

The opinions of Finnish specialist physicians on social security system

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Abstract

Background: We can argue that opinions are considered to be part of the physician's professional identity. Professional identity has been considered a result of learning. After graduation physicians usually continue to study to gain a specialisation, and we can assume that this process affects their opinions because every specialty has its own "cultural climate". Also, specialists have different views towards the welfare state because, for example, of the fact that they work with different types of population groups. Aim of the study: In this article we will describe how specialists feel about the current level of social security in Finland.

Methods: The empirical analysis in our study is based on postal survey. The 2000 working age physicians' random survey sample was picked from the register of the Finnish Medical Association (n=1092, response rate 54,6 %). The whole questionnaire included questions dealing with social security, health policy and health care system. The data was analysed using means and multinomial logistic regression analysis.

Results: This study shows that surgeons and radiologists are the most critical of social security. These groups often think that social security is excessive. In contrast, psychiatrists show a stronger tendency to support social security. All in all, Finnish specialists are more critical of the social security system than are non-specialised physicians.

Conclusions: There are many similarities between Nordic countries when we look at the historical role of medical profession. We can also assume that specialist physicians' opinions on social security are quite similar compared to those of other Nordic countries.

Key words: nordic welfare state, specialist physician, social security

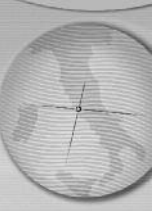
Introduction

Finland belongs to the group of countries known as Nordic welfare states. One essential part of Finnish social policy has been the implementation of broad social and healthcare services and income transfers that have been maintained by means of strong progressive taxation. The legitimacy of the present system has been examined with the help of opinion studies. These studies have usually focused on the citizens' level. It has been observed that the present social security system has been strongly supported by citizens [1]. Social security opinions of specific occupational groups such as physicians have seldom been studied. It is important to study physicians because they have so much professional power and know-how about social security through their work experience.

Many surveys about different issues have been conducted where specialisation has been one

background factor [2]. Medical specialists' opinions about social security have not been studied even though becoming a specialist may possibly affect a physician's views on social security. We can only speculate that some specialist groups, such as surgeons, may have different opinions than, for example, psychiatrists.

We can argue that opinions are considered part of the physician's professional identity. Professional identity has been considered a result of learning [3]. The Finnish Medical Association is an important agent in this learning process. For example the Association has many ideas about restructuring the Finnish public sector. Although physicians seem to be a relatively homogenous group in many ways, we can also assume that there is some internal differentiation in various areas. After the graduation doctors usually continue to studying to gain a specialisation, and we can assume that this process also affects their



opinions because every specialty has its own "cultural climate". Also, specialists have different views toward the welfare state because, for example because they work with different types of population groups. Every physician also has own norms (ideologies) and interests that influence his or her opinions [4,5]. Political orientation has been used as an indicator for ideology. Self-interests have usually been measured in groups based on age, gender or employment sectors [5,6].

An earlier study [7] tells that physicians are more critical of social security than citizen-level groups. Physicians wanted budget cuts to be targeted at something other than social or health services. Female physicians supported increased levels of social security, and, conversely, young doctors thought more often that social security is excessive. Left-wing political orientation was the clearest predictor of opinions. A surprising result was that the employment sector studied was not a significant factor as in some population surveys.

In this article we will first describe how specialists feel about the current level of social security by asking two general questions. Thereafter we will examine where the different specialists would be ready to cut expenditures. Opinions will also be analysed against background variables with help of earlier study [7].

Methods

Sample

The empirical analysis in our study is based on a larger postal survey. The whole questionnaire included questions dealing with social security, health policy and health care system. Data was collected in cooperation with the Finnish Medical Association at the beginning of 2007. A random survey sample was picked from the register of the Finnish Medical Association. Two thousand practicing physicians who resided in Finland were chosen for the sample. After the second round completed forms were returned by 1092 respondents, a response rate of 54.6 %. The structure of the sample corresponds well with the structure of Finnish physicians with regard to age, employment sector and gender [8,9,10]. The sample and the data have been presented elsewhere in a more detailed version [9].

Independent variables

The specialty variable is originally asked as in an open question. For this article the speciality variable is classified on an 11-point scale: 1) general practice, 2) internal medicine, 3) surgery, 4) psychiatry, 5) anaesthesiology, 6)

gynaecology, 7) paediatrics, 8) occupational health care, 9) radiology, 10) other specialties, 11) non-specialised. This list contains the nine largest specialities in Finland [8]. Specialities are classified by respondents' main area of specialisation in their main place of employment.

