Local Public Health Physicians in Norway from 1994 to 2002. Workload, work content, and interaction.
A story of everyday life in primary health care.

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FORORD

Livet som forsker ”på baksida av verden” – som Arthur Arntzen har omtalt det å leve i utkanten, har ikke vært lett. Det kan nok mine finansiører, veiledere, kolleger og min familie være enig i. For meg personlig har det vært en ensom prosess med mange ambivalenser og en grad av lutring jeg fortsatt er usikker på om jeg egentlig har taklet. Fremtiden må vise om forskning i satellitter utenom de akademiske arnesteder er nødvendig og godt nok. Jeg trodde i alle fall på det og mener å se spor av at flere tenker det er et gode innenfor deler av forskningen.

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LIST OF PAPERS

This dissertation is based upon the following papers. In the text they will be referred to by their Roman numerals:

I

Pettersen BJ, Johnsen R. More physicians in public health: Less public health work? Scand J of Public Health, 2005; 33: 91-98.

II

Pettersen B, Hofoss D. Are public health physicians fading out of management? Eur J Public Health, Advance Access published April 4, 2007

III

Pettersen BJ, Johnsen R. Changes in contractual systems for clinical care also affect local public health. - A nine years follow-up of physicians' mobility in the public health labour market.
Submitted.

IV

Pettersen BJ, Johnsen R. Legers oppfatning av samhandlingen mellom nivåene i helsetjenesten. [Physicians' experience with and attitudes to interaction between health care levels]. Tidsskr Nor Laegeforen. 2007 Mar 1; 127(5):565-8 [In Norwegian].

DEFINITIONS

In this dissertation the following definitions are used:

Public health [*folkehelsearbeid*]

> The science and practice of protecting and improving the health and quality of life of a community, as population-based preventive medicine, health education, control of communicable diseases, application of sanitary measures, and monitoring of environmental hazards.

Public health physician [*samfunnsmedisiner*]

> A physician working in public health

Local public health physician [*kommunal samfunnsmedisiner*]

> A physician working in public health, on the local government administration level

Community medicine [*samfunnsmedisin*]

> A medical specialty, based on a five years training program for physicians working in public health.

Family medicine [*allmennmedisin*]

> A medical specialty, which provides continuing and comprehensive clinical care for the individual and family in primary care

General practitioner [*allmennpraktiker*]

> A physician providing primary care, practising family medicine, not necessarily having the medical specialty

Municipality [*kommune*]

> Term for the lowest level of public administration in Norway

Interaction [*samhandling*]

> A kind of action that occurs as two or more objects have an effect upon one another. The idea of a two-way effect is essential in the concept of interaction, as opposed to a one-way causal effect.
>
> In searching for the correct translation into English of the Norwegian word *samhandling* we have chosen to use *interaction*, as defined here. This could be questioned, in that also the Norwegian term is discussed and our article actually partly comprises this discussion. We are aware that the concept may be covered by the concept *integration*, but to our knowledge this is not used in Norwegian literature for the corresponding Norwegian term. Other terms, like *coordination, cohesion, cooperation and collaboration*, are also used, without a specific conceptual definition or demarcation.

Vacancy

> Vacancy was defined as a complete absence of a physician in a public health physicians position during the period of data collection

Turnover

> The number of physicians who had quitted during a study period, by the total number of physicians registered in position at the beginning of the study period.

1.1 ABSTRACT

Background

The theme of this thesis is the development of public health physicians' services on the municipality level during the 1990s and the early 2000s. The origin of the study was related to interest for preventive services in the municipalities and for interaction between other health services, for how and under which framework this could be performed. The public health physician seemed crucial for this tasks and little knowledge had been presented on him and her in Norway.

Decentralisation and liberalisation reforms in primary health care and changes in the public's health and demands for health services have changed the working arena for the local public health physician, giving financial, organisational and professional challenges. The role, status and function of the local public health physician became challenged both in practice and in theory

Therefore, the main aims of this study were to describe and explore local public health physicians' work and framework over time with respect to workload, work content, professional mobility and interaction.

Study population and methods

The thesis consists of two studies among primary health physicians, the first one about working conditions in local public health at three different points of times, the second on professional collaboration between health care levels.

The first study is comprised of three cross-sectional surveys based on postal questionnaires among physicians currently working or having worked in local public health medicine in all Norwegian municipalities in 1994, 1999 and 2002. In the second study physicians working in general practice and at community and regional hospitals were interviewed in focus groups on their conduct to and their experience with professional interaction between the health care levels.

All physicians working in local public health medicine in all Norwegian municipalities in 1994, 1999 and 2002, and those who left local public health positions between 1994 and 1999 and between 1999 and 2002 were traced from 1994 to 2002. In 1994 505, in 1999 555, and in 2002 553 physicians working in local public health were included

(there were 510, 574 and 586 positions, respectively). In 1999 we found 172 and in 2002 190 physicians who had quitted working in local public health positions after 1994 and 1999, respectively. All received a postal questionnaire, with one reminder in all three surveys. For physicians in a local public health position the response rates in 1994, 1999 and 2002 were 66, 70 and 64%, respectively, and for those who had left the response rates were in 1999 and 2002 were 79 and 68%. Data on the municipalities from Statistics Norway and on each physician from the registry of NMA supplied the collected data.

The participants in the qualitative study were selected through contact persons in the region they worked and the focus group interviews were performed. The contact persons presented a framework for the study and found as many persons as possible up to 10 on three levels of health care, with some instructions on variety in age, gender, experience and, where applicable, department. The three groups consisted of 15 male and 2 female physicians with 3 months to 28 years pf experience. We used a semi-structured interview guide.

All statistical analyses for study I was performed using the statistical software SPSS for Windows. Differences between groups were tested by *t*-statistics for continuous variables; otherwise χ^2- statistics with Yates correction were used. Confidence intervals were calculated from the binomial distribution. Where means were standardised for age and sex, covariance analyses in ANOVA were performed with age and sex as covariates. Multiple regressions were used where appropriate. Factor analysis was used for data reduction within sets of observed variables, to identify clusters of related items.

In study II we used focus groups, where physicians reflected on interaction as a measure in health care. Focus groups are group based interviews, and are suitable for facilitating processes in and between the participants. The spontaneous interaction evolving in between the group members produce insight seldom achieved through other methods. Immediately after each focus group interview the researchers summed up the interviews orally and in writing. The interviews were then transcribed and analysed qualitatively through repeated reading and discussion of the transcripts. In this process all information was examined, categorised and construed (83-84).

Results

Although the number of physicians working in public health increased from 505 in 1994 to 555 in 1999 (10%) , the estimated total weekly hours decreased by 3.7% from 8715 hours in 1994 to 8386 hours in 1999. The vast majority of physicians worked in combined positions (87%), and they reduced their engagement in public health with 2.6 hours on average from 1994 to 1999. The reduction depended on remuneration model, speciality in community medicine and municipality size. They reduced their administrative tasks and evaluated their own managerial competence rather conservatively and somewhat lower in 1999 than in 1994. Many had supplementary training in management in addition to their medical education and specialty training. The number of local public health positions for physicians increased with 15% from 1994 to 2002, and women doubled their presence in the public health work force. The turnover-rate per year increased from 9% to 14% from 1994 to 2002, and the number of vacancies increased from 1% in 1994 to 6% in 2002. There was a stable core of physicians in position through the whole period, constituting one third of all local public health physicians in 2002, representing the most experienced but also the oldest physicians soon to be replaced. Younger physicians seemed to try local public health but quitted soon. Specialty in community medicine seemed to be recruiting and stabilising. There were signals of higher future stability between public health physicians in 2002 than earlier.

Physicians had different opinions on which characteristics were important to establish a good professional interaction, and their opinions varied according to which health care level they represent. While primary health care physicians emphasised confidence, respect, knowledge of each other and accessibility, that is a relational perspective; the local hospital physicians put more emphasis on capacity, i.e. competence, stability and accessibility. Physicians at the central Hospital emphasized capacity and structure, i.e. their own and collaborators' professional interest, accessibility and formalised structures for interactions. A sense of personal knowledge, verbal and written contact was important, but guidelines and treatment plans were also considered to be important for interaction. There was a strong ownership to the individual patient across all three levels.

Conclusions

Local public health in Norway was under pressure in the studied period. Despite increased numbers of positions for and more physicians in these positions, turnover increased and the work became more fragmented. Less public health work was performed, for the benefit of clinical medicine. Public health physicians seemed to be fading out of management. Structural reforms in clinical medicine are considered important for these changes, but also processes related to reforms in public administration, professional development and the medical professions development are important to understand the findings in this study. Measures for capacity and competency building are necessary to balance the situation.

To improve interaction between physicians it seems important to take into account that good interaction depends on personal and professional preferences and on what level the physician is working on. Dialog between the participants is necessary, to negotiate both goals and measures.

1.2 NORSK SAMMENDRAG

Bakgrunn

Tema for denne avhandlingen er utviklingen innenfor lokal samfunnsmedisinsk legetjeneste på 1990-tallet frem til 2002. Utgangspunktet for studien var interesse for lokalt forebyggende arbeid og for samhandling mellom helsetjenester, - for hvordan og under hvilke forhold dette kunne gjøres. Den lokale samfunnsmedisineren syntes sentral i dette arbeidet og det var lite kunnskap om samfunnsmedisineren og dennes arbeid i Norge.

Desentraliserings- og liberaliseringsreformer i primærhelsetjenesten og endringer i helse- og folkehelsetilstand og etterspørsel etter helsetjenester har endret arbeidsarena for samfunnsmedisinerne, gjennom økonomiske, organisatoriske og faglige utfordringer. Rolle, status og funksjonen til samfunnsmedisineren har vært utfordret både i teori og praksis.

Målsettingen med denne studien var å beskrive og utforske den lokale samfunnsmedisinerens arbeid og rammebetingelser over tid, i forhold til arbeidsmengde, arbeidsinnhold, mobilitet i arbeidsmarkedet og undersøke legers erfaringer med og oppfatning av samhandling.

Materiale og metode

Avhandlingen består av to studier av og i primærhelsetjenesten, den første på den lokale samfunnsmedisineren og dennes arbeid, den andre på samhandling mellom helsetjenestenivåene.

Den første studien består av tre tverrsnittsundersøkelser, basert på postale spørreskjema, blant leger som arbeidet i eller hadde arbeidet i lokal samfunnsmedisin i alle norske kommuner og bydeler i 1994, 1999 og 2002. I den andre studien ble leger som arbeidet i primærhelsetjenesten, i lokalsykehus og på sentralsykehusnivå intervjuet i fokusgrupper, med fokus på deres erfaringer med og oppfatning av samhandling mellom nivåene.

Alle leger som arbeidet i lokal samfunnsmedisin i alle kommuner og bydeler i 1994, 1999 og 2002, og de som hadde forlatt slikt arbeid mellom 1994 og 1999 og mellom

1999 og 2002 ble oppsporet fra 1994 til 2002. I 1994 deltok 505, i 1999 555 og i 2002 553 lokale samfunnsmedisinere (av totalt henholdsvis 510, 574 og 586 stillinger). I 1999 fant vi 172 og i 2002 190 leger som hadde sluttet i samfunnsmedisinsk stilling etter henholdsvis 1994 og 1999. Alle mottok et spørreskjema i posten, og vi brukte en purring i alle tre studiene. For leger i samfunnsmedisinsk stilling var svarprosenten henholdsvis 66, 70 og 64%. Data om kommunene fikk vi fra Statistisk Sentralbyrå og om den enkelte lege fra Den norske Legeforenings register.
Deltagerne i den kvalitative studien ble valgt ut av kontaktpersoner i den regionen de bodde i og hvor fokusgruppene ble gjennomført. Kontaktpersonen presenterte studien for leger på den aktuelle arbeidsplassen / i det geografiske området og fant inntil 10 frivillige deltagere på de tre nivåene, med noen instruksjoner omkring alders- og kjønnsvariasjon og tid i stilling. De tre gruppene besto av til sammen 15 mannlige og to kvinnelige leger med fra 3 måneders til 28 års arbeidslivserfaring. Vi brukte en semi - strukturert intervjuguide.

Statistiske analyser ble gjennomført på programmet SPSS for Windows. Forskjeller mellom grupper ble testet med *t*-test for kontinuerlige variabler; ellers ble χ^2 – test med Yates korreksjon brukt. For binominal distribusjoner ble konfidensintervall kalkulert. For gjennomsnitt standardisert for alder og kjønn ble kovariansanalyse i ANOVA gjort med alder og kjønn som kovariater. Multippel regresjon ble brukt hvor dette var egnet. Ved å bruke faktoranalyse for datareduksjon innenfor sett av observerte data ble knipper av relaterte data identifisert.

I studie II brukte vi fokusgrupper, hvor legene reflekterte over samhandling som tiltak i helsetjenesten. Fokusgrupper er gruppebaserte intervjuer, som er egnet til å stimulere prosesser i og mellom deltagerne. Den spontane interaksjonen som oppstår mellom gruppedeltagerne produserer innsikt som sjelden kan oppnås gjennom andre metoder. Umiddelbart etter hvert fokusgruppe intervju summerte forskerne intervjuene muntlig og skriftlig. Intervjuene ble så transkribert og analysert kvalitativt ved gjentatt lesing og diskusjon av utskrifter, og informasjonen ble gjennomgått, kategorisert og fortolket.

Resultater
Selv om antallet leger i lokal samfunnsmedisin økte fra 505 i 1994 til 555 i 199 (10 %) ble den estimerte totale arbeidstid til samfunnsmedisin redusert med 3.7% fra 8715

timer i 1994 til 8386 timer per uke i 1999. Majoriteten av legene arbeidet i kombinerte posisjoner (87%) og de reduserte sin arbeidstid i samfunnsmedisin med i gjennomsnitt 2.6 timer per uke fra 1994 til 1999. Reduksjonen var avhengig av avlønningsform, hvorvidt de hadde spesialitet i samfunnsmedisin og kommunestørrelse. De reduserte sine oppgaver innenfor administrasjon og ledelse og evaluerte sin ledelseskompetanse heller konservativt og lavere i 1999 enn i 1994. Mange hadde supplerende ledelsesutdanning i tillegg til sin medisinske utdanning og spesialistutdanning. Antall lokale samfunnsmedisinske stillinger økte med 15% fra 1994 til 2002, og kvinner doblet sin representasjon i den samfunnsmedisinske arbeidsstokken. Turnover per år økte fra 9% til 14% fra 1994 til 2002, og andelen vakanser økte fra 1% i 1994 til 6% i 2002. En stabil kjerne av leger var i samfunnsmedisinsk stilling gjennom hele perioden, og utgjorde om lag en tredjedel av alle samfunnsmedisinerne i 2002. Dette er de mest erfarne samfunnsmedisinerne, men de er også de som snart skal erstattes. Yngre leger syntes å forsøke samfunnsmedisinske stillinger men sluttet fort. Spesialitet i samfunnsmedisin syntes å være rekrutterende og stabiliserende. Der var noen signaler på bedre fremtidig stabilitet blant samfunnsmedisinere i 2002 enn tidligere.

Leger hadde ulike oppfatninger om hva som var viktig for å få til god samhandling, varierende med hvilket helsetjenestenivå de arbeidet på. Mens primærlegene vektla tillit, respekt, kjennskap og tilgjengelighet, altså det relasjonelle, vektla lokalsykehusets leger kompetanse, stabilitet og tilgjengelighet, altså kapasitet. Sentralsykehusets leger vektla egen og samarbeidspartneres faglige interesse og tilgjengelighet og formaliserte strukturer, altså mer kapasitet og struktur. Personlig bekjentskap og kontakt skriftlig og muntlig var viktig, men kliniske retningslinjer, individuelle planer, ansvarsgrupper og andre tilrettelegginger var også av betydning for god samhandling. Et uttalt klart og opplevd ”følgeansvar” for pasienten på alle tre nivåer var et uventet funn.

Konklusjon

Lokalt samfunnsmedisinsk arbeid var på stress i den aktuelle perioden. På tross av økt antall stillinger og flere leger i stillingene økte gjennomtrekken i stillingen og stillingene ble fragmentert. Det ble utført mindre samfunnsmedisinsk arbeid, til fordel for klinisk arbeid. Engasjement i administrasjon og ledelse ble tonet ned for samfunnsmedisinerne. Strukturelle reformer I klinisk medisin syntes å bidra til disse endringene, men også prosesser knyttet til reformer i offentlig administrasjon, faglig

utvikling og utviklingen av den medisinske profesjonen er viktige for å forstå funnene i denne studien. Tiltak rettet mot både kapasitets- og kompetansebygging er nødvendige for å bedre situasjonen.

Den gode samhandling er avhengig av personlige og faglige preferanser og av ståsted i helsetjenesten. Kjennskap til og forståelse for disse forskjellene er nødvendig for å utvikle tiltak for bedre samhandling og dialog er nødvendig for finne frem til felles forståelse for mål og tiltak.

2.0 BACKGROUND

Introduction

Public health and public health physicians have a strong foundation in Norway in both a long history of more than 400 years (1-5), and a broad legislation based on public health principles and favourable national economy. The development has been hilly and successful, and over the years both opportunities and challenges have been coped. Representing a crossroad, the year 1984 brought both a comprehensive decentralisation reform (1) and establishment of the specialty in community medicine (6). Both was a consequence of the choice to have both capacity and competence in community medicine out in all municipalities regardless of size, till now considered a strength for health care and public health in Norway.

Still, public health physicians in Norway are facing challenges both in theory and practice. Decentralization reforms have increased the complexity and responsibilities of primary health care services (1-3). The new focus on market-modelled financing and remuneration and on individualisation and on patients' rights indicates need for changes in organisation and new ways of dealing with both professionals and users of health services. Further, epidemics of lifestyle- and communicable diseases, realization of increasing social inequality in health and in access to health care services, the debate on the need to return the focus of epidemiology from individual risk factors to public health matters and to retain the population perspective (7-9), and national goals for interaction in health care (10-11) all call for strong and efficient local public health organisations in good interaction with health services on all levels (12-15). The local public health physician is considered important for the municipalities in mastering these challenges (16) and the workforce is thereby challenged both on capacity, competence, functions and performance (17).

Public health and community medicine – clarifications

Public health, - in Norway rather called community medicine when it relates to the medical profession, is difficult to define and delimit as a professional discipline (18-22), as many occupational groups and political and public administration on all levels have public health as a goal and a remedy for their activities. Public health is therefore considered a broader concept and professional arena than community medicine.

Physicians working in public health in Norway work under the following definition of community medicine: “a scientific discipline; focusing on the state of health for the whole or parts of the population, as on the social and environmental conditions people are living in” (23). A more operational definition is: “Community medicine’s main task is to help the society to make health related decisions. This implies securing that valid and relevant medical knowledge illuminates the political and administrative decision-making process, both locally and nationally” (24). A core set of competence in community medicine is therefore knowledge about the relationship between health and society (24-26) and how this can be used in the society and the population. Both old and new ideas are incorporated, as Vierkows “medicine is a social science, and politics nothing but medicine on a grand scale” (27-28) to new contributors presenting the New Public health (29-34). Community medicine therefore does not fit well into any of the traditional classifications or subdivision of disciplines and professional areas at the universities. It still has its foundation in medical knowledge, in addition to a broad scientific grounding in epidemiology and biostatistics, social science, economy, political science and law (23), including proficiency in different working- and collaboration methods. This constitutes both its strength and many of its challenges.

Community medicine as it appears in Norway has its parallels also internationally and the specialty in community medicine and its development and growth are seen also in other countries (22, 26, 30-32). The professional area is constantly under discussion and change, following changes in the society, - in Norway as in other countries (22, 24, 26-35).

