

Education, occupation, organisation: the dynamics of new occupations in health care

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Overview

- The research domain of new occupations in health care
- Important questions for research
- Theoretical approaches
- Examples
 - practice nurse
 - nurse practitioner
 - physician assistant
- The future



The research domain of new occupations in health care



Exploration of the research domain

<i>System</i>	↑	Educational and occupational system, mobility	↑	<i>Macro level</i>
<i>Organisation</i>		Division of labour, work processes, hierarchy		
<i>Team</i>	↓	Skill mix, multidisciplinary cooperation, productivity	↓	
<i>Individual</i>		Task performance, organisational behaviour		<i>Micro level</i>

Occupations and jobs

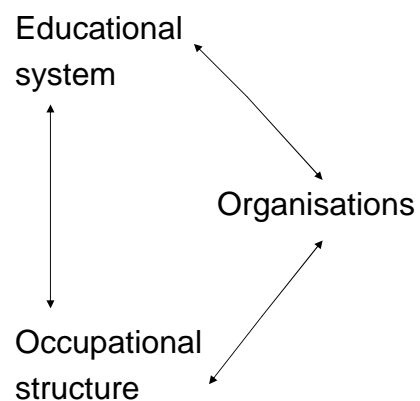
Occupation: a consistent set of work tasks that is to some extent standardised and because of that comparable between work contexts

Job: a combination of (parts of) tasks that has crystallised out within a particular organisation



New occupations in health care

- New occupations often start as jobs embedded within specific organizations
- Organisation-specific training
- Different names for the same jobs and vice versa



Important questions for a research agenda on new occupations



Research questions

- Why do some occupations gain autonomy, a legal status and public recognition while others don't?
- In what type of settings do new occupations work, what are the prospects of independent practice?
- To what extent are health care workers oriented towards the organisation they work in or towards their professional community?
- How do organisational changes affect the chances of new occupations?



Research questions (continued)

- How do changes in the educational system affect the chances of new occupations?
- How do the relationships between new and old occupations develop? How are actual work relations and what areas of work are disputed?
- Are the services of new occupations safe, effective, accessible and patient oriented?
- Are the services of new occupations substituting for services of existing professions or an extension of services?



Theoretical approaches



From single professions to mutual relationships

- Professions that are active in the same area of work form a system
- Professions protect the core of their work against intruders while outside the core they stimulate delegation of tasks



The core of the professional domain

The application of abstract knowledge to the situation of individual clients

1. Intake: does this client have a problem that needs to be solved by a professional?
2. Diagnostics: how can this client's problem be classified within the system of categories of the profession?
3. Inference: based on abstract knowledge and individual situation determine the solution to a client's problem
4. Treatment: actually implementing a solution to the client's problem



Professionalisation as a collective mobility project

By influencing the market order (closure strategies) professions

- Restrict supply of professionals
- Funnel demand to a specific occupation
- Signal quality
- Expand the market for their services

Through professional associations, educational requirements, accreditation

Creating trust with users and 3rd parties



The development of new occupations is influenced by changes in:

- Scarcity
- Technology
- Gendered relationships
- Institutions
- Organisations



Examples of actual developments in the Netherlands



Scarcity: how an impending GP shortage was solved

- There were reasons to expect a shortage of general practitioners
- A large increase in training capacity has contributed to the solution
- But that was not enough!
- Average list size is still very high compared to other European countries: 2322 patients per GP



GPs have started to work more efficiently

- More patient contacts in less time
- Reorganisation of out-of-hours services
- Decrease time intensive services:
 - less home visits
 - no open office hours
 - less involvement in patient's social problems
- Vertical delegation of tasks to practice assistants



From the mid 1980's to 2000: more delegation of tasks to practice assistants

- Triage for appointments for consultation
- Screening (pap smears)
- Care for chronically ill

Problem: educational level too low for further delegation of tasks



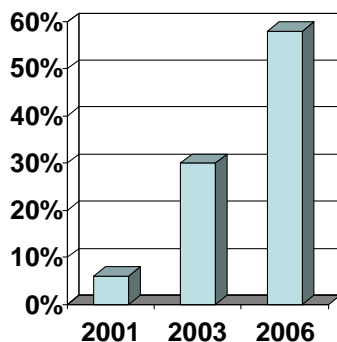
Solution: introduction of practice nurses from 2000

- Practice assistants with additional training
- Nurses with higher vocational training and additional practice nurse training
- Nurses are under the Individual Health Care Professions Act, hence:
 - own professional responsibility
 - liable to tort law

