and they had canvassed support from the staff for the broken leg, like obtaining information about the most appropriate care-giver, because the division of specialists over the catchment area was not known to the citizens. Several respondents suggested that it was an applied practice for the HCC to transfer documentation, including the anamnesis, to the A&E departments or the emergency primary care centres when the HCC referred a caller out-of-hours or when the HCC made an appointment for a caller for an early morning visit to the primary care centre. This routine was appreciated by the care-seekers, as it gave them the feeling that the waiting time was shortened and the visit went more smoothly:

> The nurse informed the A&E department that we were on our way. They know what cardiac problems are. If one is worried, it is a relief to be able to phone and get things confirmed. (user 227 2003)

> It differs from time to time. Sometimes it is very easy to talk to certain persons, with whom you get a better contact. Some persons are more talkative than others, I am a nurse but I prefer not to mention it to the HCC. (user 196)

10.5.2 The conceptions of primary care centres

In terms of the primary care centres, about half of those interviewed stated that they were very or quite satisfied with the primary care centre, while the other half expressed themselves as being either satisfied or dissatisfied. Of the latter group, 18 per cent expressed their dissatisfaction:

> We go most often to the paediatrics. We have signed up for one primary care centre. But we feel that we are refused care and that we have a lot of friends that experience the same thing. Our politicians make unserious decisions; it is not the nurses who are making mistakes. (user 253)

The comments claimed dissatisfaction because of poor accessibility over the phone as well as to getting an appointment with a general physician. From the comments the users evoked a situation perceived as unsustainable because of the lack of or constant shift in physicians. Several primary care centres seemed to base their medical provision on temporary general physicians employed by manpower agencies. The shortage of staff of this kind is usually compared with a relay race, where one physician is replacing the other in a never ending chain of

baton-changing. The interviews described that they never met the same physician twice, and words like arrogance, insensitivity and incompetence expressed the dissatisfaction connected with temporary physicians. Hence one wish that was repeated by several respondents was for sustainable relations with the same physician:

> The primary care centre, yes... I feel that it is very hard to get access over the phone. They are always under stress. Different doctors each time. I need someone to whom I can confess how I feel and can calm me down. (user 62 2003)

However, several respondents commented on their dissatisfaction about the primary care centre, but when they were asked to rate their service, the answers frequently appeared within the category of 'rather satisfied'. This way of responding was motivated by statements such as 'they are doing their very best' and 'the nurses are very pleasant', which might be seen as a sign of gratitude.

This picture of poor access and physicians continuously changing in a relay (*stafettläkare*) were confirmed by the telenurses at HCC Fyrbodal. The telenurses found it hard to refer care-seekers to some of the healthcare centres, wards and departments, which they knew experienced problems such as staff shortages and poor access over the phone. At the same time, the telenurses stated that the callers' attitudes towards the HCC and its staff had changed from the very negative attitude in the first year towards more positive feelings about the contact with HCC:

> Over the last year the health call centre has developed enormously, I feel much safer when I call them now. (user 478 2006)

> If think the primary care is useless, but our private physician is super! I have reappraised my opinion about the HCC. It is positive, I am ready to give them another chance. (user 425 2006)

In the beginning, the care-seekers were upset because they were forced to call the HCC instead of making direct contact with the A&E department – either by phone or by an immediate visit. After two years, the callers seemed used to phoning the HCC and no longer complained about it. According to the telenurses, the citizens tended to be more open for help and advice when they called the HCC, than what the telenurses were used to from their previous work in primary (emergency) care centres and special clinics. Leppänen (2002), who has analyzed the telephone calls to the primary care centres, concludes that care-seekers do not expect that the nurse at the primary care centre will make an assessment of their needs and conditions. In contrast, he states that it is usual that care-seekers encounter the nurse on the phone as more like a secretary, from whom they obtain help in getting an appointment to the physician based on their own home made diagnosis.

Access to healthcare over the phone seems to be a general problem in the urban parts of Fyrbodal, i.e. in Trestad and Norra Bohuslän, but not in the rural part, i.e. Dalsland.[103] The telenurses thought that such difficulties, in combination with long waiting times to the hospitals because of cost containment, were further reasons why more people, including new groups of callers, turned to the HCC with their worries and problems even during daytime. Poor access was also, however, a major problem at the HCC Fyrbodal. The pressures on the lines were especially severe during evenings and weekends. The statistics for the other HCCs in the region showed similar results where about 65 per cent of calls were taken within the predefined time. However, measurements of HCCs in the nearby city of Gothenburg have shown that only 10 per cent of all calls to them came through. But the situation in Gothenburg was much more severe because the HCCs are undersized and not at all dimensioned for the larger population and its greater needs (*Förstudierapport* 2005).

103 One enquiry made at all Trestad's primary centres in 2002 showed that 70 per cent of the staff answered the phone within five minutes at only four out of twenty primary care centres (*Beställarbokslut Trestad* 2002: 8-9). A similar result was presented for Norra Bohuslän (2002:9). However, the availability over the phone to the primary care centre in Dalsland was seen as very satisfactory – at five primary care centres 75 per cent of the calls were answered within five minutes and at the rest of the primary care centre 50 per cent of the calls were answered within the same timeframe (*Beställarbokslut* 2002: 9).

CHAPTER 11
ALL DOMAINS TOGETHER – A BATTLEFIELD

> …within healthcare everybody does the best they can, although it can go very wrong for the patient. Each department is only concentrating on their thing and then they let the patient go.... So nobody has the overall picture, nobody is thinking about the result – what is the result??? That is not obvious as we deal with human beings. How do we measure health? There are many definitions, aims and opinions...(telenurse 5 2003)

Considering and contrasting the main group of actors and their different conceptions, interests and actions, this chapter will analyse some of the conceptions pointing out a range of contradictions. These factors make up the actors' battlefield and are the reasons for tensions, even conflicts, in relation to the HCC Fyrbodal.

Figure 11.1 The tensions, contradictions and different interests influencing the HCC.

Institutions	Domain	Goals	Arguments
GOVERN-ANCE & POLITICS	POLITICAL DOMAIN	Strategic planning Allocation of resources Equity and justice Meet needs & demands Value for tax money	Prioritise & control Rationalise Divide work/specialise Coordinate resources Improve/restructure Halt conservatism Empower patients Steer consumption Foster new attitudes
ECONOMIC & TECHNICAL	ADMINISTRA-TIVE DOMAIN	Cost-efficiency Productivity Service delivery Control of labour & activities	Divide work/specialise Rationalise Evaluate and control Market competition Financial consciousness Coordinate resources Provide service/Empower Meet new consumption Foster new attitudes
LAWS & REGULA-TIONS CULTURE	PROFESSION-AL DOMAIN	Autonomy of work Self-regulation Ethical behaviour Consult, alleviate and cure medical problems	Professionalism Duplicity of work No continuity Competence Problem-solving TAN of higher quality Medical safety
	CARE-SEEKERS DOMAIN	Needs and demands satisfied Freedom of choice Rapid access & help 'Best' help	Service The encounter Help + perceived quality Access Security, safety, certainty

BATTLEFIELD

Legitimacy, Responsibility, Needs & Demands, Trust, Value for money, Satisfaction, Access , Credibility, Labour, Costs, Resources, Influence, Control, Information, Knowledge, Status & prestige, Working Time, Workload

Figure 11.1 summarise the actors' conceptions ending up in a battlefield. The factors that are discussed by several groups of actors are also analysed in this chapter pointing at efficiency, service (consumer patterns) and aspects of control and coordination. These are contradictory in nature or fraught with conflicts. Responsibility seems to be an all-embracing factor which is a central concern of all the actors, whereas other aspects related to work and work conditions are marginally covered.

11.1 THE HCC: IMPROVEMENT AND EFFICIENCY?

11.1.1 Modernise versus preserve

Most decision-makers saw the HCC as a way to modernise healthcare and a way to fulfil both goals for the organisation and the users (cf. Carter and Mueller 2002). The professionals, however, doubted the efficiency and the real improvements in practices. This was interpreted as the professionals' leitmotiv in terms of resistance and even conservatism by decision-makers. Administrators expressed healthcare as a battlefield of different views, i.e. between the traditional professional way to conceive what was possible to do and the politicians' extensive urge to win over public opinion and legitimacy for their actions…Located in the middle were the administrators who had themselves different opinions.

11.1.2 Disagreement about responsibility

When talking about the work and organisation within healthcare, the politicians strongly emphasised that these matters were not their responsibility due to the split in roles of purchaser and provider (cf. von Otter 2003). Their role was to purchase healthcare on behalf of the citizens. The administrators and the professionals should take care of the daily provision and management of healthcare. The split of responsibility had impacts on changes such as the introduction of HCCs. The politicians claimed they had no means for considering dissatisfaction, or responding to protests that might affect their restructuring activities, yet it was the health providers who must shoulder their responsibility and carry out any actions to eliminate the reasons for complaints (cf. von Otter 2003: 96). In Fyrbodal the politicians were unified in their opinions, although they were in opposition to the other healthcare staff and citizens and professionals. An obvious risk related to HCC Fyrbodal was expressed, by those critical, as increased bureaucracy and the duplicity of work.

11.1.3 Fewer visits but increased demand over the phone

In the UK, healthcare call centres have been shown to reduce general practitioners' workloads (Lattimer et al. 1998). Findings from the national survey carried out by Munro et al. in 2003, indicate a halt in an upward trend in demand for the out-of-hours work of general practitioners. NHS Direct has further reduced the telephone calls for advice to A&E departments (see also Jones and Playforth 2001) although it had no effect on attendances at A&E services. In Fyrbodal the patient flows to emergency care decreased with the introduction of an HCC.[104] However, the pressure on traditional

104 Certain attempts to measure patient flow to primary care centres were undertaken by the professionals, however without giving any significant results in terms of change.

healthcare phones was still extremely high, and both primary care and the HCC Fyrbodal were suffering from low accessibility. The politicians questioned themselves on how this could be possible – had the offer of new healthcare telephone lines increased the need for advice? And if that was the case, there must have been a group of people who did not manage to get through before. Or was it a matter of people who did not contact healthcare previously? The question has remained unanswered.

By introducing a 'third-party', the HCC, the expressed aim was to make it easier for people to obtain care, but one perhaps unforeseen effect might be that the service tends to increase people's demand for healthcare (see also Goode et al. 2004 for the situation in the UK). The dilemma, however, is how to meet the public demand efficiently, in terms of the appropriate use of service and effectively, and to meet the public's expectations of responsiveness to their needs. Goode et al. (2004) argue that NHS Direct in England was an answer to the rising demand for healthcare. The inception of British HCCs claimed to yield initial administrative benefits within primary care in line with the government desire to realise both clinical and financial benefits (DoH 1996). By this action, Goode et al. (2004) argued that politicians were moving professional authority and the role of primary gatekeeper and informal 'rationer' from the general practitioners in private practice to the telenurses. In Sweden, most phone calls to healthcare providers are handled by nurses, and although a similar reasoning to that in the UK is relevant for Fyrbodal, the transfer here has occurred from traditional care units to HCCs. Furthermore, the professionals expressed that their influence over the telenurses' competence had reduced as had their decisions on what care-seekers to give appointments and when appointments should be given. However, HCC Fyrbodal was considered a complement to the area's ordinary healthcare provision.

11.1.4 Harder to assess but easier to prioritise

Accordingly, one element of the HCC is about rationalisation, prioritisation and steering care-seekers. Professionals, administrators and politicians have agreed on the need to prioritise by word. When not enough prioritisations are made, expressed by decision-makers in terms of rationalisation not being enough, the professionals try to hold the politicians responsible as representatives of the public will, while the politicians claim medical knowledge as being the final basis for decision (a conclusion also made by Rosén 2002). Several reasons are stated for this: in practice it is difficult to bear the responsibility for uncomfortable decisions and it is easier to prioritise according to importance than to classify cases that should not be prioritised (see also Socialstyrelsen 2007). Professionals claim that it is one thing to draw up priorities on paper, and another to turn them into practice.

Assessments and advice are considered to be easier to carry out in face-to-face interventions. It is perceived to be less complicated to observe and make an assessment on how serious a symptom really is when facing a person. In terms of prioritisation and gate-keeping in individual cases it is, however, easier to turn away a person over the phone than in a personal meeting. Professionals at A&E departments expressed the difficulty of refusing a care-seeker, when facing him-or her and with the knowledge that the person had travelled from home at a late hour to 'see a doctor'. In that sense the HCC could prevent unnecessary travelling and make it more feasible for staff to turn away care-seekers.

11.2 SERVICE AND CONSUMER PATTERNS

Needs and demands for healthcare are related to age as well as urban or rural living. One major dilemma for the politicians was the demographic patterns embracing both many elderly people with extended needs because of multiple diagnoses and lower functioning, and the mass younger generation with high demands and wanting their needs as a consumer satisfied.

Decision-makers and professionals agreed that the younger consumers were well aware of their service rights. They desired the best service available at once. They considered healthcare to be a right as a citizen and a right that was taken for granted. Accordingly, there is good reason to believe that people demand healthcare in the same way as they demand service when consuming other products such as banking, fast-food provision, and things from out-of-hours grocery shops (convenience stores) etc. Healthcare becomes a market among other markets.

Furthermore, it is not unusual that people demand care for ailments some of which are really banal and of very little significance, according to the professionals. Consequently, the professionals, mainly physicians, become upset, because they think that citizens do not pay attention to the fact that healthcare is an expensive and scarce collective resource. Furthermore, they conceive that people lack respect for the professionals' time and consideration, especially when people rush to the A&E departments for nothing (in vain). Additionally, it is very costly to society.

For the care-seekers, on their part, healthcare is considered a citizen's right and a right that they are willing to defend. One's demand for healthcare might also be a demand (conscious or not) for other needs to be satisfied, under the guise of physical symptoms, but where healthcare tends to be the only way or solution visible and possible for such problems.

11.2.1 Adapt to needs and demands versus changing them?

Several administrators claimed that the HCC was necessary in order *to meet a new and existing pattern of healthcare consumption*. The HCC should improve health provision by promoting new patterns of seeking healthcare. Being very service-minded, the telenurses should *encourage* citizens to take care of themselves and their relatives at home with the aid of self-care advice. Service-minded telenurses are therefore urged by the administrators to encourage citizens to assume 'empowered' ways of acting, such as self-care being mindful of the rational use of healthcare.

A similar conception, however with another significance, often expressed by both politicians and administrators, was *to steer inappropriate health consumption*. To promote appropriate behaviour for a situation in Swedish healthcare, the users need to be informed, even fostered to understand the chain of care and how one should encounter healthcare.

The professionals also preferred other kinds of patient flows, at the same time as they emphasised medical safety and quality. For many nurses their efforts were focused on *health problems* and how to encounter people regardless of *the bio-medical causes* of pain, malaise, discomfort and worry.

11.2.2 The responsible care-seeker

All healthcare actors, professionals as well as decision-makers assume that people want to get help at once and they are not willing to wait. People seek help on all kinds of matters. In the UK, the HCC has been discussed (by for example Goode et al. 2004; Goode and Greatbatch 2005) as a means to increase individual responsibility by developing new forms of service provision in line with government policy. Health and responsibility, according to Beck and Beck-Gernsheim, are two basic concepts of the individualised society (2005: 139-148). Despite the lack of an explicit discussion in Fyrbodal, the responsible health consumer is also a part of the market imperative there. The care-seekers should use health service in a reasonable way (cf. Goode et al. 2004).

The role of a telenurse in an HCC was accordingly that of empowering care-seekers by helping them to take decisions for their health and their family, and to a greater extent cure and treat minor ailments at home. This was also expressed as a move from paternalistic relations, where the professional was the one 'knowing best', to 'relations of mutual respect', where the providers give professional support, advice and information in order to support the care-seekers at times of worry and distress. In such a way the professional increases the care-seeker's skills and his or her own ability (se also Goode et al. 2004: 211).

In the UK, there is a tendency to promote individual responsibility for healthcare on the part of the empowered patients acting as sophisticated 'consumers'. However, the result has been argued as being an open distributive struggle between the three original partners, that is the funders/politicians, the professionals and the patients, because patients have gained more power (Goode et al. 2004: 211). In one sense the care-seekers are those involved in the creation and evaluation of a process as reflexive actors; based on previous experience as well as interactions within the HCC in the future, they help to (re)create the service (ibid.). Leppänen (2002), for instance, shows how the callers become skilled at describing in ways such that the telenurses considered that health problems had to be taken care of instantly. For telenurses it is of particular importance to consider unstable/changing health conditions. High vulnerability care-seekers, who show signs of dramatic and rapid change in healthcare conditions are therefore well grounded to be prioritised medically, socially and psychologically as well as legally (Leppänen 2002: 93-100).

11.2.3 The exigent healthcare consumer

Dent argues (2003: 172) based on a comparative study of different European countries carried out by de Swaan in 1988 that patients have become more *proto-professionals*. By that he meant that people have a higher attachment towards their physical health and express a preference to access specific doctors with a well-known reputation or at least doctors who they believe have a good reputation. This reflects, according to Dent, an on-going process of the *medicalisation of everyday life* that is driving people to seek reassurance from the quality of the medical and the health service available. It implied that people, often from the middle-class, have learnt to express what bothers them in terms of a (quasi) proto-professional vocabulary (Dent 2003: 172). Furthermore, given the quality and the expertise of medical staff, there is a tendency to seek out the professionals that one believes are the best, who might be located in specialist care, academic hospitals or A&E departments (cf. Dent 2003).

11.2.4 A&E departments - an emblem for excellence or just another healthcare provider?

The introduction of HCCs appears to be directly related to the high number of acute visits to A&E departments, especially out-of-hours. An almost unitary conception among the group of actors was that many citizens by tradition consider the A&E departments as the best place for rapid access, housing the most proficient staff in order to get immediate healthcare. Yet, the A&E departments were wrongly perceived by the citizens as the best place for getting the best care, and a way to avoid waiting. In contrast, care-seekers at A&E departments have to wait for very long periods and only have their problems and symptoms assessed superficially , if their problem is not considered acute in medical terms, according to healthcare staff. At the end of the day, many patients visiting A&E wards are referred to primary care for a diagnosis and a first examination. Swedish healthcare is built on primary care having a gate-keeper function. A rational healthcare process requires the primary care provider to refer the patient to a specialist, if necessary.

The case seems, however, to be more complex in practice. Many physicians working at A&E departments have recently graduated from medical school and others are specialised physicians (in all fields of biomedicine but not in general medicine). Professionals at A&E argued that it was not usually the case that citizens rushed to get an appointment at A&E departments, as the physicians' competence and the time allotted there was not optimal for doing extended diagnoses. Instead, the physicians at the A&E departments should save patients from life-threatening conditions. On the other hand, primary care centres employ to a great extent physicians from manpower agencies – and as a result, an orthopaedic specialist might, for instance, be in charge at the primary centre. A possible consequence, argued by healthcare staff, was that a temporarily employed specialist in primary care might refer patients to the A&E department, because he/she was not used to matters of general medicine and minor, general problems that are frequent in a primary care. A specialist might also have the knowledge and experience of complications and advanced problems, focusing on the risks if diseases and problems are not considered. Accordingly, the speciality of the physician on duty, and not just the level of care, is very important for the diagnosis and how patients are referred. Yet the speciality of a physician does not necessarily correspond with the level of care.

11.2.5 Trust in HCCs: nursing versus gate-keeping or both

According to the users' conceptions, the medical safety and the competence of HCCs appears to be particularly important. It is possible to contact a professional to alleviate worries, who can provide support (for example share thoughts and get feedback), and who gives help to take care of oneself and one's children in the home. When telenurses provide self-care the care-seekers can avoid going to the hospital 'in vain'. Many care-seekers are aware that healthcare resources are limited. Some are upset, others consent and some consider not to bother 'the doctors' with problems that seems small, and for those reasons HCC is considered a good alternative. Of major importance is therefore that the telenurses are trustful professionals committed and skilled that can provide security and safe advice. Yet some callers are sceptical towards the telenurse's *gate-keeper function*, that she is an obstacle on the way to the doctor and towards telenurses who cannot make precise statements. The nurse might be perceived as a person who

wants to stop the access to hospitals under the pretext of prioritisation, because she does not consider the case to be acute enough. Feelings of being refused an appointment implied that some callers waited in vain on the phone.

The problems and questions put by the care-seekers are sometimes perceived as very awkward by the professionals. They say that in society people have many worries at the same time as they wish to avoid risk, uncertainty and guarantee themselves against all kinds of threats, including risks to their own individual life planning. It is for example unacceptable that health problems, illness and injuries intervene, when people are supposed to work or when they have planned for a holiday or other kinds of events considered as important. Consequently, the professionals considered themselves as available tools for helping people fulfil their individual life projects (cf. Beck and Beck-Gernsheim 2005). Such conceptions expressed by the care-seekers are generally not approved by professionals, while decision-makers and especially health administrators as well as nurses are to a greater degree debating about providing services for all kinds of problems, not just medical ones.

11.3 CONTROL AND COORDINATION

The politicians stressed the importance of control systems in order to better use taxpayers' money and more efficiently steer healthcare resources. The constructed health market was, however, considered to be complex, and it was 'a complicated process' in order to create 'superficial' competition between care-providers. The overall conception was that in the end resources are allocated by a kind of budget-process anyhow and a ceiling for costs is inevitable – the new aspect is the control exercised by the administration and new computer systems. The administrators agreed that a great deal of time and consideration are dedicated to compiling material for decision-making, carrying out follow-ups and evaluations as well as analyses (cf. Brorström 1995:40-43). For the administrators, management practices were appreciated, although there was still a problem in encouraging professionals to save money or be efficient, as there were few real incentives to stimulate such efforts (cf. Brorström 1995; Norbäck and Targama 2006).

11.3.1 Responsibility but not authority

It is claimed that today's healthcare has decentralised both work and responsibility. The professionals have, however, ambiguous attitudes on these issues, indicating that the decision-makers have little confidence in them (cf. Brorström 1995: 44). This has instead meant more complicated rules and routines for the professionals. Furthermore, responsibility is defined in financial terms and not in relation to the patients. It is difficult to evaluate the adequacy of treatments or the patients' total well-being and recovery prognoses, yet these should be the most essential performance criteria for healthcare, according to the professionals.

Professionals, represented by a departmental manager, have responsibility for budgets, manning and other resources, within the practice of separate cost units, also called here the 'independent health centres'. Accordingly, at the HCC as elsewhere in healthcare, professionals are responsible for medical quality/outcomes and should protect patients, carry out interventions and treatments in order to avoid malpractice, misjudgements and mistakes that risk harming the patients. However, the overall

framework – such as healthcare budgets, overall planning, policies and ideological ambitions for four years at a time – is related to the terms of office and defined by political decisions. Politicians continuously undertake organisational changes and the restructuring of activities, which have an impact on the daily medical service. The professionals do not feel involved or able to influence their working situation, which in turn, creates a feeling of inadequacy and lack of commitment. Yet, from the administrators' point of view, these kinds of complaints are characteristic of professionals, as they want to be involved in everything, no matter their competence, the relevance of different issues to their work and their right to decide.

The professionals consider that politicians put heavy demands on them, besides the already too high level of pressure from the patients, instead of facilitating and helping them in their duties. Mergers of hospitals and healthcare areas have been fashionable since the mid-1990s (Harrison and Calltorp 2000). The professionals described counterproductive results for medical quality in terms of enormous bureaucracy, complex issues of coordination, duplicity of work, unreasonable and irrational divisions of work, bewilderment on how to act from both professional and patient perspectives, new sub-optimality and a jealous guarding of one's special interests.

Yet it is not only the message to the professionals that is ambiguous, the political message to the citizens is also contradictory. The politicians steer the medical service by the exact amount of service that they purchase for the providers, at the same time as they promise care-seekers' and patients' rapid and unlimited access (*Guarantee of Medical Treatment* 1992, 1997 and 2005). Likewise, the HCC is considered to be an attempt to join two incompatible goals – free and rapid access to healthcare, while the organisation is strictly limited by its budget, numbers of appointments and interventions possible to manage. Free access to healthcare and to healthcare providers is, however, not applicable for HCCs, considered as the first and frequently mandatory contact with healthcare.

11.3.2 Standardisation and coordination

The well established division of labour (specialisation) has led to a healthcare organisation constructed by a multitude of independent/isolated units and occupations, which are still very concerned about their own autonomy. The coordination of actions processed by an HCC is expected to lead to a higher standardisation of practice in the entire healthcare system and a better integration between units and professionals. Such expectations were expressed both in the conceptions of the decisions-makers and by the professionals having the first contact with care-seekers in all kinds of healthcare units.

However, like other professional bureaucracies, the coordination of healthcare seems difficult to achieve because it depends greatly on voluntary and mutual adaptation among professionals (Mintzberg 1983). The vision for the HCC was to obtain the standardisation of care-seekers' first encounters with healthcare on the front-line as well as cooperation around the patient, overarching goals and a common chain of care. The HCC could be considered as a way to standardise by administrative instructions, regulations and common values as well as by a first classification of the care-seekers – the same practice for the same symptoms and problems. Such ambitions of generalisation should cover each case in terms of complexity and urgency, paying attention to the individual care-seeker, his or her context, as well as the entire

healthcare organisation and its resources. Yet desirable in theory by some, administrators in particular, such standardisation was not considered possible to materialise or apply in practice, according to most professionals.

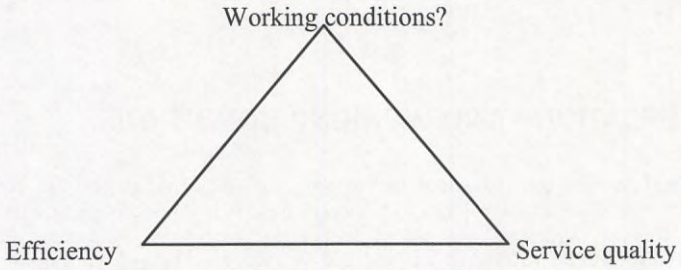
11.4 CONCLUSIONS: CONTRADICTIONS AND CONFLICTS

As with call centres in general, the health call centre is built on the attempt to achieve two fundamental as well as contradictory goals simultaneously. On the one hand, the inception of health call centres means a sharply increased level of routinisation and standardisation aimed at rationalisation and cost-efficiency. This is achieved through the transfer of control over the chain of care and processing public contacts from front-line healthcare to specified telenurses, whose role is confined to providing support, advice, education, information and referral to adequate healthcare units in cases of emergency help. On the other hand, the introduction of a health call centre enables the healthcare area to present itself to local citizens as providing a more accessible, comprehensive, user-friendly and reliable healthcare service day and night, all the year round.

Contrasting the conceptions as well as interests and actions of the different groups of actors, HCC Fyrbodal appears to be a as solution to fundamental healthcare problems. At the same time, the HCC is part of a complex healthcare organisation and it has per se different impacts in terms of contradictions and tensions. Actors disagree about the HCC's prospects for improving healthcare, and about its rationalisation impact. Furthermore, the HCC displays contradictions towards consumer patterns in healthcare – steering and fostering behaviour or meeting the care-seekers' needs and empowerment. Is the care-seeker really responsible or just an exigent consumer? Similarly, the conceptions differ greatly on acute care between healthcare staff and care-seekers. The HCC also involves valuation and control, questioning the independent healthcare units, having responsibility but not authority as well as striving to standardise and coordinate healthcare. Finally, as with healthcare in general, the issue of responsibility is of major significance for all the actors related to HCC Fyrbodal. Having these contradictions in mind it seems, however, that one important aspect is insufficiently addressed – the employment and working conditions at HCC Fyrbodal.

Figure 11.2 illustrates a triangle of three core aspects of sustainable organisations, quality of service, efficiency and a good working life. All three aspects are desired in a well-functioning society and claimed as possible both by HRM, other management and working life theories as well as optimistic partners on the Swedish labour market, (e.g. Korczynski 2002; Huzzard 2003). The relevance of the employment side of this triangle, that is working conditions, will be discussed further in chapter 12.

Figure 11.2 The triangle of focus related to HCC Fyrbodal



What might be finally concluded in this chapter is that since the 1990s, attention has largely been focused on promoting service and freedom of choice for patients/users/customers, and the official debate has focused on change activities aimed at higher efficiency and severe cost containment (cf. chapter 2). On the introduction of New Public Management, efficient management and service imperatives seemed to override the practice and rhetoric, whereas employment relations and working conditions were passed by (cf. Gustafsson 1994; Gustafsson and Lundberg 2004). In a similar way, the case-study and the main actors related to the HCC bear witness that the consequences of work and work organisation at HCC Fyrbodal were only marginally considered by others than the telenurses themselves. The employment relations and work conditions are, however, matters for the subsequent analysis in part III.

PART III EMPLOYMENT RELATIONS AND WORKING CONDITIONS IN AN HCC

CHAPTER 12
EMPLOYMENT RELATIONS AND WORKING CONDITIONS

> If we actually analyse this new so-called technology, we shall find that it is not technology at all. It is not an arrangement of physical forces. It is a principle of social order. This was true of Ford's work... He made not one mechanical invention or discovery; everything mechanical he used was old and well-known. Only his concept of human organisations for work was new. (Drucker quoted in Thompson 1989: 3).

The battlefield also regards aspects such as how the HCC's work should be organised and designed, with what kind of workforce and what might be the working conditions of the employees. Based on divergent interests as well as common goals, the employers' overall wish is to extract effort and human resources in terms of skills, problem-solving and enthusiasm from the workers who, having their own needs and goals, also try at the same time to resist the discipline and the demands that employers impose. Today, specific demands are clearly articulated by customers and colleagues, and increasingly by management itself albeit indirectly (Gabriel 2002; Sturdy et al. 2001). Employees try to use hidden or open resistance to protect themselves as well as use offensive strategies to cope with arduous work, while management has a battery of more or less sophisticated practices and rhetoric to get their way. But the employment relationship is not an equal one as management has the right to hire and fire in their hands, as well as the overall capability to design work and work organisation. Both so-called internal customers (colleagues and other departments) and external customers/users have direct influences on employees, especially at the front-line of an organisation such as that designed for telenurses at an HCC (cf. du Gay and Salaman 1992; Frenkel et al. 1999).

Conceptions of the group of actors involved bore witness to a high level of consciousness about satisfying organisational demands (efficiency and productivity) as well as care-seekers' demands. Yet very few if any demands were made by the employees about their work. Professionals outside the HCC discussed their own work situation, but otherwise the actors barely paid attention to the telenurses' employment relations or the working conditions in the HCC.

12.1 WHY BOTHER?

So a relevant question is, why are employment relations and working conditions important, when analysing an occupation group? In this chapter I intend to discuss some theoretical aspects relevant when considering employment relations and the working conditions of the telenurses.

Employment relations and working conditions are interesting and important in discussions about an occupation group. These factors explore how an occupation is conceived, shaped and influenced by institutions, the group itself and other social actors (see also chapter 6). Accordingly, there is no such thing as

an institution-free or objective approach to work organisation, contrary to what is stressed by universalist research (see eg. Rubery and Grimshaw 2003).[105]

Traditionally, research has seen work and work organisation as comprising of three core areas: the employment relationship, industrial relations and work organisation. These three areas not only provide a functional framework for analysing key areas of working life and its mechanisms, but they also assist 'in drawing out the contradictory or reinforcing aspects of labour management strategies pursued within different organisational arenas' (van den Broek 2004: 5).

12.1.1 Employment relations

Employment relations are crystallised in the employment contract – the formal embracing rules, regulations and agreements as well as the informal contract based on expectations and conceptions towards conditions, trust and promises more or less explicitly pronounced (Isaksson 2001: 175), also called the psychological contract (Rousseau 1995).

The traditional employment contract concerned a salary, a post with conditional tenure and possible promotion in exhange for hard work and loyalty (e.g. Isaksson 2001: 176). Moreover, in contemporary society the employment contract defines the daily activity of most people in their prime age. People are then interested in the rewards from working as well as its conditions and constraints. However, stable employment, internal labour markets and long career ladders are more exceptional, and employees are to a higher extent supposed to manage their work and career development themselves (Allvin and Aronsson 2001). This is relevant for Swedish healthcare, yet it is still a sector in which many employees remain for decades, or commonly their whole working life. In healthcare it is possible to change workplaces within a council or a municipality having the same overall employer – but different physical locations, collegueas, work settings and types of work content. In a nutshell, the relations between employers and employeees are still founded on the exchange of effort for security, although there are other preconditions for loyalty bonds, and new obligations (Rubery and Grimshaw 2003: 3).

Employees have an interest in both the intrinsic and the extrinsic rewards from working and yet face constraints in the conduct of their work. Employment relations are usually in focus for HRM and other management strategies covering recruitment/selection, working times, training and competence development, health and safety, as well as pay and benefits (Frenkel et al. 1999; van den Broek 2004; Bolton and Houlihan 2007).

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105 Universalist theories claim a general application regardless social or economic context (cf. the contingency approach associated with the Aston School or for a discussion about fashion in management theory see also Björklund 2003). For universalists, the social and economic organisation falls within the cognizance of general rules and models regardless of time or place (Rubery and Grimshaw 2003: 23).

12.1.2 Working conditions

Working conditions are related to a range of essential aspects of human life such as attitudes towards work, job satisfaction, pressure on mental health, psychosomatic reactions, the total life situation, leisure, family life and overall social situation as well as one's own identity (Blauner 1973/1964; Hackman and Oldham 1980, Alvesson 1993; Theorell 2006). Working conditions are affected by a number of factors, such as de-skilling and up-skilling strategies, control, autonomy and rewards, increased flexibility, routinisation and intensity, and so forth (Frenkel et al. 1999; Härenstam et al. 2006: 17). A key aspect of one's working conditions, particularly from a labour process perspective is the tension between *organisational control and employee autonomy* (Thompson and Warhurst 1998; Callaghan and Thompson 2001; van den Broek 2004), which is also often studied in terms of employee control and what is demanded from their work.

Karasek and Theorell (1990) argued that work contexts that entail high demands on workers in combination with them having low control (decision authority), few opportunities for learning and development, and low social support have negative impacts on working conditions and pose dangers/risks to workers' health (see also Karlsson and Eriksson 2000: 29-32; Härenstam et al. 2006). The widespread diffusion and application of this theory is connected both to its relevance and its applicability to all kinds of workplaces, industries, occupational groups and situations. However, it is a theory with limits and is open to various interpretations of its concepts (van der Doef and Maes 1999; Karlsson and Eriksson 2000: 33-35). But it does emphasise the satisfaction of inherent, natural needs and the impact of work design choices on human behaviour. Furthermore, the risks of high demand-low decision authority work designs are symptoms of ill-health, depression and burn-out because of low discretion over work tasks, the pace of work, work methods as well poor prospects of influencing planning and the design of one's work (Alvesson, 1993: 49-50; Karlsson and Eriksson 2000: 29-32; Norman 2005).

Overall, relevant dimensions of one's working conditions are related to the division of labour, the technological outline of work,[106] professional consciousness, emotional labour, the fragmentation of work, the monitoring of pace and order, work intensification, and skills used (Gardell och Gustafsson 1979; Thompson and Warhurst 1998; Frenkel et al. 1999).

The following section will explore some theories related to workplace relations, tensions and consensus. Central concepts here are control and autonomy. In this context, Human Relations theory and Human Resource

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106 Technology can be defined in different ways. In line with the studies of Joan Woodward, technology is often associated with mass-production and machines, equipment, and tools. However, that is just one definition; others are can see technique in the wider sense, like a conscious activity. According to the OED (Oxford English Dictionary), technology is a term used rather loosely in sociology, associated with the above mentioned aspects; or a type of social relationship dictated by the technical organisation and mechanisation of work. Technology can also be a strategy with certain implications as it limits or enhances choice, as argued by Friedman. In this sense, technology might change the work patterns of many people (Friedman 1990: 200).

Management theories will be discussed, in particular stressing the distinction between soft and hard HRM-strategies as well as different models of work organisation.

12.2 EMPLOYEE SKILLS AND WORK SATISFACTION

Labour requires, unlike other commodities, a conversion of potential power (labour power) into becoming labour (actual work efforts). Labour is also the basic source of surplus from a product or service which is driven by profit goals and based on the logic of an *accumulation of capital*. Moreover, Braverman (1985/1974) argues that there is an inherent general tendency of modern capitalism production[107] to deskill employees and degrade work. The deskilling process is a consequence of the ubiquitousness of Taylorism and Fordism (the scientific principles). According to Braverman (1985/1974: 359-68)[108] the result of advanced technology was predicted to be fewer workers involved in manual work and more employed as operators. Other consequences were predicted to be a rise in the number of people with occupational training, supervisors as well as people preoccupied in administration and services. New occupation should, however, not be confounded with higher skills or demands for more skilled workers, instead this was simply a question of other kinds of job.

Overall, Braverman argued that the growth of monopoly capital accentuates the separation of conception from execution, and the knowledge of highly skilled labour is removed from the workers into the hands of the managers. Furthermore, the division of labour is continuous, which in the long run has led to a standardisation of work and work intensification for the majority of workers (Braverman 1985/1974). Hereby work might be conceived as monotonous, unqualified and remotely controlled (Braverman 1985/1974).