Public health physicians at work

From the early development of health care in Norway some 400 years ago, physicians with interest and competence in public health have actively participated in providing services to the population, in organising and managing health care and research focused on the population and health services (4-5, 25, 37-43). Now we find their successors as employees in central governmental agencies nationally and in the counties, in hospitals and as public health physicians employed in and by municipalities. In this dissertation the last mentioned group is in focus.

A workplace of potential conflicts

Their different activities cover a range of potential tensions and conflicts, also within the medical society. Focusing on groups and environmental issues (23-25, 37), as opposed to the individually oriented clinical medicine, public health physicians are set to serve the society, while other physicians serve the individual patients. Doing this, public health physicians partly share working methods, goals, tasks and education with professionals outside their own profession and in other sectors than health (22, 39), - for example public health nurses, engineers and managers in public administration. From a sociological perspective public health physicians are working in the middle of and with a long list of conflicts between the medical profession and the society: discipline and politics (25, 40), discipline and public administration (43-44), liberal profession – public employment (44), prevention – treatment, leader – governed and public health – individual health. At the same time there are tensions within the medical profession about basic foundation for professional practice; for example loyalty to the profession or to the society, to be a leader or be governed (by whom), management versus medical practice, and differences in how to share knowledge: expelling specialisation or participatory sharing of knowledge.

Public health physicians are therefore challenged in other ways than clinicians. Most of these conflicts take place on the municipality level for the public health physician.

Local public health reformed without public health reforms

Reforms of primary health care in Norway over the last 25 years have affected public health work. The decentralising reform, enacted in 1984, stated that the municipalities, regardless of size, should provide their inhabitants health services including promotion of health and prevention of illness (1). The act required each municipality to appoint a head public health physician. With this reform, conditions of employment, responsibility and authority changed. From being appointed by the state (in a cabinet meeting [statsråd] as an official physician [embedsmann]) and having the fairly powerful position as the chairman of the local board of health, the local public health physician was appointed by the local municipality. He became a part of the public administration in a somewhat unfamiliar position as subordinate or at least with unfamiliar decision-making processes, with regulated relations to the local politicians.

On the other side the reform gave the local public health physicians opportunity to increased responsibility and also partly authority through a new appointment structure and new functions. This represented in the first place increased access to the local administrative and political administration by being entitled to attend meetings in and the power of proposal in important political boards. With supplements to the act in the late 1980s and early 1990s, especially on environmental health practice and organisational matters, but also other legal changes, the entitlements became limited and the position of the head public health physician was redefined from an executive to advisory position (40-41, 45-46). This left the local public health physician more distanced in relation to the public administration, especially the politicians.

Over this period both anecdotal and scientific reports on the situation for the local public health physicians were published. Romøren found, in his study of the five first years after the 1984-reform, that the local public health physicians came less well out of the reform than the general practitioner, with regards to recruitment, adaptation and well-being (47). Change of employer, organisational conflicts and a weak position in the municipality decision-making process were considered the reasons for the considerable problems in adaptation half of a sample of local public health physicians had in 1986.

Over the early 1990s, several stories, statements and presentations were published; reporting conflict of roles, challenges and opportunities in the public health physicians' positions (48-53). In their study, Kolstrup and Sønbø Kristiansen found good and highly prioritised collaboration with local health care personnel, while collaboration with the local public administration and politicians was less well, worse if longer organisational distance between the physician and the administration (46, 54). In a nation-wide survey of the medical profession in the mid 1990s local public health physicians were found to work shorter weeks than other physicians, but together with other physicians they worked 40% more per week than the mean Norwegian and 25% more than other academicians (55-56). As to well-being the public health physicians scored less on job-satisfaction, a little higher on job-stress and professional insecurity and lower on autonomy than general practitioners (57).

A cross-sectional study among local public health physicians in 1994 showed that local public health physicians' service was organised differently, depending on community size, organisation, remuneration model and the physician's personal factors, for example specialisation and time in position (58-59). The local public health physicians worked mainly with environmental health, management and clinical work (60). Having a broad administrative span and a high number of working relations, they seemed to have a central position in local health care. They had limited personnel- and technical resources but job satisfaction was fairly high.

Studies of turnover over up to eight years from mid 1970s to early 1990s showed varying, but ratherhigh turnover rates of 9-20% per year for the years 1974 to 1991 (61-64). The highest rates were found for the period 1985-1987 (62) considered connected to the reform on decentralizing primary health care to the local municipalities (1).

In 2001 the Act on Regular General Practitioner scheme (RGP - list system) was enacted (2-3), a contractual system based on listing and capitation, of importance also to local public health and community medicine (3, 65-66). Listing means that inhabitants/patients are asked to assign themselves to a certain general practitioner, who on his/her side has made a contract with the municipality to offer family medicine services to a certain number of the population. Capitation is a practice allowance paid by the municipality to the general practitioners, depending on the actual number of inhabitants on the list. This was both an organisational, professional and economic reform of family medicine and general practice, motivated by challenges in general practice, related to vacancies, instability, patients complaints especially on accessibility and general professional dissatisfaction in between general practitioners on organisational and economic framework. The reform has been extensively evaluated (67) and coverage, stability among and accessibility to general practitioners are found improved, while there is still doctor shortage in remote and rural areas. The gatekeeper role seems weakened. Local authorities are generally satisfied with the service provided, have low ambitions for controlling the general practitioners, and have few other means of governing than dialogue and collaboration.

The significant changes in organisation following the health care reforms and the complex and challenging work, with signals of vulnerability both on recruitment,

stabilisation, well-being and professional mastering parallel to a national call for local involvement in public health, called for more extensive research on public health physicians perceptions of the situation, their preferences and behaviour.

Interaction in health services

An important goal for government in Norway is to work for improved interaction of health services, both on the same and between the levels of care (10-11, 68-69). This is done multidisciplinary, across organisational and service boarders, and requires both competence and capacity (70). On the local arena the public health physicians are involved in promoting, organising and adjusting interaction horizontally and vertically (11, 15, 23-26).

There are plentiful challenges associated to this, as market-modelled financing and remuneration of health care and new ways of organising public services (NPM) (71-72) including the purchaser–provider split model have been launched also in Norway, both within and between the health care levels. In Norway we have ended up with strongly decentralized and liberalized family medicine, with a strong individualistic character both in content and structure, while the specialist care in hospitals are centralized and nationalized, though with an enterprise model combined with structural coordination over the country and efficiency control. Such new and different financial models represent important potential tensions between the levels. At the same time they are increasingly interdependent. The question in Norway as in other countries is how interaction in a seamless health service system could be performed, what structures and what communication methods would secure patients effective health care and satisfy all participants both professionally and personally (72-79)? Most of the measures executed have been initiated and steered by the hospital level, with little participation from primary health care. With a better understanding of the needs and desires of physicians in primary health care in Norway (80-84) the chances for success with future measures would increase. With this perspective we did a study of the experiences with and attitudes to interaction between health care levels.

3.0 AIMS

The main aims of the present study have been to describe and explore local public health physicians' work and framework over time with respect to:

- work priorities as to total public health work and to different categories of professional activity
- public health management, as to local public health physicians' involvement in management and self-reported managerial competence
- the labour market for public health physicians on municipality level, as to professional and geographical mobility

- and to explore an arena local public health physicians to a great extent are involved in:

- physicians' experiences with and attitudes to interaction between health care levels

4.0 STUDY POPULATION AND METHODS

4.1 Study design

The thesis consists of two studies among primary health physicians, the first one on working conditions in local public health, the second on professional interaction between health care levels.

4.1.1 Study I

The first study is comprised of three cross-sectional surveys based on postal questionnaires among physicians currently working or having worked in local public health medicine in all Norwegian municipalities in 1994, 1999 and 2002. The head public health physicians, the deputies and the physicians working with communicable disease control were included.

Before designing the questionnaire for physicians currently in local public health positions we interviewed six public health physicians and analysed two weeks of self-reported diary of all activities for these physicians. Relying heavily on the inputs from this, the questionnaires contained questions covering demographics, environment (physical, relational, organizational), attitudes and opinions (environment, satisfaction, motivation, tasks, management, future and more) and behaviour; of which this thesis is based mainly on demographic, environment and attitudes/opinions data. Response alternatives were continuous or categorical, with Likert scales up to 5-points.

The questionnaire used in 1994 was more comprehensive than those used in 1999 and 2002, although many questions were phrased exactly the same in all the three questionnaires.

The questionnaires to physicians who had left local public health were practically identical in 1999 and 2002, containing mainly demographic and attitudes/opinions data.

4.1.2. Study II

In the second study physicians working in general practice and at community and regional hospitals were interviewed in focus groups on their conduct to and their experience with professional collaboration between the health care levels.

4.2 Study population

Study I

All physicians working in local public health medicine in all Norwegian municipalities in 1994, 1999 and 2002, and those who left local public health positions between 1994 and 1999 and between 1999 and 2002 were traced from 1994 to 2002. To identify the participants in 1994 we used a national database at Norwegian Institute for Public health (FHI) for physicians responsible for communicable disease control, basically identifying the physicians by designation of post. To do follow-up in 1999 we had to reconstruct the list, using personal names. The confirmation of the names was done with scrupulous appreciation of the registry data, the collected data on each participant from 1994, a biographical encyclopaedia over Norwegian physicians (85) and lists from the Norwegian Medical Association (NMA) over public health physicians combined with a considerable amount of phone calls, to confirm the names.

The FHI database being heavily modified and less suitable for us, we built up the mailing list for the 1999 and 2002 studies by using a corresponding database of the NMA. This database keeps up-dated information on current position and geographical localization of each member. Again, we checked this with information from other sources and also contacted directly up to half of the municipalities to confirm the identification of the public health physicians in positions and those who had left such positions.

In 1994 505, in 1999 555, and in 2002 553 physicians working in local public health were included (there were 510, 574 and 586 positions in 1994, 1999 and 2002 respectively, but five, 19 and 33 positions were permanently vacant). In 1999 we found 172 and in 2002 190 physicians who had quitted working in local public health positions after 1994 and 1999, respectively. All received a postal questionnaire (Appendix A, B and C), with one reminder in all three surveys.

Despite extensive work to identify all those who had been in public health positions, including using their former employer and colleagues we lost some. From 1994 to 1999 13% and from 1999 to 2002 8% were lost to follow-up, i.e. had gone abroad, having become pensioners or were dead. Those who went abroad were considered lost from follow up.

For physicians in a local public health position the response rates in 1994, 1999 and 2002 were 66, 70 and 64%, respectively, and for those who had left the response rates were in 1999 and 2002 were 79 and 68%.

Larger cities (Oslo, Stavanger, Bergen and Trondheim) were included not as municipalities because they were so different in structure from the other municipalities. They were therefore represented by their urban districts, which were more equivalent to other (larger) municipalities. Of the resulting total number of municipalities in Norway (474 in 1994, 481 in 1999 and 480 in 2002) our surveys included 65, 70 and 61%, respectively, with at least one responding public health physician. All three years the smallest municipalities (with up to 1999 inhabitants) were underrepresented.

Study II

The participants in the qualitative study were selected through contact persons in the region they worked and the focus group interviews were performed. The contact persons presented a framework for the study and found as many persons as possible up to 10 on three levels of health care, with some instructions on variety in age, gender, experience and, where applicable, department. The three groups consisted of 15 male and 2 female physicians with 3 months to 28 years pf experience. We used a semi-structured interview guide.

4.3 Supplementary data

Data on the municipalities from Statistics Norway and on each physician from the registry of NMA supplied the collected data (Table 1).

4.4 Methods

4.4.1 Statistical methods Study I

All statistical analyses were performed using the statistical software SPSS for Windows (releases 10.0.5 to 14.0.1, Copyright © SPSS Inc. 1989-2005).

Differences between groups were tested by *t*-statistics for continuous variables; otherwise χ^2-statistics with Yates correction were used. Confidence intervals were calculated from the binomial distribution. Where means were standardised for age and sex, covariance analyses were performed with age and sex as covariates. Multiple regressions were used where appropriate.

Factor analysis was used for data reduction within sets of observed variables, to identify clusters of related items.

4.4.2. Qualitative analysis Study II

We used focus groups, where physicians reflected on integration as a measure in health care. Focus groups are group based interviews, and are suitable for facilitating processes in and between the participants. The spontaneous interaction evolving in between the group members produce insight seldom achieved through other methods (86-87).

Immediately after each focus group interview the researchers summed up the interviews orally and in writing. The interviews were then transcribed and analysed qualitatively through repeated reading and discussion of the transcripts. In this process all information was examined, categorised and construed (86-87).

4.5 Ethical aspects

For study I the Norwegian Data Inspectorate licensed the register of public health physicians (8552). Other ethical aspects were not considered necessary to address, in that the study population consisted of adults, based on informed consent, the information was made anonymous in all presentations and the name and identity number were kept separately.

For study II there were no official ethical or legal requirements, in that there were complete freedom to participate for adults and the information was made anonymous in all presentations.

Table 1. Supplementary data

Data source	Variable name
Statistics Norway	Municipality name
	Municipality number
	Number of inhabitants
	Centralization*
	Population density*
	Main municipality category*
	County name
	County number
	Health region
Norwegian Medical Association	Name
	Date of birth
	Sex
	Address
	Date for acceptance as Medical Doctor
	Date for authorization
	Specialty in community medicine – acceptance day
	Specialty in family medicine – acceptance day
	Other specialties – acceptance day
	Year of death

* Categorized following SSB NOC C192

5.0 MAIN RESULTS

5.1 Paper I *More physicians in public health: Less public health work?*

To study changes in work priorities in local public health medicine in Norway over the period from 1994 to 1999, we studied their estimated average total workload per week and the time spent on different professional activities**.**

Half of the physicians working in public health in 1999 were recruited after 1994. Although the number of physicians working in public health increased from 505 in 1994 to 555 in 1999 (10%) an estimation of the total weekly hours done decreased by 3.7% from 8715 hours in 1994 to 8386 hours in 1999. The vast majority of physicians worked in combined positions (87%), and they reduced their engagement in public health with 2.6 hours on average from 1994 to 1999. The reduction depended on remuneration model, speciality in community medicine and municipality size.

In summary: Local public health in Norway was under pressure in the nineties. For public health physicians, preventive medicine lost for clinical work. No promising signals of change in professional or political framework or in incentives for public health work were seen.

5.2 Paper II *Are public health physicians fading out of management?*

Although public health physicians in Norway increased in number during the 1990s, they worked less with public health, as well as public health management. The effects of these developments on public health management are largely unknown. We studied public health physicians' involvement in management and their self-reported managerial competence.

Public health physicians reduced their administrative tasks and evaluated their own managerial competence rather conservatively and somewhat lower in 1999 than in 1994. Many had supplementary training in management in addition to their medical education and specialty training.

In summary: Public health physicians seemed to be fading out of management. There is a need for development of both public health management training programs and provision of adequate resources for managerial activities.

5.3 Paper III *Changes in contractual systems for clinical care also affect local public health. - A nine years follow-up of physicians' mobility in the public health labour market.*

The number of local public health positions for physicians increased with 15% from 1994 to 2002, and women doubled their presence in the public health work force. The turnover-rate per year increased from 9% to 14% from 1994 to 2002, and the number of vacancies increased from 1% in 1994 to 6% in 2002. There was a stable core of physicians in position the whole period, constituting one third of all local public health physicians in 2002, representing the most experienced but also the oldest physicians soon to be replaced. Younger physicians seemed to try local public health but quitted soon. Specialty in community medicine seemed to be recruiting and stabilising. There were signals of higher future stability between public health physicians in 2002 than earlier.

In summary: Structural reforms in clinical medicine strongly affected the local public health labour market for physicians. The increasing turnover and the escalating fragmentation of public health physicians' work threaten local public health.

5.4 Paper IV *Legers oppfatning av samhandlingen mellom nivåene i helsetjenesten*

[Physicians' experience with and attitudes to interaction between health care levels]. Using interviews in focus groups to collect information we studied physicians' experiences with and attitudes to interaction between health care levels, and their opinions on how this can be improved.

Physicians had different opinions on which characteristics are important to establish a good professional interaction, and their opinions varied according to which health care level they represent. While GPs emphasised confidence, respect, knowledge of each other and accessibility, that is a relational perspective; the local hospital physicians put more emphasis on capacity, i.e. competence, stability and accessibility. Physicians at the central Hospital emphasized capacity and structure, i.e. their own and collaborators' professional interest, accessibility and formalised structures for interactions. A sense of personal knowledge and verbal and written contact was important, but guidelines and treatment plans were also considered to be important for interaction. There was a strong ownership to the individual patient across all three levels, which was an unexpected finding.

In summary: Good interaction seemed to be a balance between the relational perspective, with emphasis on dialogue, structural arrangements, accessibility and continuity and professional competence. In addition, there was a need to clarify responsibilities for each patient.

6.0 GENERAL DISCUSSION

This thesis is based on two different study populations approached with different study methods. Study I was follow-up surveys of local public health physicians from 1994 to 2002, using questionnaires to reveal changes in the organisation, administration and content of their work including their professional and geographical mobility. Study II was an investigation of interaction in health care, - in which public health physicians are involved. Experiences with and attitudes towards professional interaction between physicians on different health care levels were explored, using focus group interviews.

Study I showed that during the study period public health lost for clinical work, in that both for the single public health physician and for the whole country less public health work was performed, especially management but also environmental health. Increasing turnover and fragmentation of the work was a reason, a consequence or a coincidence of just as much concern. Study II showed dissimilar perspectives on interaction and on patient care, depending on which level the physicians were working at and that good interaction seemed to be a balance between the relational perspective, with emphasis on dialogue, structural arrangements, accessibility and continuity and professional competence. In addition, there was a need to clarify responsibilities for each patient.

6.1 Methodological considerations

6.1.1 Study population

6.1.1.1 Study I

For the study on local public health physicians we intended to cover all Norwegian municipalities, including all urban district of the largest cities, - represented with their current public health physicians. The identification procedures were the same in 1994, 1999 and 2002. We used a combination of methods to make sure our address lists were complete, and we think we had a most updated inventory of the personnel at each study point.

We experienced that some physicians were lost to follow-up due to them being foreigners or Norwegians travelling abroad. This may in the future represent an increasing challenge for research on physicians, taking into account the increasing number of foreigners in the crew both in hospitals and in primary health care.

6.1.1.2 Study II

For the study on interaction we relied on local contacts in a geographical area far from our working place. Overall the study was based on self-selection, from a large department in a large hospital, from a small local hospital with three departments and from 3 municipalities. We did not intend a representative sample; the representatives meeting in the focus group were experienced and engaged in interaction in health care. Unfortunately, there was an under-representation of women's perspective.

6.1.2. Response rates

The overall response rates on individual level may seem a little lower than other studies of this kind (46, 88-89). We included all public health physicians in Norway, using no selection criteria as to for example time in position, kind of appointment or characteristics of the municipality, as other studies have used. Physicians being temporarily appointed and/or foreigners may well have refused to participate, due to linguistic problems and lack of interest/dedication. The proportion of temporary appointments was on a noticeable level for the responders, and we think at an even higher level for non-responders, contributing to a lower response rate. On this background we consider the response rates comparable to other studies, and acceptable regarding being representative for public health physicians (90). Also, on the municipality level the response rates of 61-70% mean that we succeeded in including an acceptable number of all municipalities with responding public health physicians, though the smallest municipalities were underrepresented.

The differences in age and sex distribution between responders and non-responders were minor and insignificant, while more of the responders had a speciality in community medicine all three years, more responders had a specialty in family medicine (significant difference only for 1999) and responders in 2002

were older than non-responders. This may represent an information bias in that the specialists and the older may have another practice and views of their situation than non-specialist and younger. The consequences of the selection of municipalities and of individual responders represent a possible conservative estimate and description of public health. Non-responders may have been the most frustrated and most displeased ones.

