The effects of public hospital restructuring in France

The Secafi occupational health consultancy has reported on the shake-up in French public hospitals for a European study on the health impacts of restructuring on public service workers. The facts are clear: hospital restructurings are seriously harming patient care workers' health.

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The restructuring programme for French public hospitals is bringing in new private sector-inspired organization and management methods. It's a culture shock that staff are taking very hard.
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A hospital line manager faced with making major redeployments breaks down in tears, "It's so tough, huge and beyond reason that I'll never manage it!" A nurse at the same hospital is distraught, "I just can't go on! We're told to do more with less… We have to rush things, and it's not good for patients. My professional ethics and sense of public service count for nothing". There are countless such stories, and they say more than any demonstration about the ill-being created by public hospital restructuring in health care professionals on every rung of the ladder – one by having to push through reforms she doesn't believe in, the other by changes in how she does her job and its meaning.

Secafi, a consultancy specializing in working conditions, has over the past two years done 40 analytical studies commissioned by staff representatives on the health, safety and working conditions committees (HSWC) of French public hospitals in the throes of restructuring. A summary of their assessments was produced for the European "Hires Plus" project which is looking at the health impacts of reorganisations on public service workers.

In all these assignments, we had to deal with a wide range of situations related to the hospital's size (from 200 to several thousand people), nature (teaching hospitals, regional and local hospitals, public care/nursing homes, psychiatric hospitals), and location (all regions, urban and rural areas). That diversity was also reflected in the reorganization plans, which can range from physical relocation through organizational changes to the introduction of new technology or support services. But behind these different circumstances, we saw in every hospital the same effects of politically-imposed budget restraint like job cuts, shake-ups in working hours and more broadly, working conditions.

There is no doubt that plans to get public hospitals' budgets to balance raise similar restructuring and reorganization issues as for private business. The concepts involved are telling: resource syndication, flexibility, concentration, outsourcing, restructuring and, through "lean" processes, flow control, added value in processes, cutting not only waste but any act deemed "non productive", standardization, etc.

The consequences for working conditions therefore must be analysed in the same terms as in other sectors of activity, with two added variables: the "emotional baggage"[1] that any patient-facing employee carries, and the civic-minded belief that health delivery is a "public service".

Little staff consultation

Public hospital employees in France have civil servant status and so are subject to the principle of authority, meaning that they must abide by and apply the decisions of their superior. The key decisions are taken by the national policy authority. This leaves little scope for bargaining, and commensurately little leeway for hospitals that must implement these decisions to modify the plans by factoring in the outcomes of social dialogue.

There are no regular bargaining procedures for informing and consulting employee representatives. Overall projects are broken down into sub-projects. Where such procedures are actually carried out, they address individual sub-projects and rarely give an overall picture of the reorganizations under way.

Projects are progressed at a rate that prevents either staff reps or the implementing management officials from taking ownership of them and leaves them no real options. Staff representatives' views, therefore, count for little and their opinion is only seldom taken into account. Social dialogue which is already ordinarily limited is then further reduced. The positive aspects of the consultation procedure are not leveraged. Participative management with working groups can also only do so much.

The staff feel that these working groups are used by management more to pass on decisions than to find ways with workers and their representatives for enhancing the quality of work. Far from strengthening their confidence in the hospital, they often find that this participation backfires on them through standardized and impersonal solutions. The dominant feeling is then one of having been manipulated.

These findings hold good for almost all the situations studied. However, in some hospitals, a strong union coupled with the expert's support have enabled good progress to be made on limiting job insecurity, mitigating the worst organizational aspects of reorganisation, and a collaborative development of preventive and follow-up provision.

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1. On value conflicts, see also: DARES/DRESS (2009) *Rapport du Collège d'expertise : mesurer les facteurs psychosociaux de risques au travail pour les maîtriser.*

The context of hospital reorganisations in France

The status of employees: public hospital staff are civil servants. In France, the civil service is governed by a set of laws and regulations that determine the nature of the employment relationship between any individual and the public sector employer, be it central government, sub-national authorities or public hospitals. There are two main types of contract:
- tenured civil servants, selected by competition, who have a guaranteed job and career progression;
- non-tenured contract employees having none of the above guarantees.

The political context of reorganisations: a reorganization of the French public health system has been under way since 1991 to reform all policies: funding, governance, health care provision, etc. The main changes include:
- MPs set hospitals' expenditure estimates annually;
- since 2005, hospitals have had to apply private sector management standards and the fee-for-services system;
- governance is entirely within the hospital chief executive's discretion;
- plans to balance budgets include job cuts. The National Statistics Institute (INSEE) reports 10,000 jobs shed between 2007 and 2009.