Two other variables (gender and age) were chosen for the multinomial logistic regression with the help of an earlier study [7]. Other variables were included in the regression model along with the specialty variable. Through this method we can elaborate upon the significance of the two main background variables. For example, there are many male-dominated specialities [8] and this effect must be examined if we really want to clarify differences in opinions among different specialities.

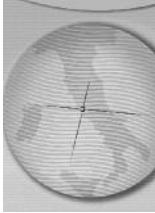
The gender variable is used as originally asked and it is dichotomous. The age variable is originally asked as in an open question. For this article it is divided into three categories: below 35, 35-49, 50-63. Results of these variables are shown only in the tables, not separately reported in the text, because the focus is on different specialist physicians'. Models, which included political orientation, were also made, but these made the models unreliable.

Dependent variables

Opinions toward the level of social security were originally measured by the following questions

- 1) Level of social security is: much too high, too high, suitable, too low, much too low
- 2) Taxes must be cut even at the expense of social security: completely agree, partly agree, cannot say, partly disagree, completely disagree. For this article these variables were classified on a three-point scale. In the logistic regression models references for the dependent variables are social security is: too low and taxes must be cut even at the expense of social security: disagree. Opinions toward the social security cutbacks were originally measured by the following question
- 3) If the state and municipalities must cut back on their spending, which expenses in your opinion could be cut back and which not (employment support, health care, income transfers, social welfare service): cannot be cut, can be cut somewhat, can be cut considerably, cannot say. In descriptive analysis we used three scale measures.

For the logistic regression model the variables about cutbacks were two-point scale. There had been only a few "cannot say" answers, and these



were removed. This solution increased the reliability of the models, since otherwise the number of empty cells would have been too large. It is technically possible to do multinomial logistic regression analysis by SPSS -program also for the two-point scale variable. In the logistic regression models reference for the dependent variable is cannot be cut. In Table 4 odds ratios are not reported in the text for those who have chosen "cannot say".

Statistical analysis

The data was analysed using means and multinomial logistic regression analysis. The odds ratios, statistical significances, 95% confidence intervals and the explanation degrees (pseudo R²) of regression models are reported. Statistical significance was determined in this article as: $p < 0.05$, $p < 0.01$, $p < 0.001$. The statistical analysis was performed using the SPSS for Windows 14 software package.

Results

Table 1 shows the frequency of the nine largest specialities in the sample, the proportion of women in each specialty, and mean age. There are large differences between the percentages of women in different specialties. The biggest percentages of women can be seen in psychiatry and gynaecology. Also, non-specialised physicians are mostly women. Older physicians are often specialised in general medicine and occupational health care. Non-specialised physicians are younger than specialised physicians.

Table 2 presents descriptive statistics comparing different specialties. Non-specialised physicians seldom think that social security is excessive or that taxes must be cut even at the

expense of social security. Compared with all other groups, surgeons are most likely to think that the level of social security is excessive. Psychiatrists are more likely to feel that social security is insufficient. Differences are also clear when we ask whether "taxes must be cut even at the expense of social security". Company doctors come more sharply into focus with this question because they are less likely to think that taxes must be cut even at the expense of social security.

Gynaecologist are the biggest group of specialists who resist cutbacks. The area where physicians were most willing to cut costs was employment support. Variations between different specialties are significant, especially within the social services. Radiologists and surgeons are the most willing to cut costs in different areas of social security. Some specialty fields, like gynaecology and paediatrics, are more in touch with social security services and thus are the most supportive of social services. (Table 3.)

The most important result is that after standardisation there are still some clear differences between specialties. The situation of surgeons and especially psychiatrists becomes more evident. Psychiatrists are less likely to think that social security is excessive than other physicians. Also, psychiatrists and company doctors seldom think that taxes should be cut at the expense of social security. Conversely, surgeons favour a lower degree of social security, also gynaecologists, paediatricians and radiologists are more likely to think that social security is excessive. However, differences in opinions are smaller when the question is tied to potential tax impacts. (Table 4.)

Non-specialised physicians usually resist savings more than specialists. Radiologists are the most

Table 1. Specialists and proportion of women and mean age in the sample.

