NEO-WEBERIANISM AND CHANGING STATE-PROFESSION RELATIONS
The case of Canadian health care

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Abstract Professions now operate in a more critical modern Western societal context. This has typically led to a major political challenge by the state to the self-regulation of such groups. It is argued, though, that the reasons for this are more complex than a knee-jerk reaction to the growing number of emerging professional scandals. Accordingly, tools are provided from a neo-Weberian perspective to analyse changes in state-profession relations — bringing state actors to the fore in a novel way. Their application is illustrated mainly through a case study of Canadian health profession regulation.

Keywords: health care, neo-Weberianism, professions.

Resumo As profissões operam hoje de maneira mais crítica no contexto da sociedade Ocidental moderna. Isto tem tipicamente levado a um maior desafio político para o estado no que toca à autorregulamentação de tais grupos. No entanto, é defendido que as razões para tal são mais complexas do que uma reacção automática ao aumento do número de escândalos profissionais emergentes. Em conformidade, ferramentas são dadas da perspetiva neo-weberiana para analizar as mudanças nas relações estados-profissão—trazendo atores do estado para a frente de maneira nova. Esta aplicação é ilustrada maioritariamente através de um caso de estudo da regulamentação das profissões da saúde no Canadá.

Palavras-chave: saúde, neo-weberianismo, profissões.

Résumé Les professions agissent aujourd'hui d'une façon plus critique dans le contexte de la société occidentale moderne, ce qui a conduit à un plus grand défi politique pour l'État en ce qui concerne l'autorégulation de ces groupes. Cependant, les raisons à cela sont plus complexes qu'une simple réaction automatique à l'augmentation du nombre de scandales professionnels qui ont éclaté. Plusieurs outils sont donnés du point de vue néo-weberien pour analyser les changements dans les rapports État-professions —en mettant en avant des acteurs de l'État sous un jour nouveau. Cette application est illustrée majoritairement à travers un cas d'étude de la réglementation des professions de la santé au Canada.

Mots-clés: santé, néo-Weberianisme, professions.

Resumen Hoy en día, las profesiones operan de manera más crítica en el contexto de la sociedad occidental moderna. Esto ha provocado un mayor desafío político por parte del Estado en lo relacionado a la autorregulación de tales grupos. Sin embargo, se defiende que las razones para tal son más complejas de lo que una reacción automática al aumento del número de escándalos profesionales emergentes. En este sentido, son dadas herramientas de la perspectiva neo-weberiana para analizar los cambios a las relaciones Estados-profesión—movilizando para un primer plano a actores del Estado de manera novedosa. Esta aplicación está ilustrada en gran parte a través de un caso de estudio de la regulación de las profesiones de salud en Canada.

Palabras-clave: salud, neo-weberianismo, profesiones.

Introduction

State-profession relations have changed substantially in many Western nations over the last few decades — not least since the 1960s and 1970s counter culture when public, political and academic opinion first started to turn against the professions (Roszak, 1995). In the wake of this challenge, in most countries the powers of professional self-regulation have been significantly curtailed, if not actually eliminated, even in classic areas such as law and medicine (see, for example, Flood, 2011; Saks, 2015). In political and public discourse, professionals and professions have been cast as self-interested, often putting their own interests — or the interests of powerful clients — ahead of the public interest (Abel, 2003; Paton, 2008). Tales of professional misconduct have been recounted, providing evidence for many that traditional patterns of professional regulation are flawed, and must be fundamentally redrawn (Dixon-Woods, Yeung and Bosk, 2011; Muzio et al., 2016). In several nations they have been (see, for instance, Chamberlain, 2013; Paton, 2008) — and some argue that the scandals surrounding events such as the Shipman serial killings in health care in Britain (Kuhlmann and Saks, 2008) and the corporate Enron fraud in America (Coffee, 2006) revealed the depth of professional misconduct, forcing the state to intervene to reconsider the lines of professional regulation to reduce the power and autonomy of professions.

While this narrative is compelling, we argue that its assumptions can be seen as simplistic. Professions and professionals are cast as power-hungry villains, while state actors are disinterested heroes who step in to save the day to protect the public. The problem with this version of the story is at least three-fold. First, regulatory transformations are not simply the result of scandals, as change has occurred even in contexts without the dramatic scandals witnessed in Britain and elsewhere. Second, this account of professional change does not capture variations across societies. While professional self-regulation has been curtailed in Britain and Australia, it has not disappeared (Evetts, 2002; Lester, 2016). In countries like Canada and the United States professional self-regulation persists and is being extended to new professional groups, even though additional layers of regulation and accountability have been introduced (Adams, 2017). Although trends to de-regulation exist in some countries, therefore, there is much evidence of increased regulation in others (Schneiberg and Bartley, 2008). Third, the tale fails to capture the complex interests and concerns of the key social actors. Notably, there is a growing body of socio-historical evidence suggesting that state actors are not simply disinterested heroes, checking the behaviour of self-interested professionals to protect the public, but rather may have their own agendas — including pursuing regulatory change for reasons that appear to be politically, ideologically, and financially motivated (Abbott, 2005; Abel, 2003; Saks, 2015). The complex drivers of state actors have therefore been downplayed in sociological theorising and research on professions.