12.2.1 Workplace relations and tensions

Accordingly, working conditions are based on the structural relationship between employers and employees and the labour process sharpens the need for skill and control at the workplace (Thompson 1989).[109] From a perspective of structured antagonism (Edwards 1979), one major criticism of Braverman's theory of control was his lack of focus on the workplace tension between employers and employees and on the resistance of workers towards deskilling and alienating work (Thompson 1989).

In a Scandinavian approach to studying worker resistance, Lysgaard argues that the workers' collective (*arbjederkollektivet*) is based on the employees'

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107 Defined by Braverman as work and work organisation in advanced capitalism.

108 According to Braverman, the means for a worker to regain the mastery of his/her work was a demystification of technology and a reorganisation of production. In Thompson's words (1990), Braverman's theory was based on an idealisation of former conditions for artisans, thus of little consequence for contemporary labour process theory.

109 However, most contemporary labour process theorists do not share Braverman's thesis of a general deskilling tendency in society, nor do they share the belief of the ubiquity of Taylorism as a system of control (Thompson and Harley 2006: 3).

efforts to maintain a human system in opposition to the managerial technical/economic system. According to Lysgaard (2001/1961), the technical/economic system of working life has insatiable, inexorable and inevitable demands, whereas the human system is based on bounded employees with multiple actions and needs besides their work, for example the principal needs for security and protection (2001/1961: 70-71). The needs for protection and security (the human system) is also one of several reasons why employees in similar positions form alliances (the collective system) as spontaneous reactions and resistance towards the controlling technical/economic system (Lysgaard 2001/1961).[110]

A central notion of the workplace in historical analyses has been described as a contested terrain of interest and as a tension between control and resistance within workplace relations (Edwards 1979). The basic assumption here is that of a structured antagonism between labour and capital (Edwards 1979). According to Thompson and Harley (2006), labour process research has long recognised 'a continuum of possible, situational-driven and overlapping worker responses to relations of ownership and control in the workplace – from resistance to accommodation, compliance and consent' (2006: 4). This is in line with Elger's comment (2001) that labour process theory in the 21th century has accepted a third way based on a relative autonomy for workers. Instead of focusing on a wider class struggle, labour process theory these days is more concerned with the tensions and developments in the organisation of work. However, in contrast to managerialist theories (for example Human Resource Management) based on competing but complementary interests (Korczynski 2002), labour process theory accounts for conflicting relations because of the incompatible interests of employer and employee (e.g. Edwards 1979; Thompson 1989; Ackroyd and Bolton 1999; Taylor and Bain 2001, Mulholland 2004).

Conflict and consensus perspectives give rise to different questions. Whereas Donald Roy (1959) tried to explain the restriction of output, i.e. why employees do not work harder, Michael Burawoy was interested in the factors that drove employees towards consent, i.e. to push themselves to work hard. Thus, Roy and Burawoy questioned the gospel of Human Relations relations theory from Elton Mayo and Roethlisberger and Dickson (1964/1939) regarding workers' non-logical systems of belief and their lack of understanding of managerial rationales (Burawoy 1979).

12.2.2 Control versus autonomy

Edwards (1979: 17) defines control as management's ability to obtain desired work behaviour from its workers. Control exists in all organisations, but what is of interest is how, to what degree and the balance of control between different parties within work relations. Edwards (1979) describes a threefold typology of control: (1) direct or simple control that exists in small firms, deriving to a high extent from the exercise of personal power from the owner in the absence of

110 Following Lysgaard, several Swedish studies have been conducted of collective resistance towards public management from employees within the healthcare sector (Lindgren 1992) and of employee antagonism towards the marketisation of public organisation (Huzell 2005).

formal rules; (2) technical control derived from the machinery deciding the pace of the work – such as the assembly line and its successors; and (3) administrative/bureaucratic control covering the institutionalisation of hierarchical power which is embedded in the social structure or the social relations of a workplace (p. 19-21). All three elements of control are designed to eliminate the employees from loitering. Management are, on their side, anxious to achieve cost advantages, to assure quality control and to obtain an internal control regime for punishing those who lag behind the output standard (Edwards 1979).

More recent studies claim, however, that Edwards's control typology needs to be combined with more general control. General control can also comprise of more indirect forms that cover the accommodation of workers to the overall aims of the enterprise. One form of indirect control is normative control, exemplified by corporate attempts to create cultural value and a basic belief system and set of values for a whole organisation (Thompson and Warhurst 1998). Normative control might also be important in decentralised structures as well as for different kinds of teamwork (Thompson and Wallace 1996). Revisiting Edwards's typology of control, Thompson and Callaghan (2001) stress that all the forms of control could and did actually exist in most work, but to a varying degree. In the same way, Perrow et al. (1986) has argued that the three forms of control – direct control, control by rules, hierarchy and administrative system as well as normative control – are complementary and partly mutually exchangeable. The contrasting notions of 'direct control' and 'responsible autonomy' were also conceptualised by Friedman (1977) from a variety of British and Scandinavian work settings, while the management's prerogative was observed by Edwards (1979) in the USA.

There are, according to Edwards, three ways of controlling social relations at work 1) by directing work tasks, specifying what needs to be done, in what order, with what degree of precision or accuracy, and in what period of time; 2) by evaluating worker performance and supervising to correct mistakes or other failures, and by identifying individual workers or groups of workers who are not performing adequately; or 3) by disciplining, with apparatuses that are used to discipline and reward workers in order to elicit cooperation and enforce compliance with management's direction of labour (ibid.)

In contrast, other approaches focus on employee influence at the workplace in terms of autonomy. According to P. K. Edwards (1986), the workplace is an area of uncertainty with consequences for work relations and the labour process. He argues that duties cannot be specified in exact detail within the framework of a social relation; the actors continuously affect the situation (also Lindgren and Sederblad 2005). Likewise, Andy Friedman argues that employees with responsible autonomy are able to exercise resistance as well as respond to management's demand for flexible production. The flexible production is needed in order to meet customer requirements for adapted products, whereas responsible autonomy is derived from the employee's own values and norms and their need for collegial relations, teamwork and social interaction (Friedman

1977; 1990).[111] This is accentuated in certain areas with professional employees claiming their professional autonomy (Freidson 2001; Friedman 2007).

Edwards's (1986) model of control is in line with Fox's model of trust and work roles (1974). Fox claims that no role can be totally diffused or totally controlled, because all jobs involve a certain amount of decision-making, although this is sometimes limited. Trust can, for example, be institutionalised in roles and values, and the moral involvement of employees. Fox argues that work roles which are considered as high-trust are linked to high discretionary content. Hence, detailed control tends to be inappropriate because workers have a degree of intrinsic control – self-control – and the emphasis is on problem-solving (Fox 1974: 19-20). This phenomenon could be exemplified, for instance, by the registered nurse or for that matter the professional physician.[112]

12.3 HUMAN RELATIONS AND HUMAN RESOURCE MANAGEMENT

The Human Relations school and its successor theories of Human Resource Management highlight the importance of internal social relations in the workplace as well as external relations outside the workplace in contrast to the Tayloristic focus on single variables. Mayo, together with colleagues from the Harvard University, Roethlisberger and Dickson (1964/1939), advocate work groups and the organisation of one coherent social system where the different parts mutually interact with each other, stressing the existence of informal group organisation in contrast to the formal. The goal of Human Relations has been expressed in terms of management's understanding of 'the employees' logic of sentiments', which is an important means of achieving a balance between the technological and the human system. The mission of 'good management' is to maintain the equilibrium of the social organisation so that individuals, through contributing their services to this common purpose [the company's], obtain personal satisfaction 'that makes them willing to co-operate' (Roethlisberger and Dickson 1964/1939: 569). The overall goal from Human Relations approaches is to adapt the social system to the technological one (Roethlisberger and Dickson 1964/1939).

The term 'human resources' was, however, first introduced by Peter Drucker in his book *The Practice of Management* in 1954. Deeply censorious of ideas originating from Taylor, Fayol and Weber in particular, Drucker argued that as a result of a strict division of labour and rigid bureaucracy, employees were narrow-minded and imperceptive of customer needs and changes in the environment.

111 See also the discussion below on post-Fordism and that on flexible specialisation in chapter 6.

112 See also the later discussion of professionals.

His remedy was flat organisations, management-by-objectives (MBO) where each division/workplace had its proper mission, measurable results and general managers in order to make the employees understand the overall of business and their contribution to its whole production (Drucker 1954).[113]

From the 1950s, Personnel Management became frequent in Swedish medium-sized and larger organisations.[114] In the wake of the Human Relations school and in line with developments in working life in Sweden, specialised support departments for personnel management were established (later to become units for Human Resource Management) and 'social engineers' (people with a social science education) were employed. The Swedish industrial relations system, however, has been based on strong tripartism between the state, the employers and the trade unions, originating in the famous formalised 1938 Saltsjöbaden Agreement (Thörnqvist 1994: 86-87). This means that the Swedish approach embraced both an industrial relations emphasis on the pluralist view of stakeholders, and an HRM perspective that strongly addressed issues of common conciliating interests. The double-edged nature of the quest for consensus in Sweden has been discussed by many researchers over the years (see for example Alvesson 1993; Huzell 2005).

12.3.1 HRM and Labour Process Theory

The core of HRM theory has at least three components. One is that employees with their skills and motivations are important assets for a company to conquer markets and develop competitiveness. A second is that many management practices focus less on some kind of direct or technical control in favour of strategies to win the hearts and minds of employees through generating commitment and general motivation. Finally, HRM is based on the general assumption of a win-win situation. By offering a the employees more, both in terms of discretion and a generous psychological contract, they will contribute to the benefit of the company and its customers, and will thereby in turn generate benefit for all parties involved (Thompson and Harley 2006). HRM has a consensus perspective aligning employer, employee and customer interests (Korczynski 2002).

Management strategies such as New Public Management and Human Resource Management are criticised for being driven by normative values putting strong pressure on performance and loyalty to the organisation and its goals. Management practices and rhetoric as well as New Public Management are mainly used to coordinate and control the workforce.

The effects of different organisational models are, however, hard to measure. Swedish healthcare has successively tried Service Management, Lean Production, Time-Based Management (TBM), Business Process Reengineering and now

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113 Human Resource Management shares many characteristics with other schools, for example the focus on company cultures such as the company climate in Organisational Development theory and the importance of creating common values expressed by Chester Barnard in the 1930s and Philip Selznick in the 1950s (Tengblad 2004: 19).

114 Good illustrations of the historical development of Personnel Management and subsequently HRM in Sweden are presented by Margareta Damm (1993) and Freddy Hällsten and Stefan Tengblad (2002).

Balanced Scorecards (Björkman 2003: 56).[115] Kaplan and Norton's vision of the Balanced Scorecard methodology, for instance, shares several similarities with Taylor's scientific management. Key performance indicators are drawn up in order to measure competence, motivation, to take responsibility and initiatives. In order to ensure that actions are rational and cost-efficient, detailed knowledge is collected by management and different perspectives – economic-financial, customer, operational, learning-growth – are compared. Although internal processes and innovation-future perspectives are included in the Balanced Scorecare, the staff's opinions are not really questioned (Björkman 2003: 83-84).

12.3.2 Two models of work organisation

The classical approach of mass-production and mass-consumption (Fordism) is based on quantity in order to maximise volume and minimise costs, through a combination of automation, standardisation, the division of labour and other Taylorist principles used to rationalise production. Consequently, the work organisation minimises skill requirements, discretion and job cycle times. Learning is limited to the repetition of simple rationalised tasks – 'practice makes perfect'. Human resources practices (also called hard) in such organisations are more about assuming that jobs can be designed to be turnover-proof, and that employees are considered as easily replaceable (Korczynski 2002; Batt and Moynihan 2002). Mass-production and mass-consumption stand in sharp contrast to the professional organisation of services and human services that focus on providing quality.

Within human service, technology is supposed to be used as a complement to labour, but technology cannot replace employees. At the core of the work organisation of such a model stands a formal education and the employees who have highly specialised skills, features normally seen as elements of soft HRM practice. The work design is constructed on autonomy and trust of the professional employee (cf. Fox 1974). Accordingly, the professionals are expected to collaborate, and as their individual work is based on analysis and problem-solving in a creative process, it cannot be standardised. The professionals are rewarded with high relative pay, benefits and employment security (Lipsky 1980; Hasenfeld 1983; Alvesson 1993; Freidson 2001).

Hard HRM-systems often lead to the introduction of strict technology or work process designs that monitor, control and evaluate less-well educated, replaceable workers, while softer HRM-systems target the moulding of trusting and important employees (e.g. Bergström and Sandoff 2000; Härenstam et al. 2006: 249).

If major emphasis is put on knowledge creation, several scholars argue for innovative strategies, whereas others proclaim efficient strategies (cf. Batt and Moynihan 2003). The efficient strategies aim at effectiveness and low costs, while the innovative ones strive to achieve innovation and new capability (Edvardsson 2007). Different organisations, although all handling a great deal of information and all considered as knowledge-intensive, might approach

115 Björkman concludes that the Japanese have not tried to implement the models of work organisation from the car industry on school and healthcare, which is the case for Sweden.

knowledge and HRM differently. Drawing on a meta-analysis of themes and discourses, Gloet and Berrell (2003: 79) identify two main strategies for managing knowledge, which are either based on codification or on personalisation. 'Codification of knowledge' refers to knowledge stored in databases, accessed and used by the employees without any particular previous training. Some organisations invest heavily in ICT projects for data warehousing, data mining and electronic libraries etc. This orientation relies on advanced management systems or ICT technology as the anchor for work. 'Personalisation of knowledge', on the other hand, is about personal development, organisational learning and sharing of knowledge through dialogues, learning histories and communities of practice etc. (Gloet and Berrell 2003; Edvardsson 2007). I find it appropriate to argue that these strategies highly overlap with the soft and hard HRM approaches described by Tengblad (2000) and Thompson and Harley (2006). Both soft and hard HRM as well as the strategies focusing on system or personal factors in order to deal with knowledge might be compared with Fernie's (2003) analysis of visionary HRM (see also Deery and Kinnie 2004).

12.4 IMPLICATION FOR THIS STUDY

An exploration of employment relations and the working conditions of the telenurses is a key element of the attempt to understand the merger of healthcare and call centre nursing. But can we conclude about the use of hard and soft HRM in practice? And how did the HCC approach the two different strategies for managing knowledge – a strategy based on codification or one based on personalisation?

The front-line position of employees in call centres, made explicit by Frenkel et al. (1999), is interesting but not explored either for the professional worker in general or for telenurse in particular. Korczynski (2002) focuses on HRM in services. This stimulated me to explore whether the same contradictory logics existed for the HCC as for other service work. The analysis, in the previous part of the book, about actor conceptions of HCC Fyrbodal and its related institutions, is an obvious confirmation of the existence of such contradictions and conflicts. The battlefield explored also reveals additional logics of a contradictory nature for the specific call centre. Consequently, it seems relevant to know more about the consequences for the telenurses.

Inspired by Frenkel et al.'s (1999: 26) multi-dimensional model, I decided to approach the organisation of work from two principal perspectives: the employment relations and the working conditions for telenurses. From critical theories on work and organisation as well as my institutional framework a vertical and a lateral dimension of relations emerged which is worthy of deeper analysis. Accordingly, I devised a model (see figure 12.1) with four important relations at stake (see below). This model also functioned as a framework for the analyses in the following chapters.

1) Political and strategic management relations,
the work relations between decision-makers and the telenurses (indirectly addressed in chapter 7-11).

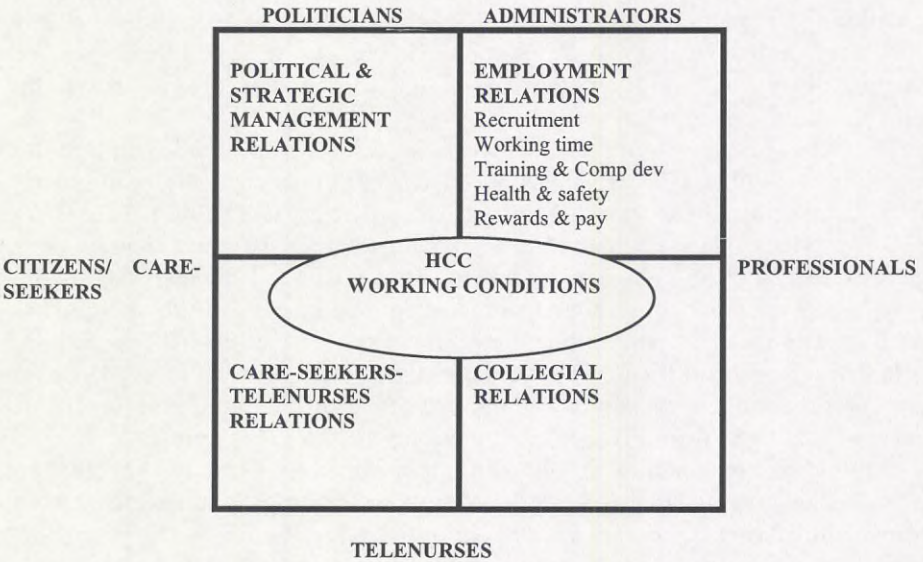
2) The employment relations,
i.e. the relations between management and the telenurses. This relationship embraces recruitment, the working time, training and competence development, health and safety issues, reward systems and the career structures (chapter 13).

3) The control relations (working conditions),
based on the employees' levels of discretion and different forms of control (mainly chapter 14).

4) Collegial relations,
the contact, social support and subordination among health professionals, i.e. between colleagues at the workplace, as well as contact with professionals in other health departments (mainly chapter 14).

5) Care-seeker-telenurses relations,
i.e. the relations between the telenurses and the care-seekers (mainly chapter 14).

Figure 12.1 Employment relation and work relations within a health call centre



CHAPTER 13
EMPLOYMENT RELATIONS

The employment relations are important when analysing the telenurses and their work. Telenurses are monitored, evaluated and rewarded according to both hard and soft criteria (cf. Edwards 1979). An emphasis might be put on knowledge captured and packaged within technology and ICT solutions as well as on knowledge within the staff, i.e. personalised knowledge (Gloet and Berrell 2003: Edvardsson 2007). The employment relations are studied here from management's perspective and their overall organisation of healthcare as well as from the employees' view of how the HCC developed. The chapter discusses how employment strategies, usually known as Human Resource Management (HRM) (cf. Tengblad 2004; Thompson and Harley 2006; Bolton and Houlihan 2007) were conceived by the staff, the telenurses.

HRM should be understood as a set of management practices and rhetoric concerned with managing 'employment relations' (cf. Korczynski 2002: 18; Frenkel et al. 1999: 14), also following the decisions-makers' interpretation of New Public Management in terms of efficiency, control and safe delivery of healthcare service in the area. The chapter focuses on strategies for monitoring work, evaluations and rewards related to the *division of work* as well as the core HR functions, namely *recruitment and selection* procedures as well as strategies for defining the *employment contract* and *working time*. Some approaches of HR are softer and strive to create a culture of learning and this was a distinct ambition of this HCC. Thus, strategies are discussed regarding *training* and *competence development* and the importance of other healthcare staff, particular contact physicians, their feedback and way of interactive learning or lack of such a pedagogy.

A central part of a call centre is *performance management* criteria which might be related to the *working environment* (organisational health and safety) as well as to evaluation of the telenurses' performance, *rewards and pay formation*. The later section focuses on the consequences of such employment relations. The conclusion is, furthermore, that HCC Fyrbodal can be distinguished as a workplace mixing hard and soft HRM strategies and the telenurses are evaluated and rewarded according to hard and soft criteria. This creates an arduous workplace, although it is positively conceived by those who have succeeded in adapting to and coping with considerable difficulties.

13.1 DIVISION OF LABOUR

In previous sections the division of labour was discussed in terms of different conceptions about telephone advice and how it should be practised - carried out by physicians versus nurses, and where to carry out the work tasks – in each health unit or in a separate HCC commonly shared for an entire healthcare area. The arrangement in Fyrbodal means that the telenurses officially carry out a first assessment, a task similar to a diagnosis that previously was exclusive to the medical profession (cf. chapter 10 above). The duty of first assessments as well the right to make appointments, have in previous chapters been shown to be

contentious and controversial issues. However, a division of labour may also be a feature of an HCC.

In the UK, there is a strict division of labour between different kinds of employees within the HCCs, such as nurse adviser, call handlers, health information advisers and librarians. A call-handler is the first to answer the phone and she routes the call either to a health information adviser or to a nurse adviser in the case of symptom-related calls. These two groups do usually phone back callers (Valsecchi et al. 2007; Wise et al. 2007; Mueller et al. forthcoming 2008).

In contrast to the British practice, there is only one level of telenurse in Swedish HCCs, mainly because it is believed that a professional person is required to separate information calls from medical calls and vice versa (HCC manager 2004).[116] Hence, the hierarchy of HCC Fyrbodal is flat in comparison with its British counterpart, NHS Direct. The other side of the coin is the limited career progression within most HCCs, including that in Fyrbodal. In HCC Fyrbodal other positions besides the telenurse are the responsible manager and the team leader, taking care of certain HRM issues. But everybody besides the HCC manager handles nursing on the phone. The HCC manager is formally responsible for the internal work as well as external contacts (in fact she has, exceptionally, many contacts within the healthcare organisation, the region and at the national level).

13.2 RECRUITMENT

13.2.1 The recruitment profile

Recruiting the 'right co-workers' is generally considered very important by management, and was also the case at the HCC. The formal requirement of competence for the HCC was a nursing registration combined with adequate specialisation and several years' experience of clinical work. The recruitment advertisements for telenurses in Sweden rarely specify a minimum length of experience in contrast to British or Canadian standards.[117] Some Swedish HCCs mention five years and some three years of experience in clinical work, but most just require long experience, as did the advertisement in HCC Fyrbodal. For the

116 As the queuing time for a Swedish HCC might be extensive (see for example the care-seekers' own comments in chapter 10), most HCCs have installed an automatic phone-voice indicating the number for making an emergency call – 112 – in case of serious accidents or acute chest pain etc. In some areas, the phone voice gives suggestions for callers to make choices: for information press one, for advice/medical consultation press two.

117 According to Collin-Jacques, the minimum required length of experience is three years for Canadian settings and five years for the British NHS Direct. However, in practice about 90 % of employees had more than five years experience (2003: 178-179). Generally high skills for NHS Direct are also identified by O'Cathain et al. (2001). When recruiting nurses to the Swedish private HCC (MedHelp), a minimum of five years of experience are required and specialised education is considered an extra merit (2005). The HCC Gothenburg liked to employ nurses with many years of working life experience and voluntarily with experience of A&E care (February 2005). The preference for nurses from A&E was also suggested by the British DoH. Otherwise, attracting paediatric nurses was particularly important for the HCC in Stockholm, as the centre would focus on small children and cover for their expected needs after the closure of a paediatric clinic (Karolinska Universitets-sjukhuset *homepage* January 2005). In Kalmar, several nurses were offered employment within the HCC when the hospital in the area was down-sizing its activity (*Göteborgs-Posten* 23 September 2004).

very first recruitment when the HCC Fyrbodal was about to start in 2002, the following headline marked the recruitment advertisement:

> We are offering a nurse-led workgroup consisting of only nurses, who will get the opportunities to form routines and a workplace based on their competence and experience. Continuous competence development including training and auscultation[118] are a part of the work.

The selection criteria put forth by the project group responsible for the pilot HCC were furthermore:

- a capacity to collaborate and interest to develop one's competence;
- a capacity to work independently and to create a trusting relationship with the callers;
- a capacity to active and emphatically listen;
- a clear telephone voice and a service-minded attitude:
- skills in other languages and in handling a computer were considered as additional qualifications. Extra attention was paid to the applicant's personality.

In August 2001 the advertisement was placed externally in several two newspapers (*ELA* and *Bohuslänningen*) as well as a professional journal (*Skandinavien Direkt*), and internally to the other parts of the healthcare organisation. The HCC manager explained that she 'wished to recruit both specialists and generalists within the field of nursing, creating a broad platform of knowledge for the entire working group to stand on' (interview HCC manager 2002). Collaboration and internal teamwork was implicitly desired by the manager.

Furthermore, the HCC manager was responsible for the recruitment and the selection process and she had therefore a defined recruitment profile for the employees of the centre. The deliberate recruitment profile was focused on nurses who had a great part of their working life behind them, as well as trying to attract people who wished to get other tasks or wanted to change their working environment.

The HCC manager thought that district nurses were especially apt for the work at the HCC, as the two jobs had several points of similarity: both implied quite a lot of individual work and decision-making based on one's own reasoning, expressed in terms of the district nurses as well as the telenurses being used to working far away from 'the support of colleagues and doctors' (interview HCC manager 2002). Besides carrying out visits to the patient's home, which distinguished the district work from the HCC, the two occupations involved a great deal of contact with people over the phone. The focus on the district nurse at the HCC as a link between the population and healthcare provides a degree of continuity with the recommendation already made by Marklund et al. (1990a) (see chapter 4 above).

The HCC manager considered this as an effective way to recruit highly experienced people. She also recruited two people who were already on their official pension but wished to continue to work part-time and supplementary hours. To my

118 Auscultation is a kind of apprenticeship, where the telenurses visit clinics and follow clinical care practices.

question what she would do with all the nurses who approached their 65th birthday (the official year for retirement in Sweden), she laughed and said that she hoped they would continue at the HCC long after their retirement, at least partly.

13.2.2 Reasons for applying to the HCC

When asking the telenurses about their reasons for applying to the HCC, the most common answers were that either they were looking to get away from an unsatisfactory work situation or they were looking for new, challenging work tasks. Several of the applicants, who later were employed at the HCC Fyrbodal, expressed both these reasons for their application. The motives mentioned by the telenurses for applying to the new workplace, bear witness to nurses who experienced traditional healthcare as a stressful and a poor work environment because of the strain, work intensification and incidence of ill-health – physical, socio-psychological and mental – it caused. Several of the 20 nurses interviewed said that they were not able to continue in the traditional healthcare organisations due to symptoms of stress, a heavy workload, physical health problems or disorders from the psychosocial work environment, such as burn-out and insomnia. They wished to change their work. The majority wanted to get away from a previous job because of the shortage of staff, mainly physicians, because they experienced conflicts at the workplace and/or because of poor management.

> I was not able to work in a satisfactory way. We had far too much work because of the lack of physicians…Consequently, the nurses had to shoulder a heavy workload. In the end, it seemed like there were neither any physicians to work for nor to assist. (telenurse 8 2002)

Several nurses witnessed of feelings of fear of being burnt-out:

> …I felt only anxiety when I thought of healthcare, in any way…//… I couldn't sleep at nights. It started processes and with the advance of things, I realised that I had to do something… (telenurse 14 2002)

Predominantly, the applicants wanted to work in HCC Fyrbodal because:

> …it sounded exciting and a bit different for somebody who has worked within clinical healthcare for many years…yes, different from direct, face-to-face patient contacts...(telenurse 2 2002).

> ...something new and not a job connected to…the operative work tasks on the floor so to say, to the same extent as out at the healthcare wards. It is another type of responsibility, and that is the reason why I applied. (telenurse 10 2002)

> I want to support the citizens as much as I can in order for them to take care of themselves, their own healthcare and health prevention…This is an important task in my opinion. (telenurse 5 2002)

In the way the telenurses expressed their expectations about the new job in an HCC, it was obvious that they looked forward to having responsibility and being able to influence at the same time as they wanted to distance themselves from aspects of the clinical healthcare that they had experienced as bad. Several nurses also highlighted the importance of supporting health prevention and promotion, a task that according them had been underestimated in today's healthcare (cf. Elo and Calltorp 2002). Other expectations about the possibility of being involved in

starting-up a new organisation as well as new working hours, working independently with one's own areas of responsibility and working only with nurses.

> It seems to be a work that fits my need of freedom. (telenurse 3 2002)

However, some of the respondents who were recruited were sceptical. The following quotation summarises the reflections of several telenurses:

> In the beginning I was a bit sceptical towards the whole idea of telephone advice nursing, ... I have done that a lot within accident and emergency care... and then I felt that we had poor support for decision-making...old books...and it was hard to get help from anyone, if that was necessary...We couldn't either get out and disturb the physicians. (telenurse 15 2002)

This last quote shows that the duties on the telephone had previously had a rather low status and the tools for helping the nurses doing a good job were undeveloped. Therefore the nurse, who handled the telephone, was pretty much in the hands of the physicians or her availability to arrange appointments in her department.

13.2.3 Selection and recruitment procedures

The HCC manager undertook all the recruitment herself and an important part of the process was, according to her, to try to preview the candidate's possibility of functioning and enjoying the new work tasks.

> It is a particular job. The appropriate candidate should be aware of the difficulties as well as the possibilities of this new work at the HCC. She should also have a good attitude and want to create something out of this. (HCC manager 2002)

The recruitment processes were normally carried out through the internal channels for spreading organisational news within the healthcare area together with advertisements in the local newspaper and a specialist health care journal. Professional contacts and networks within the health care organisation were other important sources. Several of the telenurses who were later recruited, were informed about the opening of the HCC by hearsay and from colleagues. The HCC manager mentioned such strategies as frequently applied within healthcare. The applicants came mainly from the coast and the urban parts of the healthcare area, and not so much from the rural parts, where residents had been very critical about the introduction of a separate HCC (cf. chapter 3).

Many nurses applied for the new positions within HCC Fyrbodal. The work appeared attractive, in that it opened up a new workplace with only nurses and offered new recruits the opportunity to influence their own routines and work. However, the recruitment processes were carried out through formal procedures, including a personal letter and CV, recruitment interviews by the manager and sometimes the team leader. Good recommendations and long experience were, furthermore, two important conditions for qualifying for the HCC work, according to the HCC manager.

In order to recruit for the call centre, psychological tests or simulation exercises have become increasingly frequent (Thompson and Warhurst 1998; Holtgrewe et al. 2002). In HCC Fyrbodal, no test was undertaken in order to foresee how an applicant

might act in their new role as a telenurse. This stands in contrast to EMD centres, where the emergency operators answering 112 calls are required to take an annual test to prove their ability to carry out work duties and cope with stress simultaneously. Moreover, they are provided with a one-year training course by the company that focuses on communication techniques and the usage of technical equipment (Forslund 2007: 15). Such skills the telenurses had to acquire on their own, by trial-and-error on the job.[119]

13.2.4 The telenurses employed at the health call centre Fyrbodal

The telenurses recruited in 2002 consisted of one man and 18 women. Their age ranged from 30 to 59 years (median age 49 years) and they had generally more than 20 years work experience from different organisations and specialities within the health care sector, either a background as a *reception nurse* or as a *district nurse* in primary care or the municipality's home care. Others were specialised from hospital clinical work, i.e. surgery, orthopaedics, psychiatry, haematology, gynaecology etc. A combination of both backgrounds was also possible. Other possible specialisations were, for example, palliative care, care in prisons and care for disabled persons.

Most of the recruited nurses were used to telephone advice nursing, explained as an extensive and probably expanding part of nursing. Yet only two people had previous experience from work in a specialised HCC. After two years of service, the structure of the workforce had become even more homogeneous, and by 2004 it consisted only of women, and with a higher median age of 52 years (ranging between 43 and 62 years). A majority of the remaining staff were telenurses with a background and clinical experience from primary and home care, although within a range of other specialisations. In 2004 a mid-wife was recruited and the HCC then also recruited an employee specialised in paediatrics.

Two people were born outside Sweden. One nurse was born in another Nordic country, and the another nurse was born outside Europe. They had lived in Sweden for many years and spoke Swedish fluently, without any particular accent. Besides proficiency in English and German, some nurses were fluent in Finnish, Norwegian and Arabic. When serving the bigger towns in Sweden, proficiency in foreign and minority languages was useful because of the immigrants in their area. However, the HCC manager found it hard to recruit nurses with advanced skills in foreign languages. Some with foreign backgrounds worked on temporary contracts. As they sought to work full-time and preferably at one workplace, the HCC did not fulfil their demands. Some remained on a temporary basis, others left for another job. Another problem was the number of minority languages and advanced language skills that are needed in order to really communicate and understand callers speaking a foreign language. The difficulties for a single HCC to cover several foreign languages have been put forth as an argument in favour of a national network of local HCCs. Consequently, nurses with mixed language skills could collaborate and together meet the total needs of the entire country (e.g. FCC 2003b: 53).

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119 In later years one training course in communication techniques has been offered and more training was planned.

13.2.5 Personnel dynamics – labour turn-over

The HCC experienced a particularly a high labour turn-over rate in its first year of service as one third of those originally hired left. Some of the nurses used their legal rights, valid within most Swedish health care institutions, namely the possibility to take temporary leave from their ordinary job to try a new one during a limited period. Several of those who left their HCC job after a few months did so because they experienced neck pains, pains in their shoulders and arms and complained about the repetitive movements in their work. In two cases the persons reported sick.[120] Others left because they missed the face-to-face contact with the patients, missed seeing the patients and visualising the symptoms to assess, as well as the teamwork within clinical care. Nursing in general is considered by both the nurses themselves and by other groups of actors as rather physical work with considerable human face-to-face contact (patients and colleagues) (Dahlborg-Lyckhage 2003).

> I felt that I very much missed the interaction with patients and although I have worked for almost 20 years now, I was a bit too young…in the occupation, in the way that I felt I wasn't ready…I am very social and I think I very much like to work with people. I think I came too far for that. And then it is hard to be in a health call centre…//…It is hard to carry out telephone advice nursing, when you don't see the person, and I don't know anything about the caller. (telenurse 9 2004)

The quotes above embrace the principal reasons stated by those who left the HCC. Others had the motives that the working hours did not please them or they were offered better positions. As telenurses, employees have had a great deal of interaction with all the healthcare institutions in the area, which has given many opportunities to hear about vacant positions wherever they existed. The HCC has thereby been a stepping-stone for some nurses.[121] Throughout the five years, additional recruitment processes took place at the HCC Fyrbodal, first because of massive labour turn-over during the first six months of service, and then from 2005 because more resources were required to fulfil the HCC's assignment within the healthcare area. Consequently, the politicians decided to expand the service.

Although one third of the original staff had left, the proportion of women and part-timers remained stable. One man was employed when the call centre opened, but he left the job rather quickly and no other was recruited during the time of the case-study. From the introduction in 2002 to the end of the case-study in 2006, the payroll at HCC Fyrbodal expanded from 19 nurses to 46 nurses (including one relief and eight working on an odd-hours basis). The HCC manager stated that the organisation was suffering from 'growing pains'. Three employees combined their work at the HCC with emergency work in primary care out-of-hours. In total, 16 of the employees, i.e. a third of the telenurses, had a permanent employment contract.

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120 For people with healthcare problems cardiac problems and musculoskeletal disorders the HCC is not suitable.

121 Compare the description in Smith et al. (2006) of NHS Direct as a step on the ladder for making a nursing career in the UK.

13.3 WORKING HOURS

An HCC provides service around the clock, throughout the year without exceptions. In the beginning, the HCC Fyrbodal occupied three to four lines out to the public. Gradually over the years the number of lines increased to six and at really busy times eight nurses could simultaneously answer the phones. Accordingly, one critical work task of call centre management is to predict the demand and the number of staff for the service. Initially, the HCC manager expressed many difficulties on this matter. How many callers would there be during the day, when the primary care centres were open and how many would try to reach the HCC when other healthcare providers were closed?[122]

> It was hard to predict the need during the day time, and in particular the demand in the evenings, nights and at weekends it went way beyond what we had prepared for. (HCC manager 2006)

The level of demand turned out to be very dependent on the public need, reflecting events and problems in society such as influenza epidemics, borelias etc. Furthermore, demand on the HCC was related to the opening hours and availability of the surrounding health care institutions, mainly the primary care in the area. The official statement was first that the HCC should be a complement to conventional primary care: the HCC workload peaked when the primary care centres were closed (mainly from 4 to 10 pm. and during weekends).[123] Other difficulties were connected to the smaller size of the call centre and the need to provide cover 24 hours per day with a specific number of workers and to fill all the work in shifts – especially at times of sickness and vacancies, as this implied that the existing workforce often had to cover the absentees. With few employees, it is also hard to get a cost-efficiency service in terms of a uniform workload per telenurse and shift, as there are usually slack periods within every working shift (SALAR 2005a: 21). As labour costs are the most important cost in call centres, the issue of manning is significant. HCC Fyrbodal experienced severe financial pressure and cost containment was therefore a high priority. HCC Fyrbodal tried to eliminate all possible sources of slack in the organisation in the pursuit of lean production and effective management... but this was not necessarily in the best interests of the staff and neither did it create a good working environment. On the contrary, it reduced the opportunities for social interaction among the staff and the pauses for recovery between peaks in the workload.

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122 In Sweden, as highlighted in chapter 2 above in the description of Swedish healthcare, there are a limited number of private physicians, like general practitioners. Healthcare is mainly provided by public primary care centres and the hospitals. Healthcare staff, physicians as well as nurses and other staff, are mainly publicly employed.

123 As previously stated, HCC Fyrbodal was officially considered the first line of care in the area out-of-hours in 2005.

13.3.1 Relatively many part-timers and temporary workers

Of 19 persons recruited to the HCC in 2002, eight secured full-time employment and eleven of them part-time employment.[124] The high degree of part-timers was explained by the need for a number of people working in shifts, and because the service is so arduous and demanding that full-time work might be 'too much' for most employees (HCC manager 2002). Due to financial problems and cost reductions, the HCC increased the number of part-timers to more than one third of the staff from 2003. Some of these were given other assignments within the healthcare area, while others were considered content to work part-time or simply considered the HCC to be the best available option for the time being.