6.1.3. Reliability and validity

6.1.3.1 Study I

Phrasing of the questionnaires was the same all three years of the study. Few of the key questions in the present articles have been used in other studies, meaning that the reliability and validity has not been measured. We expected our subjects to be familiar with answering questionnaires. Most questions had answering alternatives on 2- to 5-points Likert-scales. Where applicable, we had questions with spaces for supplementary, open comments.

6.1.3.2 Study II

When studying interaction we expected there would be experiences and attitudes difficult to catch by quantitative research methods. We therefore chose focus groups as the research method. A focus group is a group discussion on a specific topic of interest to the researcher. Group based communication is suited for starting and keeping up processes between the participants, producing information and knowledge seldom obtainable through other methods (86-87). The group of participants is guided by a moderator, who introduces topics for discussion and helps the group to participate in a natural and fluent discussion.

We intended a balanced representation of men and women in the groups but did not succeed, because there were few women in positions or they were hindered from participation. Otherwise, the mixture of participants was quite diverse with regards to age, time span since authorisation as physicians and experiences in health care and. Most important: the groups consisted of engaged physicians willing to reveal information, experiences and attitudes, and to contribute to further understanding of interaction and integration in health care.

The moderator was trained and experienced in group communication. All three discussions became lively, and became a rich well of views, opinions and understandings on the topic raised by the researchers. We therefore think we got hold of important information.

The two researchers participated in all groups and in an oral and written first summary of the discussions immediately after the group discussions. The interviews were transcribed and analysed by repeated reading by the individual researcher and finally a joint discussion of the transcriptions, by which the information was categorised and construed until consensus was reached. This secured thorough assessment/evaluation of the transcriptions, and a comprehensive analysis and synthesis of the information.

The three group discussions developed differently. In both hospital based groups, the interviews became processes were the reflections developed through the dialogue. The interview with the primary health care physicians was the least dynamic, with predetermined attitudes which did not change or develop during the interview. This group was also the most heterogeneous and with most antagonisms regarding opinion on and experiences with interaction between health care levels. We think the spontaneous discussions reflected important impacts of differences in continuity and geographical distances between health care professionals. The results could not be valued as generalisations, but revealed some previously less recognized elements in the interaction complex.

6.1.4 Use of registries

On the national level Norway has several official registries with a long history and high quality. With regards to public health there were no complete and updated registries. Our mailing lists were based on a list from the FHI, mainly identifying participants by designation of post. To complete follow-up it was necessary to use personal identification data. This critical transformation was done with scrupulous appreciation of several data sources, as described in the Methods chapter. Though unusual methodologically and extraordinary

demanding, we consider the resulting reconstruction a highly quality assured and necessary base for the rest of the study.
For the 1999 and 2002 studies we used the NMA registry to trace participants. In our opinion, the little delay in up-dating mailing address this registry may experience was by far compensated by using the formerly described data sources and, again, many phone calls directly to the municipalities. We therefore consider the mailing lists very updated and complete for all target groups.
Data on the municipalities from Statistics Norway and on each physician from the registry of NMA supplied the collected data. Statistics Norway is a most prominent, quality assured official data source for both research and administration. The data on each physician in the NMA registry is also considered highly quality assured, as they are based on meticulous report systems on specialisation documentation.

6.1.5 Summary - strengths and weaknesses
The dissertation consists of studies using both quantitative and qualitative research methods. The quantitative study was based upon a comprehensive database of longitudinal data on and from all public health physicians in Norway at three points of time over nine years, with acceptable response rates. Small municipalities were underrepresented and the responders were more often specialists in community medicine than non-responders. This selection could have biased the information towards opinions of more experienced and skilled physicians in positions in larger municipalities, making the results for public health work and management look better. The main results on mobility, however, would not be influenced as they were based on registry data.

The qualitative study was biased towards opinions of male physicians as only a few females participated in the focus groups. For the rest, we consider the results valid as to the variety of views of physicians employed on the different levels of health care in Norway at the time of the study.

6.2 Discussion of main results

6.2.1 Public health work changing (I, II)

From 1994 to 1999 local public health physicians reduced their engagement in public health work with on the average 2.6 hours per week, for the benefit of clinical work. This represented an estimated reduction of 3.7% in total public health work performed nationally. The changes were seen as a reduction in working hours in public health in total, in environmental health and in management, and an increase in clinical work. Parallel to this a reduction in administrative tasks took place, in that a smaller proportion of public health physicians had managerial responsibility and the administrative span for those who kept a managerial position became narrower.

The registration of workload gives input to the definition of the local public health physician [*kommunal samfunnsmedisiner*]. The questionnaire classified work content into nine different categories of professional activities, basically following the definitions in the Act relating to the Municipal Health Services, familiar to primary health care and commonly accepted as mutually exclusive. Because of small numbers in some of the categories we truncated the nine categories into five in the analysis, of which three are considered core public health work, namely environmental health practice, management and other preventive work. Within environmental health practice [*miljørettet helsevern*] control of communicable diseases and health promotion and prevention are included, though the term *communicable diseases control* appears alone more often now, following specific legislation. From this, the local public health physician could therefore be defined as a physician working with environmental health, management and other preventive work, and most often also with clinical medicine. The mixture of these tasks is different in the different municipalities, depending on both characteristics of and preferences in the municipality and the public health physician.

We would have expected increased public health work performed over the period. This because public health challenges increased in Norway as in other countries over these years, as awareness of preventive medicine and environmental health risk factors increased. Both national policy (66, 91-92, 64) and international and

national developmental work (29-33) called for local public health action. This constituted potential opportunities and responsibilities for the local public health physician, whom with necessary competence and possible capacity could utilize the position's many relationships. But this did not take place. The main reason may be that the municipalities did not have a public health policy including a public health workforce policy on how to use the local public health physician. Also in Norway some local multi-professional development went on, for example on involving public health nurses and introducing environmental engineer/consultants and public health coordinators on the broad public health arena. This may have resulted in more public health work done on other arenas and with other methods than the physicians could do. On the other side, immature multi-professional development may also have given ambivalence towards physicians not familiar with new goals and working methods, resulting in less involvement of the physicians, that is maybe to opposite of what was intended.

The decrease in time spent on public health could also be due to more aid from new technology or more secretarial assistance. Unpublished data from our studies indicate a reduction in secretarial services for the public health physician from 87% in 1994 to 77% in 1999. Likewise, in 1994 56% and in 1999 44% of the physicians reported having enough such services.
Few, if any, suitable computer programs were introduced or came into use in local public health until 1999, which was far later than in clinical medicine. The actual use and potential of internet resources for local public health physicians in Norway have been studied, showing that both perceived need for, access to, actual use of and perceived value of scientific databases/evidence were low (93-97). We therefore argue that the decrease was not related to increased secretarial support or technical accommodations.

Another explanation for the reductions may be related to the tendency, as in other countries to redefine the public health physicians' authority from executive to advisory (98-100). This tendency started in the eighties. Studies of political and public administrative processes in the 1800 and 1900s showed that the importance of the medical profession in the national health administration and in politics, i.e. the early public health physicians, was continuously reduced from a relatively

prominent position, though under considerable resistance (25, 40-42). A sociological study of health reforms in the 1980s and the 1990s concluded that also locally the dominance of the medical profession was de-emphasized, parallel with an increased integration of local health services in the remaining welfare services (43). Specifically, Romøren found the position for the public health physicians weakened following the 1982-reform (47). This development may have reduced the need for some managerial working hours, especially for human resources management.

On the other hand, modern public health also in Norway requires more health systems leadership, collaborative actions, multidisciplinary approaches, health policy development and partnership building (101-104). Holding an advisory position would presumably imply just as much such processes and use of time as in a line position.

Related to these factors were some indications of problems in the working environment, with consequences for use of working hours. Data on reasons to quit (100) indicated that for public health physicians conflicts in the relationship to the public administration and the politicians were important at least for the decision to quit, as also discussed by Romøren (47). Public health work in Norway may also be considered exceptionally demanding, because of small municipalities and weak networks between local public health physicians and centrally placed public health professionals. Lack of working methods, often invisible effects of involvement and action in such settings and the tension towards family medicine and general practice as discussed later, corresponds to less appreciated professional progress than in clinical medicine. This represents a vicious circle for physicians in public health, leading to further diminishing professional self-esteem, motivation and engagement, and to an inclination towards clinical medicine.

The vast majority of public health physicians worked both in public health and clinical medicine, meaning that they experienced what has been described as the tensions and the antipathies between public health and medicine (104). This may put strain on work management and time planning, but even more professional

strain because they represent two distinct scientific areas with disparate goals and working methods, requiring considerable professional updating (105). A part-time position in public health may, in this framework, have been easier to reduce or divide into even smaller positions than a full-time position.

In Norway, the combined position between public health and clinical medicine has been heavily discussed and mainly advocated by most participants (51, 53, 106-108), arguing for legitimacy and synergy effects in front of the single patient, the population as a whole, general practitioners, other health professionals and the other community authorities and for too few public health physicians tasks in the many small municipalities. The combined positions have also been defended with referral to the consequences of decentralization of health care with strong, locally well organised municipalities with low demand for the public health physician in management; economic constraints and recruitment and stabilization problems related to prevailing professional preferences. The physicians' role with the immediate contact to and responses from patients is also fulfilled in this mixture, of importance to many physicians. The inherent negative and self-fulfilling consequences of the combination model related to the basic professional tensions represented in the combination (104-105) and the challenging and maybe ambivalent dual professional development have been less in focus. Also, the troublesome presence in public health due to the time/presence-requirements in clinical medicine and organisational imbalance and tension if the combination is performed as a public officers on a fixed salary and as a clinician in liberalised general practice have been under-communicated. This may have closed for more comprehensive, sound measures.

In this perspective, it is understandable that the heavy and increasing demand for clinical services in primary health care over a long period (2, 110) may have influenced the balance between public health work and general practice for the public health physicians. The population's and the authorities' demand for more clinical work together with better economic incentives for that kind of work (as explained later), may have led physicians to give priority to clinical work at the expense of public health work.

Physicians' public health work has always been fixed salaried. General practice has been paid either by fee-for-service or fixed salary; the latter increasingly used some years after 1984 but waning from the mid 1990s. Public health physicians therefore had a dual professional position and possibly a dual remuneration model if they were involved in clinical work (in 1994 70% and in 1999 45% had a fixed salary for their clinical work). Up to 1984 the wages for public health physicians were considered favourable compared to the wages for physicians in general practice. From 1984 to 1999 this changed, in that the economic incentives for clinical work became increasingly better than for public health work (111). Especially, the study period was marked by the preliminary, introductory and finally, the implementing phases of the RGP – list reform (3), which is to be considered a profound liberalisation reform of clinical medicine outside hospitals. This focused the increased demand for physicians' clinical services, discontinuity in general practices and patients rights and represented more favourable economic conditions than in public health positions. For clinicians the fee-for-service system and other components of their income by far exceeded the salary for public health physicians and the fixed salary for clinical work. For the municipalities the economic incentives worked the same way; both through the fee-for-service system and by other reimbursements clinical work was to a much greater extent financed by the state than was public health work, especially if the clinical work was fee-for-service paid. Full-time positions in public health got no economic incentives from the state level, while the combined positions did. This may have brought about a strong motivation towards liberalised clinical work and fragmentation of the positions. The alluring economic force of clinical medicine became so strong that it was difficult for all partners to keep a focus on public health.

Public health physicians having specialty in community medicine worked significantly more in public health and reduced it less over the study-period than non-specialists. Specialization apparently restrained some of the forces towards reduction in public health work, which would be as anticipated, in that specialization ought to represent a higher degree of devotion to the speciality area. Of great concern is that after 1999 up till lately, the specialisation rate has been

very low, - meaning that the potential of this force will be less over the years to come.

For physicians working in smaller municipalities, public health was a minor task, following expected patterns in the size of public health problems and amount of public health tasks. Smaller municipalities usually have fewer physicians to cover all physician tasks, which could contribute to giving clinical tasks priority. Fewer specialists in community medicine in smaller municipalities may also have contributed to the tendency towards lower levels of public health work in these municipalities. However, the major changes from 1994 to 1999 were seen in the larger municipalities, where especially management work was reduced. Contributing to this reduction per individual was a higher number of public health physicians in these municipalities. They were involved in environmental and other public health work, to a lesser degree in management. These municipalities had obviously divided their positions for public health physicians into smaller positions even so that following a rough estimate, the total amount of public health work done were less in 1999 than in 1994.

A decreasing proportion of public health physicians had managerial responsibility. This reflected that management supposedly was kept by almost the same number of physicians as earlier, though there were an increased number of public health physicians. Avoiding fragmentation by keeping management on one hand was considered important to secure continuity.

The reduction in working hours in management and administrative span is though of considerable importance. This may reflect an ambivalent relationship between public health medicine and management (22, 113). It could also be related to the tendency to redefine the public health physicians' authority from executive to advisory, as discussed earlier (98-100). As mentioned previously, there were no indications of more secretarial assistance or new technology support making the management processes more effective.

From the perspective of sociology of professions these results are important. The theoretical perspective "professional project" (by Freidson and Larson, as

explained by Evans (22) has its key characteristics in “autonomy”, that is the profession’s ability to control its technical knowledge and application, and “dominance”, which is control over the work of others in the health care division of labour. In Norway, the medical profession still has a high level of autonomy although the public health physicians less (57). This may be related to the inter- and multidisciplinary character public health has developed, and also the more indirect working methods, leaving the final decision on actions to the inhabitant himself, other administrators or politicians. As described earlier, public health physicians’ position has been profoundly weakened over many years of political and administrative processes. By reduced presence in management, dominance is further reduced. It is a question whether this is understood, intended and/or a preferred development of the profession.

The mixture of services managed changed. The majority was responsible for a core set of services: general practitioners, environmental health, physiotherapy and public health nurses. But fewer public health physicians managed environmental health in 1999 than in 1994. This service also had the highest reduction in working hours. Environmental health may have become considered an integrated part of other services, or constituted so little work that the responders did not consider it a specific management area. Both explanations give rise to just as much concern as the fact itself.

The administrative span both years comprised services and departments focusing clinical medicine and individuals. This supports the notion that public health management was more health services management than actual public health management or health of populations’ management: public health lose to clinical medicine (15, 100, 114).

Still, between one-fourth and one-fifth of public health physicians’ working hours were spent in management, and still with a broad administrative span. This expresses that the municipalities still used the public health physician for important management tasks.

6.2.2 More positions and higher turnover (I, III)

The number of local public health positions for physicians increased with 15% from 1994 to 2002, the increase mainly found among the middle- to larger sized municipalities (5000-49999 inhabitants). The proportion of women increased, and there was a stable core of 200 physicians staying in their positions both in 1994, 1999 and 2002. There was an increased turnover over the study period, and the number of vacancies increased. Together this represents marked structural changes and challenges for local public health and community medicine.

The marked increase in number of positions for local public health physicians from 1994 to 1999, with a minor further increase to 2002, was higher than the number of included municipalities and urban districts. Some of these positions may be considered a result of the bigger cities completing their reforms on division into urban districts. A new law in 1994 on control of communicable diseases resulted also in some part-time positions or increased responsibility and duties for the public health physician. We have not been able to quantify the exact significance of these two changes as to the number of positions.

The increase could also have been a result of a deliberate policy, to establish recruitment positions or strengthen public health services. However, there was no support for any of these hypotheses, in that more of the positions became combined positions between public health and general practice, the public health content of the positions became less and the resulting total public health work reduced. This arrangement of the positions corresponds to limited responsibility (for example smaller administrative span), fitting better to clinical positions as general practitioners. With increasing turnover and vacancy this strategy may have become necessary for the municipalities, to cover a minimum of their obligatory public health duties.

As discussed earlier, the increasing demand for clinical work and the economic favourable conditions for clinical medicine, both for the single physicians and the municipalities, may have led to size reduction and/or splitting of the public health positions into smaller and more positions. We believe that the most important reason for the increase in number of positions was this inclination towards clinical

medicine both for the physicians and the municipalities. For the physicians this was presented as reductions in working hours and less comprehensive public health positions or as leaving local public health, for the benefit of clinical medicine. For the municipalities this was presented as a reconstruction of the positions into more, smaller positions which suited public health physicians already on site or could tempt new applicants for vacant positions.
Some of the physicians may have reduced their working hours as they approached retirement age.

More positions, though smaller, may be considered advantageous in that more physicians would represent more competence and opportunities to professional concentration on smaller areas within the broad spectre the public health physicians often work. This could be both stabilizing and recruiting and could stimulate to more, competent work. Our study did not indicate this in that the turnover rates increased over the period with increased number of positions. Also the total public health work produced was less. It might be so that the result of more positions shows up later; - maybe some of the positions were covered by, at that time, less productive physicians in training positions, preparing to take more of the responsibility and production at a later point of time.

More and smaller positions may, on the other side, represent discontinuity, fragmentation and less effectiveness. A person in a small, part-time position would supposedly gain less insight into the ongoing business, with lower chance to keep up overall responsibility and be present in ongoing processes. Evasive actions may also develop. The need for coordination and communication increases, with both other public health physicians and with the rest of the municipality administration. But this would also mean less time for active, independent work.

Norwegian municipalities are rather small, though with almost the same professional expectations to the local public health physician as in larger municipalities, besides probably less frequent and smaller sized challenges. The opportunities to establish more, smaller public health positions in such small

municipalities are considered less and the resulting quality of work could soon be questioned.

Turnover is a complex phenomenon, related to both structural and personal factors. Former studies on turnover for local public health physicians have shown fairly high rates, with some increase considered connected to a specific health care reform in 1984. We found high, increasing rates over the study period, considered related to the formerly discussed RGP list reform, announced several years before, but implemented in 2001. This reform resulted in more positions for general practitioners, with favourable economic conditions. Before the reform, public health physicians, - most of whom were part-time general practitioners, may have made professional and geographic adjustments to the coming reform, ending up in economically more favourable clinical positions. This corresponds to our finding that physicians who left local public health mostly went to clinical positions at municipality level.

Reported career plans indicating turnover rates within one year from 1994 of about 25% and within one year from 1999 of about 29%, did not come true. This, together with the reported plans for longer run gives positive signals for stability after 2002. Still, it is a question whether the consequences of the high turnover over three years became balanced by possibly higher stability later on.

The high turnover rate could be interpreted that physicians decided to quit after a shorter period in position, that younger physicians tested local public health positions, - and found it not worth proceeding in. The early phases of an appointment might be crucial for continuation. In Norway, introductory classes for newcomers have been offered infrequently nationally, while on-job training programs have not been developed. Obstacles to development and institutionalisation of such offers may be connected to the decentralization of also public health, where the municipalities are working on their own, with little organisational and professional networking. Under such circumstances quitting becomes more likely.

As discussed earlier, the public health positions may be experienced as too difficult to manage as to the role, status and duties (47, 115), resulting in high turnover, though we do not have data showing increased burden from this from 1999 to 2002.

Having a specialty in community medicine seemed to represent both higher probabilities for staying longer and for working more with public health issues. Unfortunately, besides professional satisfaction and adaptation following specialisation, little profit followed specialisation in community medicine and few other stimuli were introduced into this training over the study period, - contrary to the specialty in family medicine. This may explain why more public health physician had a specialty in family medicine than in community medicine, - both among the stable ones and among the newcomers.

There was an increase in the proportion of elderly physicians in local public health, with increasing mean age and about a third of the population of local public health physicians in 2002 having been in such position at least since 1994, some up to more than 36 years. Representing admirable seniority and an important base for training of new physicians, they also may have become a block for new physicians, unless the municipalities rearranged the positions as a part of a public health policy, aiming at strengthening public health work and workforce.

