The Professional Status of Physicians in the Nordic Countries

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TALCOTT PARSONS (1951) SEMINAL WORK ON THE medical profession created a whole field of sociological studies of the characteristics of professions in modern society. The medical profession has ever since been used not only as a prototype of an occupation that enjoys autonomy and authority over its clients, but also as a general indicator of broader structural features and especially of changes occurring in society. An example is the recent debate among American sociologists about the character and impact of the changes occurring in the social position of American physicians. These changes are not only seen as caused by structural changes in the American health care system but also as being related to more universal changes in the structure of health care delivery in modern society.

Freidson (1984, 1985) has provided an excellent review of this American debate and a summary of the three major positions. The first of these holds that the corporatization of health care forces physicians to become salaried employees in large health care organizations and thus to loose their character as a free profession (McKinlay and Arches 1985; McKinlay and Stoeckle 1987). This position has been called the proletarianization thesis. The second position argues that the emerging information society reduces the medical profession's possibilities for maintaining its knowledge monopoly, which ultimately is its major power source (Haug 1975). This has been presented as the deprofes-

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sionalization thesis. The third position predicts a continuing professional dominance of the medical profession as it has formalized a system of stratification within the profession. It is suggested that the internal differentiation between an administrative elite, a knowledge elite, and ordinary practitioners implies that the formulation, direction, and execution of the control of professional work will remain in the hands of the medical profession (Freidson 1984).

While American sociologists have indicated that the changing nature of professional control of the medical profession in the United States is part of a world-wide process, European sociologists have not hitherto been equally convinced of this. One counterargument has been that the free enterprise approach and the weak role of government in American health care delivery have led to the particular situation in the American society, which is not comparable to that in typical European societies. Nevertheless, as the governments in Europe have invested both in high-technology medicine and in public primary care, the theoretical concerns of the American debate are pertinent. High-technology medicine has concentrated health care in large and hierarchically organized hospital and medical units while the public primary care systems have created a bureaucratized medical practice in which the government often is a major or only employer. The question is then, what is happening to the relation between skill in and control over medical work in such circumstances? Braverman (1974) has provided the broader theoretical framework for understanding the gradual erosion of the craftsmen's traditional skills and control over work in the process of industrialization. A similar process is assumed to take place for both traditional professions, such as physicians (McKinlay and Arches 1985), and mass professions (Shaw 1987).

The purpose of this article is to examine to what extent changes in the social position of physicians has occurred in the Nordic countries. In order to illuminate this question, the article will first describe the rise of the medical profession in Denmark, Norway, Sweden, and Finland. As the structure of medical work has changed, the relation between the medical profession and the state to a large extent explains the current social position of physicians. It will be argued that if physicians control the management of medical work, ranging from the organization of the hospital to health planning and public administration, then they will be powerful even if they might have lost other attributes of a free profession. Finally, it will be shown that a

TABLE 1
Population per Physician in the Nordic Countries, 1860–2000

Year	Denmark	Finland	Norway	Sweden
1860	4,362*	18,472	4,808	8,674
1890	2,244	10,012	2,875	5,937
1900	1,824	7,093	2,517	4,542
1930	1,425	3,449	1,586	2,743
1950	962	2,005	985	1,440
1960	811	1,573	884	1,053
1970	629	964	684	763
1980	460	531	522	499
1985	392	482	452	398
1990	310	400	380	340
2000	290	320	300	270

Source: Berg 1980, 24; Ito 1980, 58; Statistical Yearbook of Finland 1973, 316; Nordic Medical Statistical Commission 1980, 34; Yearbook of Nordic Statistics 1987, 329; SNAPS 1986, 37.
* The data are from 1850 and derived from Rørbye 1976.

high rate of women physicians in the Nordic countries has created a dual labor market within medicine. This fact has not been taken into account by most sociologists who have discussed the future of the profession and who treat the profession in sex-neutral terms.

