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Multidisciplinary call for papers on:

Reforms, crises, and resistance in hospitals

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This call for papers is aimed at researchers in sociology, political science, economics, management, law, geography, demography, anthropology, and public health, as well as stakeholders in the fields of health and social medicine.

The deadline for submission is Monday 26 April 2021.

"The best way to relieve our hospitals is to avoid getting sick"[1]. These words, which Prime Minister Jean Castex pronounced a few days before the second lockdown was announced, sum up the line of thought that led the government to suddenly restrict movement and activity in the name of public health. These unprecedented measures, the social, economic and health consequences of which are as yet incalculable, were justified by the need to keep hospitals from being overwhelmed by a new influx of patients. In March 2020, and to a lesser extent in October 2020, the "*Plan blanc*" ("white plan")[2] also led to the cancellation of the vast majority of scheduled surgical operations, consultations and hospitalizations. While the intention was to free hospital beds and staff to deal with the Covid-19 epidemic, this came at a great cost for other patients, whose healthcare was postponed. The narratives in which hospital staff stand united in the fight against the epidemic and the government is willing to pull all stops to prevent them from having to "sort the sick" are fantasy. This dossier will shed light on the social, political and organizational factors that led a public service – the hospital system – to a point where it was no longer able to meet its users' needs[3].

The dossier, to be published in the fourth issue of *Revue française des affaires sociales* (RFAS) of 2021, will focus entirely on reforms affecting hospitals, and the crises and forms of resistance they have generated. This reflection on change in hospitals will allow for comprehensive cross-analysis of all efforts to handle the epidemic and of care workers' ways of adapting to them (by prioritizing activities, reorganizing services, changing task distribution, etc.). **Articles will be based on qualitative and/or quantitative empirical material from research that shed light on changes in hospital structures before or after the epidemic broke out. Contributions comparing crises, reforms and mobilization in public hospitals, with those occurring in other public services are welcome, as are historical or international comparisons.**

Reforms

Like many other state institutions, the public hospital system has been undergoing a series of reforms for several years now, with an aim to reduce costs and rationalize activity. In addition to the technical and managerial measures which culminated in the introduction of *Tarification à l'activité* (T2A, procedure-based pricing), *this first line of inquiry will specifically focus on the socially differentiated effects of these reforms, on the work of different categories of hospital staff.*

One of the numerous policies implemented has led to many organizational changes: the development of outpatient care, that is, the provision of medical or surgical care outside the traditional framework of full hospitalization. What is now known as the "outpatient turn"

[1] Jean Castex, speech at the *Hôpital Nord* in Marseille, 24 October 2020.

[2] The *Plan blanc* consists in mobilizing all hospital health professionals, including those on leave, to deal with a crisis (accident, terrorist attack, epidemic, etc.). It is generally activated at the local level.

[3] For a review of the literature on hospitals in RFAS, see François-Xavier Schweyer, "L'hôpital, une transformation sous contrainte. Hôpital et hospitaliers dans la revue", *Revue française des affaires sociales,* No. 4, 2006, pp. 203-223.

consists in reorganizing institutions and their departments in such a way as to shorten patients' stays in hospital and increase the proportion of medical care and services provided outside of hospitals. While these reforms are designed to respond to financial imperatives (reducing costs) by redirecting part of hospitals' workload towards ambulatory medicine[4] – their proponents also emphasize the advantages of increasing fluidity in the movement of patients from one professional area to another[5] and reducing exposure to the risks of nosocomial diseases. It would be interesting to explore **the effects of this shift on the working conditions of hospital staff,** which are already particularly difficult[6]. **The consequences of recent reforms on the roles and positions of managerial staff, on the emergence of new positions (bed managers and consultants[7]), and on the balance of power between hospital services** also warrant analysis. The logic of concentrating resources on activities considered to be profitable[8] may result in significant disparities in investment when it comes to tasks, training and recruitment. How does this **affect hospital hierarchies and competition between departments (and their heads) to obtain the patients best suited for short stays?** The consequences of this shift can also be measured in terms of the gendered division of labour in hospitals: secretaries, nursing auxiliaries and nurses, most of whom are women, often end up having to discreetly cover up the institution's shortcomings, thus allowing those who practise the noblest and most visible professions, and especially doctors, to still be seen as the heroes[9].