6.2.3 A profession on stress (I, II and III)

The findings in this study indicated that local public health physicians were on stress before and just after the turn of the century, with less work performed, the professional and organisational position under pressure and increased turnover.

In addition to the factors discussed previously, the findings could be interpreted and inferred by using theories and conceptual approaches from sociology of the professions and social and political science. This requires certain explanatory passages, but will put the empiric data into a broader perspective.

In addition to Freidson's "professional project" with its key concept "autonomy", mentioned earlier, sociology of the professions encompass also theories and

concepts on how the profession is built and defended, with relevance for the current study.

Professions seek stability of their position and their privileges, through strategies on exclusiveness on tasks and positions and on control over performance. The professions are regulated by external, often governmental measures and by internal measures. The kind and strength of these regulatory mechanisms change over time, trying to fit, compensate or even counteract each other, to keep a certain balance in the professions and between the professions and the external participants. Freidson has given important contribution to the understanding of regulation of the professions (116, 117). Traditionally, he said, the professions were protected from economic and political pressures, to ensure sufficient security for professions to work ethically and competently. Through exclusive licensing and certification of individual professionals, and accreditation or licensing of training institutions, the professions would be willing and able themselves to regulate the performance of their members. According to Freidson, these self-regulatory methods have changed, being replaced by new methods intended to impose stronger external controls, to better control the cost of services and performance of practitioners. He mentioned three forms of regulation, of which two are considered relevant for public health physicians in Norway.

He claimed that there has been a massive increase in *"bureaucratic regulation"* characterised by a proliferation of record-keeping requirements and the development of systematic methods for reviewing those records. These records and forms are in their simplest form used for billing services, but are also the foundation of a bureaucratic system for in between others supervision and review of claims and inappropriate decision-making. This kind of regulation could also be seen in Norwegian medicine and public health, both in medical practice and in the specialty training programs, called both quality assurance activity and documentation requirements.

"Mandated collegial regulation", or peer review, is a more common method of regulation for professions, Freidson said. This is a more active and formal role in regulating the members' affairs, where members are to review each others

decisions, and also to participate in making standards. Part of this are rules for "informers" (or "whistle-blowers"), which prominence differs between countries, requiring members to bring to the attention of the authorities the errant performance of colleagues. Examples from Norwegian medicine and public health practice are clinical guidelines or procedures for interaction and other practice.

Two interpretations have been made on how such regulatory mechanisms may influence the professions' status, working conditions and career patterns for their members. One is relatively modest, seeing a decline in the distinctiveness of the professions as a special kind of occupation. This is the trend toward *deprofessionalization* (118), hypothesising a continued progressive loss of the special characteristics of professions, including an erosion of the knowledge monopoly, a decline in trust in professional decisions and diminution of professional power and authority over clients, resulting in the professions becoming merely technical specialties. The other is more dramatic, seeing the professions joining other occupations in the process of *proletarianization* (119). This involves loss of control over the professions criteria for entrance, content of training and autonomy regarding the terms and content of work, the clients served, tools and means of labour and amount and rate of remuneration. By this all forms of labour drift down into the ranks of the working class, exploited by and in the opposition to the interest of the capital.

The multi-professional character of the broad public health work, the difficulties in establishing a specific knowledge and practice base for public health physicians and the withdrawal or removal of public health physicians form certain positions could be considered signs of such a development. Being aware of such an alternative understanding of the development the professional community may be prepared to bring forward specific measures.

Maybe rather comforting is Freidson's evaluation of these two interpretations of the consequences of the regulatory mechanisms (116). He rejects them; suggesting that while the essential corporate autonomy of professions is not being affected by regulatory activities, traditionally "free" professions like law; medicine and dentistry are being reorganized into a formal system of

stratification. Consequently, a formal professional elite is being created that develops standards enforced to govern the performance of the rank-and-file professional worker.

Traditionally, professions have kept the privileges to define and regulate the performance of their members, and exclude non-members from a certain set of procedures/tasks. Foucalts concept of *governmentality* sheds light on the consequences of central policies on the organization and influencing the content of local public health physicians' work. It is defined (as explained by Evans (22)) as all procedures, techniques, mechanisms, institutions and knowledge that empower political programs. Professions develop as parts of a process of governmentality, which is they are part of the apparatus that constitute the state. Autonomy as a function of governmentality requires re-negotiation and re-establishment, state formation and professionalisation is in a symbiotic relationship. Socio-political processes challenges medical expertise and performance and the medical profession reacts or adjusts to this. For local public health an example of this would be Ministry of Health's repeated interest in and description of the challenging and even critical situation for local public health physicians, on one side supportive in that they wanted the specialty in community medicine both established and strengthened, but often without any significant measures (91-92, 120). Complicating in the evaluation of such processes in Norway is that the municipalities are quite autonomous in relation to the state as regards local public health physicians, so the mechanisms could be considered punctured by lower level government.

Another concept of interest for understanding how public health work develops is *manipulated emergence* (Harrison and Wood, as explained by Evans (22)), the centre (state) decides the broad brush of policy, and then leaves it to local participants to make it work. If and when apparently good models develop, the centre will take these up and disseminate them. Within the public health field this would for example suggest that once there are high-quality training schemes or working methods established, policy will be consolidated and these models more widely disseminated. Manipulated emergence illustrates how one can view the extensive financing of health promotion and preventive projects over a long time,

aiming at developing new working methods and collaborations locally, for later broader implementation, with expected follow-up of local personnel, including public health physicians. These processes may go, and have done so, fairly independent of the professional bodies.

Also organization and management theories are relevant. Of the many relevant only the concept New public management (NPM) is mentioned specifically here (70). This concept is used by both practitioners and researchers about a set of changes in public administration over some 20 years, in which economic theory is used in market-modelled financing and remuneration and public administration is modelled and managed following principles from private sector, as a means of containing costs and improving performance through the principles of competition and markets. This has been studied in a project by Solli (121) and considered relevant to understand changes in primary health care following the RGP - list system. He classified different services in primary health care affected by the RCP – list system, according to their load of NPM-elements. Then he compared what priority these services were considered given at the introduction of the RCP-system and one year later. He concluded that services with more explicit NPM-characteristics, for example diagnostics and treatment, had higher priority than preventive services. This may indicate that clinical medicine, for which NPM principles are more easily applied, will be prioritised as long as the paradigm for development of health care is based on market-style features. Norway has been considered reluctant/slow in introducing NPM (122), maybe based on the growing critic of the concept and principles, based on evolving evidence of its inability to cope with the current health-care needs and chronic and preventable morbidities (123-126). As for local public health physicians it is a question whether NPM have expelled them and their work, and whether this was intended or could be reversed through another paradigm for primary health care services.

6.2.4 Dissimilar perspectives on interaction, a challenge for local public health physicians (IV)

Working for quality development and assurance, to secure good services for the population and professional development in health services, public health physicians are involved in many interaction initiatives between services in the municipalities and between municipality services and partners outside the municipality. For many public health physicians the general practitioners relationships are especially in focus. In article IV we showed that attitudes and experiences with interaction were depending on what health care level physicians were working; meaning that interaction was not considered the same on all levels. A resent evaluation report on how municipalities govern the local medical services after the introduction of the RGP list reform (16) showed that the local public health physician, in the managing role, acts as a "translator" between authorities and the RGPs. We believe this "translator"-role is used also in relationship to the other services in the municipalities and other health care levels, - of importance to improve quality and secure a seamless health care (122).

We asked the participants in the focus groups to discuss the concept interaction. All considered it being something like "working together with others", - often from other occupational groups than physicians and through formalised structures, with clarification of responsibility and appreciation of each others function in relationship to the patients. But they had differing opinions on which characteristics were important to establish good professional interaction and emphasised them differently.

Physicians in primary care emphasised *a relational perspective*. They have an autonomous position, financially, organisationally and professionally. At the same time important in relationship to the rest of health care, they are vulnerable: standing alone without an organisation/institution behind while working with large organisations with different thresholds, "rules of the game" and cultures for professional interaction. This requires good and direct relationships to collaborators, especially to colleagues in hospitals. In a study on how to reduce hospitalisation rates in Lofoten primary care physicians emphasised a relational

perspective, as opposed to the hospital administration who gave increased capacity higher priority (127).

For the local hospital interaction with primary care physicians in the host municipality were described as better than with those from municipalities farther away, depending on differences in continuity and knowledge of each other.
The local hospitals' are in an intermediate position in the health care hierarchy, traditionally ensuring health services for a certain geographical area, representing professional breadth/broadness and partly depth – as a buffer in the system (81, 127). In spite of structural reforms and professional development, the local hospitals still receive patients both from primary care and higher level health care, regulating its operations according to pressure from both sides. The local hospital physicians described the hospital as an extension of primary care. In relation to interaction it is therefore understandable to emphasise *capacity*.
It is also demanding on capacity to keep up the generalist competence on this level. The physicians considered themselves to have top competence in some areas, but expressed it difficult to be acknowledged for this both in relation to primary health care and higher level health care.

The central Hospital physicians emphasised *capacity and structure.* They represent highly specialised medicine, directed at diagnostics and treatment within defined professional areas. They seemed to cooperate best with an identifiable structure which could simplify communication and give foreseeable contact and response.

The differences between the three levels of health care could therefore be understood in a number of ways, but it seems as if the physicians in primary care and the local hospital emphasised the single physicians' competence and behaviour, while in the central Hospital formalised structure for interaction was focused, in addition to competence. The examples of good interaction were described connected to organised arenas or structures, rooted in management and other professions than the medical profession, and with duties beyond the single physicians'. This is in accordance with other studies (72, 129) and could be understood at a consequence of loose bonds between health care levels (130). On

the other side, stable and good personal relations seemed to compensate partly for lack of structural arrangements, especially important for primary health care physicians to experience good interaction.

These results may not be surprising, but may have been under-communicated and not acknowledged when defining goals and designing measures.

Surprisingly, physicians at all three levels seemed to express a desire to be person in charge for patient management. This was surprising because a central goal in health policy in Norway has been to keep up the system of compulsory physicians' referral and render services close to the patient, with the primary care physician as the coordinator in the interaction for their patients (11). With the new enterprise model for hospitals, the primary care physicians have an important purchaser-provider-function, at the same time there is often an order to him/her on certain duties to perform. There was no consciousness to this purchaser-provider system in the interaction described. As this is important as a basic principle for health care today, it seems important to clarify this in the ongoing businesses.

7.0 CONCLUDING REMARKS

This study on some aspects of everyday life in local public health depict mainly the tasks of the public health physician, but also the complex connections between him or her and the rest of health care locally and regionally. The results have practical implications, but do also pinpoint the need for further research.

The findings in paper I, II and III indicate that structural reforms in clinical medicine outside hospitals strongly affect the public health labour market for physicians. Both the profession's, the population's and the municipalities' inclination towards clinical practice have been strong. Though increasing need for strong and effective local public health organisations and professionals in the 1990s, physicians' local public health work has been threatened and even undermined. With the local public health physicians' pivotal position in many municipalities and their share as participants in many processes in modern public health and primary health care, there is an obvious need for considerate action to refresh both the workforce and the work. To do this, government, the medical society, professional bodies, local municipalities and research institutions have to take their share of courageous actions.

A comprehensive policy for local public health should be worked out (131), including how to develop and use a multidisciplinary public health workforce; taking into account the complex role the public health physician has in public health and in primary health care. All incentives working for high level employees on municipality level should be considered thoroughly, balancing economic, social and professional incentives (132-133). Promising initiatives have been taken over the last few years (35; 134), though the political involvement and responsibility for this is limited.
From this study some specific remarks for this process could be summarized:

- public health work is done under meagre conditions in many municipalities, indicating a need of change in both organizational structure and of professional support for the public health physicians

- the situation seems critical and both capacity and competence need to be increased soon
- as regards economic incentives it is important to realize that public health work seems to have few components suitable for liberalization
- local public health and health care require managerial expertise in public health, linked to medical knowledge and experience, also in a local context (135-136); and requires capacity and competence

Study II gives access to some of the underlying forces in interaction; describing how interaction is experienced and viewed differently depending on what place of work the physician was in. This represents challenges only possible to amend through dialogue based on mutual acknowledgement of each other as equivalently necessary for a good interaction experience and effective patient care. Considerate and engaged management on all health care levels is indispensably obligated, allocating time and arena for dialogue. Governmental level has to decide to what degree the purchaser-divider-split is a goal and a measure in health care, and with what consequences.

With a decentralised responsibility for running health care in the municipalities, and with heavy reforms both in health care and public administration the results may be difficult to foresee. This thesis uncovers just a few parts of a complex and exciting health care and further research is needed to understand and be able to adjust the course of action. Public health performance, the strong relationship between community and family medicine, the intricate relationship between public health and management, the multidisciplinary dimension of public health and the way incentives work in local health care would be important to scientifically extend the understanding of.

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Appendix A

Løpenummer: □□□□

Søkelys på samfunnsmedisinen

Bli med i trekning om kr 3 000 i programvarer til datamaskin
- fyll ut og send inn skjemaet i dag!

Angi svar ved å sette ring rundt **ett** tall på hvert spørsmål, slik: (3),
eller ved å sette et tall i **en** eller flere ruter, slik: [4] [2]

De som arbeider i en bydel skal svare ut fra **bydelen** der det i spørsmålene står "kommunen/bydelen"

FOLKEHELSA
Statens Institutt for Folkehelse
Seksjon for Helsetjenesteforskning
Geitmyrsveien 75, 0462 Oslo

1994

Først ønsker vi en del opplysninger om deg selv og stillingen din

1 Angi kjønn og alder her:
Jeg er 1 Mann 2 Kvinne Alder: ☐☐ år

2 Når tok du medisinsk embetseksamen? ☐☐☐☐

3 Hvilke spesialiteter eller grenspesialiteter har du?
1 Allmennmedisinsk spesialitet
2 Samfunnsmedisinsk spesialitet
3 Annen, beskriv .....

4 Hvilke av følgende tilleggsutdannelser har du? *(Sett evt. ring rundt flere)*
1 Kommunelege-/Bygdøykurset
2 Folkehelseutdanningen/Master of Health Administration
3 Master of Public Health
4 Distriktshøyskole-utdannelse, beskriv .....
5 Annet, beskriv .....
6 Ingen

5 Hva er din nåværende stillingsbetegnelse?
(for eksempel komm.lege I/med.fagl.ansvarlig/rådgivende lege, helsesjef/komm.lege I)
.....

6 Hvor lenge har du hatt nåværende stilling:
(angi antall år hel eller deltid) ☐☐ år ☐☐ mnd

7 Hva slags ansettelsesform har du i kommunen/bydelen?
1 Fast ansettelse
2 Midlertidig/tidsbegrenset ansettelse
3 Konstituert
4 Annet, beskriv .....
5 Vet ikke

8 Hvilken kommune/bydel arbeider du i nå?
.....(navn) (kommunenummer) ☐☐☐☐

9 Hvor lenge har du totalt arbeidet innenfor følgende typer virksomhet?
(Angi antall år. Vi er interessert i hovedkategorier av arbeidslivserfaring)

	Antall år: heltid	deltid
1 Distriktslegetjeneste før 1984	.....	.....
2 - derav med verv som helserådsordfører el. tilsv.	.....	.....
3 Kommunal allmenn legetjeneste	.....	.....
4 - derav som samfunnsmedisiner	.....	.....
5 Allmennlegetjeneste for øvrig (på normaltariff)	.....	.....
6 Bedriftshelsetjeneste	.....	.....
7 Sykehustjeneste	.....	.....
8 Forskning/undervisning	.....	.....
9 Administrasjon utover som kommunelege I/ helsesjef - beskriv	.....	.....
10 Fylkeskommunal/statlig virksomhet, f.eks. fylkeslege/Statens Helsetilsyn - beskriv	.....	.....
11 Privat firma eller foretak, - beskriv	.....	.....
12 Annet, beskriv	.....	.....

Her kommer noen spørsmål om din arbeidsbelastning. Spørsmålene skal besvares ut fra en skjønnsmessig vurdering av gjennomsnittlig belastning over noe tid

10 Hvor lang er din fastlagte arbeidstid i timer per uke i hovedstilling? *(Timer på tjenesteplanen. Ta med antall timer for alle delene av en eventuell kombinasjonsstilling)*

☐☐,☐ Timer per uke

11 Dersom du har såkalt kombinasjonsstilling, hvor mange timer per uke fastlønn og privatpraksis har du?

☐☐,☐ Timer per uke fastlønn

☐☐,☐ Timer per uke privatpraksis avtale

12 Hvor mange timer overtid (dvs. timer som må til for å få gjort det som skal gjøres i jobben) har du i gjennomsnitt i din hovedstilling i en vanlig arbeidsuke? *(Ikke forlenget arbeidstid eller utrykning på vakt, kun tilfeldig overtid)*

☐☐,☐ Timer per uke

Hvis du har sterkt varierende arbeidstid per uke, før opp et anslag for gjennomsnittlig arbeidstid og kryss av her:

☐ Sterkt varierende arbeidstid

13 Hvor mange timer primærvakt, dvs. vakter der du har direkte pasientansvar uten noen annen lege i forvakt, har du i en normal måned? *(Regn løpende timer, se bort fra omregningsfaktorer)*

☐☐☐ Timer per måned

14 Angi etter beste skjønn hvor mye tid du bruker til arbeid med følgende deltjenester *(oppgi antall timer per uke)*

1 Miljørettet helsevern (definert bredt)	☐☐ Timer
2 Administrasjon/ledelse	☐☐ Timer
3 Kurativ praksis	☐☐ Timer
4 Helsestasjon	☐☐ Timer
5 Skolehelsetjeneste	☐☐ Timer
6 Syke/aldershjem	☐☐ Timer
7 Bedriftshelsetjeneste	☐☐ Timer
8 Annet forebyggende arbeid	☐☐ Timer
9 Annet arbeid (undervisning, forskning, militærlege etc.)	☐☐ Timer
10 Legevaktarbeid (beredskap)	☐☐ Timer

Vi vil gjerne vite noe om rammene for stillingen din

15 Hvilke av følgende deltjenester har du budsjett- og personalansvar for? (Sett ring rundt tallet, evt. for flere)

1 Allmennlegetjeneste
2 Fysioterapi
3 Hjemmebasert omsorg
4 Helsesøstertjeneste
5 Jordmortjeneste
6 Ergoterapi
7 Miljørettet helsevern
8 Avdeling for forebyggende arbeid
9 Bedriftshelsetjeneste
10 Næringsmiddelkontroll
11 Annet, beskriv: .....

16 Hvem har budsjett- og personalansvar for helsetjenesten i kommunen/bydelen?

1 Helse- og sosialsjef
2 Helsesjef
3 Kommunelege I
4 Bydelsoverlege
5 Administrasjonssjef (for helse- og sosial)
6 Kommunaldirektør for helse og sosial
7 Andre, beskriv: .....

17 Personellressurser tilgjengelig for samfunnsmedisinere varierer, både i type og antall. Angi i felt A hvorvidt du har stillingshjemler for følgende typer personell, i felt B angir du hvorvidt du synes du har for lite, nok eller for mye av de enkelte typene personell. Du bes altså svare både i felt A og B, uansett.

	A		B		
	Har	Har ikke	For lite	Nok	For mye
1 Teknisk-hygienisk personell	1	2	3	4	5
2 Helsesøster	1	2	3	4	5
3 Annet helsefaglig personell	1	2	3	4	5
4 Veterinær	1	2	3	4	5
5 Sekretærhjelp	1	2	3	4	5
6 Annet, beskriv					

18 Hva av følgende utstyr disponerer du for ditt daglige arbeid i kommunen/bydelen? (Sett ring rundt tallet, evt. for flere)

1 Inneklimakoffert
2 Støymåler
3 Eget laboratorium
4 Laboratorium utenfor kommunen/bydelen
5 Fotoapparat
6 Undervisningsutstyr (overhead, eget undervisningsrom, flipover etc.)
7 EDB-utstyr med programvare
8 Annet, beskriv .....