The Development of the Medical Profession in the Nordic Countries

The Nordic countries are often envisioned as homogenous and similar as far as their social, political, and economic structure is concerned. Although there are some common features, both their past and present welfare societies differ considerably (Flora 1986). The same picture emerges as one examines the rise of the medical profession and its power in the modern health care delivery system. As early as a century ago, the current different patterns in the availability of physicians were already evident. As table 1 records, the Nordic countries can be divided into two groups if availability of health services is measured as the population per physician.

As early as in the latter part of the nineteenth century, Denmark

and Norway had a much higher ratio of physicians than Sweden and Finland. The numerical strength and concomitant professional power of physicians in Denmark and Norway were related to the early organization of the medical profession. The Danish medical association was organized in 1857 with a highest priority for the establishment of sickness funds which would guarantee the reimbursement for physicians' services (Ito 1980, 50–52). The Danish medical profession was used to an organized medical market as the earlier craft guilds had secured the provision of medical coverage for its members. When the guilds were to be dissolved in 1861, organized medicine was interested in securing the reimbursement for physicians' services and in the establishment of a functional alternative to its previous arrangements with organized consumers. The physicians were instrumental in founding sickness funds, which grew particulary rapidly in the rural areas. The sickness funds not only provided financial security for the private practitioners but allowed an actual increase in the number of private practitioners as well. While most physicians in the other countries were public employees, as shown below, 65 percent of the Danish physicians were private practitioners in 1880 (Ito 1980, 54), a feature which persisted until the 1950s (Ito 1980, 56).

The Danish medical profession managed to maintain its professional autonomy by transforming the prior health care delivery arrangements of the craft and guild society into a modern context. The local Danish medical associations negotiated the financing of their services directly with the federation of local sickness funds which consisted of local consumer cooperatives (McLeod 1975). The relatively weak role of government has led to characterization of the Danish health care system as "collective voluntarism" (Ito 1980, 65).

Norwegian physicians were trained abroad well into the nineteenth century, mainly in Denmark and Germany. Only in 1814 were the first three professors of medicine appointed at the newly established university in Christiania (Oslo). Although a domestic education of physicians had been started, the number of physicians in the beginning grew very slowly. The population was widely dispersed and confidence in folk medicine remained higher than in urban centers, circumstances which led to a small market for the services of regular physicians. The weak market position of the medical profession was eased by the government, which employed physicians in the armed forces, at the university as professors, and as medical officers in municipal health

care (Berg 1980; Elstad 1987). During the nineteenth century, a major portion of Norwegian physicians were therefore public employees, who derived their professional power from their affiliation with the government and public authorities rather than from the private market. Beginning in 1912, physicians began to receive a large part of their incomes from sickness insurance. As medicine in Norway after World War II came to be practiced within institutional settings—i.e., government-owned hospitals—a large part of these physicians remained public employees (Elstad 1987, 292).

The growth of the profession of medicine was even slower in Sweden and Finland. Unlike Denmark, there was no organized medical market stemming from the preindustrial era nor were there any large middle and working classes compared to those which in Great Britain organized the medical market through Friendly Societies (Parry and Parry 1976; Honingsbaum 1979). Both in Sweden and Finland it was the government which provided the infrastructure for the emergence and expansion of scientific medicine (Anderson 1972; Pesonen 1980). During the nineteenth century, medical practice was, as in Norway, made possible through the establishment of salaried positions by state and local government. Examples were the positions of district physician, municipal or city physician, prison physician, or finally as chief ward physician at state or municipal hospitals. The subsistence economy in the countryside and a small middle or upper class in the few, relatively small urban areas could not sustain private practice, aside of course from the practitioners of traditional folk medicine.

