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Citizen Engagement and Public Service Expectations in Local Health Care - the in(ter)vention of health house professionalism

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Abstract:

Since 2007 every second Danish municipality has established a “health house” to promote health and prevent disease among its citizens. The political goal has been to delegate responsibility for outpatient management from a regional to a local level of government. The paper’s puzzle is to explain why citizens’ and professionals’ have similar preferences for how they believe future health houses should be organized, when they differ significantly in their understandings of health and what count as knowledge about health. We have surveyed all 98 Danish municipalities and we included 19 out of 48 health houses in a qualitative study, where 33 interviews with professionals and 22 interviews with citizens were conducted together with ‘on-site’ observations. We use systematic qualitative content analyses to explore and document meanings and patterns of correspondence across the material. We conclude that the social setting of the health house does not constrain professionals’ preferences for the ideal ‘intervention site’ as they primarily seek to mark new professional turf instead of reproducing medical discourses. Citizens on the other hand, also prefer non-clinical settings however in contrast to professionals they reproduce medical discourse about health and intervention. Professionals prefer community-based over clinical social settings. Citizens prefer the same setting, but in contrast to professionals who try to carve out autonomy from the medical and clinical practice, they still prefer medical knowledge and treatment to health promoting (social) activities.

Key words:

Health professionalism, vignette method, sick role, turf marking
**Introduction**

Since 2007 every second Danish municipality has established a “health house” to promote health and prevent disease among its citizens. The political goal has been to delegate responsibility for outpatient management from a regional to a local level of government.

Health policy has become salient on the local government agenda. The current Danish Health law delegates responsibility of health promotion to local governments intended as targeted interventions towards both recovering and at-risks citizens who can benefit from a health promoting intervention (Pedersen & Petersen 2014: 276; Health Law 2010). The guidelines are set by the Health Agency and reflect a rather open-ended understanding of health promotion and prevention as described in the following white paper from the Health Board:

Health-related activity that aims to prevent the onset and progression of diseases, psychosocial problems or accidents and thereby promote public health" and health promotion as "health-related activity that aims to promote individual health and public health by providing a framework and opportunities to mobilize patients and other citizens of the resources and competence to act (Health Board: 27).

The scope and content of health promotion leave municipalities with a large discretion of how, when and with what they choose to fulfill their responsibility towards citizens. It is therefore not surprising that municipalities have chosen different ways in organization, staffing and in implementation of health promoting interventions (Aarestrup & Kamper-Jørgensen 2007: 1).

Table 1 displays the distribution of health houses in Danish municipalities and regions in the fall of 2013.

<table>
<thead>
<tr>
<th></th>
<th>Health center</th>
<th>No health center</th>
<th>Health center on the way</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>7 (3)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Mid</td>
<td>12 (5)</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>South</td>
<td>10 (4)</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Capital</td>
<td>11 (3)</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Zeeland</td>
<td>8 (4)</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48 (19)</strong></td>
<td><strong>46</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

Cell content: Denmark’s 98 municipalities. Brackets contain numbers of on-site observed health houses.
The municipalities with no health house have chosen to use existing structures and organizations such as elderly care facilities and private medical clinics or mobile solutions such as health busses to meet the ‘new’ health responsibility.

Based on these preliminary studies of the scope and content of health houses we selected 19 out of the 48 houses. They have been selected to maximize variation in organization and structuring of the physical settings. The paper’s analyses and conclusions are based on on-site observations and interviews with health professionals and citizens in these 19 health houses.

**Previous research on health houses and public health service delivery**

Earlier studies of health houses have been focused on characterizing the political, administrative or technical factors preventing an effective implementation of health interventions (Lannerström et al: 2013; Bello et al.: 2013; Ralph et al: 2013). Related to this focus are studies focusing on the effect of specific programs or of administrative systems on citizens health conditions (Lebrund-Harris: 2013; Olayiwola et al: 2013). In line with this, some studies show that health houses facilitate essential social processes in the local community enhancing solidarity and general trust among citizens with no clear association to either health promoting or preventive effects (Clauss-Ehlers: 2003; Friedman et al: 2004; Haines et al: 2007: Scotta & Shankerc: 2010) as well as sociological studies showing a relationship between health and community ‘quality’ (Hall & Lamont 2013).