The service, 24 hours a day seven days a week, implied furthermore that the working hours were highly irregular and required most staff to work during evenings and weekends, when the work pressure was at its highest. Flexible staffing and temporary employees are considered necessary for call centres to cover their manpower needs in very labour intensive work, especially when the service is provided non-stop (e.g. Strandberg and Sandberg 2007). A number of additional nurses (between ten to fifteen in number) were thus also engaged on a temporary basis to cover for sickness, staff shortages for other reasons and to cope with temporary peaks in the activity (higher demand because of epidemics and high sickness levels). Some of these covered for extended leave during several months and others worked on an hourly basis. The latter group consisted either of retired people or of people working outside the county council.[125]

13.3.2 Working in shifts and time tabling of desiderata

The working day was divided into three shifts – including one night shift. To avoid working alone, there would always be one person on duty but sleeping in a room next to the call centre workplace. This routine was discarded, in 2004 when HCC Fyrbodal began collaborating with another HCC (in Södra Älvsborg), sharing the night shift. It meant that one week the HCC Fyrbodal was responsible for replies to care-seekers in the two areas during nights. The next week the other HCC took the same responsibility. The arrangement implied that two employees worked in one of the sites at the time, and working alone at nights was avoided. The collaboration was mainly a matter of health and safety, including reducing risk and relieving the workload of the nurses. Furthermore, it implied a significant increase in cost-efficiency, as a former arrangement with a telenurse on duty (sleeping at the HCC) was no longer necessary.

However, before and after the shared night, one basic requirement of the time-tabling was that the night shift was covered. Within the HCC, timetabling was planned and carried out as a kind of timetabling of *desiderata*. It implied that the staff made a

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124 Part-time at HCC Fyrbodal meant in general working 75 % of a full-time post, i.e. 39 hours per week.

125 Because of a collective agreement in the healthcare area it was expensive to employ nurses already working in other parts of the primary care to work at the HCC, as they required overtime. The study thus reveals the existence of two groups of employees – the core or the permanent staff and a rather large group in the periphery (e.g. Håkansson and Isidorsson 2003). Unfortunately, I have not considered this latter group which of course would have been very interesting to study, for instance whether they had different conceptions of HCC Fyrbodal compared to the core group.

request for the shifts that they liked to work over the coming month. When everybody had made their request, those responsible for time-tabling drew the telenurses' attention to the shifts that were double-booked and those that were not covered in order to alert to some employees that they should change their request for certain shifts.

The method of applying the time-tabling of desiderata was greatly appreciated by most telenurses; if they were obliged to work in shifts, it was nevertheless considered a benefit to choose their working time. The method was implemented from the start at the HCC which was one of the few workplaces in Fyrbodal that tried a new way to plan its working hours. Furthermore, the team leader who was responsible for the time-tabling during the first few years then delegated the task to a person with designated time for the matter. The team leader expressed this as ... time tabling is a work task that takes up a *great* deal of time and is a *highly* unrewarding task

> I cannot take it any more, the staff do not take collective responsibility for working time. Instead, everyone has a focus on their own time. There is a lot of prestige within the staff. Time-tabling in this group could be compared with a ping-pong game trying to solve everybody's needs. (2004)

Thus, it was considered to be the staff's collective responsibility to plan and solve the issue of working time themselves. Thus timetabling was an activity that should be based on the group's free choice, but demanded their internal solidarity.

> It was decided from the start that time-tabling should be the concern of everybody…it is our own responsibility…it is we, the telenurses, who should ensure that the time is covered: it is not an issue for X [the name of the HCC manager]. (telenurse 4 2004)

The quote shows the telenurses' internalised understanding of the particularity of healthcare and the obligation to work irregular hours, although some of them preferred not to take responsibility for out-of-hours duty themselves.

13.3.3 Work-life balance: combining family and working life

The timetabling also prompted a great deal of discussions and minor controversies among the staff. Some did not want to do the night shift. One nurse expressed this in terms of working nights having effects on her sleep, circadian rhythm as well as her digestion. She thus found it difficult to cope with the night shift. Yet that was not a huge problem, as many of the others preferred the night shift. A considerable number of the staff, almost half of them, lived outside the town where the call centre was located. Consequently, many commuted distances of more than 100 kilometres between their home and the workplace. They preferred to work long days 8-10 hours and sometimes to stay over – lodging at the HCC. Accordingly, they worked for a concentrated period of time, e.g. one evening shift, slept over the night and took the following day shift. Afterwards, they had several days off, returning home. In the interviews some respondents stated that they preferred to work irregular hours, which also meant working fewer hours. According to the timetabling, one hour during the night, evenings and weekends equalled 1.5 hours of normal office time. The will to work irregular hours and to take supplementary hours was also rewarded in terms of

pay, when individual salaries were negotiated. Some of the telenurses expressed their commitment as follows:

> Now when the children are grown up I can put my energy on my work instead. (telenurse 7 2004)

Most employees had passed the age of having small children. Instead, they talked about spending time with grand-children, their families, and their favourite leisure time activities. There were two kinds of telenurses. First, those who thought that the working hours at the HCC allowed them to get time off when others in society were working – this also gave them a way of creating variation in both their working and private lives. Secondly, some staff considered it hard to combine the irregular working times with a private life. Already from the start the attitudes towards the working hours differed between the telenurses – from those who found the timetabling positive and an opportunity to influence one's own working time, to those who were indifferent, being used to working shifts and who saw it as an inherent condition of healthcare work in general. A further category was those who were negative towards working in shifts. The critical telenurses came mainly from primary care, i.e. they were used to working daytime shifts only, and had thought that the HCC should principally be a daytime activity. Initially, the project group for HCC had estimated a higher demand of health calls during the daytime. It appeared, however, that the major demand took place out-of-hours and all the shifts were changed in September 2002, after six months of service, which some of the employees found disappointing. For many of the telenurses the increase in leisure time was highly appreciated. Call centre work shakes up the traditional division between work and free time – and the move towards this pattern of working hours entailed different individual strategies and adjustments.

From my discussions with HCC managers in different HCCs, it seems as if the willingness to work supplementary hours differs from one centre to another. In some centres the staff were satisfied with their existing working hours and preferred their time off to working supplementary hours and getting an extra income (interviews HCC manager 2006). In the private HCC MedHelp, some of the employees had rather small kids and according to management, the HCC was an excellent way to combine family life and work (manager 2004). The same argument has been advanced by NHS Direct (Wise et al. 2007). The call centre workers then thought it was highly beneficial to work nights and evenings in order to facilitate the care of their children.[126]

13.4 TRAINING AND COMPETENCE DEVELOPMENT

In other call centres, team leaders and supervisors are predicated on the planned standardisation of call centre workers, e.g. predefined scripts to monitor and control call centre workers' contact with clients. Consequently the opportunity

126 Generally an important group of call centre workers are youngsters and students who are claimed to take advantage of the irregular working hours. This group however had no presence at the HCCs.

for competence development is rather limited for ordinary employees, especially when the complexity of work is low and the structure is flat (Thompson and Callaghan 2002: 119). The result is a rather generic set of skills, which might be transferable among call centres and make call centre workers more employable in other call centres (ibid.). The work in many non-professional call centres has been described as repetitive and monotonous. HCC work, on the other hand, entails handling a great deal of information and being up-to-date with a myriad of changes, medical innovations and technical developments. Based on a survey of previous telephone advice nursing, the reference group for HCC Fyrbodal elaborated a deliberate strategy in order to assure quality and compliance to legal requirements for TAN. This included documentation as well as meeting the expressed needs of a common policy for the employees and their high demands for training and support for decision-making (Kvilén Eriksson 2000a; 2000b). In the plans for HCC Fyrbodal, training, information and education should be provided to the entire workforce every second week to keep them updated with practice and news critical for the job. The telenurses should have some autonomy in their work and its organisation.

13.4.1 Two months of induction when starting

Training, especially induction training, is of major importance in most call centres, because during the training the companies teach their manuals, the use of core standards of behaviour and the correct use of scripts for structuring customer encounters (e.g. Thompson and Callaghan 2002: 109). The staff employed in 2002, when the call centre opened, received a long and varied period of induction training (two months). This first time implied lectures by physicians, nurses and other representatives from the different areas that the telenurses thought they needed to know about. The telenurses had high discretion to select their lectures and subjects and arranged a huge part of the induction programme themselves.

The period also included two sessions with the aim of the telenurses formulating an ethical and value basis for the health call centre.[127] The discussions were considered to be very important by the nurses, as it gave them an opportunity, among other things, to reflect on patient contact and the management style that they expected.[128] Creating an ethical and value basis is traditionally connected to professional groups, but in recent years it has become more frequent as a corporate strategy for forming a common understanding and a normative foundation for all kinds of work groups. The telenurses thus reflected upon their conditions, their expectations and relations with the citizens, the HCC manager, the organisational structure and their own internal collaboration (*A common value basis for HCC Fyrbodal February* 2002).

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127 Here the HCC manager only participated when a) the telenurses' first views of the ethics and value basis were presented and then b) in connection with the presentation of a revised version. The sessions were led by the nurse trainers connected to the Council for Research and Development (*FoU-rådet*) in the area.

128 During the discussion, the telenurses talked a great deal about their responsibility towards the patient. From the HCC manager they expected justice and transparent actions – many had bad experiences of too 'mild' managers with the result that informal leaders were created and workplace problems were not confronted.

Those starting their service after the official opening were introduced by the ordinary staff, normally by sitting next to an experienced telenurse and listening to her conversations with the care-seekers. The induction period varied from two to four weeks and was mainly based on informal supervision by an experienced fellow nurse, who first showed the work practice on the phone and the routines applied at the HCC. Then, when the newly employed person was ready to take her own calls, the fellow nurse listened, gave feedback and corrections in terms of the advice given and how to improve the work practice. This was an important strategy for promoting the personalisation of knowledge. No manuals, scripts or standards of core behaviour are used in HCC Fyrbodal as in many other call centres, but a handbook for induction and human resources was issued in the second year. The handbook was put together by a group of telenurses together with the HCC manager and it was used as a tool for the newly employed to get to know the HCC and its routines, procedures and policies, including HRM practices for the overall healthcare organisation.

A few proficient telenurses were first chosen for the role as casual trainer and introducer, but as time passed, additional telenurses were also given the responsibility. Accordingly, induction and competence development was carried out among the nurses and from physicians in the healthcare area, and not top-down from management as in most call centres. However, control and standardisation were ensured by the call centre technology, nursing practice and through the overall administration and policies within healthcare, which will be elaborated on at length in the following chapter about working conditions at the HCC.

13.4.2 Individual work with areas of responsibility

One major difference between the HCC Fyrbodal and most other call centres was the time devoted to individual work in areas of responsibility for the telenurses in HCC Fyrbodal.[129] This responsibility concerned different specialisations within healthcare and keeping in touch with specified local key actors at hospitals and primary care centres. This strategy might be described as a soft HRM strategy to personalise knowledge. When planning the introduction of the HCC, the HCC manager together with the work group decided the most important departments and organisations for the HCC to keep in touch with, e.g. the A&E departments in the hospitals, the pharmacies and the primary care centres for different areas. Furthermore, the areas of responsibility followed the medical content of the computerised decision-support systems, which corresponded to the major biomedical specialisations (also represented by different hospital clinics), e.g. medicine, psychiatry, dermatology, ophthalmology, orthopaedics /surgery, gynaecology and paediatrics. Other areas of responsibility included timetabling and administration in connection with the updating of medical content. The responsibility for these areas was shared among the telenurses. Furthermore, three to four nurses formed a team together for developing contacts and the updating of medical information in specific areas, e.g. dermatology, the pharmacy and the primary care centre in the northern area of Fyrbodal or

129 The individual work with areas of responsibility was common within the overall healthcare organisation, but infrequent for both telenurses in other parts of the region and other HCCs in Sweden.

whatever issues the telenurses involved were responsible for. The ambition of the HCC Fyrbodal here was to integrate training and autonomy in the telenurse's role and give her greater scope for learning and professionally handling the continuous flow of new information.[130] This was also a reason why spending 100 per cent of one's working time on the phone was not desirable for the HCC, as already mentioned in a quote by the HCC manager, because the work was too arduous. Thus continuous training took place through induction (given and received), continuous lectures and presentations given by invited guests. Such guests could be specialist physicians, pharmacists as well as representatives from the medical and medi-technical industries etc.

Besides medical/clinical training, the HCC manager was very interested in training communication and conversation methodology. She herself had taken part in external training courses and two particular sessions on the themes were provided for all the telenurses. In focus for such training was how to steer a conversation and how to make the caller satisfied with the call and the service given. When the collaboration between HCC Fyrbodal and the neighbouring HCC of Södra Älvsborg was established, common training activities were facilitated. Some of the telenurses also attended external courses in preventive care, medical prescriptions or telephone advice nursing. Only a few had, however, a diploma from one of the university courses in telephone advice nursing. Some telenurses followed a course for English-as-a-second-language. Moreover, the HCC offered debriefing sessions with a psychologist under the theme 'How to handle criticism', however, with a relatively low attendance level from the telenurses (seven telenurses) (*Annual Report HCC Fyrbodal* 2003). In general, the telenurses expressed the need for a great deal of time for reflection and discussion of their encounters with different care-seekers and a countless variety of problems.

No call logging (*med/avlyssning*) was carried out at HCC Fyrbodal, in contrast to most call centres (HFT 2000; van den Broek 2004; Norman 2005; Bain et al. 2005). But it was obvious that the nurses wanted to reflect on and discuss their conversations to a major extent, although listening to one's own conversations was awkward and hard for the telenurses to carry out on their own. This means, furthermore, that the HCC manager did not act specifically as a trainer or did not give continuous feedback to the telenurses, individually or in the group, as was the custom in many other call centres.

13.4.3 Communication through documentation

Telephone advice nursing in general as well as in HCC Fyrbodal has been characterised by a lack of feedback from the callers and on the quality of telenurses' work. What happens when the telenurse hangs up the phone? Did she make the right decision, what will happen to the callers, what opinions do others have of the case? Another issue brought up by the telenurses was the documentation and how to make it acceptable – does it cover all the symptoms, without being too detailed? Is it an understandable document for the care-seeker,

130 Being up to date with news and information was, however, a general feature of the work in HCC Fyrbodal. Formally, 20-25 per cent of the telenurses' working time was designated for meetings, training and times for the individual work with areas of responsibility. This corresponded to 20 hours during five weeks for a person working 75% of a full-time job and 28 hours per six weeks for a person carrying out a full-time job.

if he or she wants to read it? Is it satisfactory for other healthcare staff? (how is it perceived by the physicians ...?) The telenurses need to pay attention to the fact that other healthcare employees will use the documentation, if the caller is referred immediately to another healthcare provider (there is thus peer-review built into the work organisation). If the telenurse does not refer to any other healthcare provider, but decides that the caller's problems are possible to treat at home and she gives self-care advice, the documentation should give evidence of such a decision (cf. malpractice and professional vulnerability 14.8.9).

13.4.4 Feedback on patient referrals – help, support and dependence

The telenurses required feedback from the healthcare providers on what happened to the care-seekers who they referred and on the adequacy of their assessment of healthcare problems and symptoms. At the paediatric clinics, the paediatricians claimed that they had a heavy workload. For that reason, they did not want to be disturbed out-of-hours, unless it was on an extremely important matter. Instead, their suggestion was to compile all the comments and take them to the contact physicians at a meeting of the HCC.

Otherwise, the main contact between the telenurses and the physicians occurred during auscultations and was connected to the telenurses' quests for support from the contact physicians. During the first year in particular, displeased professionals tried to give direct feedback on the telenurses' assessments, which they estimated as being incorrect – mostly, because they thought call-seekers had been sent to the A&E departments in vain and by mistake. Altogether this was very badly received by the telenurses, who felt unfairly and adversely criticised. Overall, and against their high initial ambitions, the telenurses experienced the work of administering and updating the medical system for decision-support very stressful, mainly because the contact physicians conceived it as a burden.

The physicians and other healthcare staff's attitudes and actions increased the telenurses' stress and anxiety towards consultations over the phone. During their first year in service, the telenurses had to endure disruptive actions and attitudes elsewhere in the healthcare organisation. Several physicians and health care staff at different levels questioned the worth of a separate HCC and the possibility for the telenurses to carry out the service in a professional way. The staff at the primary health centres in rural areas were particularly critical. Other critical voices were heard amongst the paediatricians and staff at the A&E departments.

> Many said, when I announced that I had started to work at the health call centre... "how dare you"... and then there are physicians "how dare you, it is very complicated" – So what is the physicians' reaction? – There are many physicians that reply that "I would never dare to that! (telenurse 14 2002)

13.4.5 Frosty relations and feedback from other healthcare staff

The peak in frosty relations was reached at the end of the first year, before Christmas. Consequently the HCC manager, together with the telenurses, decided to visit the A&E departments in order to discuss their work and common goals for the two workplaces. The reason given was that the A&E departments were afraid that the HCC would not be sufficiently staffed and the A&E departments feared they would not be able to take care of all the patients referred by the HCC

for emergency reasons. The meeting was considered as a kind of crisis meeting, which led to four new meetings. During these meetings, the staff at HCC and the A&E department discussed how the HCC might arrange its work in order to ease the burden of A&E. The meetings also focused on criticisms of how the HCC handled the encounters with the care-seekers, as the telenurses were not considered fast enough and did not send appropriate patients. The telenurses, in their turn, sought to gain an understanding of the work situation at the HCC.

> Some of the professionals were very fretful specially those at the A&E departments. I think we [telenurses] have learnt to not take offence at people who are nasty... they had their reasons and... yes, in some way I can understand them as well... what could we do (telenurse 5 2004)

In connection with these discussions, the A&E department and the HCC started to exchange ideas on new practices, policies and ways to handle the care-seekers 'on the phone, in the reception and on the door step of a healthcare unit' in a more conforming manner. Other key departments were also invited and as a result the project 'Advice: Once is Enough' was initiated (see also 3.2.5).

13.4.6 One-way communication

The relationship between other healthcare actors and the telenurses was more or less based on one-way-communication during the whole case-study. This was partly because the evaluation was one-sided, and partly because it was the telenurses who initiated contact to get information about organisational matters and other changes. The HCC manager participated in different networks with managers from other areas of Fyrbodal and it was considered to be very valuable for the telenurses to be up-to-date with developments in the area. The staff's description of their work was that they still had to chase information from the primary care centres, the specialist clinics and other care-providers. This was information necessary in order to carry out the mission of the HCC, such as changed opening-times, casual problems of manning, transfers of responsibility from one department to another and so on. In any event, the contact with the paediatric clinic was especially important for the HCC as about half of the calls to the HCC were in respect of children, many of whom were less than three years old.

> ...the collaboration with the paediatric clinic has not been that good, unfortunately. But now it is improving... we have got a new contact physician. So we hope it will be good in the future. Anyhow, he appears anxious to visit us. – How has this not so good collaboration been visualised? –Yes...as a lack of interest perhaps...and then we had a contact physician who did not improve things ... we clashed about one year ago ...and then we have not had somebody to provide us with information or training from the paediatricians. It is a pity because we would have needed a lot of training from them...(telenurse 17 2004)

13.4.7 Job-enlargement and job-enrichment

A variety of tasks are offered at the HCC Fyrbodal. Some employees are permanently occupied on other tasks besides nursing on the phone and some have casual assignments related to the HCC. Permanent tasks might include time-scheduling, the coordination of the technological aspects of decision-support and trade union issues within the healthcare area. The latter might be causal tasks such as improvements in work/routines or projects in connection with the

decision-support system. In the case of special duties, the HCC manager delegates responsibility and representation tasks to the whole group or to some employees apt and motivated for their fulfilment. Examples over the years have been investigations and different projects for example on booking appointments for the primary care centres, internal training, the introduction of new members and teambuilding activities, keeping up-to-date with the development of a national net of HCCs etc. Besides this kind of *job-enrichment*, i.e. activities incorporated in the job that extend one's competence range, one's individual work with areas of responsibility and one's contact with different healthcare areas, there are different kinds of *job-enlargement* features at the HCC. Job-enlargement could simply be described as activities other than the core tasks that are incorporated in the job and extend the competence range, sometimes considered as multi-tasking (cf. for example Bittner et al. 2002: 80). These are two HRM strategies which are based on the idea of giving the employees more responsibility. According to more strict definitions, job-enlargement is distinguishable from job-enrichment, as it does not give greater authority, just more duties (Hackman and Oldham 1980). Job-enrichment and job-enlargement are, however, directly connected to HRM performance and evaluation strategies. Three steps should be undertaken by management. First, employee effort should be transformed into performance, second employee performance should be linked directly to rewards (or punishments) and employers should make sure that they want to provide it. Third, performance should be evaluated and designed to reward (punish) the employee according the extent the performance is fulfilled.

13.4.8 Empowerment of the telenurses

To make their work more challenging and maintain the required competence level, all the employees have work with individual areas of responsibility. This was considered as a management strategy to maintain both depth and breadth in the group's competence. The work with individual areas of responsibility included administration of the medical content of the decision-support system and was one element of job-enlargement.

Furthermore, the telenurses had discretion to plan their own auscultations as well as other activities for individual and group development. This means that the HCC Fyrbodal differed from British practice in that librarians updated the software system and from the national net of HCCs 1177, which has a central editorial board for updating the system and writing the medical texts. British practice might be seen as an expression of the Taylorist separation between planning and execution. At HCC Fyrbodal, there was, instead, a deliberate strategy by management to 'empower' the telenurses with help from the technical system (cf. Collin-Jacques 2003). The decision-support system could be considered as a way to increase the telenurses' knowledge, as they were responsible for compiling, writing up and review. This could be interpreted in terms of a managerial intention not to separate knowledge from those executing it; instead in a Bravermanian visionary way the craftsmen were retaining their knowledge (1984/1974). Likewise, knowledge from the physicians was to be transmitted into the computerised system for the use and benefit of the telenurses. But as the medical knowledge was in the hands of the physicians, the empowerment of the telenurse was highly dependent on their willingness and efforts to co-operate.

13.5 HEALTH AND SAFETY

As already mentioned, the centre had a high labour turn-over rate in its first year of service, when about one third of the staff left. This might reflect the particularity of the work, and perhaps the fact that neither management nor the recruited staff knew what to expect from the HCC. Some of the nurses said they left their work at the HCC because they found it too arduous, others because it did not match their expectations. About six months after the introduction of the HCC Fyrbodal, the HCC manager became ill and for another half a year she was absent for health reasons. During this time one of the telenurses took on responsibility for the ongoing managerial issues towards the working group. However, the ordinary HCC manager remained in charge of the official representation and external contacts of the HCC, during her entire period of sickness absence. But it was not until one year later, in the autumn of 2003, that the HCC manager was back working full-time again.

13.5.1 The ergonomic design of the workplace

Work related risks in physical call centre settings are the intensive time spent in front of the computer, which puts heavy strains on the neck, shoulder and the back. In a Swedish study, call centre workers have shown to have the highest risk of all occupational groups of exposure to such problems (Norman et al. 2001; Wigeaus Tornqvist 2001; Holman 2004; Norman 2005). When starting up the HCC, health and safety measures were adjusted in order to create conditions for a decent work environment. Aware that the HCC was a desk-bound job embracing monotonous and repetitive movements with risk of strain injuries, the HCC manager tried to prepare an ergonomic design of the workplace with equipment and furniture adapted for the call centre work. The physical environment encompassed adjustable work stations, the use of head-sets as well as ergonomic chairs, making it possible for the employees to vary their working position between standing and sitting.

At the inception of the HCC, it appeared to be hard to find suitable premises partly because of the requirement to locate the service outside the ordinary healthcare milieu. At the same time, it had to be connected to the overall organisation of healthcare, partly because of the level of resistance towards the HCC. But eventually, after almost a year, the HCC manager ended up by finding premises in the town of Uddevalla, in the same building as the administration of primary care. This meant that the healthcare centre was physically located outside the clinical care units. However, the premises were rather small and situated in a building from the 1960s, not particularly well adapted for call centre work. Negative physical aspects in terms of office design have been reported as creating problems in many offices (e.g. Norman 2005), and this was also the case at this workplace. Being somewhat noisy, having poor vision ergonomics and doubtable air quality, the premises were unsatisfactorily adapted for office use where many workers were gathered. Either the telenurses were obliged to sit close to each other, with the risk of feeling disturbed by each other in an open office landscape, or they were obliged to disperse their work stations over several rooms losing the possibilities for teamwork and common problem solving. First, the open-landscape was chosen but as time passed and the numbers of employees increased, HCC Fyrbodal

opted for more dispersed work stations. During the period several risk analyses were carried out and the air ventilation and noise level were regulated with satisfactory results.

13.5.2 The mental strain and the stress

The physical environment, however, was not really an issue. Instead, the interviews with telenurses bore witness to a focus on a completely different work situation and work duties compared with what they were used to in conventional healthcare. In total, the nurses were quite happy about the long induction period and the possibility to take part in planning of their training as well as the creation of routines for continuous training and development when the HCC opened in Fyrbodal.[131] One person summarised the generally positive level of appreciation at the start.

> Yes!... a good working environment. I think we have got good prerequisites to create a decent workplace. We have had a lot of training and occasions to penetrate familiar and less familiar areas. Then our work mates are sympatric as is our manager (telenurse 15 2002).

The only cloud on the sky during the induction period was the procrastination before the system had been finished due to technical problems. Because of this, the promised training on how to handle the call centre system was repeatedly postponed.

> I would have liked to...log in to the computer and see how it would work. I am not that used.... I am used to recording my interventions, but this system is completely new. I don't know where to find descriptions about symptoms or advice. I don't have a clue about a single button to push... I would have liked to sit down and just try it out before we went live...(telenurse 2 2002)

The way of working on assessments, referrals and self-care advice based on a decision-system for support was a radical change for the recruited nurses, and it was therefore conceived as very frustrating that they did not get the time they had needed to learn how to use the system before the lines were open to the public. Moreover, many of the nurses were not very familiar with different computer systems at all. This meant that during the introduction phase, they had to learn how to deal with the computer, the system, the somewhat new encounter with care-seekers together with the different routines and practices covering the whole healthcare area. The telenurses were used to work that related to patient records from their previous roles, although this was not at the same level of quality as in an HCC (Kvilén Eriksson 2000a; 2000b).

The telenurses were not accustomed to remaining seated for the whole working day in a sedentary job with constrained postures. Some telenurses, who experienced pain in the in neck, shoulders and the arms, complained about the monotonous movements at the HCC Fyrbodal.

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131 As late as in 2006, several telenurses introduced themselves as having been employed for almost five years 'but I was not there for the first induction period when it all started' (telenurses 2006).

> ... several of my colleagues got neck and shoulder problems and I myself I felt similar symptoms, ...and I took it as a sign of monotonous, physical work... although the workplace is designed to avoid such troubles (previous telenurse 15 2002)

The telenurses also claimed that their work was stressful and exhausting. One telenurse described it in terms of trying to get a great deal of work done, in order to rest in calmer periods with fewer callers. But there it is a strain on the nurse and it is no good strategy to handle too many calls in a row especially during the weekends, when the lines are constantly busy. 'I find it hard to concentrate when I am handling seven or more calls per hour for a longer time', was the conclusion of another telenurse (telenurses 17 2004). Additionally, the work with the computerised system for decision-support required a rather long induction period, even for those with long experience of former telephone advice nursing in traditional healthcare (cf. statistics of performance in table 3.1). At the beginning the nurses said it was hard to find, for example, the adequate medical domains within the support system for different calls. Furthermore, the call centre system displayed eight calls on a line at the same time for each work station. This was *per se* considered as stressful. One nurse expressed it as being a tricky and stressful combination to simultaneously listen, write and 'be fast'. At the beginning, most of the telenurse's concentration was focused on the system as such and getting used to the classifications of symptoms within different medical domains.

> It is a tricky and stressful combination to listen, write... and be fast. At the beginning, all your concentration is focused on finding your way in the system and to getting used to the classifications of symptoms. (telenurses 3 2003)

> It requires some kind of almost subtle intuition (*fingertoppskänsla*) for the contact with patients, and that is important, and when you don't have it, it becomes a real challenge. (telenurse 12 2004)

> When you are working that much with assessments all the time... when somebody is calling, you have hundreds of things circulating in your head. The hard thing is to not forget anything....that is what you fear and it is very easily done...When it concerns children you are especially afraid of making a mistake. (telenurse 6 2004)

The telenurses were free to use the computerised system as well as the Internet and other kinds of medical information sources for decision-support in order to assist them in their work. The systems applied did not contain exact prescriptions on how to carry out a call. Yet control was undertaken by the computer, which measured the number of calls received per person, per symptom, per geographical area and so on. However, in contrast to other (health) call centres, and due to technical shortages, HCC Fyrbodal could neither measure the numbers of in- or outgoing calls, nor how many of the incoming calls to the HCC actually were answered. The HCC had only the technology for measuring the actual 'production of calls', so to say.

Continuous computer work without a break is a source of health related symptoms in call centre work (Norman 2005). The HCC manager tried to encourage the staff to take short pauses during their shifts and do some stretching exercises, especially when the workload was high. The telenurses were also encouraged to exercise in their leisure

time (*Annual Report HCC Fyrbodal* 2002). At the same time, the HCC manager was of course concerned that the telenurses fulfilled the goals of calls to be answered. After three years of service, the telenurses seemed aware of the health risks, both from their own minor and major symptoms, and from colleagues on sick leave. I frequently heard the telenurses asking each other, whether they had worked long enough for the moment and reminding each other of the importance of taking a break (non-participative observations 2006). A nurse said she was pleased that they did not have to work alone at nights any longer. Besides the lack of company and support, the lonely work had sometimes had implications on the quality of work as the telenurse did not have someone with whom to discuss her assessments, decisions, possible referrals or interventions. Sometimes the nurse on duty found it hard even to get time off for going to the toilet or taking a small break.

Besides the control exerted by the decision system (see further in chapter 14), and that the telenurses suffered from a lack of feedback from their work results, they did not know what happened to the caller, after they had hung up the phone. The HCC did not allow the same degree of social interaction as in clinical nursing work. Consequently, many of the telenurses missed the face-to-face meetings. Some considered the HCC a rather lonely workplace. In peak hours, there are few possibilities to chat informally with colleagues, although from visits and observations at the HCC, I observed that interaction between the telenurses was ongoing and the telenurses consulted each other so as to give optimal advice or referrals to the care-seekers.

13.5.3 Health activities

One hour a week (calculated on working full-time) was paid by the organisation in order to carry out a preventive health activity of the nurse's own choice.[132] The nurses then had the opportunity to exercise, walk, swim, visit the gym etc., alone or in a group. This was also an aspect of the health activities provided by the manager and the workforce in order to become certified as 'a healthy workplace'. This certification included several health and safety preventive measures and guaranteed the fulfilment of certain legal requirements.[133]

13.6 PERFORMANCE MANAGEMENT

13.6.1 Normative values and qualitative goals

The HCC's goals are shared with the overall healthcare area and are officially formulated with the help of 'the Balanced Scorecard' methodology, i.e. a form of management by objectives (cf. Drucker 1954; Kaplan and Norton 1992). Basic values for guiding the work in the entire area, are other examples of normative mechanisms for monitoring performance towards specified goals. The goals are operationalised into performance targets, which are continuously evaluated (see

132 This is an HR benefit given to all the employees in the healthcare area.

133 In Swedish *Hälsodiplomerad arbetsplats* according to a project together with 'Korpen', i.e. a non-profit form of inter-organisational collaboration with the overall aim of promoting health and keep-fit activities.

also Hallin and Kastberg 2003).[134] The vision that should guide the telenurses and the entire primary care organisation of Fyrbodal was expressed as 'Good health throughout one's whole life' (*God hälsa hela livet*) and the official organisational mission of the HCC was outlined accordingly:

> We offer safe and nearby healthcare, and should be a guide in the healthcare system (*Annual report HCC Fyrbodal* 2005; 2006).

The goals of the organisation and the 'co-workers' (i.e. telenurses) were formulated in terms of the patients, the quality of service and finances. One goal was satisfied patients, meaning that 'our patients experience that we are available and give quality, health-promoting care' and 'our patients experience a positive encounter and receive safe and professional advice' (*Annual Report HCC Fyrbodal* 2005, 2006). The level of satisfaction was measured in terms of a satisfied user index. The statistics on caller satisfaction were collected through a continually conducted questionnaire (see chapter 10). The survey suggested a high degree of user satisfaction, but to be critical it did not cover the citizen perspective, only the conceptions of those who had already been in touch with the HCC. Furthermore, it neither captured the quality of the telenurses' consultation in depth, nor outcomes in terms of rationalisation and efficiency, factors which were claimed as the HCC's raison d'être.[135]

The goals of the HCC were all related to the Balanced Scorecard, and considered by management as the means for mutual adaptation towards a common vision and a well integrated organisation, based on a common culture. Thus the Balanced Scorecard is a way of securing normative control through norms and values instead of, or as in this case combined with, other control mechanisms (cf. Thompson and Wallace 1996; van den Broek 2004).

13.6.2 Quantitative objectives

In line with the overall regulation of the region, one major priority was balanced finances. This balance implied that costs were found within the framework of revenues. 'We carry out activities in order to obtain our goals, i.e. the right manning at the right time, and assessments of consequences in the longer term' (ibid.). In contrast to all other care-givers in the areas with a Diagnostic Related Group-(DRG) budget[136] fixed according to the size of the population, the HCC had an agreement that ran over several (three) years without any ceiling put on

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134 The Balanced Scorecard methodology basically embraces four processes: (1) Translating the vision into operational goals; (2) Communicating the vision and linking it to individual performance; (3) Business planning; and (4) Feedback and learning and adjusting the strategy accordingly (Kaplan and Norton 1992).

135 Sundin (2006: 98), among many other researchers, discusses the problem of measuring efficiency and productivity within service production.

136 A Diagnosis-Related-Group-budget implies that resources are allocated to a healthcare unit for the care of patients estimated according to the patients' ages, treatments, possible bi-diagnoses and complications. The allowance is calculated based on average costs for patients within a particular group of diagnoses.

performance in order to stimulate 'healthcare delivery' (cf. Panfilova 2002). In other words, HCC Fyrbodal did not risk running out of money like other health departments, because it had produced/delivered too much healthcare. Instead, the HCC had a required minimum level of 105,500 calls to handle per year and they were thereafter reimbursed for all calls above that figure.

The HCC's overall objectives considered also as targets in terms of the number of calls per week, month and year were based on the political 'purchase' of nursing on the phone and a predefined maximum waiting time for callers, i.e. 60 per cent of the calls should be accessed within three minutes. The recommended average number per hour was 6-7 calls per hour per telenurse. This corresponded to an average length of a call of around 6-7 minutes with additional time for documentation. The targets for HCC Fyrbodal were the same as the national standard suggested by 1177. This estimated production at around 9,000 calls per year (8,000-10,000) for a nurse working full-time (SALAR 2005a: 20).

Production Statistics for the HCC were displayed centrally on the workplace's whiteboard and showed performance per year, month and week. For example in May 2006, the telenurses proudly showed me that the figures for the year had so far exceeded the budget and the expected numbers. Consequently, the citizens had used the service more and the telenurses had handled more telephone calls than the preliminary calculations.

Despite the lack of detailed instruction and training procedures at HCC Fyrbodal, quantitative feedback and appraisal discussions are given based on performance in terms of outcomes, pace and analyses of the encounter. The call centre system make it possible to generate information on weekly, monthly and yearly 'production' for the employees about their group performance. The statistics are a way for the decision-makers to evaluate and control output (performance) in connection to the annual budget process. From the statistics the HCC manager also checks the degree of compliance with defined objectives. The HCC manager then uses the appraisal discussions to talk about the individual telenurse's performance, strengths and weaknesses as well as to identify needs for future development. If a telenurse has serious problems handling the approximate number of calls, the HCC manager ought however to address the problem as soon as she discovers it in order to give the telenurse help and support. This is one of the most obvious aspects of management control – including the carrot and the stick. During the period some telenurses recruited were 'recommended' to end their temporary employment at the HCC because of their insufficient knowledge and poor service encounters. The conditions at the HCC require the telenurses to be fast and always 'visible' (as in the queuing system for example). The shift might be intensive, because of the combination of listening, writing and making rapid and correct decisions. The work is also characterised by monotonous movements and a high pace. The telenurse is supposed to guide the care-seeker through the system, to support and help people, provide them with a service and make sure the care-seeker is not juggled back and forth among the institutions; but in line with perhaps not panoptical, but technological and administrative control, the telenurse is constantly judged, supervised and controlled by others within the call centre and perhaps worse by physicians and nurses in other institutions.

Feedback and control might also be conceived in terms of support. Feedback and control might also be conceived in terms of support (cf. Allvin 1997; Allvin and

Aronsson 2001). In Thompson and Callaghan's study (2002) a call centre worker gives voice to the positive side of being listened to, as it helped develop his skills.

> It is really good to have a one-to-one with someone who's listened to your calls. You never just get negative feedback. I might be a bit biased that way, because I left McDonalds because we didn't get any feedback. It was just "you did that wrong". (Thompson and Callaghan 2002: 115).