The general status of physicians as public employees seems also to have retarded the professional organization of both Finnish and Swedish physicians. Compared to the establishment of the Danish medical association in 1857 and of the corresponding Norwegian medical association in 1886, the Swedish physicians founded their professional organization only in 1903 and the Finnish physicians in 1911 (Kock 1963; Pesonen 1980). Up to this time the Swedish physicians had been more interested in improving their salary and pensions as civil servants than in defending the position of a free medical profession or a free medical marketplace which had been the goals of the medical profession in France (Herzlich 1982) and the United States (Starr 1982). The Swedish situation was paralleled in Finland. When the Finnish medical profession founded its professional organization, it did not have a cultural heritage or dominant market position as

independent practitioners from an era of economic liberalism. The Finnish medical profession has, therefore, never appealed to any "sacred trust" (Harris 1969) or "ideology of liberal medicine" (Herzlich 1982) as an ideological weapon to defend its market position. Instead, the statutes of the Finnish medical association said explicitly that its purpose was to "defend and promote the social and economic interests of the physicians" or, in today's language, to act as a trade union (Kauttu and Kosonen 1985, 36).

The late organization of the Swedish medical profession hampered its possibilities of influencing legislation enacted for the regulation of the medical market. The "sickness funds" law was enacted in 1891 in Sweden, i.e., more than a decade before the profession organized itself. By contrast, the Danish medical profession took an active role in both the initiation and further implementation of the sickness funds. This move was replicated by the Finnish medical association, which had as a major item on its agenda the enactment of a national health insurance (Pesonen 1980). This legislation was not a threat to the medical profession but only a further consolidation of its social position. Since the elite of the medical profession worked as public employees in either government-controlled hospitals or universities, it was already part of the state bureaucracy and power elite. From the turn of the century up to the early 1960s, there were close working relations between organized medicine and the National Board of Health in Finland. The relationship was characterized by interlocking membership in various organizations and by a "cosy brotherhood" (Kauttu and Kosonen 1985, 122), a type of relationship that others have characterized as a policy shaped by "private government" (Gilb 1966).

In 1947 Sweden enacted a compulsory health insurance act, which, however, was not put into effect until 1955. At this time, the governing Swedish Social Democratic Party set out to increase the number of physicians against the objection of organized medicine. The Swedish Medical Association invoked a temporary conservative policy during the 1950s, largely conducted by its chairperson Dag Knutson, who wanted to raise the professional consciousness of Swedish physicians and instill a sense of the profession's right to autonomy. Since 1960 the Swedish Medical Association has abandoned the free professional model and adopted the strategy of collective bargaining as a white-collar union (Heidenheimer 1980; Carder and Klingenberg 1980, 158–59).

In conclusion, the medical professions in Finland, Sweden, and Norway emerged with the character of a sheltered occupation, since it was the governments which protected their market positions by establishing salaried positions and hospitals. The medical professions in these countries have never been free professions of mostly independent practitioners, but have always been part of a larger corporate social system. For example, since the turn of the century only about one-third of Swedish physicians have been private practitioners (Bergstrand 1963, 701; Ito 1980, 56).

The power of organized consumers have shaped more the position of the physicians in Denmark and Sweden than in Finland and Norway. In Sweden the voice of the consumers was represented by the Social Democratic Party, which regulated both the education and practice of the physicians, whereas in Denmark the consumer cooperatives maintained a majority of the Danish physicians as general practitioners. These circumstances will be further described in the following section.

The Social Position of Physicians in the 1980s

Today, the production of medical care is characterized by a complex division of labor between various health care professions. The proportion of the physicians in the total health labor force is remarkably similar in the Nordic countries: 15 percent in Sweden in 1985 and 13 percent in Finland, Norway, and Denmark (Yearbook of Nordic Statistics 1987, 327). Yet, the internal division of labor between the physicians in the Nordic countries show some differences by major type of activity (table 2).

In 1985 Sweden had the highest proportion (94 percent) of physicians involved in actual patient care, whereas Finland had the lowest (84 percent). A majority of them worked in hospital settings in Denmark and Sweden, whereas a higher proportion worked in primary care settings in Finland and Norway. The Finnish figure reflects the impact of the Public Health Act of 1972, which established municipal health centers all over the country in order to reshift the resources from a hospital-centered to a primary-care centered health care system. In Norway the "Kommunalhälsetjänsten" of 1984 has emphasized primary care.