To capture the importance of actors' interests and values in professionalisation (and deprofessionalisation) processes we have developed an innovative neo-Weberian approach (Saks and Adams, 2016). This approach builds on the work of Weber and other neo-Weberian scholars on social action, rationality and the state

to expand neo-Weberian theorising on professions, and reveals the role of values and ethics in shaping professionalisation, in addition to group self-interests. We argue that this approach provides a more comprehensive and balanced interpretation of recent changes to professionalisation and professional regulation, and reveals the confluence of concerns — beyond simply scandals and suspicion — that underlie them. In this paper we first provide an outline of the tools developed in our theoretical approach. Then we apply this framework to recent regulatory change affecting health care professions in Canada to indicate how this approach is better able to capture the complexity of regulatory change across societies.

Neo-Weberian theory and professional regulation

Although there are perspectives on professions based on positive features such as their knowledge base and altruism (see, for instance, Greenwood, 1957; Wilensky, 1964), more recent researchers have frequently turned to neo-Weberianism to understand the process of professional development (Saks, 2012). In contrast to earlier more deferential perspectives, this approach argues that organised professional groups strive to improve their market conditions in the face of competition by pursuing exclusionary social closure, wherein they restrict access to education, credentials and opportunities to practice with the support of the state (Saks, 2010). Professional groups thereby lobby the state to achieve and maintain various forms of legal monopoly, which result in a privileged place in the market for their services in terms of income, status and power. Scholars working from a neo-Weberian perspective have demonstrated how in concrete socio-historical circumstances, professionals have successfully mobilised and utilised social closure strategies to marginalise their competitors and achieve their goals (see, for example, Burrage, 2006; Parkin, 1979; Parry and Parry, 1976).

Nevertheless, despite its current popularity, the neo-Weberian approach has not escaped criticism. Saks (2016), for instance, has argued that its proponents have at times been unduly critical of professional groups, producing a caricature of power-hungry groups with little care for others — without sufficiently drawing on empirically-based arguments. Moreover, while the approach highlights the importance of the state, it all too rarely theorises state activity; neo-Weberian scholars often ascribe a role to the state, but typically do not examine state activity closely, or provide evidence to substantiate their claims. Early work depicted state actors as simply acquiescing to professions' demands for power (Gilb, 1966). More recent studies suggest that professions are being undermined by their own excessive demands and changing public opinion, as well as increased corporatisation and marketisation (see, for instance, Abel, 2003; Light, 2010). In both old and new depictions the state is usually seen as reactive — responding to the demands of professions, the public, corporations, and others. State actors are not therefore typically cast as multi-faceted players with interests of their own.

To overcome this and other limitations, some neo-Weberian scholars of the professions have turned to Foucault (Johnson, 1993; Larson, 1990). His work on

governmentality has been seen as helpful in this context as it explores state-profession relations (as illustrated by Foucault, 1991). For Foucauldians, modern governance rests on expertise and knowledge, and the institutionalisation of expertise through the independent professions is seen as integral to the emergence of the modern state (Evetts and Dingwall, 2002). In this manner, professions may be seen to contribute to social governance. At first blush, this theory appears to advance our theorising by suggesting that the state has something to gain from professional regulation. However, the Foucauldian approach does not live up to its promise as it similarly does not explore state actors' decision making, as opposed to simply asserting that professions contribute to governmentality. Both the creation of professions historically, and recent changes to professional regulation, are ascribed to the same overarching trend — governmentality (see, for example, Johnson, 1995). As such, Foucauldians see governmentality as a social process occurring independent of the intentions of state actors. Moreover, its proponents tend to see professions as part of the state system broadly defined, thereby collapsing professions into the state, and making it difficult to examine state-profession relations. The end result is that state activity respecting the development of professions remains murky.

It should also be noted that this approach therefore does not enable the enquirer to overcome the difficulties posed by the structural Marxist approach to professionalisation, to which some neo-Weberians have also turned in the more critical climate on professions to enhance their conceptualisation of state-profession relations (see Johnson, 1977; Larson, 1977). This views professions more explicitly in terms of the class structure of capitalism based on the ownership of the means of production, in contrast simply to the relations of the market. Although there is some diversity of thought here, most such contributors see professions as having gained their privileged standing from serving as agents of social control for capital (as exemplified by Poulantzas, 1975) or as a segment of the capitalist class itself (as illustrated by Navarro, 1986). However, just as with Foucauldianism, this does not provide an effective escape route for neo-Weberians as a structural Marxist approach does not endeavour to examine the role of state actors in the process — instead tending to view the state as serving the long-term interests of the capitalist class, in a tautological manner immune to counterfactual analysis (Saunders, 2007). To overcome these limitations, and shed new light on state-profession relations, we return to Weber and neo-Weberian theorising of social action, the state, and rationality.

Social action, rationality and the state

Weber (1968: 54) defined the state as "a compulsory political organization with continuous operations… [whose] staff successfully upholds the claim to the monopoly of the legitimate use of physical force in the enforcement of its order". The modern state was seen as highly bureaucratised, and it had many different components, from the state leadership and its advisory role to the parliament or legislative assemblies, and a variety of offices. Thus, for Weber, the state was not a single entity, but a complex of institutions and actors. To understand state activity, Weber

believed, the actions of state actors and/or politicians had to be examined within these institutions. The state was not an actor, but an entity composed of actors. In his words, "When reference is made in a sociological context to a state, nation, a corporation… or to similar collectivities, what is meant is… only a certain kind of development of actual possible social actions of individual persons" (Weber, 1968: 14). Thus, Weber tells us, to understand state activity and decision making — respecting the regulation of professions and other matters — we can draw on his theory of social action, and the forces that shape it.

