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Multidisciplinary Call for Papers on:

Transformations of Social Bureaucracies

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The issue will be coordinated by:

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This call for papers is for researchers in economics, management, sociology, political science, philosophy, law, geography, demography, anthropology, as well as for health and medical-social actors.

Articles must be sent by Thursday, November 4, 2021

Few concepts have spanned the decades and disciplines as much as the idea of *bureaucracy* or have given shape to derivative concepts such as *bureaucratic power*, *bureaucratic effect*, or *bureaucratisation*. Following a three-session seminar devoted to this topic in early 2021 (online report here: https://www.publisocial.fr/seminaire-bureaucraties-sanitaires-et-sociales-compte-rendu-des-trois-seances/), several reasons have lead the RFAS today to propose a call for contributions for a dossier on the forms of bureaucratic organisation and their developments in the health and social sectors.

Bureaucracy in France was created in the first instance to assert republican principles of constitutional value – namely "equality of treatment" – by the rationalisation of collective activities. Yet, bureaucracy is also characterised by impersonality, hierarchy, and control, which are its most visible manifestations. Today, it also expresses itself in the development of forms of the technological organisation of tasks and functions. Across French society as a whole, forms of bureaucracy have evolved based on innovations that generate new rules and norms, shaped especially by the extension of digital communication in recent years.

Over the past 15 years, concerns about increasing the performance and efficiency of actions in the health and social sectors have led to a number of changes. These relate both to the management of existing bureaucracies (introduction of managerial methods from other sectors,

the creation of new professions, the changing of scale of actions, along with mergers and devolution, etc.). Changes also include the constellation of organisations that make access to rights effective from a republican perspective, ranging from associations to agencies, via mutuals or insurance companies (Benamouzig and Besançon, 2007). More generally in terms of the evolution of the welfare state and social policies, the mass and complexity of regulation, as well as the number of public and private actors working on these issues have clearly grown in recent decades. The digitisation of information and files, staff reductions, the "simplifications of procedures", and the outsourcing of government missions have not helped to reduce the means of intervention. This has been the subject of analysis mainly in terms of public spending volumes and the efforts made to sustain such spending, rather than in terms of the modalities and consequences of changes characterised by the move to bureaucratise France's system of social intervention.

In its second issue for 2022, the RFAS is seeking to document research and thinking in these areas, from a descriptive perspective of developments and by stimulating a critical analysis of the situations which they lead to.

Concerning factors favouring rapid sectoral change, social institutions and policies have been characterised by combinations of factors such as:
- the more active search for controlling welfare and social expenditure which now constitutes a major part of public finances;
- the wish to target the needs of users which are tending to diversify, leading to the multiplication of specific rules and the development of complex devices;
- a clear reinforcement of the control of requests to accompany users of services;
- the multiplication of the public institutions involved (local government bodies, agencies) as well as their work in combination, which has been accompanied by various coordination problems.

The consequences of the rapid "bureaucratisation" of the health, social, and medical-social sectors are also identifiable and sometimes appear very burdensome. Indeed, these sectors are subject to particular pressures. Social and health policies seem indeed to be multiplying specific rules, in response to the diversification of user needs, and combined with the sought-after control of public expenditure and the assertion of controls of requests for accompaniment. This is taking place at the expense of ordinary law and leading to increasingly complex measures. For example, the combination of specific fields (employment/social issues; social/health issues) and different levels of intervention (local, decentralised local and national government) to enable global and cross-cutting actions may also be accompanied by multiple coordination problems, such as the encounter of divergent professional cultures (Dresson, 2014).

Similarly, it seems necessary to examine the factors that favour these consequences:
- the reception of norms and rules by specific sections of the public, in connection with the deeper social trends (the individualisation of society, increases in social inequalities, increases in precariousness, etc.);
- the interface modalities of the institutions available to service users;

- the transfer of management and evaluation methods from other sectors, including the market economy, to objectives that are often qualitative and long-term, without taking into account the specificity of these objectives.

This call for papers addresses three areas of analysis concerning bureaucracy in the social, medical-social and health field and its evolution. They relate to: i) the interventions and positionings of different categories of stakeholders in social policies; ii) the forms of structuring and management of actors in the sector; and finally iii) an analysis of users and their involvement.