By contrast, a much higher proportion of physicians were working

TABLE 2
Active Physicians by Percentage of Activity in the Nordic Countries in 1985

	Denmark	Finland	Norway	Sweden
Hospital physicians	62%	47%	50%	65%
Nonhospital physicians	30	37	39	29
Administration	1	2	4	1
Medical research, education, etc.	4	8	4	2
Other medical work	3	6	3	3
Total	100	100	100	100
N	12,980	8,936	9,176	21,000

Source: Yearbook of Nordic Statistics 1987, 328. (The Finnish data has been reclassified.)

as administrators in Norway and Finland than in Sweden and Denmark. This implies that the physicians in the two former countries have gained control over the administrative positions, which regulate physicians' work, and have succeeded in preventing groups with other professional training (hospital administration, law, business, social sciences) from taking over the administration of hospitals and public agencies that shape health policy (see Saltman 1987; Nordby 1987).

Furthermore, in Finland twice as high a proportion of physicians was involved in medical research and education as in Denmark and Norway and almost four times as high as in Sweden.

The above figures can be interpreted in the light of the conceptual framework provided by Freidson (1984). According to Freidson, the formalization of the internal division of labor between physicians serves to keep the control over medical work in the hands of the doctors. In Sweden the knowledge and administrative elites of the medical profession—to use Freidson's terminology—are much smaller than in the other Nordic countries. By contrast, both the knowledge and administrative elites are large in Finland. This circumstance may explain the strong position of the physicians in the Finnish health care system. As suggested by McKinlay (McKinlay and Stoeckle 1987, 74), the control over hospitals in the United States has been turned over to professional administrators, and physicians are in the position of middle management, where their prerogatives are challenged by other health care workers.

Medical practitioners may not have as much professional power in Denmark and Sweden as in the other two Nordic countries, since they do not have their own power elite working for them within the establishment of science and public administration. The Swedish medical profession has attempted to create a private market for health care in an otherwise government-financed and regulated health care system. It is estimated that about one-fourth of Swedish physicians today offer private medical care through social insurance (Rosenthal 1986, 602). Parliamentary legislation, the so-called Dagmar reform of 1984, aimed, however, at curbing spare-time private practice in Sweden and, hence, the autonomy of physicians.

In the following discussion, Finland will be used as a case study for a more detailed examination of the social position of physicians. The point is to stress a feature which so far has been neglected in the current macro-level approaches in the study of the professional status of physicians. Current approaches have treated the medical profession as a sex-neutral category and have only examined the divisions within the profession by functions but without inclusion of gender as a category. An analysis of developments within the profession by taking gender into account as well, sheds new light on the applicability of Freidson's (1984) and McKinlay's (McKinlay and Arches 1985) arguments. Finland is a good choice for this purpose, because it has the highest rate of women in the medical profession within the Nordic countries. Thirty-nine percent of the physicians in Finland were women in 1985 as compared to 31 percent in Sweden, 24 percent in Denmark, and 19 percent in Norway (SNAPS 1986).

Women and male physicians practice in different organizational settings in Finland. As table 3 records, women are overrepresented in ambulatory care and at municipal health centers but clearly underrepresented in teaching, research, and administration. Furthermore, male physicians dominate in hospital work and occupational health care, a circumstance that also reflects the higher degree of specialization among male physicians. This has not, however, always been the case. The rate of specialization among physicians has increased only among men but not among women during the past two decades in Finland. For example, whereas 38 percent of the female physicians and 42 percent of the male physicians were specialists in 1960, 36 percent of the women and 60 percent of the male physicians were specialists in 1988 (Riska 1987; Finnish Medical Association 1988). The female

TABLE 3
The Distribution of Physicians in Finland by Main Activity and Sex in 1988

Main activity	Physicians		Percentage of women
	Total	Percentage	
Hospitals	5,505	42%	35%
Municipal health center	2,950	23	50
Ambulatory care	280	2	55
Occupational health care	475	4	34
Private practice	620	5	46
Teaching, research	880	7	22
Administration, army	450	3	29
Nonactive	1,890	14	44
Total	13,050	100	40

Source: Finnish Medical Association 1988.

specialists are now clustered in pediatrics, general practice, internal medicine, psychiatry, radiology, ophthalmology, and anesthesiology. By contrast, a much higher proportion of the male specialists are surgeons compared to the female specialists (16 percent and 2 percent, respectively, in 1987).

