Directions of health labor market (de)regulation in Portugal

Sentidos de (des)regulação do mercado de trabalho no setor da saúde em Portugal

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Abstract

The need for further research on the labor market in the health sector is acknowledged. With the expansion of the phenomena of objective and subjective precariousness, resulting from the neoliberal agenda of commodification of the value of work and the managerial reforms in health, the "atypicality" of labor ties and the "insecurity" of health professionals' lives have introduced segmentation and polarization logics into the labor market. The latter is no longer the stage for protected markets, but includes deregulated and "hybrid" markets. This article aims to explore the directions, with unequal implications, of the (de)regulation of the labor market in the health sector in Portugal. We begin from secondary and qualitative research supported by 32 semi-structured interviews with health professionals, which attest to the phenomenon of increasing individualization and labor subcontracting. A conceptual model is proposed that captures the meanings of (de)regulation, in a continuum of social regulation and professional mobility, translating *protected markets* (professional and internal) and *hybrid markets* (outsourced and secondary) to be tested by empirical confrontation and future research.

Keywords: Portugal; Health Professionals; Objective and Subjective Precarisation; Labour Markets; (De)regulation.

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Resumo

Reconhece-se a escassez de investigação sobre o mercado de trabalho do setor da saúde. Com a ampliação dos fenómenos de precarização objetiva e subjetiva, decorrente da agenda neoliberal de mercadorização do valor do trabalho e das reformas gestionárias da saúde, a "atipicidade" dos vínculos laborais e a "insegurança" de vida dos profissionais de saúde têm introduzido lógicas de segmentação e polarização do mercado de trabalho. Este deixa de ser palco apenas de mercados protegidos, passando a incluir mercados desregulados e "híbridos." Neste artigo pretende-se explorar os sentidos, com implicações desiguais, da (des)regulação do mercado de trabalho no setor da saúde em Portugal. Parte-se de fontes secundárias e de investigação qualitativa suportada em 32 entrevistas semiestruturadas feitas com profissionais de saúde, que atestam o fenômeno da crescente individualização e subcontratação laboral. Propõe-se um modelo conceitual que capte os sentidos de (des)regulação, num continuum de regulação social e mobilidade profissional, traduzindo *mercados protegidos* (profissionais e internos) e *mercados híbridos* (terciarizados e secundários) a serem testados por confronto empírico e investigação futura.

Palavras-chave: Portugal; Profissionais de Saúde, Precarização Objetiva e Subjetiva; Mercados de Trabalho; (Des)regulação.

Introduction

This study aims to explore the meanings (with unequal implications) of health labor market (de)regulation in Portugal. The labor market is traditionally structured by establishing professional jurisdictions consolidated in the credential and exclusivity of the monopoly of the "professional act."[1] This dominant professional market evinces the constitution of segmented markets by precarious contractual ties, including in countries with a strong trade union tradition. Likewise, new organizational arrangements articulated by the diffusion of digital platforms introduce "grey zones" or "hybrid" work regimes in the health sector (OPSS, 2022).

At the basis of this fragmentation of healthcare providers' employment relationships lie management reforms, the corporatization of governance models, the greater role of the private sector, and, more recently, temporary work companies. These trends have fostered new forms of labor deregulation and working condition instability, threatening the foundations of the socialization and work culture of an equitable and inclusive Portuguese National Health Service (NHS).

In turn, the very strong and recent pressure from the private sector, which, benefiting from the shortage of these professionals and the pandemic, has been able to attract the best professionals, especially those with careers built on long apprenticeships in public hospitals. The disruption of services due to insufficient professionals for teams to function, the high rate of absenteeism, and the excessive turnover due to leaves for the private sector are the root of the degradation of working conditions.

Moreover, the system suffers from the shortage of healthcare providers in hospitals and primary care health centers, in part because many emigrated in the first decade of the 21t century (Amaral; Marques, 2014),[2] due to the freezing of careers and the

1 The established literature on the sociology of professions recognize Anglo-Saxon and Francophone traditions. This study pressuposes the concept of professional monopoly as the control of access to the profession by the domain of expertise under the jurisdiction of the State and the constitution of a specific market based on Weber's social closure.