For each of these areas, it is desirable that the contributions submitted fit into a range of functions and actors as broadly as possible, including the functions of health, social protection, social action, and the relevant institutions. In these different areas, public or semi-public administrations usually spring to mind first, but they are far from being the only ones concerned. The field includes all actions implemented directly or by delegation within a national or local public framework or by private sector bodies, namely: social security funds, agencies, welfare institutions, mutual societies, associations, authorised non-profits or commercial organisations and establishments (private health clinics), or holders of public contracts that provide them with social objectives. It would be interesting to compare observations of actors with different statutes and, if appropriate, to highlight the movement of certain characteristics of bureaucracies between them. While critical thinking is not excluded, authors are expected above all to put forward analytical articles, based on empirical research.

Due to the complexity of dealing with the concept of bureaucracy outside an understanding of historical, social and political contexts, this call is not expecting articles to adopt international or comparative perspectives. These could the subject of another publication later.

1/ Health and Social Policy Actors: from their Design to their Implementation

Since Weber, conventional analyses of bureaucracy schematically assume that: policy decisions are defined by personnel from democratically-elected or designated institutions (the "politicians"); implementation arrangements are made by "administrators" under the authority of politicians; that employees consistently apply the rules defined by the above to individuals; and that certain technical functions may interfere with this vertical structure of power and so influence decision-making channels as they have subsequently been observed (Crozier, 1963).

The categories of actors involved today in the design, construction and implementation of health, social and medical-social policies and measures are obviously far more numerous and diversified. Some recent analyses tend to show that the simple scheme broadly corresponding to that described by Weber is more complex today in several respects (Bergeron and Castel, 2021).

The 2019-2020 IGAS special subject report examined the issue of access to employment for disabled persons, and highlighted the multiplicity of the measures, rules and actors involved, since the establishment of general guidelines and their application. This involves "politicians," "experts," "administrators and technicians" and heads of field agencies with missions of varying geometry (IGAS, 2020). Housing also reveals the entanglement of numerous regulations, budgetary standards and intervention principles, all of which cause multiple tensions with the desire to innovate, in order to meet expectations about access to self-contained housing (Mallet, 2021).

These findings have led us to question the evolution of the level and forms of bureaucratisation in the health, social and medical-social field and their justification. How have these evolved? In line with these questions, attention may be paid to the forms of social transactions which exist between all the institutions acting to make public policy. How do frequent collaborations, consultations, etc. influence the production of standards? How do negotiations and compromises take place? What are the effects on professions within bureaucracies?

Another observation concerns the rejection by some of the bureaucracy-producing agents of bureaucracy itself. "Bureaucracy" is then sometimes accused of being responsible for all kinds of dysfunctions. Thus:

- The permeability between the "political" and "technocratic" spheres helps to blur the lines between the responsibilities of each: "bureaucracy" and sometimes "administration" are used as scapegoats and are vilified by voters and users.

- Political leaders resort to experts and specialist commissions to "assist in decision-making"; in times of crisis, as the Covid-19 pandemic has shown, the functions that politicians perform may take a particular turn so that the division of responsibilities among these actors also merits examination.

- Professional technical bodies as well as associative representatives sometimes interfere strongly in decision-making processes by, for example, publicly challenging the choices of politicians or administrators. They often have better public standing than do technocrats, and they affect significantly how compromises are built, for example, that affect the conditions for public access to health and social services, while influencing representations of public action.

- Many projects are now contractualised through public procurement contracts by local government or public institutions. These contracts set out expectations *a priori* and in strict terms. The extension of this process certainly has consequences both on the way in which technical and management skills are developed within the contract-granting agencies, and on the conditions under which these "contracts" are implemented, taking into account the criteria for evaluating social interventions.

- The willingness to involve users, in the name of *empowerment*, in so-called participatory decision-making processes is also finally increasing. Representatives of front-line staff and/or users are involved, without a clear understanding of the actual effects of this participation on the ways in which benefits and services are distributed.