The above reasoning shows that there is a space between control and coaching. In HCC Fyrbodal the employees felt controlled, and some also missed the support and coaching aspect of trainer who takes an active part in the telenurses' calls. Feedback is heavily discussed both at HCC Fyrbodal and in HCCs in general. The telenurses want more feedback about the consequences of their interventions, about the factual problems and causes of single calls to the HCC. Yet such feedback is hard to obtain. The professionals in other clinical settings claim that they do not have the time or possibility to give individual feedback and more systematic feedback is restricted for legal reasons.[137] In HCC Fyrbodal, there were no possibilities of listening into calls, i.e. getting on the line when a nurse was talking to a care-seeker. Instead, workplace meetings, meetings among the telenurses as well as training sessions were used to reflect upon the calls and the interaction with the care-seekers. Consequently, most of the feedback given to the telenurse is in cases of malpractice.

13.7 REWARDS AND PAY FORMATION

13.7.1 Evaluation of job tasks and performance

The healthcare area has a performance-related payment system and the telenurses were evaluated and paid according to HR practice and the collective agreements for nurses[138] taking their performance into consideration.

The telenurses were evaluated according to how well they fulfilled the overall targets of the HCC, their competence and their performance. The evaluation criteria were (i) the total *number of calls processed* per employee, (ii) their actual *level of education* and (iii) their *willingness to irregular working time*, mainly how many extra weekends and holiday shifts that a person had carried out. One person had worked 2-4 extra shifts and another had worked 15 extra shifts. In particular, the value of working extra shifts was a criterion that the telenurses themselves found as fair and that they

137 At HCC Jämtland feedback is systematically provided by facsimiles from the healthcare providers in other departments who have encountered the caller face-to-face and examined him or her.

138 The collective agreement for nurses is settled at the national level between SALAR and SAHP. At regional, or county levels, the national collective agreement is revised by the parties' regional representatives, with the aim of adapting the central agreement to local level conditions. For nurses, the regional level thus has no regulatory function of its own; it is just an intermediate level for adaptation of centrally decided directives into separate local, workplace agreements. The local branch of the nurses' union in the Västra Götaland Region normally refers to the central agreement in order to emphasise the importance of a clear and structured pay formation process 'where the employees' results and pay development is linked together in order to obtain a positive connection between pay, motivation and results' (SAHP 2005: 7).

could agree on.[139] The result of the job evaluation process confirmed that most of the telenurses had some kind of special education or training. The majority were rated between five and six on a competence scale having seven levels.[140] However, in the end it seemed that the financial target of the HCC predominated over almost all the other targets: To be professional, have good internal and external contacts, an appropriate work environment and an adjusted working tool could only happen within a restricted financial frame set down at the centre.

Thus, like in other healthcare areas, the strategy at HCC Fyrbodal has been to promote pay differentiation. However, in other nursing occupations it is thought to be hard, if not impossible to measure the work of an individual nurse. At the HCC it is possible to standardise the format of a call (at least to some extent, but not in detail), to plan how many calls that a nurse can possibly take per hour and then control how well the single nurse follows her work description. The quantitative outcome tells us however little about the quality of the consultation over the phone and therefore other measurements are needed for evaluating quality.

In HCC Fyrbodal, the level of education should correspond to how well the telenurse carried out her work, and of particular importance was training on focused telephone advice nursing and other related issues. It seems, however, hard to evaluate the quality of an HCC consultation. Feedback from physicians, visits seen as being not appropriate to A&E departments or other healthcare providers are some indications in one direction or the another. But there are no real criteria of quality, whether the callers do not conceive or understand the telenurse's advice or decision in the way it is intended. However, a lack of understanding seems to be frequent in the case of care-seekers' contact with physicians, and a reason why they call the HCC after a medical consultation.

13.7.2 Higher salary compared to primary care and call centres in general

Swedish HCCs in general seem to run the service with slightly higher pay rates than in most other areas of primary care. The salary is also above the average for customer service workers, and in HCC Fyrbodal the employees headed the average salary of primary care nurses in the region (see also Andersson Bäck forthcoming 2009). Compared to the rest of the Västra Götaland Region, employees at the HCC enjoyed a favourable development in rates of pay. Most of the telenurses at HCC Fyrbodal improved their salaries by several thousand krona per month, a trend which was brought up when the service was presented in the

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139 Fair criteria reflecting justice has been claimed as important for a reward system and employee well-being at work in general (Maslach and Leiter 1999: 137).

140 There are different job evaluation systems in Swedish healthcare. As a part of the healthcare organisation of the Västra Götaland Region, the HCC used a job evaluation system called BAS for knowledge and skills in relation to designated tasks. Five corresponded to very broad and/or deep professional knowledge defined as very high competence within a specialisation and good knowledge about theories and principles or equivalent general knowledge, which could be three to four years attendance at a university or a university college. Six corresponded to extended knowledge within one or several professional areas, broad and/or deep knowledge about theories and principles or equivalent general knowledge which could be more than five years at university or a university college. Seven corresponded to very deep specialist knowledge in one or several professional areas, broad and/or deep knowledge about theories and principles or equivalent to a doctoral thesis at university.

local newspaper *Bohuslänningen* in March 2002 and in the professional journal for SAHP in August 2006 (Jonsson 2006). The HCC manager explained this in terms of there being discussions among management within the primary care organisation

> a telenurse should generally have a bit higher salary compared to a nurse with similar experience at a primary care centre. We have placed them a bit higher...and if you check the telenurses today, they actually have a higher salary. Then it is not easy to say if it is question of some hundred krona or some thousand krona, as there are a lot of parameters to consider. But the starting point was to place them a bit higher. (HCC manager 2005)

In later years the overall pay formation process for Swedish nurses has moved from seniority-based pay linked to the length of service within an organisation to a decentralised pay system linked to measurement of individual performance (Elvander 2006; Thörnqvist 2007). This may take place either directly through output measures or indirectly through an appraisal of work efforts (cf. Rubery and Grimshaw 2003: 181-2).[141] The main way to increase a salary occurred, according to the telenurses, in connection to a changed workplace preferably within another healthcare area. Other means were more advanced work tasks, increased responsibility or the precondition that one was able to argue for one case. Work at the HCC is considered to require considerable experience from clinical healthcare work and general skills on dealing with a vast range of healthcare symptoms and problems. Additional salary increases could also take place in the case of a new manager. All of these aspects were valid for the telenurses. First, national collective bargaining suggested a willingness to promote pay for the Swedish group of registered nurses and as a result they enjoyed rising wages in general (Thörnqvist 2007). Second, at a local level, the healthcare management's focus on the HCC together with successful individual negotiations had opened up possibilities for increased salaries.

Accordingly, the salaries at HCC Fyrbodal might reflect several things; the telenurses are a new, occasional group and it is a new workplace covering employees with long experience, high skills and a specialised nursing competence. They also carry out complicated work tasks at a distance and without face-to-face contact. Their working hours are highly irregular and the demands on their performance and up-to-date skills are high. The hierarchical structure of the healthcare field in general, covers several groups of professionals and is strongly characterised by status and prestige. The salary is another means to attract competent staff, and to make work outside the academic hospitals more attractive. In line with such strategies, nurses employed in municipal care have, for example, a relatively high salary compared to the estimated status of their work (cf. interview trade unionist at the SAHP 2006). High pay might be a way to promote the HCC as a reliable and trustworthy service in the eyes of the citizens as well as being a way to attract and retain nurses to call centre work, especially as staff turn-over has been a problem in call centres generally (e.g. Thompson and Callaghan 2002; Bordoloi 2004). As to recruitment, induction and training, these are all expensive issues for employers. Therefore there are

141 Quoting Rubery (1995) the use of performance-related pay is 'a source to new possibilities of other kinds of pay discrimination between men and women' (Rubery and Grimshaw 2003).

comparatively few employers who do really invest in good working conditions in order to retain and please their call centre workers (cf. Callaghan and Thompson 2001: 33; Strandberg and Sandberg 2007). High labour turn-over was also the case at the beginning when the HCC was introduced in Fyrbodal. Additionally, the labour market situation might influence salary levels. In 2002 the use of employees from manning agencies peaked within the regions. Hence, the employers' strategy *vis-à-vis* the HCC to provide high salaries, could be interpreted as being a deliberate means to recruit competent nurses to new workplaces and to promote the service as being as highly professional as possible in the eyes of the citizens.

In sum, the high average salary for telenurses might be the result of deliberate efforts within an individualised and decentralised process of pay formation for Swedish nurses. Management in the healthcare area as well as the national project team for HCCs *(Vårdråd Per Telefon, VPT)* have considered it important to promote the role and status of telenurses in general (e.g. VPT meeting in Stockholm 2003). Besides professional and economic factors, trade union strategies have also been very influential in the area of registered nurses in Sweden contributing to favourable pay trends since the 1995 nationwide strike (Fransson and Thörnqvist 2006).

13.8 CONSEQUENCES: EMPLOYMENT RELATIONS

13.8.1 The arduous nature of healthcare work

To some degree it is incontestable that healthcare work puts heavy demands on the staff in general, and the Swedish statistics on long term sick leave for healthcare employees is but only one indication of this. Traditional clinical work has been described as drudging, stressful and full of contradictory requirements. Injuries related to work and attrition over the years had affected some of the telenurses in their choice of HCC. The telenurses recruited to HCC Fyrbodal were people who were searching for other duties and new challenges. Yet working at the HCC appears to be a tough preoccupation characterised by other kinds of mental strain, physical pressure from desk-bound positions as well as a certain degree of monotony. However for nurses with long experience and the capacity to cope with the particular stresses and tensions of a call centre, the HCC Fyrbodal appeared to be an attractive workplace with a relative high salary level (see also Andersson Bäck forthcoming 2009).

HCC Fyrbodal seemed to represent several aspects of work and work organisation that many nurses were longing for. When first launched, the HCC Fyrbodal like its English and Scottish equivalents NHS Direct and NHS 24, promoted the new workplace as offering an opportunity for nurses in terms of using their actual experience and furthering their competence development (cf. Wise et al. 2007). It was also pointed out that it was a nurse-led service. While many Swedish health wards and departments have been led by nurses since the Chief Administrative reform of 1997,[142] this was probably not as attractive as the fact that the work group was based solely on nurses and that the telenurses would be given high discretion to design their work,

142 The reform made it possible to recruit senior managers without a medical education.

routines and practices.[143] Some of the nurses had also sought changed working hours compared to their previous work. However, as the HCC was small and the public demand for healthcare was greatest out-of-hours, irregular working hours became more frequent than the nurses had expected from the start.

After two years, collaboration with a neighbouring HCC implied that the night shift was reduced and that working alone at night was withdrawn. Job enlargement and enrichment in terms of competence development were promised when the telenurses started the new job. The ambitions were to create challenging and rewarding jobs to meet the telenurses' aspirations. This was especially supported by the HCC manager, a nurse herself. However, matters did not really turn out as expected either by the HCC manager or the telenursing staff. A great part of the latter's competence development was in the hands of the physicians and was related to the traditional healthcare hierarchy. Financial matters were in the hands of the decision-makers, and a strict focus on efficiency and staff shortages had contradictory effects on training, competence development and other strategies for developing personalised knowledge.

13.8.2 The formal and the informal side of employment relations

The case-study reflects two sides of employment and recruitment – the formal side covering rules and regulations, and the informal side covering the psychological contract comprising written and unwritten agreements (Rousseau 1995). The trend in Swedish working life is a shift towards more decentralised collective agreements. In the same way, employment agreements in the NPM era have become more individual and negotiable between single partners (Traxler et al. 2001; Fransson and Thörnqvist 2006). Within nursing there has been a shift from centralised bargaining towards more decentralised and individualised pay formation. All nurse salaries, SAHP argues, should be based on individual qualifications.[144] Thus, the strategy at HCC Fyrbodal is based on pay differentiation related to the number of calls managed, together with supplements for working irregular shifts, i.e. evenings, weekends and holidays when the pressure is highest. The prospects of salary enhancements also depended on the competence development of the telenurse and whether she was involved in improvement work of the HCC.

However, the actors' conceptions of rights and duties and of the mutual exchange at the core of the employee–employer relationship are also highly significant (cf. Isaksson 2001). In terms of the psychological contract, the employee's perspective, feelings and expectations might differ from the employer's. This leaves us in the possible situation, whereby the HCC manager and the telenurses think that they have accepted the same agreement, not knowing that they differ from each other in

143 The Swedish private HCC MedHelp stated that they were offering stimulating jobs with good development opportunities within the company, including tele-technique and computer support (February 2005). At HCC Gothenburg, competence development and good remuneration were mentioned at the end of the advertisement (17 July 2005).

144 The SAHP argues for individual bargaining in combination with a systematic and continuous evaluation of nurses' pay, i.e. the evaluation of the nurses' remuneration in relation to the actual demand for nursing staff as well as to the remuneration of other groups, of various educational backgrounds and both genders (eg. SAHP 2005).

conceptions and interpretations of this agreement, because each perceives it from their respective socio-centric way of being and acting (see also Rousseau 1995; Bergqvist 2001). Some of the telenurses were very disappointed and they left. Some expressed disappointment but estimated that in comparison with possible alternatives the HCC was the better option, and they thus remained at the HCC.

13.8.3 Different conceptions of employment relations

The telenurses had to adapt to changes and demands originating from the decision-makers, from other healthcare providers and from the flow of different care-seekers having different kinds of healthcare problems. Yet at the same time the nurses had to maintain their sense of professional integrity. The telenurses had to be flexible and willingly respond to all kinds of demands. The official statements and the recruitment ads embraced formal requirements as well as visions of recruiting employees with highly specialised competences, who enjoyed trust and respect from the rest of the healthcare units and the care-seekers. The HCC manager seemed to be well aware of some of the difficulties related to the HCC. This is why she strongly emphasised the importance of social competence, the right attitude and willingness, including an ability to create a good atmosphere among colleagues and towards care-seekers.

There is, however, a gap between management's and the call centre workers' conceptions. While management was looking for people with social skills and a customer orientation, the telenurses reported the overwhelming importance of emotional management and the lack of recognition of the complexity of the job (cf. Thompson and Callaghan 2002) embracing both call centres and nursing. Korczynski (2002) argues that managers seek to select workers with the right customer approach, attitudinal and behavioural characteristics in order to induct them to the culture and of course retain them. Flecker and Hofbauer (1998) highlight the importance for call centre workers to achieve additional skills in order to cope with new organisational requirements. Hence, they emphasise the importance of a continuing ability to learn and use social skills (p 107). Generally, technical abilities such as formal competence, keyboard skills, language skills etc. are much easier to identify than social competences and the right type of personal behaviour. Using normative strategies, the organisation tries to shape attitudes and enhance social competences. According to the managers in Thompson and Callaghan's study (2002: 110-3), call centre workers are supposed to be very, very enthusiastic, have a sense of humour, a verbal tone, pitch, fluency and energy. There is thus a focus on communication skills, how to use the voice. This was not the main focus for the telenurses. Instead, emphasis was put on how to manage a conversation to ensure that every caller received the same level of customer service, to master special techniques, awareness and influence of feelings. The telenurses were, furthermore, required to show restraint, build rapport, and evoke images of empathy. Managing the information flow through questions and situation-adapted answers are additionally requested qualities. Such characteristics are often associated with female workers (see Belt 2002). However, this contrasts with the notion of call centre workers being associated with job requirements of surviving stressful and repetitive work, including being patient, tolerant, unpatronising, and using communication skills and not provoking complaints (Thompson and Callaghan 2002: 114-5).

With the introduction of NPM in healthcare, the employee is considered a rational labour market actor. An organisation provides its employees with an identity and resources, as well as control and information such that they are interchangeable (Ahrne and Hedström 1999). Taylor established his principles of scientific management on a human being who maximised her work effort in order to obtain an optimal outcome in terms of salary. The HRM perspective, instead, includes other incentives such as the work environment, social interactions, fellowships and support for personal development, which are considered to motivate and create commitment for the individual to carry out the job. From the employers' point of view, such incentives are part of the employees' social system and human needs, which are, however, adapted to an overall management and technological logic (Roethlisberger and Dickson 1964/1939).

The logic of HRM is, thus, to create a so-called win-win situation for all actors involved – employees, customers and the organisation. Accordingly, good caller-nurse relations and satisfied customers at an HCC are assumed to be the result of a good organisation. When the care-seekers are pleased, the staff, i.e. the telenurses, are pleased, a state of affairs which is also assumed to satisfy the managers (cf. Korczynski 2002). But do the care-seekers actually think about the telenurses' well-being and satisfaction? The answer to that question is most likely to be no, and that is one reason why the value of a win-win situation in reality is low.

13.8.4 The mixture of hard and soft HRM strategies

Money is to a great extent invested in ICT and other kinds of advanced technology rather than allocated with a focus on personal and professional development such as induction, training, internal meetings, and time for reflection and exchanges of experience. However, knowledge codified in ICT and work processes directed by technical control render workers interchangeable and substitutable. This might be a more attractive strategy for management than heavy investment in people, who might leave the workplace if they are not satisfied (Callaghan and Thompson 2001: 33). As shown in a previous section, recruitment within HCC Fyrbodal was strongly focused on social competence and nurses being able to be shaped, yet also fit in to what could possibly comprise an HCC culture. In order to secure a job at HCC Fyrbodal, certain formal requirements were claimed to be necessary, yet the personality of the telenurse and personalised knowledge were seen as very important. Several of the selection criteria embraced soft skills such as a capacity to collaborate, create trustful relationships, an ability to listen and have a service-minded attitude. In line with findings from other studies, the HCC might perhaps not put social competence before necessary formal qualifications. However, after the criterion of being a nurse with long clinical experience, the social competences and skills related to telephone advice nursing were critically important criteria for being recruited to HCC Fyrbodal (cf. Thompson and Callaghan 2002; Thompson et al. 2003).

As highlighted by Korczynski (2002), the service organisation, which implies HCC Fyrbodal to the highest degree, has a goal of both fulfilling the aims of rationalisation and the aims of customer satisfaction simultaneously. However, these goals are contradictory. In order to achieve such aims, both quantity and quality requirements are put onto the telenurses: one of management's expressed goals for the

HCC was to recruit highly competent telenurses, who were committed to their work and were apt to take responsibility. The professional dimension side of the HCC, on the other hand, made it impossible to fully standardise the nursing process of assessment per telephone. However, the HCC has involved high demands on the staff's working hours, pace and tasks requiring skills, experience, problem-solving capacities as well as advanced knowledge of communication and documentation practices. The management's overall strategy was to assure medical and nursing quality, a professional encounter as well as compliance with legal requirements on documentation. At the same time, they expressed the desirability of training and support to achieve professional development of the telenurses, development of their own identity and the creation of a broad platform of knowledge for the centre as well as common policies for citizens' first encounter with healthcare in Fyrbodal. These latter factors had previously been problematic (Kvilén Eriksson 2000a; 2000b).

Control might be performed by both hard measurements and a soft culture through normative practice and a careful cultivation of an informal work culture. This means that the distinction between the two types is fluid. Their combination depends often on how the issues at hand are interpreted and contextualised (Arzbäcker et al. 2002: 31). In the name of flexibility, management combine performance data, quality evaluations, training, norms, core practice and ongoing statistical measurement according to how management perceive the need and demand (ibid.).

According to Gloet and Berrell (2003: 79), the two main strategies for managing knowledge, are either based on codification or on personalisation. 'Codification of knowledge' refers to knowledge stored in databases, accessed and used by the employees without any major concerns about training. 'Personalisation of knowledge', on the other hand, is about personal development, organisational learning and sharing of knowledge through dialogue, learning histories, communities of practice and so on (Gloet and Berrell 2003; Edvardsson 2007). The hard criteria were exemplified at HCC Fyrbodal by objectives, performance targets and short-term results. The decision-support system is based on ICT control and certain standardised procedures, in which knowledge is codified in order to reduce medical risk. The making and monitoring of assessments, advice and the documentation is thus specialised. The soft strategies can be exemplified in terms of participative management, group decisions, discussion and mutual collegial help among the telenurses. Management expressed the importance of autonomy for the individual telenurse and her problem-solving. Yet it was implicitly important to obtain the 'harder' performance targets as well as 'softer' goals in terms of service and caller satisfaction. Training as well as competence strategies have focused on more soft ways of sharing experience, undertaking auscultations, inviting lectures and guest speakers as well as stimulating personal contacts and professional development. In that way, knowledge was also possessed by the single telenurse and the HCC has had 'a culture of learning' (cf. Tengblad 2004; Gloet and Berrell 2003: Edvardsson 2007).

CHAPTER 14
WORKING CONDITIONS

> A telenurse described one of the very demanding calls, which took place a Monday morning in February. It was a highly charged morning as Mondays usually are and the phone was very busy because of an influenza outbreak. We were lacking several physicians. They were away on internal training. I had been working on the phone since 8 o'clock in the morning. When the time was approaching 11.30, I waited to be released for lunch. A younger man calls. He has a hard voice already from the start and demands an emergency appointment with a doctor. He doesn't want to talk to a bloody switchboard operator! He wants an appointment at once! I try to explain my work about making assessments for the right care level and arranging appointments or referring patients to other kinds of healthcare. My impression, however, is that this person is very hard to communicate with. He knows from the start how things are. I inform him that I am not able to give him an emergency appointment, if he does'nt tell me his problem. The only possibility I see is perhaps to arrange a telephone appointment for him with a physician within a few days. My attempts seem, however, to have no effects on him and he hangs up the phone on my, saying 'I will report you, you bastard!!' Soon after lunch I get a call from the Patient Advisory Committee [*patientnämnden*], who are questioning my action and judgement. The patient has given his version of the call. Yet, the woman at the Patient Advisory Committee understands my point and she contacts the man explaining how the system works. The story ends with the man re-calling me and I make an appointment for him with the physician one week later. These are the kinds of call that suck the blood out of you...Unfortunately, these calls are more and more frequent. The media writes about healthcare and its poor access. Then it seems like people consider it is okay to say whatever they think, as they don't have to face their conversation partner. The demands on primary care are impossible to handle. Everything should take place at once and people want to see a physician for every small problem. Furthermore, if the wrong patient is given an appointment to the physician, he or she goes mad, so we also have to be gate-keepers for the physicians. (telenurse 33 2006)

The following chapter focuses on the telenurses' working conditions by covering the tensions mainly between management and the telenurses, but also between telenurses and care-seekers and between the telenurses and other healthcare providers. Such tension is based on the pursuit of control as well as attempts at creating autonomous relations. The tension between control and professional autonomy is elucidated by a description of the *technological outline*, including the technological call/contact centre-system and the software. Furthermore the tension is related to the practice of telephone advice nursing and of the work carried out by the telenurses. But besides management (administrative) and technological imperatives, the work and work conditions are also influenced by *professional consciousness*.

This latter phenomenon reflects some kind of nursing identity and knowledge that impregnates the work process and the relationships with the care-seekers. A large part of the telenurses' work involves emotional labour. By using Bolton's typology (2000) the telenurses' emotion management is analysed in terms of different intentions. Professional consciousness also influences their work activities towards other healthcare professionals.

The chapter concludes with a discussion about working conditions embracing order, pace, repetitiveness, work intensification as well as performance management versus the telenurses' autonomy. Moreover, the telenurses' situation actualises a tension between *responsibility* and *vulnerability*.

14.1 THE TECHNICAL OUTLINE OF A HEALTH CALL CENTRE

Technical standardization (Callaghan and Thompson 2001) and rigid technological control in call centres have been emphasised in a wide range of studies (Bain and Taylor 2000; Sturdy and Fleming 2003; Mulholland 2004). When discussing the monitoring of call centre work and the organising of the labour process, it is important to distinguish the overall technology and the hardware from the software, because these aspects of the technical system have different functions. In other words, the call centre technological system for the HCC can be considered at three levels.

- *The call/contact centre system* is based on an integrated form of telephone and computer with ACDs technology. ACDs stands for Automatic Call Distribution switch, and is the switchboard connected to the telephone. The technology allows for the automatic distribution and directing of calls to nurse advisers.
- *The decision-support software* (by some telenurses called 'the infrastructure') might either consist of algorithms or guidelines. Moreover, the software contains functions for generating statistics and for staff planning.
- *The content* is based on medical information and medical descriptions, symptoms and suggestions of questions to ask. Additional information concerns the healthcare organisation opening-times, addresses etc.

Mayo et al. (2002) distinguish between two kinds of decision-support, algorithms and guidelines. Accordingly, algorithms are logically built and constitute frameworks that elicit responses (yes/no). The system proposes questions for the telenurses to put to the care-seekers. The care-seekers' answers to the questions are put into the system by the telenurses, and the system generates an adequate intervention for the nurses to provide. Consequently, the algorithms build frameworks to sets of questions for assessments leading to definitive patient dispositions (May 1998). Guidelines, on the other hand, are 'a more narrative description of the assessment steps' (Mayo 2002: 207). Guidelines have been described by telenurses as lists of available questions that nurses may elect to use during an assessment (Mayo 1998). Suggestions for disposition and/or advice may also be given by guidelines (Mayo et al. 2002).[145]

The majority of the Swedish telenurses today use a computerised decision-support system, at least those working within the net of nationally connected HCCs (SVR AB *homepage* 2007). This distinguishes them from most nurses, who do not use any computer-based tools at all for their work on the phone (e.g. Kvilén 2000a and 2000b). The healthcare of Fyrbodal is, however, one exception,

145 However, the field might seem complicated as Mayo et al. (2002) have also stated. When describing telephone advice nursing practice, the terms of protocols for the algorithms might negligently be used interchangeably with the term of guidelines (p. 208).

as the same system for decision-support existed for the HCC as well as for the primary care centre and certain hospital departments (see chapter 3 above).[146]

In Sweden, there are mainly three kinds of systems at local or regional level – Teleråd, SRÅ (in Swedish: *Symptom, Råd och Åtgärder,* i.e. Symptoms, Advice and Interventions) and a national system for 1177. For the National Project of HCC, a new decision-support system has been constructed and it was in use from 2006 by the six HCCs in the national net (SVR AB *homepage* 2007). The national decision-support system has used the existing systems as a source of inspiration, but the software and the content of the new system is written from scratch and the data included is compiled in a new way (FCC 2003b *Förstudierapport*). SRÅ and the national system for 1177 are based on symptoms, according to the methodology initiated by Marklund (1990). Marklund is also the father of SRÅ and is today involved in the development of the national system.

14.1.1 Decision-support for telephone advice nursing at HCC Fyrbodal

In contrast to the two other software systems, Teleråd used at HCC Fyrbodal has been developed by a major ICT consultant firm for the public sector (Tieto Enator) and is, instead, based on different biomedical domains (which roughly correspond to the medical organisation of different hospital clinics), e.g. medicine, psychiatry, dermatology, ophthalmology, orthopaedic/surgery, gynaecology and paediatrics etc. Teleråd is a medical decision-support system covering symptoms, clinical practice and documentation aids.

Other means to facilitate the work besides the technology, derive from medical encyclopaedia, medication books (e.g. *FASS*) or calls to other healthcare staff, mainly physicians and discussions with colleagues at the workplace. Local information and addresses of local medical providers, healthcare institutions as well as national help-lines exist in paper form and are classified in maps at the work station. From the internet and intranet the telenurses can get additional information (e.g. Informedica).[147] In sum, different software systems have been used in different local areas. In the UK, the software plays a major role monitoring how the telenurses are carrying out their work (O'Cathain et al. 2001; Collin-Jacques and Smith 2004).

The software sets a limit to the telenurse's discretion and to how much of the telenurses' competence is actually taken into consideration and. At HCC Fyrbodal, the telenurses have substantial autonomy in comparison with some other telenurses, which will be exposed in the following sections. The different Swedish systems share one feature. They are all based on guidelines for questioning and assessing the problem, and not algorithms as in the British case of NHS Direct (Collin-Jacques and Smith 2005). The Swedish national standard from 2007 tends to be the internally developed system of 1177. But Teleråd is the

146 Although the use of decision-support does not seem as extended in traditional care, a conclusion based on interviews with heads of health units, nurses and health administrators (2004)

147 The system was integrated with SVR AB in 2007 providing information at www.sjukvards-radgivningen.se

system used in the case-study and therefore the system discussed, if nothing else is mentioned. The use of the computer and the software is mandatory in order to carry out the work at HCC Fyrbodal. The following will analyse the technological imperative and its limit to telenurses' autonomy.

14.2 WORK PRACTICES AT HCC FYRBODAL

The telenurse starts her working shift by choosing a work station and logging in with her personal username and password. This means that the computer is also a modern time clock recording one's working time and providing a basis for the individual telenurse's monthly salary. Whenever the telenurse is ready for taking care of calls, she logs in and when she is has a break, goes to the toilet or is occupied with other tasks besides taking care of callers on the phone, she logs off. The computer, furthermore, registers and indicates the exact staff input, the numbers of queuing calls, the time spent for each nurse on separate calls and times between the calls. In this respect the HCC is similar to most other call centres (Deery and Kinnie 2004; Strandberg and Sandberg 2007).

In order to handle technology and their duties at the HCC, the telenurses need to renew continuously their information and knowledge base about current affairs and the healthcare area. Starting a new shift, the telenurses should revisit the white board, where notes and news are attached, in order make a note of any changes. Such news might include information about opening hours, addresses etc. or concern epidemics, poisonous food, closed clinics and other organisational matters in the healthcare area. If she has not worked for several days, the telenurse might also consult her colleagues, who can inform her about changes and aspects to pay attention to. A daily check of her email box is also recommended, as it is a channel, among others, for the HCC manager to constantly transfer information. However, during the period of study at the HCC it was apparent that the use of email differed from one telenurse to another. Therefore, staff at the HCC also attached important messages to the board so as to be visual for everybody at the workplace. The importance of being up to date with changes was expressed by almost all telenurses.[148] Several nurses also stressed the importance of reading the newspapers in order to be aware of changes of health, healthcare as well as current affairs more broadly.

Other tasks at the HCC Fyrbodal besides nursing on the phone, were undertaken by individuals within their own area of responsibility. The principal area of responsibility involved tasks related to medical administration as well as contact with other care providers within the geographical area (primary care and hospitals). The medical administration was related to the system of decision-support, which ought to be updated annually with help from the physicians in the healthcare area (see also section 13.4 about training and competence development).

148 Problems with the system, suggestions for improving decision-support, routines and other considerations were noted in a black book. This practice was applied in order to collect suggestions for improvement (cf. Kaizen) and to transfer information among the shifts and the entire work group.

14.2.1 The standardised process of handling health calls at HCC Fyrbodal

I will below explore the telenurse's work picturing the work process of call handling at HCC Fyrbodal. The work process is generally described and analysed in order to show the ideal way to handle consultations over the phone according to current training and overall healthcare policies. This ideal type[149] might be contrasted and analysed in terms of deviating actions arising from the telenurse's professional consciousness and to individual strategies to cope with stress, frustration and managing emotions within the HCC. The findings presented in the following section are important for understanding the work conditions and the on-going tensions and contradictions. As will be shown, the telenurses act on an individual basis and according to their professional identity in order to cope with the technological and management imperatives. Furthermore, attempts to standardise run against both the management of healthcare uncertainty and satisfying care-seekers' needs and demands.

The software used at HCC Fyrbodal is described as a computerised infrastructure for knowledge and information divided into three main parts, each associated with the nursing process and having the following names: i) anamnesis[150] and/or questions ii) reasons for contact iii) assessment, self-care advice and interventions. The labour process can be summarised in terms of the following duties: answering, listening and asking questions, documentation, forming hypotheses, seeking and carrying out an assessment, giving advice and/or referrals, making an action plan, making sure of that the caller has understood, documented and attested (cf. FCC 2003b). At the same time as the nurse answers the phone, i.e. she pushes the button, a new format is presented on the computer screen. If the caller is to be found within the 'the National Telephone Directory (in Swedish *Adressregistret*), which is linked to the call centre, the name and address of the caller appears automatically on the screen. Calls from mobile phones are, for example, not identified by the system. Each call produces a separate record, and all calls connected to one person constitute her/his compiled case history. However, HCC records are so far only available at the HCC. On the other hand, the HCC has no access to the case records at the primary care centres (see chapter 10 on the care-seekers).

The consultation starts with an opening phase: the nurse answers by saying that the caller has reached the HCC and by introducing herself, using her first

149 The general understanding of an ideal type is a mental construction, created in the attempt to capture and analyse a complex social world. Weber who elaborated the concept, saw it as a tool for emphasising one or several conceptions, and adding diverse phenomena into one picture (Månson 2003).

150 An anamnesis is a medical history, the patient's own description of how a disease emerged, how it has developed and the symptoms given. A contact between a physician and a patient used to originate from a phase where the physician takes the anamnesis, i.e. the patient narrates the story of the medical case. The anamnesis is documented together with the results of the assessment (examination) and is a part of the patient's case book (the author's translation from the *Swedish National Encyclopaedia*). A patient's case book is the notes that are taken and the documentation made in connection with healthcare provisions. The case book contains data about the patient's medical and personal conditions as well as measures undertaken in terms of medical provision and care (the author's translation from the Swedish National Encyclopaedia). The documentation is mandatory according to the Swedish law SOSFA 1993: 20.

name. Some telenurses also add their profession, for example 'Marie – registered nurse'.[151] Then the nurse asks the caller about his/her problem or/and how she can help.

Theoretically the telenurses distinguish between two kinds of calls: information calls and medical calls. The obvious information calls might concern information about opening-times or addresses for medical services etc., to which the nurse might answer directly. As to medical information, the nurse can answer directly or refer the callers to other institutions and helplines, e.g. the pharmacy's call centre if she is asked complicated questions about medicine.

The other kind of calls, the majority, concern medical problems. For such calls, the nurse should enter an anamnesis phase, when she allows the caller to describe the problem/s, while she listens actively. The first steps are explorative, where the nurse asks all kinds of questions in order to capture important clues and adequately analyse the caller and the problem. At this stage the nurse has probably developed one or several hypotheses about the reason/s for the caller's problem and adequate interventions. Thus, she is making an assessment. The nurse should also note the caller's anamnesis and questions put to the nurse. If it is possible, the nurse writes directly into the computer the descriptions that the caller has given, including the kind of question(s) that were in focus. The possibility for writing directly tends to be dependent on the time available, the urgency of the case and the telenurse's experience (see also Wahlberg 2004). Subsequently, the nurse tries to summarise the caller's history in the caller's own words as well as according to her understanding. Besides giving the telenurses specific information as a basis for her assessment, this phase is very important for creating contact and for the nurses to draw up a picture of the patient's orientation, understanding and possibility for self-expression. In this sense, the telenurse's practice of anamnesis does not differ from an anamnesis taken in a conventional clinical setting or an anamnesis taken by a physician.

In order to make an assessment, the telenurses use the protocols of the system, and look for an appropriate 'reason for contact'. This part of the computerised decision-support system called 'reasons for contact' contains a long list with different main headings for different biomedical domains and diseases, such as biomedical medicine, psychiatry, gynaecology and paediatrics. For example, under the title 'orthopaedics' there are different headings called 'pain/trauma' related to different parts of the human body such as the arm, the leg, the foot, the hand etc. Other headings include 'post-operative problems', 'wound damage' or 'pain related to a plaster'. Many calls are related to the main title 'infections' and its heading 'fever', 'vomiting/diarrhoea', 'coughing' etc. The 'reasons for contact' gives the nurse an extended description of general and particular diseases, including symptoms and suggestions of questions to be asked in order to further explore the caller's problem. It is designed to be a reminder to help her avoid forgetting important aspects or questions. The nurse asks all kinds of questions in order to gain a better picture of the caller, her/his symptoms and

151 The telenurse thus stresses her professional status. This was conceived by several telenurses as a strategy to avoid mistrust and misunderstandings from the callers. One nurse stated that if she had been a physician, she would probably have introduced herself as doctor, then using her surname.

the urgency of treatment required. She can also use books, call other healthcare staff or discuss the call with her colleagues. She tries to investigate, give alternatives, prioritisations related to the hypothesis in order to verify whether she can confirm or reject it (cf. FCC 2003b: 17).

The final phases involve the decision and the conclusion of the consultation: the telenurse then gives her advice or referral, together with an explanation for the decision (her assessment). The decision-support addresses the aspect of complexity and urgency of a problem. But no information is given at that time by the computerised system on the caller's personal status or about the organisational matters of healthcare. The telenurse does, however, draw a conclusion from the caller's conditions in terms of age, sex and expressed needs for the support given by the system (see also Wahlberg et al. 2005).

