Institute of Clinical Medicine
Faculty of Medicine
University of Helsinki

MANAGEMENT AND LEADERSHIP IN THE PUBLIC DENTAL SERVICE IN FINLAND BETWEEN 2003 AND 2011

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ACADEMIC DISSERTATION

To be presented, with the permission of the Faculty of Medicine,
University of Helsinki, for public examination of the Institute of Clinical Medicine,
in the auditorium 2 of Biomedicum Helsinki 1,
Haartmaninkatu 8, Helsinki on February 27th, 2015, at 12 noon.

Helsinki 2015

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ISBN 978-951-51-0519-6 (PBK.)
ISBN 978-951-51-0520-2 (PDF)

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LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the following publications:

I Alestalo P, Widström E. Lead Public Health Service Dentists' Leadership Qualities Evaluated by their Superiors and Subordinates in Finland. Oral Health and Dental Management in the Black Sea Countries 2011; 10(1): 13-21.

II Alestalo P, Widström E. Lead Public Health Service Dentists in Finland: Leaders or Dentists? Oral Health and Dental Management 2011; 10(2): 55-63.

III Alestalo P, Widström E. Women's Leadership in the Public Dental Service in Finland. Oral Health and Dental Management 2012; 11(2): 74-82.

IV Alestalo P, Widström E. Lead Dentists in the Public Dental Service in Finland during a Major Reform. Oral Health and Dental Management-Open Access 2013; 12(3): 166-73. http://omicsonline.com/open-access/2247-2452/2247-2452-12-508.pdf

The publications are referred to in the text by their Roman numerals. Original publications are reprinted with the permission of their copyright holders.

ABSTRACT

The general objective of this thesis was to study management and leadership in the Public Dental Service (PDS) in Finland during the major Dental Care Reform in 2003–2011. The specific aims were to study 1) how dentists became leaders in the PDS and 2) what characterised their leadership, 3) distribution of leadership positions between women and men, 4) chief dentists' position in the municipal hierarchy, as seen from their own superiors' and subordinates' points of view and 5) chief dentists' attitudes to the Dental Care Reform and the changes it caused in the work environment.

Four questionnaire surveys based on four data sets were carried out in 2003. The target groups were the chief dentists of the municipal PDS units (health centres) (n=265), the chief physicians (n=233), the line managers (superiors) of the chief dentists, PDS dentists who were subordinates to the chief dentists (n=365), and the chairpersons of Municipal Boards of Social Affairs and Health (MBSH) (n=233). In 2011, the target group was the chief dentists alone (n=161). Factor analysis, linear regression analysis, parametric and non-parametric tests were used in the analysis of the materials.

The results showed that only fewer than a fifth (17%) of chief dentists were full-time leaders in 2011 and they worked in the largest health centres. The rest also provided patient care, to varying degrees. In 2003 and 2011, nearly two thirds (62%) of the chief dentists identified themselves as leaders instead of seeing themselves only as dentists among other dentists in the PDS, though fewer than a third (31%) of them had applied for their posts. More precisely, just 21% of female and 43% of male chief dentists ($p<0.001$) had applied for the chief dentist posts they held.

Chief dentists felt they were better *people-oriented leaders* than *goal-oriented managers* ($p<0.001$). Nevertheless, 49% $p<0.001$) of their *job satisfaction* was explained by the fact that they were *motivated* to *lead*, their *position as superiors* to their subordinates was good, they had enough (3-4 on a scale 1-4) *decision making power*, they were good *goal-oriented managers* (good in *sum variables* ≥ 3 on a scale 1-4 from very bad to very good), and had received enough (3 on a scale 1-3) leadership education. In addition, if they had a good *position as subordinates* to their superiors, chief physicians and MBSH chairpersons ($p<0.001$), and when they had applied for their posts, they felt contented ($p<0.001$).

In 2003, their subordinates, the PDS dentists, appreciated their people-oriented female superiors highest. Chief dentists themselves as subordinates felt they received little *feedback and support* from their superiors (chief physicians), and their own subordinates, the PDS dentists, felt the same ($p<0.001$). Chief dentists' superiors (chief physicians and MBSH chairpersons) evaluated the chief dentists as good managers and leaders, whereas the chief dentists' subordinates evaluated their superiors in less positive terms.

In 2003, more than half (59%) of the chief dentists were very positive (4 on a scale 1-4) towards the recently introduced reforms of the Health Insurance Act (HIA) promoting adults' treatment in the

private sector by increasing reimbursement for dental care. Fewer than half (43%) were very positive towards the reform of the Primary Health Care Act (PHCA) improving adults' access to care in the public sector ($p<0.001$). In 2011, only 20% totally agreed (4 on a scale 1-4) that the implementation of the Dental Care Reform had succeeded. The respondents' general opinion was that the timetable for the Reform was too tight and not enough resources were allocated.

In general, the chief dentists considered their position as isolated and rather weak in the municipal hierarchy. Effective and rewarding leadership in the PDS needs more attention in the future.

ABBREVIATIONS

FDA	Finnish Dental Association
GAC	Guaranteed access to care (Change of PHCA 2004)
HIA	Health Insurance Act
HRM	Human Resources Management
MBSH	Municipal Board of Social Affairs and Health
MOHC	Municipal Oral Health Care
NBH	National Board of Health
PASW	Predictive Analytics SoftWare
PDS	Public Dental Service (MOHC in Finland)
PHCA	Primary Health Care Act
SII	Social Insurance Institution (Kela)
SPSS	Statistical Package for Social Sciences
STAKES	National Research and Development Centre for Welfare and Health
STM	Ministry of Social Affairs and Health
THL	National Institute for Health and Welfare
VALVIRA	National Supervisory Authority for Welfare and Health
WHO	World Health Organisation

Chief dentist	Lead dentist in original articles I-IV
Chief physician	Leading doctor in original articles I-IV

1 INTRODUCTION

In Finland, according to earlier and current legislation, primary health care including oral health care is the responsibility of municipalities funded by their own tax receipts, government transfers and consumer charges. According to legislation and from the point of view of municipal decision-makers, oral health care has traditionally (Tiitta 2009) been of secondary importance compared to other health care. Priorities in municipal oral health care have been initially, since the last century, totally different from those in general health care. Oral health care prioritised children and youngsters, provided health education and preventive and basic care, while general health care prioritised those who had the biggest problems without age limits and also offered complex treatment (Widström and Lehto 2000). Working cultures were different and inequalities among population groups in access to dental care increased the gap between dental care and primary health care (Alestalo and Widström 2002). Inequality in access to treatment has depended upon the age, domicile, health status, profession (e.g. divers and merchant sailors), sex and even school background, as Milen and Tala (1986) have noted.

After the 1939-1945 wars, dramatic increase in the availability and use of sugar had ruined dental health and extractions of teeth were the most frequent treatment measures, especially for adults, and even in 2000, the proportion of edentulous over 75-year-old adults was 56% (Suominen-Taipale et al. 2004). The Act on dental services for primary schools in 1956 (Finlex 297/1956) limited municipal oral health care to primary school children: children of the same age who transferred to secondary school after the fourth class were not covered.

The Health Insurance Act in 1963, HIA (Finlex 364/1963), gave reimbursement for dental care only in connection with treatment of a general illness, and at that time it was rarely used (Nyman 1971a). The situation was untenable for dental care, because inequality in dental health and in the use of dental services was great between age groups, social classes and between inhabitants of rural areas and urban areas (Nyman 1971b).

Despite the Primary Health Care Act, PHCA (Finlex 66/1972), and the success of preventive dental care, until 1980 in the PDS the service emphasis was on children and adolescents younger than 18 years of age. In rural and remote areas, the PDS also provided dental care for adults. From 1986, young adults, age group by age group, were successively and slowly given access to subsidised care in the PDS (municipal health centre service) or alternatively, when using private care, they received reimbursement of basic treatment costs from the Social Insurance Institution (SII). This expansive trend was halted in the 1990s as a result of an economic recession (Widström and Utriainen 1997). Except for some special needs groups (pregnant mothers, war veterans, etc.), most adults had to rely on private services (dentists or denturists) for their oral health care and to pay for them (Widström and Eaton 2004). About half of the dentists nationwide worked as salaried dentists in the PDS and the other half privately, mostly in the densely populated areas of the country.

Tiitta (2009c) emphasises that the goals of the PHCA were too ambitious compared with available resources and staff, especially dentists. The provincial government would have needed a dental officer to guide municipalities in the health economics in an appropriate manner, but this never occurred (Tiitta 2009c).

In 2000, the change of the PHCA (Finlex 1219/2000) removed age restrictions in adults' access to the PDS. From 1 December 2002, the prioritisation of special needs groups was not possible, but the patient's need for care, urgency and effectiveness of the treatment were defined as the criteria for care (Paunio 2002-2003).

2 REVIEW OF LITERATURE

2.1 Development of the Finnish municipal oral health care (PDS) delivery system

Over several decades in the 1900s, new health care laws were enacted and governmental and municipal health care administration was changed on several occasions.

2.1.1 School dental care

Municipal dental care for school children began in the 1910s with minimal legislation, at first in the larger cities (Nordling 1988, Keskinen 2002). The National Board of Health (NBH), the successor to Collegium Medicum (1663), was established in 1878 (Tiitta 2009a). From 1934, dentistry had had a representative in the Scientific Council of the NBH (Tiitta 2009b). The 1956 law on dental services for primary schools (Finlex 297/1956) required municipalities to arrange dental care for primary school children, and the first Chief Dental Officer was appointed to the NBH. But until the end of the 1960s, dental care was in a subordinate position in relation to other health care (Tiitta 2009b).

Administration of municipal school dental care was minimal. The Chief Medical officer or, in smaller municipalities, some other official, defined school dentists' tasks under the municipal decision-making body and only larger municipalities had a chief dentist from the 1960s. Gradually, authorities began to pay attention also to adult dental care.

2.1.2 Norm- and resource-based administration 1972-1991

In accordance with the PHCA (Finlex 66/1972), local municipalities in 1972 were made responsible for organising and running health care and social services, including oral health care. With aid from state subsidies, their own local taxation and customer charges, municipalities were required to provide these services in the PDS free of charge for the local populations under the age of 17 (Finlex 67/1972). This legislation was the largest change in municipal health care including oral health care. Though the PHCA opened the doors also to adults, only rural and remote municipalities did so. Others complied with the minimum requirements. Norms and resources were defined by five-year governmental plans and municipalities were guided and monitored by provincial governments. All municipalities had to appoint a chief dentist, responsible for the implementation of the PDS. Dentists' careers as leaders began on a larger scale.

2.1.3 Development of leadership education

Dental education in Finland began in 1892 at the University of Helsinki (Ignatius 2006). Since 1926, municipalities had been able to get state subsidy for preventive dental care and, from 1937, for all school dental care expenses. By 1940, about one hundred school dentists had been appointed (Forsius 2007). Guidance for unifying the operations was needed and it was provided for school dentists by the General Mannerheim League for Child Welfare (Nordling 1988 and Keskinen 2002). From 1972, the NBH played a key role in drawing up governmental plans, and information and guidance on the implementation of the PHCA was given by it (Tala 2007). This was also seen as the start of management and leadership education for dentists: at first, sporadically, with on-the-job training or participation in meetings arranged by the NBH to consider topical questions. From 1973, this form of training focused on the chief dentists of the largest PDS units (health centres) and, gradually, from 1988, on the chief dentists of smaller PDS units (Tala 2007). At the end of the 1960s, the concept of social dentistry became prevalent (Tala 1969). At about the same time, lectures on the subject began in universities and the first dentists took the Master of Public Health degree abroad. From 1976, dentists have been able to achieve specialist competence and from 1984 a post graduate university degree on management and leadership. Training courses in management were arranged by the Finnish Dental Association (FDA) and others (Tala 2012).

2.1.4 Information-based administration since 1992

According to Jalonen (2008), "information steering is defined as a process that includes a steerer (e.g. ministry), a steerable (e.g. municipality) and steering impulses (i.e. information)". It is required to ensure that local public organisations (in this case, municipal PDS) follow the national policy guidelines, which are norm-, resources- and information-based guidance.

A transition from norms to information-based steering happened when the National Board of Health was abolished in 1991 and some of its duties were transferred to the National Research and Development Centre (STAKES) and later in 2009 to the National Institute for Health and Welfare (THL). The municipalities got a free hand to develop public health care in whatever way they saw fit once they had reached the minimum requirement. This course of action was considered good in primary health care but not as successful in dental care. According to Stenvall and Syväjärvi (2006) and Laihonen (2009), information steering was convoluted and unstructured on the one hand and one-sided on the other, and was ineffective for municipal decision-makers. Authorities provided the information, but decision-makers did not understand the essence of the message: that a well-fare society has to offer services for all regardless of age and place of residence. Lack of central steering led to a situation where especially larger municipalities, with many private dentists, implemented only the minimal requirements in the public oral health care, and for some municipalities, not even that. About a third of the municipalities, mostly small ones in rural areas, had abolished all age limits restricting inhabitants' access to the health centre; by 1996, about a third followed the relevant statutes and a further third had their own, even tighter, restrictions. This increased inequity

(Widström et al. 1997), and it must be noted that the supervising authorities did not intervene. As time went on, this situation reverted to stricter guidance in the form of Primary Health Care Act in 2000, and in 2004 another change of that law guaranteed access to dental treatment within six months.

2.1.5 Removal of age limits

In 2001-2002, the dental care provision system was reformed (Finlex 1219/2000, PHCA), and the age limits restricting adults' use of the PDS (health centre services) were abolished. Reimbursement of private dental care by the Social Insurance Institution (SII) was also extended to cover all adult age groups (Finlex 1202/2000, HIA). Improved oral health and decreasing edentulousness among adults and the elderly had increased restorative treatment needs, and put pressures on politicians (Niiranen et al. 2008). The reform led to increased demand for dental care by adults in the PDS (municipal oral health service), where care was less expensive than in the private sector even after reimbursements. Long waiting lists for the health centres developed, especially in towns and cities that, before the reform, had considerably restricted adults' access to the health centre care (Widström and Mikkola 2008). Despite increased state subsidies to municipalities, the reform caused worries in many municipalities, with fears that increasing demand and insufficient numbers of personnel could not be balanced. Because two of the then four dental schools in Finland had been closed in the 1990s, there was a shortage of dentists in particular. After abolishing age limits, access to non-urgent PDS care had somehow to be restricted, and new guidelines based on treatment needs were implemented more regularly (STM 2004).

2.1.6 Guaranteed access to care

In 2005, another change of the PHCA (Finlex 855/2004), so called guaranteed access to care, became effective. It aimed to set timeframes for access to first aid, urgent treatment and non-emergency health care. Oral health care was also included. The time limit for access to routine (non-urgent) oral health care was set at a maximum of six months. The length of the waiting lists was monitored by the National Supervisory Authority for Welfare and Health (VALVIRA)**.** This change created new problems for many PDS units because of the increasing shortage of dental personnel in municipalities. In 2011, 12.5% (260/2084) of full-time PDS dentists' posts were vacant (Suomen Hammaslääkäriliitto 2012a). Task delegation from dentists to dental hygienists and dental nurses was considered to be an important means to improve efficiency and it was also used in the municipal oral health care (Vesivalo et al. 2006, Tseveenjav et al. 2009 and Virtanen et al. 2011), but proceeded slowly. Most PDS units just managed to get below the six-month limit concerning examination of new patients but intervals between the subsequent treatment occasions were stretched into the future, which was unsatisfactory both for patients and care providers (Soininvaara 2008).

Management locally in the PDS units had been easy during the period of guidance by norms and detailed instructions: municipalities had only to do what they were expected to from above. At that time, municipalities were seen as the local governmental body expected to fully comply with what national authorities prescribed (Pulma 1996). Despite the fact that children's and young adults' oral health had improved radically (WHO 2003), many municipalities were not able to provide dental services to older people. In contrast to the other Nordic countries, in Finland children's utilisation of dental services had increased between 1984 and 1996 (Virtanen et al. 2007). Information steering seemed to suppress the development of the 'less important' dental care alongside other health care, probably because there was no tradition of local strategy development after the governmental steering. Pressed by scarce resources, chief medical officers perhaps felt uncertain also because they did not understand dental care very well (Rabiei et al. 2012). So today 'half Finland' – as Heino (2012) interprets the feelings of physicians – longs for the return of the NBH, which monitored that the minimum requirements of availability of services were the same in different parts of the country.

2.2 Oral health care delivery systems in Europe

Public systems for the provision of oral health care are rare (Widstöm and Eaton 2004, Downer et al. 2006, Widström et al. 2010). In Europe, public dental care systems as the main care provider only exist in Eastern Europe, such as the model in Russia where dental care is a natural part of general health care (Koposova 2013). Most Eastern European countries, on joining the EU, have privatised their formerly public dental care (Widström et al. 2001). In Lithuania, fewer than half of the people, most often urban and older populations, and people with low income, have been able to use the public sector (Pūriene et al. 2008). The public systems in the Nordic countries and the ones in UK and Ireland are different from the Eastern European model. Britain's National Health Service (NHS) was established in the wake of World War II amid a broad consensus that health care, including dental care, should be made available to all (Light 2003).

In the Nordic countries, the public dental services have strong support among the population and politicians (Korhonen 2005, Widström and Eaton 2004, Widström and Väisänen 2009, Ordell 2011), and reducing inequalities is an important goal in their health policy programmes (Widström et al. 2005). Concepts from the public care provision systems pose different leadership challenges than those posed in private practice-based care provision models, and this is where the chief dentists have an important role in the PDS (Korhonen 2005, Widström and Väisänen 2009, Ordell 2011).

2.3 The current situation of Finnish municipal health care administration

According to current legislation, the Finnish municipal health care system is divided into specialised medical care (including specialised dental care) and primary health care and both are the responsibility of municipalities. Every municipality has to be a member of one of 21 hospital

districts (Suomen Kuntaliitto 2014). Except for specialised medical care, these districts (which in turn are members of a university area) are responsible for developing and monitoring some of the health centres' activities such as laboratory and RTG services, education and research. Since 1972, municipalities have been responsible for primary health care and thus for PDS, either alone or by forming healthcare organisations with other municipalities. In this study, PDS (public dental service) means municipal oral health care (MOHC) service. Each municipality or municipal federation of health care has to have a health centre.

In local municipalities, elected bodies (the municipal government and municipal board of social affairs and health) are responsible for planning, organising and evaluating the primary health care services including dental care (Suomen Kuntaliitto 2012). Chief physicians (responsible for the health centres' medical issues) are in charge of the health services and, mostly under them, chief dentists are in charge of the local PDS units. In some municipalities, the PDS is an independent unit and directly under the MBSH, and the chief dentists have right to presentation to politicians. Larger PDS units sometimes have additional principal dentists or specialists having administrative tasks. In the health centre, dental assistants and other auxiliaries often have a leading dental assistant.

The PDS has been only loosely attached to the general public health care in the municipalities (Alestalo and Widström 2002). Leadership in public primary health care in Finland has been criticised as weak, and a need for revised work descriptions and education for leaders in these organisations has been suggested (Kumpusalo 2002, Lehto et al. 2003, Virtanen 2010). These studies showed, among other things, that the nature of the leadership role was unclear, badly organised, and poorly appreciated. Physician managers do not rely on business-oriented models in public health care (Kokkinen and Viitanen 2011).

When the first survey of this study was conducted in 2003, the PDS chief dentists were facing a challenging situation, because at that time they were expected to implement the Dental Care Reform.

2.4 Management and leadership styles

2.4.1 Managerial grid model

The managerial grid model developed and presented by Blake and Mouton in 1964 is a 9 x 9 grid: the horizontal x-axis indicates concern for production while the vertical y-axis indicates concern for people (Blake and Mouton 1968). According to them, the best situation, 9/9 managerial style prevails when "there is no necessary and inherent conflict between organisation purpose of production requirements and the needs of people". The members of this kind of work team are motivated for and interested in their work and experience that the objectives of the organisation are important. Their interpersonal relationships are confidential and mutual respect exists. Management

and leadership are then balanced. In the preface of the Managerial Grid by Blake and Mouton (1968), Kolb says that "such theory becomes pertinent when choosing and training those individuals who show the greatest management potential".

2.4.2 *Human resources management, HRM*

In the recent years, the health care sector has fallen into the gulf between expensive treatment methods resulting from developments in biotechnology, while available resources, the leadership practices in health centres and hospitals, as well as in the PDS, have become matters for public discussions. How is the health care sector generally managed in Finland? Could the situation be improved by changing the style of management and leadership? According to World Health Organisation's guidelines (WHO 1993) on human resources management (HRM) of the health care sector, leadership may be defined briefly as "the capacity to secure the willing support of people in the achievement of the organisation's worthwhile goals". On the other hand, HRM (cf. personnel management) is defined as "the mobilization, motivation, development and deployment of human beings in and through work in the achievements of health goals, which is in essence a value assumption that people are not a mere factor of production but living, feeling, thinking beings who seek certain satisfaction from their work" (WHO 1993).

The Human Resources Management (HRM) described above has gained a firm foothold in Sweden's public sector (including dental care) management. Bejerot (1998) made comparisons concerning dental care between the public and private sectors, such as how expectations towards one's work, emphasising the rewards of autonomy and initiative, corresponded with the ideal and with reality. Of all occupational groups, dentists working for municipal oral health services felt the greatest discrepancy between the ideal and reality, whereas the private dentists felt the least. Also in Bejerot's further investigations, dentists in the public sector were the most vulnerable group. Hakanen and Perhoniemi (2006) observed that working conditions, especially in the PDS, had become more burdensome and dentist burnout had increased since 2003.

2.4.3 In-depth leadership model

The armed forces have a training system based on the concept of in-depth leadership (Nissinen 2001), which could be useful for managing dental care professionals who are characterised by a high level of expertise. In the in-depth leadership model, the role, decision-making and behaviour of the leader are used to outline the concept of leadership. This leadership method is based on four cornerstones. The first one is building trust, the second is motivating subordinates to strive for common goals, the third defines the leader's aim of using the subordinates' ideas while improving their capacity for independent action, and the fourth is to confront the other person as an individual.

2.4.4 Emotional intelligence

Goleman presented his own theory (1996) on the importance of emotional intelligence in leadership. He claimed that "at best, IQ contributes about 20 percent to the factors that determine life success, which leaves 80 percent to other forces". According to Goleman, "the emotional skills include self-awareness; identifying, expressing, and managing feelings; impulse control and delaying gratifications; and handling stress and anxiety". In addition, cognitive and behavioural skills are needed.

2.5 Expert organisations

2.5.1 Collegiality and authority

Health care organisations are typical expert organisations characterised by strong professionalism (Sipilä 1996, Sveiby 1990). This is challenging for the organisations because clinicians feel more loyal to the medical or dental profession than to their employer and, in the first place, feel responsible to their patients (Sipilä 1996). Autonomy of work plays an important role for them and this is supported by professional standards and norms (Sihvonen 1990, Sipilä 1996). Collegiality is also highlighted by ethical guidelines for dentists: a senior dentist in leadership position has to ensure his or her subordinate dentists' clinical autonomy (Suomen Hammaslääkäriliitto 2012). Sipilä (1996) reminds that attractiveness of work is the most important motivator for experts, but how should highly educated, independent and often stubborn subordinates be managed? The authority of an expert leader is based on his or her position, professional competence, seniority and personal charisma. Authority is needed but, on its own, it is not an adequate basis for leadership (Heifetz 1994). Heifetz and Linsky (2002a) highlight that if you have been a senior member of and are now the leader of the organisation (as often in PDS), you are a part of the problem: you have been creating it. Resistance is not always criticism towards you but suggests that your input was worth reacting to (Heifetz and Linsky 2002b). Bennis and Nanus (1986) have pointed out that the negative aspects of the use of power have led to unnecessary underestimation of authority in new leadership theories. Nevertheless, personal authority is needed to convert intention into action. In an article in the Lancet, Ham (2003) cites an observation attributed to Lao Tse – one cannot lead if no one follows. He emphasises that creating an organisation in which professionals are ready to follow a peer who has settled into a leadership position is a challenging task.

2.5.2 Fear of change

In an expert organisation like oral health care, upcoming changes challenge chief dentists' leadership-oriented abilities, because change is often a threat in a work community (Lehto 1990). Implemented reforms often influence the daily work of the employees. Resistance to change is, rather, resistance to abandoning the old more than resistance to the new – it is easier to do things as

before (Salmimies 2001a). Because leadership involves complicated human relationship work, emotional exhaustion is possible. Training in interpersonal relations therefore promotes occupational safety and health (Lonka 1999). Salmimies (2001b) in turn requires from all parties long-term commitment, maturity, and change in work attitude. Tichy and Devanna (1990) also note that change resistance comes from knowing that change always requires a trade-off: one has to give up old habits and learn new. They divided the reasons for resistance to change into three categories: technical (people like to do things as before, fear of the future, cost reduction), political (leaders must call into question old decisions and procedures to bring about change) and cultural (organisational values, longing for the good old days and the lack of a positive attitude toward change).

2.6 Motivation and team work

Sihvonen (1990) has examined work motivation in primary health care. She states that being a leader in a health centre does not provide sufficiently the appreciation which the medical personnel expect to receive from their work, nor does it create an atmosphere which encourages employees to think independently. Kekki (1993) mentions, in his study on team work and leadership in health centre clinics in Helsinki, that leadership was underdeveloped and ineffective because targets had not been set and the employees did not know who was managing the activities. Kekki draws attention towards the organisation's controlled self-government and creation of internal and external interest groups. He states (1993) that the number of internal teams is small and the extent of team work between different occupational groups in health clinics is negligible.

2.7 Motivation theories

In the 1960s, three motivation theories were presented: Adams' equity theory (1965), Vroom's expectancy theory (1966) and Locke's goal setting theory (1968).

According to Adams' equity theory (1965), people consider their treatment as just or unjust in relation to how other people are treated. The so called input/output (outcome) relationship reflects this. Input is employees' own entrepreneurship, education, ability and talent that they bring to a job, and output (outcomes) economic benefits, such as salary, and mental reward, such as position and respect, that they receive from it.

Vroom's expectancy theory (1966) is very similar to Adams' equity theory. According to Vroom, employees have to believe in their own abilities in order to success in work. Additional efforts in work also ought to bring them some kind of bonus, financial benefits or mental appreciation.

Locke's goal setting theory (1968) summarises research on the relationship between goals and task performance. The results indicate that hard goals lead to a higher level of performance than easy goals and that specific, hard goals lead to a better performance than 'do your best' type of goals. It is also argued that money, time limits, feedback, participation, and praise may affect performance through their effects on goal setting. According to Lunenburg's (2011) interpretation of the goal setting theory, goals must be difficult but attainable, accepted in the goal-setting process, and feedback must be provided on goal attainment. "Feedback helps in two important ways. First, it helps people determine how well they are doing…Second, feedback also helps people determine the nature of the adjustments to their performance that are required to improve."