2 Due to the 2011-2015 austerity crisis and the intervention of the International Monetary Fund, the European Central Bank, and the

diffusion of management and business models in the health sector. This "flight"[3] has caused difficulties for the management of human resources dedicated to the NHS (hospitals and health centers).

Due to the pandemic crisis, the inability to anticipate training needs and digital skills to face the challenges of "digital health" (OPSS, 2022), and the rejuvenation of healthcare providers, the recent social protests aimed to improve working conditions. In addition to salary revisions and career stability, symptoms of job dissatisfaction and burnout gain visibility in the face of the intensification of the pace of work exacerbated during the pandemic.

This study accepts the multidimensionality of the precariousness process of the work that is transversal to healthcare provider groups.[4] In the current framework of neoliberal ideology, this research aims to unmask the fracturing erosions of health labor market "monopolies" guided by precariousness, deregulation, and hidden surveillance processes. In turn, the specialized literature on objective and subjective precariousness (Choonara; Murgia; Carmo, 2022) can account for the background movement of the multiple faces of the labor crisis amplified by the pandemic (Marques, 2020). To operationalize it, this study relies on secondary sources that attest to the growing phenomenon of individualization and labor subcontracting and a qualitative research.

This study is organized thus: first, it describes the urgency of reflecting on the (dis)value of work in the face of the fundamental movements of **objective** and **subjective precariousness** of neoliberal capitalism, which, like an oil slick, reaches everyone and everything. Next, it frames the transformation trends in the health sector in Portugal. The third and fourth sections mobilize empirical evidence from ongoing research, illustrating the meanings of health labor market (de)regulation. The final remarks advance a conceptual model for the health labor market hoping to leverage future research.

Objective and subjective precariousness and work hybridization

The interstices of the "digital risk society" (Lupton, 2019), the "pandemic of capital" (Antunes, 2020), and the "pandemic of precariousness" (Choonara; Murgia; Carmo, 2022) show deep changes in social actors' production and conditions reproduction. As such, it is important to account for the urgency of reflecting on work (dis)value, taking as a reference the fundamental movements of **objective** and **subjective** *precariousness* of neoliberal capitalism.

Although it is impossible to precisely and consensually define the concepts of "precarious," "precariousness," and "precarization," these have long appeared in investigations and studies on the metamorphoses of labor world, and the literature has seen a systematization based on two main approaches in recent decades (Armano; Morini; Murgia, 2022, p. 29). One of them leads us to **objective precariousness** by including irregular or part-time working hours, hourly pay, temporary or short-term contracts, and service contracts. More recently, forms of employment have emerged under new designations due to digital platforms, such as "digital nomads" or freelancers, which replicate the absence of workforce regulation traces. These forms of employment diverge from the "standard labor relation" based on permanent, full-time contracts ensuring social and labor protection, which developed under the aegis of the Fordist social commitment, particularly in advanced capitalist economies (Antunes, 2018; Kalleberg; Vallas, 2018). This line of study focuses on the transformations of objective employment conditions and their consequences regarding the proliferation of low-paid jobs with poor working conditions. Thus, "good jobs, bad jobs" (Kalleberg,

European Commission, Portugal registered a high number of departures of healthcare providers abroad (Amaral; Marques, 2014).

3 The phenomenon of health worker drain is particularly present in southern European countries (Wismar et al., 2011).

4 Such precariousness includes physicians, nurses, dentists, pharmacists, radiologists, physical therapists, among others, who exercise their professional activity in various public and private organizational contexts.

2011) expresses unequal positions and power relations between those in a regulated, primary, and protected market and those pressured into secondary, peripheral, and deregulated markets.