Finally, techniques or instruments aimed at forecasting (modelling, micro-simulations, etc.), and used to evaluate ex ante and ex post the impact of alternative decisions on different categories of the public, and on financing measures, actually modify the production of standards. These sophisticated techniques allow social policies to be increasingly targeted for "priority" beneficiaries, even if the inevitable consequences are not always measured in terms of the generation of relevant documents relating to potential beneficiaries on the one hand, or in understanding the usefulness of these requests by front-line employees and social workers on the other hand.

These phenomena raise questions about the evolution of modern bureaucracies. What analyses can be made about the practical consequences of such phenomena, which lead social policies to depart from the traditional operating patterns of "classical bureaucracy", by including a diversity of actors in decision-making and changing the production of norms? Using real and concrete examples, the aim here is to identify such consequences, be they direct or indirect, for the construction and implementation of measures and policies. Contributions may, for example, examine impacts on: the complexity of regulations and social arrangements; the quality of services offered and possibly on the overall cost and effectiveness of interventions; or on the effective access to services and welfare benefits of potential beneficiaries. In particular, proposals for articles are expected to provide precise observations and analysis through case studies about the implementation and operation of some national or local arrangements, questioning the role that the phenomena mentioned above (albeit non-exhaustively) may play.

2/ Management and forms of organisation: new forms of bureaucratic expression in the health, social and medical-social sectors, given the acceleration, individualisation and digitisation of society

The idea here is to question the impact of new forms of organisation and management of administration on "government by rule". Traditional bureaucracy combines a model of organisation and authority aimed at overcoming arbitrary practices, vertical modes of coordination, and a system of drafting texts that shape and frame public action. These three dimensions have undergone profound changes over the past 20 years in connection with several social developments.

The diversification of employment relations, as with family situations, has contributed to the complexity of social policies and the texts which support them. In order to meet needs and perform functions that are heterogeneous, measures and policies have proliferated. Application texts do not always provide real room for manoeuvre for those who are responsible for implementing them. Moreover, the promotion of personalised, all-encompassing and multidimensional approaches for populations challenges the ability of social administrations operating in silos, to deploy cross-cutting actions, beyond experiments that are often limited.

Since the beginning of 1980s, several types of reforms have taken place in France to bring public actors into closer touch with the beneficiaries of social interventions and to involve local actors (elected officials, professionals, volunteers), including: laws devolving powers; the

decentralisation of central government offices; the setting up of specialised sectoral technical agencies and local government administration agencies; and even the delegation of public service missions to reputable non-profits working closely with the target populations, etc. To take into account the growing diversity of needs, the aim has been to bring public policy responses closer to the very places where they express themselves. These transformations have led to the emergence of new organisations whose precise characteristics should be analysed, particularly in view of coordination. Many reports, especially by France's parliament, have criticised the French administration's "layer cake", generated by the weight and inertia of these organisations. Yet rather than indicating a decline of the generic bureaucracy model, it may be asked whether these difficulties do not actually illustrate the diversification of bureaucracies' concrete models? To address the coordination problems experienced on the ground in dealing with the current Covid-19 crisis, France's public authorities have gone on an "organisational binge" marked by a twofold movement to marginalise existing organisations and to create quasi-organisations or meta-organisations. Is this a specific and isolated case, or common behaviour in the face of similar problems?

The development of digital tools on the ground, such as the dematerialisation of administrative approaches are also leading to the emergence of new conceptions of care and access to benefits ("go to" services). What consequences do these transformations have on the functioning of the corresponding organisations and on the health, social and medical-social professions? How can digital standards be understood from a bureaucratic/bureaucracies perspective? Is there not a paradox in promoting the personalisation of interventions while multiplying more impersonal forms of services? Or even indeed a contradiction in the fact of wanting to think about the personalisation of public policy?