	Sample % (N)	Proportion of women, %	Mean age
General practice	12,0 (131)	55,7	52
Internal medicine	4,1 (45)	35,6	49
Surgery	4,0 (44)	31,8	48
Psychiatry	7,9 (86)	79,1	49
Anesthesiology	4,4 (48)	45,8	49
Gynaecology	4,5 (49)	77,6	50
Paediatrics	1,9 (21)	66,7	49
Occupational health care	3,4 (37)	51,4	54
Radiology	2,5 (27)	37,0	50
Other specialities	18,3 (200)	47,7	49
Non-specialised	37,0 (404)	61,8	40
Total	100,0 (1092)	56,7	46

Table 2. Opinions regarding the social security and taxes.

Opinions regarding the level of social security				
	Too high	Suitable	Too low	Total
General practice	33,6	48,9	17,6	100,0 (131)
Internal medicine	44,4	40,0	15,6	100,0 (45)
Surgery	56,8	40,9	2,3	100,0 (44)
Psychiatry	28,6	50,0	21,4	100,0 (84)
Anesthesiology	37,5	45,8	16,7	100,0 (48)
Gynaecology	46,8	44,7	8,5	100,0 (47)
Paediatrics	33,3	61,9	4,8	100,0 (21)
Occupational health care	37,8	48,6	13,5	100,0 (37)
Radiology	37,0	55,6	7,4	100,0 (27)
Other specialities	42,7	47,7	9,5	100,0 (199)
Non-specialised	34,6	49,3	16,2	100,0 (402)
All physicians	37,6	48,3	14,1	100,0 (1085)
Taxes must be cut even at the expense of social security				
	Agree	Cannot say	Disagree	Total
General practice	26,0	16,8	57,3	100,0 (131)
Internal medicine	28,9	15,6	55,6	100,0 (45)
Surgery	45,5	11,4	43,2	100,0 (44)
Psychiatry	14,0	17,4	68,6	100,0 (86)
Anesthesiology	25,0	14,6	60,4	100,0 (48)
Gynaecology	22,4	16,3	61,2	100,0 (49)
Paediatrics	28,6	4,8	66,7	100,0 (21)
Occupational health care	13,5	18,9	67,6	100,0 (37)
Radiology	34,6	30,8	34,6	100,0 (26)
Other specialities	31,2	12,6	56,3	100,0 (199)
Non-specialised	25,6	11,4	62,9	100,0 (402)
All physicians	26,4	13,9	59,7	100,0 (1088)

willing to cut costs. An interesting result is that especially gynaecologists and paediatricians think that savings cannot be achieved in the case of social services. In contrast, paediatricians favour the most cut backs in employment support. Surgeons are also ready to reduce employment support costs. Actually, pediatricians are more resistant to the idea of saving on services than non-specialised physicians are, whereas in the case of income transfers and unemployment benefits the situation is opposite. All in all, differences between specialities are quite small after controlling the age and gender variables. (Table 4.)

Discussion

In 2006 approximately 63 % of all Finnish physicians were specialists. 70 % of men had at least one specialty and 57 % of women had at least one specialty. In 1999 specialists' education was revised, giving rise to 49 different specialities [10]. In earlier studies different specialty classification have been made. For example Bovier and Perneger used the following classifications: primary care, internal medicine, paediatrics,

psychiatry and surgery/radiology [11]. In this article the speciality variable was classified on an 11-point scale.

As we already know, it is important to study physicians' opinions because they have so much know-how about social security through their work experience. The study shows that there are some important differences between opinions when we look at different specialities. This is also true after standardisation by gender and age. Surgeons and radiologists are the most critical of social security. These groups often think that social security is excessive and cut to it is possible to make. In contrast, psychiatrists show a stronger tendency to support social security. All in all, Finnish specialists are more critical of the social security system than non-specialised physicians. Thus physicians' opinions on social security system indicate that the ground of the system is not very strong. Physicians are of high repute occupational group and especially this is the case if we look at the different specialists as surgeons. This is the reason that why they can reproduce the welfare state system by manipulating public opinion.

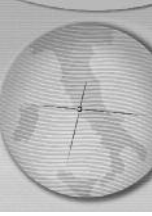
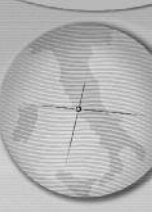


Table 3. If the state and municipalities must cut back on their spending, which expenses in your opinion could be cut back and which not, %.

