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How to analyse human resources in health
The contribution of sociology of professions

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The sociology of professions
Professions and occupations

A profession is a subset of occupations characterised by:

1) **Specialised** competences and skills with a theoretical basis

2) Competences are learned by means of a **long educational and training** process (university)

3) Discretion and **autonomy** in the job

4) **Autonomous responsibility**

Self-governing rule and bodies

Specialised competences, their discretionary use and autonomy in their job provide a legitimacy to:

- **Self-governing work regulation**, defined (or co-defined) by the profession

- **Self-governing bodies** (professional «orders» or «chambers») to rule the profession

In this way, «**professionalism**» is an ideal-type of labour regulation

Professions

Traditional professions: **doctors**, lawyers, judges, priests, architects, engineers

«New» professions: managers, accountants, firm consultants…

Welfare «new» professions (in development): **nurses**, **health technicians,** teachers, social workers…

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Main theoretical approaches

1) **Functionalism** (1930-60; Parsons)

- Professions functional to social system
- **Altruistic** behaviour
- **Trust** relationships with clients

2) **Interactionism** (1950-1980; Strauss, Abbott, Freidson)

- **Intra-professional** segments and **inter-professional** relationships (and conflicts)
- **Jurisdiction**

3) **Neo-marxism** (1970-1980; Oppenheimer)

- **De-professionalisation**

Main theoretical approaches (by and large)

4) **Neo-weberian approach (**1970-2000; Parkin, Witz, Sarfatti-Larson, Freidson, Saks)

- Professions as collective groups struggling for **power** (labour market control and social mobility)
- **Social closure**

5) **New-professionalism** (2000-…; Evetts, Noordegraaf, Adams**)**

- New professions
- **Hybrid** professionalism

Studying the health professions by the sociology of professions
Main potential fields

1) **Professionalisation** process (i.e. nurses, health technicians)

2) The **division of labour** and work organisation in healthcare organisations (task division and shifting; hierarchies…)

3) **Conflicts** between professions and within a profession, concerning:

- income
- power
- status

Studying the health professions by the sociology of professions

4) The **healthcare policy arena**

- Actors
- Institutions
- Ideas

5) The **relationship between state and professions**

- Access to professions (recruitment)
- Professional regulation
- Training
- Control

Social closure

Weber = process by which social groups seek to maximize rewards, by **restricting access to resources and opportunities** to a limited circle of those eligible, according to **certain requisites** (income, education, residency, age, gender, citizenship, ethnicity…)

Social closure is a strategy to

- monopolize resources
- defend a privileged position
- excluding social groups perceived as «inferior» (social exclusion)

Social closure

Parkin (1979; 1985) = social closure is a **strategy by which professions defend their privileged position** in the labour market and on the workplace, **from other occupations** of the same sector

- **restricting access** to specialised education and the profession (entry requirements; restricted quota) to university…; state habilitations)
- **monopolising tasks**
- preserving head positions within organisations
- **excluding** themselves to **external monitoring** and control

Strategies of social closure: Parkin

1) **Exclusion** (by privileged groups)

e.g. doctors towards nurses and other health professions

2) Usurpation (by subordinated groups)

Strategy to gain access to privileged resources

e.g. nurses towards doctors

3) Double closure (exclusion of subordinated groups and usurpation towards privileged ones)

e.g. nurses towards doctors and health assistants

Social closure and gender (Witz, 1982)

Professionalisation and social closure are part of the patriarchal division of labour, which reproduces gender relationships in «traditional» family, with

E.g.

doctors = men

nurses = women

Reproduces the husband-wife relationships

Social exclusion strategies (Witz, 1982)

1) Exclusion

According to Witz: many professions have developed excluding women until quite recent years

2) Inclusion/usurpation

3) Double closure

4) **Segregation**

Occupational segregation

- **Concentration of groups with some charactestics** (gender, ethnicity…) in some occupations and industries
- **Low salaries and status**
- **Poor career prospects**

E.g. women (or migrants) in care services and healthcare lowest positions, or in other services

Medical dominance (Freidson, 1971; 2000)

During the XX Century, the medical profession has gained a **dominant position** in the healthcare sector, both in the policy arena and in the workplaces

Maximum dominance (US and Western Europe): 1930-1970

Some countries may have a different timing

Eastern Europe countries?

Medical dominance (Freidson, 1971; 2000)

According to Feridson, medical dominance is articulated in many dimensions, as a form of **control** over

1) **their work** (tasks, methods, working hours…)

2) the **health service «market»**

- demand (what is health and illness)
- supply (as prescribers and providers)

Medical dominance (Freidson, 1971; 2000)

3) **Patients** (cultural deference)

4) **Medical education** and training (along with the state)

5) **Political decisions** concerning doctors

- Top position in health organisations
- Doctors as ministers and MPs
- Mobilising public opinion

Medical dominance (Freidson, 1971; 2000)

6) **Control over practitioners**

7) **Control over the other health occupations**

- Functional dominance
- Hierarchical dominance
- Scientific dominance
- Institutional dominance (training and selection)

Decline of medical dominance

Since the 1980-90s, many changes would have undermined medical dominance

1) **Managerialisation** (loss of control over their work)

- Managers instead of doctors in top positions
- Control over resource utilisation by doctors
- Increasing workload (clinical and administrative)

2) **End of hierarchical dominance** over other health professions

3) **Hybridisation** of medical profession

Decline of medical dominance

3**) Consumerism**

- end of cultural deference by patients
- disputes and aggressive behaviours against doctors and health professionals

4) **ICT**

- Work standardisation
- Deprofessionalisation

Decline of dominance and its main consequences

If so, decline of medical dominance? Collapse?

- contrasting evidence by research
- prevailing opinion: **partial decline**

However, these changes have certainly contributed to:

A) **loss of power, status (and sometimes income) by doctors**

Doctors as ordinary employees?

Decline of dominance and its main consequences

B) **loss of attactiveness** of the medical profession, in particular **in some «risky» specialties**, with a high workload

- GPs
- Emergency doctors
- Gynaecologists and specialists in obstetricians

C) **Loss of control over health policy**, which contributed to a substantial neglect of the health sector by governments

Negative consequences on:

- Financial resources and investments
- Planning and recruitment
- Wages and working conditions