For Weber (1968), social action was of crucial importance for sociologists. Social action consists of meaningful behaviour, which is oriented in some way towards others. In *Economy and Society,* Weber (1968) identified four types of action, although he claimed his typology was not exhaustive. The first two types were "rational" as they capture conscious, goal-oriented activity. First, instrumentally rational action is pursued to achieve "calculated ends". Second, value-rational action is tied to values or principles, and is pursued because it is "the right thing to do" rather than because the action will achieve a specific outcome or end. Other types of action noted by Weber are less intentional: Affectual/emotional action is prompted by emotions or tastes, while traditional action is the product of ingrained habit (Kalberg, 1980; Sterling and Moore, 1987; Weber, 1968).

Rational action is shaped by rationalisation processes, of which Weber discussed four types: practical, theoretical, formal and substantive rationality (Kalberg, 1980). By rationality, Weber means the "means-ends calculations that determine how decisions are made" (Geva, 2015: 172). Weber's discussion of rationality, beyond formal rationality, remains incomplete (Sterling and Moore 1987), but several scholars have drawn on references to rationality peppered throughout Weber's work to produce a more coherent theory (see, for example, Kalberg, 1980; Sterling and Moore, 1987). Still, interpretations of rationality — and especially substantive rationality — are controversial (Brubaker, 1984; Eisen, 1978). Our own interpretation relies heavily on Kalberg (1980), but is also influenced by the work of Sterling and Moore (1987) and Geva (2015).

For Weber, formal rationality is guided by rules, laws or regulations. Formal rationality became more common with the emergence of industrial societies and is associated with bureaucracy — and may have emerged as the dominant form of rationality in the modern world. In contrast, substantive rationality orders action in accordance with social values, such as duty, honour, loyalty, ethics, and religious beliefs (Kalberg, 1980; Weber, 1968). Substantive rationality is tied to societal beliefs of right and wrong, or "what ought to be" including principles of justice (Geva, 2015; Sterling and Moore, 1987). While formal rationality is in accordance with dominant rules and structures, substantive rationality can vary by social location: what seems rational from one set of values may be irrational from the point of view of another (Brubaker, 1984; Eisen, 1978; Kalberg, 1980). Other forms of rationality include practical rationality, which involves a simple calculation of what course of action is most expedient in a given set of social circumstances (Kalberg, 1980). In contrast, theoretical rationality is less directly tied to action, but rather involves the philosophical search for meaning, which may in some circumstances

shape behaviour (but need not do so). All forms of rationality co-exist, and may shape each other, and may combine to shape social action.

It is the concepts of substantive and formal rationality that scholars have found most powerful in capturing state activity. Laws and social policies are shaped not only by bureaucratic structures, regulations, and means-ends calcula- tions, but also by social values about what is right and wrong. At the same time, it is important to recognise the existence of practical and theoretical rationality. Re- searchers have utilised these ideas to examine the dynamics of legal systems (Ster- ling and Moore, 1987), and more recently to explore the enactment of policies that are gendered and racialised (Geva, 2015). Moreover, social commentators are in- creasingly noting that modern policy making is shaped by public opinion. To un- derstand social action more generally, and policy making in particular, scholars should therefore explore the influence of interests, values, and principles.

This may be particularly valuable in the present case — the exploration of professional regulation and the formation and development of professions. Draw- ing on social closure theory, some writers on the professions have treated profes- sionals as actors consumed with formal rationality and instrumental action — cutting off wider access to resources and opportunities to maximise their incomes and social authority (see, for instance, Witz, 1992). In this vein, Roth (1974) and Haug (1980) see the claims of professions to serve the public interest simply as at- tempts to delude the public, in order to facilitate their drive for higher income, sta- tus and power. However, adopting the insights of neo-Weberian social action theory, we can recognise that the interests of professionalising groups may be com- plex, shaped by formal and value rationality, as well as potentially other dimen- sions. Professionals may be committed to the public interest, and honour-bound to act in accordance with an ethical commitment based on oaths to protect their pa- tients and clients, whilst endeavouring to obtain an enhanced market position. Substantive rationality and formal rationality are therefore not necessarily contra- dictory and can combine to shape action.

These insights are especially ground-breaking when applied to state actors, whose actions, we have argued, are often ignored in studies of professions. State actors may possess a variety of interests and values that shape their activity with regard to professions in specific socio-historical circumstances. The decision of leg- islators to regulate or de-regulate professions can be shaped by political interests, practical concerns, rational-legal constraints, and a variety of values and beliefs (see also Abbott, 2005). Our expanded neo-Weberian theory not only turns atten- tion to state actors and their interests, but generates empirical questions about what factors are most salient in specific situations, when legislators and pol- icy-makers consider professions and their regulation. We argue that a focus on state activity provides new insights into the shifting nature of state-profession rela- tions, the changing nature of professional regulation, and variations across time and place.

The empirical case study: regulatory change in Canada

To demonstrate the value of our expanded neo-Weberian approach to professional regulation, we review legislative change affecting health care professions in Ontario, Canada. We examine the legislative debates to explore the interests and values that seem to shape state actors' decision making in relation to the regulation of health care professions. We argue that these debates reveal that the actions of legislators are complex. State actors are not simply responding to the demands made by professional groups and other interested parties when they legislate. Nor are they solely concerned with formal rationality, or extending the state's reach through governmentality. Rather, their actions are shaped by these concerns and many others, from personal experiences to political demands, and from practical-rational considerations of expediency to value-rational concerns for justice, equity, trust, autonomy, choice and the oft-mentioned "public interest".

