Bulletin of the *Transilvania* University of Braşov
Series VII: Social Sciences • Law • Vol. 6 (55) No. 1 - 2013

SEMI PROFESSION AND NEW PROFESSIONALISM IN THE HEALTH CARE LABOUR MARKET. THE CASE OF ITALIAN HEALTHCARE ASSISTANTS

Elena SPINA[1]

Abstract: *A new occupational profile has come into being in many European countries since the 70s in order to carry out tasks of primary care. The role of "healthcare assistant" officially came into being in 2001 in Italy. As research findings suggest, it cannot be considered as a profession and perhaps not even as a semi-profession. What seems interesting in the Italian case is its hybridization, which represents an occupational trait for Italian healthcare assistant.. They are working in context in which professionalism has changed and therefore with a slight break from the well-established professions.*

Key words: *healthcare assistant, semi-profession, new professionalism, hybridization, socio-health bureaucracies.*

1. Introduction

A new occupational profile has been created within the socio-health systems of many European countries since 1970. The new occupation provides basic care to patients within a context of rationalization, reorganization, downsizing of the welfare systems and the professionalization of nursing.

National pathways leading to the creation of this occupation are very different, despite some common elements. If the primary reason seems to be the same, many different choices have been made by different countries concerning training, work settings and the professional representation system.

The healthcare assistant (called "Operatore socio-sanitario" or OSS) has taken a regulatory definition since 2000s in Italy. However, big differentiation is made among regions: on the one hand, this role could respond to diverse territorial needs, while, on the other, it can limit the development of a corporative identity.

Moreover, working in both the social and health care sector, the Italian OSS finds it difficult to develop a sense of belonging that can compromise the possibility to plan corporative strategies

[1] Research assistant at Università Politecnica delle Marche, Departement of Economic and Social Science. Research member of *Interdepartmental* Research *Centre* on Socio-Health (CRISS).

as well to carry out a social mobility process [7].

The paper presents the main results of a research carried out in a specific local area (Marche Region).

The highlighted occupational traits of the OSS do not allow us to characterize it as a profession and perhaps not even as a semi-profession [3]. However, what is interesting in the Italian case is its hybridization (social and health field) and the fact that, being born within a universalistic system, namely the National Health Service, with a managerial connotation (since the early '90s), it operates within contexts in which professionalism has changed and therefore with a slight break from the traditionally well-established professions (such as the medical profession).

2. The OSS' job profile

This occupational profile is called Social-health assistant (OSS) in Italy. It is currently regulated by two national laws: the State-Regions Conference, dated 22 February 2001 and the State-Regions Conference, dated 16 January 2003.

Similar workers have been present since the 60s in the Italian social and health labour market, although their professional profiles are not closely regulated by the government, and their scope of practice is not clearly defined. In the early '90s, the process of managerialization of the health sector took place, and a similar occupational profile, called "Operatore Tecnico addetto all'Assistenza", was created with the aim to provide basic care.

However, the characteristics of this occupational profile seem better suited to meet health needs and hospital requirements rather than social assistance. In order to have a specialized worker in the social field, different new occupational profiles have been created by the Italian Regions. This has resulted in the fragmentation of the national scenario.

After a long debate on the general reorganization of the health and social sectors, the OSS was established in February 2001.

OSS combines many traits of former occupational profiles including a lot of their tasks and also carrying out a series of additional skills. The Italian OSS can work within the social and health field, in residential or semi-residential care facilities, public and private hospitals and at patients' homes.

Although they work under nursing supervision, the national regulation allows them to autonomously carrying out their activities. They can provide basic care to patients and do simple tasks for diagnostic support and disease treatment. They also observe and note down patients' needs and their harm-risk conditions, evaluating and collaborating for the care interventions [1]. The national law lists the functions and duties of an OSS, distinguishing between activities and skills. It also regulates training pathways and delegates the planning and organization of training courses to the local authorities (regions and provinces).

In order to become an OSS, the acquisition of a license is required. However, no enrollment in a public register or professional organization is required. This means that it is neither possible to quantify the number of Italian OSS, nor is it easy to define the number of them who are employed in the health and social sectors.

In 2003, a new State-Regions agreement regulated "additional training in health care". The law allows them to carry out other functions and tasks posing some problems: what tasks and

functions will this new occupational profile carry out?

What will its occupational domain be? And what role will it play in the socio-professional hierarchy? Faced with this ambiguity, only few Italian regions have currently organized specific training courses for this occupational profile.