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New organizational arrangements and working conditions

The new organizational arrangements make big changes to the working conditions of all staff. Hospitals are being invaded by management-speak, with terms like "resource optimization", "rationalization", "added value in processes", "process safety" intruding into clinical discussions. "Management by cost control", i.e., cutting waste, is becoming the mantra. This new "management dynamic" produces standardization of practices involving the introduction of procedures and cutting out or reducing any action judged unnecessary.

Medical procedures that are often essential are designed for working in completely stable conditions with fixed numbers of trained staff. A reorganization unsettles environments and staff, so they do not always meet the procedures' requirements. This creates differences between "prescribed work" and "actual work" that are borne by staff at the cost of a state of permanent stress. "The rules say I have to wash an infirm patient in five minutes and I also have to fill in quality procedures on the computer involving care items that I haven't got time to do now", says a nursing aide. The bureaucratic definition of "unnecessary actions" also calls into question team handover times and time spent with patients and their families. This goes to the fundamentals of professionalism and meaningful work, and to patient care workers' perceptions of their social value.

Budget squeezes result in changes to the quality of care and support provided to patients that upset nursing staff. The issue here is one of two different definitions of quality. For health workers, quality is defined by service to the patient based on giving appropriate care and personal attention. It is about all patient care workers providing coordinated care of the whole person to the patient. Managers, by contrast, see quality as a process made up of an aggregate of abstract, measurable processes. Managers' aim for it is to guard against the risk of the hospital being sued by enabling them to deal with incidents by proving that proper procedures were followed. It is the whole system of assessment and the criteria is based on that are at issue. More than resistance to change, it must be seen as a lack of a meeting of minds over a concept seen as fundamental in professions that are based on providing care and assistance to patients. A debate focused purely on quality is a key feature of the reorganization projects examined.

Another aspect related to organizational arrangements also impacts working conditions: increased form-filling and reporting requirements (accountability reports). Where there is a wave of reorganizations and legal, financial and safety constraints, red tape increases and eats into health workers' activities. They then find their jobs changing into tasks that they do not consider part of what their work is all about: "The reporting system leaves me a lot less time to spend with my patients. I have to make choices without even physically seeing them... That is particularly stressful", testifies one nurse. The various administrative reorganizations with a syndication of resources leaves administrative staff and their supervisors feeling that they are on a hamster wheel between increasingly exacting procedural requirements and reduced abilities to respond to increasingly numerous demands.

A hospital culture undermined

Any reorganization, even a partial one, has implications for all activities. For example, reorganization of operating theatres has implications for the nursing, sterilization, portering, cleaning and other departments. Here, the division of projects into sub-projects as part of a customer-supplier relationship approach may disregard the impact on indirectly affected departments. And these consequences – new tasks, work schedule changes, work peaks throughout the day, etc. – are often under-estimated.

Also, many reorganizations result in services being outsourced. This usually affects support services (cleaning, catering, laundry, etc.), but also things like sterilization units and path labs. This undermines a hospital culture that traditionally provides a full continuum of patient care with staff who have developed work units around that common care provision. Making big changes to that care provision creates a culture shock which is particularly strong in that the staff see this "industrialized" approach as taking away the personal relationship around the patient. Over and above its impact on staff and statuses, outsourcing also raises the issue of redistributing tasks on workers in other departments, with a direct impact on workloads and an undermining of workforces.

Every reorganization, however small or large, brings a change in the management of working time. In a system working to the combined constraints of staff levels pared to the bone and daily patient-facing time requirements, work schedule management is first in line for organizational adjustment. Longer daily working hours – often found, acknowledged and seen to be potentially increasing

The seven things that turn nursing into drudgery

1. Loss of time for talking to patients: quality of care suffers.
2. Being regarded as an operative.
3. Work-life imbalance.
4. The emotional drain of health care work.
5. Too few staff to provide quality care.
6. Arrangements not designed to cope with patients' dependency.
7. Lack of recognition.

Taken from the book by Madeleine Estryn-Behar, *Santé et satisfaction des soignants au travail* (2008, Presses de l'école des hautes études en santé publique) building on the European *Nurses' Early Exit Study.*

fatigue and risk – are also seen as a general worsening of working conditions. Reorganisations increasingly result in working hours that are illegal under French and European law. Thirteen hour days are commonplace, and rest periods increasingly flouted.

Bizarrely, this clashes with growing staff demands for working days to be lengthened. This stems from the squeeze put on family time, especially by time spent commuting, but also reflects a desire to spend as few days as possible at work, which speaks volumes about the general feelings of dissatisfaction with work.