However, even though these studies point at important aspects of local health care and community ‘quality’ none of them anchor their findings to the interplay between the citizen and the concrete intervention in local settings such as the health house.

Based on current reports on Danish health house activities (xxx) we know of some of the central characteristics of the working conditions of health house personnel such as the following characteristics: 1) the political goal(s) are vague, 2) the organizational structure is vague, and 3) task description is vague. We also find that 4) personnel in the health houses are health professional practitioners trained outside the medical field (universities) and taken together we argue that we can characterize them not only as professional practitioners, but also as Street-Level Bureaucrats (SLBs) not least because they have 5) a large discretion of what do to do with whom in their daily work routines within the frame of the health law, as well as they 6) have no control over how many citizens seek their service delivery.
In many ways they share both the characteristics of health professionals and street-level bureaucrats, who have to be able to navigate formal and informal rules on both the bureaucratic and the medical field.

Therefore, we choose to characterize the encounter between local health care and the citizen as a case of a street-level bureaucracy, emphasizing how organizations, rules and task performance constrain individuals’ agency when street-level bureaucrats and professionals have large discretion over public service delivery (Lipsky 1980).

Since all service delivery takes place in a concrete interaction between individuals, we designed the study to provide answers on content and variation in the encounters at the frontline of public service delivery in the health houses. However, even though we were able to define professionals in health houses as policy makers and citizens as receivers of public services, we didn’t really know what the encounters and the health house was really a (theoretical) case of?

In the following we elaborate more on the case specificity of health house encounters and we suggest distinguishing between a macro-, meso, and a micro-theoretical framework.

**Theoretical framework – Turf marking and citizen engagement**

From the literature of professional sociology we know that knowledge is a powerful tool in struggles over interests, boundaries and identities, where individuals and social groups have ambitions to monopolize their ‘market’ through entry control and authority claim-making (Abbott, Freidson, Weber). The first health houses were established in 2007 with many professional groups, different access to status, power and different kind of diagnostic practice, which lead us to expect a great deal of turf marking appears among these employees both towards each other and towards the established professionals in the medical field.

We understand the health house as a case of turf marking and authority claiming in the medical field of academics (doctors) and non-academics (health professionals such as e.g. nurses). Weber argues that marking a turf is (also) a symbolic act that works through the formal and informal inclusion criteria of authority-giving systems such as the educational system (Weber). In the health house the professionals’ job tasks and particular education do vary, however they are all
educated as health professionals from one of the 5 university colleges in Denmark and this means that they share a non-academic training as professional practitioners. We argue that this common factor is potentially co-producing both counter discourses to an academic discourse associated to the medical field and to a new health professional way to address health and the citizen in need of a health intervention.

To sum up on our theoretical framework, we understand the social processes in the health house as generated by professionals turf-marking and authority-claiming based on their educational difference to the academics (doctors), who control the ‘old’ market. In the empirical analyses we seek to carve out these social processes in the interviews and we use critical discourse analysis (CDA) to look for hegemonic and antagonistic semantics in order to explain how and why individuals perceive and act as they do when they engage in and mark turfs in health house settings.

Methodology and methods:
Our research question guiding our empirical study of health houses is primarily descriptive: What happens in the health house and how do individuals explain their presence in the house? However, by using vignette method in our data collection we makes it possible to explore in systematic and comparative ways the following question: 1) how professionals create a new turf of health professionalism, and why they prefer specific qualities over others in the health house.

We use vignette method to study content and variation in citizens’ and professionals’ public service expectations to the health house as well as to explore how institutional settings shape citizen engagement and professional behavior.

Our vignettes have been constructed to add variation of 1) entrance criteria (referral or no referral system), 2) social setting (clinical or community-based decor) and 3) health targets (health promotion or rehabilitation).