The effects of reforms aimed at cost containment can also be measured in terms of social and territorial health inequalities. **For populations living in territories that are under-equipped** with the medico-social services supposed to allow continuity of care after hospital discharge, **what are the implications of part of hospitals' workload being transferred to "outpatient" medicine?** What does **hospitalization at home mean for disaffiliated working-class patients – those who are ageing or chronically ill and isolated** due to their unstable family situation, administrative status or economic condition? Doctors' freedom in prescription and in location of practice entails significant territorial inequalities, which may be aggravated by the transfer of care from hospitals to private practices and by a shift in the funding of healthcare, from the compulsory state-sponsored health insurance scheme to the private supplementary scheme. Contributions to the dissier could seek to show the **equivalences of**

[4] On the transfer of patients to private practices, see Patrick Hassenteufel, François-Xavier Schweyer, Michel Naiditch, "Les réformes de l'organisation des soins primaires", *Revue française des affaires sociales,* No. 1, 2020.

[5] Frédéric Pierru, "Introduction. L'administration hospitalière, entre pandémie virale et épidémie de réformes", *Revue française d'administration publique,* n° 174, 2020, p. 305.

[6] Catherine Pollak, Layla Ricroch, "Arrêts maladie dans le secteur hospitalier : les conditions de travail expliquent les écarts entre professions", *Études et Résultats,* n°1038, Drees, November 2017.

[7] Nicolas Belorgey, "Trajectoires professionnelles et influence des intermédiaires en milieu hospitalier", *Revue française d'administration publique,* n°174, 2020,p. 405-423.

[8] Pierre-André Juven, "'Des trucs qui rapportent'. Enquête ethnographique autour des processus de capitalisation à l'hôpital public", *Anthropologie & Santé. Revue internationale francophone d'anthropologie de la santé*, 16, 2018.

[9] Christelle Avril, Irene Ramos Vacca, "Se salir les mains pour les autres. Métiers de femme et division morale du travail", *Travail, genre et sociétés,* n° 43, 2020, p. 85-102.

positions[10] in which the divide between rich and poor territories can be reflected and accentuated in access to care.

Crises

The fact that the *Plan blanc*, which is usually associated with emergency situations, was activated twice over just a few months in 2020, does call for close consideration of what makes the event a crisis[11]. Since the Covid-19 epidemic broke out, the term "crisis" has been used in public debate to highlight its seriousness. This draws a link with the "crisis of emergency rooms"[12] and, more generally, with the movement of hospital staff protesting against managerial reforms and the restrictions on resources being imposed on an institution that is managed on a "just-in-time"[13] basis. The government's decision to impose a general lockdown throughout the country in the name of protecting the hospital system has contributed to placing this institution at the centre of the "public health crisis". Beyond consensual discourses highlighting the extraordinary "courage" of care workers, this second line of questioning is intended to *explain how hospitals and their staff have been able to cope with this unprecedented epidemic wave without collapsing*.

The difficulties encountered in coping with the Covid-19 epidemic have also brought back into focus the weak regulatory measures imposed on private clinics compared to the ever-increasing loads and constraints placed on the public hospital system. To understand the crisis in public hospitals and its multiple facets we need to **situate it in the context of the entire healthcare system**, with close attention to the effects of the private sector's rise on the pool of doctors and nurses who are still willing to accept worse working conditions and lower pay for the sake of public service. Moreover, the private sector is far from being uniformly and inevitably attractive to hospital workers: it varies according to their class, gender, and educational background. In addition to the widening gap between the public and private sectors, there is a proliferation of parallel arrangements that are blurring the boundaries between these two worlds, for instance private hospital consultations designed to keep public hospitals attractive for specialist doctors, and increasing recourse to subcontracting. **Articles may focus on the sociology of patients who remain public service users** as opposed to those who choose the private sector more and more systematically[14], and on the rationales which lead patients to choose between public and private services, according to their social situation, the seriousness of their condition, their feeling of urgency, and the healthcare offer, between private practices and the hospital or clinical solutions available in their territory. Such competition effects lead

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[10] Pierre Bourdieu, "Effets de lieu", *La misère du monde,* Paris, Seuil, 1993, pp. 159-167.