19 Har du fast stedfortreder i din samfunnsmedisinske stilling?

1 Ja 2 Nei 3 Vet ikke

20 Har du stillingsinstruks for jobben din og når ble den eventuelt vedtatt?

1 Ja, vedtatt for mer enn 5 år siden
2 Ja, vedtatt for mindre enn 5 år siden
3 Nei
4 Vet ikke

21 Er det i din avdeling utarbeidet klare mål, retningslinjer eller regler for hvilke resultater dere skal oppnå overfor pasienter og andre brukere? (F.eks. saksbehandlingstid, ventetid før behandling, tilgjengelighet)

1 Ja
2 Nei. Gå til spørsmål 23
3 Vet ikke. Gå til spørsmål 23

22 I hvilken grad mener du at dine synspunkter ble tillagt vekt da målsettinger for arbeidet i etaten ble utformet? (Dersom du f.eks. ikke var ansatt da målsettingen ble utformet: svar "ikke aktuelt")

Svært lite vekt — Både/og — Svært stor vekt

1 2 3 4 5 ☐ Ikke aktuelt

23 Hvem er ditt/dine kontorer lokalisert sammen med: (f.eks. helsesøstertjeneste eller sosialkontor. Oppgide tre du har mest kontakt med)

1 .....
2 .....
3 .....

Det overordnede administrative og politiske system har innflytelse på og er viktig for samfunnsmedisinsk arbeid. Her kommer noen spørsmål om ditt forhold til kolleger, overordnede, politikere og politikk

24 Hvem er din nærmeste overordnede? (Skriv tittel/funksjon)

.....

25 Hva er din nærmeste overordnedes kjønn og omtrentlige alder?

Kjønn: 1 Mann 2 Kvinne Omtrentlig alder: ☐☐ år

26 Hva slags utdanning har din nærmeste overordnede? (Beskriv)

.....
.....

27 Hvilke muligheter har dine overordnede til å vurdere din innsats i jobben, gjennom f.eks. å telle opp eller registrere på annen måte hvor mye som er utført i løpet av en uke?

Det er
1 Svært lett
2 Forholdsvis lett
3 Forholdsvis vanskelig
4 Svært vanskelig
5 Vet ikke

28 Hva med dine overordnedes muligheter for å vurdere kvaliteten på det arbeidet som du utfører?

Det er
1 Svært lett
2 Forholdsvis lett
3 Forholdsvis vanskelig
4 Svært vanskelig
5 Vet ikke

29 Hva vurderer du selv kvaliteten av ditt eget samfunnsmedisinske arbeid ut fra?

Beskriv .....
.....
.....

30 Har du noen gang vanskelig for å se direkte resultater eller nytte av det du gjør?

Svært ofte	Ofte	Av og til	Sjelden	Svært sjelden
1	2	3	4	5

*31 Hvordan mener du at din **nærmeste overordnede** vektlegger de følgende oppgaver?*

	Vektlegger svært lavt				Vektlegger svært høyt
1 Sikre faglige standarder for aktivitetene	1	2	3	4	5
2 Stimulere til samarbeid mellom ulike avdelinger i etaten	1	2	3	4	5
3 Holde underordnede orientert om mål og planer	1	2	3	4	5
4 Utvikle og ta i bruk nye rutiner og arbeidsmåter	1	2	3	4	5
5 Stå for økonomistyring, regnskap og budsjett	1	2	3	4	5
6 Koordinere ulike typer aktiviteter	1	2	3	4	5
7 Være informert om synspunkter fra pasienter og pasientgrupper	1	2	3	4	5
8 Løse mellommenneskelige problemer og motsetninger	1	2	3	4	5
9 Ta initiativ i forhold til nye faglige muligheter	1	2	3	4	5
10 Være et samlende symbol, motivere, begeistre og skape entusiasme	1	2	3	4	5
11 Sørge for at regler og rutiner følges	1	2	3	4	5
12 Legge opp de daglige arbeidsrutiner	1	2	3	4	5
13 Løse problemer gjennom å endre organisasjonen	1	2	3	4	5
14 Være informert om politiske signaler	1	2	3	4	5
15 Innarbeide politiske signaler i virksomheten	1	2	3	4	5
16 Veilede underordnede, stimulere til faglig utvikling	1	2	3	4	5
17 Sørge for at nyansatte gis instruksjon og opplæring	1	2	3	4	5

32 Hvor ofte opplever du på din arbeidsplass konflikter eller dårlige forhold ?

	Ofte	Av og til	Sjelden	Aldri	Ikke aktuelt
1 Innen ledelsen eller mellom ulike ledelsesnivåer	1	2	3	4	5
2 Mellom ledelsen og øvrige ansatte	1	2	3	4	5
3 Mellom ansatte	1	2	3	4	5
4 Mellom ansatte og pasienter og andre brukere	1	2	3	4	5

33 Hvordan vil du i hovedsak karakterisere ditt forhold til følgende:

	Svært godt	Godt	Kan være både-og	Dårlig	Svært Dårlig	Vet ikke	Ikke aktuelt
1 Overordnet kommuneadministrasjon	1	2	3	4	5	6	7
2 Overordnet ledelse på helse/ sosialsektor	1	2	3	4	5	6	7
3 Pleie og omsorgssjef/sykepleiesjef	1	2	3	4	5	6	7
4 Andre avdelinger i helseetaten	1	2	3	4	5	6	7
5 Sektorpolitikerne i kommunen/bydelen	1	2	3	4	5	6	7
6 Andre politikere i kommunen/bydelen	1	2	3	4	5	6	7
7 Private/frivillige organisasjoner som utfører helsemessige oppgaver	1	2	3	4	5	6	7
8 Helsesøstre	1	2	3	4	5	6	7
9 Fysioterapeuter	1	2	3	4	5	6	7
10 Teknisk-hygienisk personell	1	2	3	4	5	6	7
11 Økonomisk-administrativt personell i helseetaten	1	2	3	4	5	6	7
12 Kommunalt ansatte leger	1	2	3	4	5	6	7
13 Private leger med kommunal avtale	1	2	3	4	5	6	7
14 Private leger uten kommunal avtale	1	2	3	4	5	6	7
15 Kommunal(e) institusjon(er) for eldre, syke, uføre	1	2	3	4	5	6	7

34 Hvilken betydning vil du si at følgende forhold har for deg i faglig oppdatering og vedlikehold ?

	Svært liten	Nokså liten	Noe	Nokså stor	Svært stor
1 Kurs, kongresser, møter	1	2	3	4	5
2 Formaliserte fagmøter og samlinger på arbeidsplassen (tidsskriftmøter, interne undervisningsmøter o.l.)	1	2	3	4	5
3 Faglig tilbakemelding gjennom epikriser, brev o.l.	1	2	3	4	5
4 Uformell kontakt med kolleger gjennom telefon eller ved tilfeldige møter	1	2	3	4	5
5 Lesing av medisinske tidsskrifter og tidsskriftartikler	1	2	3	4	5
6 Lesing av medisinske lærebøker, oppslagsverk o.l.	1	2	3	4	5
7 Informasjon, reklamemateriell og besøk fra den farmasøytiske industri	1	2	3	4	5
8 Rundskriv og annet informasjonsmateriell fra offentlig myndighet (fylkeslege, StatensHelsetilsyn, Sosial- og Helsedepartementet etc.)	1	2	3	4	5
9 Egen forskning	1	2	3	4	5
10 Systematisk evaluering av egen virksomhet (journalgjennomgang ol.)	1	2	3	4	5
11 Strukturert veiledning (f.eks. i spesialistutdanningen)	1	2	3	4	5
12 Tilbakemelding fra brukere/pasientene	1	2	3	4	5
13 Informasjon gjennom massemedia (aviser, radio, TV o.l.)	1	2	3	4	5

35 I en del arbeidssituasjoner er det slik at man er avhengig av støttespillere for å få ting gjennomført. Hvem vil du definere som dine 3 viktigste støttespillere på jobben?

1.....

2.....

3.....

36 Hvem opplever du er vanskeligst å samarbeide med i forhold til samfunnsmedisinsk arbeid? (Vurdér både faglige, profesjonsbaserte og mere personlige faktorer. Skriv stilling/yrkesbetegnelse/funksjon, ikke navn!)

Beskriv.....

.....

37 Hvordan er interessen for det samfunnsmedisinske arbeid du gjør?

	Svært stor	Stor	Middels	Liten	Svært liten
1 Blant kommunalt ansatte leger	1	2	3	4	5
2 Blant privatpraktiserende leger	1	2	3	4	5
3 Blant helsesøstre	1	2	3	4	5
4 Blant fysioterapeuter	1	2	3	4	5
5 Blant hjemmesykepleiere	1	2	3	4	5
6 Hos helse- og sosialsjefen (el.tilsv.)	1	2	3	4	5
7 Hos teknisk etat (el.tilsv.)	1	2	3	4	5
8 I miljøvernseksjon (el.tilsv.)	1	2	3	4	5
9 Hos rådmann/adm.sjef (el.tilsv.)	1	2	3	4	5
10 I hovedutvalg for helse og sosial (el.tilsv.)	1	2	3	4	5
11 I formannsskapet (el. tilsv.)	1	2	3	4	5
12 I kommunestyret (el.tilsv.)	1	2	3	4	5
13 Andre, beskriv.....					

38 Hvilken vekt mener du de følgende hensyn tillegges når viktige beslutninger skal fattes på høyeste politiske nivå i kommunen/bydelen?

	Svært stor vekt	Noe vekt	Både/ og	Lite vekt	Svært lite vekt
1 Faglige, medisinske hensyn	1	2	3	4	5
2 Økonomiske hensyn	1	2	3	4	5
3 Politiske hensyn	1	2	3	4	5
4 Hensyn til ulike profesjoners interesse	1	2	3	4	5
5 Hensyn til pasientene	1	2	3	4	5

39 Hvor mye informasjon vil du si du får fra overordnet administrativt og politisk hold om kommunens/bydelens:

	Mye	Nok	Lite	Vet ikke	Uaktuelt for meg
1 Mål	1	2	3	4	5
2 Investeringsplaner	1	2	3	4	5
3 Prioriteringer	1	2	3	4	5
4 Budsjettsituasjon	1	2	3	4	5
5 Måloppnåelse	1	2	3	4	5
6 Personal- og bemanningsmessige forhold	1	2	3	4	5

40 Hva mener du bør være de tre viktigste målsettingene for den samfunns-medisinske legetjenesten i din kommune?

1. .....

2. .....

3. .....

41 Har du i løpet av de siste 3 årene brukt

1 Din instruksjonsmyndighet over noen personellgruppe i kommunen/bydelen?
- 1 Ja. Beskriv .....
- 2 Nei
- 3 Ikke aktuelt

2 Din myndighet til å vedta stansing av virksomhet i hastesaker?
- 1 Ja. Beskriv.....
- 2 Nei
- 3 Ikke aktuelt

3 Din myndighet til å varsle kommunen og/eller tilsynsmyndigheter (fylkeslege/Statens Helsetilsyn) om at kommunen/bydelen ikke oppfyller pliktene sine etter kommune helsetjenesteloven?
- 1 Ja, har varslet kommunen. Beskriv.....
  .....
- 2 Ja, har varslet tilsynsmyndighetene. Beskriv .....
  .....
- 3 Nei
- 4 Ikke aktuelt

42 Vil du si at din jobb kan utføres etter klare regler og en veletablert praksis, eller må du utvise mye skjønn?

Svært klare regler/ veletablert praksis		Både/og		Svært mye skjønn
1	2	3	4	5

Hvis du svarte 1-2 på dette spørsmålet, gå til spørsmål 44, hvis du svarte 3-5 gå til spørsmål 43

43 Når du må utøve en viss grad av skjønn i din jobb, hvor viktig eller uviktig er signaler fra følgende personer og grupper?

	Svært viktig	Nokså viktig	Både/ og	Nokså uviktig	Svært uviktig
1 Signaler fra Storting og regjering	1	2	3	4	5
2 Signaler fra Sosial- og Helsedepartementet og Statens Helsetilsyn	1	2	3	4	5
3 Signaler fra fylkeslegen	1	2	3	4	5
4 Signaler fra fag- og yrkesorganisasjoner (f.eks. Dnlf, NSF, NHF)	1	2	3	4	5
5 Signaler fra kommunestyret/ bydelsutvalg (el. tilsv.)	1	2	3	4	5
6 Signaler fra politisk sektorstyre	1	2	3	4	5
7 Signaler fra overordnet kommunal administrasjon	1	2	3	4	5
8 Signaler fra overordnet helseadministrasjon	1	2	3	4	5
9 Signaler fra pasienter og brukergrupper	1	2	3	4	5
10 Signaler fra legekolleger	1	2	3	4	5
11 Faglige/profesjonelle hensyn	1	2	3	4	5
12 Oppslag i massemedia	1	2	3	4	5
13 Annet, beskriv	1	2	3	4	5

I samfunnsmedisinsk virksomhet inngår gjerne en del møtevirksomhet. Innholdsmessig kan dette være samarbeids- eller orienteringsmøter, og det kan tas beslutninger i varierende grad. Samfunnsmedisinere er også ofte involvert både i rene undervisningsoppgaver i eller utenfor helseetaten og har ofte rådgivningsoppgaver som ikke alltid klassifiseres som undervisning, f.eks. ved at en deltar som observatør med talerett i møtevirksomhet og blir spurt til råds underveis i møtet. Vi ønsker informasjon om disse delene av samfunnsmedisinsk virksomhet

44 Angi etter beste skjønn hvor ofte du har deltatt i planlagte møter det siste året med noen av de følgende instansene. (Ta med møter hvor du eller de nevnte instansene er enten hovedaktør eller likeverdige deltagere i samarbeidsmøter av noe slag. Her skal du ikke ta med rene undervisnings- eller rådgivningssammenkomster)

	Aldri	1 gang	2-3 ggr	Minst 4ggr
1 Administrativ ledelse for hjemmesykepleien	1	2	3	4
2 Klinisk personale i hjemmesykepleien	1	2	3	4
3 Hjemmehjelpstjeneste	1	2	3	4
4 Lokalsykehusets administrative ledelse	1	2	3	4
5 Lokalsykehusets somatisk-faglige ledelse	1	2	3	4
6 Lokalsykehusets psykiatrisk-faglige ledelse	1	2	3	4
7 Administrativ ledelse ved sykehjem	1	2	3	4
8 Klinisk personale i sykehjem	1	2	3	4
9 Fysioterapitjeneste	1	2	3	4
10 Helsesøstertjeneste	1	2	3	4
11 Miljøvernseksjon (el.tilsv.)	1	2	3	4
12 Teknisk etat	1	2	3	4
13 Skole/undervisningsetat	1	2	3	4
14 Kulturetat	1	2	3	4
15 Sosialkontor	1	2	3	4
16 Barnevern	1	2	3	4
17 Arbeidsmarkedsetat	1	2	3	4
18 Trygdekontor	1	2	3	4

45 Hvor mange timer i løpet av den siste måneden har du selv gitt undervisning eller planlagt rådgivning i eller utenfor vanlig arbeidstid til noen av de følgende gruppene? (Ta med tid både til planlegging, organisering, gjennomføring og evaluering)

1 Fastlønte allmennleger	☐☐ Timer siste måned
2 Privatpraktiserende leger	☐☐ Timer siste måned
3 Helsepersonell for øvrig	☐☐ Timer siste måned
4 Annet kommunalt personell i helseetaten	☐☐ Timer siste måned
5 Annet kommunalt personell utenfor helseetaten	☐☐ Timer siste måned
6 Politikere i helseetaten	☐☐ Timer siste måned
7 Politikere utenfor helseetaten	☐☐ Timer siste måned
8 I frivillige organisasjoner i kommunen/bydelen	☐☐ Timer siste måned
9 Alle grupper utenfor kommunen/bydelen	☐☐ Timer siste måned
10 Annet, beskriv	☐☐ Timer siste måned

46 Hvor mange timer har du i løpet av siste måneden sittet i møter med politikere i din kommune/bydel? (Ta med både planlagte større møter (f.eks. i plangrupper og hovedutvalg for helse- og sosialsaker) og mere uformelle møter hvor f.eks. en politiker oppsøker deg for å få mere informasjon om en sak)

☐☐ Timer siste måned

Statens Helsetilsyn har ansvaret for et overordnet faglig tilsyn med all helsetjeneste i landet. Fylkeslegen skal føre tilsyn med alt helsevesen og helsepersonell i fylket. I praksis vil tilsynet blant annet basere seg på kontroll av at kommuner og bydeler fører kontroll av egen virksomhet

47 Nedenfor følger noen utsagn som vi ber deg ta standpunkt til, fordi vi gjerne vil vite hvordan din kommune/bydel og du organiserer og utfører tilsyn med helsetjenesten og helsepersonellet hos dere

	Ja	Nei	Vet ikke	Ikke aktuelt
1. Det er vedtatt instruks for tilsynsvirksomheten i kommunen/bydelen	1	2	3	4
2. Det er vedtatt planer for tilsynsvirksomheten i kommunen/bydelen	1	2	3	4
3. Jeg har som medisinsk ansvarlig/rådgivende lege utarbeidet rutiner for tilsynsvirksomheten	1	2	3	4

48 Hvordan utøver du ditt tilsyn i kommunen/bydelen? Beskriv:

.....

.....

.....

.....

49 Hvor store muligheter har du i dagens situasjon til å kontrollere og styre innhold og kvalitet i tjenester som ytes av:

	Mulighetene til kontroll og styring er :					
	Svært store	Ganske store	Både- og	Ganske små	Svært små	Uaktuelt/ vet ikke
1 Kommunalt ansatte leger	1	2	3	4	5	6
2 Allmennpraktiserende leger med avtale	1	2	3	4	5	6
3 Allmennpraktiserende leger uten avtale	1	2	3	4	5	6
4 Legevaktsleger	1	2	3	4	5	6
5 Annet legevaktspersonell enn leger	1	2	3	4	5	6
6 Ambulansepersonell	1	2	3	4	5	6
7 Personell i sykehjem	1	2	3	4	5	6
8 Kommunale fysioterapeuter	1	2	3	4	5	6
9 Privatpraktiserende fysioterapeuter	1	2	3	4	5	6
10 Helsesøstre	1	2	3	4	5	6
11 Personell i åpen omsorg	1	2	3	4	5	6
12 Personell i sykehjem og institusjoner for heldøgns omsorg og pleie	1	2	3	4	5	6
13 Andre, beskriv.....	1	2	3	4	5	6

Mestring, trivsel og fremtidsplaner

50 Det har i kommunehelsetjenesten de siste årene foregått en desentralisering av oppgaver og ansvar. For mange innebærer dette delegering av nye oppgaver. Som leder i en avdeling, hvordan mener du at du mestrer de følgende oppgavene i ditt daglige arbeid?