<table>
<thead>
<tr>
<th>Table 2: Vignettes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content</strong></td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>Sønderslev municipality plans to open a health center, where it should be possible for people to access without reference. Citizens must, so to speak, be able to enter from the street. The health house must include programs of stop smoking, diet counseling, rehabilitation, mental health counseling and so on. In addition, the health house should also provide a framework for various social events that are open to all citizens in the municipality. These arrangements such as joint dinners, lectures, children's playroom, concerts and 'coffee corner' organized by volunteers from e.g. the Danish Cancer Society, and local cultural and sports associations. The municipality would like to recruit staff with different educational backgrounds, such as nurses, physiotherapists, occupational therapists, psychologists and dieticians. The staff will work in close cooperation with each other and with the volunteers, who also lives in the house. It is also supposed to be a place with</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Mårsgaard municipality also plans to open a health center. It must be adjacent to the city gym and must consist of a number of small clinics, including a clinic with a general practitioner, a rehabilitation clinic with physiotherapy, a clinic for diet advice and a psychologist practice. The health house will thus become a place where health offers are gathered under one roof. In addition, the municipality will make a series of rooms available which citizens can offer to operate, for example, a cafe, a gallery, a community center, or what will be in the public’s interest. The health house must always be open, but you will need a referral to get in the clinics, for example, from a practitioner or a municipal social worker.

We used on-site observations to gain knowledge about encounters between professionals and citizens as well as about the social and the physical setting in general (Goffman). We also used the on-site observations to validate our vignettes.

We selected the 19 health houses from a telephone survey with representatives from local health in all 98 Danish municipalities. We used a theoretical sampling strategy to select sites (maximum variation on health house types measured as type of organization, content private-public and professionalism) and a convenience sampling strategy to collect interviews with professionals and citizens at the selected sites (Lofland & Lofland 1993). We emphasized visiting health houses during periods and weekdays of high citizen presence in order to be sure that we observed encounters and citizen engagement at the site as well as to strengthen the possibility of collecting interviews with citizens. We collected 33 interviews with professionals and 22 interviews with citizens during the day of our ‘on-site’ observations. We use systematic qualitative content analyses to explore meanings and patterns of correspondence across the material.

We use systematic qualitative coding methods to manage our data, which allow us for doing both within-case and across-case analyses, as well as we use software (NVivo 10) to compare coding and check for construct validity and coding reliability.

In the following analysis we use on-site observations, vignette-responses and within-case analyses of interviews with citizens and professionals to explore whether there is evidence of turf marking and citizen engagement in the health houses.

The health house as community and clinic (on-site data)

Based on our on-site observations we identify two dominating ways of organizing the health house corresponding to the vignettes used in the interview. The first has a clinical set-up and mirrors vignette B, and the second has a community-based set-up.
and mirrors vignette A and then we see a few houses characterized as a mix between these two main types. The physical and social settings as well as the concrete decors in the health house are highlighted in table 3 below:

Table 3: On-site observations of types of health houses and numbers at the site

<table>
<thead>
<tr>
<th>Type of health house</th>
<th>Health houses*</th>
<th>Personnel</th>
<th>Citizens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based</td>
<td>M4</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>M3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>S4</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>M2</td>
<td>11</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>M5</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>N3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Clinical</td>
<td>S2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Sj1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Sj2</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>M1 (city)</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>H1</td>
<td>-25**</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>N2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>N1</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>H3</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Mix</td>
<td>S1</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Sj4</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Sj3</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Minimalist and small</td>
<td>S2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>H2</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

* Health centers are anonymous. The letters indicate the region (N = north, M = mid, S = south, H = capital and Sj = Zealand)
** Course for employees

We characterize 6 out 19 health houses as community-based, 8 as clinical, 3 as a mix of both and 2 health houses were about to close down which may explain the minimalistic settings that led us to characterize them as spartan.

Table 3 also displays the number of professionals and citizens observed at the time of the visit (2-3 hour visit in relation to interviews with professionals and citizens). Even though we should not over interpret these observations (they are not validated through repetitive visits), they do show a period of time during the opening hour with a surprisingly tied ratio between professionals and citizens. As already mentioned we visited the health houses during periods and weekdays of high citizen presence in order to be sure that we would observe encounters and citizen engagement at the site as well as to strengthen the possibility of collecting interviews with citizens.

This indicates a non-typical street-level bureaucracy, because in contrast to ‘normal’ SLBs it is heavily staffed.