For more than 10 years since the OSS was created, this occupational profile has never been object of a sociological study. Recently, however, there seems to be an increasing research interest towards this profile so much so that some empirical studies (mainly at the local level) have been carried out.

3. Methods

An empirical study was carried out in 2011. It was commissioned by the Italian Ministry of Labour and Social Policies with the aim of regulating the social professions. It was organized by the Interdepartmental Research Center on socio-health Integration (CRISS) of the Marche Polytechnic University as well as with the University of Urbino, Macerata and a national research center. The aim of the research was to analyze the structure of the social services sector and the occupational level of its labour market.

The research was made up by organizing eight focus group among OSS (and other professionals working in the social field) who work in different settings. Twenty two semi structured interviews were also administered to privilege witnesses.

The theoretical perspective we have adopted is a historical-relational research approach [14] proposed by Elias (2010) who considers professions as a result of the relational network that individuals weave during their existence. This dynamic network necessarily affects their behavior. This approach bases a profession on its social function and on the ability it has to respond to people's needs [2].

4. Results

Regardless of the field of care in which they work, the OSS seems to use a composite set of relational skills in dealing with patients. First of all, they have an active listening skill, which shows a welcoming attitude. Listening skills and observing patient's behavior brings the assistant emotionally closer to the patient's experience and makes the patient feel at ease in that specific context. The patient's perception about the role of the OSS, which is considered less formal than the other social and health professionals (including nurses), can encourage a close relationship between the two people. Physical contact, resulting from the tasks of hygiene and grooming provided by the assistants, also contributes to a more confidential relationship between the OSS and the patients.

The working environment can also affect the intensity of their relationship. Due to the presence of the patient's family members, at the patient's home there should be greater involvement and a closer relationship can be established. Conversely the hospital environment can sometimes compromise the building of a confidential relationship.

The personal care tasks vary and depend on the work environment and the type of patient. This creates difficulty in identifying the boundaries of the OSS's competencies. Due to the shortage of trained personnel, OSS often has to carry out functions and tasks that do not fall within their jurisdictional domain. Hence, there is the need for the OSS to acquire some 'boundary skills', namely

skills which are at the margins of the functions identified by laws. The perception that healthcare assistants have about their work is affected by the vagueness of the jurisdictional boundaries.

Emphasis on comparing OSS with other professionals involved in the helping process seems crucial in the representation that OSS have about itself role. Therefore the scientific exchange between different professions is considered as an essential tool because it adds value to the activity carried out by OSS, bringing completeness to the patient's clinical picture and contributing to the development of an appropriate treatment plan.

Therefore the construction of a relational network becomes fundamental for a more efficient management of the problems, in order to putting patients at the centre of the helping process.

Although the OSS have a cooperative behavior, the development of cooperative relationships between different professionals is not always easy due to the asymmetric role between them as well as to the organizational rigidity that characterize different work settings.

Depending on the context in which OSS work, the professionals they deal with can change. In hospitals, OSS usually interacts with nurses, who have a higher hierarchical position. Nevertheless, the research shows the existence of a positive interaction between the two professions, even if some tensions emerge due to the nursing profession's opposition to the social mobility project promoted by OSS.
Relationships with the medical staff are often mediated and indirect. They are cooperative and based on the information sharing system. However, communication is not bi-directional: the OSS has to provide information to the medical staff, but the latter rarely exchange their opinions with them. Therefore, the OSS seems to play a mediating role, acting as a bridge between the users' needs and the preparation of a treatment plan.

Even the relationship between OSS and social workers seems to be collaborative. The distance between them seems to be marked by their participation in the two distinct phases of the care process: OSS are less involved in the planning phase, which is carried out by the social workers, while these latter are much more involved in the operative helping process, carrying out basic activities.

Finally, the survey revealed a peculiar aspect concerning the relationship between the OSS and the health educator. In those contexts, where both profiles are working, the relationship is marked by cooperation and based on respect for each other's roles and diversities. When health educators are absent or their number is not sufficient to cover the needs, the professional boundaries are less defined which can sometimes be overstepped by the OSS. As such, the latter can perform functions and tasks that are different from those provided by the law. Therefore, they sometimes carry out educational activities falling within the health educator's professional jurisdiction.

This results in a large and sometimes improper use of this profession, which is often used to compensate for shortage of specialized personnel, i.e., the health educator.