In Canada most professional regulation occurs at the provincial and territorial level. In the province of Ontario, health care professions are governed by the 1991 Regulated Health Professions Act (RHPA). This umbrella legislation, and the Acts respecting each individual regulated profession accompanying it, regulates 26 health professions in the province. When it was passed, the Act was innovative as it not only standardised professional regulation in the province, but altered the focus of that regulation. Although self-regulating health professions continued in the province, the focus of regulation shifted somewhat from the group to the task. The Act, based on the Health Professions Legislative Review (HPLR, 1989: 4), identified 13 "potentially harmful acts and procedures", which would henceforth be defined as "controlled tasks" — such as "administering a substance by injection or inhalation" and "performing a procedure on tissue below the dermis". Only regulated health professions would be granted the right to perform these tasks. Some tasks were widely shared across regulated groups, like the aforementioned "performing a procedure below the dermis". Others were specific to a more narrow range of professionals — like prescribing a hearing aid, or fitting a dental prosthesis. The most highly controversial controlled procedure was "communicating a diagnosis" which, under previous regulatory regimes, only medical doctors and dentists could do (O'Reilly, 2000). The 1991 RHPA granted five professions the right to perform this controlled act: medical doctors, dentists, optometrists, chiropractors and psychologists. Other regulated groups were only allowed to make "assessments". Despite these controversies, the Act was viewed as introducing more flexibility into the health care system, as scopes of practice were opened up and many tasks could be performed by a variety of professionals (O'Reilly, 2000). As a result, the new regulatory system appeared to be both more cost effective and fair.

The RHPA 1991 was the product of extensive investigations, discussions, and debate. Although legislation regulating health professions had been overhauled in the 1970s after an extensive review, there was a sense that the regulatory framework was not working. Inter-professional conflict was evident. The provincial Minister of Health was inundated with requests for legislative change by both established and aspiring health professions (O'Reilly, 2000). The government was

also concerned that health care costs continued to rise and the system did not appear to be as effective or efficient as it could be. Further, there was pressure from consumer groups, and hospital administrators clamoured for change too. In response the Conservative provincial government established the HPLR appointing Alan M. Schwartz, a Toronto lawyer, to lead it. The HPLR was asked to determine which professions — both current and aspiring — should be regulated, and to develop a new structure for that regulation (O'Reilly, 2000).

This review spent several years holding hearings with interested parties, from aspiring and established professions to consumer groups, patients' rights groups, religious organisations, women's groups, and others. The HPLR finally reported its recommendations in 1989. By this time, there had been a change in government, so Premier David Peterson's Liberals accepted the report and began meeting with health professionals and other interested parties to get feedback, and to develop new legislation. The Liberal government presented their bill — the Health Professions Regulation Act — for its first reading in June 1990. The Bill did not proceed as the legislature was recessed later that month, and a September election called.

The New Democratic Party (NDP) formed the next government in the fall of 1990, and in April 1991 they introduced the RHPA — which was very similar to the legislation previously drafted and presented by the Liberals. The Bill was the subject of public hearings, and legislative committee debate and revision in the succeeding months. The Bill passed with little controversy in November 1991. Since health care reform was begun by the Conservative Party in the early 1980s, and developed further by the Liberals in the later 1980s, before the RHPA was introduced by the NDP government, there was a remarkable amount of inter-Party unity and consensus. Members of all three parties were behind the Bill, even if they sometimes disagreed over particular clauses. Most of the interest groups consulted about the Act also supported it. Although some lively debate appears to have occurred behind the scenes in committee meetings, on the floor of the Provincial Parliament, members extolled the virtues of the Act, and highlighted the important principles behind it. Their comments reveal the variety of interests, concerns, and values that shaped the legislation.

A look at legislative debates provides some support for traditional neo-Weberian accounts of profession creation. The RHPA was strongly shaped by the lobbying of established and aspiring professional groups. The HPLR considered the claims of over 75 occupational groups seeking status as self-regulating professions (O'Reilly, 2000; HPLR, 1989). In the end, only 24 were included in the 1991 Act, although legislators promised that naturopaths would be included in the years to come. Several non-regulated occupational groups formed a coalition to lobby for their own interests, most notably to ensure that professional regulation did not impede their ability to perform their work. Neo-Weberians have long contended that professional regulation is spurred by professional and professionalising groups seeking state recognition in pursuit of social closure. These groups certainly played an important role in shaping the RHPA. Nonetheless, the government was sceptical about exclusive scopes of practice, and pushed professions to be more collaborative in their aims and goals.

There is also evidence of formal rationality as one of the goals of the legislative change was standardisation and formalisation of laws and regulations. With the RHPA, all regulated health professions would be governed by the same overarching legislation, including the same principles and guidelines. This standardisation was unprecedented in the province. Moreover, it is clear that legislative change was motivated by a concern with system efficiency. The previous system of health care regulation was said to contribute to inflexibility, inefficiency and high costs. This new model was believed to be more flexible and efficient (HPLR, 1989). When discussing the RHPA, legislators also expressed some concern over the cost of regulation. Self-regulation was generally inexpensive since practising professionals supported their regulatory bodies financially. However, the RHPA proposed additional layers of accountability and a government advisory board — the Health Professions Regulatory Advisory Council (HPRAC). Minister of Health, Frances Larkin, anticipated that cost savings from a more efficient health system would offset any new costs. Generally, in legislature debates, state actors demonstrated concern for efficiency, cost, standardisation, and formalisation — means-ends concerns consistent with formal rationality.