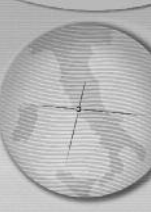
	Cannot be cut	Can be cut	Cannot say	Total
Employment support				
General practice	23,7	71,8	4,6	100,0 (131)
Internal medicine	15,6	82,2	2,2	100,0 (45)
Surgery	11,4	88,6	0,0	100,0 (44)
Psychiatry	27,9	67,4	4,7	100,0 (86)
Anesthesiology	22,9	77,1	0,0	100,0 (48)
Gynaecology	24,5	71,4	4,1	100,0 (49)
Paediatrics	9,5	81,0	9,5	100,0 (21)
Occupational health care	24,3	70,3	5,4	100,0 (37)
Radiology	14,8	81,5	3,7	100,0 (27)
Other specialities	16,6	80,4	3,0	100,0 (199)
Non-specialised	23,1	71,7	5,2	100,0 (403)
All physicians	21,2	74,7	4,1	100,0 (1090)
Health care				
General practice	66,4	33,6	0,0	100,0 (131)
Internal medicine	64,4	35,6	0,0	100,0 (45)
Surgery	61,4	38,6	0,0	100,0 (44)
Psychiatry	67,4	31,4	1,2	100,0 (86)
Anesthesiology	78,7	21,3	0,0	100,0 (47)
Gynaecology	67,3	32,7	0,0	100,0 (49)
Paediatrics	71,4	28,6	0,0	100,0 (21)
Occupational health care	59,5	40,5	0,0	100,0 (37)
Radiology	48,1	51,9	0,0	100,0 (27)
Other specialities	65,8	32,7	1,5	100,0 (199)
Non-specialised	67,5	31,0	1,5	100,0 (403)
All physicians	66,5	32,6	0,9	100,0 (1089)
Income transfers				
General practice	47,7	49,2	3,1	100,0 (130)
Internal medicine	54,5	43,2	2,3	100,0 (44)
Surgery	65,9	34,1	0,0	100,0 (44)
Psychiatry	64,7	31,8	3,5	100,0 (85)
Anesthesiology	45,8	54,2	0,0	100,0 (48)
Gynaecology	66,7	29,2	4,2	100,0 (48)
Paediatrics	52,4	47,6	0,0	100,0 (21)
Occupational health care	62,2	35,1	2,7	100,0 (37)
Radiology	59,3	40,7	0,0	100,0 (27)
Other specialities	52,8	45,2	2,0	100,0 (199)
Non-specialised	57,7	38,1	4,2	100,0 (402)
All physicians	56,3	40,7	2,9	100,0 (1085)
Social welfare service				
General practice	55,7	43,5	0,8	100,0 (131)
Internal medicine	68,9	28,9	2,2	100,0 (45)
Surgery	56,8	43,2	0,0	100,0 (44)
Psychiatry	68,2	29,4	2,4	100,0 (85)
Anesthesiology	66,7	33,3	0,0	100,0 (48)
Gynaecology	79,2	18,8	2,1	100,0 (48)
Paediatrics	85,7	14,3	0,0	100,0 (21)
Occupational health care	64,9	35,1	0,0	100,0 (37)
Radiology	51,9	44,4	3,7	100,0 (27)
Other specialities	61,8	36,7	1,5	100,0 (199)
Non-specialised	71,8	24,8	3,5	100,0 (400)
All physicians	66,6	31,2	2,1	100,0 (1085)



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Table 4. Multinomial logistic regressions: odds ratios, significances, 95 % confidence intervals and explanation degrees.