On the other hand, many workers "installed" in job precariousness externalize phenomena of insufficient training, exploitation, burnout, discouragement, incapacity, and (inter)personal distrust toward the future, leading us to a deeper reflection on sociocultural reconversion in contemporary times. The emphasis on **subjective precariousness** (Armano; Bove; Murgia, 2017) accounts for the extent of the professional progression of individualized, precarious, and uncertain conditions in social actors' life trajectories. The focus on social representations, cognitive and emotional resources, and the capacity for mobilization at the level of action contexts and interactions leads us to ontological and existential aspects of life and collective action. In other words, according to Bourdieu (1998), "precarity is everywhere," involving social actors' social conditions of production and reproduction. This understanding associates subjective precariousness with the weakening and corrosion of social bonds and labor protection, the vulnerability and uncertainty in the projection of future professionals, and the individual responsibility for the "luck or misfortune" of social actors as the entrepreneurs of themselves. The latter assume themselves as the author of their own destiny, internalizing the burden of responsibility for their existence and incorporating a precarious ethos often followed by uncertain and negative identities. Instigating social actors to their (self)exploitation and (in)voluntary servitude (Antunes, 2018) reiterates the idea of "sacralization" of the market and reinforces the thesis of the commodification of labor value and its encrustation in capital accumulation circuits.

In this dynamic of precariousness,[5] which increasingly affects large groups of workers, it is also important to account for the emergence of "hybrid" or "grey" work arrangements (Azaïs, 2019; Bureau et al., 2019; Murgia et al., 2020), which potentiate objective and subjective social and labor instability and deregulation.

Indeed, work mediated by digital[6] platforms has involved heterogeneous workers with very diverse content and status. It can represent "digital nomads," hired directly by companies or working on their own, such as subcontracted entrepreneurs or freelancers. It can lead to a "retaylorization" of work, workers' disqualification, and loss of autonomy, and to new forms of indirect and algorithmic control, contributing to managing and instrumentalizing workers. This intensification of hidden and constant surveillance of workers by algorithmic management techniques, in which data configure the main asset of capital accumulation, reinforces the neoclassical assumption that conceives labor only as a factor of production dissociated from the reproductive sphere (Huws, 2019). Thus, different and unequal work situations, positions, and social relations are at stake, rendering digital platforms as biased technical facilitators. They reinforce economic, political, and social inequalities based on dichotomies of gender, class, age, ethnicity, and others that emerge from the records of formal, informal, objective, and subjective work, amplified and exacerbated by the digitalization of the economy, society, and the COVID-19 pandemic.

Management derivatives as background trends in health

The health sector in Portugal has been the target of significant transformations in the political-economic agenda due to the implementation of organizational models close to private management and the diffusion of precarious forms in the hiring of human resources. Several authors have found a (re)strengthening of neoliberalism and

5 It is important to consider the phenomena of precariousness based on historicization and relativization processes, which give density and specificity to the sociological analyses of social workspaces.

6 Although digital platforms are a recent theme, they are in full development and take on different configurations, so their definition is yet to be fully stable. For a systematization of knowledge on this topic, see the recent ILO report (2021).

neoconservatism, contributing to the erosion of the values of solidarity lying at the basis of health and social protection systems. Considering southern Europe countries (Marques, 2018; Falleiros; Marques, 2017; Marques; Macedo, 2018; Marques; Rosário; Macedo, 2021), the transformations of the welfare state and its relation with the "welfare society" explain the resurgence of socio-labor conflicts among groups of healthcare providers who face segmented labor markets, logics of intensification of work rhythms, and the disqualification of working and career conditions. Moreover, these professionals have endured organizational imperatives based on assumptions of productivity, efficiency, and effectiveness. As such, three managerial derivatives fund trends in the healthcare sector can be identified.[7]

The first stems from the generalization of market principles and a managerial discourse based on a logic of results, quality, and evaluation of New Public Management (Bezes et al., 2011). Its diffusion in the health sector (Muzio; Kirkpatrick, 2012; Numerato; Salvatore; Fatorre, 2011) has largely contributed to the increase in the mobility and migration of healthcare providers in Europe and Portugal, reinforcing imbalances in their distribution across countries and regions and in function across public and private health systems (Wismar et al., 2011).