Nonetheless, these considerations were intertwined with other values, principles and issues, which received far more consideration in legislators' speeches. Discussions of cost were few and far between, and even when mentioning cost, legislators dismissed it as less important than the broader principles at stake. Rather, emphasis was placed on rights and values. The Act itself was said to be vitally important because of its link to Canadian values. As Gerry Phillips, a member of the Liberal Party, said in May 1991: "If there is one thing that sets Ontario and indeed Canada apart, it is the quality of our health care system, as all of us know and appreciate". Upon introducing the Bill for first reading in April 1991, the then Minister of Health, Evelyn Gigantes, framed it in terms of rights:

> Consumers… have the right to receive health services that are competently performed, services which suit their needs and choices. On the other hand, health professionals have the right to work in a system that is equitable and in which their autonomy is respected and their contributions recognized.

Gigantes also argued that there was "a need to introduce greater flexibility into our health delivery system and to have a system that carries the values of equity and fair opportunity". The legislation, then aimed to achieve specific rights and to reflect specific values. Gigantes and others claimed that the regulatory structure that best achieved these values was professional self-regulation, but this "system of self-governance" must be "more open and accountable".

Throughout the discussion of the legislation at first, second, and third reading these principles and others are mentioned by legislators regardless of party or background. All speakers on the legislation agreed that the primary and overriding interest must always be the public interest. However, legislators like Caplan and Gigantes also spoke of the need to "balance… the rights of the individual professional, the rights of the professions and the rights of the

consumer". One of the goals of this Act was to even the playing field in the system of professions, to render it less hierarchical and to expand the rights and privileges of formerly subordinate health care professionals such as nurses. While legislator Reville spoke of these changes as a reduction of "medical hegemony", the Act did little to undermine the traditional privileges of dominant professions. The emphasis was more on raising female-dominated professions to a similar status. One of this Act's great achievements, according to some legislators, was its recognition of midwifery as a self-regulating profession in the province for the first time. This was seen as a triumph of feminism, and consumer movements, as well as professional projects. Several women in the legislature, including Caplan, Gigantes and Lankin spoke in glowing terms of this change, and the RHPA generally, as a triumph of feminism and a victory for women who would now have more choice when giving birth.

One over-riding goal of the legislation was to allow consumers "freedom of choice within a range of safe options" (HPLR, 1989: 6). Another innovation in the Act that would benefit consumers concerned the new Quality Assurance mechanisms, which mandated continuing education and greater monitoring of the skill enhancement activities of professional practitioners. In the words of one member of Provincial Parliament, Paul Wessenger: "the public must be protected from unqualified, incompetent and unfit health care providers to the greatest extent possible … [and] there must be mechanisms in place to encourage the provision of high-quality care". Consumer choice and quality services were therefore core values or principles in the new legislation. The public was also seen to benefit from measures to increase professional accountability, including the expansion of lay membership on regulatory councils and disciplinary boards, and on the new HPRAC.

"Balance" was a term used frequently by legislators when discussing the legislation. One major goal of the RHPA was to balance the interests of consumers, regulated professions, non-regulated groups, members of all three political parties, and other interest groups such as those representing people with disabilities and Aboriginal groups. Moreover, legislators sought to reduce hierarchies through the legislation, and recreate more balance or equity amongst health professions. The Act sought to minimise "turf wars" amongst professions and facilitate co-operation. Legislators were willing to grant professions the autonomy and power to regulate themselves as long as they did so in the public interest, and balanced their own interests with the interests of the public. Balance, then, was an explicit goal of the legislation.

Legislators also spoke of trust and fairness. They were willing to "trust" professional groups to regulate themselves, as long as there were mechanisms in place to keep regulatory bodies accountable. Trust was even one of the criteria used by legislators and policy advisers in the HPLR (1989) when deciding who would be granted self-regulation under the RHPA. One member of the Provincial Parliament, Ernie Eves, summarised the criteria as follows:

(1) Responsibility for the profession falls within the mandate of the Ministry of Health; (2) regulation is necessary because the profession's activities pose a risk of

harm to patients, the profession's members are not supervised by another regulated profession, or there is no other mechanism to regulate the profession; (3) the profession has a body of knowledge that can form the basis for standards of practice; and (4) the profession is able to regulate itself, in that its leaders are able to favour public interest over professional self-interest, its members will comply with professional standards and rules, and its members are willing to bear the cost of self-regulation.

Thus, in regulating professions legislators considered a number of factors including knowledge, risk of harm to the public, and the ability of professionals to put the public interest first, as well as their ability to afford the cost of self-regulation. Legislators and policymakers considered whether professionals could be trusted to put the public's interest before their own.

By and large the principle of self-regulation was not challenged during legislative debate on the RHPA. However, there were members who felt the accountability measures went too far. Consider these remarks from Jim Wilson representing the Progressive Conservative Party in November 1991:

> We believe the ministerial powers granted under the legislation have the potential to erode the principle of self-government or self-regulation by the various colleges or professions. As it now stands, the government has the power "to require a council" [this refers to a council of one of the professional colleges that are supposed to have self-regulatory power over each profession] to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the Health Professions Acts or the Drug and Pharmacies Regulation Act. These are pretty sweeping powers. The Minister can actually direct councils… to do essentially anything.