The major possible interventions/referrals of calls are to self-care in order to treat the symptoms at home; referrals to A&E departments or to primary care centres (immediately or within 24 hours; the latter might consider opening-hours and the case of changing conditions). Further, possible referrals might include different kinds of medical service or specialisms. Another common decision of a consultation might be that the telenurse decides to call the care-seeker back to check whether the problems continue. In certain cases, especially with sick children, the nurse agrees on calling back the patient within one or two hours to assess the development of their health status (see chapter 10 about care-seekers). Before the nurse takes a new call, she has to document the previous one, both regarding symptoms and help given (advice, referral etc.) and sign with her name that she has treated the care-seeker. If she has referred a care-seeker to an A&E department, she sends the patient documentation to the hospital (or the primary care centre out-of-hours according to the healthcare organisation in Fyrbodal). This might be done either automatically with help from the computer or by facsimile for the small hospitals not connected to the ACDs system. From 2005, for semi-urgent problems during out-of-hours – i.e. cases not life-threatening enough to be send to A&E, but serious enough to be treated without major delays – the telenurses can arrange a morning appointment at a primary care centre. The HCC disposes of the time booking for early appointments in some primary care centres. Such appointments are made manually, by ticking a box on a paper attached to the board. Booking appointments as well as sending facsimiles allow the telenurses to leave their work station and move to another part of the premises (cf. Lindgren and Sederblad 2005).[152]

14.3 PROFESSIONAL CONSCIOUSNESS AND INDIVIDUAL STRATEGIES

The interviews with the telenurses, the non-participative observations as well as analysis of the events reveals, however, a slightly different picture of the HCC. Important statements from the politicians, health administrators, the citizens and other providers of care (nurses and physicians) are also taken into consideration.

152 Lindgren and Sederblad's study showed the importance of certain artefacts (the work time schedule, coffee percolators and the fax machine room) that served as means to escape one's work briefly (2005: 196-197).

It will thus be illustrated here how nursing practice, experience, individual strategies and strategies to cope with stress, frustration and anxiety are used when handling health calls. Consequently, technology and management control encounter the professional expression of autonomy within the framework of the HCC.

14.3.1 Giving the callers (and the telenurses) the time needed

Between each call, there is an automatic break of three minutes. However, the nurse might regulate this break, if she needs more time for documentation or if she wants to speed up the process. She is aware all the time of how many people are queuing to get through and how many nurses are currently working. A telenurse might adjust the three minute break according to how she perceives the call volumes and labour availability. This practice tended to be more frequent among very new telenurses as well as some experienced telenurses. This can also be considered as a way to cope with stress, frustration and anxiety at work. Shortened wrap-up times were also evident when the lines were busy.

According to the prescribed practice in the training and induction on call routines, the dialogue between nurse and caller might vary in depth and length depending upon the caller's particular problem. However, from observations made in the call centre, variations also followed the telenurses' practices. If a nurse felt that it was easy to intervene, she might sometimes give information and advice immediately (non-participative observations in May 2006). This was also confirmed by a national nurse trainer who sometimes perceived that if the telenurses were too anxious to help, they did not explore the care-seeker's problem deeply enough.

> As I see it, the telenurses were sometimes so anxious to help that they didn't give the care-seeker the time needed (nurse adviser and trainer for II77 March 2007).

However, almost all out of 400 users in two studies from 2003 and 2006 respectively said they felt that the nurse had given them enough time to express themselves (see chapter 10). In training provided to the nurses, the first phase of the consultation was seen as time well invested for the entire consultation and an appropriate outcome. By listening properly and giving the caller time to express her-/himself, the nurse was taught how to assess the caller and her/his credibility (self-consciousness, level of security, and conceptions of health and risk) as well as the social, cultural, and other relevant aspects related to the caller and her/his problems. An experienced telenurse is more skilled at perceiving the unspoken word and the fact that the caller usually under- or overstates her/his condition (cf. Wahlberg 2004). These aspects were, however, considered very difficult to assess, according to the telenurses.

The non-participant observations revealed, moreover, that certain nurses had to work intensively in order to follow the pace of the system. The documentation of the caller (the anamnesis, the assessment and selected interventions, outcomes) took a great deal of time to conclude. The telenurses tried hard to document within the pause between two calls given by the system. While some struggled with time, others showed a more self-confident attitude and if they needed a longer pause between two calls, they pushed the button to hold a

consultation and asked the next caller to wait. For them it seemed obvious that they needed more time to be professional. And that certain calls were more complex than others and required more minutes than those predefined.

> Between each call I get there is a time of three minutes for me to conclude the care-seekers documentation. Sometimes that time is not enough and you have to ask the following person to wait. I used to ask "would you please be so kind and wait while I finish the previous case". It is important that the documentation is correct, understandable and gives a good representation of the consultation (telenurse 11 2006).

The time to document was discussed among the telenurses. The HCC manager expressed the view that a telenurse needs training and experience regarding the documentation. It was a question of writing enough and making it understandable, but not writing too much. Some nurses spent far too much time on documentation, according to the HCC manager.

14.3.2 Acquiring new skills - the experienced nurse, but the novice telenurse

The labour process of telephone advice nursing is very difficult for newcomers. Quotes from the introduction phase illustrate how telenurses expressed the beginning as being very complex due to the multiple requirements of being fast, listening, being attentive, reading between the lines to give advice *and* provide documentation at the same time (cf. FCC 2003b). Handling the computer system is another advanced practice, a third is to know where to find different symptoms and the reasons for contact....

> The hard thing is to not being able to see. Instead you are obliged to listen and to ask a lot of questions in order to find the core of the problem. That is complicated. (telenurse 4 2004)

The pace of work is often high. If so, one then has to balance how to handle the queue and the inner stress that it might cause. One strategy to cope with stress was to admit that they could only talk to one care-seeker at a time thereby giving that person the attention needed. Once one call is concluded, it is generally time to talk to a new caller. Trying to be calm, working methodically and sandwiching call handling and pauses were strategies to cope with the stress of the work. The experienced telenurses highlighted the importance of realising that they were doing their very best and that was good enough. The red light on the screen indicated how many people were queuing and that was stressful *per se*.

> Yes, it might be a state of stress. But I try not to think about it. It has to be good,...when I have a call I have to conclude it, I cannot break in the middle of it because there are others waiting. But it is frustrating because they need help too and it might be something serious... someone who needs help quickly... then unfortunately the callers in line have to wait... and sometimes people are very angry. (telenurse 4 2004)

It was generally considered a learning process, by the experienced telenurses, to become skilled and to cope with the pace of work. Some telenurses said that it was not until after several years, that they considered themselves really competent at defining a problem, using decision-support, focusing and making prioritisations, knowing that they were monitoring the calls and not the opposite,

that the calls were monitoring them (cf. Benner 1984). However, whilst the HCC manager talked about the need for personality, passion and communication skills, the telenurses emphasised not just the importance of new skills but also of tolerance, level-headedness, flexibility, a capacity for distance and emotional self-management (Hochschild 1983). In that sense the work was also about surviving a stressful day with many and complicated calls from highly demanding care-seekers as well as other healthcare staff (cf. Thompson and Callaghan 2002: 114).

14.3.3 A hybrid between information and medical problems

One might also identify a third category as a hybrid between information and medical problems). The telenurses gave examples of parents who called in order to obtain information, for example what dosage of painkiller (e.g. antipyretic and analgesic) they might give their children. This kind of consultation then turned into a situation where the telenurse made an assessment of the child's health status, and strongly recommended other interventions to the parents then a certain dose of medication. This also suggests one of the reasons why an internal division of labour has not been implemented in Sweden.

14.3.4 Compliance with the software protocols and household remedies

As there are no algorithms in the Swedish system, the nurses do not have to retrieve, add or manipulate the data, as has been reported in the UK (Collin-Jacques and Smith 2005; Valsecchi et al. 2007). At the same time as the Swedish telenurses must rely on their experience and knowledge, they are to a different extent dependent on software protocols to answer callers' queries. At HCC Fyrbodal, the calls were not recorded and the software Teleråd did not indicate the need for special advice. That was, however, not the case with another Swedish system for decision-support, SRÅ, which is more monitoring. SRÅ issues reminders about the software based on algorithms, although not as strictly as the British system. A nurse in another HCC explained how this functioned. Once she had chosen a symptom, the telenurse was forced to follow it through the whole system. Additionally, she should give the caller the advice indicated by the software in terms of healthcare level and urgency. If not, she was obliged to make a deviation report. The nurse also stressed that it was very important to document all decisions in the computer and indicate the time of the call, although the calls were recorded.

> Recently, there was a case of malpractice regarding an operator at EMD [this HCC is co-located together with EMD *authors comment*], who did not follow the instructions and therefore he got an admonition. It is important that we follow the existing instructions and that we refer everybody who the SRÅ system instructs should be transmitted, otherwise we do risk getting a caution. But the A&E departments and other healthcare units might have a hard time understanding why certain patients are referred to them. They have a hard time understanding that it is because of the system (telenurse in an HCC operating the decision-support system SRÅ 2006).

The telenurses in Fyrbodal are supposed to follow the medical content and the information given by the system. But sometimes nurses also gave advice based on practice, experience and knowledge of the single nurse.

> Certain advice is not validated according to the system, although the nurse does give it according to her experience. (telenurse 19 2006)

Telenurses should not give any advice that is not sanctioned by the medical software and all advice given should by documented. This implied that the advice either should be included in the annually updated Swedish book of medication (*FASS*) or sanctioned by the responsible physicians at HCC Fyrbodal. However, as the telenurses in general have long clinical experience and know many 'alternative ways' to relieve pain and treat minor ailments, they can sometimes give advice 'off the record'.

There has been a debate among telenurses at HCC Fyrbodal as well as nationally about whether telenurses should advise on minor 'remedies' (household remedies) or not. This concerns advice that has not been scientifically tested and verified to be effective, but which has been shown to give results in daily practice. One oft-stated example is the use of yoghurt for genitals in order to relieve pain and irritation. This is not advice based on evidence, but obviously it is supposed to calm to a certain degree and it does no harm, according to those who believe in the method. Thereafter, there is a whole continuum of methods ranging from household remedies to homeopathy and alternative medicine, which are not evidence-based.

14.3.5 Management's attitude towards freelancing

Freelancing is one way for management to define advice given, such as that described above, that is not supported by the system or evidence-based research. The HCC manager did not encourage her staff to freelance, yet at the same time she felt that many nurses had long experience and plenty of sound advice to give on different conditions and symptoms. She expressed a fear that with a more complex system or a too simplistic system, there was an obvious risk that more telenurses start to freelance. According to her, this fear was logical because the telenurses genuinely wanted to help the callers if they could (cf. Smith et al. forthcoming). The telenurses sought all kinds of solutions, especially if they perceived that a caller was in a weak position and really was in need of help.

14.3.6 All problems have to fit into a medical problem

A major problem, not unique for HCC Fyrbodal, is all the people who are not sick enough to qualify for medical service. This is a problem that reflects Swedish healthcare and society in general including the difficulties of getting and giving adequate help. More and more people feel lonely, some having a psychological diagnosis, but many simply have problems in fully adapting to the society of today or coping with contradictory and overwhelming demands. They might have minor or major social and nursing needs, but their problems do not fit into a medical diagnosis. They, like other people in need of help, call the HCC both because of a physical problem and because of other crises and traumas that hardly can be treated through one visit to the general physician. For these callers, the telenurse can release the worries. She can let them talk and listen as well as confirm her understanding and empathy. In several cases, such support from the telenurses is probably very important for people who do not know where to turn with their questions, fears and anxieties.

14.3.7 Experienced telenurses and team discussions

There are no formal differences between the novice and the expert telenurse in terms of complexity of the cases they handle. A call is directed to the first vacant nurse. But in practice, there are certainly more experienced telenurses to whom the less competent telenurses tend to turn when they do not know what to do. Accordingly, competence and experience are constantly shared and the skilled telenurses help their colleagues handle the more complex cases. It might also be the case that there is no obvious solution to a problem or a question and the telenurse needs to discuss and reflect her thoughts with the other telenurses in order to come up with an adequate solution. To be among other experienced nurses was greatly appreciated by the telenurses at the HCC and considered an invaluable means of support. Accordingly, the HCC differed from traditional telephone advice nursing at a primary care centre, where it is common that one nurse alone handles the phone and might not search for another nurse or physician in other parts of the premises in order to discuss uncertainties.

> Then it has to be a major problem, especially if you have to disturb the doctor. But here [at HCC Fyrbodal] I can just turn to my colleague at the opposite work station and ask for her opinion. (telenurse 9 2006)

14.3.8 Organisational matters

There are different administrative routines for different hospitals and primary care centres, as well as different routines for different healthcare areas throughout Sweden. Although the majority of the callers, in this case, belonged to the catchment area of Fyrbodal, many people call from other parts of the region and elsewhere in Sweden. Likewise, the telenurses in the neighbouring HCC in Södra Älvsborg[153] had a slightly different work organisation and other routines and policies to consider. For example, while emergency cases are sent to the primary centre out-of-hours in Fyrbodal, similar patients in Södra Älvsborg are sent to the A&E department. Furthermore, in Fyrbodal the telenurses may have repeated contacts with a care-seeker in case of uncertainty, in order to follow their health status over a certain period, sometimes several days. In the other HCC, the nurses do not offer the possibility of a check-up or calling the care-seeker back. Moreover, at HCC Fyrbodal the telenurses treated cases of children below one year, but in other geographical areas such paediatric issues should be directly addressed to the hospital.[154] There is a direct connection between almost all the hospitals in the area and the HCC, except to one hospital in the very north of the catchment area. At this hospital the telenurses are obliged to undertake different administrative routines. Thus one characteristic of the HCC work is that the nurse needs an overview of the entire healthcare organisation and the general process of healthcare. Where does one find appropriate primary care, hospitals and different specialities? What actors take care of what kind of diseases according to the corporal division of parts and organs among the medical profession? Moreover, the telenurse needs local

153 The HCC with whom the telenurses in Fyrbodal collaborated.

154 This was, for instance, the case in the healthcare area of Gothenburg.

knowledge of the particular organisation of healthcare in her area. Some units accept children and others do not, to some units the telenurses might send medical patients, but not surgical patients. The interviews and discussions among the telenurses showed that there are many organisational matters to be aware of. As a result of mergers between hospitals, the specialities are split between different locations. Consequently, the telenurses had to be aware of the detailed organisation of healthcare for the whole area to avoid sending the care-seeker to the wrong hospital. The importance of local knowledge is, however, heavily debated. Those in favour of a central model of telephone advice nursing, believe that local knowledge is unnecessary and that its value has been exaggerated. Several of those working within more narrow healthcare areas stressed the importance of being well aware of local conditions and practice. The following sections explore how telephone advice nursing appeared for the telenurses in their contact with the care-seekers which also constituted important conditions of the work at the HCC.

The nurses gave examples of how they had made mistakes when new in the role of directing the care-seekers the wrong way or even to the wrong hospitals. In areas such as Fyrbodal, many small islands and minor roads, mistakes might only correspond to a few kilometres on the map, but be a matter of hours in real time. The way to treat a caller is also dependent on the experience and background of the telenurse. As district nurse in some areas, the telenurse might have enjoyed certain areas of authority that are handled by the physicians in other areas, for example the duty to change a catheter. It is obvious that the long distances and geographical character of the area such as the archipelago, forests and sparsely-populated areas have influenced the healthcare staff in Fyrbodal. The interviews beared witness to physicians who had examined small children, although it was not their responsibility because they know that otherwise the family had to travel for more than 100 kilometres to the nearest hospital, and of district nurses who travelled in large districts carrying out care in the patient's home that otherwise should have been a matter of a visit to the far distant primary care centre. Another risk of lacking local knowledge was that of upsetting physicians and healthcare staff with the 'wrong' kind of health problem.

14.3.9 Technical problems

The call centre system is a major source of problems, as the technology was not always reliable at HCC Fyrbodal. The system was introduced very late and had been out of order several times and for shorter and longer periods. Technological breakdowns created considerable additional work for the telenurse, especially as she had to document by hand on a blank sheet of paper and then fill in all the data in the computer. This was also a matter of patient security as the telenurse had no connection to medical decision-support, although she was forced to give information, advice and support as usual.

14.4 EMOTION MANAGEMENT

14.4.1 The specific kind of encounter

There were many questions and issues put to the HCC related the callers' contact with other health providers, why a doctor had done this or that, had said something etc. As the HCC should be the first level of healthcare, it might cover in principle everything and then it is, of course, very hard to be a specialist on everything (Valsecchi et al. 2007). The rest of the healthcare organisation was at least in the beginning badly informed about the HCC, the telenurses role and what kind of service the HCC could offer. They were not aware of how the callers' questions to the HCC might differ from the issues that are normally brought up in primary care, according to the telenurses. The telenurses had many cases where the parent really did not know how to treat his or her offspring. The worries as well as the questions to the HCC showed a changed conception of the body and how to treat oneself and one's family (cf. Beck and Beck-Gernsheim 2005) between different generations. Today's parents have undertaken advanced academic study, while being totally ignorant about small ailments and how to handle their health, including aspects of old household remedies.

> There are questions that I previously would never have imagined as being possible to ask, like whether you get sick by eating old eggs, how long one could wait before playing basketball after an injury, if you could breast feed your child when you have a cold. So there are a lot of questions related to changed patterns of society, but then people do also ask questions, I think, because you might be anonymous and you don't see the person that you are talking to. (telenurse 9 2006)

HCC Fyrbodal also received many queries about sexuality and sexual intercourse, especially from young people in need of information. Here the possibility to be anonymous was experienced as being very positive by some callers.

14.4.2 Emotional labour with different intentions

Emotional labour includes the telenurse showing empathy and expressing sympathy for the caller, to be calm and friendly, but sometimes also to hold back one's own feelings and not getting angry on the phone (cf. Hochschild 1983). Yet this is not always easy as the telenurses have to confront anger and conflicts over access to healthcare and the urgency of seeing a doctor as well as the callers' requests for visiting an A&E department. These even lead causally to spitefulness and disrespect from the callers' side. There are no buffers between the telenurses and the care-seekers (cf. Frenkel et al. 1999), which is why emotional management among other things consists of managing and controlling the telenurses' own feelings, energy and enthusiasm. The telenurse is the care-seekers first contact with healthcare, and as representatives and the face of healthcare, the telenurses receive the claims, when people are upset and something is not satisfactory (see also Frenkel et al. 1999). The emotional labour performed by telenurses could be described by Bolton' typology (2000) based on Hochschild's conceptual framework from 1983; analysing the intentions behind such actions, i.e. *presentational* (emotions according to general rules for human interaction); *philanthropic* (emotions given as a gift); *prescriptive* (emotions

according to organisational/professional rules of conduct) and *pecuniary* (emotions for commercial gain).

14.4.3 The patient's advocate, the companion lady, the face of healthcare, and the respectful fellow being

The telenurse's encounter is considered as very important and her assessments may be significant not only for the care-seeker, but also for initiatives taken by other healthcare organisations (cf. Edwards 1998: 51). Most telenurses are very focused on solving the problem for the patient. There are routines and regulations at the HCC and in the healthcare areas that are monitoring the telenurses, at the same time as local knowledge and skills in problem solving are required, especially out-of-hours. Sometimes when it is not possible to get in touch with an A&E department, HCC Fyrbodal has a hotline to acute care and to the physicians on duty, but this might be out of order or occupied. Sometimes negotiations and assurance from the telenurse's side are needed to convince the physician on duty that there will be time for one more patient or that this patient is in major need of help. Several nurses considered doing this as they had to handle the physicians with cunning and charm in order to convince them what was best for the patient.

> It is hard to squeeze in the patients and sometimes you really have to toady [to the physician] for the patient's sake. (telenurse 3 2006)

Most of the nurses tried to ensure that the care-seekers were not pushed around/called around between different healthcare units. The way of pushing the care-seeker around between different healthcare providers showed once again how matters of responsibility are juggled within the healthcare area. According to the policy of Fyrbodal that 'Advice: Once is Enough' it has been decided that once the department had started to help a caller, that department should also conclude the matter as far as possible. These behaviours might be described as *prescriptive emotional management* as the telenurse performs according to healthcare norms and her professional identity, i.e. the rules of conduct originating in secondary socialisation (Bolton 2000: 160). But it might also be a *philanthropic* gesture as a consequence of a nurse who genuinely cares and empathises with the care-seekers (cf. Bolton 2000: 161).

The telenurses were particularly concerned about giving service to elderly people, who had problems getting in touch with their primary care centre, who were confused or did not know where to get help. This was not stated in any policies but done out of humanity and empathy with the difficulties of getting older. The HCC also had to shoulder the social contact for some odd characters that had become regulars at the HCC. Most often this was a question of old, lonely or sick people, often with psychiatric diagnosis. They called the HCC in order to get human contact and company, as many of them experienced anxiety and insecurity, at dusk.

> X tended to phone every day so we told him that we wanted a photo of him to know with whom we were talking. But to be honest he was quite disgusting...why we had to take down the photo from our common board. He is pleased to talk for a while, but now he accepts when we say that we don't always have the time to talk to him. (telenurse 25 2006)

Regulars seem to exist to some extent also in other types of call centres, i.e. persons who call even once and twice during a night and who only wish to get a bit of company (Thompson and Callaghan 2002: 117). The telenurses gave also examples of a number of calls from people who wanted to talk dirty and shouted out about all kinds of obscenities. Sometimes they wanted to intimidate the telenurses, sometimes it was more a question of mucking around and getting a response to their behaviour, according to the telenurses. Especially in the beginning, the telenurses were caught by surprise, as time went by they tried to cope by using jokes, indifference and harsh forms of correction.

Telenurses' wishes to sometimes pay extra attention towards care-seekers in combination with the large and particular requirements of the callers, stand in contrast to what is officially required as working tasks of the HCC. A national standard was under progress and it influenced the requirement on local HCCs for example on what a normal production of an HCC should be, the statistics of numbers per hours etc. The national debate aim has aimed at a coherent telephone nursing advice service and standardised practice with possibilities to serve other areas outside one's own county. On the other hand, there are arguments that the service in terms of time and effort might be saved in the long run if extra attention is given during the first contact. In commercial as well as public call centres, the *pecuniary emotions* have become increasingly important in order to satisfy the demands of customers. The encounter should have a positive result in terms of both efficiency and customer satisfaction. In an earlier chapter (8), the healthcare administrators underlined the importance of the HCC for service delivery. This includes telenurses presenting a pleasant voice to the caller and monitoring adequate levels of healthcare (cf. Thompson and Callaghan 2002: 115). Through emotional labour, workers can manage their emotions so that they move beyond 'surface acting' and actually change their feelings, into what Hochschild (1983) call 'deep acting' (see also S. Taylor 1998, Bolton 2000). However, as shown by Hochschild (1983) this might also have unhealthy and alienating effects on the employees.

The telenurses' conceptions were that certain callers could be very demanding. Healthcare was by some considered a right to obtain as a citizen and some callers tended to stretch their demands in order to see where the limits were. Some callers might also treat the telenurses in ways that they found disrespectful, like flushing the toilet, listening to loud music and being unobservant while talking to the HCC. Other callers were arrogant, questioned the telenurse's knowledge or said that they would hold her responsible if something went wrong. The telenurses felt discouraged by these kinds of encounter. For them presentational emotion was a part of human behaviour vis-à-vis their fellows and a way of being normally polite (Bolton 2000: 160).

However, they were not persons to push around. Some stated clearly what they thought and that they could answer the callers in quite paternalist ways sometimes. They had been around for a long time and some certainly did know how to answer back. Many had experience and thought that there were limits to pampering the callers. Some telenurses found it disrespectful of the care-seekers to let their crying children shout down the phone when they talked to the telenurse, while others thought it was human to hold a crying baby. 'But there are

no babies who have died because the mother has put her/him down for a moment', one telenurse ended a discussion.

> People call in the morning in order to ask what to do, if they are ill, but without paying attention to how they feel or having even taken their temperature for example. (telenurses 16 2006)

Many calls originated from abroad either from people on vacation, with relatives abroad or people living outside Sweden. They preferred to call Swedish healthcare and some were quite demanding. On the other hand, calling from abroad might make it even harder to get in touch with healthcare.

> My daughter is staying in Australia – would you be so kind as to arrange it so that she might have the result of her tests from this or that hospital? (telenurses 3 2006)

Another specific feature of the HCC was the callers who were really aggressive, almost impossible to calm, and complained about all kinds of healthcare issues. In that sense the HCC became a primary channel for healthcare complaints and for complaints about all kinds of problems in life and society.

> I don't know, I think it is very hard with all these people who are aggressive... you try to listen to them and to understand their problems, although you understand that there are no possibilities in the world that you might help them... These are very demanding consultations, which drain you of energy. (telenurse 8 2004)

14.5 INTERACTION WITH THE REST OF HEALTHCARE

14.5.1 Maintaining and developing the decision-support

As to the updating of the medical content of the decision-support, the telenurses were supposed to share this responsibility with the physicians. It meant that the telenurses were formally responsible for the administration and the updating of the process, while several physicians were appointed to provide the system with a kind of 'evidence-based' medical content.[155] Thus, the physicians are supposed to describe symptoms and formulate the advice used by the telenurses.

One aim of the HCC, to create and maintain a system for medical decision-support, implied that the HCC was integrating the different views of primary and specialist care. The HCC attempted to administrer and compile protocols for medical descriptions and advice classified by medical domain, e.g. paediatric surgery, medical paediatrics, orthopaedics etc. However, this meant a real clash between different clinical practices, which made the telenurses work with the decision-support system progressing slowly with many interruptions and delays. Eckerlund et al. (1993) have pin-pointed the systematic deviations that exist between different levels of healthcare providers, different kinds of medical specialities and even between different geographical areas. For the work of compiling and specifying adequate advice, descriptions of symptoms and

155 Swedish healthcare in general has to date very few processes of evidence-based medicine compared to, for example, the UK and the Netherlands who were early implementors of clinical guidelines and medical audits (cf. Dent 2003: 57-58 and 93-94).

questions to ask, all the differences clashed, with divergent views on the care-seeker, resources and the role of healthcare as a result. It was perhaps possible to describe the patient and the resources available, but harder to agree on the selection of treatments and medical praxis (cf. Hallin and Siverbo 1994: 21). When collecting information for the medical content of the decision-support system, the HCC sometimes ended up between the primary and the specialist care. The telenurses argued that the groups of actors at Fyrbodal did not all agree that the HCC was a task for primary care. Most telenurses did, however, favour a generalist identity for the HCC.

> I think that at an HCC you should'nt wear the glasses of a specialist. What is required are eyes for healthcare advice at the HCC, i.e. a primary care perspective, but this is only our perspective. (telenurse 5 2004)

The telenurses therefore had a complicated role as mediator, which urged them to arbitrate between different opinions and schools of medicine represented by different specialisms and between general medicine and other specialisms. For instance, the surgeon's words stood against the orthopaedist's on how the care-seekers should be treated. This left the HCC with the contradictory task of uniting the different perspectives of specialists. Views also differed between the specialists and the general practitioners at primary care centres. In addition, there were different routines and working times at the two main hospitals, which meant that the HCC had to adapt to them both.

14.5.2 The physicians' control of the HCC

The physicians involved expressed difficulties, furthermore, in allocating time or they forgot that they were supposed to carry out certain duties for the HCC. The updating of the system was frequently postponed and caused anxiety for the telenurses, although they expressed this, as an important matter, in terms of their own development and of variation in the work. The contact between HCC staff and the physicians was supposed to take place in connection with meetings and the training undertaken by the telenurses. The physicians were consequently invited as speakers. Also here on the matter of time, some physicians considered it difficult to prioritise the HCC.

It was also hard to persuade some physicians to prioritise lecturing at the HCC. It might be easy to draw the conclusion that the HCC implied just another work task for the physicians, who already felt that the burden of work was alarming. Handling decision-support for the telenurses was not very prestigious work and had little status in the eyes of their colleagues. Lecturing was another duty that did not give any extra merits and when carrying out additional work, other duties were affected. For the physicians, the contact with the HCC was neither particularly well rewarded nor linked to status in the eyes of other physicians. It was more an additional and demanding task for them to annually go through the symptoms and advice.

The physicians' relation to the HCC was mainly considered as an act of giving help and support to the HCC, not as an assignment in order to improve the overall relations between healthcare and the care-seekers (improved patient relations) or better coordination of the common healthcare work and resources.

The physicians conceived this in terms of the telenurses needing feedback on how to carry out their work at the HCC. HCC Fyrbodal was a separate organisation with responsibility for the first patient encounter with pretty much its own identity like other departments and units in the healthcare area. However, according to the decision-makers, the HCC was supposed to imply coordination and some kind of standardisation across different healthcare providers (cf. chapter 7 and 8).

The formal view, i.e. the image that the politicians and the leading officials attempted to create of the HCC, was as the first level of care – the place to call for citizens needing immediate and urgent healthcare. But initially the primary care centre staff consider the HCC neither as an equal actor nor a colleague, although the call centre and the 40 primary healthcare centres were managed through the same organisation. Officially, the HCC was at the same hierarchical level as the primary care centres and the telenurses' closest colleagues were supposed to be at the primary care centres. But it was obvious during meetings and interactions between the HCC and the rest of the primary care organisations that the HCC was seen more as a competitor and a new and unnecessary function that would create more work for the rest of healthcare, especially in its first few years.

In interviews, the telenurses argued that they contacted the physicians and other care staff in order to discuss the care-seekers' symptoms and advice, whenever they felt it was absolutely necessary. They also tried to check the availability of other staff and the actual pressure from patients on the single care unit before referring callers. Sometimes staff at A&E departments called the HCC in order to warn that they did not have enough staff and thereby asked the HCC not to send any care-seekers. The telenurses also called health departments and physicians on duty (*jourhavande läkare*) in order to seek advice and recommendations about symptoms to observe for all kinds of care-seekers out-of-hours. Hence the physicians on duty became an important source of support for the telenurse's decision-making. Some telenurses explained, however, that they were concerned not to bother the physicians 'unnecessarily'.

The most frequent contacts between the telenurses and other care-providers occurred between departments, where a good relationship seemed to have been established and to which the telenurses said they could call without a feeling that they were being a disturbance. Previous contact networks, e.g. former employers and colleagues, were, furthermore, considered important channels for the telenurses to keep in touch with the rest of the healthcare organisation. Many telenurses had been working in the healthcare area for a very long time, and had rather large networks. Some of them tried hard to keep up their old relations, while others were more overwhelmed by the actual work at the HCC. Several telenurses seemed to be very well known by the staff in other healthcare departments. For instance, as one physician explained:

> Ah.. you mean sister Marie and sister Sara? Everybody knows them, they have been working in the area as long as I have...and that is quite some time now... (physician 11 at a hospital clinic 2004)

After two years the critical voices seemed to be a bit quieter and the criticism of the telenurses was more constructive. This development is reflected in two statements made by the telenurses:

> We should not make a diagnosis... we should only carry out assessments, and monitor the development of symptoms and then refer to someone who treats the care-seeker, but the physicians consider us as a threat. (telenurse 23 2002)

> Changes since the start of the HCC and with the good experience that our collaboration has brought lately, gave the impression that the physicians on duty are not that disrespectful any longer. It seems as if they can see the advantage of having us here and they understand that we are not coming directly from the street in order to read from the decision-support system. (telenurse 12 2004)

It was unusual that the Swedish telenurses moved back and forth between the HCC and face-to-face clinical care (compare the practice in the British HCCs as reported in Smith et al. 2005). Instead, a certain amount of the working time was supposed to be dedicated for auscultations, i.e. a kind of apprenticeship, where the telenurses visited and followed those working in clinical care for a half a day or one day in order to be up-to-date with clinical practice and changes. These visits to clinical healthcare took place during their time reserved for personal development. However, it was the nurses themselves who organised their auscultations, clinical visits and maintained a contact-net with other healthcare institutions.

The interviews reflected that the nurses found it difficult to prioritise as such their own competence development. Competence development clashed with their daily practice and the prioritisation that the phone always had to be covered before other preoccupations. The daily handling of calls was the main task of the HCC, and because of sickness and staff shortages, the areas of responsibility were rather often left aside. Some nurses were disappointed because they thought that there were too few lectures. They had hoped for more training and neither was the quality as high as expected, because some physicians were complaining more about how the assessments and referrals were done at HCC Fyrbodal than teaching and giving suggestions on how to improve the work process.

The telenurses also thought it was hard to combine external meetings with their ordinary working time. Every second Tuesday, the HCC had nurse-led meetings only for the staff. These were followed by a workplace meeting with the HCC manager and sometimes training sessions, lectures or a presentation. Furthermore, it was a goal of the staff to arrange two social activities each semester in order to create some community feeling within the HCC. However, the opening time of the site, 24 hours a day, 7 days a week, was considered as contrary to the ideal of common meetings and training sessions.

From the physicians' point of view, the 'agreement' that the contact physicians should support the telenurses and give them lectures on a regular basis, was an oral agreement and in many cases the contact physicians were not informed in beforehand about this further responsibility. Gynaecology was considered a smaller area and the HCC had only a few calls per week about problems that could be related to this speciality. The relationship with the paediatricians might be contrasted to the relationship the HCC had with the gynaecology clinic:

> We have had a very good relationship with the gynaecologists... considering our individual work with areas of responsibility it is so much easier with a person with whom there is an interaction. They have been here several times and ... they try to check what needs we have...(telenurse 19 2004)

The gynaecology clinics and the paediatric clinics could set an example of two diametrically opposite conceptions of an HCC. The gynaecology clinics had close contact with the telenurses at the HCC and they answered quickly and in a friendly tone, when the telenurses had a question. The staff at the clinic invited the telenurses to call when they hesitated or needed to know something. The relationship between the HCC and the gynaecology clinic of was established by one of the telenurses who worked at the HCC. She later returned to her old position, but retained considerable knowledge about, and a genuine interest towards the HCC:

> Our contact person has worked at the HCC, so she knows exactly how things are here. She usually contacts us, when something has happened that she believes we need to know. Of course, she perceives it a bit from our perspective... and then there is a physician, who we contact and he is also very positive towards us... is sympathetic... he has been here several times to give lectures. (telenurse 6 2004)

14.6 A FEMININE WORKPLACE FOR HEALTH CALLS

14.6.1 A women's collective – a nurse-based and nurse-led workplace

In Sweden, as in the UK, the HCC is basically a nurse-led service, in that it is supervised by a head nurse. As most call centres, the Swedish HCCs predominantly employ women. At HCC Fyrbodal there are only women. At HCC Fyrbodal, one man was employed, when the call centre opened, but he left the job rather quickly. Gender divisions at Swedish HCCs in general reflect those prevailing generally in healthcare. Women are employed in nursing, while the majority of men are found in medicine.[156] In 2006, 40 per cent of Swedish physicians were women (Swedish National Agency for Higher Education 2006: 113) and about 10 per cent of Swedish nurses were men (SAHP 2005). Yet most men in healthcare are found either in intensive, ambulatory care or psychiatric care, and relatively few men have experience of being a district nurse or being employed in other positions in primary care. One man that I discussed with from another HCC said:

> As a man you are very 'different' from the typical HCC employee, it is definitely a woman's world. (telenurse previously working in an HCC 2006)

Interviews with two men, who both had worked at different HCCs, depicted the atmosphere at their HCC generally as being very female, and both expressed a lack of multi-professional teamwork and interaction with other groups than (female) nurses. Moreover, they said they missed the pulse, the feeling of being in the middle of the action and attending critical moments, i.e. crises, traumas

156 However, if today's gender tendency at Medical School continues, the gender imbalance will end within 15 years, as 57 per cent of students are female versus 43 per cent male students in 2004/5 (Swedish National Agency for Higher Education 2006: 112).

and complicated decisions about life and death. Telenurses who work at the HCC co-located with EMD (ambulatory service) stated that attitudes to and conceptions about the work differed greatly between the telenurses and the EMD operators (interview telenurses 2006). The decision to establish HCC Fyrbodal outside the EMD was taken in order to develop skills and competences related to the particularity of telephone advice and to create a culture based on nursing practice.

Hence the HCC aimed at securing its own identity rather than merging it with the rough and masculine ambience of rapid actions[157] of dispatching ambulances as well as all kinds of emergency situations requiring other activities than nursing such as the fire brigade and the police for instance (Forslund et al. 2004). The reason for not co-locating the HCC with other healthcare organisations might, furthermore, be understood in the light of not wanting to sub-optimise any other healthcare organisations in the area. This was especially the case when considering the debate about telephone advice that preceded the introduction of the HCC in Fyrbodal. Moreover, it seems as if some callers do not expect a man to answer the phone. Another man expressed this as follows:

> Sometimes the callers question if one is a registered nurse or not. A while ago, a person first asked me that question, but then when I called an ambulance on her behalf, she said thank you very much, doctor. What a career development...a meteoric career, I would say, in just some minutes... (telenurse 27 2006)

This quote reflects the existing gender structure and the callers' prejudiced view that women are nurses and men are physicians.

> Primary care is not like hospital care. Primary care is more focused on blood pressure, infections and coughs. Moreover, it is a female organisation, with more and stronger women at the top compared to many other health institutions. (health administrator 15 2004)

Some men are employed at HCCs throughout Sweden, but many have administrative duties in combination with their work on the phone. Others are only preoccupied with administration/management issues. HCC Fyrbodal is a part of the primary care organisation. Primary care centres constitute smaller workplaces dispersed over a wide geographical distance and are situated in flatter organisational structure compared to hospital care. Secondary care, especially since the mid-1990s, often involves merging several hospitals together in a matrix of divisions under central management (Harrison and Calltorp 2000).