2.8 Incentives

Berthelsen (2010) has studied factors of importance when organising and managing municipal oral health care in Sweden and Denmark. Managerial education, one's own influence on work, decision authority and work climate characterised by professional values were found to contribute to a good work environment. Relations with patients and the opportunity to carry out high quality dentistry were the most rewarding aspects of dentists' work. She concludes that when organising and managing oral health care, professional skills and inter-personal relational characteristics of the work need to be taken into consideration (Berthelsen 2010). Ordell (2011) was interested in the management of the public dental services in Sweden. He found that there was a big gap between the formal objectives from the political level and the actual behaviour but that it was possible to influence political processes (laws and regulations) by active participation in the early stages of decision making. He also found that ideas on the management of the public oral health care were embedded in the ways the respective county councils were organized. Most county councils seemed to have a widespread belief in advantages of large PDS units instead of small ones, which may pose future problems for the provision of dental care in sparsely populated areas (Ordell 2011).

2.9 Leadership studies on general health care in Finland

Leadership in general health care and hospital organisations has been researched to a relatively great extent in Finland. Ylävaara (1993) and Korhonen (1994) have studied work in a health centre management team, which also is an important communication forum to chief dentists. Members of the management team agreed that goal setting was a manager's most important task (Korhonen 1994). Sihvonen and Kekki (1991) and Kekki (1993) in turn have studied team work and interaction between staff groups in health centre units and found that they were weak and in discord.

Kinnunen (1990) describes the organisations of health centres as bureaucratic and leader-centred. He thinks that developing leadership in health centres inevitably means some type of change in the management system, though changes of the authority hierarchy are usually met by strong resistance. Hermanson (1989) has studied the role and position of the physician in health care administration.

She states that a physician as an expert leader has difficulty to leave medical work completely. Also Tuomiranta (2002) has in her study "Leading physician – a physician or a leader" detected the contradictory role of physicians as leaders of expert organizations. She examined the applicability of the role episode model – a scale indicating role conflicts and role ambiguity – to the work of Finnish chief physicians. According to Tuomiranta (2002), the model was very applicable to conditions in Finland. She found that physicians had too little time for the leadership work and they were not even interested in it. Because the medical profession and its management have a significant influence on the health political developments in society, leadership motivation of physicians should be improved through training and through removal of obstacles. Stenvall and Syväjärvi (2006) consider as the most important municipality management know-how the ability to promote and defend officials' own field issues in municipal decision making.

2.10 Leadership studies on the PDS

Management and leadership in the PDS have previously been little examined in Finland. However, atmosphere from the personnel's point of view has been studied. According to Utriainen et al. (1992) both dentists and dental nurses turned out to be more satisfied with their workmates than with their superiors. Therefore, the leadership skills of those in superior positions in PDS must be improved. Between 1998 and 2000, ten health centres took part in a nation-wide project initiated by the Ministry of Social Affairs and Health (STM) and National Research and Development Centre for Welfare and Health (STAKES) to develop oral health care in Finland. A survey (Alestalo et al. 1998) undertaken in connection with the project revealed that, for the municipal authorities, oral health care remained remote. On the other hand, the residents' wishes and opinions had remained unknown to PDS representatives. Separation from other health care professionals made it easy for the decision-makers to accept the imbalance in the development of PDS. As Eaton (2012) states, in many countries oral health has a relatively low priority. The reason may be that dentists have been educated separately from physicians and they also practice in isolation from other health care workers (Eaton 2012).

Perttilä (1999) states that regardless of the fact that health has an important status in the value discussion of municipal decision-makers, its value diminishes under strong economical and local political pressures. Kataja (2006) studied the connection of management to organizational functioning in the PDS and concluded that the steering processes had been determined from outside the organization. Consequently chief dentists had little opportunity to influence, for example, the extent of the PDS and the methods were not always appropriate.

In 2001-2002, a large number of new citizens were given access to PDS in municipal health centres, and until 2005 waiting lists had been growing. To the chief dentists this presented a big challenge to meet the targets to improve access to the PDS, and again these targets threatened to prolong treatment periods. Soininvaara (2008) suggested that the maximum length of the course of treatment in the PDS should be defined. Also Lillrank (2003) and Peltokorpi et al. (2004) have drawn

attention to the cost of keeping patients on waiting lists in health care. The users of services should be the key players when planning the provision of services (Lehto 2001).

3 AIMS OF THE STUDY

The overall aim of this study was to examine the managerial and leadership roles of the chief dentists of municipal health centres (PDS) in a changing oral health care environment. It sought to survey how their leadership skills and positions as chief dentists in the PDS changed during the eight years from 2003 to 2011 following the Dental Care Reform in the early 2000s when changes in Primary Health Care Act, PHCA (Finlex 1219/2000), Health Insurance Act, HIA (Finlex 1202/2000), and guaranteed access to care (Finlex 855/2004) came into force. The reform in 2000 removed the age limits that had restricted access to municipal oral health care and entailed big changes in health centre services.

The specific aims were to survey and analyse (I, II, III and IV):

1. In detail, how dentists became leaders in the health centres, what motivated them, what their leadership styles and work satisfaction were like, whether they could be identified as 'leaders' or as ordinary 'dentists' in the first place, what their perceptions of their decision making power in the organisation of municipal health care were.
2. What kind of leaders municipal chief dentists were, as judged by themselves, by their superiors (chief physicians), by the Municipal Board of Social Affairs and Health (MBSH) chairpersons and by their subordinates (PDS dentists).
3. How chief dentists experienced their leadership tasks and their possibility of influencing the working community and implementing major reform.
4. How leadership positions in the PDS were distributed between women and men and how the female and male chief dentists perceived themselves as managers or leaders and whether their superiors or their subordinates found differences between female and male chief dentists**.**
5. How the chief dentists' positions and leadership changed over a period of eight years and how they felt they had managed to implement the Dental Care Reform.
6. How the changes in legislation in 2000 and 2004 influenced the activities of the PDS.

4 SUBJECTS AND METHODS

I, II, III, IV

4.1 Material

The target groups of the 2003 study were chief dentists of the municipal PDS units (STAKES, n=265), chief physicians (most of them line managers of the chief dentists) (STAKES, n=233), PDS dentists, subordinates of the chief dentists (sample by the Finnish Dental Association, n=365), and chairpersons of the Municipal Boards of Social Affairs and Health, MBSH (municipalities the same as the chief physicians, n=233). In 2011 the target group was the chief dentists only (THL, n=161).

4.2 Data collection

4.2.1 Research permission

Research permission was given by the National Research and Development Centre (STAKES) in 2003. As the names of respondents were not recorded in completed questionnaires, their anonymity was maintained. They were under no obligation to complete and return the questionnaires if they did not wish to take part in the survey. As a result it was deemed unnecessary to obtain ethical approval for the survey, and the return of a completed questionnaire was taken as consent to take part in the survey. In 2011, ethical approval was given by the Central Ostrobothnia Hospital District.

4.2.2 Drafting of questionnaires

In 2003, an internet questionnaire was designed to gather information about job applications and education for leadership positions, (time to lead), duration of tenure, leadership tasks, leadership motivation, styles and roles and position in the municipal administrative hierarchy. Furthermore, information on leadership qualities and skills, authority, feedback and support, work satisfaction and some background information was collected. The questions used in this study were based on previous studies and statements of Finnish health care (Hermanson 1989, Kinnunen 1990, Sveiby 1990, Sihvonen and Kekki 1991, Kekki 1993, Sipilä 1996, Tuomiranta 2002) and the author's long experience as a chief dentist.

Four questionnaires in 2003 and one in 2011 were used. There were 162 questions to chief dentists in 2003 (Appendix 2). The questionnaires aimed towards the other target groups in 2003, including

69 questions to chief physicians, 48 to MBSH chairpersons and 108 questions to PDS dentists (Appendices 3-5), were considerably shorter but included the same core questions. In 2011, the chief dentists were sent a similar questionnaire as in 2003 with some questions removed and new questions considering changes that had happened during the years, as well as some current matters added, altogether 148 questions (Appendix 7). Reminders and paper questionnaires were sent (more precisely in 6.3.1.).

Both closed and open questions were used. Most closed questions and statements had four response options. Two were positive and two negative. No neutral answers ("I can't say") were possible. The questionnaire was piloted by a smaller number of dentists, physicians and chairpersons. Following the pilot implementation, some questions were discarded and the wording of others was clarified.

4.2.3 Address lists

The names and e-mail addresses of all chief PDS dentists in Finland were provided by the National Research and Development Centre (STAKES) in 2003 and National Institute for Health and Welfare (THL) in 2011. A random sample of subordinate PDS dentists was selected by the Finnish Dental Association. Most names of chief physicians were provided by STAKES and completed from municipal web pages by collecting names and e-mail addresses of chief physicians and chairpersons of health boards, and when they could not found, a letter was sent addressed "to the chief physician or head of health board in municipality NN". Those who had an e-mail address were asked to complete the questionnaire directly on the Internet. The others were asked to use surface mail. The questionnaires were accompanied by explanatory letters (Appendices 1 and 6). The first surveys were carried out during the second half of 2003 and the first few months of 2004, and the second one only to chief dentists in the autumn of 2011 and January 2012. Swedish-speaking municipalities were excluded.

4.3 Methods

The answers were entered into Microsoft Excel® spreadsheets and SPSS Statistics® 13, 15 and 18 in papers I–II and later in papers III–IV, the Predictive Analytics SoftWare (PASW 18) and later IBN SPSS Statistics 22. A word-based questionnaire was used in 2011 by e-mail and responses were saved directly into PASW 18 Statistics. Also Excel 2003 was used to draw Figures in papers I-IV.

Not all respondents answered all questions and thus the n-values vary slightly in the analyses. Percentages have been calculated on the number of responses and by discarding missing answers. For analysis, both separate variables and sum variables constructed from the original variables were used. Sum variables were at first identified by using factor analysis (Analyze: Dimension Reduction: Factor; Extraction: Maximum likelihood; Rotation: Varimax) (*Table 1*). Missing

answers were replaced by the average of the sum variable of the variable in question by using the option 'Mean' of the 'Compute Variable' routine of SPSS (thus one or two missing elements were replaced by the average of the sum variable). The quality of leadership of the chief dentists was assessed using 12 positive or negative statements such as "just" or "authoritative" (see *Figure 1).* Based on factor analysis, only ten of these qualities were used as *sum variables*. The reliability of sum variables was assessed by using Cronbach's alpha coefficient which is the more reliable the nearer it is to one on a scale 0-1. In the text sum variables have been written in *italics*.

PDS units (health centres) were classified as either small (serving fewer than 20,000 inhabitants) or large (serving 20,000 inhabitants or more).

Where applicable, the following statistical methods were also used to analyse the data: computation of correlations and other descriptive statistics, cross tabulation with the chi-square test, parametric and nonparametric two-sample tests for comparing means of independent and dependent (or related) samples like the Mann-Whitney U-test and the Wilcoxon test, several samples test for comparing means of independent and dependent (related) samples like the Kruskal-Wallis H-test and linear regression analysis. For all tests the level of statistical significance used was set at 0.05.

***Table 1*. Sum variables formed by using factor analysis.**

1. From questions on qualities of leadership

Goal-oriented manager (chief dentists, PDS dentists and chief physicians) (Cr. alpha 0.813): is the sum of the following properties: innovative; convincing; goal-directed; passive/indolent (as negative); unsure (as negative). See *Table 6*, *Figures 2* and *3*.

People-oriented leader (chief dentists, PDS dentists and chief physicians) (Cr. alpha 0.856) is the sum of the following properties: just; empathetic/emotionally intelligent; reliable; authoritative (as negative). See *Figures 2 and 3.*

Weak and/or strong (good) managers and leaders (chief dentists): 4-step sum variable was formed of sum variables *goal-oriented managers* and *people-oriented leaders* above where as-strong-ones were classified in the uppermost quartiles and as-weak-ones in the three lower quartiles = both weak manager and weak leader, strong manager but weak leader, weak manager but strong leader, both strong manager and strong leader. See *Figure 4* and *5.*

2. From questions on enjoyment of work

Work well-being (Chief dentists 2003 and 2011) (Cr. alpha 0.690) is the sum variable which is constructed from the answers to the following questions: my own work well-being graded from 4 to 10 (school grades in Finland); I withstand stress and criticism; I have energy to learn new things; it is difficult to match working-life with private life (as negative); I often feel exhausted because of work (as negative); work atmosphere is good. See *Figures 4, 5* and *7*.

Job satisfaction (Chief dentists 2003 and 2011) (Cr. alpha 0.769) is the sum which is constructed from the answers to the following questions: I feel that I succeed as a leader; I feel that I am appreciated as a leader; my own work well-being is: graded from 4 to 10 (school grades in Finland); the atmosphere of dental care is good; I hold up well under pressure; I have energy to learn new things; it is difficult to match working life with private life (as negative); I am often exhausted by my work (as negative); I have enough time to lead; I have to do too much clinical work (as negative); I have to do too many items of administrative work (as negative). See *Table 6.*

Work control (Chief dentists 2003 and 2011) (Cr. alpha 0.575) is the sum which is constructed from the answers to the following questions: I have enough time to lead; I have to do too much clinical work (as negative); I have to do too many items of administrative work (as negative). See *Figure 4.*

Supportive work environment (PDS dentists 2003) (Cr. alpha 0.761) is the sum which is constructed from the answers to the following questions: the atmosphere of dental care is good; informally I can go and talk to my superior; I get positive feedback from my fellow workers; re-training because of the change is sufficient; my superior supports getting acquainted with a speciality subject. See *Figure 3.*

Mental reward from work (Chief dentists 2003 and 2011) (Cr. alpha 0.656) is the sum which is constructed from the answers to the following properties: challenge; creativity; independence of present work; possibility of influencing the future of dental care; teamwork or acting among people; value of work to the society and fellow-men. See *Figure 4*.

Self-esteem (Chief dentists 2003 and 2011) (Cr. alpha 0.816) (PDS dentists 2003, Cr. alpha 0.869) is the sum which is constructed from the answers to the following questions: I feel that I succeed as a leader (as a dentist); I feel that I am esteemed as a leader (as a dentist). See *Figure 4.*

Positive feedback to leadership (PDS dentists 2003) (Cr. alpha 0.894) is the sum which is constructed from the answers to the following questions: I am satisfied with my superior's way of leading; I fully trust my superior; my superior listens to the opinions of his or her subordinates; I support my superior in change leadership. See *Figure 5*.

Feedback and support given (chief physicians) (Cr. alpha 0.626) is the sum which is constructed from the answers to the following questions: I often give feedback to the chief dentist; I give plenty of support to the chief dentist. See *Figure 6.*

Feedback and support given (chief dentists) (Cr. alpha 0.471) is the sum which is constructed from the answers to the following questions: I often give feedback spontaneously and regularly in development conversations (two different claims for chief dentists, if development conversations left away Cr. alpha 0.540 and 79% gave ≥3 points); I listen to the opinions of my subordinates and support them. See *Figure 6.*

Feedback and support received (experienced) (PDS dentists) (Cr. alpha 0.713) (chief dentists, Cr. alpha 0.772) is the sum variable which is constructed from the answers to the following questions: I often receive feedback from my superior; I receive plenty of support from my superior. See *Figures 3, 5* and *6.*

3. Variables connecting identification and a position or role as leader or dentist

Leadership motivation (chief dentists) (Cr. alpha 0.746) is the sum variable which is constructed from the answers to the following questions: I am motivated to lead; leading the change is an interesting challenge; I am only a dentist among the other dentists (as negative); I would rather be a clinician than a leader (as negative); sometimes you have to act against the opinion of the staff; to avoid conflicts, it is better to act as have always acted previously (as negative). See *Table 6* and *Figure 4.*

Formed from the sum variable *leadership motivation* above: *identification as dentist* $1 \leq 2.99$; *identification as leader* ≥ 3 (on a scale 1-4). See *Figure 7.*

Decision-making power (chief dentists in 2011) (Cr. alpha 0.743 as*)* is the sum variable which is constructed from the answers to the following standardized questions: I have enough own independent decision-making power; I have more responsibility than power (as negative). See *Table 6* and *Figure 7.*

Positive attitude towards change (chief dentists in 2011) (Cr. alpha 0.669) is the sum variable which is constructed from the answers to the following questions: change of Primary Care Health Act (guaranteed access to care) was needed; change of Health Insurance Act was needed; individualised time between dental examinations is sensible; allocation of labour tasks between staff groups is sensible; adult people had time to get public dental services or support from SII in the private sector. See *Figure 7.*

Position as superior (chief dentists in 2011) (Cr. alpha 0.430,) is the sum variable which is constructed from the answers to the following questions: subordinates understand the goals imposed by management; I know the expectations of my subordinates towards my leadership; my position is conflicting with the expectation of subordinates towards my leadership (as negative). See *Table 6.*

Position as subordinate (chief dentists in 2011) (Cr. alpha 0.638) is the sum variable which is constructed from the answers to the following questions: the goals imposed by the uppermost political management are clear; I know the expectations of the uppermost management towards my leadership; my position is conflicting towards the goals imposed by politicians (as negative). See pages 6, 47, 48.

Implementation of the reform (chief dentists in 2011) (Cr. alpha 0.785) is the sum variable which is constructed from the answers to the following questions: How has implementation of the Dental Care Reform succeeded in your PDS unit? How has implementation of guaranteed access to care succeeded in your PDS unit? (1=very poorly…4=very well, on a scale 1-4). See *Figure 8.*

5 RESULTS

The threshold for the p-values used in this chapter is: $p>0.05$ not significant (ns.), $p<0.05$ almost significant, $p<0.01$ significant and $p<0.001$ highly significant. The bar percentages of the *sum variables* have been formed by taking the positive part ≥3 (fairly and very good on a scale 1-4) of the *sum variables* (*Figures* 1-3 and 6-8) and p-values have been reached by non-parametric tests like the Mann-Whitney U-test and the Kruskal-Wallis H-test which are based on the comparison of the medians.

5.1 Respondents (I - IV)

As shown in *Table 2*, four groups were interviewed in 2003: chief dentists, chief physicians (most of them superiors of chief dentists), PDS dentists (health centre dentists) and the MBSH chairpersons. In 2003, the questionnaires were answered by 156 (67% of 233) chief physicians, 277 (76% of 365) PDS dentists and 126 (54% of 233) MBSH chairpersons. The number of respondents in the chief dentists' group was 194, giving a response rate of 73% (194/265). In 2011, their response rate was the same 73% (117/161). Over one third of the chief dentists which responded to the questionnaire in 2011 - 38% (44/117) - had also participated in the study in 2003. Other groups were not interviewed in 2011 (*Table 2*).

Both the numbers of municipalities and chief dentists had decreased from 2003 to 2011. Municipalities had been merged and new PDS co-operation areas formed. As a result, in this material the average population per the PDS units had increased from 22,000 in 2003 to 34,000 in 2011 and the median from 11,000 to 22,000 (Mann-Whitney U-test, $p<0.001$). The PDS units were broken down to smaller ones, with a population under 20,000 and to large ones with a population 20,000 or over. Nearly three-quarters (71%; 138/194) of the chief dentists worked in small PDS units serving fewer than 20,000 inhabitants in 2003 compared with about half (47%; 55/117) in 2011 (cross tabulation with the chi-square test, $p<0.001$).

Table 2. **Target groups and respondents in 2003 and 2011. N = target size.**

	2003			2011		
Target group	**N**	**Respondents n**	**%**	**N**	**Respondents n**	**%**
Chief dentists	265	194	73	161	117	73
Chief physicians	233	156	67			
PDS dentists	365	277	76			
Chairpersons	233	126	54			
Total	1096	753	69	161	117	73

In both studies, the respondents' average length of service as chief dentists was the same, 12.5 years.

5.2 Becoming a chief dentist in the PDS (II, III, IV)

Most chief dentists acted in small PDS units. As shown in *Table 3*, contrary to expectation, the proportion of female chief dentists had not statistically significantly increased: 50% (96/192) in 2003 and 61% (71/117) in 2011 of chief dentists were women (p=ns.). The respondents in 2003 and 2011 were broken down to "young" (<50 year old) and "old" (≥50 year old) respondents. Over the years, the average age of the chief dentists had increased: 71% (82/115) were in 2011 older than 50 years compared to 50% (95/192) in 2003 (p<0.001). About third of the respondents in both years, 2003 and 2011, had applied for the post. The remaining two-thirds had been asked or "forced" to take the position because there were few or no other applicants. As also shown in *Table 3*, compared with women (over 20%) about twice as many men (over 40%) had applied for a position as a chief dentist in the PDS in both years (p<0.01). In addition *to Table 3*, men under 50 years of age had actively applied for leadership positions. In this age group, half (49%; 23/47) of men and one fifth (21%; 9/44) of women had sought a leadership position themselves (p<0.01). There was no difference between males and females over 50 years of the age. In small health centres, three times as many men (28%; 18/64) as women (9%; 6/64) had applied for such posts themselves (p<0.05). In large health centres, no statistical difference in candidate numbers was found. The p-values of this chapter were reached by using cross tabulation with the chi-square test.

Table 3. **Chief dentists' sex, age, applying for their posts, satisfaction with their leadership education in relation to years 2003 and 2011. (P-values were reached by using cross tabulation with the chi-square test and Mann-Whitney U-test). N = number of those who responded to the question, n = number of those who responded positively.**

Responded yes	2003			2011			p-value
	N	n	%	N	n	%	
Female chief dentists in PDS	192	96	50	117	71	61	**= ns.**
Age of chief dentists ≥ 50 yr	192	95	50	115	82	71	**<0.001**
Applied for the post	178	57	32	114	34	30	**= ns.**
- Females applied for the post	87	19	22	69	14	20	**<0.01**
- Males applied for the post	91	38	42	45	20	44	
Enough leadership education	179	87	49	112	76	68	**<0.01**

5.3 Chief dentists' satisfaction with their leadership education (III, IV)

As also shown in *Table 3*, respondents were more satisfied with their leadership education in 2011 than in 2003. In addition to *Tables 3 and 4*, most male chief dentists (57%; 51/91) and fewer than half 40% (36/89) of the female ones in 2003 felt that they had received enough leadership education (cross tabulation with the chi-square test, p<0.05). There were no significant differences between men and women regarding formal qualifications for office; about two-thirds of all of them were qualified as dentists only and had no higher degrees or diplomas. In both years, men were more satisfied with their leadership training, regardless of whether they were 'dentists' without any other qualifications or 'specialists' having one or more qualifications. Instead, women who were 'specialists' were much more satisfied with their leadership education than those who were not specialists (cross tabulation with the chi-square test, p<0.001).

5.4 Leadership qualifications (II, III, IV)

In *Table 4*, chief dentists with no extra education are called 'non-specialists' and all other chief dentists 'specialists'. The results in this chapter were reached by cross tabulation with the chi-square test.

***Table 4*. Chief dentists' leadership education: basic and additional qualifications in 2003 (n=185) and in 2011 (n=117). n=number of respondents.**

	Respondents				
	2003		2011		p-value
Leadership education	**n=185**	**%**	**n=117**	**%**	
Dentist only ('non-specialist')	114	62	54	46	**<0.01**
Dentist with additional education ('specialist')	71	38	63	54	
-Specialist in Dental Public Health, in clinical dental disciplines or dentist with other basic academic degree	63		41		
-Special Competence in Health Care Management ("old education")	39		8		
-Special Competence in Dental Administration ("new education" by the FDA)	2		28		
- Vocational Qualification in Management and Leadership or ongoing it	0		23		

Over the years, a greater proportion of the chief dentists had received leadership education. In 2011, over half, 54% (63/117) of the respondents were either specialists, or undergoing specialist training, had various additional leadership education, or other additional academic qualifications compared with 38% (71/185) in 2003 ($p<0.01$). It is notable that leadership education had polarized: 'specialists' had often one or two other leadership qualifications. Leadership education had also changed since 2003. Special Competence in Health Care Management in 2003 had changed to Special Competence in Dental Administration and later to Vocational Qualification in Management and Leadership in 2011. The last one is a special education meant more widely to managers and leaders. Many vacant positions for chief dentists had requested applicants to have leadership qualifications; this applied to about half of the chief dentists (53%; 32/60) in large units and 13% (7/53) in small ones ($p<0.001$) in 2011. Leadership qualifications were also required more often in those PDS units where big organisational changes had occurred in the form of both municipal co-operation areas and municipal mergers; in these, 53% (19/36) of the chief dentists reported that leadership qualifications had been important when applying for the post, in contrast to 26% (20/77) ($p<0.01$) in units having had no or only smaller changes.

Two-thirds of 'specialists' (65%) and half (51%) of the 'non-specialists' thought that their salary was too low in relation to their subordinates PDS dentists ($p<0.05$).

5.5 Working hours as a chief dentist (IV)

The proportion of the respondents who were full time leaders and did not work with patients had increased from 10% (17/177) in 2003 to 17% (19/111) in 2011 but the increase was not statistically significant (Mann-Whitney U-test, p=ns.). All full time leaders were found in the large PDS units. The average proportion of working hours in the clinic had, however, decreased from 60% in 2003 to 52% in 2011 (Mann-Whitney U-test, $p<0.05$) Still in 2011, 23% (25/111) of the chief dentists worked more than 75% of their working hours in the clinic.

5.6 Chief dentists' leadership qualities (I - IV)

As shown in *Figure 1*, twelve questions were used to survey the chief dentists' leadership qualities. The chief dentists themselves, as well as their superiors (chief physicians) and their subordinates (PDS dentists) were asked to answer these questions. Mean values were calculated to each quality assessed by study groups by using SPSS descriptive statistic frequencies. Assessments on chief dentists' leadership qualities between the study groups were tested by using the Kruskal-Wallis H-test.