	Model		Model	
	Social security is too high	Social security is suitable	Taxes must be cut even at the expense of social security	Taxes must be cut... cannot say
<i>Gender</i>				
Female	1.00	1.00	1.00	1.00
Male	1.03 (0.69-1.54)	0.76 (0.52-1.12)	1.72*** (1.28-2.32)	1.04 (0.71-1.53)
<i>Age</i>				
50-63	1.00	1.00	1.00	1.00
35-49	1.17 (0.76-1.78)	1.09 (0.73-1.64)	0.96 (0.70-1.33)	0.46* (0.22-0.95)
Below 35	2.35* (1.21-4.58)	1.77 (0.94-3.37)	1.54* (0.95-2.50)	0.88 (0.60-1.30)
<i>Specialty</i>				
Non-specialised	1.00	1.00	1.00	1.00
General practice	1.22 (0.65-2.29)	1.11 (0.61-2.01)	1.32 (0.78 - 2.22)	1.25 (0.68-2.30)
Internal medicine	1.77 (0.69-4.53)	1.07 (0.42-2.75)	1.37 (0.65-2.89)	1.21 (0.48-3.05)
Surgery	14.66* (1.91-112.45)	7.50 (0.97-58.07)	2.62** (1.28-5.37)	1.15 (0.40-3.31)
Psychiatry	0.83 (0.41-1.72)	0.86 (0.45-2.66)	0.67 (0.33-1.36)	1.12 (0.56-2.21)
Anesthesiology	1.38 (0.55-3.43)	1.10 (0.46-2.66)	1.13 (0.54-2.39)	1.06 (0.43-2.62)
Gynaecology	3.46* (1.12-10.73)	1.96 (0.63-6.04)	1.21 (0.56-2.60)	1.17 (0.49-2.78)
Paediatrics	4.20 (0.50-35.28)	4.87 (0.62-38.30)	1.30 (0.48-3.59)	0.32 (0.04-2.52)
Occupational health care	1.81 (0.61-5.42)	1.47 (0.51-4.23)	0.56 (0.20-1.55)	1.17 (0.46-2.95)
Radiology	3.04 (0.64-14.51)	3.08 (0.68-14.04)	2.62 (0.99-6.98)	3.89** (1.40-10.83)
Other specialities	2.72** (1.46-5.06)	1.98* (1.08-3.62)	1.57* (1.01-2.45)	0.99 (0.56-1.76)
N	1077		1080	
R ²	4,5		6,2	
	Model	Model	Model	Model
	Employment support	Health care	Income transfers	Social welfare service
<i>Gender</i>				
Female	1.00	1.00	1.00	1.00
Male	1.26 (0.92-1.73)	1.00 (0.76-1.32)	1.26 (0.97-1.64)	1.77*** (1.34-2.35)
<i>Age</i>				
50-63	1.00	1.00	1.00	1.00
35-49	1.22 (0.88-1.71)	0.87 (0.66-1.16)	1.10 (0.83-1.45)	0.70* (0.52-0.93)
Below 35	1.59 (0.95-2.66)	0.64 (0.40-1.00)	1.17 (0.76-1.80)	0.51** (0.31-0.83)
<i>Specialty</i>				
Non-specialised	1.00	1.00	1.00	1.00
General practice	1.13 (0.68-1.87)	0.91 (0.58-1.44)	1.64* (1.06-2.56)	1.69* (1.07-2.68)
Internal medicine	1.81 (0.76-4.30)	1.02 (0.52-1.99)	1.18 (0.61-2.29)	0.84 (0.41-1.73)
Surgery	2.55 (0.96-6.83)	1.10 (0.56-2.18)	0.71 (0.36-1.43)	1.48 (0.74-2.93)
Psychiatry	0.92 (0.52-1.62)	0.86 (0.50-1.47)	0.81 (0.48-1.39)	1.13 (0.65-1.97)
Anesthesiology	1.17 (0.56-2.45)	0.50 (0.24-1.06)	1.81 (0.97-3.39)	1.07 (0.55-2.11)
Gynaecology	1.11 (0.54-2.30)	0.89 (0.46-1.72)	0.72 (0.36-1.43)	0.59 (0.27-1.30)
Paediatrics	3.04 (0.68-13.56)	0.76 (0.28-2.02)	1.45 (0.59-3.55)	0.41 (0.12-1.45)
Occupational health care	1.10 (0.48-2.51)	1.21 (0.59-2.47)	0.90 (0.43-1.88)	1.08 (0.51-2.28)
Radiology	1.91 (0.63-5.80)	2.00 (0.90-4.48)	1.03 (0.46-2.33)	1.72 (0.75-3.96)
Other specialities	1.69* (1.05-2.73)	0.91 (0.61-1.36)	1.29 (0.88-1.90)	1.29 (0.85-1.94)
N	1037	1071	1045	1054
R ²	2,7	1,7	2,5	7,8



It is hard to explain why practicing in specialty fields affects physicians' opinions even when we standardise other variables. There are no studies regarding how specialisation changes the norms and ideologies of physicians; this will be an area to study in the future. This study shows that the old assumption that surgeons are more critical of social security and psychiatrists are more positive about it is valid. An interesting aspect is that especially gynaecologists and pediatricians think that savings cannot be achieved in the case of social services, but at the same time they are likely to think that social security is excessive. Actually, we can conclude that these two groups of specialist are the biggest supporters of social services.