The structure in a bigger private HCC mirrors, however, the gender structure of Swedish healthcare sector in general – many women on 'the production line' or on the floor, some women in administrative positions and as middle-managers/team leaders, and relatively many men at the top (cf. Durbin's 2006 study of the banking industry). According to Durbin (2006), it is evident that call centres are not careerless environments (see also Belt 2002; 2004). Women

157 On average, it does not take more than 20-40 seconds before the first action is taken in response to an emergency call (Forslund et al. 2004).

progress to a team manager level and then their advance halts. Flatter and broader spans of control (organisational structure) then prevent women from progressing as they do in the traditional, hierarchical organisation (2006: 131). Nevertheless, there is a difference between healthcare in primary care and in hospital care, where women's low representation in hospital management and in the groups of highly specialised physicians might be explained through the persistence of gender-based stereotypes (cf. Lindgren 1999). This also means that the barriers created by organisational practice make it more difficult for women to advance within hospitals than within primary healthcare.

14.6.2 The unique character of the centre

In line with the particular inception of HCC Fyrbodal, the telenurses employed in 2002 were offered the chance to design their own workplace and create its routines. A result of this, for example, was that many artefacts were discernible throughout the place – flowers, porcelain figures and ornaments in order to create a more personal atmosphere. Attention was paid to textiles and curtains. On the table next to the door in the main working room, there was a large bowl with fresh fruit as well as coffee and water placed at the free disposal of the telenurses. This might elicit the will that the staff should have a break now and then or at least find sources of new energy (cf. Lindgren and Sederblad 2006). Furthermore small details such as burning nightlights in the toilets and the booklet 'How to create excitement in your life' indicated a personal style at the workplace. The walls were decorated with paintings, a number of medical posters (e.g. one dealing with skin problems of cancerous/malign liver spot) as well as geographical maps of the catchment area. A whiteboard had a more central position in the room, and here all the statistics as well as important notices and documents were attached. Production statistics for the HCC were also displayed per year, month and week so that everybody was conscious of the work performance.

Besides the task of handling calls and the individual work in one's own areas of responsibility, the telenurses carried out the work tasks related to their work environment. On a board in the kitchen a note was attached called 'A time-table for our satisfaction'. It indicated the following duties

> Monday – hoover, shop for coffee, fruit and snacks for the enjoyment of all, and get money from bottle refunds;
> Tuesday – water the flowers, change and wash towels, empty the garbage can;
> Wednesday – clean the refrigerator, defrost the freezer on the fourth Wednesday of the month; Thursday – hoover, shop for coffee, fruit and snacks for the enjoyment of all, make an inventory of the store and make bookings; and
> Friday – water the flowers, do the dusting.

I think there are few prospects of finding a list of this kind in a male-dominated workplace, and my conclusion is that the list including common responsibilities is just one indication of the female character, combined with the fact that HCC Fyrbodal is a small workplace.

14.7 COLLEGIAL RELATIONS AMONG TELENURSES

14.7.1 The collective of telenurses

Most of the telenurses described their working environment overall in positive terms characterised by the friendly and helpful atmosphere of other telenurses. The telenurses worked closely together and it might be argued that they have also developed their own culture at the HCC. It was also the aim of the initiators to introduce a service with its proper identity. Proximity, similarities and mutual interpretations are claimed to be the necessary conditions for creating a collective culture (Lysgaard 2001/1961; Lindgren 1992). The telenurses were otherwise quite detached from the rest of healthcare in the area, which allowed them to form their own working group without direct involvement from other occupational groups. The latter, moreover, are out of sight. HCC work might also be experienced as somewhat detached. As one telenurse expressed it:

> I feel a bit apart from the rest of society in time and space. (telenurse 6 2004)

This quote might reflect that the telenurse felt apart from healthcare in general as well as from the patient and her nursing work. The detached location might also create a feeling of being far from other colleagues, the teamwork and other kinds of social interaction, as well as being apart from the rest of society (cf. a feeling of alienation expressed by Marx in for example Blauner 1973/1964). A diametrically opposed interpretation might be to consider the HCC work in terms of freedom in time and space perhaps from society, traditional healthcare including colleagues, patients as well as the medical and administrative routines in the ordinary departments (cf. discussions about collegial and physicians' control over nurses in Franssén 1999; Wise et al. 2007).

The staff also expressed that they were pleased that they had a similar education and 'were on the same wave-length'. Being all women and registered nurses of almost the same age and with somewhat similar experience and education, their interpretation of the work situation was also rather similar, as they had a rather united frame of reference based on previous experiences as well as work tasks (cf. Lindgren 2001: 219). At the same time, there were, of course, many individual thoughts, considerations about the pros and cons of the work and the essential aspects of the work. To what extent should the telenurse provide service and help and to what extent could the caller arrange it by him-/herself? How much should the telenurse inform and educate? To what extent should she convince (steer) the caller? And to what extent should she let the caller get what he/she wanted? These were some of discussion themes in the workgroup.

14.7.2 Focus on the patients and the physicians

As in Franssen's study (1997) of care in thought and action, the telenurses talked a great deal about the patients. This patient orientation seems to be ubiquitously present in their work. They showed an ambition to be loyal and helpful towards the care-seekers. They frequently took the side of the weaker groups, and the callers seemed constantly present in their minds and discussions – the reasons for calling, health problems and symptoms, the development of calls, their own conceptions and whether their conclusion and help was the most appropriate etc.

The HCC also reflects to a large extent the attitudes in society, towards life, health, ill-health, the body and physical aliments. The citizens' different ways of perceiving and taking care of their lives, their off-springs as well as using healthcare resources were vividly discussed among the telenurses and evoked different kinds of professional and human feelings, also discussed above in relation to emotional management (cf. 14.4).

However, the telenurses talked less about workplace issues, the work environment or issues of representation. They were aware of and discussed issues of workplace routines and how to organise their own work in a better way, especially the practical aspects of the job. Other subjects of their discussions were the physicians, their words and deeds as well as those of other healthcare staff. Although not physically present at the HCC, they were ubiquitously present in the telenurses' talk and conceptions about their work. In her book 'Doctors, sisters and girls (*Doktorer, systrar och flickor*) Lindgren (1992) described the traditional hierarchy that is still dominant in healthcare between physicians, nurses and assistant nurses. Traditions and the mutual dependencies might be one of several reasons for massive resistance shown by the physicians and other healthcare professionals at Fyrbodal. Lindgren (1992) argues that the sisters, i.e. the nurses have a middle position between assistant nurses and physicians. This creates space for the nurses' individuality and personality.

The position, however, is unstable, which is why they pursue alliances with the physicians as some kind of professional strategy in working life. This also explains the nurses' eagerness to embrace change and flexibility. At the same time as the telenurses at HCC strive to form close relationships with the physicians, they are also revolutionary in their claims for more, discretion, time and respect from the medical staff. In short, the telenurses have demands and expectations that the physicians did not always fulfil. Many discussions and descriptions about other parts of the healthcare system were coloured by satirical comments, gags and humour, especially in terms of how the physicians behaved and did not behave.[158] In such ways the telenurses tried to mark their identity, unique position and show resistance towards the physicians and their ways of controlling the nurses.

The telenurses are very keen to ensure that the callers are satisfied, although they logically understand that everybody cannot be satisfied all the time (cf. Hochshild 1983; Korczynski 2002). Wahlberg has also shown that telenurses have a high ambition that everybody should be pleased – the callers, the relative, colleagues and managers (2004). This is also an important cause of stress, strain and frustration especially managing the tensions and contradictory conceptions expressed by different groups of actors in relation to the HCC. Moreover, if the caller's approval or acceptance is not obtained, it is quite possible that the callers contact other health providers when they are in need of help, i.e. management's rationalisation and improvement goals are not obtained. Yet, the HCC is the official channel into healthcare and few other paths are offered.

158 It might be compared with resistance towards managerial control and discontent about the workplace expressed by similar techniques in Knights and McCabe (1998); Bain and Taylor (2000); Taylor and Bain (2003).

The working conditions at the HCC are related to the character of intermediary service work and the work tasks. The telenurse was dependent on the callers, the professionals in the healthcare area and the policies and intentions of decision-makers. To successfully execute her work at the HCC, the telenurse needs to have a decent relationship with the other healthcare organisations and their professionals. Healthcare is also a highly interactive service – the telenurses need the caller's approval both in order to carry out their job proficiently, and in relation to their own feelings of doing well and doing their job in accordance with nursing ethics. A strong ethos dominated by working in the public interest with high safety concerns shone through in my encounters with the telenurses and watching them handling their phone calls (cf. the ethos among workers in the public Track Authority described by Huzell 2005).

The interaction and support from the closest manager and colleagues were estimated as being very important, as there usually is no way for the telenurses to avoid either the callers' disappointments and complaints or the callers' exhausting and strange questions (cf. Frenkel et al. 1999).[159] Furthermore, the telenurses expressed the importance of discussing different options in regard to symptoms, diseases, possible advice to give and place for referral with colleagues in connection with calls as well as during particular training sessions and collegial meetings. Several of the nurses had left their previous job because of conflicts, strong hierarchical relations and the lack of resources in traditional healthcare. The working hours was an issue of constant discussion. There were most certainly disputes, conflicts, and all kinds of group dynamics that I was not able to identify and which were not in the focus of my study. Yet the overall and, major conflicts within the HCC were related to hierarchical ties and the lack of resources in healthcare, which the telenurses were forced to encounter and handle in the front-line of healthcare. One way to handle the care-seekers would have been to make appointments for everyone who desired them (cf. the conceptions expressed by Holmström and Dall'Alba 2002: 9-10). This would, however, not be possible as, at the same time as there were no buffers for telenurses to the care-seekers, neither were there any with the rest of the healthcare organisation to cushion the telenurses from other providers' criticisms.The source of problems was discussed in terms of the relations between the HCC and the rest of the healthcare organisations or as problems/inconveniences caused by the decision-makers, rather than an internal issue. It might even be argued that conflict with other groups was a contributing factor that strengthened one's own workplace culture, its identity and competence.

14.8 CONSEQUENCES: CONTROL VERSUS AUTONOMY

14.8.1 No discretion over the design and the use of new technology

The telenurses at HCC were not involved in the design of the ICT. It was not until one week before its opening that they first saw the software, received

159 This seemed, however, to be an issue for nurses in general. Compare with chapter 9 about the nurses in A&E departments and how to encounter the disappointment of care-seekers who for instance were not prioritised for an examination by the physician.

training and had the chance to test the functioning of the system. One telenurse made a rather pungent remark regarding the ICT introduction:

> ICT people...they are so much in their own world... they start on something and then something else will come up. There is a huge gap between ICT consultants and the users of the system. The ICT people have the technological knowledge but they have no empathy and they don't know how we telenurses will use the system... (telenurse 4 2003)

This remark also signifies how hard the telenurses found it not getting a chance to influence the ICT application, much less being able to train before the introduction of the service in 2002. The technological aspects of call centre systems are normally developed by an external ICT consultancy, as in the case of HCC Fyrbodal and are not particularly adapted to the specific needs of telenurses. At least that is how the telenurses saw it. Although one telenurse was responsible for administering the system for all levels of healthcare, this was not the same thing as being involved in the development of the system and paying the required attention to needs and practices of nursing. Strandberg and Sandberg (2007), based on a survey of managers in call centres in general, found that Swedish call centre workers usually have no discretion over their design. Furthermore, they argued that their findings are not in any way surprising because neither do managers have any discretion over the design and use of new technology (p. 52). This was also the case for the HCC manager at Fyrbodal.[160]

14.8.2 Some discretion over the design of tasks and the working time

In Fyrbodal the employees did, however, participate in the design of tasks, the work situations and the premises. This included not only the colour of curtains, but also the ergonomic fittings in the workplace as well as work routines including induction and training. One important part of the design is the working hours. The HCC from its inception applied a method of desired timetabling. This implied that the staff made a request for the shifts that they would like to work. It was greatly appreciated by the majority of the staff and was considered as a collective way of planning and staffing the HCC. But the HCC manager and the team leader regarded it as very time-consuming and strenuous work to preview the need for telephone advice in the healthcare area for assuring that all the working shifts were covered, while they considered the various needs of the staff. The hardest time-table to draw up was, according to both management and the telenurses (as in most healthcare work), the schedule for the summer months. At that time the demand for healthcare increased because of the tourists visiting Fyrbodal at the same time as the telenurses wanted to have their annual leave. Both the employees and management considered, however, that the group of telenurses, individually and collectively, was responsible for all shifts being covered.

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160 During the pre-project, the HCC manager undertook several studies of telephone advice nursing in the healthcare area. The region had, however, invested in one software system (Teleråd) in four of the healthcare areas, including both HCCs and other parts of healthcare.

14.8.3 Professional discretion over the work practice

Generally in call centre work, the ACDs technology claims to leave little control and limited possibilities for the operator to influence her/his own work. Like an automatic assembly line, the ACDs system directs the calls to the telenurses (e.g. Taylor and Bain 1999; Norman 2005). The Swedish nurses, however, do have a certain degree of control over the call centre system – they can control the order within a call and the pace of each consultation. The work practice prescribes that the telenurses shall follow a clinical process defined for telephone advice nursing based on assessments, advice and suggested interactions. This allows the telenurses to integrate their knowledge and experience of nursing into the call centre work. But the telenurses cannot control the order and the pace between the calls.

14.8.4 Some discretion over the pace of work

The pace is somewhat dictated by the system at the same time as the telenurses try to work at their own discretion. The argument is that the telenurses should give the caller the time needed and the time the nurse needs herself in order to properly address the issue, get a good picture of the caller's attitude and understanding of the problem and the situation. The telenurses also underlined the importance of correct documentation. In terms of managing the varying levels of demand made over the phone, the telenurses described this as mastering 'change of pace' (in Swedish *tempoväxling*) at work. A discussion ensued between the nurses on how to be able to 'change the pace' in the best way, as demand was quite high in the morning, then lower during the day, only to rise again from around 4 or 5 pm. and out-of-hours.

Although the telenurses have much more autonomy than their counterparts in the UK, the 'call centre model' is always a part of the work environment, represented by the technology as well as the performance criteria. The workers are always visible as each action is possible to trace and it is possible to observe each minute. The telenurses testify how they checked their daily 'production', whether they have answered the numbers of call recommended – 6 to 8 per hour – or whether they have to speed up their work rate during the last part of the shift, in order to comply with call centre statistics. The telenurses thereby felt strong pressure to prove what they had been doing during each minute of the day.

> You feel the pressure that you shall handle the 6-8 consultations per hour. For many of us, this means that you like to check your statistics in the middle of a shift to know how much you have done that day and if you need to work a bit extra. (telenurse 7 2006)

The telenurses also felt that they had professional responsibility for healthcare during the weekday and non-office time. The HCC should be a complement to primary care and the hospitals when these were closed or at least when patients had limited access to them. The HCC should be accessible in order to help the citizens. The telenurses emphasised feelings of responsibility to make people not wait on the phone, to be needed in cases of an emergency and, in particular, not to risk the health and life of somebody. Such internalised control reflects a professional consciousness, where the self-disciplined worker experiences an internalised responsibility. But in contrast to the commercial workplace, this is

more than simply pleasing external and internal customers (Du Gay and Salaman 1992; Foucault 1990; Fournier 1999). It is also a question of being a good nurse, internalised in secondary socialisation. The degree of experienced responsibility correlated, however, with the individual attempts to achieve work-life balance. Those of the telenurses who were content with their working hours conceived the HCC as a good way to combine leisure time and working time, but for some, the irregular hours were a problem because of the clash with family time and time for social activities (cf. Franssen 1997: 242).

14.8.5 The repetition of work tasks – standardisation

The calls are answered according to the amount of queuing time experienced by the caller – the first to queue, is the first answered. Furthermore, the call-back function is marked in red to indicate that a telenurse is taking care of it. The process on the phone is standardised according to nursing and medicine-technical norms and practice, but not broken into mandatory steps. Moreover, the overall practice is standardised by administrative work rules, polices and limits. It is, for example, mandatory to use the computer software. But there is neither an electronic nor a hard copy of a transcript that the Swedish telenurses need to follow during the telephone contact with the care-seekers. Consequently, the HCCs differ from many other call centres and from NHS Direct. The telenurses at HCC Fyrbodal have discretion on the design and provision of services according to the work practice and training on how to work the computer that includes a high emphasis on one's nursing identity. This means, for example that is not mandatory to fill in all the fields and the call centre system will not indicate the deviation, but it is recommended according to the nursing practice developed for, the HCC. In the end, the telenurse is responsible according to her registration.

However, the HCC is a form of rationalising work. An intervention over the phone is generally shorter than a face-to-face interaction. The HCC mainly embraces the first part of the ordinary nursing process, i.e. the assessment and only to a limited extension the planning and intervention stages. One result of many and short assignments (calls) is that the telenurses experience the consultations to be more repetitive. There are certain reasons for calling the HCC that recur, such as symptoms of fever, abdominal pain and symptoms of infections in combination with problems with tick bites, wasp stings and borrelia in certain periods. Lindgren and Sederblad (2006) compare the call centre work with an electronic birdcage, where one telephone operator said 'I feel like a parrot!' (p. 194). For HCC Fyrbodal, associations were made to the same metaphor. One nurse said that when it becomes too dull because the callers asked the same questions and the same problem appears over and over again:

> then...in the end I am more reading from the system in a rather bored voice, when I give the advice. I can also inform them to read for themselves about the problem on the Internet, and I give them the address. (telenurse 11 2006)

The telenurse's work could be described as being both repetitive and flexible, because the handling of calls follows the same structure and involves pretty much the same movements. Standardisation risks making the work dull and

monotonous, at the same time as it provides a quality assurance to the process. Accordingly, the routines might be considered in two ways. First as continuous repetition: as a dull, non-stimulating and alienating duty with the outcome being negative, from a sociological and human point of view. The rigid structure and inflexible organisation even produces self-estrangement among those involved (e.g. Blauner 1973/1964).

The standardisation of knowledge transmitted, codified and mediated by the computer means, furthermore, that essential aspects of nursing are eliminated such as household remedies and ordinary advice. These do not fit into the requirements of evidence-based research. To codify medical knowledge into the ICT software for decision-support is a Tayloristic way for management to acquire knowledge, mainly from physicians, but also from nurses (cf. Börnfelt's reasoning for the manufacturing industry 2002: 58-59). To translate medical and nursing knowledge is, however, a complicated process. Such a system requires the telenurses to have advanced knowledge from the start in order to be able to use the system. If the system is too simple and only requires basic knowledge from its users the system risks missing its goal of adequate assessments, secure advice and appropriate referrals.

Alterntaively, routines and standardisation might be considered as something positive, which brings structure and control to one's existence (cf. Brandt and Wennberg 2004). The issues at the HCC ranged from banal to life-threatening problems, and therefore standardisation and policies engender feelings of security, long-term views, equality and predictability. In the case of telenurses, the advantages seemed to be both a question of control and (medical) safety towards the users. During conferences, workplace meetings and training sessions, there was a great deal of discussion on how to encounter different callers, how to treat and respond to different situations etc. This might be interpreted as there being a major need to exchange experiences and practice, but also to set policies and decide common procedures. Defining rules and policies is a way to create control over one's situation and control is needed in order to handle all the difficulties that the telenurse faces alone on the line. Consequently, despite the levels of standardisation, technological and performance control, the telenurse enjoys some degree of autonomy in her work encounters with the care-seeker. At the same time, all groups of actors concerned have immense and often contradictory demands, and either the task, the callers, the colleagues nor management set definite boundaries to one's work as a telenurse. Consequently, at the end of the day, the telenurse herself has to settle the final boundaries of her work (cf. Allvin 1997; Allvin and Aronsson 2001). But in order to do that, she needs professional consciousness, experience, support and a great deal of courage as it is no easy task.

Furthermore, the employees also have other duties and assignments which provide additional variation to one's work. The content of the calls varies to a major extent from simple problems to more complex cases. The work also includes calls related to lonely people, people who are worried, immigrants and people who have communication problems etc. It has been argued that as service is about interaction between people, as in this case between telenurses and callers, no two meetings or encounters are totally similar. On the other hand, in

order to be professional, the telenurse classifies different persons, symptoms and problems under the same theme, in the process of making a personal case an organisational one (Lipsky 1980; Hasenfelt 1983; Taylor and Kelly 2006).

14.8.6 Work intensification

In line with the policy of the health administrators (chapter 8), the HCC might be considered as a way to work 'smarter' (rationalisation) and it is work characterised mainly by quantitative measuring. The queue line is automatically visualised on the screen. Other measurements appear in terms of performance indicators such as the required number of calls per hour, day, month, week, time available to the callers, consultation time, time for documentation and overall goals for the HCC. Measurement and evaluation are also a part of appraisal discussions (see e.g. Strandberg and Sandberg 2007). The working 'smarter and not harder' rhetoric as well as the decentralised decision-making claims within lean production, have been shown in several studies to entail, rather, work intensification and multi-tasking under modified traditional methods (Thompson and Harley 2006: 9; Börnfelt 2006). It is furthermore, a rhetoric that might be dubbed under various terms, for example, 'democratic' Taylorism or participative rationalisation (Thompson and Harley 2006).

14.8.7 Giving back the responsibility to the care-seekers

The logic of the HCC highly reflects dominant ideologies in society in general and its problems in particular. During the 1970s, the hospitals and society were to take care of everything. The intention today is, instead, to give back responsibility to the citizens and let them take care of themselves with help from the experts and from expert sources, such as the internet, brochures and literature. This also means that the patient is required to pay attention to and economise on the scare resources of healthcare. But does one make a person responsible for their own life and body? And to what extend do people have the knowledge and possibility to be responsible? In the words of telenurses, many callers try to delegate their own responsibility to the telenurses hoping that they will take over their worries, anxieties and decisions.

> Today I had a man calling wondering if he could go back to work or if he ought to stay at home some more days curing his cold. When I asked him how he, himself, felt about it, he said I am a carpenter, I am an expert at wood – you are a nurse and therefore you are an expert at people and their health, please tell me what to do! (telenurse 3 2006)

Related to the issue what is service and what is good service, the telenurses have initiated an internal discussion at workplace meetings on how to give responsibility back to the caller at the same time as callers should be pleased with the consultation. The goal has been that the telenurses, by listening and asking questions, should help the care-seeker to take an adequate decision that he or she felt pleased with. Otherwise the HCC might risk disempowering instead of empowering the citizens, according to their reasoning. This standpoint differs from other studies, where the patient's health is perceived as the telenurses' responsibility (Holmström and Dall'Alba 2002).

14.8.8 Responsibility for taking care of the service required

A debated issue at the HCC and among telenurses was the view that the telenurse should take care of the actual provision in different healthcare units assuming that care was provided somewhere in the area. Staff shortages or limited opening hours might leave the telenurse with a hard ethical dilemma on whether she should refer the callers knowing the situation or should take responsibility for the lack of access.

> Hospital U might call and advertise that we have no physicians tonight, so you can't refer any callers to us. Soon after that the other hospital N phones and say we don't have any physicians. What should I do? We write deviation reports each time. But what should we do? All primary care cases are normally sent to the A&E ... but should we take responsibility? And what to do if something happens? If there are no physicians, there are no physicians...(telenurse 17 2004)

14.8.9 Malpractice and professional vulnerability

The tension between control and autonomy is illustrated in the following quote from a British HCC, where the telenurses say 'we need a framework to be safe...' at the same time as they claim that 'there should be a bit more scope...//...to use our clinical judgment and skills' (Mueller et al. forthcoming 2008). In Sweden, the work conditions are different compared with British practice. Cases of malpractice by Swedish telenurses are not an organisational matter, but a professional matter. The HCC Fyrbodal has one general practitioner who is formally responsible for the medical setting, but the physician is not physically present at the site. She is the medically accountable person for the whole centre, but in the single case and for the single interaction with a care-seeker, the telenurse is accountable according to her registration. In Sweden the telenurses are personally liable for the final decision in respect to the caller, whereas in the UK the liability is, however, connected to the technological system and content. This implies a different level of autonomy over the labour process in HCCs in the two societies (see also Valsecchi et al. 2007). Thus, the Swedish telenurses experience and express a kind of professional vulnerability, due to being more autonomous than nurses in primary care or the hospitals and more like district nurses. They take professional responsibility for the decisions given and their registration might be withdrawn in the worst cases (cf. Edwards 1998; Holmström 2002; Wahlberg 2004).

Several telenurses in Fyrbodal discussed their worries about making mistakes: first, because the pain and damage they might cause the care-seeker in the first place, second because of the professionals' critical feedback and third, because of the risk of getting a complaint with all the consequences that followed. The quote below describes a complaint that was lodged regarding a child with stomach pains. According to the discussions, the nurse in question was not at fault, the mistake was made by the primary care centre, but the mother had called the HCC who had referred the care-seeker. Such issues caused considerable additional work for the telenurses in question, not to mention the feelings of insecurity and anxiety for her and the entire working group.

> She said they have destroyed her career.... In other businesses, faults and deviations are related to organisational mistakes and are classified accordingly, as an organisational matter. When a caller complains about something at a health call centre, it is a

> professional matter. The telenurse's licence might be withdrawn in the worst case. But it is also very difficult to be scrutinised as a person and the decisions you have made... To have your professional status questioned...it is very, very frustrating... and not only for the person accused of the mistake but for the whole work group and the entire organisation. You get stigmatised...and then there is coverage in the newspapers...(telenurse 8 2006)

These cases, in Swedish called 'Lex Maria' cases, are critical for the telenurses and have serious effects on an HCC.The telenurses expressed unanimously that the situation was very stressful and frustrating. The procedure that followed required all involved persons to provide their version of the case to the control authority, namely the National Board of Health and Welfare (*Socialstyrelsen*). Recalling the cases in order to provide a case history was expressed as being highly stressful. Instead of being an organisational matter (malfunction or common error), it becomes a professional matter and a personal issue for the telenurse.

I found that the telenurses have recourse to a practice and rhetoric of professionalism making it possible to defend some degrees of autonomy both in relation to managerial and to technological imperatives. Consequently, the telenurses try to to give callers the *quality* of care (time, professional expertise, individual attention) when they wish to give them that. Furthermore, the telenurses have an autonomy that distinguishes them from most other call centre workers (cf. Taylor and Kellys' interpretations of the limited but professional discretion among street-level bureacracts). But a typical feature of the HCC is that it does not provide any buffers against care-seekers' high demands and sometimes disrespectful behoviour. Neither is there any shielding from collegial dissatisfaction and complaints. Telenurses are directly exposed to other departments whose work activity and input they influence. This is the case in all call centres, but seems to be particularly significant for the telenurses, who work in an organisation such as healthcare, characterised by peer-review, status and distinct relations of dependency (sub-ordinations) between healthcare staff.

CHAPTER 15
HCC FYRBODAL – A DIFFERENT HEALTH CENTRE AND A DIFFERENT CALL CENTRE

> Is the work at the HCC different from other kinds of healthcare work? - Yes, in some ways this is apparent because in a clinic or primary centre you change into white clothes and you have other... duties... not only telephone advice nursing. Here you go to a place outside the hospital in your private clothes to focus on telephone consultations... (telenurse 5 2004)

This quote reflects that many telenurses face neither care-seekers, nor their colleagues, i.e. other healthcare providers, which makes the workplace different from other healthcare units. The effects of the work organisation at HCC for telenurses are feelings of isolation, alienation, control and de-skilling as well as sentiments of freedom, autonomy and up-skilling. The combination of call centre and healthcare with a focus on nursing is a HCC that differs from most other call centres. In the same way, a HCC differs from the conventional healthcare unit. Analysing and comparing the HCC will accordingly allow us to discover characteristics for the average call centre and for the traditional care unit. Furthermore, such studies elicit characteristics unique for the HCC as well as elements that the two organisational forms have in common. This chapter focuses accordingly on differences and similarities in order to find out how a HCC can contribute to our overall understanding of healthcare units and call centres in general.

15.1 FROM A HEALTHCARE PERSPECTIVE

15.1.1 Telephone advice nursing in healthcare generally and within a call centre

Work in a HCC differs from work in traditional healthcare because of the working hours. Working '24/7', applied in many call centres, does not exist in primary care at least. Moreover, the target group differs as most care-seekers in a HCC as well as in other call centres are not known to the telenurses. The telenurse has no health records from previous health care status and care given, except from the compulsory records made at the HCC (see also Wahlberg 2004: 15). In the primary care centre, the caller is a patient, often undergoing treatment and/or the reason for calling is usually to make appointments with a physician (Leppänen 2002). Consequently, it is harder for the ordinary nurse to give self-care advice than for a telenurse, and it seems less frequent that callers to the HCC treat a telenurse as a secretary. The telenurses have to rely, moreover, on second-hand information (not visual) and sometimes even third-hand information, while the nurses in a healthcare centre can always make an appointment if a case seems uncertain (cf. Wahlberg 2004: 15). In a HCC, an uncertain telenurse has to refer to other care providers with the risk of being questioned, if the care-seeker's problem proves to be too banal.

Telephone advice and call handling are ordinary functions within the conventional healthcare organisation, where they are duties among others, which nurses and sometimes assistant nurses occupy to a different extent. Several

telenurses reflected upon their earlier experience of telephone advice nursing, and witnessed how much of a novice they had felt being young, having neither the experience nor the support to really shoulder the responsibility. It was confirmed by physicians on duty who stated that the numbers of patients referred out-of-hours and their problems corresponded highly with the individual nurse and her capacity to handle people on the phone. Several interviewees mentioned practice during the 1970s, when they started their careers in healthcare. They expressed the insecure feeling of being a novice and having the duty to answer the phone during the night shift.

> When I was 19 years old, which is about twenty years ago, I had worked at the paediatric clinic for one year, when in the middle of the night a father called about his newly born daughter. He was worried that she had not woken up to be breast-fed. I checked the routines during the day and everything seemed normal. However, I got a feeling that something was not right, which is why I asked the parents to bring the child. The father stressed that the child was feeling fine, but I insisted that they should come. Fortunately – because the child appeared to suffer from a severe heart disease. I still think about this incident. How was it possible that I, a new nurse, had such a responsibility? And why did I insist on them coming? There were no real indications that the baby was not healthy! (telenurse 31 2006).

Some argued that the conception of TAN has changed during the last decade and it is no longer the youngest and the novice that has to handle the phone. With the inception of the HCC on a broader scale in the latest years, the importance of and difficulties on the phone have been recognised. But:

> Although this happened 20 years ago, the same situation could happen today – because nothing has really changed. It is still usual in health wards to let the least experienced nurses work the night shift and give them responsibility for taking the telephone calls (telenurse 30 2006).

A major difference between TAN in traditional healthcare and the HCC is, however, the degree of continuity, as in many traditional healthcare workplaces, telephone duties are alternated among many nurses. The result is that the nurses cannot become specialised at giving telephone advice, neither can they develop skills related to the particularities and difficulties of nursing over the phone (cf. Wahlberg 2004). At a primary care centre, the nurses might answer the phone standing in the corridor, at the same time as they carry out other tasks and talk to patients and colleagues. TAN might also have a subordinated role related to other kinds of care in ordinary settings. As other groups of healthcare actors have expressed it, TAN is a difficult assignment (see for example chapters 7 and 9). In most healthcare units, TAN has not been prioritised, and neither specialised training nor support has been provided until recently. Therefore the status of TAN is higher in a HCC.

15.1.2 The HCC – decision-making and conflicting needs

People dial for telephone advice because they need help at widely separate states of ill-health and inconvenience. Telephone advice nursing embraces the total field from urgent and life-threatening conditions to minor symptoms and ailments. This constitutes the essential prerequisite and creates the complexity of the occupation. In a HCC it is impossible to make any preparations, since the

nurses cannot predict who is going to call next and what issues will be raised, but they should be in readiness for all kinds of actions (Wahlberg 2004). Each call should be considered separately – a new person, diseases/symptoms and new demands on urgency. In all, the telenurses should recognise many conflicting needs and visions, which makes their role a balancing act at the intersection of the actors concerned – between a carer, a gate-keeper, an assistant to the physicians and a service provider. A non-optimal match between the care-seekers' needs, the professionals' different conception of 'appropriate practice' together with managements' emphasis on the budget frame are some sources of frustration for the telenurses (see also Holmström and Dall'Alba 2002). The particular work of telephone advice nursing always involves, furthermore, the demand to make a decision. Such decisions have consequences either for care-seekers or health providers, or both.

15.1.3 Complicated assessments, verbal and non-verbal assessments

Both nursing and medicine are empirical disciplines. Traditionally, healthcare staff are trained to make decisions based on visual information, e.g. one's pale facial colour. Training to use listening skills has not been prioritised for most healthcare staff. Most healthcare professionals have no particular training for telephone interventions and therefore little experience of other ways to make assessments and cognitively discuss, make hypotheses and suggest help for problems and symptoms. According to the telenurses, the main problem seems to be the loss of direct and face-to-fact contact, as oral forms of communication cannot be combined with visual forms. These are the special features of TAN, well confirmed in research (e.g. Edwards 1994; Edwards 1998; Wahlberg 2004). As the telenurses are unable to use their eyes for assessing the patients, they have instead to develop other senses mainly, the audition/oral sense, but also the capacity to perceive and analyse the unspoken, 'reading between the lines' (what does the caller really mean) and the actual context (Wahlberg 2004). In order to compensate for the lack of visual contact, the telenurses tend to create an inner mental picture of the patient, the pathology and the actual situation (Edwards 1994; Edwards 1998; Wahlberg 2004).

Nursing is, furthermore, a discipline emphasising the holistic view in favour of an atomistic perspective. Behavioural sciences such as psychology, pedagogy and communication skills are important nursing, but are only marginally addressed in medicine. These are skills necessary for TAN, although the medical assessment and knowledge as well as the use of a system for decision-support are most often cited as important by decision-makers and even telenurses themselves.

While the telenurses in the study of Collin-Jacques and Smith (2005: 18-9) complained about not seeing the whole picture because of algorithms and because the call centre system did not allow them to flick back and forth, the telenurses at HCC Fyrbodal claimed likewise that nursing on the phone lacked any empirical observations. Yet for the Swedish telenurses it was more an issue of visualising an inner mental picture or the wish for face-to-face encounters. It often happens that while a telenurse talks to a care-seeker on the phone, she touches and scrutinises her own hand, ribs or leg in order to get a visual and physical understanding of the problems that are brought up. It helps her to

envisage the caller in his/her context and how the symptoms might be experienced and the effects in that particular context. Based on these arguments telephone advice nursing is regarded as more than (medical) triage (Göransson 2006)[161] and a more sophisticated method than simply making a medical assessment (cf. Wahlberg 2004; Forslund et al. 2006). Thus the developing methodology of telephone advice nursing focuses on assessments based on verbal and non-verbal communication. To summarise this large field in a few sentences, communication concerns intended as well as unintended messages, which makes it a very complicated to really understand what is left unspoken, i.e. conceptions, meanings and expectations. Nurse advisers should also pay attention to how things are said – variation such as loudness, silence as well as physiological states such as oral and nasal sounds. Laughing, moaning and coughing might be other tracks for the nurses to follow in the quest for an adequate assessment (Wahlberg et al. 2003: 34).

The sources of the telenurses' assessments are diseases or symptoms. When assessing the needs of patients and the urgency of the symptoms, the telenurses also take into account (more or less consciously) the care-seeker's age, sex, life-style and socio-economic characteristics such as religion, culture, ethnicity and social class, as well as data considering one's housing area – urban or rural – and last but not least the overall behaviour on the phone (cf. Wahlberg 2004: 29). Several of the telenurses in Fyrbodal had a background as district nurses. According to the British study of O'Cathain et al. (2001), the district nurses make up a group that is highly considerate of the caller's social situation and lets it influence the advice given. How to assess the credibility of the callers, is also about evaluating whether their description is an overstatement or rather a question of an understatement compared to how a medically trained person would describe the situation (Wahlberg 2004: 27-28).

The credibility of the caller, if he or she underestimates or overestimates their symptoms and problems, was described by the telenurses as being connected to the caller's whole life-situation, e.g. whether they were rural or urban people, are from different generations, have different self-images, conceptions on healthcare problems, risks etc. One example often stated was the fisherman or farmer calling the HCC, because he had a bit of a headache. Several telenurses said that they suspected an underestimation, as these are groups that traditionally do not complain and endure pain to a higher extent, while an urban woman with a bit of a headache is perceived in another light. The general understanding[162] is that certain groups do not easily complain and do not contact healthcare providers unless it is something really serious. But in any case it is regarded as important as well complicated to assess whether a caller is under- or overestimating their problem.

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161 Triage is usually based on a measure of acuity rating as defined on different scales (Göransson et al. 2005: 433).

162 A general understanding might be a prejudice. The dividing line between the concepts if fine, and the single nurse's individual values as well as group and institutionalised conceptions are of importance for a caller's case.

Some callers tell their entire life story. It might be frustrating and hard to distinguish the relevant from the non-relevant aspects, when the care-seeker describes not only the case history of the disease, but all medical diseases that he or she has ever experienced. Many callers, especially the elderly have multiple symptoms and diseases. Consequently, the problem entails several symptoms and diseases, and it is not easy to classify within *one* 'reason for contacting' decision-support for the HCC. As a result, the experienced telenurse is flexible in her use of the computer, combining different biomedical areas and diseases with her own knowledge and experience into an overall picture, in context, but avoiding the narrow limits of atomism (cf. Benner 1984: 24).

The telenurses should be prepared to learn new things continuously and be updated on a constant stream of medical innovations, new treatments and medicines, healthcare re-organisations and internal arrangements, opening hours and vacancies as well as keeping up their competence. They should know the appropriate healthcare provider, where to refer a caller, be constantly aware of the lack of healthcare resources, or be able at least to give a consolatory word or a piece of good advice (cf. Wahlberg 2004: 27-28).