	Mestrer svært dårlig				Mestrer svært bra
1 Sikre faglige standarder for aktivitetene	1	2	3	4	5
2 Stimulere til samarbeid mellom ulike avdelinger i etaten	1	2	3	4	5
3 Holde underordnede orientert om mål og planer	1	2	3	4	5
4 Utvikle og ta i bruk nye rutiner og arbeidsmåter	1	2	3	4	5
5 Stå for økonomistyring, regnskap og budsjett	1	2	3	4	5
6 Koordinere ulike typer aktiviteter	1	2	3	4	5
7 Være informert om synspunkter fra pasienter og pasientgrupper	1	2	3	4	5
8 Løse mellommenneskelige problemer og motsetninger	1	2	3	4	5
9 Ta initiativ i forhold til nye faglige muligheter	1	2	3	4	5
10 Være et samlende symbol, motivere, begeistre og skape entusiasme	1	2	3	4	5
11 Sørge for at regler og rutiner følges	1	2	3	4	5
12 Legge opp de daglige arbeidsrutiner	1	2	3	4	5
13 Løse problemer gjennom å endre organisasjonen	1	2	3	4	5
14 Være informert om politiske signaler	1	2	3	4	5
15 Innarbeide politiske signaler i virksomheten	1	2	3	4	5
16 Veilede underordnede, stimulere til faglig utvikling	1	2	3	4	5
17 Sørge for at nyansatte gis instruksjon og opplæring	1	2	3	4	5

51 Angi ved å sette ring rundt ett tall på hvert spørsmål i hvilken grad du er fornøyd med:

	Svært fornøyd	Fornøyd	Både/og	Misfornøyd	Svært misfornøyd
1 Den ansvarsmengde du har	1	2	3	4	5
2 Fysiske arbeidsforhold	1	2	3	4	5
3 Din frihet til å bestemme hva du skal gjøre	1	2	3	4	5
4 Din frihet til å velge arbeidsmetoder	1	2	3	4	5
5 Din frihet til å bestemme arbeidstempo	1	2	3	4	5
6 Muligheten/anledningen til å bruke dine evner	1	2	3	4	5
7 Lønnsforholdene	1	2	3	4	5
8 Stillingsinstruksen	1	2	3	4	5
9 Jobben din alt i alt	1	2	3	4	5
10 Når du tenker på hvordan du har det for tiden, er du stort sett fornøyd med tilværelsen, eller er du stort sett misfornøyd?	1	2	3	4	5
11 Hvis du skulle svare på spørsmålet hvor fornøyd du var for fem år siden, hva ville du svart da?	1	2	3	4	5
12 Hva tror du du vil svare på spørsmålet om hvor fornøyd du er om fem år?	1	2	3	4	5

52 Har du planer om å skaffe deg ny jobb i løpet av de nærmeste 12 måneder?

(Sett ring rundt svar på hver linje)	Ja	Nei	Vet ikke
1 Innenfor samfunnsmedisinsk arbeid	1	2	3
2 Innenfor annet medisinsk arbeid	1	2	3
3 I annen kommune/bydel	1	2	3
4 På annet forvaltningsnivå/i avtalepraksis	1	2	3

53 Hva er det som motiverer deg til innsats i jobben du har i dag? Nedenfor er det listet opp en rekke motiver/drivkrefter. Hvor viktig mener du disse er for deg i din nåværende jobb?

	Svært lite viktig	Lite viktig	Både/og	Nokså viktig	Svært viktig
1 Se resultater av eget arbeid	1	2	3	4	5
2 Forpliktelsen og lojaliteten til organisasjonen	1	2	3	4	5
3 Samarbeid med andre	1	2	3	4	5
4 Ambisjoner, egen karriere	1	2	3	4	5
5 Innflytelse/muligheter for å påvirke	1	2	3	4	5
6 Anerkjennelse for innsats (ros)	1	2	3	4	5
7 Interessant arbeid	1	2	3	4	5
8 Prestisje blant venner	1	2	3	4	5
9 Læring og egenutvikling	1	2	3	4	5
10 Hjelpe andre	1	2	3	4	5
11 Det faglige omdømme til kommunens/bydelens helsetjeneste	1	2	3	4	5
12 Lønnsforhold	1	2	3	4	5

54 Nedenfor er det listet opp forhold i arbeidet som kan være belastende. Hva opplever du som belastende ved din personlige arbeidssituasjon?

	Svært belastende				Svært lite belastende
1 Arbeidsmengde	1	2	3	4	5
2 Tidspress	1	2	3	4	5
3 Uenighet/konflikter	1	2	3	4	5
4 Mange baller i lufta	1	2	3	4	5
5 Avbrytelser	1	2	3	4	5
6 Motstridende forventninger	1	2	3	4	5
7 Oppslag i presse, massemedia	1	2	3	4	5
8 Manglende faglig standard ved arbeidet i kommunen/bydelen	1	2	3	4	5
9 Presset økonomi i kommunen/bydelen	1	2	3	4	5

Fagutvikling og fagpolitikk

55 Deltar du i noen av følgende videre- og etterutdanningstilbud?
(Sett evt. ring rundt flere)

1 Ja, jeg leder veiledningsgruppe i samfunnsmedisin
2 Ja, jeg leder veiledningsgruppe i allmennmedisin
3 Ja, jeg er kandidat i veiledningsgruppe i samfunnsmedisin
4 Ja, jeg er kandidat i veiledningsgruppe i allmennmedisin
5 Ja, stillingen min er ledd i spesialistutdanning i samfunnsmedisin
6 Ja, stillingen min er ledd i spesialistutdanning i allmennmedisin
7 Ja, jeg tar årlig nødvendige kurs for min spesialitet
8 Ja, jeg følger desentraliserte utdanningstilbud. Beskriv: .....
9 Ja, annet. Beskriv: .....
10 Nei

56 Omtrent hvor mange dager har du deltatt på faglige kurs, kongresser, møter o.l. siste 12 måneder?

1 Ingen
2 1-5
3 6-10
4 11-15
5 16-30
6 mer enn 30

57 Får du deltatt på så mange kurs, kongresser og møter som du mener du trenger?

1 Ja
2 Nei
3 Vet ikke

Vi vil til slutt stille deg noen helsepolitiske spørsmål

58 Tenk på tilbudet av helsetjenester til befolkningen i ditt fylke.

A. Marker med et pluss i kolonnen til venstre inntil fem områder hvor du mener en økning av bevilgningene kan få relativt stor effekt i form av vunnen levetid og/eller livskvalitet for pasientene.
B. Marker med en null i kolonnen til venstre inntil tre områder hvor du mener en økning av bevilgningene vil ha liten eller ingen effekt i form av vunnen levetid og/eller livskvalitet for pasientene.
C. For hver gruppe du velger, angi med et kryss i rutene til høyre hvilke typer tiltak du særlig har i tankene.

		Forebyg-gende	Diagn./ utredn.	Behand-ling	Kontr./ oppflg.	Habilit./ rehab.	Pleie omsorg
	Alkoholikere						
	Hofteleddsllitasje						
	Pasienter med lungekreft						
	Slagpasienter						
	Barnløse (infertile)						
	Akutte psykoser						
	Mindre kirurgiske inngrep (brokk, åreknuter m.m.)						
	Kronisk vonde rygger						
	Pasienter med leddgikt						
	Trafikkofre						
	Diabetikere						
	Selvmordskandidater						
	For tidlig fødte barn						
	Pasienter med angina pectoris						
	Pasienter med nedsatt hørsel						
	Sykehusinfeksjoner						
	Ofre for seksuelle overgrep						
	Terminalt syke						
	Obstruktive lungesykdommer (bronkitt, emfysem, astma)						
	Psykisk utviklingshemmede						
	Pasienter med brystkreft						
	Grå/grønn stær						
	Høyt blodtrykk						
	Pasienter med psoriasis						
	Epileptikere						
	Aldersdemente						
	Eventuelle andre:						

Vi takker deg for din deltagelse i spørreundersøkelsen.
Du er nå klar for trekningen om kr. 3 000 i programvarer til datamaskin!

Appendix B

Løpenummer: ☐ ☐☐☐☐☐

Generalplan for samfunnsmedisinen

Angi svar ved å sette ring rundt **ett** tall på hvert spørsmål, slik: ③,
eller ved å sette et tall i **en** eller flere ruter, slik: [4] [2]

De som arbeider i en bydel skal svare ut fra **bydelen** der det i spørsmålene står «kommunen/bydelen»

Offentlige legers landsforening
1999

1 Angi etter beste skjønn hvor mye tid i gjennomsnitt du bruker til arbeid med følgende deltjenester (oppgi antall timer per uke, skriv 0 - null dersom du ikke arbeider innenfor deltjenesten).

1 Miljørettet helsevern (definert bredt)	___ Timer
2 Administrasjon/ledelse	___ Timer
3 Kurativ praksis – fastlønnet	___ Timer
4 Kurativ praksis – lønnet etter normaltariffen	___ Timer
5 Helsestasjon	___ Timer
6 Skolehelsetjeneste	___ Timer
7 Syke-/aldershjem	___ Timer
8 Bedriftshelsetjeneste	___ Timer
9 Annet forebyggende arbeid	___ Timer
10 Annet arbeid (undervisning, forskning, militærlege etc.)	___ Timer
11Legevaktarbeid (beredskap)	___ Timer
SUM antall timer per uke	___ Timer

2 Hvilken av følgende stillingstyper har du? (sett ring rundt tallet)

1 Fastlønnsstilling
2 Fast lønn og privat praksisavtale

3 Hvilke av følgende tilleggsutdannelser har du? (Sett evt. ring rundt flere)

1 Kommunelege-/Bygdøykurset
2 Folkehelseutdanning/Master of Health Administration
3 Master of Public Health
4 Distriktshøyskoleutdanning, beskriv.....
5 Annet, beskriv.....
6 Ingen

4 Hvilke av følgende deltjenester har du budsjett – og personalansvar for? (Sett ring rundt tallet, evt. for flere)

1 Allmennlegetjeneste
2 Fysioterapi
3 Hjemmebasert omsorg
4 Helsesøstertjeneste
5 Jordmortjeneste
6 Ergoterapi
7 Miljørettet helsevern
8 Avdeling for forebyggende arbeid
9 Bedriftshelsetjeneste
10 Næringsmiddelkontroll, beskriv .....
11 Annet, beskriv:.....

5 Personellressursene tilgjengelige for samfunnsmedisinere varierer, både i type og antall. Angi i felt A hvorvidt du har stillingshjemler for følgende type personell, i felt B angir du hvorvidt du synes du har for lite, nok eller for mye av de enkelte typene personell. Du bes altså svare både i felt A og B, uansett.

	A		B		
	Har	Har ikke	For lite	Nok	For mye
1 Teknisk-hygienisk personell	1	2	3	4	5
2 Helsesøster	1	2	3	4	5
3 Annet helsefaglig personell	1	2	3	4	5
4 Veterinær	1	2	3	4	5
5 Sekretærhjelp	1	2	3	4	5
6 Annet, beskriv.....					

6 Hvordan er interessen for det samfunnsmedisinske arbeidet du gjør?

	Svært viktig	Nokså viktig	Både/ og	Nokså uviktig	Svært uviktig
1 Blant kommunalt ansatte leger	1	2	3	4	5
2 Blant privatpraktiserende leger	1	2	3	4	5
3 Blant helsesøstre	1	2	3	4	5
4 Blant annet helsepersonell	1	2	3	4	5
5 Hos dine administrativt overordnede	1	2	3	4	5
6 Hos andre kommunale etater	1	2	3	4	5
7 Hos sektorpolitikere	1	2	3	4	5
8 Hos andre politikere i kommunen	1	2	3	4	5

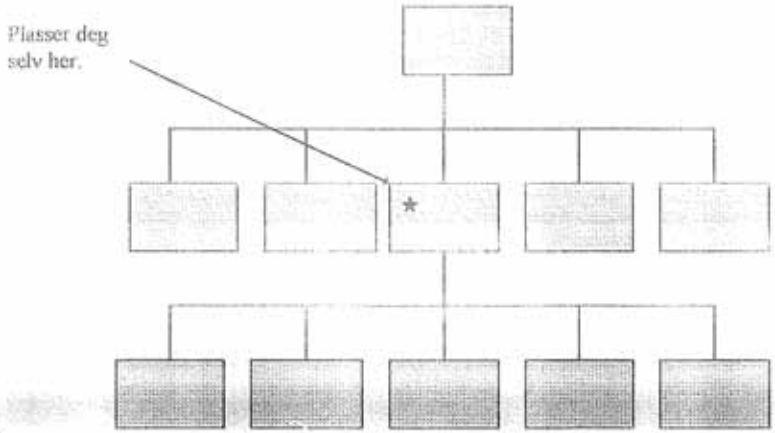
7 Angi ved å sette ring rundt ett tall på hvert spørsmål i hvilken grad du er fornøyd med:

	Svært fornøyd	Fornøyd	Både/ og	Misfor-nøyd	Svært misfor-nøyd
1 Den ansvarsmengde du har	1	2	3	4	5
2 Fysiske arbeidsforhold	1	2	3	4	5
3 Din frihet til å bestemme hva du skal gjøre	1	2	3	4	5
4 Din frihet til å velge arbeidsmetoder	1	2	3	4	5
5 Din frihet til å bestemme arbeidstempo	1	2	3	4	5
6 Muligheter/anledningen til å bruke dine evner	1	2	3	4	5
7 Lønnsforholdene	1	2	3	4	5
8 Stillingsinstruksen	1	2	3	4	5
9 Jobben din alt i alt	1	2	3	4	5
10 Når du tenker på hvordan du har det for tiden, er du stort sett fornøyd med tilværelsen, eller er du stort sett misfornøyd?	1	2	3	4	5
11 Hvis du skulle svare på spørsmålet hvor fornøyd du var for fem år siden, hva ville du svart da?	1	2	3	4	5
12 Hva tror du du vil svare på spørsmålet om hvor fornøyd du er om fem år?	1	2	3	4	5

8 Det har i kommunehelsetjenesten de siste årene foregått en desentralisering av oppgaver og ansvar. For mange innebærer dette delegering av nye oppgaver. Som leder i en avdeling, hvordan mener du at du mestrer de følgende oppgavene i ditt daglige arbeid?

	Mestrer svært dårlig				Mestrer svært bra
1 Sikre faglige standarder for aktivitetene	1	2	3	4	5
2 Stimulere til samarbeid mellom ulike avdelinger i etaten	1	2	3	4	5
3 Holde underordnede orientert om mål og planer	1	2	3	4	5
4 Utvikle og ta i bruk nye rutiner og arbeidsmåter	1	2	3	4	5
5 Stå for økonomistyring, regnskap og budsjett	1	2	3	4	5
6 Koordinere ulike typer aktiviteter	1	2	3	4	5
7 Være informert om synspunkter fra pasienter og pasientgrupper	1	2	3	4	5
8 Løse mellommenneskelige problemer og motsetninger	1	2	3	4	5
9 Ta initiativ i forhold til nye faglige muligheter	1	2	3	4	5
10 Være et samlende symbol, motivere, begeistre og skape entusiasme	1	2	3	4	5
11 Sørge for at regler og rutiner følges	1	2	3	4	5
12 Legge opp de daglige arbeidsrutiner	1	2	3	4	5
13 Løse problemer gjennom å endre organisasjonen	1	2	3	4	5
14 Være informert om politiske signaler	1	2	3	4	5
15 Innarbeide politiske signaler i virksomheten	1	2	3	4	5
16 Veilede underordnede, stimulere til faglig utvikling	1	2	3	4	5
17 Sørge for at nyansatte gis instruksjon og opplæring	1	2	3	4	5

9 Dette spørsmålet skal bare besvares av samfunnsmedisinere ansatt i kommunehelsetjenesten. Vi ønsker å få en oversikt over hvor du er plassert i det kommunale hierarkiet. Det eksisterer svært mange forskjellige organisasjonsformer, men i denne vil vi at du plasserer deg selv i firkanten med stjerne, deretter fyller du ut hvilke avdelinger eller etater som er underordnet, sideordnet og overordnet deg. Lag gjerne tilleggsbokser hvis det er nødvendig.



10 Hvordan vil du i hovedsak karakterisere ditt forhold til følgende:

		Svært godt	Godt	Kan være både -og	Dårlig	Svært dårlig	Vet ikke	Ikke aktuelt
1	Overordnet kommuneadministrasjon	1	2	3	4	5	6	7
2	Overordnet ledelse på helse/sosialsektor	1	2	3	4	5	6	7
3	Pleie- og omsorgssjef/sykepleiesjef	1	2	3	4	5	6	7
4	Andre avdelinger i helsetaten	1	2	3	4	5	6	7
5	Sektorpolitikerne i kommunen/bydelen	1	2	3	4	5	6	7
6	Andre politikere i kommunen/bydelen	1	2	3	4	5	6	7
7	Private/frivillige organisasjoner som utfører helsemessige oppgaver	1	2	3	4	5	6	7
8	Helsesøstre	1	2	3	4	5	6	7
9	Fysioterapeuter	1	2	3	4	5	6	7
10	Teknisk hygienisk personell	1	2	3	4	5	6	7
11	Økonomisk-administrativt personell i helsetaten	1	2	3	4	5	6	7
12	Kommunalt ansatte leger	1	2	3	4	5	6	7
13	Private leger med kommunal avtale	1	2	3	4	5	6	7
14	Private leger uten kommunal avtale	1	2	3	4	5	6	7
15	Kommunal(e) institusjoner for eldre, syke, uføre	1	2	3	4	5	6	7

11 Har du vært i annen samfunnsmedisinsk stilling enn den du har nå siden 1.1. 1994? Ja ☐ Nei ☐

Hvis ja, oppgi tidsrom og stillingstype

Tidsrom	Stillingstype

Kan du beskrive den/de viktigste årsaken(e) til at du sluttet i denne/disse stillingene?
(Legg gjerne ved et eget ark!) .....

.....

.....

.....

12 Hvor lenge har du hatt nåværende stilling?
(angi antall år hel eller deltid) ☐☐ år ☐☐ mnd.

13 Har du planer om å skaffe deg ny jobb i løpet av de nærmeste 12 måneder?
(Sett ring rundt svar på hver linje)

	Ja	Nei	Vet ikke
1 Innenfor samfunnsmedisinsk arbeid	1	2	3
2 Innenfor annet medisinsk arbeid	1	2	3
3 I annen kommune/bydel	1	2	3
4 På annet forvaltningsnivå/i avtalepraksis	1	2	3

14 Vi har allerede spurt deg om dine fremtidsplaner når det gjelder jobb på kort sikt. Nå vil vi gjerne at du skal se lengre fremover og ber deg svare på spørsmålene nedenfor. Vi er klar over at det er vanskelig å forutsi hvilke valg du vil gjøre i fremtiden, men ber deg svare det du i dag tror er mest sannsynlig.

Tror du at du vil søke deg bort fra samfunnsmedisinsk stilling før pensjonsalderen? Ja ☐ Nei ☐

Hvis ja, om hvor mange år? Antall år ☐

Som samfunnsmedisinske stillinger regnes i denne sammenheng:
Kommuneoverlege, Kommunelege I, bydelsoverlege, helsesjef, distriktsoverlege, fylkeslege, assisterende fylkeslege, rådgivende lege og rådgivende overlege.

15 Opplysninger om elektronisk postadresse (e-post)

Offentlige legers landsforening og Folkehelsa ønsker å sende deg informasjon og rette henvendelser til deg på din E-post adresse.

Har du tilgang til E-post? Ja ☐ Nei ☐

Tillater du slik informasjonsutveksling på din E-post adresse Ja ☐ Nei ☐

Din e-post adresse er: .....@.....

Vi takker deg for din deltakelse i spørreundersøkelsen.