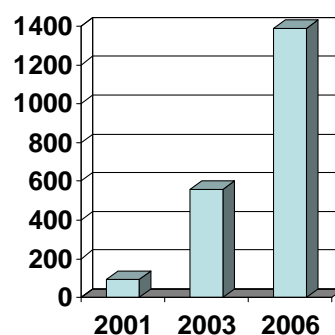


Quick introduction of practice nurses

■ % GP-practices with a practice nurse

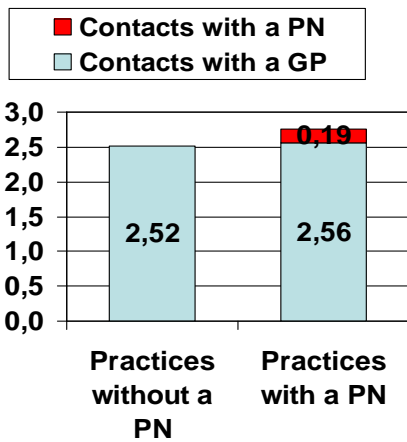


■ number of WTEs of practice nurses

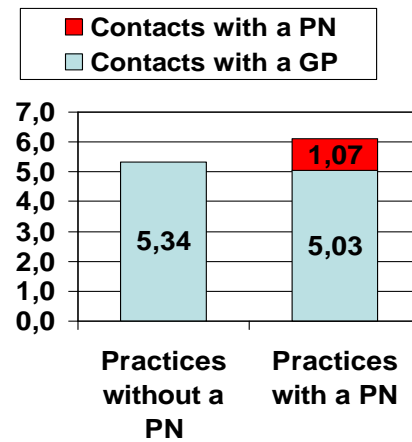


Effect of practice nurses on contacts per patient per year

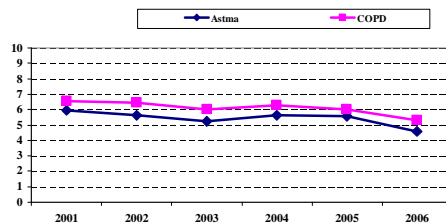
Effect for all patients



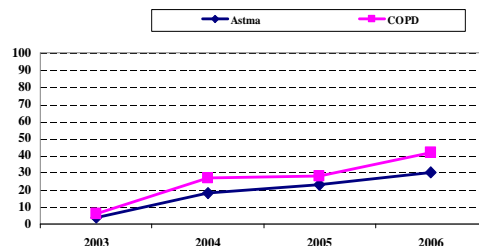
Effect for chronically ill patients



Involvement in care for patients with asthma and COPD



Number of office contacts with GP



Percentage with contact with practice nurse



Second example: the introduction of Nurse Practitioners

- 1997: first education (University hospital Groningen together with vocational training)
- 2000: professional organisation
- 2003: accreditation of education
- 2004/5: official funding for education (jointly by MoH and MoE)
- 2007: nurse prescribing possible in principle (Medicines Act, Individual Health Care Professions Act)
- 2009: recognition of specialisms in nursing; NPs as specialised nurses



Background: again scarcity

- Expected scarcity of medical specialists
- Idem for medical doctors in specialty training
- Phasing out of medical doctors not in training
- European working hours regulation
- Expected scarcity of nurses (NP as a career perspective)



Numbers educated, numbers active, areas of work

- Number in education: 430 (1-1-2007)
- Number active: 635 (1-1-2008)
- Working in:
 - hospitals 75%
 - GP practices 12 %
 - nursing homes 8%

Single biggest area of work is cardiology

- Nursing and medical tasks

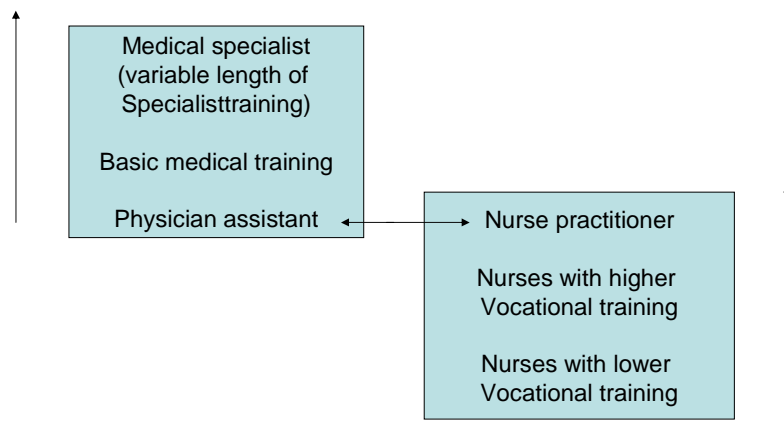


Physician assistants

- Number active: 400 (incl. those in training)
- Mainly medical tasks
- Not recognized in Individual Health Care Professions Act
- Not allowed to do reserved procedures unless supervised



The educational continuum of medicine and nursing start to touch



Technology

- Standardisation of procedures makes reallocation of tasks possible
- Time intensive technical procedures tend to be delegated
- New technology asks for new professions (radiology assistants in the past)
- New educational curriculum for medical engineers



Gendered relationships

- Classical picture of female nurses and male doctors is quickly changing
- Feminisation of medicine might facilitate reallocation of tasks to NPs



Institutions: specialization in nursing, NPs

- Education: Bachelor-Master makes specialisation easier to fit in
- Legal: nurse prescribing legally made possible, nursing specialties recognised
- Policy and ideology: decrease restrictions to entry to health care professions, breaking down closure strategies



Organisations

- Change from functional to process organizations challenges the traditional division of labour in medicine
- Larger organizations increase the possibility of new job arrangements
- And vice versa (scale increasing effect of practice nurses)



The future – driving forces

- Scarcity: increasing and changing demand for care, diminishing supply
- Technology: more standardisation, guidelines, new technology
- Feminization of medicine
- BaMa: linking educational continuum of medicine and nursing
- Organisational structuring of work becomes more important, especially in care chains