Leprohon and Patel (1995) argue that in high-urgency situations, decisions are based on symptoms and made very rapidly, while less urgent cases require more knowledge from the nurses: the nurse–caller relation here might thus be characterised by negotiations. Negotiations are for instance less frequent in emergency medical dispatch (EMD) centres. In traditional healthcare, Timpka and Aborelius (1990) found that nurses mainly related to medical diagnoses and management policies and less to patient concerns, ideas and expectations (also discussed by Wahlberg et al. 2003: 38).

15.1.4 Always referring calls and sometimes responsibility – an advantage?

Several telenurses in HCC Fyrbodal considered, however, the short and multiple calls to be an advantage and a relief compared to their former job. They claimed that previously working in a conventional healthcare unit, they owned the problem. It implied that they felt responsible. They did their best to solve the practical aspects and their best to encounter and solve the conflicts. Consequently, they had a hard time to let thoughts and problems about the job go away when they left the workplace. They reflected and discussed it over and over again. In the HCC, they found that they could leave the problems, when they left the workplace. And even calls differed, their own attitudes and particular encounters filled their thoughts; they had few resources to really improve healthcare by their own means. Daily aspects of the work in the HCC still included technical problems and staff shortages, long waiting times and a lack of obvious solutions/methods. The slight difference is that if the telenurse feels she cannot solve a problem herself or within the HCC, she has always the possibility to refer to other healthcare organisations.

15.1.5 A gate-keeper disposes resources and encounters feelings

Like some kind of coordinator of healthcare, the telenurses are expected to have good communications with the rest of the healthcare staff. Like an ambassador, a diplomat, they carry out their duties mediating between different actors.

Contradictory demands and high requirements stand, however, opposed to the telenurses' ambition of wanting everyone to be satisfied (Wahlberg 2004) and it might be hard to remain calm and friendly (Wahlberg 2007: 33) Not being able to carry out care according to their professional identity and conviction might also cause the telenurses' experience of stress and feelings of insufficiency towards the care-seekers (cf. Holmström and Höglund's (2007) ethical dilemma in TAN).

Different metaphors of a HCC transmitted different conceptions such as the picture of a HCC as a sluice (*sluss*), a gate-keeper or a threshold (*tröskel*), which are found in the official documents, the picture of a HCC as a guide (*vägledare*), (*Annual report HCC Fyrbodal* 2006) or the image of a bridge, a messenger (*budbärare*) or an ambassador. Within healthcare the term gate-keeper tends to have a negative connotation, whereas in other contexts, for instance in anthropological studies, the word conveys a very positive feeling of a person well familiar with a foreign society who is apt to guide and help newcomers (e.g. Bartilsson et al. 2000: 138).[163] In sociological terms, a gate-keeper 'is an individual who occupies a position that allows him or her to control access to goods, information, and services. Such power often extends well beyond the formal authority of the gate-keeper's official position. Gate-keepers are common in bureaucratic settings and other hierarchical organisations' (Dictionary of the Social Sciences 2005). This is a role for the street-level bureaucrat to co-ordinate collective resources (e.g. Johansson 2002) but it could also correspond to the power of a designated employee (Ahrne and Hedström 1999).

15.1.6 The HCC in comparison with traditional nursing and NHS Direct

The encounter between the telenurses and the callers is of major importance regardless of country. The telenurses are supposed to encounter patients as 'caller/customers' through multiple, yet one-off interactions which focus on one problem (symptom), rather than through longer and traditional relations based on fewer patients within a medical process of diagnosis, treatment and departure (Benner 1984; May et al. 2003; Wahlberg 2004). HCCs mainly constitute the first level of care and the first step of the nursing process. We might thus describe, in line with Wise et al. (2007), that the work at the HCC is fragmented in a way that nursing in a ward is not. However, for the British division of labour the fragmentation has been pursued much further than in Sweden. In contrast to UK practice, the telenurses at HCC Fyrbodal have a practice of giving repeated help to one caller.[164] This might concern a family with a sick child or a person with minor problems, but who needs to be secured and given advice in order to take care of his/her symptoms at home. Moreover, because of the design of the British system (software for decision-making) the British telenurses can only focus on one problem at a time (Smith et al. forthcoming). Accordingly, the problem of access to HCCs is solved by having a separate person who only answers the

163 One of the most famous gate-keepers in history is St. Peter, whose holy mission is to guard the paradise and decide who to be let in and who to send to hell.

164 Classified as referral to call back to the HCC later or that the HCC is making a new contact with a previous caller. Hence the telenurse keeps in touch, and might have new contact with a care-seeker for several hours (in rare cases a few days) on one acute problem

phone – a call handler - and who routes the calls to registered nurses (Mueller et al. forthcoming 2008: 13). However, although British callers get a quick conversation with a call-handler, it might take hours before the nurse advisors call back, based on the caller's definition of the urgency of the problem and other acute cases – 'a three' for example might imply up to a six hour wait (Goode and Greatbatch et al. 2005).

15.1.7 HCCs and telephone advice nursing – specialisation or not

In the British case, Smith et al. (forthcoming) argue that most telenurses come from different backgrounds, but are not subject to any specialisation in NHS Direct. 'Unlike elsewhere in the health service, specialised training does not correspond with specialised work practice' (Smith et al. forthcoming: 4). Consequently, expertise has not been reinforced within a particular occupational niche along professional lines, resulting in the link between knowledge, power and practice associated with specialisation being broken (O'Cathain et al. 2004; Smith et al. forthcoming). The opposite way of conceiving the telenurses is as *specialists in general care on the phone* – in the same way as general physicians are specialists in general care. This means that the specialisation in telephone advice nursing is based on its character as the first remote encounter mediated by the phone, nursing practice and skills as well as using a structured system for decision-support. Furthermore, the duties might be considered as specialised in the sense that the telenurses make general assessments and triage on a wide range of symptoms, conditions, people, and situations in order to ensure a feeling of security for the general public as well as ensuring the cost-efficient use of healthcare resources overall. Accordingly, the work and work organisation of a HCC might be considered as a specialisation in the same way as primary care is conceived as a specialisation based on its general approach. This latter argument is valid both for Sweden and for the UK. Due to different practices in HCCs, control, evaluation and possibilities for individual telenurses to act in a professional way, the Swedish and British experiences and conceptions show considerable differences (Valsecchi et al. 2007). In contrats to British practice, Swedish developments within its national network and scholars of nursing argue for the professionalisation of telenurses.

Out of sight, might imply out of control for telenurses, in comparison to the former strict control exerted through the med-technical routines, physicians' supervision and the immediate and visual contact with care-seekers/patients (see also Wise et al. 2007). Furthermore, direct contact with colleagues and the work within teams in clinical wards and primary centres might involve more direct, normative forms of control. Control which leaves employees with the discretion to work overtime or not can leave the team with patients in great need of help. This, however, is something from which the telenurse in a HCC can escape (cf. Franssén 1997; Wise et al. 2007). Working on her own gives the telenurse discretion towards the physicians, although the control via performance management and technological imperatives in HCCs is more rigid than in traditional healthcare units. It might therefore be concluded that the call centre concept and its interrelated technology imply new control forms, duties and

different work relations and tensions that has not existed in traditional healthcare settings.

15.2 FROM A CALL CENTRE PERSPECTIVE

15.2.1 Telenurses share similarities with other call centre workers

As in other call centres, calls are continuously streamed to the telenurses, creating an experience of being 'paced by the machine' akin to a worker on an assembly line (Taylor and Bain 1999). The work scheduling of calls is not controlled by nurses and nurses have no choice over which calls they get – the *queue* acts as a production pressure and work intensifier (cf. Collin-Jacques, 2003; 2004). That is the case in HCC Fyrbodal – and the description of 'locked-in' positions for call centre workers used in the MOA-study might also be appropriate for HCCs (Härenstam et al. 2004). The telenurses are locked in to their work station, but still the key is in their position – they cannot absent themselves for, say, two hours to have an appointment with the dentists without permission from their manager (and their colleagues) – but if they want to have a coffee or take a shorter break it is at their discretion – something which is impossible for bus-drivers, for example. But telenurses, like CSRs, work on their own at a fixed position at a desk, interacting with callers over the phone. In most other roles, nurses have some freedom of movement, whether based in a surgery or on a ward (although the routines there are decided by the physician and medical practice in parity with the disease of the patient and controlled by the physician). Nurses in clinical work are not physically locked in to one controlled position, but able to move around in the course of their working day within their workplace (cf. Lindgren and Sederblad 2005). According to Smith et al. one might argue that with NHS Direct, the nurses are fixed behind a desk for the first time (forthcoming). On the other hand more and more nurses remain seated. Nany nurses have office-bound work for several hours per day arising from their administrative work, managerial duties and new obligations related to the NPM practice to document and fulfil performance criteria at Swedish healthcare centres and wards. At HCC the telenurse is always visible: every step that she takes can be controlled, measured and evaluated, which makes her similar to conventional Customer Service Representatives (CSRs) and call centre workers. Several of the characteristics already mentioned are salient for all kinds of call centre work, such as facing neither customers nor other colleagues (Jewson et al. 2007), the callers are unknown, the encounter is fragmented through multiple, yet one-off interactions and the computer and the decision-support play important roles. Both CSRs and telenurses have irregular working times due to extended opening hours.

15.2.2 HCCs differ in terms of skills and autonomy

However, as mentioned, both British and Swedish telenurses differ from conventional Customer Service Representatives (CSRs) and call centre workers. First, in contrast to CSRs, telenurses must have specific professional qualifications; they must be registered nurses and they must have previously worked in 'conventional' clinical settings (see also Smith et al. forthcoming).

This clearly means that they hold an occupational identity from a previous secondary socialisation through professional training and work practice, which most CSRs do not, not even bank advisors or sale-personell (ibid.). Perhaps the telenurses share the conditions of ICT consultants in call centres, argued as belonging to a skilled group with its own autonomy within a knowledge organisation (Frenkel et al. 1999). Some telenurses work both in clinical settings (face-to-face) and in a HCC. As in traditional healthcare, nurses may work with giving telephone advice (Holmström 2002; Leppänen 2002; Wahlberg 2004; Andersson 2005) unlike CSRs, who mostly work with frontline duties on the phone. As in HCC Fyrbodal, the majority of the UK telenurses work part-time. However, in England, it is more usual that the working time is split between call centres and face-to-face settings with patients (such as hospitals and health centres) (Hanlon et al. 2005).

NHS Direct might also be used as a stepping stone into management or into different nursing specialities (Gabe et al. 2005). Some examples of telenurses moving from the HCC to other positions were also observed in HCC Fyrbodal. The call centres focusing on nursing and healthcare, such as NHS Direct and Swedish HCCs, are 'nurse-led' services. As a result, unlike the conventional medical division of labour between nurses and doctors, nurses in call centres are the dominant group and interact hierarchically with nurse *managers* rather than physicians. The same situation is relevant in Sweden although it is usual that the health service is managed by nurses responsible for a primary care centre and head of a ward in clinics. A practice according to the Swedish Act of 1997, aiming for decentralised power within clinical care, has opened up possibilities for head managers without a medical education. In particular, Swedish primary care, to which many HCCs belong, is an organisation employing more and more female staff another similarity shared with call centres in general.

Compared to call centre work overall, the HCC Fyrbodal stands out as paying relatively high salaries (see also Andersson Bäck forthcoming 2009). However, the Swedish nurses as a group, have nominally increased their average salary by 50 per cent (!) in nine years, since the implementation of individual negotiations in 1995. This has been equivalent to an increased purchasing power of 4 per cent per year. The establishment of a 'new' organisational form within the healthcare sector seemed to follow the road once taken by the trade union SAHP – to show nurses' competence and to treat the nurses more individually. Since 1995, a specialisation trend has permeated healthcare in general and the nursing profession in particular. The group of telenurses is still a rather small group of 700-1,200 employees out of 56,000 of registered nurses in Sweden. In the UK, too, the telenurses constitute a fraction of the total nursing profession.

Additionally, the telenurses are subjected to legally monitored control carried out by a State authority as well as patient advisory committees. This requires telenurses to be attentive to the rules and regulations on the patient records, individual security in databases and accountability which are closely connected to their registration as a nurse. Consequently, the telenurses have another kind of autonomy compared to their British counterparts and to other CSRs. At the same time, they are subjected to supplementary control in terms of legal and state supervision.

A HCC is characterised by the telenurses having a professional consciousness, based on commonly shared conceptions among nurses (e.g. Benner 1984), but the call centre form is usually associated with a different kind of service encounter dominated by a rhetoric of sovereign customers (du Gay and Salaman 1992). At HCCs, the callers' credibility can be openly questioned and although they are 'customers' and their wishes should be fulfilled. There are paternalistic and knowledge asymmetries between the callers and the call centre workers in HCCs. Asymmetries between employees and callers might be found in other call centres, for example in highly specialised fields focused on knowledge, i.e. ICT consultants. However, the callers' are not in the same state of vulnerability as in HCCs, and life-threatening situations are extremely rare in other kinds of call centres.

15. 3 CONCLUSIONS

Comparisons to conventional healthcare settings and other call centres show a picture of HCCs which are converging with a general model of healthcare embracing alienation and control. In certain respects, the HCCs are continuing along the path being taken in healthcare. At the same time, the HCCs seem to be diverging from a general call centre concept and average primary care centres in terms of expressed feelings of freedom and autonomy. If higher skills are equated with nursing based on face-to-face-relations and technological as well as practical applications, HCCs imply a form of de-skilling. Yet if higher skills are equated with conceptual and analytical reasoning for complex assessment, advice, education and referral, the HCCs carry ambitions of up-skilling and the professionalisation of nursing, given the distance and the particular context to be particular conditions for exploring the essence of nursing. The latter will be further developed in the last chapter 16 conclusions and discussions.

PART IV CONCLUDING DISCUSSION

CHAPTER 16
CONCLUSIONS AND DISCUSSION

Previous call centre studies range from all sectors of society, but there is a predominance of non-professional organisations, and human service organisations are still insufficiently represented in such empirical studies. Furthermore, most research on call centres derives from Anglo-Saxon parts of the world, with some exceptions such as the Global Call Centre project in progress (Holman et al. 2007). Several studies have addressed call centres from a Swedish perspective and similarly there are studies about HCCs derived from countries such as the US, Canada, Australia, the UK and Finland, but (as in Sweden) it seems so far to be a research field in its infancy. In a Swedish context, the organisation of HCCs has been introduced on a broad scale (as well as in the UK) since the late 1990s. In Sweden and the UK, there is a growing field of research concentrating on HCC as means for problem-solving connected to healthcare scarcity and connected to a willingness to change encounters and practices within nursing and healthcare. In Sweden, the HCCs have predominantly been addressed in terms of telephone advice nursing by researchers within the disciplines of nursing and general medicine.

Consequently, the review made here of previous research has revealed a blind spot – two topical and important fields that have not yet been explored. One was the particular type of HCC from the perspective of service work in *call centres,* and the other is the organisation of HCCs from the perspective of *healthcare/human service organisations focusing on nursing.*

The emphasis of this thesis is on work and work organisation in HCCs based on social relations, which are shaped and influenced by institutions and social actors. The HCCs seemed to more or less affect all the actors involved in healthcare from the telenurses and the care-seekers, to the decision-makers and the professionals, as well as the colleagues of the telenurses. Thus the thesis focuses on how this phenomenon is conceived, not only from a managerial point of view (politicians and administrators) but also from the perspectives of the workers and the care-seekers. Recalling the introduction of the thesis, the overall aim was to elicit and analyse the merger of health and call centres that focus on nursing. The first research question considered:

16.1 What are the driving forces behind the formation and development of HCCs?

A kind of HCC has existed since the 1930s in Sweden (Wahlberg 2004: 15), and over the years the telephone has been an important channel for contacts between healthcare service and the public (e.g. Spri 1973). The particular position of Swedish nurses in healthcare systems seems to have contributed to an emphasis on telephone advice nursing (TAN). However, telephone advice nursing within

specific HCCs was first extended throughout Sweden in 1997, and then as a political instrument attractive for improvement of the national healthcare organisation and its service to the public (FCC 1998; FCC 2001; FCC 2002a; FCC 2003a).

Technical innovations are generally considered as an attractive means to solve structural problems (May et al. 2003; Wahlberg 2007: 9). HCCs in particular are conceived as giving a promising structural as well as technological solution to the healthcare dilemma. Moreover, in line with the overall evolution of healthcare, HCCs demonstrate practices and rhetoric, characteristic of a kind of Swedish New Public Management (NPM). Yet NPM in Sweden is a theme also with local variations, due to the decentralised decision-making and resource allocation in Swedish healthcare.

The Swedish debate in favour of New Public Management has concerned two main problems which were merged into a common solution. The first problem was the size of healthcare, the second the administration of healthcare. The former was expressed as being caused by an inefficient healthcare apparatus and the negative effects of the politics of equality (e.g. the solidaristic wages model). The latter was related to democratic and bureaucratic aspects (Antman 1994: 20). Since the 1990s public attention has focused on service and the freedom of choice for patients, users and customers (von Otter 2003), as well as the high cost efficiency, in order to contain costs through increased competition, contracts and control (Almqvist 2007).

At the macro-level, the national initiative about a national network of HCCs and an ICT platform common for all the Swedish counties is a distinct sign of efforts from the Swedish State to monitor centrally the direction and strategic development of healthcare. Today, the Swedish State is only one actor within healthcare with few or poor instruments for regulation: it is highly dependent on developments and the power balance within the counties. During the last 20 years, the tendency instead has been towards increased county influence (cf. Calltorp 1989). The process has been mediated by different mechanisms such as the State gradually dismantling its ownership and management of healthcare, and as a result there has been less governmental control of healthcare settlements and of the distribution of physicians compared to, say, the 1980s. The local right to impose taxes on local citizens and the imperative mandate of county politicians are, furthermore, salient features of the Swedish system in comparison with, for example, the UK. The UK has, in contrast, a strongly centralised healthcare organisation, the NHS, driven by managers, often from the private sector (e.g. Pond 2007).

Other Nordic countries such as Norway and Denmark have experienced structural changes, where the ownership of healthcare has been transferred from the counties to representatives at governmental level (Johnsson et al. 2006). From this perspective the HCC organisation, established throughout Sweden, has interesting implications for the balance of power between the State and the counties. An important argument in favour of regionalisation (which is the theme of the Swedish debate) is the large variation between geographical areas in Sweden (interview Calltorp 2007). Access to healthcare and an ability to undertake medical and healthcare interventions is considered contradictory to the

fundamental rights of equality and universal access to Swedish healthcare (Johnsson et al. 2006).

16.1.1 Local forces driving formation and development

Accordingly, the combination of call centres and nursing implies new ways to conceive the organisation of work within healthcare (mainly new technology and organisation based on NMP practice and rhetoric, control mechanisms as well as new work relations). However, the isomorphic process from the commercial call centres should not be overemphasised (cf. Dent 2003; Pollitts and Bouckeart 2004). As shown, the HCC strongly emphasises the continuity of Swedish healthcare connected to its overall institutional features in political, economic, regulatory and cultural terms, and is related to the relatively limited number of physicians, most of them civil servants, the shortage of healthcare staff and insufficient access to medical services, limited resources and an ambition for freedom of choice. Other factors of major importance are rhetoric and practices towards service delivery and patient-orientation (also empowerment) as well as the management of public organisations based on market imperatives and performance control (different variations of NPM). Furthermore, the inception of HCCs can be related to new consumer demands in relation to service provision and healthcare. Such changes are attributable to the increased requirements of an exigent middle-class (cf. Dent 2003)

Moreover, the HCC considered here was influenced by specific factors in the healthcare area of Fyrbodal. These are mainly the early focus on quality parameters, evaluation and research in the previous healthcare organisation (e.g. the Bohus-model), and the birth of research on telephone advice nursing in Fyrbodal already undertaken in the 1980s (Marklund 1990). Accordingly, the formation and development of HCC Fyrbodal acquired a distinct character, which is directly connected to the second research question:

16.2 What were the conceptions of the main actors connected with an HCC – politicians, administrators, professionals and care-seekers?

During the time of the case-study (2002-2006), HCC Fyrbodal proceeded from being unknown, vaguely known and unaccepted, to becoming rather well-known and finally both well-known and accepted by users and the majority of healthcare actors such as politicians, health administrators/management and regular healthcare staff.

16.2.1 Decisions, support and resistance

In March 2002, the HCC Fyrbodal opened its telephone lines to the public. The formation of a separate HCC was met with considerable resistance, including counter-propositions, discussions and debates. Resistance was especially intense on the part of the professionals within the A&E departments and the primary care centres in rural areas. They focused on their own insufficient access, lack of resources and dashed hopes about contributing to the yearly budget as well as a changed division of labour within the healthcare area. A fierce debate took also place in the local newspaper, and different actors including the media made

various statements in the name of the patients/citizens in order to underline their own opinions. The major criticism concerned poor access to healthcare in general and to the new organisation of HCC Fyrbodal in particular.

HCCs were presented as means to improve access, cost-efficiency and healthcare service. The HCC Fyrbodal was supported by the majority of politicians, regardless of ideological belonging, and in the end by most of the officials. Moreover, the inception of the HCC concurred with an overall restructuring of healthcare in the area. The decision-makers in Fyrbodal purposely carried out actions in order to strengthen levels of trust in the telenurses and ensure smooth integration of the HCC, e.g. training in communication skills and conversation methodology for nurses handling the telephone, the Balanced Scorecard approach and a project called 'Advice: Once is Enough'. Overall, the decision-makers aimed at a common approach for all employees to address care-seekers, attain high user satisfaction and secure better control of costs by monitoring patients according a chain of care integrating different parts of primary, secondary and tertiary care (Västra Götalands Region 2004b).

Very high performance targets for the HCC were, however, one reason for the criticism towards the service. The case study clearly reveals that the possible capacity of the centre was severely overestimated as were the resources (e.g. access) of other healthcare organisations in the area. The lack of healthcare resources in an area highly influences the work in an HCC (cf. Holmström 2002; Wahlberg 2004). This is somewhat paradoxical as the lack of resources and poor access were reasons why HCC Fyrbodal was implemented in the first place. This study shows also that it was a bit naïve to believe that the newly employed telenurses, despite being very experienced, should shoulder such complex duties as those required at the HCC within just a few months and without any previous practice of call centre organisation and technology. The study shows that it took more than a year for all stakeholders to be accustomed to the changes and for the telenurses to handle the new kind of patient encounter.

16.2.2 A kaleidoscope of conceptions

The actors' conceptions of the HCC reflected highly different aspects of today's society and healthcare. Some politicians and administrators visualised a 'healthcare market' open for 'rational' choice, performance and competition, while most professionals talked about their individual workplace and position as employees and how to treat diseases and health problems as well as encountering patients. Like a kaleidoscope, the pattern shifted and it was sometimes hard to understand that the actors were referring to the same thing in interviews, at meetings and in their actions – the HCC. Politicians described the market and their policies, and were not so interested in single organisational issues, while administrators focused on an efficient management of healthcare often connected to different kinds of practices and rhetoric. The latter, for example, embraced HRM, the Balanced Scorecard, Business Process Reengineering, performance management and other conceptions towards the service, applied in the commercial sectors for many years previously (cf. Czarniawska and Sevón 1996; Björkman 2003). For administrators, it was important to rationalise and obtain

cost-effectiveness. Professionals on their part talked about the quality of care and complained about the difficulties of meeting patient demand. They questioned whether it was reasonable that they should shoulder all these problems of society, predominantly related to general malaise and psychosocial problems, i.e. problems of non-biomedical origins.... Such consultations took time that they had rather be used for serious physical symptoms and diseases. Furthermore, the care-seekers described their life and health in terms of projects to maintain. Their stories evoked insecurity/risk-taking, worry and pain that they desired to avoid or at least reduce as much as possible. Thus, they desired rapid access, a good encounter and professional help.

In the front-line of an organisation as complex as healthcare, the role of a telenurse seemed to be rather complicated. Not only should the telenurse have a patient-orientation, which one might argue is institutionalised in its role (e.g. Leppänen 2002), but she should also meet the patient in another kind of encounter based on service. Thus the telenurses are expected to produce high user satisfaction and make decisions that are measurable in terms of performance and legal regulations. At the same time, she should consider and solve care-seekers' health problems and meet them with serious interest (cf. Frenkel et al. 1999). The telenurses must be sensitive to changes in the internal and external environment. In a primary care centre, A&E department or a district nurse surgery, the nurse represents one workplace. Yet as an employee at an HCC, the telenurse is supposed to represent and be attentive to changes in the *entire* healthcare organisation. Decision-makers speak about a chain of healthcare, but healthcare or not, a chain is never stronger than its weakest link. Consequently, the telenurse is forced to face all kinds of healthcare problems from society, care-seekers, and the healthcare organisation.

Furthermore, one criticism expressed, mainly by professionals, was that if the telenurses were not properly trained and did not have the necessary experience, there was a risk of transferring old problems rather than solving them. The formation of the HCC might even cause new problems that did not exist before, because it results in additional demands on healthcare. If the decision-support and the telenurses knowledge about different symptoms are incomplete, the 'telenurse will then err on the side of safety and will send the care-seeker to a healthcare provider although it might not be necessary' (Soumi and Tähkäpää 2003: 4). The same thing risks occurring, according to telenurses themselves, if she has no discretion to act.

Visualised as operating in a battlefield with strong institutional features, the actors expressed strong and divergent conceptions towards the HCC. While some aspects passed without notice, others tended to be contradictory. Tensions between the actors' different domains were clearly evident. These contradictions and tensions were subsequently in focus when addressing the following research question:

16.3 What impacts do the different conceptions, interests and actions have and what are the contradictions and tensions?

The inception of the HCC appeared to catch the characteristics of the Swedish healthcare system in the horns of a dilemma: how do we address simultaneously and adequately (1) *equality* (equal access and universal use) for the entire Swedish population; (2) high *quality* of healthcare (positive results and medical safety); (3) an *efficient* organisation of healthcare, including high productivity, the optimal use of scare resources and public costs (cost control); and (4) *freedom of choice* (satisfied users and care-givers who experience empowerment and that their needs, demands and taxes are properly considered). Solving the overall dilemma here seems, however, to be a utopian idea.

16.3.1 The HCC: a state-driven project and new division of labour

The Swedish healthcare labour process has been shaped by the close relationship between the State, more precisely the politicians and officials in the counties, and their relationship to the medical profession (Immergut 1999; Dent 2003). This ambiguous relationship has also contributed to the general development of the Swedish nurses. Different state-driven agendas for expanding nursing roles, specialisations and consultations have been important influences on the nurses' professionalisation process since the mid-1970s.

Similarly, the progress of HCCs might be considered a state-driven project. The HCC is a project to make the healthcare service less dependent on the physician, while increasing the role of the nurse and making her more accountable for the first contact and assessment previously reserved for representatives from the medical corps. Consequently, the division of labour in Fyrbodal was discussed in terms of telephone advice carried out by physicians versus nurses, and where to carry out the work task – in each health unit or in a separate HCC commonly shared for an entire healthcare area. With the inception of the HCC, attempts were made to transfer the physicians' knowledge to the telenurses, mediated by computerised software for decision-support and telenurses' individual competence development. The decision-system is, however, to a large extent owned, designed and controlled by health administrators with help from ICT consultants. The impact of the HCC could be considered as a loss of control over this part of labour process by the physicians in favour of the decision-makers and as a result more influence for the telenurses as the first point of reference.

On the one hand the HCC is important for nursing and could be considered a significant function with high importance not only for the care-seekers, but also for the further provision of healthcare services. The HCC is designed to create trust and security for the citizens, but has also been considered a visual tool for bringing legitimacy to the decision-makers, in that it promises to solve severe problems of efficiency and access to healthcare. Critical voices both at a local, regional and national level, mainly from physicians, were heard regarding a deterioration of patient-healthcare relations and a degradation in quality with nurses making more advanced assessments (see also *Dagens Medicin* September 2003). However, an important demarcation is made between physicians and

nurses: telenurses are supposed to make *assessments*, while *diagnosis* is a term reserved for work tasks carried out by physicians (see also Tjora 2000; Wahlberg 2004: 12).

On the other hand, HCC work might be considered a necessity, but implies more administrative tasks at the first level of care, being an instance mainly for the classification and distribution of patients. After a while, most physicians bother less about who is answering the phone, considering HCCs to have released them from more routine preoccupations thus giving them more time for 'advanced' medical services. Such reasoning is in line with medicine as an empirical profession and physicians wanting to examine patients face-to-face and not over the phone. Furthermore, specialist care, complex diseases and treatments gain higher medical attention (status and respect) than minor aliments and ephemeral human interaction.

16.3.2 Market rationality versus rationality in a professional bureaucracy

Within the frame of an HCC, the professional domain also overlaps the political and bureaucratic/administrative domain. Gardell and Gustafsson (1979) outlined a picture of Swedish healthcare organisation and working conditions in the end of the 1970s. It seems as if the fundamental problems depicted therein in terms of stress and conflict are similar to those elicited in this thesis. Gardell and Gustafsson emphasised the double-edged hierarchy of healthcare, the use of management (bureaucratic) models as well as the division of labour resulting in difficulties in meeting the social and psychological needs of both staff and patients.

What might be the major shift during the 35 years that have passed since Gardell and Gustafsson's study is, however, the focus on cost containment and the related solution-based on a market for healthcare actors: 'free but regulated' yet also quasi or internal. Decision-makers at all levels in society have stressed the components of New Public Management considering the patients as consumers (e.g. Ackroyd and Bolton 1999; Bolton 2002), but not without resistance. With New Public Management, the market aims to replace the bureaucracy, which hereafter has been considered as obsolete. In the wake of NPM practices and vocabulary, a new rationality is emerging as are new concepts and a new identity for healthcare organisations (Brunsson and Sahlin-Andersson 2000). Of high significance for HCCs is the number of calls per hour and the share of callers getting self-care advice instead of referrals to other healthcare providers, i.e. the telenurses' capacity to release pressure on primary care centres and A&E departments. The discussion related to HCCs is costs per care-seeker, a cost that increases along the chain of care and is related to the complexity of medical service, staff and equipment.

16.3.3 Efficiency and the chain of care

Through market imperatives, the health administrators hope that competition in healthcare markets will enhance quality and rationalisation (this is to a great extent related to time and labour costs). Cost-efficiency is claimed to be necessary and inescapable: the Swedish population is getting older and is in need of more and more expensive care because of complicated problems and

symptoms. This development is confronted by a reduction in hospital capacities in terms of there being fewer hospital-beds, shorter average lengths of healthcare stays and a higher rate of patient flow (WHO 2005: 66) in order to reduce expenditure as well as get more value for taxpayers' money.

The official assignment for HCCs is to prioritise, sort and monitor healthcare cases and people according to the chain of care: from the simplest form of self-care undertaken by the care-seekers themselves at home, to primary care and finally more advanced secondary (hospital) care.

The decision-makers agitate on the one hand over the importance of primary care and its place in the driving seat of Swedish healthcare (cf. Saltman et al. 2006). One the other hand, the lion's share of healthcare resources is still allocated to hospitals and highly specialised healthcare, while only 19 per cent of the resources are given to primary care (WHO 2005: 16). In the same way, the majority of Swedish physicians (around 60 per cent) are found in hospitals and special clinics (WHO 2005). This reflects an overall conception of hospitals providing a higher status; in particular, university hospitals are well considered among professionals. Great attention is also paid by care-seekers, also called proto-professionals, as they try to appropriate a certain knowledge and vocabulary from medical science, as well as being newly exigent consumers of healthcare.

16.3.4 Demand management

There is, however, an obvious contradiction in meeting the care-seekers' demands for access and immediate care, which is often expressed as getting in touch with a specialist or getting immediate access, and steering healthcare demands in a rational way based on a chain of care. The Swedish HCCs should be patient-oriented and should meet the citizens' needs, at the same time as the telenurses should manage and direct the care-seekers to the most appropriate level of healthcare, according to their degree of urgency and complexity. The telenurses' management of healthcare demands can be described as a filtering process. Thus the HCC should both ensure the needs of citizens and of the healthcare organisation – embracing freedom of choice and accessibility as well as coordination and control. These goals are in many cases contradictory and a source of great frustration for the telenurses. On the phone, she is alone in her encounters with both care-seekers and healthcare representatives, while she is trying to solve individual dilemmas and overall healthcare problems.

16.3.5 Service in terms of quantity and quality

Although expressed as extremely significant, health promotion and prevention are issues that tend to have a lower priority, when time and resources are absent (Elo and Calltorp 2002). The telenurse should suggest preventive measures, give advice, support, confirm good and positive lifestyles as well as investigate and persuade patients away from negative ones. These are described, by the telenurses, as important aspects of promoting greater autonomy for the citizen to take care of his or her minor ailments. This is also in line with the assignment of Canadian HCCs to embrace the three Es – education, empowerment and encouragement (Collin-Jacques 2003: 119). Yet, it takes time to consult and

ensure that the caller has understood the implications of advice given and to know what to do (cf. Walhberg 2007: 34). The average length of an HCC consultation should be dependent on the caller' case and it might therefore vary between just a few minutes and a longer conversation of more than 15 to 20 minutes. The national requirements, however, have been proposed in order to create a Swedish standard and guidelines for HCCs, estimating a telenurse to handle 6-7 calls per hour corresponding to 9,000 calls a year, and maximum 3 minutes' waiting time for call-seekers (SALAR 2005a). Consequently, the focus on a limited average call length and well monitored telephone consultations might stand in contrast to the telenurses' belief in self-care education and to 'foster' better habits while giving advice to the public.

16.3.6 The nurse between two stools

Generally, there is an increase in the number of patients requiring more care but who are still living at home. At nights, weekends and during holidays primary care centres are not open and home care services are not available as a back-up. Consequently, many older people end up in A&E departments. Both telenurses and other kinds of nurses have to encounter the disputes between patients out-of-hours and the physicians refuse to take more appointments. The physicians are upset because they are overworked and stressed. The care-seekers are either suffering from pain or are frustrated, worried and angry, or perhaps all of these. The telenurses find themselves in the middle – encountering the negative feelings and reactions of both groups, as they desire to help and do a good job. Leaving people in pain or in states of worry is against the professional ethics of nurses and they express a willingness to 'do a good job' and take care of patients. This, however, is shown again and again to be impossible to fulfil. Not being able to work in line with one's ethical codes and convictions socialised from one's education and own experience, becomes a major source of frustration for the telenurses (also confirmed by Holmström and Höglund 2007).

In the focus of healthcare is not the accumulation of capital or creating a surplus as in other kinds of organisation driven by profit, although costs and in particular labour costs are of major importance. Healthcare organisations are thus driven by a constant chase for cost containment.

16.3.7 The rationalisation of human service and its costs

Healthcare economists normally estimate that about 80 per cent of expenses derive from staff costs. The economist William J. Baumol (1993) has stressed that there is an inevitable dividing-line between services (including healthcare and the retail trade) and manufacturing because services must always depend more on human labour than does the production of goods; consequently, there are very different preconditions for productivity increases in the two sectors. Baumol further makes a distinction between 'stagnant' services, such as cleaning, child care etc. that are very difficult to rationalise, and 'progressive' services, e.g. ICT and telecommunications, in which productivity can increase in rather the same way as in the production of goods (see also Thörnqvist 2007). Healthcare is based on both stagnant and 'progressive' services. The progressive side embraces methods and technologies for diagnosis, analysis and treatment, which are

constantly rationalised and cultivated. The stagnant side of healthcare comprises answering questions, distributing medicine, as well as caring, calming and comforting. Drawing on Baumol (1993), it is possible to argue that the HCC has been launched as a means to rationalise the chain of care. Yet given the stagnant aspects of healthcare such as human contact between for instance professionals and patients in terms of communication, confirmation, exchanges of conceptions and experience, it cannot be rationalised, and it may not even be desirable to do so. In line with the quality aspects, the quantity targets laid down by the politicians stood in sharp contrast to the professional requirements on medical quality and ethical considerations, including listening and communicating with patients. The performance targets also put constructed boundaries to the professionals' autonomy and discretion over time.

16.3.8 Service versus flexible healthcare workers – an issue of costs

The case-study shows that the issue of human resources is significant and a great deal of time and effort is spent setting up optimal manning arrangements and an efficient time-table. Labour costs are the most important costs in call centres as the service is based on humans and not on machines. The aim is to minimise the slack periods that exist within every working shift (SALAR 2005a: 21). The official picture stresses HCCs' advantages in giving excellent service to citizens and extended access to healthcare.

The debate, however, has two sides. On the one hand, it is essential for a welfare state that people in vulnerable states because of accidents, illnesses or other cases of emergency can easily get in touch with the health service without major delays. Frequent criticism points out that it is unacceptable that care-seekers do not gain to access physicians, and perhaps even get no healthcare at all over the phone. On the other hand, availability day and night in order to satisfy all kinds of service needs and information might be a benefit for citizens. But this service implies costs both for the healthcare organisation and individual costs for the individual employee in terms of working conditions. When resources are scarce, and demands for prioritisation as well as rationalisation are dominant logics in the organisation of healthcare, it is remarkable that the issue of various kinds of service is not openly debated. We can usefully compare the extension of the '24-hour society' and Engstrand's (2007) analysis of the conflict between working unsocial hours versus extended service in terms of shopping hours in the retail industry. The service imperative justifies the argument that employees in both retailing and healthcare need to be flexible, work irregular working hours and accept part-time practices. The other way around would demand more flexible citizens who accepted limited service. Such an organisation would also imply a rigid prioritisation of who is supposed to call and who is not, and as a result, an economising on tax revenues. However, this seems complicated to materialise and is not notably argued today.