Even though the caseload seems surprisingly low and hence suggest comfortable working conditions, it also suggests how their existence as a legitimate public agency may be threatened, because of low-scale service delivery. The houses have existed in years so the ration cannot be explained as an upstart situation.
We thus interpret the ratio as an indicator of a potentially pressured staffed personnel in relation to long-term survival, where they still have to prove their worth to the local government and to citizens and we except that this condition will encourage them to turf-mark their special tasks and efforts against and not towards the dominating medical field (GPs and hospital doctors).

When observing the physical and social setting of the health house we learned how the institutional arrangement of public local health service structures the room of interventions both in terms of actual social practices, but also in terms of delimiting other potential social practices such as e.g. clinical treatment in community-based settings or exercise in the clinical setting.

Even though we gain a lot of insights about the health house and its impact on the encounter between professionals and citizens, our observations also raise important questions about the observed practice. In our interview we had the opportunity to test our observations together with the more deductive intention of describing health house preferences and reasoning.

**Encounters at the frontline level: Social setting categories**

From our observations we know that health professionals work under different social settings. Some work in traditional clinical settings whereas others work in more undefined spaces without referral systems and diagnose-based interventions.

As already described we used vignettes designed to portray these two main types and we asked them to explain pros and cons as well as their preference and reasons for their preferences. First of all we find that they all use categories of health as well as categories of order, power and organizations, when they refer to the value or disvalue of both vignette A or B. The prevalence of cases and codes in our material indicate a common semantic among professionals and citizens supporting the overall clear preference for the community-based health house described in vignette A. In table 4 we present categories used by professionals and citizens when they talk about the vignettes and about why they prefer either vignette A or B.

<table>
<thead>
<tr>
<th>Code</th>
<th>Content</th>
<th>Number of cases</th>
<th>Number of codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social setting categories</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health is the dominant category used by both professionals and citizens to describe both vignette A and B, whereas categories on ‘social value’, ‘social (in)equality and ‘order’ are only used when responding to questions about vignette A. In contrast the categories ‘effectiveness’, ‘power’ and ‘organizational structure’ are alone used in responses towards interview questions about vignette B. The categorical difference between ‘order’ and ‘power’ is that ‘order’ is used to describe the interactions in the houses and the potential lack of control with citizens and activities that both citizens and professionals associate with the laissez-faire arrangement in vignette A, whereas ‘power’ is used to describe external relations such as the municipality, the state and the region, the market and the many local interests there may be in the health house.

Based on our coding we also find that most of our interviewees preferred vignette A that is the health house without a referral system and with free access and social arrangements as can be seen from table 5 below. Most favor vignette A even those professionals who work in clinical settings that is similar to the content of vignette B.

<table>
<thead>
<tr>
<th>Respondents (55)</th>
<th>Social setting</th>
<th>Vignette preference</th>
<th>A</th>
<th>B</th>
<th>Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals (33)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical (12) 4</td>
<td></td>
<td></td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Community-based (13) 2</td>
<td></td>
<td></td>
<td>8</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mix (8) 4</td>
<td></td>
<td></td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Clinical (10) 5</td>
<td></td>
<td></td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

*) All categories referring to social setting preferences have been inductively derived.
When we compare the on-site observations of the actual houses where we interviewed professionals and citizens with the result of our social setting coding we find a surprisingly missing pattern between the actual setting and the preferred setting among both professionals and citizens as well as across professional boundaries and social backgrounds.

This is surprising because according to general wisdom in post-structuralism and CDA we should see that social practices influence the discourse itself, as well as the preferences and the mindset of individuals that is we should find that the actual social setting professionals and citizens know of from their particular health house also shape their ordinary language use of health as well as their discourses and evaluation of which one of the vignettes they prefer.

However, we did not find an overlap between their actual working setting and their health house preference in terms of similarity. In the following we look into there reasoning about preferences to understand motives and intentions with the health house as well as how this relate to turf marking and citizen engagement.

**Understanding social setting preferences**

Even though we cannot identify a clear association between actual and preferred social setting of health house, we argue (based on our coding of the material) that because citizens are not everyday-users at the health house, the impact as in the constraining ‘force’ of the setting is not as strong on them as we might expect to be the case for professionals working in the setting everyday. Therefore, we interpret the non-correspondence between actual and preferred social settings among citizens to express preferences bound to other significant social settings constraining their everyday-life as e.g. their private home, their workplace or the hospital in case of regular visits [this will be backed up by referring to coding memos and within-case analyses of citizens social practices demonstrating that health (or lack of the same) are bound to other settings than the health house].