One significant reason behind specialists' differing opinions about social security is that they work in different environments and with different patient groups. Compared to surgeons, for example, psychiatrists work more with patients who have many social problems and are more in need of a strong social security system. Also psychiatry is also more patient-intensive specialty field than surgeon, which could affect the opinions. A second reason could be that speciality fields have different "cultural climates" - in other words norms, which affect physicians' opinions about social security. A third reason could be that physicians' opinions pre-dated their specialisations; it is possible to argue that physicians with different norms also sought out different specialties.

Earlier studies on survey data have pointed out that results are always sensitive to how different questions are worded [6,12]. The questions used in this survey were quite general. In the future, we should use more detailed questions in order to clarify relationships between the welfare state and specialist physicians. Also, the important thing is to clarify what is the significance of the specialization process into the social security opinions.

The results are dependent on the country and its institutional design. Even the specialty classifications are quite the same in the European region; there are some differences in work duties between different countries. The health care systems of developed countries can roughly be divided into two types: an insurance-funded model and a tax-funded national health service model. In the insurance-funded model, the private producers traditionally have a more significant position than in the tax-funded model [13]. Also the specialist physician roles are different in different health care models. There are many

similarities between Nordic countries when we look at the historical role of medical profession [14]. Thus we can also assume that physicians' opinions are quite similar when compared across the different Nordic countries.

References

- 1) Forma P. Niin hyvinä kuin huonoinakin aikoina - Suomalaisen sosiaalipolitiikkaa koskevat mielipiteet vuonna 2004. [In good and bad times - Opinions towards social policy in the Finland year 2004]. In: Kautto M, editor. Suomalaisen hyvinvointi 2006 [Welfare in Finland 2006]. Helsinki: National Research and Development Centre for Welfare and Health, Helsinki, 2006:160-84.
- 2) Midttun L. Private or Public? An empirical analysis of the importance of work values for work sector choice among Norwegian medical specialists. *Soc Sci Med* 2007;6:1265-77.
- 3) Freidson E. *Profession of Medicine. A study of the Sociology of Applied Knowledge*. New York: Harper & Row, 1970.
- 4) Gevers J, Gelissen J, Arts W, Muffels R. Public health care in the balance: exploring popular support for health care systems in the European Union. *Int J Soc Welfare* 2000;9:301-21.
- 5) Jæger M. What Makes People Support Public Responsibility for Welfare Provision: Self-interest or Political Ideology? A Longitudinal Approach. *Acta Sociol* 2006;3:321-38.
- 6) Forma P. Interests, Institutions and the Welfare State. *Studies on Public Opinion Towards the Welfare State*. Helsinki: Stakes, 1999.
- 7) Saarinen A. The opinions of Finnish physicians on social security system. (Manuscript, submitted), 2007.
- 8) Finnish Medical Association. *Lääkärit 2007 [Physicians 2007]. Statistics*. Helsinki: Finnish Medical Association, 2007.
- 9) Saarinen A. Raportti suomalaisten lääkäreiden terveyspoliittisia mielipiteitä kartoittavan tutkimuksen aineiston keruusta sekä teknisistä seikoista. [Description of the physician survey -data]. Turku: Department of Social Policy, University of Turku, 2007.
- 10) Finnish Medical Association. *Lääkärikysely 2006, tilastoja. [Physician survey 2006, statistics]*. Helsinki: Finnish Medical Association, 2006.
- 11) Bovier PA, Perneger TV. Predictors of work satisfaction among physicians. *Eur J Public Health* 2003;4:299-305.
- 12) Kangas O. Self-Interest and the Common Good: The Impact of Norms, Selfishness and Context in Social Policy Opinions. *J Socio-Econ* 1997;5:475-94.
- 13) Freeman R. Institutions, States and Cultures: Health Policy and Politics in Europe. In: Clasen J editor. *Comparative Social Policy. Concepts, Theories and Methods*. Oxford: Blackwell, 1999:80-94.
- 14) Riska E. The Medical Profession in the Nordic Countries. In: Hafferty, FW, McKinlay John B editors. *The Changing Medical Profession. An International Perspective*. New York: Oxford University Press, 1993:150-61.