Thus, the scope of action of different professionals who are involved in the helping process seems to be broad and indeterminate.

A clear separation of different roles seems to be limited by the broadness of professional domains as well as by the peculiarities of organizational and

professional contexts. This results in the existence of a "gray zone" which is the points of contact between different occupations (boundary skills). In these situations, the use of a cooperative logic has to be followed during the training phase. However, cooperation and scientific exchange between different professions can be limited by social closure [15] and usurpation strategies [12], which can be implemented by some of them in order to defend the boundaries of their skills or to increase their jurisdictional domain.

5. Some critical points

Empirical research brings to light some critical aspects. First of all, it enables us to perceive the OSS as a not so clearly defined occupational profile due to its uncertain jurisdictional domain. Furthermore, despite legislative efforts to identify its characteristics and skills, the variety of working contexts as well as the ambiguity of tasks performed by the OSS seem to reflect the typical contradictions of a still "in-progress" occupational profile.

Looking at the training system two relevant problems still remain. First of all, an imbalance between the health and social subjects in the educational program (which actually favors the former) seems to emerge. Although this occupational profile has been created to operate in both health and social sectors, the training does not seem to provide sufficient knowledge to work in the social field. The gap seems to be a result of the institutional nature of the training institutions that usually have health connotations which influences their teaching orientation, especially in the apprenticeship program.

Since an OSS has to work in a wide range of situations and contexts, the training should pay more attention to the balance between social and health areas. Focusing on providing health oriented knowledge; it could be the risk to develop a profession with a strong health connotation instead of a hybrid and versatile occupational profile that is able to meet the vast range of users' needs.

The second issue that our survey reveals is the need for a further and more specific learning activity. The current Italian training does not involve the different areas of action that require health and social assistance. Although education should remain broad in order to offer basic knowledge, it seems to hold poorly into consideration the diverse professional contexts and workplaces within which the OSS could work in the future. According to the different areas that make up the healthcare sector, specialized courses could be introduced so as to shorten the current training period.

To sum up, on the one hand the balance between the health and social subject content of education has to be pursued, while on the other hand, more attention to social subjects should be paid, which could be further integrated in the future within a general educational system.

After more than 10 years since the creation of this occupational profile, some doubts and uncertainties still remain. On the one hand, the ambiguity of the national legislation offers some margin of autonomy to the local authorities to better meet local needs. On the other hand, the legislation makes an already indefinite situation more uncertain. While respecting the national legislation, each region has to regulate the matter by delegating training to provincial governments. Therefore, while the creation of this occupational profile came from the need for a reorganization of the social professions, the level of

autonomy granted to the local governments has maintained a high degree of territorial fragmentation, creating new problems

6. What professional status for the Italian OSS?

Using the traditional sociological approaches the research findings do not allow us to define the Italian Healthcare assistant as a profession.

From a neo-Weberian perspective, lack of corporatism, as well as the absence of formal institutions (that can allow the activation of corporative strategies) seem to limit the recognition of professional status. Even according to the functionalist theory, the OSS cannot be defined as a profession because of the absence of many traits that give them a professional status (autonomy, long formal training, body of knowledge, high income, etc.). At the most, the OSS could be considered as a semi-profession because their “training is shorter, their status is less legitimated [...] there is less of specialized body of knowledge, and they have less autonomy from supervision or societal control than profession" [3].

However, adopting Elias’ analytical approach, the conditions for granting a professional status to the OSS seem to be changing. As the empirical analysis has shown, the OSS is able to respond to patients’ relational needs as well as to weave a dense relational network with other professionals. These skills seem to be useful for the construction of a professional identity, giving them a sense of belonging, which typically characterize well-established professions.

However, one limitation to the full professionalization of the OSS could be found even in Elias’ analytical perspective. As this survey shows, the care process has different connotations depending on the type of the user who interacts with the assistant and the specific social or health care sector. This suggests that the OSS’s occupational profile is characterized by dualism: those who work in the health field seem to be much more influenced by their workplace context, weaving strong relationships with the social and professional environment. Here, their activity seems to be defined as the completion of the work done by other professionals (usually the nurse). Conversely, those employed in the social field appear to be less involved in their dynamic environment. The less involvement of the OSS in the latter field seems to arise from a greater distance between the different professionals involved in the helping process (the health educator and the social worker in particular).

Lack of attention paid towards the organizational aspects of work as well as lack of specific care settings, could generate a profession that is unable to meet environmental stimuli, compromising its ability to meet the users’ needs.