Contractualisation has taken a considerable place in the allocation of resources, in terms of the transformations in the governance of public activities, concerning: agreements on objectives and management to provide resources to public institutions or social security organisations; and calls for projects to fund new forms of service delegation, etc. In this context, what happens to associations to which public services are delegated, both in terms of their governance and their action-response capabilities? What is the effectiveness of these indicators and their ability to account for the diversity of bureaucratic actors? Following work by Pierre Yves Baudot (2015) on processing times, it may be asked how these indicators are constructed and what they tell us. Finally, to what extent do the dashboards developed for reporting results track the complexity of the tasks to be performed? Do the quantitative indicators used not favour measures of organisational performance based on efficiency and effectiveness? In the absence of easy quantitative assessments, questions of relevance, of individual well-being or social utility remain obscured, despite their essential nature, including in terms of the meaning of public action.

Similarly, it would be useful to question the tools used for personnel management and their suitability for "implementation of rules" functions. They serve a dual function for supporting activity organisation and as an operational support for the work. Are they suitable to allow agents to appropriate rules? How do new forms of organisation deal with the

persistent/inevitable mismatches between rules issued by prescribing bodies and the necessary appropriation of rules?

More generally, the way bureaucracies are managed has direct consequences for their agents: on their recruitment, their duties, the very nature of their work, and on their behaviours. What are these consequences and how do agents perceive them? Several factors probably merit attention, being of particular importance, given the purposes of agents' work in the field:

- **The massive arrival of digital processing and the digitised transmission of files** have led to both a very large reduction and to a grouping of certain personnel (with the disappearance of local offices, etc.). The resulting upheaval of some of the most burdensome bureaucracies (like the social security funds) has been gradual but of great magnitude. The distribution of agents by profession (administrative, technical, etc.) has also undergone significant changes. In any case, the consequences have been very significant for public sector employees (Roux-Morin, 2004).

- At the same time**, these developments have also changed the nature of agents' relations with users**. For example, the best-informed users process their files directly via the Internet, while the interventions of employees or social workers focus on complex cases and/or persons with great difficulties. The computerisation of measures has shifted the boundaries between the tasks carried out by several types of professionals (doctors/paramedics). Many administrative agents are now confronted with more fragmented, more impersonal work (less contact with users and knowledge about their overall situations), and even significant limits in their room for manoeuvre and so eventually their control over cases. Agents may feel therefore that the meaning of their work has changed (Avenel, 2002).

In order to adapt the functioning of different organisations to such developments, **new "transversal" local organisations are progressively being sought (**mechanical and material engineering procedures (PIMMs), *France services*, multi-purpose public employees, etc.). At the national level, efforts to promote "transversality" or cross-cutting actions have emerged to facilitate simplification. But they have never fully succeeded (digital safes, sites dedicated to initial examination of all persons' rights and situations, etc.). Analyses of these experiences that seek to prevent the negative consequences of bureaucratic complexity, while identifying their successes and failures are welcome.

The encroachment of working practices and time through the implementation of incentive tools, results reporting, indicators and evaluations also merit careful observation, as do some of the tools used. Thus, professionals in particular often see pricing and its uses as means for restricting their management autonomy and access to finance. A complex redistribution may be at play here (in health, social and medical-social services) between the management of social bureaucracies by hierarchical authority/professional autonomy, on the one hand, and the powers of different categories of agents (administrative/technical and professional), on the other hand. Lastly, redistribution is also occurring across territorial levels (national/local/regional).

The widespread allocation of missions to non-profits or private organisations by calls for tender has been reported. The consequences for staff of such tenders are worth examining. In particular this relates to the hiring of experienced personnel, the precariousness of jobs, the skills concerning the local situations of professionals hired for each contract, etc. The examination of a sufficient number of concrete cases should provide information and analyses on these issues that are currently unavailable.

3/ Users of benefits, as well as medical-social and health services facing changes in the management of public policies

This third area of study is oriented toward the effects – objective and subjective – of the ways in which policies are managed on the users of health and social services. Are their needs and capabilities taken into account better or less well? Who are the "losers" and "winners"? Are they experiencing new obstacles in the processing of their files and records? How can the expression of their satisfaction or dissatisfaction be analysed? The answers to these questions are essential factors in the analysis of health and social bureaucracies today and, perhaps, beyond that, for reflections in political sociology on the relationships between some users and institutions.