The privatization, corporatization, and outsourcing (subcontracting) of the health sector has emerged as a second major trend since the early 21st century, especially since 2011, unsurprisingly coinciding with the austerity crisis (Marques; Macedo, 2018). The reforms implemented by Portuguese constitutional governments (Falleiros; Marques, 2017) have aimed to privatize health services and develop an organizational culture based on the business model of management and control of work. Specifically, (1) a significant part of public hospitals went to public business entities;[8] (2) most health centers in primary and long-term health care networks became management models contracted by financial objective and incentives;[9] (3) the chronic underfunding of various services under the supervision of the State cut public budget transfers to the NHS; and (4) private or concession health care underwent valorization as a response to the persistent "waiting lists" for surgery and consultations and the lack of family doctors.

The proliferation of diversified types of contracts in the health sector configures its third major underlying trend. On the one hand, it relates to the movement of cuts and freezes due to the austerity crisis that hit Portugal from 2011 to 2015, and, on the other hand, to the non-planning of competitive careers vis-à-vis the private sector. The attractiveness of better working conditions and salaries has resulted in the migration of healthcare providers (in certain contexts, of entire physician teams) from the public to the private sector, contributing to disqualifying and bleeding the National Health Service. At the same time, faced with an ageing and multimorbidity Portuguese population, the NHS is forced to pay for services to the private sector to ensure the satisfaction of the most pressing needs, creating efficiency and sustainability problems. In other words, the State itself is paradoxically creating conditions for the private sector to be an alternative for healthcare providers given the persistent demotivation and degradation of the NHS response.

Thus, migratory flows from the public to the private sector have leveraged deregulation strategies that healthcare providers perceive as more advantageous, together with "hybrid" regimes (Azaïs, 2019; Murgia et al., 2020) enhanced by digital platforms and "grey" areas (Bureau et al., 2019) with subcontracting and individual contracts. It is emblematic of these new (old) forms of contractual

7 In addition to these underlying trends, it is important to consider the growing participation of women in the workforce, the institutionalization of "caring" work (e.g., Portugal approved the status of "informal caregivers" in 2021), and the importance of digital skills and "digital health" requirements, which, although felt before, grew during the pandemic (OPSS, 2022).

8 Law no. 27/2002 approximated the functioning of public health services and private law, creating the legal status of "public business entity hospital" and defining the functioning of the public sector based on market competition rules.

9 According to recent data provided by its Health Regulatory Authority, mainland Portugal has a network of health centers consisting of 603 family health units (FHU) responsible for ensuring access to primary health care.

relation deregulation, even if known, to address the lack of physicians in the NHS during the pandemic, that (outsourced) recruitment companies provide "task" physicians with hourly rates that exceed the values of hospital interns.

As mentioned, the healthcare providers' lower endogenization capacity in the internal labor market, although necessary, results in objective and subjective precariousness. The next section describes the "ballast" of corrosion of healthcare providers' working and living conditions as phenomena of work rhythm intensification, demotivation, and physical and emotional exhaustion.

Ongoing research: fieldwork contributions

Research on this topic and especially on health labor show an evident scarcity (Pavolini; Kuhlmann, 2016). The systematization of secondary sources and semi-structured interviews with healthcare providers enhance the triangulation of data and the subsequent analysis of the phenomenon of increasing individualization, labor subcontracting, and their consequences on working and living conditions.

Regarding secondary sources, in addition to the available statistical data, the 2012-2016 (revised and extended until 2020) and the current National Health Plans—the *Plano nacional de saúde 2021-2030: saúde sustentável de tod@s para tod@s*—(2021-2030 National Health Plan: sustainable health from all to all) were analyzed. Legislative documents and the latest reports of the Portuguese Observatory of Health Systems were also searched: *20 Anos de Relatórios Primavera (2001-2021) (2021)* and the *Relatório de primavera 2022: e agora?* (2022) [20 Years of Spring Reports (2001-2021) (2021) and the Spring Report 2022: What Now?].