Trondheim Trykk as, Leiknes - 76 08 14 20

Løpenummer: ☐ ☐☐☐☐☐

Generalplan for samfunnsmedisinen

Angi svar ved å sette ring rundt **ett** tall på hvert spørsmål, slik: (3),
eller ved å sette et tall i **en** eller flere ruter, slik: [4] [2]

De som arbeider i en bydel skal svare ut fra **bydelen** der det i spørsmålene står «kommunen/bydelen»

Offentlige legers landsforening
1999

Mange leger med spesialitet i samfunnsmedisin eller som tidligere har arbeidet i samfunnsmedisinske stillinger arbeider i dag i stillinger som ikke er definert som samfunnsmedisinske stillinger. I følge våre opplysninger er du en av dem. Vi vil gjerne vite hvorfor du har gjort dette valget.
Når vi skal vurdere det fremtidige behov for spesialister i samfunnsmedisin ønsker vi også å vite hva leger i din situasjon tenker om fremtidig arbeid i samfunnsmedisinske stillinger.
Vi spør derfor om du vil besvare spørsmålene nedenfor.
Vi er klar over at det er vanskelig å forutsi hvilke valg du vil gjøre i fremtiden, men ber deg svare det du i dag tror er mest sannsynlig.

1 Tror du at du vil søke deg til en samfunnsmedisinsk stilling før pensjonsalderen? Ja ☐ Nei ☐

Hvis ja, om hvor mange år? Antall år ☐

Som samfunnsmedisinske stillinger regnes i denne sammenheng:
Kommuneoverlege, Kommunelege I, bydelsoverlege, helsesjef, distriktsoverlege, rådgivende lege, rådgivende overlege, fylkeslege og assisterende fylkeslege.

2 Hvilken betydning har følgende faktorer for om du skal vende tilbake til en samfunnsmedisinsk stilling?

		Svært viktig	Nokså viktig	Både/ og	Nokså uviktig	Svært uviktig
1	Den ansvarsmengde du vil få	1	2	3	4	5
2	Fysiske arbeidsforhold	1	2	3	4	5
3	Din frihet til å bestemme hva du skal gjøre	1	2	3	4	5
4	Din frihet til å velge arbeidsmetoder	1	2	3	4	5
5	Din frihet til å bestemme arbeidstempo	1	2	3	4	5
6	Muligheten/anledningen til å bruke dine evner	1	2	3	4	5
7	Lønnsforholdene	1	2	3	4	5
8	Stillingsinstruksen	1	2	3	4	5

3 Har du vært i noen samfunnsmedisinsk stilling siden 1.1.1994? Ja ☐ Nei ☐
Hvis ja, oppgi tidsrom og stillingstype:

Tidsrom	Stillingstype

Kan du beskrive den/de viktigste årsaken(e) til at du sluttet i denne/disse stillingene?
(Legg gjerne ved et eget ark!)

.....

.....

.....

.....

Vi takker deg for din deltakelse i spørreundersøkelsen.

Appendix C

Til samfunnsmedisinere i bygd og by!

Deres ref.: Vår ref.: Dato: 13.11.2002

Samfunnsmedisinen utfordres, kanskje spesielt den kommunale samfunnsmedisin. Forandringene er en del av de internasjonale trendene. Nasjonalt utfordres i tillegg samfunnsmedisinen ikke minst av fastlegeordningen. Det dreier seg om både faglige, ressursmessige og personellmessige utfordringer. Det er uklart hvordan samfunnsmedisinsk legetjeneste blir påvirket av ordningen.

OLL, tidligere Folkehelsa og Universitetene i Tromsø/Trondheim har i samarbeid med Betty Pettersen i 1994 og 1999 gjort undersøkelser om utviklingen av kommunal samfunnsmedisin. Vi har blant annet kunnet vise at til tross for at flere deler på de samfunnsmedisinske oppgavene i 1999 sammenliknet med 1994, er det totale arbeidet innen de samfunnsmedisinske feltene mindre i 1999 enn i 1994, og at potensialet for tilsig av spesialister i samfunnsmedisin til kommunal samfunnsmedisin var lite. Det er spesielt innen miljørettet helsevern og administrasjon og ledelse at reduksjonen i timetall er størst.

Universitetet i Tromsø har, som en av flere grupper/institusjoner, fått i oppdrag fra Norges Forskningsråd å evaluere hvordan Fastlegeordningen påvirker kommunenes samfunnsmedisinske og offentlige legearbeid. I forbindelse med dette ble det i 2001 gjort en intervju-undersøkelse blant 90 kommuner og bydeler og dette repeteres også i år blant 60 kommuner og bydeler. Noen av dere har deltatt i disse undersøkelsene og vi takker for det!

I tillegg til fastlegeevalueringen ønsker vi å følge mer spesifikt den kommunale samfunnsmedisin, ved at vi nå sender et spørreskjema til alle landets kommunale samfunnsmedisinere. Her fokuserer vi mer på arbeidsoppgaver, faglige og organisatoriske forhold. Vi sender også et skjema til alle leger som er registrert med spesialitet i samfunnsmedisin og til leger som vi har registrert har vært i en kommunal samfunnsmedisinsk stilling over de senere år, men som per i dag ikke er registrert å være i noen kommunal samfunnsmedisinsk stilling. Gjennom å sammenholde dataene fra alle disse undersøkelsene kan vi få en bedre forståelse av utviklingen av samfunnsmedisinsk legetjeneste i dette landet - av avgjørende betydning for den offentlige debatt omkring folkehelsearbeid og primærhelsetjeneste.

Vi håper du tar deg anledning til å besvare skjemaet, og ber om at du sender skjema tilbake innen **22.11.2002** i vedlagte svarkonvolutt.

Undersøkelsen er godkjent av Datatilsynet. Informasjonen du gir blir behandlet konfidensielt.

Dersom du har spørsmål om undersøkelsen kan vi nås på telefon, faks eller email som du finner under.

Med vennlig hilsen

Roar Johnsen
Professor dr. med.
Prosjektansvarlig
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Betty Pettersen
stipendiat

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betty@poseidon.no

DET MEDISINSKE FAKULTET
INSTITUTT FOR SAMFUNNSMEDISIN
Universitetet i Tromsø, N-9037 Tromsø, Telefon 77 64 48 16, Telefaks 77 64 48 31

Til leger som tidligere har arbeidet i kommunal samfunnsmedisin!

Deres ref.: Vår ref.: Dato: 6.11.2002

Samfunnsmedisinen utfordres, kanskje spesielt den kommunale samfunnsmedisin. Forandringene er en del av de internasjonale trendene. Nasjonalt utfordres i tillegg samfunnsmedisinen ikke minst av fastlegeordningen. Det dreier seg om både faglige, ressursmessige og personellmessige utfordringer. Det er uklart hvordan samfunnsmedisinsk legetjeneste blir påvirket av ordningen.

OLL, tidligere Folkehelsa og Universitetene i Tromsø/Trondheim har i samarbeid med Betty Pettersen i 1994 og 1999 gjort undersøkelser om utviklingen av kommunal samfunnsmedisin.
Universitetet i Tromsø har, som en av flere grupper/institusjoner, fått i oppdrag fra Norges Forskningsråd å evaluere hvordan Fastlegeordningen påvirker kommunenes samfunnsmedisinske og offentlige legearbeid.

Som en del av denne forskningen inngår en undersøkelse av blant annet årsaker til å slutte i samfunnsmedisinske stillinger og eventuelle betingelser for å komme tilbake i slik stilling. Så langt vi vet har du valgt å gå ut av en kommunal samfunnsmedisinsk stilling i løpet av de siste årene og vi vil gjerne ha dine synspunkter i den forbindelse

Vi håper du tar deg anledning til å besvare skjemaet, og ber om at du sender skjema tilbake innen **20.11.2002** i vedlagte svarkonvolutt.

Undersøkelsen er godkjent av Datatilsynet. Informasjonen du gir blir behandlet konfidensielt.

Dersom du har spørsmål om undersøkelsen kan vi nås på telefon, faks eller email som du finner under.

Med vennlig hilsen
sign.

Roar Johnsen
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Løpenummer: ☐☐ ☐☐☐☐☐

Søkelys på samfunnsmedisinen

Angi svar ved å sette ring rundt **ett** tall på hvert spørsmål, slik: ○
eller ved å sette et tall i **en** eller flere ruter, slik: [4] [4]

De som arbeider i en bydel skal svare ut fra **bydelen** der det i spørsmålene står "kommunen/bydelen"

DET MEDISINSKE FAKULTET
INSTITUTT FOR SAMFUNNSMEDISIN
Universitetet i Tromsø, N-9037 Tromsø

1. Angi etter beste skjønn hvor mye tid i gjennomsnitt du bruker til arbeid med følgende deltjenester (oppgi antall timer per uke. Skriv 0 – null dersom du ikke arbeider innenfor deltjenesten).

1	Miljørettet helsevern (definert bredt)	[ ] Timer
2	Administrasjon/ledelse	[ ] Timer
3	Kurativ praksis – fastlønnet	[ ] Timer
4	Kurativ praksis – lønnet etter normaltariffen	[ ] Timer
5	Helsestasjon	[ ] Timer
6	Skolehelsetjeneste	[ ] Timer
7	Syke - / aldershjem	[ ] Timer
8	Bedriftshelsetjeneste	[ ] Timer
9	Annet forebyggende arbeid	[ ] Timer
10	Annet arbeid (undervisning, forskning, militærlege etc.)	[ ] Timer
11	Legevaktarbeid (Ant. timer vakt utover vanlig arbeidstid)	[ ] Timer
SUM antall timer per uke		[ ] Timer

2. Hvor stor stillingsprosent har du innenfor samfunnsmedisin i din avtale med kommunen/bydelen?

.....% alternativt .....t/uke

3. Hvor stor pasientliste har du?

[ ][ ][ ][ ] pasienter [ ] ingen pasienter

4. Hvordan er det samfunnsmedisinske legearbeidet ditt betalt?

( ) Fast lønn
( ) Betalt per time utført arbeide
( ) Annen måte, beskriv.....

5. Hvordan er det kliniske arbeidet ditt betalt?

( ) Fast lønn
( ) Privat praksis avtale/fastlegeavtale (med alle avarter...)
( ) Annen måte, beskriv.....

6. Hva slags ansettelsesform har du i kommunen/bydelen ? (for ditt SM-arbeide)

( ) Fast ansettelse
( ) Midlertidig
( ) Konstituert
( ) Annet, beskriv.....
( ) Vet ikke

7. Har du fast stedfortreder i din samfunnsmedisinske stilling?

[ ] Ja [ ] Nei [ ] Vet ikke

8. Hvilke av følgende tilleggsutdannelser har du? (Sett evt. ring rundt flere)

1 Kommunelege - / Bygdøykurset
2 Folkehelseutdanning/Master of Health Administration
3 Master of Public Health
4 Distriktshøyskoleutdanning, beskriv.....
5 Annet, beskriv.....
6 Ingen

9. Hvilke av følgende deltjenester har du budsjett- og/eller personalansvar for? (Sett ring rundt tallet, evt. for flere)

		Har budsjett-ansvar	Har personal-ansvar	Har ikke budsjett- eller personalansvar for denne
1	Allmennlegetjeneste	( )	( )	( )
2	Fysioterapi	( )	( )	( )
3	Hjemmebasert omsorg	( )	( )	( )
4	Helsesøstertjeneste	( )	( )	( )
5	Jordmortjeneste	( )	( )	( )
6	Ergoterapi	( )	( )	( )
7	Miljørettet helsevern	( )	( )	( )
8	Avdeling for forebyggende arbeid	( )	( )	( )
9	Bedriftshelsetjeneste	( )	( )	( )
10	Næringsmiddelkontroll/tilsyn, beskriv.....			
11	Annet, beskriv.....			

10. Personellressursene tilgjengelige for samfunnsmedisinere varierer, både i type og antall. Angi i felt A hvorvidt du har stillingshjemler for følgende type personell. I felt B angir du hvorvidt du synes du har for lite, nok eller for mye av de enkelte typene personell. Du bes altså svare både i felt A og B, uansett.

		A		B		
		Har	Har ikke	For lite	Nok	For mye
1	Teknisk – hygienisk personell	1	2	3	4	5
2	Helsesøster	1	2	3	4	5
3	Annet helsefaglig personell	1	2	3	4	5
4	Veterinær	1	2	3	4	5
5	Sekretærhjelp	1	2	3	4	5
6	Annet, beskriv.....					

11. Hvor lenge har du hatt nåværende stilling?

(Angi antall år hel- eller deltid) [ ][ ] år [ ][ ] mnd.

12. Har du vært i annen samfunnsmedisinsk stilling enn den du har nå i løpet av de siste 5 år?

( ) Ja
( ) Nei

Hvis ja, kan du beskrive den/de viktigste årsaken(e) til at du sluttet i denne/disse stillingen(e)? (Legg gjerne ved et ark!)

.....
.....
.....

13. Hvordan er interessen for det samfunnsmedisinske arbeidet du gjør?

		Svært stor	Nokså stor	Både/ og	Nokså liten	Svært liten
1	Blant kommunalt ansatte leger	1	2	3	4	5
2	Blant privatpraktiserende leger	1	2	3	4	5
3	Blant helsesøstre	1	2	3	4	5
4	Blant annet helsepersonell	1	2	3	4	5
5	Hos dine administrativt overordnede	1	2	3	4	5
6	Hos andre kommunale etater	1	2	3	4	5
7	Hos sektorpolitikere	1	2	3	4	5
8	Hos andre politikere i kommunen	1	2	3	4	5

14. Angi ved å sette ring rundt ett tall på hvert spørsmål i hvilken grad du er fornøyd med:

		Svært fornøyd	Fornøyd	Både/ og	Misfor-nøyd	Svært misfor-nøyd
1	Den ansvarsmengde du har	1	2	3	4	5
2	Fysiske arbeidsforhold	1	2	3	4	5
3	Din frihet til å bestemme hva du skal gjøre	1	2	3	4	5
4	Din frihet til å velge arbeidsmetoder	1	2	3	4	5
5	Din frihet til å bestemme arbeidstempo	1	2	3	4	5
6	Muligheten/anledningen til å bruke dine evner	1	2	3	4	5
7	Lønnsforholdene	1	2	3	4	5
8	Stillingsinstruksen	1	2	3	4	5
9	Jobben din alt i alt	1	2	3	4	5
10	Nå du tenker på hvordan du har det for tiden, er du stort sett fornøyd med tilværelsen eller er du stort sett misfornøyd?	1	2	3	4	5
11	Hvis du skulle svare på spørsmålet hvor fornøyd du var for fem år siden, hva ville du svart da?	1	2	3	4	5
12	Hva tror du du vil svare på spørsmålet om hvor fornøyd du er om fem år?	1	2	3	4	5

15. Det har i kommunehelsetjenesten de siste årene foregått en desentralisering av oppgaver og ansvar. For mange innebærer dette delegering av nye oppgaver. Som leder i en avdeling, hvordan mener du at du mestrer de følgende oppgavene i ditt daglige arbeid?

		Mestrer svært dårlig				Mestrer svært bra
1	Sikre faglige standarder for aktivitetene	1	2	3	4	5
2	Stimulere til samarbeid mellom ulike avdelinger i etaten	1	2	3	4	5
3	Holde underordnede orientert om mål og planer	1	2	3	4	5
4	Utvikle og ta i bruk nye rutiner og arbeidsmåter	1	2	3	4	5
5	Stå for økonomistyring, regnskap og budsjett	1	2	3	4	5
6	Koordinere ulike typer aktiviteter	1	2	3	4	5
7	Være informert om synspunkter fra pasienter og pasientgrupper	1	2	3	4	5
8	Løse mellommenneskelige problemer og motsetninger	1	2	3	4	5
9	Ta initiativ i forhold til nye faglige muligheter	1	2	3	4	5
10	Være et samlende symbol, motivere, begeistre og skape entusiasme	1	2	3	4	5
11	Sørge for at regler og rutiner følges	1	2	3	4	5
12	Legge opp de daglige arbeidsrutiner	1	2	3	4	5
13	Løse problemer gjennom å endre organisasjonen	1	2	3	4	5
14	Være informert om politiske signaler	1	2	3	4	5
15	Innarbeide politiske signaler i virksomheten	1	2	3	4	5
16	Veilede underordnede, stimulere til faglig utvikling	1	2	3	4	5
17	Sørge for at nyansatte gis instruksjon og opplæring	1	2	3	4	5

16. Hvordan vil du i hovedsak karakterisere ditt forhold til følgende:

		Svært godt	Godt	Både /og	Dårlig	Svært dårlig	Vet ikke	Ikke aktuelt
1	Overordnet kommuneadministrasjon	1	2	3	4	5	6	7
2	Overordnet ledelse på helse/sosialsektor	1	2	3	4	5	6	7
3	Pleie – og omsorgssjef/sykepleiesjef	1	2	3	4	5	6	7
4	Andre avdelinger i helseetaten	1	2	3	4	5	6	7
5	Sektorpolitikere i kommunen/bydelen	1	2	3	4	5	6	7
6	Andre politikere i kommunen/bydelen	1	2	3	4	5	6	7
7	Private/frivillige organisasjoner som utfører helsemessige oppgaver	1	2	3	4	5	6	7
8	Helsesøstre	1	2	3	4	5	6	7
9	Fysioterapeuter	1	2	3	4	5	6	7
10	Teknisk-hygienisk personell	1	2	3	4	5	6	7
11	Økonomisk-administrativt personell i helseetaten	1	2	3	4	5	6	7
12	Kommunalt ansatte leger	1	2	3	4	5	6	7
13	Private leger med kommunal avtale	1	2	3	4	5	6	7
14	Private leger uten kommunal avtale	1	2	3	4	5	6	7
15	Kommunal(e) institusjoner for eldre, syke, uføre	1	2	3	4	5	6	7

17. Angi etter beste skjønn hvor ofte du har deltatt i planlagte møter det siste året med noen av de følgende instansene. (Ta med møter innenfor vanlig arbeidstid hvor du eller de nevnte instansene er enten hovedaktør eller likeverdige deltagere i samarbeidsmøter av noe slag. Her skal du ikke ta med rene undervisnings- eller rådgivningssammenkomster.)

		Aldri	1 gang	2-3 ggr	Minst 4 ggr
1	Administrativ ledelse for hjemmesykepleien	1	2	3	4
2	Klinisk personale i hjemmesykepleien	1	2	3	4
3	Hjemmehjelpstjeneste	1	2	3	4
4	Lokalsykehusets administrative ledelse	1	2	3	4
5	Lokalsykehusets somatisk-faglige ledelse	1	2	3	4
6	Lokalsykehusets psykiatrisk-faglige ledelse	1	2	3	4
7	Administrativ ledelse ved sykehjem	1	2	3	4
8	Klinisk personale i sykehjem	1	2	3	4
9	Fysioterapitjeneste	1	2	3	4
10	Helsesøstertjeneste	1	2	3	4
11	Miljøvernseksjon (el.tilsv.)	1	2	3	4
12	Teknisk etat	1	2	3	4
13	Skole/undervisningsetat	1	2	3	4
14	Kulturetat	1	2	3	4
15	Sosialkontor	1	2	3	4
16	Barnevern	1	2	3	4
17	Arbeidsmarkedsetat	1	2	3	4
18	Trygdekontor	1	2	3	4

18. Har du planer om å skaffe deg ny jobb i løpet av de nærmeste 12 måneder?
(Sett ring rundt svar på hver linje)

		Ja	Nei	Vet ikke
1	Innenfor samfunnsmedisinsk arbeid	1	2	3
2	Innenfor annet medisinsk arbeid	1	2	3
3	I en annen kommune/bydel	1	2	3
4	På annet forvaltningsnivå/ i avtalepraksis	1	2	3

Dersom du svarte nei på spørsmål 18, ber vi deg se lengre fremover og svare på spørsmålet nedenfor. Vi er klar over at det er vanskelig å forutsi hvilke valg du vil gjøre i fremtiden, men ber deg svare det du i dag tror er mest sannsynlig.

19. Tror du at du vil søke deg bort fra kommunal samfunnsmedisinsk stilling før pensjonsalderen?

[ ] Ja [ ] Nei

Hvis ja, om hvor mange år? ☐

Vi takker deg for din deltakelse i spørreundersøkelsen.