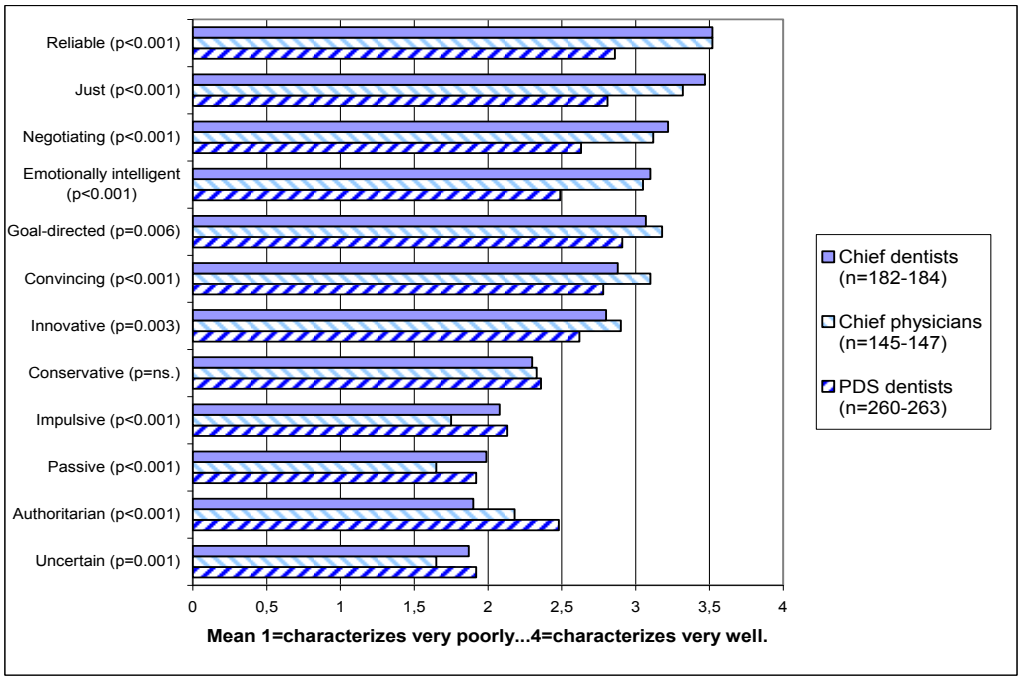

Figure 1. **Characterisation of the leadership qualities of the chief dentists by the chief dentists themselves, by their superiors (the chief physicians), and subordinates (the PDS dentists) in 2003. The results were derived by using the Kruskal-Wallis H-test.**

The chief dentists themselves and chief physicians scored higher than the PDS dentists on most positive aspects. Reliability, righteousness (justice), and goal-directedness received high scores from all groups. Chief dentists' superiors evaluated that the leadership qualities impulsive, passive and uncertain characterized their subordinates poorly. Instead, PDS dentists thought that authoritarian described their superiors as well as emotionally intelligent.

Two sum variables were formed from ten leadership qualities: *goal-oriented manager* (having concern for production) and *people-oriented leader* (having concern for people) (Blake and Mouton 1968) (*Table 1*). Ninety per cent of chief dentists in 2003 and 2011 evaluated that they were rather or very good *people-oriented leaders* (271/301) and 66% (197/300) that they were rather or very good *goal-oriented managers* (Mann-Whitney U-test, $p<0.001$).

Nearly all female (92%; 86/93) and most 78% (70/90) of male chief dentists considered that the quality of empathy or emotionally intelligent, belonging to the sum variable *people-oriented leader*, characterised them as leaders moderately or very well (Mann-Whitney U-test, $p<0.01$). On the other hand, three quarters of the men (74%; 67/90) and 59% of the women (54/92) considered that the quality innovative, belonging to the sum variable *goal-oriented manager,* characterised them as managers moderately or very well (Mann-Whitney U-test, $p<0.05$).

5.7 Superiors', subordinates' and decision-makers' views on chief dentists (I, III, IV)

At first there are some comparisons between the survey groups connecting to *Figure 2*. Most chief dentists in 2003 (162; 88%) felt they were moderately or very good *people-orientated leaders* (e.g. emotionally intelligent, negotiating) but fewer than half (108; 41%) of their subordinates agreed (Mann Whitney U-test, $p<0.001$). Nearly two-thirds (114; 62%) of the chief dentists felt they were moderately or very good *goal-orientated managers* (e.g. innovative, purposeful) but still a higher proportion (112; 74%) of their superiors thought they were (Mann Whitney U-test, $p<0.001$; *Figure 2*; *Table 1*). Most chief dentists considered themselves slightly better *people-oriented leaders* and *goal-oriented managers* in 2011 than in 2003 (Mann Whitney U-test, $p<0.05$).

Otherwise the bars in *Figure 2* represent the opinions of individual survey groups on chief dentists' leadership qualities and are so related samples. The results were reached by using the Wilcoxon test.

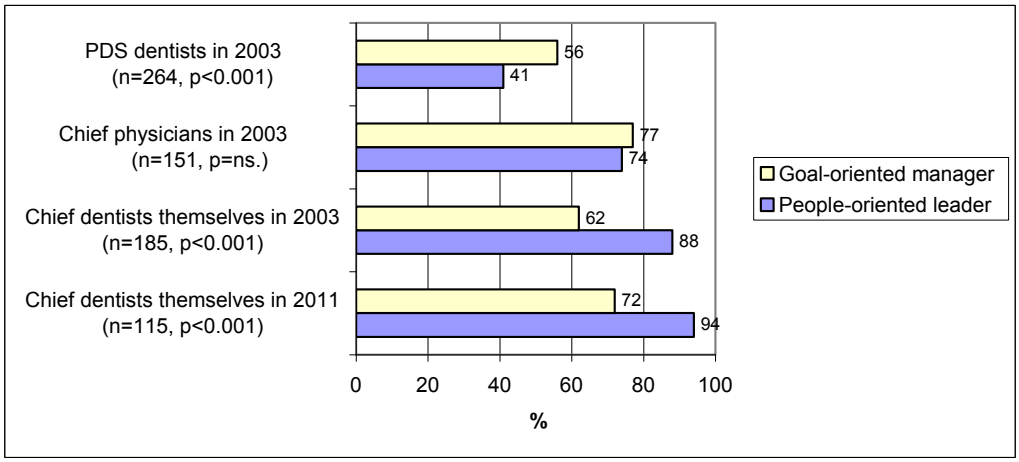

***Figure 2*. Goal-oriented managers or people-oriented leaders? Distribution of the chief dentists' own opinions in 2003 and 2011, and their superiors' (chief physicians) and subordinates' (PDS dentists) opinions on whether the chief dentists were good *goal-oriented managers* or *people-oriented leaders* (good ≥3 in sum variables on a scale 1-4). P-values were reached by using the Wilcoxon test to every group in each year.**

As shown in *Figure 3*, PDS dentists found their female superiors (female chief dentist) statistically significantly better in issues belonging to leadership skills in 2003 (p-values were reached by using the Mann-Whitney U-test).

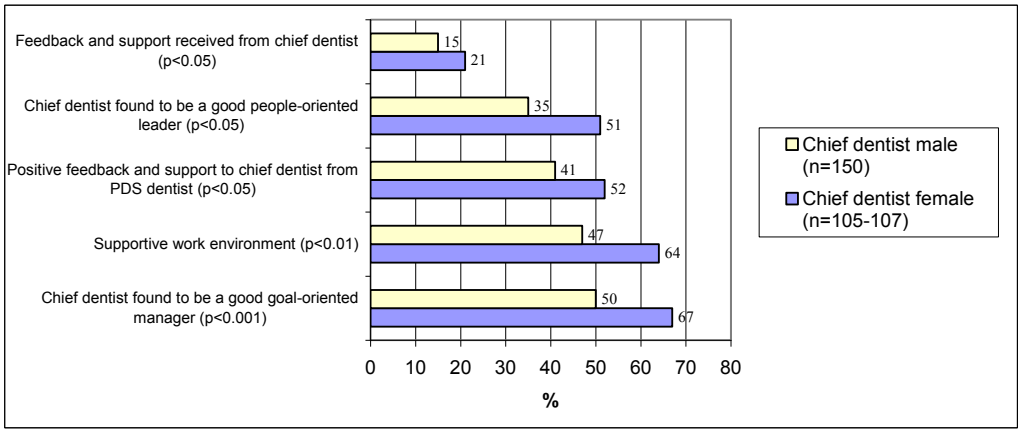

***Figure 3.* Views of the PDS dentists (subordinates) on the leadership qualities of their female and male superiors (chief dentists) in 2003. Percentage values (good ≥3 in sum variables on a scale 1-4) given by the PDS dentists compared with the sex of their superior. P-values were reached by using the Mann-Whitney U-test.**

In the views of their immediate superiors, the chief physicians and the MBSH chairpersons (municipal decision-makers) female and male chief dentists were highly and equally appreciated with respect to almost all the qualities listed in the questionnaire. For example, chief dentists scored highly as *goal-oriented managers* and *people-oriented leaders* (both medians=3.2). Two-thirds

(67%; 187/278) of the chief physicians and political MBSH chairpersons gave them four points on confidence of their judgement and on their ability to manage of their tasks (median=4).

5.8 Weak and strong or good managers and leaders (I, II, IV)

The sum variables *goal-oriented managers* and *people-oriented leaders* in 2003 and 2011 were broken down in two parts to bad (1-2 on a scale 1-4 from bad to good) and good 3-4 (3-4 on a scale 1-4 from bad to good). If chief dentists felt that they were good *goal-oriented managers* they had better (3-4 on a scale 1-4) *mental reward from work*, *self-esteem*, *leadership motivation*, *work well-being* and they had a more *positive attitude towards change* (Mann-Whitney U-test, $p<0.001$) and *better work control* (Mann-Whitney U-test, $p=0.001$) than if they felt that they were bad *goal-oriented managers*. Of the above-mentioned sum variables, if chief dentists felt that they were good *people oriented leaders* they had a slight better *self-esteem* (Mann-Whitney U-test, $p<0.05$).

The sum variables *goal-oriented managers* and *people-oriented leaders* (respondents in 2003 and 2011) were broken down into a four-scale variable 'both weak manager and leader', 'strong manager but weak leader', 'strong leader but weak manager', and 'both strong manager and leader' (procedure explained in *Figure 4*). On this breakdown most (56%) respondents were found to be not very strong or good in either of these aspects.

The results in this chapter were reached by using the Kruskal-Wallis H-test. As shown in *Figure 4*, if the chief dentists evaluated themselves as 'good or best managers but weaker leaders', their *mental reward from work*, *self-esteem*, *work well-being* and *leadership motivation* were better than that of the chief dentists who evaluated themselves as 'good or best leaders but weaker managers'**.** **'**Good managers but weaker leaders' also had best control over their work, but that difference had levelled off since 2003 and was no longer statistically significant in 2011.

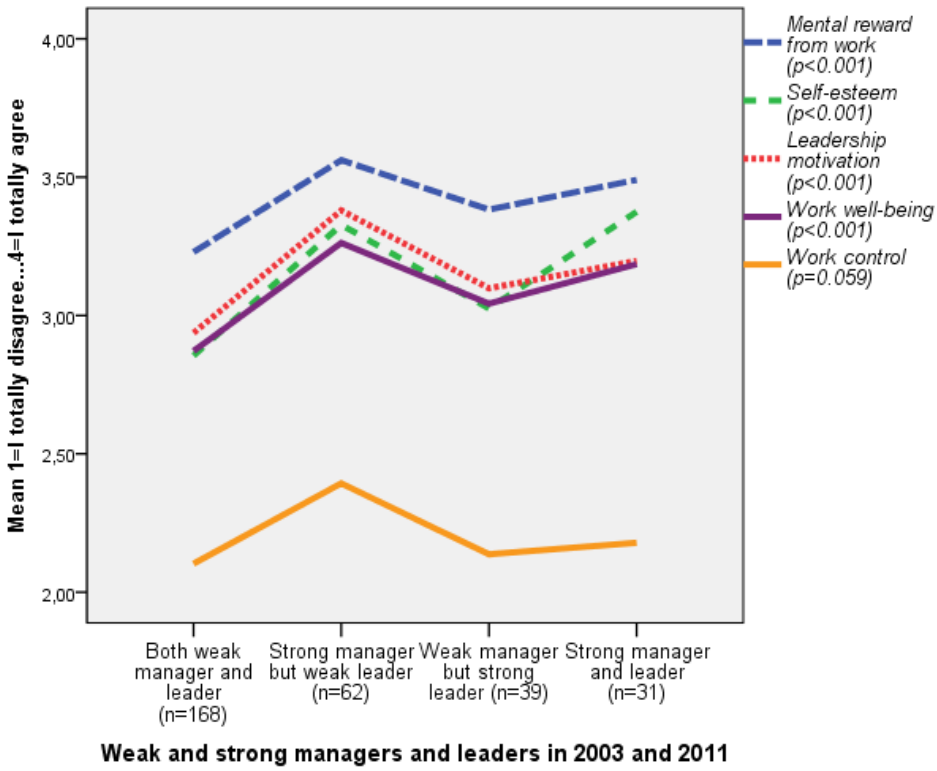

***Figure 4*. Chief dentists' own assessments of their management and leadership qualities in relation to some qualities belonging to various aspects of job satisfaction in 2003 and 2011. The variable 'weak or strong managers or leaders' was constructed from two sum variables *goal-oriented manager* and *people-oriented leader*, in which strong are the uppermost quartiles, and weak the three lower quartiles. P-values were reached by using the Kruskal-Wallis H-test.**

Figure 5 was formed in the same way as told in *Figure 4*. As shown in *Figure 5*, PDS dentists' *work well-being* and satisfaction with their superiors' leadership style *(positive feedback to leadership)* were better if they rated their superiors as good *leaders* and good *managers,* or good in either respect, than if they were rated weak. Subordinates also thought that they themselves received most *feedback and support* when their superior was both a good *leader* and good *manager.* In all aspects, these qualities were rated better when the chief dentist was considered a good *leader* but weak *manager* than when considered a good *manage*r but weak *leader*.

In addition to *Figure 5*, independently of leadership style, 64% (162/253) of all PDS dentists found that their boss sometimes acted against the opinions of the staff. But if the boss was both strong manager and strong leader only 29% (12/42) thought that he or she actually did so. Even 85% (215/253) of all PDS dentists understood that the boss had sometimes to make decisions against their opinion.

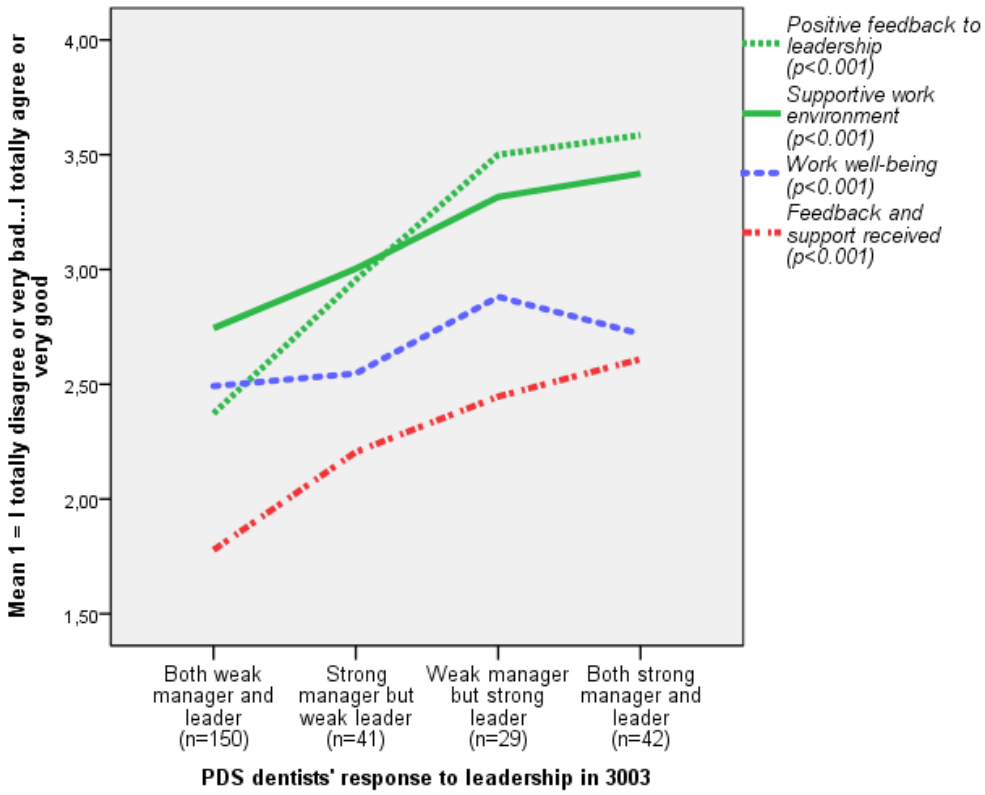

Figure 5. **Chief dentists' leadership styles evaluated by PDS dentists in relation to the sum variables: their own "*positive feedback to leadership*", "*work environment*, "*work well-being*", "*feedback and support experienced*". P-values were reached by using the Kruskal-Wallis H-test.**

5.9 Feedback and support given and experienced by the chief dentists, their superiors and subordinates in 2003 (I, III)

As shown *in Figure 6*, 124 out of 178 chief dentists (70%) and 77 out of 154 chief physicians (50%) thought they often gave *feedback* and much *support* to their own subordinates. However, few chief dentists as subordinates (38/179; 21%) and few of their own subordinates (the PDS dentists; 46/265; 17%), reported that they often received *feedback and support.* P-values between the *feedback and support* given by the superiors and experienced by their subordinates were highly significant (Mann-Whitney U-test, $p<0.001$). Chief dentists claimed that they gave much or very much feedback to their subordinates, both unofficially and through informal discussions. *Feedback and support experienced* by chief dentists from their own superiors improved their *leadership motivation* statistically significantly (Wilcoxon test, $p<0.001$).

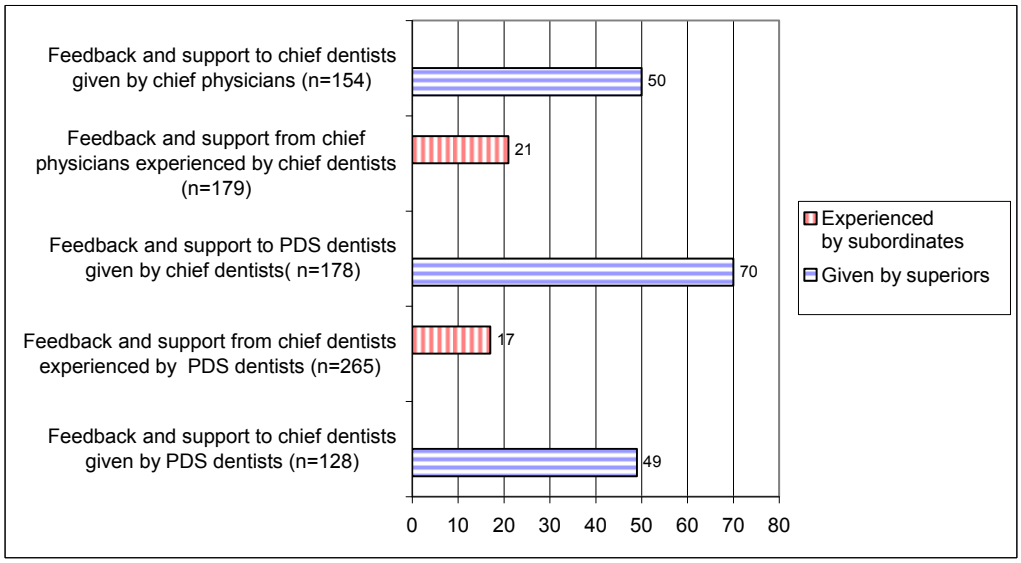

***Figure 6*. Proportions of positive answers in 2003 (points ≥3 in sum variables on a scale 1-4) to the statements "I often give or receive *feedback"* and "I give or receive much *support"* given by the chief dentists, their superiors (chief physicians) and subordinates (PDS dentists). *Feedback and support* is a sum variable of these statements. P-values <0.001 in both groups: chief physicians/chief dentists and chief dentists/PDS dentists. This result was reached by the Mann-Whitney U-test.**

5.10 Chief dentists' identity as leader (boss) or dentist among the dentists (II and IV)

The sum variable *leadership motivation* in 2003 and 2011 was divided into a two-scale variable: 1=dentists (<3) and 2=leaders or 'bosses' (≥3, on a scale 1-4). On this scale, over half (182/295; 62%) of the respondents could be 'identified as leaders' and the rest (113/295; 38%) were 'identified as dentists'.

As shown in *Figure 7* in 2011, a higher proportion of the chief dentists 'identified as leaders' had greater *decision making power*, better *work well-being,* more *positive attitude towards change*, they were better *goal-oriented managers*, their *mental reward from work* was higher, and they had better *self-esteem* than those 'identified as dentists'. As regards people-orientation, there was no difference between the groups. These results were reached by the Mann-Whitney U-test.

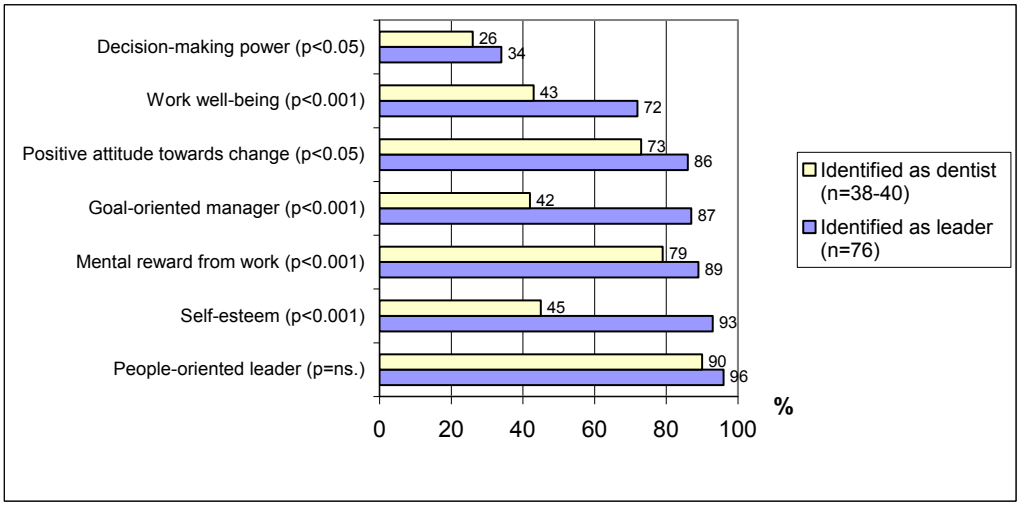

Figure 7. **Distributions of chief dentists (%) in 2011 'identified as leaders (bosses) and 'identified as dentists' according to high or good (≥3 on a scale 1-4) values given to sum variables to *work well-being*, *goal-oriented managers, people-oriented leaders, positive attitude towards change* and *decision-making power.* P-values were reached by using the Mann-Whitney U-test.**

5.11 Chief dentists' position in the municipal hierarchy in 2003 and 2011 (IV)

As shown in *Table 5,* the appreciation of career progression had become more important (≥3 on a scale 1-4) to chief dentists between 2003 -2011 ($p<0.01$). Meanwhile they had, however, lost their positions in the municipal hierarchy.

Table 5. **Chief dentists' opinions on career progression and their position in the municipal hierarchy. N=responded the question, n=responded positively. P-values were reached by using cross tabulation with the chi-square test.**

Responded yes	2003			2011			p-value
	N	n	%	N	n	%	
Career progression important	179	46	26	115	50	43	<0.01
Member of management team	187	123	65	116	61	53	<0.05
Right to participate in the MBSH meetings	185	61	33	115	24	21	<0.05
Right to make representation to the MBSH	185	22	12	115	7	6	<0.05

Membership of the management team for primary health care has traditionally been an important channel for chief dentists to make their voices heard in the municipal administration. In 2003, 65% (123/187) but in 2011 only slightly more than half, 53% (61/116), of the chief dentists were involved as such members ($p<0.05$). In the same way, the opportunity to participate in the MBSH meetings had marginally decreased: 33% (61/185) in 2003 and 21% (24/115) of the chief in 2011 dentists had the right to participate in all meetings they found important ($p<0.05$). The others could participate by invitation only. Still fewer had right to make representation to the MBSH ($p<0.05$,

Table 5). If the chief dentists had no possibility of participating in the health board or managing team meetings, as reported by 29 chief dentists in 2011, they could make their voices heard through their superiors, usually the chief physicians. In 2003 and 2011, 59% (170/286) of the chief dentists felt that dental care in the local municipalities worked as a separate entity, loosely attached to the rest of health care. However, in 2011 70% (79/113) of chief dentists thought that politicians made decisions against their opinions only seldom (58%) or never (12%). The d*ecision-making power* of chief dentists had decreased highly significantly from 2003 to 2011 (Mann-Whitney U-test, mean ranks 176.24 versus 110.17 or 63% versus 32%, $p<0.001$).

5.12 Work well-being (II, IV)

In order to find out which were the most important factors influencing the sum variable *job satisfaction,* a linear regression model was designed, where *job satisfaction* (including sum variables *work well-being*, *self-esteem* and *work control*) was explained by variables *leadership motivation*, *position as superior*, *decision-making power*, *goal-oriented manager* and enough leadership education. The stepwise variable selection routine of SPSS was used to select statistically most influential explanatory variables in the model. The results of this procedure are given in *Table 6*. Explanatory variables are in the order that describes the statistical significance best; the statistically most significant variable, *leadership motivation*, is the first one in *Table 6*. Coefficient of determination of the estimated model is 49% (100*0.490) in the last line.

Table 6. **Most important variables for the explained variable, chief dentists' *job satisfaction* in 2003 and 2011. Regression linear stepwise estimation method.**

Explanatory variables	Estimated coefficients	Std. error of the estimated coefficients	t-values	p-values
Leadership motivation	0.266	0.40278	10.098	<0.001
Position as superior	0.368	0.37451	6.710	<0.001
Decision-making power	0.430	0.35623	5.520	<0.001
Goal-oriented manager	0.471	0.34389	4.625	<0.001
Enough leadership education	0.490	0.33810	3.257	<0.001

Between 2003 and 2011, chief dentists' *work well-being* had marginally improved (Mann-Whitney U-test, $p<0.05$): 54% (98/180) in 2003 and 61% (73/117) in 2011 of them all gave positive responses to this question (points 3-4 on a scale 1-4 and school grades ≥8, including also work atmosphere).

When asked a simple question on whether chief dentists' pay was too low, suitable or too high in relation to their subordinates, a majority, 57%, (166/290) felt that it was too low. A greater majority of those who identified themselves as leaders also felt that it was too low (cross tabulation with the

chi-square test, $p<0.05$) and so experienced injustice (62% versus 52%) and that the compensation system was unfair.

5.13 Opinions on the Dental Care Reform and the success of its implementation (I, IV)

In 2003 (*Figure 8*), chief dentists had a more positive attitude towards the enlargement of the reimbursement of basic dental care in the private sector to all adults, as stipulated in the Health Insurance Act (HIA), than in 2011 ($p<0.001$), while their attitude towards the Primary Health Care Act (PHCA) leading to opening the PDS to all adults had not statistically significantly changed during those years. In 2003, 59% (114/194) of the chief dentists had a very positive (4 on the scale 1-4) attitude towards the HIA, but only 43% (83/194) were very positive towards the PHCA ($p<0.001$). In 2011**,** opinions of the importance of these laws had levelled off (especially because negative responses towards HIA had increased): half 48% (56/116) of the chief dentists totally agreed that the changes in the PHAC and in the HIA had been necessary. However, when looking at both surveys together, a slight majority 55% (170/310) of the respondents supported HIA and only 45% (139/310) the PHCA ($p<0.01$).