If the changes in the health market, working conditions, and thus the quality of life of professionals are evident, having been accentuated by the pandemic, it is opportune to illustrate these changes by testimonies that were directly collected in the framework of the investigation that concluded the first stage of our research design.[10] A qualitative, exploratory methodology was preferred. It included "entry into the field" based on 32 interviews that were intentionally applied to healthcare providers. The interviews were supported by a semi-structured script developed during information analysis on the following topics: (1) training and access to profession/employment; (2) profession and changes to the framework of Portuguese politics; and (3) perspectives for the future of work. The 32 semi-structured interviews took place from December 2017 to January 2018: nine with healthcare providers in hospitals in northern Portugal (a public-private partnership management hospital and a hospital with company status) and 23 interviews with primary health care professionals in northern, central, and southern Portugal.[11]

Uncovering unequal public-private competition: trends and reports

As health is the main global challenge for the future of the European Union (followed by climate change), the current National Health Plan (2021-2030) is structured around three central pillars: (1) the social value of health as a major goal in people's lives; (2) the central role of health as a "starting" and "end point" to achieve the 2030 Sustainable Development Goals; and (3) strategic planning in population-based health as a methodological tool with its various components and stages.[12] In view of these challenges, the following strategies are

10 This is an ongoing investigation with an exploratory phase and approximation to healthcare providers in its research design. Its main results have been published (Marques; Macedo, 2018; Marques; Rosário; Macedo, 2021). It is intended, in a phase subsequent to the aftermath of the pandemic, to reinforce the number of interviews with healthcare providers and extend them to institutional managers to frame the background trends in this study.

11 This was followed by procedures regulated by ethical principles, as established in consensual norms for the defense of human dignity and integrity, i.e., after obtaining participants' authorizations, they were made aware that the obtained data could be disclosed to the academic community, respecting the confidential nature of their identities.

12 Available at: <https://pns.dgs.pt/pns-2021-2030/> Accessed on: Oct. 23, 2023.

shown, with particular emphasis on the need to ensure "proportional universalism" and the "quality of health planning, including infrastructures and human resources."

In fact, the pandemic showed with greater crudity the human resources challenge due to this chronic underfunding and competition between the public and the private (OPSS, 2022). The lack of motivation and unattractiveness for newly graduated physicians are evident, in addition to the destruction of healthcare provider teams with a long history in the public sector. With the approval of the reform of the Basic Law on Health in 2019, the commitments included in the chapter "Satisfaction of healthcare providers"—strengthening the human resources policy of the National Health Service—aim to promote: "motivation for work at NHS, the balance between family and professional life and continuous scientific-professional evolution, with a focus on improving professional careers as an essential element in the construction of a professional project."[13]

Based on recent NHS and Statistics Portugal Transparency Portal data, it is possible to attest to the following background trends included in our literature review. First, the recurrent report of the lack of professionals throughout the systematizations of the Portuguese Observatory of Health Systems (OPSS, 2021). However, from 2016 to 2022, the number of professionals in the NHS increased, from 122,722 (March 2016) to 157,257 (March 2022). The asymmetries in the distribution of these professionals throughout the national territory remained, followed by massive departures to the private sector (OPSS, 2022).

Second, despite the extraordinary increase in working hours, from 11.2 to 21.9 million from 2016 to 2021 (OPSS, 2022, p. 39), the NHS suffered an "erosion of productivity." This can be largely explained by teams focusing on treating COVID-19 patients and postponing or canceling appointments and surgeries. However, it is considered that this problem preceded the pandemic as the "disruption of teams" stemmed from to the introduction of 35 hours per week, which forced the hiring of new younger and less experienced professionals and the increase in absenteeism rates, which went from 11.2 to 12.4%, reaching 20% during the pandemic. The causes for this absenteeism are also long-standing: "If some argue the lack of attendance control or the lack of incentives [...] others point to the high level of exhaustion of professionals due to overtime and unsatisfactory working conditions" (OPSS, 2020, p. 40).

Third, the private sector competes for scarce human resources due to the limitation of the training capacity of these professionals and the lower attractiveness in the international market. The migration of professionals to the private service may explain the trend of change in the public-private pattern in the Portuguese health system. On the one hand, the number of beds, consultations, surgeries, doctors, and nurses in the public sector relative stagnated from 2012 to 2019, unlike the increase in the private sector (OPSS, 2022, p. 41-42). On the other hand, the private sector has been involved in relatively less complex interventions, such as orthopedics (52%), ophthalmology (72%), physical medicine and rehabilitation (85%), dentistry (212%), gynecology/obstetrics (63%), and otolaryngology (64%) (OPSS, 2022).

