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HOW NEW HEALTH OCCUPATIONS COME TO BE: EXPLORING THE SOCIOPOLITICAL ECOLOGY OF THE HEALTH CARE WORKFORCE

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Sociologists report rapid growth in US health sector employment but rarely note that new health occupations have also increased in number and salience. Nine of 24 newly recognized occupations in 2010 were in healthcare; and 80% of comments on the BLS' recent reclassification focused on such occupations. A political economy perspective proposes a typology of how occupations start aligning them with Alford's 3 major US interest group coalitions: corporate rationalizers, professional monopolists, and equal health advocates. Structural features within the US health (non-) system affect when and how occupational groups start, survive, and function. Quantitative analyses and schematic case studies of recently established health occupations reveal efforts to neutralize rival claimants' to their core tasks and to address concerns of key stakeholders within US health workforce policy environment. New occupations must be: legally permitted, clinically sound, financially feasible, liability risk minimizing, community responsive, definable as a job, reproducible, and credible to patients. Seven key stakeholders involved each typically aligns across the 3 major interest group coalitions. The implications of founding sponsorship of an occupation on how its various tasks come to be defined, how different occupations engage in team functioning, and the way in which services are delivered are examined. Secular trends suggests increasing corporate dominance in the health sector has shaped how new occupations are initiated, sustained and decline. The institutionalization of new health occupations is exemplified by describing an emerging occupation tasked with moving patients across care settings (e.g., hospital to nursing home). Corporate rationalizers sponsor "transition coordinators" to enhance efficiency by smoothing care transitions to generate a predictable income stream. Professional monopolists sponsor "patient navigators" who extend professional jurisdiction by fitting into the existing clinical hierarchy. Community health advocates sponsor "patient advocates" who empower patients and communities through broadening the definition of health.

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