Given this situation, it could be argued that a limitation to the full professionalization of the OSS can arise from its dualism and the lack of being able to adapt to specific care settings. If this is true, then the existence of a gray area that defines the occupational space of semi-professions would be contemplated in Elias’ approach.

Apart from the problem of defining the professional identity of the OSS and in view of the debate on the new professionalism [4], [9], [13], what is interesting to note is the hybrid nature [10], [11] of this occupational category.

This hybridization, related to the coexistence of professional and organizational characteristics [6], appears to be a distinctive and fundamental trait of the OSS, as its occupational profile has been specifically created in order to work within professional bureaucracies. Thanks to its origin, no adaptations to managerial logic are required: by representing a constitutive trait, hybridization does not occur by activating a process, as in the case of well-established professions (e.g., doctors, nurses, etc.) which have to confront with new issues (hierarchy, bureaucracy, control of performance and output, etc.), re-negotiating their sphere of autonomy.

Therefore, if on the one hand, the OSS seems to find its ideal habitat in social and health bureaucracies, on the other hand, it may also run the risk of being dominated by outside forces (bureaucracy and market) that can compromise its professional growth. It could be possible to place this occupational category within the discourse on "professionalization from above" [8] used by bureaucratic organizations to exercise forms of supervision and control over professional work, putting the organization's objectives before those of professional groups [5].

Given the current situation, what is the future of this occupational category and what are the constraints and opportunities that the current scenario?

On the one hand, we can assume that the peculiarities of each field of assistance can fragment the category and slow down the process of construction of a collective identity. On the other hand we can imagine that the hierarchical and bureaucratic logic that permeates the Italian health care system can become a tool for raising the professional status of the OSS. At the same time, a way to escape bureaucratic control and to acquire a greater degree of autonomy for the OSS can facilitate group cohesion and foster the possibility to engage in real corporate strategies.

References

1. Benci, L.: *L'Operatore Socio Sanitario: autonomia, rapporto con i professionisti e responsabilità giuridica.* In: Rivista di Diritto delle Professioni Sanitarie, 2001, n. 3, p. 219-234.
2. Elias, N.: *Marinaio e gentiluomo. La genesi della professione navale*. Bologna. Il Mulino, 2010.
3. Etzioni, A.: *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers*. New York. The Free Press, 1970.
4. Evetts, J.: *Reconnecting professional occupations with professional organizations: Risks and opportunities*. In: *Sociology of professions: Continental and Anglo-Saxon traditions*, Svensson, L., Evetts J. (eds.). Göteborg, Daidalos, 2010, p. 123-144.
5. Evetts, J.: *A new professionalism? Challenges and opportunities*. In: Current sociology, 2011, Vol. 59(4), p. 406-422.
6. Faulconbridge, J.R., Muzio, D.: *Organizational professionalism in globalizing law firms.* In: Work, employment and Society, 2008, Vol. 22(1), p. 7-25.
7. Larson, M.S.: *The rise of professionalism: a sociological analysis*, Berkeley. California University Press, 1977.
8. McClelland, C.E.: *Escape from freedom? Reflections on German professionalization 1870-1933*. In:

The formation of Professions: Knowledge, State and Strategy, Torstendhal, R., Burrage M. (eds.). London, Sage, 1990, p. 97-113.
9. Muzio, D., Kirkpatrick, I.: *Introduction: Professions and organizations – a conceptual framework*. In: Current Sociology, 2011, Vol. 59(4), p. 389-405.
10. Noordergraaf, M.: *From pure to hybrid professionalism: Present-day professionalism in health care*. In: Public Administration, 2007, Vol. 86(4), p. 1055-1069.
11. Noordergraaf, M.: *Remaking professionals? How associations and professional education connect professionalism and organization*. In: Current Sociology, 2011, Vol. 59(4), p. 465-488.
12. Parkin, F.: *Marxism and class theory: a bourgeois critique*. London. Tavistock, 1979.
13. Saks, M.: *Defining a Profession: The Role of Knowledge and Expertise*. In: Professions & Professionalism, 2012, Vol. 1, p. 1-10.
14. Vicarelli, G.: *Per un'analisi storico comparata della professione medica*. In: Stato e Mercato, 2010, n. 90, p. 395-424.
15. Weber, M.: *Economia e società*. Milano. Edizioni di comunità, 1961.