Fourth, as a result of this change in the public-private pattern, several factors sharpen competition for salary and working conditions, reinforcing the greater attractiveness of the private sector for healthcare providers. Unlike the NHS, the private sector enjoys greater ease of hiring (new or substitutions) and the ability to negotiate contracts with total freedom (remuneration and working hours), regardless of professionals' status or career. For the OPSS (2022, p. 41), despite the relative flexibility during the pandemic, the NHS:

> It is faced with severe constraints in terms of hiring (which involves a complex and time-consuming system of authorisations), remuneration,

13 Available at: <https://www.portugal.gov.pt/pt/gc23/governo/programa-do-governo> Accessed at: Oct. 23, 2023.

and working hours (fixed by scales). In particular, the tender system does not allow the hiring of doctors, nurses, and other professionals for the staff (because they would enter as personnel expenses), ensuring cohesive teams and continuity of care and combating team disruption.

Conversely, the private sector (OPSS, 2022, p. 40):

it took advantage of the public's difficulties to attract users and professionals, and, on the other hand, there has been a consolidation of the sector, with the progressive reduction of small practices, whose financial viability was called into question during the Great Recession and the strengthening of large groups capable of coping with occasional income losses and absorbing smaller clinics.

However, budget restrictions and public tender freezes have pressured the NHS to hire professionals by supplies and services external to temporary work companies, contributing to the erosion and disruption of work teams and substantially higher costs. The presence of recruitment companies has helped to inflate hourly rates. With higher hourly pay on the basis of temporary contracts or service provision, these service providers create cleavages and inequalities in public health teams. Likewise, to mitigate the rigidity of public procurement, NHS hospitals have tried to resort to generous "payment on the spot" for consultations and surgeries in additional production and overtime payment. Overtime also evinces the divide between service and hospital physicians. In fact, this pay inequality was so great during the pandemic and so widely reported in the media[14] that it instigated the Legislative to approve Decree-Law no. 50-A on July 25, 2022. Despite the regulatory effort to establish a ceiling on the hours to be paid (50 to 70 euros per hour), differences persist as hospitals can pay up to 90.56 euros per hour to physicians providing services and ensure the operation of emergency rooms.

These changes in the health sector market, working conditions, and in professionals' quality of life show a ballast that refers to groundwork situations and experiences. The following excerpts evince the dynamics of **objective precariousness**:

I think that the path of work has taken the direction of more precariousness under a cloak of flexibility, very fashionable jargon such as "productivity" and "competitiveness" have unbalanced labor relations to the detriment of the worker and often ironically with the latter's consent. (I1, physician, 40 years old)

Within the framework of Portuguese politics, despite the large investment in training, there is a clear disinvestment in the career of these professionals, which has been stagnant for more than 18 years. This disinvestment can also be seen in recruitment, despite the increasingly accentuated shortage of these professionals in the NHS. (I3, diagnostic and therapeutic technician, 50 years old)

Interviewees also show the phenomena of **subjective precariousness** regarding their perceptions of "injustice," "management that swallows the profession," and "burnout" in the face of the recurrent pressure from hierarchies to work overtime and make up for the lack of physicians and nurses.

I see my professional evolution as a continuous injustice. [...] *With all the changes and stagnation of the nursing career, I continue to earn less than any licensed civil servant who is part of the civil service today.* [...] *This has had a direct effect on interprofessional relationships, generating unnecessary conflicts.* (I22 - Model B FHU nurse, 43 years old)

The changes were many—on the one hand the introduction of Public and Private Partnerships and, on the other hand, the freezing of Civil Service careers. [...] *The focus was on management processes, production control, cost control, the creation and monitoring of multiple indicators,*

14 For example, it was widely reported that the public hospital in Caldas da Rainha paid up to 85 euros per hour to avoid service closure (Schreck, 2022).

bringing a new reality to hospitals. [...] *I often say that management has swallowed up health.* (I5, nurse manager, 42 years old)