We cannot treat all users in a unified way here. Whatever questions are addressed, distinctions need to be looked at. These are not always traditional or obvious, but may arise between different types of public users and their reactions to reorganised and digitised bureaucracies. Are conventional dichotomies like rural/urban, youth/seniors, rich/poor, men/women, educated/poorly trained, etc. still relevant?

If we refer to the fundamentals of bureaucracies, then the objectives of the universality and neutrality of measures used to be decisive. What about today? There are several ways to answer this question:

The preservation today of the universalist objectives characteristic of bureaucratic systems could be examined, by relying on analyses conducted at a very general level, or instead by focusing on concrete cases. No doubt general rules, laws and regulations concerning benefits or services placed under public authorities are always strictly applied. But, "universal" benefits are limited and targeted, whereas measures that may challenge universalism are increasingly important, possibly introducing some personalisation or even flexibility in the treatment of users. This is the case of complementary actions by bodies other than the basic universal institutions (e.g., mutual insurance or provident institutions, non-profits, etc.). Moreover, more and more welfare benefits are targeted at specific or poor persons, and are accompanied by aid conditionality. This restricts access to them and sometimes permits an uneven interpretation of the rules. Some changes, such as the place taken by outpatient care or home care, place new burdens on budgets and family resources. Inequalities in treatment have emerged as a result.

Since the early 2000s, users' participation in the governance of policies and in the life of establishments in these sectors has been the subject of new attention. This follows the introduction of provisions that structure such participation, in particular with the Laws of 2002 (renewing social and medical-social action and creating a "health democracy"), and of the Laws

of 2005 (favouring the participation and citizenship of people with disabilities) [Avenel, 2017; Maudet, 2002]. So, have users been protected from overly technical and impersonal local or national rules, constructed by administrative bureaucracies and professionals alone? The debate continues between persons who view these reforms as an important turning point in escaping management that is not responsive to users' needs and wishes, and those who view them as a practical addition of an unhelpful and burdensome bureaucratic layer, imposing new skills on users which generate new inequalities, such as a capacity of self-narrative,. This difference of views remains largely to be elucidated using concrete examples, including recent examples of participatory democracy in some territories. Attention will also be given to the reactions of so-called "street level bureaucrats" who are in direct contact with these populations, and to these employees' degrees of autonomy in interpreting the directives of their hierarchies.

"All-out digitisation" is the paragon of the ambivalence felt by the users of public services. Sometimes seen as a step forward in the ease of access and in the speed of procedures, it is also a source of irritation and dissatisfaction following slow responses, inadequacies of vocabulary or navigation uses and in the inability of digitisation to adapt to complicated cases. Lastly, digitisation may trigger the anger of populations suffering from illiteracy, or who are not trained in digital tools, or who reside in poorly-connected areas, etc. Institutions in the social-sector, above all, have to deal with persons who are embarrassed by their remoteness, with the complexity of some "cases", and with excessive delays in situations demanding great urgency for very poor people, etc. Some organisations have indeed adapted their actions accordingly, yet do not seem to have given much publicity to their observations. General assessments would address such developments and their consequences for the "socially-vulnerable" categories of the public.

Finally, and more broadly, it may be asked whether the growing impersonal nature of bureaucratic models, in areas where users expect institutional protection, does not play a significant role in the loss of trust in the offices and services of the Republic. The fact is that, overall, members of the public identify and individualise poorly the role of each of the "behemoths" operating in the social or health sectors. Many users' perceptions of these public services see them less and less as "great social conquests by the workers", and more often as cumbersome public institutions that are not attentive to individual cases. The overlapping and multiplication of bodies, actors and institutions make access to care or access to social rights confusing. Examples analysed may be taken from private health clinics and hospitals, or the reimbursement of care related to health "sectors" (i.e., private and public providers). The provision of care is complex, so it may be asked how users orient themselves in the health care system. At the same time, the aim of this publication is to look at the loss of confidence by members of the public in France's Republican institutions. Contributions by political scientists would be welcome to expand analysis of this important dimension.

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Authors wishing to submit an article to this issue of the journal should send it with a summary and a presentation of each author to:

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before Thursday, 4 November 2021.

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