The perceived success of the PHCA was dependent of the length of the waiting list for non-urgent care*:* when it was below three months, nearly a third (32%) and, when it was longer, only 4% of the chief dentists totally agreed that the implementation of the PHCA had been successful ($p<0.001$). In 2011, an obvious minority, 18% (20/114) of the chief dentists totally agreed that the change of the PHCA, guaranteed access to care (GAC, introduced in 2005), had been necessary; slightly more than half 56% (63/114) found it unnecessary. The length of waiting lists did not influence the respondents' negative opinion of the necessity of the GAC (*Figure 8*). Nevertheless, a higher proportion (45%) of the chief dentists in those PDS units where waiting lists were short totally agreed that the implementation of the GAC had been successful ($p<0.001$) compared to 6% of the chief dentists in units that had longer waiting lists. Most (67%) respondents somewhat or totally agreed that care periods had become longer due to the reform (55% if waiting time $\leq$3 months versus 80% if >3 months) ($p<0.01$). The p-values above of opinions on the Dental Care Reform were reached by using cross tabulation with the chi-square test.

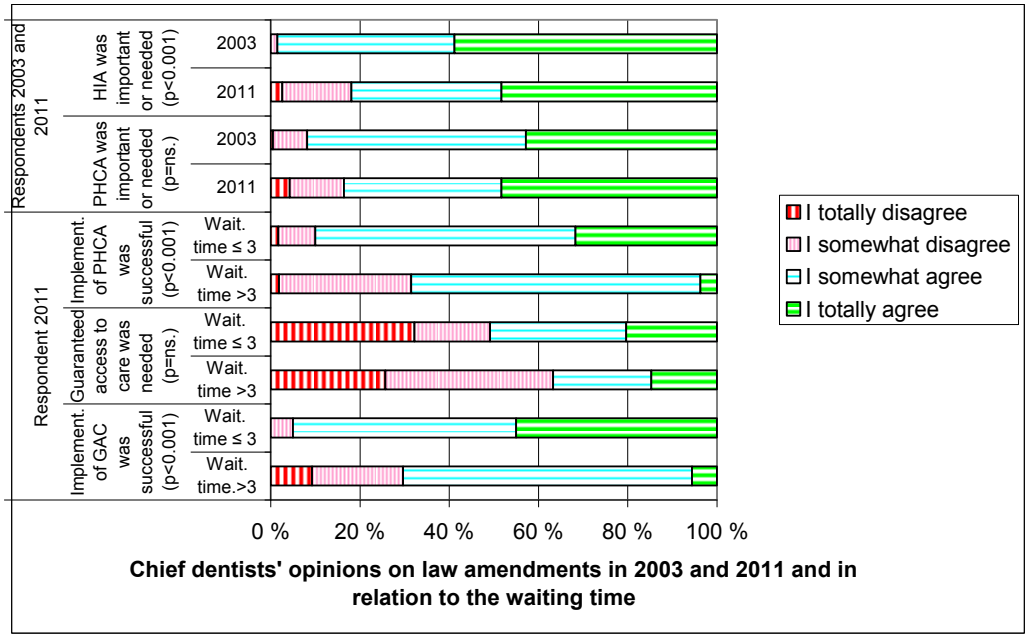

Figure 8. **Distribution of negative (I disagree, points 1-2) and positive (I agree, point 3-4) attitudes of the chief dentists in 2003 and 2011 towards changes made (in 2000 and 2004) in the Primary Health Care Act (PHCA) and in the Health Insurance Act (HIA) and towards the introduction of the guaranteed access to care (GAC in 2004, maximum wait six months) in 2011. Attitudes in 2011 were also related to the length of adult patients' waiting time for dental care in the PDS. Perceived success of the implementation of the PHCA and the GAC are also presented. In the Figure 8, the opinions of chief dentists have been tested in relation to years 2003 and 2011 and to the waiting time for care. P-values were derived by using cross tabulation with the chi-square test.**

Implementation of the reform (a sum variable) had been easier in small (less than 20 000 inhabitants), as opposed to large PDS units: 88% (46/55) of the respondents in small units and 74% (46/62) in large ones thought that implementation of the reform had been fairly or very successful (Mann-Whitney U-test, $p<0.05$). However, most respondents, 72% (73/102) thought that shortage of competent applicants to fill posts, especially dentists, had made the implementation more difficult. In 2011, 59% (11/19) of the full-time leaders and 82% (75/92) of those who had clinical hours with patients thought that *implementation of the reform* (≥3 on a scale 1-4) had succeeded fairly or very well (Mann-Whitney U-test, $p<0.01$).

6 DISCUSSION

6.1 The Finnish dental care system

According to current legislation, the Finnish health care system, including the PDS, is the responsibility of the municipalities (Järvelin 2002). Municipalities can provide primary health care services themselves, by entering into a municipal health care federation or they can buy services from the private sector. Every municipality or municipal federation must have a health centre, an MBSH, chief physician and chief dentist responsible for PDS.

There have been few studies on leadership in the Finnish PDS (Utriainen et al. 1992) until the Dental Care Reform was launched in 2000-2002**.** After that, several studies were started (Alestalo and Widström 2002, Kataja 2006, Niiranen et al. 2008). Before the Reform, the PDS was expected to take care of children and youngsters in the first place and the municipalities had a free hand to decide whether or not to include adults in the system. The official statutes defining the age limit for oral health care were seen as a recommendation. When the Dental Care Reform was introduced, 2.1 million adults (41% of the population, Tilastokeskus) became eligible for public services or reimbursement of the cost of private care. This meant big changes in most local PDS clinics and the municipalities running them. As Myllymäki (2006) states, the solution model for municipalities has most often been to request more resources and innovative development has been rare. Changes were needed also in the organisational culture in the whole Finnish public health service, which has been described as out-dated and hierarchical (Kinnunen 1990).

Thus it was important to study what kind of leaders were responsible of the implementation of this major reform of dental care in Finland, and how they experienced their status in the hierarchy. Widstöm and Väisänen (2009) have shown that the chief dental managers and chief dentists in Finland, Norway and Sweden defended the existence of public dental services. They stressed that the PDS increased equity of access to oral health care and that the PDS is responsible for the entire population, not just “selected suitable patients”, and for organising services in remote and rural areas.

Overall, the Nordic chief dental managers supported the continuing provision of services in the PDS. They felt that oral health care personnel should be financially rewarded for productivity through individualised incentive programmes (Widström and Väisänen 2009).

6.2 Methodological aspects

6.2.1 Materials

Collecting data for this study was an arduous and time-consuming process, because many e-mail addresses were not available from official sources and were difficult to find. Those that could be found were often incomplete. As Kekki (1993) had noticed, employees in complicated situations of change did not always know who was managing the activities. This was often true especially for chief physicians and chairpersons of health boards in 2003, but was also the case with chief dentists in 2011. In addition, still in 2003 many respondents felt that the Internet-based questionnaire was inconvenient to fill in and asked for a paper version. After several mailings and sometimes phone calls, the final response rates of the chief dentists (73%), their subordinates (PDS dentists, 76%), and their superiors (chief physicians, 67%) were relatively high. Reminding the respondents improved the response rate only by a few percentage points. The response rate of the municipal decision-makers (chairpersons of health boards) was lower, 54%, probably because these chairpersons found the questionnaire laborious to complete and oral health care was only a small part of their work. Nevertheless, despite this over 50% of politicians responded, indicating that the dental care reform and its implementation were considered important matters in the local municipalities.

The second questionnaire in 2011 resulted in the same response rate from chief dentists, 73%. The most usual cause for non-participation was that a number of PDS units had, because of municipal mergers, not yet appointed a chief dentist or the post was held by a temporary deputy who felt that he or she could not answer the questionnaire. However, the respond rates can be considered satisfactory when compared with an earlier study which reviewed response rates in dental questionnaire studies internationally: the mean response rate of questionnaires mailed to dentists was reported to be 64% (Tan and Burke 1997). In medical journals, published surveys of physicians have had a mean response rate of only 54%, and those of non-physicians have a mean response rate of 68% (Asch et al. 1997). The response rate was not as high as the over 80% achieved in the Finnish Dental Association (FDA, interest group of dentists) surveys about work well-being of dentists (Hakanen and Perhoniemi 2003-2006). Since the Dental Care Reform, the chief dentists have probably been the target group for many local and national surveys and they may have become tired of them. Nevertheless, the response rate was high enough to be "an indirect indication of the extent of non-respondent bias" as also found in the first survey in 2003 (Asch et al. 1997).

6.2.2 Validity

This research was a quantitative cross-sectional survey. It involved retrospectively "questioning respondents about past as well as current behaviour, attitudes and events" (Bowling, 2002a). Partly it was a "panel (follow-up of the same population) or trend (different samples at each data

collection period)" survey with the traditional form of longitudinal design, for 44 (23%; 194) persons were among the respondents in 2003 and were interviewed the second time after eight years (38%; 44/117) in 2011. Though the interdependence and differences of variables are treated in this study, it is not necessarily a cause and effect relationship. According to Bowling (2002a), "cross-sectional studies can only point to statistical associations between variables; they cannot alone establish causality." The questionnaires also involved unstructured questions which are occasionally quoted in this presentation. The study can be assessed by face validity, which according to Bowling, (2002b) "simply refers to investigators' subjective assessment of the presentation and relevance of the questionnaire: do the questions appear to be relevant, reasonable, unambiguous and clear?" Due to the large total sample of chief dentists (THL), random sampling of PDS dentists (by FDA) and their moderately high response rates, 73% and 76%, validity (accuracy) of this study can be considered good in terms of these target groups representing their opinions. but they were difficult to reach. So, the response rates of chief A list of chief physicians (most of them immediate superiors of chief dentists) was received from STAKES. The questionnaires were sent to these and to the chairpersons of the health boards (elected officials), physicians and chairpersons can also be seen as satisfactory but a certain maturation affecting the internal validity is possible, especially in the second survey in 2011.

6.2.3 Reliability

Factor analysis is used in this study in order to isolate, out of all the answers to the series of questions, only a few questions that are easy to interpret and describe best the leadership properties of the respondents. The analytical technique has been used especially for the ratio and interval scale variables, but it is widely used in social sciences for ordinal scale variables as used in this study.

Reliability means the internal consistency and repeatability of the study. As mentioned earlier in Methods, the Factor analysis was used to summarize data by forming sum variables. Their reliability was ensured by Cronbach's alpha. This method has had a lot of criticism in Finland, inter alia by Vehkalahti (2000), but it is still commonly used (*Table 1*). A couple of sum variables have a summation element included, if it lowered Cronbach's alpha only a little but was thought to be an important one. Not all Cronbach's alphas are very high in this study. There are some sum variables with few summation elements whose alpha is even less than 0.6 (it is usually recommended that the value of alpha should be more than 0.7). "Cronbach's alpha is a measure of internal consistency, that is, how closely related a set of items are as a group. A 'high' value of alpha is often used…as evidence that the items measure an underlying (or latent) construct. However, a high alpha does not imply that the measure is unidimensional (one-dimensional)" (SPSS FAQ IDRE), and in surveys one may have to settle for lower values (Alkula et al. 2002a). There were some elements, close to statistical significance, scattered in the questionnaires. This procedure may have reduced in exactly the same way ticked responses to consecutive questions. For the same reason there were also negative claims in the series of questions, but some of them may be personal views, which could have caused researcher's bias and should have been avoided (Metsämuuronen 2006). Repeatability

of the study can be challenged, because the questions in the series were not generally tested and accepted by science, but drawn up for this study. Alkula et al. (2002b), however, claim that in social sciences, the same variables are seldom used as long as the validity of the variables would become ensured but every researcher constructs his or her own variables because the matters and circumstances change.

6.3 Respondents

6.3.1 Chief dentists

According to the governmental program, during the eight years after 2003, the total number of chief dentists decreased by 39% from 194 to 117 as the size of the PDS units increased due to municipal mergers or the formation bigger health care consortia of municipalities. Although the average size of the PDS units had grown significantly between 2003 and 2011, the number of full-time leaders had not increased in the same proportion. The current study showed that chief dentists worked full-time as leaders when the PDS unit had 40,000 or more inhabitants. In units smaller than 16,000 inhabitants, the chief dentists spent only about 20% of their working time on leadership and management, which is natural for units having a small staff. Overall, the average clinical working time of the chief dentists decreased slightly as the average size of the units increased from about 22,000 to 34,000. Thus, the chief dentists were responsible for larger units in 2011 than in 2003.

The average age of the respondents had increased significantly. Half (50%) of the respondents in 2003 and nearly three quarters (71%, in 2011) were 50 years or older. If this is a trend, it is a cause for concern that younger dentists do not apply for or have not been elected to the leadership posts. The senior chief dentist had probably appointed when merging municipalities or forming new health care consortia, which is in turn good for chief dentists' career advancement.

6.3.2 Leadership education

Rather big changes had taken place in the leadership education system and also in the chief dentists' postgraduate qualifications between 2003 and 2011. Though the number of specialists in Dental Public Health had remained almost unchanged (22% in 2003 and 18% in 2011) and the degree called Administrative Competence had been removed, a different kind of leadership training had replaced it. The shorter two year course in Dental Administration, run by the Finnish Dental Association (FDA), had become popular. The disadvantages of the FDA educating leaders for the municipal health care system are that the participants cannot network with leaders in other health care areas and they may have difficulties identifying themselves as representatives of their municipal employers. Professional loyalty has been shown to be one of the big problems with clinicians as leaders (Sveiby 1990). A fair number of the respondents in 2011 had participated in the

new education Vocational Qualification in Management and Leadership run by universities for all health care leaders. It was apparent from the results of the current study that the chief dentists, who had extra qualifications in leadership, often had several degrees. The respondents in larger PDS units had significantly more leadership degrees than those in smaller units. They (53%) also needed them, more often than their colleagues in smaller units (13%), when applying for the post. Most often specialist education in Dental Public Health was requested. It is interesting to note that the decentralised health care system in Finland, as mentioned above, was one of the main reasons why specialist education in Dental Public Health started in the mid-1970s (Eaton et al. 2009).

6.3.3 Applying for the post

The finding in the current study that over two-thirds of the chief dentists (68%) had not applied for their leading positions was somewhat unexpected. However, it has been shown that the situation is often similar among chief physicians: "they have not tried to reach but accepted the leadership post" (Lehto et al. 2003). The most likely explanation for dentists' lack of interest in leadership was the small size of municipalities forming the health centres. Most chief dentists participated in clinical work to help with the long patient queues after the Dental Care Reform opened public services for all adults, to maintain their clinical skills, or to raise their salary. Only a few chief dentists did not treat patients at all. Chief physicians have also been shown to work with patients most (80%) of their working hours (Lehto et al. 2003). This is typical of expert leaders; maintaining skills is important to them.

6.4 Leadership skills

6.4.1 Goal-oriented managers or people-oriented leaders?

In 2003, over 60% of chief dentists felt that they were good *goal-oriented managers* and still more (88%) felt that they were good *people-oriented leaders* (good ≥3 on a scale 1-4). About two thirds of the chief physicians assessed that chief dentists were good *goal-oriented managers* and *people-oriented leaders* and saw no difference between these qualities. The assessment of PDS dentists of their superiors' management and leadership qualities was not as high as that of chief physicians: 56% of them thought that their superiors were good *goal-oriented managers* and only 41% thought that they were good *people-oriented leaders*. Chief dentists and personnel may need a new personal development plan with much more emphasis on interpersonal and leadership skills, as Holt (2008) suggests. Christensen lists (2004) fourteen characteristics of effective leadership that are quite close to leadership qualities used in this survey but are expressed in different words. Some of them can be categorised as managerial and some as leadership qualities, as well as qualities that are often attributed as either male (assertive and competitive) or female ones (nice and compassionate). Folta

et al. (2012) have made similar distinctions. Researches often ponder whether women should or should not change their leadership practises. Should not all chief dentists need to strive in a people-oriented direction? The gap between the opinions of superiors and subordinates is too wide to be ignored.

6.4.2 Leaders or dentists?

Though feeling their position complicated in the municipal hierarchy, 62% of chief dentists in 2003 and 2011 identified themselves as 'leaders' (bosses) rather than 'dentists' among other dentists. The sum variable *leadership motivation* had been divided in two variables: 'identified as dentist' and 'identified as leaders' Nevertheless, only a total of 40% of them in the years 2003 and 2011 felt that their mutual understanding with the upper hierarchy: *position as subordinates*, and mutual understanding with dental staff: *position as superior,* was good (≥3 on a scale 1-4 from bad to good). In 2011, twice as many of *goal-oriented managers* than *people-oriented leaders* identified themselves as 'leaders' (bosses). Chief dentists 'identified as leaders' had much better *work well-being* and *self esteem* than those identified as 'dentists'. Their *decision-making power* was also a bit greater (although minor overall) and *attitude towards change* more positive (≥3 on a scale 1-4) in comparison with chief dentists 'identified as dentists'.

6.4.3 Importance of autonomy at work and career advancement

The study showed that the chief dentists' leadership had also other characteristics in common with chief physicians. Almost all respondents in this study considered autonomy at work to be very important. Sihvonen (1990) found that it is one of the most crucial motivational factors among physicians and other health care personnel. In general, there is little opportunity for further career advancement for chief dentists. It was, however, reported to be more important for the chief dentists in 2011 than in 2003. Just as with physicians (Sipilä 1996), autonomy and the opportunity to work independently as a measure of expertise and good income as the indicator of professional rank were also important targets for chief dentists working in PDS. Chief physicians have been shown to be more interested in developing their clinical skills and they desired a clinical career more than that of a leader (Tuomiranta 2002). Over third of chief dentists (65/177) in 2003 told that they did extra clinical work after the normal working hours in the PDS or privately.

However, there were also differences compared with physicians. Among physicians, being male proved to be the most predictive factor of rise to a municipal office (Lehto et al. 2003, Hermanson 1989). This was only partly true with chief dentists. Though they were evenly divided by sex, both in small and large PDS units in 2003, they did not become leaders in the same proportion as they were represented among PDS dentists.

6.5 Position in the hierarchical system

Chief dentists felt that their position in the municipal hierarchy was relatively weak in 2003 and appeared to have become weaker up to 2011, although the PDS units after the Dental Care Reform had much larger population responsibility locally. In contrast with 65% in the first study, only half of the respondents (53%) were members of their local Health Care Management Team, the traditionally important channel to impact on oral health care decisions in municipalities. The opportunity to participate in local Health Board meetings remained at the previously low level of one third of the respondents. Not being on good terms with their immediate superior, generally the chief physician could mean that the chief dentist had difficulties getting heard by the municipal social and health board (MBSH). Chief dentists' open answers revealed that many of them did not experience their positions in municipal health policy as very strong. They felt that their own *decision-making power* had significantly decreased, and further, that they had more responsibility than power. Nevertheless, most MBSH chairpersons (80%) thought that the chief dentists had enough (3 on a scale from 1-3) independent decision–making power and decisions were made only occasionally against their opinions. MBSH chairpersons' confidence in chief dentists' abilities to carry out their duties was high. This opinion of politicians coincides with Niiranen et al. (2013), who found that most (64%) politicians thought officials used actual power in municipalities.

6.6 Issues related to chief dentists' work well-being

Nevertheless, most of the chief dentists felt motivated to lead and to some extent also had the courage to make difficult decisions that went against their subordinates' opinions. Many issues related to the chief dentists' *work well-being* would have been better managed if they had applied for their posts themselves and had received enough leadership education. However, a particular, contrary trend could also be seen between "good managers but weak leaders" and "good leaders but weak managers". Those belonging to the first, managerially oriented group were probably not emotionally as sensitive to their surroundings as those in the other group. They presumably did not suffer from various kinds of pressures and resistance brought by changes in the health centre and also managed to keep their *work-control* at a reasonable level, in contrast to more sensitive people-oriented leaders. Also Smith (2001) suggests that "the most obvious cause of doctors' unhappiness is that they feel overworked and under-supported". Young PDS physicians (Heponiemi et al. (2012) were found to suffer from similar practical problems and stress. There were five independent factors explaining nearly half (49%) of chief dentists' *job satisfaction* (3-4 on a scale 1-4): good *leadership motivation*, enough *decision making power*, good *position as superior,* being a *goal-oriented manager* and having enough leadership education (3 on a scale 1-3). In addition, as mentioned above, working in a unit in close contact with the primary health care and good *position as subordinate* (good relations with the upper hierarchy) had a strong connection to *job satisfaction*.

6.7 Leadership and PDS dentists

In the PDS, the main tools chosen for implementation of the Dental Care Reform from 2003 were recruiting new dentists (the most common way out, as Myllymäki notes 2006) or because there was a shortage of dentists and dental hygienists. Consequently, delegating tasks from dentists to dental hygienists and also to dental nurses became important (Vesivalo et al. 2006). After the reform, PDS dentists' clinical work became more demanding because the PDS started to treat more adult patients than before; the patients were older and needed more complicated treatments. Many of the PDS dentists, especially in bigger cities, had previously spent their time caring for younger patients with good oral health, resulting in frequent examinations and simple preventive treatments. The change frustrated many dentists who felt that they were in urgent need of further education in prosthetics, periodontology and endodontics because the sudden demand for more complex treatments increased markedly (Widström et al. 2010).

The problems arising from changes in daily routines, more demanding tasks, high pressure to delegate tasks and long waiting lists (Vesivalo et al. 2006, Widström et al. 2010) were closely followed by local newspapers. This may explain the PDS dentists' less favourable opinions of their chief dentists as bosses. This is worrying, because contrary to their subordinates' opinion, the chief dentists evaluated their own capabilities as *leaders* very highly. Also, they felt that they were better as *people-orientated leaders* than *goal-oriented-managers.* As for the psychological well-being of chief dentists themselves, being an innovative and *goal-oriented manager* was reported as being important. On the contrary, their subordinates' evaluations and *work well-being* spoke in favour of various qualities of the superior's emotional intelligence and of being a *people-oriented leader*.

Giving *feedback and support* to subordinates*,* non-material reward and individual interaction between the chief and staff seemed to be a stumbling point for chief dentists, as their subordinates reproached. Rewarding good work is rare and not encouraged in health care but it has a levelling effect, as Ruuska recently (2013) pointed out. Most chief dentists (65%) thought they gave often *feedback and* much *support* to their subordinates but only 17% of their subordinates agreed with them. The result is quite near to Kokkinen's finding (2007) when considering feedback and support separately. This experience seems to be a universal characteristic of many organisations. Subordinates, and in this case also chief dentists as subordinates, thought that they received much less *feedback and support* from their superiors than the superiors felt in turn they gave them; and the PDS dentists in turn felt that they supported their superiors in the leadership work much more than they themselves got support. This coincides with what Hintsa (2011) has found out. He examined municipal knowledge management and showed that municipal employees would prefer more informal or general discussions. This indicates that discussions are necessary for strengthening the sense of communality. Lönnqvist (2002), in turn, highlights the need to pay attention to rewarding long-term effectiveness instead of continuous monitoring of objectives in these discussions.

6.8 Results in relation to some motivation theories

The results of this study can be examined in the light of three motivation theories: Adams' equity theory (1965) Locke's goal setting theory (1968) and Vroom's expectancy theory (1964)

According to Adams, people tend to keep track of how they are treated in work community. The results were considered in terms of this equity theory wherein chief dentists' input was all additional, other or leadership education. Chief dentists were divided into the 'non-specialists' (with no extra leadership or other education) and 'specialists' with extra education. Education was seen their input to benefit the organisation in the implementation of change. 'Specialists' had a more *positive attitude towards change* (≥3 on a scale 1-4) than 'non-specialists'. When asked directly whether the pay was too low or appropriate in relation to their subordinates, nearly two thirds of 'specialists', versus half of 'non-specialists', responded that it was too low. Though perhaps most people would have responded in that way, salary expectations could have been one reason why these jobs were not considered very desirable.

Lunenburg (2011), when interpreting Locke's theory, says that feedback helps people determine how successful they are in their work. It seems that Locke's theory applies in this study: chief dentists who were 'identified as leaders' felt they got more *feedback and support* from their superiors than those identified as dentists ($p<0.001$), despite the fact that they experienced that *feedback and support* was minimal. Nevertheless, the more chief dentists experienced that they got *feedback and support*, the better was their *self-esteem* and *leadership motivation* ($p<0.001$). Development of interpersonal skills between superiors and subordinates may be one of the most important matters to pay attention to in oral health care.

It seemed that Vroom's motivation theory is also applied in this study: the chief dentists who were 'identified as leaders' (and thus were motivated to lead when having a post), had better *self-esteem* (their own experience of success and respect as leaders), and they appreciated more career progression. Instead, motivation issues such as salary had no statistically significant connection to their leadership motivation. According to Vroom there is little evidence to support that the more salary a worker receives the higher his or her motivation to do a good job. This is fortunate, because up to now in the Finnish municipal collective bargaining agreement system, professional success has had only a minimal impact on the level of pay. Nevertheless, as mentioned before, many chief dentists in 2003 did extra work outside their official working hours. Holt (2008) also criticises the UK National Health Service (NHS) for failed remuneration strategies.

6.9 Sex

6.9.1 General aspects

Dental care in Finland has initially been a female profession (Lääkintöhallitus 1988). The share of female dentists has remained quite stable with only minor variations from 70% in the last and current century. In 2009, their share was highest (77%) in the PDS and lowest among hospital dentists and specialists (35%) (Suomen Hammaslääkäriliitto 2012a). Until recent decades, leadership and management work have typically been male professions, especially in the upper level of the Finnish economic hierarchy and in medical profession (Suomen Lääkäriliitto 2011). In this study in 2003, half of the chief dentists (50%) and 80% of their subordinates (PDS-dentists) were women. When rising higher in hierarchy, only about a third (31%) of the chief physicians, and slightly more than a quarter (27%) of the municipal decision makers were women. In 2004, 36% of all municipal councillors elected in Finland were women and, slightly fewer than a quarter (22 %) of the chairpersons of the municipal councils were women (Pikkala 2011), which is close to the proportion of Finnish politicians reported in this study.

By 2011, the situation in the PDS had somewhat improved: the share of female leaders had increased by ten per cent nearly to 62%, but this was not statistically significantly. Why do women not seek director posts? Finland's only female director of a listed company commented in an interview that a woman only dares to apply for a demanding position if she meets all the conditions for application. A man will apply though he meets only two of ten conditions (Helsingin Sanomat 2014a). Also in this study, women were less sure than men of their ability in the posts, although there were no differences relative to men in formal qualifications for an office. Women often underestimate their merits as Frankel (2005) and Buddeberg-Fischer et al. (2003) have noticed. A female Deputy Mayor, an experienced health care professional recently nominated as minister of social affairs and health, is a case in point. When she was praised as a tough negotiator (one of the selection criteria), she was quick to point out that she's not sure about that at all (Helsingin Sanomat 2014b).