I went through the difficulty of adapting to the various computer programs, without adequate training [...] As for the working hours, since I went from intern to specialist, my 42-hour bond is exceeded. [...] Attendance control has moved from the time book to biometric control. [...] The computer system is a major generator of burnout. Several different, not interconnected applications with different passwords and recurrent failure in them with a very negative impact on consultations. (I20, FHU physician, 45 years old)

It should also be noted that the collective stance and/or resistance in this context of **objective and subjective precariousness** expresses a movement toward protecting professional jurisdictions:

In my team, the number of elements per shift was reduced, consisting of 60 nurses, two other people and I made a complaint to the Order of Nurses arising from what would be the reduction of hours of care to be provided to patients, once users and now called "clients" of the institution. Despite the fact that the service was reduced in the number of elements, we were changed from one place of work to another. (I4, union delegate nurse, 40 years old)

More recently, nurses and hospital-interning physicians' social protest movements (for example, in gynecology and obstetrics throughout the country)[15] formally declare "exemption from liability" for the professional act as they understand the absence of adequate health care provision conditions, i.e., insufficient professionals.

Final considerations

The previous sections challenged the main dichotomies by which the labor market has been interpreted since the Fordist era, proposing spaces of visibility for emerging forms of employment and using phenomena of "hybridization" and "gray zones," enhanced by the fragmentation and deregulation of labor relations. This effort aims to rethink the interpretative categories of work and employment, namely the historical binary opposition between employment and self-employment, standard and non-standardized, formal and informal forms of work. This blurring of boundaries made it possible to grasp the multiple characteristics, directions, and meanings in the labor market that seem to resist and escape dichotomous and static representations.

It highlights the importance of considering the dimensions of autonomy, power, and prestige of professions in professional markets in their most classic conceptualizations. It is intended, however, to account for the diversity of the logics and structures of functioning of those (trans)national markets in which healthcare providers circulate, including the mobilities registered between the public and private sectors. As such, for the foundations of an *European research agenda* on health workforce (Kuhlmann et al., 2018), it seems crucial to analyze the meanings of labor market (de)regulation in the health sector in Portugal. For this end, an heuristic potential of two analytical axes is mobilized, namely: (1) the power of social regulation and establishment of jurisdictions; and (2) the mobility of professionals in an inter/intra-organizational context. This results in four "ideal types" inscribed on a continuum, which can vary between greater or lesser regulation and voluntary or involuntary mobility, to be tested by

15 A letter, signed by a hundred intern doctors (i.e., linked to hospitals), was sent to the former Minister of Health, Marta Temido, in the middle of August, requesting an "apology" in the face of the decree-law that stipulates overtime and respective remuneration. The Portuguese Medical Association said that this behavior is a "wake-up call" for changes in the NHS, having received 230 requests for exemption from liability by June 2022 (Portuguese Medical Association, 2022).

empirical confrontation and future investigations: (1) **protected markets** as "professional markets" (regulation by professional monopoly) and "internal markets" (regulation labor law); and (2) **hybrid markets**, in the modalities of "tertiary markets" (voluntary mobility as wage opportunities) and "secondary markets" (involuntary mobility by the termination/non-renewal of the relationship, work).

Intentionally inscribed in a typological essay, this model under **construction** systematizes contributions from a sociology of professions and the labor market (Pavolini; Kuhlmann, 2016). It aims to capture the heterogeneity of **labor** markets in the health sector, emerging categories, and their meanings. Nevertheless, it is recognized that the visibility of new (and old) work arrangements and organization occurs alongside opacity, instability, and social and labor deregulation in the objective and subjective dimensions. This exercise of nuanced of various segments of the workforce in the health sector may also reinforce strategies of resistance in the face of degradation of working conditions, instability of careers, and future work threats. Resisting precariousness presupposes incorporating socio-evaluative dispositions and orientations, which express margins of freedom at a given moment in personal and collective history and delimit possible fields of choice and social agency.

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Authors' contributions

The author was responsible for conceptualization, research, methodology, systematization, analysis, and writing.

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