Løpenummer: ☐☐ ☐☐☐☐☐

Søkelys på samfunnsmedisinen

Angi svar ved å sette ring rundt **ett** tall på hvert spørsmål, slik: ○
eller ved å sette et tall i **en** eller flere ruter, slik: [4] [4]

De som arbeider i en bydel skal svare ut fra **bydelen** der det i spørsmålene står "kommunen/bydelen"

DET MEDISINSKE FAKULTET
INSTITUTT FOR SAMFUNNSMEDISIN
Universitetet i Tromsø, N-9037 Tromsø
2002

Mange leger med spesialitet i samfunnsmedisin arbeider i dag med kommunal samfunnsmedisin. Imidlertid arbeider svært mange i kliniske stillinger eller i andre typer stillinger på andre forvaltningsnivåer. I følge våre opplysninger er du en av disse.

Som en del av våre undersøkelser på samfunnsmedisin inngår yrkesmessig karrierevalg. Vi ønsker derfor å vite litt om din stilling i dag, og hva du tenker om fremtidig valg av arbeidssituasjon. Vi er klar over at det kan være vanskelig å forutsi hvilke valg du vil gjøre i fremtiden, men ber deg svare det du i dag tror er mest sannsynlig.

1. Hvor arbeider du i dag? (Kryss der det passer, - flere dersom aktuelt)

( ) Allmennmedisin
( ) Sykehus/spesialisthelsetjeneste
( ) Folketrygden/Rikstrygdeverket
( ) Kommunal administrativ stilling
( ) Fylkeskommunal administrativ stilling
( ) Helsetilsynet
( ) Fylkeslegeetaten
( ) Helsedepartementet
( ) Annet departement, hvilket .....
( ) Folkehelseinstituttet
( ) Universitet
( ) Høyskole
( ) Annen undervisningsstilling
( ) WHO/annen internasjonal stilling, hvilken .....
( ) Bedriftshelsetjeneste
( ) Kommunal samfunnsmedisinsk stilling
( ) Jeg er pensjonist
( ) Annet, beskriv .....

2. Dersom du er i en klinisk stilling, tror du at du vil søke deg til noen samfunnsmedisinsk stilling (eller øke din stillingsandel i samfunnsmedisinsk arbeide) før pensjonsalder?

( ) Ja — Hvis ja, om hvor mange år? ( )( )( ) antall år
( ) Nei
( ) Vet ikke
( ) Er ikke i klinisk stilling

3. Tror du at du vil søke deg til noen kommunal samfunnsmedisinsk stilling før pensjonsalder?

( ) Ja — Hvis ja, om hvor mange år? ( )( )( ) antall år
( ) Nei
( ) Vet ikke

4. Hvilken betydning har følgende faktorer for om du skal vende tilbake til en kommunal samfunnsmedisinsk stilling?

		Svært viktig	Nokså viktig	Både/ og	Nokså uviktig	Svært uviktig
1	Den ansvarsmengde du vil få	1	2	3	4	5
2	Fysiske arbeidsforhold	1	2	3	4	5
3	Din frihet til å bestemme hva du skal gjøre	1	2	3	4	5
4	Din frihet til å velge arbeidsmetoder	1	2	3	4	5
5	Din frihet til å bestemme arbeidstempo	1	2	3	4	5
6	Muligheten/anledningen til å bruke dine evner	1	2	3	4	5
7	Lønnsforholdene	1	2	3	4	5
8	Stillingsinstruksen	1	2	3	4	5
9	Andre faktorer, beskriv					

5a. Har du vært i noen kommunal samfunnsmedisinsk stilling i løpet av de siste 5 år?

( ) Ja
( ) Nei

Hvis ja, kan du beskrive den/de viktigste årsaken(e) til at du sluttet i denne/disse stillingen(e)? (Legg gjerne ved et ark!)

.....
.....
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Vi takker deg for din deltakelse i spørreundersøkelsen!

Løpenummer: ☐☐ ☐☐☐☐☐

Søkelys på samfunnsmedisinen

Angi svar ved å sette ring rundt **ett** tall på hvert spørsmål, slik: ○
eller ved å sette et tall i **en** eller flere ruter, slik: [4] [4]

De som arbeider i en bydel skal svare ut fra **bydelen** der det i spørsmålene står "kommunen/bydelen"

DET MEDISINSKE FAKULTET
INSTITUTT FOR SAMFUNNSMEDISIN
Universitetet i Tromsø, N-9037 Tromsø

Mange leger har i perioder arbeidet i kommunale samfunnsmedisinske stillinger, men har valgt å gå ut av disse. I følge våre opplysninger har du vært i en slik stilling over de senere år.

Som en del av våre undersøkelser om samfunnsmedisin inngår yrkesmessig karrierevalg. Vi ønsker derfor å vite litt om din stilling i dag, hvorfor du valgte å gå ut av kommunal samfunnsmedisinsk stilling og hva du tenker om fremtidig valg av arbeidssituasjon. Vi er klar over at det kan være vanskelig å forutsi hvilke valg du vil gjøre i fremtiden, men ber deg svare det du i dag tror er mest sannsynlig.

1. Hvor arbeider du i dag? (Kryss der det passer, - flere dersom aktuelt)

( ) Allmennmedisin
( ) Sykehus/spesialisthelsetjeneste
( ) Folketrygden/Rikstrygdeverket
( ) Kommunal administrativ stilling
( ) Fylkeskommunal administrativ stilling
( ) Helsetilsynet
( ) Fylkeslegeetaten
( ) Helsedepartementet
( ) Annet departement, hvilket .....
( ) Folkehelseinstituttet
( ) Universitet
( ) Høyskole
( ) Annen undervisningsstilling
( ) WHO/annen internasjonal stilling, hvilken .....
( ) Bedriftshelsetjeneste
( ) Kommunal samfunnsmedisinsk stilling
( ) Jeg er pensjonist
( ) Annet, beskriv .....

2. Dersom du er i en klinisk stilling, tror du at du vil søke deg til noen samfunnsmedisinsk stilling (eller øke din eventuelle stillingsandel i samfunnsmedisinsk arbeide) før pensjonsalder?

( ) Ja — Hvis ja, om hvor mange år? ( )( ), ( ) antall år
( ) Nei
( ) Vet ikke
( ) Er ikke i klinisk stilling

3. Tror du at du vil søke deg til noen kommunal samfunnsmedisinsk stilling før pensjonsalder?

( ) Ja — Hvis ja, om hvor mange år? ( )( ), ( ) antall år
( ) Nei
( ) Vet ikke

4. Har du vært i noen kommunal samfunnsmedisinsk stilling i løpet av de siste 5 år?

( ) Ja (gå til spørsmål 5)
( ) Nei

5. Vi er interessert i å vite hvilken betydning følgende faktorer hadde for din beslutning om å slutte i slik stilling:

		Svært viktig	Nokså viktig	Både/ og	Nokså uviktig	Svært uviktig
1	Den ansvarsmengde du hadde	1	2	3	4	5
2	Fysiske arbeidsforhold	1	2	3	4	5
3	Din frihet til å bestemme hva du skulle gjøre	1	2	3	4	5
4	Din frihet til å velge arbeidsmetoder	1	2	3	4	5
5	Din frihet til å bestemme arbeidstempo	1	2	3	4	5
6	Muligheten/anledningen til å bruke dine evner	1	2	3	4	5
7	Lønnsforholdene	1	2	3	4	5
8	Stillingsinstruksen	1	2	3	4	5
9	Lokalt faglig miljø	1	2	3	4	5
10	Kontakt med faglige ressursmiljøer utenfor kommunen	1	2	3	4	5
11	Andre faktorer, beskriv (Legg gjerne ved et ark!).....					

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Vi takker deg for din deltakelse i spørreundersøkelsen!

ISM SKRIFTSERIE - FØR UTGITT:

1. Bidrag til belysning av medisinske og sosiale forhold i Finnmark fylke, med særlig vekt på forholdene blant finskættede i Sør-Varanger kommune.
Av Anders Forsdahl, 1976. (nytt opplag 1990)

2. Sunnhetstilstanden, hygieniske og sosiale forhold i Sør-Varanger kommune 1869-1975 belyst ved medisinal-beretningene.
Av Anders Forsdahl, 1977.

3. Hjerte-karundersøkelsen i Finnmark - et eksempel på en populasjonsundersøkelse rettet mot cardiovasculære sykdommer. Beskrivelse og analyse av etterundersøkelsesgruppen.
Av Jan-Ivar Kvamme og Trond Haider, 1979.

4. D. The Tromsø Heart Study: Population studies of coronary risk factors with special emphasis on high density lipoprotein and the family occurrence of myocardial infarction.
Av Olav Helge Førde og Dag Steinar Thelle, 1979.

5. D. Reformer i distriktshelsetjenesten III: Hypertensjon i distriktshelsetjenesten.
Av Jan-Ivar Kvamme, 1980.

6. Til professor Knut Westlund på hans 60-års dag, 1983.

7.* Blodtrykksovervåkning og blodtrykksmåling.
Av Jan-Ivar Kvamme, Bernt Nesje og Anders Forsdahl, 1983.

8.* Merkesteiner i norsk medisin reist av allmennpraktikere - og enkelte utdrag av medisinalberetninger av kulturhistorisk verdi.
Av Anders Forsdahl, 1984.

9. "Balsfjordsystemet." EDB-basert journal, arkiv og statistikksystem for primærhelsetjenesten.
Av Toralf Hasvold, 1984.

10. D. Tvunget psykisk helsevern i Norge. Rettsikkerheten ved slikt helsevern med særlig vurdering av kontrollkommisjonsordningen.
Av Georg Høyer, 1986.

11. D. The use of self-administered questionnaires about food habits. Relationships with risk factors for coronary heart disease and associations between coffee drinking and mortality and cancer incidence.
Av Bjarne Koster Jacobsen, 1988.

12.* Helse og ulikhet. Vi trenger et handlingsprogram for Finnmark.
Av Anders Forsdahl, Atle Svendal, Aslak Syse og Dag Thelle, 1989.

13. D. Health education and self-care in dentistry - surveys and interventions.
Av Anne Johanne Søgaard, 1989.

14. Helsekontroller i praksis. Erfaringer fra prosjektet helsekontroller i Troms 1983-1985.
Av Harald Siem og Arild Johansen, 1989.

15. Til Anders Forsdahls 60-års dag, 1990.

16. D. Diagnosis of cancer in general practice. A study of delay problems and warning signals of cancer, with implications for public cancer information and for cancer diagnostic strategies in general practice.
Av Knut Holtedahl, 1991.

17. D. The Tromsø Survey. The family intervention study. Feasibility of using a family approach to intervention on coronary heart disease. The effect of lifestyle intervention of coronary risk factors.
Av Synnøve Fønnebø Knutsen, 1991.

18. Helhetsforståelse og kommunikasjon. Filosofi for klinikere.
Av Åge Wifstad, 1991.

19. D. Factors affecting self-evaluated general health status - and the use of professional health care services.
Av Knut Fylkesnes, 1991.

20. D. Serum gamma-glutamyltransferase: Population determinants and diagnostic characteristics in relation to intervention on risk drinkers.
Av Odd Nilssen, 1992.

21. D. The Healthy Faith. Pregnancy outcome, risk of disease, cancer morbidity and mortality in Norwegian Seventh-Day-Adventists.
Av Vinjar Fønnebø, 1992.

22. D. Aspects of breast and cervical cancer screening.
Av Inger Torhild Gram, 1992.

23. D. Population studies on dyspepsia and peptic ulcer disease: Occurrence, aetiology, and diagnosis. From The Tromsø Heart Study and The Sørreisa Gastrointestinal Disorder Studie.
Av Roar Johnsen, 1992.

24. D. Diagnosis of pneumonia in adults in general practice.
Av Hasse Melbye, 1992.

25. D. Relationship between hemodynamics and blood lipids in population surveys, and effects of n-3 fatty acids.
Av Kaare Bønaa, 1992.

26. D. Risk factors for, and 13-year mortality from cardiovascular disease by socioeconomic status. A study of 44690 men and 17540 women, ages 40-49. **Av Hanne Thürmer, 1993.**

27. Utdrag av medisinalberetninger fra Sulitjelma 1891-1990. **Av Anders Forsdahl, 1993.**

28. Helse, livsstil og levekår i Finnmark. Resultater fra Hjerte-karundersøkelsen i 1987-88. Finnmark III. **Av Knut Westlund og Anne Johanne Søgaard, 1993.**

29. D. Patterns and predictors of drug use. A pharmacoepidemiologic study, linking the analgesic drug prescriptions to a population health survey in Tromsø, Norway. **Av Anne Elise Eggen, 1994.**

30. D. ECG in health and disease. ECG findings in relation to CHD risk factors, constitutional variables and 16-year mortality in 2990 asymptomatic Oslo men aged 40-49 years in 1972. **Av Per G. Lund-Larsen, 1994.**

31. D. Arrhythmia, electrocardiographic signs, and physical activity in relation to coronary heart risk factors and disease. The Tromsø Study. **Av Maja-Lisa Løchen, 1995.**

32. D. The Military service: mental distress and changes in health behaviours among Norwegian army conscript. **Av Edvin Schei, 1995.**

33. D. The Harstad injury prevention study: Hospital-based injury recording and community-based intervention. **Av Børge Ytterstad, 1995.**

34.* D. Vilkår for begrepsdannelse og praksis i psykiatri. En filosofisk undersøkelse. **Av Åge Wifstad, 1996.** (utgitt Tano Aschehoug forlag 1997)

35. Dialog og refleksjon. Festskrift til professor Tom Andersen på hans 60-års dag, 1996.

36. D. Factors affecting doctors' decision making. **Av Ivar Sønbø Kristiansen, 1996.**

37. D. The Sørreisa gastrointestinal disorder study. Dyspepsia, peptic ulcer and endoscopic findings in a population. **Av Bjørn Bernersen, 1996.**

38. D. Headache and neck or shoulder pain. An analysis of musculoskeletal problems in three comprehensive population studies in Northern Norway. **Av Toralf Hasvold, 1996.**

39. Senfølger av kjernefysiske prøvespreninger på øygruppen Novaya Semlya i perioden 1955 til 1962. Rapport etter programmet "Liv". Arkangelsk 1994.
Av A.V. Tkatchev, L.K. Dobrodeeva, A.I. Isaev, T.S. Podjakova, 1996.

40. Helse og livskvalitet på 78 grader nord. Rapport fra en befolkningsstudie på Svalbard høsten 1988. **Av Helge Schirmer, Georg Høyer, Odd Nilssen, Tormod Brenn og Siri Steine, 1997.**

41.* D. Physical activity and risk of cancer. A population based cohort study including prostate, testicular, colorectal, lung and breast cancer.
Av Inger Thune, 1997.

42. The Norwegian - Russian Health Study 1994/95. A cross-sectional study of pollution and health in the border area.
Av Tone Smith-Sivertsen, Valeri Tchachtchine, Eiliv Lund, Tor Norseth, Vladimir Bykov, 1997.

43. D. Use of alternative medicine by Norwegian cancer patients
Av Terje Risberg, 1998.

44 D. Incidence of and risk factors for myocardial infarction, stroke, and diabetes mellitus in a general population. The Finnmark Study 1974-1989.
Av Inger Njølstad, 1998.

45. D. General practitioner hospitals: Use and usefulness. A study from Finnmark County in North Norway.
Av Ivar Aaraas, 1998.

45B Sykestuer i Finnmark. En studie av bruk og nytteverdi.
Av Ivar Aaraas, 1998.

46. D. No går det på helsa laus. Helse, sykdom og risiko for sykdom i to nord-norske kystsamfunn.
Av Jorid Andersen, 1998.

47. D. The Tromsø Study: Risk factors for non-vertebral fractures in a middle-aged population.
Av Ragnar Martin Joakimsen, 1999.

48. D. The potential for reducing inappropriate hospital admissions: A study of health benefits and costs in a department of internal medicine.
Av Bjørn Odvar Eriksen, 1999.

49. D. Echocardiographic screening in a general population. Normal distribution of echocardiographic measurements and their relation to cardiovascular risk factors and disease. The Tromsø Study.
Av **Henrik Schirmer, 2000.**

50. D. Environmental and occupational exposure, life-style factors and pregnancy outcome in artic and subartic populations of Norway and Russia.
Av Jon Øyvind Odland, 2000.

50B Окружающая и профессиональная экспозиция, факторы стиля жизни и исход беременности у населения арктической и субарктической частей Норвегии и России
Юн Ойвин Удлан 2000

51. D. A population based study on coronary heart disease in families. The Finnmark Study 1974-1989.
Av Tormod Brenn, 2000.

52 D. Ultrasound assessed carotid atherosclerosis in a general population. The Tromsø Study.
Av Oddmund Joakimsen, 2000.

53. D. Risk factors for carotid intima-media thickness in a general population. The Tromsø Study 1979-1994.
Av Eva Stensland-Bugge, 2000.

54. D. The South Asian cataract management study.
Av Torkel Snellingen, 2000.

55. D. Air pollution and health in the Norwegian-Russian border area.
Av Tone Smith-Sivertsen, 2000.

56. D. Interpretation of forearm bone mineral density. The Tromsø Study.
Av Gro K. Rosvold Berntsen, 2000.

57. D. Individual fatty acids and cardiovascular risk factors.
Av Sameline Grimsgaard, 2001.

58. Finnmarkundersøkelsene
Av Anders Forsdahl, Fylkesnes K, Hermansen R, Lund E, Lupton B, Selmer R, Straume E, 2001.

59. D. Dietary data in the Norwegian women and cancer study. Validation and analyses of health related aspects.
Av Anette Hjartåker, 2001.

60. D. The stenotic carotid artery plaque. Prevalence, risk factors and relations to clinical disease. The Tromsø Study.
Av Ellisiv B. Mathiesen, 2001.

61. D. Studies in perinatal care from a sparsely populated area.
Av Jan Holt, 2001.

62. D. Fragile bones in patients with stroke? Bone mineral density in acute stroke patients and changes during one year of follow up.
Av Lone Jørgensen, 2001.

63. D. Psychiatric morbidity and mortality in northern Norway in the era of deinstitutionalisation. A psyhiatric case register study.
Av Vidje Hansen, 2001.

64. D. Ill health in two contrasting countries.
Av Tom Andersen, 1978/2002.

65. D. Longitudinal analyses of cardiovascular risk factors.
Av Tom Wilsgaard, 2002.

66. Helseundersøkelsen i Arkangelsk 2000.
Av Odd Nilssen, Alexei Kalinin, Tormod Brenn, Maria Averina et al.,2003.

67. D. Bio-psycho-social aspects of severe multiple trauma.
Av Audny G. W. Anke, 2003.

68. D. Persistent organic pollutants in human plasma from inhabitants of the artic.
Av Torkjel Manning Sandanger, 2003.

69. D. Aspects of women's health in relation to use of hormonal contraceptives and pattern of child bearing.
Av Merethe Kunmle, 2003.

70. Pasienterfaringer i primærlegetjenesten før og etter fastlegereformen.
Av Olaug Lian, 2003.

71. D. Vitamin D security in northern Norway in relation to marine food traditions.
Av Magritt Brustad, 2004.

72. D. Intervensjonsstudien i Finnmark. Evaluering av lokalsamfunns basert hjerte- og kar forebygging i kystkommunene Båtsfjord og Nordkapp.
Av Beate Lupton, 2004.

73. D. Environmental factors, metabolic profile, hormones and breast and endiometrial cancer risk.
Av Anne-Sofie Furberg, 2004.

74. D. Det skapende mellomrommet i møtet mellom pasient og lege.
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