Entering the new millennium, most leaders in the middle management of social and health care were women; of these as many as 98% had nursing background, but only 29% had a physician's background (Viitanen et al. 2007). Miller and Clark (2008) also found that gender discrimination and segregation is still prevalent in the medical profession. They create barriers to the career progression of women, perhaps because of the personal sacrifices which Baecher-Lind (2012) presented as a potential explanation. Lantz (2008) had found that male leaders were more often married than female ones, did not voluntarily withdraw from workforce for family reasons, and their spouses worked full time less frequently than those of women. These behaviour models described by van Engen and Willemsen (2004) and different personality features are still seen in

working life everywhere in the world (Baxter 2002, Buddeberg-Fischer et al. 2003, Turpeinen and Toivanen 2008).

In 2000 prejudices were still found toward female leaders in responses to Gallup Poll's question about preferring a man or woman as boss (Simmons 2001). Eagly and Karau (2002), when citing this Gallup, found less favourable attitudes toward female leaders and potential leaders, though the disadvantage should have faded since 1953. If the respondents were taking up a new job and had their choice of a boss, 48% would have preferred to work for a man, 22% for a woman, and 28% either sex, or there was no volunteered difference (the corresponding percentages in 1953 were 66.5 and 25). Though PDS dentists thought that their female superiors were better leaders than their male superiors, it was no proof that they would have preferred a woman as their next boss. As Eagly and Karau (2002) stated, there is a role conflict between traditional female role and male leader role "because such behavior by a woman would be inconsistent with many people's beliefs about desirable female behaviour".

According to research (Goleman 1995 and 1999, van Engen and Willemsen 2004, Frankel 2005), women often adopt a more democratic, transformational and conciliatory leadership style while men take advantage of their organisational position and use transactional leadership style. Would women benefit from changing their leadership style to the direction adopted by men? Rosener (1990) and Lantz (2008) emphasise, however, that women, by adopting a strong leadership style, are not likely to make their way to top management but may be perceived negatively by stepping outside of their socially defined roles.

6.9.2 Women's leadership position

In this study, female chief dentists felt that their *position* both *as* a *superior* and as *subordinate* was weaker than that of their male colleagues. Men did not experience as much discrepancy between the expectations of the municipal politicians (MBSH chairpersons) and the reality of dental services in the PDS as women did. Men were certain that they had successfully mediated the goals set by politicians to their own subordinates and thought that they had also been successful in their own leadership work without bigger conflicts, indicating greater self-confidence (Vesivalo et al. 2006).

The chief physicians and chairpersons of the MBSH evaluated both the female and the male chief dentists very highly and equally in all the leadership qualities studied.

Unlike the upper hierarchy, the subordinates were in many respects more in favour of their female than their male chief dentists. The PDS dentists thought that their female superiors were better *goal-oriented managers* and *people-oriented leaders* than the male ones. They also felt that when their superior was a woman, the working atmosphere was better. In sum, the female chief dentists in this study felt they were equal to their male colleagues in many important respects. They appreciated as highly as their fellow male chief dentists the opportunities of their present work (*mental reward*

from work), such as independence and the possibility of influencing the future of dental care, but also material values, such as a good salary.

6.10 Implementation of the Dental Care Reform

Nearly all female and male chief dentists evaluated their *leadership motivation* better when they had applied for the leadership position than when they had not. Most of the female chief dentists also reported that they were more favourable *towards change* when they had become leaders of their own free will (89% versus 62%). No such difference was observed between men. It is possible that those women, who had decided to seek leadership positions on their own initiative, had adopted more open-minded attitudes towards the sometimes-troublesome procedures required in the *implementation of the oral health care reform* in the PDS.

The reform resulted in long waiting lists in many municipalities, especially in the bigger cities and demand for services exceeded supply and this caused resistance from various parties, mostly the staff of dental clinics. All of this, together with the increased stress arising from the faster pace of work, made management and leadership more challenging, especially for female chief dentists, who were shown to be more sensitive to their subordinates' feelings and more stressed than their male colleagues. A major change in the PDS had also caused stress and resistance among the staff in Sweden (Bejerot 1998).

In 2003, chief dentists had a more positive attitude towards enlarging the National Sickness Insurance reimbursements to all adult age groups using private dental care than towards opening the PDS for all age groups. This was also the attitude of their superiors and subordinates and of the dentists' professional association (FDA) but not of the municipal decision-makers, who considered both changes equally important and welcome. However, most chief dentists in 2011 felt that the Dental Care Reform changes, the removal of age restrictions to improve access to the PDS and the extended subsidy for private treatment, had been necessary measures. More than half of the chief dentists opposed the guaranteed access to care legislation, which was not primarily directed towards dental care but in practice was the only way to force the local municipalities to increase the capacity of their dental services. This was the case especially in the PDS units, where waiting lists were long. The guaranteed access to care within six months had forced municipalities, at least to some extent, to increase the resources allocated for dental care under the penalty of a fine if they exceeded the six month period (VALVIRA 2010).

Most chief dentists claimed that, since the Reform, they had been forced to work with insufficient staff, especially a lack of dentists, and to meet the increased demand for care. Because of closure of two of the then four Finnish dental schools in the 1990s, there were fewer new dental graduates available (Finlex, HE 323/1993). The two dental schools that were closed have been reopened recently. Delegation of dentists' work to dental hygienists, particularly the dental care of children, was seen as a way to solve the problem, freeing dentists to treat more demanding adult patients

(Vesivalo et al. 2006). Employing dentists from other EU countries would have been possible, but was in practice not easy for relatively small PDS units that had no experience in recruitment from abroad and the Finnish language was also a barrier. Furthermore, the two different channels of financing adult dental care often led to a situation where many municipalities did not even try to employ more dentists, because they could save municipal tax money if patients became tired of waiting for care in the PDS and instead went to the private sector subsidised by state, as was claimed a few years ago by a director of the city of Helsinki on TV (MTV 2013).

6.11 Being a chief dentist

Being a chief dentist in the PDS continued to be a rather lonely task; this had already been noted in a study in 2002 (Alestalo and Widström 2002). All PDS units participating in the study had one chief dentist, but in larger units, he or she often had a team consisting of various specialists and local chief dentists. As regards the chief dentists' position and possibilities to lead municipal oral health care in the future, the big changes planned in municipal health care organisation towards a more centralised system may be welcomed. In all groups, most respondents who had taken the opportunity to express their opinions on the Dental Care Reform stated that, with regard to lack of resources, the transfer period was too short. This is undeniable, and as Lunenburg (2011) says: goals ought to be difficult but attainable.

In recent years, to improve the capacity of the municipalities to provide primary health care services for their ageing populations, the government has increasingly begun to push municipalities to merge, in order to achieve a population of at least 20,000 inhabitants. Currently, in 2014, the government is planning to divide the country into five social and health care areas; this to secure the same level of services throughout the country.

6.12 Recommendations

Five major social services and health care areas for the whole of Finland are now planned by the national government. They are similar to the former University Hospital regions and would be responsible for the municipal services including oral health care in the region. Changes in nationwide administration and municipal management will probably follow. It would be desirable from municipal oral health care point of view that competent dental care managers and leaders are available also at the local level in municipalities to contribute the implementation of changes. It is obvious that good work conditions and high job satisfaction will help in this work. As Niiranen and Hänninen (2012) have noted, leadership is a fundamental pillar of the organisation, and working in teams and networks rather than alone should be preferred.

In this study, high job satisfaction was connected on the one hand to managerial qualities like good work motivation, independent decision-making power and being a goal-oriented manager, and on

the other hand, to leadership qualities like good and effective relations with subordinates, supervisors and municipal decision-makers, without losing sight of sufficient leadership education. It is also desirable that oral health care remains an integral part of the municipal health care.

It is desirable that management and leadership of municipal oral health care are studied more profoundly in the future due to the major changes coming. As Parks (2005) highlights, learning and practising leadership is an invitation to recognise and understand complex models, such that are expected in new Finnish organisational health care systems in short-term future.

7 CONCLUSIONS

The results of this study suggest that it is necessary to ensure that chief dentists who have to lead change have adequate leadership skills. The study confirms what Managerial Grid suggests, namely that a combination of two leadership styles, concern for people (*people-orientation*) and concern for production (*goal-orientation*), is needed to achieve good results, without forgetting the effectiveness of health promotion, and a high level of work satisfaction.

This study supports the assumption that chief dentists' position in the municipal hierarchy was not strong. Just as was the case with chief physicians, being a chief dentist in the PDS was not a highly desired job compared with clinical work. Nevertheless, a clear majority (69%) of chief dentists identified themselves primarily as leaders and the rest primarily as clinical dentists.

In the Finnish PDS, female dentists, just like female physicians in health centres, did not achieve and have not achieved chief positions in proportion to their numbers in workforce. Women had not been motivated enough or able to break the "glass ceiling" and rise to higher positions. Yet, interestingly, PDS dentists preferred women leaders to male leaders.

Over the eight-year period after the Dental Care Reform, the chief dentists' *self-esteem* in their leadership role had improved. Nevertheless, their *independent decision-making power* had decreased and their position in municipal hierarchies remained weak, although they now had considerably larger population responsibilities. This indicates that municipal oral health care is considered as insignificant and unconnected with the municipal health care system. Chief dentists are considered to be qualified in their field but are not considered to be competent to influence favourably overall health care activities.

The chief dentists were most contented with their work when they had good *leadership motivation,* a good *position as a superior*, enough *decision-making power* and enough leadership education, when they were *goal-oriented managers* and had applied for the leading post themselves and worked in cooperation with the rest of health care in agreement with the decision-makers. Therefore, supporting the leadership role and job satisfaction of chief dentists in these manifold areas is a key factor when major changes in the PDS (municipal oral health care) are required. Interpersonal skills of leaders and subordinates proved to be inadequate and should be developed.

8 ACKNOWLEDGEMENTS

First, I'm grateful to all the chief dentists, PDS dentists, chief physicians and MBSH chair persons who took the time to respond to the PDS management survey sent in 2003 and again in 2011 (in this later time to chief dentists only). Without their effort this study would not have been possible.

I wish to thank Professor Pertti Kekki for his lectures and guidance in the beginning of this work. One particular reason that made me keen on Kekki's organisational knowledge was his efficient organisation of care of the wounded after the tragic accident at the Lapua cartridge factory in 1976.

This study was on hold for several years before it was completed. I'm deeply grateful for Professor Eeva Widström, who prompted me to take up the work again in 2011. Without her encouragement and patience this dissertation would still remain unfinished. I also thank Professor Kaisu Pitkälä from the Institute of Clinical Medicine at the University of Helsinki for her encouragement to complete this work.

Doctor Paul Riordan has reviewed and corrected the language of this dissertation in its various phases. My warm thanks to him. Yet I am solely responsible for any remaining errors that the reader may come up with.

I wish to sincerely thank the official reviewers appointed by the Medical Faculty of the University of Helsinki, Professor Jorma Virtanen and Docent Heikki Tala, for their indispensable guidance and improvement suggestions. Further, I thank Researcher Hannu Tuuri from Seinäjoki University of Applied Sciences and University Teacher (emeritus) Ilkka Mellin from Aalto University for their help with the statistical part of this work.

Finally I thank my husband Olli for his support ("Eikö se jo lopu?") and for taking care of the household during my busiest writing periods, and my sons Pekka and Antti for their help with the mathematical and software related problems, and my daughter Tiina for trying to help me understand the complications of the English language.

I dedicate this work to my wonderful granddaughter Adele.

Kokkola, 2015
Paula Alestalo

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10 ABSTRAKTI

Tämän väitöskirjan päätavoitteena oli tutkia terveyskeskusten suun terveydenhuollon johtamista Suomessa kansanterveyslain muutoksen ja hoitotakuulain säätämisen jälkeisinä vuosina 2003 – 2011. Erityistavoitteena oli tutkia miten hammaslääkärit päätyivät terveyskeskusten suun terveydenhuollon johtajiksi, millaisia he olivat johtajanominaisuuksiltaan, ja millainen heidän asemansa kuntahierarkiassa oli heidän itsensä, esimiestensä ja alaistensa arvioimana. Tarkoituksena oli myös tutkia johtavien hammaslääkärien suhtautumista hammashoitouudistukseen ja muutoksen vaikutuksia työyhteisöön.

Tutkimuksen kohderyhmiä vuonna 2003 olivat terveyskeskusten johtavat hammaslääkärit (n=265), heidän lähimmät esimiehensä johtavat lääkärit (n=233), otos heidän alaisistaan terveyskeskushammaslääkäreistä (n=365) ja kuntien tai kuntayhtymien terveyslautakuntien tai yhtymähallitusten puheenjohtajat (n=233). Vuonna 2011 kohderyhmänä olivat terveyskeskusten johtavat hammaslääkärit (n=161). Aineiston analyyseihin käytettiin korrelaatiota, ristiintaulukointia ja khin neliö -testiä, faktorianalyysiä summamuuttujien muodostamiseksi, non-parametrisiä testejä ja regressioanalyysiä sekä mittarien testaamiseen Cronbachin alfa –testiä.

Tutkimus osoitti, että vain vajaa viidennes (17 %) johtavista hammaslääkäreistä oli kokopäivätoimisia johtajia vielä vuonna 2011 (10 % 2003), ja että nämä työskentelivät suurissa terveyskeskuksissa. Muut osallistuivat potilastyöhön vaihtelevassa määrin riippuen terveyskeskuksen koosta ja henkilökohtaisista intresseistä. Johtavien hammaslääkärien *työtyytyväisyys* oli hyvä (hyvä *summamuuttujissa* ≥ 3 asteikolla 1–4), kun heillä oli *hyvä johtamismotivaatio*, *tarpeeksi itsenäistä päätäntävaltaa, hyvä asema esimiehenä,* kun he olivat *asiajohtajia* ja olivat saaneet riittävästi koulutusta johtajantehtäviin (3, asteikolla 1 - 3). Tyytyväisyyttä lisäsi, jos he olivat hakeutuneet oma-aloitteisesti virkaansa ja toimivat hyvässä yhteistyössä muun terveydenhuollon kanssa (suun terveydenhuolto ei ollut eriytynyt muusta terveydenhuollosta) ja jos heidän *asemansa alaisena* (suhteessa esimieheen ja päättäjiin oli hyvä (kaikissa $p<0,001$). Heidän alaisensa, terveyskeskushammaslääkärit, pitivät naispuolisia esimiehiään parempina henkilöjohtajina kuin miespuolisia. Johtavat hammaslääkärit alaisina, samoin kuin terveyskeskushammaslääkärit heidän alaisinaan, kokivat saavansa paljon vähemmän palautetta ja tukea esimiehiltään kuin he itse ja heidän esimiehensä kokivat antavansa. Johtavien hammaslääkärien esimiehet arvioivat heidän olevan sekä hyviä asia- että henkilöjohtajia, kun taas alaisten arvio oli huonompi.

Vuonna 2003 johtavat hammaslääkärit suhtautuivat positiivisemmin sairausvakuutuslain (59 %) kuin kansanterveyslain (43 %) muutokseen ($p<0.001$). Sairausvakuutuslain muutos paransi hoitoa tarvitsevien mahdollisuuksia hakea palveluja yksityissektorilta, kun ne tulivat kaikille sairausvakuutuksesta korvattaviksi. Kansanterveyslakiin tehty muutos taas poisti ikärajoitukset hammashoitoon pääsyssä terveyskeskusten suun terveydenhuollon osalta. Vuonna 2011 mielipiteet näistä lakimuutoksista olivat tasoittuneet. Vajaa puolet (45 %) vastaajista piti hoitotakuun

säätämistä tarpeellisena. Suhtautuminen kansanterveyslain ja hoitotakuun toimeenpanon onnistumiseen oli yhteydessä jonotusajan pituuteen ($p<0.001$): jos se oli pitempi kuin 3 kk, vain keskimäärin 5 % vastaajista katsoi toimeenpanon onnistuneen erittäin hyvin ja 65 % melko hyvin; jos taas odotusaika oli korkeintaan kolme kuukautta, vastaavat prosentit olivat 38 ja 54. Vastaajien yleinen näkemys oli, että uudistusten aikataulu oli liian tiukka ja resursseja liian vähän niiden toteuttamiseen. Yleisesti ottaen johtavat hammaslääkärit pitivät asemaansa kuntahierarkiassa varsin heikkona ja asema koettiin yksinäiseksi. Johtajuuden tukeminen terveyskeskusten suun terveydenhuollossa vaatii jatkossa enemmän huomiota.

11 APPENDICES 1-7

Appendix 1

Saatekirjelmä 2003

Arvoisa vastaanottaja!

Kansanterveyslakia ja sairausvakuutuslakia muutettiin suun terveydenhuollon osalta siten, että koko väestö ikään katsomatta on yhteiskunnan tukeman hammashoidon piirissä viimeistään 1.12.2000 lähtien. Hoitoon voi hakeutua joko terveyskeskukseen tai yksityishammaslääkärille. Terveyskeskuksen hammashoidosta perittävät maksut on säädetty asetuksella ja yksityishammaslääkärin hoidosta maksetaan korvausta sairausvakuutuksesta.

Terveydenhuollon ajauduttua viime vuosina bioteknologian valtavan kehityksen mukanaan tuomien kalliiden hoitomuotojen ja käytettävissä olevien voimavarojen väliseen kuiluun on julkisessa keskustelussa herännyt kysymys terveyskeskusten ja sairaaloiden johtamiskäytännöistä. Miten terveydenhuoltoa Suomessa yleensä johdetaan ja voitaisiinko johtamiskoulutusta lisäämällä saada aikaan parannusta?

Suun terveydenhuollon johtamista ei ole tutkittu juuri lainkaan. Opiskelen Helsingin yliopiston lääketieteellisen tiedekunnan yleislääketieteen ja perusterveydenhuollon osastossa ja teen tutkimusta siitä, miten kunnallista hammashuoltoa johdetaan, miten lakimuutokset ovat vaikuttaneet hammashuollon toimintaan, miten johtavat hammaslääkärit kokevat johtamistehtävänsä, sekä miten työyhteisö ja ympäristötekijät ovat yhteydessä johtamiseen ja siten hammashuollon toimintaan. Tutkimuksen avulla pyritään myös löytämään syitä siihen, miksi hammashuolto on ollut eriarvoisessa asemassa muuhun terveydenhuoltoon verrattuna ja etsimään uusia ratkaisumalleja yhteisiin ajankohtaisiin kysymyksiin.

Haastattelulomakkeet pyritään lähettämään kaikille haastateltaville sähköpostitse internetin kautta täytettäväksi. Tarvittaessa lomakkeet lähetetään postitse.

Vastauksesi käsitellään ehdottomasti luottamuksellisesti, eikä lopullisessa raportissa mainita mitään terveyskeskusta tai henkilöä nimeltä, vaikka tutkimusteknisistä syistä kyseiset tiedot ovatkin tutkimuksen tekijän hallussa tarvittavan ajan. Oikean kuvan saamiseksi on tärkeää, että jokainen vastaa kaikkiin kysymyksiin, myös avoimiin, sillä siten saadaan kaikkein arvokkainta tietoa. Tähän kyselyyn vastaaminen ei vaadi tilastojen penkomista, vaan näkemyksiä, mielipiteitä ja käytännön kokemuksia hammashuoltoa koskevista lakimuutoksista, johtamisesta sekä johtamiseen ja toimintaan vaikuttavista tekijöistä.

Pyydän Sinua ystävällisesti vastaamaan avoimesti ja kriittisesti, sillä paikallisista olosuhteista ja ihmisten erilaisista arvostuksista johtuen näihin kysymyksiin ei ole olemassa oikeita vastauksia. Pyydän täyttämään lomakkeen madollisimman pian. Vastaan mielelläni tiedusteluihin ja kommentteihin joko puhelimitse numeroissa 06-8311669 ja 0400-669741 tai sähköpostitse osoitteessa paula.alestalo@fimnet.fi. Postiosoite on Gunellinpolku 7, 67400 Kokkola.

Vastauksistasi etukäteen kiittäen

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Stakes

Appendix 2

Haastattelulomake johtaville hammaslääkäreille 2003

Terveyskeskuksen perustiedot

1. Terveyskeskus, jossa toimit: _____

2. Terveyskeskus on:
- ☐ yhden kunnan muodostama
- ☐ kuntayhtymä

Suhtautuminen lakimuutoksiin ja muutosten vaikutukset

3. Miten suhtaudut saatekirjelmässä mainittuun sairausvakuutuslain muutokseen?
- ☐ Erittäin myönteisesti
- ☐ Melko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

4. Miten suhtaudut saatekirjelmässä mainittuun kansanterveyslain muutokseen?
- ☐ Erittäin myönteisesti
- ☐ Melko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

5. Perustele kannanottosi!

_____

6. Miten suhtauduit 1990-luvulla ajatukseen, että koko väestö pääsee terveyskeskuksen hammashoidon piiriin?
- ☐ Erittäin myönteisesti
- ☐ Melko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

7. Kun kansanterveyslain muutos oli tulossa, miten terveyskeskuksessasi varauduttiin lainsäädännön mukanaan tuomiin haasteisiin?

_____

8. Mitä konkreettisia muutoksia toimenpiteitä tai toiminnan muutoksia teitte tai mitä oli jo aikaisemmassa vaiheessa tehty, jotta kaikenikäisillä olisi mahdollisuus päästä terveys- keskuksen hammashoidon piiriin?

_____

9. Onko hammashuolto eriytynyt muusta terveydenhuollosta omassa terveyskeskuksessasi?
- ☐ Kyllä
- ☐ Ei

10. Onko vallitsevasta asiantilasta jotakin haitta tai hyötyä?
- ☐ On haittaa
- ☐ On sekä haitta että hyötyä
- ☐ Ei ole haittaa eikä hyötyä
- ☐ On hyötyä

11. Jos on jotakin haittaa tai hyötyä, niin miten se vaikuttaa?

_____

12. Muun terveydenhuollon mukainen hoitoonpääsy tarpeen mukaan on mielestäni kriteerinä:
- ☐ erittäin hyvä
- ☐ melko hyvä
- ☐ melko huono
- ☐ erittäin huono

13. Onko omassa terveyskeskuksessa tarvittu erikois-järjestelyjä terveysperusteiden määrittämiseksi?

- ☐ Kyllä
- ☐ Ei

14. Jos vastasi kyllä, niin menettelette?

_____

15. Onko omassa terveyskeskuksessasi toteutunut mahdollisuus järjestää palveluja kysyntää vastaavasti?

- ☐ Kyllä
- ☐ Ei

16. Kansanterveyslain muutos vaikutti tai vaikuttaa vastaisuudessa hammashoidon laajuuteen omassa terveyskeskuksessasi:

- ☐ erittäin paljon
- ☐ aika paljon
- ☐ jonkin verran
- ☐ ei juuri lainkaan

17. Hoitoonpääsy ennen lakimuutoksia ja niiden jälkeen:

- ☐ ikärajat oli poistettu jo aikaisemmin
- ☐ kaikki ikärajat poistettiin heti alkuvaiheessa
- ☐ ikärajat poistettiin säädetyn aikataulun mukaisesti
- ☐ ikärajoja ei pystytty poistamaan aikataulun mukaisesti
- ☐ kaikkien ikärajojen poisto ei ole näköpiirissä tällä hetkellä

18. Jos ikärajoja ei pysytty poistamaan, mitkä olivat pahimmat syyt ja miten ne pyritään poistamaan?

_____

19. Ovatko lakimuutokset aiheuttaneet terveyskeskuksessasi priorisointitarpeita?

- ☐ Kyllä
- ☐ Ei

20. Jos vastasit kyllä edelliseen kysymykseen, niin miten priorisoitte? Voit myös lähettää priorisointilistan liitteenä sähköpostiosoitteeseeni.

_____

21. Lainsäädännön muutokset ovat luultavasti lisänneet paineita tai toimintatapojen muutoksia etenkin terveyskeskuksissa. Onko ollut havaittavissa muutosvastarintaa joltakin taholta?

- ☐ Kyllä
- ☐ Ei

22. Jos vastasit kyllä, niin miltä taholta?

- ☐ Henkilöstön taholta
- ☐ Esimiehen taholta
- ☐ Luottamushenkilöiden
- ☐ Yksityissektorin taholta
- ☐ Lasten vanhempien taholta
- ☐ Joltakin muulta taholta

23. Jos on ollut vastarintaa, niin mikä on ollut syynä?

_____

24. Jos muutosvastarintaa ja vaikeuksia oli tai on, niin miten menettelit tai aiot menetellä niiden ratkaisemiseksi?

_____

25. Miten lakimuutokset tai niiden mukanaan tuoma julkisuus (jos kaikki olivat jo hoidossa) ovat vaikuttaneet palvelujen kysyntään? Kysyntä on:

- ☐ lisääntynyt huomattavasti
- ☐ lisääntynyt jonkin verran
- ☐ pysynyt lähes ennallaan
- ☐ vähentynyt jonkin verran
- ☐ vähentynyt huomattavasti

26. Käsitykseni mukaan palvelujen käyttäjien siirtymistä terveyskeskuksesta yksityispuolelle on havaittavissa:

- ☐ erittäin paljon
- ☐ melko paljon
- ☐ ei kovin paljon
- ☐ ei juuri lainkaan

27. Käsitykseni mukaan palvelujen käyttäjien siirtymistä yksityispuolelta terveyskeskukseen on havaittavissa:

- ☐ erittäin paljon
- ☐ melko paljon
- ☐ ei kovin paljon
- ☐ ei juuri lainkaan

28. Työtahtia on jouduttu kiristämään viime aikoina:

- ☐ huomattavasti
- ☐ jonkin verran
- ☐ ei juuri lainkaan

29. Onko muutos vaikuttanut jotenkin johtamistyöhösi?

- ☐ Helpottanut
- ☐ Ei vaikuttanut mitenkään
- ☐ Sekä helpottanut että vaikeuttanut
- ☐ Vaikeuttanut

30. Jos on helpottanut tai vaikeuttanut, niin millä tavalla?

_____

Johtavan hammaslääkärin vaikuttamiskanavat kunnassa

31. Lautakunnan/hallituksen kokouksissa sinulla on hammashuollon asioista päätettäessä esittelyoikeus ja/tai läsnäolo- ja puheoikeus seuraavasti:

- ☐ esittelyoikeus
- ☐ läsnäolo- ja puheoikeus aina tai oma-aloitteisesti
- ☐ vain kutsuttaessa
- ☐ käytännössä ei ollenkaan

32. Oletko johtoryhmän jäsen?

- ☐ Kyllä
- ☐ Ei

33. Mitä hyötyä vallitsevasta asiantilasta on ja miten toivoisit sen olevan?

_____

34. Onko sinulla mielestäsi tarpeeksi päätäntävaltaa sekä asia- että henkilöstöjohtamiseen liittyvissä kysymyksissä kuten toiminnan muutosten läpiviemisessä?