He went on to add:

> It seems to me that you either believe in self-regulation… and trust the professions to be self-regulating and to look after their affairs in the public good or you do not… It is a very strange concept… the new system will not work unless the government really does have a great deal of confidence in the principle of self-regulation. The day a minister starts fooling around with the activities of these supposedly self-regulating colleges is the day I think the system will start to fall apart, where professions will say, "You really don't trust us to look after our own affairs". Goodness help us if the colleges give up. We will be in real trouble.

Generally, therefore, Ontario legislators in 1991 trusted that self-regulating professionals could act in the public interest. However, they differed on the degree of government oversight deemed necessary.

Although many broad principles and values — such as the public interest, rights, balance, and trust — appear in legislative discussions around the RHPA, local and personal interests are evident. For example, members drew attention to the concerns of their rural constituents who were concerned that regulatory mechanisms

may restrict their access to services. They touched on the concerns of Aboriginal groups and people with disabilities. They recounted the concerns of specific professional groups like optometrists, nurses and naturopaths with respect to the legislation. They talked about their parties' platforms, and expressed their personal opinions. In discussions of midwifery regulation, for example, they discussed their own birth experiences, or those of family members, and talked about what the regulatory change meant for them. They mentioned their children. They acknowledged letters from their constituents, and interactions they had with representatives from professional groups. These comments underscore that state actors are people with personal interests, ties and experiences that, along with their political loyalties and responsibility to their constituents, shape their decision making.

To summarise, when Ontario legislators discussed the 1991 Regulated Health Professions Act, they revealed a variety of influences shaping their decision making. Although legislators were influenced by interest groups, they consulted widely, and sought legislative solutions that not only met rational-legal concerns for efficiency, cost and standardisation, but also substantive-rational principles like public protection, fairness, balance, freedom of choice, trust and civil rights. They were not simply focused on means-ends calculations, but with "what ought to be" and hence engaged in value-rational action. State actors were also influenced by their personal beliefs, experiences, and party platforms; thus, practical rationality and even irrational forces like emotions, shaped their decisions as well. Their social action was shaped by different kinds of rational and irrational influences and goals.

Conclusion

In the case study of health professions in Ontario in Canada, it is clear from the discussions in the Provincial Parliament and elsewhere that the professions involved did not entirely have their own way with government in terms of their self-interests as a group as a more challenging regulatory environment developed. Instead a more sophisticated neo-Weberian analysis of state-profession relations based on social action indicates that they were faced with a range of countervailing strands of argument which significantly moderated the outcome — commensurate with the concept of countervailing powers classically outlined by Light (1995). Having said this, members of the medical profession — and particularly elite medical specialists — continue to this day to retain a large measure of professional self-regulatory dominance in the Ontario health system over other health professional groups, as well as commanding high income, status and power. As such, this largely parallels the situation in other constituent provinces and territories in Canada (Hutchison et al., 2011).

As suggested at the outset, this has not been the pattern in all Western societies. In Britain, for example, a series of medical abuse scandals acted as a catalyst for the modernising Labour government of 1997 to 2010 to explicitly strive to enhance efficiency and quality, as well as to pursue a strong public protection agenda (Allsop and Saks, 2002). As a result, the medical profession developed through the

2008 Health and Social Care Act and subsequent parliamentary reforms a system of "regulated self-regulation" with the introduction of regular peer appraisals and re-accreditation of doctors, greater proportional lay membership of the General Medical Council and the independent adjudication of medical disciplinary cases (Chamberlain, 2015). In the British system too there has been a more significant element of restratification of medicine, in which the pendulum of power has swung away from medical specialists towards general practitioners in primary care in a manner that has not yet occurred in Canada (Calnan and Gabe, 2009) — especially with the establishment of Clinical Commissioning Groups chaired by generalists under the 2012 Health and Social Care Act introduced by the Coalition Government of 2010 to 2015. However, under the unique state shelter of the National Health Service — and notwithstanding the game-changing White Paper *Trust, Assurance and Safety: The Regulation of Professions in the Twenty First Century* (Department of Health, 2007) — medical self-interests have not been entirely neglected; whether through stealth or otherwise, medicine still to some degree dominates other health professions, with physicians along with lawyers remaining at the apex of the economic and status hierarchy of professions (Saks, 2015).

The main point of this paper, though, as particularly illustrated by the Canadian case, is to highlight the value of a more nuanced application of an innovative neo-Weberian approach to state-profession relations in analysing the politics behind professional regulatory change. Its value is also apparent in Britain where, for instance, in an increasingly suspicious society, the seminal 2008 Health and Social Care legislation can be seen to have been heavily shaped by a combination of formal and substantive rationality. In Parliament the then Secretary of State for Health, Alan Johnson, explained its aims:

> This is an important Bill introducing improved and integrated regulation of the health and social care system as well as enhancing the regulation of health professionals who work within it. It will help to assure safety and quality of care for all patients and service users. The Bill will also set new regulatory measures where they are necessary and enhanced regulation where it is appropriate. It will expunge provisions that are out of date and that no longer meet the needs of patients and service users.

According to Johnson, then, the Bill was intended to improve means-ends calculations in terms of efficiency. This approach was reinforced when he raised the issue of cost and the importance of "value for money", arguing that through the legislation the government:

> … will streamline regulatory activity and ensure that the [new Healthcare] commission manages its budget effectively, adopts a more independent and intelligent approach to regulation and provides a sharper focus on safety, quality and cleanliness.