Reorganisations also threaten job numbers. In France, national health employees are protected from redundancy by their civil service status, so downsizing takes place through attrition and the use of contingent employment. Objectives based on accounting criteria leave no room for a reality-check against actual work and the conditions of doing it. The affected employees find that only measurable tasks are taken into account. Face times (both with patients and other members of a work team) are reduced if not disregarded. Multitasking, held up as a surefire solution, creates feelings that special skills are going unacknowledged and fears of job downgrading.

Reorganizations, physical strain and ill-being at work

Musculoskeletal disorders and partial or total work incapacities from the manual handling of heavy loads are not a new by-product of reorganizations. These health problems were already well-known to staff working in geriatric wards, surgical units, cleaning and portering services. But while reorganizations are not solely to blame for these ills, they clearly help to make them worse. The evidence of declining occupational health among national health employees in recent years can be correlated to the faster pace of reorganisation, the most direct consequence of which is to add to the hardships of work. Taken by the main factors of poor physical working conditions for nurses identified by occupational health doctor Madeleine Estryn-Behar (see Box p. 26), reorganizations do add to the hardships of work. A first indicator of these worse working conditions is being seen today: the recruitment of foreign doctors, evidencing the difficulty of retaining nurses and a sharp decline in the appeal of public hospital work to the medical profession. High absenteeism rates (over 10%) are another significant indicator. These are becoming critical issues and the failure (or sometimes refusal) to address poor physical working conditions in reorganizations is seriously undermining both the quality of care and employees' health.

There is a clear direct link between the sharp rise in psychosocial risks and the context created by the reorganisation period. Increased stresses and strains combine with an undermining of the resources that keep employees going: the meaningfulness of work, recognition, a supportive work community[2]. The loss of meaning in work and quality of service goes against the basic ethical principles of national health service workers and the specific bond with patients. Treating care as a saleable commodity is a key determinant of ill-being at work.

Stress is closely linked to discontinuity of work paces and the weakening of collective support from the undermining of team work. People have to deal with their fatigue, fear of making mistakes, disappointment at not doing quality work and loss of self-esteem alone.

Eroding chains of command, stressful new forms of work organization and non-recognition increase tension that eats away at mental wellbeing and adversely affects physical health. Disrupted sleep, anxiety, feelings of failure and depression are early warning signs that public health services must take on board.

As we have seen, successive, near-continuous reorganizations in public hospitals run real risks of worsening employees' working conditions. Ill-being is reflected in feelings of indifference about a job for which they have a strong vocation, high absenteeism, a narrowly-focused individualisation of what is essentially a collective profession, and a fear of not doing a proper job. The progress that could be made in the institutions examined arguably requires a deep-reaching change in employer-employee relations and for the actual work done to be factored into reorganization decisions.

The institutions where the risks of deteriorating working conditions are discussed are those in which trade unions stick to their guns in a challenging environment to ensure recognition for the quality and meaningfulness of work, trying to get work schedules that take into account biological rhythms and the tempo of life, working out times and places that will strengthen workforces, and integrating occupational health issues into a preventive and curative approach. ●

2. Montreuil, E. (2011) *Prévenir les risques psychosociaux. Des outils pour agir sur la pénibilité et préserver la santé au travail*, Dunod.

A typology of restructuring

The reorganizations dealt with can be classified into three types:

1. Reorganizations from a complete overhaul of the facility development plan **akin to a restructuring in any sector of the economy. These can affect all facilities of any size. They involve a reassignment of care and support activities, with or without consolidation, usually accompanied by downsizing. Syndication of resources and multitasking always feature prominently and spatial redevelopment (renovations or new builds) are generally projected. Such reorganisations may involve an overhaul of legal structures through mergers of originally public and private facilities with changes in the employment statuses of staff.**

2. Reorganizations accompanying the opening of a new building: **while such changes involving buildings often result from Type 1 reorganizations, they are the starting point around which the hospital stakeholders come together institutionally in project management. The new building therefore symbolises a new era that putatively heralds more organizational efficiency than in the sometimes run-down old premises. But beyond the more attractive physical conditions also loom the consequences of architectural choices that may not be fully in grip and reorganizations run to economic imperatives in which working conditions are a product rather than a driver of efficiency-seeking.**

3. Reorganization of departments: **initially focussed on only part of the hospital, but always as part of a broader move to reorganize other departments also. For example, reorganization of operating theatres cannot be looked at without bringing in the care, sterilization, portering and cleaning departments involved before, after or during the surgery itself.**