- ☐ Tarpeeksi
- ☐ Joissakin asioissa tarpeeksi, joissakin liian vähän
- ☐ Liian vähän

35. Miten riittävä päätäntävalta tai sen puute näkyy työssäsi? Mainitse joitakin esimerkkejä!

_____

36. Kuuluuko koko hammashoitohenkilöstö hallinnollisesti ja toiminnallisesti alaisuuteesi?

- ☐ Kyllä
- ☐ Ei

37. Onko vallitsevasta asiantilasta haittaa tai hyötyä tai miten toivoisit sen olevan?

_____

38. Millainen on henkilöstön vaikutusvalta hammashuollon asioista päätettäessä?

- ☐ Erittäin suuri
- ☐ Melko suuri
- ☐ Aika vähäinen
- ☐ Erittäin vähäinen

39. Millainen on esimiehesi vaikutusvalta hammashuollon asioista päätettäessä?

- ☐ Erittäin suuri
- ☐ Melko suuri
- ☐ Aika vähäinen
- ☐ Erittäin vähäinen

40. Luottamushenkilöt tekevät päätöksensä hammashuoltoa koskevissa asioissa mielipiteesi vastaisesti:

- ☐ erittäin usein
- ☐ silloin tällöin
- ☐ harvoin
- ☐ ei koskaan

Johtajanominaisuudet

Miten seuraavat johtajanominaisuudet luonnehtivat sinua johtajana?

1 = erittäin hyvin; 2 = melko hyvin; 3 = melko huonosti; 4 = erittäin huonosti

		1	**2**	**3**	**4**
41.	Autoritaarinen	☐	☐	☐	☐
42.	Neuvotteleva	☐	☐	☐	☐
43.	Konservatiivinen	☐	☐	☐	☐
44.	Innovatiivinen	☐	☐	☐	☐
45.	Oikeudenmukainen	☐	☐	☐	☐
46.	Empaattinen / tunneälykäs	☐	☐	☐	☐
47.	Määrätietoinen/sinnikäs	☐	☐	☐	☐
48.	Luotettava	☐	☐	☐	☐
49.	Impulsiivinen	☐	☐	☐	☐
50.	Passiivinen / mukavuudenhaluinen	☐	☐	☐	☐
51.	Vakuuttava	☐	☐	☐	☐
52.	Epävarma	☐	☐	☐	☐

Tavoitteet ja niiden toteutuminen

Mitkä ovat olleet tärkeimmät pitkäntähtäimen visiosi tai tavoitteesi hammashuollon johtajana? Mainitse ainakin kolme!

53. Tärkein on ollut:

_____

54. Miten tavoitteen saavuttaminen on onnistunut?

- ☐ on jo toteutunut
- ☐ on paraikaa meneillään
- ☐ onnistunut hyvin
- ☐ onnistunut huonosti

55. Toiseksi tärkein on ollut:

_____

56. Miten tavoitteen saavuttaminen on onnistunut?

- ☐ on jo toteutunut
- ☐ on paraikaa meneillään
- ☐ onnistunut hyvin
- ☐ onnistunut huonosti

57. Kolmanneksi tärkein on ollut:

_____

- ☐ on jo toteutunut
- ☐ on paraikaa meneillään
- ☐ onnistunut hyvin
- ☐ onnistunut huonosti

58. Miten tavoitteen saavuttaminen on onnistunut?

_____

59. Millä keinoin olet edistänyt edellä mainittujen tavoitteiden toteuttamista ja mikä on hidastanut tai kokonaan estänyt niiden toteutumisen?

_____

60. Mille seuraavista tahoista tunnet olevasi ensisijaisesti vastuussa toiminnasta? Rastita kolme tärkeintä!

- ☐ Poliittisille päättäjille
- ☐ Potilaille
- ☐ Kuntalaisille
- ☐ Työnantajalle
- ☐ Hammashoitohenkilöstölle
- ☐ Ammattiyhdistyselle
- ☐ Esimiehellesi
- ☐ Itsellesi
- ☐ Jollekin muulle

61. Jos rastitit jollekin muulle, niin kenelle?

_____

Laadunvarmistus

62. Laadunvarmistusjärjestelmä hammashuollossa:

- ☐ on käytössä
- ☐ on kehitteillä
- ☐ on suunnitteilla
- ☐ ei ole suunnitteilla

63. Hammashuollossa tarkkaillaan asiakaspalautetta:

- ☐ jatkuvasti
- ☐ määräajoin
- ☐ satunnaisesti
- ☐ ei ollenkaan

64. Käytätkö tietotekniikan suomia mahdollisuuksia seurata ja vertailla työntekijöiden tuloksia?

- ☐ Käytän jatkuvasti
- ☐ Käytän satunnaisesti
- ☐ En yleensä käytä
- ☐ Yksikkö niin pieni, ettei ole tarkoituksenmukaista

65. Miten esität keräämiäsi tietoja alaisillesi?

_____

66. Uusien potilaiden jonotusaika ei-kiireelliselle vastaanotolle on:

- ☐ noin yksi viikko
- ☐ 2-4 viikkoa
- ☐ 5-7 viikkoa
- ☐ 2-3 kuukautta
- ☐ 4-5 kuukautta
- ☐ yli 6 kuukautta

67. Päivystys on järjestetty:

- ☐ täysin omana toimintana
- ☐ yhteistyössä yksityisten kanssa
- ☐ yhteistyössä toisen terveyskeskuksen kanssa

68. Päivystys toimii:

- ☐ joka päivä, myös aattoina ja juhlapyhinä
- ☐ vain arkipäivinä maanantaista lauantaihin
- ☐ vain arkipäivinä maanantaista perjantaihin

69. Miten hyvin päivystys mielestäsi toimii?

- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ melko huonosti
- ☐ erittäin huonosti

Yhteistyö yksityissektorin ja muiden terveyskeskusten kanssa

70. Onko paikkakunnan yksityissektorin kanssa muuta yhteistyötä kuin mahdollinen päivystys?

- ☐ Vain päivystys
- ☐ On muutakin yhteistyötä
- ☐ Ei mitään yhteistyötä

71. Miten yhteistyö yksityissektorin kanssa sujuu?

- ☐ Sujuu kitkattomasti
- ☐ On vähäisiä ristiriitoja
- ☐ On vaikeita ristiriitoja

72. Onko tehty uusia ostopalvelusopimuksia yksityisten tai muiden terveyskeskusten kanssa kahden viime vuoden aikana?

- ☐ Kyllä
- ☐ Ei

73. Myyttekö joitakin palveluja?

- ☐ Kyllä
- ☐ Ei

74. Mitä paleluja ostetaan tai myydään ja keneltä tai kenelle?

Työviihtyvyys

75. Millainen on mielestäsi hammashuollon työilmapiiri omassa terveyskeskuksessasi?

- ☐ Erittäin hyvä
- ☐ Melko hyvä
- ☐ Ei hyvä eikä huono
- ☐ Melko huono
- ☐ Erittäin huono

76. Hammashuollon työilmapiiriä:

- ☐ on tutkittu
- ☐ ei ole tutkittu

77. Oma työviihtymiseni kouluarvosanoilla (4-10) ilmaistuna on; _____

Mitkä seikat vaikuttavat eniten työviihtyvyyteesi ja onnistumisen tunteeseen nykyisessä johtamistyössäsi?

78. Myönteisimmin vaikuttaa_____

79. Toiseksi myönteisimmin vaikuttaa _____

80. Kolmanneksi myönteisimmin vaikuttaa _____

Mitkä seikat haittaavat eniten viihtymistä nykyisessä johtamistyössäsi?

81. Haittaavin on _____

82. Toiseksi haittaavin on _____

83. Kolmanneksi haittaavin on _____

84. Johtamistyön palkkaus suhteessa alaisten palkkaukseen on:

- ☐ liian pieni
- ☐ sopiva
- ☐ liian suuri

85. Hakeutuminen johtajaksi?

- ☐ Olen itse hakeutunut
- ☐ Olen tavallaan joutunut, koska ei ollut muitakaan

Tavoitteet

86. Kunnallisten päättäjien minulle asettamat tavoitteet ovat:

- ☐ selkeät
- ☐ epämäräiset
- ☐ ei näkyviä tavoitteita
- ☐ ristiriitaiset

87. Tiedän heidän johtamiseeni kohdistuvat odotukset:
- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ ei kovin hyvin
- ☐ huonosti

88. Tunnen asemani ristiriitaiseksi päättäjien asettamiin tavoitteisiin ja odotuksiin nähden:
- ☐ usein
- ☐ joskus
- ☐ harvoin
- ☐ ei koskaan

89. Alaiseni ymmärtävät työnantajan hammashuollolle asettamat tavoitteet:
- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ ei kovin hyvin
- ☐ huonosti

90. Tiedän henkilökunnan odotukset johtamistyötäni kohtaan:
- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ ei kovin hyvin
- ☐ huonosti

91. Tunnen asemani ristiriitaiseksi heidän odotuksiinsa nähden:
- ☐ usein
- ☐ joskus
- ☐ harvoin
- ☐ ei koskaan

92. Jos on ristiriitoja päättäjien tai alaisten odotuksiin nähden, niin millaisia?

_____

Johtamistyön eri osatekijöiden arvostus.

Miten tärkeinä pidät seuraavia tekijöitä johtamistyössäsi?

1 = yhdentekevä; 2 = melko yhdentekevä; 3 = melko tärkeä; 4 = erittäin tärkeä

		1	**2**	**3**	**4**
93.	Palkka	☐	☐	☐	☐
94.	Mahdollisuus vaikuttaa hammashuollon tulevaisuuteen	☐	☐	☐	☐
95.	Mahdollisuus itsenäiseen työhön	☐	☐	☐	☐
96.	Työn vaativuus ja haastavuus ja siten mahdollisuus saada tuloksia	☐	☐	☐	☐
97.	Mahdollisuus saada tunnustusta ja arvonantoa	☐	☐	☐	☐
98.	Mahdollisuus luovaan työhön ja innovaatioiden toteuttamiseen	☐	☐	☐	☐
99.	Mahdollisuus saada julkisuutta	☐	☐	☐	☐
100.	Mahdollisuus tiimityöskentelyyn ja toimimiseen ihmisten parissa	☐	☐	☐	☐
101.	Työn arvo yhteiskunnalle ja kanssaihmisille	☐	☐	☐	☐
102.	Mahdollisuus edetä uralla	☐	☐	☐	☐
103.	Mahdollisuus päivätyöhön	☐	☐	☐	☐
104.	Mahdollisuus ylläpitää myös kliinistä osaamista	☐	☐	☐	☐

Seuraavassa on joitakin väittämiä tuntemuksistasi hammashuollon johtajana

1 = täysin tai lähes samaa mieltä; 2 = jonkin verran samaa mieltä;
3 = jonkin verran eri mieltä; 4 = täysin tai lähes eri mieltä

		1	**2**	**3**	**4**
105.	Tunnen menestyväni johtajana	☐	☐	☐	☐
106.	Tunnen, että minua arvostetaan johtajana	☐	☐	☐	☐
107.	Olen motivoitunut johtamiseen	☐	☐	☐	☐
108.	Olen paremminkin yksi hammaslääkäri muiden joukossa	☐	☐	☐	☐
109.	Olisin mieluummin kliinikko kuin johtaja	☐	☐	☐	☐

110.	Muutoksen johtaminen on mielenkiintoinen haaste	☐	☐	☐	☐
111.	Koen, että muutoksen johtaminen on helppoa	☐	☐	☐	☐
112.	Joskus on pakko toimia henkilökunnan mielipiteiden vastaisesti tavoitteiden saavuttamiseksi	☐	☐	☐	☐
113.	Ristiriitojen välttämiseksi on parempi toimia kuten aina ennenkin	☐	☐	☐	☐
114.	Saan myönteistä palautetta potilailta	☐	☐	☐	☐
115.	Saan myönteistä palautetta kuntalaisilta	☐	☐	☐	☐
116.	Kuntalaisten mielipide on tärkeä palveluja järjestettäessä	☐	☐	☐	☐
117.	Yksityissektorin mielipide n tärkeä terveyskeskuksen palveluja järjestettäessä	☐	☐	☐	☐
118.	Kannan huolta myös yksityissektorin toimeentulosta	☐	☐	☐	☐
119.	Luottamushenkilöiden ja kuntalaisten mielipiteet käyvät näkemykseni mukaan hyvin yhteen	☐	☐	☐	☐
120.	Luottamushenkilöt ajavat hyvin kuntalaisten etuja	☐	☐	☐	☐
121.	Johtoryhmätyöskentely on usein ajan haaskausta	☐	☐	☐	☐
122.	Minulla on riittävästi aikaa johtamiseen	☐	☐	☐	☐
123.	Minun täytyy tehdä liian paljon kliinistä työtä	☐	☐	☐	☐
124.	Minulla on enemmän vastuuta kuin valtaa	☐	☐	☐	☐
125.	Minun täytyy tehdä usein sihteerin tai muita vastaavia töitä, joita voisi tehdä siihen koulutettu henkilö	☐	☐	☐	☐
126.	Kestän hyvin paineita ja kielteistä arvostelua	☐	☐	☐	☐
127.	Minulla on voimia omaksua uutta	☐	☐	☐	☐
128.	Tunnen itseni usein uupuneeksi työni takia	☐	☐	☐	☐
129.	Työtä ja kotiasioita on usein vaikea sovittaa yhteen	☐	☐	☐	☐
130.	Saan usein palautetta esimieheltäni	☐	☐	☐	☐
131.	Saan paljon tukea esimieheltäni	☐	☐	☐	☐
132.	Annan alaisilleni palautetta spontaanisti	☐	☐	☐	☐
133.	Anna alaisilleni palautetta säännöllisesti kehityskeskusteluissa	☐	☐	☐	☐
134.	Alaiseni voivat tulla keskustelemaan kanssani epämuodollisesti	☐	☐	☐	☐
135.	Alaiset ovat tyytyväisiä johtamistapaani	☐	☐	☐	☐
136.	Kuuntelen alaisteni mielipiteitä ja tuen heitä	☐	☐	☐	☐
137.	Henkilöstö tukee minua muutoksen johtamisessa ja yleensäkin johtamisessa	☐	☐	☐	☐
138.	Hammaslääkärit tuntevat riittämättömyyttä uusien kliinisten haasteiden edessä	☐	☐	☐	☐
139.	Täydennyskoulutus henkilökunnalle on riittävää	☐	☐	☐	☐
140.	Pelkään, että lasten ja nuorten hampaiden terveys huononee uudistuksen takia	☐	☐	☐	☐
141.	Kansanterveysasetuksen säädökset tekivät aikoinaan helpoksi olla laajentamatta hammashoitoa vanhempiin ikäryhmiin	☐	☐	☐	☐
142.	Työikäisen väestön hammashoitoon on kiinnitetty liian vähän huomiota, joten aikuisväestön oli jo aika päästä kunnallisen hammashoidon piiriin	☐	☐	☐	☐
143.	Tärkeintä oli yksityisen hammashoidon saattaminen sairausvakuutus-korvausten piiriin	☐	☐	☐	☐
144.	Työnjaon toteuttaminen on järkevää	☐	☐	☐	☐
145.	Hyvähampaisten lasten ja nuorten tarkastusvälien harventaminen on järkevää	☐	☐	☐	☐
146.	Kaksikanavainen rahoitus verovaroin (tuetaan sekä julkista että yksityistä puolta) aiheuttaa ristiriitoja kuntatasolla	☐	☐	☐	☐

Taustakysymykset

		nainen	mies
147.	Sukupuoli	☐	☐

148. Syntymävuosi nelinumeroisena _____

149. Koulutus. Rastita sopivat!

- ☐ HLL
- ☐ EHL
- ☐ EHL muu ala
- ☐ HLT
- ☐ hallinnon pätevyys

150. Oletko saanut johtajankoulutusta:

- ☐ riittävästi
- ☐ liian vähän
- ☐ ei ollenkaan

151. Taho, jolta olet saanut johtajankoulutusta;

- ☐ työnantaja
- ☐ ammattiliitto
- ☐ yliopisto
- ☐ joku muu taho

152. Millaista koulutusta tarvitsisit lisää?

_____

153. Montako vuotta olet ollut nykyisessä virassasi? Vastaa vain numeroin vuosina! _____
154. Montako tuntia perustyöaikasi on täydellä työviikolla (esim. 37, jos teet täyttä työaikaa!) _____
155. Arvioi, montako prosenttia perustyöajastasi käytät asioiden johtamiseen? _____
156. Arvioi, montako prosenttia perustyöajastasi käytät henkilöstöjohtamiseen? _____
157. Arvioi, montako prosenttia perustyöajastasi käytät kliiniseen työhön? _____
158. Mahdolliset lisätyöt ja yksityisvastaanotolla toimiminen

- ☐ Teen kotonakin johtamiseen liittyvää työtä
- ☐ Teen lisätöitä säännöllisesti
- ☐ Teen lisätöitä satunnaisesti
- ☐ En tee lisätöitä ollenkaan
- ☐ Toimin yksityisvastaanotolla säännöllisesti
- ☐ Toimin yksityisvastaanotolla satunnaisesti
- ☐ En toimi yksityisvastaanotolla ollenkaan

159. Voiko terveyskeskuksessasi yleensä tehdä halutessaan lisätöitä?

- ☐ Kyllä, niin paljon kuin haluaa
- ☐ Kyllä, rajoitetusti
- ☐ Ei voi tehdä ollenkaan

160. Jos ei voi tehdä lisätöitä, mikä on syynä?

_____

161. Hammashuollossa on käytössä:

- ☐ recall-järjestelmä kaikille
- ☐ recall-järjestelmä rajoitetusti
- ☐ ei ollenkaan recall-järjestelmää
- ☐ keskitetty ajanvaraus
- ☐ ei keskitettyä ajanvarausta

162. Mitä muuta haluaisit sanoa johtamisesta ja hammashuollon lakiuudistuksista?

_____
_____

Kiitos vastauksistasi!

Appendix 3

Haastattelulomake johtavien hammaslääkäreiden esimiehille 2003

Suhtautuminen lakimuutoksiin ja muutoksen vaikutukset

1. Terveyskeskuksen nimi _____

2. Miten suhtaudut saatekirjelmässä mainittuun sairausvakuutuslain muutokseen?
- ☐ erittäin myönteisesti
- ☐ melko myönteisesti
- ☐ melko kielteisesti
- ☐ erittäin kielteisesti

3. Miten suhtaudut saatekirjelmässä mainittuun kansanterveyslain muutokseen?
- ☐ erittäin myönteisesti
- ☐ melko myönteisesti
- ☐ melko kielteisesti
- ☐ erittäin kielteisesti

4. Miten suhtauduit 1990-luvula ajatukseen, että koko väestö pääsee terveyskeskuksen hammashoidon piiriin?
- ☐ erittäin myönteisesti
- ☐ melko myönteisesti
- ☐ melko kielteisesti
- ☐ erittäin kielteisesti

5. Onko hammashuolto mielestäsi eriytynyt muusta terveydenhuollosta omassa terveyskeskuksessasi?
- ☐ kyllä
- ☐ ei

6. Onko vallitsevasta asiantilasta jotakin haitta tai hyötyä?
- ☐ on haittaa
- ☐ on sekä haitta että hyötyä
- ☐ ei ole haittaa eikä hyötyä
- ☐ on hyötyä

7. Jos on jotakin haittaa tai hyötyä, niin miten se vaikuttaa?

_____

8. Muun terveydenhuollon mukainen hoitoonpääsy tarpeen eikä iän mukaan on mielestäsi kriteerinä
- ☐ erittäin hyvä
- ☐ melko hyvä
- ☐ melko huono
- ☐ erittäin huono

9. Onko omassa terveyskeskuksessa toteutunut mahdollisuus järjestää hammashoitopalveluja kysyntää vastaavasti?
- ☐ kyllä
- ☐ ei

10. Jos vastasit ei, mitkä ovat pahimmat syyt ja miten ne pyritään poistamaan?

_____

11. Lainsäädännön muutokset ovat luultavasti lisänneet paineita tai toimintatapojen muutoksia etenkin terveyskeskuksissa. Onko ollut havaittavissa muutosvastarintaa uudistuksen toteuttamisele joltakin taholta?
- ☐ kyllä
- ☐ ei

12. Jos vastasit kyllä, niin miltä taholta?
- ☐ hammashuolto henkilöstön taholta
- ☐ johtavan hammaslääkärin taholta
- ☐ luottamushenkilöiden
- ☐ paikallisen yksityissektorin taholta
- ☐ lasten vanhempien taholta
- ☐ olen itse vastustanut
- ☐ joltakin muulta taholta

13. Millainen on hammashoitohenkilöstön vaikutusvalta hammashuollon asioista päätettäessä ja esim. lakiuudistuksen vaatimissa toimenpiteissä hammashuoltosektorin sisällä?

- ☐ erittäin suuri
- ☐ melko suuri
- ☐ melko vähäinen
- ☐ erittäin vähäinen

14. Miten paljon johtavalla hammaslääkärillä on päätäntävaltaa toiminnan muutosten läpiviemiseksi?

- ☐ tarpeeksi
- ☐ joissakin asioissa tarpeeksi,
- ☐ joissakin liian vähän
- ☐ liian vähän

15. Luottamushenkilöt tietävät johtavan hammaslääkärin mielipiteen hammashuollon asioista päätettäessä

- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ melko huonosti
- ☐ erittäin huonosti

16. Millainen on mielestäsi johtavan hammaslääkärin vaikutusvalta hammashuollon asioista luottamushenkilöelimissä päätettäessä?

- ☐ erittäin suuri
- ☐ melko suuri
- ☐ melko vähäinen
- ☐ erittäin vähäinen

17. Luottamushenkilöt tekevät päätöksensä hammashuoltoa koskevissa asioissa johtavan hammaslääkärin mielipiteen vastaisesti:

- ☐ erittäin usein
- ☐ silloin tällöin
- ☐ harvoin
- ☐ ei koskaan

18. Oma vaikutusvaltasi johtavan hammaslääkärin esimiehenä hammashuollon asioista päätettäessä on;

- ☐ erittäin suuri
- ☐ melko suuri
- ☐ melko vähäinen
- ☐ erittäin vähäinen

19. Kunnallisten päättäjien hammashuollolle asettamat tavoitteet ovat:

- ☐ selkeät
- ☐ epämääräiset
- ☐ ei näkyviä tavoitteita
- ☐ ristiriitaiset

20. Johtava hammaslääkäri on käsityksesi mukaan sisäistänyt työnantajan hammashuollolle asettamat tavoitteet:

- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ ei kovin hyvin
- ☐ huonosti

21. Hammashuollon työilmapiiri omassa terveyskeskuksessasi on mielestäsi:

- ☐ erittäin hyvä
- ☐ melko hyvä
- ☐ ei hyvä eikä huono
- ☐ melko huono
- ☐ erittäin huono

Johtavan hammaslääkärin johtajanominaisuudet

Miten seuraavat johtajanominaisuudet luonnehtivat mielestäsi johtavaa hammaslääkäriä johtajana?
1 = erittäin hyvin 2 = melko hyvin 3 = melko huonosti 4 = erittäin huonosti

		1	2	3	4
22.	Autoritaarinen luonnehtii:	☐	☐	☐	☐
23.	Neuvotteleva luonnehtii:	☐	☐	☐	☐
24.	Konservatiivinen luonnehtii:	☐	☐	☐	☐
25.	Innovatiivinen luonnehtii:	☐	☐	☐	☐
26.	Oikeudenmukainen luonnehtii:	☐	☐	☐	☐
27.	Empaattinen/tunneälykäs luonnehtii:	☐	☐	☐	☐
28.	Määrätietoinen/sinnikäs luonnehtii:	☐	☐	☐	☐
29.	Luotettava luonnehtii:	☐	☐	☐	☐
30.	Impulsiivinen luonnehtii:	☐	☐	☐	☐
31.	Passiivinen/mukavuudenhaluinen luonnehtii:	☐	☐	☐	☐
32.	Vakuuttava luonnehtii:	☐	☐	☐	☐
33.	Epävarma luonnehtii:	☐	☐	☐	☐

Mikä tai mitkä muut johtajanominaisuudet luonnehtivat johtavaa hammaslääkäriä johtajana paremmin kuin edellä mainitut?