But if Alan Johnson emphasised that formal-legal rationality lay more strongly behind the legislation than in the Canadian case, he also drew attention to more value-focused concerns from a service perspective. In debates about the legislation, moreover, other

members of Parliament discussed broader principles related to ethics like parity, equity, human rights, transparency, and trust. Indeed, when presenting the Bill in the House of Lords in March 2008 the Parliamentary Under-Secretary of State at the Department of Health, Lord Darzi of Denham, stated that "the primary concern of the Bill is to improve and enhance the quality and safety of the care that patients and users receive". At the same time, he and others in the House of Lords were concerned with ensuring that the rights of all vulnerable groups were protected, whilst achieving a balance between the freedom of the individual and health and safety. In the debates too members of the House of Lords and House of Commons both stressed the relevance of their personal experiences and those of their families and communities, over and above their party concerns and affiliations — underlining the significance of emotions, values and practical rationality in decision making.

It should not be assumed that such refined outcomes would emerge from the now, usually negative, monolithic theories that our approach is intended to supplant. The tools that we are seeking to provide based on social actors in fact distinctively enable us to consider values and ethics as drivers of the process of professionalisation, as well as group self-interests. An intrinsic part of our argument is that the interplay of the historical and contemporary socio-political factors involved in state professional regulatory decision making can vary from country to country as well as locally within nation states — this may be especially apparent in relation to value-rational action, but is by no means restricted to this. This is underlined in Canada by the fact that Ontario has not been without its medical scandals (see, for example, Donovan, 2016), but they have failed to be as politically charged as in Britain. In conclusion, therefore, it is argued that the expanded neo-Weberian approach to state-profession relationships outlined here better captures the breadth and depth of professional developments and their rationales — both in relation to less subtle current neo-Weberian approaches and parallel theoretical frameworks such as Foucauldianism and Marxism.

References

Abbott, Andrew (2005), "Linked ecologies: states and universities as environments for professions", *Sociological Theory,* 23 (3), pp. 245-74.

Abel, Richard (2003), *English Lawyers between the Market and the State. The Politics of Professionalism,* Oxford, Oxford University Press.

Adams, Tracey (2017), "Self-regulating professions: past, present, future", *Journal of Professions and Organization,* 4 (1), pp. 70-87.

Allsop, Judith, and Mike Saks, (Eds.) (2002), *Regulating the Health Professions*, London, Sage.

Brubaker, Rogers (1984), *The Limits of Rationality. An Essay on the Social and Moral Thought of Max Weber,* London, Allen & Unwin.

Burrage, Michael (2006), *Revolution and the Making of the Contemporary Legal Profession. England, France, and the United States*, Oxford, Oxford University Press.

Calnan, Michael, and Jonathan Gabe (2009), "The restratification of primary care in England? A sociological analysis", in Jonathan Gabe and Michael Calnan (Eds.), *The New Sociology of the Health Service*, Abingdon, Routledge. pp. 56-78.

Chamberlain, John Martyn (2013), *The Sociology of Medical Regulation,* New York, Springer.

Chamberlain, John Martyn (2015), *Medical Regulation, Fitness to Practise and Revalidation. A Critical Introduction*, Bristol, Policy Press.

Coffee, John (2006), *Gatekeepers. The Professions and Corporate Governance,* Oxford, Oxford University Press.

Department of Health (2007), *Trust, Assurance and Safety — The Regulation of Health Professionals in the 21st Century*, London, The Stationery Office.

Dixon-Woods, Mary, Karen Yeung, and Charles Bosk (2011), "Why is UK medicine no longer a self-regulating profession? The role of scandals involving 'bad apple' doctors", *Social Science and Medicine,* 73 (10), pp. 1452-1459.

Donovan, Kevin (2016), "Task force calls for independent body to probe alleged sex abuse by doctors", *Toronto Star,* September, 8.

Eisen, Arnold (1978), "The meanings and confusions of Weberian rationality", *British Journal of Sociology,* 29 (1), pp. 57-70.

Evetts, Julia (2002), "New directions in state and international professional occupations: discretionary decision-making and acquired regulation", *Work, Employment and Society,* 16 (2), pp. 341-353.

Evetts, Julia, and Robert Dingwall (2002), "Professional occupations in the UK and Europe: legitimation and governmentality", *International Review of Sociology,* 12 (2), pp. 159-171.

Flood, John (2011), "The re-landscaping of the legal profession: large law firms and professional re-regulation", *Current Sociology,* 59 (4), pp. 507-529.

Foucault, Michel (1991), "Governmentality", in Graham Burchell, Colin Gordon and Peter Miller (Eds.) *The Foucault Effect. Studies in Governmentality*, London, Harvester Wheatsheaf, pp. 87-104.

Geva, Dorit (2015), "Selective service, the gender-ordered family, and the rational informality of the American state", *American Journal of Sociology,* 121 (1), pp. 171-204.

Gilb, Corinne (1966), *Hidden Hierarchies. The Professions and Government,* New York, Harper & Row.

Greenwood, Ernest (1957), "The attributes of a profession", *Social Work*, 2 (3), pp. 45-55.

Haug, Marie (1980), "The sociological approach to self-regulation", in Roger Blair and Stephen Rubin (Eds.), *Regulating the Professions. A Public-Policy Symposium*, Lexington, MA, Lexington Books, pp. 61-80.

HPLR — Health Professions Legislative Review (1989), *Striking a New Balance. A Blueprint for the Regulation of Ontario's Health Professions,* Ontario, HPLR.