[11] Alban Bensa, Eric Fassin, "Les sciences sociales face à l'événement", *Terrain. Anthropologie & sciences humaines, 38,* 2002, p. 5-20.

[12] By extension, the crisis in psychiatry also comes to mind – see Alexandre Fauquette, Frédéric Pierru, "Politisation, dépolitisation et repolitisation de la crise sans fin de la psychiatrie publique", *Savoir/Agir,* n°52, 2020, p. 11-20.

[13] Pierre-André Juven, Frédéric Pierru, Fanny Vincent, *La casse du siècle. À propos des réformes de l'hôpital public,* Paris, Raisons d'agir, 2019, p. 162.

[14] Sylvie Morel, "La fabrique médicale des inégalités sociales dans l'accès aux soins d'urgence", *Agone,* n°58, 2016, p. 73-88.

to forms of segregation which, in the long term, could undermine taxpayers' willingness to contribute to a system that is less and less universal.

Analysing the Covid-19 epidemic as a public health crisis requires us to **compare it with previous crises in recent history**, and especially the 2003 heat wave crisis. In both cases, the high mortality rates of older people was a stark reminder of the fact that individuals' chances of survival may depend on intensive care facilities and the availability of beds in intensive care units, while institutions throughout the country are far from being endowed with equivalent budgets[15]. The large number of patients in Ehpad (homes for the aged) who were sent to hospital departments and died there[16] calls for an examination of **the place of end-of-life care in the hospital system**. The case of Ehpad and psychiatric ward residents who, conversely, were not transferred to hospital wards in time also warrants a study of the rationale according to which patients are "sorted" before they even enter a hospital (by whom, according to what criteria and with what legitimacy?).

Resistance and acceptance among hospital staff

While healthcare workers all agree that working conditions are deteriorating, their reactions may vary considerably depending on their social characteristics, trajectory, militant socialization, and the department and institution at which they work[17]. Hirschman's triad allows us to broadly characterize the range of possible strategies[18]: here, *Exit* consists in leaving the public hospital to join the private sector, or changing one's professional approach entirely; *Voice* is reflected in the multiple mobilizations that have taken place in recent years even though they are known to be difficult to lead in this sector, due to minimum service obligations; and *Loyalty* encompasses all attitudes consisting in carrying on one's professional activities, fulfilling one's mission and task, yet still feeling free to criticize current developments.

Collective mobilization among hospital staff has been the subject of numerous studies[19], but far less attention has been paid to **the quieter resistance that takes place within hospital workspaces**. It might also be interesting to look at **the unlikely configurations that can emerge within hospital institutions** that are enmeshed in multiple contradictions. What explains the fact that many hospital staff do not voice their exasperation with the deterioration

[15] Jean Peneff, *La France malade de ses médecins,* Paris, Les Empêcheurs de penser en rond, 2005, p. 246; Audrey Mariette, Laure Pitti, "Covid-19 : comment le système de santé accroît les inégalités", *Métropolitiques,* 10 July 2020: https://metropolitiques.eu/Covid-19-en-Seine-Saint-Denis-2-2-comment-le-systeme-de-sante-accroit-les.html.

[16] During the first wave, Covid-19 patients from retirement homes who were transferred to hospitals accounted for almost half of the deaths recorded by Santé publique France.

[17] Fanny Vincent, "Penser sa santé en travaillant en 12 heures. Les soignants de l'hôpital public entre acceptation et refus", *Perspectives interdisciplinaires sur le travail et la santé,* 19-1, 2017.

[18] Albert O. Hirschman, *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States*. Harvard University Press, 1970.

[19] Danièle Kergoat, Françoise Imbert, Helène Le Doaré, Danièle Senotier, *Les infirmières et leur coordination,* Paris, Editions Lamarre, 1992, 192 p.; Ivan Sainsaulieu, "La mobilisation collective à l'hôpital : contestataire ou consensuelle", *Revue française de sociologie,* vol. 53, 2012, p. 461-492.

of working conditions in political terms? What should be made of the fact that part of the hospital-university elite has become hostile to managerial reforms after having advocated for them for a long time, as the only possible future for public service?

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Authors wishing to submit an article to the journal on this theme are requested to send it with an abstract and a presentation of each author.

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