34. Erittäin tai melko hyvin luonnehtii: _____
35. Erittäin tai melko hyvin luonnehtii: _____

Seuraavassa on joitakin väittämiä tuntemuksistasi myös johtavan hammaslääkärin esimiehenä.
Rastita jokaisesta kysymyksestä sopivin kohta!
1 = täysin tai lähes samaa mieltä 2 = jonkin verran samaa mieltä 3 = jonkin verran eri mieltä 4 = täysin tai lähes eri mieltä

		1	2	3	4
36.	Hammashuolto saa tietääkseni myönteistä palautetta potilailta	☐	☐	☐	☐
37.	Päättäjät saavat tietääkseni myönteistä palautetta kuntalaisilta	☐	☐	☐	☐
38.	Kuntalaisten mielipide on tärkeä hammashuollon palveluja järjestettäessä	☐	☐	☐	☐
39.	Yksityissektorin mielipide on tärkeä terveyskeskuksen hammashuoltopalveluja järjestettäessä	☐	☐	☐	☐
40.	Näkemykseni mukaan omassa terveyskeskuksessani hammashoitopalveluja tarjotaan kuntalaisten toivomassa laajuudessa	☐	☐	☐	☐
41.	Johtavalla hammaslääkärillä on enemmän vastuuta kuin valtaa	☐	☐	☐	☐
42.	Johtavan hammaslääkärin kuuluminen johtoryhmään on tai olisi tärkeää	☐	☐	☐	☐
43.	Johtoryhmätyöskentely on mielestäni ajanhaaskausta	☐	☐	☐	☐
44.	Johtavan hammaslääkärin läsnäolo päättävien elinten kokouksissa on tai olisi tärkeää	☐	☐	☐	☐
45.	Työnjaon toteuttaminen eli joidenkin tehtävien siirtäminen hammaslääkäreiltä hammashoitajille on järkevää	☐	☐	☐	☐
46.	Hyvähampaisten lasten ja nuorten tarkastusvälien harventaminen on järkevää	☐	☐	☐	☐
47.	Luotan johtavan hammaslääkärin arvostelukykyyn ja johtamistapaan	☐	☐	☐	☐
48.	Annan usein palautetta johtavalle hammaslääkärille	☐	☐	☐	☐
49.	Annan paljon tukea johtavalle hammaslääkärille	☐	☐	☐	☐
50.	Vastavuoroisesti johtava hammaslääkäri tukee minua johtamisessa ja tehdyissä päätöksissä	☐	☐	☐	☐
51.	Alaiseni voivat tulla keskustelemaan kanssani epämuodollisesti	☐	☐	☐	☐
52.	Annan alaisilleni säännöllisesti palautetta kehittämiskeskusteluissa	☐	☐	☐	☐
53.	Käsittääkseni johtava hammaslääkäri on motivoitunut johtamiseen ja menestyy tehtävässä	☐	☐	☐	☐
54.	Hammaslääkärit tuntevat käsitykseni mukaan riittämättömyyttä uusien kliinisten haasteiden edessä	☐	☐	☐	☐

55. Uudistuksen takia tarvittava täydennyskoulutus hammashoito-henkilökunnalle on riittävää ☐ ☐ ☐ ☐

56. Pelkään, että lasten ja nuorten hampaiden terveys huononee uudistuksen takia ☐ ☐ ☐ ☐

57. Kansanterveysasetuksen säädökset tekivät aikoinaan helpoksi olla laajentamatta hammashoitoa vanhempiin ikäryhmiin ☐ ☐ ☐ ☐

58. Työikäisen väestön hammashoitoon on kiinnitetty liian vähän huomiota, joten aikuisväestön oli jo aika päästä kunnallisen hammashoidon piiriin ☐ ☐ ☐ ☐

59. Tärkeintä oli yksityisen hammashoidon saattaminen sairaus-vakuutuksen piiriin ☐ ☐ ☐ ☐

60. Kunnan päättäjien ja kuntalaisten näkemykset palvelujen priori-soinnissa käyvät näkemykseni mukaan hyvin yksiin ☐ ☐ ☐ ☐

61. Kaksikanavainen rahoitus (verovaroin tuetaan sekä yksityistä että julkista puolta) aiheuttaa ristiriitoja terveydenhuollon järjestelyissä kuntatasolla ☐ ☐ ☐ ☐

62. Keski-ikäisten ja vanhusten hampaiden terveys paranee uudistuksen uudistuksen takia ☐ ☐ ☐ ☐

Taustakysymykset

63. Su kupuoli
☐ Nainen
☐ Mies

64. Syntymävuosi nelinumeroisena, esim. 1956 _____

65. Koulutus
☐ LL
☐ EL
☐ LT
☐ Hallinnon pätevyys
☐ Jokin muu kuin lääkärinkoulutus

66. Miten paljon olet saanut johtajankoulutusta
☐ Riittävästi
☐ Liian vähän
☐ En ollenkaan

67. Montako vuotta olet ollut nykyisessä johtajan virassasi? _____

68. Montako vuotta olet ollut kaiken kaikkiaan johtajana? _____

69. Mitä muuta haluaisit sanoa johtamisesta ja hammashuollon lakiuudistuksista tai tästä kyselystä?

_____

_____

Kiitos vastauksistasi!

Appendix 4

Haastattelulomake terveyslautakunnan tai yhtymähallituksen puheenjohtajille 2003

70. Terveyskeskus, jossa toimit: _____

Suhtautuminen lakimuutoksiin ja muutosten vaikutukset

71. Miten suhtaudut saatekirjelmässä mainittuun sairausvakuutuslain muutokseen?
- ☐ Erittäin myönteisesti
- ☐ Melko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

72. Miten suhtaudut saatekirjelmässä mainittuun kansanterveyslain muutokseen?
- ☐ Erittäin myönteisesti
- ☐ Mmelko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

73. Miten suhtauduit 1990-luvulla ajatukseen, että koko väestö pääsee terveyskeskuksen hammashoidon piiriin?
- ☐ Erittäin myönteisesti
- ☐ Melko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

74. Onko hammashuolto eriytynyt muusta terveydenhuollosta omassa terveyskeskuksessasi?
- ☐ Kyllä
- ☐ Ei

75. Onko vallitsevasta asiantilasta jotakin haitta tai hyötyä?
- ☐ On haittaa
- ☐ On sekä haitta että hyötyä
- ☐ Ei ole haittaa eikä hyötyä
- ☐ On hyötyä

76. Muun terveydenhuollon mukainen hoitoonpääsy tarpeen mukaan on mielestäni kriteerinä:
- ☐ erittäin hyvä
- ☐ melko hyvä
- ☐ melko huono
- ☐ erittäin huono

77. Onko omassa terveyskeskuksessa tarvittu erikois-järjestelyjä terveysperusteiden määrittämiseksi?
- ☐ Kyllä
- ☐ Ei

78. Jos vastasi ei, niin mitkä ovat pahimmat syyt ja miten ne pyritään poistamaan?

_____

79. Lainsäädännön muutokset ovat luultavasti lisänneet paineita tai toimintatapojen muutoksia etenkin terveyskeskuksissa. Onko ollut havaittavissa muutosvastarintaa joltakin taholta?

- ☐ Kyllä
- ☐ Ei

80. Jos vastasit kyllä, niin miltä taholta tai tahoilta?

- ☐ Hammashuoltohenkilöstön taholta
- ☐ Johtavan hammaslääkärin taholta
- ☐ Johtavan hammaslääkärin esimiehen taholta
- ☐ Luottamushenkilöiden
- ☐ Paikallisen yksityissektorin taholta
- ☐ Lasten vanhempien taholta
- ☐ Joltakin muulta taholta
- ☐ Olen itse vastustanut
- ☐ Joltakin muulta taholta

Johtavan hammaslääkärin vaikuttamiskanavat terveyskeskuksessa

81. Miten paljon johtavalla hammaslääkärillä on mielestäsi itsenäistä päätäntävaltaa toiminnan muutosten läpiviemiseksi?

- ☐ Liian paljon
- ☐ Tarpeeksi
- ☐ Joissakin asioissa tarpeeksi joissakin liian vähän
- ☐ Liian vähän

82. Millainen on käsityksesi mukaan henkilöstön vaikutusvalta hammashuollon asioista päätettäessä ja esimerkiksi lakiuudistusten vaatimissa toimenpiteissä hammashoitosektorin sisällä?

- ☐ Erittäin suuri
- ☐ Melko suuri
- ☐ Aika vähäinen
- ☐ Erittäin vähäinen

83. Luottamushenkilöt tietävät johtavan hammaslääkärin mielipiteen hammashuollon asioista päättäessään:

- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ melko huonosti
- ☐ erittäin huonosti

84. Luottamushenkilöt tekevät päätöksensä hammashuoltoa koskevissa asioissa mielipiteesi vastaisesti:

- ☐ erittäin usein
- ☐ silloin tällöin
- ☐ harvoin
- ☐ ei koskaan

85. Millainen on johtavan hammaslääkärin vaikutusvalta hammashuollon asioista päätettäessä?

- ☐ Erittäin suuri
- ☐ Melko suuri
- ☐ Aika vähäinen
- ☐ Erittäin vähäinen

86. Millainen on johtavan hammaslääkärin esimiehen vaikutusvalta hammashuollon asioista päätettäessä?

- ☐ Erittäin suuri
- ☐ Melko suuri
- ☐ Aika vähäinen
- ☐ Erittäin vähäinen

87. Kunnallisten päättäjien hammashuollolle asettamat tavoitteet ovat mielestäsi:

- ☐ selkeät
- ☐ epämääräiset
- ☐ ei näkyviä tavoitteita
- ☐ ristiriitaiset

Mitkä ovat tärkeimmät näistä tavoitteista?

88. Tärkein on:

_____

89. Toiseksi tärkein on:

_____

90. Kolmanneksi tärkein on:

_____

91. Johtava hammaslääkäri on käsityksesi mukaan sisäistänyt nämä työnantajan hammashuollolle asettamat tavoitteet:

- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ ei kovin hyvin
- ☐ erittäin hyvin

Seuraavassa on joitakin väittämiä tuntemuksistasi terveyskeskuksen päättäjänä.

Rastita jokaisesta kysymyksestä sopivin kohta!
1 = täysin tai lähes samaa mieltä; 2 = jonkin verran samaa mieltä;
3 = jonkin verran eri mieltä; 4 = täysin tai lähes eri mieltä

		1	2	3	4
92.	Oman terveyskeskukseni hammashuolto toimii hyvin	☐	☐	☐	☐
93.	Hammashuolto saa myönteistä palautetta potilailta	☐	☐	☐	☐
94.	Päättäjät saavat myönteistä palautetta kuntalaisilta hammashoidon järjestelyistä	☐	☐	☐	☐
95.	Kuntalaisten mielipide on tärkeä palveluja järjestettäessä	☐	☐	☐	☐
96.	Yksityissektorin mielipide n tärkeä terveyskeskuksen palveluja järjestettäessä	☐	☐	☐	☐
97.	Tärkeintä on, että valtion rahaa tulee paikkakunnalle yksityis-sektorin kautta sairausvakuutuksesta	☐	☐	☐	☐
98.	Päättäjien ja kuntalaisten mielipiteet käyvät näkemykseni mukaan hyvin yhteen kunnallisten palvelujen priorisoinnissa	☐	☐	☐	☐
99.	Näkemykseni mukaan omassa terveyskeskuksessani hammas-hoitopalveluja tarjotaan kuntalaisten toivomassa laajuudessa	☐	☐	☐	☐
100.	Työnjaon toteuttaminen eli joidenkin tehtävien siirtäminen hammas-lääkäreiltä hoitajille on järkevää	☐	☐	☐	☐
101.	Hyvähampaisten lasten ja nuorten tarkastusvälien harventaminen on järkevää	☐	☐	☐	☐
102.	Pelkään, että lasten ja nuorten hampaiden terveys huononee uudistuksen takia	☐	☐	☐	☐
103.	Kansanterveysasetuksen säädökset tekivät aikoinaan helpoksi olla laajentamatta hammashoitoa vanhempiin ikäryhmiin	☐	☐	☐	☐
104.	Työikäisen väestön hammashoitoon on kiinnitetty liian vähän huomiota, joten aikuisväestön oli jo aika päästä kunnallisen hammashoidon piiriin	☐	☐	☐	☐
105.	Tärkeintä on yksityisen hammashoidon saattaminen sairaus-vakuutuksen piiriin	☐	☐	☐	☐
106.	Kaksikanavainen rahoitus verovaroin (tuetaan sekä julkista että yksityistä puolta) aiheuttaa ristiriitoja kuntatasolla	☐	☐	☐	☐
107.	Johtoryhmätyöskentely on nähdäkseni ajan haaskausta	☐	☐	☐	☐
108.	Johtavan hammaslääkärin kuuluminen on tai olisi tärkeää	☐	☐	☐	☐
109.	Johtavan hammaslääkärin läsnäolo terveyslautakunnan tai hallituksen kokouksissa on tai olisi tärkeää	☐	☐	☐	☐
110.	Johtavalla hammaslääkärillä on enemmän vastuuta kuin valtaa	☐	☐	☐	☐
111.	luotan johtavan hammaslääkärin arvostelukykyyn ja johtamistapaan	☐	☐	☐	☐

Taustakysymykset

		nainen	**mies**
112.	Sukupuoli	☐	☐

113. Syntymävuosi nelinumeroisena _____

114. Koulutus. Rastita sopivat!

- ☐ Peruskoulu tai vastaava
- ☐ Ylioppilastutkinto
- ☐ Keskiasteen ammattitutkinto
- ☐ Korkeakoulututkinto
- ☐ Joku muu

115. Montako vuotta olet ollut nykyisessä luottamustoimessa terveyskeskuksessa? _____
116. Montako vuotta olet ollut kaiken kaikkiaan kunnan luottamustoimessa? _____

117. Mitä muuta haluaisit sanoa johtamisesta ja hammashuollon lakiuudistuksista?

_____

Kiitos vastauksistasi!

Appendix 5

Haastattelulomake terveyskeskushammaslääkäreille 2003

Suhtautuminen lakimuutoksiin ja muutoksen vaikutukset

1. Terveyskeskus, jossa toimit: _____

Suhtautuminen lakimuutoksiin ja muutosten vaikutukset

2. Miten suhtaudut saatekirjelmässä mainittuun sairausvakuutuslain muutokseen?
- ☐ Erittäin myönteisesti
- ☐ Melko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

3. Miten suhtaudut saatekirjelmässä mainittuun kansanterveyslain muutokseen?
- ☐ Erittäin myönteisesti
- ☐ Mmelko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

4. Miten suhtauduit 1990-luvulla ajatukseen, että koko väestö pääsee terveyskeskuksen hammashoidon piiriin?
- ☐ Erittäin myönteisesti
- ☐ Melko myönteisesti
- ☐ Melko kielteisesti
- ☐ Erittäin kielteisesti

5. Miten lakimuutokset tai niiden mukanaan tuoma julkisuus (jos kaikki olivat jo hoidossa) ovat vaikuttaneet palvelujen kysyntään? Kysyntä on:
- ☐ lisääntynyt huomattavasti
- ☐ lisääntynyt jonkin verran
- ☐ pysynyt lähes ennallaan
- ☐ vähentynyt jonkin verran
- ☐ vähentynyt huomattavasti

6. Käsitykseni mukaan palvelujen käyttäjien siirtymistä terveyskeskuksesta yksityispuolelle on havaittavissa:
- ☐ erittäin paljon
- ☐ melko paljon
- ☐ ei kovin paljon
- ☐ ei juuri lainkaan

7. Käsitykseni mukaan palvelujen käyttäjien siirtymistä yksityispuolelta terveyskeskukseen on havaittavissa:
- ☐ erittäin paljon
- ☐ melko paljon
- ☐ ei kovin paljon
- ☐ ei juuri lainkaan

8. Millainen on hoidon kysyntä suhteessa siihen, miten paljon voit ottaa vastaan? Kysyntää on:
- ☐ liian paljon
- ☐ sopivasti
- ☐ liian vähän

9. Työtahtia on jouduttu kiristämään viime aikoina:
- ☐ huomattavasti
- ☐ jonkin verran
- ☐ ei juuri lainkaan

10. Onko omassa terveyskeskuksessasi toteutunut mahdollisuus järjestää palveluja kysyntää vastaavasti?
- ☐ Kyllä
- ☐ Ei

11. Uusien potilaiden jonotusaika ei-kiireelliselle vastaanotolle on:
- ☐ noin yksi viikko
- ☐ 2-4 viikkoa
- ☐ 5-7 viikkoa
- ☐ 2-3 kuukautta
- ☐ 4-5 kuukautta
- ☐ yli 6 kuukautta

12. Miten hyvin päivystys mielestäsi toimii?

- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ melko huonosti
- ☐ erittäin huonosti

13. Onko paikkakunnan yksityissektorin kanssa muuta yhteistyötä kuin mahdollinen päivystys?

- ☐ Vain päivystys
- ☐ On muutakin yhteistyötä
- ☐ Ei mitään yhteistyötä

14. Miten yhteistyö tai muu kanssakäyminen yksityissektorin kanssa sujuu?

- ☐ Sujuu kitkattomasti
- ☐ On vähäisiä ristiriitoja
- ☐ On vaikeita ristiriitoja

15. Onko hammashuolto eriytynyt muusta terveydenhuollosta massa terveyskeskuksessasi?

- ☐ Kyllä
- ☐ Ei

16. Onko vallitsevasta asiantilasta jotakin haitta tai hyötyä?

- ☐ On haittaa
- ☐ On sekä haitta että hyötyä
- ☐ Ei ole haittaa eikä hyötyä
- ☐ On hyötyä

17. Jos on jotakin haittaa tai hyötyä, niin miten se vaikuttaa?

_____

18. Muun terveydenhuollon mukainen hoitoonpääsy tarpeen mukaan on mielestäni kriteerinä:

- ☐ erittäin hyvä
- ☐ melko hyvä
- ☐ melko huono
- ☐ erittäin huono

19. Oletko saanut mielestäsi tarpeeksi täydennyskoulutusta terveyskeskuksen taholta?

- ☐ Kyllä
- ☐ Ei

20. Tunnetko tarvitsevasi täydennyskoulutusta jollakin tai joillakin aloilla hammashoidon laajentuessa yhä vanhempiin ikäluokkiin?

- ☐ Kyllä
- ☐ Ei

21. Jos vastasit kyllä, niin millä aloilla?

- ☐ Kariologiassa
- ☐ Kirurgiassa
- ☐ Protetiikassa
- ☐ Parodontologiassa
- ☐ Muussa

22. Millainen on henkilöstön vaikutusvalta hammashuollon asioista päätettäessä ja esimerkiksi lakiuudistusten vaatimissa toimenpiteissä?

- ☐ Erittäin suuri
- ☐ Melko suuri
- ☐ Aika vähäinen
- ☐ Erittäin vähäinen

23. Millainen on esimiehesi vaikutusvalta hammas-huollon asioista päätettäessä?

- ☐ Erittäin suuri
- ☐ Melko suuri
- ☐ Melko vähäinen
- ☐ Erittäin vähäinen

24. Luottamushenkilöt tekevät käsityksesi mukaan päätöksensä hammashuoltoa koskevissa asioissa hammashuoltohenkilöstön mielipiteen vastaisesti:

- ☐ erittäin usein
- ☐ silloin tällöin
- ☐ harvoin
- ☐ ei koskaan
- ☐ en tiedä

25. Lainsäädännön muutokset ovat luultavasti lisänneet paineita tai etenkin terveyskeskuksissa. Oletko havainnut muutosvastarintaa joltakin taholta?

- ☐ Hmmashoitohenkilöstön taholta
- ☐ Esimiehesi taholta
- ☐ Kunnan luottamushenkilöiden taholta
- ☐ Yksityissektorin taholta
- ☐ Lasten vanhempien taholta
- ☐ Johtavan lääkärin taholta

26. Oletko itse vastustanut muutosta?

- ☐ Kyllä
- ☐ Ei

27. Työnantajan hammashuollolle asettamat tavoitteet on määritelty.

- ☐ Kyllä
- ☐ Ei

28. Tiedät työnantajan hammashuollolle asettamat tavoitteet:

- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ ei kovin hyvin
- ☐ huonosti

Mitkä ovat työnantajan hammashuollolle asettamat tavoitteet? Luettele käsityksesi mukaan kolme tärkeintä!

29. Tärkein on:

_____

30. Toiseksi tärkein on:

_____

31. Kolmanneksi tärkein on:

_____

32. Tiedän esimieheni odotukset asetettuja tavoitteita kohtaan:

- ☐ erittäin hyvin
- ☐ melko hyvin
- ☐ ei kovin hyvin
- ☐ huonosti

33. Tunnen asemani ristiriitaiseksi esimiehen ja päättäjien odotuksiin nähden:

- ☐ usein
- ☐ joskus
- ☐ harvoin
- ☐ ei koskaan

Esimiehen johtajanominaisuudet

Miten seuraavat johtajanominaisuudet luonnehtivat terveyskeskuksen johtavaa hammaslääkäriä johtajana?

1 = erittäin hyvin; 2 = melko hyvin; 3 = melko huonosti; 4 = erittäin huonosti

		1	**2**	**3**	**4**
34.	Autoritaarinen	☐	☐	☐	☐
35.	Neuvotteleva	☐	☐	☐	☐
36.	Konservatiivinen	☐	☐	☐	☐
37.	Innovatiivinen	☐	☐	☐	☐
38.	Oikeudenmukainen	☐	☐	☐	☐
39.	Empaattinen / tunneälykäs	☐	☐	☐	☐
40.	Määrätietoinen/sinnikäs	☐	☐	☐	☐
41.	Luotettava	☐	☐	☐	☐
42.	Impulsiivinen	☐	☐	☐	☐
43.	Passiivinen / mukavuudenhaluinen	☐	☐	☐	☐
44.	Vakuuttava	☐	☐	☐	☐
45.	Epävarma	☐	☐	☐	☐

Työviihtyvyys

46. Millainen on mielestäsi hammashuollon työilmapiiri omassa terveyskeskuksessasi?

- ☐ Erittäin hyvä
- ☐ Melko hyvä
- ☐ Ei hyvä eikä huono
- ☐ Melko huono
- ☐ Erittäin huono

47. Oma työviihtymiseni kouluarvosanoilla (4-10) ilmaistuna on; _____

48. Mitkä seikat vaikuttavat eniten työviihtyvyyteesi ja onnistumisen tunteeseen nykyisessä työssäsi? rastita kolme myönteisimmin vaikuttavaa tekijää!

- ☐ Tyytyväiset potilaat
- ☐ Lakiuudistuksiin tyytyväiset asiakkaat
- ☐ Voi itse säännellä työtahdin
- ☐ Ei tarvetta iltatyöhön tai muuten epäsäännöllisiin työaikoihin
- ☐ Hyvät työtoverit
- ☐ Hyvä esimies
- ☐ ATK-ohjelmien sujuvuus
- ☐ Jokin muu

49. Jos vastasit jokin muu, niin mikä? Voit myös kommentoida toisia vaihtoehtoja!

_____

50. Mitkä seikat haittaavat eniten työviihtymistäsi nykyisessä työssäsi? Mikäli sellaisia on, rastita kolme kielteisimmin vaikuttavaa tekijää!

- ☐ Tyytymättömät potilaat
- ☐ Lakiuudistuksiin tyytymättömät asiakkat
- ☐ Ei voi itse säännellä työtahtia
- ☐ Paineet iltatyöhön tai muuten epäsäännöllisiin työaikoihin
- ☐ Ristiriidat työtoverien kanssa
- ☐ Ristiriidat esimiehen kanssa
- ☐ Ongelmat ATK-ohjelmissa
- ☐ Jokin muu

51. Jos vastasit jokin muu, niin mikä? Voit myös kommentoida toisia vaihtoehtoja!

_____

52. Johtamistyön palkkaus suhteessa alaisten palkkaukseen on:

- ☐ liian pieni
- ☐ sopiva
- ☐ liian suuri

Miten tärkeinä pidät seuraavia tekijöitä nykyisessä työssäsi?

1 = yhdentekevä; 2 = melko yhdentekevä; 3 = melko tärkeä; 4 = erittäin tärkeä

		1	2	3	4
53.	Hyvä palkka	☐	☐	☐	☐
54.	Mahdollisuus terveyden edistämiseen	☐	☐	☐	☐
55.	Mahdollisuus itsenäiseen työhön	☐	☐	☐	☐
56.	Työn vaativuus ja haastavuus ja siten mahdollisuus saada tuloksia	☐	☐	☐	☐
57.	Mahdollisuus saada tunnustusta ja arvonantoa	☐	☐	☐	☐
58.	Mahdollisuus luovaan työhön ja innovaatioiden toteuttamiseen	☐	☐	☐	☐
59.	Mahdollisuus saada julkisuutta	☐	☐	☐	☐
60.	Mahdollisuus tiimityöskentelyyn ja toimimiseen ihmisten parissa	☐	☐	☐	☐
61.	Työn arvo yhteiskunnalle ja kanssaihmisille	☐	☐	☐	☐
62.	Mahdollisuus edetä uralla	☐	☐	☐	☐
63.	Mahdollisuus päivätyöhön	☐	☐	☐	☐
64.	Mahdollisuus pitää yllä monipuolista kliinistä osaamista	☐	☐	☐	☐

Seuraavassa on joitakin väittämiä tuntemuksistasi hammashuollon johtajana

1 = täysin tai lähes samaa mieltä; 2 = jonkin verran samaa mieltä;
3 = jonkin verran eri mieltä; 4 = täysin tai lähes eri mieltä

		1	2	3	4
65.	Tunnen menestyväni työssäni	☐	☐	☐	☐
66.	Tunnen, että minua arvostetaan hammaslääkärinä	☐	☐	☐	☐
67.	Olen motivoitunut terveyskeskushammaslääkärin työhön	☐	☐	☐	☐
68.	Toimisin mieluummin yksityishammaslääkärinä kuin terveyskeskuksessa	☐	☐	☐	☐
69.	Saan myönteistä palautetta potilailta	☐	☐	☐	☐
70.	Esimieheni toimii joskus hammashoitohenkilökunnan mielipiteiden vastaisesti	☐	☐	☐	☐
71.	Ymmärrän, että esimiehen on joskus toimittava vastoin henkilökunnan mielipiteitä	☐	☐	☐	☐
72.	Saan myönteistä palautetta työtovereiltani	☐	☐	☐	☐
73.	Kuntalaiset arvostavat yleensä terveyskeskuksen hammashuoltoa	☐	☐	☐	☐
74.	Kuntalaisten mielipide on tärkeä palveluja järjestettäessä	☐	☐	☐	☐
75.	Työnjaon toteuttaminen on järkevää	☐	☐	☐	☐
76.	Hyvähampaisten lasten ja nuorten tarkastusvälien harventaminen on järkevää	☐	☐	☐	☐
77.	Työilmapiiri on hyvä	☐	☐	☐	☐
78.	Minulla on riittävästi aikaa tehdä työni hyvin	☐	☐	☐	☐
79.	Tunnen itseni usein uupuneeksi työni takia	☐	☐	☐	☐
80.	Kestän hyvin paineita ja kielteistä arvostelua	☐	☐	☐	☐
81.	Saan usein palautetta esimieheltäni	☐	☐	☐	☐
82.	Saan paljon tukea esimieheltäni	☐	☐	☐	☐
83.	Luotan täysin esimieheeni	☐	☐	☐	☐
84.	Voin mennä keskustelemaan esimieheni kanssa epämuodollisesti	☐	☐	☐	☐
85.	Olen tyytyväinen esimieheni johtamistapaan	☐	☐	☐	☐
86.	Esimieheni kuuntelee alaistensa mielipiteitä	☐	☐	☐	☐
87.	Tuen esimiestäni muutoksen johtamisessa ja yleensäkin johtamisessa	☐	☐	☐	☐
88.	Työtä ja kotiasioita on usein vaikea sovittaa yhteen	☐	☐	☐	☐
89.	Pelkään, että lasten ja nuorten hampaiden terveys huononee uudistuksen takia	☐	☐	☐	☐
90.	Kansanterveysasetuksen säädökset tekivät aikoinaan helpoksi olla laajentamatta hammashoitoa vanhempiin ikäryhmiin	☐	☐	☐	☐
91.	Työikäisen väestön hammashoitoon on kiinnitetty liian vähän huomiota	☐	☐	☐	☐
92.	Aikuisväestön oli jo aika päästä kunnallisen hammashoidon piiriin	☐	☐	☐	☐
93.	Tärkeintä oli yksityisen hammashoidon saattaminen sairausvakuutuskorvausten piiriin	☐	☐	☐	☐
94.	Kaksikanavainen rahoitus verovaroin (tuetaan sekä julkista että yksityistä puolta) aiheuttaa ristiriitoja kuntatasolla	☐	☐	☐	☐
95.	Esimieheni tukee mahdollisuutta normaalin kliinisen työn ohella keskittyä myös johonkin erikoisalaan	☐	☐	☐	☐
96.	Olen itse pyrkinyt keskittymään johonkin erikoisalaan	☐	☐	☐	☐
97.	Koulutus henkilökunnalle uudistuksen takia on riittävä	☐	☐	☐	☐
98.	Tunnen usein riittämättömyyttä uusien kliinisten haasteiden edessä	☐	☐	☐	☐
99.	Minulla on voimia omaksua uutta	☐	☐	☐	☐
100.	Kunnan päättäjien ja kuntalaisten mielipiteet palvelujen priorisoinnissa käyvät hyvin yksiin	☐	☐	☐	☐

Taustakysymykset

		nainen	mies
101.	Sukupuoli	☐	☐

102. Syntymävuosi nelinumeroisena _____

103. Koulutus. Rastita sopivat!

- ☐ HLL
- ☐ EHL
- ☐ HLT
- ☐ hallinnon pätevyys

104. Montako vuotta olet ollut nykyisessä virassasi? Vastaa vain numeroin vuosina! _____

105. Montako vuotta olet ollut kaikkiaan hammaslääkärinä? Vastaa vain numeroin vuosina! _____

106. Montako tuntia perustyöaikasi on täydellä työviikolla (esim. 37, jos teet täyttä työaikaa!)
Jos olet säännöllisesti töissä vain joka toinen viikko, niin puolita viikkotyöaika! _____

107. Mahdolliset lisätyöt ja yksityisvastaanotolla toimiminen

- ☐ Teen lisätöitä säännöllisesti
- ☐ Teen lisätöitä satunnaisesti
- ☐ En tee lisätöitä ollenkaan
- ☐ Toimin yksityisvastaanotolla säännöllisesti
- ☐ Toimin yksityisvastaanotolla satunnaisesti
- ☐ En toimi yksityisvastaanotolla ollenkaan

108. Mitä muuta haluaisit sanoa johtamisesta ja hammashuollon lakiuudistuksista?

_____
_____
_____

Kiitos vastauksistasi!