Finnish women physicians can reach top positions within the profession but to a much lower degree than their male colleagues. In 1983, only 12 percent of the chief ward physicians and 14 percent of the chief physicians at hospitals were women as compared to 44 percent of the municipal health center physicians and 40 percent of the assistant physicians who were women (Riska 1987).

As the figures above show, the male physicians are innovators (research and academic medicine) and administrators of medicine as well as practitioners of corporate medicine, i.e., practice in the technology- and capital-intensive part of medicine. The higher degree of specialization among men means that they work in an environment in which medical work is highly fragmented but protected by the knowledge and administrative elite of the profession.

Women, by contrast, work within fields that are characterized by high social interaction with patients (pediatrics, psychiatry, municipal health centers) or by routine-based work (anesthesiology, pathology) and low pay. Furthermore, they tend to work within the public primary-care sector, a bureaucratized medical practice which shares the features of "proletarianized" medical work (McKinlay and Arches 1985). A recent study conducted by the Finnish Medical Association showed that physicians at municipal health centers perceived their work as stressful and suffered from burn-out more often than other physicians (Äärimaa et al. 1988). Another study of the job satisfaction of primary care personnel in Finland showed that doctors were the least satisfied among various health professionals and that the willingness to change to another work setting was lowest among nurses but highest among the primary care physicians (Piri and Vohlonen 1987).

In short, the entry of women into the medical profession has so far not meant an entry as colleagues of equal standing with the male physicians. Instead, a dual labor market for physicians has developed: one which displays the features of the traditional privileged social position of the physicians and another in which the physicians show both the features of deprofessionalization, as other health care professions are encroaching on their domain, and of proletarianization. This gender-based division of labor in medicine has also been documented in the United Kingdom (Elston 1980) and the United States (Lorber 1984; Butter et al. 1987).

Conclusions

The profession of scientific medicine in the Nordic countries derives its present social position from those economic and social conditions which prevailed when it consolidated its power position in the nineteenth century. In the absence of a market for independent practitioners, the state and municipalities in Sweden, Norway, and Finland established hospitals and salaried positions for medical officers. Denmark—a smaller country with a much higher population density and a middle class of craftsmen and merchants in its urban centers—provided a different starting point for its doctors. The Danish medical profession was already professionally organized before the mid-nineteenth century, when the old regulated medical market of the guild society was

abolished. The medical profession managed to negotiate a similar arrangement with the social forces which represented the emerging industrial society. Hence, the Danish medical profession remained outside the control of the state and negotiated directly with organized consumers concerning the terms of payment and the range of medical services and benefits well up to the 1970s. In the other Nordic countries, the state has supplied the resources of a modern health care system (salaries of health professionals and facilities) and supported the consumers' purchasing power by reimbursing them for services. Hence, both the medical profession and the consumers have been dependent on government.

Still today, the social position of the physicians in the Nordic countries is determined by the dominance of the public sector in health care (Rhode and Hjort 1986). A corporatization of health care or a growth of large private corporations in health care as in the United States is not occurring (Rosenthal 1986; Häkkinen 1987). The public debate about an emerging privatization of health care in the Nordic countries seems more to represent a symbolic, ideological warfare against the current public dominance and control of the health care system than a fundamental phenomenon. It appears that in Finland and Norway the medical profession will maintain a stronger position by its continuing control of those public institutions involved with science and health care that legitimate its professional dominance.

Although indications show that the medical profession in Finland still enjoys traditional power, the labor market of physicians is segregated by function and sex. On the one hand, physicians' work at the municipal health centers and some primary care specialties resembles the "proletarianized" work setting portrayed by McKinlay (McKinlay and Arches 1985; McKinlay and Stoeckle 1987). On the other hand, there are physicians, who, although salaried, enjoy autonomy in their work and high pay. They are working at hospitals, or in health care administration and science, and they are generating the norms and regulations for other physicians and health care professions.

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