This interpretation does not work for professionals, who work in the health house and hence spend a large amount of time in the actual setting. Here we should
definitely see a correspondence between actual and preferred setting, but we don’t. They also prefer vignette A to B. This could of course be used to question the whole validity of claiming that individuals’ preferences are shaped by the social practice and social structure. However, we are more modest and do not question the theoretical assumptions in e.g. the CDA model, but as we will demonstrate in the following, we argue that the discrepancy between the actual and the preferred social setting among professionals might reflect a special case of resistance as explained by the concept of antagonism and hegemony (Laclau 2014: 113-120)

The professionals at the health houses are, as already described, a kind of ‘new comers’ on the medical field dominated by medical professions and university educated people such as GPs and hospital’s doctors. Health professionals are non-academics educated in professional schools and university colleges. These educations have a lower status compared to universities both in terms of social and cultural authority referring to both the jurisdiction regulating professions’ domain and right to exercise certain activities such as diagnosing and blood testing and to laymen perception of a profession’s symbolic value (Weber).

We therefore interpret this in light of seeing health as a hegemonic project sustained by a number of counter discourses within the medical field such as ‘health promotion’ and ‘wellbeing’. In this battlefield, we argue that health professionals in health houses represent the counter discourse to the ‘established’ medical wisdom, which we understand as representing the hegemonic project and discourse about health. In other words, we find that professionals mark their turf as health professionals by distinguishing them from a clinical setting dominated by medical health practice and semantic.

Vignette A represent a social setting which breaks with the hegemonic project and based on our within case analyses and identifications of the internal structures in the professionals’ reasoning about why and what they think about vignette A compared to vignette B, we argue that they see vignette A as an option of creating a professional turf outside the hegemonic project of the medical field.

Below in table 6, we display the content of codes representing reproducing and opposing semantics within the two dominate discourses in the vignette responses: a medical and a health discourse.

Table 6: Dominating discourses on health house activities
We find that citizens use semantics from the medical field, when they describe the health house activities and they reproduce classic medical discourse about the body, health and intervention, whereas the professionals use a different semantic opposing medical language through a health pedagogical reasoning about health.

We interpret this as a sign of a new professional discourse within health, where reasoning about the body and intervention in the body is grounded in an opposition to a medical perspective on health. We do not find this kind of discourse among the citizens. Our interview material suggests that the college educated health professionals invent new relations between professionals and citizens and we argue that it is more the separation from the medical field (hospitals and clinics) than it is the concrete content of the health house which shape their opposition towards a dominant medical discourse and hence define their turf marking in society as a new kind of health professionals who offers services to the public no one else is capable of offering.

[THIS NEED TO BE ELABORATED MORE AS WELL AS A DISCUSSION OF VIGNETTE B’S CONFLICT BETWEEN PREFERENCE AND SOCIAL STRUCTURE]

**Conclusion:**

We conclude that both citizens and professionals prefer vignette A that mirrors a community-based health house. Even though this may affect professionals’ immediately control with resources our analyses suggest that they might gain more autonomy as a professional group with monopoly on certain public services if they
distinguish themselves as much as possible from hegemonic social settings in the clinic and in hospitals e.g. from turf-marking within a health house that is unique and different from the clinic as possible.

Citizens want free access to a medical doctor. They prefer vignette A, which reflects a community-based public house without a referral system, however they want traditional treatment and an examination by a classic GP or a specialist.

Professionals want their own turf and they have a language to describe their competences, which are not only structured against the medical discourse but also as a social discourse on the comprehensive perspective on health and the quality of life.

Hereby they may enter into another professional domain: social work. Further studies may shed light on how health professionals may be seen not only as rebels against the established in the medical field – but also as intruders in the field of social work. The in(ter)vention on health professionalism is hence not only a new player in local health care but also in the professional domain of social workers in lower level governments (SLBs).

[IS THERE A GENERAL POINT WHICH CAN BE APPLIED TO OTHER PROFESSIONALS SUCH AS PSYCHOLOGIST AND SOCIAL WORKERS?]
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