Appendix 6

Saatekirjelmä terveyskeskuksen johtaville hammaslääkäreille 2011

Arvoisa Vastaanottaja!

Kansanterveyslakia ja sairausvakuutuslakia muutettiin suun terveydenhuollon osalta vuonna 2000 siten, että koko väestö ikään katsomatta on ollut yhteiskunnan tukeman hammashoidon piirissä viimeistään 1.12.2002 lähtien.

Muutoksen käynnistyttyä heräsi kysymys myös suun terveydenhuollon johtamisesta, jota Suomessa ei aikaisemmin ollut tutkittu juuri lainkaan. Vuoden 2003 lopulla ja 2004 alussa lähetin kyselyn terveyskeskusten silloisille johtaville hammaslääkäreille ja viidelle muulle kohderyhmälle: terveyskeskusten johtavien hammaslääkärien esimiehille ja alaisille, terveyslautakuntien tai hallitusten puheenjohtajille, yksityishammaslääkäreille ja kuntalaisille. Tarkoituksena oli tutkia, miten kunnallista hammashuoltoa johdettiin, miten lakimuutokset olivat vaikuttaneet hammashuollon toimintaan, miten johtavat hammaslääkärit kokivat johtamistehtävänsä ja miten työyhteisö ja ympäristötekijät olivat yhteydessä johtamiseen ja siten hammashuollon toimintaan. Kesällä 2011 tutkimuksesta on julkaistu kaksi artikkelia.

Koska aikaa on kulunut paljon sairauden ym. takia, heräsi kysymys siitä, miten muutoksen johtaminen on sujunut johtajan näkökulmasta katsottuna, ja mitkä tekijät kuntatasolla ovat siihen vaikuttaneet.

Olen edelleen kirjoilla Helsingin yliopiston Lääketieteellisessä tiedekunnassa.

Haastattelulomake on sähköpostin liitteenä, ja pyydän palauttamaan sen mieluimmin samalla tavalla sähköpostin liitteenä alla olevaan osoitteeseen. Pyydettäessä lähetän lomakkeesta myös paperikopion. Lomake on salasanalla suojattu. Täyttäminen tapahtuu rasti ruutuun–menetelmällä. Osoitin menee ruutuun näpäyttämällä hiirellä jotakin tekstin kohtaa oikeaksi harkitulla ruuturivillä. Rastin saa tarvittaessa pois uudella hiiren näpäytyksellä.

Vastauksesi käsitellään ehdottoman luottamuksellisesti, eikä lopullisessa raportissa mainita mitään terveyskeskusta nimeltä, vaikka tutkimusteknisistä syistä kyseiset tiedot ovatkin tutkimuksen tekijän hallussa tarvittavan ajan. Oikean kuvan saamiseksi on tärkeää, että kaikki vastaavat kaikkiin kysymyksiin. ”En osaa sanoa” vaihtoehtoa ei ole, eikä lomakkeessa eteneminen edellytä jokaiseen kysymykseen vastaamista. Tyhjät kohdat tulkitaan joko ”en osaa tai halua sanoa” vastauksiksi tai sitten vastaajalla ei ole asiasta mielipidettä suuntaan tai toiseen.

Vastauksestasi etukäteen ystävällisesti kiittäen

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Appendix 7

Kysely johtaville hammaslääkäreille johtamistyöhön liittyvistä asioista 2011

1. **Terveyskeskuksen nimi: _____**

2. **Terveyskeskuksen väkiluku sopimuskunnat mukaan lukien _____**

Kysymyksiä vuosien 2000 – 2005 hammashoitoa koskevista lakiuudistuksista vastaajan oman terveyskeskuksen kannalta tarkasteltuna

(Arvioi nykyinen tilanne, vaikka et itse olisi ollut vielä johtaja tai et olisi ollut vielä paikkakunnalla.)

3. **Hammashoitouudistus oli tarpeen (välttämätön) kansanterveyslain osalta**:

täysin tai lähes samaa mieltä	☐
jonkin verran samaa mieltä	☐
jonkin verran eri mieltä	☐
täysin tai lähes eri mieltä	☐

4. **Hammashoitouudistus oli tarpeen (välttämätön) sairausvakuutuslain osalta:**

täysin tai lähes samaa mieltä	☐
jonkin verran samaa mieltä	☐
jonkin verran eri mieltä	☐
täysin tai lähes eri mieltä	☐

5. **Kansanterveyslain muutos toi uusia ikäryhmiä hoitoon omassa terveyskeskuksessani:**

erittäin paljon	☐
melko paljon	☐
melko vähän	☐
ei juuri ollenkaan	☐

6. **Hammashoitouudistuksen toteutus on onnistunut omassa terveyskeskuksessani:**

erittäin hyvin	☐
melko hyvin	☐
melko huonosti	☐
erittäin huonosti	☐

Organisaatiomuutokset

		Kyllä	**Ei**
7.	Toiminta-alueellani on tapahtunut kuntaliitoksia	☐	☐
8.	Kuntien kesken on muodostettu yhteistoiminta-alueita (Paras-hamke?)	☐	☐

9. Muuta, mitä? _____

Organisaatiomuutosten (mikäli niitä tapahtunut) **vaikutus suun terveydenhuoltoon**

1 = täysin tai lähes samaa mieltä; 2 = jonkin verran samaa mieltä;
3 = jonkin verran eri mieltä; 4 = täysin tai lähes eri mieltä

		1	**2**	**3**	**4**
10.	Hammashuolto etääntynyt päätöksenteosta	☐	☐	☐	☐
11.	Hammashuolto etääntynyt muusta terveydenhuollosta	☐	☐	☐	☐
12.	Hallintobyrokratia lisääntynyt ja monimutkaistunut	☐	☐	☐	☐
13.	Johtaminen vaikeutunut, koska päätöksenteko etääntynyt	☐	☐	☐	☐

14. Johtavan hammaslääkärin virkateitse tapahtuva tiedonsaanti huonontunut ☐ ☐ ☐ ☐
15. Johtavan hammaslääkärin itsenäinen päätäntävalta lisääntynyt ☐ ☐ ☐ ☐

Miten <u>paljon</u> seuraavat tekijät/keinot ovat edesauttaneet kysynnän ja tarjonnan tasapainottamista terveyskeskuksessasi?

1 = erittäin paljon; 2 = melko paljon;
3 = melko vähän; 4 = ei juuri ollenkaan

		1	2	3	4
16.	Hoitohenkilöstöä ollut/saatu kysyntää vastaavasti	☐	☐	☐	☐
17.	Työtiloja ja muita resursseja ollut/saatu riittävästi	☐	☐	☐	☐
18.	Potilaita hakeutunut yksityissektorille	☐	☐	☐	☐
19.	Potilaita hakeutunut yksityissektorilta terveyskeskukseen	☐	☐	☐	☐
20.	Terveyskeskuksen ja yksityisten yhteisresurssit ovat riittävät	☐	☐	☐	☐
21.	Ostopalveluita hankittu	☐	☐	☐	☐
22.	Priorisointilistat käytössä tai otettu käyttöön	☐	☐	☐	☐
23.	Työnjakoa kehitetty	☐	☐	☐	☐
24.	Yksilöllisen tutkimusvälin käyttöä kehitetty	☐	☐	☐	☐
25.	Hoitokäynnin pituutta säädellään arvioidun tarpeen mukaan	☐	☐	☐	☐
26.	Toimintatavat tehty muutoinkin joustaviksi kulloisenkin tilanteen mukaan (esim. potilaan sairauden tai pitkän matkan takia)	☐	☐	☐	☐
27.	Byrokratiaa helpotettu (henkilöstön oman järjen käyttö sallittu)	☐	☐	☐	☐
28.	Koulutusta tarjottu tarpeen mukaan	☐	☐	☐	☐
29.	Tietotekniikan (ATK) toimivuus parantunut potilastyössä	☐	☐	☐	☐
30.	ATK:n toimivuus parantunut hallinnossa (myös potilashallinnossa)	☐	☐	☐	☐
31.	Muuta Mitä? _____	☐	☐	☐	☐

Mikäli hoitohenkilöstöä ei ole saatu riittävästi, syynä on se, että:

! = täysin tai lähes samaa mieltä; 2 = jonkin verran samaa mieltä;
3 = jonkin verran eri mieltä; 4 = täysin tai lähes eri mieltä

32.	kunta ei ole perustanut tarvittavia virkoja	☐	☐	☐	☐
33.	kunta ei ole esim. säästösyistä pannut virkoja hakuun	☐	☐	☐	☐
34.	virkoihin ei ole ollut (päteviä tai sopivia) hakijoita	☐	☐	☐	☐
35.	viranhaltijoita on siirtynyt yksityissektorille, eikä virkoja täytetty	☐	☐	☐	☐
36.	viranhaltijoita on siirtynyt eläkkeelle, eikä virkoja ole täytetty	☐	☐	☐	☐
37.	terveyskeskus työpaikkana ei vedä puoleensa (syrjäinen sijainti, pieni koko ym.)	☐	☐	☐	☐
38.	muu, mikä? _____	☐	☐	☐	☐

39. Tätä hetkellä jonotusaika hoitoon pääsyyn on:

noin yksi viikko ☐
2-4 viikkoa ☐
5-7 viikkoa ☐
2-3 kuukautta ☐
4-5 kuukautta ☐
yli 6 kuukautta ☐

40. Hoitotakuu-uudistus oli tarpeen (välttämätön) jonojen hallitsemiseksi:

täysin tai lähes samaa mieltä ☐
jonkin verran samaa mieltä ☐
jonkin verran eri mieltä ☐
täysin tai lähes eri mieltä ☐

41. Hoitotakuu on toteutunut omassa terveyskeskuksessani:

erittäin hyvin	☐
melko hyvin	☐
melko huonosti	☐
erittäin huonosti	☐

42. Hoitokäyntien välit (eli hoitojaksot) ovat venyneet liian pitkiksi:

täysin tai lähes samaa mieltä	☐
jonkin verran samaa mieltä	☐
jonkin verran eri mieltä	☐
täysin tai lähes eri mieltä	☐

Eräät hammashoitouudistusten tai organisaatiomuutosten (mahdolliset) seurannaisilmiöt ovat vaikeuttaneet johtamistyötäni:

1 = täysin tai lähes samaa mieltä; 2 = jonkin verran samaa mieltä;
3 = jonkin verran eri mieltä; 4 = täysin tai lähes eri mieltä

		1	2	3	4
43.	yleisterveydeltään moniongelmaisten potilaiden lisääntyminen	☐	☐	☐	☐
44.	hammasterveydeltään vaikeaongelmaisten potilaiden lisääntyminen	☐	☐	☐	☐
45.	työn vaativuuden lisääntyminen siirryttäessä lasten ja nuorten hoidosta enenevässä määrin aikuisväestön hoitoon	☐	☐	☐	☐
46.	kiireen lisääntyminen	☐	☐	☐	☐
47.	uusien tai erikoisosaamista vaativien hoitomuotojen kasvanut kysyntä terveyskeskuksessa (esim. implantit)	☐	☐	☐	☐
48.	julkisen ja yksityisen sektorin välinen kilpailu	☐	☐	☐	☐
49.	hammashuollon etääntyminen päätöksenteosta	☐	☐	☐	☐

50. Hammaslääkäripäivystys toimii omalla paikkakunnallani:

(Yksityiskohtaisia tietoja saatavissa muualta)

erittäin hyvin	☐
melko hyvin	☐
melko huonosti	☐
erittäin huonosti	☐

Johtajanominaisuudet

Miten seuraavat johtajanominaisuudet luonnehtivat sinua johtajana?

1 = erittäin hyvin, 2 = melko hyvin, 3 = melko huonosti, 4 = erittäin huonosti

		1	2	3	4
51.	**Autoritaarinen**	☐	☐	☐	☐
52.	**Neuvotteleva**	☐	☐	☐	☐
53.	**Konservatiivinen**	☐	☐	☐	☐
54.	**Innovatiivinen**	☐	☐	☐	☐
55.	**Oikeudenmukainen**	☐	☐	☐	☐
56.	**Empaattinen/tunneälykäs**	☐	☐	☐	☐
57.	**Määrätietoinen/sinnikäs**	☐	☐	☐	☐
58.	**Luotettava**	☐	☐	☐	☐
59.	**Impulsiivinen**	☐	☐	☐	☐
60.	**Passiivinen/mukavuudenhaluinen**	☐	☐	☐	☐
61.	**Vakuuttava**	☐	☐	☐	☐
62.	**Epävarma**	☐	☐	☐	☐

Johtamistyön eri osatekijöiden arvostus

Miten tärkeänä pidät seuraavia johtajantyöhön liittyviä asioita nykyisessä työssäsi?

1 = yhdentekevä; 2 = melko yhdentekevä; 3 = melko tärkeä; 4 = erittäin tärkeä

		1	2	3	4
63.	**Palkka**	☐	☐	☐	☐
64.	**Mahdollisuus vaikuttaa hammashuollon tulevaisuuteen**	☐	☐	☐	☐
65.	**Mahdollisuus itsenäiseen työhön**	☐	☐	☐	☐
66.	**Työn vaativuus ja haastavuus ja sitä kautta mahdollisuus saada tuloksia**	☐	☐	☐	☐
67.	**Mahdollisuus saada tunnustusta ja arvonantoa**	☐	☐	☐	☐
68.	**Mahdollisuus luovaan työhön ja innovaatioiden toteuttamiseen**	☐	☐	☐	☐
69.	**Mahdollisuus saada julkisuutta**	☐	☐	☐	☐
70.	**Mahdollisuus tiimityöskentelyyn ja toimimiseen ihmisten parissa**	☐	☐	☐	☐
71.	**Työ on arvokasta**	☐	☐	☐	☐
72.	**Mahdollisuus edetä uralla**	☐	☐	☐	☐
73.	**Mahdollisuus päivätyöhön**	☐	☐	☐	☐
74.	**Mahdollisuus ylläpitää myös kliinistä osaamista**	☐	☐	☐	☐

Työhyvinvointi

75. **Hammashuollon työilmapiiri omassa terveyskeskuksessani on:**

- erittäin hyvä ☐
- melko hyvä ☐
- melko huono ☐
- erittäin huono ☐

76. **Oma viihtymiseni työssä kouluarvosanoilla (4 – 10) ilmaistuna on:** _____

77. **Johtamistyön palkkaus suhteessa alaisten palkkaukseen on:**

- liian pieni ☐
- sopiva ☐
- liian suuri ☐

1 = täysin tai lähes samaa mieltä; 2 = jonkin verran samaa mieltä;
3 = jonkin verran eri mieltä; 4 = täysin tai lähes eri mieltä

		1	2	3	4
78.	**Tunnen menestyväni johtajana**	☐	☐	☐	☐
79.	**Tunnen, että minua arvostetaan johtajana**	☐	☐	☐	☐
80.	**Olen motivoitunut johtamiseen**	☐	☐	☐	☐
81.	**Olen paremminkin yksi hammaslääkäri muiden joukossa**	☐	☐	☐	☐
82.	**Olisin mieluummin kliinikko kuin johtaja**	☐	☐	☐	☐
83.	**Muutoksen johtaminen on mielenkiintoinen haaste**	☐	☐	☐	☐
84.	**Koen, että muutoksen johtaminen on helppoa**	☐	☐	☐	☐
85.	**Joskus on pakko toimia henkilökunnan mielipiteiden vastaisesti tavoitteiden saavuttamiseksi**	☐	☐	☐	☐
86.	**Ristiriitojen välttämiseksi on parempi toimia kuten aina ennenkin**	☐	☐	☐	☐
87.	**Minulla on riittävästi aikaa johtamiseen**	☐	☐	☐	☐
88.	**Minun täytyy tehdä liian paljon kliinistä työtä**	☐	☐	☐	☐
89.	**Minulla on enemmän vastuuta kuin valtaa**	☐	☐	☐	☐
90.	**Minun täytyy tehdä usein sihteerin tai muita vastaavia töitä, joita voisi tehdä niihin koulutettu henkilö**	☐	☐	☐	☐
91.	**Kestän hyvin paineita ja kielteistä arvostelua**	☐	☐	☐	☐
92.	**Minulla on voimia omaksua uutta**	☐	☐	☐	☐
93.	**Tunnen itseni usein uupuneeksi työni takia**	☐	☐	☐	☐

94. **Työtä ja kotiasioita on usein vaikea sovittaa yhteen** ☐ ☐ ☐ ☐

Suhteet esimieheen ja alaisiin

95. **Saan usein palautetta esimieheltäni** ☐ ☐ ☐ ☐
96. **Saan paljon tukea esimieheltäni** ☐ ☐ ☐ ☐
97. **Annan alaisilleni palautetta spontaanisti** ☐ ☐ ☐ ☐
98. **Annan alaisilleni palautetta säännöllisesti kehittämiskeskusteluissa** ☐ ☐ ☐ ☐
99. **Alaiseni voivat tulla keskustelemaan kanssani epämuodollisesti** ☐ ☐ ☐ ☐
100. **Alaiset ovat tyytyväisiä johtamistapaani** ☐ ☐ ☐ ☐
101. **Kuuntelen alaisteni mielipiteitä ja tuen heitä** ☐ ☐ ☐ ☐
102. **Henkilöstö tukee minua muutosten johtamisessa ja yleensäkin johtamisessa** ☐ ☐ ☐ ☐
103. **Hammaslääkärit tuntevat usein riittämättömyyttä uusien kliinisten haasteiden edessä** ☐ ☐ ☐ ☐
104. **Täydennyskoulutus henkilökunnalle on ollut riittävää** ☐ ☐ ☐ ☐

Koko väestön hoidonpiiriin tulosta aiheutuneet muutokset

105. **Lasten ja nuorten hampaiden terveys on huonontunut uudistuksen takia** ☐ ☐ ☐ ☐
106. **Kansanterveysasetuksen säädökset tekivät aikoinaan helpoksi olla laajentamatta hammashoitoa vanhempiin ikäryhmiin** ☐ ☐ ☐ ☐
107. **Työikäisen väestön hammashoitoon oli kiinnitetty liian vähän huomiota, joten aikuisväestön oli jo aika päästä hammashoidon piiriin** ☐ ☐ ☐ ☐
108. **Tärkeintä oli yksityisen hammashoidon saattaminen sairaus-vakuutuksen piiriin** ☐ ☐ ☐ ☐
109. **Työnjaon toteuttaminen tai tehostaminen on ollut järkevää** ☐ ☐ ☐ ☐
110. **Hyvähampaisten lasten ja nuorten tarkastusvälien harventaminen on osoittautunut järkeväksi** ☐ ☐ ☐ ☐
111. **Kaksikanavainen rahoitus (verovaroin tuetaan sekä julkista että yksityistä sektoria) on aiheuttanut tai on osasyynä siihen, ettei terveyskeskukseen ole palkattu riittävästi henkilöstöä** ☐ ☐ ☐ ☐
112. **Terveydenhuollon uudistamisehdotuksissa esille nostettu Kela-korvausten poistaminen yksityissektorin hoidoista vaikeuttaisi/ hankaloittaisi terveyskeskusten toimintaa** ☐ ☐ ☐ ☐
113. **Yksityisen hoidon tukeminen palvelusetelillä Kelakorvausten sijasta tulisi todennäköisesti lisäämään byrokratiaa** ☐ ☐ ☐ ☐

Kuntalaiset ja luottamuselimet

114. **Saan myönteistä palautetta potilailta** ☐ ☐ ☐ ☐
115. **Saan myönteistä palautetta kuntalaisilta** ☐ ☐ ☐ ☐
116. **Seuraan asiakaspalautetta säännöllisesti** ☐ ☐ ☐ ☐
117. **Otan saamani palautteen huomioon palveluja kehitettäessä** ☐ ☐ ☐ ☐
118. **Kuntalaisten mielipide on tärkeä palveluja järjestettäessä** ☐ ☐ ☐ ☐
119. **Luottamushenkilöiden ja kuntalaisten mielipiteet käyvät näkemykseni mukaan hyvin yksiin** ☐ ☐ ☐ ☐
120. **Luottamushenkilöt ajavat hyvin kuntalaisten etuja** ☐ ☐ ☐ ☐
121. **Minulla on tarpeeksi itsenäistä päätäntävaltaa sekä asia- että henkilöjohtamiseen liittyvissä asioissa** ☐ ☐ ☐ ☐

122. **Mitkä ovat mahdollisuutesi osallistua päättävien elinten kokouksiin?**

(Rastita vain yksi vaihtoehto!)

Esittelyoikeus päättävien elinten kokouksissa ☐
Ei esittelyoikeutta, mutta läsnäolo- ja puheoikeus aina tai halutessani ☐
Läsnäolo- ja puheoikeus vain kutsuttaessa ☐
Käytännössä en voi osallistua ollenkaan ☐

123. Oletko johtoryhmän jäsen?

Kyllä ☐
En ☐

124. Mikäli et voi osallistua päättävien elinten kokouksiin etkä ole johtoryhmän jäsen, miten saat äänesi kuuluviin kunnallisille päättäjille?

_____
_____

125. Luottamushenkilöt tekevät päätöksensä hammashuoltoa kokevissa asioissa mielipiteeni vastaisesti:

erittäin usein ☐
silloin tällöin ☐
harvoin ☐
ei koskaan ☐

126. Henkilöstön vaikutusvalta hammashuollon asioista päätettäessä ja lakiuudistuksen vaatimissa toimenpiteissä on ollut uudistuksen jälkeisinä vuosina:

erittäin suuri ☐
melko suuri ☐
melko vähäinen ☐
erittäin vähäinen ☐

127. Esimieheni vaikutusvalta hammashuollon asioista päätettäessä on ollut uudistusten toteuttamisessa:

erittäin suuri ☐
melko suuri ☐
melko vähäinen ☐
erittäin vähäinen ☐

128. Kunnallisten päättäjien minulle asettamat tavoitteet ovat:

selkeät ☐
epämääräiset ☐
ei näkyviä tavoitteita ☐
ristiriitaiset ☐

129. Tiedän päättäjien johtamiseeni kohdistuvat odotukset:

erittäin hyvin ☐
melko hyvin ☐
en kovin hyvin ☐
huonosti ☐

130. Tunnen asemani ristiriitaiseksi päättäjien asettamiin tavoitteisiin ja odotuksiin nähden:

usein ☐
joskus ☐
harvoin ☐
en koskaan ☐

131. Alaiseni ymmärtävät työnantajan hammashuollolle asettamat tavoitteet:

- erittäin hyvin ☐
- melko hyvin ☐
- ei kovin hyvin ☐
- huonosti ☐

132. Tiedän henkilökunnan odotukset johtamistyötäni kohtaan:

- erittäin hyvin ☐
- melko hyvin ☐
- en kovin hyvin ☐
- huonosti ☐

133. Tunnen asemani ristiriitaiseksi heidän odotuksiinsa nähden:

- usein ☐
- joskus ☐
- harvoin ☐
- en koskaan ☐

Taustakysymykset

134. Sukupuoli

- Nainen ☐
- Mies ☐

135. Syntymävuosi nelinumeroisena (esim. 1966) _____

136. Koulutus

- HLL 1 ☐
- EHL (suun terveydenhuolto tai vastaava) 2 ☐
- EHL (muu ala) 3 ☐
- HLT 4 ☐
- Hallinnon pätevyys 5 ☐
- Vastaavan hammaslääkärin erikoispätevyys 6 ☐
- Muu tutkinto 7 ☐
- Mikä? _____

137. Oliko vaatimuksena virkaan joku tai jotkut näistä tutkinnoista?

- Ei ☐
- Kyllä ☐
- Jos oli, niin mitkä? (numerot) _____

138. Oletko saanut johtajankoulutusta:

- riittävästi ☐
- liian vähän ☐
- ei ollenkaan ☐

139. Onko työnantajasi panostanut riittävästi johtajankoulutukseen?

- Kyllä ☐
- Ei ☐

140. Hakeutuminen johtajaksi?

Olen itse hakeutunut ☐
Olen tavallaan joutunut johtajaksi olosuhteiden pakosta ☐

Seuraavissa kysymyksissä kirjoita vain numero annettuun tilaan!

141. Olen ollut nykyisessä johtajan virassani _____ vuotta.

142. Kaiken kaikkiaan olen ollut johtajana _____ vuotta.

143. Perustyöajastani on:

asioiden johtamista (hallintoa, kokouksia ym.) _____ %

henkilöiden johtamista _____ %

kliinistä työtä _____ %

144. Onko työnkuvasi määritelty, ja mitä velvoitteita siihen sisältyy?

Ei, sillä teen kaiken tarvittavan oman tai esimieheni harkinnan mukaan ☐
Kyllä ☐

Velvoitteita ovat: _____

_____

_____

Oman päätäntävallan rajat

145. Asioita, joista voin päättää itse:

_____

146. Asioita, jotka pitää viedä esimiehen tai johtoryhmän kanssa päätettäväksi:

_____

147. Asioita, jotka pitää viedä päättävien elinten kokouksiin:

_____

148. Mitä muuta haluaisit sanoa näihin kysymyksiin liittyvää tai yleensä julkisesta ja yksityisestä hammashoidosta?

_____

_____

Kiitos vastauksistasi!