HCCs are means for securing various aims for healthcare organisations such as efficiency, productivity and the coordination of limited healthcare resources together with a focus on the patient, her satisfaction, access and service. However, the general argument for HCCs is more silent on the healthcare staff in

question, the employment relations and working conditions as a consequence of call centre organisation, new technology and NPM practice.

16.4 How is the HCC's work organised and what are its consequences in terms of employment relations and the working conditions of the telenurses?

16.4.1 The good and the bad work organisation

The HCC confirms both the positive and the negative pictures of a call centre as presented by different scholars in the field. The HCC requires the telenurses to be skilled at interacting directly with care-seekers, while simultaneously working with integrated telephone and computer systems (cf. Taylor and Bain 1999: 102; Deery and Kinnie 2004: 2; Lindgren and Sederblad 2005: 189). The call centre organisation also includes pressures from major social relations embracing the HCC. These social relations and the bureaucratic and technical imperatives dictate (control) the pace of work performance and monitor its quality. In this sense the HCC is a controlled and regimented work organisation (cf. Frenkel et al. 1999: 13-14).

Yet the labour process at the HCC is also characterised by a form of knowledge work, where the call centre system provides employees with relevant information and systematically ranged knowledge (cf. Frenkel et al. 1999). This complements the telenurses' experience and skills such that they may provide adequate advice and make medically safe decisions. Paradoxically, this implies that HCC work is controlled and regimented, at the same time as it is borderless requiring the telenurses to set the definitive frontiers of their duty. Is the work empowering? It depends on how conceptions and actions are interpreted.

16.4.2 Control versus autonomy

The empirical findings of HCC Fyrbodal show a tension between control and autonomy. The control over telenurses is diverse – from the call centre technique, i.e. the integrated telephone and computer system materialising in the automatic distribution of calls and software for decision-support (technical control). Management practice in terms of performance evaluation, targets and statistics as well as the political process related to budget follow-up and resource allocation also play an important role in the service (bureaucratic and political control).

Furthermore, the HCC implies a relative standardisation of the way nurses handle care-seekers' on their first contact with healthcare, through training, policies, common projects and other kinds of normative control. The goal is to obtain uniform and equal encounters. The calls are automatically routed directed to the nurses and they cannot in principle adjust the pace of their work. The technology also embraces the transparency of the telenurses' actions – every moment can be visibly retraced and controlled if necessary through an accumulation of information (the call centre technology) resulting in compliance (cf. Thompson and Warhurst 1998; Coleman and Harris 2006). This disciplinary power, often called panoptical control in research studies (e.g. Fernie and Metcalf 1998), is however less elaborate in HCC Fyrbodal compared to other call centres. Moreover, the telenurses must be attentive to legal regulations connected

to patient records, individual security in databases and accountability within her registration as a nurse. This control is legally monitored and controlled by a State authority as well as patient advisory committees.

At the same time, the HCC also implies increased autonomy, no physicians are present at the centre, the service relation is of a one-to-one character and professionalism is based on secondary socialisation. Thus, it impossible to totally control either the employees or the work. The HCC is a new organisational form changing the labour process for healthcare professionals – i.e. physicians and nurses – and it makes a definite spatial separation between the nurses and physicians. On the inception of an HCC, the patient's first encounter with healthcare is based on telenurses who carry out assessments of the care-seekers in the absence of a physician (but up-to-date medical knowledge is transferred to the telenurses mediated by the system for decision-support). Consequently, the telenurse is both allowed and encouraged to make professional assessments. She has gained considerable influence over individual physicians by arranging appointments and monitoring a part of the patients flowing to A&E departments. As a result, both the nurses' work tasks and their status versus the care-seekers have been extended to cover more aspects than just answering the phone and making appointments to the physicians as in many other workplaces within healthcare.

This study of an HCC shows telenurses having high integrity, a professional consciousness, and who are completely apt to make individual decisions and actions according to their experience, skills and own judgements. Being subject to rather radical changes, the telenurses have evoked feelings of anger, tension and frustration among other healthcare staff. But away from severe group norms and the influence of physicians in the clinical setting, and given the expressed mission to coordinate healthcare provision and economise on scare resources on the bottom line, they enjoy a certain kind of autonomy. This is a fragile autonomy, however, as the telenurses are still in the hands of physicians for support and are highly dependent on other healthcare departments. As the physicians have the medical knowledge and experience, the telenurses need the advice, help and support from the physicians. But at the HCC the telenurses also gain more control compared to traditional nursing. They own the diaries of the physicians and can thereby oversee the flow of physicians' work.

16.4.3 Participation versus exclusion: support versus demands

In Fyrbodal, the management style is tolerant and this leaves space for the telenurses to form routines and practices and thereby organise themselves without the manager's direct and detailed control. The freedom to act could also be interpreted in terms of a lack of management support – from health administrators and politicians as well as the immediate line manager (cf. Maslach and Leiter 1999: 153)

Participative management, as well as certain unexpected twists and turns, have helped the telenurses to form their workplace without direct control. Similar to other areas of professional (human) service, the telenurse is alone with her contact with one care-seeker at the time. Equally, she might be on her own encountering other healthcare professionals for example when she needs advice

and help (cf. Allvin and Aronsson 2001). Thus the collective nature of telenursing becomes significant being based on the nearness, similarities and mutual interpretations of telenurses that might support them in their need for protection and security from the managerial technical/economic system (Lysgaard 2001/1961; Lindgren 1992).[165]

In the same way, protection might be needed from the physicians' medical-technical system and political rule. Furthermore, the telenurses' vulnerable situation (the human system) needs collective support and protection through contact with colleagues as well as the care-seekers. Each of the social relations circumventing the telenurses seems to have equally insatiable, inexorable and inevitable demands as well as aspects of support and rewards towards the telenurses.

HRM strategies are built on the belief that despite demanding work, activities and motivation building strategies can compensate for the hard pace and the intensive control (Kinnie et al. 2000). The aim of HR strategies is to create committed and motivated staff, who enjoy their work and remain at their positions because of the rewards that ensue. The staff at HCC Fyrbodal are not like the average group of call centre workers consisting of youngsters, many of whom are students doing their very first job (HFT 2000; Lindgren and Sederblad 2004). HCC Fyrbodal is based on women in their 40s, 50s and 60s – many of whom have previous backgrounds from management positions and positions with responsibility. Their experiences of autonomy from previous jobs might have corresponded badly with standardisation of work and tight supervision, control and evaluation traditionally associated with call centres. Accordingly, the strategy, applied in HCC Fyrbodal, of increased participation, might contribute to more committed and responsible staffs, who express satisfaction in their daily work (cf. Smith 2001).

Employee involvement in new work design is also an idea welcomed by Marx and Braverman – the employees should own, design and control their work and its output (Thompson 1989). In an HCC, employees were involved in the introduction of the centre and the planning of same, but not its technical system, which was to be the lion's share of their work! The system of decision-support was developed by technicians in collaboration with local physicians. Despite its importance for the telenurses' work, the telenurses are only superficially involved in updating the system. Considering its technical outline and use, the opportunities to influence its design are therefore highly limited for the telenurses in that they give feedback without knowing whether decision-makers and ICT-consultants would consider or understand their point of view.

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165 In Lindgrens' study (1992) it is the girls, i.e. assistant nurses, who live in a collectivistic culture characterised by a "we-spirit" that gives rise to joint security. In contrast, the nurses are individuals who, rather, create alliances with the physicians. The culture is thus marked by its corporate nature.

16.4.4 Professional responsibility versus professional vulnerability

Telenurses enjoy professional discretion as well as responsibility, although sometimes this is based on weak grounds. It is difficult to claim a monopoly on knowledge, and like nurses in general, to take charge of one's education or to fully control oneself and one's work according to the formal characteristics of the profession (Witz 1992). Yet the telenurses experience the negative side of professionalism – they are professionally vulnerable as they have personal responsibility for their actions according to their nurse registration and Swedish legalisation. Mistakes/misjudgements are professional rather than organisational matters, however, an HCC is the ultimate link in a long chain of healthcare covering a whole organisation and even more society generally. A telenurse's decision is highly related to time, resources and capacities in other parts of the healthcare system. The HCC's possibility to act is, likewise, limited by political decisions and NPM practices of using and allocating resources. However, her assessments of care-seekers is her own.

16.4.5 Upskilling versus deskilling

There seems to be both a tendency of up-skilling and deskilling in Swedish telephone advice nursing. The growing demand on the telenurses to steer care-seekers and the conversations with them call for particular forms of further education and practices for nurses as well as training in conversation and communications skills. Such new skills form together with the decision support the basic foundation for handling the calls and the relationships with the care-seekers.

Many telenurses express a feeling of deskilling as they have less contact with patients and miss the face-to-face relations with patients and physicians as well as team-working with other healthcare staff. Compared to traditional nursing, telephone advice nursing involves less practical clinical aspects and does not embrace technical instruments and technical practices as in conventional patient-work. However, with the emergence of HCCs, enhanced opportunities are offered to develop new skills compared to traditional nursing – skills at dealing with all kinds of biomedical symptoms and specialities, aural competence and competence related to context, surroundings, the assessments of individuals and their credibility, symptoms and urgency, in other words an upskilling process. In that sense, both HCCs and TAN demand more analytical skills and embraces the conceptual and abstract aspects of nursing. An individual may have long experience as a nurse, but no previous competence from specialised telephone advice nursing makes her a novice telenurse (cf. Wahlberg 2004). The advanced and complex/conceptual skills in HCCs distinguish the work from the practical work elements of nursing and from face-to-face relations. It is therefore questionable whether a process of deskilling is really taking place. Also TAN in primary care seems to have prerequisites for both degradation and development of the nursing profession (see also Fältholm and Jansson 2006).

16.4.6 The younger and older nursing generations

There seems to be two, sometimes competing, categories of nurse. One has a traditional identity more medically oriented and the other a newer identity based

on nursing (see also Sundin 2003). The traditional identity seems to be dominant in Swedish workplaces and it is an identity sub-ordinated within the medical profession. The other category of nurse seems, however to challenge the dominant knowledge monopoly of medicine in favour of a strong nursing identity. The two groups also differ in terms of critical reasoning and how they question existing medical paradigms and positivist statements (cf. Sundin 2003)

The HCC's requirement for experience disqualified many young people and other younger employees made an attempt to work at the HCC, but did not feel comfortable due to the difficulties and abstract level of making assessments and consultation by phone. It seemed that long experience from clinical care was one prequisite for enjoying one's work in the HCC Fyrbodal (see also Andersson 2005). Furthermore, HCCs might reflect the practical focus and the prioritisation of patient work for nursing in conventional settings. The patient encounter and orientation are one of the most discussed issues for nurses in general both by management and by academia (Franssén 1997).[166] The nursing strategies of professionalisation within academia focus on nursing in terms of patient-related issues – but healthcare in practice requires nurses who master different kinds of advanced technology (also Dalhborg-Lyckhage 2003). At work the technologically proficient are also those who enjoy the highest status. Compare, for example, the anaesthetic nurses with nurses in geriatric care. To care for different treatments to wounds is patient-related and clinical work, but it neither involves complex instruments/technology nor does it take place within a high status area of healthcare (often within geriatric care). Consequently, geriatric nurses have a rather modest salary in comparison with other nurses. In similar ways, telephone advice nursing suffers from a former reputation of being difficult and strenuous, but without fancy and complicated technology or even well-developed methods. This conception might also influence modern HCCs.

16.4.7 Work intensification versus less physical work

In an HCC it is impossible to know who is going to call and what issues will be raised. Many problems and issues are the same in the sense that they consider similar medical conditions, symptoms and questions. The physicians decide more or less when and what medical information and knowledge to integrate in the software. The telenurses are dependent on other healthcare organisations for information and news.

The work of HCCs might also be described in terms of work intensification. The role of a telenurse embraces a great deal of stress and psychological strain, as emphasised by other healthcare staff and the media. It is considered to be a sophisticated task to work simultaneously on the computer, listen and make assessments, whilst all the time being attentive to the health problem as well as the caller's personality, understanding and context. Applying to work at the HCC was a way to escape stress and the pressures of physical caring within healthcare units, only to find another kind of stress at the HCC. At the HCC there are no lifts for patients or similar equipment. The telenurses are not expected to run and rush physically. The telenurses have to cope with a new kind of stress when

166 HCCs are indeed about setting the patient in focus but without face-to-face contact.

managing their work and thereby remain at the HCC. In the case study, such work is exercised by highly competent nurses with long experience, especially in primary and home care nursing. Extended clinical knowledge was required when recruiting telenurses.

HCC work includes risk in terms of health and safety. The telenurses have a higher remuneration compared to other call centre workers and nursing in general. The work is perhaps not as physically demanding as that of traditional nursing, but there are high psychosocial strains on the telenurses: they always have to make a decision and they have to be responsible.

Moreover, the arduous HCC work resulted in a relatively high turnover (exit) at least in the introduction phase of HCC Fyrbodal, but the voice of dissent was barely heard (cf. Hirschman 1970). It might be that the high levels of consensus generally recognised in Swedish employment relations was also evident in the HCC; the telenurses seemed to be loyal to their employers or they quietly changed their employer and their work. For most, it was easy to find a new job, as nursing is one of the most highly demanded occupational groups in Swedish society at the beginning of the 21st century (National Agency for Higher Education 2005). Otherwise, it is quite possible that the level of sick leave might be related to level of dissatisfaction/disappointment with the work situation, i.e. hidden coping (Theorell 2006).

16.4.8 Isolation and freedom

The HCC was expressed by some telenurses as an isolated workplace, and some missed the pulse of face-to-face care, the feeling of being in the middle of actions and attending critical moments, i.e. crises, traumas and making complicated decisions about life and death. Furthermore, besides the face-to-face contact with patients, they longed for the multi-professional teamwork and interaction with groups other than (female) nurses. The decision to locate HCC Fyrbodal in their own premises was a deliberate one in order to form a separate identity and culture. The result seems to be a workplace different from others within the healthcare area.

At the same time, it is a workplace that has more contacts than any other healthcare organisations, and it is connected to activity in all other healthcare organisations and even other welfare institutions in society. Thus the HCC is supposed to take care of the coordination of occupations and specialisms in different premises. Being away from the healthcare units might also imply that the telenurses escape from some of the group norms and the collective control related to clinical work, as well as the negative side of labour collectives and nurse-doctor-alliances (cf. Lindgren 1992; Wise et al. 2007).

The HCC means new workplace alliances and strategies related to one's working time. In a clinical setting it is harder to leave one's work if closure has not been reached; at the HCC the work is independent and a telenurse is not threatened by the group norms or vulnerable patients to the same extent if she has to leave during busy periods (Wise et al. 2007).

16.4.9 Emotional labour – customer service versus nursing service

Call centres have been considered to revolutionise the relations between an organisation and its customers (users) (e.g. Taylor and Bain 2004). The commercial side of a service is about being polite, smiling, and enhancing the customers' feelings of sovereignty. The customers' needs and demands are to be covered (Hochschild 1983). Bolton's declaration (2002) 'Consumer as king in the NHS' (2002) is a mantra that has become more and more frequent in UK healthcare. However, this contrasts with the traditional conception of service in healthcare focused on empathetic feelings, genuine caring and actions that cure, secure, release pain and worry without calculative behaviour or expectations of monetary gain. The Swedish telenurses cherished the ideal of nursing built on acts of charity and beneficial gestures, but in terms of talk and action they were also concerned to ensure a satisfactory output from their consultation. A satisfactory output implied that the care-seeker was pleased with the encounter, thought that he/she had got help and that he/she followed the decision concluded between the caller and the telenurses 'on a mutual basis'. In order to achieve such relations, complementary kinds of service and communication were required for the HCC. As a result, the telenurses experienced feelings of stress, caused by contradictions between new practices versus the socialised way to encounter sick and vulnerable people.

16.5 How can this study of an HCC contribute to our overall understanding of call centres?

16.5.1 Overall convergence of systems and models, but societal divergence

The HCC Fyrbodal has a work organisation based on continuous competence development, participative management, consensus-based decision making combined with different forms of control (technological, administrative but also normative) and relatively high autonomy (Edwards 1979; Thompson and Callaghan 2002; Friedman 1990). The findings are in line with evidence from the literature on front-line service work and the cross-national studies claiming that work organisation has specific institutional features related to its national identity and sector (Ferner 1997; Ferner and Quantanilla 1998; Koskina 2006). The results correspond with Frank Dobbin and Terry Boyschuk's statement (1999) that job autonomy is high in the Nordic countries and low in the United States, Canada and Australia. In a similar way, Kågström and Rubing (2002) found differences in terms of service and control between Sweden and the UK, where Swedish call centres like the HCCs have more moderate targets and are strictly measured.

The concept of the call centre might by interpreted as a movement in the direction of a more liberal, Anglo-Saxon model of the economy. Such movements towards convergence have been shown by Smith and Meiksins (1995) in the name of the dominance effect.

This view might be confirmed by the fact that health call centres as well as other kinds of call centres in Sweden, Germany and Greece are characterised by control, work intensification and stress similar to those in the UK and US (Holtgrewe et al. 2002; Koskina 2005; 2006). Bain and Taylor (2002) point out

similarities such as high-volumes, combinations of quantitative and qualitative targets, emotional labour, strict monitoring, repetitive and routine work, which generate intolerable pressure in most call centres all over the globe (cf. Holman et al. 2007). Similarly to other call centres, HCCs are evaluating 'wrap up time' and customer satisfaction (cf. Taylor and Bain 1999: 106). Swedish call centres consequently display characteristics similar to an overall call centre model, employing in general more low cost labour, such as women, part-timers and temporary workers, but no students are employed in HCC work (cf. HTF 2000; Toomingas and Bengtsson 2007). The overall goal of call centres seem to be universal, claimed by Korczynski (2002) as being underpinned by two sometimes contradictory logics: the logic to improve cost-efficiency on the one hand, and the logic of customer-orientation on the other. Coleman and Harris (2006) summarise the characteristics of call centres in terms of management's striving for efficiency, transparency, prediction and control. All these features were also evident in the studies of HCC Fyrbodal.

On the other hand, Swedish HCCs show a tendency towards divergence from a general call centre model in terms of organisation, the trajectory followed and outcomes (cf. Pollitt and Bouckaert 2004). The employment relations in the HCC are also characterised by the specific institutions of Swedish industrial relations.

HCCs are consistent with the overall trends in Swedish nursing related to a continuous professionalisation project from the mid-1970's reform of university colleges, driven by the State, academics, trade unions and nurses themselves. Furthermore, Swedish industrial relations imply that the telenurses do not differ from the average Swedish workers in having relatively strong employment protection. Due to the coverage of collective agreements within industry, pay, remuneration and work conditions should not deviate extensively within the same sector. This is not the case for example in Germany where the establishment of new mini-jobs, self-employment as well as deregulation have created gaps between workers within the same sector (cf. Holtgrewe et al. 2002: 6-7). The decentralisation practice of NPM has, however, given Swedish public employers greater influence in shaping working conditions in order to make labour more flexible on similar lines to private industry (Toomingas and Bengtsson 2007).

Furthermore, as suggested by German studies addressing the role of technology diffusion, call centre models and institutional effects on work organisation (e.g. Holtgrewe et al. 2002; Arzbäcker et al. 2002), these studies of HCC Fyrbodal show a comparably high reliance on competence development including job-enlargement, job-enrichment as well as other soft human resource strategies.

Such soft strategies highly overlap with the soft and hard approaches to HRM described by Tengblad (2004) and Thompson and Harley (2006). Both soft and hard HRM practices are evident: both system and personal factors for dealing with knowledge and control are seen as necessary at HCC Fyrbodal. In comparisons to British call centres in general (cf. Arkin 1996; Taylor and Bain 1999; Callaghan and Thompson 2001; Bain and Taylor, 2000; Taylor et al. 2002; Bain et al. 2002) and the NHS Direct in particular (Smith et al. 2006; Valsecchi et al. 2007), the Swedish HCC appeared less authoritarian and has weaker control by the call centre technology and management practice.

16.5.2 The sectoral and occupational importance of public and human services

Healthcare is a highly emblematic part of the welfare state, which invokes considerable feelings and clear ideological positioning. Healthcare is one of the most obvious examples of collective goods, perhaps because being healthy or unhealthy is linked to the human conditions of vulnerability and insecurity. HCCs are a phenomenon integrated within the healthcare sector and therefore best viewed as one. The HCC should not primarily have commercial goals or be driven for profit (cf. Deppe 2003).

Healthcare is a welfare service, publicly planned, provided, financed, regulated and followed up by political decisions. Yet, like commercial organisations, actors in healthcare constantly discuss financial constraints and how to organise the medical service in more cost-efficient and patient-oriented ways.

Healthcare is also a sector with strong institutional features characterised by power and knowledge asymmetries as well as by competing norms- and value systems between the actors. The users of healthcare have a more vulnerable status compared to consumers of other products and services (Granquist 2001). This motivates protection for citizens in need of medical aid and the collective organisation of medical service. The nature of human service implies, furthermore, that healthcare has a great significance for the level of welfare provision in a country, in terms of both symbolic and practical values (cf. Esping-Andersen 1990). Contrary to other kinds of services, healthcare might be considered as an area where patients' (consumers') contributions to the joint production of service organisations, between patients and professionals, are especially crucial (Korczynski 2002; Goode and Greatbatch 2005). This means that health and well-being are not objective facts, but terms with subjective meanings for different individuals.[167] Furthermore, the relationship between the health professionals and the public has formerly been characterised as being essentially paternal, with the professionals knowing best and the care-seekers as passive recipients (Goode et al. 2004: 211).

Telenurses are highly qualified and competent employees having professional ambitions, i.e. a predefined and socialised identity and consciousness as a nurse. The work that telenurses are supposed to carry out – assessing the urgency of care needed, giving advice, support, information and educating, referring to appropriate healthcare levels as well as coordinating healthcare resources (Wahlberg 2004) – is complex and involves a vulnerable position between public management, healthcare colleagues and care-seeking citizens. The work in HCCs is routinised and takes a certain format, motivated by the vulnerable state of the care-seekers in order to guarantee universal access, equality, medical security, evidence-based advice and coherent guidelines integrating healthcare in an area. At the same time, telephone advice nursing requires flexibility, problem-solving and tailored relations with the care-seeker. Theoretical or higher-order contextual knowledge as well as social and analytical

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167 In Swedish there is only one word for ill-health, which covers three Anglo-Saxon concepts: Illness related to an individual's subjective conception, disease seen from a healthcare perspective in terms of medical diagnoses, and sickness connected to view of society and the employer.

skills are needed in order to identify (assess/diagnose) symptoms, solve problems and give advice, cf. Frenkel et al.'s empowered worker (1999: 39, 65) and Batt's professional service worker (2000).

16.5.3 Swedish HCCs in comparison with HCCs in other countries

The influential actor in the UK is the state at central level – in Sweden it is the state represented by the politicians and the administrators in the counties, at a decentralised level. In comparison with England and Canada, the Swedish case shows a different historical background, formation and development of HCCs together with the choice to apply another kind of call centre organisation for Swedish healthcare. The main differences seem to be that the HCCs in Sweden allow for the professional autonomy of the telenurses and provide a less strict form of technical and organisational control (see also Valsecchi et al. 2007). In contrast to NHS Direct, in Sweden the only group handling the calls are the telenurses – there are no call handlers, no health information advisors and no librarians as in the UK.

The Swedish hierarchy could be described as flat, especially in the smaller health call centres. Furthermore, in Swedish HCCs, there is no fragmentations of calls. All telenurses take the first call directed to them by the call centre system. In other words, the Swedish system does not differ between simple and complex queries.[168] No role in Swedish HCCs is defined for *only* answering the phone and giving information – as is the case with the role of call handlers in NHS Direct (Smith et al. 2004). Instead, the belief of Swedish HCCs is that consultations in most cases include some sort of medical assessment (cf. FCC 2003a).

16.6 METHODOLOGICAL CONSIDERATIONS

A study such as this has of course its methodological limits. Considering one healthcare area for a clearly defined time period could not possibly cover the wide and complex field of institutional factors. The choice of some groups of actors and how these have conceived HCCs gives a rather narrow perspective of an HCC, although this does cover many dimensions. It would have been possible to address other important stakeholders. I have for example only marginally included the views of trade unionists. They have tended, however, to be rather absent in the debate on Swedish HCCs, although there have been important discussions on call centres in general (HTF 2000; Paul and Huws 2002; HFT 2005).

Throughout the thesis I have tried to address several of my limitations, for instance, my ignorance of the temporary-staff employed at HCC Fyrbordal. In the chapter on research methodology and process (5) I have highlighted some of the critical choices and their impact. The survey showed a high degree of user satisfaction, but like other similar studies, it did not cover the citizen's

168 Accordingly, Glucksmann makes a separation between 'providing information to callers' and 'providing emergency service and help', when distinguishing the British nursing line NHS Direct from other emergency service and helplines (Glucksmann 2004: 801-808). This is not applicable for this analysis of Swedish HCCs.

perspective, only the conceptions of those who had already been in touch with the HCCs. Furthermore, I was not able to capture the quality of the telenurses' consultations in depth, nor the result in terms of rationalisation and efficiency, two factors which were claimed as raison d'être for the HCC.[169]

16.7 THE CONTRIBUTION OF THIS STUDY

In a broader perspective this research contributes to our understanding of how reforms in the organisation of Swedish healthcare, in the era of New Public Management, have led to the construction of a new work organisation and new practices such as the HCC. This phenomenon is most probably specific for the Swedish institutional context and for the Swedish variant of NPM. This is a statement based on the fact that HCCs have only been developed on a large scale in a few countries like the UK in Europe (and to some extent in Finland) as well as in the USA, Canada and Australia besides Sweden. This study could be described as heuristic and exploratory in order to understand the research object from the perspective of the groups of actors involved. Furthermore, the aim was to elicit the implications (tensions, contradictions and conflicts but also improvements) in terms of work and work organisation, for instance, in control and autonomy among other things. The combination of health focusing on nursing and the call centre concept thus provides theoretical insights about mass-production and professional human service work within healthcare and the development of the two simultaneously.

16.7.1 The need for further studies

More comparisons are needed between different health call centres from different geographical areas within Sweden as well as with other countries where the concept exists. A comparative paper in progress developed by British and Swedish groups is a minor attempt to cover some of the gaps (Valsecchi et al. 2007) as are existing comparative studies of British and Canadian HCCs. Yet other cross-national qualitative case studies are needed in order to examine the different effects of different institutions and the social relations at the centre of HCCs. Furthermore, different designs and experiences of call centre work in the healthcare sector suggest the need for further studies related to the labour process, managerial practices, employee actions and the institutional factors forming the organisation of work.

169 Sundin (2006: 98), amongst many other researchers, has discussed the problem of measuring efficiency and productivity within service production.

APPENDIX 1 HEALTH REFORMS IN SWEDEN

Parties in Government and major events Prime ministers (party)	Year	Healthcare Reform	The purpose of the reform in question
1932 –1976 Social Democrats (coalition with the Agrarian party between 1932-1936) Prime Minsters from the Social Democrats (except in 1936 when an Agrarian representative hold the position)			
	1955	The General Health Insurance	National Health Insurance in order to increase the public share of care
	1959	The Hospital Law	Act that transferred responsibility for healthcare from the State to the county councils
	1969	Healthcare Act 'Seven-crowns'	Abolished payment of patient-fees directly to physicians – instead a fee of SEK 7 was given exclusively to the hospital Abolished private beds and fees to physicians for in-patient care
	1971	Nationalised pharmacies	Abolition of the pharmacists' privileges + the foundation of a public company for Swedish pharmaceuticals Apoteksbolaget AB
	1973	The Primary Health Care Act	The act required preventive as well as curative primary service to Swedish inhabitants
1976-1982 Centre-right coalition 1976 Prime Minster from the Centre party *Politics of bargaining,* Sweden undertakes an ambitious programme of expansionary fiscal policies (Lindvall 2004)	1980	The Social Service Act	The municipalities became responsible for public services and support at all stages in life
1978-79 minority government under a Prime Minster from the Liberal party 1979-1982 Prime Minster from the Centre party			
1982-1994 Social Democrats 1982-1986 Prime Minister assassinated in 1986 1986-1991 New Prime Minister from the Social Democrats	1982	Health and Medical Service Act	The county councils became responsible for financing and providing healthcare service (incl. healthcare preventions).
Politics of expertise, the government chose another direction by undertaking major currency devaluations to avoid rising unemployment[1]	1985	DAGMAR Reform	The county councils became responsible for both public and private ambulatory care
1990 an austere budget proposition and as a result the Prime Minister responded by resigning from his post	1991	The Chief Physician Reform (Överläkarreform en)	Power centralised to the head of (clinical) hospitals /primary centres who should be an experienced physician having overall medical, financial and administrative responsibility

1991-1994 Centre-right coalition Prime Minister from the Right Party *Politics of purpose*, disinflation occurred and policymakers did not use macroeconomic instruments to prevent increasing unemployment.	1992	ÄDEL Reform	The municipalities became responsible for long-term care and the social services of the elderly and disabled
'The Finnish disease' increase in interest rates, currency speculation, tighter credit, major loss of credit for Swedish banks, fall in house prices ,state support for bank deficits, the battle of inflation at 15 %, high unemployment rate	1992	National Guarantee of Treatment	Limited waiting time for treatment. Introduced by the right-wing party and revised by the Social Democrats in 1997.
1993 deflation	1993/ 94	Disabled People Reform	Extended rights of people with functional impairment
	1994	The Family Doctor Act	The possibilities for residents to choose a family doctor
	1994	Hospital with company structure	Conversion of the first emergency hospital St Göran into an independent company within the county council of Stockholm
1994-2006 Social Democrats			
Referendum EU membership → yes			
1995 EU membership	1995	Psychiatric Reform	The municipalities became responsible for patients whose treatment has been completed
	1997	Chief Administrative reform	The law from 1991 was changed to decentralise power and introduce senior managers without a medical education
	1997	Law of Supervision	Introduction of a supervisor for every healthcare provider (the law was abolished in 1999) but see law on professional activities
	1997	Quality System	Introduction of general rules for quality systems
	1997	Guarantee of Medical Treatment	Increased access to primary care and specialised care
	1997	Drug Reform	National Drug Benefit Scheme
	1998	Drug Reform	County Councils financially responsible for drug prescriptions
The dot-com boom and the ICT crisis	1999	Law on Professional activities in the Healthcare sector	Implementation of a report system regarding all healthcare activities/provisions (accountable) to the National Board of Health and Welfare. Obligation to report incidents in connection with medical treatment
	1999	The Patients' Right Reform	Additional paragraph to the Act 1982 - Increase the county Councils' obligations towards the patients' rights in the health system, e.g. individually tailored info. The patient's right to choose their primary care physician not restricted to geographical area.
2000 the introduction of the Swedish telecom firm, Telia, on the stock market	1999	Dental Care Reform	Introduction of fixed subsidies for different types of service and free pricing for providers
Mergers of hospitals and county councils for a trial period until 2006, given the responsibility of tasks previously managed by the government e.g. business sectors, culture, roads, railways and healthcare	1999		The formation of Västra Götaland Region and Skåne Region

	1999		The privatisation of St. Göran Hospital in Stockholm
2001 EU chairmanship and riots in connection with meeting in Gothenburg improving financial situation World Trade Centre attacks 9-11	2001	Stop Law	The end of selling of emergency hospitals to commercial for-profit companies applied from 31/12 2002
	2002	Dental Care Reform	Implementation of a new high-cost protection scheme regarding denture treatment for persons above 64 years
2002 the Social Democrats promise to revisit the National Guarantee of Treatment to increase accessibility	2002	New Pharmaceutical Benefits Reform	Establishing a new authority with responsibility for determining subsidies for pharmaceuticals
2003 The formation of 'the Parliamentary Committee on Public Service Responsibility' to investigate the issue of *strengthening central control* [steering not rowing] *Tendency of concentration* within geographical areas and cooperation between County Councils regarding specialist and emergency care 2004 EU Enlargement			
Chains of healthcare within the County of Stockholm and the Västra Götaland Region, emphasising access to primary care, including improved telephone advice nursing and ambulatory care.	2005	The New National Guarantee of Treatment	The guarantee is based on the '0-7-90' rule – imply instant contact with (zero delay) with the healthcare system, contact/seeing a general practitioner within seven days and consulting a specialist within 90 days. To conclude no more than 90 days of wait between diagnosis and treatment.
2006- The right wing 'Alliance' Prime Minister from the Right Party	2006		
	2007	Abolition of the Stop Law	Renewed possibilities to sell emergency hospitals

APPENDIX 2 THE RESEARCH PROCESS

Year	Study	Major event for HCC Fyrbodal	Actors Activities	Tele-nurses	Polit-icians	Admini-strators	Profes-sionals	Care-seekers
02	I	Induction for the telenurses	Reference group meeting January Preparation entire study and Study I	X	X	X	X	
		The HCC opens	Interview with telenurses, Feb - March	X				
			Workplace observations, incl. at a staff meeting regarding ethics & value	X				
			Author's presentation to the reference group, May	X	X	X	X	
		Changed time-tabling, working-times, HCC mgr on long-term sick leave	Author's presentation to staff at the HCC, Sept	X				
	II	Deputy mgr in charge. A neighbouring HCC opens	Reference group, Oct - Nov	X	X	X	X	
03		Some nurses leave, sickness, 'crisis' meeting at A&E dept on how to improve collaboration	Preparation for Study II The users					
			Telephone interviews, March - May					X
			Author accepted for PhD studies					
		Participation in the national project 'Vårdråd per telefon'	Author's presentation to the reference group & at the HCC, Sept	X	X	X	X	
			Observations HCC, Sept	X				
		HCC mgr back full-time	Author's presentation to managers in Primary Care, Oct				X	
04		The HCC Fyrbodal initiates the HCC Södra Älvsborg to collaborate during nights.	Author's presentation to politicians, Jan		X			
	III		Reference group meeting Preparation for Study III	X	X	X	X	
			Interviews telenurses, May	X				
			Author's presentation to the reference group & at the HCC, Sept	X	X	X	X	
			Observations at the HCC, Sept	X				
	IV	The national project of 1177 invites the different HCCs in Västra Götaland Region to connect to a national network.	Reference group & preparation for Study IV, Sept					
05			Interviews with actors involved, Nov - Jan		X	X	X	
		HCC Fyrbodal is officially recognised as 'the front-line of healthcare, Nov*)	Author's presentation to the politicians, Jan		X			
		HCC makes emergency appointments & early visits	Reference group, Feb Final report, April	X	X	X	X	
	V	Decision to continue the HCC, but intro of capitation system for financing, incl. performance targets*)	Discussions Reference group, Sept	X	X	X	X	
			Detailed transcription & Analysis phase					
06		Decision taken that HCCs shall collaborate in the region *)	Author mid-time seminar at the University, Jan					
		Decision taken in the region to enlarge the HCCs *)	Reference group and preparation for Study V, Jan	X	X	X	X	
		The national project (VPT) is launched 1 June within five test areas.	Observation study VI focusing work, control & autonomy, May	X				
			Observation at training session with the HCCs of Fyrbodal and Södra Älvsborg	X				
			Supplementary interviews, March-May			X	X	
	VI		Preparation for Study VI, Sept					X
			Telephone interviews, Nov					X
			Author's presentation & observations at national meeting of 1177, Dec	X				
07		The region decides to connect all the HCCs to the national network of VPT. *)	Presentation of Study VI, Jan	X	X	X		

*) Political decisions taken by the local health councils of Fyrbodal or by the regional board of Västra Götalands Region.

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Call centres have been called the industrialisation of the service sector, characterised by monotonous, highly controlled work and standardised procedures performed in an old-fashioned, Tayloristic spirit. Stress and work intensification are known implications of such work. Healthcare on the other hand, is based on bureaucracy, but has professional staff. Nurses describe their occupation in terms of caring, cherishing, educating the sick, being dedicated and genuinely concerned for the patient, while assessing and treating individual reactions to health problems. But what happens in a health call centre (HCC)? The call centre organisation is aimed at mass-production, the monitoring of work, performance targets and control. How can this be combined with the nursing profession and the consciousness of taking care of people in vulnerable states of pain and anxiety?

The thesis draws on a study of an HCC in western Sweden, covering the period from 2002 to 2006, based on more than 80 semi-structured interviews with key actors, 400 structured interviews with care-seekers, repeated observations, written documents and other sources.

The book consists of four parts. The first focuses on the Swedish healthcare system claiming that it is not a coincidence that the HCC has been deployed since the 1990s in Sweden. The second elicits the main stakeholder conceptions towards a local HCC. This part highlights a range of contradictions related to the HCC with efficiency, service and work conditions at stake. The third part considers the HCC's impact in terms of organisational control on the telenurses as they strive for professional autonomy. Finally, the fourth part concludes the study by discussing the merger of health and call centre with a focus on nursing.

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