Hutchison, Brian, Jean-Frederic Levesque, Erin Strumpf, and Natalie Coyle (2011), "Primary health care in Canada: systems in motion", *Milbank Quarterly*, 89 (2), pp. 256-88.

Johnson, Terence (1977), "The professions in the class structure", in Richard Scase (Ed.), *Industrial Society. Class Cleavage and Control*, London, Allen & Unwin, pp. 93-110.

Johnson, Terence (1993), "Expertise and the state", in Mike Gane and Terence Johnson (Eds.) *Foucault's New Domains*, London, Routledge, pp. 141-152.

Johnson, Terence (1995), "Governmentality and the institutionalization of expertise", in Terence Johnson, Gerald Larkin and Mike Saks (Eds.), *Health Professions and the State in Europe,* London, Routledge, pp. 7-24.

Kalberg, Stephen (1980), "Max Weber's types of rationality: cornerstones for the analysis of rationalization processes in history", *American Journal of Sociology,* 85 (5), pp. 1145-1179.

Kuhlmann, Ellen, and Mike Saks (Eds.) (2008), *Rethinking Professional Governance. International Directions in Healthcare*, Bristol, Policy Press.

Larson, Magali S. (1977), *The Rise of Professionalism. A Sociological Analysis*, Berkeley, University of California Press.

Larson, Magali S. (1990), "On the matter of experts and professionals, or how it is impossible to leave nothing unsaid", in Rolf Torstendahl and Michael Burrage (Eds.), *The Formation of Professions. Knowledge, State and Strategy,* London, Sage, pp. 24-50.

Lester, Stan (2016), "The development of self-regulation in four UK professional communities", *Professions and Professionalism*, 6 (1), pp. 1-14.

Light, Donald (1995), "Countervailing powers: a framework for professions in transition", in Terence Johnson, Gerald Larkin and Mike Saks (Eds.), *Health Professions and the State in Europe,* London, Routledge, pp. 25-41.

Light, Donald (2010), "Health care professions, markets, and countervailing powers", in Chloe Bird, Peter Conrad, Allen Fremont and Stefan Timmermans (Eds.), *Handbook of Medical Sociology*, Nashville, Vanderbilt University Press, pp. 270-289 (6th edition).

Muzio, Daniel, James Falconbridge, Claudia Gabbioneta, and Royston Greenwood (2016), "Bad apples, bad barrels and bad cellars: a 'boundaries' perspective on professional misconduct", in Donald Palmer, Kristin Smith-Crowe and Royston Greenwood (Eds.), *Organizational Wrongdoing,* Cambridge, Cambridge University Press, pp. 141-175.

Navarro, Vincente (1986), *Crisis, Health and Medicine. A Social Critique*, London, Tavistock.

O'Reilly, Patricia (2000), *Health Care Practitioners. An Ontario Case Study in Policy Making,* Toronto, University of Toronto Press.

Parkin, Frank (1979), *Marxism and Class Theory. A Bourgeois Critique,* London, Tavistock.

Parry, Noel, and Jose Parry (1976), *The Rise of the Medical Profession. A Study of Collective Social Mobility,* London, Croom Helm.

Paton, Paul (2008), "Between a rock and a hard place: the future of self-regulation — Canada between the United States and the English/Australian experience", *Journal of the Professional Lawyer,* Fall 2008 special issue, pp. 87-120.

Poulantzas, Nicos (1975), *Classes in Contemporary Capitalism*, London, New Left Books.

Roszak, Theodore (1995), *The Making of a Counter Culture*, Berkeley, University of California Press.

Roth, Julius (1974), "Professionalism: the sociologists' decoy", *Work and Occupations*, 1, pp. 6-23.

Saks, Mike (2010), "Analyzing the professions: the case for a neo-Weberian approach", *Comparative Sociology*, 9 (6), pp. 887-915.

Saks, Mike (2012), "Defining a profession: the role of knowledge and expertise", *Professions and Professionalism*, 2, pp. 1-10.

Saks, Mike (2015), *The Professions, State and the Market. Medicine in Britain, the United States and Russia*, Abingdon, Routledge.

Saks, Mike (2016), "Review of theories of professions, organizations and society: neo-Weberianism, neo-institutionalism and eclecticism", *Journal of Professions and Organization*, 3 (2), pp. 170-187.

Saks, Mike, and Tracey Adams (2016), "Neo-Weberianism, professional formation, and the state: inside the Black Box", paper presented at the European Sociological Association Conference on the Sociology of Professions, University of Aveiro, September, 8-10.

Saunders, Peter (2007), *Urban Politics. A Sociological Interpretation*, Abingdon, Routledge.

Schneiberg, Marc, and Tim Bartley (2008), "Organizations, regulation and economic behavior: regulatory dynamics and forms from the nineteenth to twenty-first century", *Annual Review of Law and Social Science*, 4, pp. 31-61.

Sterling, Joyce, and Wilbert Moore (1987), "Weber's analysis of legal rationalization: a critique and constructive modification", *Sociological Forum*, 2 (1), pp. 67-89.

Weber, Max (1968), *Economy and Society*, New York, Bedminster Press (edited by Guenther Roth and Ckus Wittich).

Wilensky, Harold (1964), "The professionalization of everyone?", *American Journal of Sociology*, 70 (2), pp. 137-158.

Witz, Anne (1992), *Professions and Patriarchy*, London, Routledge.

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